

Charity Care and Community Benefit
Advocate Health Care Network and Advocate Health and Hospitals Corporation, Oak Brook, Ill.
1. How does your organization define charity care?
Advocate's charity care policy defines "charity assistance" as health care services that Advocate facilities provide free-of-charge, or at a reduced amount, to individuals who meet certain financial eligibility criteria.
What types of activities or programs does your organization include in its definition or determination of charity care?
The charity care programs extend to all activities and programs conducted by Advocate's hospitals. This policy provides for discounts to patients with incomes of up to four times the federal poverty level. Charity assistance discounts related to elective services are subject to budget constraints and are at the discretion of the hospital.
Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
It would be speculative to engage in comparisons without complete information about other healthcare organizations and their activities. However, if we were required to pay taxes, the resulting decrease in our operating income would necessarily diminish the amount of community benefits we could provide.
Does your organization maintain a charity policy?
Yes
If so, please describe the policy or provide a copy of such policy.
Copy provided at Tab 1.
Does this policy require that certain types and amounts of charity care be provided?

No
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
Medicare Program, Medicaid Program, Medical education, Bad debt cost, Charity Care cost, Subsidized health services, Cost of volunteer services, Contributions to other charitable and Community/civic organizations, Language assistance services, Other government sponsored program services (TRIAD-CHAMPUS program)
How does this differ from 10 years ago?
The information is not available as the information was either not collected or the information systems used to access such information were replaced or did not exist.
25 years ago?
N/A - Advocate was formed in 1995
3. What percentages of your patients for your most recent fiscal year were:
(a) uninsured (self pay) 2.67%
(b) covered by Medicare 38.04%
(c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals 12.98%
(d) otherwise covered by private insurance 42.70%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?
Yes. In certain cases, it is already known prior to admission that the patient qualifies for financial assistance and fees are waived upon admission. For patients whose financial circumstances are unknown, all hospitals are consistent with federal law.

<p>5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?</p>
<p>Advocate's bad debt write-offs as a percentage of gross revenue have decreased over the past five years. We would be happy to discuss this matter further with the Committee.</p>
<p>6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.</p>
<p>Advocate collaborates with numerous other tax-exempt health care organizations, including hospitals and clinics, to provide charity care and health care services. Most of these relationships are site-specific, depending on the community needs and institutions present in the local area a hospital serves. Examples provided.</p>
<p>7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.</p>
<p>No</p>
<p>8. Has your hospital or other members of your hospital system group enter into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures</p>
<p>Advocate tax-exempt entities have not entered into joint ventures that we consider to be "substantially related" to our core mission. Taxable Advocate affiliates have entered into several joint ventures. These include investments in 4 surgery centers, a surgery center management company that is a spin off of one of the surgery centers, and a free standing outpatient dialysis center.</p>
<p>9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy.</p>
<p>Advocate has entered into five joint ventures through our tax-exempt entities. Advocate has contributed to and remains a member of Hospitality Laundry Services, a not-for-profit entity that provides laundry services. Advocate and Aurora Health System, a Milwaukee not-for-profit delivery system, are partners in a laboratory joint venture. Advocate cannot track charity care provided by these entities. Advocate Health Care and Resurrection Health Care are the corporate members of Rainbow Hospice. Rainbow operates independently as a non-profit tax-exempt org. Rainbow has a policy that a patient's financial status must be estab. prior to accept for admission. Advocate entered into a joint venture with Rehab. Institute of Chicago to provide rehabilitation services to inpatients and outpatients. Pursuant to the joint venture agreement, that joint venture provides charity care in accord with Advocate's charity care. Chicago Northside MRI provides imaging services to their patients and communities. This entity offers flexible pmt plans, but does not offer charity care discounts.</p>
<p>Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced</p>
<p>Question not addressed.</p>

<p>If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant</p>
<p>Advocate does not track charity care by categories because our charity data gathering capabilities have been structured to conform with the requirements of the Illinois Community Benefits Act. The Act does not require tracking expenses by category.</p>
<p>10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons</p>
<p>Advocate does not engage in such joint ventures. Advocate lacks sufficient information to address allegations about other hospital systems or generalize about their collective practices.</p>
<p>11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture</p>
<p>Advocate's tax-exempt affiliates have engaged in relatively few joint ventures. These ventures have been undertaken to further Advocate's charitable mission.</p>
<p>12. Please provide a charity care breakdown for each entity that is a member of your hospital system group</p>
<p>Consistent with requirements of the Illinois Community Benefit Act, we disclose our charity care and other community benefit expenditures on a system-wide basis.</p>
<p>In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis</p>
<p>Advocate supports measuring charity care on an aggregate basis, because this avoids problems that could arise with respect to potential double counting of community benefits expenditures (for example if one hospital within a system group made a charitable contribution to another member of the system group). Measuring charity care on an aggregate group basis is consistent with Advocate's legal structure (7 of 8 Advocate hospitals are within a single legal entity).</p>
<p>13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?</p>
<p>Advocate has no opinion at this time on the question. Joint ventures involving Advocate's tax-exempt hospitals that deliver direct health care services to patients offer charity care under the same policies as the rest of the Advocate system.</p>
<p>If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?</p>
<p></p>

<p>14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?</p>
<p>Under GAAP, a hospital may report charity care only for those entities/joint ventures that are consolidated in the parent company's financial statements.</p>
<p>15. What types of research and teaching are performed by your hospital as a charitable or educational activity?</p>
<p>Educational Activity - Medical education at the undergraduate (1,500 students) and graduate (625 residents/fellows) levels at three hospitals. Continuing Medical Education opportunities for physicians and associates totaling 2,548 instructional hours to 21,540 participants. Research Activity - Five primary types of research occur. Other Educational Activities - Directed to non-physician health professionals and community members. For example, Advocate works with faith communities through our Parish Nurse Ministry to provide free services to community members, including educational activities directed at patients, health screenings, and support groups. IMMC sponsors a two year radiography program. Through affiliations support internships and other training in a variety of health-related fields.</p>
<p>16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital</p>
<p>Advocate, through Advocate Charitable Foundation, received almost \$20 million in fund-raising revenues in 2004. Those gifts provided support for many programs across the system as well as funds for about 10% of capital expenditures.</p>
<p>Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families</p>
<p>Appeals for general charity care and programs for low-income patients or the uninsured are made to employees, through fund-raising events dedicated to such programs, annual mail appeals, and opportunities for Internet gifts. From 2002-2004, Advocate received and spent over \$2.1 million in gifts for charity care and charity care programs.</p>
<p>17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture</p>
<p>Advocates tax-exempt affiliates have not partnered with for-profits in joint venture arrangements. In the absence of direct experience with such arrangements, Advocate cannot answer the question without speculating.</p>
<p>18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?</p>
<p>Advocate's arrangements encourage the provision of charity care by requiring adherence to our policies and procedures and medical staff bylaws, which includes its charity care policy. In some instances, we have specifically incorporated our charity care policies into our agreements with physicians. We are not in a position to control the charitable practices undertaken by independent parties. However, the practices of such independent third parties do not reduce the amount of charity care provided our hospitals.</p>

<p>19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.</p>
<p>Advocate does not track charity care expenditures based upon "service line."</p>
<p>20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?</p>
<p>The Illinois Community Benefits Act defines community benefits activities in ten categories (e.g., language assistance services, donations, volunteer services, education, and subsidized health services). The reported cost of the community health outreach programs and activities is \$61,967,000. This represents 2.4% of 2004 total operating expenses. The cost of community benefits including charity care, bad debts and unreimbursed government sponsored programs totaled \$245,583,000, approximately 3 times greater than 2004 net operating income. This figure represents 9.6% of total 2004 operating expenses - less bad debt expense.</p>
<p>21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.</p>
<p>Advocate does not track charity care offered by for-profit hospitals, ambulatory surgical facilities, physicians, urgent care centers, and other such entities. Anecdotally, we understand that our charity care policy is among the most generous in the nation among not-for-profit health care systems.</p>
<p>22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?</p>
<p>It is nearly impossible to determine the exact dollar amount spent on individuals under the age of 18. Many of our programs are focused on the community as a whole, such as our asthma outreach program, and dollars spent are not tracked separately for adults and children. However, several programs are focused solely on infants and children (e.g., Baby Advocate - a system-wide vaccination and developmental reminders program helped 36,000 families, Healthy Steps program - engages parents as partners with doctors in their child's health served 29,000 individuals). Advocate sites also contributed to children's health through free or minimal cost health fairs, immunization programs, asthma education outreach, car seat check-up programs, poison control education, and other programs that touched thousands of children's lives.</p>
<p>23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?</p>
<p>Advocate Health Care conducts clinical trails. Advocate does not attribute to charity care any losses related to clinical trails.</p>
<p>24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?</p>

<p>Costs of charity care, bad debt and government sponsored programs for our hospitals and home care agency are calculated utilizing a Medicare cost to charge ratio. The cost to charge ratio is utilized because that is the methodology established under Illinois' Community Benefit Act. Expenses for non-cost-reporting entities are determined utilizing a ratio of financial statement expenses, excluding bad debt expense, to gross charges.</p>
<p>Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences</p>
<p>With respect to Advocate's allocation of expenses to charity care and other community benefits, costs are determined utilizing our decision support cost accounting system, not our Medicare cost reports. A similarity between these methodologies is that financial statement costs are the starting point for computing costs. A distinctive feature of Medicare's methodology is that it excludes certain costs and expenses from its definition of allowable costs. The methodologies may also differ in the basis they use for allocating costs to cost centers and patients.</p>
<p>25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.</p>
<p>Acute Care Length of Stay - 2003 4.58 average (range 3.57-5.41). 2004 4.53 average (range 3.55-5.36). Cost per Adjusted Discharge - 2003 \$6,214 average (range \$5,212-\$7,977). 2004 \$6,812 average (range \$5,879-\$8,094).</p>
<p>Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues</p>
<p>Part 3</p>
<p>1. Please explain what is the average mark-up of charges over costs.</p>
<p>see Tab 1</p>
<p>What is the average private pay contractual allowance (charges to payments) weighted by payer</p>
<p>In this case, the use of the term "average" oversimplifies the determination of contractual allowances, since some payments are based upon a per diem or capitated rate. Moreover, negotiated discounts often contain a "prompt payment" clause that provides that a payor is responsible for full (non-discounted) charges if payment is not made within a specified time period (typically 30 to 60 days). System-wide, the average discount negotiated with major managed care payors is a discount of 40% to 60% off billed hospital charges. Advocate also provides services to patients insured by non-contracted managed care payors or other payors that are included within the "private pay" designation. These payors do not receive the average discount.</p>
<p>2. Please explain the reason for charging "chargemaster" rates to uninsured individuals particularly in light of the Secretary of Health and Human Services' letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status</p>

<p>Advocate continues to use a chargemaster because, until December, 2004, Medicare appeared to require billing uninsured patients at the rates set forth therein. The Secretary's letter did not resolve several issues regarding use of the chargemaster, including its relationship to outlier reimbursement. Moreover, many managed care contracts are established at a rate equal to a discount off the chargemaster rate.</p>
<p>3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy</p>
<p>Medical care is provided without charge for patients earning up to 200% of the federal poverty level, and those earning between 200%-400% of the federal poverty level receive significant discounts. These latter, discounted charges are capped, so that those earning from 200-300% of federal poverty level pay no more than 5% of their income, and those earning 300-400% of federal poverty level pay no more than 10%. In 2004, Advocate approved 99% of the charity assistance applications. For uninsured patients who received charity assistance in 2004, charity care discounts were, on average 95% of charges. Patients with a remaining balance after the charity care discount is applied are provided interest-free payment plans on an as-needed basis. It is also important to note that we instruct our hospitals to consider extenuating circumstances whenever appropriate. Bills can be adjusted even beyond what the policy would indicate if individual circumstances so warrant.</p>
<p>What is the collection rate for self-pay?</p>
<p>Advocate's system-wide collection rate for the uninsured is 3.3% of charges.</p>
<p>4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate</p>
<p>All payors are charged at the chargemaster rate. These charges are adjusted via contractual allowances where there are agreements with payors to do so, or in the case of uninsured patients, through application of Advocate's charity care policy. Also, it is inaccurate to say that commercial insurance carriers do not pay based on the chargemaster rate, as many of the discounts are based on that rate, and carriers who do not prompt-pay are required to pay the chargemaster rate. In addition, commercial liability insurers typically pay chargemaster rates for medical bills that are included in tort judgments or settlements.</p>
<p>5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status</p>
<p>There is little or no economic benefit to Advocate from charging the chargemaster rates to the uninsured. See answers to questions 2-4 for further response.</p>
<p>6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject</p>

<p>Patients at Advocate: Multi-lingual signage is posted throughout our hospitals. The signs include a statement that financial counseling, including charity assistance, is available. A hospital financial counselor's telephone number is provided. Hand-out cards are distributed to uninsured patients. Once an uninsured patient leaves the hospital: A minimum of seven attempts by phone or by mail are made over a period of 120 days to contact the patient with an offer of financial counseling and to educate them on the availability of charity care. Patient bills sent to uninsured patients include a statement in English and Spanish that Advocate is able to help the patient apply for a government-sponsored insurance program or charity care. Advocate's collection agencies are required to refer cases back to the hospital if they determine that a patient may be eligible for a gvt-sponsored program or charity care. A patient web site is being developed. Other information is provided to patients through newsletters, annual report, magazine articles, web site, etc.</p>
<p>7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff</p>
<p>Continuous process. It begins in the recruitment and hiring process, continues through new employee orientation, and is reinforced in multiple ways from day to day. Beginning in Nov. 2003 and continuing in 2004, instructor-led training was conducted for front line employees throughout the Advocate system. The program is available for new employees and through a computer-based training module on the Intranet. Additionally, Advocate's internal news letters and Intranet regularly carry articles about our charity care program. Our financial counselors receive extensive training on our policies and procedures and how to assist patients throughout the process of applying for both government-sponsored programs like Medicaid and Advocate's charity care program. Additionally, we are continually working to make the application process easier and more efficient for patients (e.g., development of financial counseling software).</p>
<p>8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.</p>
<p>Advocate did raise concerns about Medicare rules "at an earlier date" through correspondence with Secretary Thompson. In any event, Advocate has always provided discounts to uninsured patients with demonstrated financial need. Beginning in fall of 2002, we examined our charity care program and determined that, we as a leading non-profit, faith-based health system should expand the eligibility criteria for our charity care program In April 2003, prior to AHA's letter to DHHS, we raised the upper income limit for our charity care program to 400% of the federal poverty level.</p>
<p>In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule</p>
<p>Advocate has not grossed up charges on our Medicare cost reports because of a lower OPD fee schedule.</p>
<p>Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured</p>

<p>Advocate's charity care policy effectively means that charges for the uninsured are reduced. We think this is the right thing to do.</p>
<p>9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002</p>
<p>In the aggregate, Advocate's outlier payments fell by 37.6% from 1998 through 2002. Advocate has no comment on the appropriateness of alleged practices of other hospitals.</p>
<p>10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government</p>
<p>We believe it is both appropriate and necessary for not-for-profit hospitals to receive this aid. Even with the \$22 billion in payments referenced in the question, Medicare and Medicaid do not fully cover hospitals' costs of caring for their respective beneficiaries. These payments, in addition to monies saved due to tax exemption, make it possible for not-profit hospitals to care for the uninsured and beneficiaries of public programs.</p>
<p>Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt</p>
<p>see Tab 25. For 2004, Advocate received \$28,203,000 in disproportionate share payments, while providing \$184,532,000 in uncompensated care without bad debt. 2002 and 2003 not available since first year of new Illinois methodology. Add the amount of bad debt</p>
<p>11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, "the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.</p>
<p>While Mr. Bovender's point is well taken, it does tend to attribute the responsibility for this state of affairs to the provider institutions. To the extent that the systemic factors he mentions encourage this kind of practice in the first place, changing those factors could make it easier for providers to change their practices.</p>
<p>12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he "was told by both inside and outside legal counsel . . . [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS." Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice</p>
<p>Advice from legal counsel is privileged and confidential, and providing that advice in response to this request could mean that legal advice on the subject of charges, billing, and collection is no longer privileged. It would be inappropriate for Advocate to waive attorney-client privilege in response to this question.</p>

<p>13. Please provide all documents related to your hospital's consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients</p>
<p>see response to question 14</p>
<p>14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured</p>
<p>Charity Care Policy Documents - Tab 31. Community Benefits Reports - Tabs 2-5. Community Benefit Strategy - Tabs 11 and 12.</p>
<p>15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment</p>
<p>see response to question 14</p>
<p>16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals</p>
<p>Advocate is not compelled by law to file lawsuits, but to satisfy Medicare requirements for bad debt reimbursement, we are required to engage in reasonable collection efforts and to treat Medicare and non-Medicare patients (including uninsured patients) alike. In some circumstances, a lawsuit is a reasonable collection effort.</p>
<p>Please identify the amount of debt that was at issue in each suit</p>
<p>Through May 2005, Advocate has not filed any suits against uninsured patients. In 2004, 68 lawsuits (\$331,064) were filed against the uninsured, representing 0.13% of uninsured patient encounters (51,194). In 2003, Advocate filed 273 lawsuits (\$1,473,969) against the uninsured, which represent 0.53% of uninsured patient encounters (51,856). In 2002, Advocate filed 362 lawsuits (\$1,917,997) against the uninsured. In 2001, Advocate filed 413 lawsuits (\$2,637,582) against the uninsured. In 2000, Advocate filed 213 lawsuits (\$1,209,631) against uninsured.</p>
<p>Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection</p>
<p>Advocate has not sold debt owed to the hospital by any patients to another company for collection.</p>
<p>Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient</p>

accounts
N/A
Please explain how the sale of private accounts for recovery, and an concomitant claim to Medicare for payments on the same debts, is not “double dipping.”
N/A
Please provide copies of your contracts, if any, with collection agencies
Contract see Tab 33 along with a listing of current collection firms.
Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization
None of these firms is a for-profit or nonprofit subsidiary of Advocate.
Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt
Advocate does not have a relationship with a bank or credit card company that patients use to help finance debt.
Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt
Advocate identifies patients as Medicare eligible to its collection firms (Medicare Financial Class), but collection policies and procedures are the same for Medicare and non-Medicare patients.
If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt
Advocate has not sold debt owed to any hospital by any patients to another company for collection.

<p>17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action</p>
<p>Due to a negative/challenging malpractice insurance marketplace in the domestic US, due to prohibitive costs, Advocate has been forced to self-insure, and to obtain an additional off-shore reinsurance arrangement as an alternative. Advocate operates an Insurance Captive known as Advocate Insurance Segregated Portfolio Company (AISPC). It possesses an unrestricted Class B license issued by the Cayman Monetary Authority located in Grand Cayman, Cayman Islands, BWI. As of December 31, 2004, Advocate's investments in the AISPC - Core were \$2,101,115. Advocate also maintains segregated cells for two physician groups. Both cells were funded with \$100,000. Advocate anticipates these amount will rise because we have begun self-insuring our three physician groups.</p>
<p>18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.)</p>
<p>see Tab 34</p>
<p>19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain</p>
<p>Advocate has not taken that position on this issue. The provision of healthcare for a charge is a community benefit recognized in IRS rulings since 1969, and may qualify a hospital for recognition of tax exempt status if the hospital also provides certain other community benefits, such as maintaining an emergency room available to all patients regardless of ability to pay and accepting Medicare and Medicaid patients.</p>
<p>20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well</p>
<p>Net effective discount, on a system-wide basis, varies from 96.7% for uninsured patients to 34.9% for some payors.</p>
<p>Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured</p>
<p>Consideration for elective services is subject to each hospital's budget constraints and is weighed against charity care needs for non elective procedures. Part of each site charity care committee's charge is to assess and/or develop a list of approved "alternative" providers for elective procedures. As part of this process, Advocate either provided elective procedures or recommended alternative providers.</p>
<p>21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip</p>

Book III
Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18
Tab 35. and Tab 36.
Finally, please detail any payments or reimbursements made to employees for country clubs
We do not reimburse for country club dues; however, in an extremely limited number of circumstances, Advocate reimburses a small number of executives for private club dues. These reimbursements total less than \$400 a month. The executives use these memberships for meetings and other business purposes.

Charity Care and Community Benefit
Banner Health, Phoenix, Ariz.
1. How does your organization define charity care?
Medical care provided without charge or at reduced charge to uninsured and underinsured individuals who are determined to be unable to pay. Charges are classified as charity care when the individual responsible for the account applies for financial assistance and is determined to be eligible for charity care under Banner policies. Unreimbursed care provided to individuals who do not apply for financial assistance or who do not qualify for financial assistance is reported as bad debt. Collection is not pursued for charity care amounts.
What types of activities or programs does your organization include in its definition or determination of charity care?
Banner only includes in the definition of charity care the charges for medical care provided without cost or at reduced cost to uninsured and underinsured individuals. Per the policy - Medically necessary inpatient and outpatient services are covered.
Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
Banner has never undertaken an analysis as to which of its activities, policies, programs and community benefit activities it would discontinue if it were a for-profit org. Banner cannot answer the question.
Does your organization maintain a charity policy?
Yes
If so, please describe the policy or provide a copy of such policy.
Copy provided
Does this policy require that certain types and amounts of charity care be provided?
No
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
Within the definition of charity care used by Banner, it is not possible to retrieve data corresponding to the types of financial accommodations accorded to uninsured versus underinsured individuals
How does this differ from 10 years ago?
Banner is the result of the acquisition of Samaritan Health System by Lutheran Health Systems in 1999. Prior to that date, the two companies either recorded charity care inconsistently or did not report the amount. Hence, it is not possible to provide meaningful info
25 years ago?
3. What percentages of your patients for your most recent fiscal year were:

(a) uninsured (self pay) 7%
(b) covered by Medicare 27%
(c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals 18%
(d) otherwise covered by private insurance 49%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?
Only if a patient has pre-qualified for financial assistance, receives an Emergency Rating under the CO Indigent Care Program, or if the patient is readmitted and Risk Management or Patient Services Dept has directed the fees be waived in connection with care being provided to rectify a prior mistake or service error.
5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?
Banner has experienced a steady increase in bad debt levels over the past five years. In 2004, approx 40% of co-pmts and deductibles for patients covered by private ins were uncollectible.
6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.
Yes. Banner is a 50% member of City of Hope Samaritan, LLC, having City of Hope National Medical Center, nonprofit tax-exempt as the other member. The joint venture makes available advanced bone marrow transplant treatment for cancer in the Phoenix area.
7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.
Taxable income reported for various joint ventures - clinical reference laboratory services, ambulatory surgery centers (share of income from center owned by limited partnerships) and ambulatory medical campus (provides outpatient surgery, imaging and MRI).
8. Has your hospital or other members of your hospital system group enter into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures
Yes. Ambulatory surgery centers, one of the radiology centers (dissolved in 2004), risk-based joint contracting with commercial payors, and some of the clinical laboratory services.
9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy.
Banner's role in requiring and enforcing charity care policies to be adopted and implemented varies depending upon the type of joint venture, the degree of control over the activities, the nature of the activities, and whether the activity would be exempt if owned entirely by Banner. For instance, the issue of charity care is irrelevant to the two physician hospital orgs (risk-based contracting). However, Banner has exercised a role in applying and enforcing charity care policies for the ambulatory surgery centers that Banner owns, controls or exercises at least 50% of the governing powers.
Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced

The operating agreement for the Banner Surgery Center requires it to adopt a charity care policy consistent with Banner's exempt mission and purposes.
If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant
Banner Surgery Center facilities perform elective outpatient surgery. This type of service is provided far less frequently on a charitable basis than traditional inpatient hospital care.
10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons
The statement describes a market dynamic that threatens the financial viability of the safety net provided by the nonprofit hospitals, but misstates the motivation of most hospital systems. The situation is a result of the interplay of a government reimbursement system that provides relatively high margin reimbursement for certain types of government procedures, and a statutory structure that authorizes physician ownership in many of these high-margin lines of business. This "cherry-picking" scenario has been documented repeatedly (sources provided). Such joint ventures are nearly always entered into as defensive responses to the threat of physician-owned specialty provider competition.
11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture
Banner's investments in joint ventures are considered to be capital expenditures. Hence, there is no diversion from the operating budget that would be used to fund charity care.
12. Please provide a charity care breakdown for each entity that is a member of your hospital system group
All of Banner's hospitals and facilities, except joint ventures, are operated by a single entity. Charity Care 2002 \$53,511,499, 2003 \$52,140,939, 2004 \$48,269,761.
In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis
IRS guidance permits the community benefit assessment of an exempt org activities to be assessed on an aggregate basis. We believe that this is the correct approach.
13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?
No because 1) the IRS community benefit standard for tax-exemption for hospitals does not mandate a charity care requirement, 2) the nature of the business conducted by the joint venture may constitute taxable activity that is not eligible for tax exemption treatment, the IRS does not prohibit exempt orgs from conducting limited amounts of taxable unrelated trade, and 3) the opportunity for exempt hospital orgs to have a controlling interest sufficient to impose a charity care requirement upon joint ventures may not exist where hospitals are participating in physician-driven joint ventures for defensive reasons.
If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?
not applicable
14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?
The accounting for charity care will be driven by the accounting treatment accorded to Banner's interest in the joint interest. If under the equity method under GAAP, then none of the charity provided will be reported. If the joint venture is accounted for on a consolidated basis, then all of the charity care would be reported.

15. What types of research and teaching are performed by your hospital as a charitable or educational activity?
Education - Financial and admin support of medical residency and fellowship programs; provide teaching facilities, faculty members, supervised patient care for medical and nursing students; several educational assistance and scholarship programs for nursing and allied health professionals; funding of psychiatric resident rotation. Research - Nursing and therapy studies; medical educational research including projects that contribute to the body of toxicology and poison control info; alternative therapy research including music therapy, aroma therapy, acupuncture, energy healing; community and public health projects to contribute to large health org databases working toward improved health care services. Support of cell and isolet research, PET imaging studies and analysis as part of the Alzheimer's Disease and Research Center.
16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital
Activities include special events, planned giving, and direct solicitation. Donations support construction and equipping of new facilities and services, nursing and other healthcare professional education, and specific clinical activities and services. Amounts received: 2002 \$3,839,474, 2003 \$4,935,817, 2004 \$6,435,810
Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families
1) support rec'd to provide free mammograms to low-income minority women, 2) fund-raising obtained to support 19 school-based clinics funded and staffed by Banner which provide health care for low income students at over 100 schools, 3) financial assistance for children and adolescents at the Behavioral Hospital to enable patients to complete treatment.
17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture
Generally, no. The answer will depend upon the manner in which joint ventures are organized and operated, the nature of the activity conducted, and the extent of the exempt orgs control.
18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?
Generally, no. Most physicians who practice in Banner hospitals are independent community physicians who are not compensated by Banner. However, hospital based physicians who are given either exclusive contracts, e.g., radiologists, or to provide back-up coverage are required to provide care to all patients who require their services. Banner also guarantees payment for emergency department coverage by a number of specialists who provide care for all non-assigned patients, including uninsured patients, in the emergency departments of many Banner hospitals.
19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.
Most persons receiving charity care do so via emergency depts. Banner cannot break down its charity care activity in a manner requested except by means of a manual examination of each of the thousands of patient accounts.
20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?
Community Projects - call center/helpline, poison control center, prenatal program, HomeBase Youth Services (outreach service and guidance to 5,000 runaway homeless youth), Junior Achievement, Pediatric Therapy Program, Prescription Assistance Program., American Cancer

<p>Society, several Komen Race for the Cure, American Heart Assoc. 10 pages of events listed. Banner does not keep a consolidated record of the cost of the staff time devoted to these activities, which constitutes by far the largest component of the support given, nor does Banner have a method for consistently or precisely tracking the other incidental expenses for these activities.</p>
<p>21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.</p>
<p>Banner does not have the information available to it to provide a meaningful comparison with for-profit hospitals.</p>
<p>22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?</p>
<p>Banner engages in numerous programs for infants and children; however, Banner does not track its community benefit expenditures on this basis.</p>
<p>23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?</p>
<p>Banner does conduct clinical trial programs. However, Banner's participation in clinical trial programs is not included in any determination of the amount of charity care provided by Banner.</p>
<p>24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?</p>
<p>Our internal cost allocation methodologies rely on allocating costs on an average basis to the elements of care that are charged to patients, e.g., lab tests, supply items used. Because these costs estimates are imprecise on a patient-by-patient basis, the reported costs of Banner's charity care are simply Banner's best estimates. Except for the centralized costs noted, the allocation of costs to our patients at a given hospital does not include costs incurred by other hospitals within the system. Banner's allocation method is not dictated by any statute or regulation. It is the result of study and research, consultation with other healthcare professionals and systems and the application of general principles of cost accounting to each particular element of cost.</p>
<p>25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.</p>
<p>In 2004, average cost of treating an inpatient \$6,790 (range \$2,377 - \$79,506), average length of stay 4 days (range 2.74 - 21 days). Table provided.</p>
<p>Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues</p>
<p>Part 3</p>
<p>1. Please explain what is the average mark-up of charges over costs.</p>
<p>For 2004, 2.78 (gross patient rev to total expense).</p>
<p>What is the average private pay contractual allowance (charges to payments) weighted by payer</p>
<p>The purpose of the chargemaster is to set the framework for the overall pricing structure of a hospital, not to establish a fixed relationship between charges and costs. The average private pay contractual allowance for our hospital volumes only is 61%, weighted by payer. The contractual allowance weighted by payor is not readily available for our non-hospital services due to the disparate contracting and billing systems employed in these service lines.</p>

<p>2. Please explain the reason for charging “chargemaster” rates to uninsured individuals particularly in light of the Secretary of Health and Human Services’ letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status</p>
<p>This question overlooks the basic purpose of the chargemaster. This question also appears to assume that there exists a federal or status statute, regulation or guidance that prescribes or limits the charges that an exempt nonprofit hospital may charge to persons who do not have health insurance. Banner is unaware of any such authority. Banner has a generous charity care policy, and makes care available to persons having household incomes of \$125,000 or less at rates generally comparable to those paid by commercial payors. Provides a good discussion of billing issue.</p>
<p>3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy</p>
<p>See response to A.1 for Banner's policies for providing services at no charge or reduced charge. The chargemaster charges are in fact the common denominator for our hospitals' pricing structure. None of those commercial payor contracts provides for discounts as great as the discounts provided to lower income uninsured persons under Banner's charity care policies. Several comments regarding the question are also provided.</p>
<p>What is the collection rate for self-pay?</p>
<p>The collection rate, expressed as a percentage of charges, from uninsured patients was 9.69% in 2003 and 12.65% in 2004, and a significant number of uninsured patients do not make any payments at all.</p>
<p>4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate</p>
<p>Many of Banner's commercial insurance payors do reimburse Banner on the basis of percentages of the chargemaster rates. Banner believes that its policy of offering its hospital services at rates comparable to those paid by commercial payors to persons who have annual income of less than \$125,000 draws a reasonable distinction among categories of uninsured, including those who could afford health insurance but choose not to purchase it.</p>
<p>5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status</p>
<p>Net revenue collected from self-pay accounts accounted for 0.58% of revenue in 2003 and 0.91% in 2004. It should be evident that Banner is not setting prices to the uninsured on the basis that there would be an economic benefit to Banner.</p>
<p>6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject</p>
<p>The mission is displayed prominently in various public areas in Banner facilities, and is communicated in brochures, media advertising, and other public communication. Community benefit is made known through our annual Form 990. Banner does, however, advise patients of our financial assistance and charity care policies through a variety of methods, focusing on the points at which self-pay patients most often enter Banner hospitals, including emergency department waiting and registration areas stocked with bilingual materials regarding financial assistance and staffed with trained financial counselors, and colorful inserts included in billing statements.</p>

<p>7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff</p>
<p>Banner's staff members are expected to treat all patients in the same compassionate, caring, competent and professional manner, irrespective of whether they are insured. Banner's registration and patient financial accounting personnel are trained in Banner's financial assistance policies and procedures for implementing those policies. Banner does not provide specific instruction to its staff as to Banner's nonprofit status and charitable mission, although Banner is confident that its nonprofit status is well-known to its staff.</p>
<p>8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.</p>
<p>These questions are argumentative and incorporate a number of unstated assumptions that may not be accurate. Banner has traditionally not been active in national advocacy activities involving CMS or Dept of HHS. As a number of federal and state courts have recently held, in dismissing cases filed as part of the current wave of putative class actions filed, there is no law that prohibits hospitals from negotiating rates with commercial health insurance payors that are lower than (or tied in any manner to) the rates charged to self-pay patients. The courts likewise have confirmed that nonprofit tax status does not depend on the prices charged to any particular payor class.</p>
<p>In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule</p>
<p>Banner did, some years ago, gross up charges in the surgery area to account for its lower ambulatory surgery rates. This occurred several years ago, and it was not possible to investigate the details within the deadline established for this response.</p>
<p>Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured</p>
<p>Banner's position is reflected in the answers to other questions See question B.2 stating it is acceptable to lower the charges for the uninsured. Also, see question A.1. Banner's policy showing they do lower the charges for uninsured.</p>
<p>9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002</p>
<p>The relationship of charges to Medicare outlier payments is irrelevant to a hospital's tax status. The amount of outlier pmts received declined by 22.1% from 1998 to 2002; expressed as a percentage of the DRG/capital reimbursement pmts rec'd from 1998 to 2002, the outlier payments declined by 38.5%.</p>
<p>10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government</p>
<p>Banner believes that disproportionate share payments are a critical component of financial support to assist all hospitals, nonprofit and for-profit, in dealing with the substantial portion of our</p>

country's population that is not insured, and for complying with federal mandates requiring the provision of emergency medical screening and stabilization without regard to ability to pay.
Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt
2002: DSH \$21,678,701, Charity Care \$53,511,499, Bad Debt \$134,628,606. 2003: DSH \$27,895,116, Charity Care \$52,140,939, Bad Debt \$145,912,802. 2004: DSH \$35,542,700, Charity Care \$48,269,761, Bad Debt \$212,830,299.
11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, "the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.
Banner notes that the comments relating to the long history of the chargemaster system is consistent with Banner's statements that the roots of the chargemaster system have nothing to do with motivation for pricing to the uninsured. Banner has moved away from its usual and customary charges to a percentage of expected Medicare DRG reimbursement in determining the amount to be paid by patients qualifying for financial assistance. However, Banner will continue to base its financial assistance programs for outpatient services on a percentage of its chargemaster charges because the Medicare outpatient reimbursement methodology is too complicated to be modeled within Banner's current billing systems.
12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he "was told by both inside and outside legal counsel . . . [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS." Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice
To the extent that this question calls for waiver of the attorney-client privilege, Banner respectfully declines to respond to this question.
13. Please provide all documents related to your hospital's consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients
Documents provided
14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured
Documents provided
15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment
Banner does not have any community needs assessments responsive to the Committee's request.
16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals
Banner does not believe that it is compelled by law to file claims against patients, except in Alaska, where a lawsuit is required by state law in order to garnish payments owed to patients by

the AK Premenate Fund Dividend.
Please identify the amount of debt that was at issue in each suit
It is not possible to determine precisely the number of lawsuits against uninsured persons because the databases of some of the collection agencies that file lawsuits are unable to distinguish lawsuits against uninsured individuals from lawsuits against individuals with insurance for collection of the patient's portion of the account. Also, one of the collection agencies could not provide complete information. The following is the best information Banner has been able to pull together. CA - no lawsuits. AZ - 11 lawsuits since 2000, and none since 2003. see attach for amounts. CO, WY, NB - 8,744 lawsuits 1/1/2000 - 5/31/2005. see attach for amounts. AK - 2,914 lawsuits 1/1/2000 - 5/31/2005.see attach for amounts
Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection
Banner entered into an agreement involving the potential sale of accounts receivable for services rendered to patients in Banner's burn unit in circumstances where it appeared that a third party was at fault for the patient's injuries. No accounts have actually been sold, and this arrangement will be allowed to expire on July 14, 2005.
Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts
No accounts have ever actually been sold.
Please explain how the sale of private accounts for recovery, and a concomitant claim to Medicare for payments on the same debts, is not "double dipping."
Not applicable
Please provide copies of your contracts, if any, with collection agencies
Documents provided
Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization
Banner has contracts with several collection agencies. No collection agency is a subsidiary of Banner.
Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt
Banner has an agreement with an Alaskan bank pursuant to which patients at Fairbanks Memorial Hospital may apply to the bank for loans up to \$25,000 to fund payment of their accounts, and Banner guarantees payment of bank's loan. Patients are required to fill out a loan application, which is subject to acceptance by the bank. The max. term of the loans is 5 years, and the interest rate is based on the bank's "New Car Rate".
Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt
Banner does not differentiate between Medicare and non-Medicare debt.
If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt
No debt has been sold.

<p>17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action</p>
<p>Banner has established a wholly owned, captive insurance company, Samaritan Insurance Funding Ltd. (SIFL), domiciled in the Cayman Islands. This company provides the primary layers of self-insurance for general and professional liability coverage, as well as certain other ins coverage. Use of SIFL provides a cost-effective and flexible method to finance risk exposure. No Banner funds are diverted or somehow sheltered offshore through ownership and financial relationship with SIFL or otherwise. SIFL has a call account at Bank of Butterfield and maintains a balance of approx. \$200,000. Banner deposits premiums into the account and SIFL pays admin expenses and ins losses from the account. Excess funds are routinely transferred to Northern Trust, investment trustee. As of June 28, Northern Trust reported total funds for SIFL of \$1,306,609.</p>
<p>18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.)</p>
<p>Documents provided.</p>
<p>19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain</p>
<p>Banner does not have a position on the proposition advanced in the question.</p>
<p>20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well</p>
<p>Private pay contractual allowance - 61% for Banner as a whole. Basic Financial Assistance Program (for uninsured patients with household incomes up to \$125,000) – patients in Arizona pay 150% of expected Medicare DRG reimbursement for inpatient services and 28% of chargemaster charges for outpatient services. Patients in other states pay 225% of Medicare reimbursement for inpatient services and 75% of chargemaster charges for outpatient services. Enhanced Financial Assistance Program - free care if income 150% or less of the federal poverty level (FPL); if income is 150% - 500% of FPL, in Arizona, patients pay from 25% to 125% of expected Medicare reimbursement for inpatient services and from 6% to 24% of chargemaster charges for outpatient services; and in other states, patients pay from 25% to 160% of expected Medicare reimbursement for inpatient services, and from 15% to 55% of chargemaster charges for outpatient services.</p>
<p>Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured</p>
<p>Except for physicals, the other procedures are, if medically necessary, not considered to be elective and are therefore covered by Banner's financial assistance program.</p>
<p>21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip</p>
<p>Most documents were provided. We have been unable to locate expense reports for a small number of the reimbursed trips taken in 2002, and have been unable to determine travel reimbursement or locate exp reports for Mr. Craig Broman in 2002, during which he left employment at Banner. We believe these records were misplaced during the consolidation of Banner's corporate headquarters from Fargo to Phoenix.</p>

Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18

Documents provided

Finally, please detail any payments or reimbursements made to employees for country clubs

2002: President/CEO-Banner Health \$7,314, President/CEO-Banner Health Foundation \$4,499.
2003: President/CEO-Banner Health \$17,345, President/CEO-Banner Health Foundation \$5,247.
2004: President/CEO- Banner Health \$1680, President/CEO-Banner Health Foundation \$5,857.

Charity Care and Community Benefit
William Beaumont Hospital, Royal Oak, Mich.
1. How does your organization define charity care?
The cost of health care services that were provided but not paid for by patients who are unable to pay and have requested financial assistance pursuant to our charity care policy. Importantly, Beaumont does not claim "charity care credit" for the bad debt associated with patients who may be unable to pay, but who have not followed the financial assistance policy.
What types of activities or programs does your organization include in its definition or determination of charity care?
Community Benefit Reports include figures for Unpaid Costs of Public Programs (includes charity care as described above and Medicare and Medicaid cost not reimbursed), Programs for the community (includes support for unprofitable clinics, health education, health promotion events, support groups), Unreimbursed Cost of Medical Education/Research (includes graduate medical education programs), Sponsorships and Donations (includes student loans and scholarships).
Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
The most significant difference would not be the cancellation or initiation of specific programs, but would be the very nature of the basis on which Beaumont makes all decisions. New programs and the continued existence of current programs would solely be reviewed based on expected short-term and long-term returns on investment, not on community need.
Does your organization maintain a charity policy?
Yes
If so, please describe the policy or provide a copy of such policy.
Appendix B & C Individuals whose income is at or below 200 percent of the federal poverty level are entitled to free care. Individuals whose incomes are between 200-300 percent of the federal poverty level receive a sliding scale discount on their care. Patients without insurance whose incomes are higher than 300 percent of the federal poverty level receive a 15 percent discount regardless of income level. Every patient without insurance receives a discount. Beaumont gives special considerations—negotiated individually—for patients with or without insurance whose hospital accounts are greater than 30 percent of their income.

Does this policy require that certain types and amounts of charity care be provided?
No
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
Beaumont provides charity across all programs and services at our hospitals. The 10 largest departments that provide care to uninsured patients are the emergency center, hematology oncology, general surgery, cardiovascular surgery, orthopedic surgery, cardiology, hematology, nephrology and obstetrics and gynecology.
How does this differ from 10 years ago?
25 years ago?
3. What percentages of your patients for your most recent fiscal year were:
(a) uninsured (self pay)
5%
(b) covered by Medicare
43%
(c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals
4%
(d) otherwise covered by private insurance
48%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?

Patients who do not have insurance coverage and are not able to obtain insurance, may request financial assistance under Beaumont's Charity Care Program. Fees will be waived entirely or reduced based on the financial status of the individual. The patient receives the elective service even when the Medicaid and/or Charity Care process is pending.

5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?

Beaumont is observing an increase in write-offs due to non-payment of co-pays, co-insurance, and deductibles. A recent study covering a 12 month period spanning 2003 to 2004 identified \$7.5M of write-offs for bad debts from emergency center patient encounters when insured patients failed to pay these balances.

6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.

Yes, examples include Oakland County EMS Medical Control Authority, Joint Venture Hospital Laboratories LLC, Neurosurgery Affiliation with the Henry Ford Health System, Newton Elementary School in Detroit - student health care, free dental care, pre-school physicals.

7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.

No

8. Has your hospital or other members of your hospital system group enter into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures

Yes, as follows: Beaumont Services Company LLC, Beaumont Medical office building, Beaumont Integrated Delivery System, Greater Michigan Lithotripsy LLC, Beaumont Nursing Home Services, Beaumont Macomb Township ASC, LLC.

9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy.

No, all health care ventures in which Beaumont is the majority owner are governed by Beaumont's charity care policy.

Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced

See previous answer.

If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant

See previous answer.
10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons
Beaumont's intention is not to engage in joint ventures in order to shift income to physicians or other for profit entities. The joint ventures we have formed have contributed to Beaumont's financial stability, and have provided for a high quality continuum of care for our patients and community.
11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture
In addition to reviewing how joint ventures generally promote health care for the benefit of the community, the financial and general performance of any joint venture is evaluated on a continuing basis in order to avoid any such depletion of Beaumont resources. Any earnings from joint ventures are reinvested back into Beaumont and used to support Beaumont's mission.
12. Please provide a charity care breakdown for each entity that is a member of your hospital system group
Beaumont's hospital operations are contained in a single entity. Accordingly, charity care is measured for that entity alone.
In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis
See above
13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?
Beaumont believes a facts and circumstances approach is preferable. The federal tax issue should be whether participation in the joint venture raises an unrelated business tax issue or is substantially related to tax-exempt purposes. Placing a meaningful charity care requirement on the operations of a joint venture would be a significant favorable fact toward determining the activities are substantially related to tax-exempt purposes, but should not be a requirement.
If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?
If a tax-exempt hospital is the majority owner, the provision of charity care should be required.
14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?

<p>When charity care is provided by joint ventures in which Beaumont participates, Beaumont does not count charity care in its charity care amounts.</p>
<p>15. What types of research and teaching are performed by your hospital as a charitable or educational activity?</p>
<p>Beaumont, Royal Oak is a major teaching facility with 307 resident physicians in 31 programs and 38 fellows in accredited fellowship programs. Through affiliations with several universities, Beaumont educates, trains and develops skilled professionals in medicine, surgery, nurse anesthesia, pharmacy, respiratory care, and others. Residents and fellows provide primary and surgical care through ambulatory care teaching clinics. Beaumont has relationships with every nursing school in MI and provides clinical training, nursing scholarships, and loan programs, and distance learning opportunities. See Appendix T on the Beaumont Research Institute. Beaumont funded over \$7 million in research last year.</p>
<p>16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital</p>
<p>Beaumont, together with its wholly owned tax-exempt subsidiary (The Beaumont Foundation) solicits and receives contributions from the general public. Contributions: 2002 \$14,106,957; 2003 \$12,661,763; 2004 \$16,164,681.</p>
<p>Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families</p>
<p>The Board Of Directors has the flexibility to use unrestricted contributions where they have the greatest effect, including providing care for low income and uninsured patients. Some contributions with donor-imposed restrictions are for patient financial assistance, e.g., hospital departments sponsor fund-raising activities to support specific programs like Speech and Language Pathology. These funds are often restricted to providing services to the uninsured.</p>
<p>17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture</p>
<p>No. There are no negative implications on the provision of charity care or the satisfaction of the community benefit standard by Beaumont's limited involvement in joint ventures.</p>
<p>18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?</p>
<p>Our Medical Staff Bylaws clearly state the expectation that physicians commit to accept new patients "regardless of ability to pay." Members of the medical staff also donate their time in the Outpatient Clinic, a resource for primary care for a significant number of the Medicaid and uninsured patients we serve.</p>
<p>19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.</p>
<p>As noted previously, charity care costs are not allocated by service line; the costs of charity care are embedded with overall costs of hospital operations. We do know that uninsured patients are treated within every hospital department, both inpatient and outpatient, but our write-offs for charity care are not allocated back to each separate department. In 2004, our hospitals provided</p>

<p>\$5,244,728 of charity care.</p>
<p>20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?</p>
<p>Appendix A and Appendix D</p> <p>Our community programs and education activities equaled \$44.6 million in 2004.</p>
<p>21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.</p>
<p>We do not have information regarding the manner in which for-profit systems define, calculate, and report charity care expenses. All acute care hospitals in Michigan are non-profit.</p>
<p>22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?</p>
<p>Beaumont tracks our total community benefit across all hospital programs and services, and we do not specifically track free or below-cost infant and child care programs as a separate line item, although many of our programs would fall into this category.</p>
<p>23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?</p>
<p>Beaumont does conduct clinical trials. Beaumont's Charity Care policy is universally applied</p>
<p>24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?</p>
<p>We determine the costs of providing charity care by applying a fully loaded cost ratio to those charges we have identified as being written off for qualifying patients. This process is consistent with methodologies utilized for Medicare cost reporting and based on "step down" formulas and consistently applied for all cost allocation processes.</p>
<p>Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences</p>
<p>See above answer</p>

25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.

Beaumont, Royal Oak Hospital- \$7,128* Length Of Stay- 5.19 days
Beaumont, Troy Hospital - \$5,471* Length Of Stay- 3.93 days
*Case mix adjusted cost per equivalent admission

Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues

Part 3

1. Please explain what is the average mark-up of charges over costs.

Mark ups vary significantly based on item or service. Some items, like supplies and drugs, are marked up based on a cost plus mark-up rate that factors in costs to prepare and administer them. Our average mark-up is 2.9 for 2004. On January 1, 2004 Beaumont transitioned to a relative value unit (RVU) methodology for establishing charges that better reflect relative degrees of resources necessary to provide specific types of services.

What is the average private pay contractual allowance (charges to payments) weighted by payer

The range of private pay discounts is from 34 percent to 67 percent.

2. Please explain the reason for charging "chargemaster" rates to uninsured individuals particularly in light of the Secretary of Health and Human Services' letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status

Beaumont initiates charges to all patients-whether self-pay, insured, or covered by a government program such as Medicare or Medicaid- the same amount for each and every item of service, supply or medication that Beaumont provides. Beaumont does accept a wide variety of negotiated payments from various payors (e.g., government program, insurance or managed care program, flat 15% discount for all uninsured and underinsured, plus additional discounts if patient requests financial assistance under the Charity Care program).

3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy

All patients are charged the same regardless of insurance status. All uninsured patients receive a discount –up to 100% if their income level is at or below 200% of the federal poverty level. We will willingly provide discounts above our automatic 15% discount based on individual circumstances of the patient.

What is the collection rate for self-pay?

<p>We would prefer to discuss informally our information on collection rates.</p>
<p>4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate</p>
<p>The premise of this question is incorrect, at least as such question is applied to Beaumont. The chargemaster is by and large a creature of state and federal regulations that require uniform charges for purposes of allocating costs. From the chargemaster schedule, Beaumont makes a variety of discounts available as discussed in 2 above.</p>
<p>5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status</p>
<p>There is no economic benefit sought from treating the uninsured. If a patient is unable to pay his/her charges, Beaumont and its medical staff members will continue to treat that patient when the patient presents for treatment again (and again). Our charity care policy is available to uninsured patients with incomes below 300% of the federal poverty level and to others with higher incomes depending on their particular circumstances and medical needs.</p>
<p>6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject</p>
<p>Our charity care policy is posted on the Beaumont website. There are also signs posted in our Emergency Center entrances that state that all patients will be seen regardless of their ability to pay. We have a Billing and Insurance Guide pamphlet, available at every registration booth for both inpatient and out patient services and included in the admission envelope for patients who are admitted to the hospital. We have a Patients Rights and Responsibility pamphlet also available at all registration booths and included in the admission envelope. On the front of the hospital admission envelope, it states in bold: "Beaumont treats all patients regardless of their ability to pay."</p>
<p>7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff</p>
<p>All Beaumont staff are made aware of our not-for-profit status and charitable mission at their orientation session required of all new employees. (See Appendix Z, AA, BB, CC, W, & D) Staff in our Patient Registration Department receive monthly newsletters that update them on new programs or new policies that can affect patients' eligibility for government or community programs. We use this newsletter to continually remind staff of our charitable mission and Charity Care Policy. We also use our hospital-wide employee newsletter to remind all employees of our charitable mission.</p>
<p>8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital</p>

<p>industry renders its highest bills to the customers who are least able or likely to pay.</p>
<p>Beaumont, like the majority of our industry, did not believe that the Medicare rules prevented us from providing discounts based on documented financial need. However, most hospitals did believe that routinely granting waivers or discounts without regard to demonstrated financial need raised potential Medicare issues. Further, granting discounts automatically or waiving Medicare patients' co-payments and deductibles were frowned upon by intermediaries who were agents auditing and managing the Medicare program for the department of Health and Human Services.</p>
<p>In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule</p>
<p>Beaumont has never grossed up their charges on the Medicare Cost Report to inflate our outpatient chargemaster rates.</p>
<p>Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured</p>
<p>Both can qualify for discounts based on their financial circumstances or insurance plan.</p>
<p>9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002</p>
<p>Beaumont disagrees with this suggestion; to the contrary, Beaumont has incurred significant losses in our care to Medicare beneficiaries who fall into the outlier category.</p>
<p>10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government</p>
<p>Beaumont does not receive either Medicare or Medicaid DSH payments. We do believe that hospitals whose percentages of Medicaid and uninsured patients are significant, should continue to receive these payments.</p>
<p>Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt</p>
<p></p>

11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, “the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.

As described elsewhere in Beaumont's responses, Beaumont applies its charge master system in a manner that reflects its overall charitable purposes. Beaumont does not expect an uninsured patient with financial need to pay the charge master rates. We also note that one issue facing all hospitals who currently use a charge master system is that it would be virtually impossible for a hospital to change its system unilaterally. A hospital utilizing a charge master system has in place hundreds of contracts with various payors, all of which are tied to the charge master system and all of which terminate at various times. A hospital cannot simply terminate existing arrangements because it wants to move to a new system. Accordingly, absent strong cooperation by the federal government, state government, and payors, it would be extremely difficult for any hospital to adopt a different system.

12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he “was told by both inside and outside legal counsel . . . [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS.” Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice

We have not received any such legal advice.

13. Please provide all documents related to your hospital's consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients

Throughout a patient's billing process, Beaumont works with patients to attempt to identify a financial need for purposes of applying Beaumont's charity care policy. All patient statements include the following: “If you are having financial difficulty, and can not pay this balance, please call us to discuss payment options.” All patients receive a minimum of two bills before a claim is transferred to our in-house collections department. Patients receive a letter (Appendix EE) notifying them that their claim has been sent to the collections department. The patient may get a second letter and a phone call. Attorneys and outside collection agencies have been advised to offer a financial evaluation. We would be willing to discuss this informally.

14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured

As stated before, Beaumont treats every patient who comes to us for care regardless of their financial circumstances and regardless of whether they have previous unpaid bills at Beaumont. Requested documents are enclosed.

15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment

See Appendix FF and GG Since 1995, the Beaumont hospitals have been active members of Healthy People/Healthy Oakland, a broad based organization designed to improve the health care status of Oakland County residents. Beaumont studies vulnerable populations—whether they are uninsured or not—to target services in relation to diseases or health conditions. Beaumont meets with community organizations to identify health care programs we can provide to the groups they serve.

16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals.

In 2004, Beaumont generated 950,099 claims for health care services provided by our hospitals. As of 12/31/04, Beaumont had 1,752 collection lawsuits outstanding covering several years of billing activity. All but 97 of those lawsuits are being managed by attorneys retained by outside collection agencies.

Please identify the amount of debt that was at issue in each suit

Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection

Beaumont does not sell debt, so we have no further information to supply in answer to those questions.

Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts

See above answer.

Please explain how the sale of private accounts for recovery, and a concomitant claim to Medicare for payments on the same debts, is not “double dipping.”

Please provide copies of your contracts, if any, with collection agencies

See Appendix JJ

Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization
Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt
Beaumont does not have any financial relationship with a bank or credit card company for patients to finance their bills.
Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt
If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt
17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action
Beaumont and its related organizations do not have any money or investments in off shore banks or accounts.
18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.)
Appendix HH. Beaumont does not have any Type I, Type II, or Type III supporting organizations.
19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain
We do consider the cost (not charge) of care provided to individuals under our Charity Care Policy as "charity care." We do not count charity care at the charge level. We do believe that the promotion of health for the benefit of the community is a charitable purpose and is in part why we are deserving of our non-profit, tax-exempt status.

20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well

All Beaumont patients are charged the same for their health care services. But, we do not expect uninsured patients to pay the full amount—that is why we have an automatic 15% discount for all patients who are uninsured, with up to a 100% discount based on income levels. As noted in response to question B.1, due to competitive market forces, we do not want to publicly provide our discounts to all payors.

Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured

Beaumont provides preventative elective procedures such as mammograms, breast biopsies, etc. to the uninsured.

21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip

Appendix II. In 2004 the cumulative travel expenses for the top five salaried employees totaled \$12,710.88.

Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18

Beaumont does not have any Type I or Type II supporting organizations.

Finally, please detail any payments or reimbursements made to employees for country clubs

Beaumont's CEO and the President of The Beaumont Foundation have been provided with a local country club membership. For the years 2002, 2003, and 2004, the total amount of reimbursements to the CEO for club expenses was \$8,200, \$11,233, and \$9,000. With respect to the President of the Foundation, the total reimbursements for 2003 and 2004 were \$5,283 and \$6,838, respectively.

Charity Care and Community Benefit
The Cleveland Clinic, Cleveland, Ohio
1. How does your organization define charity care?
Financial assistance is offered to all patients who meet eligibility standards or who otherwise demonstrate financial hardship or extenuating circumstances that make it difficult for them to pay for services provided by CCHS.
What types of activities or programs does your organization include in its definition or determination of charity care?
All medically necessary inpatient and outpatient hospital services provided by any CCHS facility, as applicable based on the financial eligibility standards. The charity care policy provides free and discounted care to patients who do not meet the HCAP income eligibility criteria and covers a broader range of services, including professional fees for CCHS employed physicians. CCF currently employs more than 1500 physicians in 80 clinical specialties and subspecialties. The Health System is the largest provider of Medicaid services in the State of Ohio.
Which of these activities or programs would your organization not incur at all or to the same extent, if you were organized and operated as a for-profit hospital?
CCF has always operated within the non-profit environment, evaluating all programs and activities in terms of its three-part charitable mission: <i>better care for the sick, investigation of their problems, and further education of those who serve..</i> CCF could not fulfill its mission as a taxable entity. CCF has not undertaken any efforts to determine which of these types of programs are conducted by for-profit hospitals.
Does your organization maintain a charity policy?
Yes
If so, please describe the policy or provide a copy of such policy
Attachment B.1, B.11, B12.
Does this policy require that certain types and amounts of charity care be provided?
. The amount of charity care provided is determined by financial need and is not limited to a budgeted amount.
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
CCHS does not maintain information as to charity care expenditures identifiable by specific, separate categories, but rather this information is maintained on a patient account basis. Therefore, CCHS is unable to provide an answer to this question
How does this differ from 10 years ago?
25 years ago?
3. What percentages of your patients for your most recent fiscal year were:
(a) uninsured (self pay)
2.40%
(b) covered by Medicare
43.00%
(c) covered by Medicaid or other state or other governmental program providing medical care

benefits for low income individuals
8.30%
(d) otherwise covered by private insurance
46.00%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?
Yes, all patients in emergent/urgent situations are seen without regard to ability to pay. In all other situations, if a patient lacks insurance and cannot make a deposit, or has insurance but is concerned about his or her ability to pay for services, the patient is referred to a financial counselor. Patients who do not qualify for financial assistance under the charity care policy or government programs, may establish a payment plan.
5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?
Although we have no methodology for analyzing the correlation, the amount of bad debt write-offs has significantly increased over the past five years. On the basis of charges: 1999 \$54.4M, 2004 \$99.8M.
6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.
Yes. Ashtabula County Medical Center (rural community). APMC was in financial distress. CCF invested \$15 million and APMC is now managed by Meridia Health System, also part of CCHS. Grace Hospital agreement to integrate the long-term care function of Grace into a regional LTAC Healthcare system. Amherst Hospital collaboration in medically underserved area for orthopaedic care, ED and PT. Case Comprehensive Care Center is an NCI cancer center whose mission is to eliminate cancer and cancer related suffering and make available additional research opportunities and therapeutic options for patients.
7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.
Premier -group purchasing activity. CCF Innovations (a department of CCF) is charged with protecting, managing and commercializing any new CCF intellectual property. Peritec Bioscience Ltd., and CleveX Ltd. are spin-offs. CCF has minority interest.
8. Has your hospital or other members of your hospital system group enter into joint ventures with physicians or other for-profit companies or Investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures
CCF and Tenet Healthcare-Florida created a partnership for the purpose of constructing, owning and operating a 150 bed acute care hospital in Weston, FL. CCF owns 49%. CCF and Tenet have equal Board representation. Tenet is responsible for managing; CCF is responsible for training professional and clinical staff. Operated on same principles of community benefit as CCF CCF/MHS Renal Care holds a minority interest in Ohio-RGC to provide dialysis services. CCF indirectly holds a minority interest in Ohio-RGC. CCF holds a minority ownership interest in Weston Dialysis Center. CCF established the Dept of E-Radiology to provide specialist radiologist services via teleradiology. Two arrangements involve provision of services by CCF for two independent diagnostic testing facilities.
9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe charity care such policies, and how they are similar to or different from your hospital policy.
The Partnership with Tenet adopted a specific charity care policy with respect to the Hospital. Attachment B.16 and B.18. Also, the CCHS charity care policy applies to services billed by CCF staff physicians at this facility.
Also explain the role your hospital has in assuring that the charity care policy of the joint

venture is enforced
For CCF's joint venture with Tenet, a specific charity care policy was adopted (See Attachment B.16 and B.18). CCHS does not separately track charity care expenses provided by its non-profit joint ventures. For federal tax purposes, the activities of the joint ventures are treated as related charitable activities, and as such income or losses are related.
If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant
CCHS charity care policy covers all medically necessary healthcare services.
10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons
CCHS does not engage in joint ventures that shift the profitable procedures, practices and income streams to joint ventures. The goal of these collaborations is to increase abilities to offer enhanced benefits and services to their respective communities and communities at large.
11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the Investments in the joint venture
CCHS's joint venture activity is limited, therefore arrangements are evaluated on a case-by-case basis at the appropriate level of management with Board oversight. These arrangements are thoroughly reviewed with regard to CCHS's tax exempt mission and the risk to the organization. CCHS regularly reviews the arrangements for financial and regulatory compliance.
12. Please provide a charity care breakdown for each entity that is a member of your hospital system group.
CCHS total 2004 \$251M, 2003 \$201 M. 2002 \$157M, 2001 \$126M. Table provides breakdown by facility. As many healthcare organizations have done in the past, the annual amount of uncompensated care has been reported on the basis of gross charges.
In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis
Health systems need to be able to demonstrate satisfaction of IRS requirements on a health system basis. Measuring charity care on an org by org basis allows for a detailed analysis of both the needs of separate communities served and the unique nature of the contributions by each member. Reporting charity care on an aggregate basis may allow health systems to demonstrate the full value of charity and community benefits provided
13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?
Joint ventures are entered into for a wide variety of reasons and serve a wide variety of needs, depending on the community in which they operate. The level of charity care appropriate for a given joint venture should be a function of needs of the community served by the joint venture and available resources, not the level of the exempt organization's ownership in the joint venture.
If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?
Joint ventures are entered into for a wide variety of reasons and serve a wide variety of needs, depending on the community in which they operate. The level of charity care appropriate for a given joint venture should be a function of needs of the community served by the joint venture and available resources, not the level of the exempt organization's ownership in the joint venture.
14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?

<p>CCHS does not include in its Audited Financial Statements any charity care amounts provided by the for-profit joint ventures described in Question 8. CCHS holds a minority interest and, pursuant to GAAP, reflects income or losses from the joint venture as equity income, rather than consolidating the financials. However, for federal tax purposes, the activities of the joint ventures are treated as related charitable activities, and as, such income and losses are related income.</p>
<p>15. What types of research and teaching are performed by your hospital as a charitable or educational activity?</p>
<p>Teaching - Cleveland Clinic Lerner College of Medicine program to advance biomedical learning and research principles and practice (32 students per year); Sponsorship of more than 55 graduate and postgraduate education programs; in 2004 graduate (839 residents and fellows), undergraduate (452 medical students), trained 389 Allied Health students through 31 programs, continuing education (In 2003, 82000 CME certificates were awarded), and online medical education training; train emergency medical technicians; and operate a school of nursing (up to 88 graduates annually). Research – Total expenditures for research in 2004 were \$179 million and revenues received in support of research for the same year totaled \$133 million. CCF activities include laboratory and in-vitro investigations, human subject research and therapeutic clinical trial studies, genomic and proteomic analysis and epidemiology and health outcomes research. Currently conducting 2,270 clinical trials. Also, hosts and/or sponsors a variety of scientific education programs open to the public.</p>
<p>16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital</p>
<p>CCHS's Office of Development coordinates fund-raising activities. Most donors designate their gifts to a particular program. Undesignated gifts are allocated to the area of greatest priority. Pledges and new gifts: 2004 \$131M, 2003 \$127M, 2002 \$97M. There are several funds that help pay for care provided to indigent patients.</p>
<p>Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families</p>
<p>The Office of Development has an active campaign to support the Minority Men's Health Center. The Vision First program is funded primarily through targeted donations. The Children's Hospital actively seeks donors to support funds that provide care for indigent patients as well as to enhance the well-being of patients and their families.</p>
<p>17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture</p>
<p>In general, no. When CCHS is analyzing participation in a joint venture, each arrangement is reviewed to ensure that it is an appropriate use of assets and that it furthers CCF's mission.</p>
<p>18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so how?</p>
<p>Because CCF physicians are employees, CCF's financial assistance policies apply to hospital fees and professional services provided by all physicians. The amount of revenue and/or charity care provided has no direct impact on CCF physician compensation. CCHS regional hospitals employ a smaller number of physicians and are served by more traditional independent physician practices. CCHS regional hospitals employed physicians are required to see all patients, regardless of their ability to pay.</p>
<p>19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate</p>
<p>CCHS does not maintain information as to charity care expenditures identifiable by the specific</p>

healthcare services. This information is maintained on a patient account basis.
20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget?)
In 2004, free community health service programs: blood pressure, cholesterol and prostate screenings, nurse-on-call phone lines, cancer info lines, healthcare services and immunizations for women and children, and breast cancer support groups. Cash and in-kind donations include hours donated by staff during scheduled work time, overhead exp of space donated to groups for meetings and donation of food, equip, and supplies. In 2005, CCF donated \$10M to Cleveland public schools over 5 years. Cleveland Clinic/High School Partnership program: academic mentoring, job internship programs. Net cost \$27M (not all inclusive). In 2004, the Department held 49 community health talks and supported tobacco prevention programs for more than 2,000 students at ten Cleveland public schools.
21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.
The Cleveland Clinic has no information on the amount of charity care provided by for-profit health systems, since it has no for-profit competitors in Northeast Ohio.
22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?
CCF provides immunizations, counseling and education services, physical exams, and coordination of specialized services free of charge to woman and children at the Shelter for Women. The costs assoc are usually embedded in larger programs (e.g., health fairs), so they cannot be isolated and measured for this response. Vision First is a vision screening and eye exam program provided to over 5,500 children annually. Young Moms is a program to help teen mothers adjust to pregnancy both during and after the baby's birth. Boot Camp for New Dads is a workshop in which "experienced" dads help first-time fathers gain confidence and learn basic parenting skills. The Stork's Nest is a monthly prenatal health education program focused on low-income woman and their partners.
23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?
CCF is currently conducting approximately 2,270 clinical trials. If research involves clinical care that is standard of care for any other patient, such as lab tests to establish disease diagnosis, the informed consent form may indicate that the costs are the responsibility of the participant or his/her insurer, in which case a participant without ins would be eligible for charity care. Each research subject participating in a clinical trial program at a Health System facility is registered as a routine patient. In other clinical trials, there may be an internal or external source of funding that may reduce the costs of treatment to participants or result in no cost for the treatment. A Health System Institutional Review Board must review the payment structure to ensure that the subject is free of coercion and is able to make an informed decision regarding participation.
24. How do you allocate expenses (direct labor and materials, indirect labor and materials management, general and administrative, fund-raising, investment and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?
The Health System allocates indirect expenses for all purposes, including charity care, based upon a consistent methodology that is applied regardless of payor category. This methodology incorporates all costs that are unrelated to direct patient care as indirect expenses and applies a cost to charge ratio based upon an average cost for the services.
Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences

25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.
In 2003, the average length of stay for patients treated at CCF was 5.69 days (acute) and 8.44 days (non-acute). The average length of stay for 2004 was virtually the same as in 2003. CCF had the highest Medicare Case Mix Index among hospitals in the US with 500 or more beds.
Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues
Part 3
1. Please explain what is the average mark-up of charges over cost.
What is the average private pay contractual allowance (charges to payment) weighted by payer
CCHS does not have a set "mark up" of charges that is applies in a mechanical or formulistic manner. Since this question involves highly sensitive, proprietary business information, CCHS respectfully refers the SFC to the 2004 unaudited cost reports for the CCHS hospitals.
2. Please explain the reason for charging "chargemaster" rates to uninsured individuals particularly in light of the Secretary of Health and Human Services' letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not for-profit and tax-exempt status
Medicare rules require hospitals to have one schedule of chargemaster rates that apply to all patients. Prior to the recent HHS and OIG guidance, CCHS believed that the Medicare rules and guidance on collection practices restricted hospitals from offering unilateral reductions in charges to categories of patients. It is still our understanding that this new guidance does not obviate the need for CCHS to have a price list or chargemaster. The chargemaster is required by federal law, as well as by good management practices.
What is the collection rate for self-pay?
Our collection rate for self pay patients is significantly less than our collection rate for insured patients and patients covered under government programs, and amounts collected from self pay patients do not cover our costs of providing care to this patient population.
4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate.
It is not accurate to state that govt programs pay for services without regard to the chargemaster rate. The Medicare program requires hospitals to report their full charges so it can identify its portion of total charges for the application of formulas. Hospital charges are used to establish cost to charge ratios for certain hospital reimb, such as outlier payments. Commercial payors - CCHS negotiates contractual adjustments in order to participate in benefit plans, and in exchange for prompt pay requirements and other negotiated commitments. These contractual commitments have economic value which justifies a discounted rate.
5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status
There is little or no overall benefit from charging self-pay patients the chargemaster rate because of the low collection rate and because many self-pay patients are eligible for free or discounted care under our charity care policy. Our approach to pricing services is not directed at self-pay patients.

<p>6. The Committee has heard statements from Individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject</p>
<p>Information about charity care policy is posted on the CCF website, in handouts, tear off sheets, and on patient rights and responsibilities posters, and to patients at intake, admitting, and registration points throughout CCF. Info about financial assistance programs is available at CCHS regional hospitals in billing pamphlets at registration and in patient rooms, and on signs. The information is also available to all patients in the CCHS emergency depts. Info is shared with patients during billing process and throughout the collection process. Key info has been translated and made available for our non-English speaking population. In addition, signage throughout the system is being updated to ensure accuracy and uniformity.</p>
<p>Please identify what steps your hospital has taken to ensure that lower level staff who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such Information to your staff.</p>
<p>Front-line intake and registration staff and financial counselors are informed of their duties, responsibilities, and CCHS policies at regularly scheduled staff meetings and in training programs. Topics include the HCAP program, other financial assistance programs, and how to access eligibility vendors to assist patients with enrollment requirements. Further meetings were held in January-February 2005 for employees in the outpatient Family Health Centers.</p>
<p>8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.</p>
<p>Prior to the HHS and OIG 2004 guidance on this issue, CCHS believed the Medicare rules on charges and collections to restrict hospitals from offering unilateral reductions in charges to categories of patients, such as uninsured patients. CCHS developed guidelines for addressing the financial needs of its patients on a case-by-case basis. CCHS believed that this approach was fair and appropriate, and served its charitable mission.</p>
<p>In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule</p>
<p>CCHS has not grossed up its charges on the Medicare cost report because they had a lower OPD fee schedule.</p>
<p>Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured</p>
<p>CCHS would be open to discussing alternatives to the current chargemaster pricing methodology.</p>
<p>9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thuo further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate to or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002</p>
<p>CCHS has not adopted a strategy to increase outlier payments through charge adjustments, and would find such a strategy unacceptable. The growth rate in CCHS outlier payments from 1998 to 2002 average 9.2% annually at CCF, and 10.3% for the Health System as a whole. However, the calculation fails to take into account increases in Medicare discharges or increases in acuity and</p>

case mix.
10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government.
The CCHS believe it is appropriate for our org to receive Medicare and Medicaid DSH funds. These funds do not fully compensate our org or others in Ohio for the cost of care rendered to Medicare, Medicaid and uninsured patients. DSH payments are additional payments in the Medicaid and Medicare programs that, along with local tax appropriations, help hospitals finance care to low-income and uninsured patients
Please list your payments under disproportionate share for the past three years as compared to uncompensated care separating out bad debt.
DSH Pmts combined: 2004 \$16,759,025, 2003 \$16,966,033, 2002 \$20,005,905. Uncompensated Care: 2004 \$350,901,000, 2003 \$286,519,000, 2002 \$227,856,000.
11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, "the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.
CCHS uses the chargemaster pricing methodology because it is the industry standard and conforms to applicable federal requirements. Without changes to current cost reporting regiments, legal prohibitions and hospital reimb formulas, CCHS would be penalized under Medicare program requirements if CCHS discontinued use of the chargemaster. CCHS would support discussion and consideration of new pricing methodologies to replace the standard chargemaster by all interested parties
12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he "was told by both inside and outside legal counsel ... [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS." Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice
CCHS is not aware of having received any advice of counsel on this topic.
13. Please provide all documents related to your hospital's consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients
Attachments B.1, B.11, B.16, B.17. (Charity Care Policies).
14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured
See Question B.13, Question B.15. Attachment D.8, D.18-D.20. CCHS does not direct community benefit programs specifically to the uninsured, but to targeted populations based on financial need and/or special health needs. In many cases, these populations include many uninsured persons.
15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured

in its community needs assessment
2001 assessments Attachments D.11 - D.17. Needs assessments identify the health status of community and determine at-risk populations based on unhealthy lifestyles. However, at risk populations in many communities are low-income and may lack insurance.
16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these Individuals
CCHS estimates that less than half (41%) of the collections-related suits filed since March 2003 have been against self-pay patients. It has also been necessary to file suits against insured patients. Lawsuits are not required to collect debt from individuals. Suits are filed when voluntary collection and payment arrangements fail, and then, only if a patient has verified income and assets. CCHS is statutorily required to perfect claims in two circumstances: in probate court and in bankruptcy court.
Please identify the amount of debt that was at issue in each suit
CCF main campus: 2000 1 suit \$25,194, 2001 3 suits \$216,182, 2002 0 suits, 2003 1 suit \$355,474, 2004 1 suit \$25,096, 2005 0 suits. CCHS regional hospitals do not maintain lawsuit data with all necessary detail. Available info since March 2003 reflects 510 suits against insured individuals and only 353 against uninsured patients.
Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection
CCHS does not engage in the practice of selling patient debt to other companies for collection.
Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were said. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital, rigorously pursued the patient on its own, and whether or not the hospital also claimed those some accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts
Please explain how the sale of private accounts for recovery, and an concomitant claim to Medicare for payments on the same debts, is not "double dipping."
Please provide copies of your contracts, if any, with collection agencies
Attachments B.19 and B.20.
Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization
Collection agencies are independent entities (not subsidiaries of CCHS). However, CCHS has redacted the proprietary info relative to each company's fees and pricing structure.
Please describe any financial relationship with a aback or credit card company that patients use to help finance their debts
CCHS does not currently refer patients to any particular bank or credit card company to finance debt.
Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt
CCHS is required to pursue reasonable collection activities as a condition of federal health care reimbursement. CCHS does not differentiate between Medicare and non-Medicare patients with regard to debt.
If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt
17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why our organization has taken this action
Two captive insurance company subsidiaries based in the Cayman Islands. CCHS has made

deposits in offshore bank accts. These accts are used to pay administrative expenses incurred by the companies. As of June 30, 2005, there is less than \$75,000 in these accts. CCHS organized its captive insurance program in response to the lack of viable domestic carriers willing to underwrite physician malpractice liability insurance in Ohio.
18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.)
Attachments A1, A.3, E.21, E.22, E.23
19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsured is charitable even if there is a high charge associated with it? If so, please explain
CCHS believes it has an obligation to assure reasonable access to medically necessary health care services to persons in their community. While we do not take the position that the provision of health care automatically qualifies as or as a tax-exempt charitable org the overall community benefit provided by CCHS, including its charity care policy, clearly meets the community benefit standard articulated by the IRS.
20. Some hospitals have stated that all patients, insured and uninsured alike are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well
All patients are billed the chargemaster rates; adjustments are made based on governmental program requirements, contractual discounts with commercial payors, or in the case of self-pay patients, pursuant to CCHS's charity care policy. In accordance with federal and state antitrust laws, CCHS maintains its pricing information on a strictly confidential basis. We do not believe that the information regarding a net effective discount provides relevant information, and, in addition, such information is proprietary as well as competitively sensitive.
Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured
Elective –type procedures including breast biopsies. mammograms, colonoscopies and physicals that often are not covered under commercial policies are treated as medically necessary services when ordered by a physician, and they may be provided free or on a discounted basis under the charity care policy.
21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees; for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip
See Attachment E.24. and E.25.
Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B.18
See AttachmntsE.18 - E.20.
Finally, please detail any payments or reimbursements made to employees for country clubs
CCHS has not made any payments to employees for country clubs.

Charity Care and Community Benefit
Fairview Health Systems, Minneapolis, Minn.
1. How does your organization define charity care?
Charity care, known as "Community Care" within Fairview, is services provided free or at a reduced rate to our hospital patients who demonstrate an inability to pay based on their income and other financial circumstances. If a patient is unwilling to provide information, uncollected amounts are accounted for and reported as bad debt. Fairview reports Community Care at the cost of providing the services rather than at the full amount of charges foregone.
What types of activities or programs does your organization include in its definition or determination of charity care?
Community Care does not ordinarily apply to experimental or cosmetic services or other services considered by the patient's physician to be medically unnecessary.
Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
Fairview does not know if its Community Care program would be different if it were a for-profit org.
Does your organization maintain a charity policy?
Yes
If so, please describe the policy or provide a copy of such policy.
Exhibit A1.
Does this policy require that certain types and amounts of charity care be provided?
The policy does not require a specific amount of Community Care. While Fairview budgets for Community Care, the budget does not limit provision of Community Care to patients in need.
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
Fairview provides free or discounted care to patients who meet the income thresholds. Other than this, Fairview does not have categories of charity care expenditures. This has been the case for at least the last 25 years., Community benefit activities - includes education activities, Costs in excess of public program payments, Medicaid surcharge, Community Care, MinnesotaCare, Total, 1.5% of total 2004 consolidated cash expenses and 48% of total 2004 consolidated operating income.
How does this differ from 10 years ago?
See above
25 years ago?

See above
3. What percentages of your patients for your most recent fiscal year were:
(a) uninsured (self pay) 1.50%
(b) covered by Medicare 30.80%
(c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals 15.00%
(d) otherwise covered by private insurance 52.70%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?
Fairview may waive its fees upon admission for patients in financial need and in other special circumstances. Fairview keeps a patient's Community Care status on file for six months following his or her initial application.
5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?
While we assume that higher co-payments and deductibles make it more difficult for patients to pay the co-payment or deductible, isolating this variable and its effect on write-offs apart from other factors is difficult and not something for which Fairview has separately tracked data.
6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.
1) Unrelated hospital to provide physical therapy services at clinics. 2) Cooperative to purchase imaging services. Fairview bills patients and provides charity care. 3) Cooperative linen service does not provide patient care. 4) Nonprofit Corporation provides air and ground ambulance svc. It has its own charity care policy. 5) Nonprofit tax-exempt corporation is a transplant organ procurement org. 6) Group supply and equipment purchasing organization.
7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.
No
8. Has your hospital or other members of your hospital system group enter into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures
Fairview is not currently involved in arrangements that would normally be considered to be joint ventures. 1) Nonprofit corporation conducts research and education in sports medicine. Other member is an orthopedic physician group. Membership interests are not considered economic ownership interests. 2) Nonprofit corporation and a behavioral health care network. Fairview and a group of independent mental health care professionals. Working with Fairview to provide special emergency room mental health assessments. Fairview provides charity care for emergency room patients.
9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care

policy.
Critical Care Services, Inc has a charity care policy for qualifying individuals based on household income as a percent of the federal poverty guidelines, which provides for free or reduced charges for ambulance services. Fairview has representation on the BOD. Charity care provided by Critical Care Services is not included in Fairview's Community Care totals.
Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced
Fairview has representation on the Board of Directors.
If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant
10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons
Fairview does not believe any of its arrangements are captured by the assertion. There is significant misalignment in the participant interests in the health care continuum (e.g., hospitals are expected to provide the full continuum of care in the highest cost environment). The pressures on physicians lead them to search for new revenue sources. Joint ventures are a common approach to these problems. The purpose is to put the most effective, highest quality service in place without needless duplication of services and fractionalization of care. Congress should perhaps reconsider whether these arrangements should be encouraged rather than discouraged.
11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture
Fairview does not currently participate in the type of joint ventures that we believe the question addresses. In general, we understand that joint venture arrangements are usually put together to enhance performance and create additional capital, not deplete it. Overall, it is our belief that joint ventures can play an important role in providing health care services to patients that may not otherwise be provided through a hospital. The current regulatory environment disfavors many of these kinds of joint ventures.
12. Please provide a charity care breakdown for each entity that is a member of your hospital system group
Exhibit A12. FY 2004 Charity Care \$2,192,547, in the 6 months ended June 30, 2005 Charity Care \$3,231,719 (7 facilities and other entities)
In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis
While it is difficult to generalize this issue, we think that, in most, but not necessarily all cases, an aggregate group basis may be more appropriate to measure charity care.
13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?
To the extent that part of the exempt purposes relate to charity care, we understand that charity care should be part of the joint venture. Fairview believes that charity care is fact-specific and that a uniform amount of charity care requirement does not make sense. If a requirement were imposed, with respect to a joint venture, we think that the type of services provided, the needs of the community and other items unique to the joint venture would dictate the amount of charity care and not necessarily, the amount of hospital ownership. Other state-specific factors should

<p>be considered as well. Many states have created programs addressing the needs of uninsured and indigent populations.</p>
<p>If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?</p>
<p>See above</p>
<p>14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?</p>
<p>Fairview does not currently participate in any joint ventures that separately provide charity care and whose charity care results are included in Fairview's Community Care totals.</p>
<p>15. What types of research and teaching are performed by your hospital as a charitable or educational activity?</p>
<p>Approx 350-400 research studies are approved at any given time. Several disciplines: medical research (social/behavioral research, quality improvement and outcomes research), nursing research councils, physical therapist research projects, Minnesota Metro Community Clinical Oncology Programs. Most of the research conducted at Fairview is in conjunction with the University of Minnesota's Academic Health Center's research efforts. In addition to University faculty, many physicians from private practices conduct research using Fairview facilities, records or personnel. These studies are typically Phase II, III, or IV clinical trials of investigative drugs or devices. Fairview, through University of Minnesota Medical Center, serves as the core teaching facility for the University of Minnesota Academic Health Center. In 2004, Fairview incurred net costs of \$12.5 million supporting the research and education efforts of The University of Minnesota's Academic Health Center. Fairview provides a clinical training site for students in its School of Dentistry, Medical School, School of Nursing, College of Pharmacy, School of Public Health, etc. The Minneapolis campus has 4800 students.</p>
<p>16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital</p>
<p>Fairview is the sole member of the Fairview Foundation (nonprofit corporate tax exempt). It solicits and receives all charitable donations for the Fairview system. Donations to offset operating costs: 2002 \$2.4 million, 2003 \$2.8 million, 2004 \$2.8 million.</p>
<p>Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families</p>
<p>Often donations are restricted to specific purposes by the donor. In 2004, Fairview Foundation received \$45,000 to provide medical care to underinsured or uninsured patients and granted \$55,000 to provide such care. Fairview's provision of Community Care is not dependent on or limited by the amount of funds raised for this purpose.</p>
<p>17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture</p>
<p>Fairview does not currently have joint ventures with for-profit orgs. We also believe that the relationships described in response to questions A6 and A7 result in lower costs and have a positive impact on Fairview's ability to provide additional services.</p>
<p>18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?</p>
<p>Fairview does not believe that its compensation arrangements with employed physicians or other employed professionals either encourage or discourage the provision of charity care. In many cases, physicians are simply members of our medical staff who separately bill for their services and we do not have compensation arrangements with them. In our agreements with non-</p>

employed, hospital based physicians such as anesthesiologists, we require physicians to provide charity care.
19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.
Exhibit A19. Inpatient: Medical/Surgical \$1,002,813, Skilled Nursing Facility \$158,731, Obstetrics, Nursing, Neonatal \$203,007, Behavioral \$157,515, Subtotal - \$1,522,066. Outpatient: ER \$156,095, Behavioral-OP \$63,417, Ambulatory Surgery \$105,097, All other \$222,588, Subtotal - \$547,197. Total - \$2,069,263.
20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?
Community service activities - medical assistance to high school sports teams, speaking about health issues to community groups. Community health activities - tied to assessed community needs - exercise classes for inner-city immigrant women, mammogram and cervical screening for uninsured and underinsured woman. Community health partnerships - tied to assessed needs - implementing a culturally appropriate doula program for inner-city immigrant women, providing depression training to African American pastors, the creation of a wellness center that does health screenings and referrals for new immigrants. Exhibit A20 and B15 Health Partnership Survey. 2002 \$23.2M, 2003 \$21.8M, 2004 \$24.2M.
21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.
We do not have for-profit hospital competitors in MN and are not aware of any interest on the part of for-profit hospitals to enter the MN market place.
22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?
Fairview provides free or discounted immunizations through its clinics, but at this time is not able to quantify the dollar amount involved.
23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?
Fairview conducts and is involved in clinical trials and other research. Our research activities are not part of our Community Care totals.
24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?
Fairview's methodology for calculating the cost of providing Community Care uses hospital specific cost-to-charge ratios for each hospital (dividing net hospital costs into gross charges). This methodology is dictated by internal policy and differs slightly from cost-to-charge ratios developed on Medicare cost reports. The methodology is generally consistent with that used by the State of MN for hospital annual reporting requirements.
Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences
For community benefit purposes, Fairview's internal accounting procedures for reporting the cost of providing community services capture only direct costs for labor, materials and related expenses. Indirect costs are currently not tracked or included - except for certain research and education related expenses.

<p>25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.</p>
<p>Exhibit A25.</p>
<p>Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues</p>
<p>Part 3</p>
<p>1. Please explain what is the average mark-up of charges over costs.</p>
<p>For 2004 (7 hospitals), 2.24.</p>
<p>What is the average private pay contractual allowance (charges to payments) weighted by payer</p>
<p>The average private pay contractor allowance for 2004 was 45.74%. On average, Medicare, Medicaid and other governmental payors discounted charges by 64.39%. Overall 2004 contractual allowance was 53.34%.</p>
<p>2. Please explain the reason for charging “chargemaster” rates to uninsured individuals particularly in light of the Secretary of Health and Human Services’ letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status</p>
<p>The standard chargemaster prices are necessary to prepare reports required by state and federal government such as Medicare cost reports and for internal cost accounting purposes. Reimbursement in the health care industry is fragmented. These multiple and disparate reimbursement models forced hospitals to develop pricing that tries to accommodate the multiple reimbursement methodologies. While low-income and underinsured patients are initially charged the chargemaster rate, Fairview provides discounts of up to 100 percent from those charges based on our Community Care Program.</p>
<p>3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy</p>
<p>For qualifying patients, Fairview provides discounts of up to 100% for low-income, uninsured patients and also caps overall patient liability. Patient must complete a financial application. Income levels and discount: up to 200% federal poverty level (FPL) - 100% disc, 200% to 275% FPL - 75% disc, 275% to 350% FPL - 50% disc, 350% to 450% FPL 40% disc. MN residents also have a cap on their liability equal to 25% of the difference between the income limit for the category less 200% of FPL.</p>
<p>What is the collection rate for self-pay?</p>
<p>Our collection rate for self-pay patients for 2004 was 21% of charges. This does not include patients qualifying for Community Care, but does include patients whose accounts are in collection.</p>
<p>4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate</p>
<p>All patients are initially charged the chargemaster rate. Fairview is reimbursed by governmental or private payors based on their respective payment methodologies and any contractual arrangements. Some of the payor methodologies are based on chargemaster rates. Uninsured patients receive discounts based on the Community Care program. Prompt pay and advance payment discounts are also offered.</p>

<p>5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status</p>
<p>Fairview does not see an economic benefit in charging low-income, uninsured patients the chargemaster rate. A large percent of these patients' bills is discounted or written off. Our initial charge may be the chargemaster rate, but we provide Community Care so they end up paying less than the chargemaster rate, based on their ability to pay.</p>
<p>6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject</p>
<p>Brochures are available and signs are posted in patient-waiting areas. Info is available on our website. Brochures translated into Spanish and working on other languages. Patient Financial Counselors contact uninsured patients prior to their services or at the time of service (if unscheduled) to assist with financial arrangements. Counselors inform patients about potential eligibility for may programs. As part of our billing and collection process, Fairview's Central Business Office staff discusses Community Care with patients who express financial difficulty. References to the Community Care program was recently added to billing statements.</p>
<p>7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff</p>
<p>All of the staff in Fairview's Central Business Office is trained regarding the Community Care program and all personnel are instructed to assist patients with our Community Care process or the Medical Assistance process when a patient calls with questions. Fairview is implementing a comprehensive education plan to make all staff and affiliated providers aware of the Community Care program and the appropriate contact number when a patient identifies a financial concern.</p>
<p>8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.</p>
<p>Fairview has always provided charity care to patients based on federal poverty guidelines. It has been an article of faith for decades in the cost-based reimbursement areas, that a routine waiver of charges or co-pmts would lead the government and other 3rd party payors to argue that usual and customary charges for services was actually less than what appeared on Medicare Cost Reports. The government over many years has reinforced this view. CMS July 25, 2005, proposed regulations state "Medicare providers are required to maintain uniform charges for all payers." Until the Secretary's letter, hospitals had no prior government indication that waivers for uninsured would not trigger this scenario.</p>
<p>In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule</p>
<p>Fairview did not gross up its charges because of a lower OPD fee schedule.</p>
<p>Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured</p>

<p>9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002</p>
<p>Fairview did not set its charges in order to obtain more Medicare outlier payments. Exhibit B9 Average growth in outlier payments 1998 - 2004 (2.7%) [range of annual growth (32)% to 19%]</p>
<p>10. Secretary Thompson, in his letter mentioned above, noted that “Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals’ provision to help hospitals bear the cost of caring for the poor and uninsured.” In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government</p>
<p>DSH pmts were intended as a refinement of the Medicare Payment System to compensate hospitals for the greater-than-average costs incurred in the treatment of a higher share of low-income patients. Excess costs are at least 5 times greater than the DSH pmts. As significant third party payors, it is appropriate for Medicare and Medicaid programs to share in these costs as well. The DSH element of the reimbursement system is not duplicative of the general benefits of tax-exempt status, which reflect the whole range of community benefit provided, of which charity care is only one.</p>
<p>Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt</p>
<p>Comb 7 hospitals. 2002: Comb DSH \$12,162,661, Charity \$890,929, Bad Debt \$12,140,746, Uncompensated Care \$13,031,675. 2003: Comb DSH \$12,565,551, Charity \$1,421,932, B/D \$10,337,033, Uncompensated Care \$11,758,965. 2004: Comb DSH \$14,109,528, Charity \$2,069,263, B/D \$13,429,145, Uncompensated Care \$15,498,408.</p>
<p>11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, “the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90’s by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.</p>
<p>see response to Question B2</p>
<p>12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he “was told by both inside and outside legal counsel . . . [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS.” Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice</p>
<p>This is legally privileged information and, as such, is not provided.</p>
<p>13. Please provide all documents related to your hospital’s consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients</p>
<p>Exhibit B13</p>

<p>14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured</p>
<p>Exhibit B14. We do not have charity care audits.</p>
<p>15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment</p>
<p>Exhibit B15. Our community needs assessments and survey forms focus on vulnerable populations including uninsured.</p>
<p>16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals</p>
<p>Fairview cannot readily gather the historical info requested. We are in the process of implementing systems that will allow us to track this in the future. We estimate that in 2004, we brought approx 3,000 lawsuits to collect patient accts. This estimate is not limited to uninsured patients. Fairview does not feel compelled by law to file collection lawsuits to collect from uninsured patients unable to pay. We do feel an obligation to use reasonable efforts to collect from uninsured patients who have the ability to pay.</p>
<p>Please identify the amount of debt that was at issue in each suit</p>
<p>Fairview cannot readily gather the historical info requested.</p>
<p>Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection</p>
<p>Fairview does not sell patient debt.</p>
<p>Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts</p>
<p>Fairview does not sell patient debt.</p>
<p>Please explain how the sale of private accounts for recovery, and an concomitant claim to Medicare for payments on the same debts, is not "double dipping."</p>
<p>Fairview does not sell patient debt.</p>
<p>Please provide copies of your contracts, if any, with collection agencies</p>
<p>Exhibit B16</p>
<p>Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization</p>
<p>Collection agency is not a subsidiary. In the process of entering into a separate agreement with a collection law firm. Recently entered into a collection standards agreement with the MN</p>

Attorney General's office.
Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt
Fairview does not have any relationships with a bank or credit card company that patients use to finance debt.
Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt
Both insured and uninsured patients and Medicare and non-Medicare patients are treated equally during the process.
If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt
Fairview does not sell patient debt.
17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action
Fairview insures its professional and general liability risks through its wholly owned insurance subsidiary Associated Medical Assurance, Ltd., which is domiciled in Bermuda. This arrangement has been in effect since 1975 and, over time, has allowed Fairview to favorably manage its professional and general liability costs. Associated Medical has a checking account in a Bermuda bank in order to operate its business. As of December 31, 2004, the balance in the account was \$149,000.
18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.)
Exhibit B18.
19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain
The provision of health care by a hospital benefits the community as a whole if the hospital maintains an emergency room open to all persons regardless of ability to pay and provides hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement. Thus, the focus is on the provision of health care to the community as a whole rather than to the uninsured specifically.
20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well
We agree this is semantics. All patients are charged the same gross charges, but the amount actually paid depends on whether they are covered by a government plan and the government program's reimbursement methodology, a private plan and the agreement with the hospital, or uninsured and qualify for the Community Care program. The average private pay contractor allowance for 2004 was 45.74%. On average, Medicare, Medicaid and other governmental payors discounted charges by 64.39%. Overall 2004 contractual allowance was 53.34%
Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured

Community Care is available for all hospital services, except for experimental or cosmetic services or other services considered by the patient's physician to be medically unnecessary.

21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip

Exhibit B21.

Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18

Exhibit B21. Executive compensation includes base salary plus annual and long-range incentive plans. Annual incentive plan awards are made only if identified earnings are met.

Finally, please detail any payments or reimbursements made to employees for country clubs

Fairview does not pay or reimburse employees for country club memberships.

Charity Care and Community Benefit
The New York and Presbyterian Hospital, New York, N. Y.
1. How does your organization define charity care?
The provision of free or reduced charge services that are medically necessary to persons who are determined to be unable to pay for their care in whole or in part, based on their financial situation.
What types of activities or programs does your organization include in its definition or determination of charity care?
Per the Charity Care Policy - the policy applies only to medically necessary services. Some cosmetic services and any services deemed to be not medically necessary will not be considered for charity care. NYPH's location, and the population it serves, dictates the types of activities and programs that NYPH provides.
Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
It is likely that NYPH would not be able to provide the same level of community outreach services provided today. Similarly, NYPH would likely not undertake many of the research and educational activities that it performs in conjunction with its medical school affiliates, as for-profit hospitals are less likely to have relationships with academic institutions.
Does your organization maintain a charity policy?
Yes
If so, please describe the policy or provide a copy of such policy.
Attached NYPH 000001-000006
Does this policy require that certain types and amounts of charity care be provided?
NYPH's Charity Care/Financial Aid Policy does not require specified amounts of charity care to be provided.
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
Inpatient services, Emergency Room services, Outpatient Clinics, Referred Ambulatory Care, Ambulatory Surgery, Mental Health Clinic, Oncology Clinic, Chemotherapy Clinic, Mental Health Continuing Care, Ambulance Services

How does this differ from 10 years ago?
NYPH did not exist in its current form prior to 1997.
25 years ago?
See previous question
3. What percentages of your patients for your most recent fiscal year were:
The percentages below include both inpatient and outpatient care.
(a) uninsured (self pay)
8.10%
(b) covered by Medicare
21.20%
(c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals
38.40%
(d) otherwise covered by private insurance
32.20%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?
NYPH will occasionally waive its fees immediately upon admission of an inpatient (e.g., case presents novel medical issue). NYPH will do so pursuant to an agreement between the admitting physician and senior-level mgt. Waiver of fee arrangements are not routine practice, but rather are made in extraordinary circumstances. Under NYPH's Charity Care Policy, patients seen in NYPH's outpatient clinics pay for services based on a sliding fee scale. The minimum fee is \$40.
5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?
NYPH has not seen a significant effect over the past five years. NYPH attributes this to the low penetration of high deductible plans in the New York market.
6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.
In reviewing its operations to determine what type of info would assist the Committee, NYPH considered the analysis undertaken by the IRS when examining joint venture arrangement involving tax exempt entities. Under the foregoing analysis, NYPH has not entered into joint ventures with other not-for-profit, tax exempt hospitals.
7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.

In accordance with the understanding of the term "joint venture" described above, NYPH is not a joint venturer with health professionals, such as physicians or other for-profit companies or investors. To the extent NYPH earns unrelated trade or business income, this income is reported on NYPH's Form 990T.

8. Has your hospital or other members of your hospital system group enter into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures

See response to Question 7.

9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy.

In accordance with the understanding of the term "joint venture" described above, NYPH has not entered into joint ventures with other non-profit, tax-exempt hospitals, with health professionals such as physicians, or with other for-profit companies or investors to provided health care services. As such, NYPH has no other charity care policies

Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced

n/a

If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant

Historically, NYPH has not tracked charity care expenses by categories, as this info has not been needed for operational purposes. NYPH has allocated charity care expenses into categories for cost reporting purposes. NYPH does not feel that any category of charity care is more or less important than any other category.

10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons

NYPH is generally aware of the fact that a number of tax exempt hospitals have engaged in joint ventures with for-profit persons. To guard against the profit shifting implicit in the assertion, the IRS closely scrutinizes joint ventures. Although it may be relevant to examine the motivation and intent of a tax exempt hospital for engaging in a joint venture with a for-profit entity, the analysis of this issue in the context of tax exempt status has thus far focused on whether the arrangement furthers the tax exempt participant's charitable purposes and whether the arrangement results in more than an incidental private benefit to for-profit entities.

11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture

See response to Question 7.

12. Please provide a charity care breakdown for each entity that is a member of your hospital system group

NYPH reports its charity care allowance on an aggregate basis for the four campuses.

In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis

Whether charity care should be measured on an aggregate or individual basis depends on the use of the information.

13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?

The imposition of a separate charity care requirement for joint ventures in which a tax exempt hospital participates should be superfluous under existing IRS guidelines, which require that the tax exempt participant in a joint venture operate in a manner consistent with its tax exempt status regardless of the tax exempt entity's participation in the joint venture. The participation in the joint venture must further the exempt purpose of the tax exempt entity. If the organization is required to provide charity care as a condition of its tax exempt status under the community benefit standard, this requirement is not lessened by the org's participation in the joint venture.

If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?

14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?

See response to Question 7.

15. What types of research and teaching are performed by your hospital as a charitable or educational activity?

In 2004, NYPH sponsored 115 accredited residency and fellowship programs in areas such as surgery, internal medicine, pediatric cardiology, and emergency medicine. Over 2100 residents and fellows participated annually in these programs. In the research context, grants allow NYPH to provide free or reduced charge care to participants. The Healthy Schools, Healthy Families program advocates a school-based approach to healthcare, correlating students' health data with academic performance, providing more education on healthy nutritional and lifestyle habits, and providing referrals to high-risk children. Also, the Action to Control Cardiovascular Risk in Diabetes clinical trial is designed to investigate whether or not control of blood sugar, blood pressure and blood lipids improves the cardiovascular complications.

16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital

Events held include: a gala, a fashion show, dinners, benefits. NYPH's principal fund-raising initiative is called the Campaign for NYPH and it aim is to raise \$1B by 2010. Total received: 2002 \$77M, 2003 \$129M, 2004 \$134M.

Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families

In 2000, the President and CEO of NYPH established Save-A-Life, a program specifically created to help NYPH provide cutting edge care to patients regardless of their ability to pay. As part of its effort to raise funds for this program, NYPH hosts an annual dinner.

<p>17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture</p>
<p>The question is best answered by evaluating the purpose, formation and operation of the joint venture at issue. The mere partnering with a for-profit entity need not have implications on the provision of charity care and satisfaction of the community benefit standard.</p>
<p>18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?</p>
<p>NYPH employs physicians in training (commonly referred to as residents). NYPH's compensation arrangements with the residents does not in any way encourage or discourage the provision of charity care by NYPH. The residents are compensated the same regardless of whether they provide care to the indigent.</p>
<p>19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.</p>
<p>See table in response.</p>
<p>20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?</p>
<p>These activities are widely varied and include free screenings, health fairs, blood drives, seminars on health related topics, free immunizations, pharmacy assistance programs, and programs that assess health insurance eligibility. NYPH does not currently track how much is expended on its community outreach and education activities. Funding comes from charitable donations, grants, and departmental budgets.</p>
<p>21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.</p>
<p>NYPH has not conducted any analysis on how the amount of uncompensated care or charity care provided by not-for-profit hospitals differs from for-profit hospitals. NYPH notes that there are almost no for-profit hospitals in the state of NY.</p>
<p>22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?</p>
<p>NYPH does not track how much is spent on free or below-cost infant and child care programs. Funding for many of these programs comes from grants and the State. In 2004, NYPH provided free care to children in over 13,400 cases. The charges associated with this care is greater than \$3M.</p>
<p>23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?</p>
<p>NYPH in conjunction with its medical school affiliates, conducts clinical research that involves the provision of clinical services to uninsured or underinsured patients. Much of the research is supported by grants and NYPH often subsidizes this care. Since grants typically do not cover all of the costs associated with the clinical care required under the research protocol, NYPH often subsidizes this care. NYPH does not consider the cost of clinical trial programs when calculating its charity care allowance.</p>
<p>24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-</p>

sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?

NYPH does not allocate expenses for purposes of determining the amount it has expended on charity care. NYPH views charity care as a reduction in charges, rather than an expense. As such, NYPH does not include administrative, labor, fundraising, or any other costs in the calculation.

Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences

25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.

2004 (Avg length of stay, avg cost per discharge): Burn (11, \$29,840), Medical/Surgical (6.3, \$17,307), Normal Newborn (2.6, \$1,423), Obstetrics (3.5, \$6,986), Other Newborn (11.5, \$18,176), Physical Rehabilitation (12.7, \$21,376), Psychiatry (16.2, \$14,205), Transplant (31.1, \$163,107).

Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues

Part 3

1. Please explain what is the average mark-up of charges over costs.

The average mark-up of charges over costs for 2004 was 98.1% (i.e., 1.98)

What is the average private pay contractual allowance (charges to payments) weighted by payer

The average private pay (i.e., excluding Medicare and Medicaid) contractual allowances for 2004: No Fault 64.3%, Worker's Compensation 55%, Commercial 47.4%. Note: No Fault and Worker's Compensation are state regulated plans.

2. Please explain the reason for charging "chargemaster" rates to uninsured individuals particularly in light of the Secretary of Health and Human Services' letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status

NYPH provides discounts off of the chargemaster rates for uninsured patients who qualify for charity care/financial aid.

3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy

Under the Charity Care Policy, uninsured individuals with incomes less than 300% of the federal poverty level may apply for discounted care. The level of discount is dependent upon the patient's income level and family size. Eligible inpatients pay the lower of gross charges or a fee scaled amount, with the maximum fee set at the Medicaid rate. Eligible clinic patients pay a sliding fee based on the patient's income and family size. In 2001, NYPH commissioned a major

accounting firm to undertake a market based pricing analysis in an effort to ensure NYPH's charge master prices were reasonable based on the market in which its facilities were operating.

What is the collection rate for self-pay?

18.1% of charges. This number does not include self-pay international patients who come to the US to receive medical care. The collection rate for international patients is 77.4% of charges.

4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate

Charity care policy discussion. Also, uninsured patients who do not qualify for charity care, such as international patients or patients seeking elective surgery, may be charged the chargemaster rate. NYPH offers commercial insurers discounts because of the volume of patients in the plan, as well as the fact that commercial insurers typically pay in a timely manner.

5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status

There are different categories of uninsured patients: 1) international patients, 2) patients who have insurance but are undergoing an elective procedure, 3) truly uninsured patients. Truly uninsured patients typically do not pay the chargemaster rate, as these patients may apply for charity care.

6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject

As of summer 2004, NYPH posted approx 80 signs announcing its Charity Care/Financial Aid Policy in emergency rooms and admitting departments. Signs are also located in the registration areas of outpatient clinics. NYPH also distributes a handout describing the policy to patients in the admitting department, emergency dept, and ambulatory surgery dept. This handout is available in English and Spanish.

7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff

Meetings were held with Dept heads to educate them on the policy. Dept head were asked to train their staff. NYPH distributed a memo to all hospital employees on the topic. The memo is on the Intranet. The memo sets forth a summary of eligibility requirements, and the process for qualifying a patient for charity care/financial aid. A contact point is also provided. NYPH conducted audits of clinic staff to ascertain the level of compliance with the self-pay policy. When compliance issues were identified, NYPH re-trained the staff. Two trainers go on-site and re-review the Policy with the staff.

8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or

underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.

Given the myriad of rules, regulations and manual instructions issued by Medicare, NYPH feels that the Dept of Health and Human Services, Office of Inspector General and the Centers for Medicare and Medicaid Services, in collaboration, have provided helpful guidance on providing discounts to the uninsured.

In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule

NYPH does not gross up charges on the Medicare cost report to compensate for a lower outpatient department fee schedule.

Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured

As discussed in our response to Request 4, NYPH discounts its charges for uninsured patients who qualify for charity care/financial aid.

9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002

NYPH does not engage in the manipulation of cost to charge ratios. NYPH experienced an 8% decrease in outlier payments between 1998 and 2002.

10. Secretary Thompson, in his letter mentioned above, noted that “Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals’ provision to help hospitals bear the cost of caring for the poor and uninsured.” In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government

The Medicaid DSH program is designed to compensate hospitals that serve large numbers of Medicaid and uninsured patients. Twenty-five percent of the patients treated at NYPH's facilities are Medicaid patients. Based on the stated purpose of the DSH pmts - to provide financial relief to hospitals who treat a disproportionate share of low-income patients and to maintain access to hospital care for low-income patients - NYPH feels that it is appropriate to receive such aid from the Medicaid program.

Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt

2002: DSH \$44,806,897, Charity Care \$68,478,955, Bad Debt \$51,561,000. 2003: DSH \$60,465,162, Charity Care \$63,567,970, Bad Debt \$75,150,000. 2004: DSH \$35,321,310, Charity Care \$51,809,933, Bad Debt \$66,678,000.

11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, “the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.

NYPH feels that the issue of whether the chargemaster method of charging uninsured patients should be discontinued is immaterial to the extent that hospitals provide discounted care to uninsured patients under charity care/financial aid policies.
12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he “was told by both inside and outside legal counsel . . . [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS.” Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice
NYPH did not seek advice from counsel on the topic of discounting to the uninsured.
13. Please provide all documents related to your hospital’s consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients
See NYPH 000001 to NYPH 000006 and NYPH 000008 to NYPH 000014.
14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital’s treatment of the uninsured
Attached at NYPH 000001 through NYPH 000262. Attached at NYPH 000263 through NYPH 000310.
15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment
NYPH performs a formal community needs assessment every 6 to 8 years (currently completing assessment). See NYPH-000324 to NYPH-000586. New program and services needs assessed informally (e.g., Medical Director review of emergency room records. New position of VP of Community Health Development.
16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals
NYPH has filed 59 lawsuits against uninsured patients during the past 2 years. NYPH is not compelled by law to file such lawsuits.
Please identify the amount of debt that was at issue in each suit
See NYPH-000587 to NYPH-000588.
Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection
NYPH does not sell debt owed to the hospital to other companies for collection.

<p>Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts</p>
n/a
<p>Please explain how the sale of private accounts for recovery, and an concomitant claim to Medicare for payments on the same debts, is not “double dipping.”</p>
n/a
<p>Please provide copies of your contracts, if any, with collection agencies</p>
See NYPH-000589 to NYPH-000667.
<p>Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization</p>
NYPH contracts with Network Recovery Services to provide collection services. NRS is a non-profit org, related entity to NYPH. The other collection agencies are not subsidiaries or related entities.
<p>Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt</p>
NYPH does not have any financial relationships with banks or credit card companies that patients use to finance their debt.
<p>Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt</p>
As required by Medicare, NYPH does not differentiate between Medicare and non-Medicare patients with regard to debt.
<p>If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt</p>
NYPH does not sell debt owed to the hospital to other companies for collection.
<p>17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action</p>
NYPH does not maintain accounts in offshore banks as such. NYPH does have investments in certain offshore entities. In general, investments amounting to ownership of more than 10% of an offshore entity are required to be reported in connection with the filing of its Form 990. See NYPH-000849 to NYPH-893. The investment in The Medical Centre Insurance Company, Ltd. was made for the purpose of obtaining insurance coverage.

<p>18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.)</p>
<p>Attached at NYPH-000668.</p>
<p>19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain</p>
<p>NYPH believes that the provision of health care services to certain uninsured patients is inherently charitable.</p>
<p>20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well</p>
<p>- No Fault and Worker's Compensation are state regulated plans. No Fault* 64.3%, Worker's Compensation* 55.0%, Commercial 47.4%, Self Pay 81.9%, Self Pay International 22.6%</p>
<p>Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured</p>
<p>NYPH does not turn away patients in need of medically necessary services. If a patient is in need of an elective procedure, and the patient is uninsured or underinsured, the patient may apply for financial aid under the charity care policy. Eligible patients will pay discounted charges based on income and family size for the services received. If the patient is ineligible for financial aid, the patient may choose to receive the services and be billed at a later date. NYPH routinely works with all patients to establish reasonable payment plans based on individual circumstances.</p>
<p>21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip</p>
<p>Attached at NYPH 000674 to NYPH 000678. Attached at NYPH 000679 to NYPH 000893.</p>
<p>Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18</p>
<p>Attached</p>
<p>Finally, please detail any payments or reimbursements made to employees for country clubs</p>
<p>NYPH reimburses the CEO for his membership in a private social club. The CEO used this club for business related meetings and events. 2002 \$4,269.99, 2003 4,277.00.</p>

Charity Care and Community Benefit
North Mississippi Health Services, Inc., Tupelo, Mississippi
1. How does your organization define charity care?
The provision of financial assistance, compliant with all applicable federal, state, and local laws, to patients who lack the resources to pay in full for their health services.
What types of activities or programs does your organization include in its definition or determination of charity care?
The types of activities or programs which are included as eligible for charity care assistance are all medically necessary inpatient, outpatient, emergency room, and clinic services.
Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
It is highly unlikely that services which are unprofitable or minimally reimbursed, or which only benefit a small segment of patients would be provided. Such services might include ambulance and aero medical services, emergency room services, neonatal intensive care units, newborn delivery and nursery services, long-term acute care, diabetes treatment and education, pediatric services, trauma programs, neurosurgery, and HIV clinics.
Does your organization maintain a charity policy?
Yes. See www.nmhs.net . In addition to providing charity care based upon Federal poverty guidelines, NMHS also provides for catastrophic coverage. The catastrophic coverage provides charity care for both uninsured and insured patients who have extraordinary medical bills. In no event, will a patients out of pocket expenses exceed their annual income.
If so, please describe the policy or provide a copy of such policy.
Tab 1. See www.nmhs.net
Does this policy require that certain types and amounts of charity care be provided?
No, but NMHS has budgeted for approximately 5% of gross volume being charity care. The NMHS policy does not state a charity care goal, but the amounts written off (in gross patient revenue) indicates it met the goal in 6 of 10 years; the eligibility determination for charity care is essentially the same for the joint ventures and NMHS.
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
Inpatient Services: Behavioral Health, Cardiovascular, Medicine/Women/Children, Oncology, Ortho/Neuro/Rehab, Surgical, Other, Outpatient Services: Emergency Services – Outpatient, Total Charity Write-Offs
How does this differ from 10 years ago?
The total amount of charity write-offs was provided for 10 years, but the amounts were not broken down.
25 years ago?
Not provided. NMHS did exist as a system 25 years ago.
3. What percentages of your patients for your most recent fiscal year were:

(a) uninsured (self pay) 8.95%
(b) covered by Medicare 45.13%
(c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals 14.91%
(d) otherwise covered by private insurance 31.01%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?
No. Eligibility for charity care assistance requires information which must be verified, such as level of income, employment, etc. If the patient may be eligible for charity care, based on the info provided at admission, discharge, or at any time in the collection process, the patient is asked to complete an application and provide the supporting information necessary to determine eligibility.
5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?
Although we do not have data as to ALL patient coinsurance and deductibles, we do have those related to our Medicare patients. Total (all patients) Bad Debt Expense % chg: 2001 – 1.97%; 2002 – (8.19%); 2003 – (3.95%); 2004 – 34.93%. Charity write-offs % Chg: 2001 – 13.57%; 2002 – 10.63%; 2003 – 28.67%; 2004 – 47.62%.
6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.
No
7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.
No
8. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures.
Four (4) joint ventures with physician groups. (1) NMHS retained 51% interest in its free-standing ambulatory surgery center. Physicians are required to remain on the hospital staff. Physicians planned to leave the hospital and open a competing surgery center. (2) Local anesthesia group for a pain management center. (3) Radiology group for an outpatient radiology center. (4) Gastroenterology group.
9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy.
Policies provided. The joint ventures have a goal to provide 2.5 – 4% of patient charges in the form of charity care. The NMHS policy does not state a charity care goal, but the amounts written off (in gross patient revenue) indicates it met or exceeded its budgetary target in 6 of 10 years; the eligibility determination for charity care is essentially the same for the joint ventures and NMHS, slightly modified by county of residence.
Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced.
The NMHS and joint venture policies are enforced by the joint venture boards. The NMHS system does retain a majority interest in the joint ventures. NMHS reports 51% of the amount of charity care for the joint ventures in its consolidated financial statement.

If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant.
Charity care is based upon financial need, not type of service needed.
10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons.
We disagree with that assertion. We entered into joint ventures not because the health system wanted to shift revenue to physicians, but because physicians would seize most of the revenue if we did not venture with them and the community (Medicaid and uninsured) would lose access to services. Several groups of physicians were prepared to resign their medical staff members and operate solely out of their for-profit centers.
11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture?
The joint ventures in which NMHS is involved did not require an investment of cash or other liquid assets, and, therefore, has not resulted in tying up those assets in the joint ventures.
12. Please provide a charity care breakdown for each entity that is a member of your hospital system group.
Tab 12
In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis?
We account for, and report, charity for every entity in our system and don't have an opinion as to whether it should be aggregated or not.
13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?
Federal tax law should be enforced as presently stated, that the joint venture should support and further the overall mission of the tax-exempt org. The tax-exempt organization should assure that all patients have access to care irrespective of whether the care is provided at the joint venture facility or at the tax-exempt facility.
If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?
Not applicable
14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?
That charity care is reflected on the individual joint venture's financials, not on NMHS. 51% of the joint ventures charity care is rolled into NMHS system financial statement.
15. What types of research and teaching are performed by your hospital as a charitable or educational activity?
Teaching – Family Medicine Residency Program (20 residents and 7 full time faculty). Studies from physicians. Most studies are drug studies and are carried out in private physician offices. There are approximately 50 active studies primarily in the area of cardiology, gastroenterology and oncology. NMHS, other than the field of oncology, receives very little, if any, financial remuneration for participation in the study.
16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital.
Health Care Foundation of North Mississippi (HCF) is operated for the purpose of raising,

receiving, and administering funds. It is not an NMHS entity. HCF promotes annual giving both to internal and external audiences, conducts a variety of fund-raising events and promotes charitable estate planning. Donations received for capital expenditures: FY'2002 - \$705,082; 2003 - \$802,120; 2004 - \$850,091.
Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families?
Restricted HCF gifts for patient assistance programs are not specifically used to supplement NMHS cost. They are primarily used for medical assistance and other health resources not otherwise available. Approximately 30% of HCF disbursements are used for medication, transportation for treatment, nutritional support, medical equipment and other support for these patients.
17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture?
See answer to Q A.8. The joint venture charity care policy includes charity care goals and NMHS reports 51% of the amount of charity care provided by the joint venture in its consolidated financial statement.
18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?
Our employed physicians are encouraged to provide charity care. Contract template: paragraph 3 states that compensation is based upon treating charity patients and the incentive compensation model does not penalize physicians for treating the uninsured; and, paragraph 4B requires the employed physicians to undertake furnishing medical services to any patient without regard to ability to pay and to serve Medicare, Medicaid and indigent patients in a nondiscriminatory manner.
19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.
Tab 18. Also, details provided at question #2. NMHS Total charity write-offs \$45,177,000- FY'04; \$64,413,000- FY'05, as per NMHS audited financial statements.
20. What kinds of community outreach and education activities do your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?
Baby sitting courses, education on disease condition (obesity, diabetes, hypertension), health fairs, public service announcements, school health nurse program, support groups, self-help wellness programs (smoking cessation, exercise, stress management), immunization clinics for adults and children, Nurse Link telephone triage/info service, contributions for not-for-profit event sponsorship, others. A community benefit disclosure survey is being conducted, in part, to more accurately assign costs in absolute dollars. NMHS Community Health Department (FY'2005 budge) \$1,445,949 and Nurse Link telephone service (FY'2005 budget) \$1,095,608.
21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.
There are very few for-profit competitors in this area including one free-standing diagnostic (radiology) center. This diagnostic center has been opened for approximately two years and recently reported to the State Department of Health that they provide approximately 1% of its gross revenue in charity care.
22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?
We have done such services for many years, but do not have most quantified as to cost. This is part of the current project to quantify this cost, along with the cost of the other community benefit

services we provide.
23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?
Yes, we do conduct clinical trials. We do not count clinical trial costs in determining charity care. Most clinical trials are performed in private physician offices. NMHS' primary involvement with clinical research is in the role of an Institutional Review Board.
24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?
We account for charity care at the charge, not cost level, in accordance with GAAP related to the disclosure of charity care charges foregone in our audited financial statements' footnote disclosures.
Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences.
Expense allocation info not provided.
25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.
Report provided.
Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues
Part 3
1. Please explain what is the average mark-up of charges over costs.
For FY'2004, 1.96 (average charge per adj. Discharge versus average cost per adj. Discharge).
What is the average private pay contractual allowance (charges to payments) weighted by payor?
NMHS gave discounts to contracted private insurers averaging 15.9% for F Y'2004, comparable to NMHS's discounts to uninsured patients of 15%. In FY'2005, as the prevailing managed care discount increased, NMHS increased its discounts to uninsured patients to 20%.
2. Please explain the reason for charging "chargemaster" rates to uninsured individuals particularly in light of the Secretary of Health and Human Services' letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status.
Medicare cost reporting principles require that all patients be charged the same rates for the same services. The letter from the Secretary of HHS in 2004 stated, for the first time, that Medicare no longer objects to hospitals providing discounts to uninsured or under-insured patients. However, the letter did not state that hospitals should charge different rates to those patients.
3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate. What is your discount policy?
NMHS does not routinely discount charges for health care items or services not routinely grant waiver of a patient's co-payment and/or deductible. NMHS's goal is, however, to establish a policy and appropriate procedures for use in limited circumstances in which a discount might be

<p>appropriate offered to uninsured patients. NMHS may offer up to a 20% discount off inpatient and outpatient billed charges to an uninsured patient, for any uninsured patient who is not eligible for charity care, but, is between approximately 90% and 400% of the federal poverty guidelines. The discount is applicable only to items and services medically necessary.</p>
<p>What is the collection rate for self-pay?</p>
<p>Uninsured patients as a whole pay only approximately 9% of the amounts charged to them as a patient. 91% of the total charges to all uninsured patients are written off.</p>
<p>4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate.</p>
<p>See response to question B.2. (Medicare cost reporting principles require that all patients be charged the same rates for the same services). All hospitals in the NMHS system currently provide discounts to uninsured patients equal to the predominant discount provided to certain commercial insurance carriers and self-insured ERISA plans.</p>
<p>5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do, in fact, generally pay only a fraction of what has been charged. Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status?</p>
<p>There is little economic benefit to our charging uninsured patients the same charges as everyone else, since uninsured patients as a whole pay only approximately 9% of the amounts charged.</p>
<p>6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject.</p>
<p>(1) Our charity policy is posted on our internet website. (2) A Notice of Charity Care Financial Assistance is posted at all registration sites, at all areas where patients are admitted. (3) A Notice of Charity Care Assistance is printed on the backs of every collection statement where the patient is asked to pay or make payment arrangements. (4) Our Admission Agreement form, reviewed with and signed by every patient or other responsible party at admission, includes a notice of Charity Care.</p>
<p>7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff.</p>
<p>Patient Account Representatives are trained concerning the Charity Policy and related procedures. Business Office Managers in all NMHS entities are provided with the Charity Policy with income guidelines, updated at the beginning of each fiscal year. NMHS' Corporate Compliance Plan booklet is given to every employee who is expected to be familiar, and in compliance with, its contents.</p>
<p>8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question, it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call, "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.</p>
<p>Medicare has made it abundantly clear to participating hospitals that it was not appropriate to</p>

<p>provide discounts directly to patients. That position changed, for the first time, with the Secretary's letter. As an individual provider, we have not found it productive to raise with the Department concerns about what were felt to be basic tenets of the Medicare Program. It has been consistently stated by legal counsel that providing discounts to individuals was inappropriate. Medicare still requires all providers to maintain uniform charges.</p>
<p>In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule.</p>
<p>No</p>
<p>Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured.</p>
<p>We do not have different charges for different payors.</p>
<p>9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002?</p>
<p>NMHS has not and will not set chargemaster rates with any ulterior motive. Rates are set to generate the income needed to meet our charitable mission of providing superior care to anyone who needs it. The amount of outlier payments for NMHS have decreased from \$3.9 million in FY'1998 to \$2.8 million in FY'2002, a 26.85% decrease.</p>
<p>10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government.</p>
<p>Given the level of participation in cost bearing for healthcare services provided to patients covered by government programs, we believe it is appropriate for hospitals to receive any aid which is available from the government.</p>
<p>Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt.</p>
<p>NMHS 2002: DSH - \$11,044,717; Charity Care - \$20,828,785; Bad Debt - \$29,077,547. 2003- DSH- \$10,904,107; Charity Care- \$31,615,000; Bad Debt- \$41,497,709. 2004- DSH- \$11,890,153; Charity Care- \$45,177,000; Bad Debt- \$51,720,000. 2005- DSH- \$12,774,000; Charity Care- \$64,413,000; Bad Debt- \$53,942,000.</p>
<p>11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospital Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, "the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this, and it really needs to be fixed."</p>
<p>We agree that uninsured patients should not bear a disproportionate share of the cost associated with healthcare. Uninsured's share of costs should be determined by their financial resources. Unfortunately, in the absence of any action or movement by national governing bodies toward resolving the healthcare crisis of the uninsured, this population and primarily not-for-profit hospitals alone continue to bear the burden. We do agree, however, that the Federal and State</p>

regulatory systems under which hospital chargemasters have been forced to evolve have created a system that needs fixing.
12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he “was told by both inside and outside legal counsel . . . [in late 2000] that we had to get clearance [for discounting to the uninsured] through CMS.” Please identify whether your hospital has received such legal advice, and if so, please provide any written documentation of that advice.
Medicare has made it abundantly clear that it was not appropriate to provide discounts directly to patients. We suggest requesting from the American Health Lawyers Association copies of seminars provided for the last 10 years, as well as any audio tapes of those conferences, which included comments by attorneys employed by CMS, HHS, OIG, and U.S. Attorneys offices.
13. Please provide all documents related to your hospital’s consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients.
We’re not aware of having any documents, however, please see our Charity Policy and Uninsured Discount Policy previously attached.
14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital’s treatment of the uninsured.
Charity Care Policy – tab A.1., Community Benefit Reports – Tab B.14., Community benefit assessment (Economic Impact Statement for 2003) – Tab B.14; Community benefit strategy – see Charity Policy and community benefit reports; Charity care audits – we do not have any specific charity care audit reports.
15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment.
Community needs assessment – Tab B.15. (2001 and 2004). Uninsured considered – see Table of Contents.
16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals.
For October 1, 2003 – September 30, 2004, there were 5,978 suits filed against uninsured patients who were gainfully employed. From October 1, 2004 to June 30, 2005, there were 4,288 suits filed against uninsured patients who were gainfully employed. Our policy is not to file suit against uninsured patients who have no stream of income.
Please identify the amount of debt that was at issue in each suit.
The amount in debt for the aggregate claims in 2003-2004 was \$3,133,935.74. Amount of debt for aggregate claims in 2004-2005 was \$2,314,629.74. See Exhibit for individual debt amounts.
Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection.
NMHS does not sell patient account balances to private collection agencies.
Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts.
No debt is sold to private collection agencies. NMHS (hospitals and clinics) accounts are sold to

Tupelo Service Finance (TSF), a not-for-profit subsidiary of NMHS, through an intracompany transfer for 85% of balance transfer. NMHS also contracts with private collection services for accounts not collected by TSF.
Please explain how the sale of private accounts for recovery, and a concomitant claim to Medicare for payments on the same debts, is not “double dipping.”
Uncollectible account balances for Medicare coinsurance and deductibles are not allowed to be claimed on a hospital’s cost report until the period in which it is determined as uncollectible and for NMHS, this is when all in-house collection efforts are exhausted and after 120 days of collection efforts at TSF. Once an account balance has been included on the hospital’s cost report for inclusion as Medicare bad debt, any recoveries made on the account are reduced against total Medicare bad debt claim on any subsequent cost reports. Thus, no “double dipping.”
Please provide copies of your contracts, if any, with collection agencies.
Tab 16
Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization.
TSF is a subsidiary of NMHS and qualifies as a tax-exempt entity.
Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt.
NMHS has no financial relationship with a bank or credit card company that patients use to help finance their debts. Accounts are sold to TSF where the patient requests an extended payment arrangement and TSF acts as a finance company in those arrangements, charging interest where the patient is financially able to pay. The health system underwrites the cost of extended payment plans.
Please explain if you differentiate between Medicare and Non-Medicare patients in regard to debt.
Medicare account balances for coinsurance and deductibles are pursued the same as for other accounts.
If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt?
Accounts are sold as an intracompany transfer to TSF once hospital collection efforts have been exhausted, generally within a period of 90 days once insurance is resolved.
17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore banks. Identify the amount in these accounts. Please explain why your organization has taken this action.
None.
18. Please provide an organization chart including Type I and Type II supporting organizations. This chart should identify ownership interest and the type of organization (nonprofit, for-profit, partnership, etc.).
Tab 18.
19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain.
We agree that the provision of health care to uninsureds is a charitable activity.
20. Some hospitals have stated that all patients, insured and uninsured alike, are

charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual and other allowances with those groups and identify the discount offered to uninsured patients as well.

See previous responses. (1) NMHS does not contract with all insurance companies and provides discounts only to those with whom it does. Primarily, these are community employers who are self-funded ERISA plans for their insurance benefits. (2) It is arguable as to whether insureds pay less than chargemaster rates. The insured purchase insurance, thus paying premiums, for the privilege of having some portion of charges they MAY incur paid. In addition, the insured pay deductible and coinsurance amounts. These costs should be added to the cost of payment under the premise of the question. For FY'2004, NMHS's average discount to all contracted companies was 15.9%. The discount offered to uninsured who meet eligibility is up to 100%, and for those whose income exceeds the guidelines, is 15%. Government payors are not included here, as the discount they mandate does not cover the cost of providing the services. In FY'2005, as discounts increased to insurance companies and self-funded plans, NMHS raised its discount to the uninsured to 20%.

Please explain what your policies are for providing elective procedures, ex., breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured.

NMHS provides all medically necessary services, as ordered by our physicians. They include all of the services you mention, in addition to many others.

21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1,000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip.

Tab 20.

Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18.

Tab 21. Compensation is rigorously evaluated by the NMHS' Board Compensation Committee in conjunction with the Hay Group, a national compensation consulting company. Salaries are targeted at the 50th percentile for each position in their database. Salaries for the top five highest paid NMHS executive per the 2004 IRS Form 990 are:

	Compensation	Contributions to Employee Benefit Plans & Deferred Compensation
John Heer	\$509,569	\$15,917
Chuck Stokes*	\$481,000	\$15,000
Gerald Wages	\$556,418	\$30,617
Dr. Ken Davis	\$447,248	\$30,617
Greg Strahan	\$285,720	\$30,527

*Employee started in 2004, these are estimates.

Finally, please detail any payments or reimbursements made to employees for country clubs.

Year	Employee	Amount
2002	Jeff Barber, President/CEO	\$2,655.58
2002	Gerald Wages, EVP, COO, & Treasurer	\$2,593.30
2002	Greg Strahan, Vice President	\$3,234.47
2002	Robert Otwell, EVP, Administrator, NMMC	\$2,120.00
2003	Jeff Barber, President/CEO	\$2,554.14
2003	Gerald Wages, EVP, COO & Treasurer	\$2,976.19

2003	Greg Strahan, Vice President	\$3,276.94
2003	Robert Otwell, EVP, Administrator, NMMC	\$2,160.00
2004	Jeff Barber, President/CEO	\$249.44
2004	Gerald Wages, EVP, COO & Treasurer	\$3,195.74
2004	Greg Strahan, Vice President	\$3,245.36
2004	Robert Otwell, EVP, Administrator, NMMC	\$2,290.00

NMHS has, as of January, 2006, ceased paying for any country club memberships.

Charity Care and Community Benefit
Phoebe Putney Health Systems, Inc., Phoebe Putney Memorial Hospital, Inc., Albany, Ga.
1. How does your organization define charity care?
Healthcare services rendered which will not result in future cash inflows. Charity care results from a hospital's policy to provide healthcare services free of charge to individuals who meet certain financial criteria. Phoebe does not consider bad debt expense as charity care.
What types of activities or programs does your organization include in its definition or determination of charity care?
Phoebe Putney established a Community Benefit Committee with both board members and community organizations represented to oversee the programs supported by Phoebe. We often work with community groups to identify needs and design a plan to service those needs, as well as providing new ideas to strengthen existing programs. We implemented an upstream approach to find the cause of illness or broad community health problems, and we design solutions to such problems before they become larger issues inside the hospital. Per the policy - The medical care shall consist of the same standard of care rendered to all other hospital patients. The hospital policy for use of Indigent Care funds shall only provide for services, which are medically necessary and are not elective procedures in nature.
Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
Phoebe executed a marketing strategy including focus groups, TV, radio and print advertising to seek out the patients who cannot afford to pay for their services and streamlined the process for them to receive care. We would not do this if we were a for profit hospital.
Does your organization maintain a charity policy?
Yes
If so, please describe the policy or provide a copy of such policy.
Attachment C1-C
Does this policy require that certain types and amounts of charity care be provided?
Yes. Provide a minimum of 3% of gross revenues as indigent care, after bad debt and adjustments (per overview section and lease agreement). Also, the Georgia Indigent Care Trust Fund defines the hospital shall a) provide services for no charge to persons with incomes below 125% of the federal poverty level; and b) provide services for no charge or adopt a sliding fee scale for persons with incomes between 125 and, at a minimum, 200% of the federal poverty level.
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
Unreimbursed Medicare Costs, Unreimbursed Medicaid Costs, Charity Care, Unreimbursed Cost of Essential Programs/Services, Research and Teaching, Maternal and Child Health, Outreach and Education, Financial Support or Other Community Not-For-Profit, Total, 21.19% of operating

budget
How does this differ from 10 years ago?
Phoebe began rigorous accounting and disclosure of community benefits 5 years ago. Data related to charity care, specifically, is available since 1991 showing that charity care had more than doubled over that time.
25 years ago?
Data is not available to answer this question.
3. What percentages of your patients for your most recent fiscal year were:
(a) uninsured (self pay)
10.09%
(b) covered by Medicare
34.10%
(c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals
23.60%
(d) otherwise covered by private insurance
32.21%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?
Yes. Fees are waived for patients immediately when one of the following criteria has been met: 1) Patient has applied for and received a Phoebe Care Card; 2) Patient has had a prior qualifying visit within the previous six months; 3) Patient has brought in documentation to qualify for waived or discounted fees.
5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?
85% of the increase in co-payments and deductibles over the last 5 years has been written off to bad debts or charity care.
6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.
PET Imaging, LLC (20% interest) provides mobile positron emission tomography/computed tomography scanning to patients of Phoebe and other tax exempt hospitals. PET Imaging charges Phoebe for all scans and Phoebe handles all billing matters. All services provided to its patients by PET are covered under the same charity care policy as all other health care services.
7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.
Phoebe Health Ventures, Inc. owns 45% of Affinity Professional Office Building, LLC. Affinity owns a physician office building. The majority interest is owned by Physician Partners, LLC.
8. Has your hospital or other members of your hospital system group enter into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so,

please describe the nature of such joint ventures
Phoebe Health Partners, Inc. is a GA non-profit, taxable corp. This venture is a physician hospital org and is owned 50% by Phoebe and 50% by the participating physicians. The purpose of the entity is to enhance physician-hospital relations in order to better serve the community as well as to negotiate and administer managed care and other reimbursement contracting. PET Imaging (20% interest) operates a mobile imaging service. The LLC has other members which include a for-profit company.
9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy.
As Phoebe Putney's overall charity care policy applies to patients using PET Imaging, LLC, no separate charity care policy is required. Phoebe Putney structured its only patient care joint venture, PET Imaging, LLC, so that Phoebe Putney not the joint venture, retains responsibility and control over the provision of charity care. All services provided by PET are billed to the patient by Phoebe Putney and Phoebe Putney will reduce or eliminate charges for the PET imaging services if a patient meets Phoebe Putney's charity care criteria.
Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced
Not applicable.
If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant
10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons
Phoebe Putney Health System, Inc. has three joint ventures, all of which are managed to improve the efficiency and quality of our clinical services delivery, to enhance clinical operation knowledge, and to further our commitment to patient access. While we cannot comment on the motives of other not for profit entities, it has never been and never will be a Phoebe Putney policy to strategically shift the most profitable and valuable procedures, practices or income streams to for profit ventures.
11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture
At Phoebe Putney, the primary consideration for all investments, directly by Phoebe Putney or jointly with others, is how the venture furthers the mission of providing world-class charitable healthcare services to Southwest Georgia. The choice to joint venture is driven by the value that other venture partners bring to the table. As an example, a significant benefit in connection with the formation of PET Imaging, LLC was the fact that it minimized the capital investment Phoebe Putney required for this essential, but low volume, diagnostic modality (\$40,000 rather than \$2 million to purchase the equipment). Rather than depleting resources available for charity care, PET Imaging, LLC allowed Phoebe Putney to effectively use its assets to fulfill its charitable mission. Also, in connection with all joint ventures, proper steps are taken to ensure that the resources of Phoebe Putney are preserved, including Phoebe Putney receiving an interest proportional to the value of its capital contribution, agreement terms providing that all returns of capital, allocations, and distributions are made in proportion to the respective ownership interest, and requiring that all transaction and operational requirements involving the joint venture be at

arms length and at fair market value.
12. Please provide a charity care breakdown for each entity that is a member of your hospital system group
FY 2004 - Phoebe Putney Memorial Hospital- in terms of Foregone Charges, \$49,300,000, and in terms of Estimated Unreimbursed Cost, \$22,200,000. Phoebe Worth Medical Center- Foregone Charges- \$1,928,000
In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis
We believe that charity care should be attributed to the Phoebe Putney system as a whole. As the system is designed to support the hospitals, charity care provided by the hospitals and clinics should be attributed to the system as a whole. Our charity expenditures are concentrated where patient care is delivered. The corporate structure of Phoebe Putney Health System has been developed to support our patient care facilities.
13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?
No. The community benefit standard should apply only to the tax-exempt hospital. Consequently, tax exempt orgs should have controls in place to monitor whether the ventures entered into further the charitable mission of the org. Further, if the joint venture entity is established with the desire to be treated as an exempt org it should be required to meet the community benefit standard on its own. Under Federal tax law the unrelated business income provisions provide an appropriate framework to impose tax on income from activities conducted by a tax exempt hospital either directly or through a partnership joint venture that do not further the exempt purposes of the org.
If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?
Not applicable.
14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?
Phoebe structured its only patient care joint venture, PET Imaging, LLC, so that Phoebe, not the joint venture, retains responsibility and control over the provision of charity care.
15. What types of research and teaching are performed by your hospital as a charitable or educational activity?
Programs include a family practice residency program, tuition assistance, scholarships, and continuing medical education. Phoebe educates and trains our own staff and we also provide non-employees financial support in pursuing healthcare related degrees. We conduct clinical trials, primarily in oncology. Southwest Georgia Health Research Institute programs include Gateway to Care, Community Health Worker, Infant Mortality Reduction, PeachCare for Kids Outreach, and the Men's Health Program.
16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital
Examples of fund-raising activities - Children's Miracle Network - 5k run and Black and White Gala. Annual golf tournament for Hospice. Total amounts raised from all activities: 2002 \$908,077; 2003 \$789,638; 2004 \$902,602
Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families

<p>No. However, we do pursue grants from state, federal, local or private sources.</p>
<p>17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture</p>
<p>Phoebe maintains that the provision of charity care and the satisfaction of the community benefit standard is its responsibility as a tax exempt entity. Phoebe does not relinquish, abandon, or cede the responsibility for charity care by entering into joint ventures.</p>
<p>18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?</p>
<p>Yes, our physician compensation arrangements encourage the provision of charity care. Each physician contract overtly requires each physician to comply with bylaws, policies (including indigent and charity care), rules and regulations. Further, each agreement specifically emphasizes Phoebe's charitable mission, and the provision that each physician be available to perform charitable care at various community functions, or to support other medical facilities if requested to do so.</p>
<p>19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.</p>
<p>In FY 2004, Putney incurred \$22,200,000 in charity costs. They provided the following breakdown of charitable costs incurred across several practice areas. Cardiology-\$2,702,222. Maternal-\$280,671. Mental Health- \$647,577. Oncology- \$2,049,347. Rehabilitation Service- \$244,918. Pediatrics- \$ 333,069.</p>
<p>20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?</p>
<p>Total Life Center - health fairs and screenings in the community, business and industry, and the school system. Community Education - monthly TV show, quarterly health information newsletter, and seminars. Golden Key - encourage healthy senior lifestyles. Community Visions - provides grants to non-profit community orgs. Economic Development - provides financial support for various initiatives. Family Medical Centers - operate certain lines of business in neglected areas of the community. Specialty Clinics - internal medicine, convenient care centers, neurosurgery, occupational medicine. Trees of Courage- honors Americans who have died in Iraq. Lights of Love vans- provides vans to transport cancer patients to and from the hospital for treatments. Prisoner care- provides care to prisoners. Ramp Project- builds handicap-accessible ramps for disabled or elderly people in collaboration with SOWEGA Council on Aging. HIV/AIDS Volunteer Network- provides technical and financial support for this program, which operates two residences for persons with AIDS. Flu shots- free flu shots to employees and their families, volunteers, board members and residents of Morningside. 2004 Community Outreach and Education \$2,355,000 0.72% of operating budget.</p>
<p>21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.</p>
<p>Putney's charity care costs as a percent of total operating expenses was 6.94% in 2003. Our for-profit competitor in Albany, Palmyra Medical Centers, located 2 miles from Phoebe Putney, had charity care costs as a percent of total operating expenses of 1.94% during the same time period. For the 26 for profit hospitals in Georgia (outside of Atlanta), the percentage of charity care costs compared to total operating expenses is 2.7%. Also see Table 21.1.</p>
<p>22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?</p>

Infant Mortality Reduction - Patient advocates are placed in physician offices and community settings to assess the health needs of pregnant women. Maternal and Child Health - Offers education classes on parenting skills, educates mothers to stay in school, and attempts to reduce repeat teen pregnancies. Separate programs target teen fathers. Community Health Services - Prepared childbirth classes, breastfeeding classes, lactation consulting, tours, and sibling classes. First Step/Health Families - provides new parent welcome kits. Car Seat Program - Makes free infant car seats available. School Nurse Program - Places nurses in six middle schools. 2004 Child Care Programs \$783,000.

23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?

Phoebe conducts clinical trial programs as part of its cancer institute. Patients are selected based on clinical criteria established by the sponsoring org. A patient's eligibility to participate in a clinical trial program is in no way dependent on the patient's financial status.

24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?

Generally, the amounts disclosed as community benefit include only direct expenses. There is no allocation of system or hospital overhead or fixed costs. Phoebe follows the Medicare cost report methodology for community benefits disclosed as the unreimbursed costs under government payment programs and charity care. Phoebe follows its internal policy to calculate its community benefits disclosure.

Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences

Yes, we use the same approach for all community benefit disclosures. A single disclosure is prepared and used for the annual financial statements and the 990 disclosure.

25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.

Length of stay - 2003 4.51, 2004 4.64. Operating cost per adjusted discharge (adjusted for case mix index) - 2003 \$4,804, 2004 \$5,244.

Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues

Part 3

1. Please explain what is the average mark-up of charges over costs.

Ratio of charges to cost for FY 2004 was 2.01

What is the average private pay contractual allowance (charges to payments) weighted by payer

Private payer contractual allowances weighted by payer was 23.36%. Because the discount percentage is from a lower gross charge, the result is actual payments equal to or less than many other hospitals. Private Payer Charity Care 3.26% (co-pay and deductible charity). Uninsured Charity Care Total Discounts 75.55%.

2. Please explain the reason for charging “chargemaster” rates to uninsured individuals particularly in light of the Secretary of Health and Human Services’ letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status

Chargemasters are i) a requirement for compliance with the Medicare program, ii) an integral part of monitoring hospital operations, and iii) an essential component of the revenue accounting system for nearly all providers.

3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy

The controls over reasonableness of charges to the uninsured are in two main areas: controls over the actual level of gross charges and programs to assure that no one is expected to pay for healthcare at a level beyond their financial means. The Phoebe Financial Assistance policy is uniformly applied and available to patients based on household income regardless of whether they have insurance or not. Financial qualifications summarized: 100% write-off for patients with incomes at or below 125% of the federal poverty level (FPL), sliding scale write-off for patient with income between 125 and 200% of FPL, catastrophic coverage allowing a write off for patients at any income level with their obligation exceeds 25% of their annual income. Patients who qualify under this category can receive a 75% discount on such charges and then a payment plan for what a patient can pay within 24 months.

What is the collection rate for self-pay?

The amounts an individual is responsible for their care includes co-payments, deductibles, non-covered amounts, and charges. Medicare 26.51%, Commercial 32.09%, Medicaid 6.12%, Uninsured 2.68%.

4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate

The assumption that this question is based on is incorrect. Payment structures for government and commercial payers continue to be based on chargemasters. The entire healthcare finance system nationwide is built on a system of uniform charges. The relevant issue is not what is charged, but what is expected to be paid after taking into consideration contractual allowances and financial assistance programs.

5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status

Economic benefit has no impact on the formulation and administration of financial assistance policies which have been in place long before the System was formed to assure access to needed healthcare services without regard for an individual's ability to pay. Phoebe has kept its charge to cost ratio low compared to peer organizations.

6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject

Our communication strategy relies on several media: 1) regional TV and radio advertisements; 2) direct mail; 3) promotion and sponsorship of free health screenings; 4) quarterly newsletter; 5) Care Card help days; 6) documentation upon arrival and visible financial in patient registration areas; 7) distribution of printed materials throughout the hospital; and 8) website financial assistance information.

<p>7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff</p>
<p>Each individual employee is immersed in our mission and values from day one. Our front-line staff is exposed to this mission through several media, including, but not limited to: 1) financial assistance training; 2) financial outreach awareness program; 3) employee volunteer education; 4) manager observations and review; 5) employee newsletter; and 6) community outreach.</p>
<p>8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.</p>
<p>Phoebe has never considered Medicare regulations a roadblock to executing policies to assure that members of our community receive the care they need without concern for the amounts they would be expected to pay. It is relevant to point out that Mr. Fetter's characterization of the billing practices of the entire hospital industry is a broad generalization that should be taken as such. In the case of Phoebe, it is clearly not true.</p>
<p>In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule</p>
<p>No.</p>
<p>Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured</p>
<p>The Medicare program sees no complications where a provider offers discounts or allowances to commercial insurers for non-Medicare patients or uninsured or underinsured patients who meet specific financial criteria. There is a concern about blanket discounts for all uninsured patients, if such discounts result in no patients ever paying established charges.</p>
<p>9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002</p>
<p>At Phoebe we do not set our charges in order to inflate Medicare payments. This evidenced by our declining outlier payments as a percentage of total Medicare collections over the last 3 FYs. Total Outlier Payments & Annual Growth: 1998 0%, 1999 0.47%, 2000 (0.15)%, 2001 (0.19)%, 2002 0.05%</p>
<p>10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government</p>
<p>The Disproportionate Share Payments received from the Medicare program and the Indigent Care Trust Fund payments from GA are appropriate. DSH payments were intended to adjust payments for low-income or indigent Medicaid and Medicare Part A beneficiaries, not for the uninsured. Medicare beneficiaries who are low-income or indigent have a higher resource consumption than is reflected in the PPS system. Phoebe believes DSH payments are</p>

<p>consistent with its mission as a tax-exempt hospital.</p>
<p>Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt</p>
<p>Uncompensated Care (without bad debt): 2002 \$33,400,000, 2003 \$36,100,000, 2004 \$49,300,000. DSH 2002 \$15,066,897, 2003 \$17,638,172, 2004 \$20,015,321.</p>
<p>11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, “the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90’s by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.</p>
<p>We do not agree that the chargemaster should be discontinued. Tax exempt organizations should have controls and processes in place to assure that no patient is expected to pay more than their financial situation allows. The decision to continue the system or not has no bearing on the provision of care or the ultimate financial policies regarding our patients' ability to pay for care. Phoebe provides a discussion of challenges to rebasing the chargemaster.</p>
<p>12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he “was told by both inside and outside legal counsel . . . [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS.” Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice</p>
<p>No, Phoebe did not seek such legal advice.</p>
<p>13. Please provide all documents related to your hospital’s consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients</p>
<p>Attachments P13-A through O.</p>
<p>14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital’s treatment of the uninsured</p>
<p>Policy of Georgia Indigent Care Trust Fund Financial Assistance in 2000 - Attachment P14-A. Excerpt from Notes to Consolidated Financial Statements - Attachments P14-B through D. Strategic Plan - Attachment P14-E. Reports to the Community - Attachments P14-G & H.</p>
<p>15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment</p>
<p>In the past seven years Phoebe has conducted extensive community needs assessments, which have enabled us to effectively address our communities' healthcare challenges. Attachments P15A through AA. In 1997, established a Community Benefits Committee</p>
<p>16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals</p>

Number of lawsuits: 2000 385, 2001 117, 2002 198 2003 181, 2004 131. No, Nothing in the Medicare instructions requires the hospital to seize a patient's home, take them to court, or use a collection agency. Hospitals aren't required under federal law to engage in any specific level of collection effort for Medicare or non-Medicare patients. However, if a hospital intends to seek reimbursement for Medicare bad debts, a hospital must undertake reasonable collection efforts. Section 310 of the Provider Reimbursement Manual addresses what it means to undertake "reasonable collection efforts" and includes the definition of a reasonable collection effort court action and the use of collection agencies. A provider's efforts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients.

Please identify the amount of debt that was at issue in each suit

In 2000 of the 385 suits filed, 168 had between \$100-\$500 of debt, 110 had between \$500-\$1,000, 90 had \$1,000-\$5,000, 13 had \$5,000-\$10,000, and 4 had greater than \$10,000. In 2001 of the 117 suits filed, 53 had between \$100-\$500 of debt, 33 had \$500-\$1,000, 29 had \$1,000-\$5,000, and 2 had \$5,000-10,000. In 2002 of the 198 suits filed 79 had between \$100-\$500, 68 had \$500-\$1,000, 48 had \$1,000-\$5,000, 2 had \$5,000-\$10,000, and 1 had greater than \$10,000. In 2003 of the 181 lawsuits filed 41 had \$100-500 in debt, 68 had \$500-\$1,000, 67 had \$1,000-\$5,000, 4 had \$5,000-\$10,000, and 1 had greater than \$10,000. In 2004 of the 131 lawsuits filed, 46 had \$100-500 in debt, 42 had \$500-\$1,000, 38 had \$1,000-\$5,000, 4 had \$5,000-\$10,000, and 1 had greater than \$10,000. The year to date for 2005 (September 20, 2005) there were 49 suits filed, 28 with \$100-500 of debt, and 12 had \$500-\$1,000, 9 had \$1,000-\$5,000.

Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection

Phoebe does not sell debt to 3rd party collection agencies.

Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts

not applicable

Please explain how the sale of private accounts for recovery, and a concomitant claim to Medicare for payments on the same debts, is not "double dipping."

not applicable

Please provide copies of your contracts, if any, with collection agencies

Attachments P16-A through E.

Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization

Our debt collection services are with independent contractors that are not subsidiaries of Phoebe.

Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt

Phoebe does not have relationships with banks or credit card companies to facilitate patient debt financing. Phoebe does accept a patient's debit or credit card in full or partial payment of an

account.
Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt
No, we do not differentiate debt status or collections based on payer type.
If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt
Phoebe does not sell debt to 3rd party collection agencies.
17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action
As of June 30, 2005, Phoebe had \$492,779 in cash in off-shore banks. This amount represents the required cash reserves for Grove Pointe Indemnity, SPC, a wholly-owned subsidiary of Phoebe that serves solely to self-insure malpractice risk of Phoebe and its physicians. In September 2001, Phoebe incorporated Grove Pointe in an effort to increase malpractice coverage levels and reduce insurance premiums, while guaranteeing continuous and appropriate coverage for the hospital and its staff. The resulting reduction in overhead costs, time spent in negotiations and premium surpluses has resulted in savings of approx. \$1 million per year through this operation.
18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.)
Org chart provided under the answer tab.
19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain
We believe that the provision of health care and the operation of a hospital consistent with the community benefit standard is charitable.
20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well
At Phoebe, all uninsured patients are not expected to pay the full amount. Each patient's financial circumstance determines the amount they are expected to pay. The FY2004 average private payer contractual allowance weighted by payer was 23.36%. Phoebe patients who are uninsured receive a total write-off or discount of 75.55%.
Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured
The charity care policy includes all medically necessary services. This is defined as procedures performed to determine the extent or absence of a disease process. Elective procedures are those that are performed that are not necessary to improve or correct physiological functioning, but could improve appearance of a patient. The examples provided in the question are not elective procedures and thus are performed based upon physician determination of medical necessity, regardless of the patient's insurance status.

21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip

See Attachment P21-A, P21-B, and Attachment P21-C. A total of 144 trips are listed on the attachments. Notes on Attachments. Bermuda Trip 11/17-11/19/02. Fernandina Beach, FL 11/7-11/10/02. London England 5/3-5/9/03. Nassau Bahamas 10/12-10/14/03. Cayman Islands 4/11-4/13/04. Bermuda 5/25-5/26/04. Bermuda 9/22-9/23/04. Cayman Islands 1/16-1/17/05.

Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18

2003: Physician- S:\$795,180 B:\$9,999, CEO- S:\$560,437 B:\$79,957, Physician- S:\$552,918 B:9,208, Physician- S:\$538,924 B:\$10,000, Physician-S:\$537,013 B:\$8,053; 2004: Phy-S:964,583 B:\$6,506, CEO-\$682,550 B:\$75,817, Phy-S:\$703,208 B:\$10,607, Phy-S:\$671,567 B:\$10,615, Phy-614,975 B:\$10,556; 2005: Phy- S:\$816,099 B:\$6,857, CEO-S:\$705,627 B:87,689 , Phy- S:\$700,000 B:\$11,057, Phy-S:\$700,000 B:\$11,057, Phy- S:\$700,000 B:\$11,057.

Finally, please detail any payments or reimbursements made to employees for country clubs

2003: CEO \$4,870, Exec VP \$4,155, Senior VP (3) \$2,530, Senior VP \$2,340, Senior VP \$4,870, Senior VP/CFO-\$4,870, VP-\$2,340. 2004: CEO \$3,895, Exec Dir \$2,530, Exec VP \$4,645, Senior VP(2)-\$2,530, Senior VP \$1,365, Senior VP and Senior VP/CFO \$4,885, VP: \$975. 2005: CEO \$3,355, Executive Director, Senior VP, and Senior VP/CNO \$2,530, Executive VP/COO \$5,050, Senior VP \$420, Senior VP/CFO \$4,840, Senior VP \$1,815. This is reported as taxable income.

Resurrection Medical Center and Resurrection Health Care
1. How does your organization define charity care?
Discounts of up to 100% granted to low-income patients for hospital services provided to them. Both uninsured and under-insured patients can qualify for such discounts.
What types of activities or programs does your organization include in its definition or determination of charity care?
Per provided info - All medically necessary services are included. All hospitals actively work to provide a large variety of benefits to serve the respective needs of their communities. Outreach programs include sponsorship of clinics, free medical screenings, parish nurse programs, seminars and pamphlets on health care topics, health fairs, hospital-sponsored community events, a community info center accessible by phone and email. Resurrection Health Care also operates an extensive array of educational training programs for hospitals and other employees in health care fields including basic nurse asst, school of radiologic technology, College of Nursing and affiliated programs with institutions.
Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
We would continue our mission to the extent of our financial resources. Since many of our hospitals and other facilities lose money, they would not pay income taxes; however, loss of access to tax-exempt debt and pmt of other taxes would obviously hurt our ability to carry on our mission. We can only speculate that if our System were organized and operated by a for-profit org, such an org would think twice about maintaining revenue-losing services and facilities that were nonetheless vitally needed by the community.
Does your organization maintain a charity policy?
Yes
If so, please describe the policy or provide a copy of such policy.
Tab C
Does this policy require that certain types and amounts of charity care be provided?
Yes. The policy provides for an unlimited amount of charity care grants to low-income patients (with household income up to 3 times the Federal Poverty Level) based on documentation of financial need.
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
We have one category of charity care/financial assistance
How does this differ from 10 years ago?
1995 \$2,916,000

25 years ago?
1980 \$217,000
3. What percentages of your patients for your most recent fiscal year were:
(a) uninsured (self pay) 5.10%
(b) covered by Medicare 49.10%
(c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals 15.80%
(d) otherwise covered by private insurance 30.00%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?
Yes. Fee waivers, in the form of discounts against charges, are available upon admission for persons who have been granted Financial Assistance/Charity Care by any Resurrection hospital within the previous six months, and for homeless persons.
5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?
We do not have sufficient data to answer this question. We assume that the increasingly high number of patients who have no insurance has had a much more dramatic effect on our bad debt numbers. However, as high deductible plans proliferate, we assume that a certain percentage of patients will have difficulty paying their bills, resulting in bad debt.
6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.
Rainbow Hospice (with Advocate healthcare system) provides hospice services. Chicago Northside MRI Center is a general partnership by six not-for-profit hospital corporations. The partnership owns and operates a magnetic resonance imaging machine. By 2001, due to consolidations and closures, only three partners remain.
7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.
No.
8. Has your hospital or other members of your hospital system group enter into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures
Three Resurrection System hospitals have a 50% interest in a physician-hospital organization (PHO) (two taxable Illinois not-for-profit and one for-profit), which engages in managed-care contracting activities. While these PHOs arrange for managed-care contracts, the entities themselves do not provide health care, thus there is no financial, assistance, charity care component of their services. The only other interest, Keys to Recovery, is a general partner

<p>interest in a mgmt company that provides services for a hospital inpatient substance abuse program.</p>
<p>9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy.</p>
<p>Rainbow Hospice has a financial assistance/charity care program that is structured very similar to that followed by Resurrection. There are differences in discount levels. Since hospice care does not have emergency admissions, Rainbow requires financial assistance/charity care status be determined prior to admission. The Chicago Northside MRI Center offers very flexible payment plans, but does not offer charity care discounts. Patients may obtain an MRI at any of the partnering hospitals and the charity care policy would apply. The three PHOs do not provide health care. Keys to Recovery is a hospital program for which the standard financial assistance/charity care program applies.</p>
<p>Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced</p>
<p>Resurrection and the other tax-exempt member of Rainbow Hospice assure enforcement of the hospice's charity care policy through the hospice governing board, which is appointed by the members.</p>
<p>If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant</p>
<p>Not applicable; see initial response under this Question 9.</p>
<p>10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons</p>
<p>This statement does not reflect the practice or experience of our System, nor is it our impression that this is an accurate statement generally with respect to other non-profit tax-exempt hospitals or health care systems.</p>
<p>11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture</p>
<p>See previous description of our few joint ventures. The nature of these joint ventures is such that none entail a significant tying up of cash or other liquid assets.</p>
<p>12. Please provide a charity care breakdown for each entity that is a member of your hospital system group.</p>
<p>See Tab G. For a fully economically integrated system like ours, it makes sense to look at charity care, and other uncompensated care numbers, on a System basis. 2005 (11 months as of May 31) \$37,627,612</p>
<p>In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis?</p>
<p>For a System like ours, which is fully economically integrated, we believe it makes sense to look at charity care, and other uncompensated care numbers, on a System basis. We note that as tax-exempt organizations, each Resurrection hospital corp must and does meet federal tax-exemption requirements.</p>
<p>13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?</p>

<p>While we are hesitant to speculate about issues with which we have limited experience, we are of the opinion that joint ventures in which tax-exempt hospitals participate should not have a charity care requirement imposed by law. We believe that a blanket charity care requirement for all such joint ventures would inappropriately prevent tax-exempt organizations from taking into account different facts and circumstances involving each joint venture, in determining whether or not charity care, or another form of community benefit, should be a component of the joint venture.</p>
<p>If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?</p>
<p></p>
<p>14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?</p>
<p>Resurrection counts charity care as that granted by the individual institution providing care.</p>
<p>15. What types of research and teaching are performed by your hospital as a charitable or educational activity?</p>
<p>Graduate medical teaching activities - The System hospitals sponsor 17 medical residency programs, and participate in 10 joint residency programs. Over 400 resident physicians are being trained at any given time. Each hospital enters into agreements to serve as a clinical setting for nurses, therapists and technicians. Resurrection Health Care also operates an extensive array of educational training programs for hospitals and other employees (Resurrection Learning Institute) in health care fields including basic nurse assistant, school of radiological technology, College of Nursing, and affiliated programs with academic institutions. Research - All of our system hospitals are community hospitals that have always functioned primarily to serve their community's immediate health care needs and not as research institutions.</p>
<p>16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital</p>
<p>Tab I. All charitable giving is centralized in one org, Resurrection Development Foundation. Examples of charitable events: Gala, golf outings, 5k run/walk, fashion show, cocktail reception, and Cubs roof top event. Total received: FY 2003 \$6,369,610, FY 2004 \$6,415,935, FY 2005 \$6,456,138.</p>
<p>Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families</p>
<p>Donor/Fundraising Activity: auxiliary org, religious congregation, private foundation, various donors, Trust, and Annual Gala. 2003 \$2,374,263, 2004 \$934,059, 2005 \$936,950.</p>
<p>17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture</p>
<p>No. Our charity care program does not have limits and therefore is not affected by the financial results of our joint ventures with taxable entities. Similarly, our community benefit activities are not affected by our limited joint venture activities.</p>
<p>18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?</p>
<p>No. Our charity care program is independent of and unaffected by any compensation arrangements with physicians or other professionals.</p>

<p>19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.</p>
<p>Tab J. This information is imprecise, since we do not track charity care in more than one service category. Rough breakdown provided by facility.</p>
<p>20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?</p>
<p>Tab K. Outreach programs include sponsorship of community clinics, free medical screenings, parish nurse program, seminars and classes on health care topics, health fairs, pamphlets on health care topics, hospital-sponsored community events, a community info center accessible by phone and email. Education activities provided in the answer to question 15. Also, has a paramedic training program and trained medical interpreters. The Systems' financial information systems do not independently track community education and outreach activities. However, as part of the System's fiscal 2004 internal Social Accountability Report (Tab U), the cost of such community benefits programs (separate from other community benefits) was calculated as \$16,231,399; percent of net service revenue 1.32%.</p>
<p>21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.</p>
<p>We lack sufficient information to answer this question.</p>
<p>22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?</p>
<p>Resurrection System hospitals support a large number and variety of free or below-cost infant and child care programs, including affordable infant and child care immunization programs; and a variety of other programs focused on the health and safety of infants and children. Examples provided by hospital. For the programs where we have direct cost data, the System hospitals provided over \$2.7M annually.</p>
<p>23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?</p>
<p>Our hospitals participate in a relatively small number of clinical trial programs sponsored by unaffiliated entities. Such activities have no bearing on our hospitals' financial assistance/charity care programs.</p>
<p>24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?</p>
<p>We do not attribute any expenses to charity care other than the actual amount of patient liabilities written off through the discounts provided under our financial assistance/charity care program. Because we deem charity care, like our other community benefit activities, to be an intrinsic part of our health care mission, we do not engage in the level of tracking and allocation contemplated by this Question.</p>
<p>Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences</p>
<p></p>

<p>25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.</p>
<p>Tab M. Our cost accounting system does not currently permit us to calculate average cost per patient in different service lines. Total Cost per Adjusted Discharge (8 facilities): Avg \$7,574 (range \$5,416- \$9,419). Average Length of Stay: Acute (8 facilities) 4.49 days (range 3.3-5.8), Rehab (4 fac) 12.23 days (range 10.7-13.4), Psych (3 fac) 8.9 days (range 8.3-10.0), Skilled Nursing Unit (4 fac) 12.7 days (range 10.7-14.2).</p>
<p>Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues</p>
<p>Part 3</p>
<p>1. Please explain what is the average mark-up of charges over costs.</p>
<p>Ratio of gross charges to total exp (8 facilities for 11 months ended May 31, 2005) 3.12 (range 2.37-3.91).</p>
<p>What is the average private pay contractual allowance (charges to payments) weighted by payer</p>
<p>The information requested is extremely commercially sensitive. In light of the potential economic harm that could result to our System as the result of disclosure of this data, we respectfully decline to provide you with this information in the form requested. We may be able to provide you with this information for a confidential in-person review, or we may be able to provide summary information showing the range of contractual allowances incurred by our hospitals, through contracts with managed care insurance providers.</p>
<p>2. Please explain the reason for charging "chargemaster" rates to uninsured individuals particularly in light of the Secretary of Health and Human Services' letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status</p>
<p>All System hospital patients are initially assessed the same charges for the same items and hospital services. This is consistent with Medicare regulations. Bills may then be adjusted to reflect charity care discounts, contractual discounts, and gov't specified payment amounts.</p>
<p>3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy</p>
<p>See response to Q B2. The final measure of the reasonableness of the cost of care assessed to the uninsured is not measured by the charges that are initially placed on the patient's bill but by the amount that the patient pays for the services rendered, to the extent anything is paid at all. We make discounts available for all medically necessary services provided to uninsured or under-insured hospital patients who have limited household income, up to certain multiples of the federal poverty level percentages. A patient will receive a full discount (100%) if he or she can demonstrate family income at or below 100% of the federal poverty income guidelines. A partial discount will be offered when a patient's family income is greater than 100% but less than 300% of the FPL guidelines.</p>
<p>What is the collection rate for self-pay?</p>
<p>Tab O. Based on the collection rate for the self-pay payor group, the net effective discount for this group is 92.38% for all System hospitals combined.</p>
<p>4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be</p>

charged the chargemaster rate?
All bills assume the chargemaster rate as a starting point; however, this rate rarely reflects the amount actually paid, by uninsured or other patients. The poor uninsured and under-insured have access to effective discounts off charges that may be substantially more than the effective discounts of governmental and commercial payors.
5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status
There is no economic benefit from providing services to the poor uninsured who have limited financial ability to pay their hospital bills.
6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject
At the entrances and in the waiting areas of all our facilities, we have posted plaques that identify our Sponsorship Statement, Mission Statement and Core Values. This information communicates our charitable community service ministry in both English and Spanish. We also communicate via brochures, flyers, and signs located at individual facilities and in newsletters sent to households in our service area. Our website also provides info on our charitable mission. Information on the charity care program is posted in patient registration and admission areas, brochures, patient statements, website, and newsletter.
7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff
New hire orientation and formal education program entitled "Transformational Leadership. Resurrection staff involved in patient registration, admission, billing and collection are provided materials and training about the charity care discounts available.
8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.
Resurrection hospitals have long provided discounts to the poor uninsured and under-insured based on demonstrated financial need. We did not believe that Medicare rules prohibited such needs-based discounts.
In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule
None of our System hospitals have grossed up charges on their respective Medicare cost reports because of lower OPD fee schedule.
Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured

<p>All patient charges are initially booked at the standard chargemaster rate. Payments less than the chargemaster rate may then be accepted based on an uninsured or under-insured patient's qualifications under our charity care program.</p>
<p>9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002</p>
<p>We cannot comment on whether other hospitals or healthcare systems may have set chargemaster rates at certain levels with the intention of enhancing Medicare outlier reimbursement. Tab R. For several System hospitals, the amount of outlier payments declined during this period.</p>
<p>10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government</p>
<p>The total receipts of our hospitals from Medicare and Medicaid, combined, do not cover our total cost for the care of recipients. We therefore believe that it is appropriate for the federal gov't to attempt to redress this imbalance, at least in part, through the DSH program.</p>
<p>Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt</p>
<p>2003: DSH \$54,506,298, Charity Care \$17,344,879, Bad Debt \$128,574,000. 2004: DSH \$62,397,343, Charity Care \$22,386,502, Bad Debt \$147,357,576. 2005 annualized: DSH \$58,542,876 Charity Care \$41,048,713, Bad Debt \$128,199,734.</p>
<p>11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, "the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.</p>
<p>With respect to our system, we believe this it is not necessary to change the practice of initially showing the standard chargemaster charge for our services as charged to uninsured patients - in the same way it is shown as charged to all other patients. To the extent your question is intended to ask about the appropriateness of use of the chargemaster, we note that making such a fundamental change would require the active involvement and cooperation of managed care companies, and we would urge Congress to include these payors in any dialogue regarding hospital chargemaster structures.</p>
<p>12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he "was told by both inside and outside legal counsel . . . [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS." Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice</p>
<p>We have not asked for legal advice regarding providing discounts to the uninsured.</p>
<p>13. Please provide all documents related to your hospital's consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients</p>

<p>Tab T (numerous policies and protocols: Charge Master Accountability; Extended Business Office Financial Assistance/ identification of potential eligible patients; Point of Service Collections; Collections- Self-Pay (both after insurance and uninsured); Homeless Patients-charity care grants; Settlements; Authorization of Legal Action; Provisions of Charity Care Applications to Persons Receiving Waiver of Court Fees based on Claims of Indigency; Financial Assistance (Charity Care) Application for; Financial Assessment form; Financial Assessment Checklist; Financial Assistance (Charity Care) Determination letter form; and forms of bills, all noting availability of financial assistance/charity care if financial need). Tab P (photos of multiple hospital location in which charity care information is posted, in 3 languages; brochures in 3 languages regarding charity care; representative samples of patient bills noting availability of charity care; description of special pilot outreach program encouraging uninsured patients to apply for charity care; and website and community RESource newsletter communications about charity care and other community benefits); Tab K (documents relating to community clinics operated by Resurrection hospitals). We respectfully decline to provide all documents, since it would potentially result in production of documents that would be protected from discovery in the class-action litigation. However, if there are specific documents not provided here or in response to other questions you believe would be useful to your understanding of hospital practices in this area, please let us know and we will try to provide them to you. Note: Charity Care Policy provided at Tab C.</p>
<p>14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured</p>
<p>Tab C (general Charity Care policy from 1995; current Financial Assistance/Charity Care Policy, and related discount scale based on Federal Poverty Level); Tab P (photos, brochures, bills, and communications, referenced under Q.13 above); Tab T (policies and protocols referenced under Q.13 above); Tab K (multi-language brochures for hospital sponsored and supported clinics, and description of numerous community out reach and education programs); Tab L (description of free and below-cost programs for infants and children, referenced in first section, Q.22); and Tab U (resurrection internal Social Accountability Reports fro community benefits provided by all system entities from fiscal years 1998 through 2004, based on Catholic Health Association and Illinois Association guidelines).</p>
<p>15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment</p>
<p>System's Social Accountability Reports - Tab U. Our System hospitals evaluate their communities' needs on an ongoing basis, and as a result maintain and develop programs and services, including community clinics, to serve the varying health care needs of the communities they serve.</p>
<p>16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals</p>
<p>During the past 18 months, we have engaged in substantial efforts to review, refine, clarify and standardize our processes across the System for identifying which cases are and are not appropriate for lawsuits. Except to the extent filing a lawsuit may be deemed required under CMS regulations for Medicare debt, we do not believe that filing collection lawsuits are compelled by federal statutes or regulations, although it may be required as an exercise of our fiduciary duty to the System and its mission.</p>
<p>Please identify the amount of debt that was at issue in each suit</p>
<p>Tab V. In 2000, 147 lawsuits \$542,175. In 2001, 255 lawsuits \$1,344,060. In 2002, 456 lawsuits \$3,440,244. In 2003, 440 lawsuits \$3,049,511. In 2004, 169 lawsuits \$943,001. In 2005, 4 lawsuits \$30,346.</p>

Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection
We have never sold any patient debt.
Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts
We do not sell patient debt.
Please explain how the sale of private accounts for recovery, and an concomitant claim to Medicare for payments on the same debts, is not “double dipping.”
We do not sell patient debt.
Please provide copies of your contracts, if any, with collection agencies
Tab V.
Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization
The two collection agencies are unaffiliated for-profit organizations
Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt
We have no such relationships.
Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt
We do not differentiate between Medicare and non-Medicare patient debt.
If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt
We do not sell patient debt.
17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action
Resurrection controls a Cayman-based captive insurance company, which provides excess professional liability (medical malpractice) and general liability insurance for the System hospitals and other health care providers. This insurance company currently maintains approx \$190,332 in a bank acct in the Cayman Islands; this amount is based on the minimum capitalization requirements for such companies. Our System is self-insured for substantial amounts, per claim, before any excess coverage would be triggered. Our excess insurance, obtained by our captive

<p>insurance company, is therefore truly only catastrophic coverage. We use our captive insurance company as a vehicle to access the liability reinsurance markets at lower rates than we would be able to obtain if we purchased excess coverage for our hospitals directly.</p>
<p>18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.)</p>
<p>Tab A</p>
<p>19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain</p>
<p>We believe that the provision of health care services is a charitable activity, as conducted within our System. Moreover, from a review of applicable legal authorities it seems clear that the provision of health care services has long been recognized as a charitable activity, in and of itself, provided that any surpluses are used for charitable purposes.</p>
<p>20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well</p>
<p>We disagree with the statement. The payor group that includes the uninsured - as a group pay the lowest percentage of our chargemaster rates (just over 7%). Under our charity policy, uninsured individuals with financial need can receive up to a 100% disc. When a third-party payor have agreed to pay a specified rate for services, the agreed-upon rate is accepted. For all other payors, charges are billed based on the chargemaster and after applying any applicable disc. We will work with self-pay patients to develop extended pmt plans, with no interest ever added. Due to the commercially sensitive nature of info regarding managed care discs, we are unable to respond in this setting with info regarding net effective disc for our managed care payors and other private insurance payors. Tab W - Medicare and Medicaid contractual allowance percentage (avg 74.3%, range 68.7%-82.7%). Self-pay effective discount 92.4%.</p>
<p>Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured</p>
<p>Any elective procedure that is determined to be medically necessary by a patient's physician is eligible for discount under the System's Financial Assistance/Charity Care policy.</p>
<p>21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip</p>
<p>Tab X (showing information for 5 highest-salaried employees within the Resurrection System for calendar year 2002-2004: J. Toomey, President/CEO- various business travel expenses, 2002-2004; other executives: Tom Capobianco, Ex. VP, Finance- business travel, 2004; James Hill, Ex. VP. Administrative Services- business travel, 2004. Receipts also provided</p>
<p>Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18</p>
<p>Tab X- showing salary and compensation information for: J. Toomey, President/CEO- base salary range \$603,263-\$779,905, plus retention payment (2002), deferred compensation (2002, 2003), life insurance policy reimbursement (2002, 2003); and other reimbursement (2002, 2004); total compensation range \$2,323,746 (2002); \$1,329,738 (2003); \$784,090 (2004). Physicians Lim (2002-2004; \$438,139 - \$518,201), Rosenberg (2002-2003; \$380,338 - \$389,950), Paruchuri (2002; \$327,427), Charkewycz (2003; \$351,562), Kaye (2003; \$338,518), and Showel (2004; \$507,518); other System executives; Sister Donna Marie Wolowicki, CEO, Resurrection Medical</p>

Center (2002; \$383,006, including deferred compensation); Tom Capobianco, Ex. VP, Finance (2004, \$472,643, including deferred compensation), James Hill, Ex. VP Administrative Services (2004, 473,282, including deferred compensation); Jay Kreuzer, Ex. VP, CEO, West Suburban Medical Center (2004, \$473,282, including retention payment and car allowance). Total other employee benefits: J. Toomey (\$160,790 (2002), \$106,702 (2003), \$82,410 (2004)); Physicians Lim (\$40,418-\$67,499), Rosenberg (\$48,127-\$50-984), Paruchuri (\$31,915), Charkewycz (\$39,435), Kaye (\$32,786), and Showel (\$46,170); other executives Wolowicki (\$121,822), Capobianco (\$88371), Hill (\$121,892), and Kreuzer (\$64, 849).

Finally, please detail any payments or reimbursements made to employees for country clubs

No payments or reimbursements are made to any Resurrection System employees for country clubs.

**Sutter Health Sacramento CA
Charity Care and Community Benefit**

1. How does your organization define charity care?
Charity Care is defined as the provision of health care services at no charge or at a discounted charge to persons who meet certain income eligibility criteria and cannot afford to pay.
What types of activities or programs does your organization include in its definition or determination of charity care?
All medically necessary procedures are available for charity care. Charity care and discounts are generally not available for elective procedures, however, in certain cases an exception may be made. These exceptions require approval by the administration.
Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital?
Unknown – please refer to our response to Question 21 in this section.
Does your organization maintain a charity policy?
Yes
If so, please describe the policy or provide a copy of such policy.
Exhibit A 1.1
Does this policy require that certain types and amounts of charity care be provided?
The policy requires charity care for medically necessary procedures.
2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years?
Based on Social Accountability Standards (State of California - Senate Bill 697 in 1994): 1.)Unpaid Costs of Medicare, 2.) Unpaid Costs of Medi-Cal, 3.) Traditional Charity Care, 4.)Education and Research, 5.) MIA - Indigent Programs, 6.) Nonbilled Services, 7.) Cash and In- Kind Donations, 8.) Other Community Benefits.
How does this differ from 10 years ago?
Same categories reported in Exhibit A 2.1.
25 years ago?
The Sutter Health System, as currently configured, did not exist 25 years ago.
3. What percentages of your patients for your most recent fiscal year were:
(a) uninsured (self pay) 3%
(b) covered by Medicare 38%
(c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals 17%
(d) otherwise covered by private insurance 39%
4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?
Yes. For example, prior to admission, if a patient is pre-assessed for a medically necessary service, charity care is granted at time of service. Once assessed, charity care eligibility is granted for one year without need for reassessment (a benefit in case the patient readmits during the year). In many circumstances, a patient presents in the Emergency Dept without having been pre-qualified for charity care. In those instances, Sutter Health affiliates make every effort to qualify the patient for appropriate programs.

5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt write-offs of your hospital over the past five years?
Sutter Health is not able to answer this question because it does not have specific data that tracks the relationship between the increase in patient co-payments and deductibles and patient bad debt write-offs.
6. Has your hospital or other members of your hospital system group entered into joint ventures with other non-profit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.
Yes. For example, Sutter Health affiliates have entered into joint ventures with other non-profit, tax-exempt hospitals to operate a surgery center, homecare business, and to provide positron emission tomography in the community.
7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.
No.
8. Has your hospital or other members of your hospital system group enter into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures
Yes. These joint venture partners may include physicians, medical groups, or taxable organizations. For example, Sutter Health affiliates have entered into joint ventures with physicians, medical groups or taxable organizations to operate surgery centers, diagnostic centers, infusion therapy services, medical office buildings, and home care services.
9. Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital's charity care policy.
All Sutter Health tax-exempt affiliates entering into a new joint venture must comply with the Joint Venture Policy. Affiliates participating in joint ventures that do not comply with the policy are encouraged to bring the relationship into compliance or exit the joint venture as soon as reasonably possible. The Policy requires that the joint venture have binding commitments to operate for charitable purposes including both a charity care policy in place and agreed upon levels of charity care established.
Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced
The Policy also requires the Sutter Health affiliate must own 51% or more of the capital and profits of the joint venture and have voting control of the joint venture.
If your organization does not track charity care expenses by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant
The Joint Venture Policy requires that a Sutter Health joint venture have binding commitments to operate for charitable purposes including both a charity care policy in place and agreed upon levels of charity care established.
10. Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons

<p>Sutter Health believes this statement does not accurately characterize the motivation of most not-for-profit hospitals, and certainly not Sutter Health. Physicians who practice in hospitals will often build or joint venture with for-profit companies, such as outpatient/ambulatory centers, and move their patient care businesses out of the hospital. Joint venturing with physicians of the hospital staff becomes a defensive strategy in an attempt to keep some of the revenue from those outpatient services that would be lost. In addition, by participating in the joint venture, a hospital can maintain control and/or influence over the healthcare operation. Finally, by utilizing a joint venture vehicle, the hospital can ensure that a community does not have an overabundance of outpatient facilities.</p>
<p>11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture</p>
<p>Sutter Health affiliates make the initial decision to operate a healthcare service through a joint venture when there is a community benefit. The decision is based upon a number of factors. All decisions to engage in a joint venture must be approved by the Sutter Health Finance & Planning Committee.</p>
<p>12. Please provide a charity care breakdown for each entity that is a member of your hospital system group</p>
<p>Exhibit A 12.1.</p>
<p>In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis</p>
<p>Sutter Health's hospital affiliates conduct community needs assessments to best determine the health needs of its communities, identifying programs and services to meet those needs and improve overall health. Sutter Health recognizes that each community will have different needs for charity care and other forms of community benefit. Sutter Health measures charity care on both an affiliate-by-affiliate and an aggregate basis.</p>
<p>13. In your judgment, should Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement?</p>
<p>Sutter Health believes that a healthcare org can satisfy the regulations for tax-exempt status as a healthcare entity in many different ways. Therefore, Sutter Health does not believe that specific requirements or levels of charity care provided in a joint venture operation should be incorporated into federal law.</p>
<p>If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?</p>
<p>Not applicable. See above.</p>
<p>14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?</p>
<p>The affiliate participant in a joint venture does not treat the amount as charity care provided directly. In accordance with GAAP, the charity care provided by a joint venture in which an affiliate has a controlling majority interest would be recorded as part of the consolidation of the affiliate's and the joint venture's operation. If the hospital does not have a controlling interest, the pro-rated operation is show as an equity investment and charity care would not be reflected.</p>
<p>15. What types of research and teaching are performed by your hospital as a charitable or educational activity?</p>
<p>Research -- (a) laboratory-based research programs; (b) biomedical research; (c) clinical trials of drugs, medical devices, and diagnostic tests; (d) health services research and training in clinical and administrative quality improvement; and (e) clinical research involving diagnosis, treatment or disease prevention.</p> <p>Teaching --- (a) provide teaching through partnerships with community colleges, city colleges, vocational colleges, and undergraduate and graduate institutions; and (b) conduct medical education, residency education and health care profession education.</p>

Also See Exhibit A 20.1.

16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital

See Exhibit A 16.1

By raising funds for other new resources, existing funds are made available to spend on charity care or medical care to low-income or uninsured individuals or families. Donors generally want to contribute to capital or service-related needs, however, there are some endowments that provide support to fund low-income or uninsured patients.

Does your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families

No

17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture

No. In fact, by requiring other members of a joint venture to agree to the provision of charity care, the joint venture increases the availability of charity care and other community benefits.

18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?

Definitely encourage and do not discourage. For example, the physician recruitment, call coverage, and professional services agreements generally include charity care provisions, ensuring the provision of charity care by physicians and other third-parties who might not ordinarily be required to provide such care.

19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.

Sutter Health does not track charity care expenses by the hospital lines cited. In 2004, Sutter Health provided \$155 million of charity care, approx 79% of which was from inpatient departments.

20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?

Sutter Health and affiliates provide health care education through classes, seminars, health care fairs, publications, the Internet, television programs, and training for health care professionals through residency and nursing programs. Several programs are discussed. Amount expended: Community Education \$6,517,316; Research/Teaching \$17,038,873; Total \$23,556,189 (% of budget not provided). Sutter Health also partners with and subsidizes County health systems.

21. Please explain how the amount of charity care you provide differs in magnitude and kind for that provided by your for-profit competitors.

Sutter Health and its affiliates have not routinely engaged in comparison studies that evaluate its charity care and community benefit as compared with for-profit competitors. This is due in part to the fact that the competitors are predominately other tax-exempt hospitals, and most for-profit providers have exited Sutter Health's service areas and communities.

<p>22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?</p>
<p>Sutter Health does not track specific community benefit programs related to infant and child care programs. Sutter Health manages a variety of community benefit and hospital services that treat this critical patient population. In addition, many Sutter Health affiliates serve as regional referral centers for the California Children's Services program, the state's program to serve the most vulnerable, chronically ill children.</p>
<p>23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?</p>
<p>Sutter Health affiliates participate in clinical trial programs. In many cases, costs associated with the study are covered by the study sponsor. In these cases, it would be inappropriate to include or characterize these subsidized services as charity care write-offs.</p>
<p>24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards?</p>
<p>The cost of Charity Care is calculated through the following steps in accordance with discussions between Sutter Health and OSHPD:</p> <ol style="list-style-type: none"> 1. Total hospital operating expenses are adjusted to exclude other community benefit costs, bad debt, and other operating revenue sources, to arrive at the adjusted total hospital expenses. 2. The adjusted total hospital expenses (cost) are divided into total patient revenue to determine the ratio of costs-to-charges. 3. This ratio is applied to total charity care charges to determine the cost of charity care provided.
<p>Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences</p>
<p>The allocation involves a cost-to-charge ratio which is may also be used in other areas of expense allocation.</p>
<p>25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.</p>
<p>Patient day and discharge data are reported monthly. Total expenses are submitted by each hospital but are not tracked by type of treatment. 2004 Data. ALOS Gen Acute 4.4 days, Psych 8.2 days, Rehab 14.3 days, and SNF 23.8 days. Cost per Case Mix Index Adjusted Discharge \$10,501.</p>

Payments/Charges/Debt Collection/Tax-Exempt Status and Other Issues

1. Please explain what is the average mark-up of charges over costs.
2.84 (based on 2004 Audited Financial Statements)
What is the average private pay contractual allowance (charges to payments) weighted by payer
Sutter Health's average private pay (non-governmental insurance) contractual allowance (write-off percentage) is: 57.6%.
2. Please explain the reason for charging "chargemaster" rates to uninsured individuals particularly in light of the Secretary of Health and Human Services' letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status
There are a number of state and federal laws and regulations that impact the granting of discounts to uninsured patients. These laws and regulations are complex and overlapping. There was always the concern that discounts to the uninsured could directly affect the definition of "usual, customary and reasonable" fees used in health plan and insurance contracts and government reimbursement programs, such as Medicare and Medicaid. Today, the pmt methodology of most hospital managed care contracts continues to be tied to the chargemaster rates. Sutter Health addresses the needs of the uninsured through its Discount and Charity Care Policies.
3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy
Sutter Health believes that its charging and discount policies and the programs available to the uninsured are reasonable. Uninsured patients earning below 200% of the federal poverty income guidelines are eligible to receive a full charity write-off. This percentage can be as high as 400% in higher cost of living areas. Hospitals that grant partial charity care to patients earning between 201% and 400% of the FPIG discount the bill to an amount approx 120% of the Medicare reimbursement. In catastrophic cases, if a patients liability is greater than or equal to 30% of the annual family income, hospital bills exceeding 30% of their income are also written off to charity care.
What is the collection rate for self-pay?
Inpatient collections percentages for uninsured patients average less than 5%.
4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate
Sutter Health believes the premise of this question is false. HMO plans and PPOs licensed in CA negotiate contracts with providers and pay claims based on disc from c-master rates. Non-contracted HMO plans and other commercial ins plans pay c-master rates. Contracts with commercial payers contain prompt-pay provisions. The discs reflect the value to the hospital of guaranteed, timely pmt. Discs based on volume of services purchased by the plans. Sutter Health does not believe financially needy individuals should pay undiscounted c-master rates. Sutter Health addresses the needs of the uninsured through its Discount and Charity Care Policies. Sutter Health offers prompt pay disc from 10% to 50%.
5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status
Sutter Health affiliated hospitals have never considered uninsured patients as a significant or reliable source

of revenue, and believe that uninsured patients do not contribute to the hospitals' economic viability in any meaningful way. Sutter Health addresses the needs of the uninsured through its Discount and Charity Care Policies.

6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject

The Charity Care Policy requires that Sutter Health hospitals post financial assistance signage in a highly visible manner in the primary language(s) of the service area, and at multiple registration locations on each campus. Sutter Health developed and distributed financial assistance application, eligibility matrix, and a notification form in multiple languages. The Internal Audit staff performed walkthroughs at the affiliate sites to ensure signage is posted in Inpatient, Outpatient, and Emergency Dept registration and billing offices, in financial counseling depts, and as a Best Practice, in each registration cubicle. Through "secret shopping" of registration sites, a series of patient-access-to-charity-care Best Practices was also developed. Financial assistance language is also included on patient billing statements, affiliate web sites, and the Conditions of Admission or Conditions of Registration form.

7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff

All Sutter Health employees who deal directly with patients receive a comprehensive orientation regarding Sutter Health's structure, org, mission, philosophy, environment, and values. These concepts are continually reinforced through direct supervision, ongoing training, performance evaluations, and skills assessments. Sutter Health also created a standardized packet of materials to ensure all staff are aware of Sutter Health's charitable mission and are informed as to appropriate interaction with uninsured patients. Registration staffs are trained in the charity care policy, and the management of patient accounts receivable and collection practices policy. Sutter Health developed a best practice to address training of hospital billing staff.

8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.

This question contains assumptions and concepts with which Sutter Health does not agree. Medicare rules have played, and continue to play a large role in defining how hospitals bill uninsured patients. Medicare rules clearly indicate that the uniform charge is what hospitals are supposed to levy all patients, including uninsured patients. It was not until Feb 2004 that CMS clarified that discs offered to all uninsured patients do not affect Medicare pmt for outlier or new technology cases. Sutter Health believed that the combo of charity care, prompt pay disc, and installment pmt plans provided the options needed to fairly treat uninsured patients within Medicare program rules.

In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule

Sutter Health affiliates do not gross up their charges in preparing their Medicare cost reports regardless of whether they have a lower OPD fee schedule.

Please state your views on whether it is allowable or acceptable for hospitals to lower

<p>their charges for the insured and not the uninsured</p>
<p>Sutter Health affiliates maintain a c-master structure, against which they provide some payers contract adjustments, prompt-pay discs, and charity care. Sutter Health is not aware of any law or regulations that require it to offer discounts to patients who can afford to pay for ins coverage but elect not to purchase it. Sutter Health does not want to provide incentives for individuals to discontinue or not purchase ins coverage. Sutter Health addresses the needs of the uninsured through its Discount and Charity Care Policies.</p>
<p>9. It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured. Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002</p>
<p>Sutter Health believes that the strategy described is an inappropriate strategy, and have not engaged in this practice. Outlier payments: 1998 \$18.5M (5.29% of total Medicare pmts), 2004 \$26.8M (4.38% of total Medicare pmts). A 17.2% drop in outlier pmts as percent of total Medicare pmts.</p>
<p>10. Secretary Thompson, in his letter mentioned above, noted that "Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals' provision to help hospitals bear the cost of caring for the poor and uninsured." In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government</p>
<p>Typically, the hospitals that qualify for DSH payments are the most financially challenged because of the payer mix of the patients they serve. DSH pmts are not only approp, they are imperative to the long-term financial survival of not-for profit comm hospitals, and to the treatment of needy and low-income patients, a population not otherwise served by for-profit entities. The under-funding of govt healthcare programs is one of the biggest factors driving up the cost of ins premiums. DSH pmts only partially reimb hospitals for the higher cost of treating Medicare patients.</p>
<p>Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt</p>
<p>Comb 27 hospitals. 2002: DSH \$64,334,709, Charity \$86,379,000, Bad Debt \$197,316,870, Uncompensated Care \$283,695,870. 2003: DSH \$72,531,019, Charity \$108,643,000, BID \$217,992,131, Uncompensated Care \$326,635,131. 2004: DSH \$84,456,698, Charity \$152,717,000, BID \$229,951,646, Uncompensated Care \$382,668,646.</p>
<p>11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, "the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.</p>
<p>Chargemasters are integral to nearly all existing hospital reimbursement systems. Changing the reimbursement and billing systems will require participation from many different interested parties, including hospitals, physicians, health insurers, and state and federal governments. Sutter Health would gladly participate in a national discussion regarding this issue.</p>
<p>12. At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he "was told by both inside and outside legal counsel ... [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS." Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice</p>

Sutter Health has not received such advice.
13. Please provide all documents related to your hospital's consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients
Charity Care Policies - Exhibit B 14.1A. Discount Policies - Exhibit B 14.1C
14. Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present. In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured
Charity Care Audits (by Internal Audit) - Exhibit B 14.1 B. Community Benefit Reports – Exhibit B 14.2.
15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment
Community Needs Assessment (Community Benefit Plans) compiled every 3 years and may encompass multiple affiliates in a single region - Exhibit 14.3. Community Benefit Reports - Exhibit 14A.
16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals
Sutter Health is not compelled by law to file lawsuits against patients in order to collect on unpaid hospital bills.
Please identify the amount of debt that was at issue in each suit
Exhibit B 16.1.
Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection
Sutter Health hospitals do not typically sell accts to collection agencies or other vendors. Sutter Health hospitals utilize collection agencies to act as their agents in collecting on outstanding patient receivables on the hospital's behalf. Collection Practices Policy - Exhibit B 16.2.
Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts
The only situation where a Sutter Health hospital sold patient accts to an outside entity involved contracting with a vendor for the vendor to purchase, with patient approval, lien rights. The vendor would pay the hospital a contracted rate and the hospital acct was paid off. The vendor recd the proceeds of the lien when the lien was settled from insurance proceeds or litigation. Sutter Health affiliates do not claim these accounts as bad debt because the hospital receives contracted payment from the vendor up front.
Please explain how the sale of private accounts for recovery, and a concomitant claim to Medicare for payments on the same debts is not “double dipping”
With respect to Medicare patients, Sutter Health ensures that the provider can identify each Medicare co-pay/deductible to confirm that collection efforts meet the criteria established in the Medicare Provider Reimbursement Manual, Part 2, Provider Cost Reporting Forms and Instructions, Chapter 11, Form CMS

339, Section 1102.3. These criteria establish the practices to be followed in pursuing collections from Medicare patients for their co-pays/deductibles in order to claim the unpaid balances on the hospital cost report.
Please provide copies of your contracts, if any, with collection agencies
Exhibit B 16.3.
Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization
Sutter Health has only one affiliate that acts as a for-profit collection agency.
Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt
Sutter Health hospitals have no financial relationships with banks or credit card companies other than processing standard credit card payments from patients making payments on their hospital bills.
Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt
Sutter Health must ensure collection efforts meet the criteria established in the Medicare Provider Reimbursement Manual. This process may create a different treatment between Medicare and Non-Medicare patients in regard to debt.
If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt
The only situation where a Sutter Health hospital sold patient accts to an outside entity involved contracting with a vendor for the vendor to purchase, with patient approval, lien rights.
17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action
Exhibit B 17.1
18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.)
Exhibit B 18.1
19. Some hospitals have taken the position that the provision of health care, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain
The Internal Revenue Code, Treasury Regs, Revenue Rulings, case law, and other legal authorities set forth the criteria under which an organization is entitled to tax-exempt status as a charitable org. Revenue Ruling 69-545 cites the primary legal authorities establishing the provision of healthcare as a charitable activity. In accordance with current law, Sutter Health hospitals have met the requirements of section 501(c) (3) of the Internal Revenue Code.
20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well
Sutter Health affiliates maintain a consistent chargemaster structure, against which they provide some payers with contractual adjustments, prompt-pmt discounts, and charity care. Sutter Health's Charity Care Policy includes a catastrophic component that limits a patient's responsibility to 30% of their annual income. In addition, many Sutter Health affiliates give prompt pay discounts ranging from 10% to 50% to uninsured

patients who do not qualify for the charity care discount.

Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured

Per the answer to question A I., all medically necessary procedures are available for charity care. Charity care and discounts are generally not available for elective procedures, however, in certain cases an exception may be made. These exceptions require approval by the administration. In addition, many Sutter Health affiliates give prompt payment discounts ranging from 10% to 50% to uninsured patients who do not qualify for the charity care discount.

21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip

Exhibit B 21.1

Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18

Exhibit B 21.2

Finally, please detail any payments or reimbursements made to employees for country clubs

Sutter Health affiliates have not made reimbursement or payments to employees for country club facilities.