



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 28, 2012

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2012 Joint Chairmen's Report (p. 74) – Value of Tax-Exempt Status of Non-Profit Nursing Homes Relative to Community Benefits Provided

Dear Chairmen Kasemeyer and Conway:

In keeping with the requirements of the 2012 Joint Chairmen's Report (p. 74), enclosed is the Department's report on the value of the tax-exempt status of non-profit nursing homes relative to the community benefits that they provide. As an extension of the committees' interest in the community benefits provided by other non-profit health facilities, the 2012 Joint Chairmen's Report included a request that the Department conduct a study estimating the value of non-profit nursing homes' exemptions from federal, state and local taxes in relation to the community benefits they offer. The Department contracted with the Hilltop Institute at the University of Maryland, Baltimore County to prepare the study. The Hilltop Institute's findings are enclosed.

If you have any questions or need more information on this subject, please contact Marie Grant, Director of Governmental Affairs at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Chuck Milligan
Tricia Roddy
Marie Grant
Patrick Dooley
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The Hilltop Institute



analysis to advance the health of vulnerable populations

Maryland Nonprofit Nursing Homes: Valuation of Tax Exemption and Examination of Community Benefits

November 2012

**Maryland Nonprofit Nursing Homes:
Valuation of Tax Exemption and Examination of Community Benefits**

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Maryland Nonprofit Nursing Homes: Valuation of Tax Exemption and Examination of Community Benefits

Executive Summary

The Joint Chairmen's Report of the 2012 legislative session requested a study on nonprofit nursing home community benefits. The Maryland Department of Health and Mental Hygiene (DHMH) contracted with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to conduct this study of Maryland's nonprofit nursing homes licensed in 2010 (the most recent year for which complete data were available). The purpose of the study is to estimate the value of tax exemptions provided to these entities relative to the value of the community benefit they provide.

Maryland law requires that nonprofit hospitals provide community benefits pursuant to a carefully crafted statutory and regulatory scheme. Nonprofit hospitals are required to engage in certain types of activities that benefit the communities they serve. These hospitals are further required to submit detailed reports of those activities—and their associated costs—on an annual basis.

However, Maryland has not imposed community benefit requirements on nonprofit nursing homes and does not require submission of data on any similar activities in which the nursing homes may engage on a voluntary basis.

A small number of other states have charitable requirements for nonprofit entities, including nursing homes. These requirements range from full-fledged community benefit obligations to requiring only that nursing homes be certified to participate in Medicaid or that they commit to not discharging residents due to inability to pay.

To provide context and background, Hilltop studied Maryland's nonprofit and for-profit nursing homes licensed in 2010 that served Medicaid beneficiaries. Government-operated nursing facilities, facilities located outside of Maryland, and nonprofit nursing homes lacking discrete cost reports (e.g., CCRC-affiliated) were excluded from the analysis. This left a study population of 179 nursing homes. Hilltop found that the 36 nonprofit nursing homes in this group made up 20 percent of the total.

Hilltop estimated the value of tax exemption for each nonprofit nursing home based on submitted DHMH nursing home cost reports and wage surveys for 2010, DHMH appraisals from 2008 through 2010, IRS Form 990's, and other material and found that the estimated value of benefits received by Maryland's 36 nonprofit, tax-exempt nursing facilities in 2010 was \$41.2 million.

Federal law does not require that nursing homes provide hospital-like community benefits. This does not preclude Maryland from establishing its own nursing home community benefit standards as a condition of state tax exemption. Maryland has not done so to date, however, and does not presently require that nursing facilities submit data on any such activities in which they may engage on a voluntary basis. Thus, at this time, there is an absence of data upon which to base a calculation of the value of community benefits provided by nonprofit nursing homes.



Maryland Nonprofit Nursing Homes: Valuation of Tax Exemption and Examination of Community Benefits

Introduction

The Joint Chairmen’s Report of the 2012 legislative session requested a study on nursing home community benefits:

Community Benefits: The committees have in recent years been interested in community benefits offered by not-for-profit health facilities. To that end, for example, numerous studies have been conducted on the community benefits offered by hospitals. The committees are interested in extending this discussion beyond hospitals and request that the Department of Health and Mental Hygiene (DHMH) conduct a study that estimates the value of the tax exempt status enjoyed by not-for-profit nursing homes (in terms of exemptions from federal, state and local taxes) relative to the value of the community benefits provided by these organizations.

DHMH contracted with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to conduct this study of Maryland’s nonprofit nursing homes licensed in 2010 (the most recent year for which complete data were available). The purpose of the study is to estimate the value of tax exemptions provided to these entities relative to the value of the community benefit they provide. This document reflects the results of that research.

Nonprofit Hospitals: Context and Regulatory Background

There is no single definition for the term “community benefit.” In the context of nonprofit hospitals, “community benefit” describes the activities and programs the hospitals undertake pursuant to their federal charitable obligation to promote the health of a broad class of individuals in the community. As the Internal Revenue Service (IRS) specified more than 40 years ago when first articulating the community benefit standard, “the promotion of health...is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole...” Rev. Rul. 69-545, 1969-2 C.B. 117. The IRS looks to all of the relevant “facts and circumstances” to determine whether a hospital has met its community benefit obligation and, thereby, qualifies for federal tax exemption.



Nonprofit hospitals report costs associated with their community benefit activities on Schedule H (Form 990), which applies only to nonprofit hospitals.¹ The schedule consists of six parts. Hospitals report community benefits in Part I, which is titled “Financial Assistance and Certain Other Community Benefits at Cost” and includes:

- Financial assistance at cost
- Medicaid shortfall
- Costs of other means tested government programs
- Community health improvement services and community benefit operations
- Health professions education
- Subsidized health services
- Research²

Despite intense federal interest, neither Schedule H nor any IRS guidance has detailed the specific overall level or the composition of various forms of community benefits nonprofit hospitals must provide in order to qualify for or maintain tax-exempt status (Congressional Budget Office [CBO], 2006).

States, which separately confer significant tax exemptions (e.g., property tax, state and local income tax, and state and local sales tax), are not required to defer to federal tax-exemption standards; they may develop their own. At least 24 states have existing hospital community benefit requirements, either in law or regulation, in interpretive attorney general guidelines, through broader licensure laws, and through property tax exemption standards (Government Accountability Office [GAO], 2008).

The nature and scope of state-required hospital community benefits vary widely. Oregon, for example, largely adopts the federal community benefit framework, which includes but is not limited to charity care. Or. Admin. R. §409-023-0100. Rhode Island defines community benefit more narrowly: the term encompasses only the provision of hospital services (including charity care) that meet the needs of the community for primary and emergency care... R.I. Gen. Laws §23-17.14-4.

¹ Schedule H (Form 990) must be completed by a hospital organization that operated at least one hospital facility during the tax year. A hospital facility is one that is required to be licensed, registered, or similarly recognized by a state as a hospital (Instructions, Schedule H, Form 990, <http://www.irs.gov/pub/irs-pdf/i990sh.pdf>).

² Nonprofit hospitals report their community building activities—activities that benefit community health but do not involve the provision of medical care—separately in Schedule H (Form 990), Part II. This reporting dichotomy has caused confusion regarding whether community building activities “count” as community benefit.



Maryland, which has adopted and implemented its own community benefit regulatory scheme for nonprofit hospitals, largely aligns with the federal regulatory scheme but further requires that community benefit activities:

- Ultimately improve the health status and wellbeing of specific populations in the organization’s service area who are known to have difficulty accessing care and/or who have chronic needs;
- [Be] designed to impact measurable and documented health disparities and poor health outcomes;
- Generate a low or negative margin;
- Are not provided for marketing purposes; and/or
- Provide a service or program that would likely be discontinued if the decision were made on a purely financial basis (Md. Code Ann., Health-Gen. §19-303; COMAR §10.37.01.03L-3; Maryland Health Services Cost Review Commission (HSCRC), Community Benefit Reporting Guidelines and Standard Definitions, 2012)

Voluntary Efforts: Social Accountability

Because the nature of nursing homes is sufficiently different from that of hospitals, it may be inappropriate for them to assume hospital-like community benefit obligations. However, the Catholic Health Association of the United States (CHA)³ and Leading Age,⁴ recognized leaders in voluntary efforts referred to as “social accountability,”⁵ both strongly urge nonprofit homes for the aged to engage in the same types of community benefit activities as do hospitals (i.e., community health education, scholarships and funding for health professions education, subsidized health services, and in-kind donations to the community) (Leading Age & CHA, 2011; CHA, 1989). This guidance is mission-based, rather than grounded in IRS requirements. See Appendix A for a detailed listing of the CHA-recommended social accountability activities for nursing homes and other member health care providers.

Nonprofit Nursing Homes/Homes for the Aged: National/State Context

Before the 1970s, the IRS did not consider older adults to be a charitable class, nor did it consider the relief of their distress to be a charitable activity. Instead, it was IRS’s view that only

³ CHA is a membership organization composed of 600 hospitals and 1,400 long-term care and other health facilities in all 50 states.

⁴ Leading Age, formerly American Association of Homes and Services for the Aging, is an association of 5,500 not-for-profit organizations dedicated to the issues of aging.

⁵ Leading Age and CHA collaborated in developing a “Social Accountability Program” (See Leading Age & CHA, 2011).



aged individuals who were unable to care for themselves without undue financial hardship fell within the definition of a charitable class. Rev. Rul. 57-467, 1957-2 C.B. 313; Rev. Rul. 61-72, 1961-1 C.B. 188.

That is no longer the case, however. In Rev. Ruling 72-124, the IRS determined that the relief of the distress of aged individuals as a charitable purpose was not based solely on financial considerations. Instead, the ruling held that older adults as a class are highly susceptible to several forms of distress, including: the need for suitable housing: physical and mental health care: civic, cultural, and recreational activities: and an overall environment conducive to dignity and independence. Thus, the IRS ruled that a facility would be deemed tax-exempt if it meets the housing, health care, and financial security needs of the aged. These needs were defined as follows (Rev. Ruling 72-124, 1972-1 C.B. 145):

Housing - the need for housing is satisfied if the home provides residential facilities that are specifically designed to meet some combination of the physical, emotional, recreational, social, religious and similar needs of the aged.

Healthcare - the need for healthcare is satisfied if the home either directly provides some form of healthcare, or in the alternative, maintains some continuing arrangement with other organizations facilities, or health personnel, designed to maintain the physical and mental well-being of its residents.

Financial Security - the home must 1) have an established policy to maintain in residence “any persons who, become unable to pay their regular charges, and 2) provide its services “at the lowest feasible cost” commensurate with the needs of the community.

The IRS explicitly reversed prior decisions that had previously required residents of charitable homes for the aged be in financial hardship (Rev. Ruling 72-124, 1972-1, C.B. 145). A later IRS decision held that a nursing home may qualify for federal income tax exemption even if it admits as tenants only older adults who are able to pay the full stated rental charges (Rev. Ruling 79-18, 1979-1 C.B. 194).

Indeed, IRS Rev. Rulings 72-124, 79-18 and 75-198, clearly evidence the IRS’s position that “homes for the aged” satisfy their charitable obligations—and are thus eligible for federal income tax exemption—if a facility meets the needs of older persons for housing, health care, and financial security. Under the IRS’ “facts and circumstances” approach, there is no requirement that such facilities admit persons who cannot pay full charges.

Recent Federal Attention to Nursing Homes

While there has been far less federal scrutiny of the activities of nonprofit nursing homes in recent years as compared to that directed toward nonprofit hospitals, federal attention to the



nursing home industry has included some reference or implications for nonprofit nursing homes. The Centers for Medicare and Medicaid Services (CMS) initiated the Special Focus Facility (SFF) program in 1998 to encourage improvement for nursing homes with consistent noncompliance of CMS-specified quality care measures. By Congressional request, the GAO studied the effectiveness of this program in March 2010. This study found that roughly 81 percent of SFFs were for-profit facilities, compared to 15 percent being nonprofit (GAO, 2010). GAO released a July 2011 nursing home industry study, which found that facilities owned by private investment firms or other for-profit entities had more deficiencies than their nonprofit counterparts (GAO, 2011).

States with Charitable Standards for Nursing Homes

Federal law does not require that nursing homes/homes for the aged provide hospital-like community benefits. This does not preclude states from establishing their own nursing home community benefit standards as a condition of state tax exemption. In fact, a small number of states—New Hampshire,⁶ Utah,⁷ Pennsylvania,⁸ Minnesota,⁹ and Texas¹⁰—do impose specific charitable obligations on nursing homes.

New Hampshire

New Hampshire law requires that “health care charitable trusts,” a term that includes nonprofit nursing homes, provide and report “community benefits.” N.H. Rev. Stat. Ann. §§7:32-c – 7:32-h. In New Hampshire, “community benefit” includes, but is not limited to, charity care.¹¹ New Hampshire does not require that health care charitable trusts provide a mandatory minimum level of community benefits. However, charity care may be counted as community benefit only if it is in accord with a written, publicly available charity care policy. N.H. Rev. Stat. Ann. §7:32-h. Nursing homes and other health care charitable trusts must file community benefit plans annually.

⁶ In 2009, New Hampshire had 80 nursing homes, 34 percent of which were nonprofit (CMS Nursing Home Data Compendium, 2010).

⁷ In 2009, Utah had 98 nursing homes, 14 percent of which were nonprofit (CMS Nursing Home Data Compendium, 2010).

⁸ In 2009, Pennsylvania had 721 nursing homes, 46 percent of which were nonprofit (CMS Nursing Home Data Compendium, 2010).

⁹ In 2009, Minnesota had 389 nursing homes, 61 percent of which were nonprofit (CMS Nursing Home Data Compendium, 2010).

¹⁰ In 2009, Texas had 1196 nursing homes, 13 percent of which were nonprofit (CMS Nursing Home Data Compendium, 2010).

¹¹ The term also includes, but is not limited to, support of public health programs; expenditures that promote or support a healthier community; enhanced access to health care; health education and prevention activities; services to vulnerable populations; support of medical research; and education and training of health care practitioners.



Utah

To qualify for property tax exemption in Utah, nonprofit nursing homes (and hospitals) must provide “gifts to the community.” These “gifts” are roughly similar to hospital community benefits, for they may include indigent care, community education and service, unreimbursed care and medical discounts. *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265,269 (Utah 1985). Those gifts must exceed the annual property tax liability of the nursing home.

Utah’s community benefit requirement is embodied, not in statutes, but in Property Tax Exemption Standards of Practice issued by the Utah Tax Commission. County boards of equalization across the state use the standards to determine the justification for property tax exemption for nursing homes and hospitals. Property Tax Exemption Standards of Practice, Appendix 2D, *Nonprofit Hospital and Nursing Home: Charitable Property Tax Exemption Standards*,” Utah State Tax Commission, revised June 2007 (Property Tax Exemption Standards), <http://propertytax.utah.gov/library/pdf/standards/standard02.pdf>

Pennsylvania

Pennsylvania law requires that “institutions of purely public charity,” which can include nonprofit nursing homes, donate or render gratuitously a “substantial portion” of their services. “Substantial portion” is defined as a minimum expenditure requirement to be calculated in one of six different ways specified in the statute. 10 Pa. Cons. Stat. Ann. §§371- 385. Institutions of purely public charity file copies of their federal tax returns (IRS Form 990) with the state government on an annual basis.

http://www.dos.state.pa.us/portal/server.pt/community/charities/12444/the_institutions_of_purely_public_charity_act/571856

Minnesota

Minnesota has specific property tax exemption requirements for nursing homes determined to be “institutions of purely public charity.” Such nursing homes are not required to provide hospital-like community benefits. However, nonprofit nursing homes that are exempt from federal taxation under § 501(c)(3) qualify for Minnesota property tax exemption if they are certified to participate in Medicaid or if they certify that they do not discharge residents due to the inability to pay. Minn. Stat. Ann. §272.02, Subd. 90.¹²

https://www.revisor.leg.state.mn.us/statutes/?id=272.02&year=2011&keyword_type=all&keyword=272.02

¹² While research has not identified additional examples, it is conceivable that some other states may address nursing home community benefits as a matter of exemption from county and/or local taxes. Hilltop was not able to examine all property tax exemption provisions within the 50 states.



Texas

To qualify for property tax exemption as a charitable organization in Texas, nursing homes must provide “support” without regard to the ability to pay. The required support includes providing older persons with recreational or social activities and facilities designed to meet their special needs, without regard to the beneficiaries’ ability to pay. Tex. Property Tax Code Ann. §11.18(d)(3). <http://www.statutes.legis.state.tx.us/Docs/TX/htm/TX.11.htm>

For more information, see Appendix B.

Maryland Nonprofit Nursing Home Comparison

A comparison of Maryland’s nonprofit and for-profit nursing homes is limited to 2010 data related to licensed Maryland nursing homes and is based on the following data sources:

- Listing of 2010 Maryland Medicaid licensed nursing homes as provided by DHMH
- Nursing Home Compare data as compiled by CMS: <http://www.medicare.gov/nursinghomecompare/>
- Five-Star Quality Ratings for Nursing Homes as compiled by CMS: <http://www.medicare.gov/nursinghomecompare/>
- 2010 Maryland Nursing Facility Family Satisfaction Survey administered by the Maryland Health Care Commission: <http://mhcc.maryland.gov/>
- Nursing home association membership information as compiled by the Health Facilities Association of Maryland (HFAM): <http://www.hfam.org/>

Overview of All Maryland Nursing Homes

In total, there were 221 Medicaid-only, Medicare and Medicaid, and Medicare-only certified nursing homes in Maryland in 2010. These nursing homes functioned under three distinct categories of ownership: 1) for-profit, 2) nonprofit, and 3) government/state-owned. For-profit nursing homes are defined as tax-paying entities that operate under ownership of private owners, investors and/or shareholders, or as subsidiaries of corporations. Nonprofit nursing homes are non-tax-paying entities that are owned and operated by nonprofit organizations or other membership groups. Government- or state-owned, nursing homes are operated by city, state, or federal governments.



Analysis of Selected Maryland Nursing Homes

Forty-two of the state’s 221 nursing homes are excluded from this study.¹³ The resulting study population includes 179 (143 for-profit and 36 nonprofit) of Maryland’s 221 nursing homes that are Medicaid-only or dually certified as Medicare and Medicaid. As Table 1 shows, Maryland’s nonprofit nursing homes accounted for 20 percent of the study population and for-profit nursing homes accounted for 80 percent. This figure of 20 percent is part of a trend over the past decade in the decline in the number of nonprofit facilities, which have been bought out primarily by for-profit entities. In fact, a number of the facilities identified as nonprofit in the study have subsequently changed ownership and converted to for-profit status. For an inventory of the 36 nonprofit nursing homes in the study population, see Appendix C.

Table 1. Study Nursing Homes by Type of Ownership

	Nonprofit	Percentage of All Homes	For-Profit	Percentage of All Homes	Total
Nursing Homes	36	20%	143	80%	179

The vast majority of Maryland nursing homes are freestanding homes. Only two (or 1 percent) of all nursing homes in the study are located within a hospital—both of which are nonprofit homes. Sixty-four percent (115) are owned or leased by multi-facility organizations (chains), of which 6 percent are nonprofit homes.

Table 2. Maryland Nursing Homes by Affiliation

	Nonprofit	Percentage	For-Profit	Percentage	All	Percentage
Located within a Hospital	2	1%	0	0%	2	1%
Chain Nursing Homes	11	6%	104	58%	115	64%

As noted previously, nonprofit homes compose 20 percent of the study. As Table 3 displays, the number of nonprofit nursing homes as a percentage of all nursing homes in a given geographical location varies greatly by county. Of the 24 jurisdictions in Maryland, Baltimore City had the largest number of nonprofit homes (8), yet they accounted for only 28 percent of all nursing homes in that jurisdiction.

¹³ The excluded nursing homes include those that are: Medicare-only, located out of state, operating as part of a Continuous Care Retirement Community (CCRC), or government-owned. Of these, thirty-six are nonprofit nursing homes—the majority of which are CCRCs—and six are for-profit nursing homes.



Table 3. Nonprofit Nursing Homes as a Percentage of All Nursing Homes, by County

County	All Nursing Homes	Number of Nonprofits	Percentage of All Homes	Number of For-Profits	Percentage of All Homes
Allegany	7	1	14%	6	86%
Anne Arundel	14	1	7%	13	93%
Baltimore City	29	8	28%	21	72%
Baltimore	31	3	10%	28	90%
Calvert	2	1	50%	1	50%
Caroline	2	1	50%	1	50%
Carroll	8	1	13%	7	88%
Cecil	3	0	0%	3	100%
Charles	3	1	33%	2	67%
Dorchester	2	0	0%	2	100%
Frederick	6	2	33%	4	67%
Garrett	2	0	0%	2	100%
Harford	4	0	0%	4	100%
Howard	3	0	0%	3	100%
Kent	2	1	50%	1	50%
Montgomery	25	6	24%	19	76%
Prince George's	18	5	28%	13	72%
Queen Anne's	1	0	0%	1	100%
Somerset	2	1	50%	1	50%
St. Mary's	3	1	33%	2	67%
Talbot	1	0	0%	1	100%
Washington	6	2	33%	4	67%
Wicomico	2	0	0%	2	100%
Worcester	3	1	33%	2	67%
Total	179	36	20%	143	80%



Capacity

Licensed Nursing Home Beds

In 2010, there were 24,173 licensed beds in the 179 nursing homes in the study population. Twenty-one percent of these beds were located in nonprofit homes. From a low of 20 to a high of 556, the number of beds in each of the facilities varied greatly. There was little difference in the average number of beds per nursing home when controlled for ownership type, with nonprofit homes averaging 138 beds and for-profit homes averaging 134 beds. A more notable difference was found in the median number of beds, with nonprofit having 109 and for-profit having 130. See Table 4.

Table 4. Number of Licensed Nursing Home Beds by Type of Ownership

	Nonprofit		For-Profit		All	
	Number	Percentage	Number	Percentage	Number	Percentage
Less than 50	2	6%	2	1%	4	2%
50 – 99	12	33%	28	20%	40	22%
100 – 149	11	31%	64	45%	75	42%
150 – 199	7	19%	37	26%	44	25%
200 – 249	2	6%	9	6%	11	6%
250 – 299	0	0%	2	1%	2	1%
300 or more	2	6%	1	1%	3	2%
Total	36	100%	143	100%	179	100%

Occupancy Rates

Table 5 displays the 2010 occupancy rates for Maryland’s nursing homes. In 2010, 22 (61 percent) of the nonprofit nursing homes had an occupancy rate ranging from 85 percent to 94 percent. Only one nonprofit nursing home had an occupancy rate of less than 50 percent.

Table 5. Percentage of Nursing Home Beds Occupied

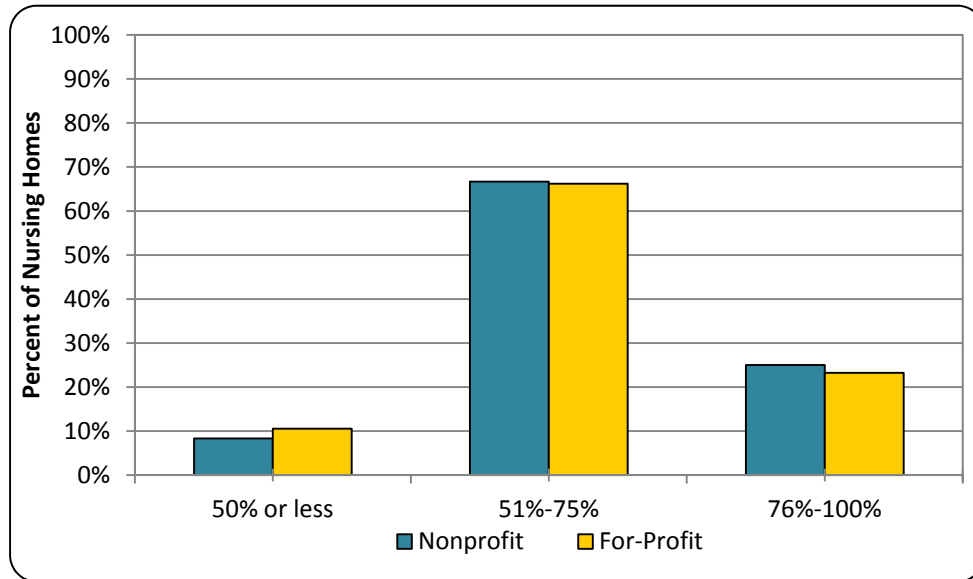
# of Beds	Nonprofit		For-Profit		All	
	Number	Percentage	Number	Percentage	Number	Percentage
0 – 24	0	0%	0	0%	0	0%
25 – 34	1	3%	0	0%	1	1%
35 – 44	0	0%	1	1%	1	1%
45 – 64	0	0%	0	0%	0	0%
65 – 74	1	3%	2	1%	3	2%
75 – 84	4	11%	19	13%	23	13%
85 – 94	22	61%	102	72%	124	70%
95 – 100	8	22%	19	13%	27	15%
Total	36	100%	143	100%	179	100%



Medicaid-Paid Days

As Figure 1 shows, the percentage of nursing homes receiving Medicaid reimbursement for nursing home days of care was very similar across provider type. In 2010, Medicaid paid for 51 to 75 percent of nursing homes days for 66 percent of nonprofit homes and 67 percent of for-profit homes. Medicaid paid for over 75 percent of nursing home days for 22 percent of nonprofit homes and 23 percent of for-profit homes.

Figure 1. Percentage of Medicaid-Paid Nursing Home Days



Nursing Home Quality

Centers for Medicare and Medicaid Services

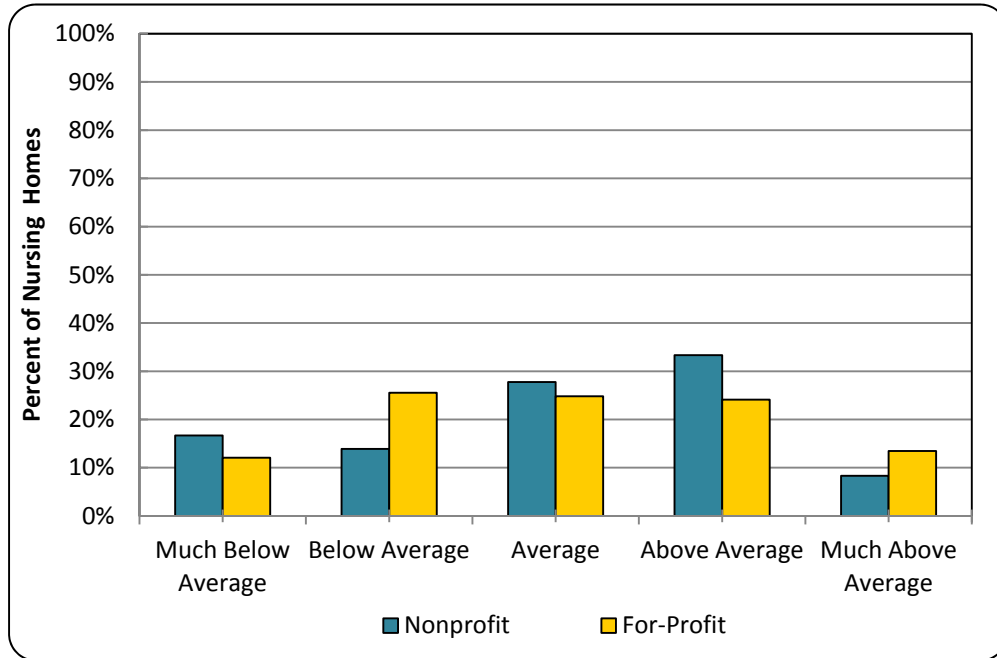
CMS created the Five-Star Quality Rating System as a tool to help consumers, their families, and caregivers compare Medicare and Medicaid nursing homes. Nursing homes are assigned a quality rating that ranges from a low of 1 star to a high of 5 stars in three domains; quality measures, health inspections, and staffing. The ratings are compiled using information from state nursing home health inspections, which review all major areas of nursing home operations; staffing reviews, which evaluate the overall staff-to-resident ratio and the level of staff training; and CMS quality of care measures, which evaluate aspects of care such as dressing and eating, safety, and medical treatment of pressure ulcers. CMS star ratings are assigned to each of the three domains and together form the basis for the nursing homes' "overall star rating."

In 2010, nonprofit nursing homes received slightly more favorable "overall" ratings than their for-profit counterparts. Over 40 percent of nonprofit nursing homes received a CMS "overall"



Five-Star rating of “above average” or “much above average,” compared to 38 percent of for-profit nursing homes and 38 percent of all nursing homes in the study. The largest percentage (33 percent) of nonprofit homes received an overall rating of “above average.” See Figure 2.

Figure 2. CMS Nursing Home Five-Star Quality Rating - Overall, 2010



As Figures 3 and 5 show, there was little difference in the quality and staffing ratings with 55 percent of nonprofit nursing homes being rated as “above average” or “much above average” on quality compared to 57 percent of all nursing homes. Nonprofit staff ratings were also in-line with the ratings for the larger collection of nursing homes with 50 percent and 51 percent, respectively. The greatest disparities were noted in the area of health inspections (see Figure 4).



Figure 3. CMS Nursing Home Five Star Quality Rating - Quality Measure, 2010

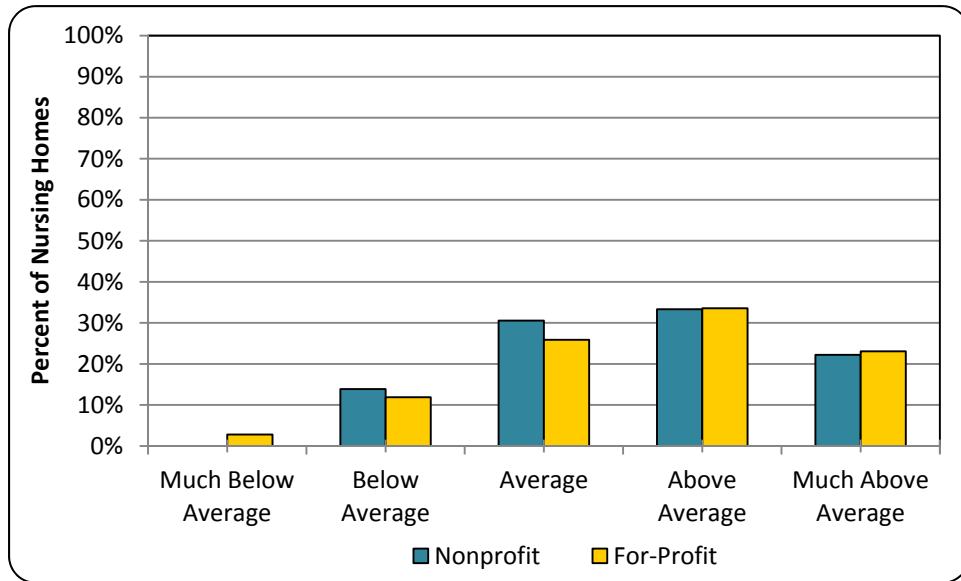


Figure 4. CMS Nursing Home Five Star Quality Rating - Health Inspection, 2010

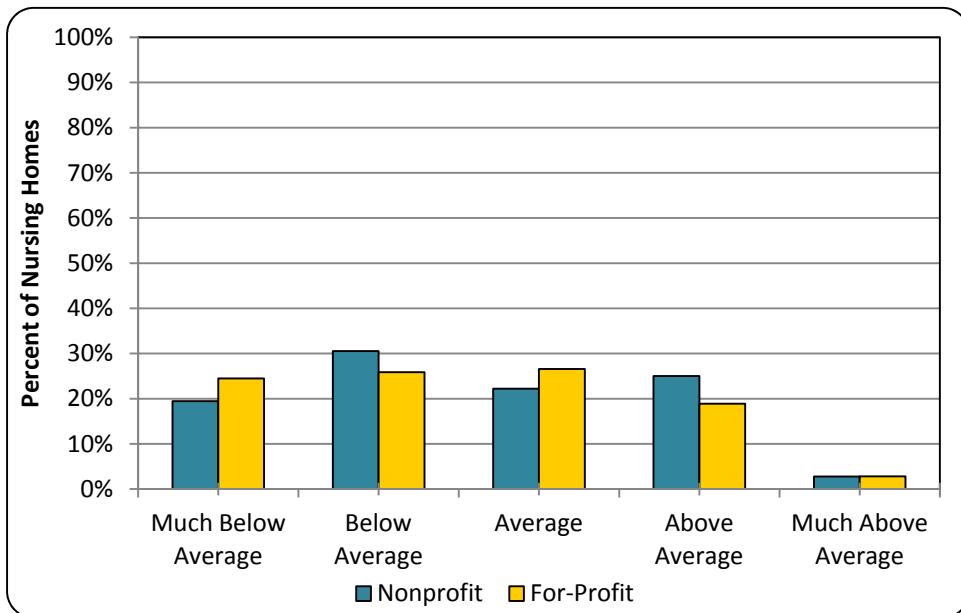
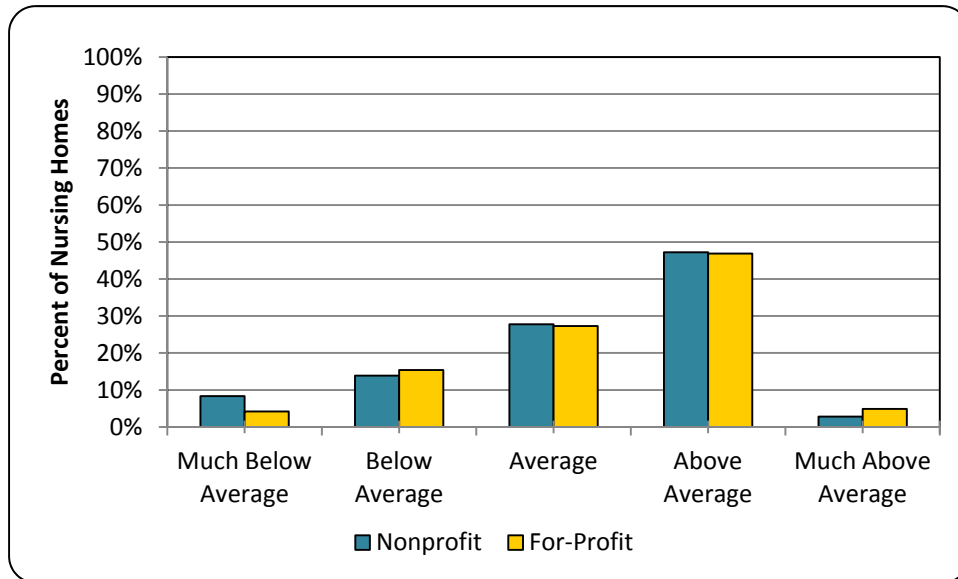


Figure 5. CMS Nursing Home Five Star Quality Rating - Staffing, 2010



Maryland Health Care Commission Nursing Home Family Survey

The Maryland Health Care Commission (MHCC) conducts the annual Maryland Nursing Facility Survey to assess the level of satisfaction of family members and/or guardians of Maryland nursing home residents. The survey is administered to Maryland nursing homes with one or more residents with a nursing home stay of 90 days or more. As Table 6 demonstrates, there was no significant difference between the nonprofit and for-profit nursing homes in the five rated domains. The 2010 survey contained 25 items, rated on a scale of 1 to 4, designed to measure the experiences and satisfaction of family members or persons responsible for nursing home residents in five key domains: 1) staff and administration of the nursing home, 2) care provided to residents, 3) food and meals, 4) autonomy and residents rights, and 5) physical aspects of the nursing home. Individual nursing home results were compared across all Maryland nursing homes and among peer groups with similar characteristics (e.g., size, type of ownership, and location).

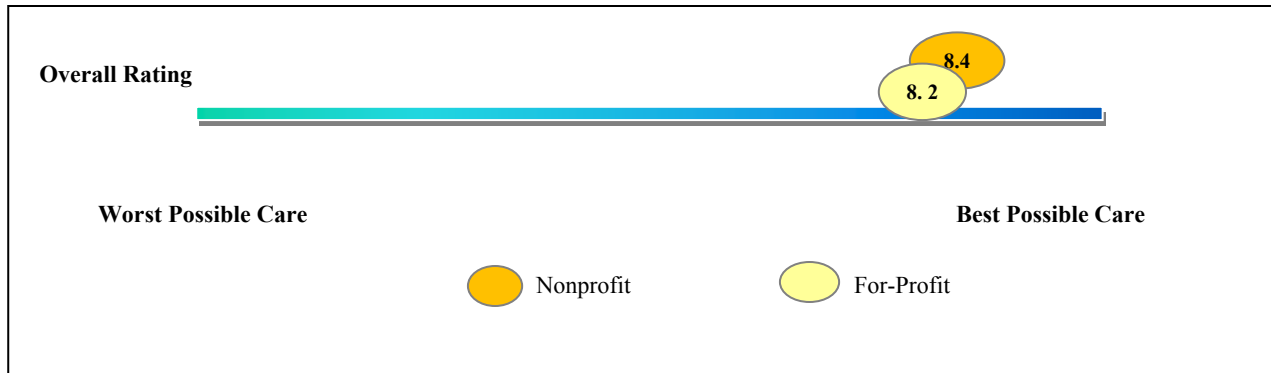
Table 6. MHCC Family Nursing Home Survey, by Domain, 2010

Domain	Nonprofit	For-Profit	All
Autonomy of Residents	3.5	3.5	3.5
Care to Patients	3.5	3.5	3.5
Food and Meals	3.5	3.5	3.5
Physical Aspects	3.4	3.4	3.4
Staff and Administration	3.7	3.6	3.6



Respondents were also asked to rate, on a scale of 1 to 10, their “overall” level of satisfaction with the care their loved one received at the nursing home. As Figure 6 shows, the 8.4 average “overall” level of satisfaction ratings for nonprofit homes was higher than the 8.2 rating achieved for the for-profit nursing homes in the study.

Figure 6. MHCC Family Nursing Home Survey - Overall Rating, 2010



When survey respondents were asked, “If someone needed nursing home care, would you recommend this nursing home to them?,” 90 percent responded “definitely yes” or “probably yes” for both nonprofit and other nursing homes.

Valuation of the Maryland Nonprofit Nursing Home Tax Exemption

Data Sources

Hilltop used a variety of data sources for this study, which are described in detail in Appendix D. These include:

- DHMH nursing home cost reports
- DHMH nursing home wage surveys
- DHMH facility appraisals
- IRS Form 990’s for tax year 2010, submitted by Maryland’s nonprofit hospitals
- Various federal and state documents providing tax rates

Methodology

Based on submitted DHMH nursing home cost reports and wage surveys for 2010, DHMH appraisals from 2008 through 2010, IRS Form 990’s and other material, the value of tax exemption for each nursing home was estimated and aggregated. Government-operated nursing



facilities, facilities located outside of Maryland, and nonprofit nursing homes lacking discrete cost reports (e.g., CCRC-affiliated) were excluded from the analysis.

To estimate the value of benefits received by nonprofit nursing facilities, Hilltop relied primarily on audited nursing home cost reports, which are used in setting facility-specific payment rates. Sales tax liability, federal and state income tax liability, and lost contributions were all estimated from these cost reports. In certain instances, particularly in estimating contributions, a facility's IRS Form 990 was used to reconcile the data found on the cost reports.

The Federal Unemployment Tax Act (FUTA) was estimated based on the facility's annual wage survey. The calculation included 95 percent of all non-agency employees included in the survey, multiplied by the maximum FUTA tax payment of \$56.

The taxable real and personal property for each facility was estimated based on nursing home appraisals. These appraisals are conducted on a rolling multi-year basis, meaning that in some instances, the most recent appraisal available was conducted in 2008 or 2009 rather than 2010. For this study, the corresponding year's tax rates were applied to the appraised values.

Full detail on the methodology Hilltop used is provided in Appendix E.

Findings

The estimated value of benefits received by Maryland's 36 nonprofit, tax-exempt nursing facilities in 2010 was \$41.2 million.

As Figure 7 shows, nursing facility benefits are grouped into three major categories: state and local taxes exempted (which includes the following taxes: sales, state real, state income, local real, local personal, and local miscellaneous); federal taxes exempted (federal income tax and FUTA); and contributions (received by nursing facilities where the donors could claim the charitable donations as tax deductions).

Table 7 provides the 2010 estimated values of each component of the benefit.



Figure 7. 2010 Nursing Home Benefits, by Category

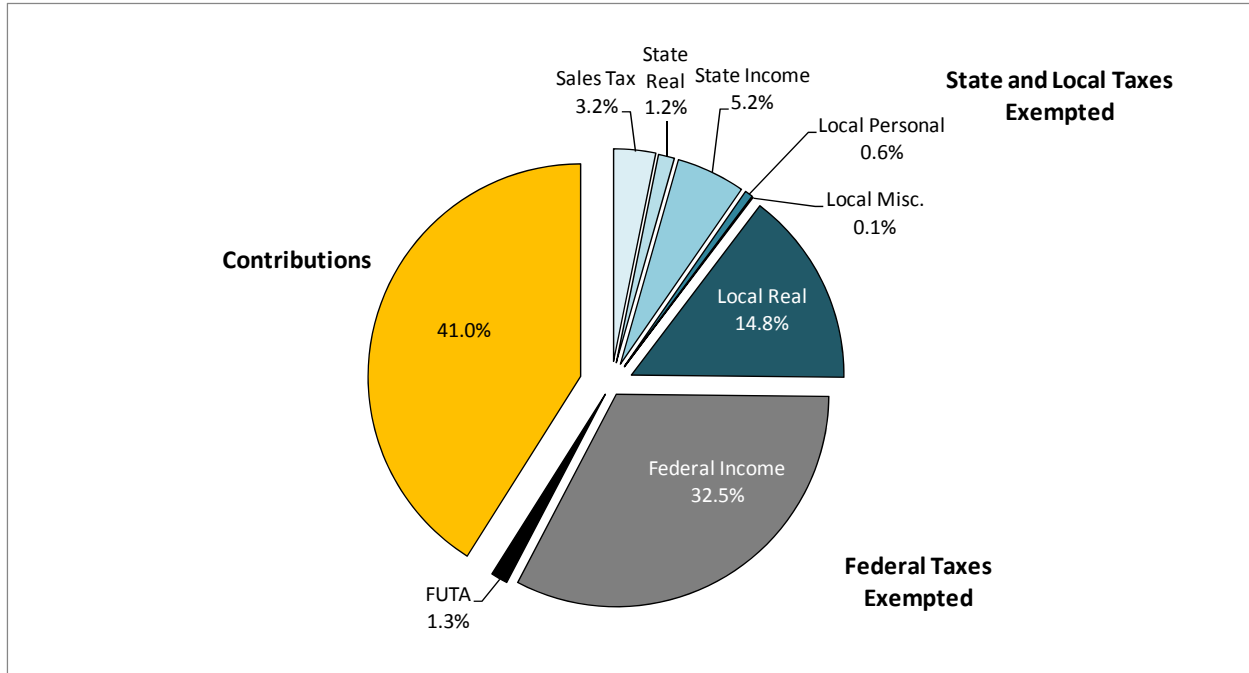


Table 7. Nursing Home Benefits (2010) (in thousands)

State and Local Taxes Exempted	
Sales Tax	\$1,312.92
State Real Property Tax	\$502.36
State Income Tax	\$2,156.74
Local Real Property Tax	\$6,108.53
Local Personal Property Tax	\$248.98
Local Misc. Taxes	\$36.00
	\$10,365.53
Federal Taxes Exempted	
FUTA	\$524.71
Federal Income Tax	\$13,393.71
	\$13,918.42
Contributions	
Contributions	\$16,905.89
Total	\$41,189.84



Limitations of Tax Exemption Valuation

There are several limitations to estimating the value of community benefits received by nonprofit nursing facilities. It is important to note that if a nursing home converted from nonprofit to for-profit, then it would likely implement various changes to its corporate structures and accounting practices. The changes—legal and within Generally Accepted Accounting Principles (GAAP)—would be made to reduce tax liability and would likely result in a reduction of taxes paid. For purposes of this analysis, no adjustment was made for probable reductions due to such changes. Additionally, if a for-profit nursing home incurs a loss in a particular year, then it pays no tax. The loss can be carried forward to reduce the facility’s taxable income in one or all of the next seven years. This analysis makes no adjustment for tax loss carry-forward when calculating net revenue.

Finally, while nonprofit nursing homes are exempt from state and local property taxes, Maryland’s rate setting system permits for-profit nursing homes to include these taxes as allowable expenses on their cost reports. These costs, which are not subjected to caps or ceilings, are reimbursed through nursing home rates.

Conclusion

The Hilltop Institute found that, in Maryland in 2010, the estimated value of benefits received by Maryland’s 36 nonprofit, tax-exempt nursing facilities that were in the study population was \$41.2 million.

Federal law does not require that nursing homes/homes for the aged provide hospital-like community benefits. This does not preclude Maryland from establishing its own nursing home community benefit standards as a condition of state tax exemption. Maryland has not done so to date, however, and does not presently require that nursing facilities/homes for the aged submit data on any such activities in which they may engage on a voluntary basis. Thus, at this time, there is an absence of data upon which to base a calculation of “the value of community benefits provided” by nonprofit nursing homes, as requested in the JCR.



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Appendix A. Social Accountability Activities

Reference 2: Homes and Services for the Aging

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Reference 2

Inventory of Community Benefit Services for Homes and Services for the Aging

This reference can be downloaded at the CHA website at www.chausa.org/guideresources.

A. Community Health Services

Community benefit services provided by homes and services for the aging are organized to be consistent with the preceding section but include examples specific to continuing care settings. Throughout the community benefit report, be careful not to double-count.

A1. Community Health Education

Count:

- Participation in community-wide health promotion programs.
- Health fairs (except when primarily used for marketing).
- Lectures or workshops by staff to community groups.
- Education for community members on special topics, such as how to care for elderly family members or how to manage certain chronic conditions, e.g., Alzheimer's disease.
- Other education and outreach, such as CPR training or nutrition classes.

2

Support groups

Count:

- Education, counseling, and support for resident family members (but not family and resident councils).
- Support groups for persons with certain diseases.
- Bereavement groups.



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Self-help programs

Count:

- Smoking cessation clinics.
- Weight loss programs.
- Exercise classes.

A2. Community-Based Health Services

Count:

- General screening programs.
- Blood pressure clinics.
- Eye and hearing exams.
- Flu and immunization clinics.

A3. Health Care Support Services

Count:

- Information and referral services.
- Transportation for elders in the community.
- Overnight arrangements and meals for family members.
- Non-paid chore services.
- Recreation services.

Resident activities

These activities should not be included in a quantitative community benefit report because resident activities, such as volunteer activities, are not an organization expense.

Include in a narrative report such resident community benefit activities as:

- Programs to help other residents.
- Telephone reassurance.



-
- Needlework and crafts to benefit others.
 - Oral history programs.
 - RSVP or Foster Grandparent programs.
 - Work with local schools.

B. Health Professions Education

B1. Student Internships in Clinical Settings

Count:

- Physicians and medical students.
- Social workers.
- Pastoral care.
- Nurses.
- Administrators.
- Therapists (such as PT, OT and speech).

2

B2. Scholarships and Funding for Professions Education

Count:

- Physicians/medical students.
- Social workers.
- Pastoral care.
- Nurses.
- Administrators.
- Therapists (such as PT, OT and speech).

Do not count:

- Scholarships for employees.



C. Subsidized Health Services

These are services offered despite a financial loss because they are needed in the community and would otherwise not be available in sufficient amounts.

C1. Special Services

Count:

- Psychiatric and mental health programs.
- Hospice services.
- Palliative care programs.
- AIDS care programs.
- Adult day care.
- Assessment and referral services.
- Spinal cord and head injury services.
- End of life services.

C2. In-Home Services

Count:

- Home health care services.
- Physician, nurse, or other visitation services.
- Hospice services.
- Senior companion programs.
- Lifeline or other phone alert systems.

C3. Other Subsidized Services



D. Research and Innovation

This group includes the development of programs offered to others for replication, speaking to peers about innovative programs and inviting others to see innovation firsthand. Do not count programs that are for the improvement of only your organization.

D1. Clinical Research

Count:

- New approaches to delivery services.
- Staff publication in professional literature.

D2. Community Health Research

Count:

- Research into problems of persons who are aging.
- Research into problems related to chronic disease.

E. Cash and In-Kind Donations

2

This group includes funds and in-kind services donated to individuals or the community at large. In-kind services include hours donated by staff to the community while on health care organization work time; overhead expenses of space donated to not-for-profit community groups (such as for meetings); and donation of food, equipment, and supplies.

E1. Cash Donations

As a general rule, count donations to organizations and programs that are consistent with your organization's goals and mission.

Count:

- Contributions and/or matching funds provided to not-for-profit community organizations.
- Contributions to charity events of not-for-profit organizations, after subtracting the market value of participation by the employees or organization.
- Contributions provided to individuals for emergency assistance.
- Scholarships to community members not specific to health care professions.



Do not count:

- Employee-donated funds.
- Emergency funds provided to employees.
- Fees for tickets to sporting events.
- Time spent at golf outings or other primarily recreational events.

E2. Grants

These include contributions and/or matching funds provided as a community grant to not-for-profit community organizations, projects, and initiatives.

Count:

- Program, operating and education grants.
- Event sponsorships.
- General contributions to not-for-profit organizations or community groups.

2**E3. In-Kind Donations*****Count:***

- Meeting room overhead and space for not-for-profit organizations and community groups (such as coalitions, neighborhood associations, and social service networks).
- Equipment and medical supplies.
- Costs of coordinating community events not sponsored by the health care organization, such as the March of Dimes Walk America (report health care organization-sponsored community events in G1).
- Employee costs associated with board and community involvement on work time.
- Food donations, including Meals on Wheels subsidies and donations to food shelters.
- Laundry services for community organizations.



Do not count:

- Employee costs associated with board and community involvement when these are done on an employee's own time and he or she is not engaged on behalf of his or her organization.
- Volunteer hours provided by hospital employees on their own time for community events (hours belong to the volunteer, not to the health care organization).
- Promotional and marketing costs concerning the health care organization's services and programs.
- Salary expenses paid to employees deployed on military services or jury duty (expenses are considered employee benefit).

E4. Cost of Fundraising for Community Programs***Count:***

- Grant writing and other fundraising costs not reported in G that are specific to community programs and resource development assistance.

F. Community-Building Activities**2****F1. Physical Improvements and Housing*****Count:***

- Neighborhood improvement programs, such as graffiti removal.
- Neighborhood and community revitalization.
- Housing rehabilitation, such as Habitat for Humanity projects.

F2. Economic Development***Count:***

- Asking contractors to contribute to community services.
- Locating services in economically disadvantaged areas.
- Job creation and job training.



F3. Community Support

Count:

- Disaster preparedness beyond what is legally required.
- Child care for community residents.
- Resident activity programs open to community members.
- Expanding existing services to include more low- and middle-income persons.

F4. Environmental Improvement

Count:

- Efforts to reduce community environmental hazards in the air, water and ground.
- Residential improvements, such as helping to paint public housing apartments, or lead or radon programs.
- Neighborhood and community improvements, such as toxin removal in parks.
- Safe removal or treatment of garbage and other waste products.

Do not count:

- Costs related to complying with laws and regulations.
- Costs related to reducing environmental hazards caused by its own activities. (Some organizations may decide to report their own efforts to reduce waste, emission and energy use in a narrative report, but the IRS does not want it reported on Form 990 Schedule H.)

F5. Leadership Development and Training for Community Members

Count:

- Language and cultural skills training.
- Life and civic skills training.
- Career development.
- Technical assistance for organizations and groups.



F6. Coalition Building**F7. Advocacy****Count:**

- Advocacy to improve public health, transportation or housing.
- Advocacy to improve access to health care by uninsured persons.
- Advocacy for needed services for elderly persons.
- Administrator or staff positions on community-service organization boards.
- Testifying on behalf of issues important to the welfare of residents and participants.

Do not count:

- Advocacy specific to facility or organization operations and financing.

F8. Workforce Development**Count:**

- Mentoring high school students.
- School partnerships for encouraging careers.
- Lectures by staff at schools.

2**G. Community Benefit Operations****G1. Assigned Staff****Count**

- Staff costs for the management of community benefit programs (not counted elsewhere).
- Staff costs to coordinate community benefit volunteers.

G2. Community Health Needs Assessments**G3. Other Resources**

Appendix B. State Requirements for Nonprofit Nursing Homes

Utah State Tax Commission

(<http://propertytax.utah.gov/library/pdf/standards/standard02.pdf>)

Standard I

The institution owning the property for which the exemptions is sought must establish that it is organized on a nonprofit basis to (a) provide hospital or nursing home care, (b) promote health care, or (c) provide health related assistance to the general public. The institution's property must be dedicated to its charitable purpose, and upon dissolution its assets must be distributable only for exempt purposes under Utah law or to the government for a public purpose.

Standard II

The institution owning the property for which the exemption is sought must establish that none of its net earnings and no donations made to it inures to the benefit of private shareholders or other individuals, as the private inurement standard has been interpreted under Section 501(c)(3) of the Internal Revenue Code.

Standard III

The institution owning the property for which the exemption is sought must establish: (a) that it admits and treats members of the public without regard to race, religion or gender, (b) that hospital or nursing home service, including admission to the institution, is based on the clinical judgment of the physician and not upon the patient's financial ability or inability to pay for services, and (c) that indigent persons who, in the judgment of the admitting physician, require the service generally available at the hospital or nursing home, receive those services for no charge or for a reduced charge, in accordance with their ability to pay.

Standard IV

The institution owning the property for which the exemption is sought must establish that its policies integrate and reflect the public interest. A rebuttable presumption of compliance with this standard is assumed if it is shown that (a) the institution's governing board has a broad based membership from the community served by the institution, as required by federal tax law, (b) the institution confers at least annually with the county board of equalization or its designee concerning the community's clinical hospital needs that might be appropriately addressed by the institution, and (c) the institution establishes and maintains a "charity plan" to ensure compliance with Standard III and Standard IV.



Standard V

Institution owning the property for which exemption is sought must establish its total gift to the community exceeds on an annual basis its property tax liability for that year. The following quantifiable activities and services are to be counted toward the “total gift to the community”:

- Indigent care – reasonable value of the hospital’s unreimbursed care to medically indigent patients. Formula – value of institution’s unreimbursed care to patients, as measured by standard charges, reduced by the average reductions afforded to all patients not covered by government entitlement programs, plus expenses directly associated with special indigent clinics
- Community education and service – reasonable value of volunteer and community service (including education and research) rendered for and by the hospital or nursing home. Measurement – unreimbursed expense
- Medical discounts – reasonable value of unreimbursed care for patients covered by Medicare, Medicaid, or other similar government entitlement programs
- Donations of time – reasonable value of volunteer assistance. Measurement – volunteer hour times a reasonable rate for services performed
- Donations of money – value of monetary donations given to a nonprofit hospital or nursing home.

New Hampshire

(<http://www.doj.nh.gov/charitable-trusts/documents/community-benefits-guide.pdf>)

7:32-d Definitions. – In this subdivision:

I. “Charity care” means health care services provided by a health care charitable trust for which the trust does not expect and has not expected payment and which health care services are not recognized as either a receivable or as revenue in the trust’s financial statements.

II. “Community” means the service area or patient population for which a health care charitable trust provides services.

III. “Community benefits” means a health care charitable trust’s activities that are intended to address community health care needs including, but not limited to, any of the following:

(a) Charity care.

(b) Financial or in-kind support of public health programs even if the programs extend beyond the trust’s service area, including support of recommendations in any state health plan developed by the department of health and human services.



(c) Allocation of funds, property, services, or other resources that contribute to community health care needs identified in a community benefits plan.

(d) Donation of funds, property, services, or other resources which promote or support a healthier community, enhanced access to health care or related services, health education and prevention activities, or services to a vulnerable population.

(e) Support of medical research and education and training of health care practitioners, including the pooling of funds by different health care charitable trusts for this purpose.

IV. “Community benefits plan” means a written document prepared by a health care charitable trust which identifies health care needs in the area served by the trust and describes the activities the trust has undertaken and will undertake to address the identified needs.

V. “Health care charitable trust” means a charitable trust organized to directly provide health care services, including, but not limited to, hospitals, nursing homes, community health services, and medical-surgical or other diagnostic or therapeutic facilities or services. “Health care charitable trust” shall not include any testamentary or inter vivos trust which is not organized to provide health care services.

VI. “Vulnerable population” means any population that is at risk of not receiving health services due to medical, financial, or other barriers.

7:32-e Community Benefits Plans. – Within 90 days of the start of its fiscal year every health care charitable trust shall develop a community benefits plan. The plan shall be developed in accordance with the following criteria on forms supplied by the attorney general:

I. The trust shall adopt a mission statement which shall be included in its plan and which shall be reaffirmed by the trust on an annual basis.

II. The plan shall take into consideration a community needs assessment conducted in accordance with RSA 7:32-f and shall identify the health care needs that were considered in development of the plan.

III. The plan shall identify the activities the trust expects to undertake or support which address the needs determined through the community needs assessment process or which otherwise qualify as community benefits and shall include all charity care in a discrete category.

IV. The plan shall include a report on the community benefit activities undertaken by the trust in the preceding year and information describing the results or outcomes of the trust’s community benefit activities. The report shall also include the means used to solicit the views of the community served by the trust, identification of community groups, members of the public, and local government officials consulted on the development of the plan, and an evaluation of the plan’s effectiveness.



V. (a) To the extent practicable, the plan shall include:

(1) An estimate of the cost of each activity expected to be undertaken or supported in the ensuing year; and

(2) A report on the unreimbursed cost of each activity undertaken in the preceding year.

(b) For reporting purposes, the cost of contributed services shall be determined in accordance with the rates, costs, units of service, or other statistical measures used for general accounting purposes by the health care charitable trust. In addition, each charitable trust shall include in its report the ratio of its gross receipts from operations to its net operating costs, as shown in its final statement of accounts for the preceding fiscal year.

VI. The process for development of the plan shall include an opportunity for members of the public in the trust's service area to provide input into development of the plan and comment upon the trust's proposed plan.

7:32-f Community Needs Assessment. – Every health care charitable trust shall, either alone or in conjunction with other health care charitable trusts in its community, conduct a community needs assessment to assist in determining the activities to be included in its community benefits plan. The needs assessment process shall include consultation with members of the public, community organizations, service providers, and local government officials in the trust's service area, in the identification and prioritization of community needs that the health care charitable trust can address directly, or in collaboration with others. The community needs assessment shall be updated at least every 5 years.

7:32-h Charity Care. – The provision of charity care may be included in a community benefits plan by a health care charitable trust only to the extent that it:

I. Does not include any sums identified as bad debt, a receivable, or revenue by the trust in accordance with generally accepted accounting principles.

II. Is provided in accordance with a written policy which is available to the public, which allows any individual to make application and receive a prompt decision on eligibility for and the amount of charity care, and notice of which is prominently displayed in the trust's lobby, waiting rooms, or other area of public access or otherwise is provided to service applicants and recipients who are served in their own homes or in locations other than a facility of the trust.

7:32-j Exemption. – If the total value of the fund balances of a health care charitable trust do not exceed \$100,000, the trust shall have no obligation to comply with the provisions of this subdivision. In addition, those health care charitable trusts for which compliance would be a financial or administrative burden, according to criteria established and administered by the director of charitable trusts, may request an exemption from the provisions of this subdivision.



An exemption, if granted, shall be valid for 3 years from the date of issuance unless it is revoked by the director of charitable trusts and written notice of such revocation is provided to the health care charitable trust.

Texas

Tex. Property Tax Code Ann. §11.18(d)(3)

(<http://www.statutes.legis.state.tx.us/Docs/TX/htm/TX.11.htm>)

(d) A charitable organization must...engage exclusively in performing one or more of the following charitable functions:

- (1) ...;
- (2) ...;
- (3) providing support without regard to the beneficiaries' ability to pay to:
 - (A) elderly persons, including the provision of:
 - (i) recreational or social activities; and
 - (ii) facilities designed to address the special needs of elderly

persons; ...

Pennsylvania

10 Pa. Cons. Stat. §375

(http://www.dos.state.pa.us/portal/server.pt/community/charities/12444/the_institutions_of_purely_public_charity_act/571856)

(d) Community service.--

(1) The institution must donate or render gratuitously a substantial portion of its services. This criterion is satisfied if the institution benefits the community by actually providing any one of the following:

(i) Goods or services to all who seek them without regard to their ability to pay for what they receive if all of the following apply:

(A) The institution has a written policy to this effect.

(B) The institution has published this policy in a reasonable manner.

(C) The institution provides uncompensated goods or services at least equal to 75% of the institution's net operating income but not less than 3% of the institution's total operating expenses.



(ii) Goods or services for fees that are based upon the recipient's ability to pay for them if all of the following apply:

(A) The institution can demonstrate that it has implemented a written policy and a written schedule of fees based on individual or family income. An institution will meet the requirement of this clause if the institution consistently applies a formula to all individuals requesting consideration of reduced fees which is in part based on individual or family income.

(B) At least 20% of the individuals receiving goods or services from the institution pay no fee or a fee which is lower than the cost of the goods or services provided by the institution.

(C) At least 10% of the individuals receiving goods or services from the institution receive a reduction in fees of at least 10% of the cost of the goods or services provided to them.

(D) No individuals [FN1] receiving goods or services from the institution pay [FN2] a fee which is equal to or greater than the cost of the goods or services provided to them, or the goods or services provided to the individuals described in clause (B) are comparable in quality and quantity to the goods or services provided to those individuals who pay a fee which is equal to or greater than the cost of the goods or services provided to them.

(iii) Wholly gratuitous goods or services to at least 5% of those receiving similar goods or services from the institution.

(iv) Financial assistance or uncompensated goods or services to at least 20% of those receiving similar goods or services from the institution if at least 10% of the individuals receiving goods or services from the institution either paid no fees or fees which were 90% or less of the cost of the goods or services provided to them, after consideration of any financial assistance provided to them by the institution.

(v) Uncompensated goods or services which in the aggregate are equal to at least 5% of the institution's costs of providing goods or services.

(vi) Goods or services at no fee or reduced fees to government agencies or goods or services to individuals eligible for government programs if any one of the following applies:

(A) The institution receives 75% or more of its gross operating revenue from grants or fee-for-service payments by government agencies and if the aggregate amount of fee-for-service payments from government agencies does not exceed 95% of the institution's costs of providing goods or services to the individuals for whom the fee-for-services payments are made.

(B) The institution provides goods or services to individuals with mental retardation, to individuals who need mental health services, to members of an individual's family or guardian in support of such goods or services or to individuals who are dependent, neglected or delinquent children, as long as the institution performs duties that would otherwise be the responsibility of



government and the institution is restricted in its ability to retain revenue over expenses or voluntary contributions by any one of the following statutes or regulations or by contractual limitations with county children and youth offices in this Commonwealth:

(I) Sections 1905(d) and 1915(c) of the Social Security Act (49 Stat. 620, 42 U.S.C. §§ 1396d(d) and 1396n(c)).

(II) 42 CFR 440.150 (relating to intermediate care facility (ICF/MR) services).

(III) 42 CFR Pt. 483 Subpt. I (relating to conditions of participation for intermediate care facilities for the mentally retarded).

(IV) The act of October 20, 1966 (3rd Sp.Sess., P.L. 96, No. 6), [FN3] known as the Mental Health and Mental Retardation Act of 1966.

(V) Articles II, VII, IX and X of the act of June 13, 1967 (P.L. 31, No. 21), [FN4] known as the Public Welfare Code.

(VI) 23 Pa.C.S. Ch. 63 (relating to child protective services).

(VII) 42 Pa.C.S. Ch. 63 (relating to juvenile matters).

(VIII) 55 Pa. Code Chs. 3170 (relating to allowable costs and procedures for county children and youth), 3680 (relating to administration and operation of a children and youth social service agency), 4300 (relating to county mental health and mental retardation fiscal manual), 6400 (relating to community homes for individuals with mental retardation), 6500 (relating to family living homes), 6210 (relating to participation requirements for the intermediate care facilities for the mentally retarded program), 6211 (relating to allowable cost reimbursement for non-State operated intermediate care facilities for the mentally retarded) and 6600 (relating to intermediate care facilities for the mentally retarded).

(vii) Fundraising on behalf of or grants to an institution of purely public charity, an entity similarly recognized by another state or foreign jurisdiction, a qualifying religious organization or a government agency and actual contribution of a substantial portion of the funds raised or contributions received to an institution of purely public charity, an entity similarly recognized by another state or foreign jurisdiction, a qualifying religious organization or a government agency.



Minnesota

Minn. Stat. Ann. §272.02, Subd. 90 (Nursing homes)

<https://www.revisor.mn.gov/statutes/?id=272&view=chapter#stat.272.02>

A nursing home ... that is exempt from federal income taxation pursuant to section 501(c)(3) of the Internal Revenue Code is exempt from property taxation if the nursing home ... either:

(1) is certified to participate in the medical assistance program under title 19 of the Social Security Act; or

(2) certifies to the commissioner of revenue that it does not discharge residents due to the inability to pay.



Appendix C. Nonprofit Nursing Homes in Study Population

This appendix is an inventory of nonprofit nursing homes used in this study.¹⁴ It contains the (1) name, address, city, state, zip code, and approximate count of beds (as reported on cost reports) and (2) mission statement and reason for public charity status (as reported on IRS Form 990, Schedule A). Of the nursing homes with a Form 990 publicly accessible (33), roughly two-thirds had Box 9 checked as their reason for public charity status – where the organization receives more than 33 1/3 of its support through gifts, grants, contributions, membership fees, and gross receipts relating to their exempt function.¹⁵ This reason for public charity status can be a reflection of the organization’s federal tax-exempt determination letter from the IRS or be different. The IRS does not make any changes to an organization’s public charity status based on what it reports in this section.¹⁶ Thus, the reason for public charity could have changed between this information and the time of this report. Table 1C describes Box 1, 3, 7, and 9. Table 2C is the inventory of nursing homes in this study.

¹⁴ Please see Appendix E. Methodology for process of identifying nonprofit nursing homes for study population.

¹⁵ Internal Revenue Service (2011). *Schedule A: Public Charity Status and Public Support*. Retrieved from <http://www.irs.gov/pub/irs-pdf/f990sa.pdf>.

¹⁶ Internal Revenue Service (2012). *Specific Instructions: Part I. Reason for Public Charity Status*. Retrieved from <http://www.irs.gov/instructions/i990sa/ch02.html#d0e111>.



Table 1C. Reasons for Public Charity Status Used by Study Population

Reason for Public Charity Status	Description
Box 1	The organization is a church, convention of churches, or association of churches. Section 170(b)(1)(A)(i). Retrieved from http://www.law.cornell.edu/uscode/text/26/170
Box 3	The organization has a principle function of providing medical or hospital care or medical education or medical research, if the organization is a hospital, or if the organization is a medical research organization directly engaged in the continuous active conduct of medical research in conjunction with a hospital, and during the calendar year in which the contribution is made such organization is committed to spend such contributions for research before January 1 of the first calendar year which begins after the date such contribution is made. Retrieved from http://www.law.cornell.edu/uscode/text/26/170
Box 7	The organization is a "corporation, trust, or community chest, fund or foundation" created or organized in the U.S. and exclusively for religious, charitable, scientific, literary, or education purposes, or to foster national or international amateur sports competition, or for the prevention of cruelty to children or animals that receives part of its support (exclusive of income received in the exercise or performance by such organization of its charitable, education, or other purpose or function constituting the bases for its exemption) from the a governmental entity or from direct or indirect contributions from the general public. Retrieved from http://www.irs.gov/instructions/i990sa/ch02.html
Box 9	The organization receives more than 33 1/3 of its support from any combination of gifts, grants, contributions, membership fees, and gross receipts relating to their exempt function. In addition, the organization does not receive more than 33 1/3 of its support from gross investment income and unrelated business taxable income. Retrieved from http://www.irs.gov/irm/part7/irm_07-026-004.html



Table 2C. Inventory of Nonprofit Nursing Homes in Study Population

Reported on DHMH Cost Reports						Reported on Form 990				
						Mission Statement				Box 1
Name	Address	City	State	ZIP	Number of Beds					
CALVERT COUNTY NURSING CENTER	85 HOSPITAL ROAD	PRINCE FREDERICK	MD	20678	149	Calvert County Nursing Center, Inc operates a 149 bed comprehensive care nursing center located in Calvert County, Maryland				x
CAROLINE NURSING HOME	520 KERR AVENUE	DENTON	MD	21629	95	Elderly and Physically Handicapped				x
CHARLES COUNTY NURSING & REHAB CENTER	10200 LA PLATA ROAD	LA PLATA	MD	20646	165	Charles County Nursing and Rehabilitation Center, Inc operates a 165 bed comprehensive care nursing home center, a 63-slot adult day care center and a 32 bed assisted living facility located in Charles County, Maryland				x
CHESTER RIVER MANOR	200 MORGNEC ROAD	CHESTERTOWN	MD	21620	98	To provide health care services to meet residents' individual needs and those of their families, and community needs by assisting residents to maintain their highest level of well-being				x
COFFMAN NURSING HOME	1304 PENNSYLVANIA AVENUE	HAGERSTOWN	MD	21740	59	To provide nursing care for the elderly			x	
COPPER RIDGE	710 OBRECHT ROAD	SYKESVILLE	MD	21784	66	Nonprofit facility to care for older people with Alzheimer's and other memory-impairing illnesses				x
COURTLAND GARDENS NURSING & REHAB CENTER	7920 SCOTTS LEVEL ROAD	BALTIMORE	MD	21208	151	Care for Elderly and Disabled				x
CRESCENT CITIES CENTER	4409 EAST WEST HIGHWAY	RIVERDALE	MD	20737	140	The Taxpayer owns and operates a long-term care facility. The Taxpayer educates medical students in the care of the elderly				x

¹⁷ Note: The reason can be the same as stated in the organization's tax-exempt determination letter from the IRS or subsequent IRS determination letters, or it can be different. Retrieved from <http://www.irs.gov/instructions/i990sa/ch02.html>.



Reported on DHMH Cost Reports						Reported on Form 990				
						Mission Statement				Box 1
Name	Address	City	State	ZIP	Number of Beds					
FROSTBURG NURSING AND REHAB CENTER (owned by Western Maryland Health System Corporation)	48 TARN TERRACE	FROSTBURG	MD	21532	88	The mission of Western MD Health System is to improve the health status and quality of life of the individuals and the communities served, especially those in need - Superior care for all we serve		x		
GLADYS SPELLMAN SPECIALTY HOSPITAL & NURSING CENTER (owned by Dimensions Health Corporation)	2900 MERCY LANE	CHEVERLY	MD	20785	61	Our stated mission is to provide high quality, efficient healthcare services to preserve, restore, and improve the health status of our community		x		
GOOD SAMARITAN NURSING CENTER	1601 E. BELVEDERE AVENUE	BALTIMORE	MD	21239	146	Provision of Long Term Care and Rehabilitative Services				x
HARBORSIDE NURSING & REHAB CENTER (Form 990 states Ravenwood Healthcare Inc)	501 W. FRANKLIN STREET	BALTIMORE	MD	21201	190	To provide nursing care				x
HARTLEY HALL NURSING HOME	1006 MARKET STREET	POCOMOKE	MD	21851	73	Hartley Hall Nursing Home is a not-for-profit organization incorporated in the State of Maryland to provide skilled nursing services to the lower Eastern Shore counties of Maryland and Virginia			x	
HEBREW HOME OF GREATER WASHINGTON	6121 MONTROSE ROAD	ROCKVILLE	MD	20852	556	Not clear			x	
HOLY CROSS REHAB & NURSING CENTER	3415 GREENCASTLE ROAD	BURTONSVILLE	MD	20866	145	Providing long-term care and rehabilitative for the elderly				x



Reported on DHMH Cost Reports						Reported on Form 990				
						Mission Statement				Box 1
Name	Address	City	State	ZIP	Number of Beds					
JOHNS HOPKINS BAYVIEW CARE CENTER	5505 HOPKINS BAYVIEW CIRCLE	BALTIMORE	MD	21224	150	Johns Hopkins Bayview Medical Center, a member of Johns Hopkins Medicine, provides compassionate health care that is focused on the uniqueness and dignity of each person we serve we offer this care in an environment that promotes, embraces and honors the diversity of our global community with a rich and long tradition of medical care, education and research, we are dedicated to providing and advancing medicine that is respectful and nurturing of the lives of those we touch		x		
KESWICK MULTICARE CENTER	700 W. 40TH STREET	BALTIMORE	MD	21211	242	Long Term Health Care for Seniors		x		
LEVINDALE HEBREW GERIATRIC CENTER	2434 W. BELVEDERE AVENUE	BALTIMORE	MD	21215	172	Levindale is a geriatric center and hospital dedicated to providing superior service in a cost effective manner for the aged, frail, and ill in institutional, community and home settings.		x		
ROCK GLEN NURSING AND REHAB CENTER	10 N. ROCK GLEN ROAD	BALTIMORE	MD	21229	115	To provide comprehensive care nursing services				x
ROCKVILLE NURSING HOME	303 ADCLARE ROAD	ROCKVILLE	MD	20850	100	To develop and operate a nursing home which provided nursing care to the elderly				x
SACRED HEART HOME	5805 QUEENS CHAPEL ROAD	HYATTSVILLE	MD	20782	102	102 bed licensed nursing home in Hyattsville, Maryland that provides nursing care services to its residents				x
SLIGO CREEK NURSING AND REHAB CENTER	7525 CARROLL AVENUE	TAKOMA PARK	MD	20912	102	We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing				x
ST. ELIZABETH REHAB & NURSING CENTER (Form 990 states De Paul House Inc)	3320 BENSON AVENUE	BALTIMORE	MD	21227	162	To provide quality, accessible and affordable housing and services in a caring and supportive environment to people 62 years of age or older				x
ST. MARY'S NURSING CENTER	21585 PEABODY STREET	LEONARDTOWN	MD	20650	200	To provide long and short term nursing and rehabilitative care to seniors				x



Reported on DHMH Cost Reports						Reported on Form 990				
						Mission Statement				Box 1
Name	Address	City	State	ZIP	Number of Beds					
STELLA MARIS	2300 DULANEY VALLEY ROAD	TIMONIUM	MD	21093	412	In the tradition of the sisters of Mercy, Stella Maris provides comprehensive range of health and housing services for the compassionate care of the elderly, the sick and the dying.				x
VILLA ROSA NURSING HOME	3800 LOTTSFORD VISTA ROAD	MITCHELLVILLE	MD	20721	101	To provide residence and nursing care for the elderly	x			
WILLIAMSPORT NURSING HOME (Form 990 states Brooke Grove Foundation, Inc)	154 N. ARTIZAN STREET	WILLIAMSPORT	MD	21795	99	Long-Term Health Care for the Elderly and Disabled				x
ALICE BYRD TAWES NURSING HOME (Form 990 states McCready Foundation)	201 HALL HIGHWAY	CRISFIELD	MD	21817	69	Hospital, Nursing Home		x		
LITTLE SISTERS OF THE POOR	601 MAIDEN CHOICE LANE	BALTIMORE	MD	21228	42	Taken from Schedule O - Little Sisters of the Poor care for the elderly, poor in the spirit of humble service which was received from Jeanne Jugan. They welcome the elderly as they would Jesus Christ himself and serve them with love and respect until death. The organization operates a home in Baltimore County, Maryland which provides nursing and residential care for the needy elderly. The home is part of the international congregation of the Little Sisters of the Poor, which was founded in France in 1839 and serves the elderly in 32 countries.				x
MARYLAND BAPTIST AGED HOME	2801 RAYNER AVENUE	BALTIMORE	MD	21216	29	Long Term Care Facility for the Elderly				x
BRADFORD OAKS NURSING & RETIREMENT CENTER	7520 SURREATTS ROAD	CLINTON	MD	20735	180	We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing				x



Reported on DHMH Cost Reports						Reported on Form 990				
						Mission Statement				Box 1
Name	Address	City	State	ZIP	Number of Beds	Reason for Public Charity Status (and not a private foundation) ¹⁷				
FAIRLAND NURSING & REHAB CENTER	2101 FAIRLAND ROAD	SILVER SPRING	MD	20904	92	We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing				x
GLADE VALLEY NURSING & REHAB CENTER	56 W. FREDERICK STREET	WALKERSVILLE	MD	21793	124	We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing				x
SHADY GROVE ADVENTIST NURSING & REHAB CENTER	9701 MEDICAL CENTER DRIVE	ROCKVILLE	MD	20850	130	We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing				x
SPRINGBROOK ADVENTIST NURSING & REHAB CENTER	12325 NEW HAMPSHIRE AVENUE	SILVER SPRING	MD	20904	91	We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing				x



Appendix D. Data Sources

The data sources that were used to conduct this study are described below.

A. DHMH Cost Reports

As part of its rate-setting process, DHMH requires nursing facilities who participate in Medicaid to submit standardized cost reports on an annual basis. These cost reports present revenues and expenses for the nursing home and other lines of business and non-operating revenues (including contributions). Each tax-exempt nursing home's audited 2010 cost report was used as the basis for estimating sales and income taxes as well as to estimate the value of lost contributions. The majority of the facilities included in this study report for the twelve-month period ending in July of 2010. Two facilities report for a twelve-month period ending in February of 2010, and seven report for the period ending in December of 2010. Six facilities had cost reports that covered an eleven-month period ending in November, rather than December, of 2010.

B. DHMH Appraisals

Appraisals of nursing facilities are conducted on a rolling three-year basis. The appraisals value land, buildings and equipment. For the purposes of the study, the value of land and buildings was subjected to applicable real property tax rates and equipment was subjected to applicable personal property tax rates.

C. DHMH Wage Survey

The annual DHMH wage and salary survey provides data on the number of employees, both staff and agency, at each facility during a selected two week period every year. That information is the basis for calculating the Federal Unemployment Tax Act (FUTA).

D. IRS Form 990

The IRS Form 990 is a required return for all nonprofit entities, filed annually. Unlike the DHMH cost reports, which include data for the nursing home only (except in the case of CCRC's, which we excluded for this reason), the 990 may include data for additional entities. For example, if a hospital owns and operates a nursing home, its form 990 will include revenues, expenses etc. for both the hospital and nursing home. As with the DHMH cost report, the majority of the facilities studied report for a 12 month period ending in July of 2010, several report for the period ending in December of 2010 and few report for periods ending in either February or November of 2010. The timeframes for both the DHMH cost report and the IRS Form 990 coincide on a facility-by-facility basis except for those facilities whose cost report periods ended in November of 2010 but whose 990s ended in December of 2010.



E. Maryland’s Revenue Structure – Legislative Handbook Series Volume III Maryland General Assembly, 2010

These handbooks state the Maryland corporate income, sales, and real property tax rates for Maryland. They were used to estimate nursing home taxes.

F. Maryland Local Government – Legislative Handbook Series Volume VI Maryland General Assembly, 2010

These handbooks state the local corporate real and personal property tax rates for each Maryland county and Baltimore City. They also list other local taxes and rates charged by these entities. These handbooks were used to estimate nursing home taxes.

G. IRS Instructions for Form 1120

IRS Form 1120 is the U.S. Corporation Income Tax Return. The federal tax rates were taken from the Form 1120 instructions and are shown below.¹⁸

Federal Corporation Tax Rates

Taxable Income (\$)	Tax Rate
0 to 50,000	15%
50,000 to 75,000	25%
75,000 to 100,000	34%
100,000 to 335,000	39%
335,000 to 10,000,000	34%
10,000,000 to 5,000,000	35%
15,000,000 to 18,333,333	38%
18,333,333 and up	35%

¹⁸ Internal Revenue Service. (n.d.). *2011 Instructions for Form 1120*. Retrieved from <http://www.irs.gov/pub/irs-pdf/i1120.pdf>



Appendix E. Methodology

A. Determination of the Study Population

To be included in the study, a nursing home needed to meet several criteria. First, the facility must have been a nonprofit during the study period (2010). Facilities often change ownership which can be accompanied by a change in tax status. Determining tax status included using CMS records and searching for IRS Form 990's for each facility, which are required of all nonprofit entities. DHMH provided final verification of a facilities nonprofit status. Second, each facility had to have a cost report and wage survey for the period examined (2010). Cost reports in particular were critical in estimating the value of the tax benefit. These cost reports generally coincided with the timeframe of the facility's form 990 except for several facilities whose cost reports covered an eleven-month period. These conditions resulted in a study population of 36 facilities.

B. Federal Unemployment Tax Act (FUTA)

The Federal Unemployment Tax Act (FUTA) rate is 0.8 percent of the first \$7,000 for each employee (\$56.00). The DHMH wage and salary survey provides the total number of regular and agency staff during a given two week period each year. Therefore the survey is not inclusive of changes in staffing that would occur throughout the year. However, it is acknowledged in our analysis that some of the employees listed on the survey terminated employment before reaching the full \$56.00, and that some additional employees began employment after the survey was conducted, but the exact extent of these fluctuations in employment are unknown. For the purpose of this estimation, total regular employees listed on the survey (excluding agency personnel), multiplied by 95 percent, multiplied by \$56.00, is used to estimate FUTA.

Both for-profit and nonprofit hospitals pay state unemployment tax.

C. Sales Tax Liability

To estimate sales tax liability, Hilltop enlisted the help of Myers and Stauffer to identify fields within the cost reports that would be subject to sales tax. Expense fields within schedules A, E, F and G were identified and subjected to Maryland's 6 percent sales tax. Additional fields within the cost reports may include costs subject to sales tax, but because they may also include non taxable expenses, they were not included.

D. Property Tax Liability

Maryland's real property tax rate is .112 percent of assessed real property value. In addition to state real property tax, every Maryland county and Baltimore City also tax real property. Unlike



the state, all but five counties (Frederick, Garrett, Kent, Queen Anne's, and Talbot) also tax personal property.

Nonprofits are exempted from state and local real property taxes as well as local real and personal property taxes. To estimate property tax liability, Hilltop utilized DHMH appraisals rather than Maryland State Department of Assessments and Taxation (SDAT) assessed values, which are the values used by the state of Maryland and local governments for tax collection.

SDAT assessments do not include assessments of personal property and may include real property not directly related to the nursing facility. The DHMH appraisals value land, buildings, and equipment. The appraisals are conducted on a rolling three-year basis. While not exact, these appraisals provide a closer estimate of property values relating directly to the nursing facility.

For the purposes of the study, the value of land and buildings at the time of the appraisal were subjected to the corresponding year's real property tax rates. Equipment values were subjected to applicable personal property tax rates in the same manner.

Due to the rolling basis of DHMH appraisals, Hilltop's analysis included three years of county tax rates: 2008-2009, 2009-2010, and 2010-2011. This information was retrieved from the following sources:

- http://www.dat.state.md.us/sdatweb/stats/08_taxrate.html
- http://www.dat.state.md.us/sdatweb/stats/09_taxrate.html
- http://www.dat.state.md.us/sdatweb/stats/10_taxrate.html

E. Lost Contributions

It is common for nonprofits, including nonprofit nursing facilities, to receive contributions from donors. The donors can deduct the contribution from their personal taxes because of the nonprofits tax-exempt status. If a nonprofit nursing home were to become a for-profit, there would be no tax advantage in contributing to the nursing home. It is likely that donors would re-direct their contributions to another nonprofit entity such as a hospital or church and that the nursing home revenue from contributions would likely disappear. For this analysis, it is assumed that revenue from contributions would be zero for all hospitals.

To estimate the value of contributions lost, the value of Grants, Endowments and Trusts listed on Schedule I of the DHMH cost report were included. Additionally, a section for miscellaneous income allows facilities to detail additional revenue. Revenue within this section labeled as contributions, donations, donated commodities/services were also included. In some instances it was necessary to reconcile contributions listed on schedule I of the cost report with contributions and grants listed on a facility's IRS form 990. One such instance involved a large contribution listed as a property transfer on Schedule I, but listed on the facilities 990 under the category of



contributions and grants. While all efforts were made to assure that only the correct contributions were included, the nature of the miscellaneous section of Schedule I make a 100% match impossible.

F. Miscellaneous Local Taxes

Nonprofit nursing facilities also enjoy exemption from several local taxes. For example, Baltimore City taxes commercial electricity as well as wireless and land telephone lines monthly. Given the data that are available, it is simply impossible to estimate the value of these miscellaneous local taxes. For purposes of this analysis, each nursing home is shown as paying \$1,000 total for the year. That figure is lower than even the smallest facility would pay; it is included only as a reminder that these taxes exist rather than as an actual estimate of what would be paid by the nursing home.

G. Federal Income Tax Liability

To determine the amount subject to federal corporate income tax, the net income as reported on Schedule A, line 17 of the cost report by each nonprofit nursing home is reduced by:

- I. Sales Tax
- II. FUTA
- III. Property Tax
- IV. Lost Contributions
- V. Miscellaneous Local Taxes

That amount is then subject to the federal tax rates shown previously. It should be noted that line 17, “Net income (Loss) per financial statements” may include revenues and or expenses for other lines of business.

H. State Income Tax Liability

The amount of income taxable by the state is reduced by the federal income tax paid. That amount is then subject to Maryland’s 8.25 percent corporate income tax.¹⁹

¹⁹ Department of Legislative Services. (2010). *Maryland’s revenue structure*. Legislative Handbook Series, Vol. 3. Retrieved from http://mlis.state.md.us/2010rs/misc/Legislative_Handbooks/Volume_III.pdf



Appendix F. States with Charitable Standards for Nursing Homes

Research has identified only a small number of states that specifically impose specific charitable obligations on nursing homes: New Hampshire, Utah, Pennsylvania, Minnesota, and Texas. Table 1F is a summary comparison of the laws in these states.²⁰

Table 1F. States with Charitable Standards for Nursing Homes

	New Hampshire	Utah	Pennsylvania	Minnesota	Texas
	Nonprofit Nursing Homes (Health care charitable trusts)	Nonprofit Nursing Homes	Nonprofit Nursing Homes “Institutions of purely public charity”	Nonprofit Nursing Homes “Institutions of purely public charity”	Nonprofit Nursing Homes “Charitable Organization”
Specific requirement applicable to nursing homes?	Yes, community benefit-like activities required.	Yes, a “gift” to the community must exceed the value of the property tax liability.	Yes, donate or render gratuitously a substantial portion of their services.	Yes, must be certified to participate in Medicaid/Medicare or certify that it does not discharge residents due to inability to pay, in order to receive exemption from property tax.	Nonprofit nursing home is a charitable organization, and therefore eligible for property tax exemption, if it provides activities and facilities to address the special needs of the elderly, without regard to the beneficiaries’ ability to pay.
Mandatory Minimum Requirement?	No	Yes. Must exceed the value of its	Yes, 6 different minimum	No	No

²⁰ See also Appendices C and D.



	New Hampshire Nonprofit Nursing Homes (Health care charitable trusts)	Utah Nonprofit Nursing Homes	Pennsylvania Nonprofit Nursing Homes “Institutions of purely public charity”	Minnesota Nonprofit Nursing Homes “Institutions of purely public charity”	Texas Nonprofit Nursing Homes “Charitable Organization”
		property tax liability.	contribution formulas in the statute.		
Reporting Requirement	Yes	Yes	Yes	No	Unclear
Requirement set forth within property tax exemption	No	Yes	No	Yes	Yes

Studies in Washington

Research identified only two studies that estimate the value of state tax exemptions for the purpose of considering the value of community benefits provided by nonprofit nursing homes. Both are 2007 studies of Washington State nonprofit nursing homes. The two studies reflect similar estimates on the total value of property tax savings. However, one study, conducted by a collaboration of nonprofit organizations, also considered a category—a “Business and Occupancy” tax break—that the other study by state legislature staff did not address. Neither study attempted to quantify the value of community benefits provided.

The first study, released in January of 2007 by the Northwest Federation of Community Organizations (NWFCO)²¹ and the Washington Community Action Network (WCAN)²² and titled *Charitable Mission Unknown: Nonprofit Nursing Homes Fall Short of Community Benefit Standards* (the Advocacy Group Study), posits that:

²¹ NWFCO described itself as a regional federation of four statewide, community-based social and economic justice organizations located in the states of Idaho, Montana, Oregon, and Washington.

²² WCAN described itself as a statewide grassroots organization with over 50,000 members, making it the largest consumer advocacy group in the state.



- Washington nonprofit nursing homes enjoyed financial advantages over for-profits
- Evidence that tax subsidies benefitted the community was unclear
- Washington nonprofit nursing homes lagged behind in serving the poor
- Tax subsidies were available to nursing homes for the wealthy
- It was difficult to identify what other community benefits Washington nonprofit nursing homes offered²³

This Advocacy Group Study estimated the business and occupation tax savings and the real estate tax savings for Washington nonprofit nursing homes as indicated in Table 2F.

Table 2F. Tax Savings for Washington Nonprofit Nursing Homes, 2005

Year	Business and Occupation Tax Break	Real Estate Tax Break	Total State Tax Break
2005	\$5,617,014	\$3,041,255	\$8,658,269

In November of 2007, the Washington State Legislature Joint Legislative Audit and Review Committee (JLARC) issued a report entitled *2007 Expedited Tax Preference Performance Reviews* (referred to here as the JLARC Report).²⁴ The JLARC Report reviewed a number of tax preferences, including the one for nonprofit nursing homes. It identified the state and local property tax savings for nonprofit nursing homes as indicated in Table 3F.

²³ The Advocacy Group Study also acknowledged that some nursing homes provided good examples of ways to fulfill their social responsibility and that it was possible that some community benefits were being delivered, unreported by other nonprofit nursing homes.

²⁴ In 2006, the Washington State legislature passed legislation requiring periodic review of tax preferences so as to determine whether their continued existence or modification served the public interest (Washington State Engrossed House Bill 1069). The legislature assigned responsibility for conducting the reviews to the staff of the Joint Legislative Audit and Review Committee, which operated under the authority of a Legislative Auditor directed to ensure that JLARC studies were conducted in accordance with Generally Accepted Government Auditing Standards.



Table 3F. Tax Savings for Washington Nonprofit Nursing Homes, 2006-2007

Year	State Property Tax Savings	Local Property Tax Savings	Total Property Tax Savings
2006-2007	\$510,000	2,320,000	\$2,830,000

The JLARC Report did not address savings derived from a business and occupation tax break, resulting in lower total valuation of the tax exemption than that reported in the Advocacy Group Study.

The JLARC Report did, however, raise the following key question for consideration by the Legislature: “Is there any readily available evidence related to the achievement of important policy objectives?” This question incorporated the following considerations:

- Whether—at least for purposes of property tax—policy objectives for nursing homes are the same as for hospitals
- Whether the nursing homes provide a benefit to the public and relieve the state of expense
- Whether the property tax exemption should apply only to property used exclusively for nursing home purposes

The JLARC Report concluded with two recommendations:

- If the Legislature wants information on community service/community benefit activities performed by nursing homes, then it should require nursing homes to report an annual community service inventory
- If the Legislature intends to continue the nonprofit nursing home property tax exemption under the assumption that these organizations are providing more charity or low-income care than other nursing homes, then the Legislature should modify the property tax exemption to be dependent on meeting a threshold of charity or low-income care

Each of these recommendations would have required new legislation, but no such legislation was ever adopted.





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