

Minnesota Hospitals: Uncompensated Care, Community Benefits, and the Value of Tax Exemptions

Minnesota Department of Health

January, 2007



Division of Health Policy
Health Economics Program
PO Box 64882
St. Paul, Minnesota 55164-0882
(651) 201-3550
www.health.state.mn.us/health/economics



Protecting, maintaining and improving the health of all Minnesotans

January 16, 2007

The Honorable Linda Berglin
Chair, Health and Human Services
Budget Division
Minnesota Senate
Room 309, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155-1606

The Honorable Thomas Huntley
Chair, Health Care and Human Services
Finance Division
Minnesota House of Representatives
585 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

The Honorable John Marty
Chair, Health, Housing, and Family
Security Committee
Minnesota Senate
Room 328, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155-1606

The Honorable Paul Thissen
Chair, Health and Human Services
Committee
Minnesota House of Representatives
351 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

To the Honorable Chairs:

Several issues have given rise to recent concerns, both in Minnesota and nationally, about the amount of uncompensated care and community benefits provided by hospitals. First, recent increases in the number of people who do not have health insurance have also likely increased the demand for hospital uncompensated care as a "safety net" for the uninsured, despite increases in the share of the population that is covered through public health insurance programs. Second, public attention has been called to the fact that when uninsured patients receive care at a hospital, they have often been billed at levels far above what private insurers or public insurance programs would have paid for the same services, and well above hospital costs. Finally, there has been increasing scrutiny of the community benefits provided by nonprofit hospitals, and whether the benefits are comparable to the tax exemptions that these hospitals receive as a result of their nonprofit status.

The 2006 Legislature required the Minnesota Department of Health to perform a study of trends in hospital uncompensated care in Minnesota, the amount of community benefits provided by Minnesota nonprofit hospitals, and the value of tax exemptions for nonprofit hospitals (Minnesota Session Laws 2006, Chapter 267, Article 1, Section 11). In addition to the analysis of data and trends, MDH is required to make recommendations about the need for more uniform charity care and debt collection policies, and the need for more uniform reporting of hospital community benefits.



Protecting, maintaining and improving the health of all Minnesotans

This report details the findings and recommendations of the study. I look forward to continuing to work with you on this issue. Questions and comments on the report may be directed to the Health Economics Program at (651) 201-3560.

Sincerely,

A handwritten signature in black ink that reads "Dianne Mandernach". The signature is written in a cursive, flowing style.

Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, Minnesota 55164-0882

Minnesota Hospitals: Uncompensated Care, Community Benefits, and the Value of Tax Exemptions

Minnesota Department of Health

January, 2007



Division of Health Policy
Health Economics Program
PO Box 64882
St. Paul, Minnesota 55164-0882
(651) 201-3550
www.health.state.mn.us/healthconomics

As required by Minnesota Statute 3.197: This report cost approximately \$53,000 to prepare including staff time, printing and mailing expenses

Table of Contents

Executive Summary	iii
Introduction	1
Uncompensated Care Trends at Minnesota Hospitals	2
Charity Care Policies and Practices	14
Community Benefits	19
Value of Nonprofit Hospitals' Tax Exemptions	26
Recommendations	27
Appendix: Study Methodology	30
Estimating the Cost of Uncompensated Care	30
Estimating Hospitals' Community Benefit	30
Estimating the Value of Tax Exemptions	31
Appendix Table 1	35
Appendix Table 2	42
Appendix Table 3	45
Appendix Table 4	51

Executive Summary

The Minnesota Department of Health (MDH) was directed by the 2006 legislature to perform a study of trends in hospital uncompensated care in Minnesota (separately identifying charity care and bad debt), charity care and debt collection policies, the amount of community benefits provided by Minnesota nonprofit hospitals, and the value of tax exemptions for nonprofit hospitals. In addition to the analysis of data and trends, MDH is required to make recommendations about the need for more uniform charity care and debt collection policies, and the need for more uniform reporting of community benefits.

Uncompensated Care

Uncompensated care, or care that hospitals provide without receiving payment, includes both charity care and bad debt. Charity care is care that is provided without expectation of payment, while bad debt is care for which a hospital expected but did not receive payment. In reporting on uncompensated care, charity care, and bad debt, MDH uses an adjustment to hospital charges to estimate the actual cost of the care provided.

In 2005, Minnesota hospitals provided \$191.2 million in uncompensated care (\$80.3 million in charity care and \$110.9 million in bad debt). After a period of stability from 2000 through 2003, uncompensated care increased by 18 percent in 2004 and an additional 26 percent in 2005. Charity care grew about twice as fast as bad debt during this 2-year period (70 percent compared to 36 percent). In 2005, uncompensated care was 2.0 percent of hospital operating expenses, which was higher than recent years but within the range of historical averages in Minnesota. Nationally, hospital uncompensated care as a share of operating expenses is much higher (5.6 percent in 2005), most likely reflecting the fact that the share of the population without health insurance is much lower in Minnesota than it is nationally.

Uncompensated care in Minnesota is concentrated among a small number of hospitals. The ten largest providers of uncompensated care account for over half of total uncompensated care in the state.

Although standard definitions for the reporting of charity care and bad debt were implemented in 2001, it appears that there may still be variation across hospitals in which uncompensated care costs are reported as charity care and which are considered bad debt. For example, among the 10 hospitals providing the most uncompensated care in 2005, the percentage of total uncompensated care that was attributed to charity care ranged from 32 percent to 95 percent. Other factors that may explain this variation include differences in hospitals' charity care policies, differences in the degree to which hospitals try to identify patients who are eligible for either charity care or public insurance programs, differences in debt collection practices, or differences in how hospitals classify charges incurred by patients for whom they are unable to document charity care eligibility.

Charity Care and Debt Collection Policies

Nearly all Minnesota hospitals have formal charity care policies that spell out criteria for determining charity care eligibility. Most hospitals reported that they consider income, assets, and eligibility for public insurance programs in determining eligibility for charity care (either free care or a partial discount from charges). Most

hospitals (70 percent) reported that they post information about charity care in public areas, and most also instruct staff to provide this information to uninsured patients (76 percent). About 40 percent reported that they provide this information to patients in a language other than English.

With regard to debt collection practices, all of Minnesota's hospitals have signed agreements with the Attorney General's office that essentially standardize debt collection practices across the industry. Most hospitals previously had formal billing and collection policies in place, but the extent of difference between the standardized policy and previous policies is not clear. Hospitals' two-year agreements with the Attorney General on debt collection practices (which also include agreements to provide discounts to uninsured patients with family incomes below \$125,000 per year) begin to expire in the Spring of 2007.

For a variety of reasons, it is difficult to determine how recent changes in Minnesota hospitals' charity care and debt collection policies have affected the amount of uncompensated care and the number of patients receiving uncompensated care. First, many other changes have occurred in Minnesota's health care marketplace that may have also influenced levels of charity care and bad debt. Second, the most recent year of data that is available is for hospitals' fiscal year 2005, which for many hospitals largely precedes their agreement with the Attorney General. In addition, hospitals' ability to provide detailed information about charity care and bad debt for more recent time periods is limited, and few hospitals were able to provide information on the number of patients receiving charity care or whose charges were written off as bad debt.

Community Benefits

Federal policy requires hospitals to provide community benefits in order to qualify as tax-exempt nonprofit entities. In part due to recent debate about the degree to which hospitals should be required to demonstrate the value of community benefits that they provide in comparison to the value of their tax exemptions, an increasing amount of attention is being paid to quantifying the value of community benefits provided by nonprofit hospitals. To the degree that there is any consensus on defining and measuring community benefit, a set of standards developed by the Catholic Health Association (CHA) and VHA Inc. is most widely used. Definitions used by the American Hospital Association are similar, but include bad debt and Medicare payment shortfalls in addition to activities that are included in community benefit under the CHA/VHA definition.

MDH used the CHA/VHA definitions to estimate the amount of community benefits provided by Minnesota hospitals in 2005. Using these definitions, MDH estimated the total amount of community benefit provided by nonprofit hospitals at \$607.2 million in 2005, including \$535.3 million at private nonprofit hospitals and \$71.9 million at government-owned community hospitals. These costs for community benefit represented about 6.4 percent of hospital operating expenses in 2005.

Value of Tax Exemptions

MDH estimated the total value of tax exemptions received by nonprofit hospitals at \$482.0 million in 2005 (\$443.6 million at private nonprofit hospitals, and \$38.4 million at government-owned hospitals). This estimate includes the value of exemptions from property tax, sales tax, and federal and state income taxes. It also includes benefits that hospitals receive through their ability to issue tax-exempt debt, as well as the deductibility of charitable contributions to nonprofit hospitals.

Recommendations

As noted above, MDH is required to include recommendations on 1) the need for more uniform charity care and debt collection policies, and 2) the need for more uniform reporting of community benefits. These recommendations are summarized below.

More uniform charity care and debt collection policies: MDH does not recommend that hospitals be required to have standardized charity care policies. However, MDH recommends the following:

- Hospitals should be required to have a written charity care policy, and to make information about charity care policies easily available to the public by posting it in public areas of the hospital and on hospital websites. Information on charity care policies and state public insurance programs should be provided to all uninsured patients.
- The Legislature should consider making standardized debt collection practices permanent in statute. In addition, it will be important to monitor charges to uninsured patients as hospitals' agreements with the Attorney General expire.

More uniform reporting of community benefits: In the interest of greater transparency and accountability, MDH recommends that hospitals be required to report on community benefits in a standardized way. Community benefit reporting should be incorporated into existing MDH data collection from hospitals, in order to ensure cooperation from all hospitals, as well as to ensure that the information reported is consistent with other financial data reported by hospitals. Definitions for community benefit reporting should be developed by MDH, with input from an advisory commission established for this purpose.

Introduction

Several issues have given rise to recent concerns, both in Minnesota and nationally, about the amount of uncompensated care and community benefits provided by hospitals. First, recent increases in the number of people who do not have health insurance have likely also increased the demand for hospital uncompensated care as a “safety net” for the uninsured. In addition, public attention has been called to the fact that when uninsured patients receive care at a hospital, they have often been billed at levels far above what private insurers or public insurance programs would have paid for the same services. Finally, there has been increasing scrutiny of the community benefits provided by nonprofit hospitals, and whether the benefits are comparable to the tax exemptions that these hospitals receive as a result of their nonprofit status.¹

In 2005, all Minnesota hospitals signed agreements with the Attorney General that required the hospitals to provide discounts from charges for uninsured patients with annual household incomes below \$125,000 per year. Specifically, hospitals agreed to provide these uninsured patients with the same discounts from charges that they provide to their largest private payer.² In addition, hospitals agreed to a uniform standard for debt collection practices that was intended to curb perceived abuses by hospitals in attempting to collect unpaid bills. The agreements between Minnesota hospitals and the Attorney General were for a period of two years, and most are due to expire in Spring 2007.

The 2006 Legislature directed the Commissioner of Health to conduct a study of hospital uncompensated care, charity care policies and debt collection practices, and community benefits provided by hospitals in comparison to the value of tax exemptions for nonprofit hospitals. Specifically, the study requires the following:³

“(a) The commissioner of health shall study and report to the legislature by January 15, 2007, the following:

- (1) trends in hospitals’ cost of providing uncompensated care, separately identifying charity care and bad debt as components of uncompensated care;
- (2) the impact of any changes in hospitals’ charity care policies and debt collection practices in the past three years on the amount of uncompensated care provided and the number of patients receiving uncompensated care; and
- (3) the value of hospital uncompensated care and community benefits in comparison to the value of tax exemptions received as a result of nonprofit status.

(b) The commissioner’s report to the legislature shall include recommendations on:

- (1) the need for more uniform hospital charity care policies and debt collection practices; and
- (2) the need for more uniform reporting of community benefits provided by nonprofit hospitals.”

¹ See, for example, Robert Pear, “Nonprofit Hospitals Face Scrutiny Over Practices,” *The New York Times*, March 19, 2006.

² The language in the agreement states: “The Hospital will not charge a patient whose annual household income is less than \$125,000 for any uninsured treatment in an amount greater than the amount the provider would be reimbursed for that service or treatment from the insurance company which provided that hospital with the most revenue for its services in the previous calendar year.” (Minnesota Hospital Association and Office of Minnesota Attorney General Mike Hatch joint news release, June 2, 2005.)

³ 2006 Minnesota Laws, Chapter 267, Article 1, Section 11

In preparing this report to the legislature, the Minnesota Department of Health (MDH) relied upon several sources of data. These included: existing publicly available data on hospital charity care, bad debt, and other financial data; a special survey of hospitals on their charity care and debt collection practices and policies conducted by MDH; the results of a Minnesota Hospital Association (MHA) survey on hospital community benefits, augmented by additional data collection by MDH from hospitals that did not respond to the MHA survey; and an MDH survey of county and city tax assessors to determine the assessed value of hospitals for property tax purposes. MDH also reviewed existing research studies on community benefits and the value of tax exemptions for nonprofit hospitals, and reviewed uncompensated care and community benefit reporting requirements in other states.

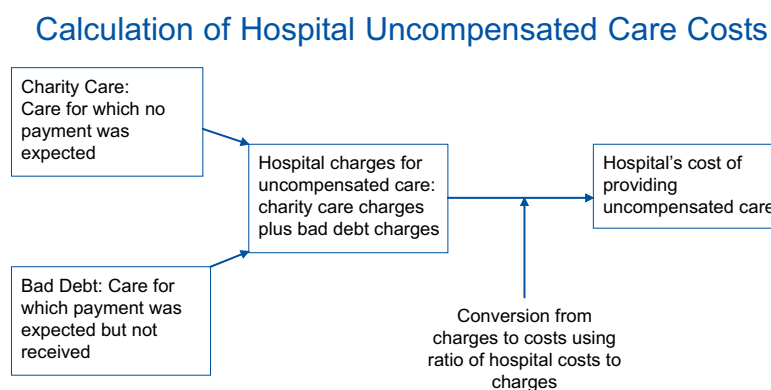
Uncompensated Care Trends at Minnesota Hospitals

Background

Historically, one of the most widely used measures of hospitals' service to their communities has been the amount of care that they provide without compensation, or uncompensated care. Uncompensated care comprises two distinct measures: charity care and bad debt. **Charity care** includes services that are provided to patients free of charge or at a discount because of patients' demonstrated inability to pay; in other words, charity care is care for which hospitals did not expect payment. In contrast, **bad debt** represents care for which a hospital expected but did not receive payment. Uncompensated care does not include contractual adjustments or losses that a hospital incurs due to payments lower than cost from some third-party payers.

In their annual financial and statistical reports to MDH, hospitals report charges for charity care and bad debt. Typically, analysts make an adjustment to these reported charges to more accurately reflect the cost that hospitals incurred to provide the services. This adjustment is referred to as a "cost to charge ratio" – in 2005, cost to charge ratios for Minnesota hospitals ranged from 33% to 147%, with an industry average of 46%.⁴ Figure 1 provides a graphical illustration of the components of uncompensated care and the adjustments that are made to estimate hospitals' cost of providing uncompensated care. All charity care, bad debt, and uncompensated care data included in this report are cost-based (i.e., have been adjusted from charges to more accurately reflect the cost of providing care).

Figure 1



⁴ The appendix to this report describes this calculation in more detail.

Minnesota law does not require hospitals to provide specific amounts of uncompensated care or to have uniform standards for the provision of uncompensated care; however, most Minnesota hospitals have developed formal charity care policies that take into account a variety of factors, such as specific community needs, in determining who is eligible for charity care. Providing charity care is also not an explicit requirement for hospitals to qualify for federal tax-exempt status as charitable organizations. Prior to 1969, the Internal Revenue Service (IRS) required that hospitals provide charity care in order to qualify for tax-exempt status. Under current policy (in place since 1969), the IRS requires that a hospital meet a “community benefit” standard, which may include but does not require charity care, in order to qualify as a tax-exempt nonprofit.⁵

Federal law does require hospitals to provide uncompensated care in two specific circumstances: first, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals that operate emergency rooms to provide emergency stabilizing treatment to all patients regardless of their ability to pay⁶; second, hospitals that received funds for construction and modernization under the federal Hill-Burton Act were required to provide specific amounts of free care.⁷

Sources of Data on Uncompensated Care

Minnesota hospitals are required to submit annual financial and statistical reports to MDH through the Health Care Cost Information System, or HCCIS. These reports are the primary source of data on hospital charity care, bad debt, and total uncompensated care in Minnesota.

Until 1990, general accounting practices held that while a differentiation between charity care and bad debt was helpful, they could be treated the same way for accounting purposes. As such, reporting of charity care together with bad debt was not uncommon through the mid-1990s. Accounting practices for charity care and bad debt changed substantially in 1990, when the American Institute of Certified Public Accountants’ (AICPA) guidance required facilities to treat charity care and bad debt differently: charity care was classified as an adjustment to revenue, and bad debt was accounted for as an operating expense.⁸

Reports to the Legislature from MDH in 1999 and 2000 identified the lack of consistent definitions of charity care, bad debt, and uncompensated care as a barrier to making comparisons across providers and gaining an accurate picture of overall charity care, bad debt, and uncompensated care at Minnesota hospitals.⁹ The 1999 Minnesota Legislature directed MDH to develop standard definitions of charity care and bad debt. In 2001, MDH

⁵ See U.S. Government Accountability Office, “Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits,” Testimony Before the Committee on Ways and Means, House of Representatives, May 26, 2005 for a discussion of the 1969 IRS ruling and the types of activities that qualify as community benefits.

⁶ Section 1867 of the Social Security Act. The law applies to all hospitals that participate in the Medicare program, which includes nearly all hospitals.

⁷ Only one Minnesota hospital, Kittson Memorial Hospital and Nursing Home, still has a Hill-Burton free care obligation. U.S. Department of Health and Human Services, Health Resources and Services Administration, “Hill-Burton Facilities Obligated to Provide Free or Reduced-Cost Health Care,” <http://www.hrsa.gov/hillburton/hillburtonfacilities.htm>, accessed November 24, 2006.

⁸ Hospital Financial Management Association, “Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers,” (http://www.hfma.org/library/accounting/reporting/ppb_charity_bad_debt.htm), approved November 2006.

⁹ Minnesota Department of Health, Health Economics Program, “Uncompensated Health Care in Minnesota: An Interim Report to the Legislature,” February 1999; Minnesota Department of Health, Health Economics Program, “Uncompensated Care in Minnesota: Report to the Minnesota Legislature,” January 2000.

adopted final rules that standardized the definitions of charity care and bad debt, with input from an advisory committee that had been established for this purpose. The rules established criteria that must be met in order for hospitals to classify care as charity care, clarified specific types of care that can be included in charity care, and established a standard definition of bad debt. Figure 2 provides the current definitions of charity care and bad debt.

Figure 2

Current Definitions of Charity Care and Bad Debt

Charity Care
<p><u>General definition:</u> Charity care means the dollar amount that would have been charged by a facility for rendering free or discounted care to persons who cannot afford to pay and for which the facility did not expect payment.</p> <p>In order for services to count as charity care, a facility must:</p> <ol style="list-style-type: none"> 1) generate and record a charge; 2) have a policy on the provision of charity care that contains specific eligibility criteria and is communicated or made available to patients; 3) have made a reasonable effort to identify a third-party payer, encourage the patient to enroll in public programs, and to the extent possible, aid the patient in the enrollment process; and 4) ensure that the patient meets charity care criteria. <p>Charity care may include:</p> <ol style="list-style-type: none"> 1) services that the provider is obligated to render independently of the ability to collect; 2) care provided to patients who meet the facility's charity care guidelines and have partial insurance coverage, but who are unable to pay the remainder of their medical bills; 3) care provided to low-income patients who may qualify for a public health insurance program and meet the facility's eligibility criteria for charity care, but who do not complete the application process for public insurance despite the facility's reasonable efforts <p>Charity care does NOT include:</p> <ol style="list-style-type: none"> 1) contractual allowances (the difference between gross charges and payments received from insurance companies or other third-party payers); 2) bad debt; 3) perceived underpayments for patients covered by public insurance programs; 4) unreimbursed costs of basic or clinical research or professional education and training; 5) professional courtesy discounts; 6) community services or outreach activities 7) services for patients against whom collection actions were taken that resulted in a financial obligation documented on a patient's credit report with credit bureaus.

Bad Debt

General definition: Bad debt means the dollar amount charged for care for which there was an expectation of payment but for which the patient is unwilling to pay.

In determining whether to classify charges as a bad debt expense, a facility must:

- 1) presume that a patient is able and willing to pay until and unless the facility has reason to consider the care as a charity care case under its charity care policy and the facility classifies the care as a charity care case;
- 2) include as a bad debt expense any unpaid deductibles, coinsurance, copayments, noncovered services, and other unpaid patient responsibilities.

Source: Minnesota Rules, Chapter 4650

In addition to establishing standard definitions for reporting of charity care and bad debt, the 2001 rules required hospitals to report charity care adjustments and the number of charity care contacts by family income (income below 275 percent of federal poverty guidelines (FPG), above 275 percent of FPG, and unknown family income). The purpose of this reporting requirement was to gain information on the demographic composition of the population receiving charity care, an information gap that had been identified by the 1999 and 2000 MDH reports to the Legislature as important to understanding changing needs for uncompensated care and the uneven distribution of uncompensated care across facilities.

It is important to note that although these rules establish standard definitions for *reporting* on charity care and bad debt, they do not require that hospitals establish uniform *policies* for determining who is eligible for charity care or when to write off expenses as bad debt. Hospitals continue to establish their own policies, consistent with their resources, the needs of their communities, and their missions.

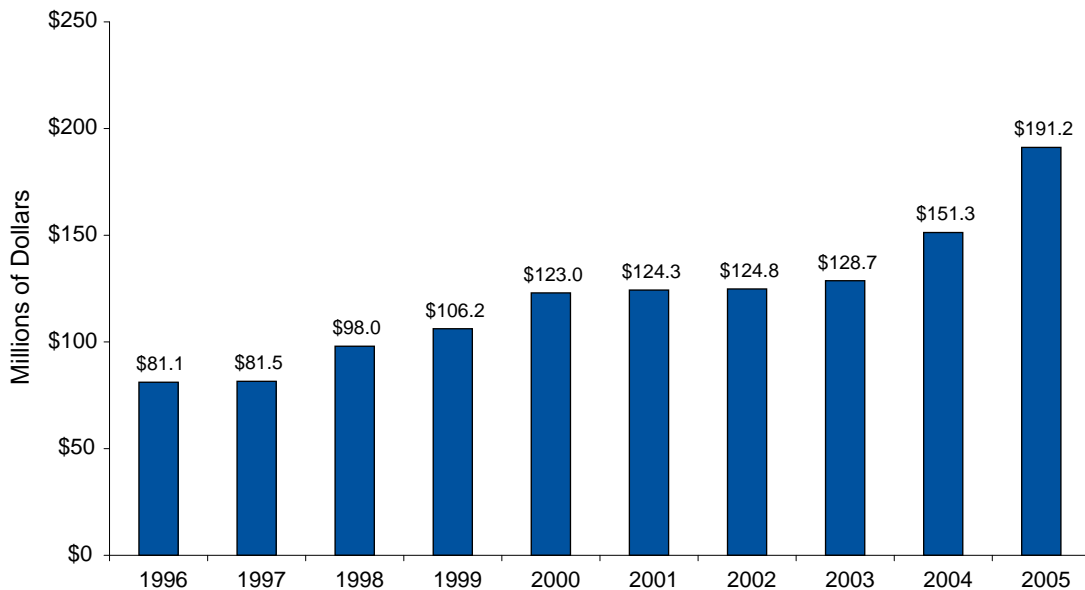
As a result of the agreements between Minnesota hospitals and the Office of the Attorney General in 2005, a new category called “self-pay discounts” was added to HCCIS reports for 2005. This reporting category is intended to include the discounts from charges that hospitals committed to provide to uninsured patients with family incomes below \$125,000 per year. Hospitals reported a total of about \$80.1 million in self-pay discounts from charges for 2005. Amounts reported in the “self-pay discount” category do not count as charity care or bad debt, and therefore are not included in uncompensated care. However, they may have had an impact on the amounts of charity care and bad debt reported for 2005. Anecdotal evidence suggests that there was some confusion among hospitals about whether discounts that a hospital provided under its charity care policy in 2005 should be reported as charity care adjustments or self-pay discounts. If hospitals reported discounts provided to patients who were eligible for charity care in the self-pay discount category, charity care for 2005 would have been under-reported. The new policies on uninsured discounts and debt collection could affect charity care and bad debt in other ways as well – for example, the discounts may encourage more uninsured patients to pay their bills and/or work out payment schedules with hospitals, ultimately reducing bad debt expense; the provisions of the agreements that standardized debt collection practices could also have an impact on bad debt expense.

Trends in Charity Care, Bad Debt, and Uncompensated Care

Minnesota hospitals incurred about \$191 million in uncompensated care costs in 2005 (see Figure 3). In contrast to the relatively stable level of uncompensated care costs that hospitals reported between 2000 and 2003, uncompensated care increased by about 18 percent in 2004 and an additional 26 percent in 2005. In 2004 and 2005, uncompensated care costs increased about 2.6 times faster than hospitals' operating expenses (total increase of 48.5 percent vs. 18.7 percent). One factor that has likely contributed to the recent increase in uncompensated care is an increase in the number of Minnesotans without health insurance. Between 2001 and 2004, the share of Minnesotans with employer-based health insurance declined from 68.4 percent to 62.9 percent; although public coverage increased during this period (from 21.2 percent to 25.1 percent of the population), it did not fully offset the decline in private coverage.¹⁰

Figure 3

Uncompensated Care Costs at Minnesota Hospitals, 1996 to 2005



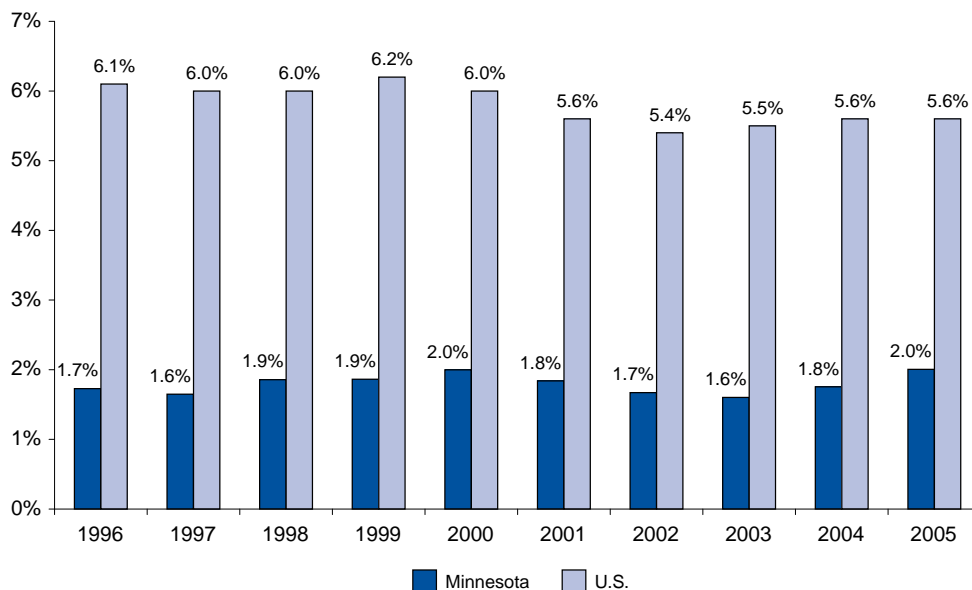
Source: MDH, Health Care Cost Information System

Despite the recent rapid growth, uncompensated care as a percent of hospital operating expenses in Minnesota remains lower than the national average, as shown in Figure 4. In 2005, Minnesota hospitals spent an average of 2.0 percent of their operating expenses on uncompensated care, less than half the national average of 5.6 percent. The fact that Minnesota's uninsurance rate has historically been among the lowest in the nation is a key reason why uncompensated care in Minnesota is so much lower than the national average.

¹⁰ Minnesota Department of Health, Health Economics Program, and University of Minnesota School of Public Health, "Health Insurance Coverage in Minnesota: Trends from 2001 to 2004," February 2006.

Figure 4

Uncompensated Care as a Percent of Hospital Operating Expenses

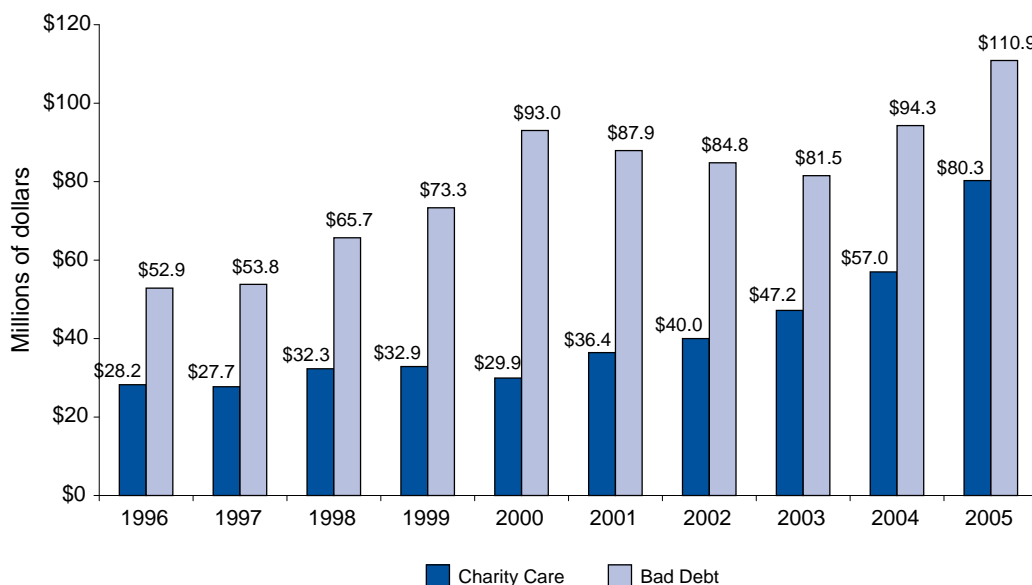


Sources: MDH, Health Care Cost Information System, American Hospital Association

Figure 5 illustrates trends in the components of uncompensated care. Although the overall level of uncompensated care was stable from 2000 to 2003, hospitals reported an increase in charity care (from \$30 million to \$47 million, a 57 percent increase) and a decline in bad debt (from \$93 million to \$82 million, a decline of nearly 12 percent) during this period. It is not possible to determine how much of this change, if any, is due to the implementation of standardized definitions of charity care and bad debt in 2001. Between 2003 and 2005, reported costs of charity and bad debt both increased substantially: charity care rose by about 70 percent over the 2-year period, while bad debt increased by about 36 percent.

Figure 5

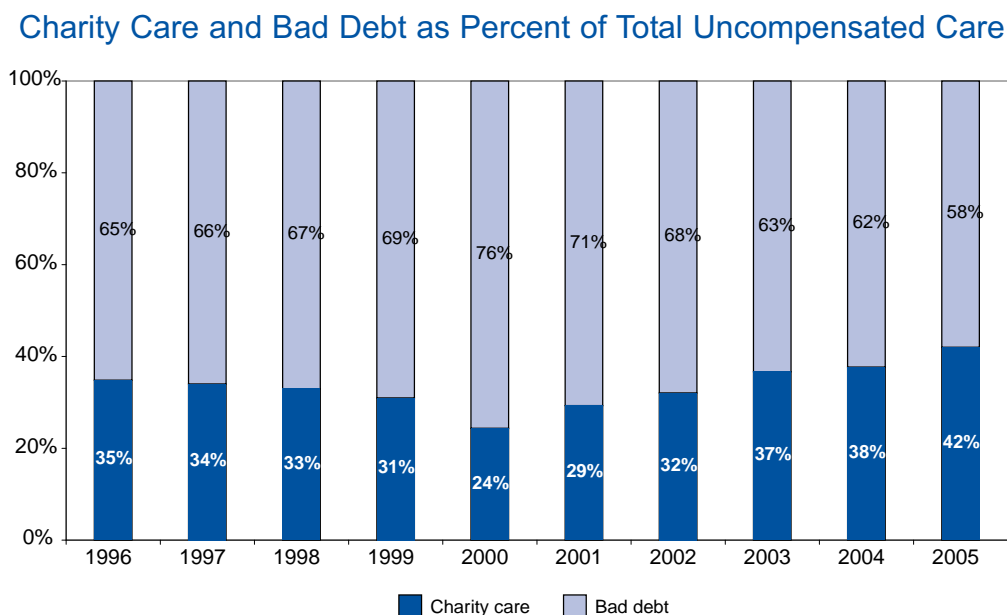
Minnesota Hospitals' Trends in Charity Care and Bad Debt, 1996 to 2005



Source: MDH, Health Care Cost Information System

The historical trend in charity care and bad debt as a share of total uncompensated care is presented in Figure 6. In 2005, bad debt was responsible for 58 percent of Minnesota hospitals' uncompensated care costs, and charity care accounted for 42 percent. The share of uncompensated care attributable to bad debt has been declining in recent years, while the share attributable to charity care has increased. Again, it is not possible to determine how much of this change may have been attributable to changes in the definitions and reporting of charity care and bad debt. It appears, however, that there may still be variation across hospitals in how charity care and bad debt are reported (this issue is discussed in more detail below).

Figure 6

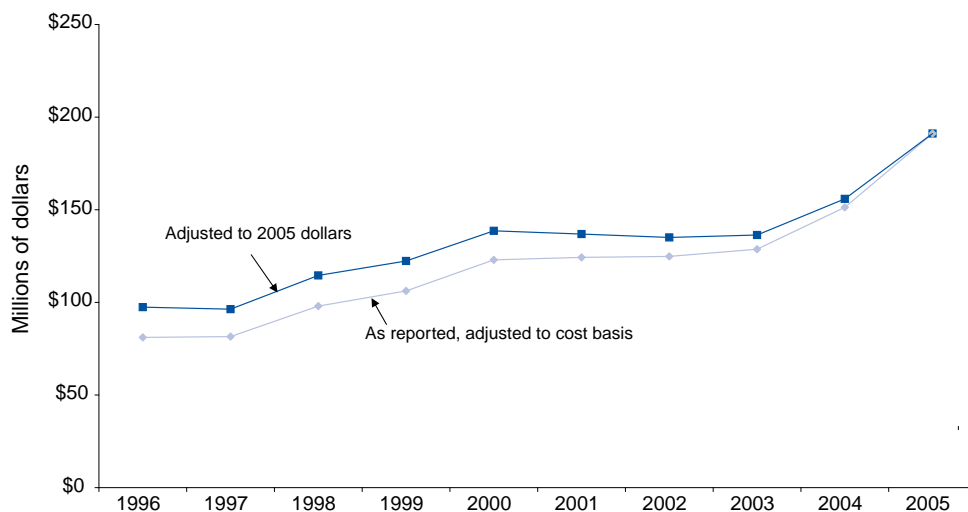


Source: MDH, Health Care Cost Information System

Figure 7 illustrates the trend in uncompensated care, adjusted for inflation (in 2005 dollars). Adjusted for inflation, total uncompensated care actually declined slightly in 2001 and 2002. Even after adjusting for inflation, however, the increase between 2003 and 2005 was large (about 40 percent).

Figure 7

Inflation-Adjusted Uncompensated Care



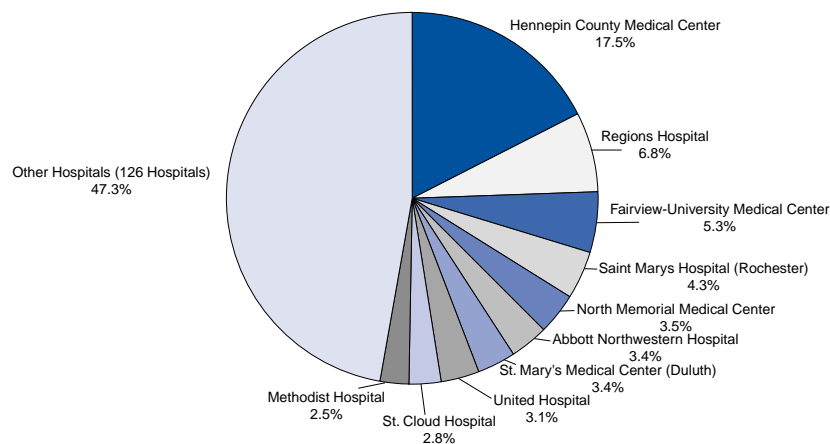
Source: MDH, Health Care Cost Information System; adjustment to 2005 dollars was calculated using GDP implicit price deflator.

Variations in Uncompensated Care

Historically, the financial burden of providing uncompensated care has been concentrated among a relatively small number of hospitals in Minnesota. The largest single provider of uncompensated care is Hennepin County Medical Center, which provided about 17.5 percent of total uncompensated care in Minnesota in 2005 (see Figure 8). Regions Hospital was the second-largest provider of uncompensated care, with 6.8 percent of the total, and Fairview-University Medical Center accounted for 5.3 percent. The ten largest providers of uncompensated care accounted for 53 percent of total uncompensated care in Minnesota in 2005, with the remaining 126 hospitals accounting for the other 47 percent.

Figure 8

Distribution of Uncompensated Care by Hospital, 2005

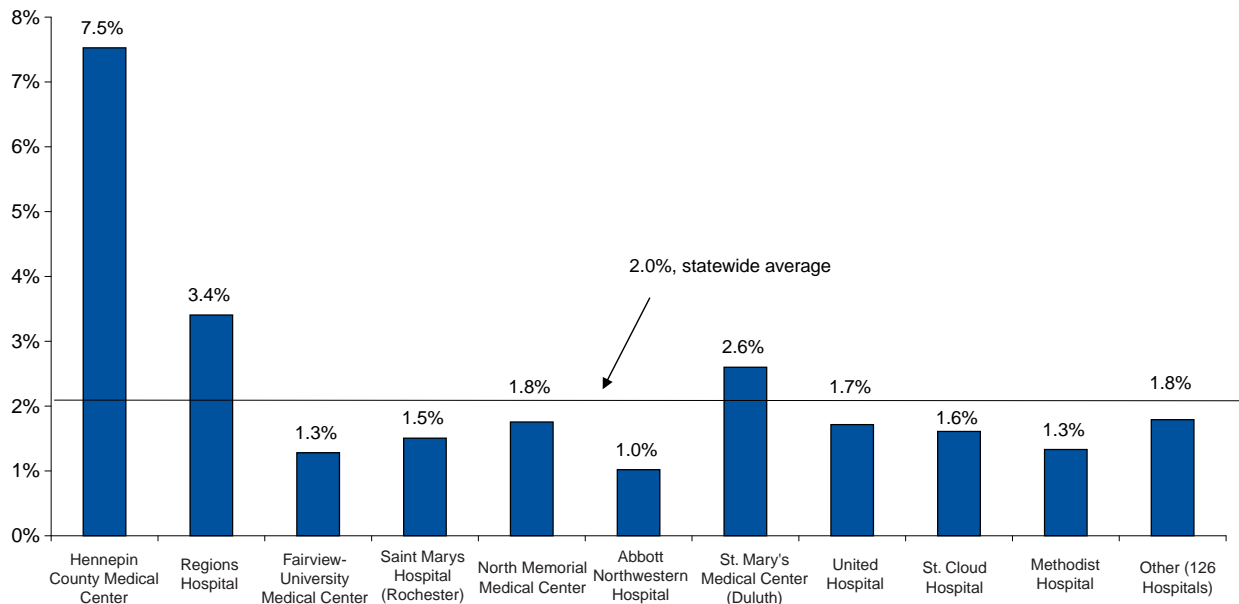


Source: MDH, Health Care Cost Information System

For the 10 largest providers of uncompensated care, Figure 9 illustrates the variation in uncompensated care as a percentage of operating expenses. In addition to having the highest level of uncompensated care, Hennepin County Medical Center also had the highest uncompensated care as a share of operating expenses (7.5 percent) in 2005. Regions Hospital spent 3.4 percent of hospital operating expenses on uncompensated care and St. Mary's Medical Center spent 2.6 percent. The other seven of the ten largest providers of uncompensated care spent less than the state average of 2.0 percent of hospital operating expenses on uncompensated care.

Figure 9

Ten Largest Providers of Hospital Uncompensated Care in 2005: Uncompensated Care as Percent of Hospital Operating Expenses

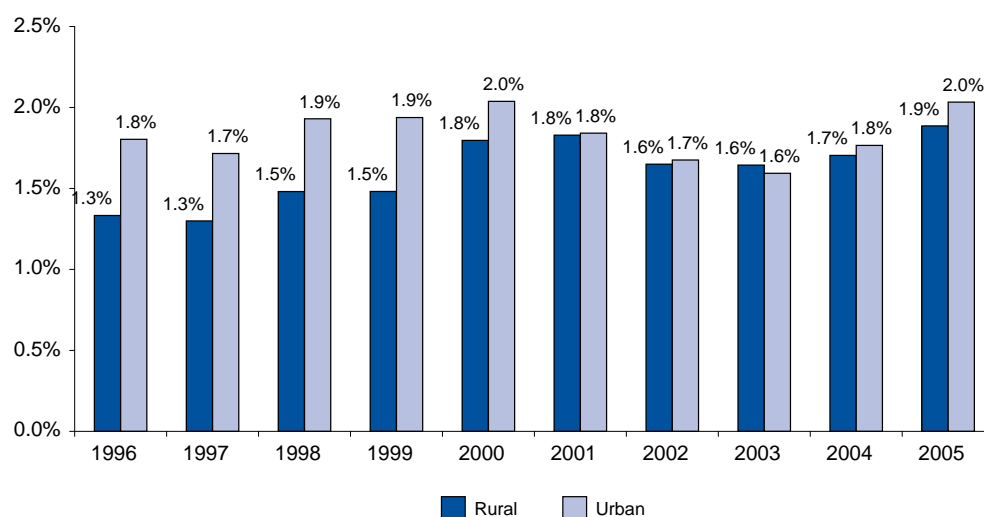


Source: MDH, Health Care Cost Information System

In 2005, uncompensated care as a share of operating expenses was about the same for urban hospitals as it was for rural hospitals (2.0 percent and 1.9 percent, respectively, as shown in Figure 10). In the late 1990s, urban hospitals typically reported a substantially higher ratio of uncompensated care to operating expenses than rural hospitals, but this difference has virtually disappeared. Table 1 provides additional information on uncompensated care by hospital size and ownership. The largest hospitals in Minnesota (more than 200 licensed beds) provide about two-thirds of total uncompensated care. Private nonprofit hospitals provide over three fourths of hospital uncompensated care in Minnesota, but uncompensated care as a share of operating expenses is lower for nonprofits (1.7 percent in 2005) than it is for government hospitals as a group (4.0 percent in 2005); if Hennepin County Medical Center is excluded from the analysis, however, uncompensated care as a percent of operating expenses at private nonprofit hospitals and government hospitals is about the same (1.7 percent in 2005).

Figure 10

Uncompensated Care Trends for Rural and Urban Minnesota Hospitals: Uncompensated Care as Percent of Operating Expenses



Source: MDH, Health Care Cost Information System. "Urban" includes hospitals located in counties that are part of a metropolitan statistical area (MSA); hospitals in counties that are not part of an MSA are defined as rural.

Table 1

Uncompensated Care by Type of Hospital

	2000	2001	2002	2003	2004	2005
In millions of dollars:						
Total, all hospitals	\$123.0	\$124.3	\$124.8	\$128.7	\$151.3	\$191.2
By geography:						
Rural hospitals	\$18.1	\$20.4	\$21.2	\$22.9	\$26.1	\$33.5
Urban hospitals	\$104.8	\$103.9	\$103.6	\$105.8	\$125.2	\$157.6
	\$123.0	\$124.3	\$124.8	\$128.7	\$151.3	\$191.2
By number of licensed beds:						
25 or fewer	\$2.5	\$2.5	\$3.3	\$3.3	\$3.9	\$4.4
26 to 50	\$10.2	\$11.4	\$11.4	\$12.6	\$14.1	\$16.0
51 to 100	\$12.3	\$12.8	\$15.0	\$16.0	\$16.7	\$24.5
101 to 200	\$15.3	\$13.4	\$14.0	\$13.0	\$15.8	\$19.0
More than 200	\$82.8	\$84.2	\$81.1	\$83.8	\$100.8	\$127.2
	\$123.0	\$124.3	\$124.8	\$128.7	\$151.3	\$191.2
By type of ownership:						
Government	\$27.6	\$30.3	\$30.0	\$30.8	\$36.3	\$45.3
Private nonprofit	\$94.2	\$94.0	\$94.7	\$97.8	\$115.0	\$145.8
Private for-profit	\$1.2	\$0.1	\$0.1	\$0.1	\$0.0	\$0.1
	\$123.0	\$124.3	\$124.8	\$128.7	\$151.3	\$191.2
As percent of operating expenses:						
Total, all hospitals	2.0%	1.8%	1.7%	1.6%	1.8%	2.0%
By geography:						
Rural hospitals	1.8%	1.8%	1.6%	1.6%	1.7%	1.9%
Urban hospitals	2.0%	1.8%	1.7%	1.6%	1.8%	2.0%
By number of licensed beds:						
25 or fewer	2.0%	1.6%	1.9%	1.8%	1.7%	1.7%
26 to 50	2.1%	2.3%	2.0%	1.9%	2.0%	2.2%
51 to 100	2.0%	1.8%	1.8%	1.8%	1.8%	2.0%
101 to 200	2.0%	1.5%	1.4%	1.2%	1.3%	1.5%
More than 200	2.0%	1.9%	1.7%	1.6%	1.8%	2.1%
By type of ownership:						
Government	3.5%	3.6%	3.3%	3.2%	3.5%	4.0%
Private nonprofit	1.8%	1.6%	1.4%	1.4%	1.5%	1.7%
Private for-profit	5.3%	3.5%	3.0%	3.5%	2.9%	0.5%

Consistency of Reporting Across Hospitals

As noted earlier, standardized definitions for charity care and bad debt were adopted in 2001 in an attempt to improve the comparability of charity care and bad debt across hospitals. However, it appears likely that there is still variation across hospitals in which uncompensated care costs are allocated to charity care and which are considered bad debt. For example, among the ten hospitals providing the most uncompensated care in 2005, the percentage of uncompensated care that was attributable to charity care ranged from 32 percent at Fairview-University Medical Center to 95 percent at Regions Hospital (see Table 2). For the 126 other Minnesota hospitals, there is also substantial variation in charity care as a percentage of total uncompensated care (ranging from 0 to 80 percent in 2005, with a median of 21 percent for all hospitals).

Table 2

Charity Care as Percent of Uncompensated Care

	2001	2002	2003	2004	2005
Total, all hospitals	29.3%	32.0%	36.7%	37.7%	42.0%
<u>By geography:</u>					
Rural hospitals	15.9%	15.0%	15.9%	16.9%	21.0%
Urban hospitals	31.9%	35.5%	41.2%	42.0%	46.5%
<u>By number of licensed beds:</u>					
25 or fewer	22.6%	12.9%	14.5%	15.5%	20.2%
26 to 50	13.4%	12.2%	12.5%	13.9%	18.5%
51 to 100	13.9%	13.2%	17.3%	21.2%	26.7%
101 to 200	27.7%	20.8%	24.2%	25.9%	32.4%
More than 200	34.2%	41.0%	46.8%	46.4%	50.1%
<u>By type of ownership:</u>					
Government	27.9%	34.2%	37.4%	36.9%	39.8%
Private nonprofit	29.8%	31.4%	36.4%	37.9%	42.7%
Private for-profit	1.6%	12.1%	5.3%	14.4%	7.1%
<u>Largest providers of uncompensated care:</u>					
Hennepin County Medical Center	32.1%	43.2%	47.0%	45.2%	47.1%
Regions Hospital	87.7%	93.8%	96.6%	97.1%	95.2%
Fairview-University Medical Center	5.8%	10.2%	24.1%	23.6%	32.4%
Saint Marys Hospital (Rochester)	56.3%	58.7%	50.1%	42.5%	47.4%
North Memorial Medical Center	23.2%	33.1%	32.9%	34.6%	44.4%
Abbott Northwestern Hospital	37.0%	32.6%	49.1%	53.2%	63.5%
St. Mary's Medical Center (Duluth)	45.8%	41.4%	44.5%	35.4%	32.8%
United Hospital	23.7%	19.8%	34.2%	42.4%	55.1%
St. Cloud Hospital	31.6%	33.9%	35.0%	36.9%	36.7%
Methodist Hospital	5.8%	12.0%	7.3%	19.5%	40.8%

From the data available, it is not possible to determine whether these differences are the result of inconsistent reporting across hospitals or over time, or whether they are the result of other factors (for example, differences in facilities' charity care policies, differences in the degree to which facilities assist patients in enrolling in public programs and/or collect on bad debt, or differences in how hospitals treat charges incurred by patients for whom they are unable to document eligibility for charity care). Among hospitals with relatively small amounts of uncompensated care, another contributing factor to variation in charity care and bad debt as a share of total uncompensated care could be random variation in the number of patients who qualify for uncompensated care or the result of having a small number of cases that are more expensive than average.

Charity care as a share of total uncompensated care increased by 12.7 percentage points from 2001 to 2005 (from 29.3 percent to 42.0 percent of the total), as shown in Table 2. Beginning in 2001, all of the data should reflect the standardization of the definitions of charity care and bad debt. Factors that may have played a role in

this increase include changes in hospitals' charity care policies, changes in the degree to which hospitals attempt to collect on bad debt, changes in the degree to which hospitals assist patients in obtaining public coverage or document patients' eligibility for charity care, an increase in the number of uninsured patients receiving charity care, or an increase in the percentage of people who are insured but cannot afford to pay their portion of the hospital bill.

Table 2 also illustrates significant variation across different types of hospitals in the share of uncompensated care that is attributed to charity care. For example, the largest hospitals experienced the biggest increase (about 16 percentage points) in the ratio of charity care to uncompensated care, while hospitals with 25 or fewer licensed beds experienced a 2 percentage point decline. Among the ten largest providers of uncompensated care in 2005, some hospitals show much more change in the ratio of charity care to total uncompensated care over time than others, as shown in Table 2. For example, reported charity care as a percentage of total uncompensated care grew from 6 percent to 32 percent for Fairview-University Medical Center between 2001 and 2005, and from 6 percent to 41 percent for Methodist Hospital; meanwhile, charity care as a percentage of uncompensated care declined for some other hospitals, and was relatively stable for others.

The changes in definitions used for reporting of charity care and bad debt that were implemented in 2001 also required hospitals to report on the number of charity care cases and the amount of charity care by family income. However, 72 out of 133 Minnesota hospitals that reported any charity care reported all of it in the "unknown income" category in 2005. Because most hospitals use income as a criterion for charity care eligibility, it seems unlikely that family income is truly unknown for most charity care cases at hospitals that did not provide the breakout by income. In other words, there is substantial room for improvement in the consistency of reporting of hospital charity care by income. Among hospitals that do report breakouts by income level, about 75 percent of total charity care was provided to patients with family incomes less than 275 percent of federal poverty guidelines. (Nearly all of the charity care that was reported for patients with family incomes above 275 percent of poverty guidelines was reported by Regions Hospital.)

Upcoming Changes in Reporting of Charity Care, Bad Debt, and Self-pay Discounts

Beginning with data reported in HCCIS for 2007, there will be some changes in reporting of charity care, bad debt, and self-pay discounts. One reason for the changes is to clarify how hospitals should report charity care and bad debt in light of confusion regarding what to include in the new self-pay discount category. Another reason for the change is to collect more detail on charity care and bad debt to allow for a more in-depth understanding of uncompensated care, and to calculate a more precise cost to charge adjustment for uncompensated care. These changes will be reflected in data reported for 2007 and future years. Specifically, the following changes in hospital reporting of charity care, bad debt, and self-pay discounts will take place:

- **Charity Care:** This category includes the dollar amount that would have been charged for providing health care services for which there was no expectation of payment because the patient met the hospital's eligibility requirements for charity care. Starting in 2007, hospitals will separate free care (100% discount) from charity care provided as a partial discount from charges, and will report charity care separately for insured and uninsured patients. Hospitals will also begin to report separately on "purchased charity care services," which are services that a hospital purchases on behalf of a specific individual who is eligible for charity care in order to prevent a future need for potentially more costly inpatient or outpatient hospital charity care. In addition, hospitals will be asked to provide the average percentage discount that they provide for people who qualify for partial charity care discounts.

- **Bad Debt:** This category includes the dollar amount charged for health care services for which the hospital expected to receive payment but did not. Starting in 2007, hospitals will report bad debt for insured and uninsured patients separately. New definitions also specify that if a patient qualifies for a self-pay discount or a partial charity care discount but does not pay the remaining portion of the bill, that the discounted amount (the amount provided with no expectation of payment) cannot be counted as bad debt. (In other words, bad debt includes only amounts that hospitals expected to collect.)
- **Self-Pay Discounts:** This category includes discounts for patients who qualify for discounts to uninsured patients with household income below \$125,000 per year. Starting in 2007, self-pay discounts are not to be reported in this category if the discount is included in a hospital's charity care policy. In addition, hospitals will be asked to provide information on the percentage discount that they apply to bills for these self-pay patients.

Financing of Hospital Uncompensated Care

Uncompensated care provided in hospitals is financed through a variety of mechanisms. Disproportionate Share Hospital (DSH) payments from Medicare and Medicaid are the largest sources of funding for hospital uncompensated care. DSH payments are not directly targeted for hospital uncompensated care, but the funds are allocated to hospitals to offset the costs of serving low-income patients. At the national level, it is estimated that roughly 70% of hospital uncompensated care is financed through Medicare and Medicaid DSH payments.¹¹ In 2004, Minnesota hospitals received \$66 million in Medicare DSH payments and \$42 million in Medicaid DSH payments. Other sources of funding for uncompensated care include tax appropriations (primarily for government owned hospitals) and grants and donations. Hospitals may also finance uncompensated care by shifting some of the cost to third party payers, or by absorbing the cost.

Charity Care Policies and Practices

The legislation requiring this study directs MDH to analyze the impact of any changes in hospitals' charity care policies and debt collection practices in the past three years on the amount of uncompensated care provided and the number of patients receiving uncompensated care. In order to address these questions, MDH conducted a survey of all Minnesota hospitals to collect information on their charity care policies, debt collection policies, recent changes in these policies, and information that would allow for an analysis of the impact of recent changes on the dollar volume of uncompensated care and the number of patients receiving uncompensated care.

Minnesota Hospitals' Charity Care and Debt Collection Policies

Nearly all Minnesota hospitals have an explicit charity care policy. Of the 135 hospitals operating in Minnesota in 2006,¹² 128 provided MDH with a copy of their charity care policy. Five hospitals indicated that they do not currently have a formal charity care policy, but several of these hospitals reported that they are in the process of

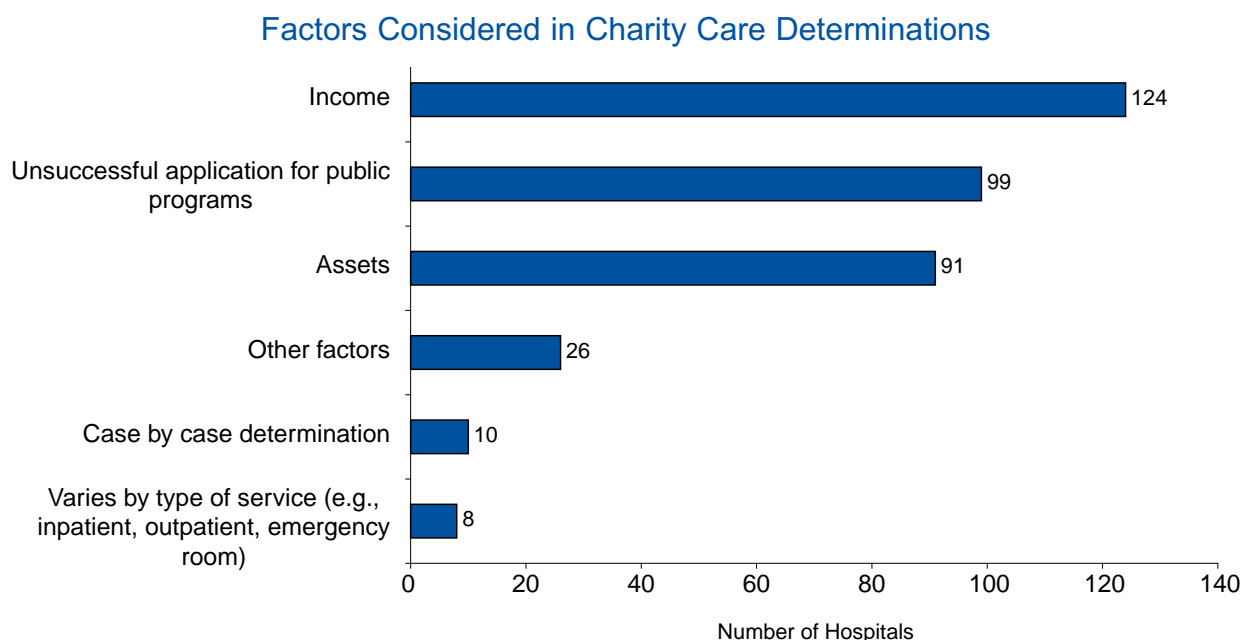
¹¹ Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured Issue Update, May 2004, and Jack Hadley and John Holahan, "How Much Medical Care Do The Uninsured Use, and Who Pays For It?" Health Affairs Web Exclusive, February 2003.

¹² One hospital, Minnewaska Regional Health System, closed in 2005 and is not included in this analysis.

developing one. Two hospitals did not provide information on whether they have a charity care policy. Most hospitals (107 out of the 128 that provided copies of their charity care policies) reported that their policies have been reviewed, changed, or updated since 2004.

Most Minnesota hospitals use their charity care policies to define eligibility requirements for free or discounted care. Only 10 hospitals reported that they do not use fixed criteria to make a determination, but instead determine eligibility on a case-by-case basis (see Figure 11). However, hospitals with specified eligibility criteria and those that determine eligibility on a case-by-case basis use similar information to decide which cases are eligible for charity care. In total, 124 out of the 128 hospitals that provided copies of their charity care policies use income to determine eligibility for charity care.¹³ Most hospitals (91 out of 128) also consider patients' assets in their charity care determination process.¹⁴ In addition, most hospitals' charity care policies (99 out of 128) require that patients be determined to be ineligible for public insurance coverage in order to qualify for charity care.

Figure 11



Source: MDH survey of hospitals. Includes information from 128 hospitals that provided a copy of their charity care policy.

The income guidelines used in determining eligibility for charity care vary across hospitals. MDH analyzed available charity care policies to identify the income thresholds used by hospitals to determine patient eligibility for full (100% discount) and partial (sliding scale discount) charity care. Table 3 shows the variation in income limits used to determine eligibility for both full and partial charity care for 123 hospitals that provided this

¹³ Some use family income and some use household income.

¹⁴ One hospital reported using an asset test only, without regard to income.

information.¹⁵ According to MDH's analysis of charity care policies, ninety-one hospitals use specific income guidelines to determine eligibility for free care and 89 hospitals use specific income guidelines for determining eligibility for partial charity care.

Table 3

Guidelines Used by Minnesota Hospitals to Determine Charity Care Eligibility

Income limit (as % of federal poverty guidelines)	Number of hospitals providing:	
	Free Care (Full Discount)	Partial Discount
100% or below	27	1
101 to 150%	14	6
151 to 200%	31	34
201 to 250%	8	10
251 to 300%	11	15
301 to 350%	0	3
351 to 400%	0	14
401 to 450%	0	5
Above 450%	0	1
Income limits used, but information not provided	19	30
Determination made on case by case basis	0	1
Other	2	2
Not offered	11	1
	123	123

Federal poverty guidelines vary by family size. For example, the 2006 federal poverty guideline is \$9,800 for a one-person family; \$13,200 for a 2-person family; \$16,600 for a 3-person family; \$20,000 for a four-person family; and \$3,400 for each additional person.

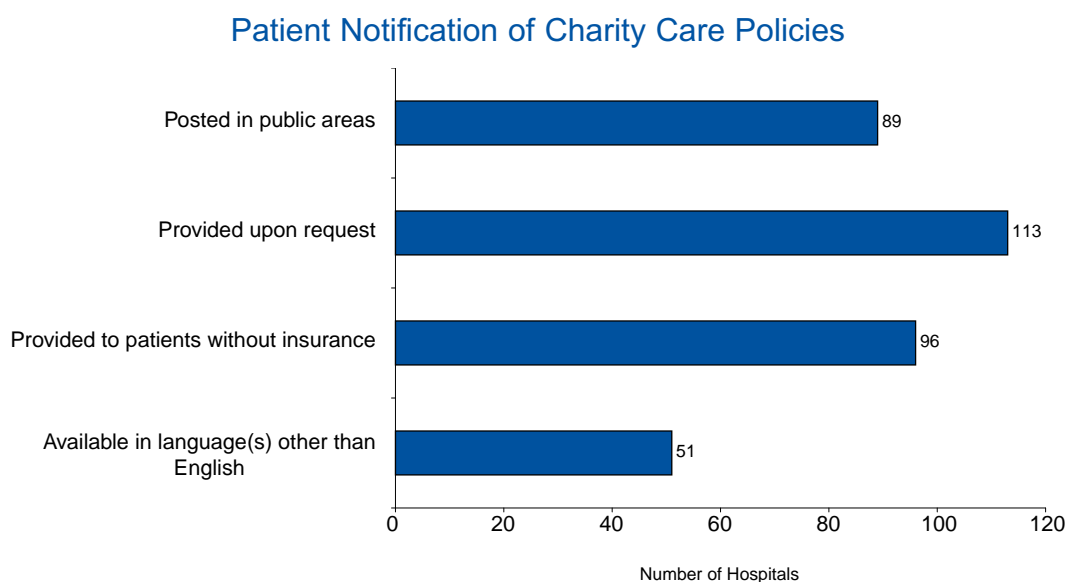
In addition to differences among hospitals in income and asset standards used for determining charity care eligibility, there are many other ways in which hospitals' charity care policies vary. For example, some hospitals offer charity care only to uninsured patients, while others include insured patients in their eligibility criteria. Some base eligibility for charity care on where the patient lives (e.g., in the primary service area of the hospital). Others specify a range of health care services that are included and excluded from charity care eligibility. Some hospitals' charity care policies place a cap on a patient's liability for out of pocket costs, and others limit patient liability to a certain percentage of their income. Finally, some hospitals set explicit annual budgets for charity care and make decisions about charity care according to this budget.

There is relatively little variation in the types of information that hospitals require patients to provide in order to document eligibility for charity care. In general, patients are asked to list and document their income (household or family income) from all sources and the assets they hold. There is some variation in what hospitals count as assets for the purpose of determining charity care eligibility (for example, whether a second car is included in the calculation). Finally, some hospitals explicitly consider the potential hardship that the full or discounted medical bill presents by also collecting information on monthly expenses.

¹⁵ Five hospitals reported that they use the U.S. Department of Housing and Urban Development (HUD) Very-Low income Guidelines instead of the Federal Poverty Guidelines. Eligibility for full charity care in these hospitals requires an income at or below 130% of the HUD Very-Low Income Guidelines, and the sliding scale for partial charity care eligibility requires that patient income limits are between 130% and 195% of the HUD guidelines.

MDH's survey on hospital charity care policies also collected information on the ways in which hospitals communicate their charity care policies to patients (see Figure 12). Most hospitals (70 percent) reported that they post information about charity care in public areas, or instruct staff to provide it to patients without insurance coverage (76 percent of hospitals). Seven hospitals reported that information about charity care discounts is provided to patients only upon request. Finally, about 40 percent of hospitals reported that they make this information available to patients in a language other than English. Some hospitals indicated that they also inform patients about charity care policies by including information on patient bills, hospital websites, or by other means.

Figure 12



Source: MDH survey of hospitals. Includes information from 128 hospitals that provided a copy of their charity care policy.

With regard to hospitals' policies on debt collection, the agreements that all of Minnesota's 136 hospitals signed with the Attorney General's office in the spring of 2005 effectively standardized debt collection policies across the industry. Of the state's 135 hospitals, 64 percent reported having had formal billing and collection policies in place prior to signing the agreement with the Attorney General. The extent of difference between the new standardized policy and previous policies is not clear, but likely varies across hospitals.

Impact of Changes in Charity Care and Debt Collection Policies

For several reasons, it is difficult to determine how recent changes in Minnesota hospitals' charity care and bad debt collection policies have affected the dollar volume and number of patients receiving uncompensated care. First, the most recent year of hospital financial data that is currently available is data for hospital fiscal year 2005, which for many hospitals largely precedes their agreement with the Attorney General.¹⁶ In order to get a more timely and accurate picture of trends in uncompensated care, the survey that MDH conducted for this

¹⁶ Data that hospitals report to MDH is provided on a fiscal year basis. For 29 hospitals, fiscal year 2005 ended before or soon after the agreements with the Attorney General's office were signed.

study asked hospitals to provide information on charity care, bad debt, and self-pay discounts for semiannual periods (in order to better distinguish the effect of changes that may have occurred in the middle of a year) from the first half of 2003 through the first half of 2006. Not all hospitals provided detailed financial information in response to this question, and even fewer were able to report on the numbers of patients in each of these three categories. As a result, MDH's ability to analyze the impact of changes in hospitals' charity care and debt collection policies is very limited. Only 103 hospitals reported historical charity care data, and 107 hospitals reported historical data on bad debt. With regard to the number of patients, only 26 hospitals provided information on the number of patients receiving charity care, and 8 provided information on the number incurring bad debt.¹⁷

Several other factors complicate this analysis. For example, as noted earlier most hospitals have changed their charity care policies since 2004. For many, the changes were relatively minor, such as changes that update income criteria to correspond to new federal poverty guidelines. In many cases, however, MDH was unable to determine the extent of changes to a hospital's charity care policy in order to distinguish major changes from minor ones. In addition, many other types of changes such as an increase in Minnesota's uninsured population,¹⁸ increases in the cost of providing care, and increases in the number of people with high-deductible health insurance policies (or other significant enrollee cost sharing requirements) were occurring in Minnesota's health care marketplace during the same time period, making it very difficult to isolate the impact of changes in hospital policy on the level of uncompensated care provided.

During most of the period shown in Table 4, growth in charity care outpaced that of bad debt (the exception to this is the first half of calendar year 2004). The strongest growth in charity care was observed for the first half of 2005, when charity care grew by 34 percent compared to the previous 6 months; growth in bad debt was also highest during this period (20 percent). Due to the limited availability of data and the many other changes taking place during this time period, it is impossible to determine how much, if any, of the changes observed were due to changes in hospitals' charity care and/or debt collection policies.

Table 4

Part-Year Analysis of Changes in Charity Care and Bad Debt, 2003 to 2006

	Charity Care (\$ millions)	Growth vs. Previous Six Months	Bad Debt (\$ millions)	Growth vs. Previous Six Months	Total Uncompensated Care	Growth vs. Previous Six Months
2003: 1st half	\$20.8		\$43.0		\$63.8	
2nd half	\$26.5	27.5%	\$43.0	-0.1%	\$69.5	8.9%
2004: 1st half	\$28.9	9.1%	\$48.0	11.7%	\$76.9	10.7%
2nd half	\$34.6	19.8%	\$50.4	5.1%	\$85.0	10.6%
2005: 1st half	\$46.4	34.1%	\$60.7	20.4%	\$107.1	26.0%
2nd half	\$58.1	25.2%	\$63.6	4.8%	\$121.7	13.6%
2006: 1st half	\$55.5	-4.4%	\$59.0	-7.2%	\$114.5	-5.9%
Number of hospitals included in analysis:	103		107		107	

Note: figures reported in this table are based on data reported through an MDH survey conducted specifically for this study, while data on charity care, bad debt, and uncompensated care used elsewhere in this report is from HCCIS. One possible reason for the difference between this table and data reported elsewhere is that these data were reported by hospitals for time periods that may not coincide with their fiscal years (HCCIS data is reported on a fiscal year basis).

¹⁷ Twenty hospitals provided information on the number of visits resulting in charity care, and 14 provided information on the number of visits resulting in bad debt.

¹⁸ Minnesota Department of Health, Health Economics Program, and University of Minnesota School of Public Health, "Health Insurance Coverage in Minnesota: Trends from 2001 to 2004," February 2006.

Community Benefits

As noted earlier, current federal policy applies a “community benefit standard” to determine whether hospitals qualify as tax-exempt nonprofits. The community benefit standard does not explicitly require that hospitals provide charity care, although charity care is one component of community benefit. IRS guidance has defined several types of other activities that qualify as community benefits: these include operating an emergency room open to all members of the community without regard to their ability to pay; maintaining an open medical staff; treating patients receiving public assistance; and using surplus funds to improve facilities, patient care, medical training, education, and research.¹⁹

The past few years have seen considerable debate about the degree to which nonprofit hospitals should be required to demonstrate the value of community benefits that they provide. Critics of current IRS policy argue that the community benefit standard does not require any measurable difference in behavior between nonprofit and for-profit hospitals.²⁰ Others have pointed out that there is wide variation in hospitals’ public reporting of the community benefits they provide.²¹

At least partly as a result of this public debate, there have been many attempts at clarifying the definition of “community benefits” and increasing uniformity in the way that hospitals quantify and report community benefits. (Many activities that qualify as community benefit under the IRS standard, such as operating an emergency room that accepts all patients regardless of ability to pay and maintaining an open medical staff, are not necessarily quantifiable.) To the degree that there is any current consensus on defining and measuring community benefit, a set of standards developed by the Catholic Health Association (CHA) and VHA Inc. is most widely used.²²

The CHA/VHA standards for measuring and reporting on quantifiable community benefits include the following:

- Charity care;
- Payment shortfalls from providing care to patients insured by Medicaid and other public programs for indigent care (but not Medicare). Under the CHA/VHA definition, payment shortfalls should include provider taxes that are used as matching funds for federal Medicaid resources, and Medicaid DSH payments to hospitals should be subtracted from the shortfall;
- Community health services – examples include community health education, community-based clinical services such as free clinics and screenings, health care support services, and self-help programs;
- Health professions education;
- Subsidized health services (services that operate at a financial loss, such as trauma services, burn units, and neonatal intensive care units);
- Research;

¹⁹ U.S. Government Accountability Office, “Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits,” Testimony Before the Committee on Ways and Means, House of Representatives, May 26, 2005.

²⁰ Written statement of John D. Colombo, Professor of Law, University of Illinois College of Law, Urbana-Champaign, before the House Committee on Ways and Means, May 26, 2005.

²¹ U.S. General Accounting Office, “Nonprofit Hospitals: Better Standards Needed for Tax Exemption,” Report to the Chairman, Select Committee on Aging, U.S. House of Representatives, May 1990.

²² Catholic Health Association, “A Guide for Planning and Reporting Community Benefit,” 2006.

- Financial and in-kind contributions made by the hospital to benefit individuals and/or the community at large;
- Community-building activities – examples include economic development activities, community support system enhancements, environmental improvements, and leadership development training for community members; and
- Community benefit operations, which includes the cost associated with dedicated staff, costs associated with assessing community health needs, and other costs associated with community benefit strategy and operations.

The CHA/VHA standards provide detailed guidance as to what types of costs and activities should be included in community benefit and which should not, as well as a software program to help hospitals apply these standards to their community benefit activities. Not everything that is included under the CHA/VHA definition of “community benefit” is necessarily a contribution that a hospital makes voluntarily to benefit its community as part of its charitable mission; for example, the definition counts provider taxes as part of community benefit. It is important to note also that this definition of community benefit may also be different from the standard that would be used if a hospital’s tax-exempt status were being challenged.

The American Hospital Association (AHA) has called for standardized public reporting of community benefit (as an attachment to nonprofit hospitals’ annual filings with the IRS on Form 990) using a model that is based on the definitions developed by CHA/VHA.²³ Although the CHA/VHA standards have come to be used as a starting point for most discussions about quantifying hospital community benefits, there are a few significant areas of disagreement about what to count when measuring community benefits.

First, various parties have taken different positions on whether hospital shortfalls from caring for Medicare patients should also be included in community benefit. The AHA has argued that Medicare payment shortfalls should be included,²⁴ while the current CHA/VHA standards exclude Medicare shortfalls. The CHA/VHA guidelines justify excluding Medicare payment shortfalls from community benefit because Medicare payment policy is intentionally set to cover the costs that an “efficient” hospital would incur to serve Medicare patients.²⁵ The Healthcare Financial Management Association (HFMA), a trade organization for health care financial management executives, has noted that Medicare payment shortfalls are different from Medicaid in the sense that the Medicare program serves all elderly and disabled patients regardless of income, in contrast to Medicaid which is specifically for low-income populations; in other words, payment shortfalls from Medicaid are shortfalls incurred from serving the poor (and thus more directly related to a nonprofit hospital’s charitable mission), while Medicare payment shortfalls are not. HFMA has taken the position that decisions about including Medicare shortfalls in community benefit should be made on a hospital by hospital basis.²⁶

²³ Testimony of the American Hospital Association before the U.S. Senate Committee on Finance on “Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals,” September 13, 2006.

²⁴ AHA testimony, September 13, 2006.

²⁵ Cinda Becker, “Charitable Intentions,” *Modern Healthcare*, June 5, 2006.

²⁶ Hospital Financial Management Association, “Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers.”

A second issue of debate about what should be included in community benefit is the treatment of bad debt. AHA recommends including bad debt in the calculation of community benefit, while CHA/VHA and HFMA have recommended excluding it. The primary argument for including bad debt in community benefit is that it likely includes services provided to patients who were eligible for charity care but either did not complete the application process or were not aware of their potential eligibility. If this is the case, an alternative to counting bad debt as community benefit would be to make greater efforts to identify charity care eligible patients. The main argument against including bad debt in community benefit is that bad debt is an ordinary cost of doing business experienced by all hospitals (nonprofit and for-profit) and all health care providers. In addition, bad debt is not the result of deliberate actions taken by nonprofit hospitals to further their charitable missions.

In a recent Minnesota Hospital Association (MHA) report on community benefits provided by Minnesota hospitals, the calculation of community benefits included charity care, Medicaid payment shortfalls and the Medicaid surcharge, MinnesotaCare taxes, and other community benefit programs and activities.²⁷ In addition to the “total cost of community benefits,” which is intended to conform to CHA definitions, MHA also presented information on the “total value of community contributions,” which adds Medicare payment shortfalls, bad debt, and “other community contributions” to the total cost of community benefits.

In the analysis of community benefits at Minnesota hospitals that follows, MDH used the CHA/VHA definitions. Table 5 provides a comparison of the CHA/VHA and AHA recommendations on how community benefits should be calculated, and also shows how hospitals in other states currently report on community benefits. Community benefits provided by hospitals are reported in at least 22 states (12 with mandatory reporting, and 10 with voluntary reporting). In states with mandatory reporting requirements, a state agency usually collects the information. In seven states with voluntary reporting, the hospital association collects the information; in one state (Massachusetts), the Attorney General collects the information. An additional two states – Pennsylvania and Utah – do not have a reporting requirement for this information, but hospitals must provide a minimum level of community benefits in order to retain their property tax exemptions. In addition to Pennsylvania and Utah, Texas also requires that nonprofit hospitals provide a minimum level of community benefit.

²⁷ Minnesota Hospital Association, “Minnesota Hospitals: Serving and Strengthening Our Communities 2006 Community Benefits and Economic Impact Report,” December 2006.

Table 5

Community Benefit Reporting in Other States

	Government sponsored health care:			Other community benefits (net expense)								
	Charity Care	Bad Debt	Medicare shortfall	Medicaid shortfall	Other public programs shortfall	Community health services	Health professions education	Subsidized health services	Research	Financial and in-kind contributions	Community-building activities	Community benefit operations
CHA/VHA Method	x			x	x	x	x	x	x	x	x	x
AHA Method	x	x	x	x	x	x	x	x	x	x	x	x
<u>States with mandatory reporting:</u>												
California	x		x	x	x	x	x	x	x	x	x	x
Connecticut*												
Georgia*												
Idaho**	x	x	x	x	x	x		x		x	x	x
Illinois**	x	x	x	x	x	x	x	x	x	x	x	
Indiana	x		x	x	x		x	x	x	x		
Maryland	x		x	x	x	x	x	x	x	x	x	x
New Hampshire	x					x	x		x	x	x	x
New York*												
Rhode Island	x	x		x		x	x		x	x	x	
Texas	x	x	x	x	x	x	x	x	x	x	x	x
Washington	x											
<u>States with voluntary reporting:</u>												
Massachusetts	x					x	x	x	x	x	x	x
Michigan	x	x	x	x	x	x	x	x	x	x	x	x
Missouri	x	x	x	x		x	x		x	x	x	x
Nebraska	x	x	x	x	x	x	x	x	x	x	x	x
North Carolina	x		x	x	x	x	x	x	x	x	x	x
Oregon	x	x	x	x	x	x	x		x	x	x	x
Pennsylvania***	x	x	x	x	x	x	x	x	x	x	x	x
Tennessee	x	x	x	x	x	x	x	x	x	x	x	x
Utah***			x	x	x	x	x	x	x	x	x	x
Wisconsin	x					x	x	x	x	x	x	x

*These states have mandatory reporting of community benefits, but do not have a standard form for reporting.

**Idaho requires community benefit reporting by hospitals operating 150 or more beds; Illinois requires it for hospitals with more than 100 beds

***These states do not have mandatory reporting, but nonprofit hospitals must provide a minimum level of community benefit in order to retain their exemptions from property taxes.

Community Benefits Provided by Minnesota Hospitals

In general, public reporting of community benefit at a level of detail similar to that defined by the CHA/VHA reporting standards has not been a practice to date among Minnesota hospitals. Several data sources were used by MDH in analyzing community benefit, including a survey conducted by the Minnesota Hospital Association that was augmented by a supplemental MDH survey sent to hospitals that did not respond to the MHA survey. In total, 107 of 135 hospitals in the state responded to the MHA survey (some hospital systems provided a single response that reported community benefit at the system level).²⁸ An additional 19 hospitals responded to the supplemental MDH survey, including nine that do not currently keep track of or estimate community benefits. Nine hospitals did not respond to the survey.

²⁸ Fairview Health Services, Allina Hospitals and Clinics, Children's Hospitals and Clinics, and Saint Mary's/Duluth Clinic Health System reported data at the system level, representing a total of 18 hospitals.

This section of the report provides summary information on community benefits, and the appendix includes detailed information by hospital or system. Due to several different types of data limitations, the data included in this report should be considered to be, at best, a rough estimate of community benefit provided by Minnesota hospitals. There are at least three significant limitations to the data:

- **Missing information:** In addition to having no information on community benefits for the nine hospitals that do not track community benefits and the nine hospitals that did not respond to requests for information, the data that were reported by hospitals appear to be incomplete in many instances. Many hospitals did not report on all the categories of community benefit that were included in the survey, and it is not clear if the reason for this is because 1) they did not have any activities to report, 2) they were unable to quantify community benefits in this category, or 3) they chose not to report it.
- **Large differences between information reported on the community benefit survey and similar information in hospitals' annual financial and statistical reports to MDH:** Several categories of information that were included in the community benefit surveys are also tracked by MDH on an annual basis through the HCCIS reporting system. As a check for quality and reasonableness of the survey data, MDH compared information reported on the community benefit surveys to similar information included in the HCCIS reports. In many instances, large differences were found between the survey data and the annual reports. For example, the community benefits surveys collected information on charity care (cost, not charges). In aggregate, hospitals reported \$43 million more in charity care cost on the community benefit survey than the cost-based amounts estimated by MDH for 2005 using data from HCCIS reports (a difference of 37 percent).²⁹ Similarly, there is a difference of \$81.2 million (or 28 percent) between the amounts that hospitals reported as Medicaid (and other state public program) underpayments and the amounts that MDH calculated from HCCIS data.
- **Uncertainty about consistency of the data across hospitals:** Because many hospitals may have only recently begun efforts to quantify community benefits, and may be using different methods, the degree to which information is reliable and comparable across hospitals is unclear. As an example, the survey asked for the amount of community benefits in several categories, such as education, research, and community health services. The survey also asked hospitals to provide information on revenues related to these activities so that net community benefits could be calculated. However, many hospitals did not report offsetting revenues for these activities: it is unclear if this may be because they had none (although they could have reported zero if this were the case), because they reported net rather than gross numbers to start with, or because they did not calculate net benefits. To the degree that some hospitals may have reported gross rather than net benefits provided to the community, the estimates of community benefit in this report would be overstated.

Because of these data limitations, and in order to provide information that is as comparable as possible across hospitals, MDH chose to estimate information on hospital community benefits using information from HCCIS where possible. In the analysis that follows, estimates of charity care and state public program payment shortfalls were calculated by MDH from HCCIS. Other data used in the analysis come from hospital responses to the community benefits survey; as noted above, however, the quality and consistency of the information cannot be independently verified and thus comparisons across hospitals should be made with caution.

²⁹ While some differences may arise due to differences in the method that MDH uses to adjust charity care charges to cost, the difference between the community benefits surveys and HCCIS data on charity care is too large for the adjustment to cost to explain the difference.

In aggregate, MDH estimates that Minnesota hospitals provided \$607.2 million in community benefits in 2005 (see Table 6). The cost of providing charity care was \$80.3 million, payment shortfalls for Minnesota public insurance programs accounted for an additional \$194.7 million (or about 14.7 percent of the estimated cost of providing care to these patients), public program taxes and offsetting Medicaid Disproportionate Share (DSH) payments accounted for another \$163.1 million and other community benefits were \$235.0 million. These community benefits are offset by \$65.9 million in Medicare disproportionate share (DSH) payments, which are explicitly intended to offset hospitals' cost of providing charity care and serving low-income patients.

Table 6

Estimated Community Benefit Provided by Minnesota Hospitals, 2005

	Millions of dollars		
	Private nonprofit hospitals	Government hospitals	All nonprofit hospitals
Charity care	\$62.2	\$18.0	\$80.3
State public programs: payment shortfall and taxes			
Payment shortfalls	\$164.5	\$30.2	\$194.7
Medical care surcharge	\$71.5	\$8.8	\$80.3
MinnesotaCare Tax	\$109.6	\$14.8	\$124.4
Less: Medicaid Disproportionate Share payments	(\$29.1)	(\$12.5)	(\$41.6)
Subtotal, state public programs and taxes	\$316.5	\$41.3	\$357.8
Other quantifiable community benefits:			
Cost of subsidized services	\$59.1	\$19.2	\$78.4
Education	\$74.8	\$3.1	\$77.9
Research	\$22.8	\$0.0	\$22.8
Financial contributions	\$12.6	\$1.0	\$13.7
Community health services	\$35.1	\$2.6	\$37.7
Community-building activities	\$2.6	\$0.2	\$2.8
Community benefit operations	\$1.0	\$0.7	\$1.8
Subtotal, other community benefits	\$208.1	\$26.9	\$235.0
Offset: Medicare Disproportionate Share payments	<u>(\$51.6)</u>	<u>(\$14.3)</u>	<u>(\$65.9)</u>
Net community benefits	\$535.3	\$71.9	\$607.2

MDH calculated the payment shortfall from state public insurance programs as the difference between the estimated cost of caring for patients insured by public programs (total charges, adjusted by a cost to charge ratio) and the actual payments received by hospitals for services to those patients. More detailed information on how the public program payment shortfall was calculated is provided in the appendix. The Minnesota Department of Human Services implemented a re-basing of its fee for service payment rates for inpatient hospital services in January 2007 for all of the state public insurance programs. The re-basing of rates will result in lower hospital Medicaid payment shortfalls than would have otherwise occurred. For example, the re-basing is expected to result in an increase of approximately 25.9 percent in Medicaid's payments for fee for service inpatient hospital services.

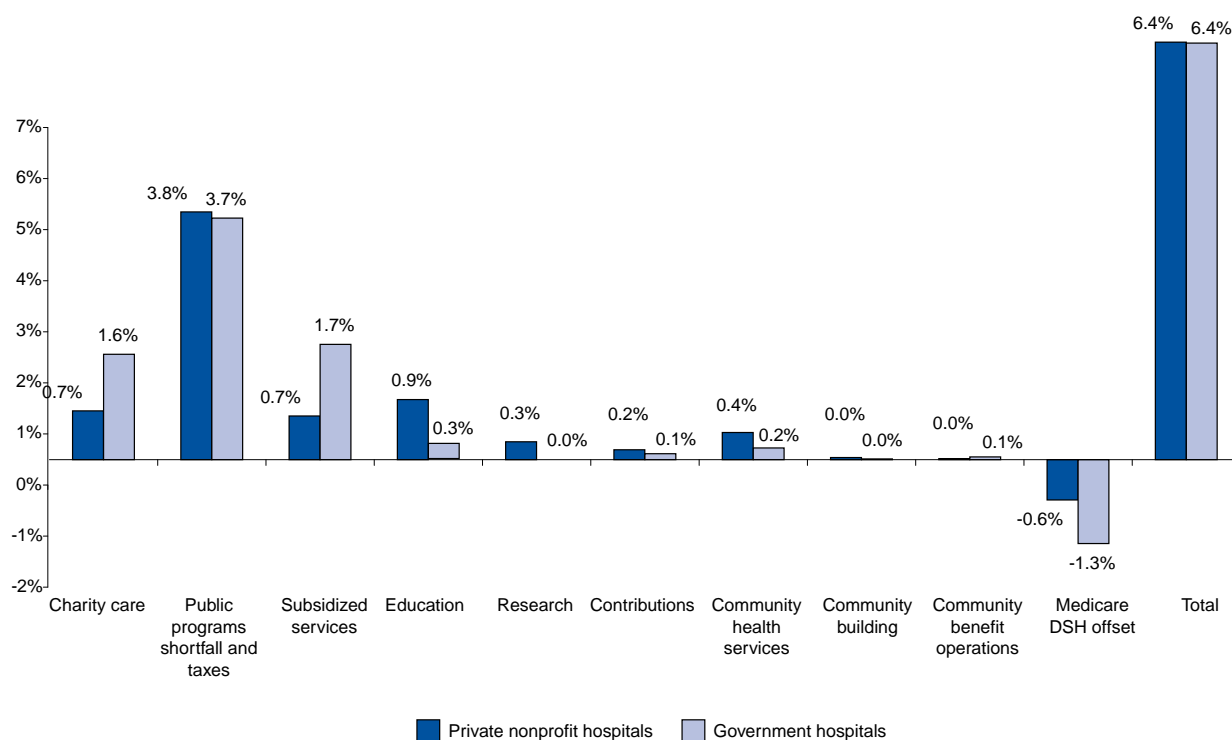
Table 6 also provides information on community benefits for private nonprofit hospitals as a group and for government owned hospitals. (Minnesota's two for-profit hospitals are not included in this analysis for two main reasons: first, there are no explicit expectations that for-profit hospitals provide community benefits; and second, Minnesota's two for-profit hospitals include a small rural hospital and a long-term care hospital, and estimates for these hospitals would not be representative of for-profit hospitals in general or comparable to other hospitals in Minnesota as a group.)

Given the predominance of private nonprofit hospitals in Minnesota (90 hospitals representing 86 percent of available hospital beds in the state), it is not surprising that private nonprofit hospitals provide the vast majority of community benefits. With the notable exception of Hennepin County Medical Center, government-owned hospitals are typically much smaller and more likely to be located in rural areas than other Minnesota hospitals. Community benefit as a percentage of operating expenses is estimated at 6.4 percent for both and government owned hospitals.

Figure 13 illustrates community benefit as a percentage of operating expenses by category of community benefit and type of hospital. As a share of operating expenses, government hospitals spend more than private nonprofits on charity care and subsidized services, but also receive higher offsetting Medicare DSH payments. Private nonprofit hospitals spent more as a share of operating expenses than government hospitals on education, research, and community health services.

Figure 13

Community Benefits as Percent of Operating Expenses



The community benefit data presented so far were calculated in a manner intended to be consistent with the CHA/VHA standards. As noted earlier, however, there is debate about what should be included in community benefit: specifically, some people argue that bad debt and Medicare payment shortfalls should be counted as community benefits. MDH estimates that including bad debt would add an additional \$110.8 million to Minnesota hospitals' net community benefit, and that counting Medicare payment shortfalls would add another \$524.2 million.

Value of Nonprofit Hospitals' Tax Exemptions

This section estimates the value of tax exemptions granted to nonprofit hospitals in Minnesota. For this analysis, MDH adapted methods that have been used in other published reports on the value of nonprofit hospitals' tax exemptions. Some estimates are based on methods used by the Minnesota Department of Revenue in its biennial tax expenditure report,³⁰ while others are based on methods used by researchers specifically evaluating nonprofit hospitals' tax exemptions.³¹ The primary sources of data for this analysis were HCCIS data an MDH survey of county tax assessors, and data from nonprofit hospitals' (and related organizations) filings with the IRS (Form 990).

For purposes of this study, MDH estimated the value of six types of tax exemptions from which nonprofit hospitals benefit: property taxes, sales taxes, state and federal income taxes, the ability to borrow at lower rates due to federal tax exemptions on bond interest, and the ability of donors to deduct contributions to nonprofit hospitals from their federal and state income taxes. Details on the methodology used in estimating the value of tax exemptions are provided in the appendix, and the tables in the appendix include estimates by hospital or hospital system.

MDH estimates the value of tax exemptions for Minnesota nonprofit hospitals at \$482.0 million in 2005. Table 7 presents these estimates by type of tax separately for private nonprofit hospitals (\$443.6 million) and government owned hospitals (\$38.4 million). (Although calculating the value of tax exemptions for government owned hospitals is somewhat of an academic exercise, it serves as a useful comparison point.) Consistent with their larger share of the hospital market, Minnesota's private nonprofit hospitals received a higher share of the total estimated value of tax exemptions (88 percent of the state and local tax exemption and 96 percent of the federal tax exemption).

Table 7

Estimated Value of Tax Exemptions, 2005

	Millions of Dollars		
	Private Nonprofit Hospitals	Government Hospitals	All Nonprofit Hospitals
<u>State and Local Taxes</u>			
Property tax	\$83.2	\$16.6	\$99.8
Sales tax	\$69.0	\$9.0	\$78.1
State income tax	\$25.9	\$2.3	\$28.2
Tax deductibility of contributions	\$19.7	\$0.2	\$19.8
<u>Federal Taxes</u>			
Federal income tax	\$114.5	\$9.6	\$124.2
Tax-exempt bond financing	\$52.6	\$0.1	\$52.7
Tax deductibility of contributions	\$78.7	\$0.6	\$79.3
Total estimated value of tax exemptions	\$443.6	\$38.4	\$482.0

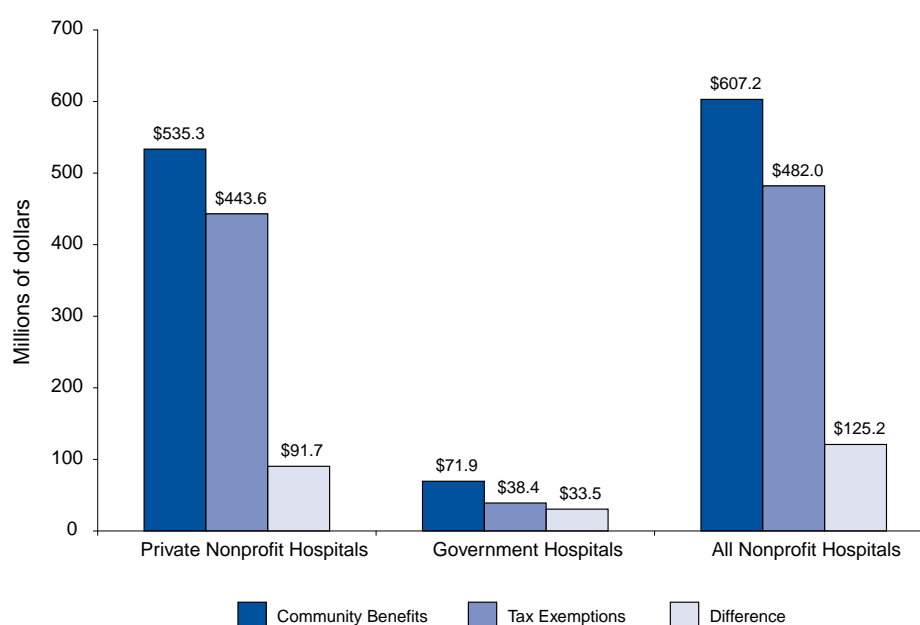
³⁰ Minnesota Department of Revenue, "State of Minnesota Tax Expenditure Budget, Fiscal Years 2006-2009," February 2006.

³¹ See, for example, N. Kane and W. Wubbenhorst, Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption, *The Milbank Quarterly*, Vol. 78, No. 2, 2000.; Center for Tax and Budget Accountability, H. O'Donnell and R. Martire, An Analysis of the Tax Exemptions Granted to Cook County Non-Profit Hospitals and the Charity Care Provided in Return, May 2006; Research Triangle Institute, Specialty Hospital Evaluation, Final Report, September 2005.

Figure 14 compares the estimated value of community benefits provided by nonprofit hospitals and the estimated value of tax exemptions. Because there is uncertainty surrounding both the community benefit and tax estimates, this comparison should be considered only a rough guide to the relative size of community benefits and value of tax exemptions. As shown in the figure, the estimated value of community benefits for private nonprofit hospitals in Minnesota is about \$91.7 million higher than the estimated volume of tax exemption (a difference of 17 percent). The estimates of community benefit and tax exemptions for government owned hospitals are smaller in absolute, with a difference of \$33.5 million, but wider when expressed as a percentage difference (47 percent).

Figure 14

Estimated Community Benefits and Value of Tax Exemptions for Minnesota Hospitals, 2005



Recommendations

The legislative charge to perform this study directed MDH to make recommendations in two specific areas:

- First, the need for more uniform hospital charity care policies and debt collection practices; and
- Second, the need for more uniform reporting of community benefits provided by nonprofit hospitals.

This section discusses MDH's recommendations in each of these two areas.

More uniform policies on charity care and debt collection

Ideally, hospitals develop their charity care policies to be responsive to varying needs in the communities that they serve. The research conducted in the course of this study shows that while there is a fair amount of variation in Minnesota hospitals' charity care policies, Minnesota hospitals are generally using similar approaches to defining eligibility for charity care. As a result, MDH does not recommend that hospitals be required to adopt more uniform charity care policies. However, MDH does recommend the following:

- All hospitals should be required to have a written charity care policy;
- Hospital charity care policies should be easily available (posted in public areas and on hospital websites); and
- All hospitals should make efforts to identify and notify uninsured patients who may be eligible for public insurance programs or charity care.

As noted earlier in this report, most Minnesota hospitals have already adopted these practices.

With regard to reporting of charity care and bad debt, it appears there may still be variation across hospitals despite the adoption of standard definitions in 2001. This situation was complicated further for the 2005 reporting year, when a new category for "self-pay discounts" (separate from charity care and bad debt) was added to the HCCIS report, in part to track discounts that hospitals provided pursuant to their agreements with the Attorney General's office. Anecdotal reports indicate that there was significant confusion over how to report charity care and self-pay discounts, especially if a hospital has incorporated a discount policy into its charity care policy. As described earlier in this report, MDH has already implemented changes for reporting year 2007 that address this issue and provide additional detail on the components of charity care and bad debt.

Finally, the report also discusses the two-year agreements between Minnesota hospitals and the Attorney General's office regarding debt collection practices and discounts for uninsured patients. The legislature should consider making the standardization of debt collection practices permanent in statute. While it is somewhat beyond the scope of this report to make specific recommendations regarding discounts, it is worth noting that prior to hospitals' agreements with the Attorney General nearly all hospital patients received significant discounts from hospital charges, except the uninsured. In Minnesota's hospital industry as a whole, hospitals' costs of providing services are less than half the amount that is charged.³² The issue of charges and discounts to uninsured patients will be important to monitor as hospitals' agreements with the Attorney General begin to expire.

Uniform reporting of community benefits

While it is somewhat beyond the scope of this report to make specific recommendations regarding discounts, it is worth noting that prior to hospitals' agreements with the Attorney General nearly all hospital patients received significant discounts from hospital charges, except the uninsured. First, the data are incomplete: only 107 out of 135 hospitals provided information in response to the MHA survey, and many survey responses were not

³² As noted earlier, the cost to charge ratio for Minnesota's hospitals as a group was 46 percent in 2005.

complete. An additional 19 hospitals provided information directly to MDH (including nine that indicated they do not track this information), but nine provided no information at all. Second, in some cases there are large differences between the data reported on the surveys conducted for this study and annual hospital financial and statistical reports to MDH that tie to audited financial statements. Third, although hospitals were asked to provide information in a manner consistent with CHA/VHA community benefit definitions, it is not clear how consistently those definitions were applied.

In the past few years, increasing attention has been paid to questions of transparency and accountability in the health care system. Legislation has been passed in Minnesota that is intended to provide greater transparency of health care providers' prices, and it is becoming easier to obtain information on quality of care at the provider level as well. MDH recommends that in the interest of increased public transparency and public accountability of health care nonprofits, Minnesota nonprofit hospitals should be required to publicly report on community benefits, and to do so in a standard way. These reports should be incorporated into the existing annual financial and statistical reports (HCCIS reports) that hospitals make to MDH. Incorporating community benefit reporting into the HCCIS system will ensure cooperation from all hospitals, as well as ensure that data reported as community benefits are consistent with other financial data reported by hospitals. Currently, CHA and the AHA are separately encouraging nonprofit hospitals to include a report on community benefit as an attachment to their annual filings with the IRS. However, these organizations are promoting different standards for reporting, and although the reports to the IRS are public information, the data are not currently assembled into a database that is easily accessible to the public or that allows for comparison across hospitals.

Although the standards developed by the CHA/VHA for community benefit reporting provide a good starting point for developing definitions for community benefit reporting in Minnesota, MDH recommends that an advisory commission be established to provide recommendations to the Commissioner of Health on standards and definitions for community benefit reporting. For example, the advisory commission would be directed to consider in detail the arguments for and against inclusion of expenses such as bad debt and Medicare payment shortfalls in community benefit. The advisory commission should be required to make its recommendations to the Commissioner by October 1, 2007. The Commissioner would make a final decision on the community benefit reporting standards, and standardized public reporting of hospital community benefits would begin with hospital fiscal year 2009.³³

Summary of Recommendations to the Legislature:

- Hospitals should be required to have a written charity care policy, to make it available to the public by posting it in public areas of the hospital and on hospital websites, and to provide information on charity care policies and state public insurance programs to uninsured patients.
- The Minnesota Legislature should consider making standardized debt collection practices permanent in statute. In addition, it will be important to monitor charges to uninsured patients as hospitals' agreements with the Attorney General expire.
- Finally, the Legislature should require nonprofit hospitals to publicly report on community benefits in a standardized manner. Details of what should be included in the reports should be developed by the Minnesota Department of Health, with input from an advisory commission.

³³ Many hospitals will already be well into their 2008 fiscal year by the time standards can be adopted, and would need additional time to modify their system of tracking this information.

Appendix: Study Methodology

Estimating the Cost of Uncompensated Care

A cost to charge ratio is used to adjust reported charity care and bad debt to a cost basis, in order to more accurately reflect the cost of providing care. This adjustment is only an estimate of the cost of providing uncompensated care; some (but not all) hospitals maintain cost accounting systems that more accurately track the costs of providing specific services on a patient by patient basis.

The cost to charge ratio that MDH used for this report is a relatively simple adjustment that is used by most analysts, and also by the American Hospital Association (AHA). It is derived by dividing a hospital's total operating expenses by the sum of patient care charges and other operating revenue:

$$\frac{\text{total operating expenses}}{\text{patient charges} + \text{other operating revenue}}$$

Estimating Hospitals' Community Benefit

Charity care adjustments

MDH used the estimates of cost-based charity care described above in calculating hospital community benefit. The CHA/VHA community benefit definitions use a slightly different method of adjusting charity care to a cost basis that subtracts some types of expenses from the numerator of the cost to charge ratio calculation, in order to avoid double counting of community benefits.³⁴ These adjustments would result in an estimate for charity care that is lower than the estimate used in this report, but not all of the data needed for this adjustment were available to MDH.

Another alternative for adjusting charity care to a cost basis would be to use cost to charge ratios that hospitals report in their annual cost reports to Medicare. Cost to charge ratios in the Medicare cost reports are generally lower than the ratios calculated using MDH's method, and therefore would result in a lower estimate of charity care. MDH estimates that using either the CHA/VHA definition (with the data available) or the cost to charge ratios from the Medicare cost reports would result in estimated charity care costs for Minnesota hospitals that are between \$2.6 million and \$10.7 million lower than the \$80.3 million estimate used in this report.

³⁴ In order to avoid double counting of community benefits, CHA/VHA's method subtracts public program taxes, other operating revenue, the cost of subsidized health services, and donations for charity care.

State public programs payment shortfall and taxes

For purposes of this study, MDH estimated state public program payment shortfalls from HCCIS data rather than from the community benefit surveys, due to substantial inconsistencies between the two sources of data and greater reliability of the HCCIS data (because the HCCIS data are required to be consistent with hospitals' annual audited financial statements). In addition, estimating these components of community benefits using HCCIS data ensures that the same methodology is used across all hospitals, and that the resulting estimates are therefore comparable.

The CHA/VHA hospital community benefit calculations include payment shortfalls from Medicaid (MA) and other state public programs (MinnesotaCare and General Assistance Medical Care). The public program payment shortfall was calculated by comparing the estimated cost of providing services to patients insured by state public programs (total charges, adjusted by the same cost to charge ratio used above in estimating the cost of providing charity care) to actual payments from public programs. Consistent with the CHA/VHA definitions, provider taxes (the medical care surcharge and the MinnesotaCare provider tax) were included in the calculation of community benefit,³⁵ and Medicaid Disproportionate Share Hospital (DSH) payments were subtracted.

Estimating the Value of Tax Exemptions

This section of the appendix describes the data sources and methods used by MDH to estimate the value of nonprofit hospitals' tax exemptions. The analysis does not consider any actions that hospitals might take to minimize their tax liability if they were not exempt from tax.

Property taxes

In Minnesota, the county assessor's office is the governmental agency that assesses property values for tax purposes. To estimate the value of nonprofit hospitals' tax exemption, MDH collected information on the valuation of hospital property and property tax rates from each of the 80 Minnesota counties with at least one hospital (in Hennepin County, some information was provided by city assessors). MDH combined information on the property values and property tax rates to arrive at an estimated value of the property tax exemption for each hospital. In aggregate, the MDH estimate of \$99.8 million is higher than the \$76 million statewide estimate published by the Department of Revenue in its tax expenditure budget; part of this difference may be explained by the fact that MDH did not attempt to estimate the potential reduction in property tax rates that would occur if currently tax-exempt hospital property were added to local tax bases. In addition, because MDH requested information on specific facilities from counties, we may have had more comprehensive information on property values.

There are several other potential limitations to the property tax estimates used in this study. First, the assessed values of property that is not taxed may not be as up to date or accurate as they would be if actually used for the purpose of collecting taxes. Second, because of the complexity of the way that property taxes are calculated, it

³⁵ The CHA/VHA guidelines state: "... [p]rovider fees (taxes or assessments) that are used as matching funds for federal Medicaid resources are included in the costs of Medicaid/other public program services." (Catholic Health Association, "A Guide for Planning and Reporting Community Benefit," 2006, p. 98.)

was sometimes difficult to determine an inclusive effective tax rate to apply to the assessed value of hospital property. Finally, there may have been some variation in the ways that county assessors responded to MDH's request for information (for example, although the request was for hospital property only, some may have also included information for attached facilities such as nursing homes or clinics).

Sales taxes

If nonprofit hospitals were not tax-exempt, they would be required to pay state sales tax (and in some cases, local sales tax) on purchases. For purposes of this study, MDH adapted the method used by the Minnesota Department of Revenue in its tax expenditure budget to estimate the value of the sales tax exemption for Minnesota hospitals in aggregate.

The data used to estimate the value of the sales tax exemption were 2005 data on hospital operating expenses from HCCIS. Two adjustments were made to hospital operating expenses to estimate the amount of spending that would be subject to sales tax: an adjustment to remove estimated spending for medical devices (because these are exempt from tax) and an adjustment to estimate how much of the remaining operating expenses would be subject to tax. For this second adjustment, MDH assumed that 12 percent of hospital operating expenses (excluding estimated medical device spending) would be subject to tax, based on the methodology used by the Minnesota Department of Revenue. Finally, to estimate the value of the tax exemption, MDH multiplied the estimated taxable spending by state and, where applicable, local sales tax rates.

One limitation of this approach is that it relies on estimates of tax exempt medical devices and the percentage of other operating expenses that would be taxable that are several years old (data and model estimates from 1997). However, it is not clear if this biases the estimate upward or downward. For example, while it is clear that spending on medical devices has increased over time, it is not necessarily the case that the same is true of medical device spending as a share of hospital operating expenses (in other words, we do not know whether medical device spending increased at a rate that was faster or slower than other spending).

Federal and State Income Taxes

To estimate the value of nonprofit hospitals' exemption from federal corporate income tax, MDH calculated three-year averages (data for 2003 through 2005) for net income and donations and contributions for each hospital from HCCIS. Three-year averages were used in order to better approximate a "typical" year, since hospitals' net income can vary substantially from year to year.

To estimate the federal taxable income for each hospital, the estimated sales, state income, and property taxes were deducted from net income less donations and contributions. An average effective income tax rate of 33.4 percent³⁶ was used to calculate the value of the federal corporate income tax exemption.

To estimate the state taxable income for each hospital, the same three year averages derived for use in the federal taxable income calculation were used. The estimated sales, federal income, and property taxes were then deducted from net income less donations and contributions. The state corporate tax rate of 9.8 percent was then applied to the estimated taxable income amount to compute the value of the state corporate income tax exemption.

³⁶ The average effective tax federal income tax rate for hospitals, nursing, and residential care facilities, as reported by the IRS for 2003 ("2003 Corporation Source Book of Statistics of Income," May 2006).

Tax-exempt debt

Another benefit that nonprofit hospitals receive as a result of their tax-exempt status is the ability to obtain debt financing through tax-exempt bonds. This financing mechanism allows hospitals to borrow at interest rates lower than they would otherwise have to pay. A recent Congressional Budget Office (CBO) study estimated that the value of benefits that hospitals received by issuing tax-exempt debt was approximately \$1.8 billion nationally in 2002, and accounted for 14 percent of the total value of tax exemptions received by nonprofit hospitals.³⁷ According to CBO estimates, the cost of capital for nonprofit hospitals was about 2.1 percentage points lower than the cost of capital incurred by for-profit hospitals in mid-2006.³⁸

MDH obtained information on the amount of Minnesota hospitals' outstanding tax-exempt bonds from nonprofit hospitals' annual filings with the IRS (Form 990). Because some health systems report on a consolidated basis, MDH estimated the percentage of outstanding bonds attributable to hospitals by using a three-year average ratio of hospital capital expenses to capital expenses for physician offices and outpatient care centers (78.6 percent) from national data on construction of health care facilities.³⁹ To estimate the value of the benefit that hospitals receive by issuing tax-exempt debt, MDH multiplied the estimated amount of outstanding tax-exempt hospital debt by the CBO's estimated 2.1 percentage point difference in the cost of capital for tax-exempt versus taxable hospital debt.

One limitation of this analysis is that the data on the amount of outstanding hospital debt may have been incomplete – for example, some hospital debt that was issued by parent organizations may have been excluded.

Tax deductibility of contributions

Nonprofit hospitals also benefit from the fact that individuals and corporations can deduct the value of charitable contributions from their income taxes. In other words, when an individual contributes \$1 to a charitable organization, it costs the individual less than \$1 because the contribution can be deducted for income tax purposes. It is not clear, however, how charitable giving to hospitals would change if they were no longer nonprofits. In the extreme, individuals could divert all of their current contributions to other charities, and hospitals would lose the entire value of their current donations. On the other hand, individuals might still be willing to contribute, but in smaller amounts to reflect the fact that they can no longer deduct the contribution from their taxable income.

For purposes of this study, MDH estimated the benefit to hospitals of the tax deductibility of contributions as the cost of these deductions to the state and federal governments. MDH obtained data on contributions to nonprofit hospitals from IRS Form 990 filings. The value of charitable contributions received by a hospital was multiplied by marginal tax rates for state (7 percent) and federal (28 percent) income taxes.

Similar to the method used for estimating the benefit to hospitals from tax-exempt bond financing, when information was only available at the system level MDH assumed that only a portion (78.6 percent) of the contributions were specifically made to hospitals. The estimate includes contributions to hospitals, a portion of contributions to hospital systems, and contributions to health-related foundations that are associated with hospitals. It excludes contributions to foundations that are not health-related (even if those foundations are related to hospitals).

³⁷ U.S. Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits," December 2006.

³⁸ U.S. Congressional Budget Office, "Nonprofit Hospitals and Tax Arbitrage," December 2006 (p. 5).

³⁹ U.S. Census Bureau, "Annual Capital Expenditures: 2004 (2003, 2002), March 2006.

Appendix Tables

Appendix Table 1

2005 Charity Care, Bad Debt, and Total Uncompensated Care

Hospital Name	City	Charity Care	Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Operating Expense
Private Nonprofit Hospitals					
Abbott Northwestern Hospital	Minneapolis	\$4,184,209	\$2,403,136	\$6,587,345	1.0%
Albany Area Hospital and Medical Center	Albany	\$15,885	\$47,414	\$63,299	1.1%
Albert Lea Medical Center - Mayo Health System	Albert Lea	\$233,281	\$1,868,199	\$2,101,480	2.4%
Austin Medical Center - Mayo Health System	Austin	\$231,505	\$1,236,263	\$1,467,768	1.8%
Bethesda Rehabilitation Hospital	St. Paul	\$768,331	\$279,897	\$1,048,228	1.5%
Buffalo Hospital	Buffalo	\$329,389	\$571,345	\$900,734	2.3%
Cambridge Medical Center	Cambridge	\$980,704	\$673,789	\$1,654,494	2.9%
Children's Hospitals and Clinics, Minneapolis	Minneapolis	\$877,178	\$813,258	\$1,690,436	0.7%
Children's Hospitals and Clinics, St. Paul	St. Paul	\$340,091	\$792,518	\$1,132,609	0.8%
Cloquet Community Memorial Hospital & C&NC	Cloquet	\$59,951	\$522,383	\$582,334	2.6%
Community Memorial Hospital	Winona	\$194,906	\$819,026	\$1,013,931	2.2%
Deer River HealthCare Center	Deer River	\$24,404	\$449,387	\$473,791	4.8%
Divine Providence Health Center	Ivanhoe	\$13,533	\$24,859	\$38,392	1.5%
ELEAH Medical Center	Elbow Lake	\$5,583	\$38,117	\$43,700	1.3%
Ely-Bloomenson Hospital & Nursing Home	Ely	\$8,526	\$131,315	\$139,841	1.2%
Fairmont Medical Center - Mayo Health System	Fairmont	\$29,945	\$975,217	\$1,005,162	1.7%
Fairview Lakes Regional Medical Center	Wyoming	\$862,139	\$2,766,073	\$3,628,212	3.1%
Fairview Northland Regional Hospital	Princeton	\$604,451	\$1,367,665	\$1,972,115	2.6%
Fairview Red Wing Medical Center	Red Wing	\$398,986	\$1,491,686	\$1,890,672	2.7%
Fairview Ridges Hospital	Burnsville	\$958,961	\$2,246,943	\$3,205,904	2.4%
Fairview Southdale Hospital	Edina	\$1,313,034	\$2,836,174	\$4,149,208	1.4%
Fairview University Medical Center - Mesabi	Hibbing	\$395,006	\$726,143	\$1,121,149	1.6%
Fairview-University Medical Center	Minneapolis	\$3,260,935	\$6,810,684	\$10,071,619	1.3%
Falls Memorial Hospital	International Falls	\$54,066	\$249,557	\$303,623	2.3%
First Care Medical Services	Fosston	\$25,806	\$358,357	\$384,163	4.7%

Hospital Name	City	Charity Care	Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Operating Expense
Gillette Children's Specialty Healthcare	St. Paul	\$219,674	\$187,472	\$407,146	0.4%
Glencoe Regional Health Services	Glencoe	\$68,085	\$748,782	\$816,868	2.6%
Graceville Health Center	Graceville	\$4,054	\$30,362	\$34,416	0.9%
Grand Itasca Clinic and Hospital & C&NC	Grand Rapids	\$56,060	\$877,541	\$933,600	1.7%
Hendricks Community Hospital Association	Hendricks	\$2,793	\$37,325	\$40,118	1.0%
Immanuel St. Joseph's - Mayo Health System	Mankato	\$323,344	\$1,892,436	\$2,215,780	1.7%
Kittson Memorial Healthcare Center	Hallock	\$49,153	\$12,320	\$61,473	1.4%
Lake City Medical Center - Mayo Health System	Lake City	\$12,838	\$80,890	\$93,728	0.9%
Lake Region Healthcare Corporation	Fergus Falls	\$50,183	\$245,794	\$295,978	0.7%
Lake View Memorial Hospital & Home	Two Harbors	\$7,596	\$81,628	\$89,224	1.4%
Lakeview Hospital	Stillwater	\$165,040	\$790,666	\$955,707	1.6%
LakeWood Health Center	Baudette	\$74,795	\$85,958	\$160,753	2.6%
Lakewood Health System	Staples	\$234,337	\$531,574	\$765,911	2.4%
Long Prairie Memorial Hospital & Home	Long Prairie	\$44,835	\$132,536	\$177,371	1.7%
Luverne Community Hospital	Luverne	\$29,265	\$106,015	\$135,280	1.3%
Madelia Community Hospital	Madelia	\$43,680	\$232,435	\$276,115	5.0%
Madison Hospital	Madison	\$6,937	\$68,190	\$75,127	1.4%
Melrose Area Hospital - CentraCare	Melrose	\$7,922	\$29,940	\$37,862	0.6%
Mercy Hospital	Coon Rapids	\$2,887,847	\$1,854,592	\$4,742,439	2.0%
Methodist Hospital Park Nicollet Health Services	St. Louis Park	\$1,960,215	\$2,844,306	\$4,804,521	1.3%
Millie Lacs Health System	Onamia	\$59,235	\$658,346	\$717,581	4.0%
Miller-Dwan Medical Center	Duluth	\$323,686	\$995,979	\$1,319,666	2.3%
Minnesota Valley Health Center	Le Sueur	\$10,449	\$48,728	\$59,177	1.7%
New Ulm Medical Center	New Ulm	\$296,103	\$462,945	\$759,048	1.5%
North Country Health Services	Bemidji	\$188,271	\$1,466,213	\$1,654,484	2.5%

Hospital Name	City	Charity Care	Bad Debt	Total		Uncompensated Care as % of Operating Expense
				Uncompensated Care	Uncompensated Care	
North Memorial Medical Center	Robbinsdale	\$2,988,312	\$3,740,029	\$6,728,341		1.8%
North Valley Health Center	Warren	\$30,118	\$50,545	\$80,663		2.2%
Northwest Medical Center	Thief River Falls	\$0	\$235,974	\$235,974		1.1%
Olmsted Medical Center	Rochester	\$430,046	\$1,017,283	\$1,447,328		4.2%
Owatonna Hospital	Owatonna	\$138,986	\$379,129	\$518,115		1.9%
Phillips Eye Institute	Minneapolis	\$84,083	\$105,249	\$189,332		0.8%
Pine Medical Center	Sandstone	\$22,982	\$221,559	\$244,541		3.2%
Queen of Peace Hospital	New Prague	\$81,430	\$94,810	\$176,240		0.8%
Regina Medical Center	Hastings	\$55,930	\$608,510	\$664,439		1.9%
Regions Hospital	St. Paul	\$12,448,343	\$622,704	\$13,071,047		3.4%
Ridgeview Medical Center	Waconia	\$194,269	\$427,383	\$621,652		0.7%
Riverview Healthcare Association	Crookston	\$19,918	\$279,026	\$298,944		1.3%
Riverwood HealthCare Center	Aitkin	\$13,313	\$517,557	\$530,870		2.1%
Rochester Methodist Hospital	Rochester	\$2,326,689	\$2,121,317	\$4,448,006		1.6%
Roseau Area Hospital & Homes, Inc.	Roseau	\$25,257	\$169,182	\$194,439		1.4%
Saint Elizabeth's Medical Center	Wabasha	\$91,981	\$90,228	\$182,209		1.8%
Saint Marys Hospital	Rochester	\$3,898,229	\$4,328,279	\$8,226,508		1.5%
Sioux Valley Canby Campus	Canby	\$54,170	\$34,440	\$88,610		1.1%
Springfield Medical Center - Mayo Health System	Springfield	\$18,032	\$39,114	\$57,146		1.0%
St. Cloud Hospital	St. Cloud	\$1,963,596	\$3,382,130	\$5,345,726		1.6%
St. Francis Medical Center	Breckenridge	\$144,056	\$462,531	\$606,587		4.0%
St. Francis Regional Medical Center	Shakopee	\$562,472	\$1,323,536	\$1,886,008		2.5%
St. Gabriel's Hospital	Little Falls	\$138,955	\$297,604	\$436,560		1.8%
St. James Health Services	St. James	\$8,955	\$232,549	\$241,504		2.7%
St. John's Hospital	Maplewood	\$1,266,885	\$1,646,463	\$2,913,347		1.7%

Hospital Name	City	Charity Care	Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Operating Expense
St. Joseph's Area Health Services, Inc.	Park Rapids	\$96,073	\$349,578	\$445,652	1.6%
St. Joseph's Hospital	St. Paul	\$1,797,952	\$1,461,769	\$3,259,720	1.8%
St. Joseph's Medical Center	Brainerd	\$926,486	\$595,515	\$1,522,001	2.0%
St. Luke's Hospital	Duluth	\$554,083	\$2,397,353	\$2,951,435	1.6%
St. Mary's Medical Center	Duluth	\$2,136,460	\$4,386,090	\$6,522,550	2.6%
St. Mary's Regional Health Center	Detroit Lakes	\$77,337	\$619,649	\$696,985	2.6%
Stevens Community Medical Center	Morris	\$298,176	\$209,445	\$507,621	2.1%
Tracy Area Medical Services	Tracy	\$44,370	\$120,547	\$164,917	2.3%
Tri-County Hospital	Wadena	\$143,853	\$187,353	\$331,206	1.4%
Tyler Healthcare Center, Inc.	Tyler	\$28,450	\$19,164	\$47,614	1.0%
United Hospital	St. Paul	\$3,289,949	\$2,680,523	\$5,970,472	1.7%
Unity Hospital	Fridley	\$1,849,340	\$1,749,688	\$3,599,028	2.4%
Waseca Medical Center - Mayo Health System	Waseca	\$84,526	\$381,556	\$466,082	3.0%
Westbrook Health Center	Westbrook	\$17,618	\$29,575	\$47,194	1.4%
White Community Hospital & C&NC	Aurora	\$3,016	\$44,369	\$47,385	1.1%
Woodwinds Health Campus	Woodbury	\$597,121	\$888,272	\$1,485,393	1.9%
Total, Private Nonprofit Hospitals		\$62,249,019	\$83,549,955	\$145,798,973	1.7%

Hospital Name	City	Charity Care	Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Operating Expense
Government-Owned Hospitals					
Appleton Municipal Hospital and Nursing Home	Appleton	\$9,918	\$22,628	\$32,546	0.7%
Avera Marshall Regional Medical Center	Marshall	\$17,449	\$266,360	\$283,809	1.3%
Bigfork Valley Hospital	Bigfork	\$16,727	\$41,001	\$57,728	0.9%
Bridges Medical Services	Ada	\$29,466	\$44,474	\$73,941	2.0%
Cannon Falls Community Hospital	Cannon Falls	\$9,302	\$182,905	\$192,207	3.4%
Chippewa County-Montevideo Hospital	Montevideo	\$13,868	\$158,976	\$172,843	0.9%
Clearwater Health Services	Bagley	\$0	\$112,164	\$112,164	1.3%
Cook County North Shore Hospital	Grand Marais	\$25,210	\$29,984	\$55,194	0.9%
Cook Hospital & C&NC	Cook	\$0	\$79,595	\$79,595	1.3%
Cuyuna Regional Medical Center	Crosby	\$156,767	\$341,808	\$498,575	1.7%
District One Hospital	Faribault	\$215,273	\$727,737	\$943,011	2.8%
Douglas County Hospital	Alexandria	\$209,990	\$252,924	\$462,914	0.8%
Glacial Ridge Health System	Glenwood	\$3,851	\$31,411	\$35,262	0.5%
Granite Falls Municipal Hospital & Manor	Granite Falls	\$14,504	\$130,208	\$144,712	1.6%
Hennepin County Medical Center	Minneapolis	\$15,758,002	\$17,717,193	\$33,475,195	7.5%
Hutchinson Area Health Care	Hutchinson	\$45,468	\$365,285	\$410,753	0.9%
Jackson Medical Center	Jackson	\$16,468	\$22,079	\$38,547	0.7%
Johnson Memorial Health Services	Dawson	\$7,664	\$69,310	\$76,974	1.4%
Kanabec Hospital	Mora	\$435,530	\$518,899	\$954,429	3.9%
Mahnomen Health Center	Mahnomen	\$11,833	\$118,335	\$130,168	4.3%
Meeker County Memorial Hospital	Litchfield	\$9,393	\$163,874	\$173,268	1.1%
Mercy Hospital & Health Care Center	Moose Lake	\$31,460	\$167,634	\$199,094	1.2%
Minnewaska Regional Health System	Starbuck	\$13,979	\$72,407	\$86,386	2.1%
Monticello-Big Lake Hospital	Monticello	\$98,490	\$1,400,389	\$1,498,879	4.5%
Murray County Memorial Hospital	Slayton	\$11,585	\$126,527	\$138,112	1.4%

Hospital Name	City	Charity Care	Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Operating Expense
Northfield Hospital & Long Term Care Center	Northfield	\$22,904	\$509,206	\$532,110	1.8%
Ortonville Area Health Services	Ortonville	\$24,273	\$199,534	\$223,807	2.8%
Paynesville Area Health Care System	Paynesville	\$40,390	\$275,499	\$315,889	1.8%
Perham Memorial Hospital and Home	Perham	\$3,487	\$142,435	\$145,922	1.6%
Pipestone County Medical Center	Pipestone	\$24,095	\$96,380	\$120,475	1.1%
Redwood Area Hospital	Redwood Falls	\$41,970	\$186,382	\$228,352	2.0%
Renville County Hospital	Olivia	\$6,644	\$79,728	\$86,372	1.1%
Rice Memorial Hospital	Willmar	\$203,057	\$782,047	\$985,104	1.4%
Sibley Medical Center	Arlington	\$58,178	\$67,193	\$125,371	1.5%
Sleepy Eye Municipal Hospital	Sleepy Eye	\$12,387	\$105,684	\$118,070	1.9%
St. Michael's Hospital & Nursing Home	Sauk Centre	\$36,254	\$157,186	\$193,441	2.4%
St. Peter Community Hospital	St. Peter	\$57,216	\$286,665	\$343,881	2.9%
Swift County-Benson Hospital	Benson	\$26,912	\$33,700	\$60,613	0.8%
United Hospital District	Blue Earth	\$116,416	\$123,036	\$239,452	1.9%
Virginia Regional Medical Center	Virginia	\$70,621	\$591,731	\$662,352	1.8%
Wheaton Community Hospital	Wheaton	\$4,249	\$51,717	\$55,966	1.0%
Windom Area Hospital	Windom	\$19,669	\$135,784	\$155,452	1.5%
Worthington Regional Hospital	Worthington	\$88,188	\$261,133	\$349,321	1.8%
Total, Government-Owned Hospitals		\$18,019,107	\$27,249,147	\$45,268,256	4.0%

Hospital Name	City	Charity Care	Bad Debt	Total Uncompensated Care	Uncompensated Care as % of Operating Expense
Private For-Profit Hospitals					
Lakeside Medical Center, Inc. - Hospital	Pine City	\$1,237	\$39,760	\$40,997	2.1%
Regency Hospital of Minneapolis	Minneapolis	\$4,726	\$38,738	\$43,465	0.3%
Total, Private For-Profit Hospitals		\$5,963	\$78,498	\$84,462	0.5%
Total, All Minnesota Hospitals		\$80,274,089	\$110,877,600	\$191,151,691	2.0%

Charity care, bad debt, and total uncompensated care are adjusted from charges to reflect estimated hospital costs.

Appendix Table 2

Estimated Hospital Community Benefits, 2005

Hospital Name	City	State Public Programs										Net Community Benefits	Community Benefits as % of Operating Expenses
		Charity Care	Public Program Payment Shortfalls	Taxes	Less: Medicaid DSH	Subtotal, Public Program Payment Shortfalls and Taxes	Cost of Subsidized Services	Education	Research	Other Community Benefits*	Less: Medicare DSH Payments		
Private Nonprofit Hospitals and Systems													
Albany Area Hospital and Medical Center	Albany	15,885	2,284,737	135,524	16,212,270	135,524	812,869	547	9,891	269,162	161,847	2.8%	
Albert Lea Medical Center - Mayo Health System	Albert Lea	233,281	2,284,737	1,430,591	3,715,328	3,715,328	812,869	131,296	1,003,326	269,162	5,626,938	6.3%	
Allina Health System ⁽¹⁾	Various	14,040,609	20,790,869	37,837,104	400,500	58,227,473	4,264,000	10,748,000	4,536,000	5,017,246	86,798,837	5.5%	
Austin Medical Center - Mayo Health System	Austin	231,505	1,604,634	1,213,209	2,817,843	2,817,843	11,600	11,600	800,796	435,063	3,426,681	4.2%	
Bethesda Rehabilitation Hospital	St. Paul	768,331	2,726,241	913,878	406,493	3,233,626	147,242	186,553	147,242	4,335,752	4,335,752	6.2%	
Children's Hospital ⁽²⁾	Mpls./St. Paul	1,217,269	26,031,694	12,610,371	16,212,270	22,429,795	12,110,000	-191,000	3,625,000	40,426,065	40,426,065	10.7%	
Cloquet Community Memorial Hospital & C&N	Cloquet	59,951	821,888	432,468	1,783,755	432,468	169,655	148,200	38,560	848,834	848,834	3.8%	
Community Memorial Hospital	Winona	194,906	961,867	961,867	14,840	1,783,755	243,000	74,600	74,600	2,296,261	2,296,261	5.1%	
Deer River HealthCare Center	Deer River	24,404	553,188	195,126	14,840	733,473	2,009	2,009	28,125	92,078	695,933	7.0%	
Divine Providence Health Center ⁽³⁾	Ivanhoe	13,533	74,742	17,045	91,787	91,787				105,320	105,320	4.2%	
ELEAH Medical Center ⁽⁴⁾	Elbow Lake	5,583	59,999	59,999		59,999				65,492	65,492	2.0%	
Ely-Bloomenson Hospital & Nursing Home ⁽⁵⁾	Ely	8,526	366,307	158,985	525,292	525,292				533,819	533,819	4.7%	
Fairmont Medical Center - Mayo Health System	Fairmont	29,945	1,374,033	1,103,865	4,577,824	2,477,898		235,392	131,783	2,875,018	2,875,018	4.9%	
Fairview Health System ⁽⁶⁾	Various	7,793,512	38,819,304	35,740,025	4,577,824	69,981,506	10,037,964	959,853	15,996,769	10,840,774	108,431,830	7.7%	
Falls Memorial Hospital	International Falls	54,066		255,668	502	255,166	615,181	17,172	7,968	949,553	949,553	7.2%	
First Care Medical Services	Fosston	25,806	4,020,625	298,076	2,376,925	298,076		298,334	15,000	47,292	291,590	3.6%	
Gillette Children's Specialty Healthcare	St. Paul	219,674	4,020,625	2,565,391	2,376,925	4,209,092	9,183,082	298,334	250,549	3,478,259	10,648,124	11.6%	
Glencoe Regional Health Services	Glencoe	68,085	1,002,859	673,827	1,676,686	1,676,686	635,540			2,380,311	2,380,311	7.6%	
Graceview Health Center	Graceville	4,054	10,419	39,524	49,943	49,943			7,600	61,597	61,597	1.7%	
Grand Itasca Clinic and Hospital & C&N	Grand Rapids	56,060	1,979,871	683,618	2,663,489	2,663,489				681,058	2,038,491	3.6%	
Hendricks Community Hospital Association	Hendricks	2,793	56,898	52,567	109,465	109,465	44,000	24,989	4,373	723,033	185,620	4.6%	
Inmanuel St. Joseph's - Mayo Health System	Mankato	323,344	4,870,230	2,312,826	7,183,056	7,183,056		810,943	427,731	8,022,041	8,022,041	6.2%	
Kittson Memorial Healthcare Center ⁽⁷⁾	Hallock	49,153	8,180	64,887	73,067	73,067			58,941	122,221	122,221	2.9%	
Lake City Medical Center - Mayo Health System	Lake City	12,838	58,557	200,176	258,733	258,733				330,512	330,512	3.2%	
Lake Region Healthcare Corporation	Fergus Falls	50,183	1,184,222	772,907	1,957,129	1,957,129	835,000			2,842,313	2,842,313	6.7%	
Lake View Memorial Hospital & Home	Two Harbors	7,596	7,092	175,488	182,580	182,580		10,000	15,000	215,176	215,176	3.3%	
Lakeview Hospital	Sillwater	165,040	409,784	1,173,419	1,583,203	1,583,203	2,214,798		283,116	4,248,158	4,248,158	7.0%	
LakeWood Health Center	Baudette	74,795	132,136	142,585	274,721	274,721			117,388	466,904	466,904	7.5%	
Lakewood Health System	Staples	234,337	355,663	619,037	3,518	971,162		45,000	5,150,000	6,400,519	6,400,519	19.9%	
Long Prairie Memorial Hospital & Home	Long Prairie	44,835	272,285	222,399	494,684	494,684	1,270,679	8,380		1,818,578	1,818,578	17.0%	
Luverne Community Hospital	Luverne	29,265	18,723	194,170	212,893	212,893		31,560	44,917	318,634	318,634	3.0%	

State Public Programs

Hospital Name	City	Public Program Payment				Subtotal, Public Program Payment				Cost of Subsidized Services				Other Community Benefits*				Net Community Benefits	Community Benefits as % of Operating Expenses
		Charity Care	Shortfalls	Taxes	Less: Medicaid DSH	Shortfalls	Shortfalls and Taxes	Shortfalls and Taxes	Subsidized Services	Education	Research	Community Benefits*	Less: Medicare DSH Payments	Net Community Benefits					
Madelia Community Hospital ^(a)	Madelia	43,680		81,508		81,508										125,188	2.3%		
Madison Hospital ^(b)	Madison	6,937		75,616		75,616										82,553	1.5%		
Meiorice Area Hospital - CentraCare	Meiorice	7,922		124,569		124,569		142,927								275,418	4.0%		
Methodist Hospital Park Nicollet Health Services	St. Louis Park	1,960,215	3,458,273	7,415,812		10,874,085			2,226,947	2,765,669	1,670,967					19,497,863	5.4%		
Millie Lacs Health System ^(c)	Onamia	59,235	83,586	330,298	10,748	403,135										330,663	1.9%		
Minnesota Valley Health Center ^(a)	Le Sueur	10,449	29,910	53,806		83,716										94,165	2.7%		
North Country Health Services	Bemidji	186,271	2,866,504	1,074,810	450,457	3,490,857					109,467					2,500,967	3.8%		
North Memorial Medical Center	Robbinsdale	2,988,312	8,045,790	7,169,875	385,029	14,830,636		3,758,209	2,103,386	373,408	2,119,718					23,709,964	6.2%		
North Valley Health Center	Warren	30,118	58,006	31,001		89,007		29,029								148,153	4.0%		
Northwest Medical Center	Thief River Falls		322,690	343,853	6,623	659,920		19,000			144,000					670,168	3.2%		
Onsted Medical Center	Rochester	430,046	560,869	1,106,704	32,549	1,635,023										1,859,452	5.3%		
Pine Medical Center	Sandstone	22,982	248,191	53,284		301,475					119,312					443,769	5.8%		
Queen of Peace Hospital	New Prague	81,430	22,902	488,934		481,436		1,150,625	4,425		228,021					1,945,937	9.4%		
Regina Medical Center	Hastings	55,930	245,206			1,129,127			37,020		1,293,669					2,515,746	7.1%		
Regions Hospital	St. Paul	12,448,343		6,580,210	3,051,292	3,528,918		4,365,308	40,394,267	2,626,008	697,813					56,103,296	14.6%		
Ridgeview Medical Center	Waconia	194,269	1,219,485	2,013,610		3,233,095			4,456		128,861					3,560,681	4.2%		
Riverwood Healthcare Association	Crookston	19,918	427,238	547,793		975,031					92,910					994,950	4.3%		
Riverwood HealthCare Center	Aitkin	13,313		438,853		438,853			142,167		687,243					887,970	2.7%		
Rochester Methodist Hospital	Rochester	2,326,689		5,270,552		5,270,552			21,902		268,827					7,887,970	2.8%		
Roseau Area Hospital & Homes, Inc.	Roseau	25,257	83,572	365,162		468,734		450,743	23,750		183,280					1,151,764	8.5%		
Saint Elizabeth's Medical Center	Wabasha	91,981	333,581	203,985		537,566		778,425	4,030		86,330					1,498,332	14.6%		
Saint Marys Hospital	Rochester	3,896,229	8,970,995	10,219,814		19,190,809			2,074		292,306					23,383,418	4.3%		
Saint Mary's/Duluth Clinic Health System ^(j)	Duluth	2,460,146	7,979,673	6,349,690	630,482	13,698,881		446,040	8,043,983	1,196,103	4,991,529					22,834,352	7.4%		
St. Joseph's Hospital	St. Paul	54,170		125,725		125,725		744,559	2,500		12,053					939,007	11.8%		
Springfield Medical Center - Mayo Health System	Springfield	18,032		117,994		117,994		36,000			32,935					204,961	3.6%		
St. Cloud Hospital	St. Cloud	1,963,596		6,374,680	274,367	6,100,313		288,142	1,622,344	21,536	2,899,124					9,263,489	2.8%		
St. Francis Medical Center	Brackendale	144,056	217,720	309,624	1,287	526,057		187,848	114,094		88,280					1,060,335	7.0%		
St. Francis Regional Medical Center	Shakopee	562,472	852,805	2,049,289		2,902,094		73,000	76,000		239,000					3,564,613	4.7%		
St. Gabriel's Hospital	Little Falls	138,955	393,943	475,559		869,502			10,530		253,266					1,120,014	4.6%		
St. James Health Services	St. James	8,955	195,960	143,357		339,317		642,304	26,506		37,450					1,054,532	11.7%		
St. John's Hospital	Maplewood	1,266,885	2,738,267	4,064,672		6,802,939			1,884,044		275,715					10,229,582	6.0%		
St. Joseph's Area Health Services, Inc.	Park Rapids	96,073	874,392	566,779		1,441,171		158,235	7,340		174,476					1,591,580	5.6%		
St. Joseph's Hospital	St. Paul	1,797,952	3,247,658	3,479,325	109,935	6,617,048			2,127,503		358,078					9,571,751	5.3%		
St. Joseph's Medical Center	Brainerd	926,486	3,946,334	1,615,697	33,561	5,530,470			1,160,470		172,083					6,978,953	9.1%		
St. Luke's Hospital	Duluth	554,083	4,009,392	3,385,465		7,394,857		113,000	1,953,900		860,200					8,400,557	4.7%		
St. Mary's Regional Health Center	Detroit Lakes	77,337	632,181	516,559	66,404	1,082,336			77,827		123,017					652,012	2.4%		
Stevens Community Medical Center	Morris	298,176	173,539	559,147		732,686		206,500	2,500		65,690					1,305,552	5.4%		
Tracy Area Medical Services	Tracy	44,370	8,869	82,394		91,263					6,009					141,643	1.9%		
TiL-County Hospital	Wadena	143,853	784,735	442,852	32,837	1,194,750		2,145,095	46,495	72,820	1,037,594					4,640,607	19.6%		
Tyler Healthcare Center, Inc. ^(a,b)	Tyler	28,450		34,485		34,485										62,935	1.3%		
Waseca Medical Center - Mayo Health System	Waseca	84,526	320,793	305,670		626,463			891,199		122,708					1,724,886	11.0%		
Westbrook Health Center	Westbrook	17,618		28,573		28,573					3,889					50,090	1.5%		
White Community Hospital & C&NC	Aurora	3,016		64,417		64,417		4,370	16,785		502					89,091	2.1%		
Woodwinds Health Campus	Woodbury	597,121	1,315,446	1,878,612		3,194,058			153,172		184,518					4,128,869	5.2%		
Total, Private Nonprofit Hospitals		62,249,018	164,505,487	181,091,067	29,076,643	316,517,911		58,139,127	76,896,044	22,759,197	52,233,961					537,044,071	6.5%		

Report to the Minnesota Legislature

State Public Programs															
Hospital Name	City	Charity Care	Public Program Payment		Taxes	Less: Medicaid DSH	Subtotal, Public Program Payment Shortfalls and Taxes		Cost of Subsidized Services	Education	Research	Other Community Benefits*	Less: Medicare DSH Payments	Net Community Benefits	Community Benefits as % of Operating Expenses
			Shortfalls	Shortfalls											
Government Hospitals															
Appleton Municipal Hospital and Nursing Home ^(b)	Appleton	9,918	52,536	52,536	15,943	52,536	52,536	377,645	56,425	500	267,569	149,344	62,454	1.3%	
Avera Marshall Regional Medical Center	Marshall	17,449	552,710	552,710	16,943	686,577	686,577	377,645	47,414	500	105,344	149,344	1,256,821	5.7%	
Bigfork Valley Hospital	Bigfork	16,727	228,602	72,139	15,943	300,941	300,941	20,000	10,000		19,400	230,374	470,426	7.3%	
Bridges Medical Services	Ada	29,466	67,508	84,000		151,508	151,508	20,000	10,000		-1,949	290,766	230,374	6.3%	
Cannon Falls Community Hospital	Cannon Falls	9,302	138,488	152,278		290,766	290,766				15,000	238,862	298,119	5.2%	
Chippewa County-Montevideo Hospital	Montevideo	13,868	209,994	209,994		209,994	209,994				1,107	244,914	244,914	1.3%	
Clearwater Health Services	Bagley	127,791	116,191	175		243,807	243,807		17,000		64,000	412,633	165,578	2.8%	
Cook County North Shore Hospital	Grand Marais	25,210	20,102	120,267		140,369	140,369					412,633	412,633	6.8%	
Cook Hospital & C&NC	Cook	256,852	74,781			331,633	331,633					1,111,118	1,111,118	3.8%	
Cuyuna Regional Medical Center ^(b)	Crosby	156,767	358,005	602,223	5,878	954,351	954,351				39,254	269,323	720,408	2.1%	
District One Hospital	Fairbault	215,273	750,496	30,780		715,716	715,716		15,488		250,000	2,129,472	2,129,472	4.6%	
Douglas County Hospital	Alexandria	209,990	1,392,037	1,127,445	3,677	2,519,482	2,519,482	35,000	29,000		8,900	293,537	647,055	10.1%	
Glacial Ridge Health System	Glenwood	3,851	190,701	142,181		329,204	329,204	85,646				26,594,937	26,594,937	3.3%	
Granite Falls Municipal Hospital & Manor	Granite Falls	14,504	184,487	184,487		184,487	184,487				11,205,111	209,230	1,027,857	6.0%	
Henriep County Medical Center	Minneapolis	15,758,002	17,696,770	10,521,428	12,439,073	15,779,126	15,779,126	6,262,920			79,668	209,230	1,027,857	2.2%	
Hutchinson Area Health Care	Hutchinson	45,468	1,111,951	1,111,951		1,111,951	1,111,951		80,000		56,000	220,123	1,400,348	5.8%	
Jackson Medical Center ^(b)	Jackson	16,468	86,328	86,328		124,615	124,615		83,000		21,500	35,534	35,534	1.2%	
Johnson Memorial Health Services	Dawson	7,664	80,793	91,997		172,790	172,790					120,603	685,375	4.4%	
Kanabec Hospital	Mora	435,530	550,882	529,559		1,080,441	1,080,441				239,412	5,271,285	5,271,285	32.6%	
Mahnomen Health Center ^(c)	Mahnomen	11,833	23,701	23,701		23,701	23,701					126,138	2,549,603	7.7%	
Meecker County Memorial Hospital ^(b)	Litchfield	9,393	494,485	302,099		796,584	796,584	4,357,289	19,355			46,495	3,445,476	11.9%	
Mercy Hospital & Health Care Center	Moose Lake	31,460	255,641	372,087	3,959	623,769	623,769				605,024	743,424	743,424	9.2%	
Minneapolis Regional Health System ^(a)	Starbuck	13,979	105,450	136,942		136,942	136,942	510,145			68,959	591,359	591,359	3.3%	
Monticello-Big Lake Hospital	Monticello	98,490	1,450,606	620,012	3,511	2,067,106	2,067,106	144,463	87,401		67,328	467,347	467,347	5.2%	
Murray County Memorial Hospital	Sargento	11,585	53,081	145,553		198,634	198,634					506,943	506,943	4.6%	
Northfield Hospital & Long Term Care Center	Northfield	22,904	516,618	724,190		1,240,808	1,240,808	1,576,740	43,416		48,197	743,424	743,424	9.2%	
Oronville Area Health Services	Oronville	24,273	192,990	121,938		314,928	314,928	312,610	37,438		68,959	591,359	591,359	3.3%	
Paynesville Area Health Care System	Paynesville	40,390	111,476	333,096		444,572	444,572	163,717	42,834		67,328	467,347	467,347	5.2%	
Perham Memorial Hospital and Home	Perham	3,487	189,981	189,981		189,981	189,981					506,943	506,943	4.6%	
Pipestone County Medical Center ^(c)	Pipestone	24,095	222,848	260,000		482,848	482,848				160,000	563,977	563,977	4.9%	
Redwood Area Hospital	Redwood Falls	41,970	33,397	243,610		277,007	277,007	15,000	70,000		28,308	1,135,806	819,696	12.3%	
Renville County Hospital	Olivia	6,644	118,327	118,327		118,327	118,327	301,656	6,000		1,170,711	1,135,806	819,696	12.3%	
Rice Memorial Hospital	Willmar	203,057	2,104,485	1,285,467		3,389,952	3,389,952	4,872,446	419,336		12,673	585,485	585,485	7.1%	
Sibley Medical Center	Arlington	58,178	124,640	124,640		124,640	124,640	389,277	1,717		30,013	223,137	223,137	3.6%	
Sleepy Eye Municipal Hospital	Sleepy Eye	12,387	85,890	94,847		180,737	180,737				3,165	919,443	919,443	11.6%	
St. Michael's Hospital & Nursing Home	Sauk Centre	36,254	113,492	139,454		252,946	252,946	616,417	8,660		31,871	658,766	658,766	5.8%	
St. Peter Community Hospital	St. Peter	27,216	280,709	220,048		500,757	500,757	68,922			2,420	150,068	150,068	2.0%	
Swift County-Benson Hospital	Benson	26,912	120,736	120,736		120,736	120,736					610,931	610,931	4.7%	
United Hospital District ^(b)	Blue Earth	116,416	206,959	287,555		494,514	494,514				89,292	460,726	2,060,924	5.7%	
Virginia Regional Medical Center	Virginia	70,621	1,690,515	599,407	927	2,288,995	2,288,995		72,742		30,743	337,262	337,262	3.3%	
Wheaton Community Hospital	Wheaton	4,249	100,077	61,378		161,455	161,455	193,608	5,000		43,890	96,440	96,440	5.0%	
Windom Area Hospital	Windom	19,669	100,206	183,867	15,545	268,528	268,528		5,175		96,440	421,530	421,530	6.2%	
Worthington Regional Hospital	Worthington	88,188	803,567	431,814	9,696	1,225,484	1,225,484				3,692,470	14,346,677	70,133,548	6.2%	
Total, Government Hospitals		18,019,108	30,220,121	23,616,290	12,530,165	41,308,245	20,235,579	500	1,226,323	500	3,692,470	14,346,677	70,133,548	6.2%	

All Minnesota Nonprofit Hospitals	80,268,127	194,725,608	204,709,357	41,608,808	357,826,156	78,374,706	22,759,697	607,177,619	65,899,865	6.5%
------------------------------------------	-------------------	--------------------	--------------------	-------------------	--------------------	-------------------	-------------------	--------------------	-------------------	-------------

Appendix Table 3

Estimated Value of Property, Income and Sales Tax Exemptions, 2005

Hospital Name	City	State/Local Taxes			Federal Tax		Total
		Property Tax	State Income Tax	Sales Tax	Federal Income Tax		
Private Nonprofit Hospitals							
Abbott Northwestern Hospital	Minneapolis	3,572,633	1,493,324	5,394,246	8,152,281		18,612,483
Albany Area Hospital and Medical Center	Albany	76,340	78,834	44,118	334,582		533,875
Albert Lea Medical Center - Mayo Health System	Albert Lea	816,200	389,016	743,067	1,627,288		3,575,571
Austin Medical Center - Mayo Health System	Austin	152,708	210,090	628,658	824,677		1,816,13
Bethesda Rehabilitation Hospital	St. Paul	1,403,992	0	628,403	0		2,032,395
Buffalo Hospital	Buffalo	452,284	76,335	305,956	430,478		1,265,053
Cambridge Medical Center	Cambridge	331,683	662,579	448,484	2,922,730		4,365,477
Children's Hospitals and Clinics, Minneapolis	Minneapolis	1,353,867	807,801	1,884,524	3,640,231		7,686,423
Children's Hospitals and Clinics, St. Paul	St. Paul	367,684	0	1,348,413	0		1,716,097
Cloquet Community Memorial Hospital & C&NC	Cloquet	379,597	122,327	172,675	491,531		1,166,129
Community Memorial Hospital	Winona	600,416	125,259	351,961	542,195		1,619,831
Deer River HealthCare Center	Deer River	396,001	81,458	77,233	354,623		909,316
Divine Providence Health Center	Ivanhoe	194,017	0	19,522	0		213,539
ELEAH Medical Center	Elbow Lake	119,698	0	25,906	0		145,604
Ely-Bloomenson Hospital & Nursing Home	Ely	187,697	97,954	87,752	457,108		830,510
Fairmont Medical Center - Mayo Health System	Fairmont	396,400	22,136	458,432	113,235		990,204
Fairview Lakes Regional Medical Center	Wyoming	1,393,596	106,399	895,542	1,213,337		3,608,874
Fairview Northland Regional Hospital	Princeton	343,987	0	594,760	0		938,747
Fairview Red Wing Medical Center	Red Wing	732,974	154,699	550,624	584,761		2,023,058
Fairview Ridges Hospital	Burnsville	838,347	828,945	1,036,700	3,949,425		6,653,416
Fairview Southdale Hospital	Edina	1,229,522	786,368	2,330,382	3,753,434		8,099,706
Fairview University Medical Center - Mesabi	Hibbing	922,309	136,816	543,684	627,792		2,230,601
Fairview-University Medical Center	Minneapolis	1,525,208	1,470,729	6,560,062	6,116,871		15,672,871
Falls Memorial Hospital	International Falls	128,300	81,546	101,615	376,567		688,028
First Care Medical Services	Fosston	199,360	40,309	62,951	207,235		509,855

Hospital Name	City	State/Local Taxes			Federal Tax		Total
		Property Tax	State Income Tax	Sales Tax	Federal Income Tax		
Gillette Children's Specialty Healthcare	St. Paul	156,420	185,231	818,483	899,425	2,059,560	
Glencoe Regional Health Services	Glencoe	81,466	252,167	243,345	1,065,793	1,642,77	
Graceville Health Center	Graceville	115,454	0	28,502	0	143,956	
Grand Itasca Clinic and Hospital & C&NC	Grand Rapids	258,123	552,437	433,436	2,565,905	3,809,901	
Hendricks Community Hospital Association	Hendricks	176,107	6,671	31,500	29,931	244,209	
Immanuel St. Joseph's - Mayo Health System	Mankato	53,061	533,785	1,147,744	2,060,434	3,795,025	
Kittson Memorial Healthcare Center	Hallock	87,806	0	33,099	0	120,905	
Lake City Medical Center - Mayo Health System	Lake City	160,466	91,307	80,922	394,097	726,792	
Lake Region Healthcare Corporation	Fergus Falls	591,818	220,936	327,799	895,884	2,036,438	
Lake View Memorial Hospital & Home	Two Harbors	217,487	125,903	54,906	556,866	955,163	
Lakeview Hospital	Stillwater	1,249,199	244,780	468,754	1,047,425	3,010,157	
LakeWood Health Center	Baudette	425,058	16,209	48,119	62,419	551,805	
Lakewood Health System	Staples	261,799	186,200	249,743	832,458	1,530,199	
Long Prairie Memorial Hospital & Home	Long Prairie	254,234	97,837	82,933	391,761	826,764	
Luverne Community Hospital	Luverne	57,900	52,936	81,567	244,068	436,471	
Madelia Community Hospital	Madelia	170,706	29,664	42,533	118,942	361,846	
Madison Hospital	Madison	84,324	70,263	42,514	310,232	507,332	
Melrose Area Hospital - CentraCare	Melrose	196,600	126,607	53,274	527,764	904,245	
Mercy Hospital	Coon Rapids	2,131,300	1,464,491	1,853,609	6,259,800	11,709,200	
Methodist Hospital Park Nicollet Health Services	St. Louis Park	4,439,665	601,486	2,795,553	2,661,748	10,498,453	
Mille Lacs Health System	Onamia	352,000	126,304	137,715	580,364	1,196,383	
Miller-Dwan Medical Center	Duluth	1,774,874	232,428	518,564	862,050	3,387,916	
Minnesota Valley Health Center	Le Sueur	174,400	0	26,629	0	201,029	
New Ulm Medical Center	New Ulm	498,904	0	421,832	83,542	1,004,278	
North Country Health Services	Bemidji	757,600	111,107	555,086	461,226	1,885,019	

Hospital Name	City	State/Local Taxes			Federal Tax		Total
		Property Tax	State Income Tax	Sales Tax	Federal Income Tax		
North Memorial Medical Center	Robbinsdale	6,609,555	776,737	2,970,757	3,272,569	13,629,617	
North Valley Health Center	Warren	37,174	0	28,923	0	66,097	
Northwest Medical Center	Thief River Falls	354,130	0	162,593	0	516,723	
Olmsted Medical Center	Rochester	646,891	465,369	290,433	2,175,470	3,578,163	
Owatonna Hospital	Owatonna	217,660	480,994	212,388	2,034,503	2,945,546	
Phillips Eye Institute	Minneapolis	350,036	97,182	203,194	470,252	1,120,664	
Pine Medical Center	Sandstone	68,868	33,434	59,766	156,409	318,476	
Queen of Peace Hospital	New Prague	192,200	29,573	161,008	116,839	499,620	
Regina Medical Center	Hastings	867,405	332,838	273,418	1,518,708	2,992,369	
Regions Hospital	St. Paul	1,472,960	765,457	3,430,324	3,069,320	8,738,061	
Ridgeview Medical Center	Waconia	1,045,562	289,628	660,768	1,346,116	3,342,075	
Riverview Healthcare Association	Crookston	713,177	6,365	179,397	67,798	966,737	
Riverwood HealthCare Center	Aitkin	329,736	100,466	197,149	488,001	1,115,353	
Rochester Methodist Hospital	Rochester	3,820,371	1,421,211	2,383,075	5,908,023	13,532,680	
Roseau Area Hospital & Homes, Inc.	Roseau	219,512	281,488	105,117	1,166,905	1,773,022	
Saint Elizabeth's Medical Center	Wabasha	133,124	33,172	79,583	142,635	388,514	
Saint Marys Hospital	Rochester	8,583,363	0	4,557,897	0	13,141,260	
Sioux Valley Canby Campus	Canby	333,634	0	61,698	0	395,332	
Springfield Medical Center - Mayo Health System	Springfield	104,094	98,566	44,216	414,805	661,680	
St. Cloud Hospital	St. Cloud	3,063,110	1,594,125	2,771,165	6,403,494	13,831,894	
St. Francis Medical Center	Breckenridge	172,450	178,741	117,868	674,986	1,144,045	
St. Francis Regional Medical Center	Shakopee	1,040,800	563,893	590,280	2,275,008	4,469,981	
St. Gabriel's Hospital	Little Falls	306,710	83,981	186,945	357,710	935,346	
St. James Health Services	St. James	121,478	0	69,963	0	191,441	
St. John's Hospital	Maplewood	1,022,818	1,087,306	1,326,943	5,440,079	8,877,147	

Hospital Name	City	State/Local Taxes			Federal Tax		Total
		Property Tax	State Income Tax	Sales Tax	Federal Income Tax		
St. Joseph's Area Health Services, Inc.	Park Rapids	107,300	86,096	221,053	427,983	842,432	
St. Joseph's Hospital	St. Paul	2,816,962	333,382	1,624,064	1,382,570	6,156,978	
St. Joseph's Medical Center	Brainerd	1,701,223	429,222	592,147	1,699,168	4,421,760	
St. Luke's Hospital	Duluth	1,470,778	448,888	1,602,869	1,839,099	5,361,634	
St. Mary's Medical Center	Duluth	2,131,850	1,505,962	2,243,056	7,205,138	13,086,005	
St. Mary's Regional Health Center	Detroit Lakes	434,571	99,299	208,038	399,849	1,141,757	
Stevens Community Medical Center	Morris	203,248	115,844	187,350	441,808	948,249	
Tracy Area Medical Services	Tracy	125,966	0	56,733	0	182,699	
Tri-County Hospital	Wadena	390,477	0	183,187	0	573,664	
Tyler Healthcare Center, Inc.	Tyler	124,171	0	36,635	0	160,806	
United Hospital	St. Paul	4,800,069	1,012,840	3,113,403	3,682,513	12,608,824	
Unity Hospital	Fridley	2,248,500	0	1,182,539	0	3,431,039	
Waseca Medical Center - Mayo Health System	Waseca	231,115	78,062	121,561	326,928	757,667	
Westbrook Health Center	Westbrook	18,119	0	26,558	1,444	46,122	
White Community Hospital & C&NC	Aurora	120,566	0	33,553	0	154,119	
Woodwinds Health Campus	Woodbury	1,627,345	0	609,531	0	2,236,876	
Total, Private Nonprofit Hospitals		83,220,670	25,931,795	69,040,978	114,538,643	292,732,086	

Hospital Name	City	State/Local Taxes			Federal Tax		Total
		Property Tax	State Income Tax	Sales Tax	Federal Income Tax		
<u>Government Hospitals</u>							
Appleton Municipal Hospital and Nursing Home	Appleton	79,609	6,324	37,829	34,378	158,140	
Avera Marshall Regional Medical Center	Marshall	1,271,090	93,966	171,662	369,877	1,906,595	
Bigfork Valley Hospital	Bigfork	255,656	53,155	50,228	226,439	585,479	
Bridges Medical Services	Ada	502,784	0	28,459	0	531,243	
Cannon Falls Community Hospital	Cannon Falls	110,872	0	44,377	0	155,249	
Chippewa County-Montevideo Hospital	Montevideo	100,028	74,497	146,285	331,586	652,396	
Clearwater Health Services	Bagley	73,150	0	66,495	0	139,645	
Cook County North Shore Hospital	Grand Marais	30,750	75,124	60,503	338,663	505,040	
Cook Hospital & C&NC	Cook	89,626	14,659	47,100	79,920	231,305	
Cuyuna Regional Medical Center	Crosby	1,266,952	181,866	229,033	672,721	2,350,572	
District One Hospital	Faribault	307,993	82,818	260,780	316,127	967,719	
Douglas County Hospital	Alexandria	654,606	94,017	457,844	355,574	1,562,041	
Glacial Ridge Health System	Glenwood	94,532	16,856	49,791	87,948	249,127	
Granite Falls Municipal Hospital & Manor	Granite Falls	387,608	101,145	69,603	439,716	998,072	
Hennepin County Medical Center	Minneapolis	1,819,479	0	3,710,299	0	5,529,778	
Hutchinson Area Health Care	Hutchinson	222,578	172,625	370,332	780,471	1,546,007	
Jackson Medical Center	Jackson	163,030	5,816	43,233	28,310	240,389	
Johnson Memorial Health Services	Dawson	137,768	24,627	43,139	94,987	300,520	
Kanabec Hospital	Mora	267,500	97,919	187,942	414,241	967,602	
Mahnomen Health Center	Mahnomen	102,556	26,635	23,232	102,584	255,007	
Meeker County Memorial Hospital	Litchfield	345,804	73,119	120,820	272,152	811,895	
Mercy Hospital & Health Care Center	Moose Lake	455,767	92,891	125,320	440,548	1,114,526	
Minnewaska Regional Health System	Starbuck	80,350	0	31,512	0	111,862	
Monticello-Big Lake Hospital	Monticello	519,555	0	256,521	0	776,076	
Murray County Memorial Hospital	Slayton	176,742	69,873	76,905	261,238	584,757	

Hospital Name	City	State/Local Taxes			Federal Tax		Total
		Property Tax	State Income Tax	Sales Tax	Federal Income Tax		
Northfield Hospital & Long Term Care Center	Northfield	731,924	329,499	223,612	1,361,879	2,646,914	
Ortonville Area Health Services	Ortonville	231,888	10,175	62,485	34,680	339,228	
Paynesville Area Health Care System	Paynesville	250,900	107,268	138,027	427,491	923,685	
Perham Memorial Hospital and Home	Perham	289,246	90,784	70,001	411,581	861,612	
Pipestone County Medical Center	Pipestone	578,281	69,039	85,211	275,648	1,008,179	
Redwood Area Hospital	Redwood Falls	545,342	39,211	89,195	145,610	819,357	
Renville County Hospital	Olivia	148,388	13,475	59,107	80,913	301,883	
Rice Memorial Hospital	Willmar	750,654	24,498	606,188	222,021	1,603,361	
Sibley Medical Center	Arlington	153,798	40,306	63,959	183,530	441,593	
Sleepy Eye Municipal Hospital	Sleepy Eye	118,486	11,117	48,446	49,424	227,472	
St. Michael's Hospital & Nursing Home	Sauk Centre	519,844	43,680	61,629	202,535	827,688	
St. Peter Community Hospital	St. Peter	289,526	0	92,617	0	382,143	
Swift County-Benson Hospital	Benson	109,904	25,828	56,916	121,198	313,845	
United Hospital District	Blue Earth	311,523	25,810	100,004	135,004	572,341	
Virginia Regional Medical Center	Virginia	1,138,176	0	279,373	0	1,417,549	
Wheaton Community Hospital	Wheaton	220,698	0	44,381	12,551	277,630	
Windom Area Hospital	Windom	392,613	35,628	78,452	139,920	646,613	
Worthington Regional Hospital	Worthington	290,426	36,403	153,512	189,079	669,420	
Total, Government Hospitals		16,588,002	2,260,650	9,022,360	9,640,545	37,511,556	

All Minnesota Nonprofit Hospitals

	99,808,672	28,192,445	78,063,338	124,179,187	330,243,642
--	-------------------	-------------------	-------------------	--------------------	--------------------

Appendix Table 4

Estimated Benefits to Hospitals of Tax-Exempt Debt and Deductibility of Contributions, 2005

	Deductibility of Contributions		
	Tax-Exempt Debt	State	Federal
Private Nonprofit Hospital Systems			
Allina Hospitals and Clinics	13,426,318	2,162,362	8,649,447
Avera Health	0	18,064	72,254
Benedictine Health System	1,569,329	58,307	233,226
Catholic Health Initiatives	0	72,122	288,488
Centracare Health System	5,355,656	419,516	1,678,065
Children's Hospitals and Clinics	3,067,823	716,682	2,866,730
Fairview Health Services	7,995,121	723,851	2,895,404
HealthEast Care System	3,303,780	377,236	1,508,942
Mayo Foundation	820,112	13,097,649	52,390,596
Park Nicollet Health Services	4,568,644	49,846	199,383
Sioux Valley Hospitals & Health System	0	1,928	7,711
SMDC Health System	1,722,498	75,584	302,335
Total	41,829,282	17,773,145	71,092,582
Non Affiliated Private Nonprofit Hospitals			
Cloquet Community Memorial Hospital & C&NC	0	246	983
Community Memorial Hospital	445,558	18,245	72,982
ELEAH Medical Center	0	2,891	11,563
First Care Medical Services	15,182	6,523	26,093
Gillette Children's Specialty Healthcare	118,650	530,762	2,123,047
Grand Itasca Clinic and Hospital & C&NC	0	3,947	15,787
Immanuel St. Joseph's-Mayo Health System	0	5,317	21,268
Kittson Memorial Healthcare Center	3,780	7,696	30,784
Lake Region Healthcare Corporation	138,180	0	0
Lakeview Hospital	0	15,006	60,022
Lakewood Health System	835,354	27,385	109,542
Madelia Community Hospital	25,111	6,811	27,246
Mille Lacs Health System	0	25,198	100,790
Minnesota Valley Health Center	0	12,582	50,330
North Country Health Services	1,159,725	0	0
North Memorial Health Care	3,631,950	158,379	633,516
North Valley Health Center	2,457	8,608	34,432
Northwest Medical Center	117,438	0	0
Olmsted Medical Center	387,247	11,254	45,017
Queen of Peace Hospital	139,335	6,398	25,592
Regina Medical Center	550,496	15,398	61,594
Regions Hospital	1,568,497	870,779	3,483,116
Ridgeview Medical Center	0	1,999	7,997
Riverview Healthcare Association	0	36,474	145,897
Riverwood HealthCare Center	0	23,888	95,552
Roseau Area Hospital & Homes, Inc.	207,127	36,564	146,257
St. Luke's Hospital	1,225,189	36,435	145,738
Stevens Community Medical Center	62,782	2,969	11,876
Tri-County Hospital	108,084	21,828	87,311
White Community Hospital & C&NC	0	2,920	11,680
Total Non Affiliated Private Nonprofit Hospitals	10,742,140	1,896,503	7,586,010

	Deductibility of Contributions		
	Tax-Exempt Debt	State	Federal
<u>Nonprofit Government-Owned Hospitals</u>			
Appleton Municipal Hospital and Nursing Home	0	684	2,736
Douglas County Hospital	0	374	1,497
Hennepin County Medical Center	0	140,258	561,030
Johnson Memorial Health Services	0	1,227	4,908
Mercy Hospital & Health Care Center	0	2,812	11,247
Sibley Medical Center	85,365	12,123	48,490
Total Nonprofit Government Owned Hospitals	85,365	157,477	629,907
All Minnesota Private Nonprofit Hospitals	52,571,423	19,669,648	78,678,592
All Minnesota Nonprofit Hospitals	52,656,788	19,827,125	79,308,499

To obtain additional copies of this report,
please contact:

Minnesota Department of Health
Minnesota Health Information Clearinghouse
P.O. Box 64882
St. Paul, Minnesota 55164-0882
(651) 201-5178 or 1-800-657-3793
TDD: (651) 201-5797

If you require this document in another format, such as large print, Braille or cassette
tape, call (651) 201-5178



Printed with a minimum of 10% post-consumer materials. Please recycle.

