Nonprofit Hospitals:

Inconsistent Data Obscure the Economic Value of Their Benefit to Communities, and the Franchise Tax Board Could More Closely Monitor Their Tax-Exempt Status

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The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning whether the activities performed by nonprofit hospitals that are exempt from paying taxes because of their nonprofit status, truly qualify as charitable activities that provide a broad public benefit and are consistent with exempt purposes.

This report concludes that when taken as a percentage of net patient revenues—the actual amounts a hospital receives from patients and third-party payers, such as health coverage programs—the uncompensated-care costs provided by nonprofit and for-profit hospitals were not significantly different, both including and excluding Medi-Cal costs. Benefits provided to the community, which only nonprofit hospitals are required to report, differentiate nonprofit hospitals from for-profit hospitals, but the categories of services and the associated economic value are not consistently reported among nonprofit hospitals.

Although state law requires that tax-exempt hospitals submit a community benefit plan that describes the activities undertaken to address community needs and assign and report economic values to those benefits, it does not mandate a uniform reporting standard. As a result, tax-exempt hospitals report their community benefits using different categories and different methods for calculating their economic value. In addition, we noted significant errors in the values for tax-exempt hospitals' property reported by county assessors. Lacking more reliable data, we used the reported economic value of community benefits and reported property values to estimate the value of taxes not paid by tax-exempt hospitals. We estimated that the community benefits reported by tax-exempt hospitals, which were about $656 million in 2005, were roughly 2.7 times the $242 million in income and property taxes not collected. However, because our estimate is based partially on flawed data, more precise estimates based on complete and accurate data could produce a different result. Moreover, the Franchise Tax Board does not adequately monitor the continuing eligibility of California's income-tax-exempt nonprofit hospitals.

Respectfully submitted,

Elaine M. Howle

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State Auditor

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Results in Brief

State law permits certain organizations, including hospitals, to obtain exemptions from paying state corporation income taxes (income taxes) and local property taxes if they are organized and operated for nonprofit purposes. California has roughly 344 private hospitals in operation, of which about 223 are eligible for income and property tax exemptions because of their nonprofit status. State law gives the Franchise Tax Board (tax board) the responsibility of determining whether an organization, such as a nonprofit hospital, qualifies for an exemption from paying income taxes, and the State Board of Equalization (Equalization) and county tax assessors (county assessors) are responsible for determining whether nonprofit hospitals qualify for an exemption from paying local property taxes.

State law also requires the Office of Statewide Health Planning and Development (Health Planning) to annually collect financial information from hospitals and other health facilities. Hospitals are required to follow Health Planning's accounting and reporting manual when reporting their financial information. Included in the financial information are amounts that Health Planning uses to estimate the value of care that nonprofit and for-profit hospitals provide without receiving compensation (uncompensated-care costs). However, because the term *uncompensated-care cost* can include many different categories of care, Health Planning has provided three methods of estimating those costs using combinations of three accounts reported by the hospitals: charity care, bad debt, and the contractual adjustment for the county indigent program (CIP). The charity care account includes the unpaid charges for services provided to a patient whom a hospital determined cannot pay in part or in full. Bad debt is the uncollectible payment that a hospital expected a patient to pay but did not receive. The CIP is a program unique to California that is available to certain individuals the State has identified as indigent. The CIP contractual adjustment account is charged with the difference between the amount the hospital received under the CIP and the amount it would have charged a patient who could pay.

According to Health Planning, it chose the three components of its estimates of uncompensated-care costs to be similar to national standards and still take into account the unique reporting requirements of the CIP. Although Health Planning limits its estimate to three components, we expanded the estimate to include a fourth component—the unreimbursed costs of providing services to those eligible for Medi-Cal. We included Medi-Cal costs because (1) the guidance provided to hospitals by the American

Audit Highlights . . .

Our review of tax-exempt hospitals revealed the following:

- *About 223 of California's 344 hospitals are eligible for income and property tax exemptions because they are organized and operated for nonprofit purposes.*
- *Comparing financial data reported by nonprofit and for-profit hospitals indicated the uncompensated care provided by the two types of hospitals was not significantly different.*
- *Benefits provided to the community, which only nonprofit hospitals are required to report, differentiate nonprofit hospitals from for-profit hospitals, but the categories of services and the associated economic value are not consistently reported among nonprofit hospitals.*
- *The values of tax-exempt buildings and contents owned by nonprofit hospitals are frequently misreported by county assessors.*
- *Lacking more reliable data, we used the reported economic values of community benefits and tax-exempt property to estimate that reported community benefits of $656 million for 2005 were roughly 2.7 times the estimated $242 million in state corporation income taxes and property taxes not collected from nonprofit hospitals.*
- *The Franchise Tax Board, which administers state income tax exemptions, could better use available tools, such as annual filings and audits, to monitor the continuing eligibility of nonprofit hospitals for their tax exemption.*

Hospital Association identifies those costs as a component of uncompensated-care costs and (2) Medi-Cal costs are significant to both nonprofit and for-profit hospitals.

Using the total financial data for charity care, bad debt, and the CIP contractual adjustment obtained from Health Planning, we compared the uncompensated-care costs of the nonprofit hospitals with those of for-profit hospitals for the five-year period from 2001 to 2005, both including and excluding Medi-Cal costs. When taken as a percentage of net patient revenues—the actual amounts a hospital receives from patients and third-party payers, such as health coverage programs—the uncompensated-care costs of the two types of hospitals were not significantly different, both including and excluding Medi-Cal costs. However, the various community benefits that nonprofit hospitals provide differentiate them from for-profit hospitals.

State law also requires that most tax-exempt hospitals annually submit a community benefit plan (plan) to Health Planning. However, the law clearly states that a plan cannot be used to justify the tax-exempt status of a nonprofit hospital. A plan must describe the activities the hospital has undertaken to address community needs and must assign and report the economic values of the community benefits the hospital provides. In addition, it must list services that would be provided to the community by both nonprofit and for-profit hospitals, as well as services that only tax-exempt hospitals are required to report, such as community-oriented wellness and promotion, medical research, and other outreach activities.

Although state law requires that tax-exempt hospitals submit plans to Health Planning, it does not require Health Planning to review the plans to ensure that hospitals report the same types of data consistently, nor does Health Planning do so. Our review of the plans submitted by a sample of eight tax-exempt hospitals and our discussions with hospital staff revealed differences in the categories included in the plans and the methods used to calculate the economic values of community benefits. For example, some plans included the unreimbursed cost of Medicare, as recommended by the American Hospital Association, whereas others did not.

We tried to compare the economic values of the community benefits that tax-exempt hospitals provided with the income taxes they did not pay; however, the absence of complete and accurate data precluded a reliable and meaningful comparison. According to the tax board, it has not attempted to estimate the income taxes not collected from tax-exempt hospitals. Therefore, we estimated the uncollected taxes using the state corporation income tax rate and the economic values that tax-exempt hospitals assigned to the

benefits they provided to their communities and reported in their plans in 2005. We used the reported values of these community benefits under the assumption that nonprofit hospitals use revenues that might otherwise be considered profits to provide community services. However, because tax-exempt hospitals reported their community benefits in an inconsistent manner, it was difficult to determine the community benefits that only tax-exempt hospitals might provide. Using our methodology, we estimated the income taxes not collected to be $58 million, but we cannot attest to the reliability of that estimate.

We also estimated the amount of property taxes not collected from tax-exempt hospitals, using the values of the buildings and contents owned by tax-exempt hospitals and reported to Equalization. Although we found numerous errors in the values that prevented us from ensuring the reliability of our calculation, this methodology resulted in an estimate of $184 million in uncollected property taxes in 2005. Combining the two estimates revealed that the economic value of the community benefits reported by the tax-exempt hospitals, which was about $656 million in 2005, was roughly 2.7 times the $242 million in income and property taxes not collected. However, more precise estimates based on complete and accurate data could produce a different result.

As we indicated previously, we found numerous errors in the amounts the county assessors submitted on statistical reports to Equalization. In fact, we found errors in the reported values for four of the 12 hospitals we reviewed, representing a total error of about $204 million. The errors for the remaining 211 nonprofit hospitals in the State that are eligible for tax exemption are unknown. Equalization performs surveys of county assessors to determine the adequacy of the procedures and practices they apply in valuing property for the purpose of taxation and for administering property tax exemptions. Including in these surveys a process for determining whether the county assessors are accurately reporting the values of tax-exempt properties on the annual statistical reports would be valuable.

The tax board, which administers state income tax exemptions, could improve its process of reviewing nonprofit hospitals to ensure their continued eligibility for the exemption. We found minor weaknesses in the process the tax board used in the past to determine the eligibility of nonprofit hospitals for income tax exemptions. However, legislation effective January 1, 2008, will allow the tax board to rely on the federal income tax exemptions determined by the Internal Revenue Service (IRS). Although it was unable to obtain IRS reports and other information on the federal review process and thus could not gain a full understanding of the method the IRS uses to determine eligibility for tax exemptions,

the tax board contended that its research of the IRS Web site, publications, and tax law enabled it to conclude that the IRS process is sufficient to ensure proper determination of state exemption status. The tax board also stated that because state and federal laws on tax exemption are essentially identical, the additional audits it plans to perform—made possible by the workload reduction resulting from its use of IRS eligibility determinations—will compensate for any differences in quality between the state and federal review processes. The tax board indicated, however, that until it identifies the actual savings in workload that may occur when the new law is implemented, it cannot evaluate the opportunities for performing audits of nonprofit hospitals or plan for the number or frequency of such audits.

Moreover, the tax board does not use the tools available to it, such as annual filings and audits, to monitor the continuing eligibility of nonprofit hospitals for income tax exemption. According to management staff at the tax board, annual filings, which contain information such as financial data and changes in business activities, offer the tax board's Exempt Organizations Unit (unit) a useful tool for reviewing ongoing compliance with the requirements for maintaining tax-exempt status. However, the unit does not review the information in the annual filings. Rather, according to tax board management, the revenue information is recorded in the tax board's automated data system, and technicians review the forms only for class code errors and discrepancies in entities' names, numbers, or accounting periods. Management at the tax board stated that the large volume of initial applications for income tax exemptions and limited personnel prevent unit staff from reviewing the annual filings.

In the absence of monitoring by the tax board, hospitals exempt from income taxes sometimes submit annual filings that do not contain all the information required by the form or its instructions or information required under the California Code of Regulations (regulations). In our review of the most current annual filings of nine tax-exempt hospitals, we noted that three did not include the required schedules of other income, five did not include required depreciation schedules, and seven did not include the names and addresses of the five employees who received the highest annual compensation in excess of $30,000 and the amounts each received, although this information is required by the regulations. Moreover, we found that neither the form for the annual filing nor the instructions for completing the form covered all the information the tax board's regulations required. The tax board stated that it is not possible to include all the requirements of the regulations on the form or in the instructions for completing the form.

Regular auditing is another tool the tax board could use to monitor the tax-exempt status of nonprofit hospitals. However, the tax board does not regularly conduct audits of tax-exempt hospitals, even though, based on data provided by the tax board, the revenues of these hospitals represent 17 percent of the total revenue of all tax-exempt organizations. According to the tax board, an audit can originate when members of the public express concern that a tax-exempt organization may be functioning in a manner requiring revocation of its tax-exempt status. The tax board indicated, however, that it could not identify any complaints that might have prompted audits of tax-exempt hospitals, because it does not maintain a central record of the receipt or disposition of those complaints. Rather, complaints against tax-exempt organizations are stored in the tax board's paper files and cannot be easily retrieved.

The tax board stated that the revenue information from annual filings entered into its automated record-keeping system could be used to identify income-tax-exempt nonprofit hospitals to be considered for audit. However, because the tax board has not ensured that all tax-exempt nonprofit hospitals are distinctly identified in its electronic data system, it is unable to efficiently generate a list of the hospitals that might require audits. According to the tax board, creating such a list would necessitate manually reviewing the hard-copy files of the approximately 72,000 tax-exempt organizations operating in the State to determine which are tax-exempt hospitals.

Recommendations

If the Legislature expects plans to contain comparable and consistent data, it should consider enacting statutory requirements that prescribe a mandatory format and methodology for tax-exempt nonprofit hospitals to follow when presenting community benefits in their plans.

If the Legislature intends that exemptions from income and property taxes granted to nonprofit hospitals should be based on hospitals providing a certain level of community benefits, it should consider amending state law to include such requirements.

To ensure that it provides accurate information regarding the value of property that is tax exempt, Equalization should consider including in its surveys of the county tax assessors a process for verifying the accuracy of the values reported on the annual statistical reports submitted by the county assessors.

After it identifies the staff resources that are no longer required for reviewing tax exemption applications, the tax board should implement its plan to use those resources for performing audits of tax-exempt entities, including hospitals.

The tax board should consider developing methodologies to monitor nonprofit hospitals' continuing eligibility for income tax exemption. These methodologies should include the following activities:

- Review the financial and other information from the annual filing submitted by hospitals exempt from income taxes.
- Ensure that the annual filing contains all the information the tax board's regulations specify as necessary for determining eligibility for an income tax exemption.
- Track complaints in a manner that enables the tax board to identify potential trends in noncompliance by income-tax-exempt hospitals and initiate audits of those hospitals.
- Adequately identify tax-exempt hospitals in its automated database, enabling it to use the information in the database to profile those hospitals and identify any potential noncompliance with the law.

Agency Comments

Equalization and the tax board agree with our findings and state they have begun or will begin implementing our recommendations. Health Planning agrees with our findings, but provided added clarification regarding our description of uncompensated-care costs.

Introduction

Background

State law provides that certain organizations, including hospitals that are organized and operated for nonprofit purposes, can be exempt from paying state corporation income tax (income tax) and local property taxes. Of the roughly 344 private hospitals operating in California, about 223 may be eligible for income and property tax exemptions because of their nonprofit status. Additionally, to qualify for a local property tax exemption, a hospital cannot have had operating revenues that exceeded operating expenses by more than 10 percent in the preceding fiscal year, unless the hospital used the excess for debt retirement, plant or facility expansion, or operating cost contingencies. According to data provided by the Franchise Tax Board (tax board), in 2005 nonprofit hospitals represented about 17 percent of the gross revenues of all entities that were exempt from paying income taxes, which include corporations, community chests, and trusts organized and operated exclusively for religious, charitable, scientific, public safety testing, literary, or educational purposes; to foster national or international amateur sports; or for the prevention of cruelty to children or animals.

The Legislature has found that private nonprofit hospitals meet certain needs of their communities by providing essential health care and other services. Public recognition of their unique status has led to favorable tax treatment by the government. In exchange, the Legislature has declared that tax-exempt hospitals assume a social obligation to provide community benefits in the public interest. As of January 1, 1995, state law requires most tax-exempt hospitals to prepare a community needs assessment evaluating the health needs of the community served by the hospital and to update that assessment at least once every three years. The law further requires most tax-exempt hospitals to annually adopt a community benefit plan (plan) that identifies the activities the hospital has undertaken to address community needs. However, state law also explicitly states that a plan cannot be used to justify the tax-exempt status of a hospital.

The Tax Board Grants State Income Tax Exemptions

The tax board administers both personal and corporation income taxes. State law authorizes the tax board to issue the rulings and regulations that are necessary and reasonable to carry out the provisions related to organizations that are exempt from income taxes. The three members of the tax board are the state controller, the chair of the State Board of Equalization (Equalization), and the

director of the Department of Finance. An executive officer appointed by those three members and confirmed by the Senate directs the staff supporting the tax board. California's Revenue and Taxation Code authorizes the tax board to administer and enforce the provisions of the State's corporation tax law and gives it the power to demand that an entity provide information and make available for examination or copying any books, papers, or other data that may be relevant to ascertaining the correctness of a tax return.

Requirements for Hospital Organizations to Receive an Income Tax Exemption

- The organization must be organized and operated for nonprofit purposes.
- None of its net earnings can benefit any individual.
- No substantial part of the organization's activities can involve carrying on propaganda or otherwise attempting to influence legislation.
- The organization cannot participate or intervene in any political campaign on behalf of or in opposition to any candidate for public office.
- On dissolution, the organization's assets must be distributed to a tax-exempt organization.

Source: California Revenue and Taxation Code, sections 23701 and 23701d.

Currently, state law also requires that any hospital seeking exemption from income taxes submit an application for exemption to the tax board, along with a filing fee. Further, it outlines the conditions that a hospital must meet to be eligible for an exemption, some of which are described in the text box. Legislation effective January 1, 2008, states that an organization granted tax-exempt status under federal law no longer has to file an exemption application with the tax board or submit a filing fee but can receive a state exemption based on its federal income tax exemption. However, organizations that have not received federal income tax exemptions must still apply for state exemptions under the new legislation.

The tax board's Exempt Organizations Unit (unit) is responsible for reviewing the applications nonprofit organizations submit and determining whether they are eligible for exemption from paying state income taxes. According to data provided by the tax board, about 72,000 active organizations have been granted tax-exempt status, including roughly 160 hospitals.

Every hospital that has received tax-exempt status and has annual gross receipts exceeding $25,000 must annually file a form to report certain financial information, including gross income and total expenses and disbursements, in addition to other information that the tax board may require. According to the tax board, the purpose of the form is to provide the unit with an annual overview of the finances of exempt organizations, and it is an important source of information when other issues are brought to the unit's attention. The tax board also indicated that the form is a useful tool for reviewing a nonprofit organization's ongoing compliance with the requirements for maintaining its tax-exempt status.

Equalization and County Tax Assessors Jointly Administer Local Property Tax Exemptions

State law specifies that a property eligible for a property tax exemption must be used exclusively for religious, hospital, charitable, or scientific purposes and must be owned and operated by a community chest, fund, foundation, limited-liability company, or corporation organized and operated for one of these purposes. Additionally, the property owner must meet the requirements outlined in the text box. Equalization is responsible for determining whether organizations are eligible to receive property tax exemptions, referred to as welfare exemptions in state law. If Equalization finds an organization eligible, it issues an organizational clearance certificate (certificate) for the organization to submit to the county tax assessor (county assessor) when applying for exemption from paying property taxes in that county. A certificate is valid until Equalization determines that the organization no longer meets the requirements of state law, revokes the certificate, and notifies the organization through the mail and the county assessor through a posting on Equalization's Web site.

Requirements for a Property Tax Exemption

- The owner is not organized or operated for profit.
- None of the owner's net earnings benefit any private shareholder or individual.
- The property is used for the actual operation of the exempt activity.
- The property is irrevocably dedicated to qualifying purposes, and on the liquidation, dissolution, or abandonment by the owner, the property must not benefit any private person except a fund, foundation, or corporation organized and operated for religious, hospital, scientific, or charitable purposes.
- Specific to hospitals, during the preceding fiscal year, operating revenues, excluding gifts, endowments, and grants, must not have exceeded operating expenses by more than 10 percent, unless the excess revenues were used for debt retirement, plant and facility expansion, or operating cost contingencies.

Source: California Revenue and Taxation Code, Section 214.

State law gives Equalization the authority to prescribe the procedures and forms needed to grant a property tax exemption. Therefore, Equalization requires each applicant to provide the following information in its initial filing: (1) the organization's name, corporation identification number, address, financial statements, articles of incorporation, and amendments; and (2) a valid, unrevoked letter or ruling from either the tax board or the Internal Revenue Service stating that the organization qualifies for an income tax exemption. State law requires that Equalization also determine whether the organization (1) provides services and incurs expenses, including salaries, that are excessive compared with the services and expenses reported by comparable public or private institutions and (2) conducts operations that directly or indirectly materially contribute to the private gain of one or more individuals.

After issuing a certificate to an organization, Equalization requires that an organization, on a four-year cycle, submit information similar to the information included in the initial filing to determine whether the organization should retain its certificate. In addition, Equalization can institute an audit or verification at any time to ascertain whether an organization continues to meet the requirements for a welfare exemption.

After an organization receives a certificate, the respective county assessor is responsible for determining whether the organization's property is actually used for the exempt purposes indicated. Additionally, when an organization makes a capital investment to expand its property—for example, adding a wing to a hospital—state law requires that the county assessor consider whether the expansion is justified by the contemplated return and serves the interest of the community. On an annual basis, an organization that has received a local property tax exemption for a specific property must provide certain information regarding the property to the county assessor and must report whether the exempt use of the property has changed. County assessors can also audit organizations seeking property tax exemptions, and under state law, county assessors have the authority to deny an exemption even if Equalization issued the organization a certificate.

The Office of Statewide Health Planning and Development Collects Hospital Data

State law designates the Office of Statewide Health Planning and Development (Health Planning) as the single state agency responsible for collecting annual financial reports from all licensed health facilities in California. The annual reports disclose financial information in the form of detailed income statements, balance sheets, statements of revenue and expense, and supporting schedules. Health Planning makes the data it gathers available to the public on its Web site.

To promote uniformity in the accounting data health facilities include in their annual financial reports, the California Code of Regulations requires that facilities, such as hospitals, prepare annual reports in accordance with Health Planning's accounting and reporting manual. Health Planning staff perform a thorough desk audit of the financial data submitted by hospitals to attempt to validate the reliability of the information. These desk audits include reviewing the reported amounts for completeness and reasonableness. Additionally, Health Planning stated that it works with the hospitals throughout the desk audit process to clear up or correct any questions or errors identified and to ensure that data submitted comply with the regulatory requirements specified in the accounting and reporting manual.

State law that became effective January 1, 1995, required most tax-exempt hospitals in California to develop a community benefit plan annually and submit it to Health Planning. The plan must specify the benefits the hospital intends to offer the community, either alone or in conjunction with other health care providers, and activities the hospital has undertaken to address community

needs within the hospital's mission and financial capacity. Required elements of the plan include measurable objectives to be achieved within specified time frames and benefits to be provided for vulnerable populations and the broader community. Additionally, to the extent possible, the tax-exempt hospital must assign economic values to the community benefits specified in the plan. State law does not require hospitals to provide the required information in any specific format. In addition, state law does not grant Health Planning the authority to apply any sanctions if a hospital is not prompt or is entirely remiss in submitting a plan. As a condition of licensure, however, hospitals must maintain written policies regarding discount payments and charity care for financially qualified patients and, as of January 1, 2008, must submit the policies to Health Planning every other year, or when the hospitals make significant changes to their policies.

The Office of the Attorney General Oversees the Transfer of Assets and Investigates Complaints

Although not involved in determining hospitals' tax-exempt status or reviewing the annual financial reports nonprofit hospitals submit, the Office of the Attorney General (attorney general) nonetheless provides some oversight of nonprofit hospitals. For example, under state law, any nonprofit corporation that operates or controls a health facility is required to provide written notice to and obtain the written consent of the attorney general before entering into an agreement or transaction to sell, transfer, lease, exchange, option, convey, or otherwise dispose of its assets to a for-profit corporation or entity, or to a mutual-benefit corporation or entity, when a material amount of the assets of the nonprofit corporation is involved in the agreement or transaction. The attorney general's notification and written consent is also required for the transfer of control, responsibility, or governance of a material amount of the assets or operations of a nonprofit corporation to any for-profit corporation or entity, or to any mutual-benefit corporation or entity. The attorney general is mandated to protect charitable assets for the use of the intended beneficiaries and has jurisdiction over all entities and individuals holding assets in trust for charitable purposes.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to conduct an audit to ascertain whether the activities performed by hospitals that are exempt from paying taxes because of their nonprofit status truly qualify as allowable activities consistent with their exempt purpose.

Specifically, the audit committee requested that we (1) determine the roles of the entities involved in determining tax exemptions and the extent of oversight they exercise over nonprofit hospitals to ensure that they comply with requirements for tax exemption and community benefit reporting; (2) examine the financial reports and any community benefit documents prepared during the last five years by a sample of both nonprofit hospitals and hospitals that operate on a for-profit basis and determine the value and type of community benefits and uncompensated care provided; (3) compare the community benefits provided by nonprofit and for-profit hospitals, and compare the types of care that both types of hospitals provide without receiving compensation (uncompensated care); (4) review the financial information and the claims submitted to Equalization or other agencies by nonprofit hospitals to determine whether they meet income requirements to qualify for tax-exempt status; (5) assess, to the extent possible, how tax-exempt nonprofit hospitals use excess income, to ensure that the uses are permissible and reasonable in terms of expansion of plant and facilities, additions to operating reserve, and the timing of debt retirement; and (6) determine the most current estimated total annual value of the taxation exemptions of both state corporation income taxes and local property taxes for nonprofit hospitals.

Finally, the audit committee asked us to determine whether the community benefits and uncompensated care provided by nonprofit hospitals meet the requirements for exemption from local property and state income tax. However, although state law outlines the requirements a nonprofit hospital must meet to receive an exemption from paying taxes, it does not specify community benefits and uncompensated-care costs as requirements. Additionally, although state law requires most tax-exempt hospitals to annually submit to Health Planning a plan, which may include an uncompensated-care element, the law also clearly states that the information included in the plan a nonprofit hospital submits cannot be used to justify its tax-exempt status.

To determine the roles of the entities involved in determining eligibility for tax exemptions, we reviewed state laws and regulations and interviewed officials from the tax board, Equalization, Health Planning, the attorney general, and nine county assessors' offices. We found that the tax board is responsible for granting state income tax exemptions, whereas both Equalization and the county assessors are responsible for granting welfare exemptions, which exempt organizations from paying local property taxes.

To review the extent to which the tax board ensures that nonprofit hospitals are complying with the income tax exemption requirements, we reviewed the tax board's process for granting

the initial income tax exemption and for monitoring a nonprofit hospital's continuing eligibility for the exemption. We evaluated whether the tax board appropriately granted tax exemptions to the five nonprofit hospitals that have requested exemptions since 2000 by reviewing the initial applications. We compared the applications and attached supporting documents with the legal requirements. Further, we assessed whether each of the sampled hospitals submitted the required documents and whether the tax board made the appropriate decision. Additionally, each nonprofit hospital that has received an income tax exemption annually submits to the tax board an information return that includes financial information and activities. We reviewed whether the tax board uses this form as a method to monitor a nonprofit hospital's continuing eligibility for a tax exemption. We also selected a sample of nine of these forms to determine whether the nonprofit hospital appropriately submitted the supporting schedules and documents as required by state regulations.

To review the extent to which Equalization and the county assessors ensure that nonprofit hospitals are complying with the local property tax exemption requirements, we reviewed their processes for granting the initial exemption and for monitoring a nonprofit hospital's continuing eligibility for an exemption. According to Equalization, as part of its statutory authority, it periodically reviews certain documents, such as formative documents and financial statements, to ensure that the organization continues to meet the organizational requirements for the property tax exemption. It last performed this review in 2005, focusing on the approximately 200 hospital organizations (hospitals) that had received the property tax exemption, and it found that all continued to qualify for the exemption, including the 15 that reported operating revenues exceeding their operating expenses by more than 10 percent. We selected six of these 15 hospitals, as well as another six that were geographically distributed throughout the State. We ensured that the checklist Equalization used addressed all of the elements required for an organization to qualify for an exemption. In addition, we evaluated Equalization's decisions that these hospitals continued to be eligible for property tax exemptions by reviewing the same documents that Equalization used to make its decision. These documents included the most recent amendments to the articles of incorporation and evidence of their state and federal income tax exemption, among others. We performed a similar review of the procedures Equalization followed in determining the eligibility for tax exemption of the only two hospitals that have requested a property tax exemption since the review performed in 2005.

To review the process county assessors follow to determine tax exemption eligibility, we selected 12 hospitals located in nine counties. We visited the county assessors' offices at these nine counties and reviewed the files for the 12 hospitals to determine whether the county assessors ensured that Equalization had issued organizational clearance certificates and whether the county assessors performed field inspections to ensure that the properties were being used for the exempt purposes indicated on the certificates.

To compare the value of uncompensated care provided by nonprofit hospitals to the amount provided by hospitals that operate for profit over five years—2001 to 2005—we used certain accounts included in the annual financial reports submitted to Health Planning by all hospitals, which can be found on Health Planning's Web site. We verified that all hospitals required to submit the financial reports had done so by comparing the hospitals on the Web site to the Department of Health Services' list of licensed hospitals. To ensure the accuracy and consistency of the accounts we used to derive the costs of providing uncompensated care, we evaluated Health Planning's desk audit procedures for validating the information provided by the hospitals. We concluded that Health Planning performs sufficient testing and follow-up work to ensure that the data reported by the hospitals are adequate.

To determine the total value and types of community benefits provided by nonprofit hospitals, we obtained the community benefit plans that nonprofit hospitals submitted to Health Planning, which typically contain tables listing values for various community benefits the hospitals provide. We used the values for certain benefits included in these tables to estimate the value of forgone state income taxes, as described later; however, we could not compare the values of these benefits to the values of the benefits provided by hospitals that operate for profit because state law does not require for-profit hospitals to report their community benefits to the State. Additionally, we selected a sample of eight nonprofit hospitals, obtained their plans for a five-year period—2002 to 2006—and discussed them with appropriate staff at the hospitals to identify the methodologies they used in creating their plans. Finally, we surveyed eight hospitals that operate for profit to determine whether they prepare anything similar to the plans submitted to Health Planning; the seven for-profit hospitals that responded to our survey indicated that they do not prepare similar plans.

To assess whether nonprofit hospitals meet the income requirements to qualify for their tax-exempt status and to determine, to the extent possible, whether nonprofit hospitals use excess income for permissible purposes, we reviewed a sample of six of the 15 hospitals that, during Equalization's 2005 review, reported operating revenues that exceeded operating expenses

by more than 10 percent. Equalization requested that these six hospitals submit documentation to support that they planned to use the excess income for permissible purposes, which include plant and facility expansion, debt retirement, or reserves for operating contingencies. We reviewed this documentation as well as Equalization's process for performing additional verification of the information with county assessors. Our review found that Equalization appropriately determined that the six hospitals were using their excess income for permissible purposes.

Finally, to estimate the most current annual value of nonprofit hospitals' income tax exemptions, we determined that we could not provide an estimate using a net income figure, for a variety of reasons. However, we were able to provide an estimate using the economic values of certain community benefits, which we describe in Chapter 1, and multiplied that amount by the 8.84 percent income tax rate. To estimate the annual value of nonprofit hospitals' local property tax exemptions, we obtained the value of property owned by nonprofit tax-exempt hospitals reported to Equalization for 2005 and multiplied that amount by 1 percent, the base local property tax allowable under the California Constitution. To determine the reliability of those amounts, we compared them to a sample of records held by nine county assessors.

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Chapter 1

CONSISTENT DATA ARE NOT AVAILABLE TO FULLY ANALYZE THE ECONOMIC VALUES OF THE BENEFITS NONPROFIT HOSPITALS PROVIDE THEIR COMMUNITIES

Chapter Summary

State law requires the Office of Statewide Health Planning and Development (Health Planning) to collect financial information annually from all health facilities. Using these financial data, we compared the value of the care that nonprofit and for-profit hospitals provide without receiving compensation (uncompensated-care costs) for the five-year period from 2001 through 2005, both including and excluding Medi-Cal costs. Our comparison revealed that when taken as a percentage of net patient revenues—the actual amounts a hospital receives from patients and third-party payers—the uncompensated-care costs of the two types of hospitals did not differ significantly. However, the various community benefits that tax-exempt nonprofit hospitals provide differentiate them from the for-profit hospitals.

State law requires most tax-exempt hospitals to submit an annual community benefit plan (plan) to Health Planning, describing the activities the hospital has undertaken to address the needs of its community and the economic values of those beneficial activities. However, the law provides only limited guidance regarding the content of the plan and does not mandate a uniform reporting standard. Thus, in reviewing the plans that eight tax-exempt hospitals submitted from 2002 through 2006, we found significant variations in the plans that precluded us from performing any meaningful comparisons of the economic values the hospitals reported. Although the guidance provided in the law does not require uniform reporting, two hospital associations offer hospitals some guidelines. Additionally, the Internal Revenue Service (IRS) is proposing a new schedule for hospitals to prepare to be included with the informational return that all income-tax-exempt organizations must file. If adopted, the IRS anticipates using the new schedule for the 2008 tax year. The new schedule will require tax-exempt hospitals to report their community benefits and uncompensated-care costs and could influence hospitals to pattern their plans after the schedule's methodologies and format.

We attempted to compare the economic values of the community services provided by tax-exempt hospitals to the state corporation income taxes (income tax) they did not pay, but the absence of complete and accurate data precluded a reliable and meaningful comparison. According to the Franchise Tax Board (tax board),

it has not attempted to estimate the income taxes not collected from tax-exempt hospitals. We therefore attempted to estimate uncollected income taxes by using the corporation tax rate and the economic values of the benefits tax-exempt hospitals reported they provided to their communities instead of paying taxes in 2005. This methodology enabled us to estimate that nonprofit hospitals would have paid $58 million in income taxes in 2005 had they not been tax exempt. However, because tax-exempt hospitals did not report their community benefits in a standard format, it was difficult to determine the community benefits that a tax-exempt hospital might provide as compared to the benefits that all hospitals provide to their communities. Therefore, we cannot attest to the reliability of our estimate.

We also attempted to estimate the amount of property taxes not collected from tax-exempt hospitals, using the value of the buildings and their contents owned by tax-exempt hospitals and reported to the State Board of Equalization (Equalization). This methodology resulted in an estimated $184 million in uncollected property taxes in 2005. However, the numerous errors we found in the values limit our ability to attest to the reliability of this estimate of the value of the forgone property taxes.

Based on values reported in the plans submitted by tax-exempt hospitals in 2005, the economic value of the community benefits provided by the hospitals was about $656 million. This amount is approximately 2.7 times the $242 million in income and property taxes we estimated they did not pay. As we noted previously, however, more precise estimates based on complete and accurate data could produce a different result.

Finally, we attempted to compare the economic values and types of community benefits provided by tax-exempt nonprofit hospitals to those provided by for-profit hospitals. We found that state law does not require for-profit hospitals to report the community benefits they provide, as it does for nonprofit hospitals. Thus, we could not perform this comparison.

Nonprofit and For-Profit Hospitals Do Not Report Significantly Different Levels of Uncompensated-Care Costs

Using data hospitals submitted to Health Planning, we found that the costs that California's nonprofit and for-profit hospitals incur for providing uncompensated care—the cost of services hospitals provide without receiving payment—when taken as a percentage of net patient revenues, did not differ significantly. However,

tax-exempt nonprofit hospitals report various types of community benefits that for-profit hospitals do not, as we describe in the next section.

As we indicated in the Introduction, Health Planning is the single state agency designated to collect financial information from all health facilities, an obligation it fulfills by requiring the facilities to submit annual financial reports. Health Planning uses certain information included in these financial reports to calculate and publish its estimates of the uncompensated-care costs of both nonprofit and for-profit hospitals. State law requires that each hospital with an active license annually submit financial information to Health Planning within four months of the close of its fiscal year. To ensure uniformity of accounting and reporting procedures, state regulations also require that health facilities comply with the systems and procedures detailed in the accounting and reporting manual published by Health Planning. When a health facility submits its financial report, its staff must certify under penalty of perjury that the accounting used in developing the financial report meets the requirements of the accounting and reporting manual.

To ensure uniformity of accounting and reporting procedures, state regulations also require that health facilities comply with the manual published by Health Planning.

Health Planning uses certain information contained in the financial reports to estimate hospitals' uncompensated-care costs. These financial reports include several accounts identified as deduction-from-revenue accounts, such as bad debt, charity discounts, and contractual adjustments for government and private health coverage programs. Health coverage programs include managed-care plans, fee-for-service plans, Medicare, Medi-Cal, and county indigent programs (CIPs). A deduction-from-revenue account includes the amount defined as the difference between the gross patient revenue—the full amount the hospital would have charged the patient or the health coverage plan for the services it provided—and the amount the hospital ultimately collected from the patient or the amount the health coverage plan paid the hospital. For example, when a patient covered by Medi-Cal receives a service from a hospital, Medi-Cal reimburses the hospital at the Medi-Cal rate for that service, which typically is not the full amount the hospital charges. The hospital's financial report captures the difference in a deduction-from-revenue account. Because the term *uncompensated-care costs* can include many different categories of care, Health Planning has provided three methods of estimating uncompensated-care costs using combinations of the following deduction-from-revenue accounts reported by hospitals: charity care, bad debt, and the contractual adjustment for the CIP (CIP adjustment account).

The charity care account reflects the unpaid charges for services provided to a patient whom the hospital has determined cannot pay, in part or in full. These patients may be billed for only a

Although the term uncompensated-care costs can include many different categories of care, Health Planning provided three methods using combinations of the accounts reported by hospitals for charity care, bad debt, and the contractual adjustment for county indigent programs in its calculations.

portion of the charges or for none at all. We discuss in greater detail later in this chapter the hospitals' criteria for charity care eligibility and how the thresholds established by each hospital can directly affect the amount it includes in its financial report under the charity care account. Health Planning defines *bad debt* as the amount of accounts receivable a hospital determines is uncollectible because of certain patients' unwillingness to pay for the services they received. The third account that Health Planning uses in its calculation of uncompensated-care costs is the CIP adjustment account. According to Health Planning, the CIP is unique to California when calculating uncompensated-care costs. Under the CIP, hospitals are paid a portion of the charges for services they provide to patients eligible for the program. The difference between what the hospital receives under the CIP and the amount it would have charged a patient who could pay is accounted for in the hospital's CIP adjustment account. According to Health Planning, before the State implemented the CIP, amounts written off for these types of patients would have been reported in the charity care account.

Health Planning has chosen not to include in its estimates of uncompensated-care costs other types of revenue deductions, such as the difference between the full amount a hospital would charge for its services and the amount it receives as reimbursement for patients participating in health coverage programs, such as Medi-Cal or Medicare. Health Planning stated that it chose to estimate uncompensated-care costs using only charity care, bad debt, and the CIP adjustment account to be similar to national standards while taking into account the unique CIP reporting requirements for California. Health Planning also indicated that it has excluded items, such as when Medi-Cal reimbursements do not cover the cost of providing the service, because these components have traditionally been excluded from estimates of uncompensated-care costs.

Hospitals report their charity care, bad debt, and contractual adjustment for the CIP accounts in terms of charges rather than actual costs. According to Health Planning, because different hospitals include different markups on costs in their charges, estimated costs can be helpful when comparing hospitals' uncompensated-care costs. Thus, to inform the public about the actual costs incurred by hospitals providing uncompensated care, Health Planning multiplies each of the three accounts it uses to estimate uncompensated-care costs by a cost-to-charge ratio intended to convert hospitals' reported charges to estimates of actual costs incurred. According to Health Planning, there is no universal definition for a cost-to-charge ratio for calculating uncompensated care costs, and the ratio can be calculated in different ways depending on the specific purpose of the analysis.

However, Health Planning has chosen to define the cost-to-charge ratio it uses as a hospital's total operating expenses less other operating revenues divided by the gross patient revenue; this definition is provided in state law for use in an unrelated state-funded health care program.

Using the total of Health Planning's data for charity care, bad debt, and the CIP adjustment account, we compared Health Planning's estimated uncompensated-care costs of for-profit hospitals to those of nonprofit hospitals. However, nonprofit hospitals outnumber for-profit hospitals in California and, for 2001 through 2005, nonprofit hospitals reported significantly higher net patient revenues and uncompensated-care costs than for-profit hospitals. Thus, to provide a meaningful comparison, we divided total uncompensated-care costs by net patient revenues to obtain a ratio for comparing the two types of hospitals. Net patient revenues are the actual amounts a hospital receives from patients and third-party payers, such as health coverage programs. When we averaged uncompensated-care costs for the five-year period, we found uncompensated-care costs as a percentage of net patient revenues for nonprofit and for-profit hospitals to be about 3.6 percent and 3.5 percent, respectively. This calculation did not include the Kaiser Foundation hospitals (Kaiser). According to Health Planning, Kaiser cannot meaningfully report deductions from gross revenue for charity care, bad debt, or other third-party contractual adjustments because it does not report gross revenues based on fee-for-service charges; the majority of Kaiser's revenues are based on dues prepaid by its members.

When we averaged uncompensated-care costs for a five-year period, we found uncompensated-care costs as a percentage of net patient revenues for nonprofit and for-profit hospitals to be about 3.6 percent and 3.5 percent, respectively.

Although Health Planning uses only three accounts to estimate the uncompensated-care costs of nonprofit and for-profit hospitals, we expanded our comparison of these costs to include Medi-Cal contract adjustments. We included these adjustments because guidance provided to hospitals by the American Hospital Association, which we discuss in greater detail later in the chapter, specifies that the unreimbursed costs of providing services to patients eligible for Medi-Cal are part of uncompensated-care costs. Further, costs associated with Medi-Cal are significant to both nonprofit and for-profit hospitals. In the financial reports they submit to Health Planning, hospitals include accounts identified as deductions from revenue for Medi-Cal contract adjustments. Using the same methodology described previously, we combined the Medi-Cal uncompensated-care costs with the costs for the other three accounts—charity care, bad debt, and the CIP adjustment account—divided the total by the net patient revenue, and averaged these costs for the five-year period from 2001 through 2005. We found that when we included Medi-Cal costs, the total uncompensated-care costs as a percent of net patient revenues for nonprofit and for-profit hospitals increased to 16.9 percent and 20.6 percent, respectively. Although the uncompensated-care costs

are not significantly different for the two types of hospitals, as we will discuss in the next section, nonprofit hospitals also report various other types of community benefits that differentiate them from for-profit hospitals.

Lack of Specific Guidance Regarding the Content of Community Benefit Plans Precludes Any Meaningful Comparison of the Plans

In requiring most tax-exempt nonprofit hospitals to annually submit to Health Planning a plan, state law specifies that hospitals must describe activities they have undertaken to address community needs and report the economic values of those activities. During the five-year period we reviewed, most tax-exempt hospitals complied with these requirements. Regarding the content of a plan, however, the law offers hospitals limited guidance and does not specify a uniform reporting standard. Thus, in reviewing the plans of eight tax-exempt hospitals submitted from 2002 through 2006, we found significant variations in the plans, preventing us from performing any meaningful comparisons of the economic values reported in those plans. Although the law is not specific enough to require uniform reporting, two hospital associations have provided hospitals with some guidelines. Moreover, the IRS has proposed a new schedule relating to community benefits that hospitals would have to include with the informational return it requires all tax-exempt organizations to file. If adopted, the IRS anticipates using the new schedule for the 2008 tax year. The new schedule will require tax-exempt hospitals to report their community benefits and uncompensated-care costs. Additionally, the methodologies and format of the new schedule could serve as patterns for hospitals to follow when developing their plans.

Significant variations across the 40 plans we reviewed prevented any meaningful comparisons of the economic values reported in those plans.

Most Tax-Exempt Hospitals Have Complied With State Law by Annually Preparing and Updating Their Community Benefit Plans

In the law requiring tax-exempt hospitals to submit plans to Health Planning, the Legislature asserted that nonprofit hospitals assume a social obligation to provide community benefits to the public in exchange for favorable tax treatment. The Legislature further declared that the public would derive a significant benefit from tax-exempt nonprofit hospitals' periodically identifying and documenting the benefits they offer their communities. State law also defines community benefit and provides a list of activities and programs that a hospital may include as a community benefit in its plan. The list of community benefit activities and programs identified in state law appears in the text box.

However, although the law also states that the community benefits reported by nonprofit hospitals cannot be used to justify the hospitals' tax-exempt status, the law still requires hospitals to engage in charitable activities to maintain their tax-exempt status. According to the Senate floor analysis, the legislation enacting these laws was needed in response to a federal court ruling that a not-for-profit health facility did not qualify for tax-exempt status because it did not meet the federal tax code's community benefit requirements. The Senate floor analysis also indicated that at that time, community benefits from nonprofit hospitals were assumed but not measured. The analysis concluded that the legislation was necessary to provide a formal evaluation of the various methods that could become the basis for defining and measuring community benefits, enabling hospitals to defend their status as tax-exempt charitable institutions.

We found that most of the tax-exempt nonprofit hospitals have complied with the law and prepared or updated their plans annually. State law requires tax-exempt nonprofit hospitals to submit their plans to Health Planning no later than 150 days after the hospital's fiscal year end. If a hospital is late or negligent in submitting a plan, Health Planning has no authority to impose penalties on the hospital other than, according to Health Planning, publicly disclosing the name of the hospital and the fact that it either has not submitted its plan or that the plan was late. Health Planning is the only state agency that collects plans, and it is not required to review the plans for accuracy, consistency, or completeness.

Hospitals Receive Little Guidance From State Law in Preparing Community Benefit Plans

State law that became effective January 1, 1995, clearly does not authorize or require a specific format for hospitals to follow in preparing plans until the Legislature considers and enacts recommendations made by Health Planning. In a 1998 report to the Legislature, Health Planning made some recommendations to standardize the

State Law's Definition of Community Benefit

State law defines "community benefit" to be a hospital's activities that are intended to address community needs and priorities, primarily through disease prevention and improvement of health status, including, but not limited to, any of the following:

1. Health care services rendered to vulnerable populations, including charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Childrens Services Program, or county indigent programs.
2. Community-oriented wellness and health promotion.
3. Prevention services, including health screening, immunizations, school examinations, and disease counseling and education.
4. Adult day care.
5. Child care.
6. Medical research and education.
7. Nursing and other professional training.
8. Home-delivered meals to the homebound.
9. Sponsorship of free food, shelter, and clothing to the homeless.
10. Outreach clinics in socioeconomically depressed areas.
11. Financial or in-kind support of public health programs.
12. Donation of funds, property, or other resources that contribute to a community priority.
13. Health care cost containment.
14. Enhancement of access to health care or related services that contribute to a healthier community.
15. Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, prevention, and social services.
16. Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health.

Source: Health and Safety Code, sections 127340 and 127345.

plans, but the Legislature chose not to implement any of those recommendations. Instead of requiring a standardized format, state law lists certain elements that every plan must contain, as shown in the text box. Additionally, state law provides a list of activities that a hospital may include in its plan, as shown in the text box on page 23. Hospitals may, but are not required to, list those types of activities in their plans.

Required Elements of a Community Benefit Plan

1. Mechanisms to evaluate the plan's effectiveness, including, but not limited to, a method for soliciting the views of the community served by the hospital and identification of community groups and local government officials consulted during the development of the plan.
2. Measurable objectives to be achieved within specified time frames.
3. Community benefits categorized into the following framework:
   a. Medical care services.
   b. Other benefits for vulnerable populations.
   c. Other benefits for the broader community.
   d. Health research, education, and training programs.
   e. Nonquantifiable benefits.

Source: Health and Safety Code, Section 127355.

Without statutory guidelines related to format and content, hospitals have attempted to interpret state law and use other existing guidelines when developing the formats of their plans. For example, hospitals classify the various types of community benefit activities they provide according to the five general framework categories shown in the text box, as they believe appropriate. As a result, two hospitals could assign the same activity to two different framework categories. For example, Sutter Medical Center, Sacramento (Sutter), and Kaiser both include donations to community-based programs in their plans but place the economic value under different framework categories: Sutter lists it under "Benefits for the Broader Community" and Kaiser places it under "Other Benefits for Vulnerable Populations." Further, hospitals use various methodologies for calculating the economic values of the benefits they include in the required framework categories because state law provides no guidance as to the methodologies they should be using.

As we mentioned earlier, at the request of the Legislature, Health Planning reviewed the plans submitted by tax-exempt nonprofit hospitals and reported its findings and recommendations in 1998. In that report, Health Planning explained how the lack of clarity in the law resulted in reported valuations of community benefits that were inconsistent and incomparable. Health Planning stated in its report that "owing to the lack of uniformity in reporting the economic value of community benefits, it would not be possible, for example, to attempt to provide an aggregate value of the benefits reported." To improve the comparability of the plans, Health Planning recommended that hospitals report the economic value of community benefits according to a mandated accounting system and within six mandated categories. The Legislature chose not to implement these recommendations, and hospitals continue to report on community benefit activities in many different ways.

Meaningful Comparisons of the Economic Values of Reported Community Benefits Are Not Possible Without Uniformity of Content and Methodology

Our review of a total of 40 plans that eight tax-exempt hospitals submitted to Health Planning from 2002 through 2006, as well as discussions with hospital staff, highlighted the significant variations in the plans. The plans differed in the types of uncompensated-care costs and activities that hospitals chose to report and in the methodologies they used when calculating the economic values of the community benefits. Further, hospitals changed the content and methodologies they use in developing their plans over time. These differences make it difficult, if not impossible, to compare the economic valuations included in the plans. Our review found that the 40 plans generally varied in the following areas:

- Number and types of framework categories included in the tables showing the economic values of the community benefits.
- Activities listed as community benefits.
- Accounting methodologies, both in collecting community benefit data and in calculating the economic value of various activities.

Although state law specifies five framework categories of community benefits that hospitals must include in their plans (see the text box), our review revealed that some nonprofit hospitals used fewer categories, whereas others chose to expand the number of categories. The Appendix contains the economic valuation tables from the plans of the eight tax-exempt nonprofit hospitals we reviewed, which illustrate the differences in the framework categories and activities used by the hospitals. The two tables that present the most striking differences are the ones provided by Sutter and Kaiser. While Sutter used only two framework categories to report values for all of its community benefits, Kaiser used four main framework categories, under which it reported the economic values of 33 activities.

Hospitals we reviewed did not consistently report similar activities as community benefits.

Further, the hospitals we reviewed did not consistently report similar activities as community benefits. We found three instances in which hospitals included activities in their plans that other hospitals chose to exclude. In its plans, Methodist Hospital of Southern California (Methodist Hospital), within the categories shown in the Appendix, included benefits it provides its own employees, including a day care center subsidy, employee appreciation events, holiday meals and gifts, and awards to employees. In another example, Methodist Hospital included the costs of standard in-service training for its employees as a community benefit. All five of the plans we reviewed for Stanford Hospitals and Clinics (Stanford) included the costs of

its Department of Guest Services as a benefit under the category "Benefits for the Larger Community." According to Stanford, because many patients of the hospital use these services, the reported cost includes the costs of providing some educational services and health care support to patients and their families in the course of their inpatient or outpatient treatment. The reporting guidelines of the combined Catholic Healthcare Association and Voluntary Hospital Association (CHA/VHA) recommend that these types of activities and costs not be included as community benefits, and the guidance offered by state law is not specific enough on this topic, exacerbating the incomparability of the plans.

Further illustrating the diversity of the plans that tax-exempt nonprofit hospitals have submitted, we found that the plans varied as to whether they included the unreimbursed cost of Medicare as a community benefit.

Further illustrating the diversity of plans that tax-exempt nonprofit hospitals have submitted, we found that the plans varied as to whether they included the unreimbursed cost of Medicare as a community benefit. For 2002 through 2006, two of the eight hospitals we reviewed did not include the unreimbursed cost of Medicare services as a community benefit and consistently excluded it from their economic valuation tables. Kaiser and Cedars-Sinai Medical Center (Cedars-Sinai) explained that this choice reflects their respective internal guidelines and policies. However, according to Cedars-Sinai, the hospital has revised its reporting policies and began including the unreimbursed costs of Medicare in its 2007 plan. Although not apparent in its economic valuations table in the Appendix, according to Sutter and the descriptions in its plans, it revised its policy in 2006 and excluded the unreimbursed cost of Medicare from its 2006 plan. It had included Medicare in its plans for each of the previous four years we reviewed. Methodist Hospital included only half of its unreimbursed Medicare cost in its 2005 plan, and for 2006 it produced two tables, one including the cost and one without the cost. The four other hospitals we reviewed consistently included the unreimbursed Medicare cost as a community benefit.

The policies hospitals follow regarding charity care also vary, providing another example of differences in community benefit reporting that could influence the amounts reported in the plans and in the annual financial reports submitted to Health Planning. We reviewed the policies of a sample of both nonprofit and for-profit hospitals and found that their charity care policies use various income levels when determining whether a patient qualifies for full or partial charity care. As shown in Table 1, the policies we reviewed for full charity care offered by nonprofit hospitals identified qualifying income levels ranging from 200 percent to 400 percent of the federal poverty level. Medical services at discounted prices, or partial charity care, are offered to patients with incomes ranging from 200 percent to 500 percent of the federal poverty level. Thus, the amounts reported as charity care in both the plans and the

Table 1

Charity Care Policies of Eight Nonprofit Hospitals and Seven For-Profit Hospitals Use Various Percentages of the Federal Poverty Level to Determine Eligibility

NONPROFIT HOSPITAL	FULL CHARITY (UP TO PERCENT OF FPL)	NOTES	PARTIAL CHARITY (UP TO PERCENT OF FPL)	NOTES
Sutter Medical Center, Sacramento	200%	Regardless of Federal Poverty Level (FPL), an uninsured patient's liability shall not exceed 30 percent of their annual income.	400%	Discount applies to payments above 120 percent of Medicare rate.
California Hospital Medical Center	200		500	Patients with incomes of 200 percent to 300 percent of FPL receive services at average Medicare rates; at average prevailing managed-care rates with income at 300 percent to 500 percent of FPL; discounts are determined on a case-by-case basis when income exceeds 500 percent of FPL.
Cedars-Sinai Medical Center	200		450	Uninsured patients pay 5 percent to 15 percent of charges (maximum is Medicare rate); underinsured patients pay 10 percent to 40 percent (maximum is Medicare rate).
Saint John's Hospital and Health Center	200		399	Patients with outpatient balances of less than $5,000 are eligible for a sliding discount from 0 percent to 50 percent; patients with inpatient/outpatient balances greater than $5,000 are eligible for a 50 percent discount.
Kaiser Foundation Hospitals	200	Regardless of FPL, if a special circumstance, which may include loss of income, unusually high health care costs, death of a primary wage earner, or disaster, significantly compromises the patient's ability to pay for services, a patient may qualify for a discount on a case-by-case basis.		Regardless of FPL, if a special circumstance, which may include loss of income, unusually high health care costs, death of a primary wage earner, or disaster, significantly compromises the patient's ability to pay for services, a patient may qualify for a discount on a case-by-case basis.
Stanford University Medical Center	400	Charity may be offered if a patient has high medical costs exceeding 30 percent of income in one year.	400	Charity may be offered if a patient has high medical costs exceeding 30 percent of income in one year.
Methodist Hospital of Southern California	200		200	
California Pacific Medical Center	400			Low-income uninsured patients with medical expenses that exceed 15 percent of family income are eligible for charity care.
Average FPL Percentage	**250%**		**392%**	

FOR-PROFIT HOSPITAL	FULL CHARITY (UP TO PERCENT OF FPL)	NOTES	PARTIAL CHARITY (UP TO PERCENT OF FPL)	NOTES
Pacifica Hospital of the Valley	400%		400%	Discount is equal to Medicare reimbursement for that service.
Anaheim General Hospital	199		299	
Doctors Medical Center	200	$50 co-pay required for all but deceased patients.	400	$50 co-pay required for all but deceased patients.
Regional Medical Center of San Jose	200			
Temple Community Hospital		Case-by-case basis.		Discount on a case-by-case basis.
Mad River Community Hospital	300		300	
Kindred Hospital, Sacramento		Case-by-case basis.		Discount on a case-by-case basis.
Average FPL percentage	**260%**		**350%**	

Source: Most recent charity care policy during 2002 through 2006 period for nonprofit and for-profit hospitals as noted above.

financial reports hospitals submit to Health Planning vary depending on each hospital's charity care policies. For-profit hospitals' policies showed similar ranges of qualifying income levels for full charity care and a narrower range for the partial charity care offered. Although recent legislation provides some consistency by requiring that each hospital limit the payments it expects to receive from patients with incomes at or below 350 percent of the poverty level, hospitals can still have varying policies identifying more generous thresholds.

The uncompensated-care costs reported in the plans also reflect a variety of economic valuation methods, making the resulting data incomparable across plans.

The uncompensated-care costs reported in the plans also reflect a variety of economic valuation methods. The eight hospitals we reviewed stated that most of their plans capture some estimate of actual costs, not charges. However, the hospitals calculate those costs in many different ways, making the resulting data incomparable across plans. For example, according to Sutter and Stanford, they use actual costs less reimbursements in preparing the economic valuation tables included in their plans. On the other hand, Saint John's Hospital and Health Center and California Pacific Medical Center apply cost-to-charge ratios against charges to estimate the cost of providing Medi-Cal, Medicare, and charity care services.

California Hospital Medical Center (California Hospital) and Cedars-Sinai use various cost-to-charge ratios to calculate some types of uncompensated-care costs and use a cost-accounting system that captures actual costs for other types of uncompensated-care costs. According to California Hospital, it revised its methodologies for calculating costs in 2006, responding to the Catholic Healthcare West mandate that member hospitals report uncompensated-care benefits at cost, not based on charges. Specifically, for plans up to 2005, California Hospital used a preestablished cost-to-charge ratio of 28 percent, from an annual cost report, in calculating the value of Medicare, Medi-Cal, and charity care services. In 2006 the hospital began using actual costs for Medicare and Medi-Cal and stated that it will do the same for charity care beginning in 2007. Cedars-Sinai stated that it has consistently reported actual unreimbursed Medi-Cal costs and, for 2003 through 2006, used a cost-to-charge ratio to calculate charity care costs. Specifically, Cedars-Sinai stated that it calculates the "traditional charity" care ratio by dividing the total cost of providing care to a particular sector of charity patients by the total charges. Cedars-Sinai then multiplies this ratio by the total charges for all patients deemed unable to pay.

Methodist Hospital uses a third methodology to estimate actual costs, designed to capture the additional costs of equipment and infrastructure depreciation as a community benefit. According to Methodist Hospital, it multiplies the actual costs of Medicare, Medi-Cal, and charity care by 125 percent; the additional 25 percent

accounts for the costs of equipment and depreciation. Finally, Kaiser stated that it currently reports the actual direct costs of community benefit services provided, less any reimbursements.

In addition to reporting community benefit activities in a variety of different ways, the plans we reviewed also varied in their presentation of measurable objectives. State law requires hospitals to include in their plans measurable objectives to be achieved within specific time frames (see the text box on page 24). The level of detail provided in the plans that we reviewed varied significantly. For example, California Hospital provided highly detailed reports on its community benefit programs in its plans for 2005 and 2006. Each of the plans presented several specific measurable objectives, the results achieved during the year, and new objectives to be achieved in the coming year. As part of its diabetes prevention services, for example, California Hospital identified in its 2006 plan that one objective was for all participants with a certain diabetes risk test score to be referred to a health care provider for diagnostic testing for the disease. In contrast, Methodist's plans included general goals rather than specific objectives for each community benefit program it reported. For instance, Methodist reported the number of people served by each program during the year but did not establish targets for the number of people it desired to serve.

In addition to reporting community benefit activities in a variety of different ways, the plans we reviewed also varied in their presentation of measurable objectives.

Health Care Associations Provide Hospitals Some Guidance in Preparing Plans, and a New Schedule Proposed by the IRS Could Make Plans More Consistent

As we described earlier, the guidance the law provides hospitals in developing their plans is not specific enough to be considered a unified reporting standard. However, two hospital associations offer guidelines that hospitals have the option to follow when developing their plans. The two associations are the American Hospital Association (AHA) and the CHA/VHA. Again, however, the guidelines provided do not necessarily assist in providing a unified reporting standard for the plans, because each organization advises hospitals to report the economic values of community benefits and uncompensated-care costs according to a different framework.

In a November 13, 2006, letter to member hospitals, the AHA outlined its policy on reporting community benefits, stating that hospitals should report bad debt and the unreimbursed cost of Medicare as community benefits. In contrast, the 2006 CHA/VHA guidelines advised hospitals not to consider bad debt as a community benefit and presented arguments both in favor of and against including Medicare losses, without drawing a definitive conclusion on the matter. Rather, the CHA/VHA guidelines provide circumstances hospitals should consider when deciding whether

they should include the unreimbursed Medicare cost as a community benefit. Finally, both the AHA and the CHA/VHA instruct hospitals to report the economic values of community benefit activities at cost. However, the CHA/VHA provides much greater detail in its guidelines, advising hospitals on various methods for reporting costs and characterizing a comprehensive list of specific activities as either "countable" as community benefits or "uncountable." The text box summarizes the associations' guidelines and their differences.

Categories for Community Benefit Reporting From Industry Guidelines

Catholic Healthcare Association of the United States/ Voluntary Hospital Association (CHA/VHA):

- Charity care
- Uncompensated Medicare cost under some circumstances
- Uncompensated Medicaid cost
- Uncompensated costs of other public programs
- Community health services
- Health professions education
- Subsidized health services
- Research
- Financial contributions
- Community-building activities
- Community benefit operations

American Hospital Association (AHA) suggests the following additions to the CHA/VHA guidelines:

- Uncompensated Medicare cost is included under all circumstances
- Bad debt is a new category

Sources: CHA/VHA and AHA Web sites.

In a more recent effort to standardize community benefit reporting, the IRS has proposed that tax-exempt hospitals prepare an additional schedule to be included with the informational return it requires all organizations with federal income tax exemptions to file. If adopted, the IRS anticipates using the new schedule for the 2008 tax year. The new schedule will require tax-exempt hospitals to report their community benefits and uncompensated-care costs. The IRS based the schedule on the standards set by the CHA/VHA, with the intention of eliciting discussion from hospitals and related organizations on the feasibility of providing the information, although it recognizes that there are alternative reporting models. Because all federally tax-exempt hospitals must complete the informational return each year, the new schedule, if adopted, might influence hospitals to follow the schedule's methodologies and format when developing their plans. As a result, the plans might become more uniform and comparable.

Incomplete and Inaccurate Data Preclude a Reliable Comparison Between the Economic Values of the Community Benefits That Nonprofit Hospitals Provide and the Taxes They Do Not Pay

We attempted to compare the economic values of the community services provided by all tax-exempt hospitals in the State with the amounts of income and property taxes they were exempt from paying in 2005. To estimate the forgone taxes, we developed two methodologies for the two types of taxes. However, the absence of complete and accurate data prevented our making reliable and meaningful comparisons. Thus, although our methodology for calculating forgone income taxes not collected resulted in an estimate of $58 million, we cannot attest to the reliability of the estimate. Likewise, although the methodology we used

to calculate forgone property taxes resulted in an estimate of $184 million, the reliability of that number is suspect. Numerous errors we found in the values the county tax assessors (county assessors) reported amounted to about $204 million just for the 12 hospitals we reviewed and an unknown amount for the remaining 211 nonprofit hospitals eligible for tax exemption.

As shown in Table 2, the total economic value of the community benefits reported by tax-exempt hospitals in California was about $656 million, which is approximately 2.7 times the $242 million we estimated those hospitals did not pay in income and property taxes in 2005. However, more precise estimates based on complete and accurate data could produce a different result.

Table 2
Ratio of Community Benefits Provided by Nonprofit Hospitals to Estimated Taxes Forgone by the State for 2005 (Dollars in Millions)

	AMOUNT	TAX RATE	ESTIMATED TAXES NOT PAID
Community benefits	$656	8.84%	$58
Assessed value of property	18,384	1.00	184
Total Estimated Taxes			**$242**

Benefit-to-Tax Ratio = $656:$242 = 2.7:1

Sources: Community benefit plans (plans) for 2005 that nonprofit hospitals submitted to the Office of Statewide Health Planning and Development (Health Planning). Annual statistical report for 2005 prepared by the Board of Equalization, which summarizes information that county assessors provide to it on the assessed value of their tax-exempt property.

Note: In general, the amounts shown do not include small and rural hospitals because they are not required to submit plans. However, if one of these types of hospitals did submit a plan to Health Planning in 2005, those community benefit values have been included.

Our Inquiries Revealed No Reliable Data for Estimating Income Taxes Not Collected From Tax-Exempt Hospitals

When we attempted to identify the value of income taxes not collected from tax-exempt hospitals, we encountered several barriers. According to the tax board, it has not performed any estimates of this kind. Further, although tax-exempt hospitals report revenue, expenses, and income to Health Planning, they do not report what their taxable income would be, if they were taxable entities, to the tax board. In an October 2005 letter to the State Assembly Committee on Revenue and Taxation, the California Hospital Association stated that hospitals organized and operated as nonprofit tax-exempt entities do not maintain an alternative accounting and record-keeping system that indicates what their tax liability would be if they were organized differently. Moreover, as nonprofit entities, they operate in a charitable manner to provide

services to the community rather than in a profitable manner to provide an economic return to investors. Therefore, any estimates of the taxes the tax-exempt hospitals might pay based on the current levels of income they report to Health Planning would be speculative and could not predict how the tax-exempt nonprofit hospitals' use of revenue or assets might change if they operated on a for-profit basis.

Because state law recognizes that most tax-exempt hospitals should provide benefits to their communities as a result of their tax exemptions, we attempted to estimate the amount of income taxes not paid by these hospitals using the state corporation income tax (income tax) rate and the economic value of community benefits reported by the tax-exempt hospitals to Health Planning. We used the most recent year available with the greatest percentage of data submitted, 2005.

Reports of community benefits submitted to Health Planning by tax-exempt hospitals contain services that would be provided to the community by both nonprofit and for-profit hospitals. These include medical services provided to the community at discount prices and funded by programs such as Medi-Cal, Medicare, and contracts with counties for services to indigents, as well as charity care subsidized by the hospitals (uncompensated care). Both types of hospitals report the values of these services to Health Planning in annual financial reports.

Only tax-exempt hospitals are required to submit annual reports on community services like community-oriented wellness and health promotion, medical research and education, and other outreach activities.

However, only tax-exempt hospitals are required to submit annual reports on community services such as community-oriented wellness and health promotion, medical research and education, and other outreach activities. We refer to these types of services as community benefits and, in calculating taxes not collected, attempted to separate them from uncompensated care, which nonprofit hospitals also include in their annual reports. Thus, to estimate income taxes not collected from tax-exempt nonprofit hospitals, we used the income tax rate of 8.84 percent and the total economic value of the community benefits. As shown in Table 2 on the previous page, we estimated the uncollected state income tax for the tax-exempt hospitals to be approximately $58 million in 2005.

As we discussed earlier in the report, state law prescribes no standardized format for reporting community benefits. As a result of inconsistent reporting by tax-exempt hospitals, we could not always identify whether the community benefits they reported could be provided by both nonprofit and for-profit hospitals or were exclusive to nonprofit hospitals. In addition to the value of the community benefits contained in Table 2, we noted a total of $223 million in reported services that we could not classify as either uncompensated care or community benefits.

Errors in Reported Property Values Reduce the Reliability of Estimated Property Taxes Not Paid by Tax-Exempt Hospitals

To estimate the value of the property tax exemptions granted to tax-exempt hospitals, we used the annual statistical reports that county assessors submitted to Equalization in 2005 and the 1 percent property tax rate established in the California Constitution. In a statistical report, a county assessor must include the value of the buildings and their contents owned by each tax-exempt hospital in the county. Using these reports, we estimated that the property taxes not paid by tax-exempt hospitals totaled about $184 million for 2005, the most current year for which information was available for nonprofit hospitals exempt from both property and income taxes.

When we attempted to verify the accuracy of the county assessors' reported values for 12 hospitals, we found many errors in the amounts they reported to Equalization.

However, when we attempted to verify the accuracy of the county assessors' reported values for 12 hospitals, we found many errors in the amounts they reported to Equalization. For example, in its 2006 statistical report, one county assessor incorrectly reported about $185 million in tax-exempt hospital buildings and $61.6 million for the buildings' contents as being the property of other religious and charitable organizations. Another county assessor overreported the value of a hospital's buildings by $47.8 million. That county assessor also reported about $92 million for hospital buildings and no value for contents and could not tell us at the time of our visit whether the value of the contents was reported with the value of the buildings or omitted from the report. A review of Equalization's aggregated statistical report for all counties in 2005 revealed that 14 county assessors reported values for hospital buildings but no values for their contents. Because we found errors in the reported values for four of the 12 hospitals we reviewed, representing a total error of about $204 million, and the errors for the remaining 211 nonprofit hospitals in the State eligible for tax exemption are unknown, we cannot attest to the reliability of the estimate we calculated using the property values reported by the county assessors. Further, Equalization has no assurance that the information included in the statistical reports is accurate.

As we discuss in Chapter 2, Equalization performs surveys of county assessors to determine the adequacy of the procedures and practices they apply in valuing property for the purposes of taxation and for administering property tax exemptions. We believe it would be valuable to include as part of these surveys a process for determining whether the county assessors are accurately reporting the values of tax-exempt properties on the annual statistical reports.

No Comparison of the Values of the Community Benefits Provided by Tax-Exempt Hospitals and by For-Profit Hospitals Was Possible

State law does not require for-profit hospitals to submit reports describing the community benefits they provide as it does for nonprofit hospitals.

In attempting to compare the economic values and types of community benefits provided by California's tax-exempt nonprofit hospitals with those provided by for-profit hospitals, we found that state law does not require for-profit hospitals to submit reports describing the community benefits they provide, as it does for nonprofit hospitals. Thus, we could not perform this comparison.

Nonetheless, we contacted a sample of eight for-profit hospitals to determine whether they prepared community benefit plans for their own purposes or tracked any expenditures related to community benefits. The seven for-profit hospitals that responded to our inquiries indicated that they do not prepare community benefit plans. However, two of the seven hospitals reported that they tracked and spent some of their funds on community benefits. One hospital told us that it budgeted $380,000 for community benefit expenditures in 2006 and provided a listing of its community outreach activities for a two-year period. The other hospital told us it spent $500 each year on breast cancer awareness public service announcements.

Recommendations

If the Legislature expects plans to contain comparable and consistent data, it should consider enacting statutory requirements that prescribe a mandatory format and methodology for tax-exempt nonprofit hospitals to follow when presenting community benefits in their plans.

If the Legislature intends that the exemptions from income and property taxes granted to nonprofit hospitals should be based on hospitals providing a certain level of community benefits, it should consider amending state law to include such requirements.

To ensure that it provides accurate information regarding the value of property that is tax exempt, Equalization should consider including in its surveys of the county tax assessors a process for verifying the accuracy of the values reported on the annual statistical reports submitted by the county assessors.

Chapter 2

THE FRANCHISE TAX BOARD COULD IMPROVE ITS ADMINISTRATION OF EXEMPTIONS FROM STATE CORPORATION INCOME TAXES GRANTED TO NONPROFIT HOSPITALS

Chapter Summary

The Franchise Tax Board (tax board), which administers exemptions from state corporation income taxes (income tax), could make some improvements to its practices of reviewing nonprofit organizations, including hospitals, to determine their eligibility for the exemption. Specifically, we found minor weaknesses in the tax board's past practices of determining nonprofit hospitals' eligibility for income tax exemptions. However, legislation effective January 1, 2008, will allow the tax board to rely on determinations of exemptions from federal income taxes performed by the Internal Revenue Service (IRS).

Unfortunately, because it has not been able to obtain complete information from the IRS, the tax board does not have a full understanding of the federal review process. According to the tax board, however, it has gathered enough information to conclude that the process the IRS uses to determine exemptions is sufficient to ensure proper state oversight. The tax board also indicated that state and federal laws are essentially identical in the area of tax exemption; therefore, any qualitative differences between the state and federal review processes will be addressed by the additional audits made possible by the decrease in workload created by the implementation of the new law. Finally, we found that the tax board does not use the tools available to it, such as annual filings and audits, to monitor nonprofit hospitals' continuing eligibility for income tax exemption.

Legislation effective January 2004 changed the responsibilities of the Board of Equalization (Equalization) and county tax assessors (county assessors) in determining property tax exemptions. Currently, Equalization reviews the organization and operation of nonprofit hospitals to determine whether they meet the organizational eligibility requirements for property tax exemption, and county assessors review the use of specific properties to determine the eligibility of those properties. Based on our review of the study Equalization conducted from 2005 through 2006, it appears to have made appropriate determinations of nonprofit hospitals' organizational eligibility. In addition, Equalization provides guidance to county assessors in meeting their responsibilities in determining property tax exemptions.

Information on county assessors' review of specific properties was limited because records on initial determinations of tax exemption must be retained for only six years, and most tax-exempt hospitals have been in operation longer than that. Nevertheless, county assessors appear to comply with statutory requirements in determining the eligibility of existing properties for property tax exemptions.

Recent Legislation Affects the Tax Board's Responsibilities for Granting Income Tax Exemptions

Legislation that becomes effective on January 1, 2008, will allow the tax board to grant state income tax exemptions based on determinations of federal income tax exemptions performed by the IRS.

Before the recently passed legislation, the tax board granted eligible nonprofit organizations, including hospitals, exemptions from paying state income taxes after reviewing application packages those organizations were required to submit. In the application packages, nonprofit hospitals had to include information intended, in part, to demonstrate that they met the statutory requirements that they be organized and operated for nonprofit purposes and that they placed restrictions on the use of the organizations' assets. We found minor weaknesses in the tax board's past practices for granting income tax exemptions. However, legislation that becomes effective on January 1, 2008, will allow the tax board to rely on determinations of federal income tax exemptions performed by the IRS. Under the new law, a qualifying nonprofit organization seeking an income tax exemption will no longer be required to submit an application package to the tax board. Rather, the organization will be exempt from state income tax after submitting to the tax board a copy of the notification from the IRS of the organization's exemption from federal income taxes.

However, the tax board does not have a complete understanding of the IRS review process for determining tax-exempt status. According to the tax board, although it has recently been in frequent contact with the IRS to obtain information regarding this process, it has not been able to obtain relevant IRS reports and other information. Rather, according to the tax board, it has gained its current understanding of the IRS review process through research on the IRS Web site, publications, and tax law. Through this research, the tax board has determined that the IRS exemption determination process is sufficient to ensure proper determination of state exemption status.

According to the tax board, because state and federal laws are essentially identical in the area of tax exemption, it concluded that additional audits, made possible by the decrease in workload created by the implementation of the new law, will compensate for differences in quality, if any, between the state and federal review processes.

The tax board stated that approximately 30 percent of the applications it receives annually are from organizations that already have federal exemptions. However, when the law goes into effect, a current backlog will delay the realization of workload savings until the spring or summer of 2008. Management for the tax board's Exempt Organizations Unit (unit) has decided that resources formerly used for application package review will be redirected to scrutinize ongoing compliance of tax-exempt entities, to ensure that they are complying with requirements for maintaining their tax-exempt status. The tax board also stated that until it identifies the actual savings in workload that may result from the implementation of the new law, it cannot evaluate the opportunities for performing audits of tax-exempt hospitals or plan for the number or frequency of such audits.

The Tax Board Has Limited Assurance That Nonprofit Hospitals Remain Eligible for State Income Tax Exemptions

Because the tax board does not effectively use the monitoring tools available to it, it has limited assurance of nonprofit hospitals' continuing eligibility for income tax exemptions. For example, an organization that qualifies for an income tax exemption is required to submit an annual filing called the California Exempt Organization Annual Information Return (Form 199) to report financial information and changes in activities, among other items. According to the tax board, the purpose of Form 199 is to provide the unit with an annual overview of the financial information of exempt organizations and is an important source of information when issues are brought to the unit's attention regarding a specific organization. The tax board also stated that Form 199 would be a useful tool for reviewing ongoing compliance. However, the tax board does not review the information to determine organizations' ongoing eligibility for income tax exemptions. Rather, according to the tax board, when it receives the forms, staff record the revenue information and review the forms for potential errors in the class code—which indicates an entity's designation, such as a general corporation, homeowners' association, or private foundation—and discrepancies in entity names, numbers, or accounting periods.

The tax board does not review information submitted in annual filings to determine organizations' ongoing eligibility for income tax exemptions.

In the absence of review by the tax board, it is not aware that income-tax-exempt organizations do not always submit the information required in the annual filing. In our review of the most current annual forms on file with the tax board for nine tax-exempt hospitals, we noted that three did not include schedules of other income and five did not include the depreciation schedules as required by Form 199. In addition, we found that Form 199 or its instructions did not address information that tax-exempt organizations are required to submit under the California Code of

Regulations (regulations). For example, we found that seven of the nine forms we reviewed did not include schedules of the names and addresses of the five employees who received the greatest amount of annual compensation in excess of $30,000 and the amounts each received, although this information is required by the regulations. The tax board stated that it is not possible to include all requirements of the regulations in Form 199 or its instructions. Although this seems reasonable, the tax board is not able to detect when organizations do not include required information, since it does not review the Form 199s. According to the tax board, the large volume of initial applications for income tax exemptions and limited staff prevent it from reviewing the forms.

Conducting regular audits of nonprofit hospitals could help the tax board monitor their continued eligibility for income tax exemptions. Such audits are especially important because, based on data provided by the tax board, the revenues of tax-exempt nonprofit hospitals represent 17 percent of the total revenue of the State's tax-exempt organizations. However, according to the tax board, it performs audits only when members of the public complain to the tax board that a tax-exempt organization, including hospitals, may be functioning in a manner that could require revocation of its tax-exempt status. Despite this assertion, the tax board could not provide a record of complaints filed against tax-exempt nonprofit hospitals, stating that the complaints against tax-exempt organizations including hospitals, are stored in the tax board's paper files and are difficult to retrieve. The tax board claims that it has not received any complaints concerning nonprofit hospitals and therefore has not conducted any audits. However, because the tax board does not maintain a central record of the complaints it receives against tax-exempt nonprofit hospitals or the disposition of those complaints, we question how it would know that it has not received any complaints. In fact, the tax board told us that it believes there is value to tracking these complaints and is planning to do so.

Because the tax board has not ensured that income tax-exempt hospitals are distinctly identified in its electronic data system, it is unable to efficiently generate a list of all hospitals that could be selected for audit.

The tax board also stated that the revenue information from the Form 199s that is entered into its record-keeping system could be used for identifying tax-exempt hospitals to be considered for audit. However, because the tax board has not ensured that income-tax-exempt hospitals are distinctly identified in its electronic data system, it is unable to efficiently generate a list of all hospitals that could be selected for audit. According to the tax board, creating such a list would require manually reviewing the hard-copy files of approximately 72,000 active tax-exempt organizations to determine which ones are nonprofit hospitals.

Finally, the tax board stated that the IRS expects to perform an audit within three to five years after each organization receives a federal tax exemption, and it would notify the tax board of any

revocations. However, the tax board does not currently coordinate with the IRS to identify audits of California tax-exempt hospitals in a manner that would allow the tax board to adequately rely on IRS audits for assurance of continuing eligibility. For example, the tax board told us that it does not know the extent of the review conducted in an IRS audit, the timing or frequency of IRS audits, or which organizations the IRS audits. According to the tax board, sharing taxpayer information between the tax board and the IRS requires a memorandum of understanding (memorandum). Although a memorandum does exist, it does not establish a functioning line of communication between the tax board's unit and the IRS. The tax board stated that the unit receives notifications from the IRS about revocations of tax-exempt status for only some organizations, but the tax board does not know how this line of communication originated or why the IRS conveys the revocations for only a small number of organizations. According to the tax board, it is currently developing a new memorandum with the IRS that will establish many lines of communication, but it was unable to tell us when the memorandum will be completed. The tax board believes the new memorandum will allow the IRS to share the results of its audits of tax-exempt hospitals with the tax board.

The tax board told us that it does not know the extent of the review conducted in an IRS audit, the timing or frequency of IRS audits, or which organizations the IRS audits.

Equalization Appears to Properly Review Eligibility for Property Tax Exemptions and Provides Guidance for County Assessors

After a change in state law in 2004, Equalization implemented a process to review all nonprofit hospital organizations (hospitals) to which it had previously granted exemptions from property taxes to determine whether the hospitals were properly organized and operated as required by law to continue to qualify for exemptions. Equalization plans to repeat the reviews on a four-year cycle. From our review of Equalization's process, it appears that it reached appropriate conclusions regarding the hospitals' eligibility for the exemptions, which state law refers to as welfare exemptions. In addition, Equalization provides both mandatory and advisory guidance to county tax assessors, who determine whether property claimed as exempt is actually necessary and used for the purposes allowed under law.

Legislation Effective in 2004 Changed the Administration of the Property Tax Exemption for Nonprofit Organizations

Before January 2004 a nonprofit organization seeking a property tax exemption needed to file two copies of an application with the county assessor. The assessor then reviewed the applicant's organizational documents and examined how the property was

used to determine whether the organization and its property qualified for property tax exemption. After attaching the results of the review to the application, the county assessor would then forward the documents to Equalization for a secondary review. Equalization would either agree or disagree with the county assessor's determination and notify the assessor and the applicant of its decision.

A change in the law eliminated the duplicate reviews. Since January 2004 Equalization has determined whether a nonprofit organization is eligible for a property tax exemption by evaluating whether it is organized and operated for a qualified purpose. An applicant that meets the statutory requirements receives an organizational clearance certificate (certificate) from Equalization. The applicant sends the certificate and the application to the county assessor, which then determines whether a specific property claimed is necessary and being used for an exempt activity. The county assessor also considers whether any capital investment for expansion of a physical plant is justified by its anticipated use and serves the interests of the community.

Equalization Appears to Have Reached Appropriate Determinations Regarding Property Tax Exemptions for Nonprofit Hospitals

During the period from 2005 through 2006, Equalization reviewed 201 hospitals to which it automatically issued certificates to ensure that they continued to qualify for property tax exemption.

At the end of 2003, as a result of the change in the law, Equalization automatically issued certificates to the hospitals that had previously qualified for property tax exemptions. During the period from 2005 through 2006, Equalization reviewed those 201 hospitals to ensure that they continued to qualify for their certificates. Beginning in 2009 Equalization intends to continue these reviews for all hospitals on a four-year cycle. We examined a sample of Equalization's reviews of the information submitted by hospitals and found that it had reached appropriate conclusions on their eligibility for property tax exemptions.

In the Introduction we presented the eligibility requirements for the property tax exemption, including allowable organizational purposes and income limitations. Equalization requested that each hospital submit a periodic filing that Equalization can use to ensure that it continues to meet the qualifications for exemption. The filing also requires a copy of the applicant's financial statements, statement of debts, names of the top-five positions with salaries exceeding $1,500 weekly or $78,000 annually, and any amendments to its articles of incorporation.

According to Equalization, from 2005 through 2006 it relied primarily on desk reviews to ensure that hospitals remained eligible for the property tax exemption. For its desk reviews, Equalization used a checklist to ensure that it covered significant legal requirements and maintained evidence of its review of required documents. Equalization's review included the following items:

- A hospital's original income tax exemption letter from the IRS or the tax board and a printout from the IRS Web site showing that it was currently exempt from federal income taxes or notes from a phone call to the tax board to confirm state tax-exempt status.

- A printout from the secretary of state documenting how the hospital was organized and whether there had been any recent amendments to articles of incorporation, and copies of those amendments.

- Copies of the hospital's federal informational returns to substantiate revenues and expenses and printouts from its Web site to substantiate exempt activity.

After gathering these documents, Equalization then reviewed the most recent amendments to the articles of incorporation to ensure that the hospital had legally required statements about the dedication of assets to exempt purposes. It also conducted a review of the highest salaries and the financial statements to ensure that no individual within the organization was receiving disallowed financial benefit from the hospital's activities.

One requirement for the property tax exemption is that a hospital may not have operating revenues that exceed operating expenses by more than 10 percent unless it spends the excess revenue on plant and facility expansion or debt retirement or sets it aside for operating contingencies. For the 15 hospitals that it identified as having surplus income, Equalization asked for explanations of how they spent their surpluses. Equalization analyzed each hospital's explanation to determine whether it spent the surplus income for an allowable purpose. Information from each hospital that Equalization reviewed included minutes from meetings of its board of directors showing that the directors approved the surplus income for an allowable purpose. Information from each hospital that Equalization reviewed included minutes from meetings of its board of directors showing that the directors approved the surplus income for an allowable purpose. To further verify a plant and facility expansion, Equalization contacted county assessors and, if possible, found information from newspapers or the hospital's Web site about the expansion.

For the 15 hospitals that it identified as having surplus income, Equalization asked for explanations of how they spent their surpluses.

After completing its review of the 201 hospitals, including 15 with surplus incomes, Equalization published on its Web site a report in May 2006 stating that all the hospitals continued to qualify for their certificates. According to Equalization, however, it found that some of the hospitals had dissolved, reorganized, or were no longer operating as hospitals; therefore, as of June 2007, 158 hospitals held certificates.

Equalization published a report in May 2006 stating that all the hospitals continued to qualify for their certificates; we reviewed Equalization's efforts and found that its conclusions were appropriate for all the files in our sample of hospitals.

We reviewed Equalization's efforts and found that its conclusions were appropriate for all the files in our sample of hospitals. For example, we evaluated the same evidence that its staff did for six of the 15 hospitals that had surplus incomes, including the organizations' explanations and evidence of how they used the surpluses. Additionally, we selected six hospitals without surplus incomes and reviewed their applications and the supporting documents that Equalization had researched and documented. To further test Equalization's process for awarding certificates, we reviewed the two new hospitals given certificates since May 2006. Finally, because Equalization may revoke a certificate when an organization dissolves, is reorganized, or is no longer qualified, we reviewed the documentation for two hospitals whose certificates Equalization had revoked.

Equalization Provides Guidance to County Assessors in Administering the Property Tax Exemption

As part of its role in administering property tax exemptions, Equalization advises county assessors regarding their role in granting exemptions for specific properties. Some of its guidance for assessors is mandatory and some is advisory. Mandatory guidance for county assessors includes forms and rules that Equalization has issued. Forms include the initial application that an organization submits to receive an exemption and the annual claim form an exempt organization must file. Rules include those related to exemptions, property valuation principles and procedures, classification of property, audits, hearings by county boards, changes in ownership, and qualifications of appraisers. Equalization also publishes on its Web site a list of the organizations that currently hold certificates and those that have recently had their certificates revoked.

The advisory guidance Equalization provides to county assessors includes voluntary workshops for staff in the assessors' offices and printed guidance on its Web site, such as the *Assessors' Handbook* published by Equalization, frequently asked questions and answers, and letters to county assessors. According to Equalization, it also provides advice over the telephone. Further, as required by state law, Equalization performs surveys at least once every five years at each

county assessor's office to determine the adequacy of the procedures and practices the assessor employs in valuing property for purposes of taxation and its administration of the property tax exemption. As a result, Equalization reported that it surveyed the practices of 12 county assessors in 2005 and 11 in 2006. In our review of Equalization's most recent surveys of 12 county assessors, we found that its staff conducted interviews and examined claims to determine whether the county assessors were appropriately administering the property tax exemption and advised the assessor's office when they found any problems. In these 12 surveys, we found that nonprofit hospitals were included in 27 percent of the claims that Equalization tested. From the 12 surveys that we reviewed, Equalization found only one instance of a need for improvement in a county assessor's administration of property tax exemptions involving hospitals.

Our review of Equalization's most recent surveys of 12 county assessors found that its staff conducted interviews and examined claims to determine whether the county assessors were appropriately administering the property tax exemption and advised the assessor's office when it found any problems.

Limited Information Suggests That County Assessors Comply With Statutory Requirements in Administering Property Tax Exemptions

Once Equalization determines that a nonprofit hospital is organized and operated for an exempt purpose, the property cannot be exempted from property tax until the county assessor determines that the hospital's property is used for the operation of the exempt activity and does not exceed the amount of property reasonably necessary to accomplish the exempt purpose. Further, state law requires county assessors to consider whether any capital investment for expansion of a tax-exempt property is justified by the anticipated use of the property and required to serve the interests of the community. After reviewing the limited information available, we concluded that county assessors appear to comply with the law in determining the eligibility of properties for tax exemptions. Although the county assessors appear to be administering property tax exemptions for hospitals appropriately, we found numerous errors in the values of tax-exempt hospitals the county assessors submitted on statistical reports to Equalization, as we describe in more detail in Chapter 1.

To apply for a property tax exemption, an organization, such as a hospital, must submit an application to the county assessor's office. The types of information included in the application are the corporation name and identification number, operating statement, and balance sheet. In addition, the applicant must certify under penalty of perjury that the property is used for exempt activities and provide a description of the primary and incidental use of the property. Lastly, the applicant must state whether it is considering making any capital investment in the property within the next year.

Required Components of an Assessor's Review of Applications for Property Tax Exemption

1. Determine if the use of property qualifies for exemption.
2. Identify if property is leased, rented, vacant, unused, or in excess of what is reasonably necessary to conduct the organization's exempt activities.
3. Review financial statements.
4. Ensure that the organization holds a valid certificate issued by Equalization.
5. Ensure that the application and attached documents are complete and properly signed and that the stated property use is eligible for exemption.
6. Conduct a field inspection to verify that the claimant uses the property exclusively for exempt purposes and activities.

Source: *Assessors' Handbook*, Section 267, October 2004.

The county assessor reviews the application to determine if the hospital meets the legal requirements for exemption. The *Assessors' Handbook*, includes guidance on how the assessor is to review the application. The text box shows some of the requirements of that review process. We limited our review to the most important areas of the process: whether county assessors had performed inspections to determine if the use of the property was for exempt purposes and whether the organization had been issued a valid certificate by Equalization.

We obtained only limited information regarding nonprofit hospitals' applications for exemption because state law requires that the applications be retained for six years after January 1 of the first tax year for which the exemption was granted. For eight of the 12 hospitals we selected for review, counties had not retained the applications because the required retention period had passed. However, after reviewing the applications of the remaining four hospitals, we determined that the county assessors had properly granted the tax exemptions in accordance with state law. We found evidence that field inspections were performed to determine that the property was being used for exempt purposes, and we verified that each of the hospitals possessed a valid certificate issued by Equalization through review of the hospitals' annual claims for property tax exemption.

State law requires that each hospital granted a property tax exemption submit an annual claim for exemption to the county assessor's office. The annual claim requires the hospital, in part, to provide information regarding the current use of the exempt property. For example, the annual claim requires the hospital to indicate whether the use of any portion of the property that received an exemption had changed in the last year. From our review of the most recent annual claim submitted by each of the 12 hospitals in our sample, we determined that none of the hospitals reported changes to the use of the exempt property that might require the county assessors to conduct additional procedures, such as field inspections, to ensure that the properties were still being used for exempt purposes.

We reviewed recent expansions or improvements made to hospital properties that were previously exempt to determine if assessors performed inspections of the new properties. However, only limited information was available for review. We could review inspection records related to only eight of the 12 hospitals selected for testing

because some hospitals did not own the properties or there were no recent improvements or expansions. Five of the eight hospitals made expansions or improvements during the period from 2001 through 2005. Of these, two lacked evidence of field inspections.

Recommendations

After it identifies the staff resources that are no longer required for reviewing tax exemption applications, the tax board should implement its plan to use those resources for performing audits of tax-exempt entities, including hospitals.

The tax board should consider developing methodologies to monitor nonprofit hospitals' continuing eligibility for income tax exemption. These methodologies should include the following activities:

- Review the financial data and other information on the Form 199 annually submitted by tax-exempt hospitals.
- Ensure that the annual Form 199 contains all the information required to determine eligibility for an income tax exemption in accordance with state law.
- Track complaints in a manner that allows it to identify potential trends in a tax-exempt hospital's noncompliance with the law and initiate audits of such hospitals.
- Adequately identify tax-exempt hospitals in its automated database so it can use the information in the database to profile those hospitals and identify any potential noncompliance with the law.

The tax board should gain an understanding of the frequency and depth of IRS audits of tax-exempt hospitals to identify the extent to which it can rely on IRS audits and factor that reliance into its monitoring efforts.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of the report.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

Date: December 13, 2007

Staff: Denise L. Vose, CPA, Audit Principal
Norm Calloway
Sunny Andrews, MSW
Joseph Jones, CIA
Whitney M. Smith
Lea Webb, MPA

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at (916) 445-0255.

Appendix

ECONOMIC VALUATION TABLES FROM THE COMMUNITY BENEFIT PLANS OF EIGHT NONPROFIT HOSPITALS

As outlined in state law, the Legislature has determined that in exchange for favorable tax treatment, nonprofit hospitals assume a social obligation to provide community benefits in the public interest. In addition, state law requires most tax-exempt hospitals to prepare and submit to the Office of Statewide Health Planning and Development (Health Planning) a community benefits plan (plan) every year. The plans include economic valuation tables in which the hospitals assign values for categories of benefits and include activities within those categories that the hospitals have undertaken to address community needs. Although state law makes it clear that the plans do not need to follow specific formats, it does identify specific framework categories of services and activities that should be part of the plans. However, state law does not provide a comprehensive list of the types of activities that should and should not be considered community benefits.

Our review of the plans of a sample of eight nonprofit hospitals, as well as discussions with their staff, found that the plans submitted to Health Planning differed in the types of uncompensated-care costs and activities the hospitals chose to include or not include in the plans and in the methodologies they use when calculating the economic values of the community benefits. The following economic valuation tables from the plans of the eight nonprofit hospitals we reviewed clearly illustrate the differences in the framework categories and activities used by the nonprofit hospitals, thus making it difficult to allow for a meaningful comparison of the information included in the plans.

Table A.1
Community Benefit Values Reported by the California Hospital Medical Center in Plans for 2002 Through 2006

CATEGORIES		2006	2005	2004	2003	2002
Benefits for the poor	Traditional charity care	$17,886,980	$5,018,839			
	Unpaid costs of Medicaid	14,218,601	*			
	Other public programs	2,682,530	*			
	Community health services	0	528			
	Totals for the Poor	**$34,788,111**	**$5,019,367**			
Benefits for the broader community	Unpaid costs of Medicare	2,168,467	*			
	Community health services	2,749,322	3,789,343			
	Health professions education	1,163,726	1,971,300			
	Subsidized health services	3,806,357	2,223,691			
	Donations	647,799	621,979			
	Community building activities	1,305	1,434			
	Community benefit operations	60,583	*			
	Totals for the Broader Community	**$10,597,559**	**$8,607,747**			
	Totals	**$45,385,670**	**$13,627,114**			
Unreimbursed costs	Traditional charity care			$6,568,811	$2,094,256	$3,310,345
	Unpaid costs of Medicare			(4,706,480)	(3,350,641)	0
	Unpaid costs of Medicaid			5,846,436	11,125,234	0
	Other public programs			*	0	28,322
	Subtotals for Charity Care			**$7,708,767**	**$9,868,849**	**$3,338,667**
	Community education and outreach			97,117	50,408	58,919
	Screenings			23,375	32,158	14,296
	Immunizations			0	0	1,256
	Other nonbilled services			2,150,998	0	694,911
	Subtotals for Community Services			**$2,271,490**	**$82,566**	**$769,382**
Medical education	Physicians, nurses, technicians and other			1,970,603	1,931,780	1,941,983
	Scholarships/funding for health professionals			3,000	0	0
	Other medical education			0	0	0
	Subtotals for Medical Education			**$1,973,603**	**$1,931,780**	**$1,941,983**
Subsidized health services	Emergency/trauma care			663,836	613,134	578,518
	Neonatal/obstetrical/newborn care			32,794	48,000	55,827
	Other subsidized services			1,303,062	1,068,472	796,097
	Subtotals for Subsidized Services			**$1,999,692**	**$1,729,606**	**$1,430,442**
	Cash/in-kind donations			*	667,185	509,400
	Community building			0	0	1,300
	Totals			**$13,953,552**	**$14,279,986**	**$7,991,174**

Source: California Hospital Medical Center's community benefit plans for 2002 through 2006.

* This subcategory title does not appear in the community benefit plan.

Table A.2
Community Benefit Values Reported by the California Pacific Medical Center in Plans for 2002 Through 2006

CATEGORY	PROGRAMS AND SERVICES INCLUDED	2006	2005	2004	2003	2002
Services for the poor and underserved	Traditional charity care	$5,017,000	$5,100,000	$4,126,000		
	Unpaid costs of Medi-Cal	37,346,000	40,346,000	30,320,000		
	Other benefits for the poor and underserved	6,509,000	4,086,000	1,614,000		
	Total Quantifiable Services	**$48,872,000**	**$49,532,000**	**$36,060,000**		
Benefits for the broader community	Unpaid cost of Medicare	58,788,000	61,747,000	46,552,000		
	Non-billed services	592,000	268,000	547,000		
	Education and research	9,438,000	8,046,000	7,679,000		
	Cash and in-kind donations	576,000	549,000	586,000		
	Other community benefits	5,000	1,000	0		
	Total Quantifiable Benefits	**$69,399,000**	**$70,611,000**	**$55,364,000**		
	Totals	**$118,271,000**	**$120,143,000**	**$91,424,000**		
Benefits for the community	Traditional charity care				$2,147,000	
	Unpaid costs of public programs:					
	Medicare				44,837,000	
	Medi-Cal				26,673,000	
	Total Unpaid Costs of Public Programs				**$73,657,000**	
	Non-billed services				4,958,000	
	Education, research, and training				6,785,000	
	Cash and in-kind donations				665,000	
	Other community benefits				5,000	
Benefits for vulnerable populations	Traditional charity care					$1,490,000
	Unpaid costs of public programs:					
	Medicare					12,401,000
	Medi-Cal					16,373,000
	Subtotal for Vulnerable Populations					**$30,264,000**
	Non-billed services					5,528,000
	Education, research, and training					9,107,000
	Cash and in-kind donations					707,000
	Other community benefits					1,000
	Totals				**$86,070,000**	**$45,607,000**

Source: California Pacific Medical Center's community benefit plans for 2002 through 2006.

Table A.3
Community Benefit Values Reported by the Cedars-Sinai Medical Center in Plans for 2002 Through 2006

CATEGORY	2006	2005	2004	2003	2002
Traditional charity care	$21,768,000	$29,696,000	$12,504,000	$11,111,000	$44,694,000
Unpaid cost of state programs	81,565,000	72,239,000	68,297,000	56,696,000	49,569,000
Unpaid cost of specialty government programs	4,344,000	5,238,000	*	*	*
Community benefit service and programs	28,180,000	31,249,000	22,494,000	23,993,000	20,658,000
Totals	**$135,857,000**	**$138,422,000**	**$103,295,000**	**$91,800,000**	**$114,921,000**

Source: Cedars-Sinai Medical Center's community benefit plans for 2002 through 2006.

* This category title does not appear in the community benefit plan.

Table A.4
Community Benefit Values Reported by the Kaiser Foundation Hospitals in Plans for 2002 Through 2006

CATEGORY	PROGRAMS AND SERVICES INCLUDED	2006	2005	2004	2003	2002
Medical care services for vulnerable populations	Medi-Cal shortfall	$120,283,096	$160,771,151	$130,065,487	$99,446,389	$60,940,278
	Healthy families	11,475,412	14,549,240	9,157,334	1,854,138	396,206
	Steps plan	*	17,295,747	14,915,496	12,919,886	6,982,948
	Kaiser Permanente (KP) child health plan	*	4,873,296	*	*	*
	KP Cares for Kids child health plan	*	*	3,689,689	2,049,417	532,453
	Charity care: charitable health coverage programs	22,026,394	*	*	*	*
	Charity care: medical financial assistance program	29,861,169	*	*	*	*
	Charitable care	*	26,141,915	38,717,220	23,486,841	8,785,500
	Grants and donations for medical services	8,067,035	21,582,849	*	*	*
	Subtotals	**$191,713,106**	**$245,214,198**	**$196,545,226**	**$139,756,671**	**$77,637,385**
Other benefits for vulnerable populations	Educational outreach program	545,156	478,955	479,977	441,315	381,616
	Educational theater programs	†	†	4,220,881	3,507,958	3,090,478
	Watts counseling and learning center	2,221,101	2,080,326	2,044,065	2,021,016	1,880,163
	KP Cares for Kids administrative costs	*	*	*	882,138	526,614
	Summer youth and INROADS programs	1,707,981	1,542,161	1,931,611	1,607,524	1,401,948
	Community health partnership	*	*	279,864	123,990	131,974
	Regional and local Senate Bill 697 grant funds	*	*	4,966,749	3,878,094	3,641,395
	Regional community clinic partner program	*	*	2,737,573	2,057,565	*
	Community clinics partnerships	*	*	*	*	1,413,605
	Regional HIV/AIDS grants	*	*	367,500	360,000	347,000
	Grants and donations for community-based programs	8,659,713	22,404,034	*	*	*
	Community benefit administration and operations	6,296,990	2,633,066	*	*	*
	Community needs assessments	*	223,736	*	*	*
	Subtotals	**$19,430,941**	**$29,362,278**	**$17,028,220**	**$14,879,600**	**$12,814,793**

CATEGORY	PROGRAMS AND SERVICES INCLUDED	2006	2005	2004	2003	2002
Benefits for the broader community	Community health education and promotion programs	751,158	928,545	1,137,975	1,190,968	2,594,890
	Educational theater programs	5,389,116	4,276,677	†	†	†
	Facility, supplies, and equipment (in-kind donations)	1,384,238	772,016	376,001	876,524	917,463
	Staff time	814,656	786,284	3,251,024	3,621,553	3,372,183
	Regional and local community relations grants	*	*	3,342,013	*	*
	Community relations grants	*	*	*	4,344,686	2,807,879
	Community giving campaign administrative expenses	45,485	89,711	*	*	*
	Grants and donations for the broader community	7,569,003	10,878,394	*	*	*
	National board of directors fund	843,865	831,084	852,796	820,005	801,788
	Subtotals	**$16,797,521**	**$18,562,711**	**$8,959,809**	**$10,853,736**	**$10,494,203**
Health research, education, and training	Graduate medical education	37,076,626	30,168,809	26,567,233	29,721,608	26,389,812
	Nonphysician provider education and training programs	14,162,325	*	*	*	*
	Provider education and training programs	*	14,792,790	14,868,324	14,093,999	12,384,901
	Grants and donations for the education of health professionals	1,061,205	1,107,811	*	*	*
	Health research	10,109,135	9,056,771	16,478,724	12,021,375	9,303,588
	Medical libraries and resource development	3,290,184	9,723,975	7,533,160	6,335,903	6,446,667
	Grants and donations for evidence-based medicine	240,556	9,831,306	*	*	*
	Subtotals	**$65,940,031**	**$74,681,462**	**$65,447,441**	**$62,172,885**	**$54,524,968**
	Totals	**$293,881,599**	**$367,820,649**	**$287,980,696**	**$227,662,892**	**$155,471,349**

Source: Kaiser Foundation Hospitals' community benefit plans for 2002 through 2006.

* This subcategory title does not appear in the plan.

† This subcategory title does not appear under this category in the plan.

Table A.5
Community Benefit Values Reported by the Methodist Hospital of Southern California in Plans for 2002 Through 2006

CATEGORY	2006	2005	2004	2003	2002
Traditional charity care	$7,414,281	$7,070,606	$5,986,479	$5,275,789	$4,152,850
Unpaid costs of Medicare	7,733,251	3,125,672	5,738,052	3,267,660	3,032,131
Unpaid costs of Medicaid	4,953,743	4,512,226	3,005,497	2,430,891	1,924,205
Community health services	1,998,816	1,686,115	1,641,645	1,586,088	1,405,739
Health professions education	275,667	102,565	77,851	60,552	50,133
Subsidized health services	463,876	379,962	271,295	217,150	215,087
Donations	42,165	13,705	75,694	34,175	24,494
Totals	**$22,881,799**	**$16,890,851**	**$16,796,513**	**$12,872,305**	**$10,804,639**

Source: Methodist Hospital of Southern California's community benefit plans for 2002 through 2006.

Table A.6
Community Benefit Values Reported by the Saint John's Hospital and Health Center in Plans for 2002 Through 2006

CATEGORY	PROGRAMS AND SERVICES INCLUDED	2006	2005	2004	2003	2002
Medical care services	Unpaid cost of Medicare program	$24,278,930	$17,095,537	$20,768,726	$20,102,637	$14,284,695
	Charity care	1,926,579	1,843,700	691,258	1,314,332	442,847
	Low margin service: child and family development center	1,663,675	1,179,949	880,543	623,738	209,537
	Unpaid cost of Medi-Cal program	1,397,305	1,189,273	619,741	917,696	496,337
	Free services to local nonprofit organizations	633,656	589,838	686,314	625,582	641,234
	All other medical care services	350,469	286,497	267,603	270,721	216,911
Other services for vulnerable populations	Community benefit team, services for local schools, services for seniors, care for the poor projects, donations to community organizations to improve access to health services	1,967,829	1,967,538	2,208,879	1,956,080	1,677,007
	Low margin service: CFDC infant, toddler and preschool program	725,061	706,534	782,818	797,474	749,160
Other services for the broader community	Community outreach, community health education, donations to community organizations to improve health and wellness	840,230	912,746	1,154,409	726,576	656,513
Health research, education, and training programs	Support for health research, nursing education, and continuing medical education	1,115,080	740,918	1,032,736	989,312	1,957,555
	Totals	**$34,898,814**	**$26,512,530**	**$29,093,027**	**$28,324,148**	**$21,331,796**

Source: Saint John's Hospital and Health Center's community benefit plans for 2002 through 2006.

Table A.7
Community Benefit Values Reported by the Stanford Hospitals and Clinics in Plans for 2002 Through 2006

CATEGORY	2006	2005	2004	2003	2002
Benefits for vulnerable populations, excluding Medicare shortfall	$62,651,765	$48,398,505	*	*	*
Medicare shortfall	15,578,371	9,250,136	*	*	*
Benefits for vulnerable populations	*	*	$59,579,231	$48,994,608	$34,012,673
Benefits for the larger community	7,984,943	4,259,603	3,814,345	3,867,194	4,716,640
Health research, education, and training	16,522,882	15,795,862	16,151,265	14,629,921	11,859,995
Totals	*	*	**$79,544,841**	**$67,491,723**	**$50,589,308**
Totals, Excluding Medicare Shortfall	**$87,159,590**	**$68,453,970**	*	*	*
Totals, Including Medicare Shortfall	**$102,737,961**	**$77,704,106**	*	*	*

Source: Stanford Hospitals and Clinics' community benefit plans for 2002 through 2006.

* This category title does not appear in the community benefit plan.

Table A.8
Community Benefit Values Reported by the Sutter Medical Center, Sacramento, in Plans for 2002 Through 2006

CATEGORY	2006	2005	2004	2003	2002
Benefits for the poor and underserved	$64,801,000	$65,644,000	$41,706,000	$49,413,000	$24,943,000
Benefits for the broader community	7,101,000	52,282,000	75,428,000	66,127,000	38,552,000
Totals	**$71,902,000**	**$117,926,000**	**$117,134,000**	**$115,540,000**	**$63,495,000**

Source: Sutter Medical Center, Sacramento's community benefit plans for 2002 through 2006.

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(Agency response provided as text only.)

November 27, 2007

Board of Equalization
Office of the Executive Dirtector
450 N Street
Sacramento, California 95814

Ms. Elaine Howle, State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

This is the Board of Equalization (BOE) response to the audit report entitled "Nonprofit Hospitals: Inconsistent Data Obscure the Economic Value of Their Benefits to Communities, and the Franchise Tax Board Could More Closely Monitor Their Tax-Exempt Status".

The Bureau of State Audits (BSA) report included one finding for the BOE:

- To ensure that it provides accurate information regarding the value of property that is tax exempt, Equalization should consider including in its surveys of the county tax assessors a process for verifying the accuracy of the values reported on the annual statistical reports submitted by the county assessors.

The BOE agrees with the BSA recommendation. The County-Assessed Properties Division will incorporate steps in their survey review of county tax assessors to verify proper classification of exempted property based upon the type of organization within the welfare exemption. This will provide more accurate reporting of exempted values of hospitals to BOE.

If you have any questions regarding our response, please contact me or Lisa Thompson at 324-2701.

Sincerely,

(Signed by: Ramon J. Hirsig)

Mr. Ramon J. Hirsig, Executive Director

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(Agency response provided as text only.)

11.27.2007

Franchise Tax Board
Executive Office
PO Box 115
Rancho Cordova, CA 95741-0115

To: Elaine Howle, State Auditor
Bureau of State Audits
555 Capitol Mall, Ste. 300
Sacramento, CA 95814

From: Selvi Stanislaus

Draft Bureau of State Audit Report

Memorandum

Thank you for the opportunity to review the draft audit report prepared by your staff for the Joint Legislative Audit Committee.

We appreciate your recommendations for improving the exempt organizations program. We concur that improvements can be made.

Following are specific comments to the report and the recommendations:

Bureau of State Audits (BSA) Recommendation: After it identifies the staff resources no longer required for reviewing tax exemption applications, the tax board should implement its plan to use those resources for performing compliance audits of tax-exempt entities, including hospitals.

Franchise Tax Board (FTB) Response: We agree and will focus on increased compliance audits, as resources are available.

BSA Recommendation: *The tax board should consider developing methodologies to monitor nonprofit hospitals' continuing eligibility for income tax exemption that include the following activities:*

- *Review the financial data and other information on the Form 199 annually submitted by tax-exempt hospitals.*

- *Ensure that the annual Form 199 contains all the information required to determine eligibility for an income tax exemption in accordance with state law.*

FTB Response: We will begin to develop an audit program to review the Form 199 for hospitals to gain a better understanding of compliance issues and materiality thresholds for ongoing review.

- *Track complaints in a manner that allows it to identify potential trends in a tax-exempt hospital's noncompliance with the law and initiate audits of such hospitals.*

FTB Response: We concur. We have already implemented a new procedure to log all complaints into a computer database that documents the organization name, type, issue, and action taken.

- *Adequately identify tax-exempt hospitals in its automated database so it can use the information in the database to profile those hospitals and identify any potential noncompliance with the law.*

FTB Response: We agree. As resources are available, we will begin updating the codes to separately identify tax-exempt hospitals from other types of charitable organizations.

BSA Recommendation: *The tax board should gain an understanding of the frequency and depth of IRS audits of tax-exempt hospitals to identify the extent to which it can rely on IRS audits and factor that reliance into its monitoring efforts.*

FTB Response: We agree. We are currently finalizing the Special Procedures Report and Memorandum of Understanding (MOU) with the IRS that will allow FTB to receive additional information on tax-exempt organizations. In addition to notification of final IRS actions authorized under the existing MOU, the new agreement will entitle FTB to receive information on proposed denials, revocations, and audit adjustments and names of organizations that have applied for federal exemption under IRC 501(c)(3).

Again, we appreciate the opportunity to provide you with this response. If you need any further information or would like to discuss any of the issues above, please feel free to contact Philip Yu at 845-3388.

(Signed by: Lynette Iwafuchi for Selvi Stanislaus)

Executive Officer

(Agency response provided as text only.)

November 27, 2007

Office of Statewide Health Planning and Development
400 R Street, Suite 310
Sacramento, California 95811-6213

Elaine M. Howle*
State Auditor
California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

We have reviewed the draft report prepared by the Bureau of State Audits (BSA) at the request of the Joint Legislative Audit Committee regarding the economic value of the benefits provided by non-profit hospitals to their communities. We did not identify any significant areas of disagreement, but do want to clarify some references related to "uncompensated care costs" which appear on pages 3, 4 and 24 of the report. (1)

The report states that the Office of Statewide Health Planning and Development (OSHPD) "has chosen" to estimate uncompensated care costs using charity care, bad debts, and county indigent program (CIP) contractual adjustments. These statements are made in the context of the BSA's decision to include Medi-Cal un-reimbursed costs in some of its uncompensated care cost calculations.

To clarify, OSHPD does not have a pre-determined definition of uncompensated care costs. Instead, our financial data products provide three methods to estimate and display uncompensated care costs, as follows: 1) charity care, 2) charity care and bad debts, and 3) charity care, bad debts, and the CIP contractual adjustment. This allows data users to decide which method best meets their needs. In the cited instance, the BSA selected the third method with the addition of Medi-Cal un-reimbursed costs.

If you would like to discuss this further, please contact Michael Rodrian, Deputy Director, Healthcare Information Division at 916-326-3801.

Sincerely,

(Signed by: David M. Carlisle)

David M. Carlisle, M.D., Ph.D.
Director

* California State Auditor's comment appears on page 61.

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Comment

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM THE OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

To provide clarity and perspective, we are commenting on the Office of Statewide Health Planning and Development's (Health Planning) response to our audit report. The number corresponds to the number we have placed in Health Planning's response.

Health Planning was concerned about the references related to uncompensated-care costs we made in our report. Based on its suggestion, we clarified the text appearing on pages 1, 2, and 19. (1)

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press