CARILION
Franklin Memorial
Hospital

August 3, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: Comments on Schedule H

It is my understanding that the Internal Revenue Services (IRS) is accepting comments on changes to the Schedule H (Hospitals), Form 990. On behalf of Carilion Franklin Memorial Hospital (CFMH), an acute care, 37 bed hospital in Franklin County, Virginia, I offer the following comments and observations.

Our facility is a not-for-profit community hospital committed to providing quality, cost-effective care to all patients, regardless of financial status. We serve a high population of Medicare and Medicaid patients, totaling 60 percent of all patients during fiscal year 2006. In addition, as a part of our commitment to serve all members of the community regardless of ability to pay, over $4.5 million worth of charity or free care was provided in 2006 at CFMH. The hospital also wrote off almost $3.2 million in bad debt that year, mostly incurred by patients unable to pay for their care, but who declined to take advantage of the charity care program.

We also benefit the community through grants to support improvements in health care, such as our support of a local substance abuse program, free clinic, and child advocacy center. Our staff participates in health screenings and educational events, as well as county-wide emergency preparedness activities and training. Our staff is also heavily involved in other activities benefiting our local community and service agencies, such as the United Way campaign, the Relay for Life in support of the American Cancer Society, the American Heart Association's HeartWalk, and many other events. We are also strong supporters of our local business organizations, such as the Chamber of Commerce and Retail Merchants Association.

These and other community benefits are already provided in other parts of Form 990. For example, detailed information on charity care is provided in Part I of Schedule H. Information related to a hospital's revenues and Medicare and Medicaid payments will be included in Form 990.

180 Floyd Avenue Rocky Mount, VA 24151-1389 Phone 540-483-5277

I am concerned that the new Hospital Schedule H does not allow complete reporting of the benefit a hospital such as ours provides to the community we serve. By redefining the community benefit, Schedule H permits others to determine which programs and services are most appropriate for our communities.

It is important to us and to our community that the full cost of serving our community – including the costs of caring for Medicare patients, and the cost of serving patients who need help paying their bill but fail to ask for it – be recognized and counted as community benefit.

Additionally, based on our initial review, the burden of reconfiguring financial and data record-keeping systems in time to begin capturing the substantial amount of data required just for the Part I Community Benefit Report by January 1, 2008 would be a daunting task. It is made virtually impossible by the fact that the instructions, definitions and worksheets needed to collect that data are not expected to be finalized until mid-2008. To require hospitals to overhaul financial and data recordkeeping systems before the definitions, line item instructions and worksheets for making the calculations required for Schedule H are completed is unreasonably costly and disruptive. Implementation should be delayed until 2010, to accommodate the delay the IRS anticipates in issuing instructions, as well as the need to adjust or create systems to capture the required financial information.

I also urge that Schedule H be streamlined to eliminate questions that are burdensome and confusing, and that fail to provide meaningful information to the community. The added layers of requests for information will require considerable additional hours of extra staff work, and some information requested is competitively sensitive.

We recognize that there are other concerns about Schedule H, Form 990 and many other schedules. We urge you to work with the hospital community to identify and resolve those issues before asking us to file a new Form 990 or any of its schedules.

Thank you for the opportunity to comment on draft Schedule H.

Sincerely,

William D. Jacobsen
Hospital Administrator

I

August 8, 2007

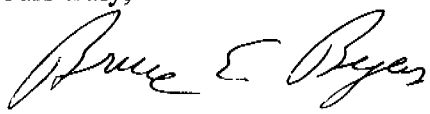
IRS Form 990 Redesign
SE:T:EO
Washington, DC

Regarding redesign of Form 990: Suggestion for Part II "Compensation".

Please keep the requirement for reporting "*average hours per week devoted to position*" in Part II, the Compensation section.
An employee of a tax-exempt can also work for a subsidiary of the tax-exempt. When the subsidiary is a for-profit business, the commingling of personnel becomes an issue of concern. It is essential to have an accounting for the hours a person devotes to each entity in order to have meaningful figures. So, I want to recommend that the "*average hours per week devoted to position*" also be required with the "*related organization*", whether or not the position is compensated.

Also, regarding page 2: Because a compensated person may not work full-time, may I suggest that the *$100,000* threshold be changed to a "per hour" threshold? For example, require reporting the compensation of anyone making $50 or more per hour for time "devoted to position".

Yours truly,



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[1] LICENSED IN DC, FL, GA, SC, TN, TX & VA
AUTHORIZED TO PRACTICE IN NC
[2] LICENSED IN FL, GA & TX
[3] LICENSED IN FL & TX
[4] LICENSED IN FL

August 10, 2007

MICHAEL E. BATTS, CPA
MANAGING SHAREHOLDER

VIA FACSIMILE, EMAIL AND U.S. POSTAL SERVICE

The Honorable Max Baucus
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The Honorable Charles Grassley
United States Senate
135 Hart Senate Office Building
Washington, D.C. 20510-1501

The Honorable Henry M. Paulson, Jr.
Secretary of the Treasury
Department of the Treasury
1500 Pennsylvania Avenue, NW
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Mr. Steven T. Miller
Commissioner, Tax Exempt and Government
Entities Division (TE/GE Division)
Internal Revenue Service
1111 Constitution Avenue NW
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Ms. Catherine Livingston
Assistant Chief Counsel
Exempt Organizations/Employment Tax/Government Entities
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The Honorable Charles B. Rangel
United States Congress
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Washington, D.C. 20515

Mr. Kevin M. Brown
Acting Commissioner
Internal Revenue Service
1111 Constitution Avenue NW
Washington, D.C. 20224

Mr. Eric Solomon
Assistant Secretary (Tax Policy)
Department of the Treasury
1500 Pennsylvania Avenue NW, Room 3120
Washington, D.C. 20220

Ms. Lois G. Lerner
Director, Exempt Organizations Division (T:EO:RA:T)
Internal Revenue Service
1111 Constitution Avenue NW
Washington, D.C. 20224

Re: **Identifying Terrorism-Supporting Activities of Tax-Exempt Organizations using Forms 1023 and 990**

Ladies and Gentlemen:

I am writing to offer both strong support and strong caution in connection with your interest and efforts related to identifying terrorism-supporting activities of tax-exempt organizations. I am a Certified Public Accountant and my firm assists numerous tax-exempt organizations in complying with applicable tax laws.

Our firm has noted with increasing interest the recent communications by your committees and agencies regarding the desire to better identify activities of exempt organizations that may constitute support of terrorism. We are specifically very concerned about the clear trend in the direction of requesting on Forms 1023 and 990 more detailed information from nonprofit organizations related to their international grant-making and other activities. As you know, these forms (with limited redactions) are subject to public inspection pursuant to Internal Revenue Code Section 6104. Form 990 is generally readily available on the Internet[1].

While we strongly support the desire and effort on the part of the federal government, in the interest of antiterrorism, to obtain and identify specific information about the international activities of nonprofit organizations, we also strongly oppose, in the interest of the health and safety of people carrying out the legitimate charitable and religious work of nonprofit organizations, making certain specific information publicly available. For example, many legitimate U.S.-based nonprofit organizations engage in missionary efforts, humanitarian relief efforts or human rights efforts in highly volatile regions of the world. If these legitimate nonprofit organizations are required to publicly disclose details of their work in such regions (including names, locations and other identifying information regarding the people and organizations with whom they are cooperating or to whom they are making grants), such public disclosures may very well put the organizations or the people with whom they work in serious danger.

IRS officials appropriately note that under current federal law, information provided by a nonprofit organization on Form 1023 or Form 990 is required to be made public with the very limited exceptions that certain "trade secret, patent, process, style of work, or apparatus" information may be redacted from public inspection copies of Form 1023[2] and donor-identifying information is redacted from public inspection copies of Form 990[3]. In other words, if the information is provided on Form 1023 or Form 990, the IRS and the filing organization have no choice but to make the information publicly available[4].

Additionally, there is a clear and present trend in the direction of requiring more specific information from nonprofit organizations about their international activities. Some of the information being requested on Forms 1023 and 990 (or under consideration for inclusion) will, undoubtedly, result in the public disclosure of individual or entity-identifying information. For example, the current Form 1023 includes the following questions:

> **12a Do you or will you operate in a foreign country or countries? If "Yes," answer lines 12b through 12d. If "No," go to line 13a.**
>
> **12b Name the foreign countries and regions within the countries in which you operate.**
> **12c Describe your operations in each country and region in which you operate.**
> **12d Describe how your operations in each country and region further your exempt purposes.**

The current Form 990, line 22b, requires a schedule of grants made and a box that should be checked if the grants include "foreign grants." The instructions to line 22b state:

> On the applicable schedule show: (a) each class of activity; (b) grantee's name, address, and the amount given; and (c) (in the case of grants to individuals) relationship of grantee if related by blood, marriage, adoption, or employment (including employees' children) to any person or corporation with an interest in the organization, such as a creator, donor, director, trustee, officer, etc. [Emphasis added]
>
> On the applicable schedule, classify activities in more detail than in such broad terms as charitable, educational, religious, or scientific. For example, identify payments for nursing services, laboratory construction, or fellowships. [Emphasis added]

The draft Form 990 presently under consideration includes a specific schedule[5] dedicated to international activities. The schedule requires specific information about the countries in which the filing organization operates, including the number of employees or agents in the country and a specific description of the activities conducted in each country. The schedule also requires identifying information about specific grant recipient "organizations or entities," including their city (or region) and country, along with the purpose of the grants made.

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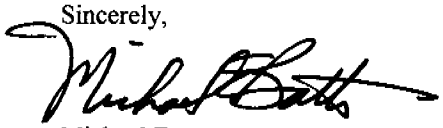
[1] See www.GuideStar.org
[2] Sec. 6104(a)(1)(D)
[3] Sec. 6104(d)(3)
[4] Subject to the very limited exceptions noted in the previous sentence
[5] Schedule F, entitled "*Statement of Activities Outside the United States*"

As noted previously, the information on Form 990 (and, likely, Form 1023 in the future) is readily available worldwide on the Internet[6]. Therein lies the danger, under current law, associated with requiring on Forms 1023 and 990 specific information about international activities of exempt organizations. Anyone in the world with Internet service, including terrorists or others who would seek to harm those doing legitimate charitable work, has instant access to information about a filing organization's activities in a given region of the world. Putting this information in the wrong hands could be disastrous to those organizations and people involved in the charitable work.

We believe there is a simple solution to this problem. Code Section 6104 should be amended to exclude from the requirements for public inspection (in connection with Forms 1023 and 990) specific information that would or could reveal the identities of individuals, organizations and locations of an organization's international activities, including its employees, agents, beneficiaries and grantees. Logistically, such information could still be required to be submitted to the IRS as part of filing the forms (and thereby provide the federal government with the appropriate information to aid in its antiterrorism activities). The IRS could utilize a specific schedule for obtaining all of this type of information (as it does now, for example, with Schedule B of Form 990, which includes donor-specific information not subject to public inspection.) The schedule could be omitted from public disclosure copies of Forms 1023 and 990[7].

We sincerely hope that in your efforts to address the very important issue of terrorist-supporting activities, you will carefully consider the very real dangers that can result from public disclosure of specific information about the international activities of America's charities and religious organizations. We ask you to pursue appropriate modifications to Section 6104 in order to address this most serious matter.

Sincerely,



Michael E. Batts

MEB:lmc

[6] See www.GuideStar.org

[7] We note that the draft Form 990 currently under consideration includes a separate schedule – Schedule F – related to activities outside the United States. If all information that provides or could lead to the identification of a filing organization's activities, employees, agents or beneficiaries (whether individuals or other entities) were restricted to that Schedule, and if that Schedule were closed to public inspection by way of amendment to Section 6104 of the Internal Revenue Code, we believe the concerns raised herein would be substantially addressed with respect to Form 990. A similar approach should be taken with Form 1023.

From:	Ravi Arora
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Form 990 revisions comments
Date:	Tuesday, August 14, 2007 6:50:39 PM
Attachments:	

I would like to contribute my comments as follows:
It will be beneficial for the organizations' members (who contribute time and/ or money) if some form of requirements in Part III for the latest election process of governing body and the availability of Bylaws and other related documents appropriately added. If any changes to these Bylaws are made they should be re-recorded periodically with a Federal or State agency where the members have easy access and where they can file complaints of any impropriety.

Ravi

From:	Mike Assaf
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	comments
Date:	Tuesday, August 14, 2007 11:44:53 AM
Attachments:	

Ladies and Gentlemen

Thank you for your efforts in making this form more useful to all, including compensation consultants and those advising clients on intermediate sanctions. I have been helping tax exempts—mainly hospitals establish a rebuttable presumption of reasonableness for many years, as a (now retired) Towers Perrin principal. I am beginning to do some work in this area under the Investech banner. The work has forced me to develop ways to evaluate benefits and to make market comparisons, and to examine the valuation methods of others. I would like to comment on form 990 and especially schedule J.

I understand the intent of form 990 Part II Section B, but I think part e of question 5 casts a broader net than is needed. Most community hospitals rely on local businessmen and especially a local banker to bring expertise to the board. It would be difficult for a hospital to use one bank and ask a different banker to serve. Recall that these are volunteer, unpaid directorships. The same goes for insurance agents, etc. The existence of today's global financial corporations also exacerbates this issue. I feel you will get many more positive responses here than you will want to sift through. Perhaps the key here is limiting the definition if officer for purposes of this question.

On schedule J I have four issues.

First, I have not been in favor of excluding qualified plans because executives are generally compensated on national market bases and other employers based on local or regional markets (because of the labor pool they are recruited from) SERPs alone may not be comparable across organizations. A generous SERP may be simply bringing the total up to a national market level.

Second, I was not able to definitively tell what benefits were to be included. The use of section numbers is confusing to clients and even practitioners. For example, most hospitals maintain a broad based self insured medical plan which I believe relies on section 105 not 119 for exemption. I would make it clear that each benefit

that is compensatory be included, whether or not broad based and whether or not taxable. This, along with including qualified plans will give you the whole picture and will guarantee comparability. I believe I read that you get to disclose in a footnote if previously reported deferred comp is again reported when taxed for Medicare. Thanks for that. Reiterate the 4958 warning that indicates that if it's not in the schedule J it won't be presumed compensatory.

Third, I think you need to define a difference between deferred comp and SERPs so we get comparable data. Deferred comp is comp that is voluntarily deferred—or erned but not vested and may be paid out before retirement, and everything else should be a SERP—one opinion.

Fourth, I think you need to advise on uniform valuation methods. My advice:

1. For defined benefit plans, you could use the SEC's proxy valuation method. It's easy for actuaries to do and consistent. You will get howls and surprises, as it results in VERY high costs for older execs. A gentler approach would be to lump all DB benefits together, estimate the retirement benefit at SSNRA and use a actuarial method that smoothes the cost—I like entry age normal-because it gives a DB cost comparable to a DC cost for the same benefit, again, creating uniformity among plans and entities. Most actuaries can evaluate the five or six execs needed on a spreadsheet.
2. For defined benefit plans, the employer contribution.
3. For any broad based group health plan, the GROUP premium for the coverage chosen by the exec—(family, single, etc.) less the employer contribution. Use COBRA rates if self insured plans as a proxy for group rates. Consider whether you want to simplify by assuming everyone has full family coverage—which gives you uniformity across companies.
4. Value life and disability at group rates. The difficulty here is the myriad ways short term disability and sick pay are handled. Some are self insured up to six months and some are insured after the fourth day.
5. Ask one of your actuaries for an opinion, but you might value insured disability at the group rate, and self insured plans at 3% for example) of the total benefit that would be paid if the employee collected self insured sick and disability pay until the insurance kicked in.
6. Evaluate split dollar as the taxable benefit plus any increase in executive equit deemed non taxable. (I don't think that's possible any more but some may think they have a way)

I think most other things should break into dollar amounts.

I hope this helps. I've been at this a very long time. Please contact me if You would

like further discussion. I want to see this useful—meaning accurate and uniform.

From:	Betty VanDerWerff
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	comments
Date:	Wednesday, August 15, 2007 9:03:41 AM
Attachments:	

On the form 990 the names and addresses of key employees and directors should not appear on the form. Our country has so many avenues for identity theft and this gives one more. Also, not to mention kidnappers and other criminals (knowing how much a person makes and where they live). Our country has been pushing homeland security and I feel this is one place that our government is failing that issue. Just leaving the names and addresses off would still give the snoopy reader enough information to see if the top execs are making too much.
There is confidentiality within our own organization and especially compensation. This breaches that confidentiality.

I ask that you really consider all of the consequences of this. I am sure I have only touched on a couple.

Sincerely,
Betty VanDerWerff
Director of Finance and Accounting
Sioux Valley Energy
Colman, SD

From:	Doris Shuman
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	FORM
Date:	Wednesday, August 15, 2007 9:35:07 AM
Attachments:	

I truly like the design of the new form. It seems to put the most important/relevant information upfront where the public for their inspection can easily understand it.

Doris Clendenen Shuman, CPA PC
P O Box 2478
Abingdon, VA 24212-2478
276-628-5662
276-628-3889 fax

From:	Ronnie Wilkins
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comments on proposed Form 990
Date:	Wednesday, August 15, 2007 12:16:07 PM
Attachments:	

Thank you for the opportunity to comment on the proposed changes to Form 990. Some of the changes I think are quite good, but others I disagree with. Please note the following comments.

1. Part 1 asks for the number of members of the organization's governing body and the number of independent members. I have two concerns about that. First, asking the question implies that the organization "should" have independent members, which is not legally required and in the vast majority of non-profit organizations would neither be practical nor helpful. I don't understand why you would ask for information about something that there is no statutory authority for. My second concern about independent members has to do with the common understanding of "independent". I realize that in many organizations it is the board, itself, that appoints new board members. However, in our case I would argue that all of our governing body members are independent. We have a nominating committee that is elected by the membership. The nominating committee then presents a slate of candidates with at least two candidates for each office, and the members vote for their choice. I can't see how such a process could produce anything but independent members of the governing body. A member of the governing body from outside the membership would not have the expertise to deal with the issues of concern to our professional society, and likely would not have the motivation to attend meetings in which he/she has little understanding of what is going on.
2. Also in part one you ask for the compensation of officers, directors, and key employees as a percentage of revenue. I will be happy to share that information and in the case of our professional society it is going to make us look very good. However, some small community based organizations that provide important services are not going to look so good, and will be

subject to being judged in an unfair light. If a community based shelter for abused women happens to spend the majority of its small budget on its staff, who provide most of the services of the organization, what is the problem with that? This information is going to be misleading and unfair in many cases.

3. In Part II, I commend you for raising the salary level to $100,000 in the requirement to report the compensation of the 5 highest paid employees. In today's world, I think this is a much more reasonable number.
4. In Part III, you ask about a number of policies; e.g. conflict of interest policies, whistleblower policies, document retention and destruction policies, etc. Again, these are not legally required for non-profit organizations and I don't understand why you ask for information that is not legally required of the organization. We have most of these policies, but not all, and there is nothing wrong with our position. We are quite comfortable that we are governing the organization in a responsible way with all due accountability to our members and to the public. Your request for this information is beyond your statutory authority it seems to me, and could be very confusing for the public. If an organization does not have a document retention policy, for example, is that a bad thing? I don't think necessarily so.
5. Finally, with regard to my primary objections and concerns, I think that if you believe that non-profit organizations should have independent board members, policies that you seem to want to dictate, etc. then you should take that to Congress and ask them to change the law. I would have no objection to a healthy open public debate on these issues in the legislative branch of government, where I think they rightfully belong.

From:	Debbie Robinson
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	comment period
Date:	Thursday, August 16, 2007 11:20:40 AM
Attachments:	

For many of my clients, the proposed changes will require increased cost of preparing the Form 990, even though many are rather simple organizations. Many of my clients are just now learning of the proposed changes and want to comment. They would like to see the comment period extended in order to perform a cost benefit analysis of the changes.

Is there any consideration being given to extending the comment period and how can individual organizations best recommend to the IRS that the comment period be extending.

Debbie Robinson, CPA
Priddy & Holifield, PA CPAs
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501-374-9241
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From:	Elba Linares
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comments to the IRS on the New Form 990
Date:	Friday, August 17, 2007 8:05:31 AM
Attachments:	Comments to IRS re New Form 990.pdf

Attached are The New York Community Trust comments on the New Form 990.

Lorie A. Slutsky
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THE NEW YORK
COMMUNITY TRUST NYCT

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August 16, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

Submitted via email to: Form990Revision@irs.gov

The New York Community Trust (NYCT) welcomes the opportunity to comment on the redesigned Form 990. We applaud the IRS for recognizing the inadequacies of the current form and its desire to create a new form that enhances transparency of nonprofits to the public, promotes compliance with Treasury regulations, and minimizes the burden on filing organizations. While the current Form 990 certainly needs improvement, we are concerned that some of the proposed changes will increase dramatically the burden on some filers or even promote non-compliance as they may be too burdensome on the filer.

We respectfully submit the following comments related to the redesigned Form 990 that is scheduled for the 2008 tax year.

Comments on Core Form 990

Page 1, Part I

Lines 8a and b – Requiring an organization to calculate a percentage for compensation as part of total program expense implies that there will be "good" and "bad" percentages. It also implies that time spent by officers and key employees in management and fundraising is a bad thing as it will adversely impact the percentages. The IRS wants nonprofits to spend

more time on compliance and governance issues, and so we expect that officers and key employees will need to allocate more of their time to management and general expenses. We recommend Line 8b be omitted; a reader can derive that information for him or herself.

Lines 9a and b – Requiring this information will guarantee that organizations that file 990T will be requesting additional extensions of time to file Form 990s. The 990T currently has an automatic extension of 6 months, while the Form 990 has an automatic three month extension. As with any taxpayer, the 990T filer cannot complete the form until it has received Schedule K-1s. For example, NYCT filed its Form 990 in early August and the 990T is not complete because we are still waiting for all of the K-1's. While we have received enough information to estimate our taxes and unrelated business income for financial statement purposes, we will not have final forms until late September, at the earliest. This would seem to be at odds with the Senate Finance Committee's objective to have Form 990s filed earlier so that more timely financial information is available.

Lines 11-16 – For endowed institutions, these percentages may vary significantly from year to year due to the definition of investment income that is to be reported here. Most institutions invest for total return; they generally report as investment income interest and dividends and realized and unrealized gains and losses. The Form 990 excludes unrealized gains or losses from investment income.

Line 24b – We are unclear as to the purpose of this percentage and again are concerned that it will suggest that there are "good" and "bad" percentages. This number will vary greatly depending on whether or not an institution is endowed and the nature of its programs and we recommend that it be deleted.

Page 2, Part II - We are assuming that the term "institutional trustee" refers to a trustee that is a member of the "governing board" of an institution and not just managing and acting as custodian of the assets. This requires clarification.

We also are concerned about privacy issues with respect to listing names of staff with salaries. We believe that the names of staff are not as important as titles or duties and responsibilities. It would make more sense to require organizations to list the five highest paid full-time staff, and eliminate the officers' category as officers may be either full-time staff or board members, depending on the structure of the organization.. If the Service is interested in identifying governing board members that are compensated, it should ask for that information.

Page 4, Part III

Line 3b – We agree that it is important for organizations to have conflict of interest policies. It also is valuable to know if any transactions were reviewed under it, but we question the value of tracking the number of times it is used. We are concerned that organizations will want to have a "low" number and so will craft very broad conflict statements or do very cursory reviews, and defeat the purpose of having a conflicts policy.

Line 11 – We recommend adding a question about the public availability of an annual report.

Line 12 – In order to compile data electronically from the forms, we suggest having check boxes for the filer to complete, rather than "write-ins".

Page 6, Part V

Line 6 – The Glossary lists the types of disqualified persons in accordance with the PPA. The list includes "Investment advisors of sponsoring organizations." This broadened definition now includes all investment advisors of a community foundation whether or not that advisor has a relationship to a donor. We think this information is of little value to the reader and suggest this line be deleted. If it is determined that the information is valuable, we request that the line be broken into 5 parts to reflect the five types of disqualified persons listed in the instructions. This will provide more specific information and be more informative to readers.

Line 11D – We assume that filers should use the lobbying definition in Code section 501(h); the proposed instructions are confusing in this regard and need to be clarified.

Page 9, Part VIII

Line 8b – Though this question is on the current Form 990, the instructions have changed. The new instructions require that a filer check "yes" only if the 990T has already been filed when the 990 is filed. We are concerned that this will further delay 990 filings, so that the filers will be able to answer this question in the affirmative.

Comments on Schedule A

Overall, we find this new schedule to be quite helpful in explaining the public support test. We are unclear whether the additional year added to the public support test will be the current year being reported or an earlier year. We also request clarification as to whether a private letter ruling is required before classifying a contribution as an "unusual grant."

Comments on Schedule B

While this schedule did not change, we believe that a change would provide clearer information. We find three classifications of contributions in Part 1, column d to be confusing. We recommend deleting "person" or replacing it with non-payroll as it can be an individual or corporation making the gift.

Comments on Schedule D

Page 1, Part V – We assume that this list can be by categories, such as "furniture and fixtures", and that a filer is not expected to list individually every desk, chair, etc. This should be clarified in the instructions.

Page 2, Part IX – We are unclear as to what is meant by an "account similar to a donor advised fund, but not a donor advised fund." If the Service wants to collect this information, it must provide a clear definition of what is intended.

Page 3, Part XII – We are unclear as to the definition of an endowment fund. Is this governed by state law? Can this include "board designated" endowments? We are also unclear as to the investment line. Does this include unrealized gains and losses? Most organizations with endowments manage them on a total return basis, and so excluding unrealized gains or losses from these balances would be misleading, not to mention burdensome to the organization. It is also another point of confusion for the reader as the audited financials of an organization will differ from the tax return.

Comments on Schedule F

As a general comment, the definition of what constitutes foreign grantmaking has been expanded to the point that providing the requested information will pose an impossible burden on filers, and the information collected will increase confusion rather than improve transparency. Instead of focusing on grants to organizations established outside the United States, the definition includes U.S. charities if more than one-half of their activities are outside the United States, as well as grants to U.S. organizations if intended to support activities outside the United States, such as a tsunami relief efforts. How are grantmakers to separately identify these organizations, and to do so on a timely basis for filing? Does the IRS have a way to do this? Organizations' percentages of activities within and without the U.S. are likely to change from year to year, requiring filers to obtain the data and then to calculate and re-calculate the numbers.

In addition, Part I, Lines 5(a) and (b) require knowledge of whether a donor to a grantmaking organization is in some way related to the foreign grantee. For public charities with hundreds of donors, this determination presents an unreasonable burden.

Comments on Schedule I

Part I, Lines 2a and b – This is impossible to complete and an invasion of donor privacy. Donor names are currently protected from public disclosure. The Trust has over 800 donor advisors, and most are involved in their communities and donate other resources, such as their time, to many charitable organizations. It is probably impossible for us to make this determination; it is certainly a burden. We strongly urge the IRS to remove this question as other reporting requirements prevent against private inurement.

Part II – We agree with the Service that electronic filing is an important goal, and it will make the returns more accessible more quickly. As a grantmaking institution, we are concerned about completing this schedule as we make grants annually to well over 2,000 organizations. Most grantmaking organizations list their grants on their websites, in newsletters, and in annual reports, so the information is available to the public. The Trust lists all grant recipients who receive $20,000 or more in our annual report. We would suggest that a higher dollar cut-off or an amount based on a percentage of grant expense be used here. For example, on Schedule B for contributions, organizations can choose to list all contributions over $5,000 or just those that are 2 percent or more of total contributions. We suggest 5 percent of grants be used as an alternative to a flat dollar amount.

Comments on Schedule J

Line 1 – The detail requested in this schedule is very helpful; however, we suggest the total column be moved after column C and before column D. It makes no sense to add nontaxable benefits and nontaxable expense reimbursements to taxable compensation and call it total compensation.

Line 3 – Check boxes for the items listed, instead of grouping them all together, will make these easier to complete and provide greater clarity.

Comments on Schedule M

Part I, Column c –The method of valuation used by the charity is irrelevant here as the charity is not claiming a tax deduction. The law requires donors, not donees, to obtain qualified appraisals to support their tax deductions.

Line 27 – The value of this information is dubious. There is not a direct relationship between the gifts listed on the schedule and the number of 8283 forms received during the year because the forms are due with individual tax returns and may be sent to the charity after the end of the charity's tax year. For example, a gift of closely-held stock is made on December 31, the donor sends the charity the Form 8283 to sign in January; the charity would not count this form on the return filed in the same year as the gift, but rather in the following year.

The New York Community Trust welcomes changes to the Form 990, but they must be attainable, manageable and add value to our charitable mission. We believe that the Form 990 revisions proposed need to be changed to meet that goal.

If you have any questions or require clarification of any of the points, please feel free to contact our Chief Financial Officer, Kit Conroy at kac@nyct-cfi.org.

Sincerely yours,

Lorie A. Slutsky
President

From:	Phyllis Edans
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Please consider
Date:	Friday, August 17, 2007 12:35:04 PM
Attachments:	

Extending the comment period, many have not had enough time to fully review the document.

Phyllis L. Edans, CPA, CAE
Chief Financial Officer
American College of Emergency Physicians
PO Box 619911
Dallas, TX 75261-9911
972-550-0911 ext 3130
FAX: 972-580-2816

Advancing Emergency Care

Escape From the Ordinary
Scientific Assembly 2007
Seattle, Washington Oct. 8-11
Register at www.acep.org/sa

From:	Andrea Stritzke
To:	*TE/GE-EO-F990-Revision; lthomas@cuna.com;
CC:	
Subject:	Comments on IRS Form 990 Redesign
Date:	Friday, August 17, 2007 1:52:25 PM
Attachments:	990redesign ltr.doc image002.gif

Please accept this comment in regards to the IRS Form 990 redesign on behalf of the Iowa Credit Union League. A copy of the comment letter is also attached to the email.

August 17, 2007

Form 990 Redesign
ATTN: SE:T:EO
1111 Constitution Ave., N.W.,
Washington, DC 20224

To Whom It May Concern:

I appreciate the opportunity to comment on the IRS's proposed redesigned form 990. The Iowa Credit Union League (the League) is the trade association representing 147 Iowa credit unions.

We are concerned with the IRS precluding group 990 returns. Until the 2006 tax year when it discontinued the service, the State of Iowa Division of Credit Unions filed a group 990 for all of the Iowa state-chartered credit unions. Knowing what kind of burden would be put on the smaller credit unions to file an individual 990, the Iowa Corporate Central Credit Union (Iowa Corporate) applied to be the central filer for the Iowa state-chartered credit unions with the intent to continue filing the group 990 for tax year 2006 and beyond. After a long and bureaucratic process, Iowa Corporate

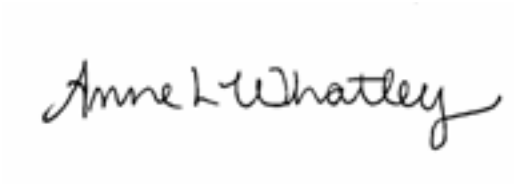
appears to be on the verge of obtaining IRS approval to file the group 990 on behalf of the Iowa state-chartered credit unions.

The ability of Iowa Corporate to continue filing the group 990 for the state-chartered credit unions has been an immense help to the smaller and mid-size credit unions. Most of the credit unions do not have personnel able to complete the 990, and many of the credit unions do not have the financial resources to hire an accountant. The group 990 has taken the administrative and financial burden of the form 990 off the credit unions, allowing them to focus on serving their members.

It is our understanding that several credit union trade associations file the group 990 on behalf of their state-chartered credit unions. Thus, the IRS should consider the impact of precluding the group 990 as such action will affect numerous institutions and provide an influx of returns. We urge the IRS to continue allowing group 990 returns to be filed.

Thank you for the opportunity to comment. Should you have any questions, please call me at (515) 221-3005.

Sincerely,



Anne L. Whatley
Vice President of Regulatory Strategy
Iowa Credit Union League

cc: Lily Thomas, CUNA

From:	Colleen Picklo
To:	*TE/GE-EO-F990-Revision;
CC:	Valerie Sellers; Karen Ali;
Subject:	New Jersey Hosptial Association Comments on Schedule H
Date:	Tuesday, August 21, 2007 4:35:32 PM
Attachments:	NJHA Comments on Schedule H.pdf

Please find attached an electronic version of comments from the New Jersey Hospital Association. Thank you

Colleen Picklo
Operations Manager
Health Planning Department
609-275-4020

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

August 21, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: COMMENTS ON SCHEDULE H

On behalf of the New Jersey Hospital Association and the 116 hospitals it represents, thank you for the opportunity to comment on the new draft Schedule H (Hospitals) to Form 990. We are writing now because we understand that the Internal Revenue Service is requesting early comment on the forms and plans several rounds of changes.

We appreciate the willingness of the IRS to solicit feedback and engage in discussion regarding the draft changes. Reflected below are several serious concerns that we have regarding Schedule H.

- **The timeframe for implementation of these significant changes is far too short**, particularly for states that have not had a standardized annual reporting process. It undoubtedly is also problematic for states that already have a system of reporting that may have to be modified to accommodate the proposed IRS reporting requirements. As a result, we request implementation be delayed until 2010 to allow hospitals to adjust or create systems to capture the required financial information. Further, the delayed implementation will accommodate the delay the IRS anticipates in issuing instructions.

  It is a daunting task in itself to reconfigure financial and data record-keeping systems in time to begin capturing the substantial amount of data required just for the Part I Community Benefit Report by Jan. 1, 2008. It is made virtually impossible by the fact that the instructions, definitions and worksheets needed to collect that data are not expected to be finalized until mid-2008. To require hospitals to overhaul financial and data record-keeping systems before the definitions, line item instructions and worksheets are completed is unreasonably costly and disruptive.

  Given the number of questions and concerns that have surfaced about Schedule H, we urge the IRS to consider providing a second draft in 2008 and another review period with a goal of finalizing the schedule by Dec. 31, 2008. That would give hospitals sufficient time to revise their financial and data record-keeping systems to track and capture new required information.

760 Alexander Road ■ PO Box 1 ■ Princeton, New Jersey 08543-0001
Tel 609-275-4000

- **The full value of hospital community benefit is not captured in Schedule H** but should be. Specifically, Schedule H does not include bad debt and Medicare shortfalls as a community benefit. The reality is that a significant percentage of bad debts reflect care provided to populations that do not necessarily qualify for charity care or Medicaid but the cost of care would be financially devastating. In these cases, the hospital has absorbed the cost of providing care. Last year, New Jersey hospitals were reimbursed, on average, only 52 percent of the cost to care for the charity care population. Collectively, hospitals absorbed more than $650 million in charity care, a cost that should have been borne by the State. This is also the case with Medicare shortfalls as hospitals routinely must cover the cost of providing care that the government fails to reimburse. By assuming this financial responsibility, hospitals serve communities that might not otherwise have access to care.

  Hospitals qualify for the charitable purpose of promoting health by meeting the community benefit standard. The community benefit standard permits hospitals to tailor their programs and services to the needs of the individual community. Among those needs is providing care for elderly Medicare patients and low-income patients who may not be able to afford the costs of their care. Yet hospitals provide this care proudly, and the costs absorbed in doing so should be reflected as a community benefit on Schedule H.

  Part I "Community Benefit Report" in draft Schedule H allows hospitals to report and receive community benefit credit for Medicaid and other government program underpayments, but not for Medicare underpayments. ***We believe Medicare underpayments should be included.*** Medicare, like Medicaid, does not pay the full cost of patient care. As a result, hospitals must absorb and compensate for these underpayments. Currently, Medicare reimburses New Jersey hospitals 89 cents for every dollar spent on inpatient care. These underpayments from Medicare, among other sources, have contributed to the negative margins that more then 50 percent of New Jersey hospitals all experience. It should also be recognized that an increasing number of Medicare beneficiaries are low-income. More than 46 percent of Medicare spending is for beneficiaries whose income is below 200 percent of the federal poverty level. As such, ***Medicare underpayments represent a real cost of serving members of our community and should be counted as community benefit.***

- **The cost of patient bad debt is community benefit.** As currently drafted, Schedule H does not count patient care bad debt expenses as community benefit. We know that a significant majority of bad debt is attributable to low-income patients, who for many reasons decline to complete the forms required to establish eligibility for hospitals' charity care programs.

  A 2006 Congressional Budget Office report cited two studies indicating that "the great majority of bad debt was attributable to patients with incomes below 200 percent of the federal poverty level." The fact is that despite our best efforts, many of our patients still do not identify themselves as needing financial assistance. It is important to hospitals and their patients that ***the full cost of serving the community – including the cost of serving patients who need help paying their bill but fail to ask for it – be recognized and counted as community benefit.***

- **Schedule H needs to be streamlined to eliminate questions that are burdensome and confusing and that fail to provide meaningful information to the community.** The proposed chart on Schedule H, Part II relating to billing should be eliminated. It has no bearing on determining whether a hospital is meeting the community benefit standard, and it should not be used to create new reporting standards.

  Relevant information is already provided in other parts of the Form 990. For example, detailed information on charity care will be provided in Part I of Schedule H. Information related to a hospital's revenues and Medicare and Medicaid payments will be included in Form 990.

  Beyond that, the chart's added layers of requests for information are burdensome and will require significantly greater staff time. Some of the information requested is competitively sensitive. The chart displays information in a form that will confuse, not inform, the community.

  If the IRS requires more information on charity care policies and practices, or the way in which hospitals support other community benefit activities and programs, it should ask those questions instead of creating new reporting obligations that would be burdensome and will confuse communities instead of providing them with the information they need.

We recognize that there are other concerns about Schedule H, Form 990 and many other schedules. We urge you to work with the hospital community to identify and resolve those issues before asking us to file a new Form 990 or any of its schedules.

Thank you for the opportunity to comment on draft Schedule H.

Sincerely,

Gary S. Carter, FACHE
President and CEO

From:	Hatton, Mindy
To:	*TE/GE-EO-F990-Revision;
CC:	Ashford, Deborah T.;
Subject:	Comments of the American Hospital Association on IRS Draft Schedule H
Date:	Tuesday, August 21, 2007 2:23:36 PM
Attachments:	AHA Final Comments on IRS Schedule H 8-21-07.doc

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The comments of the American Hospital Association on IRS draft Schedule H are attached.

Melinda Reid Hatton
Senior Vice President & General Counsel
American Hospital Association
325 7th Street N.W. Suite 700
Washington, D.C. 20004
(202) 626-2336

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

August 21, 2007

By Electronic Filing

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

RE: COMMENTS ON DRAFT SCHEDULE H

On behalf of our nearly 5,000 member hospitals, health care systems, networks and other health care providers, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit comments on the draft Schedule H for Hospitals. We are submitting our comments well in advance of the September 14 due date to give the Internal Revenue Service (IRS) time to consider our comments and request any additional information. The AHA will submit comments on Form 990 and other schedules in a separate letter.

We appreciate the work that the IRS has put into draft Schedule H, and your willingness to hear comments from the hospital community. We particularly appreciate the efforts of IRS officials who participated in our conference calls about Schedule H with hospital leaders, and met with the AHA and other associations representing tax-exempt hospitals to discuss the field's concerns.

In the wake of such an ambitious effort by the IRS, it is not surprising that the tax-exempt hospital community has such concerns. In many instances, Schedule H fails to meet the goals that the IRS set. The IRS explained these goals as follows:

- *Enhancing transparency means providing the IRS and its stakeholders with a realistic picture of the organization and its operations, along with the basis for comparing the organization to similar organizations.*
- *Promoting compliance means the form must accurately reflect the organization's operations and use of assets, so the IRS may efficiently assess the risk of noncompliance.*
- *Minimizing the burden on filing organizations means asking questions in a manner that makes it relatively easy to fill out the form, and that do not impose unwarranted additional recordkeeping or information gathering burdens to obtain and substantiate the reported information.*

As the following comments will demonstrate, draft Schedule H often falls short of these goals and, as a result, will be of limited use to the IRS and other reviewers. In too many instances, hospitals would experience extraordinary burdens gathering and reporting the requested information – information that is often unrelated to compliance. At the same time, the information requested would fail to provide reviewers with a comprehensive view of the filing organization, particularly hospital systems, and thereby increase the risk that the IRS would suspect noncompliance when none was present. And the information requested could be presented in a misleading and/or overly abbreviated manner that would confuse instead of inform reviewers.

Our concerns about Schedule H can be summarized as follows:

- The filing deadline is far too short. It should be extended to tax year 2010.
- Schedule H should be redesigned to:
    - focus on the five pillars of the community benefit standard;
    - incorporate the full value of community benefit that hospitals provide; and
    - eliminate burdensome and misleading questions that are unrelated to community benefit or compliance.

We recognize that, until the questions are revised and coupled with instructions and worksheets, it is not possible to identify all the issues hospitals may face in implementing Schedule H. However, we have tried to identify as many issues as possible that we believe the Service needs to address.

SCHEDULE H FAILS TO ACHIEVE THE GOALS THE IRS SET FOR ITSELF

The overarching problems with Schedule H are two-fold: First, it neither limits itself to nor properly incorporates the pillars of the community benefit standard. While we appreciate the complexity involved in the IRS' development and release of so many important and complicated documents, the AHA opposes <u>any</u> effort to change the community benefit standard, including through the expedient of a form.

Second, it departs, sometimes radically, from discretionary reporting that the tax-exempt hospital community has agreed provides value in the service of transparency, even though the burden of providing such information is substantial.

SCHEDULE H FAILS TO ADHERE TO THE COMMUNITY BENEFIT STANDARD

<u>The community benefit standard, which requires the promotion of health in accordance with community needs in the absence of private benefit, is the legal basis for hospitals' tax exemption</u>. Therefore, to be consistent with the basis on which tax exemption is granted to hospitals, the IRS should incorporate the community benefit standard into Schedule H, in the same manner it is incorporated into other forms and reflected in the IRS' own rulings and legal precedent. Further, the IRS should rely on it exclusively to determine compliance.

For almost 40 years, the community benefit standard, set forth in Revenue Ruling 69-545, has been the standard used by the IRS, the courts and the tax-exempt community in determining tax-exemption for hospitals and health care organizations. The reasons for that ruling and for the movement away from a "financial-ability" standard are still compelling. As the U.S. Supreme Court recognized in 1976:

> "[T]he concept of the nonprofit hospital and its appropriate and necessary activity has vastly changed and developed since the enactment of the Nonprofit Institutions Act in 1938. The intervening decades have seen the hospital assume a larger community character. Some hospitals, indeed, truly have become centers for the 'delivery' of health care. The nonprofit hospital no longer is a receiving facility only for the bedridden, the surgical patient, and the critical emergency. It has become a place where the community is readily inclined to turn, and because of increasing costs, physician specialization, shortage of general practitioners, and other factors is often compelled to turn, whenever a medical problem of import presents itself." Abbott Laboratories v. Portland Retail Druggists Ass'n., 425 U.S. 1, 11 (1976).

The Court recognized that hospitals have evolved into community organizations whose mission, appropriately, is to promote the health of the entire community. In numerous rulings since 1969, the IRS has recognized that the "promotion of health" is a charitable purpose in and of itself.

Revenue Ruling 69-545 recognized that a variety of factors are the pillars of the "community benefit" standard, including operating an emergency room open to all regardless of ability to pay; having an independent board of trustees composed of representatives of the community; having an open medical staff policy with privileges available to all qualified physicians; providing care to all persons in the community able to pay either directly or through third-party payers; and utilizing surplus funds to improve the quality of patient care, expand facilities and advance medical training, education and research.

Those same factors are reflected in the form hospitals use to apply for tax exemption: Form 1023, Application for Recognition of Tax-Exempt Status, Schedule C. It is additionally concerning that Schedule H does not incorporate that same focus and inquire about those factors in seeking to determine compliance. At the very least, this inconsistency could unfairly increase the likelihood of a hospital being subjected to an IRS audit.

Since 1969, the IRS has applied the community benefit standard by looking at how its five pillars relate to the facts and circumstances of particular hospitals and their communities. This has allowed hospitals to meet the unique needs of their communities, instead of adhering to a rigid "one size fits all" standard. This standard, for example, has allowed hospitals to:

- develop programs that provide uninsured and underinsured patients with free or discounted prescription medications;
- operate dental clinics in public elementary schools;

- help women in the community receive annual breast and pelvic exams;
- strengthen their community's emergency preparedness;
- prepare and support disadvantaged children for school by providing free immunizations and school supplies, as well as after school care;
- provide chaplain visits and counseling for patients;
- support ongoing medical research projects;
- support nurse education and development programs;
- provide counseling and education to prevent and/or address domestic violence;
- make neighborhoods healthier and safer with programs to repair dilapidated or abandoned homes and other neighborhood preventive health services; and
- provide many other services tailored to, and needed by, the community.

Because the mission of hospitals is not just to tend to the sick and injured, but also to promote the health of their communities, many hospital programs and activities go beyond traditional health care. Often, the local hospital provides the social safety net that others have abandoned. Hospitals should be rewarded for assuming this mantle of responsibility and their efforts should be recognized as community benefit. To do otherwise, would, in effect, permit the IRS to substitute its judgment about a community's needs for that of an independent board of hospital trustees who truly know and represent the community served by the hospital.

SCHEDULE H SHOULD BE DELAYED UNTIL 2010

The hospital community has demonstrated in many ways its commitment to transparency. However, even under ideal conditions, the burden of reconfiguring financial and data record-keeping systems to capture by January 1, 2008 the substantial amount of information required just for Schedule H is a daunting task. It is made virtually impossible without the necessary instructions, definitions and worksheets that the IRS does not expect to finalize until the following June. Even if the IRS completes the revised form and instructions before June 2008, it is impossible for hospitals to predict what will need to be changed to permit data collection by January 1, 2008.

The tax-exempt hospital community has agreed that reporting a diversity of community benefit in a uniform manner, as reflected in part by the Catholic Hospital Association's and VHA's *Guide for Planning and Reporting Community Benefit* (Guide), is another important step toward transparency. However, the IRS should not lose sight of the practical challenges and costs that commitment entails. For example, a rural hospital that has had some experience with the Guide reports that it requires between 20-22 days of staff time to collect and report the required information.

We conservatively estimate that only half of the nation's tax-exempt hospitals have had practical experience gathering and reporting data using the Guide. Those that have not will therefore require additional time to, among other tasks, redesign or purchase and install the necessary new software systems. And if other areas of questioning remain on Schedule H, they would require substantial additional work and cost.

We believe that, had the IRS conducted an analysis of the burden of complying with the new Schedule H, the analysis would have demonstrated a clear need for at least a two-year delay.

Given the number of concerns and questions about Schedule H, we urge the IRS to provide a second draft in 2008, followed by a review period, with a goal of finalizing the schedule and instructions by December 31, 2008. That would give hospitals all of 2009 to revise their financial and data record-keeping systems so that they accurately capture the new information that would be reported for tax year 2010.

MEDICARE UNDERPAYMENTS AND BAD DEBT ARE COMMUNITY BENEFIT

The IRS should incorporate the full value of the community benefit that hospitals provide by counting Medicare underpayments as quantifiable community benefit and modifying the chart, instructions and worksheets accordingly. That is because:

- Providing care for the elderly and serving Medicare patients is an essential part of the community benefit standard.
- Medicare, like Medicaid, does not pay the full cost of care. Currently, Medicare reimburses hospitals only 92 cents for every dollar they spend to take care of Medicare patients. The Medicare Payment Advisory Commission (MedPAC) in its March 2007 report to Congress cautioned that underpayment will get even worse, with margins reaching a 10-year low at *negative* 5.4 percent.
- Many Medicare beneficiaries, like their Medicaid counterparts, are poor. More than 46 percent of Medicare spending is for beneficiaries whose income is below 200 percent of the federal poverty level. Many of those Medicare beneficiaries are also eligible for Medicaid -- so-called 'dual eligibles."

There is every compelling public policy reason to treat Medicare and Medicaid underpayments alike. Medicare underpayment must be shouldered by the hospital in order to continue treating the community's elderly and poor. These underpayments represent a real cost of serving the community and should count as a quantifiable community benefit.

Patient bad debt is a community benefit. Like Medicare underpayment, there also are compelling reasons that patient bad debt should be counted as quantifiable community benefit.

- A significant majority of bad debt is attributable to low-income patients, who, for many reasons, decline to complete the forms required to establish eligibility for hospitals' charity care or financial assistance programs. A 2006 Congressional Budget Office (CBO) report, *Nonprofit Hospitals and the Provision of Community Benefits,* cited two studies indicating that "the great majority of bad debt was attributable to patients with incomes below 200% of the federal poverty line."

- The CBO concluded that its findings "support the validity of the use of uncompensated care [bad debt and charity care] as a measure of community benefits" assuming the

findings are generalizable nationwide; the experience of hospitals around the nation reinforces that they are generalizable.

Despite hospitals' best efforts, patient bad debt is a fact of life. The IRS should not ignore it or attribute it to a lack of industry on the part of the tax-exempt hospital community. It is, rather, part of the evolving burden hospitals must shoulder in helping patients who, for many reasons, decline to take advantage of available financial assistance. It is a real cost of serving the community and the IRS should recognize any reasonable method to count patient bad debt as a quantifiable community benefit.

THE SCHEDULE H FORM NEEDS TO BE CHANGED

In addition to incorporating questions necessary to determine compliance with the community benefit standard, to the extent that the IRS intends to ask discretionary questions, we have a number of recommendations for streamlining the form to eliminate unnecessary burden and for improving the questions that remain.

Eliminate Questions Unrelated to Community Benefit

The proposed chart on draft Schedule H, Part II relating to billing should be eliminated for many reasons. First, because the information sought in the chart has no relationship to the community benefit standard, it does not contribute to the IRS' goal of promoting compliance.

Second, providing the information required by the billing chart is burdensome, and thereby undermines the IRS' goal of minimizing burden. By necessity, hospital billing operations are complicated. Hospitals do not retain the data in the same discrete categories requested by the IRS. For example, many, if not most, hospitals classify patients as "self pay," not "insured" and "uninsured" as the chart suggests. Sorting data to satisfy the chart's requirements would be immensely burdensome. In its comment letter to the IRS, one Texas hospital estimated that "it may require up to a month of extra staff work" just to provide this information. Similarly, a hospital in New Hampshire estimated it would require "in excess of 1,000 hours of extra staff work to provide."

Third, the data requested could be competitively sensitive. In markets across the country that are characterized by a shrinking number of health insurance plans, asking for information about discounts is tantamount to revealing confidential information on the discounts insurers demand from hospitals. This cannot be the sort of transparency the IRS was seeking.

The AHA is committed to helping the IRS get the information it needs to meet its goals. However, in this instance, it is difficult to determine precisely what relevant information is unavailable. If the IRS is seeking more information on Medicare and Medicaid revenues, that can be found in draft Form 990; if it seeks more information on charity care, that can be found in the section on quantifiable community benefit; if it seeks more information on a hospital's financial assistance practices and policies, those subjects are covered by other questions in Schedule H. If more detail is required on any of those subjects, portions of the Form or schedule

can be enhanced to include them. The IRS should not create defacto new reporting requirements through the expedient of this billing chart.

Include Community Building Activities as Quantifiable Community Benefit
The IRS should reinstate reporting for community-building activities, which would include community activities undertaken by hospitals that contribute to the overall mental, physical and social well-being of the community.

In its decision cited earlier, the U.S. Supreme Court recognized that hospitals had evolved beyond the activities anticipated in 1938. Likewise, hospital activities have evolved beyond those anticipated by the Court in 1976. They now include serving as a community's health care safety net, with activities such as providing transitional housing for patients, maintaining and updating emergency preparedness, leadership in addressing environmental concerns, and many other less-traditional activities that have become part of the "larger community character" hospitals have adopted responsibility for because, quite simply, no one else is meeting those needs.

The programs now labeled as "community building" contribute to prevention of illness or otherwise address concerns that ultimately affect the community's health and well-being. Moreover, these programs are part of the responsibility assumed by every tax-exempt hospital's independent board of trustees, which is composed of representatives of the community. Once again, the IRS should not substitute its judgment about a community's needs for the judgment of those who are part of the community. Also, the IRS should be concerned that any decision not to include this category could discourage the provision of these community benefits by hospitals, and therefore, leave the community without services upon which it relies.

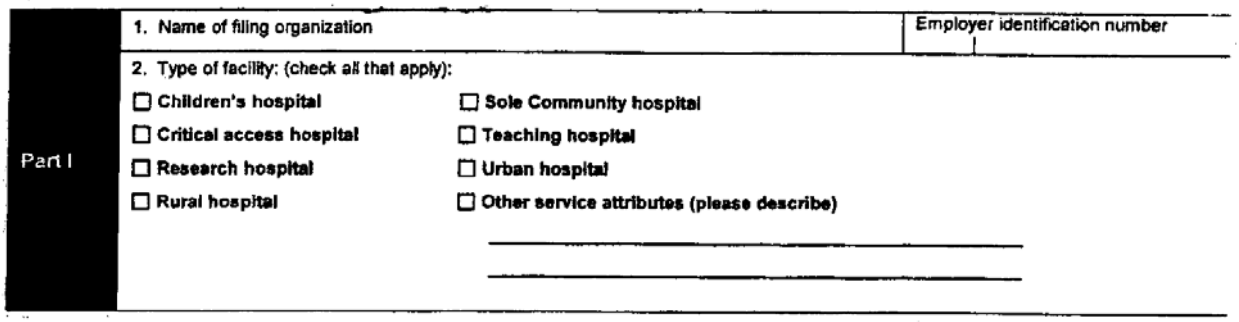
Other Recommended Improvements to the Form:

1. Information on nonquantifiable benefits should precede other requests for information.

   The IRS should reconfigure the form to ensure that questions related to the community benefit standard and discretionary questions on nonquantifiable benefits precede the chart now labeled "Community Benefit Report."

2. The information provided by a hospital should be placed in context.

   IRS should, at the front of the form, add a new section with checkboxes allowing the filing organization to indicate the type of facility or facilities making the report, as follows:



Part I	1. Name of filing organization	Employer identification number
	2. Type of facility: (check all that apply):	
	☐ Children's hospital	☐ Sole Community hospital
	☐ Critical access hospital	☐ Teaching hospital
	☐ Research hospital	☐ Urban hospital
	☐ Rural hospital	☐ Other service attributes (please describe)

3. The IRS should permit live links to hospital information or attachments.

   For a number of questions, including those pertaining to assessing community health needs, community benefit reports and charity care policies, where the amount of space provided is not sufficient to fully describe the hospital's activities, programs or policies, the IRS should permit (not require) the insertion of live links to such information on a hospital Web site, or allow attachments. The IRS already allows attachments to draft Form 990 and should do so here or permit live links.

4. The question on emergency room policies should be reformulated.

   The current question on emergency room policies and procedures should be included among those questions on the front of the form that pertain to the community benefit standard. It also should be streamlined to eliminate confusion and provide information consistent with the community benefit standard and with the experience gained by the IRS in asking similar questions as part of its Compliance Check Questionnaire project.

   We recommend the question be changed to read as follows:

   > "Does the organization operate an emergency room? □ yes □ no.
   > If yes, is it operated 24 hours a day? □ yes □ no.
   > Other than being at capacity, did your emergency room deny services to anyone who needed services? □ yes □ no.
   > If yes, explain."

5. The schedule should highlight a hospital's fundraising efforts for community benefit programs.

   To reflect the commendable efforts of many hospitals in raising additional funds for community benefit programs and activities, the IRS should add a question allowing the hospital to provide information about those activities, whether undertaken by the hospital itself or through related organizations. The worksheets also should properly reflect the value of this fundraising, giving hospitals full financial credit for these efforts as well.

6. Questions on management companies and joint ventures should be merged into other forms or eliminated.

Hospitals are required to provide information on joint ventures three times in three different forms: Form 990, Schedule H and Schedule R. This redundancy does nothing to enhance transparency or minimize burden. As a result, these questions should be eliminated from Schedule H.

If these questions are significant to the IRS, then the entire tax-exempt sector should be required to respond to them. Questions on potential private inurement or benefit arising from ventures, for example, pertain to all exempt organizations, not just hospitals. It is unfair to hospitals, and ultimately to reviewers, to limit those questions to Schedule H.

7. Who must file should be clarified.

As drafted, all organizations that respond "yes" to the question "Did the organization operate, or maintain a facility to provide hospital or medical care?" must complete Schedule H. This question is too broad and will sweep up facilities that are not hospitals. A definition of "hospital" should be added as follows:

"A hospital is a health care organization that has a governing body, an organized medical staff and professional staff, and inpatient facilities and provides medical, nursing, and related services for ill and injured patients 24 hours per day, seven days per week. *A hospital is a facility (and all of its components) that is licensed in its state as a:*

√ *hospital*
√ *chronic disease hospital or hospital for treating certain disease categories*
√ *rehabilitation hospital*
√ *acute long term care hospital*
√ *children's hospital*
√ *psychiatric hospital*
√ *research hospital*

A hospital does <u>not</u> include:

√ *a nursing facility (including a skilled nursing facility, convalescent home, or home for the aged)*
√ *free standing outpatient clinic*
√ *community mental health or drug treatment/rehabilitation center*
√ *physicians' offices*
√ *facility for mentally retarded/developmentally disabled*
√ *facility for treating alcohol and drug abuse*
√ *hospital wing of a school, prison or convent*
√ *faculty practice plan*

8. The question on charity care policies should be reformulated.

   The question now labeled 13b on charity care policies should be revised as follows: "[i]nclude in the description whether the organization (a) bases eligibility for free or discounted care on federal poverty guidelines, income or asset levels, (b) applies such policy to all of its facilities and allows its facilities to adapt its policy to particular community or individual needs, and (c) budgets annually for charity care."

   Hospitals are often faced with situations where patients in need don't neatly fit into a predetermined category, and hospitals need to deviate from their policies to provide assistance. The question should anticipate that hospital policies will need to be flexible enough to accommodate those situations.

   We would also suggest that the IRS consider labeling this question "financial assistance policies."

9. As drafted, Schedule H must be completed in the aggregate for all facilities/hospitals under a single EIN. Part IV Facility Information asks for each "facility" to be listed. Filers with multiple hospitals under a single EIN should have the option to complete Schedule H on either an aggregate basis or by completing it for each hospital included in the EIN.

10. For the section labeled "Quantifiable Community Benefits," in addition to moving it, change the chart heading from "Charity Care" to "Unreimbursed Costs for Care Provided," and change the column (b) header from "Persons Served" to "Patient Encounters." Omit the references to community benefit in the column (c) and (e) headers and restate as "Total expense" and "Net expense."

11. Instructions relating to community benefit operations should clarify that this category may include permissible physician recruitment expenses if part of an overall community benefit strategy in line with Revenue Ruling 97-12.

12. Improvements to Worksheets 5 (health professions education) and 7 (research) that will be submitted to the IRS by the Association of American Medical Colleges (AAMC) should be incorporated into worksheets for Schedule H.

13. Line 12a should be revised to ask whether the organization *or a related organization* prepares an annual community benefit report. This reflects the fact that, within a health system, an affiliated foundation of a hospital or the parent holding company may actually prepare a system-wide or hospital-specific community benefit report on behalf of the hospital.

14. The facility chart requires that the programs be described for each facility. This information could amount to multiple pages for many hospitals. The chart should be

streamlined to ask only for the name and address of the facility in column A and for the "type" of facility in column B.

We appreciate the opportunity to submit our comments, and we especially appreciate the IRS' efforts to reach out to the hospital community and better understand its concerns. We welcome the opportunity to help the IRS improve draft Schedule H. If you have any further questions, please contact me at (202) 626-2336 or mhatton@aha.org.

Sincerely,

Melinda Reid Hatton
Senior Vice President and General Counsel

From:	Palmers
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	
Date:	Tuesday, August 21, 2007 1:54:23 PM
Attachments:	

We have just finished an initial review of your Background Paper on Redesigned Draft Form 990.

Implementation of these regs is going to take time, necessitating some changes to our accounting system.

We ask for a transition period of at least one year after the regulations are promulgated, eg, applicable to the 2008 tax tear at the earliest..

Glenn Palmer, Financial Chair
Botanical Gardens at Asheville

From:	Johnson Brenda
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	IRS--990 Comment Letter
Date:	Tuesday, August 21, 2007 1:44:33 PM
Attachments:	08.10.07.IRS 990Comment Ltr.MHA.CP.pdf

Brenda B. Johnson, Executive Assistant
Maryland Hospital Association (MHA)
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Maryland
Hospital Association

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August 10, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, N.W.
Washington, D.C. 20224

Re: Comments on Proposed Form 990 and Schedule H

On behalf of the 69 member hospitals of the Maryland Hospital Association (MHA), this letter is written to submit our comments on the draft revised Form 990 and Schedule H. We appreciate the IRS efforts to solicit public comment on its draft form and schedules.

Maryland Hospitals Merit Special Consideration under Schedule H

At the outset, we want to emphasize that Maryland hospitals meet and exceed the community benefit standard established by the 1969 IRS Ruling. That standard requires hospitals to: (1) operate an emergency room open to all regardless of ability to pay; (2) have an independent board of trustees comprised of representatives of the community; (3) have an open medical staff policy with privileges available to all qualified physicians; (4) provide care to all persons in the community; and, (5) utilize surplus funds to improve the quality of patient care, expand facilities, and advance medical training, education, and research.

For the last 30 years, Maryland hospitals have met these community benefit obligations in a unique manner that builds the costs of uncompensated care—charity care and patient bad debt—and graduate medical education into the rates that hospitals are reimbursed by all payors. The system is based in federal and state law and benefits all Maryland residents, including those in need of financial assistance to pay their hospital bills.

And, Maryland is the only state in which all payors—governmentally-insured, commercially-insured, or self-pay—are charged the same price for services at any given hospital.

Under this system, Maryland hospitals are regulated by a state agency—the Health Services Cost Review Commission (HSCRC)—that is required to:

- Publicly disclose information on the cost and financial position of hospitals;
- Review and approve hospital rates;
- Collect information detailing transactions between hospitals and firms with which their trustees have a financial interest; and,
- Maintain the solvency of efficient and effective hospitals.

- more -

More recently, in 2000, the Maryland state legislature required the HSCRC to establish a framework for reporting hospitals' community benefits and issuing a report annually regarding hospitals' community benefit totals *(see attached reporting format)*.

According to the HSCRC, Maryland hospitals provided over $233 million in charity care, in fiscal year 2006. Beyond that, our hospitals provided an additional $490 million worth of benefits to their communities through other activities, such as clinics for underserved communities, education programs for at-risk populations, and community health improvement advocacy, among others. These programs and services touched the lives of over 700,000 people.

Therefore, the IRS needs to takes measures to clearly distinguish Maryland hospitals from other hospitals, so that the quantifiable benefits our hospitals' reports will not be misinterpreted.

We suggest the IRS allow Maryland hospitals to provide a standard notation or explanation on the front page of the form or some other mechanism to alert reviewers to their unique circumstances. We believe it is vital to assure that their information is reviewed in the proper context and not used in aggregate calculations.

The Draft Form 990 and Schedules Will Require a Two-Year Transition

Based on our experience with data reporting in Maryland, we recommend the IRS extend the implementation of the revised Form 990 and its draft schedules until at least 2010. Given the large amount of data that the IRS is seeking, a two-year transition is essential to ensure accuracy.

Delete the Billing Chart on Draft Schedule H

We also recommend that the billing chart that appears on page 2 of draft Schedule H be eliminated. Among other concerns, Maryland's unique rate-setting system would render that chart even more confusing for reviewers of the data.

In conclusion, we thank the IRS for this opportunity to comment on the draft Form 990 and its new schedules. Please do not hesitate to contact us with comments, questions, or concerns.

Thank you for your consideration of our suggestions.

Sincerely,
MARYLAND HOSPITAL ASSOCIATION

Cal Pierson

Calvin M. Pierson
President

Attachment

Maryland Hospital Community Benefit Report
FY 2006

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

June 8, 2007

Maryland Hospital Community Benefit Report
(Fiscal Year 2006)

Introduction

Each year, the Health Services Cost Review Commission ("Commission" or "HSCRC") collects hospital community benefit information from individual hospitals to compile into a publicly-available statewide Community Benefit Report (CBR). This larger statewide document contains summary information for all submitting Maryland hospitals; individual hospital community benefit reports and additional documents are available in written format at the Commission's offices. Individual community benefit report data spreadsheets will be available on the Commission's website in June 2007.

The community benefit report is an opportunity for each Maryland hospital to critically examine, evaluate, and report the nature, impact, long term sustainability, and success of community benefit activities. The HSCRC has viewed the CBR as a work-in-progress, evolving to keep pace with the changing environment of national experience and, in part, to the start-up nature of Maryland's efforts. It is expected that Maryland's initiative will take several years to mature.

For the Commissions third community benefit report, Maryland hospitals and the Commission worked collaboratively with one anther and many interested parties, including local health departments and other State and national organizations. The HSCRC commits to continuing this work to further improve the report and to refine definitions as needed.

What are Community Benefits?

As defined under current Maryland law, community benefit means an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:

- Health services provided to vulnerable or underserved populations;
- Financial or in-kind support of public health programs;
- Donations of funds, property, or other resources that contribute to a community priority;
- Health care cost containment activities; and
- Health education, screening, and prevention services.

As evidenced in this report, Maryland hospitals provide a broad range of health services to meet the needs of their communities, often receiving partial or no compensation. These activities are expected from Maryland's 46 not-for-profit hospitals however, as a result of the tax exemptions they receive.[1]

CBR – 2006 Highlights

For FY 2006 Maryland hospitals reported providing a total of over $723 million in benefits to their communities. Of this, $253 million was provided in health professionals education activities, over $233 million in charity care, over $143 million for mission driven

[1] As Maryland's only for-profit hospital, Southern Maryland Hospital is not required to submit a community benefit report, under the law. Southern Maryland did, however, submit a community benefit report to the HSCRC for FY 2006 which has been included in this report.

health services, $50 million in community health services, $14 million in financial contributions, $12.5 million in community building activities, just under $5 million in foundation community benefit initiatives, $5.6 million in research efforts, and $5.8 million in community benefit operations.[2]

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit
Community Health Services	649,849	7,743,277	$50,244,104
Health Professions Education	4,412,762	388,468[3]	$253,359,231
Mission Driven Health Services	1,954,102	708,464	$143,107,928
Research	38,665	30,155	$5,606,697
Financial Contributions	43,393	232,318	$14,472,956
Community Building	139,016	108,948	$12,527,653
Community Benefit Operations	83,244	99,355	$5,851,868
Charity Care	n/a	n/a	$233,152,469
Foundation	11,554	441	$4,961,715
Total	7,332,565	9,311,425	$723,284,621

For additional detail and description of subcategories under each community benefit category, please see the chart under Attachment I – Aggregated Hospital CBR Data.

Background

Since 2003, the Commission has worked with the Maryland Hospital Association and interested hospitals, local health departments, and health policy organizations and associations on the original details and format and updates to the community benefit report. The Fiscal Year 2006 report represents the HSCRC's third effort to capture Maryland Hospital Community Benefit data.

The reporting period for this Community Benefit Report is July 1, 2005 – June 30, 2006. Hospitals submitted their individual community benefit reports by January 1, 2007 to the HSCRC using audited financial statements as the source for calculating costs in each of the care categories.

The Maryland data reporting spreadsheet and instructions draw heavily on the VHA community benefits initiative, which offers ten-plus years of voluntary hospital community benefit reporting experience across many states and individual community benefit reporting efforts. The VHA developed a standardized approach to community benefit definitions and

[2] These totals include hospital reported indirect costs, which vary by hospital from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

[3] For health professions educations, many hospitals did not provide the number of encounters in their community benefit data.

reporting practices, which was then tailored with help from VHA, Catholic Health Association (which also has many years of national community benefit reporting experience), the Maryland Hospital Association, and participating members of the Community Benefit Workgroup to fit Maryland's unique regulated environment.

Maryland had to make special accommodations to reflect the benefits of hospital rate setting on community benefits. In other states, the majority of hospital community benefits are reported in three areas – shortfalls from governmental payers, charity care, and medical education costs. In Maryland, however, the HSCRC rate setting system builds the costs of uncompensated care (both charity care and bad debt) and teaching for graduate medical education in the rates hospitals are reimbursed, and all payers (including Medicare and Medicaid) pay the same rates for hospital care. To this end, the HSCRC provides data in this report on the revenue provided for the Nurse Support Program, uncompensated care, and graduate medical education, which are funded through hospital rates by all payers (see Attachment III). In their individual community benefit reports, hospitals were asked not to include revenue provided from hospital rates as offsetting revenue.

While it would be impossible for the HSCRC to provide a one-for-one match with the data reported by hospitals in the individual CBRs, the Commission believed it was necessary for readers to understand that Maryland hospitals receive offsetting revenue through hospital rates for programs identified within the individual community benefit reports.

Changes to Community Benefit Reporting: FY2005 to FY 2006

As described in HSCRC's FY 2005 Community Benefit Report, the Commission adopted the VHA, CHA, and Lyon software changes, modified (as before) to meet Maryland's unique regulated environment. This change offered a vetted and standardized approach to community benefits reporting developed after more than a year of collaboration among a diverse group of national health care organizations. The improved guidelines also permitted Maryland hospitals the ability to track their performance to external health care organizations. This again places Maryland at the forefront of public reporting and accountability, an important feature as groups continue to challenge whether or not not-for-profit health care organizations deserve continued tax exemption status.

Due the wide variety of changes from 2004 to 2005, and for more comparability between annual statewide reports, the Commission chose to keep the 2006 reporting format identical to the 2005 format. Additionally, hospitals were asked to file mission statements, charity care policies, and/or community needs assessments used if there had been an update or revision since the hospital's original submission to the HSCRC. Most hospitals did not file updates or revisions to their policies. Hospitals were also required to provide a description of gaps in the availability of specialist providers to serve the uninsured in the hospital.

Indirect Costs

As in 2005, hospitals were permitted two options within the indirect cost column. The first is unchanged from FY 2004 – the ability to allow the spreadsheet to calculate a standard indirect cost amount by community benefit category (based on the number entered under spreadsheet I1, calculated from the hospitals financial data).

In FYs 2005 & 2006, hospitals also had the ability to enter a specific dollar amount in the indirect cost column for a particular community benefit initiative or program if it believes the spreadsheet number is unreasonable or if it believes direct costs are already contained within the

hospital's reported direct costs. This enabled hospitals to distinguish indirect costs by community benefit initiative on the spreadsheet.

Issues

The standardized reporting format for community benefits will not result in identical reports from Maryland hospitals. As most hospitals address community needs in the most appropriate manner and setting, reporting of the community benefit may not be allocated in exactly the same category or result in the same amount of reportable costs. For example, one hospital may conduct childhood immunizations at its local Head Start facility, while another hospital may find that an on-campus hospital facility is more centrally located to the community.

Physician Subsidization Costs

In previous years, many hospitals identified broad physician subsidy costs. The subsidies varied by hospital service (obstetrics, pediatrics, psychiatric, neonatal, emergency, and anesthesiology) and by type (on call, charity care provided by facility-owned physician groups, and general subsidy costs). Based on this experience, the Commission asked hospitals to include more detail describing the nature of these physician subsidies for the FY 2005 & 2006 report.

For FY 2006, hospitals reported over $52 million in physician subsidies, which includes the hospital services and types describe above. The number is slightly down from FY 2005, where over $53 million in physician subsidies was reported. The Commission would like to credit the drop in physician subsidies reported to properly allocated subsidies. It is difficult, however, to draw such a conclusion as many hospitals have not provided sufficiently detailed information for review. Additionally, indirect costs for physician subsidies varied widely between and among hospitals, from 0-82% among hospitals and from 0-30% within one hospital reporting different types of physician subsidies. Compounding the issue is that some hospitals simply applied the hospital's standard hospital indirect cost percentage to its unique physician subsidy program.

As such, the Commission will be convening a workgroup of interested parties to more thoroughly examine the issue of physician subsidies and how they relate to community benefits. The HSCRC expects to convene this group during the 2007 summer for use in the FY 2007 CBR.

The HSCRC would direct readers to the individual hospital community benefit report submission of interest for readers interested in more information regarding an individual hospital's reported physician subsidy information. The individual submissions are available for review in the HSCRC office.

Indirect Cost Ratio

Hospitals report the direct costs of offering specific community benefits initiatives in their CBR inventory worksheet. To eliminate the probability that hospitals would uniquely account for indirect costs (overhead, accounting, and personnel costs, etc.), the HSCRC originally directed hospitals to calculate a specific indirect cost ratio from the hospital's Annual Cost Report data that is used throughout the hospital's CBR inventory worksheet. The model for calculation can be found within the HSCRC's CBR instructions.

While hospitals were directed to use the annual audited cost report data to calculate the ratio, ratios continue to vary widely between hospitals. While the HSCRC permitted indirect costs to be applied to all community benefit categories, for FY 2005 and FY 2006 the Commission asked hospitals to pay closer attention to how indirect costs are accounted for, and

to consider if direct costs include either a portion or the total of indirect costs for a particular category. Additionally, many hospitals believed that the standard formula that computed indirect costs in the HSCRC reporting spreadsheet did, in fact, overestimate indirect costs for a community benefit reporting category, especially as they related to hospital community benefit projects that were unique to a particular facility.

An example of the indirect cost ratio issue can be seen when comparing two disparate categories where an identical cost ratio is applied. Using a standardized indirect cost percentage for such items as cash donations, physical and environmental improvements, etc. and medical education community health services, and charity care, a hospital with a 50% indirect cost ratio that contributes a $100,000 donation to its local United Way organization yields a $50,000 indirect cost value that is applied to the hospital's total CBR activity. As a result, many hospitals suggested that having the option of overriding the standard percentage within a community benefit category may provide a more accurate accounting of community benefits in future reports.

To that end, the HSCRC worked with hospitals to provide hospitals the ability to override the standard indirect cost ratio within the CBR worksheet in FY 2005, which was again the practice for FY 2006. The numerous changes between the FY 2004 and FY 2005 community benefit reporting categories introduced complications in comparing one year's totals to the next. The following chart is a comparison of FY 2005 and FY 2006 community benefit reporting categories and is much more indicative of the growth or decline within each community benefit category.

	2006 Net Community Benefit W/Indirect Costs	2005 Net Community Benefit W/Indirect Costs	% Increase from 2005 to 2006 W/Indirect Costs	2006 Net Community Benefit W/O Indirect Costs	2005 Net Community Benefit W/O Indirect Costs	% Increase from 2005 to 2006 W/O Indirect Cost
A. Community Health Services	$50,244,103.64	$45,437,118.30	10.58%	$30,338,977.11	$26,355,956.32	15.11%
B. Health Professions Education	$253,359,231.32	$255,118,493.77	-0.69%	$173,613,608.72	$174,572,577.67	-0.55%
C. Mission Driven Health Services	$143,107,927.87	$120,647,698.17	18.62%	$81,208,866.98	$65,930,115.93	23.17%
D. Research	$5,606,697.39	$6,463,049.74	-13.25%	$1,526,975.79	$2,046,912.17	-25.40%
E. Financial Contributions	$14,472,955.94	$13,112,273.49	10.38%	$12,606,178.37	$10,850,036.07	16.19%
F. Community Building Activities	$12,527,652.85	$11,109,868.13	12.76%	$7,140,464.32	$6,031,135.47	18.39%
G. Community Benefit Operations	$5,851,868.42	$3,407,408.66	71.74%	$3,668,226.17	$2,288,295.83	60.30%
H. Charity Care	$233,152,468.91	$194,734,508.78	19.73%	$233,152,468.91	$194,734,508.78	19.73%
J. Foundation Community Benefit	$4,961,714.63	$5,678,755.66	-12.63%	$3,549,993.01	$3,625,864.31	-2.09%
K. Total Hospital Community Benefit	$723,284,620.98	$655,709,174.71	10.31%	$546,805,759.36	$291,700,893.79	87.45%

In total, community benefit activities overall increased by 87.45%, without including indirect costs. When counting indirect costs, the overall increase rises by 10.31%.

Community Benefits Evaluation and Community Needs Assessments

During the FY 2004 reporting period, many hospitals had difficulty reporting on community benefit evaluation efforts. Most hospitals have undertaken a community benefits evaluation, but efforts range from patient satisfaction surveys to evaluations of the effectiveness

of a targeted community benefit initiative. As the community benefit law is broad with regard to evaluation efforts, the Commission had asked hospitals to provide information on the steps taken to evaluate the effectiveness of its community benefit initiatives and chose not to prescribe the type of evaluation effort Maryland hospitals should employ. Additionally, the Commission believed it was necessary to focus first year reporting efforts on implementing the new community benefit reporting requirements and achieving as much data consistency between hospitals as possible.

The Commission worked with many interested parties to develop an evaluation framework for hospitals to use in determining appropriate information to submit along with the community benefit data spreadsheet for FY2005. The evaluation framework contained a list of succinct questions that hospitals were to pose internally and answer to give the public a better understanding of how a hospital's community benefit are evaluated, if they are incorporated into the facility's overall strategic plan, the sustainability of initiatives, and other related information.

Many hospitals chose to use the evaluation framework. Some hospitals, however, continue to use existing or hospital specific evaluations. As such, evaluations efforts continue to be inconsistent across reporting hospitals.

Hospital Rate Support for Community Benefit Programs

In Maryland, the costs of uncompensated care (both charity care and bad debt) and graduate medical education are built into rates that hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC also includes amounts in rates for hospital nurse support programs provided at Maryland hospitals. To avoid accounting confusion between programs that are not funded in part or in whole through hospital rate funds (regulated) or programs that are not funded by the hospital rate funds (unregulated), the HSCRC asked hospitals not to include revenue provided in rates as offsetting revenue on the CBR worksheet.

The following section details the amounts of Nurse Support Program, uncompensated care, and graduate medical education (both direct and indirect), costs that are included in rates for Maryland hospitals in Fiscal Year 2006 funded by all payers.

Nurse Support I Program

The Nurse Support Program provides hospitals with grants to increase the recruitment and retention of nurses in Maryland hospitals. In FY 2006, just over $8.5 million was provided to Maryland hospitals to increase the recruitment and retention of nurses in Maryland hospitals.

For further information about funding provided to specific hospitals, please see Attachment II.

Uncompensated Care

The HSCRC includes amount in hospital rates for uncompensated care; this includes charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). In FY 2006, over $793 million was provided in Maryland hospital rates for the provision of both charity care and hospital bad debt funded by all payers. Hospitals were asked not to include revenue provided through hospital rates as offsetting revenue on the CBR worksheet.

For further information about funding provided to specific hospitals, please see Attachment II.

Graduate Medical Education

Another social cost funded in Maryland's rate-setting system is the cost of graduate medical education (GME), generally for interns and residents trained in Maryland hospitals. Graduate medical education costs are divided into direct and indirect medical education components for identification and reimbursement purposes. Direct medical education costs are benefits of residents and interns, faculty supervisory expenses, and allocated overhead. By contrast, indirect medical education expenses are generally described as those additional costs incurred as a result of the teaching program (e.g., increase patient severity associated with teaching programs and inefficiencies, such as extra tests ordered by interns/residents or the extra costs of supervision). The Commission utilizes an annual hospital intern and resident count to assist in quantifying the direct and indirect costs of medical education in physician training programs and recognizes only the interns and residents included on the survey up the hospital's cap. Any resident and intern costs above the hospital's recognized cap, therefore would not be funded through hospital rates.

While the intern and resident information has been collected for FY 2006 from Maryland hospitals, the HSCRC has not yet calculated the amounts. FY 2005 numbers, therefore, are used in Attachment II for illustrative purposes only.

For further information about funding provided to specific hospitals, please see Attachment II.

Conclusion

The HSCRC views Maryland's Community Benefit Report as an evolving project, where the Commission hopes to continue building upon the success of three year's reporting efforts and add to the value of the report in future CBRs.

The Commission would like to thank the many hospitals' and public and private organizations' efforts that culminated with the production of this report. We would also ask for their continued assistance, as the Commission works to refine and improve the public policy value of Maryland's Community Benefit Report.