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Charles N. Kahn III
President

August 31, 2006

BY FACSIMILE AND U.S. MAIL

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Investor-Owned Hospitals and Charity Care

Dear Senator Grassley:

This letter supplements our July 20th response to your earlier request for information about charity care provided by our investor-owned hospital members. Our July 20th response addressed many of your questions using data we had collected previously covering 2004. However, for several others, we needed additional time to solicit information from our membership in order to be completely responsive. Since our last letter, most of our hospital members have responded to our annual membership survey covering 2005, which was issued prior to receipt of your letter and in part collects the information you seek on a number of topics, including uncompensated care. Also, many of our members also have provided substantial additional information requested by your letter.

As with our earlier submission, our responses are arranged to correspond to the format of your letter. Again, we developed our responses with the understanding that the Finance Committee seeks only information about general acute care community hospitals that we represent.

CHARITY CARE AND COMMUNITY OUTREACH

1. **Describe the Federation of American Hospitals ("FAH") and your membership. How many and what types are represented by FAH? What is the average size and capital expenditure of member hospitals by type? What is the average patient composition (uninsured, covered by Medicaid or other state or other governmental programs, or otherwise covered by private insurance) by type of member hospital?**

We supplement our earlier response with newly obtained information. FAH's representation includes approximately 20 institutional hospital companies with a total of approximately 1,000 hospitals. Of those 1,000 hospitals, about 500 are full-service, short stay hospitals with about 100 of those facilities located in rural areas. FAH members operate in most of the 50 states (plus Puerto Rico and the District of Columbia), and employ about 500,000 individuals. In 2005, the average size of our hospitals was 225 beds for urban hospitals and 94 beds for rural hospitals. The average capital expenditure for our hospitals in 2005 was $8.7 million for urban hospitals and $3.8 million for rural hospitals.

With respect to the average patient composition in 2005, we collected this information based on a third party payer mix rather than on a patient visit basis, with the following results. For urban hospitals, the average patient mix was 28.4 percent Medicare fee-for-service, 10.3 percent Medicaid, 8.5 percent uninsured, and 52.8 percent primarily private insurance such as managed care and commercial (although also included are small amounts of workers compensation coverage, auto insurance coverage, Tricare and Medicare managed care). For rural hospitals, the corresponding amounts are 33.4 percent Medicare fee-for-service, 10.2 percent Medicaid, 9.9 percent uninsured, and 46.5 percent private insurance (including all of the insurance types outlined above).

2. **Do your member hospitals have charity care policies or obligations? Among your members, how is charity care usually defined? Does the FAH have a position on the provision of charity care and if so, what is the FAH's position? Does the FAH provide recommended language or materials to members concerning charity care policies? If so, please provide copies of these materials. Provide examples of some of your member hospitals' policies as well.**

In our first response, we provide examples of three members' charity care policies for your consideration. We now provide two additional examples:

- One FAH member has a policy that provides for a 100% charity care discount for patients who qualify under the system's policy, with the caveat that patients are responsible for a flat rate co-payment amount that is set based on patient type. There are four ways to qualify for a charity care allowance under this policy:
    - charity care for the catastrophic medically indigent, which include patients whose family income is less than 300 percent of the Federal Poverty Guidelines (FPG);
    - statutory charity care – relevant to facilities that participate in various federal, state, and/or county uncompensated care programs;

- non-statutory charity care – those patients that meet the company's charity care criteria, but who are not subject to a statutory charity care program. The governing charity care criteria will be set on an individual market basis by the company's financial assistance department; and,
- charity care for Medicaid denied stays/care and non-covered services – for Medicaid-qualified patients who have an outstanding balance after the Medicaid program payment, if any.

- Another FAH member has a charity care policy that provides for a 100 percent charity care discount for any patient who receives non-elective treatment and whose household financial resources and/or income is at or below a specified percentage of the FPG. The qualifying financial or economic criteria are determined by individual hospitals. Two examples of specific hospital policies are:

    - At one hospital, patients are entitled to charity care if they qualify as either financially indigent or medically indigent. Under this policy, patients are financially indigent if their annual income is less than or equal to 200 percent of the FPG. Patients will be medically indigent if they have an annual income that is less than or equal to 400 percent of the FPG and owe the hospital an amount that exceeds 10 percent of their annual income.
    - At a second hospital, patients are entitled to charity care if they qualify either as financially indigent or "cost share" indigent. Patients are financially indigent if their annual income is less than or equal to 185 percent of the FPG. Patients qualify for cost share indigence if their annual income is between 185 percent and 300 percent of the FPG. For cost share indigent, patients are required to pay 1 percent of the account balance or $50, whichever is greater.

3. Has the FAH conducted or commissioned research or done any seminars, lectures, or other similar educational campaigns for members regarding charity care? If so, describe the nature of these programs and provide any materials.

Our previous answer to this question reflects our complete response.

4. How much uncompensated care is provided by the average member hospital? What are the components of uncompensated care and their respective amounts? How are each of these components calculated?

As previously indicated, our 2006 survey defines "uncompensated care" to include: (1) charity care; (2) bad debt; and (3) discounts. To clarify, the discount category generally describes discounts to individuals who are uninsured or low-income, or for those who are insured, but for whom the remaining amounts owed to the hospital would result in a financial hardship for the patient. Notably, the discount category does not include contractual allowances under third party payer agreements. Based on the new FAH survey results, in 2005, the average FAH member acute care hospital provided $21.1 million in uncompensated care, which is a 37 percent increase over 2004. The uncompensated care figures breakdown as follows: (1) $5.2 million in charity care, (2) $10.2 million in bad debt, and (3) $5.7 million in discounts.

How each component of uncompensated care is calculated may vary from member to member. Generally, charity care figures are taken from each company's financial statements as a reduction to revenue and are determined by whether a patient meets the standards under the respective members' charity care policies. Bad debt figures also are reported on each company's financial statements and are determined based upon uncollected patient liability. Many members report discounts in their financial statements as the amounts which are posted to uninsured patients under the prevailing company discount policy. Some members have a similar discount policy for underinsured patients and, in those cases, the discounts are also reported on the financial statements.

5. **How is uncompensated care reported by member hospitals? How are the components of uncompensated care reported by member hospitals?**

We believe our responses to the previous question also provide a complete response to this question.

6. **How is charity care reported by member hospitals? How are the components of charity care reported by member hospitals?**

As stated above, our members generally report their charity care amounts on their annual financial statements as a reduction in revenue. This number also is reported to the Securities and Exchange Commission on the company's "10-Q" filings.

7. **How much charity care is provided by member hospitals located in the same geographic region as a tax-exempt or government hospitals? How much charity care is provided by member hospitals in regions where there are no tax-exempt or government hospitals?**

Our members' charity care policies do not condition the availability of charity care in a particular market based on whether they are the sole hospital service provider or compete with other hospitals – public or private. In fact, one FAH member that operates primarily rural hospitals reports that 85 percent of its facilities are the sole providers of hospital services in their respective geographic areas and all those facilities have a formal written charity care policy in accordance with the parent company's policy and procedures.

8. **What type of community outreach and educational activities do your member hospitals conduct, and on average how much is expended on such activities?**

Our members engage in many different community outreach and educational activities and make donations to worthwhile causes in their communities. For example, in 2005, one member made corporate contributions totaling $15.4 million to such causes. Generally, our members are involved in, provide outreach through, and make contributions to the Alcohol and Drug Council, Alzheimer's Association, American Cancer Society, American Diabetes Association, American Heart Association, American Lung Association, local chapters of the American Red Cross, Big Brothers Big Sisters, Special Olympics, local Boys & Girls Clubs, local Chambers of Commerce, Healthy Woman, local Humane Societies, local libraries, local senior centers, local parks and recreation departments, Leukemia & Lymphoma Society, local public school systems, local health fairs and free health screenings, March of Dimes, Minnie Pearl Cancer Foundation, Nashville Sounds (local sports),

National Kidney Foundation, National Multiple Sclerosis Society, local Rotary Clubs, Senior Circle, Susan G. Komen Breast Cancer Foundation, and local YMCAs and YWCAs.

Our members also have related foundations that make significant grant awards annually. One member's foundation gave $23.9 million in grants in 2005 focus on chosen areas of health and well being and childhood and youth development. Another member's foundation awarded more than $7.5 million in grants last year, including $1.7 million in employee matching gifts, $1.2 million for disaster relief, and approximately $632,000 in scholarships. Another member established a foundation to assist its employees who were affected by Hurricane Katrina. This foundation collected between $2 million and $3 million dollars, which were distributed to affected Gulf Coast employees and their families.

When required, our members report their levels of community outreach and education. For example, Nevada requires all hospitals to file community benefit statements. One example of a reported community benefit is member's hospital that provided a grant to a local university to support programs designed to facilitate entry-into-practice for nurses and to develop strategies regarding how to address the nursing shortage.

9. Explain how the amount of charity care your member hospitals provides differs in magnitude and kind from that provided by tax-exempt hospitals.

Our previous answer to this question reflects our complete response.

10. Explain the various forms of discounted care your member hospitals provide. What are the components of discounted care? What is the range of discounts provided by your average member hospital?

Our members provide discounted care in different ways. Our answers to earlier questions in this section address your inquiry related to charity care. Separate from charity care, many members also operate a discount program for non-elective services provided to uninsured patients. One member's hospitals offer a discount of 20 percent off of gross charges for uninsured patients who do not qualify for governmental programs, charity care, or any other discount program the hospitals offer. Others offer discounts to uninsured patients at locally set rates that are equivalent to the managed care discounts they receive off of gross charges.

To clarify, we reported on other members' discount programs in our July 20th letter. However, those summaries were combined with our earlier charity care responses to question 2 of this section.

11. Please explain FAH's position regarding whether bad debt should be treated as charity care.

Our previous answer to this question reflects our complete response.

COMMUNITY ACCOUNTABILITY

1. Some have argued that exemption for non-profit hospitals can be justified solely on the basis that they are accountable to the community, whereas investor-owned

hospitals are accountable only to stockholders. How do investor-owned hospitals maintain accountability to the communities they serve?

Our previous answer to this question reflects our complete response.

2. **What types of research and teaching are performed by your member hospitals?**

In addition to information previously reported, several of our members have open research protocols involving federally sponsored trials through the National Cancer Institute Cooperative Groups and the National Institutes of Health in a variety of clinical diagnoses. Our members also participate in drug clinical trials (Phases I through IV) for private pharmaceutical companies as well as clinical trials for private medical device companies. Our member facilities often have Institutional Review Boards that oversee research activities to ensure compliance with Food and Drug Administration and Office of Human Research Protections requirements. Our members have found that these research initiatives in community hospital settings have been beneficial for needy patients, who previously had to travel great distances to gain access to, and participate in, similar research initiatives.

3. **To your knowledge, are there instances where your member hospitals are the only providers of health care in their community and thus must admit and treat the medically indigent even though doing so might be inconsistent with an investor-owned hospital's mission?**

Our previous answer to this question reflects our complete response.

4. **Many non-profit hospitals have come under attack for inappropriately charging the uninsured charges greater than they charged insured patients for the same care and for improper collection practices. What steps has FAH taken with its member hospitals to assure that patients are treated fairly with respect to charges, billing, and collection practices?**

Our previous answer to this question reflects our complete response.

5. **Do your member hospitals enter into joint venture arrangements with non-profit hospitals, other investor-owned providers, physicians, or others to deliver health care?**

We clarify our earlier response to reflect that while FAH members participate in joint ventures, those business arrangements are not currently a prevailing business model among our members.

TAXES

1. **Does the FAH collect member information regarding the taxes paid by investor-owned hospitals? If so, provide information on Federal, State, and Local taxes paid by investor-owned hospitals, specifically breaking out income tax, property tax, employment taxes, and other taxes for each level of government. If possible, provide this information as a percentage of gross revenues and a percentage of net income.**

Based on recent responses to our annual membership survey, we are able to provide more recent information to supplement the tax figures previously provided for calendar year 2004. In 2005, FAH's acute care hospital members incurred approximately $1.03 billion in income tax expenses, $408 million in property taxes, and $544 million in sales taxes. In addition, our hospitals paid more than $200 million in other assorted taxes, such as provider taxes, indigent taxes, and franchise taxes, which vary considerably from state to state, as well as some $1.3 billion in employment taxes.

We hope this information is helpful to the Finance Committee's work on tax-exempt hospitals and charity care. If you have any questions about this letter or need additional information, please contact me, Steve Speil at (202)624-1529 or Jeff Micklos at (202)624-1521.

Sincerely,