

I. INTRODUCTION

A. History and Background of The Cleveland Clinic Foundation

A brief history of The Cleveland Clinic Foundation (“CCF” or “Cleveland Clinic”) is necessary to provide background and context for the materials that follow. The Cleveland Clinic was founded in 1921 in Cleveland, Ohio by four physicians who envisioned a group practice in which individual members would share clinical expertise and specialization and dedicate themselves to the education of future medical practitioners, and where innovations in medical procedures and practices would be encouraged through basic and applied research activities.

The Cleveland Clinic began with a staff of six surgeons, one radiologist, four internists and one biophysicist. As early as 1921, they recognized that medicine was far too complex for any one person to fully comprehend and that it would be in the best interests of patients if the resources and talents of multiple specialties were pooled for the development and application of the best medical techniques. The four founders also envisioned a corporate structure that would support their vision and one which involved the oversight and direction by a separate board of community trustees in matters unrelated to patient and medical practice issues. The original clinic facility was located on the near east side of Cleveland, in the area where the main campus of CCF is located today. In 1924, CCF opened its first hospital on property near the original clinic facility. To this day, although larger and broader in scope, CCF continues to operate as an integrated and cooperative group practice, as an academic medical center and as an active research institute.

From 1921 to the present, the Cleveland Clinic has always employed and salaried its physicians and Ph.D. scientific investigators without incentive compensation. CCF currently employs more than 1,500 physicians in 80 clinical specialties and subspecialties and approximately 250 faculty level scientists working as part of CCF’s research institute. Specialization and subspecialization have characterized the practice and growth of CCF, while its commitment to the integration of research and education into a dynamic healthcare practice has allowed CCF and its physicians and researchers to make many important contributions to the practice of medicine over the years. A summary of many such key contributions is included on pages A.4 through A.6 of Appendix A, included as Attachment A.1.

The *U.S. News and World Report’s* 2005 Annual Report of America’s Best Hospitals again ranked CCF as the fourth best hospital in the United States and has consistently ranked the hospital in the top six for the last 15 years. Moreover, this report has named the Cleveland Clinic’s Heart Center best in the United States each of the past eleven years. Ten other medical specialties at CCF are also ranked in the nation’s Top 10 in 2005; namely, Urology (No. 2), Digestive Disorders (No. 2), Rheumatology (No. 4), Orthopedics (No. 5), Kidney Disease (No. 6), Neurology & Neurosurgery (No. 6), Ear,

Nose & Throat (No. 7), Hormonal Disorders (No. 8), and Respiratory Disorders (No. 10).

B. Development of the Cleveland Clinic Health System

In the late 1980's, CCF leadership recognized a need to enhance health care provided in the regions where the patients they serve live, by coordinating and integrating care to a broader spectrum of the community. To this end, CCF embarked on the development of the Cleveland Clinic Health System ("CCHS" or "Health System") first by developing satellites throughout Northeastern Ohio to deliver geographically distributed primary care and select specialty services, and finally by affiliating with several well-established Cleveland community hospitals and hospital systems. Expansion activities in fast-growing areas of Florida, allowing for further geographic diversity, commenced during this same time period.

The Cleveland Clinic is the parent organization of the Health System, an integrated health system consisting of an academic medical center, community hospitals, family health centers, various ancillary services, and a large group of physicians and physician researchers, as described in more detail below. Development of the Health System has provided opportunities to deliver the best possible healthcare, to implement uniform quality standards throughout the system, and to promote efficient and effective use of shared resources by the individual member hospitals.

An example of the success of this model is the Quality Institute founded by CCHS in 1998 to measure and continuously enhance the quality of care throughout CCHS. Teams of doctors, nurses and others identify quality measures for patient conditions commonly treated at CCHS facilities. The Quality Institute collects data about these conditions to ensure CCHS hospitals and clinicians are meeting expected levels of quality. In 1999, CCHS was the first health system in Northeast Ohio accredited as a system by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). JCAHO is our nation's largest accreditor of health care organizations. All of the hospitals, outpatient clinics and home health care programs in the CCHS are accredited by the JCAHO under its hospital accreditation program. In 2001 and 2003, the JCAHO awarded CCHS the coveted Ernest A. Codman Award for demonstrating successful use of data for measuring and improving the quality and safety of health care. In 2001, the award recognized CCHS's initiative to improve the use of ACE inhibitors and, in 2003, for a stroke quality improvement program.

In addition, in September 2004, CCF was awarded a 2004-2005 Consumer Choice Award from National Research Corporation ("NRC"). Healthcare consumers surveyed by NRC in Northeast Ohio named CCF as the area's best healthcare provider with the highest quality of service. In 2003, CCF was awarded Magnet status for nursing excellence by the American Nurses Credentialing Center; only one percent (1%) of hospitals nationwide has achieved this status.

Ohio Satellites

In the mid-1990's, the Cleveland Clinic began to develop ancillary outpatient clinics ("Family Health Centers") to provide primary care and select specialty care services in convenient community settings and to support the mission of CCF. Currently there are 14 Family Health Centers serving communities throughout Northeastern Ohio. CCF uses these facilities in support of its charitable activities. More than 300 physicians practicing in 45 different specialties are employed by CCF specifically to work in the Family Health Centers. Specialists from the main CCF campus also routinely see patients in the Family Health Centers.

The CCF charity care policy applies to all medically necessary services provided at the Family Health Centers. Educational and community health programming and patient outcome and other clinical research activities also take place at the Family Health Centers.

Ohio Hospitals

From 1995 through 1998, CCF directed particular attention to establishing strategic alliances with several of Northeast Ohio's best community hospitals and hospital systems:

- In 1995, with Marymount Hospital, then affiliated exclusively with the Sisters of St. Joseph of the Third Order of St. Francis, a Roman Catholic Church congregation, operating a 237-bed, general acute-care hospital in Garfield Heights, Ohio;
- In 1996, with Lakewood Hospital, which operates, in conjunction with the City of Lakewood, a 279-bed, general acute-care hospital in Lakewood, Ohio;
- In 1997, with Fairview Health System (now known as Cleveland Clinic Health System-Western Region), which operates two separate hospitals: Fairview Hospital, a 414-bed, general acute-care hospital located on the border of Fairview Park, Ohio but in the City of Cleveland; and Lutheran Hospital, a 199-bed, general acute-care hospital located on the near west side of Cleveland, Ohio;
- In 1997, with Meridia Health System, (also known as Cleveland Clinic Health System – Eastern Region), a 972-bed hospital system, with four separate hospitals all located on the eastern side of Cuyahoga County, Ohio; and
- In 1998, with Health Hill Hospital (now known as The Cleveland Clinic Children's Hospital for Rehabilitation), a 47-bed, unique children's specialty rehabilitation facility on the near east side of Cleveland, Ohio.

The Cleveland Clinic is the sole member or the sole regular member of the community hospitals and health systems described above. Each of the community hospitals and health systems affiliated with CCHS has long been recognized as a charitable institution, and each operates in furtherance of CCF's far-reaching, three-part charitable mission consisting of *better care for the sick, investigation of their problems and further education of those who serve*. Members of CCHS dedicate substantial resources each and every year in support of this mission. The regional hospitals operate as traditional community hospitals and are served primarily by independent physicians and group physician practices.

All of the Ohio-based CCHS hospitals are located within Cuyahoga County. The Cleveland Clinic main campus, Cleveland Clinic Children's Hospital for Rehabilitation, Fairview Hospital, and Lutheran Hospital are in the city of Cleveland. Huron Hospital, one of the four hospitals within the Meridia Health System, is located in the city of East Cleveland. Euclid Hospital (another member of the Meridia Health System), Lakewood Hospital, Marymount Hospital and South Pointe Hospital (another member of the Meridia Health System) are located in Euclid, Lakewood, Garfield Heights and Warrensville Heights, respectively. Each of these locations is an "inner-ring" Cleveland city suburb, with median household income levels ranging from as low as \$20,542 in East Cleveland, to \$40,527 in Lakewood.

Florida

During the late 1980's, the Cleveland Clinic established an integrated group medical practice on the east coast of Florida as part of its continued efforts to provide primary care and select specialty care services on a geographically dispersed basis. Development in Florida has expanded to the point where today, the Cleveland Clinic maintains a hospital and outpatient medical facility in Naples, Florida and an outpatient medical facility in Weston, Florida, and participates in a partnership that owns and operates a hospital on the same campus as the outpatient medical facility in Weston. (See discussion of Joint Ventures in Part A hereof for further explanation of this partnership.)

C. Information Concerning Response

The following response has been prepared on the basis and in the format of information that is currently maintained by CCF and, as appropriate, CCHS for internal management purposes, for bond financing purposes or for regular state, federal or local government reporting purposes. In the event CCF either does not maintain information in a manner responsive to a particular question or has not retained information for as many years as requested, CCF has endeavored to provide as much relevant information as possible. Further, to the extent possible, CCHS has answered all questions posed. However, the responses do not always appear in the same order as in your letter. We felt that by grouping questions of a similar subject together (such as charity care or joint ventures), we are able to provide a more cohesive response.

In addition, it is important for the Committee to be aware that certain nonprofit class action litigation that is pending in state and federal courts against certain hospitals and hospital systems (including CCHS) imposes unique constraints and burdens in providing the Committee with information which may lose the protection of privilege or would require a response which could compromise available defenses.

As this Committee may know, beginning in July 2004, a small cadre of plaintiffs' attorneys filed virtually identical class action lawsuits against 340 nonprofit hospitals and hospital systems in 21 states, alleging a variety of theories and causes of action aimed at the hospitals' delivery of medical services to the uninsured and underinsured and at the hospitals' corresponding pricing, billing and collection practices. At its core, the lawsuits alleged that the hospitals failed to provide a sufficient level of "charity care" to uninsured patients, thus breaching their obligations as tax-exempt entities, and further alleged that the hospitals engaged in improper and inappropriate billing and collection practices against those patients who could least afford to pay.

While the litigation in U.S. Federal District Courts has met with near uniform rejection of plaintiffs' theories, leading to widespread voluntary and involuntary dismissals, some plaintiffs' attorneys have moved to local state courts and are pursuing their theories there. CCF and CCHS are named in one state court case (the corresponding case in the U.S. District Court for the Northern District of Ohio having been dismissed). Discovery in the state court case is underway and this response to your inquiry has become a target for this discovery.¹

Our concerns are also based in part on the history of statements made by the plaintiffs' attorneys which have mischaracterized information and the law. Given the backdrop of the concurrent litigation and the confidential and proprietary nature of the information sought by certain of the Committee's questions, CCF has prepared the following responses as specifically and thoroughly as possible, but at times, framed in more general terms where necessary.

Confidentiality

CCHS respectfully requests that the enclosed response, as well as the attached documentation, be maintained and used by the Committee strictly on a confidential basis, and that CCHS be informed in advance if this response will be made public.

¹ In the written discovery directed to CCF, the plaintiffs' attorney asks CCF to "[p]roduce all documents and responses produced in response to Senator Grassley's May 25, 2005 letter to you seeking certain information."

II. RESPONSE

PART A: CHARITY CARE AND COMMUNITY BENEFIT

CCHS has, for many years, maintained “charity care” policies that delineate guidelines and eligibility criteria for receiving either partial or total financial assistance for healthcare services. Under these policies, the Health System offers charity care to meet community needs by providing healthcare services at a full or partial discount to patients who cannot afford to pay for those services. In addition to services provided under these policies, the Health System provides healthcare services to low-income Medicaid patients. The Health System is the largest provider of Medicaid services in the State of Ohio. Reimbursement from this public program typically falls well short of the associated costs of providing care.

The Health System provides healthcare services to all members of the community regardless of how or if they are insured. Moreover, the Health System strives to make these services accessible to everyone in the community through the operation of eleven 24-hour, full-service emergency departments.

The Health System makes significant positive contributions to the communities it serves through:

- Sponsorship of, participation in, and/or funding for specific free or subsidized community services and outreach programs; and
- Sponsorship and support of community education and public health services.

In addition, and in particular, the Cleveland Clinic independently meets the standards of Internal Revenue Code (“IRC”) Section 501(c)(3)², through its:

- Sponsorship of more than 55 graduate and postgraduate education programs; and
- Extensive clinical (applied) and basic research activities.

All members of the Health System contribute to and participate in charitable activities that far exceed those that are reflected by the healthcare services provided to the communities they serve. Charity care is very important, but it is only one kind of benefit that the Cleveland Clinic, a healthcare institution, academic medical center and research institute, and its Health System hospitals, collectively provide as a nonprofit healthcare system.

In providing healthcare services without regard to ability to pay, as well as significant research, education and public health education and outreach programs, the Cleveland Clinic and the other members of the Health System meet the community benefit standard imposed by the Internal Revenue Service’s interpretation and application of

² Section 501(c)(3) of the Internal Revenue Code of 1986, as amended.

IRC §501(c)(3)³. The Cleveland Clinic, as well as the other members of the Health System, also meet the other charitable organizational and operational standards set forth by Revenue Ruling 69-545.⁴

CHARITY CARE

The Senate Finance Committee has asked many specific questions and requested detailed information concerning our organization’s “charity care” policy and practices. Due to the commonality of information relevant to Questions 1 through 5, 12, 18, 19, 21, 24 and 25 in Part A of the May 25, 2005 letter, we have grouped our responses accordingly.

As reflected in the following responses, CCHS:

- Provided over \$251 million⁵ in financial assistance to patients who qualified for “charity care” under CCHS policies;
- Maintains “charity care” financial assistance policies that apply across the Health System; and
- Offers “charity care” covering a full range of healthcare services, including physician professional services provided by the over 1,500 employed physicians.

Question 1. How does your organization define charity care? What types of activities or programs does your organization include in its definition or determination of charity care? Which of these activities or programs would your organization not incur, at all or to the same extent, if you were organized and operated as a for-profit hospital? Does your organization maintain a charity policy? If so, please describe the policy or provide a copy of such policy. Does this policy require that certain types of amounts of charity care be provided?

Basics of the Policy: Eligibility and Services Covered

Under the terms of *The Cleveland Clinic Foundation Uncompensated Charity Care Policy* (the “CCF charity care policy”), as well as the *Cleveland Clinic Health System Regional Hospitals Uncompensated Charity Care Policy* (the “CCHS charity care policy”), copies of which are included as Attachments B.1, B.11 and B.12, respectively⁶, financial assistance is offered to all patients who meet income eligibility standards or who otherwise demonstrate financial hardship or extenuating circumstances that make it difficult for them to pay for services provided by CCHS. Under the terms of the charity care policy, medically necessary healthcare services are eligible to be provided (i) free of

³ Id.

⁴ IRS Rev. Rul. 69-545.

⁵ See 2004 CCHS Audited Financial Statements and Response to Question A.12.

⁶ The standards for charity care under the two policies are the same, but some procedures vary due to different administrative structures. The term “charity care policy” as used herein refers collectively to the CCF Charity Care Policy and the CCHS Charity Care Policy, as implemented throughout the Health System.

charge to persons whose family incomes are at or below 200% of the Federal Poverty Income Guideline; and (ii) on a discounted basis according to a sliding scale, to persons whose family incomes are between 200% and 400% of the Federal Poverty Income Guideline. In addition, financial assistance is available to persons at all income levels if out-of-pocket expenses for healthcare services are greater than 25% of annual family income and under other exceptional circumstances. The charity care policy offers the opportunity for financial assistance to both uninsured persons and to insured persons who meet the eligibility standards.

The charity care guidelines described above have been in place at CCF since July, 2004, and at the regional Health System hospitals since the fall of 2004. The charity care policy in place at CCF for many years prior to July, 2004 was very similar to the current policy. A copy of the pre-2004 policy, entitled *The Cleveland Clinic Foundation Policy of Patient Financial Responsibility*, is included as Attachment B.2. For many years prior to 2004, the Cleveland Clinic Health System regional hospitals operated under various financial assistance guidelines which followed the Ohio HCAP program (described below) and also offered sliding fee discounts for family incomes ranging up to 200% to 250% of the Federal Poverty Income Guideline. The first comprehensive CCHS regional hospital charity care policy, adopted in early 2003, is provided as Attachment B.13. Adoption of uniform policies and procedures throughout the Health System is an ongoing process and CCF continues to provide oversight to ensure consistent application and practices under the policy.

The current charity care policy covers all medically necessary inpatient and outpatient hospital services provided at any CCHS facility, as applicable based on the financial eligibility standards. The amount of charity care provided is determined by financial need and is not limited to a budgeted amount.

Due to the fact that CCF employs all physicians who provide services at the main campus hospital and at the Family Health Centers, the charity care policy also is available to all patients who receive medically necessary physician services at the CCF main campus and at the fourteen Family Health Centers, whether delivered on an inpatient or outpatient basis. Although the CCHS regional hospitals operate as more traditional community hospitals with independent physicians and physician groups, they do employ a small percentage of physicians. CCF employed physicians also provide some services at the CCHS regional hospitals. Services provided by all CCF and CCHS regional Health System-employed physicians also are covered under the charity care policy. Furthermore, elective-type procedures including breast biopsies, mammograms, colonoscopies and physicals that often are not covered under commercial policies are treated as medically necessary services when ordered by a physician, and they may be provided free or on a discounted basis under the charity care policy.

The charity care policy supplements the Ohio Hospital Care Assurance Program (HCAP), a disproportionate share hospital program, which provides basic, medically necessary hospital services free of charge to persons who document income at or below 100% of

the Federal Poverty Income Guideline.⁷ The charity care policy provides free and discounted care to patients who do not meet the HCAP income eligibility criteria and covers a broader range of services, including professional fees for CCHS employed physicians.

Implementation of the Policy

At CCHS, all patients are seen without regard to ability to pay in emergency cases or, in non-emergency cases, based on the physician's determination that the health care services are medically necessary. If a patient lacks insurance and cannot make a deposit, or has insurance but is concerned about his or her ability to pay for services, the patient is referred to a financial counselor or a financial services representative. The determination of Medicaid eligibility or eligibility for charity care may be made before or after initial services are rendered. However, medically necessary services are provided regardless of the timing of the eligibility determination. Patients who do not qualify for assistance may work with a financial counselor or a patient financial services representative to set up a payment plan.

Information about the charity care policy is posted on the CCF website, and is available to CCHS patients at registration, during the billing process and throughout the collections process. Financial counselors are present on-site at each CCHS hospital and at all Family Health Centers to assist patients in qualifying for governmental assistance programs and charity care.⁸

CCHS endeavors to improve continuously its communications with patients on the availability of charity care. Patient statements are being updated to include detailed information regarding the current charity care policy, and an insert describing the charity care program is included with CCF billing statements. A summary description of the charity care policy is available in CCF patient registration areas and from financial counselors. CCHS also distributes a patient friendly billing brochure that describes the charity care policy and provides contact numbers. Further, as described below, information about the policy is provided throughout the billing and collection process.

The Committee has asked here and in Part A, Question 21 what types of activities or programs our organization would not incur if organized as a for-profit hospital. CCF has always operated within the nonprofit environment, evaluating all programs and activities in terms of its three-part charitable mission consisting of *better care for the sick, investigation of their problems and further education of those who serve*. CCF could not fulfill its mission as a taxable entity. CCF has not undertaken any efforts to determine which of these types of programs are conducted by for-profit hospitals.

⁷ The HCAP program is described in more detail in our response to Part B, Question 10.

⁸ For a more detailed discussion about how CCHS provides information to patients and families regarding the availability of financial assistance programs, see our response to Part B, Question 6.

Question 2. What are the 10 largest categories of charity care expenditures incurred by your hospital for the past five years? How does this differ from 10 years ago? 25 years ago?

CCHS does not maintain information as to charity care expenditures identifiable by specific, separate categories (*i.e.* per particular healthcare service such as pediatrics, emergency room visits, etc.), but rather this information is maintained on a patient account basis. Therefore, CCHS is unable to provide an answer to this question. However, as described above, the charity care policy applies to a full range of medically necessary healthcare services, including physician services provided in both inpatient and outpatient settings by the over 1,500 physicians employed by CCF and the CCHS regional hospitals. CCHS has maintained charity care policies for many years and while income eligibility levels may have changed throughout the years that these policies have been in place, the scope of services covered by the policies has remained substantially the same.

Question 3. What percentage of your patients for your most recent fiscal year were: (a) uninsured, (b) covered by Medicare, (c) covered by Medicaid or other state or other governmental program providing medical care benefits for low income individuals, or (d) otherwise covered by private insurance?

The breakdown of CCHS patients by payor category fall within the following categories: (a) 2.4%, self-pay (b) 43%, Medicare; (c) 8.3%, Medicaid, and (d) 46%, commercial payors.⁹

Question 4. Does your hospital ever agree to waive its fees immediately upon admission of a patient? If so, under what circumstances?

Yes, at CCHS, all patients in emergent and urgent situations are seen without regard to ability to pay, including acceptance of patients transferred from other facilities. In all other situations, if a patient lacks insurance and cannot make a deposit, or has insurance but is concerned about his or her ability to pay for services, the patient is referred to a financial counselor or a financial services representative. The determination of Medicaid eligibility or eligibility for financial assistance under the charity care policy may be made before or after initial services are rendered. However, medically necessary services are provided regardless of the timing of the eligibility determination. Patients who do not qualify for financial assistance under the charity care policy or governmental assistance programs, such as Medicaid, may work with patient financial services to establish a payment plan.

⁹ CCHS Data

Question 5. What effect, if any, has the increase in patient co-payments and deductibles had on patient bad debt writeoffs of your hospital over the past five years?

Although we have no methodology for analyzing the correlation between increased co-payments and deductibles to increases in CCHS’s “bad debt” write-offs, the amount of “bad debt” write-offs has in fact increased significantly over the past five years. The bad debt amount for 1999, determined on the basis of charges, was \$54.4 million.¹⁰ This amount grew to \$99.8 million for calendar year 2004, also determined on the basis of charges.¹¹

Question 12. Please provide a charity care breakdown for each entity that is a member of your hospital system group. In your opinion, should charity care be measured on an aggregate group basis or on an organization-by-organization basis?

**CLEVELAND CLINIC HEALTH SYSTEM
Charity Care
(In Millions)¹²
Year Ended December 31**

	2004	2003	2002	2001
The Cleveland Clinic Foundation	\$124	\$95	\$76	\$59
Cleveland Clinic Florida	\$2	\$1	-	-
Cleveland Clinic Naples Hospital	\$6	\$4	\$3	-
Home Health Operations	\$2	\$2	\$1	\$1
Marymount Hospital	\$10	\$7	\$5	\$4
CCHS Western Region (Fairview & Lutheran)	\$30	\$19	\$15	\$13
Lakewood Hospital	\$13	\$12	\$11	\$8
Meridia Health System	\$63	\$61	\$46	\$40
Cleveland Clinic Children’s Hospital for Rehabilitation	-	-	-	-
CCHS TOTAL:	\$251	\$201	\$157	\$126

Audited financial statements are prepared on a consolidated basis for the entire Health System. “Uncompensated care charges” are regularly reported on a system-wide basis as part of these audited financial statements. Uncompensated care represents the total amount of both bad debt and charity care expenditures under the charity care policy for each year. As many healthcare organizations have done in the past, the annual amount of uncompensated care has been reported on the basis of gross charges. Copies of CCHS Audited Financial Reports for calendar years 2000 through 2004 have been included and

¹⁰ CCHS Audited Financial Statements

¹¹ Id.

¹² This number is determined on the basis of charges. Further, if a number is not listed, the facility’s charity care expenditures were less than \$1million; however, charity care was provided by all of these facilities.

marked as Attachments E. 12 through E.16. The amount of charity care provided pursuant to these policies for the entire Health System (determined on the basis of gross charges) has increased dramatically from \$113 million in 2000 to \$251 million in 2004.¹³ These amounts reflect only the amount applicable to the charity care policy. No other charitable expenditures, including those for research and education, are included in these figures.

The Committee has requested opinions as to whether or not “charity care” should be measured on an aggregate group basis or on an organization by organization basis. Due to the ever increasing integration of services necessary to serve the Community and the need to utilize resources optimally, health systems need to be able to demonstrate satisfaction of IRS requirements on a health system basis.

Measuring charity care on an organization by organization basis allows for a detailed analysis of both the needs of separate communities being served by each member of a system and the unique nature of the contributions by each member. Reporting charity care on an aggregate group basis however, may allow health systems to demonstrate the full value of charity care and community benefits provided.

Question 18. Do your compensation arrangements with physicians and other professionals in any way encourage or discourage the provision of charity care by your hospital or hospital system? If so, how?

In 2004, CCHS provided over \$251 million in charity care (determined on the basis of charges). As discussed earlier, CCF is organized as a nonprofit, multi-specialty group practice that employs all physicians on a salaried basis. This model is a unique structure that serves to enhance charity care and encourages physician participation in other community benefits, such as research and education. CCF employs over 1,500 physicians who practice at its main campus and in the Family Health Centers located throughout the Northeast Ohio region. Because CCF physicians are employees, CCF’s financial assistance policies apply to both CCF hospital fees and to professional services provided by all physicians employed by CCF. Therefore, the financial assistance policies for CCF hospital services and physician services are aligned. In addition, CCF employed physicians are compensated almost exclusively on a salaried basis, with the amount determined on the basis of market ranges for similarly situated specialists in other top academic medical centers. The amount of revenue and/or charity care provided has no direct impact on CCF physician compensation.

CCHS regional hospitals employ a smaller number of physicians and are served by more traditional independent physician practices. Services of employed CCHS physicians are covered under the charity care policy, and with respect to these physicians, the financial assistance policies for hospital and physician services are similarly aligned. CCHS regional hospitals employed physicians are required to see all patients, regardless of their ability to pay.

¹³ CCHS Audited Financial Statements

Question 19. Please provide a breakdown of your charity care expenditures, across emergency room services, urgent care services, intensive care services, rehabilitation, maternity care, mental health care, cosmetic surgery, chemical dependency and outreach, and any other categories you consider to be appropriate.

CCHS does not maintain information as to charity care expenditures identifiable by the specific healthcare services listed in the question provided, but rather this information is maintained on a patient account basis. However, as stated previously in Question 2 of Part A, CCHS Charity Care Policy applies to the full range of medically necessary healthcare services.

Question 21. Please explain how the amount of charity care you provide differs in magnitude and kind from that provided by your for-profit competitors?

As a nonprofit, charitable organization, CCHS's activities are driven by its mission, rather than a responsibility to individual, private investors. CCHS's charitable mission permits CCHS to identify and target community need to be addressed by its charitable activities and services, without regard to shareholder profit. An example of the magnitude and kind of charity care provided by CCHS is its status as the largest Medicaid provider in the State of Ohio, affording access and programmatic attention to the needs of the poorest areas of the communities it serves. In addition, the involvement of local officials on advisory committees focuses the attention of CCHS management on responsiveness to the unfilled healthcare needs of local constituencies. Further, subsidized health services provide a level of charitable care to the community more easily accomplished where shareholder profit is irrelevant.

The Cleveland Clinic has no information on the amount of charity care provided by for-profit health systems, since it has no for-profit competitors in Northeast Ohio.

Question 24. How do you allocate expenses (direct labor and materials, indirect labor and materials, management, general and administrative, fund-raising, investment, and other) for purposes of determining the amounts you consider to have been expended on your charity care programs? Does this allocation include costs incurred pursuant to a cost-sharing arrangement with other members of your hospital system group? Is this allocation mechanism dictated by internal policy, Federal or State regulatory requirements, financial accounting principles, or other standards? Is your allocation of expenses to charity care consistent with expense allocation procedures you use to allocate expenses for other purposes, regulatory or otherwise? Please explain any similarities and differences.

The Health System allocates indirect expenses for all purposes, including charity care, based upon a consistent methodology that is applied regardless of payor category. This methodology incorporates all costs that are unrelated to direct patient care as indirect expenses and applies a cost to charge ratio based upon an average cost for the service.

Question 25. Please provide a statistical breakdown of the hospital's average cost per patient and the average length of stay of your patients. Feel free to provide as much detail as you consider to be appropriate to demonstrate the range of costs and stays across different types of treatment.

In 2003, the average length of stay for patients treated at CCF was 5.69 days (acute) and 8.44 days (non-acute).¹⁴ Based upon internal financial information, the average length of stay for 2004 was virtually the same as in 2003.

CCF had the highest Medicare Case Mix Index among hospitals in the United States with 500 or more beds, according to a recent report of such information.¹⁵ The Medicare Case Mix Index is regarded as a key indicator of the complexity of the cases handled by CCF.

Statistical information regarding the average cost per patient for CCHS has been requested. This information is highly sensitive and proprietary in nature. While we recognize that certain patient cost information can be calculated based upon publicly available documentation, such as Medicare Cost Reports, the Medicare methodology for determining allowable costs does not include all direct and indirect costs incurred in the ordinary course of business.

COMMUNITY BENEFIT

In the same manner as the response to all charity care policy-related questions above, we have grouped our responses to all questions relating to all other recognized forms of community benefit. Therefore, responses to Questions 15, 20, 22, and 23 are set forth below.

The Health System's federal tax-exempt status under Section 501(c)(3) of the IRC is evaluated under the "community benefit standard" described in IRS Revenue Ruling 69-545, which recognized that the "*promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole.*" IRS Revenue Ruling 69-545 modified the previously established "financial ability standard"¹⁶ by introducing other considerations to be included in the analysis of the organization's structure and activities.

The Health System, which operates community hospitals, family health centers, an academic medical center, a medical school, post-graduate and allied health education programs, and a research institute, meets the needs of its communities in three interrelated but distinct ways: providing charitable healthcare services, sponsoring education and research programs and making many other valuable contributions to the community. Charitable healthcare services include the provision of healthcare services

¹⁴ Appendix A to the Official Statement, p. A-29.

¹⁵ Appendix A to the Official Statement, p. A-29, citing *Federal Register*, August 11, 2004.

¹⁶ IRS Rev. Rul. 56-185.

(i) at full or partial discount to patients who cannot pay (*i.e.* under the charity care guidelines); (ii) to low-income, Medicaid patients for whom services are not reimbursed commensurate with their cost or on a basis comparable to typical commercial payors; and (iii) that are supported through ongoing capital expenditures and operating support because they consistently operate at a loss. Second, the Health System participates in and sponsors a large number and diverse variety of research and education programs. Lastly, the Health System devotes considerable resources to the development and support of community programs and other outreach activities. Many of the Health System's subsidized activities and programs are not included in the calculation of charity care, but are of essential value to the communities we serve. These community outreach activities and significant education and research programs are outlined below.

Question 15. What types of research and teaching are performed by your hospital as a charitable or educational activity?

The Health System's investment in research and education is long standing and substantial. Each member of the Health System conducts extensive research and education activities. The Cleveland Clinic, one of the largest academic medical centers and research institutions in the country, is structured to promote the advancement of research and education through an academic structure under the leadership of the Chief Academic Officer with the following divisions: Cleveland Clinic Lerner School of Medicine of Case Western Reserve University; the Division of Education; the Division of Clinical Research; and the Lerner Research Institute. While CCHS receives payments from the Federal Government for certain educational activities, the costs associated with providing these programs exceed the amount of such governmental payments. Following are descriptions of the Divisions and prominent activities within each.

Cleveland Clinic Lerner School of Medicine of Case Western Reserve University

In May 2002, the Cleveland Clinic entered into an agreement with Case Western Reserve University ("Case") to establish a new and unique medical school called the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University (the "College"). Through combined efforts, CCF and Case created a unique medical education program to advance biomedical learning and research principles and practice. The principle purpose and educational mission of the College is to attract and educate, in specially designed programs, a limited number of highly qualified persons who seek to become physician investigators and scientists and who will advance biomedical research and practice to the benefit of both local communities and the public at large. The College program admits approximately 32 students per year. In contrast to a traditional four-year medical school program, the College program is a five-year program, including, as part of the curriculum, training in research and development, and the writing and conducting of a research thesis. The first two classes (64 students) have now matriculated.

Division of Education

The Division of Education encompasses not only medical residency programs, but several other areas of professional education which are coordinated by several departments, including the following: the Departments of Graduate Medical Education and Undergraduate Medical Education; the Center for Continuing Education; the Cleveland Clinic Journal of Medicine; and the Center for Online Medical Education Training. Additional information on these educational activities is included in Attachment C.4 through C.21.

Graduate Medical Education and Undergraduate Medical Education

In 2004, 839 residents and fellows and 452 medical students rotated through CCF as part of its medical education programs. The Division of Education offers 55 Accredited Residency Training Programs, and trained 723 residents and fellows in ACGME/ABMS approved programs and 110 advanced fellows in clinical settings in 2004. CCF's program is far larger than any other program in the state of Ohio. CCF accounts for 10% of the hospital beds in the state but trains 21% of the interns and residents in the state.

Allied Health Education

The Division of Education trained 389 Allied Health students through 31 programs in 2004. The Allied Health Program is designed to provide healthcare professionals not just to CCHS, but to the community as a whole. For example, CCHS has an extensive training program for emergency medical technicians, including the EMS Academy and the Certified Intensive Care Paramedic Program. The EMS Academy strives to provide the highest quality of education for all levels of EMS providers. The Certified Intensive Care Paramedic program establishes the new national educational standard for paramedics seeking to advance their career to the critical care level. Working with the National Flight Paramedic Association, the Association of Air Medical Services and the Board of Critical Care Transport Paramedic Certification, the CCHS western region has established a curriculum that provides paramedics with the education, knowledge, skills and critical thinking that is required at the critical care level.

In the CCHS eastern region, Huron Hospital operates a School of Nursing that graduates up to 88 nurses annually from its diploma program. Thirty seven percent (37%) of the 2003 graduates were minority students. Huron School of Nursing is approved by the Ohio Board of Nursing and accredited by the National League for Nursing Accrediting Commission (NLNAC).

Center for Continuing Education

The Center for Continuing Education's mission is to share the Health System's wealth of knowledge with physicians, nurses, and other medical professionals across the country and all over the world. This Center is responsible for one of the largest and most diverse CME programs in the country. In 2003, 82,000 CME certificates were awarded. This

continuing education program recently was certified by the Accreditation Council for Continuing Medical Education as exemplary in its programs and organization and awarded "accreditation with commendation."

Cleveland Clinic Journal of Medicine

CCF has published scientific papers by its professional staff since 1932 in *The Cleveland Clinic Quarterly*. In 1987, the Division of Education changed the name to *The Cleveland Clinic Journal of Medicine* ("Journal") and increased publication to six times per year. Total circulation of the *Journal* in 2004 was 1,200,000, most of whom (1,176,000) were physicians. See Attachments C.23-C.25 for recent samples of the *Journal*.

Research Overview

While several community hospitals affiliated with the Health System perform research, most academic research activities are conducted at CCF; therefore, this response focuses on CCF's research activities.

CCF participates in a broad spectrum of research activities, including laboratory and in-vitro investigations, human subject research and therapeutic clinical trial studies, genomic and proteomic analysis and epidemiology and health outcomes research. All of these research activities contribute to the promotion of human health through the evaluation of the causes of disease and novel therapeutic approaches to various disease states. CCF is currently conducting approximately 2,270 clinical trials, making it one of the largest clinical trial sites in the country. CCF maintains on its public website examples of some of the clinical trials that are currently enrolling participants, a copy of which is attached as Attachment C.2.

Total expenditures for research in 2004 were \$179 million and revenues received in support of research for the same year totaled \$133 million.¹⁷ Additional information on CCF's research activities may be found at Attachments C.1, C.2 and C.3.

Division of Clinical Research

The clinical research activities of CCF are coordinated by the Division of Clinical Research and represent physicians conducting applied research programs in over 80 clinical specialties and subspecialties. The Division of Clinical Research supports and encourages research by its physicians by providing infrastructure support and by directly supporting specific research projects proposed by its staff. CCF invests in direct support of clinical research infrastructure annually. CCF provides salary support to enable physicians to devote half of their time to research and each physician-investigator receiving salary support also receives seed money in support of his or her project. Another initiative providing direct support is CCF's Research Programs Council which, in 2004, funded 42 projects.

¹⁷ CCHS Data

CCF also expanded its clinical research infrastructure through its recently constructed General Clinical Research Center (“GCRC”). CCF received matching funds from the National Center for Research Resources, a unit of the National Institute of Health (“NIH”), to develop a dedicated clinical research unit in the hospital. Funding is distributed among more than 80 centers located at major academic medical centers and teaching hospitals to support investigator-initiated human subjects research and provide dedicated research staff, space and supplemental support for project costs. The GCRC currently runs 37 research projects that sponsor research in a wide range of disciplines, including cancer, cardiopulmonary disease, neuroscience, orthopedics, gastroenterology, pediatrics and nephrology. The GCRC has seven inpatient/outpatient rooms, two procedure rooms, a core laboratory, nursing reception and work area, and a dedicated research subject advocate to protect the interests of research participants and provide education and training on human subject research.

Infrastructure support within the Division of Clinical Research also provides critical ancillary services for advancement of the research enterprise. For example, the Department of Quantitative Health Sciences (“QHS”) within the Division has as its goal the support of translational and outcomes research to bridge the gap between patient care and clinical research. To accomplish this goal, QHS will capture information from CCF’s 3,000,000 patient experiences per year, in a format that protects patient privacy and confidentiality but permits quantitative analysis that may translate to new standards of clinical care. The Department of Bioethics is also part of the Division of Clinical Research and provides ethics consults for CCF’s personnel, patients and their families as part of the medical decision-making process of the hospital. The Department of Bioethics is also available to all researchers at CCF to review and coordinate study design to ensure the protection of all research participants and to minimize the risks from participation in the research. The operation of these ancillary departments is primarily an operating cost to CCF with no offsetting revenue from external sources.

Centers of Excellence

CCF further demonstrates its commitment to research by supporting clinical innovation and research at several highly regarded centers and institutes that have been organized within CCF. For example, the Cleveland Clinic Heart Center (comprised of the departments of Cardiovascular Medicine, Thoracic and Cardiovascular Surgery and Cardiovascular Anesthesiology) is a world-renowned cardiac care center that advances care through the development and refinement of new techniques and by performing groundbreaking studies on the causes of heart disease. Examples of 2003 research accomplishments of the Heart Center include identifying a specific gene as a cause of human coronary artery disease, pioneering a variety of surgical innovations and furthering the clinical community’s understanding of risk factors for coronary heart disease. Other centers of clinical and research activity include the Cleveland Clinic Head and Neck Institute, the Glickman Urological Institute, the Taussig Cancer Center and the Children’s Hospital.

Case Comprehensive Cancer Center

In September 2003, Case Western Reserve University School of Medicine (“Case”), University Hospitals of Cleveland (“UHC”) and CCF agreed to form a consortium that united the cancer research activities at each institution under a single leadership and common organizational structure. The consortium, which was named the Case Comprehensive Cancer Center, is an NCI-designated Comprehensive Cancer Center, whose mission is to eliminate cancer and cancer related suffering. In support of its mission, Case, UHC and CCF each commit leadership, personnel and funding and operate under a set of uniform guidelines and a jointly managed review and monitoring structure to ensure consistency and quality work by all of the members.

The Lerner Research Institute

The Lerner Research Institute (“LRI”) is the fifth largest research institute in the country and employs approximately 250 Ph.D. investigators. CCF completed a campaign to build LRI in 1998, which occupies a 300,000 square foot facility. LRI investigators conduct basic research in LRI laboratories with the support of a variety of core services, including central cell, electronics, flow cytometry, gene expression, hybridoma, imaging, phosphorimager, mass spectrometry, polymer, proteomics and photographic services, through its integrated research community consisting of eight departments and eight centers of study. CCF provides ongoing operational support for LRI scientists in the form of base salaries, administrative support, and funding for LRI’s core research services and facilities. These operating costs are substantial, and are greater than grants and other funding for research. Many of the Ph.D. investigators actively collaborate with physician-investigators in CCF’s clinical departments to advance clinically-relevant translational research. In 2004, CCF’s new NIH awards exceeded \$70 million and LRI ranked seventh nationally in American Heart Association funding.

The Lerner Research Institute also hosts and/or sponsors a variety of scientific education programs that are open to the public. By way of example, LRI hosts the following programs on an annual basis: Annual Lerner Lecture (2004 topic was “Regulation of Neurogenesis in the Adult Nervous System”); Annual Page Lecture (2004 topic was “Genetic Control of Cardiac Development and Disease”); Nanomedicine Summit; Bone Summit; and Cartilage Innovation Summit.

Question 20. What kinds of community outreach and education activities does your hospital conduct, and how much is expended on such activities (in absolute dollars and as a percent of your budget)?

Community Outreach Programs

The Health System as a whole conducts a large number of community outreach programs that provide a diverse range of services to the community that are directed to both at-risk populations and special needs groups, as well as the general population. Each hospital

has dedicated staff to coordinate local community outreach activities, and operating expenses for these programs and activities are largely subsidized by the hospitals. Funding for certain programs, however, may come through charitable donations as well as sponsorship fees or unrestricted grants from corporate sponsors. Community outreach programs typically fall into three categories: community health services, cash and in-kind donations, and community building.

Community health services include activities carried out to improve the general health of the local communities. These activities extend beyond the normal and routine patient care activities and do not generate bills, although for certain programs a small fee may be assessed. Benefits in this category include community health education, community-based healthcare services, support groups, healthcare support services, self-help programs, community spiritual care, social service programs and many others. In 2004, free community health service programs included: blood pressure and cholesterol screenings, prostate screenings, nurse-on-call phone lines for triaging acuity, cancer information lines, healthcare services and immunizations for women and children at the local women's shelter, and breast cancer support groups.

Cash and in-kind donations represent funds and services donated to individuals and the community at large. Benefits counted as in-kind services include hours donated by staff to the community during scheduled work time, overhead expenses of space donated to nonprofit community groups for meetings and donation of food, equipment, and supplies.

Community building activities include cash, in-kind donations and budgeted expenditures for the development of community programs and partnerships. Physical improvements in the community are one type of community building activity. As described below, in 2005 CCF donated \$10 million to the greater Cleveland area public schools.

In 2004, CCHS provided community programs and services at a net cost of approximately \$27 million.¹⁸ Large categories included the provision of health-related services throughout the communities served and allied health education programs. (More detailed descriptions of key community programs and services are included in Attachment D.1 through D.10). Not all community program costs and services are reflected in the estimate above. Departments throughout the Health System sponsor their own community programs and outreach activities. These costs are often embedded in the Department's costs and budgets and, as a result, cannot be isolated and tallied for this response.

As noted above, in 2005, the Cleveland Clinic pledged an additional \$10 million in cash and services over the next five years to support and enhance educational opportunities for Greater Cleveland area public school students. A portion of the pledge is earmarked to connect Cleveland Municipal School District schools to the OneCleveland network, a high-speed Internet system created to service nonprofit organizations. This will connect the Cleveland city schools to the electronic resources of the Health System, Cleveland's universities, libraries and cultural institutions.

¹⁸ CCHS Data

There are also certain departments that are dedicated to community outreach and education, namely the Department of Patient Education and Health Information and the Office of Civic Education.

The Department of Patient Education and Health Information disseminates knowledge to the community through hard copy materials and the internet, via websites. Cleveland Clinic staff members contribute articles and commentaries on health related news topics. The Department's own website offers information on over 900 health topics and is updated daily. In 2004, the Department held 49 community health talks and supported tobacco prevention programs for more than 2,000 students at ten Cleveland public schools.

The Office of Civic Education Initiatives provides education outreach services to Northeast Ohio communities. The Office develops educational programs with local and regional schools in the areas of science, math, health and wellness. The Office integrates arts and culture to foster innovative and creative learning opportunities for students working closely with Cleveland's cultural institutions. Its chief programs currently include:

The Cleveland Clinic/John Hay High School Partnership

This program is an active collaboration between CCF and an inner-city high school across a broad range of academic, mentoring, jobs and internship programs. These programs combine school attendance with half-day work experience at CCF for school credit or pay. The program includes a comprehensive biological-medical thematic curriculum, speakers and demonstrations, career shadowing, teacher grants, mentoring and preceptorship, hands-on work exposure to health care careers, and after-school and summer employment. The program consists of six thematic areas specialty areas, as described below:

1. The Medical Biological Health Science Program -

This program, offered in partnership with CCF, is a demanding four-year college preparatory curriculum, with senior research projects advised by CCF scientists and presented at CCF.

2. The Biomedical Engineering Program -

The Biomedical Engineering Program is focused on engaging students with engineering interests. It is structured in a similar fashion to the Medical Biological program.

3. The Medical Office Assistant Program -

The Medical Office Assistant Program is a demanding four-year school-to-work curriculum leading to careers as medical desk receptionist, medical file clerk, medical

transcriptionist, or medical secretary. This program is offered in partnership with Cuyahoga Community College in Cleveland, Ohio.

4. The Business Co-op School to Work

Occupational Work Adjustment/Occupational Work Experience School to Work

Special Education School to Work –

These three separate programs combine school attendance with half-day work experience at CCF for school credit or pay.

The Cleveland Clinic Science Internship Program

Leveraging its almost 20 years experience with the John Hay Partnership, the Health System has begun a new summer internship program for students from other area high schools. This program offers a summer internship program for up to 50 junior and senior high school students from throughout the Greater Cleveland area. The nine-week program places students with paid positions in various departments and specialties at CCF and at other locations throughout the Health System. The program is among the first to be administered by the Office of Civic Education Initiatives, which develops educational programs with local and regional schools in the areas of science, math, health and wellness. The office also integrates arts and culture to foster innovative and creative learning opportunities for students working closely with Cleveland's cultural institutions.

Question 22. How much does your hospital spend on free or below-cost infant and child care programs, such as childhood immunization programs?

The Health System sponsors flu shot clinics and other immunization programs available to the public at its various facilities. These programs also are offered at community locations, such as health fairs. Additionally, CCF provides immunizations, counseling and education services, physical examinations, and coordination of specialized services free of charge to women and children at the City of Cleveland's Shelter for Women. The costs associated with immunizations and other services, however, are usually embedded in larger health programs (e.g., health fairs), so they cannot easily be isolated and measured for this response.

The Health System provides many programs intended to benefit families in the community. Additional detail regarding these programs is provided in the response to Question 20 in Part A and the related attachments. Many of these programs are specifically aimed at children and parents. Examples include:

Vision First

Vision First is a comprehensive vision screening and eye examination program provided to over 5,500 children annually. This program, which began in 2002, was initiated by CCF and is funded by community foundations and sponsors. Utilizing a specially equipped van, CCF screens inner-city children in pre-school, kindergarten and first grade at each of the appropriate Cleveland Municipal School District buildings. The van is staffed by an ophthalmic technician who will screen for the presence of anisometropia and/or strabismus, the two leading causes of amblyopia in children. An optometrist is available to perform a complete ocular examination on children who fail the screening. A prescription for glasses is written for those who need them. Children who require management are referred to area pediatric ophthalmologists for follow-up treatment.

Young Moms

Young Moms is a program offered to help teen mothers adjust to pregnancy both during and after the baby's birth. The series of classes, free of charge and held after school hours, is designed to help teach young mothers the foundations of parenting and infant care. The program staff works to connect the mothers with community resources, including helping the young women to obtain insurance, pediatricians, and other basic provisions parents need to support a child. The young mothers are encouraged to keep attending the classes after their baby's birth.

Boot Camp for New Dads

Boot Camp for New Dads is a workshop in which "experienced" dads help first-time fathers gain confidence, learn basic parenting skills such as feeding and diapering, and teach the new dads the importance of a support system for their new baby.

The Stork's Nest

The Stork's Nest is a monthly prenatal health education program specifically focused on educating low-income women and their partners on the stages of pregnancy and the first years of childhood. Program participants earn credits that can be redeemed at a retail store for gently-used baby clothing.

Question 23. Does your organization conduct clinical trial programs, and if so, how does your organization treat such programs for purposes of determining charity care?

The Health System engages in a wide variety of research activities, including participating in clinical trials. As stated in the answer to Part A Question 15, CCF is currently conducting approximately 2,270 clinical trials. In many clinical trials the research being conducted is part of a therapeutic program for the research participant, meaning that there is a therapeutic agent, such as a drug or device, being administered to treat an underlying disease or condition. Generally for therapeutic research, the clinical

care provided to a research subject, including diagnostic methods and disease monitoring, is the same or substantially similar as that provided to any other patient. The research component of the therapeutic program is to evaluate the safety and efficacy of the therapeutic agent or other clinical procedure through the collection of data to track adverse event occurrences and analyze patient outcomes.

Each research subject participating in a clinical trial program at a Health System facility is registered as a routine patient. As part of the research review process by the facility's Institutional Review Board ("IRB"), the researchers must disclose in the informed consent document the costs of participating in the research. If the research involves clinical care that is standard of care for any other patient, such as laboratory or imaging tests to establish disease diagnosis, the informed consent form may indicate that the costs are the responsibility of the participant or his/her insurer, in which case a participant without insurance would be eligible for charity care under the charity care policy.

In other clinical trials, there may be an internal or external source of funding that may reduce the costs of treatment to participants or result in no cost for the treatment. Because a reduction of medical costs that would normally be incurred by a patient as part of a treatment program may be considered an incentive to the patient and may result in undue influence or coercion over his or her decision to participate in a clinical trial, the IRB must review the payment structure to ensure that the subject is free of coercion and is able to make an informed decision regarding participation. This is particularly important in clinical trials where the patient may be asked to participate in a clinical trial for a new therapeutic agent in lieu of receiving a course of treatment that is already approved and standard of care for the patient's disease.

Another part of the research review process by the IRB is the consideration of the patient population to be targeted for participation in the research. One of the three ethical principles in research, as established by the Belmont Report issued by the Department of Health, Education and Welfare in 1979, is justice, which is to ensure fairness in the distribution of the benefit and the burden of research. This principle is implemented by ensuring a fair selection of participants in a clinical trial so that discrete populations are not unfairly burdened or benefited as a result of participation. For instance, it would not be acceptable to recruit only the poor to a study that may require the administration of an investigational product in substitution of an approved product that is generally accepted standard of care by the medical community. Likewise, it would not be acceptable to only allow participation by those that can afford to pay for access to new therapeutic agents that have the hope for greater efficacy than the current approved products. In this regard the researchers and the IRB are responsible for ensuring that the recruitment practices or other parts of the research program reach a diverse population as appropriate for the goals of the clinical trial.

As discussed in response to Question 15, the Health System maintains and makes available internal endowment funds to be used for funding research projects, where it may be necessary and appropriate to reduce or cover the costs of the research. Members of the Health System may also partner with external funding sources, including the

federal government, such as the NIH, and public and private persons, such as the American Heart Association, NASA, other research institutions and universities, pharmaceutical companies, medical device manufacturers, and biotechnology start-ups. By engaging in both internal research and pursuing extramural research partners, the Health System is better able to further its mission by investigating both the causes of disease and evaluating and discovering new and novel approaches to the prevention and treatment of disease.

CCHS is also committed through its research programs to enhancing scientific knowledge and educating the public and the medical community on alternative therapies and health care options. To ensure its ability to further its mission, CCHS ensures that in all relationships with external research sponsors and collaborators that the Cleveland Clinic and its researchers retain the right to publicly present the results of the research. Through the sharing and public discussion of research results, the public and medical community can achieve a greater level of understanding to make informed health care decisions. In addition to presenting research findings at professional medical associations and conferences, staff members contribute to peer-review journals and other publications available to the general public.

JOINT VENTURES

CCHS recognizes the value in collaborating with outside entities to assist CCHS in furthering its mission of providing better care to the sick and educating those who serve. In structuring its relationships, CCHS values and encourages the independence of its partners so that CCHS and each partner retain their separate corporate identities to continue to fulfill their original missions and purposes. The goal of these collaborations is to allow both CCHS and its partner to increase their abilities to offer enhanced benefits and services to their respective communities and the community at large. In many of its collaborations with other hospitals and other healthcare systems, CCHS offers financial assistance and contributions to allow for capital improvement and program development.

Many of these arrangements do not take the form a traditional joint venture model, but rather one of a collaborative relationship. CCHS has partnered with many healthcare institutions throughout the years primarily in the delivery of certain specialty healthcare services, such as cardiothoracic surgery, radiology and radiation oncology, to provide a tertiary level of care that the institutions could not otherwise provide. The demand for a high degree of specialization and the complex nature of effective healthcare management are two of the motivating factors behind many of these relationships. CCHS has contracted with several nonprofit hospitals, both in Northeast Ohio and elsewhere, to manage and provide these services. For example, CCF provides cardiothoracic surgery services to MetroHealth System, which is comprised of a 731-bed public teaching hospital and Level I Trauma Center located in Cleveland, Ohio. These arrangements typically involve the creation of a committee, with local hospitals and CCHS personnel to provide oversight to and coordination of the delivery of healthcare services and to conduct other quality-related activities. CCHS receives a management fee commensurate

with the fair market value of the management services provided, but otherwise does not participate or share in the local hospital's earnings or net profits. This is the traditional model CCHS utilizes when it determines that collaborating with another entity would further its mission.

In addition, CCF has entered into similar collaborative agreements with international hospitals due to the fact that CCHS has had a history of attracting international patients as well as international health care professionals, who seek training and education at CCHS. CCF has collaborative arrangements with one hospital in Cairo, Egypt, one in Saudi Arabia and two in India. Pursuant to the terms of the arrangements, CCF provides policies, operational and medical expertise, and quality improvement tools which are useful to the management of these hospitals and the provision of medical services. CCF physicians occasionally travel to these sites to directly supervise medical care and provide administrative expertise. In some cases, CCF has received a minor ownership interest or participation in the hospital's revenues. These arrangements have not required an investment of cash by CCF, but rather the rights granted are in exchange for CCF's services and expertise. The terms of the arrangements protect CCF from financial and other risks associated with the operations of such hospitals. These collaborative agreements permit CCF to continue to be an international referral center, as well as share its expertise and further its mission on a global level.

CCHS has entered into a limited number of arrangements which could be considered joint ventures, as defined below. Most of these arrangements are with other tax-exempt entities, but a few are with for-profit corporations for the reasons previously outlined. Except for the Premier arrangement described below which involves CCF and the Meridia Health System, CCF is the only entity within CCHS that participates in joint ventures, as defined below. When CCF enters into such joint ventures, each arrangement is reviewed to ensure that the arrangement is an appropriate use of CCF assets and that it furthers CCF's charitable mission. CCF retains the right to evaluate the joint ventures on an on-going basis, to continue to participate so long as the arrangement acts in furtherance of CCF's charitable mission and to terminate its participation in the joint venture if necessary.

In responding to the questions relating to joint ventures, we have included information regarding our participation in limited liability companies, general partnerships, limited partnerships and corporate arrangements, whether with tax-exempt organizations or for-profit companies or investors. We are including only activities that fall within the following categories, as outlined in the letter from Senator Grassley: (i) joint ventures with other nonprofit, tax-exempt hospitals to provide charity care or healthcare services; (ii) joint ventures with physicians or other for-profit companies or investors to conduct activities that fall within the definition of unrelated trade or business as set forth in IRC Section 513 and the Treasury Regulations promulgated thereunder; and (iii) joint ventures with physicians or other for-profit companies or investors to conduct health care activities substantially related to our core charitable mission. We are interpreting the last category as those joint ventures which provide healthcare services directly to patients. We interpret the joint venture questions to exclude from our response information

regarding equity interests held by CCHS as investments in companies, including both corporations and limited partnerships, in which CCHS's role is that of a passive investor.

Question 6. Has your hospital or other members of your hospital system group entered into joint ventures with other nonprofit, tax-exempt hospitals to provide charity care or health care services? If so, please describe the nature of such joint ventures.

Ashtabula County Medical Center

The Ashtabula County Medical Center ("ACMC") is a private, nonprofit acute care hospital providing inpatient and outpatient services for Northeast Ohio. Ashtabula County is a rural community approximately 50 miles northeast of Cleveland. The ACMC health care family includes the Ashtabula County Medical Center, The Ashtabula Clinic, The ACMC Foundation, Glenbeigh Hospital and Outpatient Centers, Ashtabula Regional Home Health Services and Community Care Ambulance Network. The Ashtabula Clinic, a department of the Medical Center, is a multi-specialty group practice consisting of 23 primary care and specialty physicians. The 241-bed medical center is the largest in Ashtabula County and has been delivering healthcare services for more than a century.

In 1998, ACMC was in financial distress and in an effort to maintain this valuable community asset, CCF agreed to make a \$15 million investment in return for becoming a special member. Among its rights as a special member of ACMC with certain reserved powers, CCF has the right to approve certain material transactions and elect CCF representatives to the Board of Trustees. Additionally, ACMC is managed by Meridia Health System, also part of CCHS, pursuant to a separate management agreement. This management agreement gives ACMC the opportunity to overcome some of the challenges it faces as a stand alone rural hospital by allowing it to take advantage of expert executive management, operational programs, quality measures and other activities. This in turn improves the quality of care that ACMC delivers to its patients.

Grace Hospital

Grace Hospital was founded in 1910 by a group of physicians as an acute care community hospital. In 1995, Grace was the first hospital in Cuyahoga County, Ohio to be registered as a long-term acute care hospital ("LTAC"). It is located in an inner-city neighborhood of downtown Cleveland. It is both Medicare- and Medicaid-certified. The hospital provides specialized care and comfort to individuals coping with catastrophic illness or injury. The hospital's goal is to restore patients to the highest level of independence in preparation for transition to home, rehabilitation, skilled nursing, assisted living, or other less intense levels of care. LTAC services include pulmonary rehabilitation, ventilator weaning, left ventricular device programming, wound care and neurological rehabilitation. Grace has enjoyed particular success in weaning ventilator-dependent patients. Through lease arrangements, Grace also offers LTAC services on-site at Amherst, Fairview, Huron and Lakewood hospitals.

While Grace Hospital is an independent hospital, CCF and Grace Hospital entered into a definitive agreement to explore cooperative methods to integrate the long-term care function of Grace into a regional LTAC healthcare system. As a result, CCF became a special member of Grace with the right to approve certain change in control transactions and material adverse changes to the governing documents. CCF and Grace each have the right to appoint two representatives to the other party's Board of Trustees, provided that participation by such representatives can be limited as necessary to comply with applicable laws. There is no integration of personnel or consolidation of financial matters between the organizations. Pursuant to separate agreements negotiated at arms-length, Grace leases certain space in Fairview Hospital, Huron Hospital and Lakewood Hospital (three members of CCHS) for fair market rent. CCF has also entered into a Loan Commitment to Grace for a revolving line of credit up to \$5 million dollars at fair market interest. To ensure that CCF's financial assistance is used to enhance benefits to the surrounding communities, the loan agreements require that Grace Hospital use the funds only for capital improvement projects or operating expenses for existing owned and leased facilities.

Comprehensive Health Care of Ohio, Inc. ("CHC"), Amherst Hospital Association (Amherst) k/n/a The Hospital for Orthopaedic and Specialty Services

Formerly known as Amherst Hospital, The Hospital for Orthopaedic and Specialty Services features a center of excellence in orthopaedics within a general services hospital. A collaboration between EMH Regional Healthcare System and CCHS delivers patient care at The Hospital for Orthopaedic and Specialty Services. The collective capability of these health care systems provides critical, innovative medical care for the residents of Lorain County, Ohio. Lorain County is designated as a medically underserved area by the U.S. Department of Health and Human Services.

Per an Affiliation Agreement executed in 2003, CCF became one of two members of Amherst, together with Comprehensive Health Care of Ohio, Inc. ("CHC"), another nonprofit corporation. As sole voting members, both CHC and CCF have the power to elect Trustees; four of the eight trustees are appointed by CCF. In addition, CCF agreed to contribute \$2.6 million to Amherst and to extend a line of credit to finance certain project start-up costs. CCF's contribution was restricted to upgrading patient care areas to improve patient care. The Hospital for Orthopaedic and Specialty Services has since been redesigned and upgraded, offering expanded services to better provide patients with comprehensive medical and orthopaedic care, inpatient and outpatient physical therapy and emergency department services.

Case Comprehensive Cancer Center

In September 2003, Case Western Reserve University ("Case") School of Medicine, University Hospitals of Cleveland ("UHC") and CCF agreed to form a consortium that united the cancer research activities at each institution under a single leadership and common organizational structure. The consortium, which was named the Case Comprehensive Cancer Center ("Center"), is a National Cancer Institute-designated

Center whose mission is to eliminate cancer and cancer related suffering, make available additional research opportunities and therapeutic options for patients of the participating institutions and provide another level of review and protection for human research subjects by creating a review board specialized in oncology. In support of this mission, the members of the Center are committed to a set of operating principles. Each member supplies leadership, support personnel, expertise and substantial funding in support of the effort. The Center operates a single protocol review and monitoring system that is responsible for the scientific review and prioritization of all clinical and population cancer research conducted by the Center. All patient, population and tissue related cancer research conducted by the Case Comprehensive Cancer Center is reviewed and approved by a jointly managed review structure and a jointly operated Institutional Review Board.

Question 7. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct unrelated trade or business activities? If so, please describe the nature of such joint ventures.

Premier

Premier is an alliance of nonprofit hospitals and healthcare systems to improve the cost-effectiveness of their operations. This is not a joint venture with physicians or a for-profit company, but rather with other nonprofit organizations. We include it because the alliance is a for-profit limited liability company and CCF categorizes this as an unrelated business activity. CCF and the Meridia Health System, both members of CCHS, each have an ownership in Premier Purchasing Partners, LP, (1.4% and 0.6%, respectively). Income from the partnership's business is allocated 99% to the limited partners and 1% to the General Partner, Premier Plans, LLC. This partnership conducts the activity of group purchasing for exempt hospitals and health systems. By participating in this group purchasing activity, CCF and CCHS can improve quality while reducing costs and improve the financial health of the organization so it can continue to operate in furtherance of its charitable purposes and convey benefit to the communities it serves.

CCF Spin-Off Companies

Through the practice of medicine and the advancement of scientific knowledge, CCF improves and lengthens life for its patients and the beneficiaries of the research carried on by its clinicians and scientists over the years.

To carry out that purpose effectively and to comply with federal and state laws requiring commercialization of government-funded research, CCF is committed to commercialize any new intellectual property ("IP") developed by its professional staff, employees, agents, students and trainees. CCF invests the net income from commercializing IP in the research endowment, sharing a portion of that net income with the creator(s) of the IP to promote continued creation and development of medical innovations in the spirit of the Bayh-Dole Act and in accordance with institutional policies governing technology

transfer and conflicts of interest. CCF Innovations (“CCFI”), a department within CCF, was established in June 2000 to “benefit the sick through the broad and rapid deployment of CCF technology.” CCFI is charged with protecting, managing and commercializing CCF IP.

PeriTec Biosciences, Ltd. and CleveX, Ltd. are spin-off companies in which CCF maintains minority ownership interests whose income may be treated as unrelated business income.

PeriTec Biosciences

PeriTec Biosciences, Ltd.’s mission is to create and develop innovative vascular and cardiovascular surgical products that improve surgical outcomes through product longevity and cost effectiveness. The company’s technology involves the incorporation of bovine biological tissue, peritoneum, into several implantable product applications - peripheral vascular stents, dialysis and leg bypass grafts, percutaneous aortic heart valves and vascular patches.

CleveX

CleveX is dedicated to providing advanced skin biopsy and wound healing solutions. Its first product, NaeveX, is a one-step device that delivers safe and consistent results through a patent pending excision and stapling device.

Weston Dialysis Center, LLC

Weston Dialysis Center, LLC is a joint venture with a for-profit corporation, DaVita, Inc. Since this entity provides healthcare services directly to patients, it is described in more detail below.

Question 8. Has your hospital or other members of your hospital system group entered into joint ventures with physicians or other for-profit companies or investors to conduct health care activities you consider to be substantially related to your core charitable mission? If so, please describe the nature of such joint ventures.

Weston Hospital/Tenet Health Care-Florida

CCF and Tenet Healthcare-Florida, Inc. (“Tenet”) created a Florida general partnership (the “Partnership”) pursuant to a Partnership Agreement (the “Partnership Agreement”) in 1998, for the purpose of constructing, owning and operating a 150-bed acute care hospital located in Weston, Florida (the “Hospital”) as well as outpatient and other services and business related to the business of the Hospital. CCF and Tenet decided to form the Partnership and jointly operate the Hospital because their respective strengths were complementary to one another. Tenet had considerable experience in managing hospitals, encompassing aspects such as information systems technology, patient records,

purchasing, scheduling and so forth. CCF, on the other hand, has experience in operating a group medical staff model, advancing research techniques and conducting significant teaching programs. CCF structured the formation and operation of the Partnership so as not to deviate in any material fashion from its traditional Cleveland campus model, or from its long-time operation as a nonprofit, tax-exempt organization. Therefore, the campus was designed to permit operation of this integrated medical model. The other reason for entering into the Partnership was the need to replace an aging and dysfunctional physical plant that did not accommodate the integrated model of medicine. Tenet could not only bring certain expertise to the venture but could also share and thereby reduce the financial risk to CCF inherent in constructing a new campus.

In addition to the Partnership Agreement, several additional agreements between the parties taken together create the legal and business arrangement through which the Hospital is operated, managed and staffed. In general, the arrangement between CCF and Tenet can be summarized as follows:

- CCF owns a 49% interest in the Partnership. Tenet owns a 51% interest in the Partnership;
- Control of the Partnership by the partners is not based on equity ownership but rather is shared equally between the partners through rights established in the documents governing the boards of the Partnership and the Hospital. CCF and Tenet have equal Board representation;
- Pursuant to a Management Agreement with the Partnership, Tenet is responsible for managing the Hospital; and
- Pursuant to a Medical Services Agreement with the Partnership, CCF is responsible for providing the professional and clinical staff.¹⁹

The Partnership is operated on the same principles in regard to community benefit as guide the operation of CCF. According to the governing documents, the Partnership is to be operated so that the community will realize certain benefits: “improved healthcare delivery, increased availability and accessibility of medical services and creation of a proper blend of medical education and research sufficient to distinguish the healthcare services of the Hospital from traditional community hospitals’ services and to meet the need of the community all in furtherance of CCF’s charitable purposes.” These same governing documents forbid the Partnership from acting in a manner that would jeopardize CCF’s tax-exempt status.

The Partnership has established a number of policies and programs to actualize these intended community benefits. The Partnership has adopted a specific charity care policy with respect to the Hospital. (See Attachments B.16 and B.18) This policy had to be approved by the Partnership’s board and therefore required CCF oversight and approval.

¹⁹ This arrangement is similar to the joint venture described in IRS Revenue Ruling 2004-51, which approved a joint venture with the following facts: the partnership allocated control over the administration and operational duties to the for-profit partner, while control over the educational mission and related activities was allocated to the nonprofit partner. The allocations of control and responsibilities in the joint venture between CCF and Tenet are consistent with this ruling.

The purpose of such policy is to define charity care and to distinguish charity care and indigent care from bad debt and to establish policies and procedures to ensure consistent identification, accountability and recording of such. The policy defines charity care as all healthcare services that are provided to patients who are financially unable to satisfy their debts resulting from a determination of a patient's inability to pay. In addition, the Hospital operates a full-time emergency room and no one is denied care in the emergency room regardless of ability to pay. Finally, due to the fact that CCF directly employs physicians, the CCHS charity care policy applies to services billed by CCF staff physicians at this facility.

The Hospital operates an integrated medical model that effectively coordinates the care of patients. Most of the physicians practicing at the Hospital are employees of CCF and all of the medical direction is provided by CCF physicians. Many of the employees of the Hospital had previously worked in the old hospital owned by CCF and therefore, were trained in the context of a tax-exempt entity. In addition, CCF sponsors several accredited residency programs at the Hospital that contribute to education of the next generation of physicians, including internal medicine and geriatrics.

Ohio Renal Care Group

In order to provide efficient and accessible dialysis services to its communities, CCF and MetroHealth System ("Metro") decided to collaborate and explore options for developing dialysis centers throughout the area and formed CCF/MHS Renal Care Company, Ltd. ("CCF/MHS Renal Care"). Metro is a 731-bed public teaching hospital located in Cleveland, Ohio. Accordingly, CCF/MHS Renal Care joined with Renal Group, Inc., a Tennessee for-profit corporation ("RCG-Tenn") to form Ohio-Renal Care Group LLC ("Ohio-RGC") for the purpose of providing renal dialysis and renal care facilities at several locations in the Greater Cleveland area.

CCF holds a majority ownership interest in CCF/MHS Renal Care and both institutions appoint two managers to this entity. The managers essentially act as this entity's board and one of their primary purposes is to appoint one Metro manager and one CCF manager to serve as managers to the Ohio-RGC.

Under the terms of this agreement creating Ohio-RGC, RCG-Tenn holds a majority interest and CCF/MHS Renal Care holds a minority interest. Accordingly, CCF indirectly holds a minority interest in the operations of the Ohio-RGC facilities.

The managers have charge of the affairs of the Ohio-RGC. RCG-Tenn and CCF/MHS Renal Care each appoint two managers although one RCG-Tenn manager and two CCF/MHS Renal Care managers constitute a quorum. For certain decisions involving, for example, expenditures over certain thresholds, a unanimous vote of all managers is required.

Weston Dialysis Center, LLC

DaVita, Inc., a for-profit corporation that operates one of the largest chains of dialysis centers in the country, formed a limited liability company with CCF, Weston Dialysis Center, LLC, to provide dialysis services and establish dialysis centers to serve the Weston community. The Weston community is a younger, working class community located near the Everglades. It is much less seasonal and less developed than the resort communities found in that region in Florida. Prior to this arrangement, there was not an outpatient dialysis center located in the community. Patients had to drive at least 5 - 10 miles, usually more, from their homes to receive this care. CCF did not believe that an inpatient dialysis unit would serve the needs of the patients that only needed dialysis on an outpatient basis, nor was this alternative financially feasible for the patients. Further, the Weston hospital facility did not have the physical capabilities or equipment to establish an outpatient dialysis unit.

In an effort to fill this gap in the healthcare services provided to the Weston community, DaVita approached CCF with a plan to establish the now-existing facility. DaVita engaged CCF to provide a medical director and oversight of the medical services being provided at the facility to ensure that quality care is delivered.

Under the terms of the arrangement, CCF holds a minority ownership interest in Weston Dialysis Center, LLC. CCF provides oversight and management of the medical services provided at the various sites, as well as a Medical Director. DaVita provides the management of the facilities. The various services provided by the parties are delineated in a separate Management Services Agreement and a Medical Director Agreement entered into by the parties, the fees under which are commensurate with the fair market value of the services provided.

Department of E-Radiology

CCF established the Department of E-Radiology to provide specialist and sub-specialist radiologist services and quality assurance programs for all imaging modalities via teleradiology to more remote sites that are not in the immediate vicinity of CCHS. The goal of these arrangements is to assure the availability of high quality, technologically advanced clinical services and professional providers in a more cost-effective and clinically efficient manner than the sites can achieve on their own; and to support services that enhance the ability of community physicians to provide specialty diagnostic services for their patients, thus improving the access to and quality of patient care available to these outlying communities. A subsidiary of CCF subleases to these centers quality diagnostic equipment and arranges for equipment maintenance services, access to a state-of-the art software program that enables images to be transmitted via teleradiology, and management services.

Two of these arrangements established by E-Radiology currently involve, at least in part, a sharing of certain management revenues. These arrangements are described below.

While these are not joint ventures in the traditional sense (*i.e.*, no separate entity was established by the parties), we have included them in our response since they involve more than economic participation.

The first arrangement involves the provision of services (as described above) by CCF for two independent diagnostic testing facilities (“IDTFs”) in Niles, Ohio and Boardman, Ohio (approximately 65 miles and 77 miles from CCF main campus, respectively) which are operated and partially owned by a physician group. Niles is located in Trumbull County and Boardman is located in Mahoning County, both of which are designated as Medically Underserved Areas by the U.S. Department of Health and Human Services. The physician-owners are radiologists who do not refer to the site. Further, the arrangement precludes referrals for professional services between the IDTFs and CCF. Under the second arrangement, CCF owns and operates an IDTF located in Twinsburg, Ohio, which is in Summit County, also designated as a Medically Underserved Area. A for-profit diagnostic imaging company provides certain services to CCF; however it does not perform any marketing services, it does not have physician-investors and is not otherwise in a position to refer patients to the IDTF.

Question 9. *Do any of your hospital or hospital system joint ventures have charity care policies that require certain types or amounts of charity care to be provided? If so, please describe such policies, and how they are similar to or different from your hospital’s charity care policy. Also explain the role your hospital has in assuring that the charity care policy of the joint venture is enforced. If your organization does not track charity care expense by such categories, please explain why not, and provide a narrative response that explains whether there are certain categories of care for which charity care is more important or is not relevant.*

Please see the response to Part A, Question 8 for a discussion of the charity care policy implemented in CCF’s joint venture with Tenet.

CCHS does not track charity care expenses provided by its joint ventures. Please see the response to Part A, Question 14 for more information.

Please see the response to Part A, Question 1 for a discussion of the categories of care that are covered by the CCHS charity care policy.

Question 10. *Please respond to the following assertion: Many nonprofit, tax-exempt hospitals engage in joint ventures that shift the most profitable and valuable procedures, practices, and income streams to the joint ventures so that the greater profits and value may be shared with physicians and other for-profit persons.*

CCHS does not engage in joint ventures that shift the profitable procedures, practices and income streams to joint ventures. Please see the introductory paragraphs to this Joint

Venture section and the answer to Part A, Question 11, below for an explanation of considerations CCF uses in evaluating potential joint ventures.

Question 11. How do you assure that your joint ventures with others do not deplete your hospital's resources that otherwise would be available for charity care, such as by tying up cash and other liquid assets in the investments in the joint venture?

As noted above in the introductory paragraphs to this Joint Venture section, CCF is the only entity within CCHS that participates in joint ventures (other than the Meridia Health System in the Premier relationship described in Question 7 above).

CCHS's joint venture activity is limited, therefore arrangements are evaluated on a case-by-case basis at the appropriate level of management with Board oversight. As described above, the types of joint ventures CCHS enters into are supportive of CCHS's mission for a targeted purpose to address a particular need that has been identified. Controls and other mechanisms are structured properly to preserve CCHS assets. Significant risk exposure or expenditures of assets receive Board-level attention, in addition to the review at the highest levels of management. These arrangements are thoroughly reviewed with regard to CCHS's tax exempt mission and the risk to the organization. CCHS regularly reviews the arrangements for financial and regulatory compliance. CCF retains the right to evaluate the joint ventures on an on-going basis, continue to participate so long as the arrangement acts in furtherance of CCF's charitable mission and terminate its participation in the joint venture if necessary.

Question 13. In your judgment, should the Federal tax law require each joint venture in which a tax-exempt hospital participates to have a charity care requirement? If so, should the amount of the requirement differ depending upon the extent of ownership by exempt hospitals in the joint venture?

Tax exemption is advanced whenever hospitals provide uncompensated care to the indigent, the uninsured or underinsured. Under current law, whether the hospital has met the burden of showing qualification for tax exemption is judged by the community benefit standard, which recognizes the potential for a variety of means for fulfilling the healthcare needs of our nation's diverse communities.

As discussed above, joint ventures are entered into for a wide variety of reasons and the joint ventures themselves serve a wide variety of needs, depending on the community in which they operate. This requires a flexible approach to determining which services are best suited to a particular community and how best to allocate limited resources to meet the needs of a particular community through the joint venture. CCF carefully considers the needs of the community when establishing joint ventures. The level of charity care appropriate for a given joint venture should be a function of needs of the community served by the joint venture and available resources, not the level of the exempt organization's ownership in the joint venture.

Question 14. How does your hospital account for charity care provided by a joint venture in which the hospital participates? For example, if your hospital is a 50% owner of a joint venture, and the joint venture provides \$100 of charity care, do you count \$0, \$50, \$100, or some other amount, as charity care provided directly by your hospital?

CCHS does not include in its Audited Financial Statements any charity care amounts provided by the joint ventures described in Part A. Question 8 above.

In the joint ventures described in the above answer to Part A Question 8, CCHS holds a minority interest and, pursuant to GAAP, reflects income or losses from the joint venture as equity income, rather than consolidating the financials.

However, for federal tax purposes, the activities of the joint ventures are treated as a related charitable activities, and as, such income or losses are related income.

Due to the fact that CCF directly employs physicians, the CCF charity care policy applies to professional services billed by CCHS employed staff physicians at any of these joint venture facilities and is included in the CCHS charity care figures.

Question 17. In general, does partnering with for-profits in a joint venture arrangement have implications on the provision of charity care and the satisfaction of the community benefit standard by the joint venture or by the overall hospital system that participates in the joint venture?

In general, partnering with for-profits does not necessarily impact the ability of tax-exempt hospitals to provide an appropriate level of charity care and otherwise meet the community benefit standard.

A Section 501(c)(3) organization may form and participate in a partnership with a for-profit organization and meet the operational test for exemption under Section 501(c)(3) if: (i) participation in the partnership furthers a tax-exempt purpose; and (ii) the partnership arrangement permits the exempt organization to act exclusively in furtherance of its exempt purpose and only incidentally for the benefit of the for-profit partners. *See Revenue Ruling 98-15 and Revenue Ruling 2004-51.*

When CCHS is analyzing participation in a joint venture, CCHS acts in accordance with the considerations set forth above, and each arrangement is reviewed to ensure that it is an appropriate use of assets and that it furthers CCF's mission.

PHILANTHROPY

Question 16. Please describe any fund-raising activities conducted by your hospital in an attempt to supplement fees for services and other revenues. Specifically, provide for the last three years the amount of charitable donations received by your hospital. Does

your organization ever conduct fund-raising activities which commit the donations raised by the activity to be used to provide medical care to low-income or uninsured individuals or families?

CCHS's Office of Development coordinates the fund-raising activities on behalf of CCF and CCHS. The Office of Development received in pledges and new gifts approximately \$131 million in charitable donations in 2004; \$127 million in 2003; and \$97 million in 2002.²⁰ Most donors designate their gifts to a particular program or fund to support their specific areas of interest. If the donor does not designate how the gift is to be used, it is deemed an undesignated gift which is then allocated to the area of greatest priority. For substantial gifts, the Board of Trustees of CCF designates the area(s) of greatest priority at the time of the donation, based on institutional needs.

There are particular funds that help pay for care provided to indigent patients, such as the Dr. William E. Lower Special Account (established to provide beds in the hospital for indigent patients with genitor-urinary problems); the James Brown Endowment Fund, the Dr. Thomas E. Jones Memorial Fund, the Michael J. Clemens Fund for Palliative Care, and the Joseph Gibson & Ella Laughlin Moore Memorial Fund (all established to assist indigent patients requiring medical care or treatment); and the Zakat Fund (established to assist financially needy Muslim patients being treated at the CCF irrespective of their nationalities).

Additionally, certain fund-raising activities are targeted to provide funds for programs which provide medical care to patient populations that historically have been comprised of low-income or uninsured and underinsured individuals and families. A few examples of these programs are described below:

Minority Men's Health Center

The Office of Development has an active campaign to support the Minority Men's Health Center whose mission addresses health disparities in our local minority population by treating not only urological diseases and disorders, but by also serving as a conduit for underserved patients needing access to other healthcare services. The Minority Men's Health Center recognizes that the minority community faces economic barriers that lead to disparities in access to the medical system and patient education. As the region's largest healthcare system, CCHS attempts to address this health care crisis that exists within the minority community through structured programs of clinical care, research, community outreach, patient education, and facilitated patient access. Free periodic Minority Men's Health Fairs are conducted in order to screen for prostate cancer, colon cancer, diabetes, hypertension, glaucoma, and other conditions. These Health Fairs take place at the main campus and at the 14 Family Health Centers throughout Northeast Ohio. All patients are seen regardless of insurance status and, when applicable, provided assistance to enroll in programs such as Medicaid and Ohio's Hospital Care Assurance Program, so they may get the care they need.

²⁰ CCHS Data

Vision First

Vision First is described more thoroughly in the response to Part A, Question 22, above. Vision First is funded primarily through targeted donations to keep this vital program to serve inner-city children.

The Children's Hospital at The Cleveland Clinic

The Children's Hospital at The Cleveland Clinic ("The Children's Hospital") actively seeks donors (individuals, corporations, and foundations) to support funds that provide care for indigent care as well as to enhance the psychological, emotional, and financial well-being of patients and their families. Oftentimes, families cannot financially afford care and/or services for a variety of reasons and The Children's Hospital strives to ensure that every child, regardless of financial standing and/or insurance circumstances, receives the care of The Children's Hospital.

Additionally, funds are actively sought to support The Cleveland Clinic Children's Hospital for Rehabilitation. The Cleveland Clinic Children's Hospital for Rehabilitation houses the only freestanding pediatric rehabilitation hospital in Ohio, and one of a few of its kind in the nation. Its mission is to improve the quality of life and health status of children with chronic illnesses and disabilities by offering compassionate and innovative medical, surgical and rehabilitative care. The staff works together to provide a comprehensive, coordinated and family-centered program of services, research and education with the goal of maximizing each child's potential. Children and their parents are offered extensive family education. Specialty programs offered include the following: Pediatric Kidney Dialysis, Center for Autism, Feeding Disorders Program, Motor Control Program, Specialized Family Care (foster care) Program, Traumatic Brain Injury Program, and Wheelchair and Seating Clinic. An example of one of The Children's Hospital's specific campaigns targeted towards programs at The Cleveland Clinic Children's Hospital for Rehabilitation is the Center for Autism's Family Assistance Fund. This fund is designed to financially assist families with two or more children with autism receiving self-pay services (either full tuition or a portion) through the Center for Autism. The goal of this program is to offer assistance to families who are financially responsible for services. Insurance oftentimes does not cover the extensive services required to treat autistic children.

Partnership for Families

The Partnership for Families Program was established to further CCHS' charitable purposes by providing a second cycle of In Vitro Fertilization ("IVF") at no cost to infertile couples for whom a second cycle is not financially feasible. This Program is funded by gifts made through CCHS' Office of Development. It recognizes the psychological and financial impact of infertility, and its mission is to assist these couples realize their dream of having a child. The Board administering this program consists of approximately 23 couples from various backgrounds who have experienced infertility or knows someone who has, and appreciates the financial and psychological impact of

infertility. The Chair of the Board is a CCF Board of Trustees member; the Physician Advisor is a CCF staff physician. Couples who have had one unsuccessful cycle but cannot afford a second cycle may apply to the Partnership for Families Program. If the couple is selected by meeting certain medical and financial prerequisites, the Partnership for Families fund will cover the expenses associated with the process, except for the medications which are donated by the pharmaceutical company who manufactures the medications used for IVF.

PART B: PAYMENTS/CHARGES/DEBT COLLECTION/TAX-EXEMPT STATUS AND OTHER ISSUES

Relationship of Charges to Costs and Payments

Question 1. Please explain what is the average mark-up of charges over costs? What is the average private pay contractual allowance (charges to payments) weighted by payer?

CCHS does not have a set “mark up” rate of charges to costs that it applies in a mechanical or formulistic manner. CCHS provides an extraordinary array of services, procedures and care to its patients, some of which are provided at cost, and others of which are provided above or below cost. Since this question involves highly sensitive, proprietary business information, CCHS respectfully refers the Finance Committee to the 2004 unaudited cost reports for the CCHS hospitals (see Attachments E.7 through E.11). Please note that the Medicare cost to charge ratio is greater than CCHS’s actual cost to charge ratio because the Medicare program disallows certain costs.

Chargemaster Pricing Methodology and Discount Practices

The following Questions 2-5 are related, and answers to one question may also be responsive to other questions in this group.

Question 2. Please explain the reason for charging “chargemaster” rates to uninsured individuals particularly in light of the Secretary of Health and Human Services’ letter of February 19, 2004 to the President of the American Hospital Association and also in light of your not-for-profit and tax-exempt status.

Medicare rules require hospitals to have one schedule of chargemaster rates that apply to all patients – Medicare, commercially insured, Medicaid beneficiaries and the uninsured.²¹ Prior to the recent HHS and OIG guidance referred to in Question 2, CCHS, as commonly understood at the time, believed that the Medicare rules and guidance on collection practices restricted hospitals from offering unilateral reductions in charges to categories of patients, such as uninsured patients.²² It is still our understanding that this new guidance does not obviate the need for CCHS to have a price list or chargemaster, both to meet ongoing legal requirements and as a management tool.

The chargemaster is required by federal law, as well as by good management practices. CCHS’s bills to patients and its calculation of charges for the purpose of recognizing and recording gross revenues are based on its chargemaster prices. The hospital then deducts

²¹ Historically, this requirement has prevented distortions in Medicare Cost Reports (that could have resulted in higher amounts of cost being allocated to Medicare) and thus has protected the Medicare Program.

²² Outside of safe harbors and other agency-issued guidance for managed care plans and shared risk arrangements.

from gross revenues “contractual adjustments” that reflect the discounts given to commercial payors in exchange for contractual commitments, as well as adjustments based on Medicare and Medicaid payments, and write-offs and discounts based on our charity care policy.

Maintaining a chargemaster or price list is good accounting practice and gives CCHS a way to measure (despite complex payment mechanisms such as DRGs) how much it is discounting its services, which is important management information. This practice also is consistent with Medicare cost reporting regulations, which recognize charity care as a “reduction in charges” made by the provider.²³ The fact that volume discounts are provided to commercial payors, or that CCHS accepts a statutory rate from governmental payors, or that CCHS discounts and writes off charges on a case-by-case basis in accordance with the CCHS charity care policy, does not obviate the need for it to have a price list or chargemaster.

Question 3. Please explain how fairness or reasonableness of charges to the uninsured can be assured even in instances where you offer discounts where those discounts are discounts from the already high chargemaster rate? What is your discount policy? What is the collection rate for self-pay?

CCHS exercises judgment in determining fair and reasonable charges, taking into account the overall amount of funding necessary to secure the ongoing financial viability of the organization. While all patients are “charged” the full list price, the amount due from a patient may be adjusted for various reasons, including charity care write-offs and discounts. Patients who qualify for charity care pay a “discounted rate,” as do Medicare and Medicaid beneficiaries and patients enrolled in contracted third-party benefit plans. Under the charity care policy, patients with incomes up to 400% of the Federal Poverty Income Guideline are eligible for discounts ranging from 100% to 35% of billed charges, and all patients, regardless of income level, are eligible for financial assistance in cases of hardship or extenuating circumstances.

The CCHS charity care policy is described in more detail in Part A, Questions 1 and 4.

Our collection rate for self pay patients is significantly less than our collection rate for insured patients and patients covered under governmental programs, and amounts collected from self pay patients do not cover our costs of providing care to this patient population.

²³ 42 CFR 413.89.

Question 4. If government programs pay for hospital services for its enrollees without regard to the chargemaster rate and commercial insurance carriers throughout the country likewise pay not based on the chargemaster rate, please explain why the uninsured continue to be charged the chargemaster rate?

The Medicare program, the single largest payor for hospital services, as well as the various state Medicaid programs, pay at levels established by statute and administrative procedures. However, it is not accurate to state that government programs pay for hospital services without any regard to the chargemaster rate. The Medicare program requires hospitals to report their full charges so that it can identify its portion of total charges for the application of certain formulas. Moreover, hospital charges are used to establish the cost to charge ratio that drives certain aspects of hospital reimbursement, such as outlier payments.

With respect to commercial payors, CCHS negotiates contractual adjustments to its list prices in order to participate in limited access health benefit plans that direct patients to our facilities (through in-network benefits, lower copays and deductibles, etc.), and in exchange for prompt pay requirements and other negotiated contractual commitments.²⁴ CCHS's collection rate on commercial accounts is significantly higher than its collection rate on self pay accounts, and payments are more timely. These contractual commitments have economic value which justifies a discounted rate. CCHS may reserve the right to require a payor to pay the full chargemaster rates if it fails to meet these commitments, especially the prompt pay and benefit design requirements.

In the case of uninsured and underinsured patients, CCHS voluntarily discounts or writes off its charges, based solely on financial need, in accordance with its charitable mission.

Question 5. Please explain what is the economic benefit to your hospital of charging uninsureds the high chargemaster rate when uninsured people generally have less of an ability to pay hospital charges and do in fact generally pay only a fraction of what has been charged? Does this benefit justify your action particularly in light of your not-for-profit tax-exempt status?

There is little or no overall economic benefit to CCHS from charging self-pay patients the chargemaster rate because of the low collection rate, as noted above in response to Part B, Question 3, and because many self-pay patients are eligible for free or discounted care under our charity care policy. Our approach to pricing services is not directed at self-pay patients. CCHS recognizes that persons who are uninsured and underinsured may have difficulty paying for medical services, especially when faced with unexpected illness, high cost procedures, or chronic disease, and for that reason, CCHS has long maintained a charity care policy, which is described in Part A.

²⁴ In Ohio, commercial managed care payors (other than ERISA plans and payors administering governmental plans), are subject to the Ohio prompt pay law, Ohio Revised Code Sec. 3901.38 et. seq. Federal regulations set payment standards for ERISA and other governments sponsored plans. None of these requirements are applicable to self-pay patients.

In addressing issues of access to medical care, there is not a bright line between the insured and the uninsured. All uninsured are not poor; conversely, some patients with insurance have difficulty paying medical bills. Through its charity care policy, CCHS recognizes the vulnerability of insured and underinsured patients as well as fully-insured patients struggling with extenuating circumstances, and provides assistance to all patients, not just the uninsured. Please see our response to Part B, Question 6, below, which describes the various ways in which CCHS communicates its charity care policy to patients.

Informing Patients About the Hospital Charity Care Policy

Question 6. The Committee has heard statements from individuals that have gone to many not-for-profit, tax-exempt hospitals in the very recent past and have seen no evidence of the fact that they make their tax-exempt and charitable missions known to patients via signs in patient access areas, brochures, booklets and the like. Please comment on what your hospital does to provide such visible information on the subject.

Informing the public that charity care is available is an important element of the CCHS charity care program. Information about the charity care policy is posted on the CCF website, www.clevelandclinic.org (click on “Understanding Your Bill”), and is available in the form of handouts, “tear off sheets,” and on patient’s rights and responsibilities posters, and to patients at intake, admitting, and registration points throughout CCF.

Likewise, information about financial assistance programs is available at CCHS regional hospitals in the form of patient friendly billing pamphlets located at the point of registration and in patient rooms, and on signs (with mandated language about the Ohio HCAP program written in English and Spanish). An informational hand-out describing the CCHS Charity Care and Financial Assistance Program, written in English and in a second language common to the population of the area served (Hispanic, Russian, or Italian), will be available in all CCHS regional hospitals in July 2005 for front line employees to give to patients.

The information described above is available to all patients presenting in CCHS Emergency Departments; however, in compliance with EMTALA, care is provided in all emergency cases without regard to ability to pay. Additionally, financial counselors are present on-site at all CCHS hospitals and by telephone to assist patients in qualifying for governmental assistance programs and hospital charity care. All self-pay patients, as well as insured patients who express concern about their ability to pay for health care services, at the time of service or at any time thereafter, are referred to financial counselors or financial service representatives for information and assistance.

Information about the CCHS charity care policy and the availability of financial assistance is shared with patients during the billing process, and throughout the collection process. CCF provides a patient friendly billing brochure that describes the charity care policy and provides contact numbers, and patient statements include detailed information

regarding the charity care policy. The CCHS patient statements also are being updated to include this information.

CCHS is continuously improving its communication with patients on the availability of charity care. Key information has been translated and made available for our non-English speaking population. In addition, signage throughout the system is being updated to ensure accuracy and uniformity.

Copies of all the foregoing patient information materials, describing the charity care program and available financial assistance programs, can be found at Attachments B.3 through B.6, B.14 and B.15.

Training and Education for Front Line Staff

Question 7. Please identify what steps your hospital has taken to insure that lower level staff, who are actually the front-line staff, are aware of your not-for-profit status and charitable mission and have been instructed to implement the same in their treatment of uninsured patients. Please produce any documents conveying such information to your staff.

Front-line intake and registration staff and financial counselors are informed of their duties, responsibilities, and CCHS policies at regularly scheduled staff meetings and in training programs. Topics include the HCAP program, other financial assistance programs, and how to access eligibility vendors to assist patients with enrollment requirements. For example, the rollout of the expanded charity care policy in 2004 was accompanied by extensive, systemwide training of front line staff, financial counselors and patient financial services personnel. Further meetings were held in January-February 2005 for employees in the outpatient Family Health Centers.

Copies of the meeting agendas, handouts and follow-up memoranda, customer service script and a PowerPoint program, are included at Attachments B.7 through B.10.

Medicare Regulatory Concerns

Question 8. If your hospital believes that Medicare rules created roadblocks to providing discounts to the uninsured, as is evidenced by the President of the American Hospital Association's (AHA) December 2003 letter to the Department of Health and Human Services, why did your hospital, or your hospital through the AHA not raise the same with the Department at an earlier date? In considering this question it is noteworthy that in December of 2002, Trevor Fetter, the CEO of Tenet Healthcare, stated in an investor conference call "I would like to turn to an issue that has bothered me for years. I mentioned earlier that Medicare requires hospitals to set charges the same for everyone. This means that the uninsured or underinsured patient receives a

bill of gross charges. In other words, the entire hospital industry renders its highest bills to the customers who are least able or likely to pay.”

In addition, please state whether your organization ever grossed up their charges on the Medicare cost report because they had a lower OPD fee schedule? Please state your views on whether it is allowable or acceptable for hospitals to lower their charges for the insured and not the uninsured?

As discussed above in response to Part B, Question 2, prior to the HHS and OIG 2004 guidance on this issue, and as commonly understood at the time, CCHS believed the Medicare rules on charges and collections to restrict hospitals from offering unilateral reductions in charges to categories of patients, such as uninsured patients, unless protected by an applicable safe harbor or statutory exception, such as shared risk arrangements. Accordingly, CCHS developed guidelines for addressing the financial needs of its patients on a case-by-case basis. For the reasons discussed above, CCHS believed that this approach was fair and appropriate, and served its charitable mission. As noted in our response to Part B, Question 11, below, CCHS would be open to discussing alternatives to the current chargemaster pricing methodology.

CCHS has not grossed up its charges on the Medicare cost report because they had a lower OPD fee schedule.

Impact of Charges on Outlier Payments

***Question 9.** It has been suggested that one of the reasons that a hospital may have maintained these high chargemaster rates is that it allows the hospital to obtain more in the way of Medicare outlier payments thus further costing the government additional money for the care of the uninsured.*

Please explain why your hospital, as a tax-exempt not-for-profit hospital, feels that this is appropriate or inappropriate. What was the growth rate in your Medicare outlier payments from 1998 to 2002?

CCHS has not adopted a strategy to increase outlier payments through charge adjustments, and we would find such a strategy unacceptable. The growth rate in CCHS outlier payments from 1998 to 2002 averaged 9.2% annually at CCF, and 10.3% annually for the Health System as a whole. However, the calculation of the average annual growth rate in outlier payments fails to take into account the increase in Medicare discharges during this time period, or increases in acuity and case mix. At CCHS, the number of Medicare discharges increased 3.8% annually from 1998 to 2002. In addition, while Medicare outlier payments to the Health System have increased and decreased during the time period 1998-2002, CCHS hospitals have at all times met the standards identified in CMS Transmittal No. A-02-122, dated December 3, 2002, for determining whether a hospital might be receiving excessive outlier payments.

Disproportionate Share Hospital Payments

Question 10. Secretary Thompson, in his letter mentioned above, noted that “Medicare and Medicaid have a long history of doing their part to help the uninsured that includes paying hospitals \$22 billion each year through the disproportionate share hospitals’ provision to help hospitals bear the cost of caring for the poor and uninsured.” In light of the fact that you are a tax-exempt not-for-profit hospital, please comment on whether or not you believe it is appropriate for your hospital to receive such aid from the government. Please list your payments under disproportionate share for the past three years as compared to uncompensated care, separating out bad debt.

Disproportionate share hospital (“DSH”) funds are provided through both the Medicare and the Medicaid programs. DSH payments are “additional payments in the Medicaid and Medicare programs that, along with local tax appropriations, help hospitals finance care to low-income and uninsured patients. DSH payments also ensure communities have access to high-cost services, such as trauma and emergency care, burn services, and specialty care in children’s hospitals.”²⁵

The Cleveland Clinic Health System believes it is appropriate for our organization to receive Medicare and Medicaid DSH funds. These funds do not fully compensate our organization or others in Ohio for the cost of care rendered to Medicare, Medicaid and uninsured patients.

The Medicare and Medicaid DSH programs are administered differently, but in neither case is payment tied to for-profit or nonprofit status. Medicare DSH is based on the hospital’s percentage of Medicare SSI patients and Medicaid patients. Medicaid DSH is a joint federal-state program, and states have more flexibility to establish the criteria for distributing funds. A hospital is designated as a Medicaid DSH hospital if its low-income utilization rate is 25% or more, or its Medicaid utilization rate is greater than the mean Medicaid utilization rate in the state. States also have authority to designate additional hospitals as DSH.

In Ohio, Medicaid DSH funds are distributed under the Hospital Care Assurance Program (“HCAP”). The State of Ohio assesses a tax on hospitals, and pools the funds with the purpose to redistribute the monies to the contributing hospitals in proportion to their relative charity care expenditures, subject to changes in the distribution methodology adopted by the State and changes in the federal share. The State of Ohio receives a federal match, which, when added to the State pool, increases the amount available for distribution to each hospital from the original offering.²⁶

²⁵[http://www.naph.org/Content/NavigationMenu/About Our Members/Frequently Asked Questions1/FAQpdf2.pdf](http://www.naph.org/Content/NavigationMenu/About%20Our%20Members/Frequently%20Asked%20Questions1/FAQpdf2.pdf)

²⁶http://www.lbo.state.oh.us/123ga/publications/special/ohioissues/issue_07.pdf

The Medicare and Medicaid (HCAP) DSH payments to CCHS for the last three years for which such information is available appear below:

CCHS MEDICARE DSH PAYMENTS

2004	2003	2002
\$10,940,417	\$7,467,435	\$5,248,258

**MEDICAID DSH (Ohio HCAP)*
CCHS Assessments and Distributions**

	2004	2003	2002
Assessment from CCHS	\$20,688,320	\$18,707,620	\$20,416,290
Distribution to CCHS	\$26,506,928	\$28,206,218	\$35,173,937
Net Amount	\$5,818,608	\$9,498,598	\$14,757,647

Information regarding uncompensated care provided by CCHS for the same time period is presented in the following table:

CCHS TOTAL UNCOMPENSATED CARE²⁷

	2004	2003	2002
Bad Debt Expense	\$99,797,000	\$85,140,000	\$70,605,000
Charity Care	\$251,104,000	\$201,379,000	\$157,251,000
Total Uncompensated Care	\$350,901,000	\$286,519,000	\$227,856,000

Alternative Pricing Methodologies

Question 11. Do you agree that the chargemaster method of charging uninsureds should be discontinued? In answering, I would ask that you consider the statement of Mr. Jack Bovender, the Chairman and CEO of Hospitals Corporation of America, one of the largest for-profit hospitals in the country. Mr. Bovender has stated, “the chargemaster system on which hospitals rely to set pricing and billing codes have a 40 year history of changes that have distorted the relationship between price and cost. It grew out of a time when decreasing Medicare reimbursement prompted cost shifting to

²⁷ Calculated based on hospital charges.

the private sector and this was exacerbated in the 90's by aggressive managed care discounting. I am not here to try to justify this and it really needs to be fixed.”

CCHS uses the chargemaster pricing methodology because it is the industry standard and conforms to applicable federal requirements, as discussed in response to Part B, Question 2. Without changes to current cost reporting requirements, legal prohibitions and hospital reimbursement formulas, CCHS would be penalized under Medicare program requirements if CCHS discontinued use of the chargemaster. As indicated earlier, CCHS would support discussion and consideration of new pricing methodologies to replace the industry standard chargemaster by all interested parties, including the government and commercial payors as well as health care providers.

Legal Compliance Advice

Question 12. *At the hearing of the Oversight Investigation Subcommittee of the House Energy and Commerce Committee on hospital billing dated June 24, 2004, Mr. Bovender stated that he “was told by both inside and outside legal counsel . . . [in late 2002] that we had to get clearance [for discounting to the uninsured] through CMS.” Please identify whether your hospital has received such legal advice and if so, please provide any written documentation of that advice.*

The CCHS chargemasters undergo extensive internal reviews by various operating divisions, including the Division of Finance. CCHS is not aware of having received any advice of counsel on this topic.

Documents Regarding Billing Practices for Uninsured Patients

Question 13. *Please provide all documents related to your hospital’s consideration of medical charges for billing practices, charity or indigent care, discounts or write-offs to uninsured patients.*

The Committee is referred to the discussion of this subject, in Part A, Question 1. Documents responsive to this question include the current CCF, CCHS regional hospital and Florida charity care policies, attached at Attachments B.1, B.11, B.16 and B.17.

Documents Regarding Charity Care Policy and Community Benefit Reports, Assessments, Strategy and Audits

Question 14. *Please provide all documents relating to your charity care policy, community benefit reports, community benefit assessment, community benefit strategy and/or charity care audits for the time period of January 1, 1998 through the present.*

In providing the same, please identify specifically where those documents consider your hospital's treatment of the uninsured.

See the responses to Part B, Question 13, above, with respect to the CCHS charity care policy, and to Part B, Question 15, below with respect to community needs surveys and strategies. In addition, various CCHS community benefit reports are attached at D.8 and D18 through 20. Consistent with our charity care policy, CCHS does not direct community benefit programs specifically to the uninsured, but to targeted populations based on financial need and/or special health needs. In many cases, these populations include many uninsured persons.

Documents Regarding Community Needs Assessments

Question 15. Please provide any community needs assessment done by you or on your behalf during the time period of January 1, 1998 through the present. In providing the same, please identify specifically where your hospital considered its treatment of the uninsured in its community needs assessment.

The Cleveland Clinic has had a far reaching mission since its inception in 1921 to meet the needs of the community by providing “*better care for the sick, investigation of their problems, and further education of those who serve.*” CCHS defines the community it serves broadly, to include local residents, citizens of the state, region, country and the international community. CCHS’s assessment of, and outstanding performance in meeting patient needs through education, research, and patient care, are detailed in its response to the Committee’s questions in Part A. CCHS as a whole conducts a broad spectrum of outreach programs and services in the community. CCHS hospitals sponsor a variety of programs for at-risk populations and special needs groups, as well as for the broader community. The specific needs targeted by these programs have been identified by experience and through community needs assessments that identified health problems in the communities served by the hospitals.

In 2001, the Health System commissioned preparation of several community health needs assessments. Reports were prepared for the CCHS eastern region, western region and for Marymount Hospital. Separate assessment reports also were prepared for three hospitals in the eastern region (Hillcrest, Huron and South Pointe). See Attachments D.11 through D.17. Community needs assessments are designed to identify the health status of the community and determine at-risk populations based on unhealthy lifestyles. Thus, they focus on clinical health problems (for example, diabetes, heart disease and obesity), not insurance status. However, at-risk populations in many communities in Cuyahoga County are low income, and individuals in these populations may lack insurance.

Collectively, the community health assessments provided important insights regarding needs and health problems in the geographic regions served by all Health System hospitals, including the CCF academic medical center. In some parts of the metropolitan Cleveland area, both the population demographics (rate of education, unemployment

rates) and physical and mental health ratings (percentage experiencing depression or poor health) are worse than the state average. These community needs assessments paralleled similar, national efforts conducted by the Centers for Disease Control and Prevention and were based on telephone interviews and census data. The data gathered in the assessments informed development of community outreach programs described in Attachments D.11 through D.17.

Collections Activities

Question 16. Please identify how many lawsuits you have filed against uninsured patients for the current year and the preceding five calendar years and please identify whether or not you are compelled by law to file such lawsuits in order to collect from these individuals. Please identify the amount of debt that was at issue in each suit. Please identify any times you have sold debt owed to the hospital from uninsured patients to other companies for collection.

Please state the amount the debt(s) was sold for, and the terms under which such private collection accounts were sold. In particular, please estimate the volume and value of accounts sold to private companies in the past five years, and whether those sales were made after your hospital rigorously pursued the patient on its own, and whether or not the hospital also claimed those same accounts for purposes of collecting the 70% bad debt payments made available to hospitals that despite best efforts, fail to recover aged patient accounts. Please explain how the sale of private accounts for recovery, and an concomitant claim to Medicare for payments on the same debts, is not “double dipping.”

Please provide copies of your contracts, if any, with collection agencies. Please identify whether this collection agency is a for-profit or nonprofit subsidiary of your organization. Please discuss any financial relationship with a bank or credit card company that patients use to help finance their debt. Please explain if you differentiate between Medicare and Non Medicare patients in regard to debt. If you sell debt, what is your policy on when that debt is sold, particularly in terms of the age of the debt.

CCHS does not target the uninsured for debt collection suits. To the contrary, CCHS works aggressively on behalf of patients to seek out and verify insurance coverages, including COBRA benefits for patients even when the patients themselves are uncertain if insurance is available, still active, or even applies. In fact, more typically, CCF has filed suit on behalf of patients against insurance companies to force declarations of coverage and payment of claims.

Additionally, CCHS employs financial counselors to work actively with patients to identify and qualify them with payors and with any and all available public assistance programs (such as WIC, Victims of Crime Programs, Children’s Assistance Programs, and Ohio’s HCAP Program).

The uninsured are not singled out for suit. CCHS estimates that less than half (41%) of collections-related suits filed since March 2003 have been against self-pay patients. It has also been necessary to file suits against insured patients who refused to submit a claim for coverage, who had insurance and received direct payment from the insurance company but refused to remit funds to CCHS, or patients who had insurance but refused to pay their co-pays/deductible as required by their insurance policy.

Lawsuits are not required to collect debt from individuals. Suits are filed when voluntary collection and payment arrangements fail, such as when patients refuse to cooperate with CCHS representatives in the billing process, and then, only if a patient has verified income and assets (job, real property, bank accounts). CCHS is statutorily required to perfect claims in two circumstances: in the probate court for medical debt owed by the estate of a deceased patient, and in the bankruptcy court for debt that may be owed by a bankrupt debtor. CCHS’s role in probate court proceedings usually is passive; most often the probate attorney has previously identified medical bills as an anticipated debt of the estate. With respect to bankruptcy matters, CCHS does not “force” the patient into a bankruptcy filing; rather, CCHS files its claim only after it learns of the bankruptcy.

Available records indicate that in the last 5 years CCF commenced suit against main campus patients who lacked verified insurance coverage as follows (information regarding lawsuit data with respect to the CCHS regional hospitals, Cleveland Clinic Florida, and other ancillary sites and services is discussed below):

YEAR	NO. OF SUITS FILED	TOTAL AMOUNT OF DEBT
2000	1	\$25,194
2001	3	\$216,182
2002	0	\$0
2003	1	\$355,474
2004	1	\$25,096
2005	0	\$0

As this chart shows, the number of lawsuits filed by CCF against main campus patients is almost negligible when compared to the number of patients treated at CCF during this time period (*e.g.* approximately 2.7 million patient encounters in 2003; nearly 2.9 million in 2004).

The CCHS regional hospitals do not maintain lawsuit data with all the necessary detail for the time period requested by the Committee. Available information regarding lawsuits filed on behalf of CCHS regional hospitals since March 2003 (a period during which CCHS increasingly standardized its system-wide billing and collection policies and practices), reflect a total of 510 suits against insured individuals, and only 353 against uninsured patients—an extremely small fraction of annual patient encounters, as measured by ER visits and hospital discharges from CCHS regional hospitals: 330,000 in 2003; over 430,000 in 2004.

As to collection activity involving ancillary CCHS services and sites, from 2000 to present, available information reflects that no suits were filed against patients seen by Cleveland Clinic Florida physicians or at the Cleveland Clinic Florida Hospital in Naples; 40 suits were filed for Regional Anesthesia services (lawsuit data does not distinguish the patient's insurance status); and 148 suits were filed against patients seen at a physician clinic in Wooster, Ohio (again, without regard to insurance status). During this same period (2000 to present) Wooster physicians had nearly one million patient visits.

CCHS does not engage in the practice of selling patient debt to other companies for collection.

CCHS is providing the Committee with copies of its current contracts with collection agencies, all of which are independent entities (not subsidiaries of CCHS). However, to protect the competitive interests of the companies, CCHS has redacted the proprietary information relative to each company's fees and pricing structure. (Copies of CCHS's current contracts with collection agencies are compiled as Attachments B.19 and B.20.)

CCHS does not currently refer patients to any particular bank or credit card company to finance debt.

CCHS is required to pursue reasonable collection activities as a condition of federal health care program reimbursement and in accordance with accounting rules for bad debt write-offs. CCHS has been compliant with the CMS regulations that require hospitals to engage in reasonable collection efforts. Accordingly, CCHS does not differentiate between Medicare and non-Medicare patients with regard to debt.

Off-Shore Bank Accounts

Question 17. Please identify any money or investments that your hospital or related organization (including supporting organization or private foundation) has in off-shore bank. Identify the amount in these accounts. Please explain why your organization has taken this action.

In conjunction with the operations of its two captive insurance company subsidiaries based in the Cayman Islands, CCHS has made deposits in offshore bank accounts. These accounts are modestly sized and used to pay administrative expenses incurred by the companies. As of June 30, 2005, there is less than \$75,000 in these accounts.

CCHS maintains a captive insurance program to address the medical malpractice crisis that exists in Ohio (and in many other states). CCHS maintained a self-insurance arrangement with a domestic carrier until that carrier went into receivership in December 1997. Shortly thereafter, CCHS organized its captive insurance program in response to the lack of viable domestic carriers willing to underwrite physician malpractice liability insurance in Ohio. CCHS competitively bids its insurance program annually.

Type I and Type II Supporting Organizations

Question 18. Please provide an organization chart including Type I and Type II supporting organizations. The chart should identify ownership interest and the type of organization (nonprofit, for profit, partnership, etc.).

CCHS is providing the Committee with current organizational information as reported in the 2004 Cleveland Clinic Health System Obligated Group Offering Statement (the "OS"). In particular, see Attachment A.1, p. A.3 for the operational chart reported in Appendix A of the OS; see also Attachment A.3 for a copy of the corporate structure chart reported at p.3 the OS.

CCHS received a group exemption letter from the IRS on July 25, 2000. See Attachment E.21. As such, CCF is the parent organization in the group and all of its affiliated tax exempt entities (as of that date) are "subordinate" organizations recognized as exempt from taxation pursuant to Section 501(c)(3) and Section 509(a) of the IRC. The current roster of subordinates is included in the 2004 CCHS annual group listing provided at Attachment E.22; see therein Exhibit IV.C.

CCHS has also prepared a listing of all CCHS affiliates identifying the name of each affiliate, its tax status, including as applicable, IRC Section 509(a)(1), (a)(2) or (a)(3) status, and the type of supporting organization. See Attachment E.23. As explained above, the affiliates listed in Attachment E.23 are the current subordinates in CCF's group exemption as reported to the IRS. They are also the same affiliates listed in Part VI, Line 80B of the Form 990, as all tax-exempt organizations are required to report to the IRS. See Statement 14 in Attachment E.18.

Hospital Charges and Federal Tax Exemption

Question 19. Some hospitals have taken the position that the provision of healthcare, no matter the cost to the patient, is inherently charitable. Do you agree that the provision of health care to uninsureds is charitable even if there is a high charge associated with it? If so, please explain.

CCHS believes it has an obligation to assure reasonable access to medically necessary health care services to persons in their community. In support of that obligation, CCHS's charity care policy provides free or heavily discounted care to persons with incomes up to 400% of the Federal Poverty Income Guideline, and permits a case-by-case determination of financial assistance in all other cases. In addition, CCHS provides a substantial array of additional community benefits including medical education, advancing knowledge through research, subsidized health services, and many other programs for our community. CCHS's resources are directed to serve community needs throughout the areas served by the Health System. While we do not take the position that the provision of healthcare automatically qualifies an organization as a tax-exempt charitable

organization, the overall community benefit provided by CCHS, including its charity care policy, clearly meets the community benefit standard articulated by the Internal Revenue Service. In addition, in accordance with Internal Revenue Service requirements, CCF and the CCHS regional hospitals are organized and operated for the purpose of serving this charitable mission, and not for the benefit any private person or shareholder.

Question 20. Some hospitals have stated that all patients, insured and uninsured alike, are charged the same amount for services. It seems that this is a response based on semantics as it is my understanding that all insureds and government payors ultimately are expected to pay less than the chargemaster rate while uninsured patients are expected to pay the full amount. Please respond and in your response identify the net effective discount to all patient groups based on contractual or other allowances with those groups and identify the discount offered to uninsured patients as well. Please explain what your policies are for providing elective procedures, ex. breast biopsies, mammograms, colonoscopies, physicals, etc. to the uninsured.

Please refer to our responses to Part B, Questions 2-5 for a more detailed response.

All patients are billed the chargemaster rates; adjustments are made based on governmental program requirements, contractual discounts with commercial payors, or in the case of self-pay patients, pursuant to CCHS's charity care policy. It is not accurate to state that the CCHS "expects" uninsured patients to pay full billed charges, in light of our charity care policy and low rate of self-pay collections. If that statement is accurate, it would be equally correct to say that CCHS expects all publicly and privately insured patients to pay full billed charges because those charges are the reference point for establishing the bill.

The CCHS charity care policy covers many elective procedures that may not be covered by commercial payors. Elective-type procedures including breast biopsies, mammograms, colonoscopies and physicals that often are not covered under commercial policies are treated as medically necessary services when ordered by a physician, and may be provided free or on a discounted basis under the charity care policy.

In accordance with federal and state antitrust laws, CCHS maintains its pricing information on a strictly confidential basis. As discussed in response to Part B, Question 4, a variety of factors determine the level of discounts given commercial payors, and prices paid by governmental programs are set by regulatory processes. Charity care discounts, on the other hand, are provided in accordance with CCHS's charitable mission, and the level of discount is determined by financial need. Thus, we do not believe that the information regarding a net effective discount provides relevant information, and, in addition, such information is proprietary as well as competitively sensitive.

Compensation Information

Question 21. Please provide for the last three years a detailed breakdown of travel of your five top salaried employees: for trips over \$1000 please provide receipts for hotel; meals; airfare and all other reimbursed items as well as the purpose of the trip. Please provide all salaries and other benefits provided to these five individuals for the last three years from any organization identified in question B18. Finally, please detail any payments or reimbursements made to employees for country clubs.

Please refer to Form 990 filed by CCHS for each of the three previous years shown in attachments E.18 through E.20. Also enclosed is a detailed breakdown of travel expenses for the top five CCHS salaried employees for the period from July 1, 2002 through June 30, 2005, provided in Attachment E.24.

Travel expenses were incurred and reimbursement for expenses was paid in accordance with The Cleveland Clinic's Meeting Attendance and Expense Reimbursement Policy and Guidelines, a copy of which included as Attachment E.25. CCF only reimburses for expenses incurred when traveling on CCF business or when attending approved professional meetings or engaging in other pre-approved professional activities. We trust the Committee will treat this information as if it were confidential taxpayer return information pursuant to Section 6103 of the IRC, as amended.

As described above, CCF is an international academic medical center that attracts, educates, and trains healthcare professionals from around the world. CCF physicians also lecture at international medical conferences. In addition, and as described in the introduction to the joint venture section, CCF has a limited number of international collaborations. CCF receives numerous requests for such collaborations and the travel information described in Attachment E.24 includes situations where CCF executives were considering such opportunities.

CCHS has not made any payments to employees for country clubs.