CALIFORNIA STATE AUDITOR

Nonprofit Hospitals

Statute Prevents State Agencies From Considering Community Benefits When Granting Tax-Exempt Status, While the Effects of Purchases and Consolidations on Prices of Care Are Uncertain

August 2012 Report 2011-126

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August 9, 2012 2011-126

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

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor (state auditor) presents this audit report concerning whether nonprofit hospitals are providing a public benefit that justifies their tax-exempt status and whether the purchase or consolidation of nonprofit hospitals has resulted in reduced access to or affected the pricing of health care.

This report concludes that although state law requires most tax-exempt hospitals to prepare annual community benefit plans identifying the amount of benefits that the hospitals provided during the year, state law clearly states that the amount of community benefits provided cannot be used to justify the tax-exempt status of nonprofit hospitals. Additionally, we found that no statutory standard or methodology exists for hospitals to follow when calculating these benefits. Further, the four hospitals we reviewed have policies that qualify patients for full or partial charity care using different federal poverty levels, as allowed by state law. Moreover, hospital officials believe that the income levels of patients visiting the hospitals are the reason that some hospitals provide more uncompensated care, including charity care, despite employing the same policies as other hospitals that are part of the same organization.

Additionally, because of limited data we could not determine whether the changes in prices for health care services resulted directly from changes in ownership or operatorship of a hospital. Specifically, the unavailability of pricing data for some hospitals we reviewed and the unique codes the hospitals use to group medical services and related charges kept us from determining how changes in ownership or operatorship affected the prices of health care. Although three of the four hospitals reduced or discontinued some services, we could not determine the effects on communities resulting from such actions. However, we did find that the costs of uncompensated care increased after a change in owners or operators for three of the four hospitals we reviewed.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Summary

Results in Brief

The Legislature expects nonprofit hospitals to provide such community benefits as free or reduced-cost medical care to the poor in exchange for the State's favorable tax treatment of these hospitals. However, as noted in a 2007 report by the California State Auditor (state auditor), the amounts of community benefits the hospitals provide cannot be used to justify their tax-exempt status. Specifically, state law requires most tax-exempt hospitals to prepare annual community benefit plans[1] that describe the activities that the hospitals have undertaken to address community needs and that report the amount of community benefits that the hospitals provided during the year. Community benefits can include health care services that hospitals render to vulnerable populations and for which the hospitals do not receive full compensation. This uncompensated care encompasses free care (full charity care) or discounted care (partial charity care) for financially qualified patients. However, as was the case during our 2007 audit, state law clearly states that state agencies cannot use a community benefit plan to justify the tax-exempt status of a nonprofit hospital. Since our 2007 report, the Internal Revenue Service has required nonprofit hospitals to provide additional information on their tax returns regarding the activities, policies, and practices of each hospital operated during the tax year. Nevertheless, federal law, like state law, does not require nonprofit hospitals to deliver specific amounts of community benefits for the hospitals to qualify for tax exemptions.

In reviewing four nonprofit hospitals—California Pacific Medical Center St. Luke's Hospital (St. Luke's), El Camino Hospital Los Gatos (Los Gatos), Mission Hospital Laguna Beach (Laguna Beach), and San Leandro Hospital (San Leandro)—we saw that each hospital had its own method to calculate its costs to provide health care services for which it did not receive compensation (costs of uncompensated care). Indeed, no statutory standard or methodology for calculating these amounts exists. We reviewed the methods that the four nonprofit hospitals used to quantify their community benefits and to determine what to include as costs of uncompensated care for the hospitals' fiscal year ending in 2010. All four followed guidance from Catholic Health Association of the United States (CHA), a national nonprofit organization representing Catholic institutions and other health care organizations. Using CHA guidance, none of the four hospitals

[1] The four hospitals we reviewed—St. Luke's, Los Gatos, Laguna Beach, and San Leandro—report their community benefits as part of the total community benefits delivered by their parent organization.

Audit Highlights . . .

Our review of nonprofit hospitals with tax-exempt status highlighted the following:

» *The amounts of community benefits the hospitals provide cannot be used to justify their tax-exempt status.*

» *Neither federal nor state law requires nonprofit hospitals to deliver specific amounts of community benefits for the hospitals to qualify for tax-exempt status.*

» *For the four nonprofit hospitals that we reviewed, we determined the following:*

- *Each had its own method of calculating its costs of providing uncompensated health care services because no statutory standard or methodology of calculating these amounts exists.*
- *Each included the cost of charity care and the unpaid costs of public programs in their community benefit plans.*
- *Each provides a different level of charity care because laws do not require a specific level.*

» *Because of limited data, we could not determine whether changes in prices for health care services resulted directly from changes in ownership or operatorship.*

» *Costs of uncompensated care increased after a change in owners or operators for three of the four hospitals we reviewed.*

we reviewed considered as a component of their respective overall community benefits the hospital's expenses pertaining to bad debt, which is the unpaid portion of bills for patients who have the ability to pay but who are unwilling to do so. Instead, the 2010 community benefit plans for the four hospitals included the costs of charity care and the unpaid costs of public programs, such as the California Medical Assistance Program (Medi-Cal) and county indigent programs. During our review, we also noted that one of the four hospitals used its cost-accounting system to help quantify the amount of community benefits it provided. Other hospitals estimated these amounts using a ratio that converts the charges for provided health care services to their actual costs.

Each of the four hospitals we reviewed have different standards for determining who can qualify for charity care. For example, a family of four with an income at 350 percent of the federal poverty level and no insurance may qualify for full charity care at one of the four hospitals we reviewed, but the same family would qualify only for partial charity care at the other three hospitals. The cause for this disparate treatment stems from state law, which requires only that nonprofit hospitals allow those whose incomes are at or below 350 percent of the federal poverty level to apply for charity care. Therefore, a nonprofit hospital can establish for itself the level of charity care it will provide patients based on the patients' financial status, so long as the hospital allows those at or below 350 percent of the federal poverty level to apply for at least partial charity care.

Although the amount of full or partial charity care provided by nonprofit hospitals varies according to the hospitals' policies, these amounts also vary among nonprofit hospitals with the same policies because the financial demographics of the hospitals' communities are different. For example, St. Luke's is one of five hospitals that are part of the California Pacific Medical Center (CPMC). All CPMC hospitals use the same financial assistance policies. Nevertheless, St. Luke's provided more uncompensated care during 2010 than did the other hospitals. Specifically, St. Luke's provided charity care during 2010 that was equal to roughly 17 percent of its net revenue. In contrast, the other four CPMC hospitals provided combined charity care equaling 4 percent of their net revenue. Officials at CPMC attribute the high uncompensated care for St. Luke's to the low income levels of patients who visit that hospital compared to the income levels of those who visit the other CPMC hospitals.

In addition to examining health care costs at the four nonprofit hospitals, we also attempted to evaluate whether prices for health care services changed when new owners or operators acquired the hospitals. However, because of limited data we could not determine whether the changes in prices for services at the four hospitals resulted directly from changes in ownership or operatorship.

Specifically, the unavailability of pricing data for two of the four hospitals kept us from determining how changes in ownership or operatorship affected the prices of health care. State law required hospitals to submit their pricing data[2] annually beginning July 1, 2004, which was after the purchase of the two hospitals. For the remaining two hospitals we reviewed, we could not determine how changes in each hospital's ownership affected the pricing of health care services. During our review, we noted that the new owners at both hospitals brought with them their own unique codes to group medical services and their related charges. As a result, it was not possible to identify the charges of certain medical services before and after a hospital was sold, and to determine whether there were significant price changes in particular procedures or hospital services. The Office of Statewide Health Planning and Development (Health Planning), does not require hospitals to provide their pricing data in a standardized format.

We also could not determine the effects on communities resulting from reductions or terminations of services after new owners or operators acquired the four nonprofit hospitals. We found that the new owners or operators for three of the four hospitals made some changes in services after the acquisition. However, they all cited safety or cost concerns for their decisions. For example, Eden Medical Center's board of directors decided to close San Leandro's skilled nursing unit in 2006. The hospital staff indicated that the decision to close the skilled nursing unit occurred after Medicare changed its reimbursement method. Further, hospital staff believed that other facilities in the area would meet community needs for such services.

On the other hand, costs of uncompensated care increased after a change in owners or operators for three of the four hospitals we reviewed. Laguna Beach was the only hospital that reported a decrease in costs of uncompensated care in 2010, a year after it was acquired by Mission Hospital Regional Medical Center. Between 2008 and 2010, the hospital reported a $6 million decrease in unreimbursed Medi-Cal costs. According to the hospital's controller, the previous owner's decision to discontinue labor and delivery services in 2008 and its skilled nursing unit in 2009, before the purchase, may have affected Medi-Cal patients' use of hospital services.

Finally, we assessed whether Health Planning adequately monitors hospitals' submissions of data required by state law. State law designates Health Planning as the office responsible for collecting

[2] Health and Safety Code, Section 1339.55, requires hospitals to provide Health Planning with pricing data that must be shared with the public.

certain information from hospitals. By collecting, tracking, and making this information available to the public, Health Planning increases the transparency of hospitals in California. Our review found that Health Planning identified 15 nonprofit hospitals that were required to submit community benefit plans in 2010 but did not do so. However, Health Planning stated that the law does not allow it to penalize those hospitals for failing to provide such plans.

Recommendations

If the Legislature intends for nonprofit hospitals' tax-exempt status under state law to depend on the amounts of community benefits they provide, it should consider amending state law to include such requirements.

If it expects each nonprofit hospital to follow a standard methodology for calculating the community benefits it delivers, the Legislature should either define a methodology in state law or direct Health Planning to develop regulations that define such a methodology.

If the Legislature intends to ensure compliance of all hospitals required to submit community benefit plans to Health Planning, it should consider revising state law to allow Health Planning to assess a penalty to those hospitals that do not comply.

Agency Comments

Health Planning concurs with our findings.

Introduction

Background

According to the Department of Public Health (Public Health), 289 of the 572 licensed health facilities were nonprofit corporations as of June 2012. State law provides that entities organized and operated for nonprofit purposes can be exempt from paying the State's corporation income taxes (corporation taxes) and property taxes. The Legislature has declared that in exchange for favorable tax treatment by the government, nonprofit hospitals assume a social obligation to provide community benefits in the public interest. State law defines community benefits to be a hospital's activities that are intended to address community needs and priorities, primarily through disease prevention and improvement of health status. These activities can include health care services rendered to vulnerable populations for which hospitals do not receive full compensation (costs of uncompensated care), such as charity care, which is the portion of a patient's bill that is uncollectible due to the inability to pay. Community benefits can also include the unreimbursed cost of other types of services, such as child care, adult day care, medical research and education, and nursing and other professional training.

Various state agencies oversee different aspects of nonprofit hospitals' operations, including monitoring the hospitals' tax-exempt status, providing public transparency for the reported community benefits, and ensuring that purchases of nonprofit hospitals do not affect the public adversely. The Franchise Tax Board (tax board) is responsible for granting exemptions from the State's corporation tax, and county assessors and the State Board of Equalization (Equalization) are responsible for granting the property tax welfare exemption. The Office of Statewide Health Planning and Development (Health Planning) is responsible for collecting various information that hospitals are required to provide and making that information available to the public. Finally, the Office of the Attorney General (attorney general) must provide written consent or a written waiver before a nonprofit hospital enters into an agreement or transaction to transfer a material amount of assets or control of those assets to another entity, except in certain circumstances. Among the factors the attorney general considers when determining whether to consent to the agreement or transaction is whether it is fair and reasonable to the nonprofit entity and in the public interest.

Requirements for Hospitals Obtaining Tax-Exempt Status

In December 2007 the California State Auditor (state auditor) released a report on nonprofit hospitals concluding that although state law requires most tax-exempt hospitals to annually submit community benefit plans to Health Planning that assign economic values to the community benefits provided, state law provides that such plans cannot be used to justify the tax-exempt status of nonprofit hospitals. This law has not been amended since our 2007 report and thus still does not allow the State to use community benefit plans to justify the tax-exempt status of a nonprofit hospital. As a result, neither the tax board nor county assessors or Equalization considers the amounts of community benefits the hospitals provide when granting tax exemptions to nonprofit hospitals. Instead, they grant tax exemptions based on other information about the organization, including the distribution of its net earnings and the entities' articles of incorporation. Further, although federal law does not require a specific amount of community benefits, the Internal Revenue Service (IRS) has recently revised the forms that nonprofit hospitals must submit annually to require additional information on hospitals' activities related to community benefits.

The Tax Board's Role in Exempting Hospitals From State Corporation Income Taxes

Requirements That an Organization Must Meet to Receive a Corporation Tax Exemption From the State

- The organization must be organized and operated for nonprofit purposes.
- None of its net earnings can benefit any individual or private shareholder.
- No substantial part of the organization's activities can involve carrying on propaganda or otherwise attempting to influence legislation, except when allowed under federal law.
- The organization cannot participate or intervene in any political campaign on behalf of or in opposition to any candidate for public office.
- The organization's assets are irrevocably dedicated to tax-exempt purposes.

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

The tax board administers both personal income and corporation taxes. State law authorizes the tax board to issue the rulings and regulations that are necessary and reasonable to carry out the provisions related to organizations—including hospitals—that are exempt from corporation taxes. As the text box details, the statutory requirements for hospitals to receive a corporation tax exemption focus on the activities of the organization and its distribution of net earnings. To obtain an exemption from state corporation taxes, hospitals must submit an application for tax exemption to the tax board, along with a filing fee of $25. In January 2008 state law was amended to allow the tax board to rely on the IRS's prior determination that an organization qualified for tax exemption. As a result, a hospital that has previously obtained federal exemption under Section 501(c)(3) of the Internal Revenue Code need only provide to the tax board a shortened application and proof of the IRS's determination that it is a tax-exempt organization.

Equalization's Authority in Granting Property Tax Welfare Exemptions

Much like the tax board, Equalization has the authority under state law to prescribe the procedures and forms needed to grant a property tax exemption to organizations—including the property tax welfare exemption. State law specifies that a property is eligible for the property tax welfare exemption if it is used exclusively for religious, hospital, charitable, or scientific purposes, and the property is owned and operated by a community chest, fund, foundation, limited-liability company, or corporation organized and operated for one of these purposes. An organization seeking the property tax welfare exemption must file a claim with Equalization for an organizational clearance certificate (certificate). After reviewing the claim for a certificate, Equalization determines whether an organization qualifies for the exemption and issues the certificate if the qualifications are met. Once the organization has obtained a certificate, it may file a claim for the welfare exemption with the county assessor, who determines whether the property meets the requirements in state law for the exemption, including that the property is actually being used for exempt purposes—as shown in the text box.

Requirements That an Organization Must Meet to Receive a Property Tax Welfare Exemption

- The entity is not organized or operated for profit.
- None of the owner's net earnings benefit any private shareholder or individual.
- The organization uses the property for the actual operation of the exempt activity.
- The property is irrevocably dedicated to the qualifying purposes. In addition, when the owner liquidates, dissolves, or abandons the property, that property must not benefit any private person except a fund, foundation, or corporation organized and operated for religious, hospital, scientific, or charitable purposes.

Source: California Revenue and Taxation Code, Section 214.

Federal Requirements for Tax-Exempt Hospitals

Enacted in March 2010, the Patient Protection and Affordable Care Act changed federal law to require that hospitals, in order to receive exemption from federal taxes under Section 501(c)(3) of the Internal Revenue Code, must conduct a community health needs assessment and adopt an implementation strategy to meet those needs; must have a written financial assistance policy; must limit charges for emergency or other medically necessary care for individuals eligible for assistance under the financial assistance policy; and must not engage in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy. The IRS amended its Form 990, Schedule H, *Hospitals* (Schedule H), for tax years 2010 and 2011 to require additional facility information from tax-exempt hospitals regarding the activities, policies, and practices of each hospital operated by the organization during the tax year. As of March 2012 the IRS continued to seek information and recommendations from the tax-exempt health care community as it works to refine both IRS Form 990 (Form 990) and Schedule H to reflect and fully implement the federal requirements. However, Internal Revenue

Code, Section 501, does not prescribe a specific amount of community benefits that hospitals are required to provide in order to maintain their tax-exempt status under Section 501(c)(3).

Health Planning's Collection and Publication of Hospital Data

Health Planning is responsible for collecting various data from hospitals and making such data available to the public on its Web site or upon request. State laws designate Health Planning as the office responsible for collecting an array of data from hospitals, such as community benefit plans, fair pricing policies, and annual financial information. Excluding small and rural hospitals, and other hospitals meeting certain requirements, private nonprofit hospitals are required by state law to develop and annually submit to Health Planning a community benefit plan that describes the activities they undertook to address community needs and to assign and report economic values of those benefits. Further, state law requires certain hospitals to maintain an understandable written policy regarding charity care and discount payments for financially qualified patients. The law mandates that such policies include clearly stated eligibility criteria and procedures for those policies, a description of the review process, and written policies for debt collection practices—collectively referred to as a fair-pricing policy. Each hospital required to maintain a fair-pricing policy is mandated by state law to provide a copy of that policy to Health Planning on a biennial basis.

State law also requires all licensed hospitals to submit to Health Planning financial information, including a balance sheet and income statement. To ensure uniformity of accounting and reporting procedures, state regulations require that health facilities comply with the systems and procedures detailed in the accounting and reporting manual published by Health Planning. In addition, a state law, known as the Payers' Bill of Rights,[3] generally requires licensed general acute care hospitals, psychiatric acute hospitals, and special hospitals that use a charge description master to annually submit to Health Planning beginning in July 2004 their charge description masters—more commonly referred to as *chargemasters*. According to Health Planning, chargemasters contain the prices of all services, goods, and procedures for which separate charges exist. In connection with submitting its chargemaster, a hospital must also submit a list of average charges for 25 common outpatient procedures as well as the estimated percentage change in gross revenue due to price changes.

[3] Chapter 582, Statutes of 2003, added sections 1339.50 through 1339.59 of the California Health and Safety Code.

Health Planning collects these various data and performs limited work to ensure the accuracy of some of the data that hospitals provide. Specifically, Health Planning asserts that it performs desk audits of the financial information submitted by hospitals to validate the reliability of the information, and it reviews the reported amounts for completeness and reasonableness. Health Planning tracks each hospital's submission of its chargemaster and fair pricing policies and reviews these items to determine whether all submission requirements have been satisfied. Health Planning makes these data available to the public through its Web site.

The Attorney General's Review and Approval of the Purchases of Nonprofit Hospitals

State law requires a nonprofit corporation that operates or controls a health or similar care facility to provide notice to, and obtain written consent or a written waiver from, the attorney general prior to entering into an agreement or transaction to sell or otherwise dispose of, or transfer control of a material amount of its assets. State regulation specifies that such an agreement or transaction involves a material amount of assets or operations when more than 20 percent of the hospital's assets or operations are involved, the facility involved has a fair market value in excess of $3 million, or the facility is a general acute care hospital. The attorney general's process for determining approval for the sale of a nonprofit hospital may include preparing an independent health care impact statement to identify the significant effects on the availability and accessibility of health care services on the affected community. In addition, the attorney general is required to hold at least one public meeting to receive comments from interested parties. When approving the transaction, the attorney general may require the parties involved to meet certain conditions designed to mitigate potential adverse effects on the community. Some conditions required by the attorney general may include maintaining a certain level of services and charity care costs for at least five years after the transaction closes.

To ensure that the purchaser of a nonprofit hospital is adhering to the conditions of consent, the attorney general has required purchasers to submit annual compliance reports while such conditions are in effect. The compliance reports generally address how parties involved in the transaction are complying with each condition placed by the attorney general when approving the transaction. In addition to reviewing the compliance reports, the attorney general may also review the hospital's financial data submitted annually to Health Planning as part of its monitoring.

According to information provided by the attorney general, since 2002, 17 nonprofit hospitals have requested the attorney general's consent. A deputy attorney general stated that ultimately the attorney general consented to the transactions involving 16 of these 17 hospitals. As we describe in Appendix A, nonprofit hospitals may enter into agreements with affiliates or execute transactions in their normal or usual course of activities. The attorney general does not have to provide consent or a waiver for these types of transactions.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) asked the state auditor to conduct an audit to determine whether nonprofit hospitals provided a public benefit that met legal criteria to justify their tax-exempt status. Specifically, the audit committee asked the state auditor to review and assess how nonprofit hospitals calculate the costs of uncompensated care when the hospitals are demonstrating their public benefit. Additionally, the audit committee asked us to examine whether the purchases of nonprofit hospitals and the consolidations of community health facilities resulted in reduced access to health care services or affected the pricing of those services. The audit committee also requested that the state auditor determine whether nonprofit hospitals with multiple facilities provided consistent charity care and other public benefits across their communities and whether the charity care and public benefit warranted their nonprofit status. The audit analysis that the audit committee approved named six objectives. Table 1 lists the six objectives and the methods we used to address those objectives.

Table 1
Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed such relevant state laws as the California Health and Safety Code, the California Corporations Code, and the California Revenue and Taxation Code, as well as such regulations as the California Code of Regulations, Title 22. We also reviewed Section 501 of the United States Internal Revenue Code, federal court decisions, and the Internal Revenue Service (IRS) tax forms related to nonprofit hospitals.
2 For a sample of three to five nonprofit hospitals, review and assess how each hospital calculates uncompensated care for the purpose of demonstrating public benefit, and include the following: a. The percentage of uncompensated care that is attributable to each method of estimated costs (for example, charity care, bad debt, and contractual adjustment for the county indigent program) and how the value calculated from each method is determined. b. The criteria for determining bad debt, including whether a hospital must demonstrate a reasonable effort to collect a debt, and whether hospitals consider a patient's income when determining bad debt.	For the four hospitals we selected, we did the following: • Reviewed their fair pricing policies, which include policies related to charity care and bad debt collection. • Visited the selected hospitals, interviewed appropriate staff, and reviewed documentation related to how hospitals make a determination related to charity care, bad debt, and the county indigent program, as well as the efforts that hospitals make to collect bad debt, including whether they consider patients' income. • Reviewed hospitals' community benefit plans and interviewed appropriate hospital staff to understand what they consider as costs of uncompensated care and how they calculate the costs. • Reviewed hospitals' supporting documents related to financial data used to calculate the costs of uncompensated care.
3 To the extent possible, examine whether the purchases of nonprofit hospitals and the consolidations of community health facilities have resulted in reduced access to health care services or affected the pricing of those services. This examination should determine the following: a. Whether the purchase or consolidation resulted in the closure of emergency rooms, a reduction in access to emergency room care within communities, or both. b. Whether the purchases or consolidations resulted in the discontinuation of specific services, a reduction in access to specific services within communities, or both. c. Whether the purchase or consolidation resulted in a net reduction in the amount of uncompensated care provided within a community. d. How the purchases or consolidations affected the pricing of health care services in affected communities.	• We judgmentally selected hospitals for review based on a variety of factors. Specifically, we considered the Office of the Attorney General's (attorney general) listing of purchases involving nonprofit hospitals. We also considered data provided by the California Department of Public Health (Public Health) to identify hospital facilities that had consolidated with other organizations. Finally, we sought to search for and identify nonprofit hospital facilities being operated by entities other than its owners. To conduct such a search, we performed and found the following: 1) Internet searches did not reveal any such hospitals within California. 2) Although Public Health has information on a hospital's licensee—the entity responsible for operating the nonprofit hospital—the data it provided did not separately identify the nonprofit hospital's owner. As a result, we could not identify instances where a nonprofit hospital's licensee and owner were different entities. 3) We contacted a legislative advocate for the California Hospital Association for a listing of nonprofit hospitals where the owner and operator were different; however, the legislative advocate could not provide such a listing. • Once we had selected four hospitals for review, we generally assessed whether the purchase, consolidation, or change in operatorship affected emergency room care and other services by reviewing each hospital's patient utilization data maintained by the Office of Statewide Health Planning and Development (Health Planning). As applicable, we also considered whether any reduction in service was consistent with any conditions placed on the hospital by the attorney general. Finally, we used financial information collected by Health Planning to assess whether there were changes in each hospital's cost of uncompensated care and changes in each hospital's prices for medical services.

continued on next page . . .

	AUDIT OBJECTIVE	METHOD
4	Determine whether nonprofit hospitals with multiple facilities provide charity care and other public benefits in all communities in which the facilities reside, and ascertain whether the nonprofit hospitals provide care and benefits in a manner that is consistent across communities and that warrants the hospitals' nonprofit status.	• Reviewed the statutory criteria for granting tax exemptions to nonprofit hospitals and whether community benefits play a role in hospitals' qualifying for these exemptions. • Using the same four hospitals selected for other objectives, performed the following: 1) Compared the charity care and other policies for hospitals within the same multi-facility hospital system to identify any differences among the hospitals. 2) Reviewed hospitals' financial data available from Health Planning and identified uncompensated care. We compared the uncompensated care to the uncompensated care at other hospitals within the same multi-facility hospital system. 3) Followed up with hospitals if we identified significant differences in uncompensated care.
5	Review and assess the degree of transparency of the public benefit activities provided by nonprofit hospitals.	• Reviewed state laws to identify requirements for hospitals to submit certain information to Health Planning. • Reviewed and assessed Health Planning's procedures for ensuring that hospitals complied with submission requirements for fair pricing policies, chargemasters, community benefit plans, and financial information. • Selected a sample of 29 hospitals to review for their fair pricing policies, chargemasters, community benefit plans, and financial information. We determined whether Health Planning had received the required information.
6	Review any other issues that are significant to the assessment of the public benefits provided by nonprofit hospitals. This review should include a follow-up on the status of significant recommendations from the 2007 report by the California State Auditor (state auditor).	• Reviewed all recommendations included in the state auditor's 2007 audit report. • Determined the status of recommendations by reviewing the reports the state auditor issued between 2008 and 2012 detailing the implementation of the state auditor's recommendations and the recommendations not fully implemented after one year. We also performed limited work at the Franchise Tax Board to verify implementation of our previous recommendations.

Sources: The California State Auditor's analysis of Joint Legislative Audit Committee audit request number 2011-126, the planning documents, and analysis of information and documentation identified in the table column titled *Method*.

Audit Results

Nonprofit Hospitals Use Different Methods to Calculate the Costs of Uncompensated Care Because No Statutory Standard or Methodology Exists

The four hospitals we reviewed use slightly different methods to calculate and report the cost of health care services that they provide without receiving compensation (costs of uncompensated care). Although state law defines for state planning and reporting purposes some types of activities that may be considered community benefits, it does not require hospitals to include these costs as part of their community benefits. Although there is some guidance available from two national organizations to help hospitals define their community benefit activities, both differ in what should be included when defining costs of uncompensated care. The four hospitals we reviewed indicated that they follow the community benefit guidelines established by the Catholic Health Association of the United States (CHA), a national nonprofit organization representing Catholic and other health care institutions, to develop their community benefit plans[4] and exclude some costs otherwise allowed by state law when calculating their community benefits. However, there is no standard methodology for calculating the costs associated with uncompensated care.

Certain nonprofit hospitals may receive an exemption from paying state corporation tax and property taxes. In exchange for favorable tax treatment, the Legislature has declared that private nonprofit hospitals assume a social obligation to provide community benefits in the public interest. State law requires certain private nonprofit hospitals owned by a tax-exempt corporation and licensed as a general acute care, acute psychiatric, or special hospital to submit annually to the Office of Statewide Health Planning and Development (Health Planning) a community benefits plan. However, although state law defines the types of

State Law's Definition of *Community Benefit*

State law defines *community benefit* as a hospital's activities that are intended to address community needs and priorities. These activities may include any of the following:

1. Health care services rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, or other government-sponsored programs.
2. Community-oriented wellness and health promotion.
3. Prevention services, including, but not limited to, health screening, immunizations, school examinations, and disease counseling and education.
4. Adult day care.
5. Child care.
6. Medical research and education.
7. Nursing and other professional training.
8. Home-delivered meals to the homebound.
9. Sponsorship of free food, shelter, and clothing for the homeless.
10. Outreach clinics in socioeconomically depressed areas.
11. Financial or in-kind support of public health programs.
12. Donation of funds, property, or other resources that contribute to a community priority.
13. Containment of health care costs.
14. Enhancement of access to health care or related services that contribute to a healthier community.
15. Services offered without regard to financial return because they meet a community need, as well as other services, including health promotion, prevention, and social services.
16. Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health.

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

[4] The four hospitals we reviewed—California Pacific Medical Center St. Luke's Hospital, El Camino Hospital Los Gatos, Mission Hospital Laguna Beach, and San Leandro Hospital—report their community benefits as part of the total community benefits delivered by their parent organization.

activities that constitute community benefits, as shown in the text box, it does not require that hospitals include all of these activities when reporting their community benefits.

There are national organizations that provide to hospitals differing guidance defining the costs of uncompensated care. For example, in November 2006 the American Hospital Association issued guidance on reporting community benefits that included in its reporting framework the unpaid costs of government-sponsored health care, such as Medicare, which is allowed under state law. However, CHA recommends that hospitals not include the unreimbursed costs of Medicare as a community benefit. The four hospitals we reviewed follow CHA guidance when reporting their community benefits and do not include unreimbursed costs of Medicare as part of the costs of uncompensated care, even though state law allows it. Similarly, as described in guidance from CHA, these hospitals do not include bad debt, which Health Planning defines as debt from a patient who has the ability but is unwilling to pay, when calculating the costs of uncompensated care for the purpose of demonstrating community benefit.

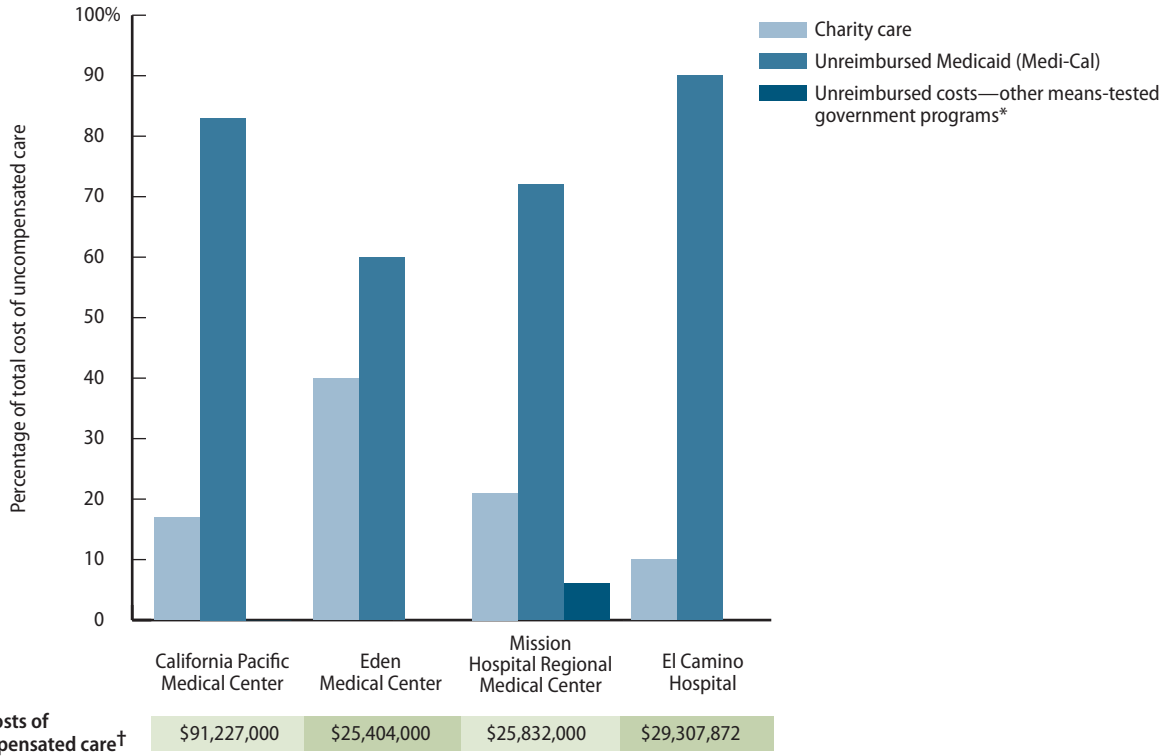
The four hospitals we reviewed follow CHA guidance when reporting their community benefits and do not include unreimbursed costs of Medicare as part of the costs of uncompensated care, even though state law allows it.

Based on the 2010 community benefit plans for the four hospitals we reviewed, which were the most recent plans available from Health Planning at the time of our audit fieldwork, each hospital included the cost of charity care and the unpaid cost of public programs, such as Medi-Cal, in their calculation of community benefits. One hospital we reviewed also reported community benefits resulting from participation in its county's health program for the medically indigent. Mission Hospital Laguna Beach (Laguna Beach) and its parent facility, Mission Hospital Regional Medical Center (Mission Hospital), entered into an agreement with Orange County to provide hospital services to all indigent persons covered by the agreement. According to the agreement, indigent persons covered must meet certain eligibility criteria including being a legal resident of Orange County, having income at or below 200 percent of the federal poverty level, and not otherwise being eligible for Medi-Cal. Nevertheless, as Figure 1 shows, the unreimbursed Medi-Cal costs account for most costs of uncompensated care for the hospitals we reviewed.

The categories hospitals use to compute the costs of uncompensated care for the purposes of demonstrating community benefit are similar to those the Internal Revenue Service (IRS) requires hospitals to include on its Form 990, Schedule H, *Hospitals* (Schedule H). The purpose of this schedule is to provide information on the activities and policies of, as well as the community benefits provided by, the nonprofit hospitals. The schedule specifically requests hospitals to report community benefits at cost. The IRS requires hospitals to report charity care costs, unreimbursed costs for Medicaid, and the

costs of other government programs for which eligibility depends on the recipients' incomes or asset levels. Although the IRS also requires hospitals to provide bad debt expense, it does not require hospitals to report this information as part of community benefits on Schedule H.

Figure 1
Percentage of the Total Costs of Uncompensated Care Attributable to Various Categories



Sources: The 2010 community benefit plans and the Internal Revenue Service (IRS) forms of the four hospitals we visited.

* According to the IRS Form 990, Schedule H instructions, a means-tested government program is a government program for which eligibility depends on the recipient's income or asset level.

† The four hospitals we reviewed—California Pacific Medical Center St. Luke's Hospital, El Camino Hospital Los Gatos, Mission Hospital Laguna Beach, and San Leandro Hospital—report their community benefits as part of the total community benefits delivered by their parent organizations, whose costs appear here.

However, because there are no statutory standards for calculating the costs of uncompensated care, the four hospitals we reviewed use various methods to determine the cost of uncompensated care. Although state law requires hospitals to include in their community benefit plans the economic value of community benefits, such as uncompensated care, it does not prescribe a specific methodology for calculating the economic value of such benefits. Further, CHA guidance acknowledges that a uniform methodology for calculating community benefit cannot be achieved because some facilities use a cost-accounting method—a system for recording and reporting measurements of the cost of manufacturing goods or performing services in the aggregate and in detail—while

others use a cost-to-charge ratio—a ratio that converts patient charges to the cost of services provided. The IRS allows each hospital completing Schedule H the flexibility to use a cost-accounting system, a cost-to-charge ratio, or another method to determine the cost of services. El Camino Hospital, the parent organization of El Camino Hospital Los Gatos (Los Gatos), indicated that it uses a cost-accounting system to determine its costs of uncompensated care. According to the director of revenue and reimbursement, the hospital's cost-accounting system tracks costs and allocates both direct and indirect costs to each patient visit. Unlike El Camino Hospital, Mission Hospital, the parent organization of Mission Hospital Laguna Beach, uses a cost-to-charge ratio from its cost-accounting system to determine the costs of all reported community benefits. Eden Medical Center, which operates San Leandro Hospital (San Leandro), and California Pacific Medical Center St. Luke's Hospital (St. Luke's) also apply cost-to-charge ratios.

To determine the uncompensated cost of Medi-Cal, the four hospitals first determined the total cost of Medi-Cal services by using their cost-accounting system, by applying a cost-to-charge ratio to the charges for such services, or by a combination of the two methods.

The four hospitals we reviewed determine the cost of uncompensated care by calculating the actual cost of services provided and reducing that cost by any reimbursement they received for those services. Specifically, to determine the uncompensated cost of Medi-Cal, the four hospitals first determined the total cost of Medi-Cal services by using their cost-accounting system, by applying a cost-to-charge ratio to the charges for such services, or by a combination of the two methods. They then reduced these costs by any payments they received—such as Medi-Cal reimbursements from the State or payments from the patient. The remaining costs represent the uncompensated costs of Medi-Cal services, which the hospitals report in their community benefit plans. Regardless of whether hospitals used their accounting systems or cost-to-charge ratios, their methodologies for calculating their community benefits seemed reasonable. For example, El Camino Hospital reported roughly $26.4 million as the unpaid cost of Medi-Cal in its 2010 community benefit report. To determine that amount, El Camino Hospital used its cost-accounting system to determine the cost associated with providing Medi-Cal services—roughly $35.6 million. The hospital then reduced that cost by $9.2 million in payments the hospital received or expects to receive related to those services. The four hospitals' approaches to determining the cost of their charity care follow roughly the same methodology.

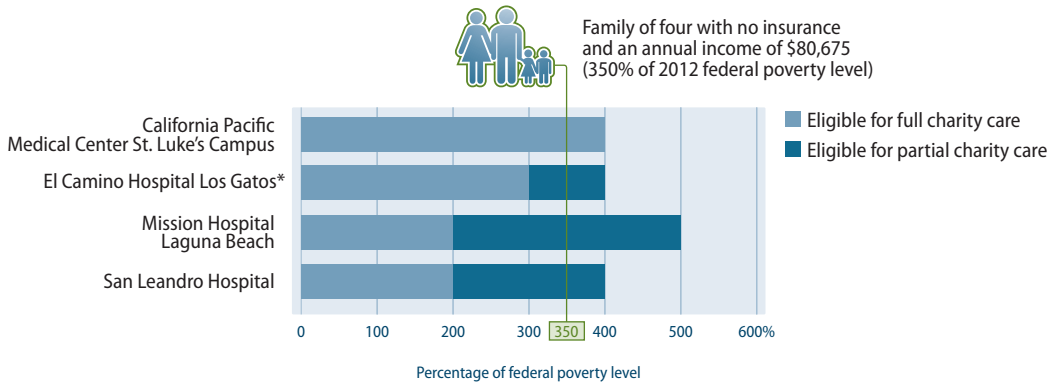
Hospitals Have Different Income Requirements When They Decide Who Is Eligible for Charity Care

State law requires hospitals to maintain an understandable written charity care policy, as well as a written policy regarding discount payments for financially qualified patients. According to Health Planning, charity care results in free medical care for the patient, whereas a discount payment policy refers to instances where the hospital will reduce a medical bill based on the patient's financial

circumstances (partial charity care). The four hospitals we reviewed generally included both full and partial charity care in a single policy and used different income levels to determine whether patients qualified for one of the two types of charity care. State law requires that hospitals allow uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level to apply for participation under a hospital's charity care or partial charity care policy. Additionally, state law permits hospitals to grant eligibility for charity care or partial charity care to patients with incomes greater than 350 percent of the federal poverty level. Thus, our review of four hospitals' charity care policies found they use different income levels when establishing criteria for providing charity care. Further, our review noted that some hospitals maintain enhanced charity care policies that provide discounts to patients who may not otherwise qualify for charity care.

Each of the four hospitals' charity care policies provides at least partial charity care to patients with incomes at or below 350 percent of the federal poverty level. For example, St. Luke's provides full charity care to uninsured patients with family incomes at or below 400 percent of the most recent federal poverty level and who have no source of payment for any portion of their medical expenses, such as government benefit programs. In contrast, Laguna Beach considers a patient eligible to receive full charity care if that patient has a family income at or below 200 percent of the current federal poverty level. Laguna Beach still complies with state law because it allows those with family incomes above 200 percent and below 500 percent of the poverty level to apply for partial charity care, as Figure 2 shows.

Figure 2
Percentages of Federal Poverty Levels That the Four Hospitals Use to Qualify Patients for Full or Partial Charity Care Applied to a Hypothetical Family of Four



Sources: The most recent charity care policies for the four hospitals we visited and the 2012 Federal Poverty Guidelines from the U.S. Department of Health and Human Services' Web site.

* According to the charity care policy for El Camino Hospital Los Gatos, an insured patient will qualify for full charity care if the patient's net annual income is less than 400 percent of the federal poverty level and if his or her annual out-of-pocket expense exceeds 10 percent of the total annual income of the patient or the patient's family and the maximum government rate exceeds the insurance company payment.

As a result of the differences in the percentage of federal poverty level that hospitals use, the same family may qualify for free medical care at one hospital while still having to pay a portion of its medical bill at another.

As a result of the differences in the percentage of federal poverty level that hospitals use, the same family may qualify for free medical care at one hospital while still having to pay a portion of its medical bill at another. For example, according to the U.S. Department of Health and Human Services' guidelines, the federal poverty level for a family of four during 2012 was $23,050. Therefore, as Figure 2 shows, a family of four with no insurance and an income of $80,675 in 2012, or 350 percent of the federal poverty level, would qualify for full charity care if it received medical services from St. Luke's. However, the same family would qualify for only partial charity care for health services received from Laguna Beach, Los Gatos, or San Leandro.

One hospital's policy we reviewed provides charity care to patients even if they do not provide all necessary documents needed to determine eligibility. As part of its charity care policy, Laguna Beach states that an eligible patient may qualify for its financial assistance program by following application instructions and making every effort to provide the hospital with documentation and health benefit coverage information such that the hospital may make a determination of a patient's qualification for coverage under the charity care program. However, Laguna Beach recognizes that some patients may not engage in the traditional financial assistance application process, leaving the hospital with limited information with which to assess the patient's financial eligibility. If the patient does not provide the required information, Laguna Beach uses an automated, predictive scoring tool to qualify patients for charity care. According to the hospital's director of patient accounting, the scoring tool leverages databases with more than 9,000 sources and more than two billion records, including judgments, liens, bankruptcy, and legal activity, none of which are from a traditional credit bureau. This scoring tool estimates the patient's likely socioeconomic standing, as well as the patient's household income and size, to predict the likelihood that a patient qualifies for charity care.

Similarly, St. Luke's and San Leandro, both affiliates of Sutter Health, allow patients with special circumstances to benefit from charity care or discounted medical services even if they otherwise would not meet the hospital's financial eligibility criteria. For example, St. Luke's allows income-eligible Medicare and Medi-Cal patients to apply for financial assistance for denied stays, denied days of care, and noncovered services. However, the hospital's chief financial officer or designee must approve and document the decision for a complete or partial write-off under its special circumstance charity care category.

Hospitals With the Same Policies Might Provide Different Amounts of Charity Care Based on the Populations They Serve

A nonprofit hospital that serves a low-income community might provide more charity care than other hospitals serving more affluent areas, even though both hospitals share the same charity care policies. The four hospitals we reviewed are part of larger health organizations that operate multiple hospitals. Some of these hospitals operate under a consolidated license and apply the same charity care policies at all hospitals under that license. However, despite following the same charity care policies, some hospitals we reviewed provide different amounts of charity care. The hospital officials we spoke with point to the demographics of the patients that visit the hospitals as their explanation for this disparity.

Health Planning allows hospitals operating under a consolidated license to use the same discount payment and charity care policies at all hospital locations. These organizations are required to file and identify on the IRS's Schedule H all hospital facilities they own or operate. According to each Schedule H prepared by the organizations that operate the four nonprofit hospitals we reviewed, these organizations own or operate multiple facilities, as the text box shows. Further, three of the four hospitals we reviewed operate under consolidated licenses with other hospitals that are part of the same organization. The fourth hospital we reviewed operates under its own license, separate from the other facilities that are part of the same nonprofit organization. The organizations indicated on Schedule H that they use the same charity care policy at all of the hospitals they own.

Hospitals Operating Under the Same Full and Partial Charity Care Policies

Three of the four hospitals we reviewed operate with other hospitals under a single license and follow the same full and partial charity care policies. The California Pacific Medical Center hospitals also follow the same policies even though they operate under different licenses.

El Camino Hospital
License 070000660

1. El Camino Hospital
2. *El Camino Hospital Los Gatos*

Mission Hospital Regional Medical Center
License 060000146

1. Mission Hospital Regional Medical Center
2. *Mission Hospital Laguna Beach*

Eden Medical Center
License 140000030

1. Eden Medical Center
2. *San Leandro Hospital*

Sutter West Bay Hospitals (partial listing)
License 220000197

1. California Pacific Medical Center–Pacific Campus
2. California Pacific Medical Center–California West Campus
3. California Pacific Medical Center–California East Campus
4. California Pacific Medical Center–Davies Campus

License 220000070

5. *California Pacific Medical Center St. Luke's Hospital*

Sources: Internal Revenue Service Form 990, Schedule H, *Hospitals*, and Office of Statewide Health Planning and Development's Automated Licensing Information and Report Tracking System.

Note: Names of the hospitals we reviewed appear in bold type.

Despite using consistent charity care policies, the charges related to charity care and other uncompensated care, such as unreimbursed Medi-Cal services, differed at the hospitals we examined. To allow for a meaningful comparison of the charges related to charity care and other uncompensated care that each hospital provided, we divided the charges for each category of uncompensated care by the net revenue for each hospital. Table 2 on the following page shows the results of the comparison.

Table 2
Uncompensated Care as a Percentage of Net Revenue for the Four Nonprofit Hospitals and Other Hospitals That Are Part of the Same Organization

HEALTH ORGANIZATION AND HOSPITAL	NET REVENUE*	CHARITY CARE†	CHARITY CARE AS A PERCENTAGE OF NET REVENUE	TOTAL UNCOMPENSATED CARE†‡	TOTAL UNCOMPENSATED CARE AS A PERCENTAGE OF NET REVENUE
Mission Hospital Regional Medical Center					
Mission Hospital Regional Medical Center	$366,624,621	$22,593,795	6.16%	$156,178,958	42.60%
Mission Hospital Laguna Beach	61,841,976	3,005,331	4.86	11,420,160	18.47
El Camino Hospital					
El Camino Hospital	436,747,859	10,958,082	2.51	87,510,314	20.04
El Camino Hospital Los Gatos	76,433,999	273,865	0.36	11,440,041	14.97
Eden Medical Center					
Eden Medical Center	278,072,145	34,663,401	12.47	156,138,241	56.15
San Leandro Hospital	85,493,391	8,540,984	9.99	59,663,106	69.79
Sutter West Bay Hospitals					
California Pacific Medical Center (CPMC)—Pacific Campus Hospital (Parent)§	1,088,744,773	46,108,563	4.24	317,179,306	29.13
CPMC St. Luke's Hospital	112,221,633	19,445,489	17.33	188,348,781	167.84‖

Sources: Internal Revenue Service Form 990, Schedule H, *Hospitals,* and financial information collected by the Office of Statewide Health Planning and Development (Health Planning) and supporting documents provided by hospital administrations for their fiscal years ending in 2010.

* The amounts shown for *Net Revenue* generally represent the hospital's net patient revenue after considering deductions for bad debt and contractual adjustments for the California Medical Assistance Program (Medi-Cal) and other programs.

† The amounts shown for *Charity Care* and *Total Uncompensated Care* generally represent deductions from each hospital's gross patient revenue and thus do not necessarily represent each hospital's actual unreimbursed cost of providing these services (costs of uncompensated care). As a result, the amounts shown in the table may not agree with the uncompensated care or community benefit amounts hospitals report to Health Planning, which are typically reported at cost. In this table, we present these amounts on a revenue basis in order to compare them to net revenue.

‡ The amounts shown for *Total Uncompensated Care* include deductions from a hospital's gross patient revenue for services provided under its charity care policies, as well as for services provided under Medi-Cal and county-sponsored health programs for the medically indigent.

§ CPMC Pacific Campus is the parent hospital of a consolidated license that includes CPMC California West, CPMC California East, and CPMC California Davies. Because these hospitals are consolidated, CPMC Pacific Campus submitted their financial reports as a single report.

‖ The total uncompensated care for CPMC St. Luke's Hospital represents the total charges related to charity care and Medi-Cal services for which the hospital did not receive reimbursement or payment. This amount exceeds the net revenue, which represents the charges related to all services for which it received reimbursement or payment.

As Table 2 shows, the charges related to charity care provided as a percentage of net revenue at St. Luke's—roughly 17 percent—were significantly greater than the charges related to charity care provided at the other California Pacific Medical Center (CPMC) hospitals, which were just over 4 percent. We found similar differences in the charges related to unreimbursed Medi-Cal at St. Luke's compared to the other CPMC hospitals. Using Health Planning's encounter summary reports for emergency department and ambulatory surgery and its hospital discharge summary, we noted that of the 31,600 total patients that St. Luke's discharged in 2010, more than 12,500 were Medi-Cal patients. Although the other CPMC locations discharged a total of 92,600 patients during the same period, only about 6,000 were Medi-Cal discharges. Given the large number of Medi-Cal patients discharged at St. Luke's, it seems reasonable that St. Luke's would likely have more

patients who qualify for charity care programs because of their financial status. Table 2 also shows that other hospitals operating under the same charity care policies have different amounts of uncompensated care.

The Change in Ownership for Nonprofit Hospitals Had Undetermined Effects on Prices for Medical Services and Access to Care

In reviewing data that the four hospitals submitted to Health Planning about their operations, we could not determine whether the acquisitions of these nonprofit hospitals affected prices for medical services. Each year, certain hospitals are required to submit a uniform schedule of charges—represented by the hospital as its gross billed charge for a given service or item, regardless of payer type—to Health Planning. State law defines this uniform schedule as the hospital's charge description master (chargemaster). However, our review of chargemaster data found that hospitals do not report their gross charges for specific services following a standardized format, thus preventing a comparison of what was charged for the same service between the previous and current owner or operator. In fact, Health Planning's Web site acknowledges that hospitals are not required to provide their chargemasters in a standardized format, thus making it impossible to aggregate hospital pricing data. Our review also noted that three of the four hospitals we reviewed changed aspects of health care—such as reducing the number of emergency medical treatment stations or discontinuing skilled nursing services—however, the results of these changes on the public's access to care are unclear. For example, removing an emergency medical treatment station does not necessarily mean that fewer patients were effectively served by the hospital. Hospital officials with whom we spoke cited safety concerns or cost considerations as the motivation for the changes. Finally, our review noted that although three of the four hospitals showed an increase in their costs of uncompensated care, one hospital had a decrease in the costs of uncompensated care reported under its new ownership.

Three of the four hospitals we reviewed changed aspects of health care—such as reducing the number of emergency medical treatment stations or discontinuing skilled nursing services—however, the results of these changes on the public's access to care are unclear.

Limited Data Prevented Us From Determining Whether Nonprofit Hospitals' Changes in Ownership or Affiliation Raised the Prices of Medical Services

We found that the hospitals have unique chargemaster codes and descriptions that are different from those used by the previous owners or operators of these hospitals. For example, the new owner of Laguna Beach uses seven-digit codes on its chargemaster, but the previous owner of the hospital used codes with four or five digits. Further, the director of revenue and reimbursement for El Camino

Hospital noted that even if the description of a medical service is the same, the service may not actually be the same from one year to the next. For instance, we noted that the 2010 chargemaster for El Camino Hospital identified one service as "CPR Services" with charges that were more than $1,000 higher than the charges for the same item with the same description from the 2009 chargemaster. The hospital official explained that the 2010 charges combined two 2009 charges. Because the coding and the definitions of items changed from year to year and from operator to operator, we could not compare a hospital's chargemaster information with the chargemasters used by a previous owner or operator. Therefore, we could not determine whether a hospital's prices for medical services changed after its purchase or consolidation.

Because the coding and the definitions of items changed from year to year and from operator to operator, we could not determine whether a hospital's prices for medical services changed after its purchase or consolidation.

In addition to reporting chargemaster data, hospitals are also required to calculate and report an estimate of the percentage increase in their gross revenue due to any price increase for patient services. Based on our review, hospitals generally calculate the effect on revenue by applying the current year's prices to the prior year's volume of medical services and by comparing the resulting revenue to what it was under the prior year's prices. We attempted to review this data for the year before, the year of, and the year after a hospital's change in ownership to determine whether the four hospitals' revenues increased as a result of price changes; however, such data were not always available for the four hospitals depending on when the purchase or consolidation took place. State law required hospitals to begin providing their chargemastes to Health Planning in July 2004. However, St. Luke's affiliated with Sutter Health in 2001, effectively giving Sutter Health governing control. Further, the lease agreement between San Leandro and Sutter Health's affiliate Eden Medical Center to operate the hospital went into effect in May 2004. Because these two acquisitions transpired before chargemaster and revenue change information was required, we did not have the necessary data for these hospitals to perform a comparative analysis, as Table 3 shows.

For the remaining two hospitals we were able to perform a comparative analysis; however, we cannot determine whether the changes in prices resulted from the acquisition of another facility or were due to other factors, such as increased cost to provide services. Because the new owners applied their charges for services at these two hospitals, we compared the percentage of revenue change due to price changes the new owners reported before and after the purchase. As Table 3 shows, price changes had a negative effect on revenue for El Camino Hospital during the year following its purchase of the buildings of the former Community Hospital of Los Gatos. However, Mission Hospital, which acquired South Coast Medical Center, reported that price changes had a positive effect on hospital revenue following the

acquisition. As we discuss in Appendix A, Mission Hospital purchased the former South Coast Medical Center in 2009 and renamed it Mission Hospital Laguna Beach. According to the data that Mission Hospital provided to Health Planning, increases in prices resulted in a roughly 4.6 percent increase in revenue during the year before it purchased the new hospital. In the year following its acquisition of South Coast Medical Center, Mission Hospital reported that price changes led to an 8.6 percent increase in revenue. According to a hospital representative, prices are affected by the increases in managed care agreements and competition with area hospitals.

Table 3
Percentage Changes in Revenue That Resulted From Price Changes at the Parent Organizations of the Four Hospitals We Reviewed

OWNER OR PARENT ORGANIZATION	ACQUIRED HOSPITAL	TYPE OF ACQUISITION	YEAR OF ACQUISITION	PERCENTAGE CHANGE IN REVENUE FOR THE PARENT ORGANIZATION AS A RESULT OF PRICE CHANGES		
				DURING YEAR BEFORE ACQUISITION*	DURING YEAR OF ACQUISITION*	DURING YEAR AFTER ACQUISITION
Mission Hospital Regional Medical Center	South Coast Medical Center	Purchase	2009	4.57%†	5.36%	8.64%
El Camino Hospital	Community Hospital of Los Gatos ‡	Purchase	2009	7.00	2.80	(3.82)§
Eden Medical Center	San Leandro Hospital	Lease Agreement	2004	Data Unavailable‖	Data Unavailable‖	Data Unavailable‖
Sutter Health	St. Luke's Hospital	Affiliation#	2001	Data Unavailable‖	Data Unavailable‖	Data Unavailable‖

Source: Annual data with charge description master information that hospitals submitted to the Office of Statewide Health Planning and Development (Health Planning).

Note: We did not audit these percentages because Health Planning does not require hospitals to provide supporting documentation for the revenue totals used for those calculations.

* Because these figures were reported before the acquisition of the hospital, they do not reflect any activities of the acquired hospital.

† Using the 2007 and 2008 total revenue amounts provided to Health Planning by Mission Hospital Regional Medical Center, we found that the reported percentage was incorrectly calculated. The correct percentage appears on this table.

‡ As described in Appendix A, El Camino Hospital purchased the building formerly operated as the Community Hospital of Los Gatos.

§ This figure is for El Camino Hospital's Mountain View campus because El Camino Hospital did not have the necessary information for the Los Gatos campus.

‖ Until July 2004, state law did not require hospitals to report this data. Further, Health Planning did not require hospitals to submit this data until July 2006

\# As defined in Corporations Code Section 5031, a corporation is considered an affiliate of another corporation when the latter controls the former or when both corporations are under common control.

As part of our review of price changes, we inquired of hospitals about their methodologies for establishing prices for medical services. Each hospital has a different process for determining how to set the price for a particular medical procedure or service. For example, Mission Hospital's controller stated that the hospital has a committee of staff members from throughout the hospital who review pricing factors and present recommendations to the hospital board. According to El Camino Hospital's director of revenue

Because the hospitals use methods that consider multiple factors when determining prices, we could not isolate a specific reason for the changes in prices.

and reimbursement, the hospital hires a third-party contractor that studies the prices of other hospitals in the area to make recommendations for changes to prices of various medical services. The other two hospitals stated that they use a software program or their staff to evaluate or implement price changes. Because the hospitals use methods that consider multiple factors when determining prices, we could not isolate a specific reason for the changes in prices.

Hospitals' Reductions in or Terminations of Some Medical Services Had Unknown Effects on Their Respective Communities

The new operators of three of the four hospitals we reviewed made some changes in services. According to hospital officials, these changes were made because of safety and cost considerations. During the audit we attempted to review documentation supporting the hospitals' explanations, but such material was not always readily available, and we noted that the Office of the Attorney General (attorney general) had not prohibited the hospitals from terminating these services. The services provided by the fourth hospital, Los Gatos, were new. As we explain in Appendix A, El Camino Hospital acquired the buildings once occupied by Community Hospital of Los Gatos, a for-profit hospital. Community Hospital of Los Gatos had closed its operations before the purchase by El Camino Hospital. Therefore, any changes in Los Gatos' services are independent of those provided by Community Hospital of Los Gatos.

To determine whether the acquisition affected the level of medical services provided to the community, we reviewed the data that identify the type and number of licensed beds, number of licensed treatment rooms, and number of patients that use the various services (utilization), which hospitals annually submit to Health Planning. We generally focused on the year before, the year of, and the year after the transaction. As we explain in Appendix A, the attorney general reviewed the acquisitions of South Coast Medical Center and St. Luke's by Mission Hospital and Sutter Health, respectively. For South Coast Medical Center the attorney general required the new owner to report on its compliance with the attorney general's conditions through 2014. The attorney general required, among other things, that for five years from the date of the transaction's closing, the new owner must maintain a certain level of charity care. Further, the attorney general required the new owner to maintain certain services, such as 24-hour emergency medical services as licensed at the time of the attorney general's approval, until December 31, 2012 or for five years from the transaction closing date if certain seismic retrofitting requirements are met. The attorney general's review of the hospital's annual

compliance reports through June 2011 found that the new owner is complying with the conditions of the purchase approval. We noted that the hospital discontinued implanting pacemakers and eliminated its cardiac catheterization room in 2009; however, maintaining these services was not a part of the attorney general's conditions. According to the hospital's controller, patients who required these discontinued services were transferred to Mission Hospital, the parent facility, which continued to provide these services.

Although the attorney general approved St. Luke's 2001 affiliation[5] with Sutter Health, it did not require compliance reports. According to a deputy attorney general, the attorney general required compliance reports starting with the transactions it approved in 2003. Our review found that St. Luke's eliminated its acute psychiatric unit five years after the affiliation. The continuing operation of this unit was not included in the attorney general's conditions of approval. According to a Sutter Health vice president, the unit was closed due to financial and safety issues. She stated that the unit could not be locked down when required and the population was never large enough to justify the cost of the necessary modifications. Further, in 2008 CPMC moved the neonatal intensive care unit and the inpatient pediatric program located at St. Luke's to another CPMC hospital. Sutter Health explained that these units averaged fewer than two patients per day.

We noted that St. Luke's also changed the number of emergency medical treatment stations several times since its affiliation with Sutter Health in 2001. As one condition of approving this affiliation with Sutter Health, the attorney general required that the hospital maintain an emergency room service at least at the licensure level current at the time of the affiliation and for a minimum of five years after the date of affiliation. Between 2001 and 2002, the hospital reduced the number of emergency medical treatment stations by three from the 13 stations it operated previously. However, according to a branch chief at the Department of Public Health (Public Health), the licensure of the emergency room is not dependent on the number of treatment stations. Thus, the reduction in the number of treatment stations would not impact the licensure level. In fact, St. Luke's increased the emergency room treatment stations to 13 in 2005 and 14 in 2006. However, the hospital again reduced the number of stations to 10 in 2008. A Sutter Health vice president stated that the emergency medical department space was reconfigured for better use and access to the emergency department. According to 2008 patient utilization data

[5] According to state law, a corporation is considered an *affiliate* of another corporation when the latter controls the former or when both corporations are under common control.

that St. Luke's submitted to Health Planning, the number of visits to the hospital's emergency department increased slightly after this reduction of treatment stations. However, any effects on patients, such as wait time, resulting from this change are unknown.

Similarly, the Eden Medical Center's board of directors decided to eliminate the skilled nursing unit at San Leandro in 2006. According to a vice president at Sutter Health, the hospital determined that it could not cover its costs after Medicare transitioned its reimbursement from a cost-based system to a prospective payment system. A prospective payment system is a reimbursement method that is based, in part, on a fixed predetermined amount. According to the vice president, the hospital management determined that there were other facilities in the area that provided this service; thus, its skilled nursing facility was not needed to fulfill a community need.

Costs of Uncompensated Care Generally Did Not Decrease After the Purchase of the Hospitals We Reviewed

The reduction in uncompensated care at one hospital appears to have resulted from actions the previous owner took just before the sale of the hospital in July 2009.

As Table 4 shows, the costs of uncompensated care declined after a change in owner or operator for only one of the four hospitals we reviewed. All four hospitals we reviewed were acquired by entities that already owned or operated at least one other hospital that had already established various policies, including charity care. These entities extended their existing policies to the new facilities they acquired. The reduction in uncompensated care at Laguna Beach, formerly known as South Coast Medical Center, appears to have resulted from actions the previous owner took just before the sale of the hospital in July 2009.

Mission Hospital, which acquired the former South Coast Medical Center, complied with the attorney general's conditions of the purchase approval with regard to the amount of charity care provided, as well as its continued participation in the Medi-Cal program. Despite providing the amount of charity care required by the attorney general, between 2008 and 2010 it reported a considerable decrease in total costs of uncompensated care due to significantly lower unreimbursed Medi-Cal costs, which made up nearly 40 percent of these costs for the hospital in 2010. The previous owner of the hospital discontinued its labor and delivery services in 2008 and its skilled nursing unit in 2009 before the purchase which, according to the hospital's controller, may have affected utilization by Medi-Cal patients. According to Health Planning's data, in 2008 the hospital had 583 patient days related to 218 discharges for perinatal services or health care related to childbirth and 8,883 patient days related to 14 discharges from the skilled nursing unit. Although we could not determine how many of these discharges involved

Medi-Cal patients, the cost of unreimbursed Medi-Cal declined after the ownership changed in 2009. Specifically, unreimbursed Medi-Cal decreased from $7.3 million in 2008 to $1.3 million in 2010.

Table 4
Costs of Uncompensated Care Before and After the Acquisitions of the Four Hospitals We Reviewed

OWNER OR PARENT ORGANIZATION	ACQUIRED HOSPITAL	YEAR OF ACQUISITION	COSTS OF UNCOMPENSATED CARE AT THE ACQUIRED HOSPITAL*	
			YEAR BEFORE ACQUISITION	YEAR AFTER ACQUISITION
Mission Hospital Regional Medical Center	South Coast Medical Center	2009	$8,721,135	$3,385,002
El Camino Hospital	Community Hospital of Los Gatos†	2009	2,239,791	2,847,122
Eden Medical Center	San Leandro Hospital	2004	4,491,365	7,486,039
Sutter Health	St. Luke's Hospital	2001	24,509,575	35,032,332

Sources: Annual financial data that hospitals submitted to the Office of Statewide Health Planning and Development (Health Planning) and the hospitals' financial records.

* When calculating the costs of uncompensated care presented here, we used Health Planning's method to develop a cost-to-charge ratio to ensure a uniform methodology. We applied this cost-to-charge ratio to hospitals' deduction from revenue accounts. Therefore, the figures presented in this table may not represent the actual cost of uncompensated care.

† As described in Appendix A, El Camino Hospital purchased the building formerly operated as the Community Hospital of Los Gatos.

Health Planning Adequately Monitors Hospitals' Submission of Data Required by State Law

As we described in the Introduction, state law designates Health Planning as the office responsible for collecting various data from hospitals, including community benefit plans, fair pricing policies, annual financial information, and chargemaster data. Health Planning increases transparency by tracking hospitals' compliance with statutory requirements to submit data and, through its Web site, by giving the public access to the data. Although a few hospitals submitted the required data late or not at all, we generally found that Health Planning adequately monitored hospitals' compliance with statutory submission requirements.

State law requires certain nonprofit hospitals to submit a community benefit plan to Health Planning no later than 150 days after the hospital's fiscal year ends. Health Planning maintains and posts on its Web site a listing of hospitals that are required to submit a community benefit plan and tracks whether the hospitals submit the required reports. We compared this list for the 2010 reporting year to a list of all licensed nonprofit hospitals from Public Health and found that Health Planning's list included all 218 nonprofit hospitals required to report under state law. However, Health Planning identified 15 of the 218 hospitals that had not submitted their community benefit plans for the 2010 reporting year as of March 2012. According to its accounting and reporting systems

State law does not allow Health Planning to penalize hospitals that are delinquent in their submission of community benefit plans.

section manager, Health Planning contacts hospitals via email, but it does not pursue delinquent hospitals further because state law does not allow Health Planning to penalize hospitals that are delinquent in their submission of community benefit plans.

For the other types of information hospitals are required to submit, state law allows civil penalties and makes general acute care hospitals' submissions of fair pricing policies a condition of licensure to ensure compliance. Generally, Health Planning uses the condition of licensure provision in state law to encourage compliance with the statutory requirement to submit fair pricing policies. As we discussed in the Introduction, state law requires certain hospitals to provide a copy of their fair pricing policies to Health Planning at least biennially. During our review, we found that Health Planning had adequately tracked the submission by more than 400 hospitals that were required by state law to submit fair pricing policies for the 2010–11 submission period. Although Health Planning did not identify any noncompliant hospitals during the 2010–11 submission period, it had identified five such hospitals for the 2008–09 submission period. Health Planning provided us with the letter that it sent to Public Health notifying the deputy director of the Center for Health Care Quality that these five hospitals did not satisfy the statutory requirement.

Finally, although state law allows for civil penalties to be assessed on a hospital that does not file its chargemaster data as required, Health Planning did not pursue any penalties for these submissions during the 2010 reporting period. Health Planning's tracking document showed that during the 2010 reporting period 42 hospitals—roughly 10 percent—were more than 30 days late in their submission of chargemaster data to Health Planning. However, we noted that all hospitals had submitted their chargemaster data within 90 days from the July 1 statutory deadline. According to one of its deputy directors, Health Planning grants extensions to allow hospitals to submit their chargemaster data within a reasonable amount of time from the deadline outlined in state law—usually 90 days. However, the deputy director stated further that Health Planning would assess the $100 per day penalty to a hospital if the hospital were egregiously avoiding its responsibility to submit chargemaster data.

Recommendations

If the Legislature intends for nonprofit hospitals' tax-exempt status under state law to depend on the amounts of community benefits they provide, it should consider amending state law to include such requirements.

If it expects each nonprofit hospital to follow a standard methodology for calculating the community benefits it delivers, the Legislature should either define a methodology in state law or direct Health Planning to develop regulations that define such a methodology.

If the Legislature intends to ensure compliance of all hospitals required to submit community benefit plans to Health Planning, it should consider revising state law to allow Health Planning to assess a penalty to those hospitals that do not comply.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the scope section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

Date: August 9, 2012

Staff: Grant Parks, Audit Principal
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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

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APPENDIX A

BACKGROUND ON SELECTED HOSPITAL TRANSACTIONS AND STATE OVERSIGHT

As the Introduction explains, state law requires a nonprofit corporation that operates or controls a health or similar care facility to provide notice to, and obtain written approval or a waiver from, the Office of the Attorney General (attorney general) prior to entering into an agreement to sell, or otherwise dispose of, or to transfer control of a material amount of its assets. However, there are certain transactions involving nonprofit hospitals that do not require state oversight. For example, nonprofit hospitals can enter into agreements or other transactions with affiliates after giving the attorney general notice or in the usual and regular course of their activities. What follows is a description of the types of transactions involved with the four hospitals we reviewed and the oversight, if any, they received from the attorney general.

El Camino Hospital Los Gatos

According to the Office of Statewide Health Planning and Development (Health Planning), El Camino Hospital Los Gatos (Los Gatos), previously known as Community Hospital of Los Gatos, was first licensed in 1962 to the Tenet Healthcare Corporation (Tenet), a for-profit entity. According to an El Camino Hospital official, Tenet operated the Community Hospital of Los Gatos on a property it leased from a third party. Tenet's documents indicate that the Community Hospital of Los Gatos ceased operations in April 2009, as the text box shows. Following the closure of Community Hospital of Los Gatos, El Camino Hospital, a California nonprofit corporation, purchased the buildings. According to the director of revenue and reimbursement, Los Gatos opened its doors to patients in July 2009 after performing repair and maintenance work and obtaining a license. Because this transaction did not involve a sale of a nonprofit hospital, the transaction did not require the attorney general's approval.

History of El Camino Hospital Los Gatos

April 2009–Community Hospital of Los Gatos terminated its lease and ceased operations.

July 2009–El Camino Hospital opened a new hospital at the same site as the former Community Hospital of Los Gatos.

Operating under a consolidated license with its parent facility, El Camino Hospital in Mountain View, Los Gatos is an extension of the parent facility.

California Pacific Medical Center St. Luke's Hospital

St. Luke's Hospital started as an Episcopalian charitable hospital in 1871, as the text box shows. After years of financial difficulties, St. Luke's Hospital, a nonprofit entity, affiliated[6] with Sutter Health in 2001. Because the affiliation involved the transfer of control of a nonprofit hospital, the attorney general reviewed and approved the transaction in June 2001. According to a vice president at Sutter Health, St. Luke's Hospital merged with California Pacific Medical Center (CPMC), another affiliate of Sutter Health, in 2007 and was renamed California Pacific Medical Center St. Luke's Hospital (St. Luke's). State law does not require the attorney general to approve transactions involving affiliates; nonetheless, the attorney general acknowledged receipt of the required notification. Although considered a CPMC campus, St. Luke's operates under a separate license from the other four CPMC campuses, which operate under a consolidated license.

History of California Pacific Medical Center St. Luke's Hospital

1871–St. Luke's Hospital opened as an Episcopalian charitable hospital.

2001–St. Luke's Hospital affiliated with Sutter Health.

2007–St. Luke's Hospital merged with California Pacific Medical Center.

Mission Hospital Laguna Beach

South Coast Medical Center opened in 1959 and joined Adventist Health System/West in 1997. In July 2009 Mission Hospital Regional Medical Center (Mission Hospital), a California nonprofit public benefit corporation, purchased South Coast Medical Center, as shown in the text box. Because South Coast Medical Center was a nonprofit hospital, the law required that it receive approval from the attorney general prior to its purchase. The attorney general approved the sale in June 2009 and placed conditions on the transaction. Some of these conditions included maintaining emergency medical services and acute psychiatric services at the same level as before, continuing participation in Medi-Cal, and providing community benefit services with annual increases. To demonstrate compliance with the terms of approval, the attorney general required Mission Hospital to submit annual compliance reports through 2014.

History of Mission Hospital Laguna Beach

July 2009–Mission Hospital Regional Medical Center purchased South Coast Medical Center, which became Mission Hospital Laguna Beach.

After the purchase, Mission Hospital renamed South Coast Medical Center as Mission Hospital Laguna Beach. The hospital operates under a consolidated license with Mission Hospital, which is located in Mission Viejo.

[6] According to state law, a corporation is considered an *affiliate* of another corporation when the latter controls the former or when both corporations are under common control.

San Leandro Hospital

According to Health Planning, San Leandro Hospital was first licensed in 1960. In 2004 the Eden Township Healthcare District (district)[7] purchased San Leandro Hospital as shown in the text box. According to a Sutter Health official the seller was Triad Hospitals, Inc., a for-profit entity. Because the seller was a for-profit entity, the attorney general was not required to review the purchase. Upon purchasing the hospital, the district leased it to Eden Medical Center, a nonprofit corporation. According to a Sutter Health official, Eden Medical Center's governing board included five members of the district's board of directors, five members appointed by Sutter Health, and the medical center's chief executive officer.

History of San Leandro Hospital

2004–Eden Township Healthcare District (district) purchased San Leandro Hospital and leased it to Eden Medical Center.

2008–Sutter Health, Eden Medical Center, and the district entered into a new agreement giving Sutter Health the option to purchase San Leandro Hospital.

The district entered this transaction with Eden Medical Center in an effort to reduce costs by aligning operations. As a result, the district and Eden Medical Center agreed to a lease in 2004. Under the terms of this 2004 lease, the district retained ownership of San Leandro Hospital, and Eden Medical Center was responsible for operating the hospital. Additionally, the 2004 lease stipulated that Eden Medical Center, which also owned and operated another hospital called Eden Medical Center in Castro Valley, would build a replacement for that hospital with Sutter Health guaranteeing Eden Medical Center's obligation. The lease also stated that Eden Medical Center would purchase San Leandro Hospital if the replacement hospital did not open on or before December 2011.

According to a Sutter Health official, Sutter Health informed the district in 2006 that it could not feasibly build the replacement hospital due to rising construction costs. The district, Eden Medical Center, and Sutter Health entered into an agreement in 2008 that stated that Sutter Health was to build and own the replacement hospital with the district having no ownership interest. The agreement also stated that Sutter Health would develop an improvement plan for San Leandro Hospital to continue general acute care services until June 30, 2009, and that on or after July 1, 2009, it could reduce or eliminate services at the hospital. Sutter Health, as specified in the 2008 agreement, exercised its option to purchase San Leandro Hospital in July 2009. However, the district contended that certain district board members who approved the 2008 agreement had a financial interest in the

[7] A local health care district may be organized, incorporated, and managed as provided in Health and Safety Code, Section 32001. Further, under Health and Safety Code, Section 32121, a local district can establish, maintain, and operate health facilities.

agreement, and therefore litigation ensued. According to a Sutter Health vice president, the transfer of the title to Sutter Health has not occurred as of May 24, 2012.

San Leandro Hospital is operating under a consolidated license with Eden Medical Center as the parent facility.

APPENDIX B

STATUS OF RECOMMENDATIONS FROM PRIOR AUDIT

In 2007 the Joint Legislative Audit Committee requested that the California State Auditor (state auditor) conduct an audit to ascertain whether the activities performed by hospitals that are exempt from paying taxes because of their nonprofit status truly qualify as allowable activities consistent with their exempt purposes. In December 2007 we issued a report titled *Nonprofit Hospitals: Inconsistent Data Obscure the Economic Value of Their Benefit to Communities, and the Franchise Tax Board Could More Closely Monitor Their Tax-Exempt Status*, Report 2007-107. This report concluded that when taken as a percentage of net patient revenues—the actual amounts a hospital receives from patients and third-party payers, such as health coverage programs—the costs of uncompensated care provided by nonprofit and for-profit hospitals were not significantly different even when these costs both included and excluded California Medical Assistance Program (Medi-Cal) costs. Additionally, benefits provided to the community, which only nonprofit hospitals are required to report, differentiate nonprofit hospitals from for-profit hospitals, but the categories of services and the associated economic value were not consistently reported among nonprofit hospitals.

In the 2007 report, we made three recommendations to the Franchise Tax Board (tax board), two recommendations to the Legislature, and one recommendation to the State Board of Equalization (Equalization). We reviewed the information that the tax board and Equalization provided to us in response to our December 2007 audit to assess their implementation of our recommendations. We presented these assessments in our February 2009 report titled *Implementation of State Auditor's Recommendations, Audits Released in January 2007 Through December 2008* (subcommittee report). If applicable, we also presented these determinations in our January 2012 report titled *Recommendations Not Fully Implemented After One Year*[8] (accountability report). We performed limited work to corroborate our assessment of the status of recommendations to the tax board from our 2007 report. Table B on the following page summarizes our determinations regarding the implementation of our recommendations indicated in our subcommittee and accountability reports. As Table B shows, the tax board and Equalization have fully implemented all applicable recommendations from the 2007 audit report. Finally, during our current audit work we found that our recommendations to the Legislature had not been implemented, as we did not locate any law implementing those recommendations.

[8] Report 2011-041 issued in January 2012.

Table B
Status of Recommendations From Report 2007-107 Issued by the California State Auditor in December 2007

RECOMMENDATION	STATUS OF RECOMMENDATION
If the Legislature expects community benefit plans to contain comparable and consistent data, it should consider enacting statutory requirements that prescribe a mandatory format and methodology for tax-exempt nonprofit hospitals to follow when presenting community benefits in their plans.	**Not implemented.** As of June 1, 2012, state law did not include the implementation of either recommendation made to the Legislature.
If the Legislature intends that the exemptions from income and property taxes granted to nonprofit hospitals should be based on hospitals providing a certain level of community benefits, it should consider amending state law to include such requirements.	
To ensure that it provides accurate information regarding the value of property that is tax exempt, the State Board of Equalization (Equalization) should consider including in its surveys of the county tax assessors a process for verifying the accuracy of the values reported on the annual statistical reports submitted by the county assessors.	**Fully implemented.** Equalization indicated that its survey of county assessors now includes a review of the exemption values contained in the county assessors' annual statistical reports. Equalization also stated that it uses a survey review worksheet to examine individual exemption claim records for proper classification by the county assessors and to ask questions of assessors' personnel on their practices and procedures. Finally, Equalization issued a letter to all county assessors informing them of our finding and that it was incorporating these verification steps into its survey of the county assessors.
After it identifies the staff resources that are no longer required for reviewing tax-exemption applications, the Franchise Tax Board (tax board) should implement its plan to use those resources for performing audits of tax-exempt entities, including hospitals.	**Fully implemented.** According to one of its audit supervisors, as a result of our 2007 audit, the tax board began using its Professional Audit Support System database to select and track audits of tax-exempt entities. The audit supervisor also indicated the tax board has added five audit staff and created an Exempt Audit Program. As a result, the tax board completed 106 audits since January 1, 2009, and 118 audits were in progress as of June 2012. Additionally, according to one of its auditors, the tax board is also currently involved in the review of a tax-exempt hospital.
The tax board should consider developing methodologies to monitor nonprofit hospitals' continuing eligibility for income tax exemption. These methodologies should include the following activities: • Review the financial data and other information on the Form 199 annually submitted by tax-exempt hospitals. • Ensure that the annual Form 199 contains all the information required to determine eligibility for an income tax exemption in accordance with state law.	**Fully implemented.** According to a manager in its Business Entities Section, the tax board has reviewed and updated its Form 199, and it has determined that Form 199 contains all of the information required to determine an entity's eligibility for tax exemption.
We recommended that the tax board consider developing methodologies to monitor nonprofit hospitals' continuing eligibility for income tax exemption. These methodologies should include the following activities: • Track complaints in a manner that enables the tax board to identify potential trends by tax-exempt hospitals and initiate audits of those hospitals. • Adequately identify tax-exempt hospitals in its automated database, enabling it to use the information in the database to profile those hospitals and identify any potential noncompliance with the law.	**Fully implemented.** The tax board has updated the codes in its Business Entities Accounting System to distinguish tax-exempt hospitals from other types of charitable organizations. The tax board also has implemented a procedure to log all complaints into a computer database that documents information about the individuals or businesses and the subjects' alleged tax violation.
The tax board should gain an understanding of the frequency and depth of Internal Revenue Service (IRS) audits of tax-exempt hospitals to identify the extent to which it can rely on IRS audits and factor that reliance into its monitoring efforts.	**Fully implemented.** In September 2008 the tax board entered into a disclosure agreement with the IRS that allows disclosure to the tax board of IRS tax return information. In that agreement, the IRS also agreed to send reports to the tax board regarding organizations with California addresses covered under the federal tax exemption in Internal Revenue Code 501(c)(3).

Sources: The report by the California State Auditor (state auditor) titled *Implementation of State Auditor's Recommendations: Audits Released in January 2007 Through December 2008*, Report 2009-406, February 2009; the state auditor's report titled *Recommendations Not Fully Implemented After One Year, The Omnibus Audit Accountability Act of 2006*, Report 2011-041, January 2009; and supporting documentation from the tax board.

(Agency comments provided as text only.)

July 27, 2012

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

Re: Response to draft audit report regarding nonprofit hospitals

Dear Ms. Howle:

The Office of Statewide Health Planning and Development (OSHPD) has reviewed your audit report, entitled "Nonprofit Hospitals: Statute Prevents State Agencies From Considering Community Benefits When Granting Tax Exempt Status, While the Effects of Purchases and Consolidations on Prices of Care Are Uncertain," that was requested by the Joint Legislative Audit Committee. OSHPD concurs with the findings. Consistent with state law OSHPD monitors the submission of required data by hospitals, and posts the information collected on its website.

Thank you for your efforts and for allowing OSHPD to participate in the audit.

Regards,

(Originally signed by: Stephanie Clendenin)

Stephanie Clendenin
Chief Deputy Director

cc: Suanne Buggy
Health and Human Services Agency

cc: Members of the Legislature
Office of the Lieutenant Governor
Little Hoover Commission
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press