

J U N E 2 0 0 4

REPORT TO THE CONGRESS

Sources of Financial Data
on Medicare Providers

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MEDpAC Medicare
Payment Advisory
Commission

601 New Jersey Ave., NW • Suite 9000 • Washington, DC 20001
(202) 220-3700 • Fax: (202) 220-3759 • www.medpac.gov

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Executive summary

Executive summary

In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Congress asked MedPAC to report on sources of financial data that can be used to evaluate the financial condition and solvency of health care providers, such as hospitals and home health agencies. To gather information for this report, we convened two expert panels to discuss (1) measures of providers' financial condition and (2) sources of data that can be used to construct those financial measures. In this paper we present our findings regarding the measurement of health care providers' financial performance and discuss ideas for improving the collection and reporting of financial data.

The legislative mandate for this study focuses on Medicare providers' total financial performance, not on evaluating Medicare payment adequacy. In our work on payment updates, MedPAC examines whether Medicare payment rates are adequate to cover the Medicare costs of an efficient provider by examining a series of indicators, including Medicare margins. In contrast, this report examines the measures and data sources that best contribute to an understanding of total (all payer) profitability and solvency.

Audited financial statements can provide the information needed to assess the total (all payer) financial condition of providers, but those financial statements are not collected in a standardized electronic format on all providers. Medicare cost reports on providers are available in an electronic format, but currently do not include all of the key information found in audited financial statements. In addition, there is an eight-month delay before the electronic cost report data are available, and the definition of the reporting entity is imprecise.

Policymakers could gain a better understanding of the total financial performance of providers if the part of the Medicare cost reports that deals with total financial performance (referred to as Schedule G) were revised to:

- Report what is normally shown in providers' audited financial reports including an income statement, a cash flow statement, a statement of changes in net assets, and a balance sheet as well as information on revenues by payer type. The fiscal intermediaries could tie the key variables in a revised Schedule G to variables from the audited financial statements to improve accuracy.
- Be reported separately and earlier than the rest of the cost report, and possibly more often. A separate revised Schedule G could be available within three months of the end of the provider's fiscal year. A quarterly electronic filing to CMS of a revised Schedule G could be required within 45 days of the close of each period. Although quarterly data would not be audited, it would provide interim information on financial status.
- Reflect the income and assets of a single reporting entity (the smallest corporate entity including the provider). A second report of consolidated data for the provider and its affiliates (such as a hospital combined with a physician practice) could be required when the provider is part of a larger organization.

The value of the additional information would have to be balanced against any additional burden on providers. A revised Schedule G would enable analysts to compute multiple measures of financial performance in a timely manner. The revised Schedule G could be used to compute total profit margins, cash flow generated from operations, changes in the net assets of providers, and the providers' level of

cash and other liquid assets. Analysts could examine these measures over several years to limit the influence that one-time events (e.g., a loss on the sale of securities) have on individual measures in a single year. By examining a broad set of financial measures over several years, analysts could gain a more complete picture of providers' financial performance.

MedPAC shares the Congress's concern about the lack of timely data on providers' financial performance. As a major purchaser of health care, the Medicare program should expect timely information from providers so that the program can monitor beneficiaries' access and the accuracy of its payment methods. Under the current system, financial data received through Medicare cost reports lag the end of a providers' fiscal year by eight months, at best. A large portion of the lag is due to providers' taking five months to submit their reports. Because MedPAC is charged with recommending payment changes for the future (usually two years ahead), the lack of timely data is particularly frustrating.

MedPAC understands that financial analysts receive financial data that is more timely—including quarterly or monthly reports—than is the case for Medicare. The Commission recognizes that financial analysts receive total (all payer) financial information, not the detailed Medicare cost report data needed to assess Medicare payment adequacy. The suggestions we include in this report—to align the Schedule G with other financial statements and perhaps provide this information more often—would provide improved total (all payer) financial information to the Congress.

The Congress also asked MedPAC to examine the Internal Revenue Service (IRS) Form 990 and evaluate it as a source of information on private not-for-profit hospitals' investments, endowments, fundraising, and access to capital financing. The IRS Form 990 is filed by nonprofit organizations as an information return designed to help the IRS and state charity regulators ensure that nonprofit organizations remain true to their charitable purpose. It includes data on providers' revenues, expenses, assets, investments, endowments, and fundraising expenses. However, there are some important limitations to the data reported in the Form 990—including that they are neither timely nor consistently reported—and it would not be practicable to use this source on a large scale. Appendix B discusses our findings on use of the Form 990 in more detail. ■

**Sources of financial data
on Medicare providers**

Introduction

The Congress often needs to assess the claims by certain providers of Medicare services that they are suffering financial distress. Such claims of financial distress are often couched in terms of the total (all payer) financial performance of providers, which reflects revenues from all sources, not just Medicare. Each year, the Commission examines whether Medicare payment rates are adequate to cover the Medicare costs of an efficient provider by examining a series of indicators, including Medicare margins.¹ This mandated study focuses on Medicare providers' total financial performance, not on evaluating Medicare payment adequacy. Therefore, this report examines those measures and data sources that best contribute to an understanding of total (all payer) financial performance of Medicare providers.

Legislative mandate

The Congress tasked MedPAC in Section 735 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) with two studies. The first is on the need for current data and available sources of current data, to determine the solvency and financial circumstances of hospitals and other Medicare providers of services. The second is on using information provided on Internal Revenue Service (IRS) Form 990 to report on investments, endowments, and fundraising of hospitals participating in the Medicare program and their related foundations, and access to capital financing for private and not-for-profit hospitals. Because the contents of the two studies are related, this report considers both issues.

Issues

Understanding the financial circumstances of hospitals and other providers requires answering the following key questions:

- What measures best characterize health care providers' profitability?
- What measures are good predictors of providers' future solvency?
- What data sources provide the most timely and accurate data?
- How can we improve existing data sources to provide more timely and accurate data?

In an ideal world, we could identify measures that would give an unambiguous indication of a provider's current and future financial circumstances, we would have a source of data that was complete and nearly instantaneous to compute the measures, and the data would be available for all providers in a standard electronic database. Analysts would also be able to compute financial measures for the industry, individual providers, and specific product lines within each provider.

But the world is far from ideal. We have found that the data available, and hence the measures that can be computed, have major shortcomings, such as:

- The reporting entity can vary by provider and data source. An organization providing hospital care, for example, can report as just the hospital itself, as a combination of the hospital and related entities such as medical practices and foundations, or as an entire system of hospitals and other providers.
- Data sources that might provide more complete information on the entities are not readily accessible in electronic form and are not consistently reported.
- The Medicare cost report, one of the most comprehensive data sources (in terms of number of providers), is not particularly current and is often unaudited.
- Too much significance is attached to total margins to the exclusion of other measures of total financial performance.

We have identified some improvements that, although they do not come close to the ideal world, may help the Congress and others better understand the total financial circumstances of Medicare providers. The definition of entities could be improved to allow more consistent and complete analysis. An expanded set of measures might provide a more complete picture of providers' financial circumstances. The part of the Medicare cost report dealing with total financial performance could be aligned with providers' audited financial statements which would improve accuracy and reporting this data separately might improve their timeliness. Also, we observe that careful consideration of the measures might show multi-year data to be more predictive than single year data of the total financial circumstances, particularly solvency, of health care providers.

In the remainder of this report we describe our analytic approach; discuss measures of financial performance, their limitations, and what questions they can help us answer; and describe sources of data for computing measures, their limitations, and how they might be improved. Appendix A provides a reference guide to financial measures. Appendix B provides an in-depth discussion of the IRS Form 990 and its potential use in financial analysis.

Analytic approach

To evaluate measures of financial performance and sources of financial data, we examined past research on financial measures and held meetings with two expert panels from the public and private sectors. From the public sector, we held a panel discussion with individuals from the Congressional Budget Office, the General Accounting Office, the Department of Health and Human Services' Office of Inspector General, and the Centers for Medicare & Medicaid Services (CMS). From the private sector, the panel included accountants, academics, and consultants involved in evaluating the profitability and solvency of health care providers. The private sector panel also included individuals who assist states in setting payment rates. The panel discussions focused on defining appropriate measures of total financial performance and obtaining complete and accurate data to construct those measures. The panel commented on specific financial reporting concerns regarding hospitals, skilled nursing facilities, home health agencies, and dialysis facilities.

Financial measures

Our panel members discussed several measures of providers' total profitability and solvency. We describe some of the most useful measures below. These measures are appropriate for evaluating providers' total profitability and solvency, but are not generally appropriate for measuring the profitability of serving specific types of patients, such as Medicare patients.

Measuring total profitability

Our government and private sector panels tended to have different perspectives on measuring total financial performance. The government representatives rarely examined total financial performance, and when they did, they focused almost exclusively on providers' total margin—a measure of profitability. The private sector academics, consultants, and accountants on our panel tended to use a broader set of profitability measures including cash flow measures such as free cash flow. (For definitions of free cash flow and other financial measures see Appendix A.)

Total and operating margins

The total margin is the ratio of net income (total revenue minus total expenses) to total revenue. Net income includes both operating and nonoperating revenues and expenses. One problem with focusing purely on providers' total margins is that one-time events, such as a loss on the sale of marketable securities, can have a significant impact on total margins. While nonoperating losses affect total margins, they have little or no impact on the profitability of providing patient care.

To remove the effect of nonoperating losses, some analysts and bond rating agencies examine operating margins instead of total margins. The operating margin is the ratio of operating income to operating revenue. While operating margins are useful when examining an individual provider, both panels cautioned that providers are inconsistent in distinguishing between operating and nonoperating revenues and expenses. Unless the user can individually correct for differences in the way providers allocate revenues and expenses between operating and nonoperating categories, the operating margin may prove misleading when comparing two groups of providers.

Given the inconsistent reporting of data, the private sector panel felt that total margins in conjunction with other measures shown in Appendix A may more accurately indicate differences in the profitability of individual providers. While operating margins are problematic when comparing individual providers, they still can provide useful information when looking at industrywide changes in operating margins over time. If individual hospitals are consistent in their reporting of operating expenses from one year to the next, there will be minimal bias in the measures of change in operating margins over time.

Free cash flow

Net income is computed by subtracting both cash expenses and noncash expenses such as depreciation and bad debt from total revenue. In contrast, free cash flow ignores noncash expenses and revenues. Free cash flow is calculated by starting with cash flow generated from operations (cash revenue minus net cash expenses) and subtracting the price of capital investments that are required to maintain the provider's ability to serve patients. After paying the price of required capital improvement, the owners of the facility are "free" to use the remaining operating cash flow to reduce debt, build financial reserves, or pay dividends to equity owners. If a provider has a high level of noncash expenses, such as depreciation, but has few requirements for capital improvements, the free cash flow generated by the facility may exceed the reported income of the facility. The difficulty with calculating "free" cash flow is that the analyst must estimate the required capital expenditures for the provider.

Return on investment

Total margin and operating margin reflect the income to the owner of the facility relative to the facility's revenue. In contrast, return on investment (ROI) reflects profitability relative to the total amount of funds invested in a facility by stockholders and bondholders. On an aggregate level, ROI is a useful indicator of how attractive an industry is to private investors and creditors.

Measuring solvency

Congress specifically requested that this report discuss the solvency of providers. Our panel of financial experts discussed measures that could reflect a provider's risk of bankruptcy or closure. These indicators included cash flow measured as earnings before interest, taxes, depreciation, amortization, and rent (EBITDAR), changes in net assets, and the strength of the provider's balance sheet.

EBITDAR

EBITDAR is a cash flow measure that looks at earnings before capital costs and taxes. It can be used as a predictor of bankruptcy or closure. If EBITDAR is lower than a facility's interest and rent expenses, the facility is not generating enough income from operations to pay for these fixed costs. Unless the provider has significant financial reserves or is receiving transfers from related entities, the provider may eventually be forced to declare bankruptcy. Bankruptcy, however, does not always mean closure—a provider with low but positive EBITDAR may restructure its debt or lease payments and continue to provide services to patients. Debt restructuring is possible when there is **positive** EBITDAR that can be used to pay the restructured debt service and lease expenses. If a provider consistently generates **negative** EBITDAR, it may face closure unless it receives financial support from related entities. Analysts frequently examine the ratio of EBITDAR to fixed costs such as interest and lease expenses.

Measuring changes in net assets

Solvency is difficult to assess by only examining provider income or EBITDAR because these measures do not factor in the influence of transfers from related entities and unrealized gains or losses on investments held for sale. Transfers from related entities are usually not reported on the provider's income statement and are not normally considered factors in computing profit margins. Appreciation in the value of investments held for sale is generally not realized until the securities are sold. To track transfers from related entities and unrealized gains and losses, an analyst should examine a statement of changes in net assets.

Examining the balance sheet

Profitability measures, cash flow measures, and changes in net assets are all indicators of how fast a provider is either building or draining financial reserves. When examining the risk of bankruptcy or closure, it is important to examine the size of a provider's financial reserves in addition to the rate at which the provider is draining those reserves. For example, an analyst could calculate annual rate of decline in a provider's net assets relative to the provider's level of cash and unrestricted investments. This would indicate how long the provider could survive while generating negative changes in net assets. A simpler approach, which is often used by our private sector panel and bond rating agencies, is to calculate a measure called "days cash on hand," which measures how long a facility could theoretically survive without collecting any revenue (see Appendix A). In addition to measuring days cash on hand, our panel also examined debt-to-asset ratios and debt-to-equity ratios when evaluating the strength of a provider's balance sheet.

Multi-year data

When evaluating the strength of a provider's cash flow and balance sheet, it is often important to examine more than one year of data. Examining trends over three or five years will reduce the influence of single-year fluctuations on financial ratios. Single-year phenomena could be provider-specific, such as stock market losses, or industrywide trends such as requirements for increased contributions to defined benefit pension plans. Capital expenditures are also highly variable and should be examined over multiple years when evaluating the capital needs of an industry.

Required financial statements

To examine all of the measures listed in Appendix A, our panel suggested that we obtain all four standard types of financial statements: income statement, balance sheet, cash flow statement, and changes in net assets. The statement of changes in net assets allows the tracking of transfers to and from related entities that do not appear on the income statement. A table of the various measures and the financial statements

**TABLE
1****Location of data for financial measures in standard financial statements**

Measure	Income statement	Cash flow statement	Changes in net assets	Balance sheet
Total margin	•			
Operating margin	•			
EBITDAR	•			
Free cash flow		•		
Return on investment	•			•
Changes in net worth			•	
Debt to capitalization				•
Average age of plant	•			•
Days cash on hand	•			•

Note: EBITDAR (earnings before interest, taxes, depreciation, amortization, and rent). Financial measures are defined in Appendix A.

from which they can be obtained is shown in Table 1. While the expert panels believed that receiving a full breadth of financial information is useful, they stressed the importance of using sources of data that clearly define the reporting entity and accurately report data from that entity.

Sources of data

Different sources of data are available to compute measures for examining hospitals' and other providers' financial circumstances. For each source, we are interested in which providers are included in the data, how timely and accurate the data are, whether the data are consistent across providers, and if the data include all the elements needed for thorough financial analysis.

Data sources examined include:

- audited financial statements
- survey information
- Internal Revenue Service Form 990
- Medicare cost reports

Audited financial data

Audited financial statements include the following four components, each of which provide different types of detailed financial information on providers:

- income statement (operating revenues and expenses, nonoperating gains and losses);
- cash flow statement (cash flows from operating, investing and financing activities);
- statement of changes in net assets (unrestricted assets and funds restricted by donors); and
- balance sheet (assets, liabilities, and net assets).

These four statements typically include all the data needed to compute total profitability and solvency measures discussed in the previous section.

Publicly traded corporations and providers or systems issuing publicly traded bonds are required to file audited financial statements. These audited financial statements are publicly available, but are not compiled in an organized and consistent database. Footnotes included in the audited financial statements are a key to understanding provider operations, but are not easily standardized into an electronic database.

The Security and Exchange Commission's (SEC's) Form 10K is filed annually with the SEC by publicly traded corporations. Form 10Ks include audited financial statements for entire companies, but may not provide information on individual providers that are subsidiaries of the larger public corporation. Publicly traded companies are also required to file quarterly statements (10Qs) that include unaudited quarterly financial data. Nonprofit organizations issuing tax-exempt debt have, with some exceptions, been required since 1996 to file annual financial statements with the SEC through municipal repositories.

Providers that are privately held, nonprofits that do not issue publicly traded bonds, and government providers, for example, might not file audited financial statements. Financial statements for these providers may have to be obtained directly from these providers unless their state requires them to report.² Obtaining them directly from each provider may well be impractical.

Survey data

Survey information could provide more updated information on provider finances. For example, Databank is a survey operated by state hospital associations that collects data monthly. This survey provides information on hospitals' total revenues, expenses, and utilization. The primary limitations of the survey are that it is not nationally representative because it does not include all states and currently is not publicly available. It also is limited to hospitals; it does not include other types of providers.

The American Hospital Association's (AHA) annual survey provides much of the same data as Databank, but only once a year. It includes a large national sample of hospitals. However, some of the key financial data that could be used to track provider financial performance are not publicly available. Also, as with all voluntary surveys of providers, the AHA survey may suffer from selection bias. Providers must be willing to participate in the survey, but if willingness to participate and profitability are correlated, then survey data on profit margins would be biased. An alternative would be to make participation mandatory.

Internal Revenue Service Form 990

IRS Form 990 is filed by nonprofit organizations as an information return designed to help the IRS and state charity regulators ensure that nonprofit organizations remain true to their charitable purpose.³ In 2000, more than 220,000 public charities and 60,000 private charities filed an IRS Form 990. In health care, for example, private nonprofit hospitals, nursing homes, dialysis facilities, and home health agencies are all required to file Form 990. The 990s provide data on provider revenues, expenses, assets, investments, endowments, and fundraising expenses.

Data on the 990s, however, can be difficult to convert to standardized financial ratios. The forms do not differentiate among donor restricted and unrestricted revenues and expenses, which makes it difficult to compute some of the needed financial measures. Also, it is not very timely, key data elements are not

electronically available, data are not consistently reported among different providers and it is not audited. Further, only nonprofit providers report on Form 990s. In addition, there is a problem with determining affiliated organizations, because not all filers of 990s completely describe their affiliated organizations.

Because part of our legislative mandate in the MMA required us to examine use of the Form 990 data, we contracted with Dr. Nancy Kane, professor of management at the Harvard School of Public Health and an expert in the use of hospital financial data, to investigate using the Form 990 data. Her report is provided in Appendix B.

Medicare cost reports

The main limitations of the data sources discussed thus far is that they do not provide data on all providers and are often not readily accessible. Some sources provide comprehensive and timely information on providers' total financial performance, but that is not sufficient to overcome their other limitations.

In contrast, the Medicare cost reports are the one source of publicly available financial data that includes most providers of Medicare services. Providers submitting Medicare cost reports include hospitals, both general and specialized (e.g., psychiatric, rehabilitation, long-term care), skilled nursing facilities (SNFs), home health agencies, dialysis facilities, and hospices. Physicians and ambulatory surgical centers do not submit Medicare cost reports. The Medicare cost reports were designed to determine final settled payments for Medicare services and are filed annually with CMS. In addition, except for dialysis providers, each cost report includes a specific section (Schedule G) that provides total financial information on the provider.⁴

The Medicare cost reports are a primary source of data used by CMS, MedPAC, providers, and financial analysts to examine providers' Medicare financial circumstances. In this section, we discuss their limitations and what improvements could be made to make them more useful for assessing total financial performance. We examine how the data might be improved in terms of completeness (whether they include everything needed to get a complete financial picture), timeliness, accuracy (auditing and cost allocation), and consistency (entity definition).

What is in the cost report?

The Medicare cost report consists of a series of worksheets, most of which are designed to portray the cost of providing Medicare services. This is because the cost report was developed when facilities were reimbursed based on their costs. The content and processing of Medicare cost reports was designed to result in a "settled" cost report on which reimbursement could be made. The report provides a detailed allocation of costs between Medicare and other payers and among types of services. Some items are still reimbursed based on the cost report (e.g., bad debt, medical education). It also provides some descriptive data such as the number of beds and discharges.

The section on total financial performance—Schedule G—consists of four worksheets:

- Worksheet G: Balance sheet
- Worksheet G-1: Statement of changes in fund balances
- Worksheet G-2: Part I patient revenues and Part II operating expenses
- Worksheet G-3: Statement of revenues and expenses (including nonpatient income and expenses)

Completeness of cost report data

Schedule G is missing some key variables needed for calculating measures of total financial performance such as interest expenses, depreciation expenses, and capital expenditures. These variables were reported on a schedule that is no longer required. Because users of this information have requested its return, CMS has indicated to us that they may resume requiring this schedule.

Schedule G was designed more than 20 years ago and is not consistent with the format and content of providers' audited financial statements for several reasons:

- It does not fully comport with the current generally accepted accounting principles (GAAP) that audited financial statements follow.
- It fails to clearly separate other operating revenues from nonoperating revenues, which can lead to inaccurate construction of operating margins.
- Operating and nonoperating expenses are not consistently defined or separated.
- Depreciation, interest, and bad debt expenses are not separately reported.
- Nonincome related changes in net assets (equity), such as capital donations, transfers to and from affiliates, and unrealized gains and losses on marketable securities, are not always excluded from the calculation of operating and total income.⁵

Making cost report data more complete. Our private sector panel felt strongly that Schedule G should be revised to include an income statement, cash flow statement, balance sheet, and statement of changes in net assets. This new Schedule G would follow the format of standard audited financial statements.⁶ It should be less burdensome for providers because they would present the same information as in their existing financial statements. In the case of hospitals, they would no longer have to break down revenue into minor categories such as vending machine rental and parking lot revenues, as is currently required by Schedule G. Instead, they would report the standard broad categories of patient care revenues, other operating revenues, and nonoperating revenues—all of which would need to be clearly defined. A statement of cash flows would allow a more complete description of cash flows than is possible from combining data from different schedules on the current cost report.

Providers often maintain data on the amount of net patient revenue received from different types of payers, namely Medicare, Medicaid, private insurance, and other. This information is currently not available on the cost reports. The AHA collects this type of information on hospitals, but it is not publicly available. A revised Schedule G could include an additional worksheet called *Worksheet G-5* that reports charges and net revenues by payer as well as by inpatient and outpatient service lines (see Table 2).

The cost report also lacks information on service use for outpatient departments. This prevents easy analysis of changes in outpatient volume or changes in payments or costs per unit of output. Showing visits in the suggested worksheet would help in analysis of hospital financial performance. The information on worksheet G-5 may not be readily available from all providers and thus may create an extra burden for some.

In summary, Schedule G could be revised to include a statement of cash flows and a statement of changes in net assets, employing data that are already part of providers' financial statements. The first four schedules of a revised Schedule G would be changed to match standard financial statements. A fifth schedule

**TABLE
2**

Type of patient	Charges	Discounts/ allowances	Net patient revenue	Discharges or outpatient visits
Medicare				
Medicare fee-for-service (inpatient)				
Medicare fee-for-service (outpatient)				
Total Medicare fee-for-service				
Medicaid				
Medicaid fee-for-service (inpatient)				
Medicaid fee-for-service (outpatient)				
Total Medicaid fee-for-service				
Other types of insurance				
Other insurance (inpatient)				
Other insurance (outpatient)				
Total other insurance				
Self pay				
Self pay (inpatient)				
Self pay (outpatient)				
Total self pay				
Total for all inpatient discharges				
Total for all outpatient visits				

would provide a breakdown of revenue by payer type as shown in Table 2. The primary advantages of using Schedule G for this purpose is that it is collected nationally from all Medicare providers and could be made available in a standardized electronic format.

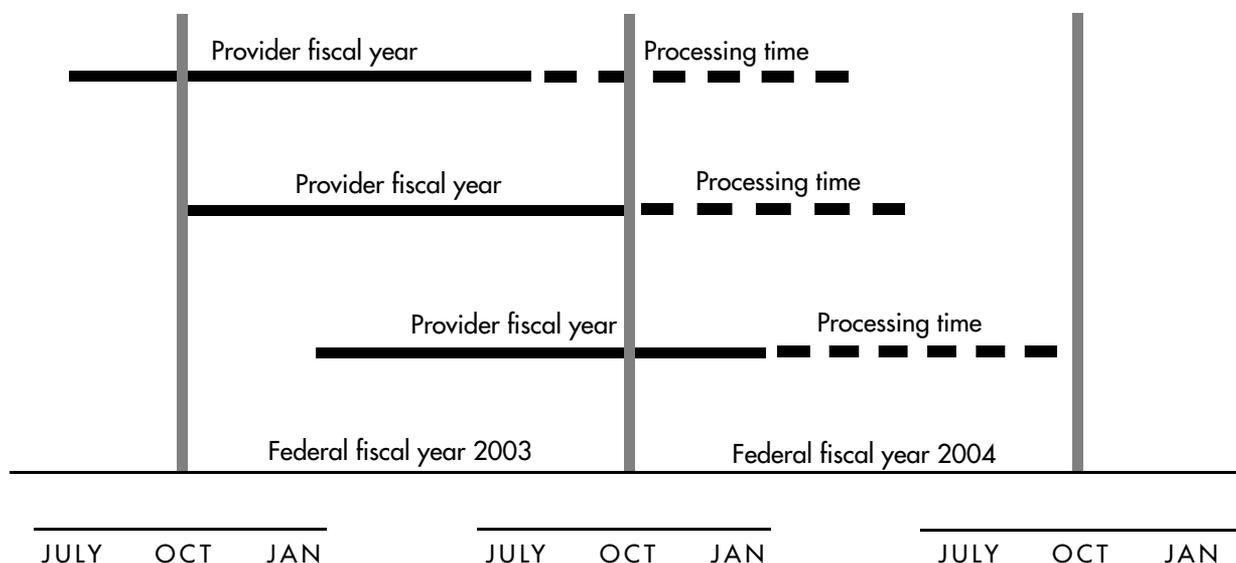
Timeliness

One of the limitations in using cost report data for financial analysis is their lack of timeliness. On average, cost report data are available seven or eight months after the close of the reporting period. The age of the cost report data is a function of the time allowed to complete cost reports (5 months), and the time the fiscal intermediaries and CMS take to approve cost reports and process them into the data system (2 to 3 months). A delay by providers, the fiscal intermediaries, or CMS, though, will add to this turnaround.

But, because providers’ fiscal years do not all begin at the same time, the average data lag over all providers is greater than the eight-month lag for any particular provider at any point during the year. Figure 1 shows the timing of cost report data for the three most common provider reporting periods that substantially overlap federal fiscal year 2003. Data for providers with a cost reporting period that coincides with the federal fiscal year, from October 1, 2002 to September 30, 2003 (the middle line in Figure 1), should be available in May of 2004. Data for providers that started their fiscal year on January 1, 2003 (the bottom line) should be available in August of 2004. By October of 2004, the data available would lag the end of the provider’s reporting year by about one year on average and should include almost all providers’ fiscal year 2003 cost report data. Some data might be delayed even longer because of other problems.

**FIGURE
1**

Timing of cost report data



Most providers report on their costs using a calendar year: about one-third of hospitals, three-fifths of SNFs, over half of home health agencies, and four-fifths of dialysis providers. The next most common reporting periods are the federal fiscal year (October 1 to September 30) or from July 1 to June 30. Providers' reporting periods affect the time lag of the data. For example, in October 2004, data for January 1 to December 31, 2003 reporters will lag the end of the reporting period by 9 months, and for July 1 to June 30, 2003 reporters, it will lag by 15 months.

The first cost reports with a majority of the cost reporting period overlapping federal fiscal year 2004 would be for providers with a July 1, 2003 to June 30, 2004 fiscal year. CMS, however, would not have the data for such providers from the fiscal intermediaries (FIs) until February 2005. The time lag inherent in this system creates difficulties for its users (please see text box).

What causes the delay in data reporting? Providers have five months after the end of their fiscal year to submit their cost reports to the FI. Providers have a strong incentive to file cost reports by the due date, since CMS has the authority to halt all payments to the provider until the cost report is submitted. Providers are required to file cost reports electronically (unless they receive a waiver from CMS).

Although the five-month window may appear long, some critical data often are not available until four months after the end of a provider's cost reporting period. For instance, finalized Provider Statistical and Reimbursement (PS&R) reports, which contain finalized payment and charge information from CMS by service line, are sent to providers by CMS's FIs up to 120 days after the close of the provider's fiscal year. The long delay is to ensure that the cost reports reflect the majority of bills for Medicare services provided during the reporting period. An earlier submission of the PS&R reports may result in underreporting Medicare revenues, and thus would require a later revision to the cost report. Providers also face delays in receiving final information on the number of Medicaid eligible patient days from state Medicaid agencies for computing Medicare disproportionate share payments. (In the future, CMS will be required to provide

Data timelines and updates

The timeliness of Medicare cost report data is a particular source of frustration for the Commission and the Congress when determining updates for the prospective payment systems in Medicare. Decisions affecting billions of dollars in Medicare payments have to be made using data that are not current. There are two sources of this frustration.

First, the Commission has to make update recommendations well in advance of when the updates take effect. For example, updates that will take effect in fiscal year 2006 will be determined in early 2005, based on analytic work begun in the Fall of 2004, using data available in October. In October 2004, data will be available from fiscal year 2003. The data will only lag the end of the reporting year by about a year on average, but, because it is being used to determine a future update, it will be removed from the date the update takes effect by two to two and a half years and thus will appear to be even older—fiscal year 2003 compared to fiscal year 2006. No matter how current the data, the time lag between when update recommendations are made and when the updates take effect will remain, as will the perception of using old data. This problem is exacerbated when reporting is delayed because of administrative or legislative changes that cause unusual delays.

The second source of frustration is the perception that private sector reporting is much faster—corporations commonly report financial data within 45 days of the end of each quarter. The data commonly reported within 45 days however, is not detailed cost accounting data similar to that in the cost report. Rather it is income, cash flow, and balance sheet information reflecting total (all payer) financial results. Although this data does not address financial performance under Medicare, which is crucial for the Commissions work on updates, it may inform the Congress on providers' total financial circumstances. Later in this report we discuss how CMS could require quarterly reporting of financial data to inform the Congress. ■

that information to hospitals.) Providers and our panel members also assert that providers need about five months to accurately complete cost reports.

After a cost report is submitted, the FI has 30 days to determine if the cost report is acceptable and another 30 days to enter cost report data into the healthcare cost report information system for transmission to CMS. Although this may appear to be a lot of time for these two activities, the FIs receive most cost reports in three large batches reflecting providers' fiscal years, beginning October 1, January 1, or July 1. The large volume of cost reports potentially makes it difficult to reduce the amount of time the FIs need to process the cost reports. The FIs process cost reports for hospitals, SNFs, home health agencies, dialysis centers, and hospices on the same schedule.

Once CMS receives cost report data from the FIs, it posts the data to its system within 24 hours. CMS creates public use cost report files for the different types of providers at the close of each fiscal quarter. CMS usually takes about 30 days to produce the files and 15 more days to get them onto the Internet for downloading. However, by special request, CMS has produced special analytic files reflecting the data in its system at a specific point in time, increasing the timeliness of the data by a couple of months. Such special requests, though, can be burdensome and place competing demands on the agency, and thus should

only be made when the additional data that potentially could be gained from the request would add substantially to the completeness of the data.

Cost reports therefore can become available—at the earliest—7 to 8 months after the close of providers' fiscal years (if obtained by special request), or 9 to 11 months if waiting for quarterly files to become available on the Internet. In some years, other factors have resulted in even greater delays. These include revisions in cost report forms to reflect legislative policy changes that have resulted in extensions of the filing deadlines for providers, and technical problems with the cost report data systems and PS&R reports.

Improving timeliness. CMS and providers could make changes to try to get cost report data quicker, but at best, these methods will improve timeliness by only one to three months. Possible changes include:

- Having providers use estimates of their Medicare revenues from their billing systems so they can file their cost reports without waiting for the final PS&R report. This, however, may decrease the accuracy of the cost report data and increase the burden on providers and CMS. Many providers do not have data systems that can accumulate the claims information detail necessary to file the cost report. These systems also can be expensive. Initial estimates for charge and revenue data may not be accurate and would require providers to refile their cost reports when final PS&R data become available.
- Automating the process so cost reports are sent simultaneously to the FI and to CMS for immediate input into the cost report data system, thus making cost reports available for analysis before the FI accepts them. While this has the potential to provide more current data, later revisions to the data might be necessary after the FI accepts the cost report.
- Streamlining cost reports so they are easier to fill out with a quicker turnaround. Such a wholesale reform of cost reports is beyond the scope of this report. Even with a major reform, however, getting better and more timely data depends on the timing of providers' fiscal years and the time required for CMS to create a data file.

If only total (not Medicare-specific) financial data are needed, more timely reporting is possible. Providers could report annual total financial data (a revised Schedule G) earlier, separate from the rest of the cost reports. This might be the least disruptive and most effective means to gather more recent data on total financial performance. The data reported on Schedule G comes from provider financial statements and thus could be reported separately, on a more expedited basis than the rest of the cost report. If Schedule G were to be revised to comport with annual audited financial statements, total financial data should be available three months after the close of providers' fiscal years, which is when audited financial statements are generally produced.

Most providers maintain unaudited monthly financial statements. The SEC requires public companies to provide quarterly unaudited financial statements 45 days after the end of the quarter (this is moving to a 35-day requirement). If Schedule G were redesigned to align with these unaudited financial reports, Schedule G data could be reported on a quarterly or semiannual basis to CMS in a similar time frame, providing much more up-to-date data on providers' total financial performance than would be available by waiting until annual cost report data become available. Although quarterly data would not be audited and are generally less accurate than full year statements, they would provide interim information on the financial status of the industry. This would represent some additional reporting burden.

This option would not require that the Medicare portion of the cost report be completed earlier or submitted more often. Only the Schedule G information would be required. We would note that this option would only provide total financial data, and would not provide updated information on performance under Medicare. Quarterly data on total financial performance should not be used to establish Medicare payment policy.⁷

Accuracy

Another concern with the cost report is accuracy. One issue is that under prospective payment methodologies the majority of the data on the cost report is not used to determine payment to the provider and therefore is not audited. A second concern is the cost allocation process and whether changes could be made to provide more accurate estimates of allocated costs, either by payer or across service lines of business.

Auditing. Many have expressed concern about the accuracy and quality of Medicare cost report data as providers converted to prospective payment systems. Because providers are no longer receiving payment directly on the basis of costs, the quality and level of effort providers put into accurately calculating Medicare costs may have eroded. On the other hand, providers may also have less incentive to try to strategically allocate costs when payments are no longer based on costs. The quality of total financial performance data also is a concern, as this portion of the cost report (Schedule G) does not receive serious audit attention because it is not used for payment.

Although CMS provides some checks on the quality of Medicare data in the cost report (text box, p. 15) the focus is primarily on factors that affect payment, which are now just a few of the line items in the report (e.g., Medicare bad debt payments). If cost report data will be used to evaluate providers' financial health, CMS may have to set as an auditing objective that the data in Schedule G accurately reflect the data in audited financial statements.

For most providers, the current audit process reveals little about the accuracy of the Medicare cost information. Because audits take considerable time, they do not provide information on the accuracy of the most recent year of data. However, audits of dialysis facilities are an example of how audits can contribute. Pre-audit Medicare allowable costs were higher than post-audit Medicare allowable costs by 4 percent in 1996.

Improving data accuracy. A limited number of full scale random audits on the parts of the cost report that are not now reviewed could provide some insight into the quality of the data and potentially identify cost report items that auditors should focus on in the future. The level of effort required to conduct more extensive audits would be substantial. The panel estimated that a full scale audit of a hospital's cost report may take an FI 1,000 to 2,000 hours to complete, not including the time and resources imposed on the provider.

Alternatively, audits could be targeted to suspected problem areas within the cost reports. Such audits may provide a more limited picture of the accuracy of the data than a full scale audit, but they would not be as time consuming and costly and could still be used to improve the accuracy of the data.

To provide a broader incentive for providers to accurately report their Medicare costs, CMS could be authorized to impose penalties on providers if an audit found that they inappropriately calculated Medicare allowable costs or misreported their total financial information. CMS would not have to audit all providers, because random audits with penalties should have a sentinel effect on providers' reporting accuracy.

Checking the quality of Medicare cost report data through desk reviews and audits

The cost reports go through a series of quality checks at different stages in the process.

- *Acceptance*—Fiscal intermediaries (FIs) check to make sure the key cost report fields are completed and the report is signed. These are the “as submitted” cost reports. FIs have 30 days to accept or reject a cost report after it is received from the provider.
- *Tentative settlement*—The FIs check the settlement lines on the cost reports to make sure they appear reasonable and consistent with past years’ cost reports. The FI might adjust the settlement amounts. These cost reports are considered “tentatively settled.” The FIs are required to complete this process within 60 days after the cost reports are accepted.
- *Desk review*—The FIs may then conduct a desk review of the cost reports. The actual desk review process can take from a few hours to over a week depending on the provider type and the issues being reviewed. For hospitals, these reviews generally focus on a few specific areas such as direct and indirect medical education payments, disproportionate share hospital payments, bad debt payments, and organ acquisition payments. The desk review is often used to identify providers and issues that might be subject to a more extensive audit. Desk reviews usually start after cost reports have been tentatively settled (about nine months after the close of the fiscal year). FIs receive cost reports at various times throughout the year, with heavy concentration of cost reports received 3 or 4 times per year. As a result, the desk review process occurs throughout the year. It is CMS’s goal to have cost reports that are not the subject of a field audit settled within 12 months of accepting the cost report.
- *Audits*—On average, about 15 percent of providers’ cost reports are audited at some level each year. The proportion of providers CMS audits, however, varies across settings. Hospitals may be subject to audits more frequently than skilled nursing facilities, for instance. CMS is required to audit dialysis facilities’ cost reports at least once every three years. There is no such audit requirement for other types of facilities. Audits generally focus on a limited number of issues where payment is made based on the data on the cost report. FIs rarely audit Medicare costs for items reimbursed under the inpatient or outpatient prospective payment system or the total financial data reported on Schedule G of the cost reports. Cost reports that are subject to a field audit are generally settled two to three years after the end of the provider’s cost reporting period. ■

Alternatively, if Schedule G were revised to comport with audited financial statements, requiring the fiscal intermediaries to tie specific variables from the full year Schedule G to variables from the audited financial statements might improve accuracy. Some fiscal intermediaries may do this already, and doing so would place no extra burden on providers but would put extra demands on the FIs. Random audits of Schedule G might also be useful but would be more costly for all concerned.

Cost allocation. Although it is not an issue for reporting total financial performance, cost allocation is important if costs by sector or payer are needed. Implementation of the inpatient prospective payment system provided hospitals with an incentive to shift costs from inpatient to other settings where payments were cost based. Charge setting practices (different markups for different services) may substantially influence the allocation of ancillary costs among these settings. The text box below discusses cost allocation issues in more detail.

Recognizing that cost allocation issues may affect margin estimates by service, in the case of hospitals, MedPAC has focused on the overall Medicare margin, which includes most services provided by hospitals (inpatient, outpatient, SNF, home health, rehabilitation and psychiatric units). Our panel of private sector and academic experts thought that the overall Medicare margin provides a relatively accurate assessment of the financial performance of providers under Medicare.

Cost allocation

Providers with more than one product line must allocate joint costs, such as general administration, to their various revenue generating sectors. The allocation of joint costs presents a problem for the accurate measurement of product line costs (e.g., inpatient, outpatient, skilled nursing). Some of the statistical bases of allocation (such as square feet and charges) might result in an over-allocation of costs to secondary services compared to core missions, such as inpatient services.

Overhead costs, such as administrative and general, can be allocated in a number of different ways. The default on the cost reports assigns costs based on accumulated costs. Other methods could be used, but the alternatives will not necessarily result in a better assignment of costs. All approaches are somewhat arbitrary. How indirectly allocated expenses are treated is one of the issues to consider in looking at financial performance at the service level (e.g., inpatient, outpatient, skilled nursing facilities). Hospitals with sophisticated cost accounting systems may be able to give a truer picture of hospital costs for specific services, and therefore may provide for a more accurate measurement of sector costs. However, not all hospitals use these sophisticated systems.

One incremental improvement that could be made in the cost allocation process is to require the direct assignment of certain expenses that are often treated as indirect costs. Direct assignment allocates the actual cost of an item to the department where the service is used. According to our private sector panel, about 20 percent of hospitals currently do not directly assign pharmacy or medical equipment expenses, for example. Benefit expenses are another area where direct assignment could improve the accuracy of cost accounting, because providers should know the benefit costs of each employee and the department to which the employee is assigned. The default allocation apportions benefit costs based on employee salaries.

MedPAC is studying hospital cost allocation practices. This study may provide some evidence on the accuracy of cost allocation methods across sectors among hospitals that have invested in systems to get a better understanding of the cost of different services. More complex cost allocation techniques might better assign costs among sectors—particularly where charges have previously been the basis for allocation. These more complex methods, if applied to the cost reports, potentially would improve their accuracy but would also increase the amount of information providers need to report. ■

Consistency

One of the most challenging issues in the analysis of providers' total financial performance is defining the reporting entity. Hospitals, for example, are often embedded in organizations encompassing more than just the acute-care facility, such as:

- Integrated systems, in which the hospital “vertically integrates” across the continuum of care through common ownership or control with primary care physician practices, specialist practices, nursing homes, assisted living facilities, home health care agencies, community health centers, and wellness centers, among other services and facilities;
- Multi-hospital systems, in which hospitals are “horizontally integrated” into either local, state, regional, or national hospital chains; or
- Obligated groups, in which a cluster of entities, several hospitals and other related affiliates and subsidiaries, are jointly liable for the repayment of long-term debt.

The impact of being part of a larger entity can be significant, as Table 3 illustrates for a major teaching hospital in the northeast.

In Table 3, the sample hospital alone shows the strongest results. The hospital and its wholly owned subsidiaries—which include two physician subsidiaries (one of which incurred significant operating losses) and a real estate company—exert negative financial pressures on the hospital. The consolidated system, which includes several smaller community hospital integrated systems, is considerably weaker on all dimensions than the hospital alone. The hospital transfers large amounts of cash to support these other entities and these transfers erode the hospital's equity and cash over time. If the transfers had not been made, the hospital's equity financing and days cash on hand ratios would have been even stronger.

**TABLE
3**

Selected financial ratios for sample hospital based on reporting entity, 2002

Financial ratios	Hospital only	Hospital and wholly owned subsidiaries	Consolidated multi-hospital integrated system
Profitability			
Total margin	6.0%	4.4%	2.0%
Operating margin	3.2%	1.7%	0.0%
Liquidity			
Days cash on hand	195	183	164
Solvency			
Equity financing	63%	63%	56%
Debt service coverage	4.9	4.3	3.5
Average age of plant (years)	6.2	6.2	6.6

Source: Nancy Kane, Harvard University School of Public Health.

The Medicare cost report and the IRS Form 990 tend to report on the hospital only, although this is not always the case. For this particular sample hospital, the Medicare cost report Schedule G corresponded to the consolidated statements of the hospital and its wholly owned subsidiaries, while the 990 corresponded to the hospital entity alone.

Improving consistency. To obtain a comprehensive view of hospital financial condition, and to understand the reasons for a particular situation, it is most useful to have financial reports on both the hospital and on the larger organizational entity with which the hospital has financial and operating transactions. The footnotes of the audited financial statements clarify these transactions when the statements report on the hospital only; in a consolidated statement, a consolidating schedule is often provided, which not only reveals the hospital affiliate transactions, but also the financial condition of the affiliates themselves.

The private sector panel thought it was important to require that Schedule G include data from the smallest corporate entity that includes the provider. The statement of changes in net assets for the provider would report on transfers to and from related entities. Panelists thought a second Schedule G that reports on data from the consolidated entity would also be useful to provide information on potential resources that may be available to the provider, and to understand what transactions may take place between the provider and larger corporate entity. ■

Endnotes

- 1 Please see *Report to the Congress: Medicare Payment Policy*, March 2004 and March 2003 for discussion of the Commission’s method for assessing Medicare payment adequacy and why total (all payer) margin information does not directly play a role in that assessment.
- 2 About 20 states require hospitals to file audited financial statements with the state.
- 3 For more information, see <http://www.guidestar.org/learn>.
- 4 We use the term Schedule G to refer to the section of the cost report on total financial data. It is called Schedule G on the hospital, SNF, and hospice cost reports, and Schedule F on the home health agency cost reports. Dialysis providers’ cost reports have no analog to the Schedule G. Exceptions for reporting on Schedule G may be provided for some government owned providers who do not have separate financial statements.
- 5 For further discussion on the limitations of Schedule G, please see “The Medicare cost report and the limits of hospital accountability: Improving financial accounting data”, by Nancy M. Kane and Stephen A. Magnus in the *Journal of Health Policy, Politics and Law*, 25, no. 1 (February 2001).
- 6 Standards for financial statements differ for government and private providers. Decisions would need to be made as to whether they would need to follow a single standard in a revised Schedule G.
- 7 Please see *Report to the Congress: Medicare Payment Policy*, March 2004 and March 2003 for discussion of the Commission’s method for assessing Medicare payment adequacy and why total (all payer) margin information does not directly play a role in that assessment.

A P P E N D I X A

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Measures of total financial performance
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**TABLE
A**

Measures of total financial performance

Measures	Strengths of the measure	Weaknesses of the measure	Utility in measuring performance
PROFITABILITY			
<p>Total margin (excess margin)</p> $\frac{\text{total revenue} - \text{total expenses}}{\text{total revenue}}$	Comprehensive measure of all revenue relative to all costs. Widely understood.	Includes noncash charges and investment income. Does not include some transfers from related entities.	A reasonable measure of profitability when averaged over several years. EBITDAR and changes in net assets may be better measures of solvency.
<p>Operating margin</p> $\frac{\text{operating revenue} - \text{operating expenses}}{\text{operating revenue}}$	In theory it removes non-operating revenues and costs from the profitability measure.	Providers are not consistent in distinguishing between operating and nonoperating expenses and revenues.	The value of the measure is limited by inconsistency among providers in distinguishing between operating and nonoperating expenses and revenues.
<p>EBITDAR</p> <p>Earnings before interest, taxes, depreciation, amortization, and rent (EBITDAR).</p>	Valuable indicator of a facility's financial viability. Adjusts for differences in provider debt levels.	Does not account for needed capital improvements, needed increases in working capital, or some transfers between related entities.	Facilities with EBITDAR lower than interest and rent expenses are candidates for restructuring under bankruptcy. Facilities with negative EBITDAR may face permanent closure unless they receive financial support from related entities.
<p>Free cash flow</p> <p>Net income from operations plus depreciation and amortization, less increases in working capital and needed capital expenditures.*</p>	Adjusts for noncash charges such as one-time losses on the sale of assets. Uses needed capital expenses rather than depreciation.*	Can vary due to differences in debt levels and rental payments. Requires estimates of needed capital expenditures.*	Is a general indicator of providers' financial health and of whether private investors have an incentive to invest in the industry.
<p>Return on investment</p> $\frac{\text{earnings before interest and taxes}}{\text{total debt} + \text{net worth}}$	Relates profits to the amount of assets invested in the provider.	Does not evaluate whether depreciation reflects needed capital expenditures; is affected by investment returns.*	Indicates whether private investors have an incentive to invest in the industry and expand capacity.
<p>Changes in net worth</p> $\text{net worth} = \text{assets} - \text{liabilities}$	Includes transfers from and to related entities that increase or decrease net worth. These transfers are not always reflected in net income or operating cash flow.	Does not indicate whether the change in net worth is due to changes in income or transfers to or from related entities.	Is most valuable when used with a net income or cash flow measure to evaluate solvency.

continued on next page

**TABLE
A**

Measures of total financial performance (continued)

Measures	Strengths of the measure	Weaknesses of the measure	Utility in measuring performance
CAPITAL STRUCTURE AND LIQUIDITY			
Debt to capitilization $\frac{\text{debt (current + long term)}}{\text{total assets}}$	Indicates degree of leverage. Avoids the problem of negative equity that affects debt-to-equity ratios.	The depreciated value of assets may not reflect the market value.	Can indicate solvency when used with a profitability measure and days cash on hand.
Average age of plant $\frac{\text{accumulated depreciation}}{\text{depreciation expense}}$	Indicates whether significant cash flows will be needed to modernize facilities. It is a leading indicator of cash flow needed rather than lagging indicator of cash flow expenses.	When old assets are sold, they may gain a new basis, making depreciation expense small relative to book value. Hence, the sale of a hospital can make the measure meaningless.	Aggregate industry trends in this variable indicate the industry's recent efforts to expand capacity.
Days cash on hand $\frac{\text{cash + unrestricted investments}}{(\text{total expenses} - \text{bad debt expenses} - \text{depreciation}) / 365}$	The measure is not easily manipulated. High levels of days cash on hand equate to a very low near-term bankruptcy risk.	Low levels of cash on hand do not always indicate financial troubles.	Tells how long the provider could survive without receiving any operating revenue. It is not useful for providers that have a parent organization (such as a for-profit hospital chain) that holds cash for its subsidiaries. It is most useful when examining highly leveraged providers with limited access to capital.
DEPARTMENTAL PROFITABILITY AND EFFICIENCY			
Cost per discharge or outpatient service $\frac{\text{allocated costs}}{\text{units of service}}$	Indicates cost pressures in the health care system and providers' comparative advantages in providing different types of care.	Difficult to allocate joint costs to specific services. Difficult to measure the number of units of outpatient services due to differences in the complexity of each outpatient service.	Tracks changes in costs. Can compare costs among different types of providers of the same type of service.
Direct contribution margin $\frac{\text{service area revenues} - \text{direct expenses}^{**}}{\text{service area revenues}}$	Avoids the issue of allocating joint costs.	Requires more precise allocation of direct costs. Ignores the impact of volume on overhead.	Is a rough upper bound on an individual department's profitability. Can compare profitability of departments.

Note: EBITDAR (earnings before interest, taxes, depreciation, amortization, and rent). Measures of profitability can be computed for any type of provider with complete financial statements.

* To estimate needed capital expenditures, members of the expert panel suggested using average capital expenditures over the past five or ten years. Changes in working capital include changes in accounts payable, changes in accounts receivable, and changes in inventory. Free cash flow will also include the benefit of any deferral of taxes that can occur due to differences in generally accepted accounting principles and tax accounting.

** When estimating the direct costs for a revenue generating area or a specific diagnosis related group, charges are converted to estimated costs using a direct cost-to-charge ratio. Indirect costs are ignored.

A P P E N D I X B

**IRS Form 990 as a data source
for reporting on hospital investments,
endowments, and access to capital**

**IRS Form 990 as a Data Source for Reporting on
Hospital Investments, Endowments, and Access to Capital**

Report to the Medicare Payment Advisory Commission

Nancy M. Kane, DBA
Professor of Management
Department of Health Policy and Management
Harvard School of Public Health

Federal Contract Number T-13606721

IRS Form 990 as a Data Source for Reporting on Hospital Investments, Endowments, and Access to Capital

Introduction

Congress requested the Medical Payment Advisory Commission (MedPAC) to submit a report to Congress on “investments, endowments, and fundraising of hospitals participating under the medicare program and related foundations;” and on “access to capital financing for private and for not-for-profit hospitals” using return information provided under Form 990 of the Internal Revenue Service (IRS). This report evaluates the IRS Form 990 (Form 990) as a source of data on investments, endowments, fund raising, and capital financing for hospitals and hospital-related entities such as foundations.

The Form 990, *Return of Organization Exempt from Income Tax*, is an annual information return filed with the IRS and available to the public. All tax-exempt organizations with greater than \$25,000 in gross receipts, excluding churches and other religious organizations, are required to file. In 2000, more than 220,000 public charities and 60,000 private charities filed some version of the Form 990.¹

The reporting schedules on the IRS Form 990 include:

- Part 1, a statement of revenues, expenses, and changes in net assets (with useful details disclosed in attachments to the Form)
- Part 2, a statement of functional expenses, with various line items broken out into program services, management and general, and fundraising
- Part 3, a statement of program service accomplishments (often answered by referral to an attachment)
- Part 4, balance sheets (where, again, much of the useful detail is in an attachment)
- Part 5, a list of officers, directors, trustees, and key employees, reporting titles, hours worked and compensation details
- Part 6, other information, including the names of related organizations, both exempt and nonexempt (again supplemented by attachments)

The Form 990 is used by the IRS, state oversight agencies, donors, and others interested in the charitable activities and financial accountability of charities, including the media. The primary focus of the users is to determine whether the organization continues to meet requirements for tax exemption. Thus the Form 990 requires disclosure of items that permit consideration of potential private inurement such as management and board compensation, large financial transactions with independent contractors, and loans to managers or board members. It also requests disclosure of details related to fundraising revenues and expenses, unrelated business activity, control and financial relationships with other charitable and nonexempt organizations, lobbying activity, and a statement of

¹ From “Guide to Using NCCS Data” p.4, found at nccsdataweb.urban.org/kbfiles/468/nccs-data-guide-v3a.pdf

the relationship of revenues and expenses to tax-exempt purpose. While this information is critical to the oversight of charitable activities, it does not meet many of the basic requirements of those concerned with financial condition.

This report will describe the strengths and weaknesses of the Form 990 as a data source for analyzing hospital financial condition, with a particular emphasis on what is needed for a reliable analysis of hospital investments, endowment, and access to capital. It is organized as follows:

- Availability of Form 990 data for financial analysis of hospitals
- Basic financial information needed to assess hospital investments and endowments, and evaluation of the Form 990 as a data source
- Basic financial information needed to assess hospital access to capital, and evaluation of the Form 990 as a data source
- Assessing the impact of related entities on hospital financial performance, and evaluation of the Form 990 as a data source
- Level of effort required to systematically gather information from 990s on a large sample of hospitals
- Changes that could be made to improve the Form 990 usefulness as a source of basic financial information about hospital investments, endowments, and access to capital
- Summary of Form 990 Benefits and Drawbacks

Availability of Form 990 Data for Financial Analysis of Hospitals

In recent years, Congress expanded public access to Form 990 filings; individuals seeking to review a charitable organization's Form 990 can now request a copy from any filer and receive it by mail or from a web site. This has led to the development of a public web site, www.guidestar.org², where 990 filings to the IRS are posted, including the filings of private nonprofit hospitals. Historically, Form 990 reports on Guidestar are electronic images of hard-copy reports. The infrastructure is in place at the IRS to begin electronic filing of Form 990s in 2004 for fiscal year 2003.

Besides Guidestar, the IRS maintains electronic databases of standardized data on tax-exempt organizations, based on items drawn from the Form 990 filings. The variables in the electronic databases are generally subsets or samples of Form 990 reports. For instance, the IRS Return Transaction Files (RTF) contain up to 60 of the financial variables on all filing organizations, depending on the year; however the Form 990 requests 105 items in 6 pages of forms, and these are generally supplemented with attachments that can run an additional 20 – 40 pages or more. The RTF files form the basis for the National Center for Charitable Statistics core files; the NCCS data corrects large errors from the RTF files and adds some data elements, but only major aggregate

² The Guidestar web site is owned and maintained by Philanthropic Research, Inc. (PRI), operating as *Guidestar*. PRI obtains the Form 990s from the IRS and posts electronic copies on their web site, where the information is publicly available for free. PRI is supported by grants and gifts from users, including several large foundations.

variables such as total revenues and total assets are maintained in the NCCS data sets. In addition, errors are common because the original source of the data, the IRS RTF files, were created for regulatory and not for research purposes. The NCCS guide to using its core data sets includes the statement that “financial data in the nonprofit database files should be used with great caution.”³

Thus the Form 990s are not yet available in an electronic database that collects enough detail to make it useful for large-scale analysis of private nonprofit hospitals. Instead, analysts must download the image copies of individual hospital Form 990s available on Guidestar, and enter variables by hand into an electronic database such as an excel spreadsheet. This has obvious implications for the level of effort required to gather Form 990 data on a large sample of hospitals, discussed in a later section of this report.

Hospital Form 990 reports are generally filed between 8 and 11 months after the close of the fiscal year in question. Although the IRS requires that the Form 990 be filed five months after the close of the fiscal year, in practice 3 and 6 month extensions are regularly requested by hospitals and routinely granted by the IRS. As of April 2004, the most recent fiscal year available for most hospitals’ Form 990s on Guidestar is 2002.

Basic financial information needed to assess hospital investments and endowments

Investment and Endowment Assets

Investments in this context are assets composed of marketable securities such as stocks and bonds. Endowments are investments that have been set aside, either by donors or by hospital boards, to generate income that supports the hospital’s operating and capital needs. How much hospitals have invested in marketable securities, and how much of those might be dedicated to current operating needs versus long-term purposes either by donor restriction (permanently restricted endowment) or board designation (quasi-endowments, or amounts designated by the board to function as endowment) is an important policy question. Endowments and quasi-endowments are investments whose principal is expected to be held “in perpetuity”, while some or all of the interest and dividend income and some of the gains earned on the principal may be available for current operating or capital purposes.⁴

There are at least two major policy issues involving investments and endowments. One question is whether hospitals have *enough* investments - whether or not hospital reserves of investments provide adequate financial flexibility, either to subsidize temporary

³ Guide to Using NCCS Data, op.cit., p 6.

⁴ When the donor does not expressly state the amount of income and gains of a donor-restricted endowment permitted to be used for current purposes, the board is generally subject by state law to a maximum “return” that they are allowed to recognize (e.g., 7% of the fair market value of the endowment assets) for current operating or capital purposes; what is not used for current operating purposes is generally credited to restricted net assets. There is no such legal restriction on “quasi-endowments”, that is, amounts the board has chosen to set aside to act as endowment; boards could choose to spend not only the income but also the principal of amounts that they have designated as endowments without legal restrictions.

operating deficits or to internally finance needed capital projects. The other side of the question is whether hospitals have *too much* in investments – whether they have been accumulating high levels of marketable securities, perhaps by borrowing tax-exempt debt at levels above what they would have needed for capital purposes had they used more of their available internal resources. This might indicate an inefficient use of tax-exempt debt. For instance, Gentry estimates that as much as \$32 billion of the \$55.9 billion in tax-exempt liabilities of hospitals in 1996 could have been avoided if hospitals spent their endowments instead of borrowing.⁵ Particularly in the stock market boom of the mid-to-late nineties, hospitals faced strong incentives to invest available funds in capital markets to generate investment income and gains, which had a much higher return than the interest expense required of tax-exempt debt. As one hospital system noted in its 1999 Bond Prospectus: “Management has taken a pro-active approach to managing the debt position and the investment portfolio for the System. The overall weighted average interest rate on long-term debt is 5.50%, while the overall investment portfolio has generated an average annual return in excess of 14%. The long-term debt to capitalization of 46% has allowed the System to achieve an investment portfolio with unrestricted and undesignated days cash on hand of 255 as of June 30, 1998. Management continuously monitors the asset allocation of the investment portfolio based on the financial markets and capital needs of the System.”⁶

For a complete assessment of the adequacy or excess level of investment, it is important to be able to identify investments held by related organizations on behalf of hospitals, such as foundations or parent organizations. Such investments have historically not been disclosed on the balance sheet of the hospital entity, but recent accounting pronouncements now require hospitals to disclose their interest in foundation assets held on their behalf in the hospitals’ own balance sheets.⁷ However, related entities still have an important influence regarding understanding hospital access to capital, an issue that will be described later.

To address the question of the adequacy or excess of hospital investments, it is important to be able to identify both the amount and the use limitations on hospital investments. *Unrestricted* investments (generally, current short term investments and board-designated investments) provide the reserve resources needed to insure financial flexibility; *donor-restricted* investments (both temporarily and permanently restricted) are not available for general operating purposes other than those specified by a donor. Temporarily restricted assets are held until a donor-specified capital or operating purpose is undertaken; as funds are spent for those purposes, the value is recognized as either operating revenue or a capital donation. Permanently restricted assets are held in perpetuity, although a portion or all of the return on those assets is available for donor-specified or general operating

⁵ Gentry WM. “Debt, Investment, and Endowment Accumulation: The Case of Not-for-Profit Hospitals”, 2002. *Journal of Health Economics* 21 (5): 845-872.

⁶ Official Statement for Revenue Bonds, Series 1999 A , UPMC Health System. P. A-15.

⁷ Statement of Financial Accounting Standards Number 136, “Transfers of Assets to a Not-for-Profit Organization or Charitable Trust that Raises or Holds Contributions for Others”, effective for fiscal periods beginning after December 15, 1999. Some hospitals identify these investments as “Interest in Net Assets of (Name of Related Entity)”, while others simply combine the investments held by related entities with the hospital’s traditional investments on the hospital balance sheet.

purposes. If a hospital is in danger of bond default or is unable to meet payroll, it cannot use donor-restricted investments for those needs. Hospitals that violate donor restrictions can and are sued, either by the donors or the state attorney general with jurisdiction over charitable assets. A third type of limitation on investments is what falls under the general heading of *trustee-held* or contractually limited; this includes debt service reserve funds, amounts set aside for self-insurance purposes, and other contractually-based limitations. Trustee-held funds are not available for general operating purposes, other than the ones for which they have been set aside, without the danger of violating a contract (subject to renegotiation of the contract).

Thus it is important in assessing the adequacy of hospital investment to be able to properly categorize all investment funds reported by the hospital. Table 1 summarizes those categories.

Table 1: Key Investment Characteristics

Type of investment	Available for general operating and capital purposes:
<i>Unrestricted Fund:</i>	
Operating cash and short-term investments	Yes
Board-designated investments	Yes, subject to Board approval
Trustee-held investments	No, unless contract can be renegotiated
<i>Restricted Funds:</i>	
Temporarily restricted investments	No
Permanently restricted investments	No

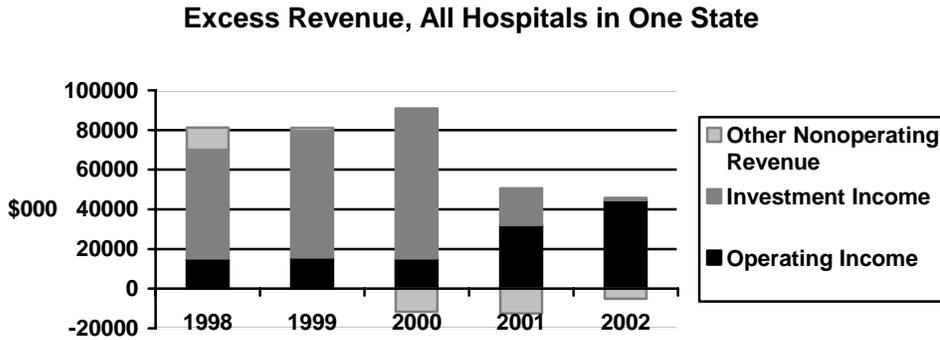
Unfortunately, the Form 990 does not break out investments by type of limitation. All investments in securities are reported in Line 54 (Part IV – Balance Sheets) as a single number. Also, while in audited financial statements hospitals must now disclose their interest in a foundation or parent holding investments on their behalf, they don’t always classify that interest as “investment in securities” in the Form 990. Identifying investments available for general operating and capital purposes is not a straightforward process if the Form 990 is the only source of information.

Investment and Other Non-Patient Sources of Revenue and Expense

Investment Revenues and Expenses

Besides the question of the adequacy or excess of the level of investments held by hospitals, the income generated by investments plays an important role in the assessment of hospital financial performance. To the extent that “total margin” is used for policy-making purposes, it is important to understand the relative contribution of investment income versus income from operations (providing patient care) to the hospital industry’s bottom line. Figure 1 below describes the five year history of investment income versus operating income as sources of total income for all the hospitals in one state, based on an analysis of their standardized audited financial statements.

Figure 1:



Operating income remained flat at roughly \$15 million over the period 1998-2000; however excess revenue (total income from all unrestricted sources) grew over the same period, due to the substantial and growing contribution of investment income. In 2001 and 2002, excess revenue dropped sharply, due to a steep fall-off of investment income. However operating income more than doubled in 2001, and continued to grow in 2002.

It is also informative to understand the components of investment income that drive trends. Investment income includes interest and dividends, which accrue over time as the security is held; it also includes gains and losses, which are the result of trading the security. Finally, it can include “impairments”, which reflect unrealized losses in the market value of held securities, losses that are deemed by management to be permanent and material in nature. Realized and unrealized gains and losses are the most volatile of investment returns, and can play a significant role in the “bottom line” of hospitals. Table 2 describes the nature of the investment income for the One State example in Figure 1 for the year 2002, when Investment Income dropped to only \$1 million, down from a peak of \$75 million just two years earlier:

Table 2: Investment Income Breakdown in 2002, One State

Interest and Dividends	\$ 31,851,725
Realized gains (losses)	(\$ 14,026,600)
Impairment of investment assets	(\$ 16,663,249)
Total Investment Income	\$ 1,161,876

If Congress is looking to the Form 990 as a data source that might clarify the role played by investment income and its contributing components, it can be misled by the reporting structure of the Form 990. According to generally accepted accounting principles (GAAP) and industry practice, investment income is credited to the Statement of Operations (the nonprofit term for “income statement”) only under some conditions; in other conditions, investment income is credited to restricted net assets (an equity account) and should not affect the income statement. Table 3 lays out the three types of investment income described earlier, and the conditions that determine how the investment income is recognized.

Table 3: Recognition of Investment Income According to GAAP

Investment Classification:	Dividends and Interest	Realized gains and losses	Unrealized gains and losses
Unrestricted Investments: -Operating -Board-Designated -Trustee-held	Nonoperating Revenue or Gain ⁸	Nonoperating Revenue or Gain	Change in net assets unless the loss is considered permanent (impaired assets); losses on impaired assets are generally recognized as Nonoperating Losses
Donor-Restricted Investments: Temporary Permanent ⁹	Change in restricted net assets	Change in restricted net assets	Change in restricted net assets

As Table 3 indicates, whether or not investment income and/or unrealized losses affect a hospital’s bottom line depends on the investment classification and some considerations by the board and management. These distinctions are reported in a consistent fashion when using audited financial statements, and can be standardized using the footnotes to the audited statements when necessary. Unfortunately, the Form 990 requests dividends, interest, and realized gains/losses without recognition of whether they should be treated as nonoperating revenue (and hence affecting the hospital’s bottom line) or as a change in restricted net assets. Thus there is a tendency to over-report investment income as revenue when using the Form 990, because the restricted amounts are not segregated from the unrestricted amounts.

Other Non-Patient Sources of Revenue and Expense

There is a similar and at times bigger classification problem with respect to the treatment of contributions and grants. Without proper recognition of donor restrictions, the Form 990 income statement will recognize more revenue and expense, gains and losses, as part of the income statement than will the income statement reported in the audited financial statements. This problem is worse in large teaching hospitals, which tend to have substantial amounts of restricted donations and grants, than it is in smaller community hospitals with less donor-related activity. Table 4 compares the income statement provided in the audited financial statements of a large teaching hospital with the income statement derived from the same hospital’s Form 990 in 2002.

⁸ Some hospitals classify the interest income on operating and trustee-held investments as “other operating income”

⁹ As mentioned earlier, some of the return on endowments may be appropriated by the Board for operating purposes; those amounts would be included as nonoperating revenue on the income statement

Table 4 uses the example of a major teaching hospital to illustrate where the largest mismatches occur. In the area of “other operating revenues” (line 2), most of the \$10.7 million in government contributions and grants (line 2.1) reported as revenue in the Form 990 were classified as increases in restricted net assets in the audited statements. The Form 990 includes in “other operating expenses” (line 7) about \$16 million more in expenses than does the audited financial statement. Nonoperating Revenue is significantly different in the area of gifts and donations (line 10), where the Form 990 is \$8 million greater, and realized losses (line 12), where the Form 990 losses are greater by almost \$3 million. Most of the items listed in the “Variance” column would have been treated as changes in restricted net assets in the audited financial statements. The Nonoperating Loss (line 13) reported in the audited statement is likely to be part of the Other Operating Expenses variance on the Form 990 (line 7).

While the end result, Excess Revenue, is only off by \$1.8 million, the variances among the individual categories throw the operating income off by \$5.8 million, and the Form 990 operating margin is 40% lower than that derived from audited financial data.

Table 4: Comparison of Form 990 and Audited Financial Income Statement Elements, Sample Major Teaching Hospital, 2002 (in thousands)

	Audited Financials	Form 990	Variance ¹⁰
Operating Revenues			
1. Net Patient Service Revenue	459,354	459,354	
2.1 Government Contributions		10,664	
2.2 Miscellaneous Revenue		8,332	
2. Other Operating Revenue	8,718	18,996 (sum of 2.1 + 2.2)	10,278
3. Total Operating Revenue	468,072	478,350	
Operating Expenses:			
4. Depreciation and Amortization	29,668	29,668	
5. Interest Expense	5,880	5,880	
6. Provision for Bad Debt	25,668	25,668	
7. Other Operating Expenses	393,513	409,669	(16,156)
8. Total Operating Expenses	454,083	470,239	
9. Operating Income	13,989	8,111	
Nonoperating Revenue:			
10. Gifts and donations	4,578	12,850	8272
11. Interest and Dividends	11,318	11,712	394
12. Realized gains (losses)	(473)	(3,400)	(2927)
13. Other Nonoperating Gains (Losses)	(1,948)		1,948
14. Total Nonoperating Revenue	13,475	21,162	
15. Excess Revenue	27,464	29,273	
Profitability			
16. Operating Margin	3.0%	1.7%	
17. Total Margin	5.7%	5.9%	

¹⁰ Positive = better performance on 990 with respect to income.

Smaller hospitals also have mismatches due to the classification of revenues and expenses as operating or nonoperating; while the numbers are small, so are the margins, so the impact of misclassification can be significant when looking at profitability ratios. Table 5 illustrates this problem using a small rural critical access hospital.

Table 5: Comparison of Form 990 and Audited Financial Income Statement Elements, Sample Small Rural Critical Access Hospital, 2001 (in thousands)

Income Statement	Audited Financial Statement	Form 990	Variance
1. Net Patient Service Revenue	13,461	13,461	
2. Other Operating Revenue	303	476	173
3. Total Operating Revenue	13,764	13,937	
4. Operating Expense	12,962	13,978	(1016)
5. Operating Income	803	(39)	
6. Investment Income	72	72	
7. Unrestricted Contributions and Other	(789)	53	842
8. Excess Revenue	86	86	
Operating Margin	5.8%	-0.3%	
Total Margin	0.7%	0.6%	

It appears from Table 5 that the operating expenses (line 4) on the Form 990 include items that the audited financial statements have classified as part of nonoperating losses (line 7). While the nature of those items is not disclosed in either report, how it is classified makes a big difference with regard to how one views the hospital's operating performance.

Basic financial information needed to assess hospital access to capital

Basic Measures of Access to Capital

There are dozens of financial measures derived from income statements and balance sheets that might be used to evaluate a hospital's access to capital, among the standard categories of profitability, solvency, and liquidity. In addition, there are measures derived from the statement of cash flows that describe the sources and uses of cash in terms of operating activities, investing activities, and financing activities. While the types of analysis that can be derived from a cash flow statement are very useful, these will not be discussed here as there is no Statement of Cash Flows in the Form 990.¹¹

Table 6 below identifies 7 commonly used ratios for assessing a hospital's access to capital. Average values of these ratios for a set of hospitals ranked by their relative financial condition are provided. The financial classifications of all the hospitals in one state were determined by the author and colleagues in an unrelated research effort. The classifications were based on 7 years of standardized audited financial statements; this table shows only the ratio values for the 7th year, which was 2000. The purpose of this

¹¹ See, for instance, Kane, NM. Profits: A misleading measure of financial health; the case of Massachusetts hospitals. *Journal of American Health Policy*. June; Vol. 1, No. 1. 1991.

table is to illustrate the utility of the 7 ratios as analytic tools for determining hospital access to capital. The hospitals in the “Distressed” category did not have access to new longterm debt, and many “Red Flag” hospitals would have trouble gaining access if they were not in a large multihospital system that could raise debt based on system rather than individual hospital performance.¹²

Table 6: Average Ratios by Financial Condition

2000 PERFORMANCE GROUP	ADVANTAGED 25%	SUSTAINING HISTORIC POSITION 38%	RED FLAG 29%	DISTRESSED 8%
<i>Profitability</i>				
Average Total Margin	0.13	0.05	0.01	(0.09)
Average Operating Margin	0.06	0.01	(0.03)	(0.12)
<i>Liquidity</i>				
*Average Days in Accounts Receivable	73days	70. days	72.days	73 days
Average Days Cash on Hand, including board-designated investments	400 days	230 days	172 days	141 days
<i>Solvency</i>				
*Average Equity Financing Ratio	0.72	0.69	0.45	0.46
Average Debt Service Coverage Ratio	5.98	3.77	2.03	(0.36)
<i>Other Ratios</i>				
*Average Age of Plant	7.94 years	8.34 years	9.77 years	11.26 years

Availability of Basic Measures from Form 990 Reports

Of these seven ratios, only the three that are starred can be reliably calculated using data reported in the standard forms of the Form 990 (not relying on the attachments, which provide varying degrees of necessary detail). The unreliability of the profitability ratios have already been discussed in the context of differences in restricted and unrestricted, operating and nonoperating classifications between the Form 990 and the audited financial statements.

The Days Cash on Hand ratio requires appropriate reporting of investment categories, including the ability to separately identify Board-designated from Trustee-Held and Donor-Restricted Investments, and the ability to recognize when “Other Investments” are marketable securities. For some hospitals it is possible to approximate this ratio using the Form 990, but for large hospitals with a lot of donor-restricted activity or related foundation assets, the Days Cash on Hand ratio can be significantly off the mark.¹³

¹² Note that these category labels reflect composite data on financial performance and are not intended to signal a judgment regarding reasonable or appropriate performance.

¹³ For instance, in 2002 one very large, well-endowed teaching hospital disclosed in its audited statements a \$534 million “interest in the net assets” of its supporting foundation; however, in the Form 990, the \$534 million was not reported on line 54, “Investments – securities,” instead, it was reported on line 56, “Investments-Other”, without further disclosure. If the Form 990 had been the sole source of information

The Debt Service Coverage Ratio cannot be routinely calculated from the Form 990 because there is no indication of the annual amount of principal repayment required; on an audited financial statement, the easiest way to determine this is to use the previous year’s current longterm debt. However the Form 990 does not separate current from noncurrent assets or liabilities. Also Excess Revenue is not a reliable number on the Form 990 for the reasons discussed earlier.

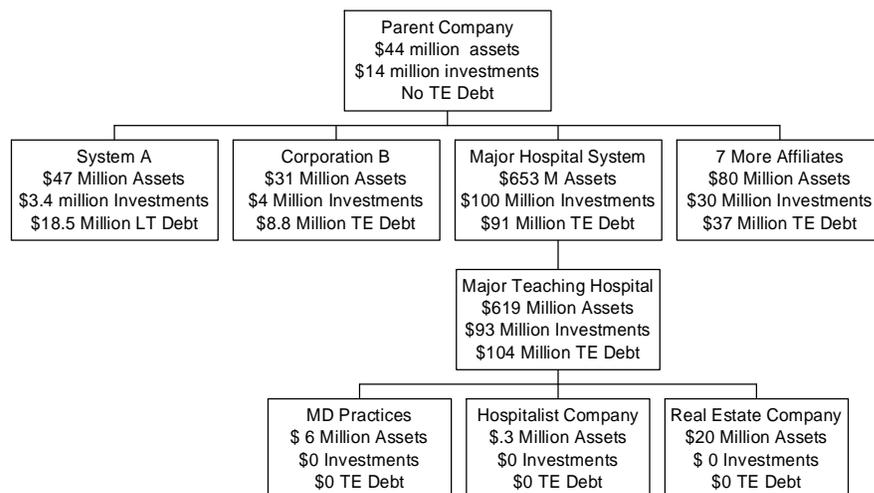
Thus the Form 990 is not as useful as one would like for evaluating a hospital’s access to capital.

Assessing the impact of related entities on hospital financial performance

The Form 990 generally reports on a single entity within a system; Part VI line 80 (b) requests the name(s) of related exempt and nonexempt organizations, and these are usually supplied in an attachment which can include dozens of organizations. It is possible to locate the Form 990 of many of the tax-exempt entities on the list, and the total income¹⁴ and end-of-year assets of taxable subsidiaries are disclosed in Part IX.

Figure 2 provides an abbreviated version of the structure of a single-state multihospital system in 2002, one of several structures typical for the industry. It is based on the consolidated audited financial statements, using the consolidating statements of the various member entities to provide entity-specific financial information.

Figure 2: Single State Multihospital System Related Entities¹⁵



on investments in securities, the analysis would have generated a “days unrestricted cash on hand” ratio of only 86 days, when the actual value, including the unrestricted assets held by the supporting foundation, was 219 days.

¹⁴ Some organizations take the term “total income” to mean revenues, and others to mean the net of revenues minus expenses.

¹⁵ The four major subsystems of the whole System include multiple subsidiaries; the total number of entities within the System number roughly 40.

At the least, using the Form 990 to find and consolidate all related entities to determine the financial condition of the whole system is tedious and a paper-intensive process. Sometimes it is impossible due to missing filings and nondescript disclosures (e.g., over half the assets of an entity may be called “inter-organizational receivable” or “miscellaneous other”). However understanding the impact of related entities on hospital access to capital is important, as Table 7 illustrates.

Table 7: Comparison of Key Ratios by Reporting Entity, Single State Multihospital System, 2002

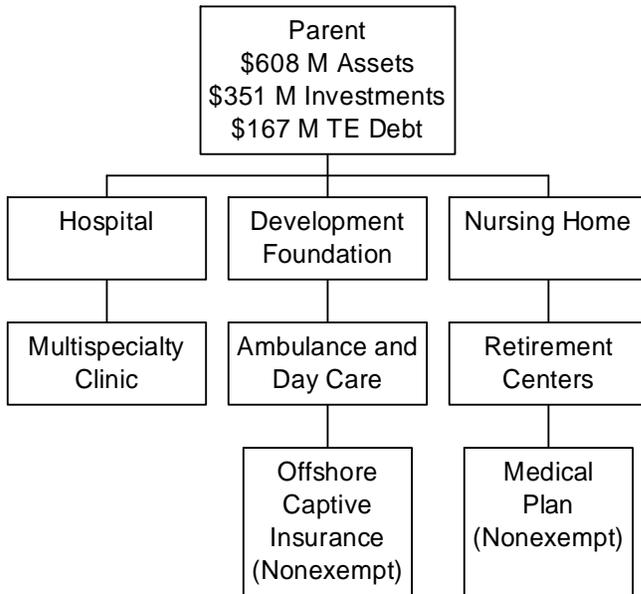
Ratio	Major Teaching Hospital Only	Single Hospital plus wholly-owned subsidiaries	Consolidated System in Single State
Operating Margin	3.2%	1.7%	0.2%
Total Margin	6.0%	4.4%	2.0%
Days in Accounts Receivable	53	53	56
Days Cash on Hand	195	183	164
Equity Financing	63%	63%	56%
Debt Service Coverage	4.9	4.3	3.5
Average Age of Plant	6.2	6.2	6.6

Source: Audited financial statements and consolidating schedules by entity

In Table 7, the consolidated system is considerably weaker than the hospital only or the hospital plus its wholly owned subsidiaries. In addition, key ratios for the Major Teaching Hospital, including Days Cash on Hand and the Equity Financing Ratio, are lower than they would have been had the Major Teaching Hospital entity not been transferring cash and equity to its subsidiaries and other affiliates. For instance, in 2002, the Major Teaching Hospital transferred almost \$17 million to subsidiaries and other related entities, out of a total profit or excess revenue of \$27 million; in 2001 it transferred out \$10 million of a total profit of \$26 million. These affiliate relationships have a significant impact on the investment and net asset position of the Major Teaching Hospital.

One problem with all sources of financial data – the Form 990, the audited financials, and the Medicare Cost Report – is that of defining the reporting entity and its financial relationships – including loans, guarantees, and equity transfers – with other entities whose financial condition is not disclosed. The problem of disclosure can also occur when the hospital entity only is the object of analysis. Some hospital systems do not maintain audited data for their individual parts. The “Foundation Model” structure shown in Figure 3 illustrates the problem – the only financial data is at the consolidated level.

Figure 3: Foundation Model



(Note: All entities below the parent are subsidiaries of the parent, but are not subsidiaries of each other even though the chart puts some entities below others.)

The Form 990 for the hospital within this Foundation model did not provide much detail; for instance, \$101 million of its total assets of \$177 million were “intercompany accounts”, and the 990 income statement reconciliation to the audited financial statements in Part IV A and B carried a disclaimer stating that the financial statements are audited on a consolidated basis only, so audited information by entity is not available.

In sum, the reporting entity issue is an important one with respect to being able to assess a particular hospital’s access to capital; while the audited financial statements provide the most detailed information about related entities and contingent financial obligations of a hospital entity, they do not always disclose the entire constellation of relationships among affiliates that are financially relevant for understanding a particular hospital’s financial position.¹⁶

¹⁶ For instance, in the bankruptcy of the Allegheny health system known as AHERF, complex relationships among various obligated groups were inadequately disclosed in the audited financial statements, misleading creditors as to the extent of financial obligation and the limited liquidity of the whole.

Level of effort required to systematically gather information from 990s on a large sample of hospitals

Because of the lack of GAAP-compliant footnotes, the reporting limitations noted above, and the non-uniform reporting of information in attachments, financial analysis of hospitals using the Form 990 takes more effort than does analysis of audited financial statements. For meaningful assessment of hospital financial performance relevant to determining access to capital, a minimum of three years, and preferably five years of financial data would be needed. Based on the author’s own experience using Form 990s, standardizing five years of Form 990 data into electronic spreadsheets could easily take 8 hours (for an easy one) to 16 hours (for more complex organizations) per hospital, and more time would be needed if information on related entities was included. To standardize a database including 100 hospitals (excluding related entities) with 5 years of data, one would need to budget at least 200 days of a highly trained financial analyst’s time. It is difficult to project how much time it would take to complete a database that included all available information on related entities, as some hospitals have only a few related entities, while others have 50 or more.

Changes that could be made such that the Form 990 provides basic financial information required for reliable financial analysis

Some simple changes could make the Form 990 far more valuable as a data source for hospital financial analysis. The simplest change would be to require that the hospital attach an audited financial statement, complete with footnotes, as part of its Form 990 filing. The audited financial statement should correspond to the reporting entity, either as a whole or in the consolidating schedules (which must be included in the attachment) if a more consolidated audited is submitted.

If the audited statements cannot be required as attachments, there are other changes that could be made to the Form 990’s instructions and/or format. These are presented in Table 8.

Table 8: Recommendations for Changing the Form 990

Recommended Change:	Elements on Form 990 Affected
Separate donor-restricted from unrestricted revenues and expenses	Part 1: 1 (a-d), 4,5,8 (a-c), 9c, 11, 17 (Can be carried forward into Parts II and VII as well – the elements that are summarized in Part 1)
Require that Revenues and Expenses be classified either as Operating Revenues and Expenses, or Nonoperating Gains and Losses, in accordance with GAAP and industry practice	Part VII, lines 95 – 103 –request an attachment that separates revenues into Operating and Nonoperating Part II, request an attachment that separates expenses into Operating and Nonoperating
Require disclosure of donor restrictions and other limitations (externally by contract, board designated) on Investments in Securities	Part IV, Line 54 – request an attachment providing limitations in accordance with those provided in audited financial statements
Require that an interest in the net assets of a support organization or foundation be disclosed and the nature of the assets of the support organization clarified	Either require that the interest be reported as part of Investments in Securities (Part 1, line 54) or explain any other reporting method in an attachment
Separate longterm debt into current and noncurrent portions	Part IV, line 64 (a and b) – separate into current and noncurrent portion, or disclose in an attachment

Summary of Form 990 Benefits and Drawbacks

Table 9 summarizes the benefits and drawbacks of using the Form 990 as a data source for reporting on hospital investments, endowments, and access to capital.

Table 9: Benefits and Drawbacks to the Form 990

Benefits	Drawbacks
<ul style="list-style-type: none"> • All private nonprofit hospitals report 	<ul style="list-style-type: none"> • Omits public and for-profit hospitals
<ul style="list-style-type: none"> • Balance sheet provides some useful ratios 	<ul style="list-style-type: none"> • To get the most out of an analysis, must use attachments which can add 40+ pages and are not consistent among hospitals or across years
<ul style="list-style-type: none"> • With some changes, income statement could be very useful 	<ul style="list-style-type: none"> • Electronic filing just beginning, and attachments not standardized
<ul style="list-style-type: none"> • Provides useful hospital-entity level data in most cases, supplementing consolidated audited statements 	<ul style="list-style-type: none"> • Not audited data

On the benefits side, the Form 990 must be filed and made public by all private nonprofit hospitals, which makes it far more accessible than audited financial statements of hospitals. Audited financial statements are not centrally collected at the national level; there are various collections of them for various purposes at municipal repositories¹⁷, Medicare intermediaries, some state departments of health or related agencies, and some state hospital associations. Even when they are centrally collected in a state or by an intermediary, they are not always made available to the public. The data reported in the Form 990 is certainly better than nothing, and its availability on the Web is a unique convenience.

On the drawbacks side, the Form 990 is missing some key data elements, which have been much of the focus of discussion in this paper. It may be possible to request that the IRS change or modify the reporting format and instructions for hospitals, as they do represent some of the very largest charities in the country; but hospitals are only a small number of the hundreds of thousands of charities filing.

In addition, public and for-profit hospitals do not file Form 990s. This would limit any national sampling to the universe of hospitals that are private not-for-profit; while this is the dominant group of hospitals, and the one that independently accesses the tax-exempt capital markets and relies on investments and endowments for supporting operating activities, it is not the full universe of hospitals. The nonprofit constraint would be an even bigger problem for obtaining financial data for provider types such as nursing homes and home health agencies where a higher proportion are investor-owned than in the hospital industry.

¹⁷ These are filings by “obligated groups” of entities, including a hospital, that have issued tax-exempt debt since 1995; these required filings are made available, for a fee, in municipal repositories such as Bloomberg or MuniIris; they also form the database for other commercial financial data companies such as Merritt Millenium

Finally, Form 990s are not yet available in an electronic database that would permit easy sampling of a nationally representative group of hospitals for purposes of informing national policy. An appropriate financial analysis of hospitals using the Form 990 requires painstaking effort by people with a high level of financial sophistication. While the same is true of audited financial statements, the audited financials are prepared in accordance with generally accepted accounting principles, and provide a level of disclosure that is superior to that of the Form 990. The combination of the Form 990 and audited financials on a web site could greatly advance our knowledge of the investments, endowments, and access to capital of private not-for-profit hospitals, but it would require a significant investment to build an electronic database of a meaningful sample.

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Chantal Worzala, Ph.D.

Daniel Zabinski, Ph.D.

Research assistants

Vivek Garg, B.S.

Sarah Lowery, B.A.

*Special assistant to
the executive director*

Marian Lowe

Administrative staff

Reda H. Broadnax, B.S.

Executive officer

Wylene Carlyle

Diane E. Ellison

Donna M. Fletcher

Plinie (Ann) Johnson

Rachel Vallieres, B.A.

Cynthia Wilson



601 New Jersey Avenue, NW • Suite 9000 • Washington, DC 20001
(202) 220-3700 • Fax: (202)220-3759 • www.medpac.gov