Bill as Introduced

HB 1144-LOCAL - AS INTRODUCED

2000 SESSION

00-2224
10/01

HOUSE BILL ***1144-LOCAL***

AN ACT relative to the property tax exemption of not-for-profit hospitals.

SPONSORS: Rep. Weyler, Rock 18; Rep. Quandt, Rock 20; Rep. Beaulieu, Rock 11; Sen. Krueger, Dist 16; Sen. Brown, Dist 17

COMMITTEE: Municipal and County Government

ANALYSIS

This bill requires the legislative bodies of towns, cities, and districts to authorize the tax exemption for not-for-profit hospitals at least every 3 years.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 1144-LOCAL - AS INTRODUCED

00-2224
10/01

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand

AN ACT relative to the property tax exemption of not-for-profit hospitals.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Not-for-profit Hospitals; Property Tax Exemption; Reference Added. Amend RSA 72:23, V to read as follows:

V. The buildings, lands and personal property of charitable organizations and societies organized, incorporated, or legally doing business in this state, owned, used and occupied by them directly for the purposes for which they are established, provided that none of the income or profits thereof is used for any other purpose than the purpose for which they are established. ***Except where specifically provided in law, the status of the exemption from property taxes for not-for-profit hospitals shall be subject to the requirements of RSA 72:23-o.***

2 New Section; Taxation of Not-for-profit Hospitals. Amend RSA 72 by inserting after section 23-n the following new section:

72:23-o Taxation of Not-for-profit Hospitals. Each city, town, or village district shall, by vote of its legislative body at least once in every 3-year period, affirmatively declare that the buildings, land, and personal property of each not-for-profit hospital within its taxing district shall be exempt from taxation for the not-for-profit hospital's property taxes assessed by the city, town, or district. A negative vote shall authorize the tax collector of the taxing district to assess, collect, and hold any tax revenues received from a not-for-profit hospital under this section in the same manner as provided in law for the tax revenues of the city, town, or village district.

3 Effective Date. This act shall take effect April 1, 2000.

Amendments

Rep. Quandt, Rock. 20
Rep. Weyler, Rock. 18
Rep. Beaulieu, Rock. 11
March 13, 2000
10/04

Amendment to HB 1144-LOCAL

Amend the title of the bill by replacing it with the following:

AN ACT establishing a committee to study the exemption from property taxes for not-for-profit hospitals.

Amend the bill by replacing all after the enacting clause with the following:

1 Committee Established. There is established a committee to study the exemption from property taxes for not-for-profit hospitals.

2 Membership and Compensation.

I. The members of the committee shall be as follows:

(a) Three members of the house of representatives, appointed by the speaker of the house.

(b) Three members of the senate, appointed by the president of the senate.

II. Members of the committee shall receive mileage at the legislative rate when attending to the duties of the committee.

3 Duties. The committee shall study the exemption from property taxes for not-for-profit hospitals, including the process for review of their status by municipalities.

4 Chairperson; Quorum. The members of the study committee shall elect a chairperson from among the members. The first meeting of the committee shall be called by the first-named house member. The first meeting of the committee shall be held within 45 days of the effective date of this section. Four members of the committee shall constitute a quorum.

5 Report. The committee shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the senate president, the house clerk, the senate clerk, the governor, and the state library on or before November 1, 2000.

6 Effective Date. This act shall take effect upon its passage.

2000-3764h

AMENDED ANALYSIS

This bill establishes a committee to study the exemption from property taxes for not-for-profit hospitals.

Municipal and County Government
March 17, 2000
2000-3850h
10/01

Amendment to HB 1144-LOCAL

Amend the title of the bill by replacing it with the following:

AN ACT establishing a committee to study the exemption from property taxes for not-for-profit hospitals.

Amend the bill by replacing all after the enacting clause with the following:

1 Committee Established. There is established a committee to study the exemption from property taxes for not-for-profit hospitals.

2 Membership and Compensation.

I. The members of the committee shall be as follows:

(a) Five members of the house of representatives, appointed by the speaker of the house.

(b) Five members of the senate, appointed by the president of the senate.

II. Members of the committee shall receive mileage at the legislative rate when attending to the duties of the committee.

3 Duties. The committee shall study the exemption from property taxes for not-for-profit hospitals, including the process for review of their status by municipalities.

4 Chairperson; Quorum. The members of the study committee shall elect a chairperson from among the members. The first meeting of the committee shall be called by the first-named house member. The first meeting of the committee shall be held within 45 days of the effective date of this section. Six members of the committee shall constitute a quorum.

5 Report. The committee shall report its findings and any recommendations for proposed legislation to the speaker of the house of representatives, the senate president, the house clerk, the senate clerk, the governor, and the state library on or before November 1, 2001.

6 Effective Date. This act shall take effect upon its passage.

2000-3850h

AMENDED ANALYSIS

This bill establishes a committee to study the exemption from property taxes for not-for-profit hospitals.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 1144 Date

Committee M+C Gov't

**** Please Print All Information ****

Name	Address	Phone	Representing	(check one) Pro	Con
Yvonne Manasi		603695 7354	Anthem BCBSNH		X
Katharine Eneguess	122 NO MAIN CONCORD.	224-538-5	Business & Industry		X
Kristen Sheppard	The Bryant Group Cornish, NH	2283322	Wentworth-Douglass Assoc Hospital		X
Kathryn Tanchak	Laconia City Hall	527-1268	City/Laconia		X
Susan Irwin	80 Highland Street	524-3211 LRGH	Laconia NH		X
ANTHONY JULIANO	125 AIRPORT RD. CONCORD.		NH HEALTH UNDERWRITERS		X
Lisa Drouin	Catholic Medical Ctr.	603-663-6053	Manchester NH		X
Lee Quandt	ROCK #20	772-3417		X	
DAVID MINNIS		228-8191	NH HEALTH CARE		X
Pat Kruger	Dist 16			X	
Bob Geiser	Executive Dir		TAX Coll		X

Hearing Minutes

HOUSE COMMITTEE ON MUNICIPAL AND COUNTY GOVERNMENT

PUBLIC HEARING ON HB 1144-LOCAL

BILL TITLE: relative to the property tax exemption of not-for-profit hospitals.

DATE: February 2, 2000

LOB ROOM: 301 **Time Public Hearing Called to Order:** 11:00 am

Time Adjourned:

(please circle if present)

Committee Members: Reps. Hess, Patten, P. Cote, Rice, Brundige, Sabella, Griffin, Leone, Noyes, Hager, Akins, Lovejoy, Lockwood, Foster, Rosenfield, Fraser, Kelley, McGuirk, Salatiello, St. Cyr, Sarette, Simon and Zerba.

Bill Sponsors: Reps. Weyler, Quandt, Beaulieu and Sens. Krueger and Brown.

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

* **Rep. Weyler**: testified in support of this bill, see attached.

Rep. Kelley: If we put this into effect what will prevent the hospitals from raising it's rent?

Rep. Weyler: Feasible but at the maximum of what why can get away with.

Rep. Foster: Why would we want to change something that appears to be working?

Rep. Weyler: The hospitals should try to help reduce healthcare costs in the community.

Rep. Beaulieu: testified in favor as there is too much community, non-profit, charity, and public funds. The cost shifting is unbelievable. Who pays the bill? We think the towns these hospitals are should be able to look at the operations.

Rep. Sabella: Are you suggesting that the hospitals should be returning some charitable acts to the community?

Beaulieu: Yes

Terry Knowles: Attorney General's Office takes no position on the bill but she did say a new "Community Benefits Act" which took place January 1, 2000 has addressed much of this issue. See attached Guidelines Booklet.

Rep. Hess: Is there a statutory provision where people can review the conditions etc. relative to profit and non-profit entities such as hospitals?

Knowles: Yes, public accountability is in effect as of January 1, 2000.

Rep. Akins: Do these organizations have the wherewithal to deal with bad debt?

Knowles: Yes, under RSA 72 it is spelled out about charity and writing off of bad depts.

Rep. Brundige: Are you saying that there is no need for HB 1144?

Knowles: No, just wanted you to be aware.

Maura Carroll: NHMA we do have some concerns about the issue of the property tax exemption. We are looking at hospitals as well. She thinks the sponsors may be looking in the right direction. The property tax, it has to be looked at carefully. There should be a section on the RSA's addressing the non-profit or charitable issue. This has been a very controversial issue for many years. We appreciate what the tax-exempt entities do for the communities, but they may be putting pressure on some of our communities and citizens.

Rep. Hess: Did you say that SB 69 wasn't designed to be involved in tax exemption?

Maura Carroll: Yes

Martin Gross and Leslie Melby testified against the bill. Mr. Gross said he was counsel for NH Hospital Association and Ms. Melby was the Executive Director of NH Hospital Assoc.

✱ Mr. Gross also said 1.) This bill will politicize the local hospitals regarding property exemption especially in 3 communities and 2 hospitals; purely political example also deals with statewide property tax. And 2.) Why no need? Under the law community hospitals must apply for charitable statues each year. Only property used for charitable use is exempt. The state has already passed laws to tighten this up. Lebanon is proof that a community can challenge the hospital. If you wind up pulling the rug out from under the hospital to provide charitable services, it will be a problem. Hospitals pay many taxes on non-exempt property. An example is Concord Hospital. By adding taxes to charitable hospitals, this would deny several thousands of dollars for the benefit of healthcare (including elderly and poor) This would transfer funds from healthcare services to other areas. Statewide $11,000,000 given to community healthcare would be diverted elsewhere. This bill would create a political vote and be very subjective. It would violate many principals of the constitution. He urges ITL at it would totally politicize.

✱ Leslie Melby: offered written testimony (See booklet)

Rep. Brundige: Why don't the hospitals use these organizations that collect bad debt?

Melby: They do, but some aren't successful.

Major Wheelock: Crotched Mountain Rehab appeared in opposition as he thought this would 1.) Single out hospitals 2.) Inconsistent treatment, some are exempt and others are not 3.) Loss of exemption would raise costs, which would raise rates 4.) RSA 72:23N were enacted in 1996 and already allow for all tax exempt properties, not just hospitals Example: Crotched Mountain now pays the town of Greenfield $40,000 in taxes and if this was passed, they could be paying $400,000plus.

✱ Adele Fulton: City of Lebanon supports HB 1144 she thinks based upon testimony thus far it appears as if there needs to be better guidelines or clearly define charity or non-profit organizations

relative to hospitals. She thinks basically the public has been more charitable to hospitals and vice versa.

Rep. Simon: How would you blend your recommendation criteria with a public vote?

Adele Fulton: Through the local officials

The Chairman recessed the hearing at 12:42 until another date to be announced.

Pink cards were set aside for those who did not have a chance to speak.

The following people attended the hearing but did not speak, and voted accordingly:

Yvonne Nanasi, opposes the bill
Katharine Eneguess, opposes the bill
Kristen Sheppard, opposes the bill
Susan Irving, opposes the bill
Anthony Juiliano, opposes the bill
Lisa Dionne, opposes the bill
Lee Quandt, supports the bill
David Minnis, opposes the bill
Pat Krueger, supports the bill
Bob Geisel, opposes the bill

Respectfully submitted,

Rep. Richard Leone, Clerk

Continued public hearing held February 9, 2000 at 10:00 am, ended at 11:33 am

Rep. Quandt: testified in support of the bill. This bill is a home control type bill. The community is being denied taxes.

Rep. Hess: Are you in favor of the concept of having referendum, which would be to review a hospital status every three years?

Rep. Quandt: Right now it is about the best system.

Claudia Mahar: Vice President for Hospital Services of St. Joseph Hospital testified against the bill. She believes that we should continue with the present system. She admits it's a different issue, but feels HB 1144 would jeopardize the program in place. (Charitable status)

Rep. Hess: Do you know what percentage with St. Joseph Hospital of their income is given to bad debt and pre-case?

Ms. Mahar: About the same as other hospitals.

Kevin Callahan: President Exeter Hospital testified against the bill. He bases much of his support to the document presented by Attorney Martin Gross on February 2.

*George Wells, New London Hospital, submitted a letter

He strongly feels that if this bill is adopted it would seriously impact the effectiveness of charitable care given presently by the hospitals. A letter dated 1/20/2000 from Cheshire Medical Center in opposition to HB 1144-see attached.

Rep. Brundige: wanted to know if the town of Exeter charged the hospital for town services such as fire and police? Mr. Callahan said no.

Rep. Kelley: Do you set a limit in those people who are given charitable health care?

Mr. Callahan: No, not if they qualify in that status.

Rep. Kelley: Is it correct that you have about $50,000,000.00?

Answer: Yes, endowment account.

Kevin O"Leary: Finance Officer of Exeter Hospital verified that it was about 50 million.

Rep. Hess: wanted to know about the book value of Exeter Hospital. Mr. O'Leary thought the hospital was about 30 million and another 6 million non-taxable assets.

Rep. Hess: Asked if the charitable care of gross revenue at Exeter was about 1.5-2%?

Answer: thought anywhere from 1.5-3%.

Mr. Callahan said that the premise of most charitable organizations was to have the purpose of giving a free service. Hospitals are put in a very different position as they deliver services in a different way. However, they do make provisions for charitable care and are responsible. He also said that in good economic times a lower percentage of charitable care is given. If an economic slow down should occur, people will not be denied. If it's 3-5% charitable case, so be it.

Rep. Griffin: Do poor people know there are programs available to them at the hospitals?

Callahan: Yes, we try to advertise that. Yes, we have done it. Has it been successful? No.

Rep. Weyler: testified again in favor of the bill. He said not to be mislead by the lack of tax exemptions at the hospitals. We tax the hospitals on rooms and meals and gave much of it back through Medicare money. We administered a 6% hospital tax but get reimbursed 96% of it through the medicaid program. We collect 60 million. The feds give us 60 million and we give it back to the hospitals. He wanted to emphasize there are many mechanisms going.

Rep. Patten: In section 2 of the bill, it gives the legislative body a chance every three years to review the status, what guidance can you give to the hospital communities?

Rep. Weyler: This needs a lot of review. He recommends that is go to interim study.

Rep. Rice: Since these hospitals serve several communities, how do you treat the host community fairly?

Rep. Weyler: Well, host communities make up a lot in sales, use of restaurants etc. from those visiting the hospitals.

Rep. Sarette: Could you explain the difference between non-taxable and taxable part of hospitals?

Rep. Weyler: If a hospital loses their non-for-profit status, they lose greatly in taxes. Presently, they can shift expenses from one area to another easily. (I.e. run clinic at a deficit) He further elaborated that "two things in this state have no competition, education and hospitals"

Rep. Hess: Where is it set up with a separate tax exempt categories for hospitals?

Rep. Weyler: There should be no separation. He said the committee should take a look at the hospitals and get monies out of them as we do with private schools. A hospital of 1920 was more charity oriented in 2000 into a different thing (business looking for tax breaks)

Rep. Hess: The IRS has a designated charity code isn't the state walking into clouded territory?

Rep. Weyler: You have far more faith in the federal government than I do.

Rep. Rosedfield: If the hospital buildings were to be taxed, how would you do it?

Rep. Weyler: It would need to be reviewed.

Rep. Noyes: Do you have an opinion of what a hospital is worth? On a willing seller-willing buyer? If they are going to be asked to do charity, how do you establish a value?

Rep. Weyler: Much depends upon how the hospital is used. Alot will depend on the new owner and how they operate.

Rep. McGuirk: Does the medicaid money have anything to do with this problem? It is used to.....

Attorney Martin Gross testified again against the bill. He wanted to make sure that:

1) Paying taxes won't decrease public benefits. For instance, Concord Hospital pays $500,000 now, but if this law were passed, we'd have to pay an additional $1,000,000 and it would have to come from the public in some way.
2) Hospitals get money from Medicare but go back to the state, the state of NH gets $61,000,000 from Medicare monies, hospitals only process it. NH and Louisiana are only two states using these monies to help state budget.
3) I suggest you can't find a way to make this work. Leave the system as it is. Don't turn this into a political issue. Local government already has the authority to review the process.

Michael Cimon: Adm. of Orthopedic Association testified in favor of the bill. The hospitals of purposely hampered the development of OPA centers, and he claims his program does not receive public funds. He gave another testimony (see attached)

Terry Knowles: of the Attorney General's office gave clarifying information as to what function her office has. They handle the #990 form.

Rep. Sarette: wanted to know what local officials can go by.

Rep. Knowles: Each hospital has to furnish a statement on there by laws, and identify their community and what it offers for services.

Respectfully submitted,

Richard C Kenney

Rep. Richard Leone, Clerk

~~Left the county system~~

~~Absent bill of the poor?~~
Does not vote/much?
Discourage giving?

HB 1144

Relative to the property tax exemption of not-for-profit hospitals

* Rep Weyler testified in support of the bill see attached

Rep Kelly: If we put this into effect what would prevent the hospital from raising its rent?

Rep Weyler: Feasible but at the maximum of what they can annex with

Rep Foster: Why would we want to change something that appears to be working?
Weyler: The ~~Community~~ Hospital should try to help reduce healthcare costs in community

Rep Beaulieu testified in favor as there is too much community, non profit, charity and public funds. The cost shifting is unbelievable. Who pays the bill? We think the towns these hospitals are should be able to look at the operations.

Sabella: Are you suggesting that the hospitals should be returning some charitable acts to the community
Beaulieu: Yes

Community benefits

Terry Knowles of Attorney General's office takes no position on the bill but she did say a new "Community Benefits Act" which took place January 1, 2005 has addressed much of this issue. See attached Guidelines Booklet.

Hess: Is there a statutory provision where people can review the conditions etc relating to prof and non-profit entities such as hospitals?

Knowles: yes, public accountability is in effect as of Jan 1, 2005

Atkins: Do these organizations have the wherewithall to deal w/ bad debt?

Knowles: Yes, under RSA 72:1 it is spelled out about charity and writing off of bad debts

~~Rep Emerton: In this case what the trouble~~

Rep Bandiera: Are you saying that there is no need for HB 1144

Knowles: No, just wanted you to be aware

Maura Carroll, NHMA We do have some concern about the property & income of the property tax exemption — We are looking at hospitals as well

Sen Stands the opposite may be declining in the coming direction. Since the state relies heavily on the property tax, it has to be looked at carefully.

There should be a ~~tax~~ section in the RSAs addressing the non-profit & charitable issue.

This has been a very controversial issue for many years. We appreciate what the tax exempt entities do for the communities, but they may be putting pressure on some of our communities and citizens.

Sen: Did you say that SB69 wasn't designed to be involved in tax exemption stand?
Carroll: Yes - Pa case

Martin Gross & Leslie Melby testified against the bill.
Gross — Council of NH Hosp Assoc.
Melby — Exec director of NH Hosp Assoc.

* Scattered Mr. Gross: (1) this bill will polarize the local hospitals re: prop exemptions, especially in 3 ~~towns~~ communities of 2 hosp., purely political & also dealt w statewide prop tax. (2) Why no need? Under law community hospitals must apply for charitable status each year — only property used for charitable use is exempt. The state has already passed laws to tighten this up. Lebanon is proof that a community can challenge the hospital.

If you wind up pulling the rug out from ~~under~~ under the hospital to ~~give~~ provide charitable services, it will be a problem

Hospitals pay many taxes on non-exempt property. Ex. Concord Hospital

By adding taxes to charitable hospitals, this would deny several thousands of dollars for the benefit of healthcare (indigent, elderly, poor etc)

This would ~~be~~ transfer funds from healthcare needs to ~~something~~ other areas.

Statewide $11,000,000 ~~given~~ community healthcare would be diverted elsewhere

This bill would create a potential mess and be very subjective. It would violate many principles of the constitution.

He urges ITC as it would totally politicized

* Leslie Melby - offered written testimony (booklet)

Rep Brandeis: Why don't the hospitals use these organizations that collect bad debt?

Melby: They do, but some aren't successful

Major Wheelock – Crotched Mt Rehab Ctr

Appeared in opposition as he thought this: (1) Single out hospitals

(2) Inconsistent Treatment – some are exempt and others are not

(3) Loss of exemption would raise costs which would raise rates

(4) RSA 72:23 N was enacted in 1996 and already allows for all the exempt properties – not just hospitals

Ex. Crotched Mt now pays Town of Greenfield $40,000 in taxes --- if this bill were passed, they could be paying $400,000+.

* Adele Fulton – City of Lebanon supports HB 1144

She thinks based upon testimony thus far it appears as if there needs to be better guidelines or clearly define Charity or non-profit organizations relative to hospitals

She thinks basically the public has been more charitable to hospitals than vice versa.

Rep Simon: How would you blend your recommended criterion with a public vote?

Fulton: Through the body the local officials

The Chairman recessed the hearing at 12:42 until another date to be announced

HOUSE COMMITTEE ON MUNICIPAL AND COUNTY GOVERNMENT

PUBLIC HEARING ON HB 1144-LOCAL

BILL TITLE: relative to the property tax exemption of not-for-profit hospitals.

DATE: 2/2/2000

LOB ROOM: 301 **Time Public Hearing Called to Order:**

Time Adjourned:

(please circle if present)

Committee Members: Reps. Heed, Patten, P. Cote, Rice, Brundige, Sabella, Griffin, Leone, Noyes, Hager, Akins, Lovejoy, Lockwood, Foster, Fraser, McGuirk, Salatiello, St. Cyr, Sarette, Simon and Zerba.

Bill Sponsors: Reps. Weyler, Quandt, Beaulieu and Sens. Krueger and Brown.

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

2/09/00

HB 1144 — Continued hearing — 10 AM

Rep. Brandt — Testified in support of the bill
This bill is a home control type bill. The community is being denied taxes

Rep Hess: Are you in favor of the concept of having referendum which would be reviewed a hospital status every three years?

Rep Brandt: Right now it is about the best system.

Claudia Mahar, Vice President for Hospital Services St. Joseph Hospital testified against the bill. She believes that we should continue with the present system. She admits it's a different issue, but feels HB 1144 would jeopardize the program in place (charitable status)

Rep Hess — Do you know what percentage of St Joseph Hospital ~~[illegible]~~ of their income is given to bad debt and pre-care?

Ms Mahar: About the same as other hospitals

Kevin Callahan, Pres. Exeter Hospital testified against the bill. He has much of his ~~[illegible]~~ opposition the document presented by attorney Norton Gross on Feb 2

New London Hospital.

* A letter was sent by Leroy Wells, (see attached)

He strongly feels that if this bill is adopted it would seriously impact the effectiveness of charitable care given presently by hospitals.

* A letter (1/26/90) from Cheshire Medical Center in opposition (See attached)

Rep Brundige wanted to know if the town of and police? Enfield charged the Hospital for town services such as fire Mr. Callahan said no.

Rep Kelly: Do you not account on those people who are given charitable health care?

Mr. Callahan: No, not if they qualify in that status.

Rep Kelly: Is it correct that you have about $50,000,000

Callahan: Yes, endowment account

→ Kevin O'Leary, Treasurer of Exeter Hospital verified that it was about 50 Million

Rep Hess wanted to know what the book value of Exeter Hospital. Mr. O'Leary thought the hospital was about 30 million and another 6 million non-taxable assets.

Rep Hess asked if the charitable care of gross revenue at Exeter was about 1.5-2+%.
M. Callahan thought anywhere from 1.5% to 3%.

Mr Callahan said that the premise of most charitable organizations have the purpose of giving a free service. Hospitals are put in a very different position as they deliver service in a different way. However, they do make provisions for charitable care and are responsible. He also said that in good economic times a lower percentage of charitable care is given. If an economic slow down should occur people will not be denied. If it's 3-5% charitable care, so be it.

Rep Griffin: Do poor people know there are programs available to them at the hospitals?

Callahan: Yes, we try to advertise that. Yes, we have done it. Has it been successful? No.

Rep Weyler testified again in favor of the bill. He said not to be misled by the lack of tax exemptions at the hospitals

We taxed the hospitals on room + meals and gave much of it back through medicare prog. We administered a 6% hospital tax but got reimbursed 96% of it through the Medicaid program.
We collect 60,000,000 -- The Feds give us 60,000,000 and we give it back to the hospitals. We wanted to encourage there are many mechanisms going

Rep Patton: On section 2 of the bill, it gives the legislature body a chance every 3 yrs to assess the status, what guidance can you give to hospital communities?

Rep Weyler: This needs alot of review. He recommends that it goes to interim study.

Rep Rice: Since these hospitals serve several communities, how do you treat the host community fairly?
Rep Weyler: Well, host communities make up alot in sales use of restaurants etc ~~for~~ from those ~~attending the~~ visiting the hospital.

Rep Seratke: Could you explain the difference between non-taxable and taxable part of hospitals?

Rep Weyler: If a hospital loses this not-for-profit status they lose greatly in Texas. Presently, they can shift expenses from one area to another easily (i.e. run clinic at a deficit)

He further elaborated that "two" things in this state have no competition — Education and Hospitals.

Rep Hess: Why set up a separate tax exempt category for Hospitals?

Rep Weyler: There should be no separation. He said the Committee should take a look at the hospitals and get monies out of them as we do w/ private schools. A hospital of 1920 was more charity oriented in 2000 it's a different thing (business looking for profits)

Rep Hess: The IRS has a designated charity code, isn't the state walking into clouded territory?

Rep Weyler: You have had more faith in the Federal Govt than I do.

Rep Rosenfeld: If the hospital buildings were to be taxed, how would you do it (assess it)?

Rep Weyler: It would need to be reviewed.

Rep Hayes: Do you have an opinion of what a hospital is worth? On a willing seller - willing buyer? If they are going to be asked to do charity, how do you establish value?

Rep Weyler: Much depends upon how the hospital is used. Alot will depend on the new owner and ~~how he/she~~ how they operate.

Rep McQuirk: Does the medicaid money have anything to do w/ this problem? This used to

Attorney Morton Gross testified again against the bill. He wanted to make sure that:

(1) Property taxes won't decrease public benefits

For instance, Concord Hospital pays $500,000 now, but if the taxes were phased, would have to pay an additional $1,000,000. and it would have to come from the public in some way.

(2) Hospitals get $'s from medicare but go back to the state

State of NH got $61,000,000 from medicare monies. Hospitals only process it... NH and Louisiana are only 2 states using these monies to help state budget

(3) I suggest you can't find a way to make this work. — Leave the system as it is. Don't turn this into a potential issue. Local Gov'ts already have the authority to review the process.

Michael Cuman, Adm of Orthopedic Association testified in favor of the bill. The Hospitals of Pennsylvania hampered the development of OPA centers. He claims this program does not receive public funds. He gave written testimony (See attached)

Terry Knowles of Attorney Generals office gave clarifying information as to what function her office does. They handle the #990 form.

Rep Sarselle wanted to know what a local official can or can't say.

Rep Knowles Each hospital has to furnish a statement on their tax-exempt, identify their community and what it offers for services.

Sub-Committee Minutes

HOUSE COMMITTEE ON MUNICIPAL AND COUNTY GOVERNMENT

SUBCOMMITTEE WORK SESSION ON HB 1144-LOCAL

BILL TITLE: **relative to the property tax exemption of not-for-profit hospitals.**

DATE: March 7, 2000

Subcommittee Members: Full committee work session

Comments and Recommendations:
Adele Fulton from Lebanon gave an overview of non-profit, broad brush of what's going on. 1970 non profit 48 million tax breaks, 1992 1.2 billion, Federal and state taxes, easy to become a non profit organization, Can a non profit organization make a profit?

NFL, NHL, NRA

What do they do with profits? Expand buildings, give higher salaries

Hospital Medicare, example Harvard University $5 billion 1990
Mayo Clinic 90 million-built an airport

Healthcare organizations are most profitable organizations. Profits from hospitals are being used for something other than what was intended. Small non-profit hospitals are still struggling, considered charitable. In the 18th and 19th centuries hospitals were financed by philanthropists. 20th century changed due to healthcare itself, successful programs at hospitals. Healthcare isn't in itself a charitable endeavor. The issue to qualify is if its operating in a charitable fashion or it isn't. Most hospital administrators are paid generously. Some are paid $300,000-$500,000. Most hospitals give 2-4% to charity care, many invest in other businesses. Large sums of cash on hand

Jim Varnum: President of DHMC Clinic (VA Hospital) committed to healthcare, teaching and research, legislative charter-1889, property exempt from taxation. Acknowledges the bill is problematic. They claim their charitable services extend to a wide area. RSA 732 municipality still has power to grant or deny tax exemptions. He claims Lebanon takes a very narrow view. Why it's a charitable organization:
Never refuses anyone who can't pay
11+ million over past 5-10 years
All resources devoted to care teaching and research
Trains many doctors-biotech
DHMA helps many local communities
Governed by a board of trustees
Keep costs down
Examples of services rendered: CHAD Children's Hospitals, Dialysis services for northern NH & VT and Norris Cotton Cancer Center

He claims programs often lose money but he said they are supplemental / subsidized. DHMC all monies are dedicated to serviced for the benefit of the public.
What is the dispute?
All properties assessed
Hospitals filed for exemptions
Atty. Fulton says land under hospital is held by a holding company, the city denied because the corporation doesn't provide healthcare and the buildings are owned by the hospital, one condo by Dartmouth Medical School, one for skin purposes and one used for hospitals. He also said Lebanon is looking at it as a

compartmental view and not integrated. All condos are being challenged to determine whether they are taxable.

Rep Hess: Can you determine between DHMA and HCA, Columbia, Healthcare etc?

Answer: The mission is to focus on community needs.

Rep. Hess: What vein is Lebanon looking at? What is the difference between 2/3 and 1/3 exemptions? What criteria could be put into law that would resolve both parties?

Fulton: We need to distinguish what qualifies for exemption and what doesn't. We need guidelines for municipalities.

Varnum: this has been brought up in 11-12 states, where clarification is made.

Rep. Brundige: Regarding agreement lieu of taxes with the city?

Varnum: Yes, $2 million, 10 years, $5 million impact fees for water/sewer etc.

Rep. Simon: Define excess profit?

Fulton: Covers operating expenses, bonded debt, updating equipment, if more are you over charging? Why the substantial profits?

Fulton: We haven't started discovery as yet. This review is in a 3-year cycle.

Rep. Hess: What is the lime line on this litigation?

Fulton: Long time because the court thought the parties might work it out. Potential trial date by Feb 2001 or a lot longer.

Rep. Rosenfield: You are not exactly supporting this bill.

Fulton: No, not the way it's written. Each case is different.

Varnum: says just getting the facts out will take a long time.

Fulton: says we need to look at the totality of the organization, salaries, services etc.

Rep. Fraser: wanted to know why this is a problem in so many other states.

Fulton: says because hospitals are operating differently than in the past, very little distinction between profit and non-profit hospitals

Rep. Rice: wanted to know what is profit and what isn't?

Varnum: All funds are placed back into new service, debt service, equipment, programs etc. Profits slow in that net operating margin

Rep. Kelley: If certain standards were put in as an amendment would you support this bill? Is voting at the town meeting or city council?

Rep. Hess: Are you saying this is a fact driven issue? Reviewed on a case by case basis? The criteria has to address non-profit issues.

Rep. Sarette: Process for publishing salaries.

Varnum: Board of Trustees receives no compensation, they are all volunteers

Amendments:

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. _____

Seconded by Rep. _____

Vote: _____

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. _____

Seconded by Rep. _____

Vote: _____

Respectfully submitted,

Richard C. Leone

Rep. Richard Leone
Subcommittee Chairman/Clerk

Fees the types

HB1144 Work Session 3/07/00

Lebanon — Adell Fulton Atty — Represents
City of Lebanon
Hermedy Non-Profit Reform ——

Broad Brush / What is going on —
1970 — Non profit 48 Billion tax breaks
1992 — 1.2 Billion
Federal & State / Rural Trust
→ Easy to become a non-profit organization
Federal
Can a non-profit organization make a profit?
Yes
NFL, NHL, NRA, Hosp.

What do they do w/ profits - Expand,
Construct buildings, give higher salaries
Income
Free American
Hospital Medicine - Medicaid V #5 bill 1990
Ex. Harvard Univ.
$30,000,000 1/2 %
Mayo Clinic
90M = 6+2 M / 14% profit
Built an airport / $773 Million
Health Care Organizations are most profitable organizations.

Rules from Hospitals are being used for something other than what was intended

Small non-profit hospitals are still struggling - considered charitable

No slippery slope

18th + 19th Century hospital were financed by Philanthropists

20th century change due to healthcare itself - successful programs at hospitals -

Healthcare isn't in itself a charitable endeavor

The issue to qualify is if it's operating in a charitable fashion & it isn't

Most hospital ~~hospitals~~ administrators are paid generously - Some $300,000 - $500,000

Ex. profits at DMC were very high

Most hospitals give 2-4% charity care (for profit & non-profit)

Many invest in other businesses

Large sums of cash on hand

— Total spent on Health care was National Defense

Jim Varnum President of DHMC Clinic
(MHMC - Clinic - & Hospital)

Committed to Medical Care, Teaching & Research
Legislative Charter — 1889
Property exempt from taxation

— Acknowledge the bills problematic
May claim their charitable service extend to a wide area

RSA 732 — Municipality still has power to grant or deny tax exemptions

Claim Lebanon takes a very narrow view.
Why is a charitable organization:
(1) Never refuses anyone who can't pay
(2) 11+ Million over past 5-10 yrs.
(3) all resources devoted to care teaching & Research
(4) Attracts many doctors — biotech
(5) DHMC - helps many local communities
(6) Governed by a board of Trustees
(7) Keeps cost down (ave. 2% past 7 yrs)
(8) Examples of service rendered
CHAD Children Hospital
Dialysis serves for Northern NH + VT
Norris Cotton Cancer Ctr.

Claims programs often lose money that he says they are supplemented/subsidized
Ex. DART Helicopter $700,000/yr.
Hazardous Materials etc

DHMC — All monies are dedicated to services for the benefit of the public

What is the dispute? Started 18 mos ago
(1) All properties assessed
(2) Hospital filed for exemptions
(3) (A) City Fulton says land under hospital is held by a holding company (DHMC) — The city denied because the Corp doesn't provide health care
(B) Buildings are owned by the hospital
(1) One owned by Dartmouth Medical School
(2) one for skin purposes
(3) one used for hospital

Jim Varnum says Lebanon is looking at it as a computerized new and not integrated.

All documents/orders/ are being challenged to determine whether they are taxable

Hess — Congeniality between DHMC and HCA, Columbia Healthcare, etc.

Varsuna says their mission is to focus on community needs.

Ness - What pain is Lebanon looking at?
What is difference between 2/3 and 4/5 exemptions?

Ness: What criteria could be put in to law that would resolve both parties?

Fulton: We need to distinguish what ~~does~~ qualifies for exemption and what doesn't (Need guidelines for municipalities)
Varsuna said this has been brought up in 11-12 states, where clarification is made

Brundige - Re: agreements b/w town/city?
Varsuna - Yes, #2 Mill 10 yrs; 5+ Mill impact fee for water/sewer etc...

Simon: Define Excess profit?
Fulton: Covers operating expenses, bonded debt, updating equipment - If not, do you overcharging. Why the substantial profit?

Fulton: "We haven't started discovery" as yet.
This review is on a 3 yr cycle.

[redacted]

Dear what is the time line on this litigation?
Fulton – Long time because the court thought the parties might work it out
Potential trial date by Feb. 2001 or a lot longer
Rosenfield: You are not exactly supporting this bill?
Fulton: No, not the way it's written. Each case is different

Varnum says just getting the facts out will take a long time.

Fulton says we need to look at the totality of the organization (ie salaries, services etc)

Frazer wanted to know why this is a problem in so many other states.
Fulton says because hospitals are operating differently than in the past (very little distinction between profit + non-profit hospitals)

Reid wanted to know what is profit and what isn't
Varnum – all funds are plowed back into new service, debt service, equipment, programs, etc

Profits shown in [Net Operating Margin]

Kelly - If certain standards were put in as an amendment, would you support this bill?

Voting at Town Mtg or City Council

Hess - Are you saying this a "fact" driven issue, viewed on a case by case basis?

The criteria has to address non-profit issues

Sack - process for publishing salaries, board of trustee pay etc.?

Varnum - Bd of Trustees receives no compensation - They are all volunteers.

When you discussed an exception - No consent

Ended 3:10 PM

Testimony

ADELE M. FULTON

MICHAEL ELLIS*
DAVID R. FALL**

*ADMITTED IN ME, NH AND OR
**ADMITTED IN CA AND NH

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March 15, 2000

Mr. David Hess, Chair
Municipal and County Government Committee
301 Legislative Office Building
33 North Main Street
Concord, NH 03301-6328

Re: HB 1144
Our File No. 5221(A-16)

Dear Mr. Hess:

Thank you for the opportunity to discuss the above-referenced proposed legislation and related taxation issues on February 7, 2000 on behalf of the City of Lebanon. The Committee's questions were thoughtful and I hope they learned information that was helpful to their consideration of HB 1144.

At its conclusion, Mr. Varnum provided the committee with copies of a report prepared by the Dartmouth-Hitchcock Medical Center. You indicated that I should feel free to provide copies of the report I prepared for the City of Lebanon regarding the specific facts applied to current law underlying the City's decision to tax DHMC. In reference to the discussion that day, enclosed please find 25 copies of that report, which was made a public document in March 1998.

Please do not hesitate to let me know of any comments or questions.

Sincerely,

Adele M. Fulton

Adele M. Fulton

delta\Lit\DHMC\LI\HB 1144 ltr Hess re reports.doc
Enclosure
cc: James McSweeney
Normand Bernaiche

REPORT ON THE TAXABLE STATUS

OF THE

DARTMOUTH-HITCHCOCK MEDICAL CENTER

FOR THE CITY OF LEBANON

Prepared By:

Adele M. Fulton
Gardner & Fulton
78 Bank Street
Lebanon, NH 03766

February 1998

TABLE OF CONTENTS

Executive Summary 1

REPORT ON TAXABLE STATUS OF DARTMOUTH-HITCHCOCK MEDICAL CENTER 2

Description of DHMC Land and Buildings 2

Legal Requirements for Charitable Tax Exemptions 3

Analysis and Conclusions Regarding DHMC and Related Entities 5

I. Charitable Status of DHMC 5
Conclusions Regarding Charitable Status of DHMC 7
Status of Hospital's Buildings If DHMC Land Is Taxable 10

II. Charitable Status of the Hospital 12
Use and Occupancy of Facilities by Hospital 13
Conclusions Regarding the Hospital's Charitable Status 16

III. Charitable Status of the Clinic 24

APPENDIX 30

Exhibit A: A History of Hospitals in America 31

Executive Summary

On behalf of the City of Lebanon, a review was conducted regarding the taxable status of the Dartmouth-Hitchcock Medical Center ("DHMC") during 1997. DHMC and its related entities claimed they were qualified for charitable tax exemptions.

All real estate is taxable in the State of New Hampshire unless an organization qualifies for one of the exemptions authorized by statute. A tax exemption can only be granted as a matter of State law, and organizations claiming exemptions must show they are qualified for exempt status.

DHMC owns the land of the medical center. DHMC does not provide healthcare; it has no employees, and it does not serve the general public. DHMC's corporate purposes focus only on serving the member organizations that pay for services rendered and control DHMC at the same time. Any benefits the public may receive from DHMC are too remote to be considered charitable, and DHMC does not qualify for tax exempt status; it is not a charity.

Mary Hitchcock Memorial Hospital ("Hospital") owns the buildings on DHMC's land, and its facility is used to provide healthcare services. Healthcare is not an inherently charitable activity, because even for-profit hospitals can provide quality healthcare. After reviewing documents provided by the Hospital, there appears to be no significant difference between the Hospital's use and occupation of real estate and services provided by for-profit hospitals that are paying taxes. The Hospital has a policy to receive full payment for services, if at all possible. The amount of "charity care" given by the Hospital is negligible and mirrors the levels of charity care by for-profit hospitals. Further, the Hospital generates a profit from patient revenues and uses those revenues to subsidize a for-profit investment company and the Dartmouth Medical School, a private and prestigious educational institution. While the Hospital's corporate purposes may be charitable, its use and occupancy of the real estate does not appear qualified for charitable tax exempt status.

Since DHMC and the Hospital do not appear qualified for tax exempt status, the entire medical center should be taxable as a matter of law, regardless of activities by the Clinic and Dartmouth Medical School. However, since the Clinic claimed it was a charity, as well, its corporate purposes and use of the real estate was reviewed.

The Clinic uses a portion of the medical center for doctors' offices and provides professional services to patients at the Hospital. However, the Clinic employs no physicians. It relies on obtaining professional services from Hitchcock Clinic, Inc., a for-profit corporation that has always employed all practicing physicians at the Hospital and pre-dates the existence of the Clinic. Documents revealed no measurable difference between the Clinic and Hitchcock Clinic, Inc. Even though the Clinic employs no physicians, the Clinic regularly describes itself as a physician group practice and top management for the Clinic is the same as for Hitchcock Clinic, Inc. The Clinic has purchased for-profit physician group practices with no apparent change in operation of those practices. It appears, therefore, that the Clinic is a non-profit facade for the for-profit Hitchcock Clinic, Inc., and the Clinic is not qualified for tax exempt status.

REPORT ON TAXABLE STATUS OF DARTMOUTH-HITCHCOCK MEDICAL CENTER

By Adele M. Fulton, Esq.
February 1998

On behalf of the City of Lebanon, Attorney Ira Weiss and I conducted a lengthy examination of the Dartmouth-Hitchcock Medical Center (DHMC) located in the City as DHMC and its affiliates claim they qualify for tax exempt status as charities.

All real estate in New Hampshire is subject to real estate taxes, according to state law. RSA 72:6. A tax exemption, therefore, is not a discretionary matter; it is not negotiable. A tax exemption can only be granted if a landowner qualifies for one of the exemptions authorized by the State Legislature. Further, the landowner bears the responsibility of providing the information necessary to show whether it qualifies for a tax exemption. RSA 72:23-m.

In order to review DHMC's eligibility for a tax exemption for land owned in the City of Lebanon, the City requested numerous documents and answers to specific questions. During 1997, hundreds of documents provided by DHMC and its related entities were reviewed, and meetings with DHMC representatives took place on two occasions. DHMC and its affiliates form a very complex organization, all of which own, use or occupy the land and buildings in various manners and under numerous agreements. This report distills the enormous amount of information given to the City by DHMC and its related entities and provides a legal opinion regarding a tax exemption, as well.

For future reference, I will refer to the various DHMC-related entities as follows:

- Dartmouth-Hitchcock Medical Center → DHMC
- Mary Hitchcock Memorial Hospital → the Hospital
- The Hitchcock Alliance → the Alliance
- Hitchcock Clinic (non-profit corporation) → the Clinic
- Hitchcock Clinic, Inc. (for-profit corporation) → HCI
- Matthew Thornton Health Plan → MTHP
- Dartmouth College → the College
- Dartmouth Medical School → the Medical School
- Veterans' Administration Hospital → the VA Hospital

Description of DHMC Land and Buildings

In 1988, Dartmouth College (the College) donated 225 acres of vacant land in the City of Lebanon to Dartmouth-Hitchcock Medical Center (DHMC). DHMC as landowner then entered into a ground lease in 1988 for the 225-acre parcel with the Mary Hitchcock Memorial Hospital (the

Hospital) for the purpose of constructing and owning a new medical center on 82 of the 225 acres which were financed, in part, by revenue bonds issued by the New Hampshire Higher Educational and Health Facilities Authority.[1] The ground lease indicated it was a prerequisite to bonding that the Hospital have title to the facilities constructed with the proceeds of the bonds. The initial term of the ground lease was 40 years, and after the expiration of the initial term, the lease would be automatically renewable for ten 10-year terms unless DHMC, the College, the Hospital and The Hitchcock Clinic (the Clinic) chose otherwise.[2] The Hospital agreed to pay rent to DHMC in the amount of $100 per year and to be responsible for paying all costs and expenses of the facilities, including real estate taxes.[3]

DHMC and the Hospital also agreed that a portion of the facilities constructed would be leased to the Clinic and to the College (for use by the Dartmouth Medical School), and, in addition, a leasehold condominium could be created subject to the ground lease.[4] The leasehold condominium would consist of three units (one each for the Hospital, the Clinic and the College), common area and limited common area.[5] The Clinic and College would lease their condominium units from the Hospital with the option to purchase them; in the event they did not exercise their options, the Hospital was to convey all of its right, title and interest in the entire facilities to DHMC for one dollar.[6] The DHMC condominium association would have four members—the three unit owners plus DHMC, each having one vote. It would take a vote of ¾ of the members to adopt any decisions of the association.[7]

In 1991, the new medical center in the City of Lebanon, a 363-bed acute care facility consisting of 1,075,000 square feet, was completed and occupied.[8] The Clinic and the College leased portions of the facility from the Hospital and agreed to pay rent in amounts representing their pro rata portions of principal, interest and related financing expenses associated with the Hospital's bond financing for the construction of the facilities.[9] In June 1993, the College advance-refunded the portion of the bonds allocable to the Medical School unit and repaid its obligation to the Hospital under the lease, but the College did not exercise its option to purchase the condominium unit from the Hospital.[10] In 1995, a 115,000 square foot addition was completed which includes the Norris Cotton Cancer Center.

Since neither the Clinic or the College have yet exercised options to purchase their condominium units, the condominium status of the medical center is not legally relevant to this analysis. The Clinic and the College are only tenants under leases with the Hospital and sub-lessees to DHMC.

Legal Requirements for Charitable Tax Exemptions

DHMC and its related entities are only entitled to a tax exemption from real property taxes if: 1) they meet the legal requirements of being a "charity" *and* 2) they can demonstrate charitable use and occupation of the land according to New Hampshire law. RSA 72:23, V; RSA 72:23-l.

The legal requirements in New Hampshire can be summarized as follows:

1. Underlying Motive Is Generous and Benevolent: Charitable organizations must first be engaged in some kind of "charity." Something is given to the public without expectation of something of equal value being given in return; i.e., there is a significant absence of *quid pro quo*.

A public charity is not an "enterprise . . . undertaken as a commercial venture, with a money-profit motive, or as a group devoted to its own social enjoyment." Instead, its "underlying motive is of generosity and benevolence creating a purpose to bestow in direct form some benefit for the public."[11]

> The word "charity" as commonly used implies any act of kindness or benevolence. In the legal sense, the term may be more fully defined as a gift, to be applied consistently with existing laws, for the benefit of an indefinite number of persons.[12]

2. Charitable Activity Meets Essential Human Need: The actions of charitable organizations must advance the spiritual, physical, intellectual, social or economic well-being of the general public.[13]

3. The General Public Is the Intended Recipient: Charitable organizations must provide benefits to a substantial, or indefinite, segment of the general public, or function for the general public good or welfare. Such organizations cannot be structured and administered so they are principally operated to benefit their own members or those of any related organization. Otherwise, the organizations are, in effect, private in nature.[14]

4. Gifting is Not Discretionary: The organizations cannot have uncontrolled discretion over if, when, or whom receive their benefits. The provision of public benefits must be obligatory and enforceable against the organizations by the Attorney General or some other public official.[15]

5. Members Do Not Benefit Monetarily: There can be no pecuniary profit or benefit to their officers or members.[16]

6. Income and Profits Used for Public Charity: Their income and business profits must be used for their charitable purposes.[17]

7. Charitable Use Cannot Be *De Minimis* or Slight: Charitable use and occupancy of real estate cannot be slight, negligible or insignificant but must be substantially in performance of public purposes.[18]

8. Charitable Use Demonstrably Different: The use of real estate by a charitable organization must be substantively different than if it were used and occupied by a non-charitable organization.[19]

9. Burden of Proof on Charitable Organizations: Any organization claiming it is eligible for a charitable tax exemption has the burden of proving it is a public charity and that it uses and occupies the real estate for charitable purposes.[20]

Analysis and Conclusions Regarding DHMC and Related Entities

There are several organizations that either own, use or occupy the land and buildings comprising the 82 acres on which the medical center is located in the City. The analysis begins with the landowner (DHMC) and then reviews how the land and buildings are used and occupied for which charitable exemptions have been claimed.* It should be noted that the College, as a lessee, has claimed an educational exemption for a portion of the medical center. The claim for the educational exemption was not reviewed and, based on the opinions expressed below, does not appear to be necessary.

I. Charitable Status of DHMC

DHMC is the owner of the land on which the entire medical center rests. As the landowner, DHMC claimed a charitable tax exemption from the City's real estate taxes for the tax year 1997 on the basis that DHMC provided healthcare as a service of public good and its beneficiaries are patients unable to pay and residents of the region.[21] DHMC is only entitled to a tax exemption from real property taxes if it meets all nine of the requirements summarized above.

DHMC was originally formed in 1973 as the result of a report written by a "Center Planning Committee" endorsed by Dartmouth College, the Hospital and the for-profit Hitchcock Clinic, Inc. (HCI). The Committee responded to a request of these three entities to recommend a plan to unify all of the components of the Center into an effective confederation capable of carrying out their mutual purposes.[22] The Committee recommended a Center organization as a separate structure and coordinating body, where each component retained its corporate integrity and right to pursue its own fundamental purpose while respecting and accommodating the needs of the other components, including committing themselves to the principles of joint decision-making in order to function effectively as a whole. It also recognized that each of the components should be and should remain economically viable and self-sustaining.[23]

---

* The review and analysis of the medical center generally followed this outline:

I. Is the landowner a charitable corporation?
   - A. If yes, is its use and occupancy of the land charitable? (See Section II.)
   - B. If not, the land—and possibly all buildings—are taxable (making Section II unnecessary).

II. Is the building owner/ground-lessee a charitable corporation?
   - A. If yes, is its use and occupancy of the buildings charitable?
     1. If yes, are the lessees of the buildings charitable?
        - a. If yes, is their use and occupancy of the buildings charitable?
        - b. If not, those portions of the buildings used by lessees are taxable.
     2. If not, all the buildings are taxable.
   - B. If not, all the buildings are taxable.

DHMC was then incorporated as a nonprofit corporation in 1983. Its corporate purposes for which it were established are as follows:

> (a) In an academic medical center of the highest quality, to support, promote, advance and strengthen . . .
>
> Dartmouth Medical School, conducted by Trustees of Dartmouth College, . . .
>
> Mary Hitchcock Memorial Hospital, . . .
>
> Hitchcock Clinic, . . .
>
> Veterans Administration Medical and Regional Office Center . . .
>
> and such other not-for-profit organizations dedicated to charitable, scientific and education purposes as the Board of Trustees of the Corporation elects to support, provided that each such supported organization qualifies under §501(c) and §509(a)(1) or (2) of the Code,
>
> by providing the supported organizations with services (including without limitation administrative, planning and other services) designed to promote, advance and strengthen the interdependent and synergistic activities of the independent supported organizations in the areas of (i) healthcare (including multi-disciplinary and regional health care programs), education and research, (ii) government and public relations, (iii) charitable fundraising and other resource development activities, (iv) logistical services, and (v) other activities not inconsistent with the purposes of the supported organizations.
>
> (b) To promote in equal measure, within the Corporation and among the supported organizations, both excellence in medical education and research and excellence in the provision of health care.
>
> (c) To operate itself exclusively for charitable, scientific and educational objects and purposes, and in furtherance of a charitable, scientific and educational objects and purposes now or at anytime hereafter fostered by such not-for-profit and tax-exempt organizations as the Board of Trustees of the Corporation elects to support.[24]

DHMC's corporate purposes indicate its primary obligation is to fill a supportive and administrative role for the Medical School, the Hospital, the Clinic, and the VA Hospital. According to the most recent set of by-laws provided by DHMC, 11 of the 12 members of the DHMC Board of Trustees are representatives of the Hospital, the Clinic, the Medical School, and Matthew Thornton Health Plan (MTHP). The VA Hospital has only one representative. The by-laws permit, but do not require, up to five additional trustees to be elected by the Board.[25] DHMC is not entitled to representation on the Boards of the Hospital, the Clinic, the Medical School or the VA Hospital.[26]

DHMC has no employees.[27] Even though DHMC claimed in its application to the City for an exemption that DHMC provided healthcare, DHMC states in other documents that it does not provide healthcare. Rather, it appears to function as a corporate forum for joint planning and operations. DHMC also reportedly provides consultative, administrative and fund-raising services to its members.[28]

The members pay for any services rendered by DHMC based on Administrative Service Agreements between the institutions.[29] In the 1994 fiscal year, the members paid almost $6.4 million to DHMC for services rendered: the Hospital paid $2.1 million, the Medical School paid $3.0 million and the Clinic paid $1.3 million.[30] These payments comprised 97% of DHMC's total revenue for the 1994 fiscal year. Similarly, in the fiscal year 1995, these three members paid almost $6.2 million or 94% of DHMC's total revenue for that fiscal year.[31] Expenses of DHMC to provide services to the member institutions matched DHMC's total income in both 1994 and 1995.[32] Apparently due to some internal reorganization, the three members paid significantly less money to DHMC (a total of $1.96 million) during the fiscal year 1996, but it still comprised 96% of DHMC's total revenue for that fiscal year. Expenses of DHMC to provide services to its members in 1996 totaled $1.95 million.[33]

The fourth member of DHMC, the VA Hospital, did not make any payments to DHMC in 1994 through 1996, and since it only has one vote on the DHMC board (whose members are aligned with the Medical School, the Hospital or the Clinic), its role appears relatively insignificant at DHMC. The VA Hospital is a member of DHMC since it can provide additional facilities for resident training, education and research for Medical School students.[34]

Conclusions Regarding Charitable Status of DHMC

The law requires that DHMC, as landowner, qualify first as a charity before a charitable exemption is permitted. RSA 72:23, V; RSA 72:23-l.

DHMC was formed by the Hospital, the Medical School and the Clinic, all of which serve as both members of, and the Board of Trustees to, DHMC. The members support DHMC to the extent they want DHMC to serve their purposes. DHMC has no employees, does not provide healthcare and is not a medical institution.

DHMC's corporate purposes are focused on its members and not on the general public. The purposes do not even mention the public. DHMC's only legal obligation, therefore, is to serve the members that pay for services. Income is received from DHMC members and used for DHMC members, so the general public is not directly benefited by DHMC. It is, essentially, a private organization controlled by the Hospital, Clinic and the Medical School for their benefit.

Even though DHMC's corporate purposes describe supporting "other not-for-profit organizations dedicated to charitable, scientific and education purposes," the support of such organizations is entirely discretionary with DHMC. A public official could not force DHMC to

serve other organizations. Society of Cincinnati v. Exeter, 92 N.H. 348 (1943); Nature Conservancy of New Hampshire v. Nelson, 107 N.H. 316 (1966).

According to well-settled New Hampshire law, DHMC does not appear to be a charity. Even though DHMC could argue that its ultimate beneficiaries are the general public by way of serving the Hospital, Clinic and the Medical School, the link between its purposes and the benefits to the general public is too remote. DHMC's primary purpose is non-public; its dominant function is private.

Supreme courts of other jurisdictions have rejected claims of charitable purposes when presented by similar facts. In Massachusetts Medical Society v. Assessors of Boston, 340 Mass. 327, 164 N.E.2d 325 (1960), the Massachusetts Medical Society sought an abatement and an exemption for its real estate which was denied by the board of assessors.

The real estate consisted of a four-story building that had the offices of the Society's officers and its post-graduate medical institute. Its corporate purposes were the preservation and recovery of health and the encouragement of medical institutions. It had certain membership requirements, its dues were paid by members, and the Society received income from the publication of the "New England Journal of Medicine."

The Society sponsored courses in various branches of medicine for the benefit of active practicing physicians and published a monthly schedule of medical meetings, lectures and seminars at hospitals and medical schools without charge. It also maintained a speaker's bureau which furnished physicians without charge to speak on medical and health topics. In addition, the Society operated a 24-hour telephone service in greater Boston to provide doctors in emergencies, and in one year, more than one-third of the calls were referred to non-members of the society.

While recognizing that the Society was involved in beneficial work, the Court expressed concern that the work of the Society involved a more remote method of activity than was typically deemed "charitable."

> As we have said many times, charity and charitable corporations are not limited to almsgiving, but comprehend a wider field of activity for the improvement and happiness of man. While new objects have been and must be added to comprehend the wide variety of gifts which may be classed as charitable, the more remote the object and method become from the traditionally recognized objects and methods (relief, religion, education and public works) the more care must be taken to preserve sound principles and to avoid unwarranted exemptions from the burdens of government.

Id. at 331-332. (Citations omitted.) The Massachusetts Supreme Court concluded that, in this case, the Society was not a charitable institution since the principal object of the Society's efforts was to benefit its members and not the general public.

The Court held that the decision of the board of assessors denying the exemption was correct. The purposes of the Society showed it was operated primarily for the benefit of a limited group of persons and the public would derive only incidental benefits from its work. Even though the work of the Society was laudable, this indirect benefit was not sufficient to bring the Society within the class traditionally recognized as charity. Id. at 332-333.

DHMC would similarly provide only indirect and incidental benefits to the public as it was formed only to benefit its dues-paying members. Even though the Clinic and the Hospital, for example, are engaged in public endeavors, DHMC, like the Massachusetts Medical Society, has no obligation to the general public and functions solely as a supporting organization to the members.

In a very recent case with even more similarities to DHMC and its corporate affiliations, the Pennsylvania Supreme Court in Sacred Heart Healthcare System v. Commonwealth of PA, 673 A.2d 1021 (1996), came to the same conclusion.

Sacred Heart Healthcare System (SHHS) was created in 1984 as part of a reorganization of Sacred Heart Hospital in Allentown, Pennsylvania. Various for-profit and nonprofit subsidiaries were also formed in 1984, including a for-profit pharmacy corporation and a real estate subsidiary. SHHS was designed to perform various services, including accounting, human resources management, administrative management, data processing and community relations for the affiliated corporations, including Sacred Heart Hospital. All of these services had been performed by Sacred Heart Hospital prior to the 1984 reorganization. SHHS was controlled by the Sacred Heart Hospital; a majority of the SHHS directors were also directors of Sacred Heart Hospital.[35]

The corporate purpose of SHHS was to improve the quality of healthcare delivered to the public. It accomplished this purpose by supporting Sacred Heart Hospital and its affiliates. Its activities benefited the affiliated corporations which provided services to legitimate subjects of charity. SHHS claimed that it was entitled to an exemption of a sales and use tax in Pennsylvania, because it was an institution of purely public charity.

SHHS argued that, when determining whether it qualified for an exemption, its role should be viewed as an integral part of Sacred Heart Hospital and the affiliated organizations. The Pennsylvania Supreme Court disagreed. It held that SHHS was a separate corporation which had to meet all criteria of the charitable exemption statutes on its own merits, without being able to benefit from its supportive role to other institutions.

> Where a taxpayer divides itself into separate corporate entities, the taxpayer cannot insist that the Commonwealth ignore those distinct legal entities so as to find that it is something that it is not. . . . [T]he Hospital created SHHS and the other affiliated corporations because that organizational structure operates to its advantage by improving the Hospital's efficiency, increasing its Medicare/Medicaid reimbursement, and its potential for bond financing. We will not disregard the fact that SHHS is an independent entity merely because, in this situation, that organizational form works to the disadvantage of SHHS.[36]

SHHS further argued that it advanced a charitable purpose, because it functioned to improve the quality of healthcare to the public and its articles of incorporation provided that it was only operated for charitable purposes. But the Court disagreed again.

> The express purpose of SHHS . . . is to benefit the Hospital and subordinate units, and the benefit to the public described in the articles of incorporation is, at most, a by-product of its service to its affiliated organizations. In terms of its actual operations, SHHS provides administrative and management services to only a small group of affiliated corporations, both for-profit and non-profit, for a fee, and not to the general public or any segment of the general public.
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> . . .
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> . . . SHHS does not benefit a substantial and indefinite number of persons who are legitimate subjects of charity. Instead, SHHS benefits a small number of affiliated non-profit and for-profit corporations which cannot be considered legitimate objects of charity. . . . Any benefit SHHS confers on the needy is secondary to the direct benefit it provides to its corporate siblings.[37]

The Pennsylvania Supreme Court held that SHHS was not a public charity and it did not qualify for tax exempt status.[38]

The law in New Hampshire is similar to the law applied by the courts in Massachusetts and Pennsylvania. An organization such as DHMC formed to benefit only its members, even members that directly provide healthcare services to the public, does not qualify DHMC to be a charity. DHMC is a separate and distinct corporate entity, and DHMC must meet the criteria for charitable exemptions on its own merits. DHMC's corporate purposes must directly benefit the general public.

As the corporate purposes of DHMC are essentially private in nature, it does not appear to be a charity. As such, DHMC should not be qualified for a charitable tax exemption. Since a tax exemption under RSA 72:23, V first requires ownership of real estate by a charity, it is not necessary to further review how DHMC uses and occupies the land. DHMC's real estate should be taxable.

Status of Hospital's Buildings If DHMC Land Is Taxable

Typically, the owner of land is the owner of improvements upon the land, and the question of exemption requires only an analysis of the landowner as a charity. The land must first be *owned* by a charity. If the landowner is not a charity, a lessee may be a charity but there is no charitable tax exemption of the real estate. (A local example of this involves the Clinic: a private company owns land and buildings leased to the Clinic in Hanover. Regardless of the Clinic's use and occupation of the real estate and its claim of being a charity, the landowner pays taxes.)

In this case, however, the owner of the improvements (the Hospital) is different than the owner of the land (DHMC). This presents unique complications in analyzing the taxable status of the medical center. The question presented is whether leasing taxable land and owning only the improvements puts the Hospital in the position of an owner of real estate under RSA 72:23, V or whether it is a lessee.

There is law in New Hampshire which permits owners of distinct interests in real estate to be taxed separately[39] and precedent has also been established in New Hampshire that buildings that are privately-owned on government land are taxable.[40] But there is no precedent in New Hampshire that establishes whether tax exempt status is available to the building owner in the event the landowner is taxable. This would be a question of law to be finally decided by the New Hampshire Supreme Court based on the facts presented.

If the Court concludes that the land must be owned by a charity before the building owner can qualify for tax exempt status, no further analysis is needed. If DHMC is not charitable and is taxable, the Hospital as lessee and its sub-lessees (the College and the Clinic) would not qualify for charitable tax exemptions regardless of the Hospital's ownership, use and occupancy of the buildings.

The Court may hold, on the other hand, that the Hospital, holding legal title to the buildings, is eligible for independent consideration as an owner of real estate and not merely as a lessee. In such a case, the question would be whether the Hospital, on its own merits, is a charitable institution and whether it uses and occupies the buildings for its charitable purposes. Further, since the Hospital has leased portions of the buildings to the Clinic and the College, RSA 72:23,V-a would apply. This statute expressly authorizes a charity which owns real estate to qualify for a charitable tax exemption even if the owner does not use and occupy the real estate—if a lessee is a charity and uses and occupies the real estate for its charitable purposes.

RSA 72:23, V-a states that real estate is exempt if:

> [t]he real estate and personal property [is] owned by any organization described in [RSA 72:23, V] of this section and occupied and used by another organization described in said paragraphs, but only to the extent that such real estate and personal property would be exempt from taxation under said paragraphs if such property were owned by the organization occupying and using the property, as long as any rental fee and repairs, charged by the owner, are not in clear excess of fair rental value.[41]

Assuming for the sake of argument that the Court concluded in favor of the latter situation, the following sections analyze whether the Hospital as an owner is charitable and if it uses and occupies the buildings for its charitable purposes.

II. Charitable Status of the Hospital

The Hospital claimed an exemption from the City's real estate taxes for the tax year 1997, because it was a charity using the real estate to provide healthcare to residents in New Hampshire without regard to patients' means for paying for the care.[42] The Hospital is only entitled to a tax exemption from real property taxes if it meets all nine criteria listed above.

Mary Hitchcock Memorial Hospital was founded in 1889 in the Town of Hanover as the principal teaching facility for Dartmouth Medical School, founded in 1797 as one of Dartmouth's professional schools. In the Charter of the Hospital provided to the City and dated August 23, 1996, it states the following as its corporate purposes:

> . . . . Said corporation shall be and remain a body politic for the purpose of furnishing and providing such nursing care, medical care and surgical treatment, as is usually furnished and provided by similar institutions . . . . Said corporation shall have one or more members who need not be natural persons but may be a corporation. A purpose of the corporation shall be to foster the establishment, development, expansion and operation of an integrated regional healthcare delivery system for the benefit of health care consumers by supporting, among other things, the corporation's sole member, The Hitchcock Alliance (the "Alliance") and other charitable and federally tax-exempt organizations of which the Alliance is the sole member or with which it may be affiliated.[43]

Further, its Bylaws include the following objectives:

a. Establishment and maintenance of an institution with permanent facilities that include inpatient beds and medical services to provide diagnoses and treatment for patients, and associated services such as, but not limited to, extended care and home care.

b. Conduct of any education activities related to rendering care to the sick and injured, or the promotion of health, that in the opinion of the Hospital's Board of Trustees may be justified by the facilities, personnel, funds, and other requirements that are or can be made available.

c. Promotion of and conduct of scientific research related to the medical and related health care fields insofar as in the opinion of the Board of Trustees such research can be carried on in, or in connection with, the Hospital.

d. Participation so far as circumstances may warrant, in activity designed and carried on to promote the general health of the communities served by the Hospital.

e. To foster the objectives and promote the development of the Dartmouth-Hitchcock Medical Center.[44]

The Hospital's objectives to provide for the medical treatment needs of the general public could be characterized as being traditionally charitable in nature. The Hospital's purposes to conduct educational and scientific activities, however, are stated in such a way as to give sole discretion to the Hospital whether these take place.

The Hospital includes in its objectives the promotion, development and support of both the Hitchcock Alliance and the Dartmouth-Hitchcock Medical Center. The Alliance is merely a holding company with no capital, employees or capability to benefit the general public. As neither DHMC or the Alliance appear to be charities, the question can be raised whether supporting these two corporations in its corporate objectives affects the Hospital's claim of a charitable nature since neither provide healthcare or any other benefits directly serving the general public.

However, the larger issue is whether the use and occupancy of the buildings, either by the Hospital or its lessees, fulfills the State's legal requirements (as summarized above).

Use and Occupancy of Facilities by Hospital

The Hospital uses and occupies only one portion of the medical center identified as a condominium unit. In 1991, in its first year of occupancy, persons admitted into the Hospital for inpatient treatment numbered 14,964, which increased to 17,925 by 1994.[45]

Patient discharges also grew each year. Between 1991 and 1995, discharges increased from 15,475 to 19,004, an average annual growth rate of 5.3%. Over the same period, the Hospital's length of stay declined from 7.3 days to 6.0 days. The Hospital stated this was a favorable trend given the fact that certain payors, including Medicare, pay hospitals a fixed amount on a per-discharge basis. In addition, between 1991 and 1995, surgical procedures increased at a 5.0% annual growth rate and emergency room visits increased 8.7% annually.[46]

The Hospital reported that its market share increased dramatically between 1991 and 1994. In the Hospital's local service area, defined as 26 cities and towns within a 30-minute drive of the Hospital, its share of admissions increased from 66.6% in 1991 to 72.4% in 1994. Within the broader region bordered by the Green Mountains to the west and the White Mountains to the east, the Hospital's market share increased from 38.3% in 1991 to 44.3% in 1994.[47] Comparing itself with nine other hospitals in the broader region, the Hospital observed that eight of them had fewer than 100 licensed beds and six had fewer than 50 licensed beds, with the only exception being the VA Hospital.[48]

The Hospital's patient care is not provided by physicians employed by the Hospital. Rather, the Hospital contracts with the Clinic for physician services. The history of the Hospital and the Clinic shows that the two organizations have worked cooperatively for most of this century.

Prior to 1927, the professional medical staff at the Hospital all had private practices. In cooperation with the Hospital, the professional medical staff (5 physicians and a nurse-bookkeeper-

secretary) formed a physician group practice in 1927 to pool income, skills and expenses in order to attract specialty physicians to the area.[49] The Hospital recognized that this arrangement offered benefits to its operations, since there would be unified control and responsibility for the care furnished to Hospital patients. The Hospital provided office space for the physicians and for the administration and bookkeeping departments of the group practice.[50] As the relationship between the Hospital and the physician group developed, the physicians supplied funds from their profits to the Hospital so the Hospital could construct additions. The physicians then used the new doctors' offices for outpatient appointments while the Hospital kept legal title to the additions.[51]

Not much has changed since then. Even though the physician group has greatly increased in size and the Hospital has moved to the City of Lebanon, the physicians still use the Hospital buildings for their outpatient practices and provide inpatient treatment to Hospital patients. Were the Hospital and the Clinic physicians unable to come to agreement regarding the terms under which the physicians provide services, the Hospital would have difficulty providing specialty healthcare services.

Although moving expenses and other costs associated with moving the Hospital from Hanover to Lebanon caused a reduction in surplus revenue in 1991 and 1992, the Hospital has generally met or exceeded its financial objectives in the fiscal years 1991 through 1995.[52] It appears to have profited directly from patient services, as well:

- In the Hospital's fiscal year ending June 30, 1994, surplus income from patient services was $11.6 million. Additional income from bequests and investments gave the Hospital a total surplus in 1994 of $18.5 million.[53]

- In its fiscal year ending June 30, 1995, surplus income from patient services was $3.9 million. The Hospital's total surplus for the fiscal year 1995 was $12.2 million when non-operating gains were added.[54]

- After a change to its fiscal year to end on September 30, 1996, the Hospital's surplus from patient services was $4.3 million for 1996. With additional income received in 1996, its total surplus in 1996 was $17.8 million.[55]

The Hospital also reported that, consistent with its mission to provide charitable services, it provided needed healthcare services to residents and visitors of New Hampshire and Vermont without regard to their ability to pay.[56] Its financial statements indicate that such charity care is provided to patients who meet certain criteria under its charity care policy, and the care is provided either without charge or at amounts less than established rates.[57] For 1994 through 1996, it reported providing charity care at established rate levels in the amounts of $8.5 million in 1994, $9.1 million in 1995, and $8.2 million in 1996. The Hospital calculated that this amounted to 2.9% of its gross patient service revenue each year.[58]

These amounts described as charity care are based on *gross charges*, not on the cost of the services.[59] In retail terminology, this would be analogous to calculating charity care at the retail

price rather than on the wholesale cost. Relying on charges to estimate charity care can inflate the value of charity care by as much as 20%-35%.[60] The difference between actual cost to the Hospital and the established rates is suggested by the contractual discounts on those rates that the Hospital agrees to receive from third-party payors, including Blue Cross Blue Shield or Medicare and Medicaid. The Hospital reported that its contractual discounts reducing gross charges totaled almost $58 million in 1994, $67 million in 1995, and $53 million in 1996. However, most subscribers with most commercial insurers pay for services based on the established rates.[61]

Even with contractual discounts and some level of charity care included in its expenses, the Hospital still made a profit each year solely from patient care. The Hospital's profit from patient revenue is probably significantly higher, since it is likely the profit reported is calculated after the Hospital fulfills its contractual obligations to DHMC, to the Medical School, to the Alliance, to the Clinic, or to any other related corporation.[62]

For instance, in 1992 the Hospital agreed to subsidize education at the Medical School and to do what was necessary to increase income to accomplish that objective. In an agreement among the Hospital, the College, the Clinic and the Matthew Thornton Health Plan, they agreed they were dependent upon revenues derived from patient care for the bulk of support for educational, research and patient care activities. They noted:

> [t]here is a fundamental relationship among the magnitude of the patient care activities, the size of the clinical and support staffs, and academic capacity such that the academic mission of the parties cannot be maintained and enhanced without improved financial results from patient care services.[63]

The parties agreed that the Hospital and the Clinic were expected to operate in a manner to generate an excess of revenue over expenditures. In contrast, the Medical School was expected to "break even" with support from the Hospital and the Clinic.[64] They further agreed to plan jointly to generate new net annual revenues by means including volume increases to produce net revenues in the aggregate and price adjustments to increase net revenues.[65]

The agreement included specific financial commitments from the Hospital to support academic and research activities at the Medical School in the amount of $3.8 million per year. Further, the Hospital would support Graduate Medical Education Teaching and Support Services in the amount of $800,000 and then compensate the Clinic $3.0 million annually for teaching, administration and supervision services. The Hospital agreed to assume the full costs of all psychiatric residents previously borne by the Medical School, as well.[66]*

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* The Clinic similarly agreed to support the Medical School in increasing amounts starting at $0.7 million and ending at $2.7 million. The Clinic also agreed to pay the Medical School additional amounts in recognition of the "numerous tangible and intangible benefits" provided by the Medical School in annual amounts starting at $3.7 million in 1993 and ending with $5.7 million in 1997. (1992 Financial Agreement Among Dartmouth College, Dartmouth Medical School, Mary Hitchcock Memorial Hospital, The Hitchcock Clinic and Matthew Thornton Health Plan, page 4-5.)

Profit from patient service revenue at the Hospital has been directed to other activities, too, including MHMH Enterprises, Inc., a for-profit corporation which invests in real estate and has a partnership interest in a home infusion therapy company. Another wholly-owned subsidiary, Hitchcock Imaging Services, Inc., a nonprofit corporation, is reportedly inactive currently but was formed to provide certain magnetic resonance imaging (MRI) services to the Hospital.[67] The Hospital also gave a $1.65 million donation to the Clinic in the 1995 fiscal year to assist the Clinic's efforts to expand in the region.[68]

Another significant investment in capital was made in the Matthew Thornton Health Plan (MTHP). In 1989, DHMC became the owner of MTHP. As a result of that affiliation, DHMC, the Clinic and MTHP entered into an affiliation agreement. The Hospital provided an initial investment of $3 million as unrestricted capital to MTHP. The Clinic made the same investment. MTHP physicians became for-profit HCI employees while MTHP facilities became Clinic-owned and operated. The Clinic and MTHP entered into medical services agreements including provisions that they would share in the gains or losses associated with covered inpatient hospital, surgical outpatient and certain other services.[69] This developed a referral system so former MTHP primary care physicians would send patients to the Hospital for specialty care. The system proved to be profitable as it increased the volume of Hospital patients. MTHP itself profited from the affiliation, as its fund balance improved from a deficit of approximately $1 million to a surplus of over $37 million as of June 30, 1996.[70] MTHP was able to donate $5 million to the Clinic in 1996 to support further regional expansion efforts.[71] DHMC sold MTHP to Blue Cross Blue Shield of New Hampshire for approximately $46 million in late 1997.*

Profit from patient care revenues has also paid the salaries of Hospital administrators. The Hospital provided limited salary information about its employees to the City, but the *Valley News* reported in 1997 that James Varnum, the President of the Hospital, made approximately $375,000 as base salary in 1996 and, with the value of his benefits package, his total compensation increased to $513,000.[72]

Conclusions Regarding the Hospital's Charitable Status

The Hospital has the burden to show that its ownership, use and occupancy of the real estate meets the criteria summarized above. The Hospital has provided documents showing that the facilities are used for healthcare. The Hospital claims it is a charity, because it has a policy of providing care without regard to ability to pay, it provides charity care, and it provides other

* Though some information has not been confirmed in writing, reportedly, because of concerns by the New Hampshire Attorney General's office regarding DHMC profiting from the sale of a nonprofit, DHMC was permitted to retain only a portion of the proceeds of the sale. DHMC received approximately $10 million in cash at the time of the sale and a promise of additional proceeds from Blue Cross Blue Shield worth approximately $10 million over a period of seven years. The remainder of the proceeds was used to establish a new charity in New Hampshire providing healthcare. (NH Higher Educational and Health Facilities Authority Revenue Bonds, The Hitchcock Clinic Issue, Series 1997, page A-21; information also provided by the New Hampshire Attorney General's office.)

community benefits such as the Women's Health Resource Center, community support groups, and the like.

Healthcare in and of itself is not *per se* charitable, however, since for-profit hospitals can provide the same services. The facilities, therefore, should be used and occupied by the Hospital in a manner demonstrably different than the manner in which for-profit hospitals function. There must be distinguishing features between a charitable institution and a for-profit institution providing the same services. A charitable hospital should be giving a gift to the public with a notable absence of a *quid pro quo* of equal proportions as compared to a non-charitable institution where patients merely get what they pay for in cash.

For instance, in Appeal of City of Franklin, 137 N.H. 622 (1993), the issue was whether the Franklin Home for the Aged qualified for a charitable tax exemption. The facts showed the Home cared for elderly persons for a charge. It had an endowment of over $800,000 generating income of approximately $55,000 per year which subsidized the overhead and the expense of caring for its residents. The rates charged by the Home were based upon expenses and reduced by the income generated by the endowment. The Home did not generate a profit.

The officers of the Home were not paid for their services, and the wages and salaries of the employees were lower than market compensation for the same services at several area nursing home facilities that operated for profit. The cost of care at the Home was between 15-20% less than at the for-profit nursing homes. The Home did not receive Medicaid or Medicare, so when a resident was admitted, the resident agreed that when funds ran out, that individual would be transferred to a Medicaid facility. The Home continued to care for residents until they were accepted at Medicaid facilities at no charge to the resident.

The Court held that, for over 50 years, the actions of the Home showed that their only purpose was to provide nursing care for aged residents at the lowest cost possible, and their actions carried that purpose out. Rates charged did not include a profit margin nor were based on what the market could bear. As much as it could afford to reduce costs and still "break even," it did so. The Home qualified as a charitable institution which used its real estate for charitable purposes.

In a more recent case, Housing Partnership v. Town of Rollinsford, 141 N.H. 239 (1996), the Supreme Court reversed a trial court's decision that the Housing Partnership qualified for tax exempt status. The corporate purpose of the Housing Partnership was to "facilitate the development and preservation of decent, safe and affordable housing for low and moderate income persons." The Partnership had acquired 13 multi-family dwellings with a total of 117 rental units, including two apartment buildings in the Town of Rollinsford. The town claimed that the Housing Partnership was not a charity, and it was not eligible for tax exempt status. After a trial, the trial court concluded that the Housing Partnership was indeed a charity, because its purposes were charitable. In addition, the trial court decided the Housing Partnership used and occupied the land directly for charitable purposes and was eligible for tax exempt status.

The Supreme Court agreed with the trial court that the Housing Partnership was a charity, because its goals were measurable, enforceable and intended to serve the public good. However, on

the "use and occupancy" principle based on RSA 72:23, V, the Supreme Court disagreed with the trial court and reversed the decision. The facts related to the use and occupancy of the land showed that the apartments were not rented directly for charitable purposes and were simply an adjunct to the charitable purpose of the corporation.

The trial court had found that the rents charged by the Housing Partnership were close to market levels and that they were not keyed directly to market rates but rather based on the operating costs of the apartments including debt service, utility costs, maintenance expenses and a management fee charged by the plaintiff. Further, rents would increase as costs increased. The rental fees were not based on the income levels of the tenants but only on the costs to the Partnership.

The Supreme Court held that, on these facts, there was only an indefinite benefit to the general public and the charitable purposes of the Partnership were only indirectly furthered by its use of the real estate. The Court stated that the Housing Partnership had failed to demonstrate that the rental of the units was significantly different from the rental of units by a non-charitable organization and as such, the use and occupancy of the real estate was not charitable.[73]

The New Hampshire Supreme Court has never heard a case regarding a charitable tax exemption of a hospital, so there is no authoritative precedent in a review of the Hospital's tax status. But hospitals are being scrutinized increasingly in the United States and several supreme courts have held that hospitals claiming to be charitable should do more than merely provide healthcare, which for-profit hospitals provide, as well. There should be a demonstrable difference in their operations, similar to the facts and principles described by New Hampshire Supreme Court in Housing Partnership, *supra*, and in Appeal of City of Franklin, *supra*.

In Utah County v. Intermountain Health Care, Inc. 709 P.2d 265 (1985), Intermountain Health Care, Inc. (IHC) was a nonprofit corporation that owned and operated, or leased and operated, 21 hospitals in the State of Utah. IHC owned other subsidiaries, including one for-profit entity. It was supervised by a Board of Trustees who served without pay; it had no stock and no dividends or pecuniary profits were paid to its trustees or incorporators. Upon dissolution of the corporation, none of its assets could inure to the benefit of any private person.

IHC's policy with respect to all of its hospitals was to charge patients for hospital services whenever it was possible to do so. Those hospital charges were paid either by patients, by private insurance companies, or by the government in programs such as Medicare and Medicaid. IHC and the individual hospitals also were the recipients of private bequests, endowments, and contributions. The issue in this case was whether two hospitals owned by IHC were tax exempt from real estate taxes. The Utah County Board of Equalization ruled they were not tax exempt, but the Board's ruling was reversed by the appellate Utah State Tax Commission. That decision was appealed to the Supreme Court of Utah which held that, based on the facts, the hospitals should not be qualified for tax exempt status.

In reviewing the matter, the Court observed:

> An entity may be granted a charitable tax exemption for its property . . . only if it meets the definition of a "charity" or its property is used exclusively for "charitable" purposes. Essential to this definition is the element of a gift to the community.
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> . . .
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> A gift to the community can be identified either by a substantial imbalance in the exchange between the charity and the recipient of its services. . . . Where material reciprocity between alleged recipients and their alleged donor exists—then charity does not.[74]

The Utah Supreme Court then outlined the history of hospitals in the United States, noting that, since care of the sick had traditionally been considered an activity that was regarded charitable in American law, it was important to review the contemporary social and economic context of such care. They observed that nonprofit hospitals were traditionally treated as tax-exempt charitable institutions because, until late in the 19th century, they provided custodial care for those who were both sick and poor. Hospitals derived income largely or entirely from voluntary charitable donations then, not from government subsidies, taxes, or patient fees as they do now. Hospitals developed into market institutions financed increasingly out of patient fees in this century with an orientation towards "professionals and their patients" and away from "patrons and the poor." (The Court's entire summary can be found in the Appendix as Exhibit A.)

The Utah Supreme Court established six factors as a guideline for reviewing claims for charitable tax exemptions of real estate.* It analyzed the evidence regarding IHC and the two hospitals based on these six factors. First, the corporate purposes of the hospitals did include objects that are traditionally charitable and at least met the first criteria. As to whether the hospitals were supported by donations and gifts, they found that the current operating expenses for the hospitals were covered almost entirely from patient charges. Even though one of the hospitals had received a substantial donation, there was no evidence that the donation had any effect on the maintenance and operation of the hospital. Further, the Court found there was no evidence that the hospitals charged

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* The six-factor test the Utah Supreme Court established was: (1) whether the stated purpose of the entity is to provide a significant service to others without immediate expectation of material reward; (2) whether the entity is supported, and to what extent, by donations and gifts; (3) whether the recipients of the "charity" are required to pay for the assistance received, in whole or in part; (4) whether the income received from all sources (gifts, donations, and payment from recipients) produces a "profit" to the entity in the sense that the income exceeds operating and long-term maintenance expenses; (5) whether the beneficiaries of the "charity" are restricted or unrestricted and, if restricted, whether the restriction bears a reasonable relationship to the entity's charitable objective; and (6) whether dividends or some other form of financial benefit or assets upon dissolution are available to private interest, and whether the entity is organized and operated so that any commercial activities are subordinate or incidental to charitable ones. Utah County at 269-270. The Court indicated that this six-factor standard had been adapted from the test articulated by the Minnesota Supreme Court in North Star Research Institute v. County of Hennepin, 306 Minn. 1, 6, 236 N.W. 2d 754, 757 (1975).

rates for their services any different from rates charged by other similar entities nor that donations had made any difference in the charges to patients below prevailing market rates.[75]

Third, the Court reviewed whether the recipients of the services of the hospitals were required to pay, in whole or in part. They found that the policy of the IHC hospitals was to collect hospital charges from patients whenever it was reasonable and possible to do so; however, no person in need of medical attention was denied care solely on the basis of lack of funds. The record also showed that neither hospital demonstrated any substantial imbalance between the value of the services it provided and the payments it received apart from any gifts, donations, or endowments. "The record shows that the vast majority of the services provided by these two hospitals are paid for by government programs, private insurance companies, or the individuals receiving care. Collection of such remuneration does not constitute giving, but is a mere reciprocal exchange of services for money."[76]

The Court also noted that the record showed that, even though free service did exist, it was deliberately not advertised out of a fear of a "deluge of people" trying to take advantage of it. Instead, every effort was made to recover payment for services rendered.[77]

The Supreme Court concluded that the IHC hospitals did not qualify for real estate tax exemptions, because there was little to no distinction between the nonprofit and for-profit hospitals:

> In summary, . . . we believe that the defendants in this case confuse the element of gift to the community, which an entity must demonstrate in order to qualify as a charity under our Constitution, with the concept of community benefit, which any of countless private enterprises might provide.
>
> We have no quarrels with the assertion that Utah Valley Hospital and American Fork Hospital meet great and important needs of persons within their communities for medical care. Yet this meeting of a public need by a provision of services cannot be the sole distinguishing characteristic that leads to an automatic property tax exemption. The usefulness of an enterprise is not sufficient basis for relief from the burden of sharing essential cost of local government. Such a "usefulness rule" would have to be equally applied to for-profit hospitals and privately owned health care entities which also provide medical services to their patients.
>
> We note, for example, that the increasing emphasis on competition in health care services is resulting in significant expansion of the activities and roles of health care providers generally, including hospitals, both for-profit and nonprofit. Laboratory services, pharmaceutical services, "birthing" centers, and outpatient surgical units are becoming common adjuncts to traditional hospital care. It would be impossible to justify a distinction, within the constitutional boundaries of "charitable" activities, between outpatient surgical services, for example, provided on property owned by a IHC hospital and those provided on privately owned property, where both are identical and are remunerated at the same rate.[78]

As the Utah Supreme Court recognized, the line between charitable and non-charitable activity becomes indistinguishable unless a charity is required to provide services without an expectation of payment in equal proportion to the benefits given in return. The Pennsylvania Supreme Court has held likewise. *See* Hospital Utilization Project v. Commonwealth, 487 A.2d 1306 (1985) ("In all our decisions on this subject, there can be discerned as a prerequisite to the taxation exemption . . . that it, or the portion of its property, in respect to which exemption is claimed, must possess an eleemosynary characteristic not possessed by institutions or property devoted to private gain or profit. What is 'given' must be more nearly gratuitous than for a price which impresses one as being proportionate to the services rendered.")

There are courts in some jurisdictions which have chosen not to follow the more rigorous requirements of the Utah and Pennsylvania Supreme Courts. Some have held that simply providing healthcare to the general public regardless of individual ability to pay and not passing on excess revenue to shareholders is sufficient to qualify for charitable tax exemptions. *See, e.g.*, Medical Center Hospital of Vermont, Inc. v. City of Burlington, 566 A.2d 1352 (1989); Downtown Hospital Ass'n v. Tennessee State Board of Equalization, 760 S.W.2d 954 (1988).

Without clear precedent, one cannot predict how the New Hampshire Supreme Court would decide a case involving the charitable claim of the Mary Hitchcock Memorial Hospital. But the New Hampshire Supreme Court decisions appear aligned more closely with the analyses applied by the Utah and Pennsylvania Supreme Courts. It is well-settled in New Hampshire, by common law and statute, that merely having charitable purposes, providing a needed service to the public, and being organized in a manner where excess revenue is not paid to shareholders (a non-profit corporation) is insufficient to qualify for a charitable tax exemption. *See* RSA 72:23-l. The Court has specifically required findings of distinctive operations including generosity and an element of gifting to the public as compared with commercial or for-profit ventures. *See, e.g.*, Appeal of City of Franklin, *supra;* Housing Partnership, *supra*; Young Women's Christian Ass'n, 89 N.H. 40 (1937).

Applying the principles of the New Hampshire Supreme Court to the facts provided by the Mary Hitchcock Memorial Hospital, the following observations can be made:

- The Hospital has certain criteria that must be met before charity care is given. The charity care may be given at no cost, or at charges less than established rates. Magellan Health Services, Inc., a national for-profit behavioral healthcare company with a for-profit psychiatric hospital in Nashua, New Hampshire, reported that it provided healthcare services without charge or at amounts less than its established rates to patients who meet certain criteria under its charity care policies.[79]

- The Hospital has not provided a copy of its charity care criteria, but the fact that such criteria exists suggests that the Hospital's policy is to require payment for services at established rates (the "retail" price) as its general policy, and then only to reduce its established charges or require no payment if a patient provides sufficient information to show he or she is eligible for such charity care.

- There is no evidence that the Hospital welcomes persons who cannot afford to pay for its services, that it posts information about the availability of charity care, or that it provides information about charity care options to patients when sending bills to collect payment. Rather, it appears the Hospital tries to collect its charges when at all possible, like any other business, including the use of collection agencies if regular billing does not work.*

- The Hospital reports that its charity care amounts to 2.9% of gross patient service revenue, which would likely be a smaller percentage if it were calculated based on the cost of such care to the Hospital. Either way, it represents a *de minimis* or negligible percentage of total gross patient service revenue.

- The Hospital's charity care of 2.9% of gross patient service revenue in 1994, 1995 and 1996 appears similar to charity care levels of for-profit hospitals. The for-profit Portsmouth Regional Hospital in New Hampshire, owned by the Columbia/HCA chain of hospitals, reported for the years 1994, 1995 and 1996 that charity care ranged from approximately 2.1% to 2.3% of its gross operating revenue.[80] The for-profit Magellan Health Services, Inc. reported that its charity care, at established rates nationwide, ranged from 2.8% to 3.6% of total net revenue in the years 1994, 1995 and 1996.[81]

- The Hospital provides healthcare to all individuals, regardless of their ability to pay. Similarly, the for-profit Columbia/HCA hospital chain reports that its hospitals provide "vital, quality and life giving services to . . . communities, meeting an individual's needs regardless of his or her ability to pay."[82]

- The Hospital describes its accomplishments and increasing potential for patient revenue in terms of "market share" in New Hampshire and Vermont and that its objective is to create a fully-integrated healthcare system. The Hospital reports that it has consistently increased its market share since moving to Lebanon.[83] The for-profit Columbia/HCA and Magellan hospital corporations also speak in terms of "market share" and indicate that their objectives of developing fully-integrated healthcare systems will increase profits.

- The Hospital reports that its charity care includes providing community benefits, such as seminars, clinics and similar activities in various communities. The for-profit Columbia/HCA hospital chain also provides community benefits, including funding a medical education program to help locate more primary care physicians to medically under-served areas, establishing a youth foundation, assisting a program for patients with various diseases, and the like.[84]†

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* See, e.g., the 1992 Financial Agreement Among Dartmouth College, Dartmouth Medical School, Mary Hitchcock Memorial Hospital, The Hitchcock Clinic and Matthew Thornton Health Plan, page 10, where a commitment is made to secure financial reimbursement for patient care services to the fullest extent possible while promoting fair, reasonable and efficient patient billing and collection procedures.

† The focus on providing clinics, seminars and similar community benefits within various communities appears to be a conscious marketing strategy for some nonprofit and for-profit hospitals. Columbia/HCA

- The Hospital has used some of its income and profits to support a for-profit business: MHMH Enterprises, Inc., an investment strategy used by many nonprofit and for-profit businesses alike.

In short, the Hospital has not provided evidence to the City that its facility functions in any significant way different than a for-profit hospital.

As to other requirements of New Hampshire law for a charitable tax exemption, though its services meet essential human need and are available to the general public, the Hospital appears to exercise some discretion through its charity care criteria over which persons receive "charity care." Most notable, however, is that the Hospital appears to be operated like a commercial venture, seeking to increase its "market share" in competition with other hospitals, apparently charging rates based on what the market will bear, rather than in giving healthcare to the public for the least possible cost. In fact, it is likely that some of the Hospital's expenses passed on to patients as service charges reflect the costs of competition and the Hospital's expansionist objectives to increase market share.

Further, while subsidizing the Medical School may be commendable and providing support to educational programs may benefit the public eventually, it is an indirect benefit at most. The Hospital is using some of its income or profits for the benefit of a tax exempt private and prestigious educational institution which accepts only students that qualify for its programs. Dartmouth Medical School is not open to the general public and supporting the Medical School does not meet New Hampshire's charitable criteria. It seems likely that the cost of services to patients could be decreased if the Hospital no longer provided financial support to the Medical School.

In addition, the Hospital is using some of its income or profits for a for-profit subsidiary venture, MHMH Enterprises, Inc. While the level of support or investment to MHMH Enterprises is not known, this, too, does not meet charitable criteria. RSA 72:23, V specifically prohibits income being used for anything other than charitable purposes: "The buildings, lands and personal property of charitable organizations [shall be exempt] . . . provided that *none* of the income or profits thereof is used for any other purpose than the purpose for which they are established." (Emphasis added.)

As such, we have to conclude that, while the Hospital may have charitable purposes, its use and occupancy of the facilities does not appear to be charitable. The Hospital has not shown that its use and occupancy of the facilities is different in any significant way than the use a for-profit hospital would make of the same facilities. It has not shown that its patients would know the difference, either. The Hospital, therefore, does not appear qualified for a charitable tax exemption.

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reports that these endeavors increase its goodwill and market share. The Wall Street Journal reported that similar efforts were made by a nonprofit tax exempt Baptist Hospital in Nashville, Tennessee in order to compete with a Columbia/HCA hospital in Nashville. (Wall Street Journal, July 14, 1997; Columbia/HCA 1995 Annual Report.)

III. Charitable Status of the Clinic

Since we have concluded that neither the landowner, DHMC, nor the owner of the buildings, the Hospital, appear to use and occupy the medical center for charitable purposes, no further review is necessary to conclude that the entire medical center should be taxable.

However, the Clinic plays a significant role in the use and occupancy of the real estate and a review was conducted of its corporate purposes and use of the facilities. The Hospital pays for the services of the Clinic and relies on Clinic/HCI physicians to fulfill its own corporate purposes. The Clinic also leases a condominium unit from the Hospital, subject to the ground lease from DHMC.

The Clinic claims to be a charity and eligible for a charitable tax exemption on its own merits since the Clinic provides healthcare and education for the public good. The Clinic indicates there is a charge for its services in accordance with a fee schedule but that it also provides free care in significant amounts and accepts Medicare/Medicaid assignment.[85]

For the real estate to be entitled to an exemption from real property taxes, both the owner of the real estate and the lessee must be charitable, and the lessee must use and occupy the real estate for charitable purposes, pursuant to RSA 72:23, V-a (Supp. 1997).

The Clinic is the outgrowth of a partnership formed in 1927 of five physicians in Hanover. In cooperation with the Hospital, these five physicians and a nurse-bookkeeper-secretary decided to pool their income, skills and expenses in order to attract specialty physicians to the area.[86] The Hospital provided office space for the physicians and for the administration departments of the group practice since this arrangement offered unified control over the care furnished to Hospital patients.[87] The relationship between the Hospital and the physician group continued to develop, and the physicians supplied funds from their profits to the Hospital for construction of various additions for use by the physicians with title remaining with the Hospital.[88]

By 1946, the physician group had grown to a staff of 55 and was re-organized as a for-profit corporation, Hitchcock Clinic, Inc. (HCI), largely to develop a better retirement plan for its members.[89] The physicians still pooled their income, skills and expenses.[90]

In 1973, HCI, along with the College and the Hospital, agreed to form a joint venture—Dartmouth-Hitchcock Medical Center. In 1983, the operations of the for-profit HCI were transferred to a new nonprofit corporation, The Hitchcock Clinic (the Clinic). HCI was not dissolved, though, and it is active today. Also in 1983, the nonprofit Clinic became a member of DHMC with the College and the Hospital.

The corporate purposes of the nonprofit Clinic are:

> the diagnosis, treatment and care of human ailments and the study of the causes and prevention thereof; the promotion of medical, surgical, and scientific learning and

skill; the investigation of problems of health, hygiene, and public welfare; the aid and advancement of scientific research in medicine and related fields; and the conduct of educational activities in medicine and related fields.[91]

The Clinic's purposes appear to be charitable in nature, since they focus on performing "some service of public good or welfare advancing the spiritual, physical, intellectual, social or economic well-being of the general public or a substantial and indefinite segment of the general public." RSA 72:23-l (Supp. 1997).

The issue regarding the Clinic is whether its use and occupancy of the real estate is also charitable. When reviewing documentation from the Clinic, the fact is quickly apparent that one cannot review the Clinic's use and occupancy of the medical center without also reviewing HCI's use and occupancy.

For instance, the Clinic reported that it delivered healthcare services over a wide geographic area. Indeed, since the mid-1980s, the Clinic has expanded rapidly and has purchased or leased many facilities in New England which are sites where medical care can be obtained.[92] But while the Clinic has more than 2,000 employees, none of the employees are physicians.[93] The Clinic cannot fulfill its corporate purposes of "the diagnosis, treatment and care of human ailments" without obtaining the services of persons qualified to give professional medical treatment.

The Clinic provides the personnel necessary to provide medical treatment through an exclusive Professional Services Agreement between HCI and the Clinic.[94] *All* of the physicians that provide services in the nonprofit Clinic facilities are employed by HCI, the for-profit corporation that still functions as a private physician group practice which is physician-owned and physician-directed.[95] Even though the physicians agreed to transfer legal responsibility for healthcare to the Clinic in 1983, the physician stockholders of HCI desired to maintain a significant degree of independence and control over their professional affairs and the terms and conditions of their individual and collective employment.[96]

This independence and control over their own affairs is maintained through the ownership of stock in HCI. Of the more than 500 physicians employed by HCI, 137 are stockholders. Other physicians are classed as affiliated members, associates and assistants. The stockholders and affiliated members elect the seven-member HCI Board of Directors.[97]

The dependency of the nonprofit Clinic upon the for-profit HCI physicians becomes clearer when reviewing the Clinic's statement submitted for bonding purposes by the New Hampshire Higher Educational and Health Facilities Authority. The Clinic was able to qualify for low-cost loans only as a nonprofit organization through the Authority, but its informational filing describes itself as "the largest multi-specialty physician group practice in New England and one of the largest in the United States."[98] The Clinic is not a physician group practice, however. It employs no physicians. Only the for-profit HCI employs physicians.

The Clinic's informational filing encouraging investment in its bonds continues:

> Approximately 500 physicians practice at the Clinic's 49 facilities located throughout New Hampshire and Vermont. These physicians generate over one million outpatient visits a year, admit patients at hospitals throughout [New Hampshire and Vermont] and currently account for approximately 28% of the inpatient surgical and medical admissions in [New Hampshire.][99]

In the Lebanon medical center, nearly all of the medical and surgical admissions were attributable to admissions of patients by the for-profit HCI physicians.[100] Further, the Clinic reported that, because of the "Clinic Physicians," it enjoyed a strong competitive position in the healthcare market in the region.

> Within its Service Region [of New Hampshire and Vermont], competitor practices exist in each market area, particularly in southern New Hampshire. In the more urban communities of southern New Hampshire, Clinic practices generally represent between 15% to 25% of the physician provider market, except for the Seacoast Region, where Clinic Physicians represent less than 5% of the physician population, and the Keene area, where Clinic Physicians represent more than 75% of the area's practicing physicians. Competitors are generally organized as smaller private practices or under local community hospital PHOs, as no other independent group practice exists in [New Hampshire] with more than 25 physicians.[101]

As these statements indicate, the Clinic represents itself as one and the same organization with the HCI physicians. There is virtually no difference between the non-profit Clinic and the for-profit HCI corporations. They are one seamless operation working towards a common goal. Even their stated corporate purposes are almost identical.*

Further, top management of the Clinic is the top management of HCI. The Chief Executive Officer, the Chief Financial Officer, and the Director of Human Resources for the Clinic serve as the primary management team of HCI.[102] Two members of the Clinic's Board also serve on HCI's Board. The Clinic appears to be nothing more than a nonprofit corporate facade through which the for-profit HCI physicians act.

The history of the Clinic bears this out. From the beginning of the group physician practice in Hanover, the physicians avoided real estate taxation by funding expansions to their practice site through the Hospital, permitting the Hospital to take title to the real estate additions while actually

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* HCI's corporate purposes are: To maintain and operate a clinic for the treatment of human ailments and injuries and to employ duly qualified physicians surgeons and other medical and professional personnel for such purposes; to study human ailments and injuries and the causes, prevention, relief and cure thereof; and to promote medical, surgical, scientific learning and research in Hanover, New Hampshire, elsewhere in The State of New Hampshire and outside of the State in such states or foreign countries as it may be convenient to carry on the business of the corporation. (Articles of Agreement of Hitchcock Clinic, Inc., Article II, dated December 2, 1946.)

using and occupying those additions for their own offices. The physicians provided inpatient medical services in the Hospital, but they continued their private practices by seeing patients in their own offices on an out-patient basis. If the physicians had taken title to the facilities used as doctors' offices, the facilities would have been taxable.

The Clinic's history also shows that, in 1973, a Committee recommending the formation of DHMC also recommended that each member of the confederation, including HCI, retain its corporate integrity and right to pursue its own fundamental purposes. This plan was endorsed by the for-profit HCI. In a 1982 speech before the nonprofit Clinic was established by Dr. Cardozo, president of HCI, he encouraged the members of HCI to accept non-profit status for six advantageous reasons related to avoiding unnecessary taxation. A commitment was made to the physicians that they would still be involved in determining their own levels of compensation and establishing the goals of the group.

The commitment to the physicians of HCI has apparently been fulfilled by the continued existence of HCI as the employer of all physicians that work at the Clinic, and the two corporations continue to operate in tandem with almost no distinction.

The Clinic, though, has defended its relationship with HCI by claiming that HCI always operated more like a nonprofit charity anyway.* The Clinic's apparent basis for claiming HCI has operated as a charity relies on the fact that the physicians in HCI pool their income in order to subsidize lower-income-producing specialists and it has never paid a dividend to stockholders.[103] But these claims lack merit.

First, it is difficult to imagine a court accepting that the for-profit HCI is really a charity in disguise, particularly when HCI never dissolved and the physician stockholders of HCI decided to remain in control of the for-profit corporation. Apparently they did not want to become employees of the nonprofit Clinic.

Second, merely pooling physician income to subsidize lower-income specialties only serves to benefit the members of HCI; it does not benefit the public in any way. While it is commendable that the physicians are willing to share income with fellow members of the profession, nevertheless, HCI is principally operated to benefit its own members, which is antithetical to being a public charity.

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* In 1984, HCI tried to transfer all of its assets to the Clinic and dissolve without a vote of the stockholders and without distributing the assets to the stockholders. Upon objection of one of the physician stockholders who believed such action would be illegal and violate HCI's articles of incorporation, HCI filed a declaratory judgment action in superior court. One of HCI's arguments in favor of permitting such a transfer was that HCI had always acted as a charitable corporation and it was obliged by agreements with the Hospital and the College to distribute the assets to the nonprofit Clinic and not to the stockholders. While the trial court agreed, the New Hampshire Supreme Court did not, which reversed the decision of the trial court and indicated there was no legal basis for concluding that HCI, a for-profit corporation, should be treated any differently than other for-profit corporations. In the Matter of Hitchcock Clinic, 127 N.H. 62 (1985).

Third, as stated previously, it is not legally significant that dividends are not paid to stockholders, since nonprofit corporations do not qualify for charitable tax exemptions simply on that basis. RSA 72:23-l.

It is interesting to note that the Clinic and HCI agreed that the salary structure of the physicians would be commensurate with salaries at other comparable national and regional academic medical centers and that the Clinic would pay additional salary supplements to HCI physicians as awards and incentive compensation to attract and retain physicians and to motivate physicians to promote the prosperity of the Clinic.[104] For the period ending September 30, 1996, the Clinic paid HCI more than $87 million for physician salaries, benefits and related expenses.[105]

The claim by the Clinic that it is a charity, distinct from the for-profit HCI, is questionable, as well, if one reviews the Clinic's acquisition of physician practices elsewhere in New Hampshire. For instance, in 1993, the Clinic acquired the Keene Clinic in Keene, New Hampshire. This was a for-profit physician group practice, and the real estate owned by the Keene Clinic was taxed. When Hitchcock Clinic acquired the Keene Clinic, the physicians of the Keene Clinic became employees of HCI while the real estate and operations of the Keene Clinic were absorbed by the nonprofit Hitchcock Clinic.[106]

One wonders how the operations changed when a nonprofit "charity" acquired the for-profit Keene Clinic. The Hitchcock Clinic did not provide information regarding any changes. The Clinic did agree to employ all of the Keene Clinic support staff at pay levels comparable to their then-current levels of pay and it was stipulated that no promise or commitment had been made to increase salaries or expand benefits *other than had already been disclosed* in a document that still remains confidential.[107] The Hitchcock Clinic, though it claims a charitable tax exemption in Lebanon, has not challenged taxation in Keene and pays real estate taxes to the City of Keene, which is perhaps an implicit acknowledgment that no change occurred sufficient to support a charitable tax exemption.

The nonprofit Clinic has attempted to distinguish itself from the for-profit HCI by obtaining an agreement from HCI that the HCI physicians would cooperate fully with the Clinic to accomplish the Clinic's charitable purposes.[108] One wonders how effective this agreement is since the physicians of HCI are the primary means through which the Clinic receives income. The Clinic simply could not operate without the HCI physicians. At the same time, the Clinic is the sole source of HCI's income.[109]

If one observes the Clinic's use and occupancy of the medical center facility, its operations appear very similar to operations conducted by many, many physicians working either individually or in smaller group practices that are either physician-owned or incorporated as for-profit businesses (Keene Clinic being one such example). The HCI physicians have offices at the medical center where they see patients by appointment, and the Clinic is open only during typical business hours when HCI physicians are working and then is closed in the evenings and weekends, similar to many smaller facilities serving as doctors' offices that pay taxes as part of the cost of doing business.

In short, the Clinic/HCI (as one operation) appears to be a well-managed successful physician group practice which has made good business decisions to advance the interests of the whole group. But the Clinic as a lessee of the medical center does not appear to come within the requirements of New Hampshire law as a charitable corporation qualified for charitable tax exempt status. The Clinic is HCI, and HCI is the Clinic—and as long as HCI is a for-profit corporation, no matter how commendable HCI's practices are for its physicians, a for-profit corporation cannot also be a charity. It must bear its fair share of the tax burden as a member of the local community.

> Taxes are not penalties but are contributions which all inhabitants are expected to make (and may be compelled to make) for the support of the manifold activities of government. Every inhabitant and every parcel of property receives governmental protection. Such protection costs money. When an inhabitant fails to contribute his share of the costs of this protection, some other inhabitant must contribute more than his fair share of that cost.[110]

It is, therefore, our opinion that the Clinic is not a charity, nor is its use and occupancy of the medical center charitable.

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APPENDIX

Exhibit A: A History of Hospitals in America

The following is a statement of the Utah Supreme Court summarizing the history of hospitals and healthcare in America in Utah County v. Intermountain Health Care, Inc. 709 P.2d 265 (1985):

> We are convinced that traditional assumptions bear little relationship to the economics of the medical-industrial complex of the 1980's. Nonprofit hospitals were traditionally treated as tax-exempt charitable institutions because, until late in the 19th century, they were true charities providing custodial care for those who were both sick and poor. The hospitals' income was derived largely or entirely from voluntary charitable donations, not government subsidies, taxes, or patient fees.
>
> > Footnote: "Voluntary" hospitals, like public hospitals (which evolved from almshouses for the dependent poor), performed a "welfare" function rather than a medical or curing function: the poor were housed in large wards, largely cared for themselves, and often were not expected to recover. Early voluntary hospitals had paternalistic, communal social structures in which patients entered at the sufferance of their benefactors, "had the moral status of children," and received more moralistic and religious help than medical treatment.
> >
> > Voluntary hospitals were charities for the quite obvious reason that they housed and tended to those who were both sick and poor, i.e., those without resources and in need of charity. Because hospitals performed no medical treatment function and because they were largely institutions for the poor, the non-poor in need of medical treatment and their treating private physicians overwhelmingly avoided them.
>
> The function and status of hospitals began to change in the late 19th century; a transformation was substantially completed by the 1920's. From charities, dependent on voluntary gifts, [hospitals] developed into market institutions financed increasingly out of payments from patients. The transformation was multi-dimensional: hospitals were redefined from social welfare to medical treatment institutions; their charitable foundation was replaced by a business basis; and their orientation shifted to "professionals, and their patients," away from "patrons and the poor."
>
> > Footnote: This transformation was propelled significantly by (1) the professionalization of nursing and doctoring, and (2) advances in medical science, particularly in hygiene and anesthesia. Not only did the quality of medicine improve, but more importantly, the practice of medicine rapidly became linked to hospitals. Consequently, hospitals ceased being custodial holding institutions for the poor and instead became centers of medical treatment, especially surgery, attractive, for the first time, to private physicians and paying patients. A major consequence of this change was a great increase in the cost of establishing and

> operating hospitals. Hospital budgets soared beyond the capacity of charity to meet them. While the change increased costs, it also enlarged the potential for income. Many people were now coming to hospitals who could afford to pay, and since the real value of hospital care had increased, charges would not drive them away. Hospitals' ability to attract and financial need for paying patients, in turn, greatly increased the power of physicians over hospitals at the turn of the century as physicians acted as "feeders," controlling the traffic of paying patients to hospital beds. Hospitals had gone from treating the poor for the sake of charity to treating the rich for the sake of revenue.

The magnitude and character of the change in hospital care is suggested by a number of factors. (1) The social composition of hospital patients appears to have changed until by the early 20th century it became quite similar to the population at large. The change in hospital architecture (large wards were replaced with private rooms) suggests the same movement away from the poor to paying patients. (2) The number and percentage of paying patients increased as did the percentage of revenue derived from patient fees. This revenue amounted to over 65 percent for general hospitals in the country as a whole by 1922. Public appropriations amounted to about 18 percent; endowment income amounted to 3.6 percent; and donations added 5.7 percent. (3) The practice of not permitting physicians to charge private patients for their services in hospitals was abandoned during this period. In 1880, according to one study, no hospital permitted physician fees. By 1905, 47 of 52 New England hospitals surveyed permitted physicians to charge for services to private patients. (4) Before 1880, less than 2 percent of physicians had hospital privileges; by 1933, 5 of 6 physicians had hospital privileges. (5) The number of hospitals increased, according to census figures, from 178 in 1872 to over 4,000 in 1910. (6) Between 1890 and 1920 there was a substantial growth in for-profit hospitals, organized by physicians and corporations, as the opportunity for profit in the hospital business improved. All of the above factors indicate a substantial change in the nature of the hospital; a part of that change was the gradual disappearance of the traditional charitable hospital for the poor.

Also of considerable significance to our review is the increasing irrelevance of the distinction between nonprofit and for-profit hospitals for purposes of discovering the element of charity in their operations. The literature indicates that two models, described below, appear to describe a large number of nonprofit hospitals as they function today.

(1) The "physicians' cooperative" model describes nonprofit hospitals that operate primarily for the benefit of the participating physicians. Physicians, pursuant to this model, enjoy power and high income through their direct or indirect control over the nonprofit hospitals to which they bring their patients. The nonprofit form is believed to facilitate the control by physicians better than the for-profit form. This model has also been called the "exploitation hypothesis" because the physician "income maximizing" system is hidden behind the nonprofit facade of the hospital. A minor variation of the above theory is the argument that many nonprofit hospitals operate as "shelters" within which physicians operate profitable businesses, such as laboratories.

(2) The "polycorporate enterprise" model describes the increasing number of nonprofit hospital chains. Here, power is largely in the hands of administrators, not physicians. Through the creation of holding companies, nonprofit hospitals have grown into large groups of medical enterprises, containing both for-profit and nonprofit corporate entities. Nonprofit corporations can own for-profit corporations without losing their federal nonprofit tax status as long as the profits of the for-profit corporations are used to further the nonprofit purposes of the parent organization. . . . The emergence of hospital organizations with both for-profit and nonprofit components has increasingly destroyed the charitable pretentions (sic) of nonprofit organizations: "The extension of the voluntary hospital into profit-making businesses and the penetration of other corporations into the hospital signal the breakdown of the traditional boundaries of voluntarism. Increasingly, the polycorporate hospitals are likely to become multihospital systems and competitors with profit-making chains, HMO's and other health care corporations."

The foregoing discussion of the economic environment in which modern hospitals function is critical to our analysis in this case because it is an analysis which is generally not present in any of the cases relied upon by the dissenting opinions. Those cases, in our view, do not take into account the revolution in health care that has transformed a "healing profession" into an enormous and complex industry, employing millions of people and accounting for a substantial proportion of our gross national product. Dramatic advances in medical knowledge and technology have resulted in an equally dramatic rise in the cost of medical services. At the same time, elaborate and comprehensive organizations of third-party payers have evolved. Most recently, perhaps as a further evolutionary response to the unceasing rise in the cost of medical services, the provision of such services has become a highly competitive business.

Id. at 270-272 (citing and quoting Paul Starr, The Social Transformation of American Medicine (1982); David Rosner, A Once Charitable Enterprise, (1982); Pauley & Redisch v. Not-For-Profit Hospital as a Physicians' Co-operative, 63 Am. Econ. Rev. 87 (1973); Clark, Does the Nonprofit Form Fit the Hospital Industry? 93 Harv. L. Rev. 1416 (1980).

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[1] Ground Lease between DHMC and the Hospital, June 15, 1988.
[2] Id.
[3] Id.
[4] Id.
[5] Declaration of DHMC Condominium, October 11, 1988.
[6] Id.; see also Ground Lease between DHMC and the Hospital.
[7] By-Laws of the DHMC Condominium Unit Owners' Association, October 11, 1988.
[8] Vermont Educational and Health Buildings Financing Agency Revenue Bonds, Series 1996, Appendix A, page A-1, 29.
[9] NH Higher Educational and Health Facilities Authority Revenue Bonds, The Hitchcock Clinic Issue, Series 1994, Appendix A, page A19.
[10] MHMH Responses to City's Requests, February 1997.
[11] Young Women's Christian Ass'n v. Portsmouth, 89 N.H. 40, 41, 44 (1937).
[12] 71 Am Jur 2d *State and Local Taxation* § 363.
[13] RSA 72:23-l; *see also* 71 Am Jur 2d *State and Local Taxation* § 363.
[14] Appalachian Mountain Club v. Meredith, 103 N.H. 5, 10 (1960).
[15] Society of Cincinnati v. Exeter, 92 N.H. 348 (1943); Nature Conservancy of New Hampshire v. Nelson, 107 N.H. 316 (1966).
[16] RSA 72:23, V.
[17] RSA 72:23,V.
[18] Nature Conservancy of New Hampshire v. Nelson, 107 N.H. 316 (1966); Wentworth Home v. Portsmouth, 108 N.H. 514 (1968).
[19] Housing Partnership v. Rollinsford, 141 N.H. 239, 244 (1996).
[20] Nature Conservancy of New Hampshire v. Nelson, 107 N.H. 316, 319 (1966); RSA 72:23-m.
[21] Form BTLA A-9 for the tax year 1997 filed by DHMC with the City.
[22] Report of the Center Planning Committee, Appendix 18, Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023.
[23] Report of the Center Planning Committee, Appendix 18, Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023.Id.
[24] Articles of Agreement, Dartmouth-Hitchcock Medical Center, Article IV.
[25] DHMC Corporate By-Laws, amended through September 23, 1995.
[26] NH Higher Educational and Health Facilities Authority Revenue Bond, The Hitchcock Clinic Issue, Series 1997, Appendix A, page 19.
[27] DHMC responses to City's questions, February 1997.
[28] 1995 Form 990 of the Internal Revenue Service, Part VIII; Vermont Educational and Health Buildings Financing Agency Revenue Bonds, Series 1996, Appendix A, page A-25; DHMC responses to City's questions, February 1997.
[29] 1995 Form 990 of the Internal Revenue Service, Part VIII; see Coopers & Lybrand Financial Statements of DHMC for the Years Ended June 30, 1994 and 1995, Note B.
[30] Coopers & Lybrand Financial Statements of DHMC for the Years Ended June 30, 1995 and 1994.
[31] Id.
[32] Id.
[33] Coopers & Lybrand Financial Statements of DHMC for the Years Ended June 30, 1996 and 1995.
[34] Report of the Center Planning Committee, Appendix 18, Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023.
[35] Sacred Heart Healthcare System v. Commonwealth of PA, 673 A.2d 1021, 1022-1023 (1996).
[36] Id. at 1025.
[37] Id. at 1026-1027.
[38] Id. at 1028.
[39] RSA 75:2, 3.
[40] Indian Head National Bank v. Portsmouth, 117 N.H. 954 (1977); Lin-Wood Dev. Corp. v. Lincoln, 117 N.H. 709 (1977).

[41] RSA 72:23,V-a (Supp. 1997).
[42] Form BTLA A-9 for the tax year 1997 filed by the Hospital with the City.
[43] Mary Hitchcock Memorial Hospital Charter, Section 1.
[44] Mary Hitchcock Memorial Hospital Bylaws, Article 1, Section 1.1.
[45] Vermont Educational and Health Buildings Financing Agency Revenue Bonds, Series 1996, Appendix A, page A18.
[46] Id at page A17.
[47] Id.
[48] Id.
[49] Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023, page 11; NH Higher Educational and Health Facilities Authority Revenue Bonds, The Hitchcock Clinic Issue, Series 1997, Appendix A, page 1.
[50] Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023, pages 6-7.
[51] Joint Committee on Clinic-Hospital Relations, Appendix 12, Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023.
[52] Vermont Educational and Health Buildings Financing Agency Revenue Bonds, Series 1996, Appendix A, page A19.
[53] Financial Statements of Mary Hitchcock Memorial Hospital by KPMG Peat Marwick For Years Ending June 30, 1995 and 1994.
[54] Id.
[55] Financial Statements of Mary Hitchcock Memorial Hospital by KPMG Peat Marwick For Years Ending September 30, 1996 and 1995.
[56] Financial Statements of Mary Hitchcock Memorial Hospital by KPMG Peat Marwick For Years Ending June 30, 1995 and 1994, Note 3, and for Years Ending September 30, 1996 and 1995.
[57] Financial Statements of Mary Hitchcock Memorial Hospital by KPMG Peat Marwick For Years Ending June 30, 1995 and 1994, Note 2.
[58] Financial Statements of Mary Hitchcock Memorial Hospital by KPMG Peat Marwick For Years Ending June 30, 1995 and 1994, Note 3, and for Years Ending September 30, 1996 and 1995.
[59] Financial Statements of Mary Hitchcock Memorial Hospital by KPMG Peat Marwick For Years Ending June 30, 1995 and 1994, Notes 3 and 4; Responses of Hospital, February 1997.
[60] "Opportunities Lost & Opportunities Taken, a Report on the Hospital Use of Medicaid Enhancement Funds 1991-1997" by New Hampshire Citizen Action/North Country Institute, December 1997.
[61] Financial Statements of Mary Hitchcock Memorial Hospital by KPMG Peat Marwick For Years Ending June 30, 1995 and 1994, and for Years Ending September 30, 1996 and 1995.
[62] See Financial Statements of Mary Hitchcock Memorial Hospital by KPMG Peat Marwick For Years Ending June 30, 1995 and 1994, Note 1.
[63] 1992 Financial Agreement Among Dartmouth College, Dartmouth Medical School, Mary Hitchcock Memorial Hospital, The Hitchcock Clinic and Matthew Thornton Health Plan, page 1.
[64] Id. at pages 3-4.
[65] Id. at page 4.
[66] Id. at pages 4-5.
[67] Vermont Educational and Health Buildings Financing Agency Revenue Bonds, Series 1996, Appendix A, page A24.
[68] The Hitchcock Clinic Financial Statements for the Years Ending September 30, 1996 and 1995, Note 3.
[69] Id.
[70] NH Higher Educational and Health Facilities Authority Revenue Bond, The Hitchcock Clinic Issue, Series 1997, Appendix A, pages A21.
[71] The Hitchcock Clinic Financial Statements for Year Ending September 30, 1996 and 1995, Note 3.
[72] Valley News, October 6, 1997.
[73] Housing Partnership v. Town of Rollinsford, 141 N.H. 239, 244 (1996).
[74] Utah County v. Intermountain Health Care, Inc. 709 P.2d 265, 269 (1985)(citations omitted).
[75] Id. at 273.
[76] Id. at 274.
[77] Id.
[78] Id. at 276-277.

[79] Securities and Exchange Commission Form 10-K/A for Magellan Health Services, Inc. for the fiscal year ended September 30, 1996.
[80] Information provided by Ms. Leslie Pope, Vice President for Marketing and Public Relations, Portsmouth Regional Hospital.
[81] Securities and Exchange Commission Form 10-K/A for Magellan Health Services, Inc. for the fiscal year ended September 30, 1996.
[82] Columbia/HCA 1995 Annual Report, page 6.
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[85] Form BTLA A-9 filed by Hitchcock Clinic with the City of Lebanon for the tax year 1997.
[86] Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023, page 11; NH Higher Educational and Health Facilities Authority Revenue Bonds, The Hitchcock Clinic Issue, Series 1997, Appendix A, page 1.
[87] Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023, pages 6-7.
[88] Joint Committee on Clinic-Hospital Relations, Appendix 12, Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023.
[89] Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023, page 11.
[90] Interim Report of Committee on Investigation of Retirement Plan and Foundation Organization, Appendix 4, Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Inc., Docket E-82-023.
[91] Articles of Agreement of Hitchcock Clinic, Article II, dated February 26, 1983.
[92] NH Higher Educational and Health Facilities Authority Revenue Bond, The Hitchcock Clinic Issue, Series 1997, Appendix A, pages A28-29.
[93] Hitchcock Clinic Responses to Requests of City of Lebanon, February 1997.
[94] NH Higher Educational and Health Facilities Authority Revenue Bond, The Hitchcock Clinic Issue, Series 1997, Appendix A, pages A12-13.
[95] Hitchcock Clinic Responses to Requests of City of Lebanon, February 1997.
[96] Professional Services Agreement between the Clinic and HCI, July 1, 1992.
[97] NH Higher Educational and Health Facilities Authority Revenue Bond, The Hitchcock Clinic Issue, Series 1997, Appendix A, pages A12-13.
[98] Id. at pages A1, A12-13.
[99] Id. at page A1.
[100] Id. at page A19.
[101] Id. at page A27.
[102] NH Higher Educational and Health Facilities Authority Revenue Bond, The Hitchcock Clinic Issue, Series 1994, Appendix A, pages A4, A7.
[103] Agreed Statement of Facts, In the Matter of Hitchcock Clinic, Docket No. E-83-023.
[104] Professional Services Agreement between the Clinic and HCI, July 1, 1992, Exhibit D.
[105] NH Higher Educational and Health Facilities Authority Revenue Bond, The Hitchcock Clinic Issue, Series 1997, Appendix A, pages A12-13.
[106] KCI Acquisition Agreement, November 30, 1993.
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[110] Hospital Utilization Project v. Commonwealth of Pennsylvania, 487 A. 2d 1306 (1985).

InterTown RECORD 50¢

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Community Hospitals Struggling to Survive

P1

New London Facing $3M Revenue Slash

by George Edmunds
InterTown News Service

New London Hospital, which serves communities throughout the Kearsarge-Lake Sunapee region, is facing a loss of $3,005,508 from fiscal year '98 through fiscal year '02 as a result of the federal government's Balanced Budget Act (BBA) of 1997, according to hospital CEO Maureen McNamara.

The local hospital also stands to lose $250,000 in the wake of the Tufts medical plan collapse, and faces a challenge shared with all 26 acute care hospitals in New Hampshire; that of adjusting to a constant reduction in the level of reimbursement from commercial health insurers.

"As costs begin to climb, our reimbursements are being cut," said McNamara. "It's a constant challenge to balance controlling costs while sustaining and improving quality of service."

Miriam Watson, communications manager for the N. H. Hospital Association, said yesterday that the BBA's trimming of Medicare reimbursements will cost the state's acute care hospitals more than $155 million over a five-year period. "I have aggregate data available from 20 of the state's 26 acute care hospitals," she said yesterday afternoon. "Therefore, the total impact to New Hampshire should be somewhat higher."

Although Congress passed what Watson termed "minimal relief" last year, hospital authorities see that relief as little help and are hastening to find ways to continue services and expand to meet competition. Weeks Memorial Hospital, Lancaster, will lose $1.5M, according to CEO Scott W. Howe. The 49-bed Franklin Regional Hospital in nearby Franklin will lose $2.5 million, said CEO Walter A. Strauch. "For us this gains more significance because 70% of our in-patient activity is directed at the Medicare population."

Despite the BBA reductions and rising costs, McNamara ssid New London Hospital has developed a system of care which will guarantee

See HOSPITALS -Page 3

"Despite the crunch, we are trying to meet the needs of the community."
Scott Howe, CEO
Weeks Memorial Hospital, Lancaster

"With about an $800,000 loss last year... we're looking hard to provide the same amount of service with fewer dollars. It's a tough battle for us."
Walter A. Strauch, CEO
Franklin Regional Hospital
Franklin

"We're trying to reduce expenses in all areas that do not affect some of the vital services we provide."
Peter Gosline, CEO
Monadnock Community Hospital
Peterborough

"As we talk with some of the Congressmen, I don't think they understand the full impact of what's happening nor do I think it's very high on their priority list."
Tom Clairmont, CEO
Lakes Region General Hospital
Laconia

Pg 2

Aggregate Data Show 20 of 26 N. H. Acute Care Hospitals Losing $155 Million

HOSPITALS

(Continued from Page 1)

iprovements in the quality and depth of medical service.

"We just completed a strategic planning process...which lows us to make certain we can take people through a continuum of care from wellness to acute episodes to long-term are. It's what we're calling the New London Hospital System Care." The system includes wellness and prevention programs, emergency services, ambulance services, long-term are and rehabilitation, hospice, home health care, visiting pecialists, diagnostic services, inpatient services, and physician services: internal medicine, family practice, pediatrics, eneral surgery, OB/GYN, and ophthalmology.

To provide these services, the VNA, Clough Center, the ewport Health Center, and a newly formed New London hysicians Group, will all reside under the umbrella of the lew London Hospital Association.

"This gives us a framework with which to create more programs that will assure the people that they won't have to eave their community to get their primary care services. hat's our major goal," McNamara said.

"The people have told us they don't want to leave their community for primary care and so our goal is to make certain ve can meet all their primary care needs right here. ...We ave a very strong group of primary care doctors here and a umber of visiting specialists from Hanover and Concord nd our goal is to build stronger relationships with them so hat they really understand and support our vision of providing more of the service right here in New London.

"No doctor," she added, "has the luxury of sitting around waiting for patients these days, so we have to assure that we have the volume to justify their spending time here. It's really a Catch 22.



Maureen A. McNamara, New London Hospital's president and CEO

"With Medicare being cut, Medicaid being cut...and commercial insurers shopping for the best prices, in order for us to continue to do what we're doing – to pay for the technology that is needed to have a state-of-the-art facility that will attract the best physicians out there – we need the volume.

"We need to make sure that people know and understand what our capabilities are and we need to make sure that they can access the system when they need it," McNamara said.

"The outcry from the community up until now has been that they haven't been able to get into their physicians' offices when they needed them. And so a lot of effort has been put into making certain that they can do that. The hospital did enter into arrangements with most of the primary care providers in town over the past 18 months or so. Now most of the physicians are employed by the hospital."

McNamara said the hospital did this to assure the community that there would be medical care in the future. Many doctors were talking about the fact that when they retired, they weren't sure what was going to happen to their practices because they cannot afford to bring in young partners to sustain the practice.

The hospital physicians group is still evolving, McNamara said. It's a step she said was taken "for the good of the community."

Other Activity at New London Hospital

"We have a big, active initiative right now in customer service," said McNamara. "We feel that service will distinguish us from our 'competition' in the future. Service will be our niche." She said the hospital will continue to do a good job in servicing patients, patients' families, and their visitors. "But, we want to go the extra mile – we always know we can do better."

Meanwhile, it's important that the community understands that New London Hospital is dealing with the same demons that are threatening the entire health care industry: the reduced reimbursements, the fact that the hospital is not allowed to keep patients as long as it once was, and that the hospital is now limited as to the types and numbers of testing it can conduct.

"The fact that we have the New London Hospital System of Care allows us to refer to the VNA on appropriate and timely basis, move people into a skilled bed or a long-term care bed on a timely basis as well," McNamara said. "And, of course, having the doctors so closely linked that when things appropriately should be done on the outpatient side, then we have the advantage of not only having the doctors who work here, but those who visit here that we can link people to quickly."

Balanced Budget Amendment Shortfalls

New London Hospital	$3.5 million
Weeks Memorial, Lancaster	$1.5 million
Franklin Regional, Franklin	$2.5 million
Lakes Regional, Laconia	$7.2 million
Monadnock Community	$3.0 million
Cheshire Medical Center	$10.6 million
St. Joseph's, Nashua	$8.4 million
Upper Conn. Val., Colebrook	$865,905
Portsmouth Regional	$10 million
Elliot Hospital, Manchester	$18.7 million
Concord Hospital	approx. $500,000*

* due to Tufts Medical Plan problem

In Peterborough

Peter Gosline, CEO of the Monadnock Community Hospital, Peterborough, is projecting about a $3-million BBA loss over five years. "Our bottom line each year is very close to the wire, and to accommodate that level of reduction is a great challenge for us. We're looking very seriously at all aspects of the business."

Gosline said there are four things his hospital is trying to do: reduce expenses in all areas that do not affect some of the vital services; share services such as purchasing and information systems with other organizations and hospitals; look for areas of growth; and get the word out to the public that Medicare reductions will have an impact on their community hospital. He sees citizen political actions as a vital step to address the Medicare problem.

Gosline said outpatient services are being expanded at the Peterborough hospital and a new rehabilitation and welcome facility is now under construction on campus.

In Laconia

The Lakes Region General Hospital in Laconia stands to lose $7.2 million to the BBA and CEO Tom Clairmont believes people will react when they learn the depth of the problem.

People have not reacted because they have not been made aware of the crisis, he said. "In the President's budget, he proposed more cuts for hospitals. Unfortunately, hospitals aren't very popular until people need them," Clairmont said.

"More importantly, as we talk with some of the Congressmen, I don't think they understand the full impact of what's happening nor do I think it's very high on their priority list." He added that he was not so sure that local representatives were aware either.

In Franklin

Franklin Regional Hospital has a 12-town service area with a population of about 28,000, according to CEO Strauch. The Medicare patient load is pushed up because of the hospital's proximity to the 150-bed veterans' nursing home (which is planning a 50- to 80-bed addition); and three smaller nursing homes.

"We had an $800,000 loss for the hospital last year," said Strauch, "and we're looking hard to understand how to provide the same amount of service with fewer dollars. It's a tough battle for us.

"We recognize that as a primary care facility, we must maintain up-to-date facilities. We're looking to move into a $3.2 million expansion and remodeling which will be centered around medical office facilities and our operating suite. We're hoping to break ground this spring."

In Lancaster

Scott W. Howe, administrator of Weeks Memorial Hospital, Lancaster, said the BBA represents one of that hospital's biggest challenges. "A reduction of $1.5 million over the next five years...is a significant dollar amount for us to try and reduce our budget. And it has really put the squeeze on what we can do for our community.

"We're looking at expenses," said Howe, "and trying to find areas where we can reduce. This may mean an end to certain services we can provide such as health screenings.

"My other biggest concern is the nursing shortage that's developing. We're having a very hard time up in this area recruiting nurses," said Howe. "The salary range for nurses is going to grow rapidly while we're trying to deal with the BBA."

Just as is the case in other hospitals, Weeks Memorial is looking for new services it might provide. "With our strategic planning process, we're developing a number of actions. We (Lancaster) have the highest rate of diabetes in Coos County... so we're in the process of dealing with it and helping the people," Howe said. "Despite the crunch, we are trying to meet the needs of the community."

Pg 5

COMMENTS FOR COMMITTEE WORK SESSION OF ON HB 1144, RELATIVE TO PROPERTY TAX EXEMPTION FOR NON-PROFIT HOSPITALS

James W. Varnum
President, Mary Hitchcock Memorial Hospital
March 7, 2000

Good afternoon, Mr. Chairman and members of the Committee. I'm Jim Varnum, president of Mary Hitchcock Memorial Hospital in Lebanon, NH. I want to thank you for inviting me here today to speak on HB 1144 and how it relates to our hospital in the Lebanon community. I hope my comments will be helpful to you in considering the disposition of this Bill.

MHMH is one of the four organizations—Mary Hitchcock Memorial Hospital, Dartmouth-Hitchcock Clinic, Dartmouth Medical School and the VA Hospital in White River Jct, VT--which comprise the Dartmouth-Hitchcock Medical Center. HB 1144 pertains to hospitals, but due to the integrated nature of DHMC it is difficult for me to speak and provide examples only from the MHMH perspective.

Mary Hitchcock Memorial Hospital is committed to patient care, teaching and research. The extent of our commitment and integration of these functions in our patient care services makes us a unique hospital in New Hampshire. We have a legislative charter, dating back to 1889, that grants Mary Hitchcock tax exempt status as a public charity. The hospital's charter states "... and said institution being in the nature of a public charity, its property shall be exempted from taxation."

You've heard numerous reasons from other speakers at your hearings about why HB 1144 is inexpedient to legislate. Mary Hitchcock Memorial Hospital agrees that HB 1144 is problematic. We believe it is premature for the Legislature to make changes to the current law.

First, current law already gives municipalities the power to grant or deny applications for tax exemptions. HB 1144 would give each hospital's local community the authority to vote on the tax exempt status of the hospital, without considering the charitable activities that extend far beyond that community. In Mary Hitchcock's case, five percent of our patient admissions are from Lebanon; our "community", and the benefit of our charitable services, extends to nearly all parts of New Hampshire and Vermont.

Secondly, this Legislature recently enacted a law that requires health care charitable trusts to determine community needs, develop a community benefits plan in consultation with the public, and report on community benefit activity. We believe it's important to allow time to observe the impact of this law. RSA 7:32-e took effect January 1, 2000. The new law will allow the public to participate in community-based needs assessment and fully understand all that hospitals do for our communities. The plan and report that we are required to file in accordance with RSA 7:32 *does not* automatically grant us tax exempt status. The municipality still has the authority to grant or deny tax exemption. But the reports will help communities understand the community benefits hospitals provide which are a major portion of what makes them charitable.

The definition of charitability is at the heart of the questions that are before your committee, and also at the heart of our dispute with the City of Lebanon. Lebanon claims we are not a charitable organization by taking a very narrow view of the applicable New Hampshire law and focusing primarily on the amount of charity or free care. Other pertinent facts about our charitability are dismissed or not mentioned. I want to focus my remarks on why I believe MHMH is a charitable organization.

-Nobody from New Hampshire or Vermont is ever refused medically necessary care at DHMC because of inability to pay.

-During the period 1992-1997 DHMC provided an average of $11.6 million annually in free care, more than double the amount of free care provided by any other hospital in New Hampshire.

-DHMC is the largest provider of care to uninsured and indigent patients in New Hampshire.

-DHMC is the largest provider of Medicaid services in New Hampshire (most Medicaid reimbursement is less than actual cost).

But despite DHMC's tremendous commitment to providing charity care, this is only a small part of our charitability. Mary Hitchcock Memorial Hospital, at its very core, is charitable because it acts on behalf of the public in everything it does. All of our resources are under the responsibility of a Board of Trustees whose members come from the community we serve. All of our resources are dedicated to our patient care, education and research purposes and are returned to the community through our services. Our services are driven by community and regional needs. Numerous programs cost much more than we receive in payments, and many are provided at no cost. Let me elaborate:

-DHMC educates and trains hundreds of physicians, biomedical scientists, students, medical residents and other health care providers. Each year, nearly 10,000 practicing providers in our region attend DHMC's continuing education programs.

-DHMC conducts medical research that improves patient care.

-DHMC develops and subsidizes high-cost, highly specialized, programs (such as the high risk infant program, a Level 1 Trauma Center, the air ambulance service and the Children's Hospital at Dartmouth (ChaD), which are only available at DHMC and which would not otherwise be available in our rural region.

-DHMC supports the continuing viability of medical providers in rural communities unable to support those providers without DHMC help.

-DHMC develops and applies the most advanced medical knowledge and treatments.

-DHMC is governed by lay boards of trustees who have ultimate responsibility for ensuring that DHMC meets its charitable and educational missions and goals.

-DHMC's compliance with its charitable mission is subject to review by the New Hampshire Attorney General's Division of Charitable Trusts.

-DHMC works hard to cut costs and minimize rate increases. For example, over the past seven years we had four years with moderate rate increases, two years with no rate increases, and one year with a rate reduction. Over those seven years the average rate increase has been 2%, which is less than the rate of inflation during this period.

-DHMC annually plans an excess of revenues over expenses in order to provide for debt retirement (incidentally, a requirement also of our bond covenants) and capital facilities replacement. No dividends or other distributions are made to individuals on DHMC boards or in management. All assets of the DHMC constituent organizations are maintained for the fulfillment of its health care charitable and educational mission.

Let me amplify these points with several examples:

- One example is the Children's Hospital at Dartmouth, which is known as CHaD. Chad provides the only pediatric intensive care unit in NH, the state's most advanced intensive care nursery, and access to advanced pediatric care for children who are acutely ill or have serious chronic conditions. Without CHaD, children in Northern New England would have to go to Boston for this advanced level of care. Our physicians, nurses and other staff visit every New Hampshire hospital regularly to review outcomes of pediatric patient transfers, assess needs for services in their communities, and establish locally-based specialty clinics to support children's needs. We work closely with the State of NH Maternal and Child Health Program to provide special services, frequently at no cost or less than cost. We do this because of our organization's sense of responsibility to work with other hospitals and community providers to improve the health and well being of the citizens of New Hampshire.

- When dialysis patients in northern New Hampshire and Vermont identified the hardship it caused them to travel to Lebanon for dialysis treatments several days a week, DHMC developed a dialysis program with the hospitals and physicians in Northern NH and VT in Whitefield, NH to improve local access to this critical service so patients and families would not need to travel such long distances for needed care.

- Our Norris Cotton Cancer Center programs directly benefit people who live in this region. One example is our breast cancer activities. New Hampshire has the sixth highest incidence of breast cancer among women in the United States. We have coordinated programs – from screening to treatment and research – to help address the needs of women in this state. We have staff dedicated to assist women through their breast cancer evaluation and treatment experience. This is NOT profit-motivated healthcare. Some of our services are developed in coordination with the State. Where there's a void, our staff develop new services to help meet the needs of women throughout the region, frequently working with other organizations and hospitals.

- Our programs often lose money, but we subsidize them because they meet an important community or regional need. For example, the Dartmouth-Hitchcock Air Response Team, known as DHART, is a helicopter transport service that provides critically ill patients throughout New Hampshire and Vermont with urgent specialized care and transportation to the most appropriate facility far faster than ground transportation. Mary Hitchcock subsidizes this service in the amount of about $700,000 a year.

- We provide support for NH residents free of charge through services such as the NH Poison Information Center (with over 19,000 calls annually), the Injury Prevention Center and the Cancer Help Line.

- At home in Lebanon, we provide free health screenings, free preventive care and educational programs, and support for community social service agencies, local schools, police and ambulance services. Our staff donates time to local free clinics. We financially support the Good Neighbor Clinic with Alice Peck Day Memorial Hospital each year. We cover our physicians' expenses, such as liability and licensing expenses, when they donate time to see patients at that clinic. Community groups use our DHMC facilities for their meetings and activities.

Last year we prepared a community benefit report to identify and quantify our charitable services. It addresses in more detail why we believe so strongly that we meet and exceed all aspects of charitability. If we have changed over the years, it has been to become more helpful and involved in many communities throughout New Hampshire. Our outreach clinics and our relationships with local hospitals to bring DHMC's talent and expertise to patients in their local communities. I have copies of our charitability report for you to review at your convenience. It will give you more specific information, including financial amounts, about the full range of DHMC's charitable services.

I could further enumerate the community benefits which Mary Hitchcock Memorial Hospital provides in Lebanon, the Upper Valley and throughout New Hampshire and Vermont. Mary Hitchcock Memorial Hospital is a charitable organization that provides our citizens with services that meet identified community needs. Unlike an investor-owned hospital, none of our revenue is returned to stockholders or private citizens. All our assets are invested in our charitable mission, under the direction of a voluntary, community Board of Trustees.

In summary, under current law municipalities already have authority to grant or deny tax exemptions annually. The NH legislature has recently passed an important new community benefits reporting law which will strengthen local understanding and dialogue about the benefits of charitable health care organizations such as I have described today. I urge you vote HB 1144 inexpedient to legislate.

Thank you for allowing me to present my comments. I hope they have helped you to understand why we feel so strongly that we are a charitable, tax exempt organization.

I'd be happy to respond to your questions.

Report on Charitability and Inventory of Charitable Benefits Provided by Dartmouth-Hitchcock Medical Center

Eugenia Hamilton
The Hitchcock Alliance
April 2, 1999

Accepted by votes of the Boards of Trustees
- Mary Hitchcock Memorial Hospital (April 8, 1999)
- The Hitchcock Clinic (April 24, 1999)

Contents

	Pages
Charitability	1 - 5
Study Process	6 - 7
Study Findings	8 - 15
Concluding Remarks	16 – 17

I. Charitability

In the most general sense, a charity is an organization which serves the public and which does not return profits to directors or shareholders. In return, charities may be granted exemption from Federal, State, or local taxation. That said, "no single all-inclusive definition of a 'charity' is applicable to all situations"[1] (p. 155 Southwick).

Since the value of tax-exemption can be considerable, there has been much legal debate about the nature of the "service" or "benefits" which justify the label of "charitable." While there is a "national" definition of a charitable corporation for purposes of exemption from income taxes under the Internal Revenue Code, state laws are varied and inconsistent and, therefore, can be confusing. As a result, recently the tax-exempt status under state law of hospitals and other charities has been challenged in court in several jurisdictions.

New Hampshire RSA 72:23 states that "'charitable' . . . shall mean a corporation, society, or organization established and administered for the purpose of performing, and obligated by its charter or otherwise, to perform some service of public good or welfare advancing the spiritual, physical, intellectual, social or economic well-being of the general public or a substantial and indefinite segment of the general public that includes residents of the state of New Hampshire, with no pecuniary profit or benefit to its officers or members, or any restrictions which confine its benefits or services to such officers or members, or those of any related organization" (emphasis the author's).

This legislation is consistent with the general definition of charity. Although financial relief for the poor ("almsgiving") would obviously be a charitable activity, it is not specifically mentioned in the New Hampshire statute. According to Southwick (p. 158), there are any number of reasons why care of the indigent is not an essential element of charity for hospitals, including the view that both the wealthy and the poor are appropriate beneficiaries of charity when they are the victims of illness or injury. It is interesting to note that education, like almsgiving, has been recognized universally as a charitable endeavor.

Even though substantial case law exists to support the position that, "as long as there is no private gain or profit, promotion of health is per se a valid charitable purpose . . . the institution can be self-supporting and earn a profit as long as the profits are utilized for institutional needs. . ." (p. 158 Southwick), challengers argue that since hospitals charge for the care they provide, and expect payment from those who can afford to pay,

they do not deserve exemptions. Consequently, as primarily "self-funded charities," who rely heavily on service-generated revenues, hospitals in several states are being asked to account for the benefits they provide to their communities.

A number of factors have led to the questions regarding the exemptions of hospitals and health care providers, including the growth of investor owned hospitals, the need of state and local governments to find new sources of revenue, and in some states the heavy demands on public hospitals to care for all indigent patients, particularly in large cities. The latter is not an issue in New Hampshire. Challengers assert that nonprofit hospitals provide insufficient free care for the poor, that investor-owned and not-for-profit hospitals are indistinguishable from one another in their operations, and that the community benefits provided by hospitals do not justify their exemptions from taxes. Unfortunately, hospitals' strategies developed to survive and compete in a dramatically changed environment, including creation of complex, often times large, legal structures, have further blurred the public's perception of hospitals as charitable. (In 1992, Federal legislation was introduced which sought to move the standard for hospital tax exemption away from the community benefit approach to a "relief of poverty" or "charity care" standard. It was defeated, as was similar proposed legislation in New Hampshire in 1994.)

Only policy extremists have suggested abolishing the tax-exempt status of hospitals altogether. Instead, public debate has focused on the nature and amount of the benefits which justify tax exemption. Until the DHMC case, the exemption of academic medical centers had not been challenged, with other jurisdictions apparently accepting, without question, the overwhelming nature of the public benefit provided when the activities of a hospital are combined with the educational and research activities of a medical school. For this reason, the literature describing how hospitals can fulfill their charitable obligations has focused on local community benefits which should be provided by community hospitals. Education and research are mentioned, but don't receive the focus that is justified when assessing an academic medical center. The Hospital Research and Education Trust (AHA), in conjunction with the Kellogg Foundation Hospital Community Benefit Project (1989-1992),[2] has proposed four hospital community benefit standards:

"1) Evidence of the hospital's formal commitment to a community benefit program for a designated community (which is further defined as 'a reasonably circumscribed geographic area, in which there is a sense of interdependence and belonging').

2) The program includes hospital sponsored projects for the designated community (which): 1) improve health status; 2) address health problems of minorities, the poor, and other medically underserved populations; 3) contain the growth of health care costs.

3) The hospital's program includes activities designed to stimulate the organization and individuals to join in carrying out a broad health agenda in the designated community.

4) The hospital fosters an internal environment that encourages hospital-wide involvement in the program."

One hundred and thirty-one demonstration site hospitals voluntarily participated in a demonstration project to implement these standards. With the exception of Robert Wood Johnson University Hospital in New Brunswick, N.J., none were regional academic medical centers.

In 1992 Tom Kleinhanzl and Dan Jantzen audited the community benefits provided by Mary Hitchcock Memorial Hospital, using the HRET standards.

In 1995, the New Hampshire Hospital Association (NHHA) published "Guidelines for Evaluating Hospital Community Benefits." The publication included Mary Hitchcock's 1992 Community Benefits Audit worksheet as a model for others to use. In the guidelines, the Association restated the four HRET standards, and recommended hospital adoption of the Catholic Health Association's "Social Accountability Budget,"[3] which focuses on 1) completing an inventory of community services, 2) assessing community needs, and 3) communicating community benefits.

NHHA's community service categories provided the framework for this DHMC Inventory of Charitable Benefits:

1) Charity care
2) Shortfall between costs and revenues of publicly funded care (Medicaid).

3) Cost of non-billed services (which are not intended primarily for promotional purposes), including public clinics, screenings, health fairs, lectures, school health efforts, free meals, counseling, pastoral care, transportation, telephone information services, family support, Christmas baskets, support to other community agencies, donation of equipment and staff time, and space are all listed in the CHA inventory.
4) Health education and training for health professionals and for the community.
5) Research.
6) Low or negative margin services provided to afford access to necessary care.
7) Community leadership and volunteer services (including avenues for community dialogue, leadership in needs identification, advocacy, and support for personal volunteerism).

Attachments 2-6, which detail the charitable services provided by DHMC, note the authority (Catholic Health Association, etc.) which recognizes each service listed as charitable.

Accurately delineating the extent of charitable activity provided by DHMC requires capturing of all of the forms of community benefits or public services provided by DHMC, not just the free or subsidized care to indigents.

The concept of "community benefit" is essential to every non-profit hospital's charitable mission, with the provision of free care to the indigent as one important component, but not necessarily the primary one. For this reason, California, Indiana, Kansas, Pennsylvania, Texas, New York, and Utah have passed legislation requiring that not-for-profit hospitals have mission statements that set out the charitable purposes and goals of the organizations, and develop community benefit plans that assess health care needs, set timelines, objectives, and budgets, and evaluate impact. These community benefit plans must be developed in collaboration with the community served to assure that the benefits provided are those that the community wants and needs. This exercise serves at least three purposes: to acknowledge responsibility for a defined community (as opposed to an enrolled population), to promote a systemic definition of health and its determinants (extending beyond clinical care to include social, environmental, economic and behavioral forces), and to assume stewardship for health status in partnership with the rest of the community. Similar legislation has been proposed in New Hampshire.

A recent Association of American Medical Colleges (AAMC) publication, "Meeting the Needs of Communities,"[4] specifies the various categories of public benefits which are provided, almost exclusively, by academic medical centers and their faculty, including higher proportions of charity care, access to technology-intensive services, research and advances in treatment, and specialized care of patients transferred from other hospitals. A second AAMC study[5] underscores the major role played by academic medical centers in creating economic vitality for their locales, both through their role as a major employer, and through the impact that access to state of the art medical care has on an area's reputation as a "nice place to live and work." (In Louisville, Kentucky, state and city leaders are so enthusiastic about the value of having a vibrant biomedical research enterprise in their midst that they are giving $110 million in public and private dollars to endow university based research positions.[6]) The value of an academic medical center in dollars may be immeasurable, but the local community benefit is nothing short of immense. As an example, the second edition of "100 Best Small Towns in America" awarded Lebanon, New Hampshire the number 3 spot due in part to the availability of physicians (other factors included per capita income, proportion of 25-34 year olds, public school expenditures, and proportion of residents with a college education)[7].

II. Study Process

From August 1998 through January 1999, the author interviewed or corresponded with over one hundred and sixty individuals, internal and external to DHMC. In each internal interview, the same question was asked: "To what expressed needs have you responded on behalf of DHMC, without expectation of payment to the institution for the services provided?" (This question is based on the Catholic Health Association concept of "unbilled services.") Interviews with leaders from David's House and the Good Neighbor Health Clinic helped provide an external perspective on DHMC's charitable reputation in the community.

Investor-owned hospitals use their resources to pay dividends to shareholders, whereas DHMC invests the resources at its disposal to further the well-being of the general public (VHA Community Benefit Standard[8]). While investor-owned hospitals track success in terms of profits, DHMC's measures of performance are access, satisfaction, and clinical quality. The goal of this study is to fully understand what charitable benefits are created with those investments for the public good. The study emphasizes the charitable benefits provided by The Hitchcock Clinic and Mary Hitchcock, with Dartmouth Medical School primarily mentioned when it assists with shared DHMC endeavors, since its charitable efforts, primarily educational or research in nature, span both the Lebanon and Hanover Medical School campuses. Additionally, the financial and other support provided to DMS by THC and MHMH are consistent with the notion that charitability includes support and provision of education/teaching.

The costs of free or subsidized care to the indigent and the unreimbursed costs of government sponsored care were calculated by Dan Jantzen, Vice President, Finance, and James Bartlett, Controller, for 1997 (DHPA figures were provided by Jane Piotrowski of DMS). Only individuals determined to be indigent were classified as recipients of charity care; bad debts are not included. Charge dollars were reduced, using the institution's ratio of costs to charges, to estimate costs.

The definition of "charity" varies by state. All states count the cost of free or reduced price care provided to the medically or financially indigent plus the costs of providing services to Medicaid enrollees which are not covered by Medicaid revenues. Most jurisdictions also include shortfalls between the costs of Medicare services and the amounts paid by Medicare.

Some states also permit including any charges (as opposed to costs) not paid by Medicare or Medicaid. To be conservative, only the cost of charity care to the indigent, and unsupported costs of indigent care funded through Medicaid are reflected in the DHMC calculations.

During the interviews, the types of other charitable benefits provided by DHMC tended to fall into distinct categories:

1) Community services, which are provided to DHMC's local service area of twenty-six towns. (The effort to explicitly measure benefits provided to Lebanon proved to be impossible, since no record is kept of the residence of individuals screened or educated, nor are the sites of health promotion, etc. currently tracked geographically.)

2) Regional services which draw upon the unique capabilities which are only found at academic medical centers.

3) Activities which enhance local access to care in the rural and isolated communities which lie beyond DHMC's primary service area.

4) Education of medical students, post-graduate medical residents, and other health professionals, as well as lifelong education for regional health professionals (ensuring that their knowledge is kept up-to-date and that they don't experience professional isolation common in rural regions).

Each of these four categories is divided into two sections. "Large Dollar" Initiatives (more than $2500 annually in costs, in 1998 dollars where available) are listed first. A listing of smaller or non-quantifiable representative acts follows. Expenditures for marketing/public relations purposes have been excluded, as have the value of volunteer efforts by DHMC staff during personal time and services provided for which costs are fully reimbursed (e.g., state contracts). The latter may not add dollars to the DHMC ledger of benefits, but they are of great value to the community and often are services the State would otherwise provide. In the totals for each category, no dollars are attributed to the non-quantifiable acts, although the value to the community of some of these benefits is obviously high. Examples of charitable services are scattered in bold print throughout the report. A complete listing may be found in the attachments.

III. Study Findings

1. Charity Care: In 1997, MHMH provided approximately $6,407,000 in free care to the indigent. This amount was determined by applying a ratio of costs to charges to $7,999,000 in charges for charity care. Bad debts are not reflected in this amount. During that same year, MHMH's total charity care alone represented 23.3% of the charity care provided by all New Hampshire hospitals, while the hospital provided only 16.2% of the hospital days. Thus, not only was MHMH the #1 provider of charity care, it provided a disproportionately higher share than other hospitals. The cost of charity care provided by THC was $1,735,000. DHPA provided $138,000 in charity care.

   Both MHMH and THC provide necessary care to all residents of Vermont and New Hampshire who need it, regardless of ability to pay. This policy is discussed with patients when they register for admission to the hospital and signs to this effect are prominently displayed in all clinical waiting areas, as well as at the main information desk. Patients whose family income does not exceed 200% of the Federal Poverty Guidelines are not required to make any payment toward the cost of their medical care, with those earning more paying on a sliding scale.

   Payment for publicly-sponsored indigent patients (by Medicaid) does not cover the full cost of their care. Unreimbursed Medicaid costs to MHMH totaled $1,356,000; to THC they totaled $2,668,000; to DHPA they totaled $77,000.

   It is also important to note that, contrary to the policy of many other physicians, at DHMC the physicians do not close their practices to uninsured or Medicaid patients. Several physicians commented that because of this policy, it is not uncommon for patients to be referred to them by other doctors who chose to decline to care for these patients.

2. Local Community Services: As part of its mission, DHMC delivers services to its twenty-six town primary service area. These services are similar to those provided by many community hospitals. Among these, major initiatives (costing more than $2500 each annually) include public health screenings and community health education and support for the Good Neighbor Clinic and David's House, among others. Examples (although not an exhaustive list)

of local community services provided whose cost is unknown are also provided. The quantifiable local unbilled community services provided cost DHMC almost $600,000 annually (Attachment 2).

> **Example: The Pregnancy Resource Center (PRC) is open to all expectant parents, regardless of where they plan to deliver. Scholarships are available to couples who cannot afford the childbirth preparation classes. In addition to parents, the PRC director teaches 600 students in 29 high school health education classes all over the Upper Valley.**

(Note: Efforts to promote the hospital through marketing and public relations were excluded from the costs shown. Services which serve both a marketing and a public service function (e.g., the Women's Health Resource Center) do not have their full budgets reflected.)

These local community services are provided in response to requests from individuals or organizations, or in response to otherwise identified community needs, and go far beyond the community needs identified in the 1996 needs assessment process.

Finally, increasingly the literature on community benefits includes physical community development (such as construction of sewer or water lines for shared use) and the role that hospital facilities play as anchors for attracting taxable economic development (e.g., development of Centerra in response to DHMC's relocation to Lebanon). These forms of community benefit are noteworthy, but are not tallied in this report, since only annual operating expenditures are included. Nonetheless, they represent real value to the community.

3. Regional Services: As one of only two integrated academic medical centers in Northern New England (University of Vermont Medical Center being the other), DHMC contributes its unique capabilities toward support of the health needs of New Hampshire and Eastern Vermont.

> **Example: The Norris Cotton Cancer Center (NCCC) is one of only 35 federally designated cancer centers nationwide. All are in not-for-profit medical centers. Local cancer patients don't have to travel to New York City or Boston for the newest cancer protocols. NCCC is a world leader in prevention, as well as in treatment, since much of the work linking diet and cancer prevention was performed by NCCC**

researchers. After testing new treatments, NCCC helps others to offer them. The cancer hotline insures that symptomatic people quickly get screened. One gentleman who had symptoms suggestive of cancer called several times before he would leave his name, since medical encounters elsewhere had led to draconian payment demands. The cancer hotline person first addressed his financial worries so that he would identify himself and then arrange for immediate diagnosis and treatment. As the grateful patient subsequently wrote, "Thank you . . . I no longer fear an imminent death . . . thank you."

Once again, quantification of the benefits provided is based on the cost of services for which no billing occurs, or for which billing only covers a portion of the program costs. Perhaps more important to the public good than the dollars, is the access to state of the art health care in a rural environment. Underfunded clinical services are not reflected here (to avoid double counting of charity/public funding amounts reflected in Attachment 1). However, the cost of maintaining standby emergency or intensive care is classified as a charitable benefit by several states and by the Catholic Health Association.

Other examples of programs which receive substantial institutional support include the Children's Hospital at Dartmouth, the Regional Perinatology Program, and the NH State Poison Control Program.

Example: For 42 years, the DHMC Poison Control Center (PCC) has guided prevention and treatment of poisoning for both lay people and health care workers. Designated as a state program in 1981, the PCC fields over 19,000 calls annually, including all 911 generated poisoning reports. The PCC identifies and studies "clusters" of neighboring poisonings to identify perils to the public health. (A leather treatment spray caused several people to experience respiratory distress several Christmases ago; the PCC was able to identify and help remove the offending agent from the market.) The PCC identifies tablets seized by law enforcement officers, advises high school teachers on safe use of lab chemicals, and warns parents about risky holiday plants like poinsettia and mistletoe.

These regional services would not be available in New Hampshire were it not for DHMC presence as an academic medical center.

Example: Contrary to the policy of most biomedical libraries, the Dana and Matthews Fuller collections and internet access are available to the public and health professionals at no charge.

Academic medical centers are valuable, in part, because they provide access to modern medical science usually found only in major cities. It is highly unusual to have an academic medical center with its highly specialized faculty in a rural area like the Upper Connecticut River Valley of New Hampshire and Vermont. As the AAMC states, "specialized services are costly. They include the expense of fully staffed "standby" units such as . . . Level 1 Trauma Centers, . . . and the performance of uncommon procedures such as organ transplantation"[4] (p. 4). Rural areas simply don't sustain such programs without a major commitment of resources from the state and/or the organization.

The AAMC study underscores the breadth of services which are provided nationwide by teaching hospitals in order to meet academic goals, but which in turn provide access to tertiary services which would be otherwise unavailable. Without its academic role and teaching faculty, DHMC would be a community hospital, and the community would be unlikely to have local access to a Level I trauma program, a transplant program, or a pediatric intensive care unit (most of which are found only in non-profit academic medical centers). Teaching hospitals "serve more severely ill patients than other hospitals" (AAMC p. 57). The patients they receive in transfer "tend to be more severely ill and medically indigent than patients transferred to other hospitals" (AAMC p. 65). This is certainly the case at DHMC where the case mix (which measures patient complexity) is in the 97th percentile of all hospitals in the country (at 1.8354, MHMH's Medicare case mix is higher than those of Yale or Johns Hopkins). This incredibly high case mix can only be explained for a medical center in a rural area, by the referral of large numbers of very sick patients from a broad region.

DHMC's performance supports the conclusions of the AAMC study. In addition to America's first diagnostic x-ray, DHMC developed the state's first intensive care unit and nursery, open heart, neurosurgery, and radiation therapy programs. Today's patients get convenient access to a host of tertiary programs through the programmatic investment of DHMC resources and the availability of highly specialized physicians because of the Center's academic role.

As one interviewee put it, "we are the place people look to for advice and we give it freely."

> **Example: DHMC's environmental officers help with local hazardous spills – whether from a truck accident on Interstate 91 or a mercury problem in local area high schools (in response to the latter, DHMC is facilitating creation of a "mercury monster" partnership with Federal and state environmental agencies to promote safe disposal of mercury thermometers). To further protect the environment, DHMC is eliminating the use of ethylene oxide in sterilization. The safety equipment this process necessitated will be donated to local fire departments.**

DHMC specialists all carry pagers in order to be available to provide medical consults around the clock.

> **Example: Over the last year, the Infectious Disease Section alone received requests for over 600 telephone consultations.**

Hundreds of people tour the facility annually to learn from DHMC design, waste treatment and energy systems, and patient care units. It is assumed that, whatever the topic (advanced directive forms, medical record policies, rape protocols, quality improvement), DHMC staff are the experts. They give advice because frequently we <u>are</u> the experts. Little of this is quantified anywhere, because the staff view such assistance as DHMC's charitable obligation.

> **Examples: Dr. Hal Sox, DHMC Chair of Medicine, is on leave in Washington, D.C. to serve as Chair of the American College of Physicians. Dr. Peter Silberfarb, DHMC Chair of Psychiatry, is President of the American Board of Psychiatry and Neurology.**

Annually, DHMC incurs <u>$1.8</u> million in costs for the broad range of quantifiable regional services provided for the good of the public (see Attachment 3 for details).

4. <u>Rural Access to Care</u>: DHMC's service area is largely rural and, in some cases, quite isolated. Historically, many of the small communities in our broader Connecticut River Valley service region have been Federally designated as medical shortage areas. For decades, DHMC has been committed to supporting <u>local</u> access to

health care services so that people do not have to travel great distances for basic health services. Usually DHMC must subsidize that access. In 1997, that subsidy amounted to over two million dollars, for such programs as the Air Rescue Team, The Hitchcock Alliance, the regional practices of The Hitchcock Clinic, and the North Country Dialysis Center, in Whitefield, NH (see Attachment 4). These subsidies are not provided as a means of capturing referrals since DHMC is the only tertiary center available to these locations.

5. Education: All three members of DHMC have a deep, shared commitment to academic medicine, as is reflected in these excerpts from the Mission Statement of the Hitchcock Clinic.

> "to improve our understanding of the causes, courses, treatments and prevention of disease . . .
> "to share our knowledge where it does good."

Each year, DHMC educates 288 medical students and 266 residents. DHMC's continuing education programs enroll almost ten thousand practicing health professionals each year, insuring that their knowledge is up-to-date, and that they don't experience the professional isolation inherent in rural areas. In addition, DHMC provides clinical training for a host of other health professionals, including seventy-five nursing, thirty emergency medical technology, twenty laboratory technology, fourteen physical therapy, six ministry, six pharmacy, three radiology technology, three social work, two occupational therapy, and one speech pathology students every year. Medical Assistant students (from NH Technical College) and nurse practitioner students (UNH, UVM, Rivier, Northeastern) also rotate through DHMC. DHMC broadcasts over 10 hours weekly of televised rounds to other hospitals.

> **Example: Our emergency room physicians serve as medical advisers to New Hampshire and Vermont emergency medical services districts, each of which meets 4-6 times a year. In addition to providing basic, intermediate, and paramedic classes to local ambulance squads, DHMC faculty have taught EMTs to intubate and defibrillate critically ill individuals. Similarly, faculty provide skills updates to ski patrols and wilderness rescue squads.**

In addition to providing direct financial support to Dartmouth Medical School, the members of The Hitchcock Clinic are the

clinical faculty of Dartmouth Medical School. An effort has been made to conservatively, roughly estimate the cost of this teaching time, although arriving at an exact figure is obviously impossible since education is woven throughout the days and nights of DHMC physician faculty (Attachment 5). Support of education at DHMC costs the clinic and hospital over twelve million dollars annually.

Thus, in summary, the total documented costs of charitable benefits provided annually by DHMC are approximately:

Charity Care	$8,280,000
Underfunded Medicaid	4,101,000
Local Services	594,000
Regional Capabilities	1,868,000
Enhanced Rural Access	2,119,000
Support for Education	11,921,000
	$28,883,000

Research: DHMC both receives external funding (totaling more than 39 million dollars) for biomedical and health services research, and supplies institutional support for the creation of new knowledge about the causes and cures of disease. Many faculty serve on study committees or as editors/reviewers for medical journals (Attachment 6). The Hitchcock Foundation funds research grants to residents and faculty and sponsors the annual Helmut Schumann Lecture for Healthful Living. The medical breakthroughs which result from this research are of value to New Hampshire and to the nation – both now and for the future.

Example: In 1997, the Department of Psychiatry alone provided over 125 scholarly papers. The Norris Cotton Cancer Center bulletin board displays 24 recently published papers, which represent only a portion of the output of these faculty. Topics range from prevention ("Over the Counter Analgesics and Risk of Ovarian Cancer") to clinical practice ("Can We Improve Breast Pathology Reporting Practices? A community-based breast pathology quality improvement program in New Hampshire") to basic science ("T-cell Receptor . . Expression on Tumor-Infiltrating Lymphocytes from Renal Cell Carcinoma.") Each article's byline is DHMC, Lebanon, New Hampshire. Recently, NCCC research linking calcium supplements to a reduced risk of colon cancer garnered national attention.

Philanthropy: Public support through dollars and volunteer hours play a key role in supporting DHMC. In 1998, volunteers logged in 50,000 hours and 7,000 individuals made financial contributions toward our charitable work. DHMC could not have constructed the Lebanon campus without $51,000,000 in charitable donations, or later built the Rubin Cancer Building, or enlarged the Pediatric Intensive Care Unit (Attachment 7). Volunteers staff the DHMC Gift Shop whose proceeds fund essential equipment.

Government Support: Some commentators define charitable benefits to include services which, if not provided by medical centers, would become the responsibility of government, at taxpayer expense. Without DHMC, the State Hospital would have difficulty attracting psychiatric staff, there would be no Poison Center or Cancer Hotline, there would be no Air Medical Rescue Team. (A list of the many such services is provided in Attachment 8).

Example: The Emergency Department often sees victims of domestic violence. One faculty member in the ER has committed herself to prevention of this serious problem through service on the Governor's Commission on Domestic and Sexual Violence (where she helps to develop protocols on identification and intervention for emergency personnel at other hospitals), through teaching at the additional NH Leadership Seminar against domestic violence, and through leading DHMC's work as an educational site for other hospitals through the US Initiative on Domestic Violence. She also participates in the NH Domestic Violence Fatality Review Committee.

IV. Concluding Remarks:

The interviews revealed that most DHMC staff assume it is their job to respond to public needs, without worrying about where the dollars will come from. In the true tradition of charity, they draw little distinction between institutional resources used for public benefit (e.g., paid staff hours, supplies) and their own personal contributions of unpaid time and effort.

> **Therapeutic massage is provided at no cost. The Poetry Project encourages women to use writing as a source of healing. Since animals can cheer lonely patients, dogs from the Humane Society visit (after DHMC checks them for communicable diseases and parasites at no charge). Relaxation tapes, games, music, and clean laundry are provided to patients and families. The Elderlife Program strives to reduce the decline and infirmity which beset so many elderly hospitalized patients by providing daily visits, meal companions, special recreational activities, and plans for helping patients stay healthy at home. DHMC staff conduct over 20 free specialized support groups for patients and families contending with complex diseases.**

The staff's inherent commitment to charitable service makes it difficult to precisely inventory charitable work, because no one tracks unrecompensed hours or dollars expended. For this reason, this study probably considerably understates the charitable benefits provided by DHMC and its people. Put another way, many of the staff interviewed work at DHMC in large part because they personally identify with its charitable mission. They do not (and do not want to) distinguish between what they do which "pays" and that which doesn't. They simply meet needs and let the dollars fall where they may. Some of their quotes say it best:

> **"Do the right thing is the clear mandate here."**
> **"We don't flaunt it, we just do it."**
> **"I'm proud that at DHMC patients who can't pay aren't just tolerated, they get red carpet treatment."**
> **"It's scary to think what <u>wouldn't</u> happen if DHMC weren't here."**

Concluding Note: The author appreciates the opportunity this project has provided for her to learn about the thousands of charitable acts – large and small on behalf of countless individuals – and the wonderful people of DHMC who perform them. She is grateful for the extensive

comments and information provided by Tom Csatari, Dan Jantzen, Jim Bartlett, and Bernice Shaw. Since this is the work of a non-lawyer, this report is intended to be an informative, not a legal, document.

Attachments

1. Charity care
2. Local community benefits
3. Regional benefits
4. Enhanced local rural access to care
5. Education
6. Research
7. Philanthropy
8. Services provided by DHMC to offset the burden on state government
9. Bibliography

1. **Charity care/underfunded publicly paid care (dollar amounts reflected charges which were converted to <u>costs</u> using the institution's ratio of cost to charges).**

A. <u>Major Initiatives: (>$2500 annually)</u>

	$ Value	Organization
• Charity care	$6,407,000	MHMH
	$1,735,000	THC
	$138,000	DHPA
• Underfunded Medicaid	$1,356,000	MHMH
	$2,668,000	THC
	$77,000	DHPA
	$12,381,000	Subtotal

Contact: Dan Jantzen,MH
Jim Bartlett, THC
Jane Piotrowski, DMS

2. Local Public Services (characteristically provided by many hospitals)

(unless noted otherwise, costs do not include space and allocated overhead.)

A. Major Initiatives: (>$2500 annually)	Cite	$ Value	Contact, Organization
• Public health screenings [1]	CHA	$37,000	Buttrey, MH
• Public health information [2]	CHA	$16,200	Holmes, MH
• Women's Resource Center [3]	CHA	$90,420	Shamos, MH
• Support for Good Neighbor indigent clinic [4]	CHA	$46,000	Bronson, MH Bronson, THC
• Pregnancy Resource Center [5]	CHA	$41,643	Metcalf, THC
• Lifeline phones [6]	CHA	$4,400	Coffey, MH
• Crisis counseling [7]	CHA	$148,188	Rudman, MH
• $/year land lease to David's House [8]	CHA	$15,000	Jantzen, DHMC
• Space for public meetings [9]	CHA	$25,950	Kendricks, DHMC
• Mass casualty planning [10]	In lieu of govt.	$5,000	Fuller, MH
• Free breast feeding follow-up clinics [11]	CHA	$59,337	Abbott, MH
• Hitchcock Helping Hands raises [12]	CHA	$73,106	Geraghty, MH, THC
• Employee Christmas baskets for 89 families	CHA	$12,000	Terry, MH
• Advance Transit	CBISA	$20,000	Kelleher, MH
		$594,000	Subtotal

B. Local Representative Actions: (assumed to cost less than $2500 each annually)

- Processing guardianships [13]
- Blood alcohol tests [14]
- Consultation to schools [15]
- Support groups for routine conditions [16]
- Free consultation on injury avoidance [17]
- Alcohol treatment team [18]
- Cardiac rehab lectures & exhibits [19]
- Emergency psych program [20]

2. Local Public Services (characteristically provided by many hospitals)

B. Local Representative Actions: continued

- Public concerts [21]
- Operation Sneak A Peak [22]
- Civic group speakers [23]
- Blood drives for Red Cross [24]
- City of Lebanon wellness group participation [25]
- Convened monthly Lebanon Prevention partnership [26]
- Teen smoking advice [27]
- Free health fair for NH Employment Security Agency [28]
- MDs volunteer as team doctors for area sports teams
- Advance directives counseling [29]
- Mentor and orient high school and college students interested in health care careers [30]
- Classes in CPR, choke saving and negotiation skills [31]
- Provide medical coverage for Boy/Girl Scout sleepovers [32]
- School lice counts [33]
- Train WISE volunteers [34]
- Home fair booths (some paid for by staff) to screen and educate [35]
- Provide vehicle assistance in our parking lots 24 hours [36]
- Walk patients' seeing eye dogs [37]
- Escort blind family members of patients [38]
- Great American Smoke Out [39]
- Assist community members find child care [40]
- Community health library[41]
- Sponsor Lebanon High School robotics team [42]
- DHMC MDs staff well child clinics [43]

2. Local Public Services: DHMC fulfills the needs of a local region of twenty-six towns (ten of which are also served by Alice Peck Day, another valued community resource).

K. Buttrey	1	MHMH maintains an annual budget to cover the expenses associated with providing free community health testing, including such items as cholesterol blood tests, mammograms, prostate screening and so on.
D. Holmes/ K. Coburn	2	MH and THC support community health education which is advertised in a Community Health Education calendar mailed twice yearly to 5,219 addresses. The current calendar describes twenty events available free to the public from January through May 1999. These cover topics ranging from Alzheimers to parenting to bereavement to alternative medicine. In cases where fees are charged, scholarships are generally available to those who cannot pay. This figure reflects the annual budget.
E. Shamos	3	The Women's Health Resource Center (WHRC) maintains an extensive collection of health and lifestyle books, journals, and videos which are available to the public. In addition to free monthly lectures (publicized in the CHE calendar, above), WHRC provides referrals to community social services, and participates in numerous employer and community health fairs, emphasizing heart, cancer, and osteoporosis awareness. The seven professional conferences they have sponsored are available on videotape at no charge to the public. They administer the American Cancer Society "Reach to Recovery" Program which pairs breast cancer survivors with newly diagnosed patients. Similar patient matches are facilitated for women scheduled for urinary incontinence and hysterectomy surgery. They are currently planning a Girl's Self Esteem Day for Lebanon seventh grades, to provide health and life planning information, followed by continued e-mail mentoring by local professional women. Programs are also presented at the Lebanon Senior Center and the Powerhouse Mall on nutrition. The WHRC administers the NH breast/cervical cancer screening program in this region. If a girl or women is nervous about her first pap test or mammogram, a volunteer will accompany her to provide emotional support. They cover test costs (see 1, above) for women who aren't eligible for the NH program, but can't afford the test themselves. WHRC provides free consultative advice to other hospitals that want to start similar programs in their communities. Hundreds of women use the WHRC annually - in person or by phone. Their informational newsletter goes to over 5,000 addresses. The amount represents half of the center's budget, as well as brochure support from Public Affairs. The budget is reduced, since DHMC gains some referrals from the WHRC, since marketing is a portion of their role, with health promotion and self care their dominant function.

2. Local Public Services: DHMC fulfills the needs of a local region of twenty-six towns (ten of which are also served by Alice Peck Day, another valued community resource).

P. Manganiello	4	The Good Neighbor Clinic in White River Junction grew from the vision and effort of a DHMC physician, Dr. Paul Manganiello. In addition to financial support, numerous physicians, nurses, and other employees provide the volunteers who provide services at this highly utilized indigent clinic. Residents and medical students rotate through GNC and DHMC personnel serve on the Board. Patients who require specialized procedures or care are treated, free, at DHMC. The $40,000 represents direct monetary support only, and does not reflect the cost of donated liability insurance (from THC), free lab work, free e-mail service or the clinical information computer connection. The $6,000 reflects costs of Vermont licenses provided by the Clinic.
S. Edwards	5	The Pregnancy Resource Center is available to all women considering or experiencing pregnancy, regardless of where they plan to deliver. In addition to an extensive collection of loaned free books and videotapes, the PRC offers twenty-two sibling classes; monthly four session early pregnancy, breast feeding and infant care classes. The only sessions for which it charges are childbirth preparation classes (available to those unable to pay on scholarship; 14% of the attendees participated free over the last two years). The PRC sponsors play groups. Its 4th Trimester mother's group is especially popular with new arrivals to the Upper Valley. In addition to parents, the PRC trains childbirth trainers at no charge. Many of their classes are available nights and weekends, to accommodate working parents. In addition, the PRC offers free nutrition counseling and fields frequent telephone questions. The amount is 2/3 of the direct expense budget, exclusive of space or overhead. As with WHRC, this reflects the non-marketing aspects of this program. The PRC director is an active contributor to high school health classes throughout the region, presenting twenty-nine sessions in 1998 to over 600 students at Lebanon, Hanover, Hartford, Newport, and Oxbow high schools, as well as Lebanon, Hanover and Orford elementary and junior highs. Hannah Home students are also taught at PRC.
K. Coffey	6	Homebound elderly persons are provided special phone monitoring. While most pay for this service, twenty receive scholarships (at a cost of $370 per month).
J. Rudman	7	The social service provides crisis counseling to Upper Valley residents at no charge, in addition to providing support to patients and their friends and families.
	8	Twenty-five year $1 land lease for 3 1/2 acres underlying David's House, which provides lodging to 1,000 families a year while children are hospitalized.

2. Local Public Services: DHMC fulfills the needs of a local region of twenty-six towns (ten of which are also served by Alice Peck Day, another valued community resource).

H. Kendrick	9	So far in 1998, our meeting rooms have been used 404 times by groups from outside DHMC, with another 115 scheduled through the end of the year. Space used ranges from conference rooms to auditoria. $50/hour rental was used to reach the figure indicated, regardless of the size of the facility. Groups include school career days, support groups, garden clubs, toast masters, Twin State Businessmen, Franklin Pierce College, NH Technical Community College.
R. Fuller	10	DHMC organizes disaster drills, involving multiple mock casualties, to insure preparedness and to assist local fire and police meet disaster drill compliance requirements.
M. Abbott	11	Nurses see an average of 5 moms a day who are beginning breast feeding, as well as fielding phone inquiries and distributing free supplies and books. This reflects salary and supplies expenses only.
B. Geraghty	12	The completely employee run annual appeal distributes funds to 160+ not-for-profit organizations.
A. Higgins	13	Two or three times annually, patients without family become unable to make decisions for themselves. In those cases, we hospitalize them (for from 4-6 weeks) and assume the legal fees entailed in acquiring legal guardians for them. No dollars cited.
E. Corcoran	14	At the request of local police departments, our Emergency Department performs approximately one hundred free blood alcohol tests. No dollars cited.
--	15	In addition to assistance from the Pregnancy Resource Center director (see 5 above) numerous staff provide free consultation to schools, teachers, and students on such topics as health education, nutrition, school nursing, and health careers. As an example, when a child is seriously, chronically ill, DHMC nurses go to his classroom to prepare teachers and classmates for his return. No dollars cited.
--	16	Community support groups, including Alcoholics Anonymous, Overeaters Anonymous, Breathe Free, and Cardiac Support look to our staff for expert advice. No dollars cited.
K. McAndrew	17	Our occupational health staff provide free on-site work place assessments intended to reduce work-related injuries. Sites assessed include the Lebanon and Hanover Fire Departments, in response to concern about rising workmen's compensation costs. In addition, they have provided free training on employee drug use recognition to the Upper Valley Health Coalition. No dollars cited.
B. Lewis	18	DHMC, together with West Central Services, APD, and Headrest, has organized a community-wide alcohol treatment program. An in-house DHMC team provides assistance to emergency room and inpatients.

2. Local Public Services: DHMC fulfills the needs of a local region of twenty-six towns (ten of which are also served by Alice Peck Day, another valued community resource).

B. Wolf	19	Outreach education on cardiac disease prevention is provided at numerous community events. No dollars cited.
B. Lewis	20	24 hour access to psychiatric services meets a pressing Upper Valley need. These patients are without financial resources.
C. Welch	21	Over 40 professional and amateur musical events, publicized and free to the community, are often scheduled annually in the DHMC rotunda. The piano was donated by the husband of a breast cancer victim. Twenty-four art exhibits are presented in 6 locations throughout the building, with a special emphasis on the work of local artists. In addition, interactive arts programs are offered to patients by DMS students under the aegis of the Koop Institute.
C. Saler	22	To reduce the trauma of surgery, children attend twice monthly sessions, which introduce them to the hospital under non-threatening circumstances. No dollars cited.
--	23	Staff frequently speak to local groups. Last winter two physicians presented monthly sessions at a senior center. Other presentations have been given for service clubs, Hannah House, and Kendall. No dollars cited.
J. Aubuchon	24	DHMC conducts the Red Cross Blood drives at which employees represent 98% of the donations.
K. Coburn	25	DHMC staffer, Kate Coburn, advised Lebanon's wellness planning group. No dollars cited.
K. Coburn	26	Coburn also convened the "Lebanon Prevention Partnership" which produced the Lebanon area resource directory and applied successfully for a HUD grant. No dollars cited.
J. Sargent	27	Dr. Jim Sargent responds to email inquiries from teens on how to avoid tobacco use. No dollars cited.
K. Coburn	28	The Community Health Department produced a health fair for the clients of the NH Employment Security Agency. No dollars cited.
A. Higgins	29	In addition to providing mandated hospital admission advanced directive information, Risk Management personnel participated in creation and implementation of the NH legislation. No dollars cited.
--	30	Staff members are frequently "shadowed" by local high school and college students who are considering entering health professions. No dollars cited.
--	31	The general public is offered classes in CPR, choke saving, and on negotiation (violence avoidance) skills, both on-site and at local area schools and clubs (including OKA Karate in Lebanon, Norwich day care, Kearsarge, Newbury, Hartford, Vermont Christian). These classes are often taught by employees on a volunteer basis, with DHMC providing equipment and supplies. No dollars cited.

2. Local Public Services: DHMC fulfills the needs of a local region of twenty-six towns (ten of which are also served by Alice Peck Day, another valued community resource).

G. Bru	32	Camp outs now require medical backup. Our physicians serve in this role as volunteers. No dollars cited.
J. Proehl	33	In addition to school lice counts, other "public health" surveillance tasks are performed by our staff. No dollars cited.
J. Proehl	34	WISE volunteers intervene in many crises, including domestic violence. They receive their training in the necessary skills from DHMC staff, at no charge. No dollars cited.
J. Stephenson	35	A number of health education/screening booths are manned by volunteers from DHMC annually at the Lebanon-Hanover Home Show. Last year, a DHMC physician covered the rental of 3 booths and over 2 1/2 days screened 400 persons for stroke risk, including instructions for follow-up. No dollars cited.
R. McClintock	36	Twenty-four hours a day, free vehicle assistance is supplied in our parking lots to people who have dead batteries, flat tires, no fuel, or who have locked themselves out. Our switchboard handles 5-6000 calls daily, triaging emergencies, providing directory assistance, and answering questions.
S. Featherstone	37	When blind patients are admitted, staff or volunteers walk their seeing eye dogs so that the patient will not be rendered "sightless." No dollars cited.
S. Featherstone	38	Similarly, blind patient visitors are escorted through the building.
K. Coburn	39	This smoking cessation event involves almost a thousand local residents annually and is coordinated locally by DHMC.
J. Rudman	40	In addition to providing subsidized day care to employees, DHMC staff provide advice to community members about how to locate reliable childcare. No dollars cited.
B. Garrity	41	Within the Matthews Fuller Library on the fifth floor of DHMC is a collection of 1093 video tapes, books, and journals (as well as internet access) aimed at the lay audience, and used by 9000 people annually at no charge. Web page guides the public to consumer health sites. No dollars cited.
S. Calkins	42	The Lebanon High School robotics teams. DHMC sponsored participation in the national competition in Orlando, Florida. (support of $1,000)
S. Brown	43	Clinics in Canaan, White River Junction, and elsewhere are staffed by MDs at a charge of $25./hour, far below cost.

3. Unique Regional Capabilities:

A. Major Initiatives: (>$2500 annually)	Cite		$ Value	Contact, Organization
• State Poison Control Program [1]	CHA	'97	$445,000	Shaw, MH
• Children's Hospital at Dartmouth [2]	CHA		$424,980	Brown, MH
• Norris Cotton Cancer [3]	CHA		$387,600	Czachowski, DHMC
• Level 1 Trauma Support [4]	CHA		$102,323	Shaw, MH
• Dana and Matthew Fuller Health Sciences [5]	CHA		$195,000	Garrity, DHMC
• Patient emergency funds [6]	CHA		$16,243	Rudman, MHMH
• Toxic, biohazard waste assistance [7]	CBISA		$22,000	Vargo, DHMC
• Ethics Program [8]			$54,500	Keller, Shaw MH
• Public service announcements for March of Dimes	CHA		$3,000	Guth, MH
• Food trays for breast feeding moms or hospitalized babies	CHA		$6,500	Shaw, MH
• Free patient and family support groups[9]	CHA		$15,831	Rudman, MH
• Croatian Health Partnership[10]			$195,000	Charbeneau, MH
			$1,868,000	

B. Regional Representative Actions: (assumed to cost less than $2500 each annually)

- Only NH and/or NE tertiary care programs for many clinical conditions [11]
- Free patient and family support groups[12]
- Regional peer review [13]
- National board participation [14]
- Phineas Gage Day [15]
- Cranial autopsy service [16]
- Operation crash [17]

3. Unique Regional Capabilities:

B. Regional Representative Actions: (continued)

- EMT run sheet audits and blood tubes[18]
- Family overnight support [19]
- Park cars for elderly and disabled patients [20]
- Support for regional organ bank [21]
- Annual public symposiums on topics [22]
- Music therapy [23]
- Art cart [24]
- Deputy NH medical examiners service [25]
- Health and safety exhibits provided statewide
- Cancer Survivor's Day [26]
- Risk Management consultation [27]
- Glasses, hearing aids, dentures lost in transfer are replaced.
- Free advice on prevention programs [28]
- Assist in birth parent searches [29]
- Poetry project [30]
- Special patient needs [31]
- Free consultations with specialists [32]
- X-ray artifacts [33]
- Support to Vermont Cardiac Network [34]
- Staff play major leadership roles in state, regional, and national professional organizations [35]
- Staff participate in state and national policy forums [36]
- Staff provide expert testimony on behalf of the state in domestic violence and child abuse cases.

3. Unique Regional Capabilities: As New Hampshire's only academic medical center, DHMC possesses unique expertise in many areas. Individuals and organizations from New Hampshire and Vermont, as well as from across North America (and in some cases, internationally) look to DHMC in order to benefit from that expertise.

L. Courtemanche 1

For forty-two years, DHMC has operated the New Hampshire Poison Information Center. In 1981 the Center was designated as the official state poison program by legislation. With the exception of the 800 phone line, all funding comes from DHMC. Twenty four hours a day poison calls (19,013 in 1997) are answered by pharmacists, nurses, and doctors. Information and guidance is provided to hospitals, veterinarians, ambulance squads, educators, and the lay public. Every 911 ambulance dispatch activates a call to the Center, and 90% of those episodes are tracked by follow-up calls from the center until the outcome is clear. Of the 19,000 calls, 15,000 involved human poisonings, and another 765 involved animals.

The staff tracks cluster outbreaks, and helps to remove hazardous substances from the market. Currently, significant increases have been seen in both heroin and herbal poisonings. After receiving 14 calls regarding respiratory distress, together with the Oregon Center, they identified the propellant in a leather spray as hazardous. Similarly, they are seeing increasing poisonings due to substances purchased over the internet. Among their various roles, they advise chemistry teachers on laboratory exposure, provide press releases about poisonous holiday plants, identify tablets for police statewide to determine whether or not they are prescription or illicit drugs, facilitate water testing for arsenic, and educate school nurses about the current inhalant fads. Their data is submitted annually to the national center for poison control to assist in epidemiologic studies. Amount reflects direct expenses budgeted only.

J. Brooks 2

The Mission of the Children's Hospital at Dartmouth (CHaD) is to achieve the highest level of health for the children of New Hampshire and Eastern Vermont. CHaD (a member of the National Association of Children's Hospitals) encompasses a broad spectrum of services specially designed to meet the health needs of children. In addition to many of the state's only pediatric subspecialists, CHaD provides education to health professionals and the general public. Examples of CHaD programs include the William E. Boyle, Jr. Community Pediatrics Program (which assists chronically ill children and their families with the emotional, social, and financial burdens they face as well as providing advanced training to their caregivers. This program grew out of Dr. Boyle's pioneering work with 4 cystic fibrosis victims). Other CHaD efforts include the Dartmouth Center for Genetics and Child Development (which provides diagnostic services and support for families with concerns

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2 cont'd about developmental disabilities, congenital malformations and genetic conditions), the state's only intensive care nursery (and headquarters for the two state neonatal/pediatric system/transport service), the Hood Center (which focuses on insuring that every child has a "medical home," and helps families work together to meet needs of children), the STAR program (which prepares teens with lifelong chronic diseases to prepare for assuming the responsibilities of adulthood), special clinics for chronically ill children, a four part parenting lecture series, the Injury Prevention Center (which recently sent an educational mailing about alcohol and pregnancy to 5,000 day care centers, physician offices, and schools), and the Perinatal HIV project. A CHaD physician heads the US Committee on Immunization practices. CHaD faculty serve on 6 journal editorial boards and are reviewers for over sixty journals. CHaD's child life program strives to reduce the impact of illness on the social and intellectual development of children through play therapy and diversional entertainment, with support provided to siblings and schoolmates of seriously ill children, as well. Pet visits are facilitated. Through the Reach Out and Read Program, books are given to children 6 months of age and older at their well-child visits, with story times held in waiting areas. 2-5 child life students are educated here each term. A Child Health and Safety Fair is held annually, as are frequent presentations on seat belt use, gun safety, and immunizations. The Children at Risk Team seeks to identify and prevent recurrences of child abuse. DHMC staff provide volunteer support for camps organized to give chronically ill children (with arthritis, asthma, diabetes, cancer, cystic fibrosis, and hemophilia) a normal childhood summer experience. These are but a few examples of CHaD's work. The twenty year old New Hampshire Perinatal Program has contributed to New Hampshire's very low infant mortality rate (5 vs. 7.3 deaths nationally/100 live births). DHMC OB/GYN and pediatric specialists travel throughout New Hampshire to provide education and on-site consultations. All transported patients are discussed annually at the referring institutions, in conjunction with specially targeted educational offerings. In 10 years, the program has provided 100,000 hours of professional education. These educational offerings are backed by a 24-hour free physician consult service which is activated 1000 times annually, and faculty who provide leadership for statewide efforts to reduce unnecessary caesarean sections and improve the quality of care for mothers and newborns, regardless of where care is provided. It is impossible to accurately document all of the various types of support

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2 cont'd

provided to CHaD. For the purposes of this report, included are:

- $ 5,084 Injury Prevention salary (per S. Hopkins)
- $258,896 OB/CHaD Regional Education (per S. Myers) (THC/MH support)
- $ 65,000 Child Life Program (per C. Sailer)
- $ 96,000 CHaD community relations (health fair, education, prevention (per S. Brown)

$424,980 Note that this amount does not reflect the considerable cost of maintaining standby tertiary pediatric capability.

Myers, Rocchio Greenberg

3

Norris Cotton Cancer Center is one of 35 comprehensive cancer centers, designated nationally by the National Cancer Institute (all at not for profit medical centers). The NCCC provides cancer education, research, and treatment. In addition to making the latest in treatments available to patients, NCCC has been a world leader in cancer prevention. Its researchers discovered the preventive quality of vitamin A-like compounds, and research due out in January links calcium carbonate to colon cancer prevention. If NCCC were not here in Lebanon, cancer patients would have to go to Boston (Dana Farber) or NYC (Sloan Kettering) for equivalent care. 150 physicians and research scientists translate research funding into new medical applications for cancer detection, treatment, and prevention. Special services include intraoperative radiotherapy, hyperthermia, stereotactic brain surgery, infusion pumps for pain control, seed implants, and a coagulation clinic. A 1-800 number receives 1300 calls annually from cancer patients and their families seeking information and support, and links callers to appropriate local care (only 4-8% result in referrals to DHMC). NCCC operates the state cancer registry, conducts tumor rounds at small hospitals, establishes chemotherapy protocols for local treatment, and provides advice to New Hampshire on patterns of cancer occurrence. The Robert Wood Johnson Foundation recently awarded NCCC a three year grant to help improve end of life care given to cancer patients. A free service provides familial risk counseling in a confidential setting, so that insurers do not have the opportunity to disqualify coverage. NCCC coordinates the NH Mammography Network which helps to maintain the quality of breast screening services. The NCCC Flatow Cancer Library provides information for patients and families. NCCC's is the only statewide registry for skin cancers in the US, and ours is perhaps the only bone marrow transplant program not to require a cash deposit before care is provided. The amount cited reflects support from DHMC members to NCCC.

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4 DHMC is extensively committed to improving trauma care through life-support and EMT training. Approximately $3,300 (per Tobin) is used to teach 30 EMTs peripheral blood starts. In order to learn to quickly start IVs, local paramedical and EMT students get clinical experience in our emergency and pediatric departments. Twenty do practicums in the ICU, with substantial numbers gaining experience in the Emergency Department. Dr. K. Little has taught 50 local EMTs intubation skills, as well as serving as their medical advisor for their district. We provide a building to house the Upper Valley EMS consortium. Trauma outreach training is provided annually to twelve hospitals, and our staff have conducted 90% of NH's trauma center designations. The Kiwanis sponsor our pediatric trauma equipment distribution program to local quads, and we provide 4-5 courses annually.

5 As the largest biomedical libraries north of Boston, ours are open to anyone for on-site access. Doctors and nurses are assisted with medline searches and anyone can access information via our computers for a fee.

J. Rudman 6 These budgeted funds are intended to meet the special needs of indigent patients. They have been used to purchase clothing, meals for family members, taxi fares, and any other special needs which may arise, especially for patients who come from a distance for care.

R. Vargo 7 Approximately 15% of the time of the environmental programs staff is committed to public service external to DHMC. Examples of this work include the Donation Depot (which collects and redistributes used medical equipment, books, linens, and supplies to schools, third world medical relief efforts, and veterinarians), town hazardous waste collections (often held in DHMC parking lots), work with Lebanon and Lyme school janitors to reduce pediatric asthma, and assistance with local hazardous material spills (the recent I91 truck accident in Hartford). This department conducts cross training with area fire departments, and wrote the joint Lebanon-Hanover emergency plan. DHMC is working to eliminate use of ethylene oxide (in sterilization), and when this is achieved, all of our ethylene oxide safety equipment will be donated to Fire Departments. This department conducts the annual state radiation drill, and has assisted in truck stops to search for illegal hazardous transports. They (with Richmond School) co-founded the Upper Valley Materials Exchange among schools. The American Hospital Association has recognized DHMC for its landmark waste management program which in turn has resulted in international requests for advice (including reduction of accidental needle sticks among people foraging the Amazon amidst hazardous waste, teaching visiting South Africans the proper use of autoclaves and incinerators to reduce transmission of disease, and helping Egypt reduce infant mortality related to formaldehyde use in

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	7 cont'd	incubators). In addition to vigorous institutional recycling, we teach employees how to recycle at home. We helped organize the Upper Valley Materials Exchange which redistributes equipment and supplies to schools and non-profits via a web page we developed with Richmond Middle School students. As a result of six children being exposed to mercury poisoning (in which cases we advised on school cleanups), we are developing a "Mercury Monster" partnership among DHMC, pharmacists, the EPA, and NH to appropriately dispose of mercury thermometers. We are trying to help NH get a grant to do this. Amount reflects 15% of staff salaries per Shaw.
J. Bernat	8	DHMC pays part of the salary of a physician, as well as other program costs for a regional medical ethics resource. In addition to addressing thorny patient care issues (which often occur in tertiary care centers), the Ethics program provides public and professional ethics education and consultation to other institutions considering starting ethics programs. Dr. Bernat, the director, also serves as a special advisor to the Vatican on issues related to the determination of death (amount per Kelleher).
J. Bernat	9	The Vermont Ethics Network facilitates ethical explorations and education for Vermont Health care providers. DHMC is founding member (amount per Kelleher).
	10	For several years, DHMC assisted in the medical redevelopment of formerly Communist Croatia, in cooperation with U.S. Agency for International Development. DHMC staff assisted with implementation of new programs, and with the introduction of positive changes.
	11	Conditions include AIDS, advanced epilepsy, mycosis fungoides, among others. Special services include kidney transplantation, pediatric surgery, bone marrow transplants, endoscopic ultrasound, endovascular aneurysm repair, brain spectroscopy, chemo embolization, pediatric intensive care, many pediatric subspecialties, and MR angiography, among others. MH was the site of the first diagnostic x-ray, ever, and created one of the first intensive care units. MH/THC had the state's first intensive care nursery, open heart and neurosurgery programs, and radiation therapy programs, among many others, and has the state's only American College of Surgeons designated level I Trauma Center. No dollars cited.
J. Stephenson	12	Included are regular meetings of support groups for patients and family members to help them cope with complex medical conditions, including epilepsy, traumatic brain injury, arthritis, stroke, breast cancer, fibromyalgia, hemophilia, infertility, pediatric diabetes, emphysema, awaiting lung transplants, prostate cancer, bereavement, renal disease, parental bereavement, morbid obesity, insulin pump recipients, women with HIV, Alzheimer's, chronic headaches, Crohn's/colitis,

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	12 cont'd	implantable cardioverter defibrillators, and spinal cord injuries. In addition to space, DHMC provides expert advice and facilitation. No one is charged, regardless of where he/she receives medical care. Most groups meet monthly, with some convening more frequently. No dollars cited.
--	13	Upon request, DHMC physicians participate in peer review efforts at other hospitals to complement the efforts of the local medical staff. No dollars cited.
--	14	DHMC physicians participate in National Boards as examiners, determining which applicants are eligible for specialty certification. No dollars cited.
S. Reeves	15	Phineas Gage was a railroad worker in Cavendish, VT who accidentally ran a metal rod through his head, effectively separating the right and left hemispheres of his brain. This unfortunate accident provided one of the biggest scientific discoveries of the nineteenth century: that the right and left sides of the brain have independent functions. This year a big medical symposium and community celebration was held in Cavendish to mark the hundred and fiftieth anniversary of Phineas' misfortune. In addition to the scientific papers presented, DHMC involved the entire community: • DHART helicopter landed and students learned about on-site treatment of head injuries. • A jello brain mold (peach flavored) was used to demonstrate brain fragility. • A DHMC staffer drove to Concord to borrow New Hampshire's crash test dummy outfit to wear in the parade, to stress the importance of seat belts. • A head trauma patient, accompanied by a speech pathologist, discussed recovery and rehabilitation. • Every student was bombarded with 2 messages - always wear a protective helmet when engaging in sports, and say no to drugs and alcohol. • First aid for seizures was presented for fifth and sixth grades. No dollars cited.
J. Silverstein	16	Brains of patients from across NH and VT who were thought to have died from Alzheimer's are autopsied, free, at DHMC, to rule out Jakob-Creutzfeldt (mad cow) disease. No dollars cited.
J. Proehl	17	Frequent programs on injury prevention are presented by the DHART team. As a result of the success of Gage Day, DHART, ED Trauma, Neurosciences, and Rehab. have offered an injury and stroke education road show to 78 school systems. By March '99, six had already responded positively.

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	18	All EMT run sheets from the region are reviewed by our trauma service as a quality assurance measure. Free blood tubes are provided to emergency squads, to hasten availability and improve reliability of emergency blood samples. No dollars cited
J. Rudman	19	Free cots, linens, showers (and, if necessary, transportation and meals) are provided to family members who come from a distance. A recent study indicated that on average 50 family and friends stay over night at DHMC to be near loved ones. No dollars cited. MAY BE SIGNIFICANT.
R. McClintock	20	No form of tip or payment is accepted for this service. No dollars cited.
K. Lord	21	Due to DHMC support for organ procurement, the number of organs donated here has doubled over the last two years. No dollars cited.
--	22	Recent topics have included breast cancer, depression, and cardiac disease in women. No dollars cited.
H. Bridge	23	Volunteer musicians are recruited to play relaxing music for patients during hospitalization. No dollars cited.
H. Bridge	24	In addition to bringing artwork to decorate the rooms of longer stay patients, volunteers coordinate rotating art exhibits in public areas. No dollars cited.
J. Silverstein	25	DHMC pathologists serve as deputy NH medical examiners, doing on-site visits as needed. No dollars cited.
S. Myers	26	500 current and former patients attended daylong social and educational event to learn about new cancer research and to provide emotional support to one another. Included in NCCC budget.
A. Higgins	27	Expert advice on avoiding safety and malpractice risks is provided to other hospitals and health care organizations. No dollars cited.
K. Coburn	28	DHMC's community health director serves on a number of local efforts (e.g., the Lebanon Police Department program to address gangs and swindles) as well as participating in the State Committee for health promotion. She organized New Hampshire's state program which offers wellness programs to municipal workers, as well as helping private employers start walking clubs for their employees. In community health budget
J. Rudman	29	In addition to helping infertile couples connect with adoption resources, our social workers advise individuals about how to locate birth parents. No dollars cited.
	30	A nurse practitioner holds free workshops to help patients express their feelings through poetry. Over 75 have participated so far. No dollars cited.

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J. Rudman	31	Desperately ill patients often have special wants and needs, and the staff at DHMC enjoy meeting those needs - both on company time and on their own. Teddy bears, fried clams, birthday cakes, celebrations, are all part of the healing process, especially for patients far from home and those facing terminal illnesses. No dollars cited.
	32	Virtually every specialty has a physician on call, twenty-four hours every day, to provide free consultation to any colleague who phones. No dollars cited.
M. Clinton	33	A recent x-ray of a 2000 year old Chinese bronze urn for the Hood Museum uncovered a hidden signature of the artist. No dollars cited.
B. Wolf	34	$2,000 is supplied annually.
	35	Some examples: DHMC neonatologists created the newborn intensive care system for New Hampshire. Our staff conduct state trauma center designations on behalf of the EMS consortium. We are the site responsible for state radiation disaster readiness. Under contract, we provide the physicians of NH State Hospital and manage the state cancer registry. No dollars cited.
	36	Examples include the NH Osteoporosis Task Force, the NH C-Section Task Force, the VT/NH Primary Care Committee, the NH Diabetes Task Force, the Governor's Council on Domestic Violence, the state Certificate of Need Board, Good Beginnings, NH Healthy Babies, and NH Victims Assistance Commission. No dollars cited.

4. Support for local access to medical care in a rural (and in 14 areas Federally designated as "underserved") region:

A. Major Initiatives

		$ Value	Contact, Organization
• Dartmouth-Hitchcock Air Rescue Team operating loss [1]	CHA	$700,000	Shaw, MH
• MHMH support to rural hospitals through The Hitchcock Alliance [2]	CHA	$717,963	Page MH
• THC subsidy for locally sited regional physician practices [3]	CHA	$551,250	Bartlett, THC
• North Country Dialysis Center loss [4]	CHA	$100,000	Jantzen, MH
• PICU Transport[5]	CHA	$50,000	Shaw, MH
		$2,119,000	

B. Representative Actions: (assumed to cost less than $2500 each annually)

- Assistance with physician recruitments [6]
- Consultative advice to community MDs [7]
- Report on community health status [8]
- The only access to emergency care for twenty-six towns from midnight to 7 a.m.

4. Support for local access to medical care in a rural (and in 14 areas Federally designated as "underserved") area.

	1	DHART air transports seriously ill or injured patients without concern for their ability to pay. This also permits local ambulance squads to avoid 4-8 hours on out of area trips. A ground safety course on landing zones has been presented at all hospitals, to make reception of helicopters safer. All skiways have received training in hypothermia, shock, and packaging of injured skiers for transport. Each DHART crew member is responsible for updating a designated region on current trauma care. All outcomes are tracked, to insure the program's benefits justify its costs. In many parts of the country, emergency air transport services are publicly funded.
A. Page	2	The Hitchcock Alliance was formed to insure that local access to health care is maintained in the mostly rural communities of the Connecticut River Valley. Through guidance supplied by DHMC-based staff, costs of supplies, insurance, and regulatory compliance are reduced, capital financing is acquired, patient care is coordinated and improved. Each Alliance member pays annual dues, but all Alliance members except Mary Hitchcock receive benefits in excess of the dues they pay. Amount (per Page) is excess of MHMH support over value derived.
J. Bartlett	3	The Hitchcock Clinic has created group practices in rural areas, to help with the recruitment and retention of needed physicians. Those practices operate at a loss.
B. Mroz	4	Patients from the NH North Country previously had to travel several hours three times weekly for dialysis at DHMC. A center was opened in Whitefield to reduce travel time, thereby increasing the likelihood that dialysis patients can maintain jobs and support families. A second similar center is being discussed for the Vermont Northeast Kingdom. Amount per Jantzen.
	5	A pediatric transport service sends specially trained nurses to accompany critically ill newborns and children to DHMC.
M. Ward	6	Because of THC's extensive contacts and experience in recruiting physicians, we frequently help small hospitals needing to fill vacancies. No dollars cited.
M. Ward	7	In a similar vein, free consultative advice on practice management is informally provided to community physicians. No dollars cited.
E. Hamilton	8	THA recently completed a comprehensive report on health - and the risks to future health - in the eight Alliance communities. This report will be used to identify major health problems on which to focus attention by Alliance community health improvement teams. In addition to incidence of disease and use of health care, the report compares such factors as income, level of education, smoking rates, radon and lead exposure, and isolation. No dollars cited (included in support to THA).

5. Medical and Health Professional Education, Including Lifelong Education for Regional Health Professionals: (>$2500 annually)

A. Major Initiatives:		$ Value	Contact, Organization
• Dollars in financial support provided to Dartmouth Medical School [1]	CHA '98	$5,405,000	Bartlett, THC
• Teaching Physicians [2]	CHA '97	$4,323,000	Bartlett, THC
• Additional costs borne in service to the academic mission: [3]	CHA '97	$1,300,000	Jantzen MH, THC
• Nursing school clinical experience/training [4]	CHA	$200,429	Kobocovich, MH
• Rehabilitation training program[5]	CHA	$37,750	Tobin, MH
• Chaplaincy/Pastoral education [6]	CHA	$261,750	McCoy, MH
• Med. tech training [7]	CHA	$25,000	Silverstein, MH, THC
• Office of Continuing Health Education subsidy [8]	CHA	$225,000	Holmes, MH,THC,DMS
• Telecommunicated educational videos [9]	CHA	$75,000	Kulig, MH
• Patient education [10]	CHA	$48,000	Kobokovich, MH
• Schweitzer Fellowship	CHA	$20,000	THC, MHMH
		$11,921,929	Subtotal

B. Representative Actions: (assumed to cost less than $2500 each annually)

- On-site physician "fellowships" [11]
- List of rounds at DHMC circulated to regional physicians [12]
- THC grand rounds at other hospitals [13]
- Career days [14]
- Train APD, VA, VNA staff in basic and advanced life support.
- Free CPR training for parents of intensive care babies and children.
- Free staff training [15]
- Drug recognition training [16]
- Internet Medline access

5. Medical and Health Professional Education, Including Lifelong Education for Regional Health Professionals:

J. Collins 1 The Hitchcock Clinic provides direct financial support to Dartmouth Medical School. Amount per Bartlett.

J. Collins 2 Physicians who are teaching medical students and residents while seeing patients see fewer patients per hour. In one specialty, when physicians are accompanied by students, they can only see 2-3 patients per hour, compared with 5-6 patients per hour in a strictly clinical practice. (Two weeks ago, a community physician who had volunteered to "take" a medical student for the day called to cancel because a full roster of patients was scheduled for that day.) Amount per Kelleher is net of any Medicare payments.

J. Collins 3 An academic medical center requires full-time salaried department chairs who oversee education and research, as well as patient care. They generally do very little, if any, patient care themselves. DHMC has ten clinical chairmen. Approximately 2/3 of the cost of their salaries and offices is borne by the Clinic and Hospital. Amount per Jantzen reflects that support, net of any patient revenues generated by the chairs.

L. Kobokovich 4 Budget per Kobokovich for nursing education and research (see footnote 4, page 18, for research description) which includes 75 nursing students annually from Colby Sawyer, UNH, and other schools, as well as 50 licensed nurses who come here to update their skills. In a similar vein, region nurses come to DHMC to enhance their clinical knowledge and skills. Examples:

- Nursing home nurses were taught dialysis
- Critical care nurses from small hospitals do skills updates in DHMC ICUs
- Virtually every cancer chemotherapy nurse outside Chittenden County learned to do so at DHMC. No dollars cited.

Additionally, our nurses go out to provide training at hospitals throughout the region.

D. Tobin 5 Other professional training programs teach 6 pharmacy ($7750 net of stipends received), 14 physical therapy, 2 occupational therapy, and 1 speech pathology students (averaging a cost of $30,000 per year per Tobin at 8 hours teaching per week for 10 weeks at $22/hour).

P. McCoy 6 The five person Chaplaincy program at DHMC fulfills three vital interrelated roles:

a. Provision of pastoral services for patients, families, and the community. Pastoral services emphasize responses to critical needs which emerge from patient needs, including individual and family support, four weekly worship services (which are televised to inpatients), interfaith holiday services, memorial services for deceased patients, staff, and volunteers. The chaplains are on call twenty-four fours a day. They coordinate a

6 cont'd

volunteer bereavement support program for families who have experienced a sudden death They participate in memorial services which bring together organ recipients and the surviving family members of donors as well as for parents who have experienced stillbirths or newborn deaths. They offer welcome to all community pastors who visit parishioners. Chaplaincy started the first cancer support group at DHMC fifteen years ago. They have performed weddings for dying patients, and are working with an employee group to enhance spirituality in the work place (including sponsorship of concerts November 11 by a cleric composer). The recent David's House/CHaD tree planting ceremony honored children who have died.

b. Continuing pastoral education for regional clergy.
They offer 8-10 week seminars to train lay pastoral counselors from area churches. They provide free annual symposia on topics of relevance to clergy (on October 29, 30 attended the session on domestic violence). The clergy support group meets twice monthly, with participants driving from as far as 1 1/2 hours away. They are currently discussing creation of a local interfaith caregiver's network which would use volunteers to meet the many needs of the ill, including transportation, supportive visits, and errands.

c. Accredited clinical pastoral education for theology students
They provide practice-based education for 6 ministry students every summer, as well as three over the winter. This is a formal part of ministry training in hospital chaplaincy. Amount reflects chaplaincy program budget ($270K) per McCoy, net of donated support ($8250).

J. Silverstein — 7 — 20 UNH med tech students per year have received their clinical training in our labs for the past fourteen years. We recoup about half of our costs of $50,000-60,000 per Silverstein.

D. Holmes — 8 — The Department of Continuing Education receives support to provide continuing professional education. In 1997, 9,723 health professionals participated in their offerings. The amount shown reflects DHMC's subsidy of this work.

R. Kulig — 9 — MHMH Productions provides four hours (weekly) of medical grand rounds broadcast to other sites, as well as twenty videotaped copies of these rounds. They broadcast about six hours weekly of other educational programming, as well as 150-200 hours yearly of special conferences and educational administration. The figure shown reflects their budget net of any revenues (halved to eliminate use for meetings).

5. Medical and Health Professional Education, Including Lifelong Education for Regional Health Professionals:

L. Kobokovich	10	Budget for patient education per Kobokovich.
D. Holmes	11	Area physicians may spend time doing "mini-fellowships" at DHMC, to update their clinical knowledge or to learn new skills (e.g., a family practitioner may spend a week learning basic dermatology to reduce the number of patients requiring referrals to specialists). The $125/week we charge primarily covers continuing education credit processing costs, not the time of our faculty. No dollars cited.
D. Holmes	12	Distributed to 2,500 physicians and 12,000 nurses in the region. No dollars cited.
D. Holmes	13	In 1997, 34 DHMC MDs provided educational rounds at other hospitals at the charge of $125 plus mileage, regardless of the preparation and travel time entailed. No dollars cited.
R. McClintock	14	In addition to "health career" days participation at numerous area high schools, DHMC hosts an annual career day here for approximately 300 students. In addition to health professions, the DHMC day highlights opportunities in skilled crafts, including electrical engineering, plumbing, and carpentry. No dollars cited
K. McAndrews	15	Area-wide employees facing special health risks are given special training. As an example, Dartmouth employees were briefed on avoiding pathogenic exposure before beginning work on sewer line relocation. No dollars cited.
K. McAndrews	16	Our occupational health director provides drug recognition training for state and municipal law enforcement officers on behalf of the National Traffic Safety Administration. She is currently coordinating Drug Awareness Day under the sponsorship of the NH Safety Council, the NH State Police, and Drug Free New Hampshire. No dollars cited.

Biomedical and Health Services Research:

A. Major Initiatives: (>$2500 annually)	$ Value	Contact, Organization
• Research grants [1]	$37,800,000	Bauer, DMS
	$1,200,000	Shoob, Hitchcock Foundation
	$260,000	Bauer, MH
	$331,000	Bauer, THC
• Support for Northern New England Cardiac Disease Study Group [2]	$49,000	Kelleher, MHMH
	$39,640,000	

B. Representative Actions:
- Staff serve on national research review committees and journals [3]
- Nursing research internal support [4]

Biomedical and Health Services Research (>$2500 Annually)

A. Bauer	1	Research grants from the National Institutes of Health, as well as from private non-profit foundations, enable DHMC to conduct extensive research into both basic science and medicine.
B. Wolf	2	Northern New England Cardiac Disease Study Group was organized over ten years ago by DHMC physicians to compare and improve survival rates from heart disease at all northern New England medical centers which perform open heart surgery and cardiac catheterizations. Dollars reflect the nursing position at DHMC which is dedicated to gathering the data for this project. This effort has been a model for similar programs around the world, and has expanded knowledge of the factors which contribute to successful cardiac outcomes.
--	3	Many faculty serve on study committees (the prestigious groups who decide which research proposals are worthy of NIH or foundation funding) and as editors/reviewers for nationally respected medical journals. In addition, DHMC faculty publish many scientific articles, present national and international research conferences, and lead multi-institutional research studies. No dollars cited.
L. Kobokovich	4	Nursing research into such areas as how to measure quality of care, how to best transfer premature babies home, how to avoid blood clots in catheters, whether to let family members into recovery rooms, how to control fever, etc., etc. are ongoing, with our results, protocols, and policies shared with other institutions.

Philanthropic and Volunteer Support

While insurance coverage has reduced the reliance of non-profit hospitals on charity, both philanthropic support and volunteer hours remain important factors for DHMC.

Major Areas:	**$ Value**	**Contact, Organization**
• Philanthropic support for construction of DHMC campus	$51,000,000	Blum, DHMC
• 7,000 donors annually		
• Pink Smock proceeds	$200,000	Bridge, DHMC
• DHMC volunteer hours (50,000 @ $10 minimum wage/benefit)	$500,000	Bridge, DHMC
• Rubin Building (houses Norris Cotton Cancer Center)	$11,800,000	Blum, DHMC
• Pediatric Intensive Care Unit	$800,000	Blum, Thompson, DHMC

Finally, in the course of researching the benefits provided by DHMC, we learned of countless volunteer or fundraising efforts by staff, on their own time, as natural extensions of their professional roles. A small sample:

- 5 DHMC folks cooked weekly Listen dinner in Enfield last week in August. Helped Lebanon Rotary gather 19 boxes of food on Saturday in August.
- Scandinavian AIDS patient - MD gave her his frequent flier miles.
- Off duty DHART team drive ambulance when weather conditions forbid flying to bring victims back.
- Dental rehab for Pediatric Medicaid patients.
- Coburn funded to coordinate volunteer work of DMS students in smoking prevention.
- YB Reasonable employee jazz band does seven benefits a year.
- Dartmouth students serve as volunteer visitors to lonely mental health patients.
- Humane Society brings in dogs to visit depressed patients. We test the dogs for fecal pathogens at no charge.
- Employees are active blood donors.

DHMC provides services which would otherwise be responsibility of **state** or **city governments**, including:

- State EMS/trauma review
- State intensive care nursery review
- State cancer registry
- State poison control center
- State deputy medical examiners
- State air rescue team
- State provider of health care for the indigent
- Clinics in underserved areas
- State clinical education of physicians, nurses, occupational, speech and physical therapists, medical technicians, and EMS personnel
- Policy and legislative expertise in a variety of areas
- Screenings
- Radiation disaster preparedness
- Processing of guardianships
- Performance of police blood alcohol determinations
- Professional staffing of State mental hospital
- Staffing for well child clinics
- Cancer helpline
- Regional high risk perinatology program
- Toxic and biohazard waste assistance
- Drug use recognition training for state police

Footnotes

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3. Catholic Health Association, "Social Accountability Budget for Not-for-Profit Healthcare Organizations," 1989.

4. Association of American Medical Colleges (AAMC), "Meeting the Needs of Communities: How Medical Schools and Teaching Hospitals Ensure Access to Clinical Services," 1998.

5. Report, "Economic Impact of AAMC Member Institutions," 1996.

6. Karen Pallarito, "Bucks for Brains: Louisville Revs up its Research Engine," Modern Healthcare, 8/24/98.

7. Norman Crampton, The 100 Best Small Towns in America, 2nd Edition, Macmillan, NYC, 1995.

8. Voluntary Hospitals of America, "Voluntary Standards: A Framework for Meeting Community Needs," 1992.

Other Resources

J. David Seavy, J.D., "Community Benefit Prevails," Health Progress (1992 Catholic Health Association).

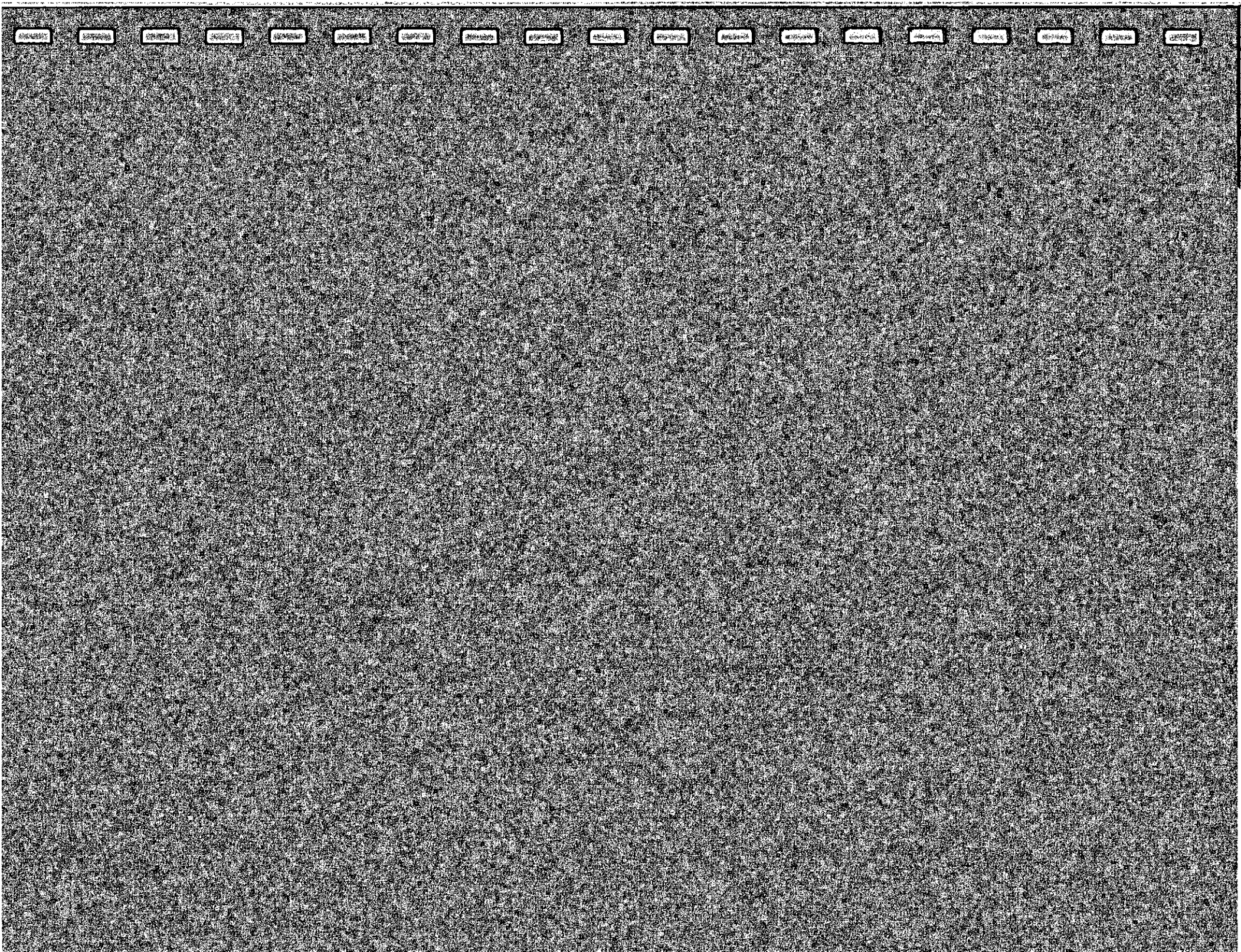
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Noble, et al., "Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives," Journal of Law, Medicine, and Ethics, 26 (1998): 116-37.

Summit on State Community Benefit Planning and Reporting Laws, Washington, DC, November, 1998.

Jay Greene, "CHA, VHA Collaborate on Software," Modern Healthcare, February 12, 1996.



Statement of New Hampshire Hospital Association in Opposition to HB 1144
–Relative to the Property Tax Exemption of Not-for-Profit Hospitals-

February 2, 2000

House Bill 1144 would impose a special burden on New Hampshire's community hospitals not shared by any other kind of charitable organization–to obtain an affirmative vote of a municipality's legislative body, at least once every 3 years, in order to maintain exemption from property taxation. The Bill would not just single out community hospitals as a class for this kind of special treatment; in municipalities with more than one community hospital, each hospital could be treated differently for purposes of tax exemption, depending on the result of the required vote.

Apart from the potential harsh effects the Bill would impose on community health care organizations struggling to deal with major changes in their financial environment, the Bill's unequal treatment of community hospitals raises very serious concerns under the New Hampshire Constitution, as this Statement will outline.

There is no need for this bill, or the potential confusion it would create. Present law requires community hospitals to demonstrate they are performing charitable functions in accordance with their charters, to be eligible for property tax exemption. Their continued eligibility should not become a purely political matter, subject to shifting winds of political sentiment. The Bill should be reported as "Inexpedient to Legislate".

This Statement will first outline the current law governing tax exemption of community hospitals, as charitable organizations; then will discuss how the Bill would appear to work; and

hospitals, as charitable organizations; then will discuss how the Bill would appear to work; and finally will describe the Bill's potential Constitutional problems.

I. Current Law Regarding Property Taxation of Community Hospitals as Charitable Organizations

Charitable organizations in general are exempt from property taxes pursuant to RSA 72:23, V and RSA 72:23-l. However, the exemption conferred on a charitable organization is not unlimited: "[o]nly that part of the property which is used *directly* for charitable purposes is exempt from property tax." *The Housing Partnership v. Town of Rollinsford*, 141 N.H. 239, 242 (1996); *see also* RSA 72:23-m.

An organization claiming tax exemption bears the burden of demonstrating both the organization's status as "charitable," *see Nature Conservancy v. Nelson*, 107 N.H. 316, 319 (1966), and the applicability of the tax exemption to particular property of the organization, RSA 72:23-m. Thus, an organization seeking charitable tax exemption must file annual reports with each municipality in which the organization has property claimed as exempt. RSA 72:23, VI; RSA 72:23-c. These annual reports, submitted on forms prescribed by the New Hampshire Board of Tax and Land Appeals, must (a) contain a statement of the organization's financial condition for the preceding fiscal year, RSA 72:23, VI; (b) include "such other information as may be necessary to establish [the organization's] status and eligibility for tax exemption," RSA 72:23, VI; and (c) provide the municipality's selectmen or assessors with a list of all real estate and personal property claimed as exempt, RSA 72:23-c, I.

Furthermore, upon the written request of the municipality, an organization seeking tax exemption must provide additional "materials ... including its organizational documents, nature of

membership, functions, property and the nature of that property, and such other information as shall be reasonably required to make determinations of exemption of property." RSA 72:23-c, II.

To qualify as "charitable", an organization must be *obligated* to carry out its stated purpose for the public benefit. RSA 72:23-l; *see also The Housing Partnership*, 141 N.H. at 239. Indeed, the Attorney General or other public officials may legally enforce the charitable organization's duty if the organizations's service is not performed. *Appeal of City of Franklin*, 137 N.H. 622, 625 (1993).

Consistent with the definition of "charitable" in RSA 72:23-l, New Hampshire law has consistently recognized community hospitals as charitable organizations. *See, e.g.*, RSA 292:1 (authorizing incorporation for the "establishment and maintenance of hospitals, homes for the aged and for invalids, and other charitable institutions"); *Mark H. Wentworth Home v. City of Portsmouth,* 108 N.H. 514 (1968) (plaintiff was "a charitable corporation organized ... for the purpose of operating a home for individuals having incurable conditions"); *Dowd v. Portsmouth Hospital*, 105 N.H. 53 (1963) (defendant was "a charitable institution [organized] for the purpose of caring for the ill and injured and generally to promote the health and welfare of citizens in the community area").hospitals. In addition, under legislation enacted in 1999, community hospitals are now required by law to carry out processes to assure that they provide "community benefits" in keeping with their charitable purposes. *See RSA 7:32-e through 32-l.*

II. <u>What HB 1144 would do.</u>

House Bill 1144 would subject a particular class of charitable organizations - - "not-for-profit hospitals" - - to the special requirements of a new statutory provision. The new statutory provision

would **require** each municipality's legislative body to take a vote, "at least once in every three-year period," affirmatively declaring a property tax exemption for "**each** not-for-profit hospital within its taxing district." Presumably, a separate vote would be required for each hospital in municipalities with more than one (there are 3 such municipalities in New Hampshire, Nashua, Manchester and Lebanon). A negative vote would authorize the taxation of a hospital's property. In this way, House Bill 1144 would segregate community hospitals from the general charitable property tax exemption provision (RSA 72:23, V) and would subject them (alone among all other kinds of charitable organizations) to the additional special requirement of a triennial affirmative vote.

HB 1144 would be different from any present law governing tax exemption. Although existing tax statutes allow an individual municipality the option of adopting **additional** specified exemptions, *see, e.g.*, RSA 72:62 (individual municipality may adopt exemption for real property having solar power equipment), or of **increasing** the amount of a particular state-granted exemption, *see* RSA 72:23, IV (individual municipality may provide exemption in excess of $150,000 for dormitories, dining rooms, and kitchens of educational institutions), House Bill 1144 would for the first time authorize an individual municipality to **deny** a tax exemption available to other charitable organizations; would subject a particular kind of charitable organization to a special requirement; and would allow municipalities to grant or deny exemptions to individual community hospitals on a selective, non-uniform and purely subjective basis.

III. House Bill 1144 raises serious Constitutional problems

As discussed, HB 1144 would subject a particular class of charitable organizations (not-for-profit community hospitals) to the special requirement of a triennial vote and, in doing so, would

allow a municipality to deny to a community hospital a property tax exemption that is available to all other charitable organizations in the municipality. Also as noted, the Bill would allow selective denial of property tax exemption to one community hospital in a municipality, while granting an exemption to another hospital in the same municipality. HB 1144 would authorize this selective denial of a state-granted tax exemption without providing any standards or policy objectives to guide a municipality's vote on the availability of the tax exemption.

By doing so, HB 1144 appears to violate several principles embodied in the New Hampshire Constitution: equal protection of the laws, as guaranteed by Part I, Articles 1, 2, and 12; due process, as guaranteed by Part I, Article 15; equality and uniformity of taxation, as required by Part I, Article 12 and Part II, Articles 5 and 6; and state legislative authority over taxation, as required by Part I, Article 28 and Part II, Article 2.

A. HB 1144 would deny community hospitals the equal protection of the laws

The equal protection guarantee of the New Hampshire Constitution requires "that those who are similarly situated be similarly treated," *Opinion of the Justices*, 115 N.H. 222, 223 (1975), and extends to both the grant of privileges and the imposition of restrictions, *Gazzola v. Clements*, 120 N.H. 25, 30 (1980). "An act, which operates on the rights or property of only a few individuals, without their consent, is a violation of the equality of privileges guaranteed to every subject." *Rosenblum v. Griffin*, 89 N.H. 314, 321 (1938). As the New Hampshire Supreme Court has explained, analysis of a statute's compliance with the requirement of equal protection necessarily involves consideration of the purposes of the statute, the state's interest in promulgating it, and the interests of those disadvantaged by the statute. *See Belkner v. Preston*, 115 N.H. 15, 17 (1975); *State*

v. Amyot, 119 N.H. 671, 673 (1979).

HB 1144 would allow an individual municipality to deny property tax exemption to a particular class of charitable organization (community hospitals), even though a community hospital could satisfy the generally applicable statutory requirements for entitlement to charitable exemption. In other words, HB 1144 would adversely affect community hospitals that have (a) submitted the necessary financial documents and organizational information to establish their status as charitable, (b) demonstrated that particular property claimed as exempt is used *directly* for charitable purposes, and (c) performed the *obligatory* public services that render the organizations charitable. Thus, HB 1144 wouldn't merely restrict tax exemption to "genuine" charitable organizations or limit the extent of the exemption to "core" property of charitable organizations. Instead, it would load an additional, political burden on community hospitals. This raises the question whether the Bill promotes **any** reasonable public policy–if anything, the Bill would merely **discourage** the establishment and maintenance of community hospitals performing obligatory charitable services for the public benefit. *Compare*, *Opinion of the Justices (Municipal Tax Exemptions for Electric Utility Personal Property)*, (decided December 7, 1999, at page 7) (legislature could constitutionally permit municipalities to *grant* tax exemption to certain kinds of electric utility property because stated purpose of the exemption was to *encourage* the development of competition in the electric supply market).

In the absence of any rational characteristic or purpose that would justify singling out a community hospital in relation to the statutory objectives and requirements of the charitable tax exemption, House Bill 1144's imposition of a special burden on the exemption would seem to violate the equal protection guarantee of the New Hampshire Constitution. *See Gazzola*, 120 N.H. at 29

(differing procedural protections afforded to landowners, based solely on differing purposes for which state condemned land, violated equal protection guarantee because differences were unrelated to statutory purpose); *Amyot*, 119 N.H. at 673 (public safety law's differing weight limits, based solely on nature of commodity hauled by trucks, violated equal protection guarantee because differences did not serve statute's safety purposes); *Belkner*, 115 N.H. at 19 (differing time limits for administrators to commence actions, based solely on the numbers of terms in each county's Superior Court, violated equal protection guarantee because differences did not advance the statutory purpose of providing for survival of pending tort actions). Indeed, the New Hampshire Supreme Court has held that tax statutes violate equal protection if differences in tax treatment are not supported by a "rational basis." *See Cagan's, Inc. v. Dep't of Rev. Admin.*, 126 N.H. 239, 246 (1985) ("Since we find no difference in service sufficient to distinguish [for purposes of the meals tax] between the sales, we find no rational basis to justify taxing the sales from the [vending] machine but not the sales from the supermarket shelf").

B. HB 1144 would deny community hospitals due process of law

In addition to violating equal protection principles by authorizing the selective withdrawal of a state-granted exemption, HB 1144 would seem to deprive community hospitals of due process of law, by failing to provide any standards to guide hospitals or municipal legislative bodies. Due process requires that a statute not be so vague as to fail to give a person of ordinary intelligence a reasonable opportunity to know what is prohibited, required or contemplated by the statute. *Asselin v. Town of Conway*, 137 N.H. 368, 371 (1993); *In re Doe*, 123 N.H. 634, 641 (1983). An impermissibly vague statute presents two fundamental problems: (1) it fails to provide citizens with

"fair warning" as to the statute's requirements; and (2) it fails to provide explicit standards for public officials charged with implementing or applying the statute, thereby creating an unjustifiable potential for arbitrary and discriminatory actions. *See Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 498, 71 L. Ed.2d 362, 371 (1982); *Bama Tomato Co. v. U.S. Dep't of Agriculture*, 112 F.3d 1542, 1547 (11th Cir. 1997).

HB 1144 suffers from these very problems because it contains **no** standards to guide community hospitals or to restrict municipal legislative bodies. Thus, a community hospital would have no way of knowing what activities or conduct on its part would cause a municipality to grant or deny the exemption, and a municipality could deny the tax exemption to a particular hospital on a purely arbitrary and subjective basis. Worse yet, HB 1144 would adversely affect only those community hospitals that would have already satisfied rational criteria for charitable status and tax exemption under other provisions of law. *See Guillou v. State*, 127 N.H. 579, 580-81 (1986) (statute held unconstitutional because it authorized revocation of driver's license without providing any guidance or standards whatsoever -- and thereby created unjustifiable "potential for arbitrary and unprincipled decisions").

C. HB 1144 would result in unequal taxation.

As the New Hampshire Supreme Court recently explained, Part I, Article 12 and Part II, Articles 5 and 6 of the New Hampshire Constitution "work in conjunction to ensure the fairness of any scheme of taxation enacted by our legislature." *Smith v. N.H. Dep't of Revenue Admin.*, 141 N.H. 681, 685 (1997). Taken together, "these three constitutional provisions require that taxation be just, uniform, equal, and proportional." *Id.* at 686. Although the legislature may classify various

property as taxable or non-taxable and, in doing so, may exempt certain property from taxation if the exemption is supported by "just reasons," *Opinion of the Justices (Municipal Tax Exemptions for Industrial Construction)*, 142 N.H. 95, 99 (1997), the New Hampshire Constitution mandates that "similarly situated taxpayers be treated the same." *Smith*, 141 N.H. at 686. The legislature is constitutionally prohibited from making classifications on the basis of taxpayers or property owners. *Opinion of the Justices*, 131 N.H. 640, 642 (1989); *Opinion of the Justices*, 115 N.H. 306, 308-09 (1975). However, "a reasonable classification [of property] which is sufficiently inclusive to constitute a distinctive class will be upheld." *Opinion of the Justices (Municipal Tax Exemptions for Electric Utility Personal Property)*, (decided December 7, 1999, at page 7) (in light of legislative policy to encourage competition in the electric supply market, electric utility personal property constituted a sufficiently inclusive and distinct class of property); *Compare Opinion of the Justices*, 118 N.H. 33, 345-46 (1978) (because "the end product of all electric generating plants is the same regardless of their size," ad valorem tax could not constitutionally apply solely to electric plants with a large generating capacity).

In light of these principles, an exemption from taxation must be reasonable, equal and uniform among similarly situated property owners. *Opinion of the Justices*, 131 N.H. at 642-43 (deduction for compensation under the business profits tax "must be available to *all* business organizations" to satisfy constitutional requirements); *Felder v. City of Portsmouth*, 114 N.H. 573, 579-80 (1974) (homeowners' exemption law unconstitutional because it resulted in "disuniformity of taxation" by allowing "some homeowners to take full exemptions, others only partial exemptions, and still others none at all"); *see also Eyers Woolen Co. v. Gilsum,* 84 N.H. 1, 8 (1929) (a special exemption, "giving to one party an immunity from taxation not enjoyed by others similarly situated,"

is invalid under the New Hampshire Constitution).

HB 1144 would violate the New Hampshire Constitution's guarantees of equal and uniform taxation by subjecting each community hospital (but not other charitable organizations) to the special burden of a triennial affirmative vote, thereby permitting individual municipalities to withdraw the tax exemption from particular community hospitals. By doing, HB 1144 demonstrates lack of the required element of uniformity that the New Hampshire Supreme Court has emphasized in its recent decisions concerning the constitutionality of tax exemptions. *See, e.g., Opinion of the Justices (Municipal Tax Exemptions for Electric Utility Personal Property),* .(decided December 7, 1999. at page 7) (exemption would "apply to all like property within the municipality); *Opinion of the Justices (Municipal Tax Exemptions for Industrial Construction)*, 142 N.H. at 101 (reasoning that if individual municipality opted to enact tax exemption, the exemption would be available to *all* new construction for the *same* duration, and concluding that the "exemption would apply equally and uniformly within the taxing district, thereby satisfying constitutional requirements"). Moreover, no "just reasons," legitimate policy objectives, or other criteria appear in House Bill 1144 for allowing municipalities to treat community hospitals differently from similarly situated charitable organizations. *See Claremont School District v. Governor,* (decided October 15, 1999, at page 4) (Supreme Court has "struck down legislation when the means employed to effect a tax exemption failed to comport with the articulated justification"); *Opinion of the Justices*, 113 N.H. 87, 89-90 (1973) (rebate to some taxpayers but not others would violate the Constitution because no criteria existed to govern the rebate and, therefore, the rebate was not "sustainable upon grounds of reasonable classification").

D. HB 1144 would impermissibly delegate State legislative authority.

Part II, Article 2 of the New Hampshire Constitution vests "supreme legislative authority" in the state legislature, and Part I, Article 28 prohibits the imposition of any taxes "without the consent of the people, or, their representatives in the legislature, or authority derived from that body." Although the state legislature is not prohibited from establishing the terms of a general tax statute while leaving the determination of whether it shall have the force of law to individual municipalities, *see Opinion of the Justices*, 115 N.H. 228, 230-31 (1975), or from allowing individual municipalities to make local regulations not inconsistent with state law, *see State v. Rogers*, 105 N.H. 366, 371 (1964), the New Hampshire Supreme Court has refused to interpret these constitutional provisions as authorizing "a total abdication and delegation of the legislative authority to towns, without any guidelines, supervision or legislative review whatsoever." *Girard v. Town of Allenstown*, 121 N.H. 268, 272 (1981) (declining to interpret broadly worded statute as delegation by state legislature to municipalities, of authority to enact rent control ordinances because such an interpretation "would raise serious constitutional questions").

"The taxing power is fundamentally vested in the legislature, and exemption from taxation is an exercise of the power." *Trustees of Phillips-Exeter Academy v. Exeter*, 92 N.H. 473, 480 (1943); *see also Opinion of the Justices (Tax Plan Referendum)*, slip op. at 5 (dated March 11, 1999) ("The power of taxation is an attribute of sovereignty belonging to the people; and this power, so far as it has been granted at all, has been delegated under our constitution to the legislature"). Consequently, any delegation of the power to tax or create exemptions must be "regulated by some definition of policy and purpose" and controlled by "prescribed objectives." *Trustees of Phillips-Exeter Academy*, 92 N.H. at 480. Without such standards or limits on these legislatively delegated

powers, the taxing body's "freedom of discretionary action is too broad and unconfined" and the potential for "lack of uniformity" is too great. *Id.* (holding statute unconstitutional because educational institution's entitlement to tax exemption was entirely dependent upon approval, by state board of education, of institution's curriculum).

Measured against these principles, HB 1144 would appear to involve an unconstitutional delegation of legislative power to tax and exempt. As discussed previously, HB 1144 provides no standards or guidance to control municipal legislative bodies in voting on exemption for a community hospital. This would result in very real potential for arbitrary and unprincipled action. The exemption vote could turn on justification, good or bad, or no reason at all.

IV. Conclusion

HB 1144 would violate equal protection by authorizing the selective withdrawal of the tax exemption from a community hospital "similarly situated" to other charitable organizations; would offend due process by failing to provide any standards or guidelines for community hospitals or municipal legislative bodies; would result in unequal and non-uniform taxation of similarly situated property owners, without "just reasons" for the different treatment; and would unconstitutionally delegate the state legislature's power to tax and exempt, without providing any standards or guidelines to limit the decision of municipal legislative bodies. In addition to the unjustifiable hardship the Bill would impose on New Hampshire's community hospitals, these serious defects require rejection of the Bill.

HB 1144
Feb. 2, 2000
Testimony of Rep. Ken Weyler
to Municipal and County Government Committee

We have a problem in New Hampshire with the cost of healthcare. After several years of double digit increases in our Rockingham County health plan, we are now faced with a 50% increase. In national statistics, only Minnesota is listed as a more healthy state than New Hampshire, yet we have healthcare costs that are some of the highest in the country. This last summer and fall, a group of our colleagues held several meetings in the Rockingham County Complex to look at this healthcare problem.

Why am I bringing all this to the Municipal and County Government Committee? Back in the summers of 1991 and 1992, as a member of this committee, I chaired the study committee looking at property tax exemption. Based on information available then, we found community service as the reason to allow property tax exemption to churches, charities, schools and hospitals.

At the time, one member made the statement that, although there were 24 not-for-profit hospitals in the state and only two for profit, he saw no difference in the prices charged or the salaries paid between the two classes.

My study this last year revealed to me that the not-for-profit hospital in my area was not about community service; it was about completely monopolizing healthcare in my region. Through the certificate of need process, the Exeter Hospital could stop most competition. Through the APEX healthcare arrangement with the Portsmouth Hospital and about two hundred doctors in the area, they negotiated prices that helped lead to the demise of the Tufts HMO. We discovered that many of the doctors in APEX are actually contract employees of the Exeter Hospital. Any doctor that arrives new to the area is told to join APEX or have no hospital privileges. The hospital uses its financial clout to open clinics, nursing homes and health clubs.

Last summer, the medical director of Tufts Health Plan told our committee that he could airlift a patient from Exeter by helicopter to Boston, have the patient treated in Boston, and upon recovery, helicopter the patient back to Exeter for less money than it would cost for similar treatment in Exeter.

While Portsmouth Hospital sent 18 million dollars out of state to its corporate owners, and also paid millions in property taxes, Exeter Hospital added another eleven million dollars in "surplus" to an account that exceeds fifty million dollars.

This is no struggling community service hospital fighting to survive. This is the biggest money machine in my region. The monopoly they have created is a drain on the finances of every family in my district. We as a legislature need to do something to fix this. Those of us who studied the issue have a multi-pronged strategy. We must change the certificate of need process. We must investigate restraint of trade and monopolistic practices. Here in this committee I hope you will support making a hospital's property tax exemption subject to a local vote.

Please do no be persuaded by the lobbyists bringing in the poorest community hospital they can find. I am not out to destroy that hospital. I am out to empower the members of its community to show its appreciation. But what of communities forced to support a huge money machine who makes healthcare more expensive for them. Let those people judge also. Be very careful as legislators that our first duty is to the greater good and not to the entity that sends the most lobbyists.

For identification:
Health Services Department
Boston University School of Public Health
80 East Concord Street
Boston, Massachusetts 02118
(617) 638-4664

21 September 1993

Amy Kaufman
Results Womens' Fitness
64 Epping Road
Exeter, New Hampshire 03833
FAX: 603-778-7401

Dear Ms. Kaufman:

I was surprised and unhappy to learn that the Exeter Hospital is planning to invest in building a very large and costly center for exercise, rehabilitation, and "wellness" in your town.

I conclude that this project is inappropriate for three reasons. Before presenting them, let me briefly identify myself and provide background.

Identification. I have studied and worked in the health care field for over twenty years, focusing on hospitals, and have taught health care finance, planning, and administration here at the Boston University School of Public Health for ten years. I write in my personal capacity, and not in the course of my employment here at Boston University.

Background. Exeter Hospital enjoys very considerable financial resources. In fiscal year 1991, according to New Hampshire hospitals' own financial reports, compiled by the New Hampshire Hospital Association, Exeter Hospital earned $4.8 million in surplus revenue on a total revenue base of $37.8 million, for a margin of 12.7 percent. Only three other New Hampshire hospitals (Berlin, Huggins, and Upper Connecticut Valley) earned higher margins. Exeter is bigger than the other three together, measured by total revenue.

Concerns. First, what is the best use of this money? While it may be fashionable for a hospital to spend money on wellness or health spas, I think that hospitals should stick to their main job in this country, which is to take care of us when we are sick. It is a mistake for hospitals to divert their energy and their resources into ancillary fields-- areas in which they typically lack experience and expertise. Why would hospitals do this? Perhaps to protect their revenue bases by diversifying. Perhaps because their administrators or trustees crave variety and change. And perhaps because they are not sufficiently committed to using their resources to meet their core mission, to heal the sick.

Second, I strongly doubt that Exeter Hospital is yet doing close to enough to use its very considerable financial resources to meet the needs of sick people in the community. How much free care does the hospital provide to uninsured, unemployed, or other low-income people? In 1991, Exeter Hospital devoted a sum equal to only 7.8 percent of total revenue to all uncompensated care, including both bad debt and free care. This was only 12th-best among the 26 New Hampshire acute care hospitals and actually below the statewide average of 8.1 percent. With its very considerable financial resources, I would expect that Exeter Hospital would be doing more to serve uninsured or underinsured people. This could involve direct service by paying for free care or hiring physicians and other caregivers in hospital clinics to assure needed care to people who cannot pay for it.

(Some might say that Exeter Hospital is located in an area where few low-income or uninsured people reside. But is this really true? In the current prolonged recession, which has hit New Hampshire so badly, how far does a hospital need to look to find people in need of reduced-cost care or free care?)

Third, if the hospital finds, after honest and serious efforts, that it does not to provide more reduced-cost or free care, it always has the option of cutting its prices. Health care costs are extraordinarily high in the United States, and Exeter Hospital could bestow a great benefit on its community by acting to reduce its own revenues-- and therefore the costs of all who live, work, or do business in the area.

I realize, Ms. Kaufman, that you have your own reasons for questioning Exeter Hospital's proposed new facility, but this has not influenced my opinion. The foregoing summarizes my professional assessment of the appropriateness of Exeter Hospital's plans, as you have described them to me.

Yours truly,

Alan Sager, Ph.D.
Professor

February 9, 2000

Representative David Hess
Chair, Municipal & County Committee
68 Pine Street
Hooksett, NH 03106

Dear Representative Hess:

In regard to House Bill 1144 and rescheduled hearing, I was scheduled to testify on February 2nd on behalf of New London Hospital. My personal commitments now make it impossible for me to appear at the hearing today. However, I am forwarding with this letter, a copy of the testimony I had planned to give on the 2nd, with the request that it become a part of the record for your Committee.

In regard to House Bill 1144, I listened to the testimony on February 2nd and if I am permitted a comment, it is that while there may be concerns in regard to Exeter Hospital or Mary Hitchcock Hospital, these same concerns cannot be reasonably applied to New London Hospital.

New London Hospital currently pays $30,000 in property taxes to the Town of New London and if we were denied our tax exempt status on the hospital, we would be liable for an additional $80,000. It would then be necessary to reduce services or programs or delay purchase of needed equipment in order to pay this tax. And while I don't presume to speak for other hospitals, it seems logical that they would face a similar dilemma.

To New London Hospital, finding HB 1144 "Inexpedient to Legislate" seems a reasonable and defensible decision.

Respectfully yours,

George G. Wells.

Statement of New London Hospital in Opposition to HB 1144,
"Relative to the property tax exemption of non-for-profit hospitals"

House Municipal and County Government Committee

February 2, 2000

Good morning, Mr. Chairman and members of the Committee. My name is George Wells. I'm from South Sutton, and I'm a trustee at New London Hospital. I'm here to speak in opposition to HB 1144.

I've been on the Board at New London Hospital for over thirty years, so I know first hand how important a charitable trust such as New London Hospital is to the communities we serve. In Fiscal Year 1998, our little hospital provided $174,819 in uncompensated care. We did this in the face of shrinking resources that have resulted from unprecedented Medicare cuts as well as the extreme continuing pressure of the managed care industry.

Hospitals are the cornerstone of community-based health care in our communities. It is where uninsured patients go to get the care not accessible to them anywhere else. In many places that businesses have declared "unprofitable", hospitals continue to reach into the community to help those who need it the most. (Example: the Rock Dental Clinic). For the uninsured, hospitals are the health care safety net open 24 hours a day, seven days a week, 365 days a year.

It is the not-for-profit nature of the hospital that compels members of our communities to volunteer and give of their time so generously to ensure that the hospital remains a strong and vital component of the health care service delivery system. That's why there are some 600 hospital trustees currently serving on New Hampshire hospital boards. There are thousands of hospital auxilians in New Hampshire, plus an uncounted number of hospital volunteers. These people dedicate their valuable time to their community hospitals. In the mind of a trustee, auxilian or hospital volunteer, the thought of a tax on

an institution they so willingly serve is contrary to the stated charitable mission of every hospital and it carries with it the suggestion that they haven't given enough.

If a property tax were to be imposed on New London Hospital, we'd have no choice but to cut back on some aspect of the hospital's operation, as there's no possible way to pass this cost on to others. The real cost would be to those patients who rely on a service that had to be scaled back or who rely on charity care to cover the cost of their illness. Or perhaps the cost would be the reduction or elimination of certain community health programs on which our patients have come to rely. This proposal threatens our ability to update our equipment or add services to meet the rising expectations of our patients to offer the best health care available. We believe they deserve it.

I therefore urge you not to place this tax burden on the shoulders of those who do so much for the citizens of this state, and I ask you to find HB 1144 inexpedient to legislate.

Thank you for the opportunity to speak with you today.

CATHOLIC
Medical
CENTER

February 2, 2000

Representative David Hess, Chairman
House Municipal and County Government Committee
State House
Concord, NH 03301

Dear Rep. Hess and M &CG Committee Members:

As the president and CEO of Catholic Medical Center, Manchester, I urge you to vote "NO" on HB 1144, "Relative to Property Tax Exemption for Non-for-Profit Hospitals. Unfortunately I am unable to personally appear before your committee on this morning; however, it is the position of Catholic Medical Center that this legislation, if passed, will create additional serious financial issues for hospitals.

New Hampshire's communities are fortunate to have access to exceptional hospitals that have assumed the additional responsibility for taking care of the health of our communities. Our care, and therefore our expenditures, are not limited to patients in hospital beds. It is that extension of our services that makes us unique and allows us to live up to our non-profit status.

For CMC, in fiscal year 2000 we have budgeted $5.1 million dollars in community services and charity care. We are anticipating spending more than that in FY 2001 and FY2002.

Through our Community Services Division, Catholic Medical Center has long made the commitment to our service area to budget for and maintain a network of services designed for the care of the less fortunate and needy at a total cost of $2.7 million this year alone.

And example of the many programs we offer is the GREAT Day Program, a facility for the elderly poor and those on fixed incomes. At no charge, we provide health screenings, flu shots, consultation and medical referrals and a myriad of other services at a subsidized housing site in Manchester. Last year there were almost 6,000 visits at GREAT Day.

Our Prime Time Center for Healthy Aging is a comprehensive resource center designed to keeping the aging population active and healthy with over 13,000 active participants.

In collaboration with our community services, we address the problems of the homeless in Manchester through a mobile community health team which served 740 people last year; the Albert D. Poisson Special Care Dental Facility is another great example of community collaboration for the poor, much of the funding coming directly from Catholic Medical Center. This dental clinic for the poor had 5,138 appointments during a year.

100 McGregor Street Manchester, NH 03102
phone 603.668.3545 fax 603.668.5348

Our parish nurse program provides registered nurses and screening programs to over 13 parishes in the community, again at no cost. OUR PLACE is a pregnancy and parenting program for pregnant teens that has helped 869 young people give birth to healthy babies and give them the skills to parent. OUR PLACE continues its relationship with these young parents for five years.

In addition, CMC provides many educational and learning opportunities for our community, we have contributed financially to other social service agencies and we build into our annual budget expenditures specific to the care of those without the ability to pay.

At the same time, we have faced tough reimbursement issues with our managed care payors and a decreasing Medicare budget. Yet, we must maintain high levels of professional expertise and equipment and continue to remain at the cutting edge of healthcare which our state has come to expect, and which it deserves.

Catholic Medical Center, as you are aware, is in a turnaround phase. While we've made great progress during the past six months in rebuilding our organization, we still have much challenge ahead to ensure we are a viable community asset long into the future.

The additional burden of property taxes, which we estimate could cost CMC almost $600,000, would have a serious impact on our organization. We have accepted the challenge of helping our communities at great expense. Now please help us by voting NO.

Sincerely,

Alyson Pitman Giles
President/CEO

TESTIMONY ON HB 1144 LOCAL

MUNICIPAL AND COUNTY GOVERNMENT

FEBRUARY 2, 2000

Mr. Chairman and members of the Committee, my name is Adele Fulton and I appear before you on behalf of the City of Lebanon to speak in support of the goals in HB 1144.

The City applauds the notion in this bill that hospitals should become more accountable to the public for their activities, including whether they qualify for property tax exemptions under the historical assumption that they are "charitable."

Charity in this country, and in New Hampshire in particular, has always required the concept of "gifting"—where something is given having more value than what is received in return. Unfortunately, that notion has little application to many hospitals these days. Over the last century, hospitals that were built to care for the poor who were also sick became community hospitals increasingly dependent on fee-paying patients, which then emerged by the end of the century as highly commercial businesses in a multi-billion-dollar health care industry representing a significant percentage of the nation's gross national product. Clearly, there is a lot of money in health care these days, which was not the case 100, or even 50, years ago. Though hospitals today bear little resemblance with hospitals in the early to mid-1900s, hospitals still seem to assume they deserve the tax treatment applicable in the early half of the 20th century. The assumptions of both hospitals and the public should be updated for the 21st century.

Ironically, the public has actually been more charitable to hospitals than hospitals have been to the public, by granting generous tax exemptions without asking for anything in return. Charity care provided by all hospitals in New Hampshire ranges from less than 1% to a high of only 2.5% of gross income, and that is calculating charity care in the most generous manner favorable to hospitals. At the same time, some hospitals have amassed significant cash reserves, paid generous administrative and physician salaries, expanded operations, competed fiercely with other health care providers (both nonprofit and for-profit), and have even charged higher prices than for-profit facilities providing similar services in some cases. It appears that being either a non-profit and for-profit entity increasingly has little meaning in the health care industry since for-profit commercial operations are mirrored closely by the non-profit sector. The question raised by these facts is whether charitable tax exemptions of non-profit hospitals really provide the public benefit initially intended or whether they actually benefit private enterprise by offering a competitive advantage to non-profit hospitals over their taxable counterparts.

The generosity of the public today in granting exemptions is even more significant than it was in the early half of the last century, because hospitals have expanded their operations and have continued to increase the space used for medical and auxiliary purposes, thereby decreasing the taxable property municipalities and schools can rely upon to pay for necessary public services and educating children.

So, the City of Lebanon supports the goal in HB 1144 which would require hospitals to become more accountable to the public bearing the burden of tax exemptions.

The City does want to express some concern related to the practical implementation of HB 1144 with the statutory scheme for tax exemptions. Giving legislative bodies the authority to vote on tax exemptions for some institutions, but not others, permits the decision-making to be governed by more political, rather than judicial, processes and could result in unequal taxation of similarly-situated institutions within New Hampshire.

Part of the difficulty the public would face, if it were to vote on granting exemptions, is the complexity of the modern health care system. The public could become the target of sophisticated media and public relations campaigns financed by hospitals attempting to convince the public they are deserving of the generous tax breaks. Unless the public were to have to time to examine and understand the annual reports, tax returns, corporate and contractual inter-relationships between health care organizations, and similar health care-related issues, it would have a difficult time knowing how to vote. Giving hospitals the opportunity to gloss up their images for an anticipated public vote while their operations remain, most likely, unchecked and unchallenged might create some undesirable results.

The City's chief concern is that the meaning of "charity," which has traditionally required a gift of services from an organization to the public to qualify for the exemption, may continue to lose its significance, because clear standards that would apply to hospitals are missing. If the legislature does not establish the standards, then the general public is not likely to know what to ask for, or require, before holding hospitals accountable for charitable activity by vote. It presents the opportunity, then, that exemptions could, in effect, be given away to commercial institutions within the modern health care industry based on historical assumptions rather than current facts.

The City would like to encourage this Committee, therefore, to consider establishing updated criteria for exemptions that would apply to modern hospitals now that we have crossed into the 21st century. For instance, this Committee could require certain standards of organizations seeking to be exempt that would include the following characteristics:

1. They are organized to advance charitable purposes that provide significant services to others without immediate expectation of material reward;
2. They donate or render gratuitously a substantial portion of their services, so that what is given to the public is of greater value than the price considered proportionate for the services rendered;
3. They seek to serve a substantial and indefinite class of persons who could not otherwise afford the services;
4. They relieve the government of some of its burden;
5. They operate entirely free from private profit motive and are substantially distinguishable from commercial enterprises; and
6. They operate, depending on gifts, donations and payment for services, in order to meet, rather than exceed, operating and long-term maintenance expenses.

These characteristics clarify the standards that would be expected for exemptions, which would be applied equally and fairly to all hospitals. Put simply, they would require hospitals to operate like charities before being granted charitable exemptions.

It is to be expected that many hospitals, feeling entitled to tax breaks after so many years when no one has asked questions, will sound the alarms and claim that requiring them to operate like charities will force them out of business. But no one is asking or encouraging any hospital to go out of business. The hospitals would only be asked to pay taxes from their profits like all other commercial enterprises that pay taxes with which they compete. If they choose to operate like charities with the characteristics described, they would deserve the exemptions. Certainly, the public would benefit, and should benefit, by clarification of charitable standards, so hospitals either support the public by paying taxes or support the public by operating charitably. Hospitals should not have it both ways, however.

The City would like to thank this Committee for its work in considering HB 1144 and offer its appreciation for encouraging greater accountability by hospitals to the public. The City would also like to encourage the establishment of clearer standards that would apply to modern hospitals in New Hampshire, so that the value of charitable exemptions, which cost the public every year in lost revenue for municipal, county and school services, is not weakened by the ever-increasing commercialization of the health care industry but, rather, is preserved and protected for the benefit of the public and for those deserving organizations that operate charitably.

Thank you very much for the opportunity to speak to you.

The Cheshire Medical Center

An Affiliate of C&H Health System of the Monadnock Region

580 Court Street, Keene, New Hampshire 03431-1729 (603) 352-4111

Robert J. Langlais
President / CEO

January 26, 2000

Rep. David Hess
Chairman
House Municipal & County Government (M&CG) Committee
68 Pine Street
Hooksett NH 03106

Re: House Bill 1144 – Relative to Property Tax Exemption for Not-for-Profit Hospitals

Dear Rep: Hess:

On behalf of the Cheshire Medical Center Board of Trustees, staff, and patients, I would like to express strong opposition to House Bill 1144, entitled, "Relative to Property Tax Exemption for Not-For-Profit Hospitals," which I understand will be heard before the House Municipal & County Government Committee on Wednesday, February 2, 2000. Unfortunately, I will be unable to attend the committee hearing on February 2nd, due to a prior engagement that will require my attendance at an out-of-state meeting.

The Cheshire Medical Center, like many other rural community hospitals in the State of New Hampshire, have been unduly impacted by cutbacks in Medicare and managed care reimbursement and are currently operating on very slim net operating income margins. Passage of House Bill 1144, which threatens not-for-profit hospitals' tax exempt status for property taxes, would severely impact the financial viability of many organizations like the Cheshire Medical Center. We estimate that if the property tax exemption for our hospital were eliminated, it would result in an annual added cost of approximately $1.2 to $1.3 million. This annual added expenditure exceeds our average annual net operating income by more than two fold and would have resulted in significant net operating income losses over the last five years, severely jeopardizing the sustainability of the hospital's continued operation.

As a rural community health care organization, our organization serves as an essential community resource, providing many programs and services for which there is no compensation, and providing large amounts of free care for those without insurance and in need of medical services. House Bill 1144 would severely impact our financial ability to continue to be this needed resource for the people who live and work in Southwest New Hampshire. Accordingly, we are requesting your strong support and assistance in opposing House Bill 1144.

Sincerely,

Robert J. Langlais, FACHE
President/CEO

cc: Rep. Roger Zerba
Rep. Paul McGuirk

Testimony delivered at the February 9, 2000 sub committee hearing:

My name is Michael Cimon and I am the Administrator for Orthopedic Professional Association, a group of eight orthopedic surgeons who have served the Lakes Region for over 35 years. I have worked in healthcare for over 25 years, 15 years in hospitals and the past 10 years for OPA.

Nearly four years ago, we approached Lakes Region General Hospital with a proposal to develop an ambulatory surgery center in the Lakes Region to service our growing patient population who more and more were requiring orthopedic surgery on an outpatient or ambulatory basis.

Initially the Hospital was eager to discuss the idea and actually took it a step further. They encouraged us to open the joint venture up to all of the surgeons in the community and develop a multi-specialty center rather than just an orthopedic surgery center. We historically had always worked well with the Hospital. Our practice has been the major orthopedic service provider for the Lakes Region since the mid 60's.But things changed when the Hospital administration realized that it would not be in total control of this new center.

Threats to other surgeons who expressed a desire to participate. Lengthy phone calls by the Hospital President to interested physicians threatening their referrals (the Hospital owns most of the primary care doctors' practices in the area). One by one, doctors began to drop out of the project. The Hospital CEO even went so far as to try to individually recruit the members of our Group to work for the Hospital in a futile attempt to break up our Group. They began to advertise and actively try to recruit their own Orthopedic surgeons by guaranteeing them a referral base – promising referrals from their own Hospital owned primary care doctors.

The Hospital single handedly has stopped our surgical center project in its tracks. Their team of attorneys and expert consultants offered testimony at the CON Board hearings that successfully confused the members into believing that we MAY be over the threshold of $1.07 million.

They challenged our Supreme Court filing, they filed suit in Belknap County Superior Court attempting to stop our entire project requesting a "construction cease and desist", and continued to counter ever attempt we make to gain the necessary approvals to proceed with the licensing and

opening of our one room surgery center to serve the patients of the Orthopedic Professional Association.

But they haven't stopped there. They have openly condemned our actions in the community buy waging a major public relations campaign aimed at discrediting the physicians and administration of OPA. Meetings with Hospital employees, volunteers and medical staff focused (and continue to) on the "damage" done by OPA to the financial stability of the Hospital. Every change to the employee benefit program, lack of pay increases or hiring freeze is blamed on OPA.

They have amended the health insurance plan for their 1000 employees and their families, with the cooperation of Blue Cross Blue Shield, to disallow services provided in an ambulatory surgery center and to deny reimbursement to a physician performing services at an ambulatory surgery center.

They have forced per diem and part time employees who once worked for both OPA and the Hospital to decide on one or the other – no longer can a part time employee supplement his or her hours by working for both organizations.

The have successfully eliminated competition for ambulatory surgery in the Region by delaying our project for nearly a year now with no end in sight.

All of this done and financed by public health care tax exempt dollars. The concept of protecting a virtual monopoly by using public funds is disturbing and must be considered when granting tax exempt status to hospitals.

The Doctors of OPA continue to use the Operating room facilities at LRGH and will continue to do so despite the on going battle. We will also continue to cover the emergency room 24 hours a day 365 days a year and will continue our long standing tradition of provide quality orthopedic care to the patients of the Lakes Region regardless of their ability to pay. Yet we receive no tax exemptions for this at any level. You must remember that while hospitals tout their charitable missions, it is the individual providers who end up absorbing the costs of charitable services provided. These providers pay state and local property taxes and federal income taxes.

We strongly support HB 1144 authorizing the legislative bodies of towns and cities to authorize the tax exemption status of not for profit. This bill will help to control health care practices that ultimately result in victimizing the patients and citizens of New Hampshire.

New Hampshire Hospital Association

February 14, 2000

The Honorable David Hess
Chairman, Municipal & County Government Committee
Legislative Office Building, Room 301
33 N. State St.
Concord, NH 03301

RE: HB 1144-L

Dear Representative Hess:

Maryann Simoni, RN, Vice President, Patient Care Services at New London Hospital, asked that I forward her testimony in opposition to HB 1144-L to you. Ms. Simoni was unable to attend the hearing on this bill on February 9th.

She asked that her comments be considered by your committee as you deliberate on HB 1144.

Thank you.

Sincerely,

Leslie Melby
Vice President
Government Relations

Attachment



Maryann Simoni RN,C
Vice President Patient Care Services

Re: HB 1144-L
Relative to the Property Tax Exemption of not-for-profit hospitals

- A funding crisis already exists in health care, driven especially by the Balanced Budget Act. The impact for New London Hospital is $1.5 million to deliver the identical care we now provide.
- Non-profit hospitals must make sufficient profit to direct dollars into improving technology and assuring competitive salaries. Our patients expect and deserve the best care possible. Competition for highly skilled licensed nursing staff in a low employment environment impacts an already serious nursing shortage. We must be able to invest in recruitment and retention strategies and keep salaries competitive.
- Pharmaceutical costs are skyrocketing at a rate of 15% per year. We have little leverage here and can not treat our patients without these medications.
- Like many small community Hospitals over 70% of our patients are over the age of 65 and eligible for Medicare. Older patients have complex illnesses that increase the patient's length of stay in the hospital, which negatively impacts the hospitals reimbursement.
- The reimbursement and eligibility for home care has also been reduced. This increases the need for charitable community service for a particularly vulnerable and fast growing aging population.
- This bill affects big and small hospitals alike. We deliver an array of community services that benefits all age groups. If critical funds continue to be diverted away from those that are able to provide those services, we just can not continue to do as much with less.

Maryann Simoni, RN,C
V.P Pt. Care Services

270 County Road
New London, NH 03257
(603) 526-2911

FRISBIE MEMORIAL HOSPITAL

February 9, 2000

Rep. David Hess, Chairman
House Municipal and County Government Committee
68 Pine Street
Hooksett, NH 03106

Dear Mr Hess:

Please consider this letter a request not to support HB 1144 re: property tax on non-profit hospitals.

I have numerous reasons and would be glad to provide those to you.

Sincerely,

Alvin D. Felgar
President & CEO

CC: Leslie Melby

11 WHITEHALL ROAD ▪ ROCHESTER, NEW HAMPSHIRE 03867-3297 ▪ PHONE (603) 332-5211 ▪ FAX (603) 332-2699

androscoggin valley hospital

February 10, 2000

Representative David Hess, Chairman
House Municipal and County Government Committee
68 Pine Street
Hooksett, NH 03106

Dear Representative Hess:

I am writing about House Bill 1144 on behalf of our Board of Directors who represent the communities that we serve. We feel that HB 1144 discriminates against hospitals as a class of charitable organizations. Many charitable organizations in our community, as well as the municipal government itself, provide identical services to some of those services provided by the hospital. For example, three organizations within our community provide home health and hospice care to our residents. One of those organizations is in fact the City of Berlin. To potentially subject one of those organizations to taxation appears to be arbitrary and unfair.

HB 1144 also appears void of any objective basis for decisions, granting town selectmen absolute decision-making authority. This can have the affect of allowing very few individuals (the selectmen) of a town with a hospital to control the provision of healthcare services within a much broader community. This would not be an issue if every town in the State had its own hospital; however, the planning for and provision of healthcare services requires a broader-based, regional planning mechanism. The State, through the charitable trust, now requires substantial reporting under the community benefit legislation recently passed. The lack of an objective basis for tax decision-making could potentially be in conflict with the intent of the community benefit reporting system.

We are also concerned that potential additional cost (taxation) comes at a time that many hospitals in the State are operating at a deficit. Federal reductions in the Medicare program and Federal and State reductions in the Medicaid program have forced many hospitals to reduce services and eliminate programs. Additional financial burdens of taxation could force many hospitals to close depriving the vulnerable senior population of services. House Bill 1144 could further fan the flames of rapidly increasing healthcare costs. We need to be looking at ways to reduce costs and expand access to services. We would be most willing to discuss this issue further with you.

Sincerely,

Donald F. Saunders
President

DFS:dlg

59 page hill road • berlin, new hampshire 03570-3542 • telephone 603/752-2200

FRISBIE MEMORIAL HOSPITAL

February 15, 2000

Representative David Hess
68 Pine Street
Hooksett, NH 03106

Dear Representative Hess:

I am writing to urge your support *against* two different house bills: HB1144 and HB1464.

HB1144, Relative to Property Tax Exemption for Not-for-Profit-Hospitals: As a not-for-profit community hospital, we feel that the $1.5 million in charity care, plus the $3.5 million in bad debts from indigent patients, annually returned to our local community are significant contributions. Property taxes would place an unfair burden on our hospital.

HB 1464: The second house bill diminishes the value of the CoN process by excluding land and equipment costs from projects. The current Certificate of Need process is a fair, equitable process for health facility proposals to be considered to avoid unnecessary duplication and help to control costs. This bill would be counter to the intent of the CoN.

Thank you for your consideration. As Chairman of the NH Hospital Association and President & CEO of a community hospital, I would appreciate the opportunity to discuss either of these bills with you at your convenience.

Sincerely,

Alvin D. Felgar
President & CEO

11 WHITEHALL ROAD ▪ ROCHESTER, NEW HAMPSHIRE 03867-3297 ▪ PHONE (603) 332-5211 ▪ FAX (603) 332-2699

WENTWORTH-DOUGLASS HOSPITAL

February 15, 2000

State Representative David Hess
Chairman, House Municipal and
County Government Committee
68 Pine Street
Hooksett, NH 03106

Dear Representative Hess,

I am writing in regards to HB 1144, which would require municipalities to vote whether to continue the property tax exemption for hospitals.

Wentworth-Douglass Hospital firmly opposes this bill. We do not feel allowing the City of Dover to determine the hospital's tax exempt status is fair due to the fact that our primary service includes the towns of Rollinsford, Durham, Somersworth, Barrington, Lee, Madbury, Berwick and South Berwick, Maine. Not allowing these towns a "voice" in the determination of our tax-exempt status is wrong because the medical coverage and community benefit we provide covers a wide region encompassing tens of thousands of individuals.

We also have concerns with our ability to continue providing community benefits at our current level if we are faced with an annual property tax bill. We currently provide many community benefits and set aside ten percent of our hospital's net operating revenue for the provision of community benefits.

Non-profit hospitals are required to submit a Community Needs Assessment and Benefit Plan to the Office of the Director of Charitable Trusts. This Benefit Plan demonstrates the value of our community benefit. I would suggest that you obtain copies of these New Hampshire hospital's plans from the Charitable Trusts Office so you and other proponents of HB 1144 can see the impact non-profit community hospitals have on the health of their communities. Forcing non-profit hospitals to pay property taxes will have a negative impact on their ability to continue providing community benefits.

I ask that you reconsider this bill and welcome your questions. I may be reached at 603-740-2802.

Sincerely,

Gregory J. Walker, FACHE
President & CEO

789 Central Avenue
Dover, New Hampshire 03820
Telephone 603-742-5252

GUIDELINES FOR PREPARATION OF THE COMMUNITY BENEFITS PLAN BY HEALTH CARE CHARITABLE TRUSTS PURSUANT TO RSA 7:32-e

Office of the Attorney General
Charitable Trusts Unit
33 Capitol Street
Concord, NH 03301-6397

Telephone: 603-271-3591
Fax: 603-271-2110
Website: www.state.nh.us/nhdoj/CHARITABLE/char.html

Philip T. McLaughlin
Attorney General

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Director

Terry M. Knowles
Registrar

TABLE OF CONTENTS

I. Introduction and Background 1

II. The Role of the Director of Charitable Trusts 1

III. Definitions 2

IV. Elements of the Community Benefits Plan 3

V. Community Benefits Plan Reporting Form 5

APPENDICIES

Appendix I: Community Benefits Law RSA 7:32-c-1 6

Appendix II: Samples: 7

Description of Community Programs or Services
Summary of Quantifiable Community Benefits Expenditures
Summary of Non-Quantifiable Community Benefits Expenditures
Community Benefit Inventory for Social Accountability

Appendix III: Application for Extension of Time to File Community Benefits Plan ... 8

Appendix IV: Resources 9

COMMUNITY BENEFITS PLAN

I. Introduction and Background

On July 16, 1999, Senate Bill 69, an act relative to health care charitable trusts and community benefits, was signed into law by Governor Shaheen. The purpose of the legislation is to ensure that health care charitable trusts provide the communities they serve with benefits in keeping with the charitable purposes for which the trusts were established and in recognition of the advantages the trusts enjoy. The legislation requires each health care charitable trust develop a community benefits plan within 90 days of the start of its fiscal year. Each health care charitable trust is required to:

- submit its community benefits plan to the Director of Charitable Trusts on an annual basis;
- provide notice to the public of the availability and process for obtaining a copy of its community benefits plan; and
- prominently display such notice in its lobby, waiting rooms, or other area of public access.

The effective date of the law for health care charitable trusts with a total value of fund balances of at least $1,000,000 is on January 1, 2000; health care charitable trusts with a total value of fund balances of at least $100,000 must comply effective January 1, 2001; any health care charitable trust with a total value of fund balances of less than $100,000 is exempt from the provisions of this law.

This bill requires that the health care charitable trust the prepare a community needs assessment (RSA 7:32-f), seek input from the public during all phases of the process, including the development of the community benefits plan (RSA 7:32-e IV and VI), and provide notice to the public of the availability of the community benefits plan (RSA 7:32-g).

II. The Role of the Director of Charitable Trusts

The new legislation is an amendment to RSA Chapter 7, Director of Charitable Trusts, and adds a new section to the existing statute: 7:32-c to 7:32-l. Jurisdiction for the administration and enforcement of the new law is under the supervisory authority of the Attorney General, Director of Charitable Trusts. The law requires that within 90 days of the start of its fiscal year every health care charitable trust shall develop a community benefits plan. Every health care charitable trust must submit its community benefits plan to the Director of Charitable Trusts **on an annual basis** no later than 90 days after the start of the trust's fiscal year. Failure to meet this deadline may result in a fine of not more than $1,000 plus attorneys fees and costs for each violation.

An extension of time for filing the community benefits plan may be granted by the Director upon application made by the health care charitable trust and for good cause shown.

The Director of Charitable Trusts may grant an exemption from the provisions of RSA 7:32-c to 7:32-l to those health care charitable trusts for which compliance would be a financial or administrative burden. An exemption, if granted, shall be valid for a period of three years from the date of issuance unless it is revoked by the Director of Charitable Trusts and written notice of such revocation is provided to the health care charitable trust.

III. Definitions

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

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

Community benefits means a health care charitable trust's activities that are intended to address community health care needs. Community benefits may include the following:

(a) Charity care.

(b) Financial or in-kind support of public health programs even if the programs extend beyond the trust's service area, including support of recommendations in any state health plan developed by the Department of Health and Human Services.

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

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

(e) Support of medical research and education and training of health care practitioners.

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

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

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

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

IV. Elements of the Community Benefit Plan

Mission Statement: Each health care charitable trust must adopt a mission statement which must be reaffirmed on an annual basis.

Definition of community and population served: The health care charitable trust must identify the service area and/or patient population for which the trust provides services.

Community Needs Assessment: Each health care charitable trust must complete or update a community needs assessment every three years. Community needs assessments may be conducted in collaboration with other health care charitable trusts. Each assessment must include consultation with members of the public, community organizations, service providers, and local government officials in the trust's service area in identifying and prioritizing community needs for each health care charitable trust to address directly, in collaboration with others, or through other organizational arrangements.

Definition of Community Benefit: Including but not limited to charity care; financial or in-kind support of public health programs even if the programs extend beyond the trust's service area, including support of recommendations in any state health plan developed by the Department of Health and Human Services; allocation of funds, property, services, or other resources that contribute to community health care needs identified in a community benefits plan; donation of funds, property, services, or other resources which promote or support a healthier community, enhanced access to health care or related services, health education and prevention activities; or services to a vulnerable population; support of medical research and education and training of health care professionals.

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

Community Benefit Planning and Reporting: Each health care charitable trust must adopt and annually update a community benefit plan responding to the identified community needs describing the results or outcomes of the trust's community benefits activities. The report shall also include the means used to solicit the views of the community served by the trust, identification of community groups, members of the public, and local government officials consulted on the development of the plan, and an evaluation of the plan's effectiveness. To the extent practicable, the plan shall include an estimate of the cost of each activity expected to be undertaken or supported in the ensuing year and a report on the unreimbursed cost of each activity undertaken in the previous year. For reporting purposes, the cost of contributed services shall be determined in accordance with the rates, costs, units of service, or other statistical measures used for general accounting purposes by the health care charitable trust. In addition, each charitable trust shall include in its report the ratio of its gross receipts from operations to its net operating costs, as shown in its final statement of accounts for the preceding fiscal year.

Public Disclosure: The statute requires that a copy of the community benefits plan shall be submitted to the Director of Charitable Trusts within 90 days after the start of the trust's fiscal year and every health care charitable trust shall at least annually provide notice to the public of the availability and process for obtaining a copy of its community benefits plan and shall prominently display such notice in its lobby, waiting rooms, or other areas of public access.

Penalty for Noncompliance: Failure to comply with the public disclosure requirement may carry a fine of $1,000 plus attorneys fees and costs for each violation.

V

THE COMMUNITY BENEFITS PLAN

REPORTING FORM

Office of the Attorney General
Charitable Trusts Unit
33 Capitol Street, Concord, NH 03301-6397
603-271-3591
www.state.nh.us/nhdoj/CHARITABLE/char.html

COMMUNITY BENEFITS PLAN – REPORTING FORM

Pursuant to RSA 7:32-c - l

FOR FISCAL YEAR BEGINNING _____

_____ _____

Organization Name **Federal Tax Identification Number**

_____ _____

Street Address **State Registration Number**

_____

City **State** **Zip Code**

The following information and attachments must be included in the community benefits plan filed with the Director of Charitable Trusts:

I. a. General Background Information:

Name and Address of the chief executive officer and board chair:

b. Organizational Structure:

Please attach:

•A copy of the charitable trust's articles of incorporation, constitution, and by-laws, or other instrument of creation.

•A list of the names and addresses of the officers and directors of the organization.

•A brief description of the governance and administrative structure of the health care charitable trust, its parent and subsidiary entities, if any.

II. Community Benefits Contact Person:

•Name and Title:
•Address:

•Telephone Number:

III. Mission Statement:

Statutory reference: ***RSA 7:32-e I.***

The health care charitable trust must provide its most recent mission statement and the date it was adopted. The mission statement must describe the purpose of the health care charitable trust and delineate how the mission statement related to the community benefits reported. The mission statement must be reaffirmed on an annual basis.

Please attach a copy of your mission statement.

IV. a. Program Information

Does your health care charitable trust have a strategic plan that addresses community benefits?

Yes _____ No_____

If yes, please **attach** a copy of the plan or section(s) of the plan pertaining to community benefits.

b. Program Narrative:

Please provide the following information in a concise statement:

- **Who has responsibility for the community benefits programs and activities?**
- **Who is responsible for their implementation?**

If more than one individual is responsible for implementation (1) please provide a list of the names and the project(s) to which each individual has been assigned or (2) provide the number of individuals assigned to each project.

- **How was the health care charitable trust's board involved in development the community benefits program and activities?**

V. Definition of Community and Population Served:

Statutory reference: ***RSA 7:32-d II.***

The community may be defined in terms of geographic boundaries, special populations, community groups, demographic characteristics, health status, health resources, healthcare utilization data, etc. **A description of the methodology used in identifying and determining the community/population served by the organization must be attached**. How does your organization define its community? How was this definition developed? **Please be specific.**

VI. Community Needs Assessment Information:

Statutory reference: ***RSA 7:32-f***

Following the development of the initial Community Needs Assessment, the assessment must be updated every three years. The charitable trust must consult with members of the public, community organizations, service providers, and local government officials in the trust's service area in order to identify and prioritize the community needs which the health care charitable trust can address directly, or in collaboration with others. The report shall also include the means used to solicit the views of the community served by the trust, identification of community groups, members of the public, and local government officials consulted on the development of the plan, and an evaluation of the plans effectiveness. The Assessment may include, but not be limited to, a description of community demographics, community health indicators, income level of the affected population, specific primary, acute, or chronic health care needs, assessment of the health care charitable trust's capability of responding to identified needs, and the availability of other service providers, both public and private. The Assessment must include a description of the methodology utilized in evaluating and identifying community needs.

- **Please describe how community input was solicited and used in developing the community benefits plan.**

- **Once the needs of the community were identified please describe the process utilized to prioritize the projects chosen.**

- **Please attach a copy of the most recent Community Needs Assessment**

The responses to the following two questions will be used in assessing the overall cost of implementing this law.

- **Did the organization hire an outside firm to prepare the Needs Assessment?**

Yes_____ No_____

If the answer is yes, what was the cost of the Needs Assessment?
$_____

- **If the answer is no and the plan was completed internally, how many personnel hours were required to prepare the Needs Assessment?**

_____

VII. Collaboration:

Statutory reference: ***RSA 7:32-f and 7:32-l.***

If the community needs assessment is being prepared in collaboration with other health care charitable trusts, **please attach** a list of the name(s), address(es), and telephone number(s) of the collaborating organization(s) and the relationship, if any, between these organizations. One health care charitable trust should be selected as the contact for the collaborative.

Please Note: One copy of the community needs assessment should be filed for the collaborative. Participating charitable trusts should make reference to this collaborative assessment in preparing their community benefits plans.

What was the beginning date of the fiscal year used for this collaboration?

_____

VIII. Community Benefit Plan:

Statutory reference: ***RSA 7:32-e.***

The document filed must include a listing of community benefits or benefit activities planned by the health care charitable trust. **Health care charitable trusts working in collaboration with other organizations are required to provide individual information pursuant to RSA 7:32-l.** For each community benefit plan, the following information must be included:

- A description of the benefit or benefit activity and how the activity will further the mission of the organization and the objectives of the community needs assessment.

- The need to be addressed and the target/affected population for the benefit

- The goal(s) to be accomplished

- Measurable objectives to be achieved within the target dates and the methodology utilized to measure outcomes.

- If the plan was prepared in collaboration with other health care charitable trusts, please complete Section VII.

IX. Inventory and Valuation of All Community Benefits:

Statutory reference: ***RSA 7:32-d III and 7:32-e IV and V***

Describe in detail the cost of the community benefits planned by the health care charitable trust and the methodology for estimating the cost. The plan shall include an estimate of the cost of each activity expected to be undertaken or supported in the ensuing year and a report on the unreimbursed cost of each activity undertaken in the preceding year. For each quantifiable benefit, the trust should provide an economic valuation which identifies the unreimbursed cost to the trust of providing the benefit and the method for calculating that cost. Nonquantifiable benefits should be identified separately and described in narrative form.

X. Annual Assessment of Community Benefits Activities:

Statutory reference: ***RSA 7:32-e IV***

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

Please be sure the assessment section is included in the plan.

THE COMPLETED COMMUNITY BENEFITS PLAN MUST BE FILED WITH THE ATTORNEY GENERAL WITHIN 90 DAYS OF THE BEGINNING OF THE FISCAL YEAR. FAILURE TO FILE THE PLAN MAY RESULT IN THE IMPOSITION OF CIVIL PENALITIES OF $1,000 PLUS ATTORNEYS FEES AND COSTS (RSA 7:32-g III)

EXTENSIONS MAY BE REQUESTED BY FILING THE APPLICATION FOR EXTENSION OF TIME TO FILE COMMUNITY BENEFITS PLAN FORM WITH THE ATTORNEY GENERAL.

NOTE: A copy of RSA 7:32-c – l will be included with the form mailed to health care charitable trusts.

APPENDIX I

COMMUNITY BENEFITS LAW

COMMUNITY BENEFITS

§ 7:32-c. Purpose.

The purpose of this subdivision is to ensure that health care charitable trusts provide the communities they serve with benefits in keeping with the charitable purposes for which the trusts were established and in recognition of the advantages the trusts enjoy. It acknowledges that each community is unique and its particular health care problems and needs should be examined and the community benefits provided by health care charitable trusts which serve it should be directed toward addressing the issues and concerns of that community. Community involvement in the development of community benefits plans is necessary to make the health care charitable trusts more responsive to the true needs of the community. State oversight of the planning process and public access to the community benefits plans will assure appropriate use of the resources of health care charitable trusts.

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

§ 7:32-d. Definitions.

In this subdivision:

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

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

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

(a) Charity care.

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

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

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

(e) Support of medical research and education and training of health care practitioners.

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

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

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

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

§ 7:32-e. Community Benefits Plans.

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

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

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

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

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

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

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

ensuing year; and

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

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

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

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

§ 7:32-f. Community Needs Assessment.

Every health care charitable trust shall, either alone or in conjunction with other health care charitable trusts in its community, conduct a community needs assessment to assist in determining the activities to be included in its community benefits plan. The needs assessment process shall include consultation with members of the public, community organizations, service providers, and local government officials in the trust's service area, in the identification and prioritization of community needs that the health care charitable trust can address directly, or in collaboration with others. The community needs assessment shall be updated at least every 3 years.

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

§ 7:32-g. Notice to Director of Charitable Trusts and Public; Administrative Fine.

I. Every health care charitable trust shall submit its community benefits plan to the director of charitable trusts on an annual basis no later than 90 days after the start of the trust's fiscal year. The trust and the director of charitable trusts shall make all community benefits plans available to the public and, where practicable, shall place the reports on an internet site or web page. Every health care charitable trust shall at least annually provide notice to the public of the availability and process for obtaining a copy of its community benefits plan and shall prominently display such notice in its lobby, waiting rooms, or other area of public access.

II. An extension of time for filing the community benefits plan may be granted by the director.

III. The director may impose an administrative fine upon a charitable organization that

violates any provision of RSA 7:32-g, I, in an amount not to exceed $1,000 plus attorneys fees and costs for each such violation.

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

§ 7:32-h. Charity Care.

The provision of charity care may be included in a community benefits plan by a health care charitable trust only to the extent that it:

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

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

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

§ 7:32-i. Enforcement.

Nothing in this subdivision shall derogate from authority of the attorney general, or the rights of others, provided by common law or other statute.

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

§ 7:32-j. Exemption. RSA 7:32-j effective until January 1, 2001.

If the total value of the fund balances of a health care charitable trust do not exceed $1,000,000, the trust shall have no obligation to comply with the provisions of this subdivision. In addition, those health care charitable trusts for which compliance would be a financial or administrative burden, according to criteria established and administered by the director of charitable trusts, may request an exemption from the provisions of this subdivision. An exemption, if granted, shall be valid for 3 years from the date of issuance unless it is revoked by the director of charitable trusts and written notice of such revocation is provided to the health care charitable

trust.

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

§ 7:32-j. Exemption. RSA 7:32-j effective January 1, 2001.

If the total value of the fund balances of a health care charitable trust do not exceed $100,000, the trust shall have no obligation to comply with the provisions of this subdivision. In addition, those health care charitable trusts for which compliance would be a financial or administrative burden, according to criteria established and administered by the director of charitable trusts, may request an exemption from the provisions of this subdivision. An exemption, if granted, shall be valid for 3 years from the date of issuance unless it is revoked by the director of charitable trusts and written notice of such revocation is provided to the health care charitable trust.

History

Source. 1999, 312:1, eff. Jan. 1, 2000; 312:2, eff. Jan. 1, 2001.

Amendments—1999. Substituted "$100,000" for "$1,000,000" in the first sentence.

§ 7:32-k. Effect on Eligibility for Property Tax Exemption.

Compliance with this subdivision shall not establish eligibility for a property tax exemption under RSA 72:23, V, but may be considered if relevant to the criteria established in RSA 72:23, RSA 72:23-*l*, and at common law.

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

§ 7:32-l. Combined Needs Assessments, Planning, Reporting.

Health care charitable trusts may satisfy the requirements of RSA 7:32-e, RSA 7:32-f, and RSA 7:32-g, individually or in a combination with other health care charitable trusts, provided that information required to be reported under RSA 7:32-e, V(a) and (b) shall be specifically reported for each health care charitable trust participating in a combined plan or report.

History

Source. 1999, 312:1, eff. Jan. 1, 2000.

APPENDIX II

SAMPLES

Appendix II: Sample Description of Community Programs or Services

Category	Program Name Administrator Title Phone Number Total Number Staff Involved	Target Population Number Served Program Area	Program Goal Time Frame	Community Contact Organization Phone Number Total Community Participants	Assessment Performed? Identified Needs Data/Info Source	Outcomes	Total Expenses ($) Cash ($) Grants($) In Kind ($)	Administrative Costs ($)[1]
Education Information Access Health Screenings	Elders Living at Home Program Matt Siegel Manager, Community Partnerships Staff Involved: 6	Low-income, isolated seniors. Number served: TBD Boston	Place nursing students at community clinics in Boston Housing Authority (BHA) buildings to provide health education, screenings and referral services to low-income, isolated elders. Time: 1 year	Elders Living at Home Program (617) 638-6139 UMASS College of Nursing (617) 287-7500 Boston Housing Authority (617) 292-0340 Participants: 6	Yes - Tufts Health Plan contracted The Medical Foundation in Boston to conduct quantitative research and a series of focus groups with elders and elder caregivers in Boston. Needs assessment indicated significant barriers to health care access for isolated elders.	TBD - program in development stages.	$26,083 $26,083 Grant	$755
Education Information Access Direct Care	SHEA Program Matt Siegel Manager, Community Partnerships Staff Involved: 6	Low-income, isolated seniors. Number served: TBD Boston	Connect Boston elders isolated by language, culture and poverty to health care, health education and health promotion activities. Time: 1 year	Kit Clark Senior Services (617) 825-5000 Boston Housing Authority (617) 292-0340 Participants: 8	Yes - Tufts Health Plan contracted The Medical Foundation in Boston to conduct quantitative research and a series of focus groups with elders and elder caregivers in Boston. Needs assessment indicated significant barriers to health care access for isolated elders.	TBD - program in development stages.	$51,656 $51,656 Grant	$549
Education Volunteerism	Waltham Partnership for Youth Lynn Basilio Community Partnerships Coordinator Staff Involved: 2	Students enrolled in Waltham High School's Bridging Education and Technology Program (BEAT) Number Served: 12 Waltham, MA	Provide career training and guidance to students, many of whom have disabilities. Time: 1997-98 School Year	Waltham Partnership for Youth Lauren Gibbs (781) 893-8858 Participants: 3	School identified students in BEAT Program as in need of career guidance and counseling.	Helped develop overall curriculum and presented to 12 students about career development and training.	$0	$371

[1] Describe methodology utilized in estimating administrative costs.

Category	Program Name Administrator Title Phone Number Total Number Staff Involved	Target Population Number Served Program Area	Program Goal Time Frame	Community Contact Organization Phone Number Total Community Participants	Assessment Performed? Identified Needs Data/Info Source	Outcomes	Total Expenses ($) Cash ($) Grants($) In Kind ($)	Administrative Costs ($)[1]
Grants, Donations, and Scholarships	Matt Siegel Manager, Community Partnerships Staff Involved: 2	A variety of organizations that benefit our target populations including: women and infants, elders and teens. Number served: N/A Massachusetts	Total Corporate Philanthropy contributions to support annual fundraisers and events of various non-profits. Support is generally provided in small amounts.	Various non-profits. See Appendix C for a detailed breakdown of organizations and amounts.	N/A	N/A	$46,466 See Appendix C for a detailed breakdown of organizations and amounts.	N/A
Grants, Donations and Scholarships	Fall 1997 Tufts Health Plan 10K for Women Jacqui DeCourcey Promotions Manager (781) 466-9424 Staff Involved:	Medically underserved women throughout Massachusetts. Number served: N/A Massachusetts	Grant awarded as part of 10K road race to organization that provides free mammograms. Time: 1 year	Mobile Diagnostic Services, Inc. (MDSI) (508) 655-7400 Participants: 3	No formal assessment performed.	General support for MDSI's community-based mammography	$10,000 $10,000 Cash	$55
Grants, Donations and Scholarships	Teen Mini-Grants Matt Siegel Manager, Community Partnerships (781) 466-9490 Staff Involved: 1	Teens from diverse backgrounds from Metro Boston. Number served: TBD Metro Boston	Ten mini grants awarded to teens for youth-initiated health promotion programs. Time: 1 year	Winchester Hospital's Community Health Institute (617) 729-9000 Participants: 2	No formal needs assessment performed.	TBD - grants recently awarded, programs in process.	$1,500 $1,500 Grant	$138

Category	Program Name Administrator Title Phone Number Total Number Staff Involved	Target Population Number Served Program Area	Program Goal Time Frame	Community Contact Organization Phone Number Total Community Participants	Assessment Performed? Identified Needs Data/Info Source	Outcomes	Total Expenses ($) Cash ($) Grants($) In Kind ($)	Administrative Costs ($)[1]
Health Coverage	Rx Fund Matt Siegel Manager, Community Partnerships Staff Involved: 2	Low income, and uninsured patients who cannot afford necessary prescription drugs. Number served: TBD Greater Worcester	Create a fund which volunteer physicians can access when treating an elderly patient who needs prescription drugs but can not afford them. Time: 1 year	Worcester Healthcare Outreach (WHO) (508) 753-6644 Participants: 2	Yes - Demographic assessment of low-income uninsured elders in Worcester area performed by WHO.	TBD - program ongoing.	$10,000 $10,000 Grant	$275
Health Coverage	Fishing Partnership Health Plan (FPHP) Russ Guertin Account Manager (781) 466-1070 x2336 Staff Involved: 20	Uninsured and underinsured individuals and families working in the Massachusetts fishing industry. Number served: open to all within fishing community. Coastal Massachusetts	Provide healthcare coverage to uninsured and underinsured people in the fishing community. Time: Ongoing	The Massachusetts Fishermen's Partnership (MFP) (978) 282-4847 Participants: 10	Yes - "Health Survey of the Fishing Population in Massachusetts" completed by Health Care For All in Nov. 1996. Survey indicated large numbers of uninsured and underinsured individuals as well as family income well below state averages.	Enrollment began Dec. 1, 1997. To date 1,250 total members have enrolled in FPHP. Outreach program to increase enrollment currently underway at MFP.	$103,944 $54,374 Grant $49,570 In Kind	$5492
Health Screening	Stress Profile Kathy Hewes, Health Promotion Specialist (781) 466-9400 x3311 Staff Involved:	Women of diverse backgrounds who reside in neighborhoods and communities served by Carney Hospital. Number served; N/A Dorchester area	Provide information, resources and stress profiles to increase awareness of the benefits of a healthy lifestyle. Time: 1 day	Patient Services at Carney Hospital (617) 296-4000 Participants: N/A	No formal assessment performed.	Participated in one day community health fair.	$460 $460 In Kind	$330

Category	Program Name Administrator Title Phone Number Total Number Staff Involved	Target Population Number Served Program Area	Program Goal Time Frame	Community Contact Organization Phone Number Total Community Participants	Assessment Performed? Identified Needs Data/Info Source	Outcomes	Total Expenses ($) Cash ($) Grants($) In Kind ($)	Administrative Costs ($)[1]
Health Screening	Nutrition Profile at Lowell General Hospital Health Fair Nancy Bastarache Health Promotion (781) 466-2395 Staff Involved: 3	Lowell Residents Number served: N/A Lowell, MA	Raise awareness and educate residents on recommended nutrition and diet. Time: 1 day	Lowell General Hospital's Cancer Center (978) 937-6464 Participants: N/A	No formal assessment performed.	Participated in one day community health fair.	$480 $480 In Kind	$165
Health Screening	Boston Coalition for Adult Immunization Matt Siegel Manager, Community Partnerships Staff Involved: 3	Low-income and underserved elders in the Boston, MA area. Number served: ~4,000 Boston	Increase access to and availability of flu and pneumococcal vaccines among elder population throughout Boston. Time: 2 years	Boston Coalition for Adult Immunization c/o Massachusetts Peer Review Organization (781) 890-0011 Participants: 20	Yes - Assessment conducted by Boston Coalition for Adult Immunization using national studies including those from Centers for Disease Control.	During 1997 season, more than 4,000 flu shots provided at 47 community-based clinics throughout Boston. Health professional students exposed to community health improvement process.	$26,450 $26,450 Grant	$1,030

Summary of Quantifiable Community Benefit Expenditures for 1997

Total *Actual* Operating Expenses in 1997:	$69,577,577	Total *Actual* Uncompensated Care in 1997:	$9,131,935

	Expended in 1997			Budgeted for Fiscal Year 1998		
Community Benefit Program *The following is an accounting of Jordan's **estimated** contribution to collaborative community-based programs to provide free health education and health promotion services in addition to uncompensated care as reported above.*	*Estimated* Gross ***Community Benefit Value***	Grants, Donations, Other Revenue	*Estimated* Net Expenditure	*Estimated* Gross Budget	Anticipated Grants, Donations, Other Revenue	*Estimated* Net Budget
Greater Plymouth AIDS Consortium	$2,052	0	$2,052	$2,000	0	$2,000
HALT Community Partnership *Active Parenting Program*	$16,050	0	$16,050	$18,000	$7,000	$11,000
South Shore Community Partners in Prevention -- CHNA 23	$4,770	0	$4,770	$5,000	0	$5,000
Healthy Massachusetts 2000	$528	0	$528	$600	0	$600
Mother-To-Mother Peer Breast Feeding Support Group	$4,567	$2,100	$2,467	$4,800	$2,100	$2,700
OPERATION: Safe Prom	$1,070	0	$1,070	$1,200	$1,050	$150
Mass*Moves* Project	$654	0	$654	$1,200	0	$1,200
Interfaith Clergy, Mental Health & Substance Abuse Work Group	$455	0	$455	$600	0	$600
Greater Plymouth Human Services Council	$1,500	0	$1,500	$1,500	0	$1,500
Massachusetts Tobacco Control Program Initiative	$30,179	$30,179	0	$40,000	$40,000	0
Totals	$66,825	$32,279	$34,546	$74,900	$50,150	$24,750

	Expended in 1997			Budgeted for Fiscal Year 1998		
Community Service Program *The following is an accounting of Jordan's **estimated** contribution for hospital-based programs to provide free health education, health promotion and screening services in addition to free patient care as reported above.*	*Estimated* Gross ***Community Benefit Value***	Grants, Donations, Other Revenue	*Estimated* Net Expenditure	*Estimated* Gross Budget	Anticipated Grants, Donations, Other Revenue	*Estimated* Net Budget
Breast & Cervical Cancer Screening Program	$150,629	$101,949	$48,680	$152,000	$102,000	$50,000
Massachusetts Well Women Project	$44,059	$44,059	0	$44,000	$44,000	0
Transportation Program/Oncology Clinic	$47,000	0	$47,000	$47,000	0	$47,000
Emergency Advanced Life Support Services Coordination & Greater Plymouth Area Medical Emergency Network	$9,152	0	$9,152	$10,000	0	$10,000
Immunizations/Screenings *(Influenza, Hypertension, Tuberculosis, Hepatitis B, Skin and Prostate Cancer)*	$8,000	0	8,000	$13,400	$5,000	$8,400
Health Information and Referral Services (*JordanCall and Non-Billed Counseling Services)*	$60,000	0	$60,000	$62,000	0	$62,000
Support Groups	$8,000	0	$8,000	$8,000	0	$8,000
Chaplaincy Program and Pastoral Care	$25,000	0	$25,000	$26,000	0	$26,000
Regarding Women Community TV Project	$1,500	0	$1,500	$1,600	0	$1,600
Community Education Program (*includes community health fairs*)	$111,400	$36,584	$74,816	$120,000	$40,000	$80,000
Family Education Program	$59,260	$40,892	$18,368	$60,000	$49,000	$11,000
Volunteer Services*	$708,000	0	$708,000	$708,000	0	$708,000
Medical Resource Library	$1,500	0	$1,500	$1,500	0	$1,500
Totals	$1,233,500	$223,484	$1,010,016	$1,253,500	$240,000	$1,013,500

* This listing represents the estimated value of personnel if services were to be accomplished by additional paid staff. This figure is calculated using an estimated 59,000 volunteer hours of service provided in 1997.

	Expended in 1997			Budgeted for Fiscal Year 1998		
Other Community Contributions *The following is an **estimate** of Jordan staff contributions to the community on behalf of the health system in addition to uncompensated patient care expenses reported above.*	*Estimated* Gross ***Community Benefit Value***	Grants, Donations, Other Revenue	*Estimated* Net Expenditure	*Estimated* Gross Budget	Anticipated Grants, Donations, Other Revenue	*Estimated* Net Budget
Professional Education and Training & Membership in Community Organizations (*includes supervision of nursing students, laboratory, social service, and health education student internships, ACLS training, career fairs, medical & nursing student guest lecturers; board of directors, etc.)*	$30,850	0	$30,850	$32,000	0	$32,000
Donations of Medical Goods and/or Services	$20,494	0	$20,494	$21,000	0	$21,000
Community *Christmas Basket Donation Program*	$12,000	0	$12,000	$12,500	0	$12,500
Totals	$63,344	0	$63,344	$65,500	0	$65,500

Summary of Non-Quantifiable Community Benefits
[NOTE: Must be accompanied by a narrative of the programs and services]

In addition to our community-based partnerships, some of Jordan's ***hospital-based programs*** provide access to free health education, health promotion and screening programs, and support groups and they include:

The Breast & Cervical Cancer Initiative
Transportation Program
Emergency Advanced Life Support Services Coordination
Immunizations/Screening (Influenza, Hypertension, Tuberculosis, Hepatitis B, Skin & Prostate Cancer)
Health Information and Referral Services
Alcoholics Anonymous
Breast Cancer/Cancer
Breastfeeding
Cardiac Rehabilitation
Diabetes
Epilepsy
Fibromyalgia
Chronic Fatigue Immune Dysfunction Syndrome
Impotence
Infant Loss
New Cord (Laryngectomee patients)
Post-Partum Depression
Stroke Club
Widows and Widowers
A Place to Start (Transitional Assistance Program)
Health Care Proxy Information/Education
Regarding Women Cable TV Program
Social Services
The Chaplaincy Program
Financial Counseling
Medical Resource Center

Sylvania Medical Center
Summary of Quantifiable Benefits
For period from 01/01/98 through 12/31/98

4/ 2/98

	Persons Served	Total Expense	Offsetting Revenue	Net Community Benefit	% of Hospital Expenses	% of Hospital Revenues
Traditional Charity Care:	1,500	105,000	3,000	102,000	10.2	6.8
Unpaid Costs of Public Programs:						
Medicare	705	50,000	1,250	48,750	4.8	3.2
Medicaid	275	187,000	45,000	142,000	14.2	9.4
Other Public Programs	75	105,000	10,000	95,000	9.5	6.3
Community Services:						
Nonbilled Services:						
Community Health Educ. and Outreach	1,075	190,088	8,630	181,458	18.1	12.1
Patient Education on Disease Prevention and Homecare	0	0	0	0	0.0	0.0
Other Nonbilled Services	10	1,150	150	1,000	0.1	0.0
Subtotals (Community Services)	**1,085**	**191,238**	**8,780**	**182,458**		
Medical Education:						
Physicians, Nurses, Techs and Other	131	6,968	208	6,760	0.6	0.4
Scholarships/Funding for Health Professionals	0	0	0	0	0.0	0.0
Other Medical Education	0	0	0	0	0.0	0.0
Subtotals (Medical Education)	**131**	**6,968**	**208**	**6,760**		
Subsidized Health Services:						
Emergency and Trauma Care	25	438	13	425	0.0	0.0
Neonatal Intensive Care	50	4,213	1,563	2,650	0.2	0.1
Free-Standing Community Clinics	0	0	0	0	0.0	0.0
Collaborative Efforts in Preventive Medicine	10	563	15	548	0.0	0.0
Other Subsidized Health Services	0	0	0	0	0.0	0.0
Subtotals (Subsidized Services)	**85**	**5,214**	**1,591**	**3,623**		
Research:	50	2,340	138	2,202	0.2	0.1
Cash / Inkind Donations:	75	7,800	3,000	4,800	0.4	0.3
Community Building:	1,006	44,103	2,463	41,640	4.1	2.7
Grand Totals:	**4,987**	**704,663**	**75,430**	**629,233**	**62.9**	**41.9**

4/ 2/98
Sylvania Medical Center
Summary of Community Services
ALL ACTIVITIES
For period from 01/01/98 through 12/31/98

	Low Income	The Broader Community	The Total Community
Number of activities	3	7	10
Persons served	1,135	1,297	2,432
Staff hours	203	194	397
Volunteer hours	47	30	77
Total community benefit expense	193,578	64,085	257,663
Offsetting revenue	8,918	7,262	16,180
Net community benefit expense	184,660	56,823	241,483

Sylvania Medical Center
List of Occurrences
ALL ACTIVITIES
For period from 01/01/98 through 12/31/98

			Persons	Cost
1	**A1**	**Community CPR**		
6/25/98		test	500	1,370
12/31/98		year to date	575	180,088
			1,075	181,458
2	**B1**	**Safe Sitters**		
3/25/98		February Meeting	56	5,680
5/25/98		May meeting	75	1,080
			131	6,760
3	**D**	**CPR Expo**		
5/25/98		april session	50	2,202
			50	2,202
7	**C1**	**Body Recall Program**		
9/15/98		first week of september class	25	425
			25	425
9	**F1**	**Festival of Lights**		
2/15/98		December light show	1,000	41,040
			1,000	41,040
14	**E**	**Creative Imagery**		
4/ 1/98		April meeting	75	4,800
			75	4,800
18	**C2**	**Dining Out Class**		
3/25/98		July get together	50	2,650
			50	2,650
29	**F3**	**VBAC (Vaginal Birth After Cesarean)**		
3/25/98		March lecture	6	600
			6	600
30	**C4**	**Maternity Tours -- TTH and FH**		
2/15/98		February tour	10	548
			10	548
31	**A9**	**Brothers & Sisters & Babies**		
1/15/98		January Meeting	10	1,000
			10	1,000
Grand Totals:			2,432	241,483

Sylvania Medical Center
Summary of Activities by Category
For period from 01/01/98 through 12/31/98

	# of Persons	Expenses	Revenues	Benefit
A - All Nonbilled Services				
A1 - Community Education and Outreach	1,075	190,088	8,630	181,458
A9 - Other	10	1,150	150	1,000
Totals (A - All Nonbilled Services)	**1,085**	**191,238**	**8,780**	**182,458**
B - Medical Education				
B1 - Physicians, Nurses, Techs, Etc.	131	6,968	208	6,760
Totals (B - Medical Education)	**131**	**6,968**	**208**	**6,760**
C - Subsidized Health Services				
C1 - Emergency and Trauma Services	25	438	13	425
C2 - Neonatal Intensive Care	50	4,213	1,563	2,650
C4 - Collaborative Efforts in Preventive Medicine	10	563	15	548
Totals (C - Subsidized Health Services)	**85**	**5,214**	**1,591**	**3,623**
D - Research				
D - RESEARCH (ALL)	50	2,340	138	2,202
Totals (D - Research)	**50**	**2,340**	**138**	**2,202**
E - Cash and Inkind Donations				
E - CASH AND INKIND DONATIONS (ALL)	75	7,800	3,000	4,800
Totals (E - Cash and Inkind Donations)	**75**	**7,800**	**3,000**	**4,800**
F - All Community Building Activities				
F1 - Physical Improvement	1,000	43,440	2,400	41,040
F3 - Support System Enhancements	6	663	63	600
Totals (F - All Community Building Activities)	**1,006**	**44,103**	**2,463**	**41,640**
Grand Totals	**2,432**	**257,663**	**16,180**	**241,483**

COMMUNITY BENEFIT INVENTORY FOR SOCIAL ACCOUNTABILITY (CBISA)

Activity

Community Services
Information Survey Form

Community Service Categories (Choose the ONE BEST FIT / PRIMARY FOCUS)

A. NONBILLED SERVICES
- ☐ A1. Community Education & Outreach
- ☐ A2. Screenings
- ☐ A3. Support Groups
- ☐ A4. Counseling
- ☐ A5. Self-help
- ☐ A6. Immunizations
- ☐ A7. Clinics
- ☐ A8. Patient Education
- ☐ A9. Other

B. MEDICAL EDUCATION
- ☐ B1. Physicians, Nurses, Technicians, etc.
- ☐ B2. Scholarships/Funding for Profession Education
- ☐ B3. Other

C. SUBSIDIZED HEALTH SERVICES
- ☐ C1. Emergency & Trauma Services
- ☐ C2. Neonatal Intensive Care
- ☐ C3. Free-standing Community Clinic
- ☐ C4. Collaborative Efforts in Preventive Medicine
- ☐ C5. Other

☐ D. RESEARCH (ALL)

☐ E. CASH & INKIND DONATIONS (ALL)

F. COMMUNITY BUILDING ACTIVITIES
- ☐ F1. Physical Improvement
- ☐ F2. Economic Development
- ☐ F3. Support System Enhancements
- ☐ F4. Environmental Improvements
- ☐ F5. Leadership Development & Skills Training

Title of Activity: _____

Description: _____

_____

_____

Sponsoring Dept #: _____ Contact Person: _____

Dept. Name: _____ Phone: _____

Objectives: _____

_____

_____

☐ Is this a collaborative effort? If so, who are your partners? _____

_____

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Activity

Community Services
Information Survey Form

☐ Is this activity duplicated in the community?

User Definable Codes
Character: _____ Numeric: _____

☐ Does this activity address an unmet community need?

Outcomes (general): _____

_____

_____

Outcomes (specific):

Outcome Description	Measures: Percent	Measures: Other Numeric
(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____
(4) _____	_____	_____
(5) _____	_____	_____

ACTIVITY SETTING / LOCATION:
- ☐ Inpatient
- ☐ Outpatient
- ☐ In Facility
- ☐ Community (School, community center, mall)
- ☐ Workplace
- ☐ Home
- ☐ Other_____

ACTIVITY FORMAT:
- ☐ Seminars
- ☐ Health Fairs/Screenings
- ☐ Events/Meetings
- ☐ Speaker's Bureau
- ☐ Newsletter
- ☐ TV/Radio
- ☐ Clinic
- ☐ Other _____

SPECIAL NEEDS POPULATION
- ☐ 1. Persons with disabilities
- ☐ 2. Racial, cultural and ethnic minorities
- ☐ 3. Uninsured/underinsured
- ☐ Other_____

County: _____

Estimated # in Targeted Population: _____

Age of Targeted Audience:
- ☐ infants
- ☐ children
- ☐ teens
- ☐ adults
- ☐ seniors
- ☐ all ages

Gender:
- ☐ male
- ☐ female
- ☐ both

Targeted for:
- ☐ poor
- ☐ broader community

----------BUDGETS / EXPECTED RESULTS FOR FISCAL YEAR----------

Budgeted persons served: _____ Budgeted Staff Hours: _____ Budgeted Volunteer Hours: _____

Budgeted Total Expense:_____ Budgeted Offsetting Revenue & Support: _____

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Health Concerns

Community Services
Information Survey Form

"Healthy People 2000" Health Concerns

PUT A CHECK MARK BY EACH HEALTH ISSUE THAT THIS ACTIVITY ADDRESSES:

ADDICTIONS
- ☐ Alcohol
- ☐ Drug Abuse
- ☐ Tobacco
- ☐ Other _____

CANCER
- ☐ Breast
- ☐ Cervical
- ☐ Colorectal
- ☐ Lung
- ☐ Prostate
- ☐ Skin
- ☐ Other _____

CARDIOVASCULAR — Group I
- ☐ Blood Pressure
- ☐ Cardiac Rehab
- ☐ Cholesterol
- ☐ Stroke
- ☐ Other _____

CHRONIC DISEASES
- ☐ Alzheimers
- ☐ Arthritis
- ☐ Diabetes
- ☐ Hemophilia
- ☐ Inflammatory Bowel
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Other _____

ENVIRONMENTAL HEALTH
- ☐ Environmental Health

FAMILY / CHILDREN
- ☐ Childbirth
- ☐ Genetic Counseling
- ☐ Other _____

INFECTIOUS DISEASES
- ☐ Hepatitis
- ☐ HIV
- ☐ Influenza
- ☐ Measles/Rubella
- ☐ Sexually Transmitted Diseases
- ☐ Other _____

OCCUPATIONAL HEALTH & SAFETY — Group II
- ☐ Occupational Health & Safety

MENTAL HEALTH
- ☐ Anxiety/Panic Disorders
- ☐ Compulsive Behavior Disorders
- ☐ Depression
- ☐ Grief
- ☐ Stress Management
- ☐ Suicide
- ☐ Violent/Abusive Behavior
- ☐ Other _____

NUTRITION
- ☐ Nutrition
- ☐ Eating Disorders/Weight Loss
- ☐ Other _____

PHYSICAL ACTIVITY / FITNESS
- ☐ Aerobics
- ☐ Biking
- ☐ Exercise
- ☐ Mall Walking
- ☐ Run
- ☐ Other _____

PULMONARY
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Other _____

SAFETY / FIRST AID — Group III
- ☐ Burn Prevention
- ☐ Driving Safety
- ☐ Fall Prevention
- ☐ Poison Control
- ☐ Prescription Drug Use
- ☐ Other _____

OTHER
- ☐ Head/Spinal Cord
- ☐ Hearing
- ☐ Oral Health
- ☐ Vision
- ☐ Other _____

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Health Goals

Community Services
Information Survey Form

Group I — HEALTH PROMOTION

- ☐ 1. Promote Physical Activity & Fitness
- ☐ 2. Promote Nutrition
- ☐ 3. Reduce Tobacco Use
- ☐ 4. Reduce Use of Alcohol & Other Drugs
- ☐ 5. Promote Family Planning
- ☐ 6. Improve Mental Health & Reduce Mental Disorders
- ☐ 7. Reduce Violent & Abusive Behavior
- ☐ 8. Promote Education & Community-Based Programs

Other _____

_____

Group II — HEALTH PROTECTION

- ☐ 1. Reduce Unintentional Injuries
- ☐ 2. Improve Occupational Safety
- ☐ 3. Improve Environmental Health
- ☐ 4. Improve Food & Drug Safety
- ☐ 5. Improve Oral Health

Other _____

_____

Group III — PREVENTIVE SERVICES

- ☐ 1. Improve Maternal and Infant Health
- ☐ 2. Prevent Heart Disease and Stroke
- ☐ 3. Prevent Cancer
- ☐ 4. Prevent Diabetes and Chronic Disabling Conditions
- ☐ 5. Prevent HIV Infection
- ☐ 6. Prevent Sexually Transmitted Diseases
- ☐ 7. Prevent Infectious Diseases
- ☐ 8. Provide Clinical Preventive Services

Other _____

_____

Group IV — Other _____

_____

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Occurrence

Community Services
Information Survey Form

Date: ____/____/____ Title of Activity: _____

Brief description: _____

Sponsoring Dept. #:_____ Persons Served:_____ Total Staff Hrs (Paid & Volunteer): _____

Volunteer Hrs (non-staff): _____

EXPENSES

Salaries (enter line A-dollars or B-hours):
A.) Dollars .....$ _____
B.) Paid Staff Hours _____

Purchased Services.....$ _____

Supplies.....$ _____

Other Direct Expenses.....$ _____

Indirect Expenses.....$ _____

FUNDING & OFFSETTING REVENUE

Foundation / Fundraising.....$ _____

Grants / Support.....Source of grant: _____.....$ _____

Fees.....$ _____

Other (voluntary contributions, etc.).....$ _____

END OF DATA ENTRY

Form completed by:

Name / Phone:_____ Date:_____

Department Name: _____ Dept #:_____

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APPENDIX III

APPLICATION FOR EXTENSION OF TIME

TO FILE COMMUNITY BENEFITS PLAN

Department of the Attorney General, Charitable Trusts Unit
33 Capitol Street
Concord, NH 03301-6397

Telephone: 603-271-3591
Fax: 603-271-2110

APPLICATION FOR EXTENSION OF TIME TO FILE COMMUNITY BENEFITS PLAN

This application for extension of time must be received on or before the due date of the community benefits plan in order to be accepted.

NAME OF ORGANIZATION: _____
CURRENT ADDRESS: _____
STATE REGISTRATION NUMBER: _____

COMPLETE THE FOLLOWING

I REQUEST AN EXTENSION OF TIME UNTIL: _____

DATE OF FISCAL YEAR END: _____

REASON FOR EXTENSION (attach additional sheets if necessary):

Date: _____ **By:** _____
Title: _____
Phone #: _____

FAILURE TO FILE THE COMMUNITY BENEFITS PLAN WITH THE ATTORNEY GENERAL IN A TIMELY MANNER MAY RESULT IN COURT ACTION AND THE IMPOSITION OF CIVIL PENALTIES OF UP TO $1,000 PER VIOLATION PLUS ATTORNEYS FEES AND COSTS (RSA 7:32-g III)

APPENDIX IV

RESOURCES

RESOURCES

The Community Health Assessment – Guidelines for New Hampshire Health Charities
Kevin Barnett and Bruce Spitz (attached)

Data for Community Focused Research – Office of Planning and Research, New Hampshire Department of Health and Human Services (December, 1999) (attached)

A Community Development Approach to Community Needs Assessment, July 1994, Funded by The New Hampshire Division of Public Health Services under a grant from the Robert Wood Johnson Foundation Practice Sights Initiative (available for review at each of the nonprofit hospitals, the State Library in Concord, the Department of Health and Human Services, Office of Community and Public Health, and the Department of the Attorney General, Charitable Trusts Unit)

The Community Health Assessment
Guidelines for New Hampshire Health Charities

Purpose

1. To identify health, economic, and social indicators of health, with an emphasis on illuminating disproportionate unmet health-related needs.

2. To identify existing community assets that serve as entry points in the design of interventions to address health-related needs in a cost-effective and sustainable manner.

3. To provide a means to build partnerships with the full spectrum of community stakeholders.

A. Assessing Community Health "Deficits"

1. **Secondary Data Collection** - There is a wealth of existing data collected by public and private sector agencies available for use in the identification of disproportionate unmet health needs. Examples include census data, county health statistics, hospital discharge data, crime data, and agency surveys (e.g., section 330 clinics, foundations). This information should be the starting point for the assessment, and *in most cases is sufficient to identify disproportionate unmet health needs in a particular target community.*

2. **Primary Data Collection** - In some cases, a review of secondary data may illuminate significant gaps in information that are necessary to identify unmet health needs. It may be appropriate to conduct some form of primary data collection to provide a more complete assessment. Common forms of primary data collection include surveys, focus groups, key informant interviews, or town hall meetings.

Focus groups, key informant interviews, and town hall meetings represent the most frequently employed methods to solicit normative information (i.e., personal opinions) from community stakeholders. Of equal importance, *these methods provide a means for increasing public awareness and facilitating broad engagement in health improvement initiatives.*

If a more formal survey is determined to be necessary, it is important to mobilize external resources such as academic institutions and public health agencies who possess the expertise, and in some cases the legal responsibility to assess the health of the community. It is often appropriate for health charities within a particular geographic region to pool resources for a common process. *Surveys can be costly, and it is important to reserve the maximum volume of charitable resources to address unmet health needs.*

B. Assessing Community Health "Assets"

This component of the assessment is essential to identify resources in the community that may serve as entry points for health improvement program activities. In this manner, health charities can invest resources strategically to address health-related needs in a community by enhancing the efficacy of existing agencies and community groups. This is accomplished by investing financial and in-kind resources, providing technical assistance, or designing complementary programmatic activities.

1. **Organizational/Institutional Outreach** - Identify existing program activities, target areas and

populations, active participants, decision making bodies, and program goals and objectives.

a. County departments (e.g., public health, social services, economic development)
b. City departments (e.g., police, probation, parks & recreation, economic development)
c. Academic institutions (e.g., k-12, community colleges, vocational schools, universities)
d. Religious organizations
e. Community-based service organizations
f. Community advocacy/interest organizations
g. Local business (e.g., chamber of commerce, merchants associations)

2. **Community Member Outreach** - This component is essential for the development of programs that seek involve community members on an ongoing basis for program development, implementation, monitoring, and governance. Particular care should be taken to solicit information (and participation) from all representative members of communities in terms of age, gender, culture and ethnicity.

a. Community member professional skills
b. Community member personal skills/capacities
c. Support groups (e.g., neighborhood watch, disaster preparedness groups)
d. Informal support systems (e.g., child care, transportation arrangements)
e. Historical repository (e.g., longtime residents).

3. **Community Physical Infrastructure** - An important part of building a healthy environment is the effective use of physical space in local communities as a focal point for activities. This often involves the transformation of property and buildings that may have previously exemplified a lack of civic vitality.

a. Available space (e.g., vacant buildings, lots)
b. Inherent advantages (e.g., locational issues, layout - convertibility)

C. Assessing Health Charity "Assets"

Health charities should conduct a parallel assessment and mobilization of internal "assets" to facilitate optimal engagement, impact, and sustainability.

1. Staff resources

a. Existing expertise and interest in participation
b. Organizational affiliations and knowledge of particular communities

2. Existing programs and procedures

a. Identify current program content focus, target(s), resources, and objectives
b. Review current mission, operating procedures relevant to community benefit goals.

3. Leadership development

a. Develop framework for CEO, CFO, and trustee involvement
b. Conduct presentations and trainings with medical and administrative staff

Data for Community-Focused Research

A Working Inventory with References to Other Relevant Data

Developed by the Office of Planning and Research
New Hampshire Department of Health and Human Services

For the Kids Cabinet Data Subcommittee

January, 2000
(Rev 6)

Introduction

Increasingly, attention within communities is being focused on data at the sub-state level in trying to understand the differences in the needs - and the resources to meet those needs - for diverse populations.

Community assessments focused on identifying the health and social services needs of the young and the elderly, access to care for the low income, or meeting the needs of culturally diverse minorities, requires both data at the local level and a context for its analysis. The growing consensus is that the best data is, at least, community-level data, if not data at the postal zip code level or US Census tract-level, balanced with data at 'regional,' state and national levels.

This 'user's guide' to readily available community-level data, and other data potentially useful for providing context and perspective, was developed as part of the Kids Cabinet Data Subcommittee work as a means of simplifying the discovery process for individuals not familiar with data available across a wide spectrum of sources. It is by no means complete and it makes no judgements about the usefulness or accuracy of the data. ***Each data user needs to seek out the 'fine print' that underlies each data element to understand their appropriateness for a given line of research.***

There are three major sections to this inventory:

- Data that are available in print;
- Data that are available electronically for downloading and subsequent manipulation; and
- Data that are electronically displayed.

Each section includes, in *ITALICS*, data sources, though not at a community level, that may prove useful to research: county level and other aggregations of data are sometimes all that are available for some indicators. They may also be the level at which the data is most useful or reliable, given the size of the numbers.

A fourth section has been included to provide researchers with a cursory understanding of data and information that may be useful in providing context or perspective in their work. These are, generally, higher-level data sources that present state and national data and, frequently, analysis.

The final section is a compendium of some of the indicators developed as part of the Community Health Information System, created by the Center for Health Policy Studies at the School of Public Health, University of Texas/Houston, and the Episcopal Health Charities of Texas. These are provided to assist communities in the development of a systematic approach to using available data.

There is a wealth of data available to the researcher, especially for those with access to the Internet. An effort will be made to keep this 'guide' current and usable. Comments on changes, additions, corrections and deletions would be greatly appreciated and may be sent to John D. Bonds, Office of Planning and Research, NH DHHS, 129 Pleasant Street, Concord, NH (jbonds@dhhs.state.nh.us).

Community-Based Data and Other Data Relevant to Community-Focused Research

Material in *Italics* provide aggregated data at a level above the community level and are useful to community planners, particularly where low numbers handicap research at the community level.

Data Available In Print

*A1	1999 New Hampshire Community Profiles	SOICC of New Hampshire, 228-3349 (Maintaining this resource has been recently assigned to the New Hampshire Employment Security (NHES))
*A2	New Hampshire Vital Statistics Report 1992-1997 *The 1997 Vital Statistics Annual Report is due out in February 2000.*	NH DHHS, Office of Community and Public Health (OCPH), Health Statistics and Data Management, 1-800-852-3345, x4671 (For years prior to 1992, check for the availability of/access to the Vital Statistics Annual Reports or see their Web site, below, for further information)
A3	1998 Kids Count New Hampshire	Children's Alliance of New Hampshire 225-2264 (Check with the Children's Alliance for the availability of/access to the 1995 and 1996 Kids Count New Hampshire Reports, and for copies of the national Kids Count Data Books, discussed below)
*A4	1997 County Profile *Related materials from the same agency are the annual Vital Signs report, which also provides a variety of data at the State level*	NHES, 224-3311 Includes community-level data (An annual publication. Check for availability of reports from prior years. Earlier years may also be available electronically at the NHES Web Address given below. This source also has a wealth of other information at its Web site.)
*A5	1998 Population Estimates of New Hampshire Cities and Towns	New Hampshire Office of State Planning (NHOSP), 271-2155 (Population estimates are also available for prior years and have been projected, at the county level, through 2020. Check the Web Address below or contact OSP directly)
*A6	*Primary Care Data Set, 1993-1997*	NH DHHS, OCPH, Health Statistics 1-800-852-3345, x4671 • The 1990-1994 Edition is available electronically. See C4 below • The 1993-1997 Edition is available electronically, See C6 below
*A7	*Communicable Diseases in New Hampshire, 1997 Annual Report*	NH DHHS, OCPH, Communicable Disease Surveillance 1-800-852-3345 x0279

* = Also available electronically

	Downloadable Data Files	
B1	Selected Characteristics of New Hampshire Municipalities (DBF format)	NHOSP http://www.state.nh.us/osp/planning/guide/docs/muni.html
B2	Selected Tax Data for New Hampshire Municipalities (DBF format)	NHOSP http://www.state.nh.us/osp/planning/guide/docs/taxdbf.html
B3	Unemployment Rates for New Hampshire Cities and Towns (7/98, 6/99 and 7/99))	NHES, ELMIB http://www.nhworks.state.nh.us/elmi/c&t_laus.htm
B4	*Local Area Unemployment Statistics*	NHES, ELMIB http://www.nhworks.state.nh.us/elmi/laus.htm
	Data Electronically Displayed	
C1	New Hampshire Resource Net (State Data Center)	NHOSP http://www.state.nh.us/osp/planning/sdc.html
	• Population Estimates	
	1998 NHOSP Population Estimates for NH Cities and Towns	*Also available by County by age, race and sex and a special table for the State by age and sex for 1998 only*
	Historical Estimates (70-79, 80-89, 90-98)	
	1997 Estimate of Population by Age, Sex, Race and Hispanic Origin for New Hampshire and Counties	
	• Housing Data	
	Residential Rental Cost Surveys, 1997 and 1998	Via link to the NH Housing Finance Authority. Requires Adobe Acrobat Reader (free from numerous Web locations – Available at the Web Address given in C6, below). Very slow to download
	• Economic Data	
	Unemployment Rates for New Hampshire Cities and Towns	Via link to NHES, ELMI (Also available as a .zip file)
	Per Capita Income by County 1990-97	
	Median Household Income by County, 1995	
	Median Income of Households by State, 1996	Via link to US Census
	Poverty Data by County	Based on work by the US Census
	➢ *County Estimate of Related Children 5-17, 1995*	
	➢ *County Estimate for People <18 in Poverty, 1995*	
	➢ *County Estimate for People of All Ages in Poverty, 1995*	
	Additional Poverty Data	Via link to US Census and CPS
	Consumer Price Index	Via link to US Bureau of Labor Statistics

- Tax Data
  Equalized Municipal Tax Rate, 88, 93, 98
  Equalized Taxable Valuation per Resident, 80, 90, 98

C2 1999 New Hampshire Community Profiles — NHOSP
http://www.state.nh.us/osp/planning/sdc.html

C3 Economic & Labor Market Information — NHES
http://www.nhworks.state.nh.us/lmipage.htm

- Unemployment Statistics

  Local Area Unemployment Statistics
  Unemployment Rates for New Hampshire Cities and Towns (7/98, 6/99 and 7/99))
- Wages and Benefits
  1996 New Hampshire State & Metropolitan Area Wages
  1996 New Hampshire Nonmetropolitan Area Wages
- Employment Levels
  Firms by Size Within Each County, 3/97

C4 Population Health Data — Dartmouth Medical School, Area Health Education Center
http://www.dartmouth.edu/~ahechome/popdataindex.htm

- *Primary Care Data, 1990-1994* — The previous iteration, by State, County and Hospital Service Area. See C6, below, for the Web Address to the 1993-1997 Edition.

C5 Education Reports and Statistics — NH Department of Education
http://webster.state.nh.us/doe/Reports%20and%20Statistics/reports.htm

Assessment Test Results (NHEIAP), 1998
Cost per Pupils by District, 1996-7, 1997-8
Drop Out Data
Fall Enrollment K-12 Totals, 1997
Property Tax Assessment & School Tax Rates, 1997
Student Teacher Ratio, 1997-8
Teacher Average Salary, 1997-8

C6 Health Statistics — NH DHHS, OCPH
http://www.dhhs.state.nh.us/healthstats

- Population Data — Population data from OSP. Also links with OSP for other data
- Vital Statistics, 1993-1997 — The 1997 Vital Statistics Annual Report is to be released in February 2000

Summary by County, Most Recent Year — Table form

	Births by County and Town, 1992-1996	Table form
	Deaths by County and Town, 1992-1996	Table form
	Death Rates for Selected Causes of Death (Age Adjusted), 1996	Table form
	Marriages by County and Town, 1993-1997	Table form
	Divorces by County, 1993-1997	Table form
	• Reports	All in PDF format. Requires Adobe Acrobat Reader, available for download at this address
	Primary Care Access Data, 1993-1997	Tables and graphs at the State and Hospital Service Area level for a variety of indicators
	Vital Statistics Report, 1992-1997	The full report contains much more than the tables listed above
	Cancer in New Hampshire	For 1995 and 1996, via link to the New Hampshire Cancer Registry at the Norris Cotton Cancer Center, Hanover, NH. The 1997 report is available only in print at this date. See information at the Health Statistics Web Address, above.
C7	Communicable disease data	NH DHHS, OCPH http://www.dhhs.state.nh.us/nhcdcs Select the "Statistics and Reports" link
	Annual Report, 1997	Information available on a wide range of communicable diseases
	Bulletins and other Reports	More recent information on specific topics

Other Potentially Useful Data

Two useful sources for data on risk behaviors, among adults and youth, are the Behavioral Risk Factor Surveillance Survey (BRFSS) and the Youth Risk Behavior Survey (YRBS). Both are conducted in New Hampshire by different state agencies.

- For the BRFSS, contact the Office of Community and Public Health (271-7812 or lpowers@dhhs.state.nh.us) for the Behavioral Risk Factor Surveillance for New Hampshire Adults: Selected Survey Results, 1991-1995. The 1997 results are to be released soon.
- Contact the Department of Education (271-3888 or jjohnson@ed.state.nh.us) for the 1997 New Hampshire State Department of Education Youth Risk Behavior Survey Report. (Reports from prior years are potentially available from both sources.) The 1999 YRBS results are available on the Internet at http://webster.state.nh.us/doe/ by following the links the 1999 Youth Risk Behavior Survey results.

The federal Centers for Disease Control and Prevention is the national sponsoring agency for both surveys and the state and national results, as well as descriptions of the surveys, are available at http://www.cdc.gov/scientific.htm by selecting the surveys by title, listed in the Surveillance section.

CDC also sponsors "CDC Wonder," a database and tool box useful for health planners, and the National Center for Health Statistics, which has a wealth of data and information. Both of these can be accessed on the Internet at the same address as given above.

The Office of Planning and Research, NHDHHS, has released the first report in a series of reports on health insurance Coverage Survey. The "Results from the New Hampshire Health Insurance Coverage and Access Survey" and the two page issue brief is available from the Internet at is available http://www.dhhs.state.nh.us/Planning/HlthCSys.nsf/vMain?Openview by following the Health Insurance Survey links.

The US Census has a wide variety of data available, especially via the Internet. Much of it can be structured by the user (identify the years, identify the communities, identify the variables, etc). Public libraries have text copies of the reports and much of the 1990 data is available on CD-ROM. Electronically, use:
http://www.census.gov/ or http://factfinder.census.gov/java_prod/dads.ui.homePage.HomePage.

The US Census also does the "Statistical Abstract of the United States" which includes the "County and City Data Book" for cities and counties with population over 25,000, and the "State Profiles." The Internet address is http://www.census.gov/statab/www.

Findings from the Current Population Survey, which produces a variety of information on health (including health insurance), economic, and employment conditions, with significant caveats for use and interpretation, especially given the sample size for New Hampshire, are available at http://www.bls.census.gov/cps/cpsmain.htm.

The Urban Institute, a Washington, D.C.-based think tank, has produced, as part of its Assessing New Federalism initiative, a downloadable database that covers a spectrum of health, social, economic and demographic data. It can be located by selecting the State Database button at http://newfederalism.urban.org/. The Urban Institute also publishes the "State Level Databook on Health Care Access and Financing." It can be ordered from their publications link at their Web site, or by contacting the University Press of America, 4720 Boston Way, Lanham, MD 20706 (800) 462-6420.

Another useful source for national statistics that compares states on different measures is Morgan Quitno. They annually publish the "State Rankings," the "Health Care State Rankings" and the "Crime State Rankings." They also have produced quarterly statistical trends and have developed a statistical trend for each state. These publications are particularly useful in that they routinely glean the most current data from a wide variety of primary data sources, which are clearly identified and which often prove useful to delving deeper into particular issue areas. Contact Morgan Quitno Press, 512 East 9th Street, PO Box 1656, Lawrence, KS 66044-8657 (1-800-457-0742). Information is also available at their Web site: http://www.morganquitno.com.

A number of other non-governmental organizations produce a wealth of useful data and information. These include the Center on Budget and Policy Priorities, at http://www.cbpp.org which produces the annual state-by-state income trend analysis, and the Anne E. Casey Foundation, which produces the annual "Kids Count Data Book," which displays data on a number of measures for each state and the nation. The electronic, interactive, version of the book is available at http://www.aecf.org/kidscount/kc1999/.

Potential Indicators for Community Health and Well-Being

A good source of information on indicators, as well as on the conduct of needs assessments in general, is the electronic Community Health Information System that has been developed by the Center for Health Policy Studies at the University of Texas, Houston, School of Public Health and the Episcopal Health Charities. The Community Health Information System is available at http://www.sph.uth.tmc.edu:8051/. The indicators section, in particular, provides a short and clear criteria discussion for selection of indicators, a comprehensive listing of indicators, and a conceptual model for their consideration and use. The indicators are grouped according to sources, which include

- Population Health Measures
- The Centers for Disease Control - "Consensus Set of Health Indicators for the General Assessment of Community Health Status - United States,"
- Institute of Medicine - Improving Health in the Community - Proposed Indicators for a Community Health Profile
- Amenable Conditions - Preventable Mortality
- Healthy Cities' Measures of Community Well-Being
- Vulnerable Populations
- Institute of Medicine -- Access Indicators
- APEXPH -- Part II -- The Community Process -- Health Data
- HEDIS 3.0 Reporting Set Measures

The following pages presents the indicators drawn from five of these nine sets.

The Community Health Information System is particularly valuable for its broad focus. In addition to material on indicators and measures, assistance is provided for "Assets Mapping." Traditionally, the community needs assessment process focuses on only a single dimension – identification of needs, deficiencies and problems. Assets mapping can enhance that approach by providing a balance. It has also been used as a stand-alone process. Assets mapping focuses on a developing a profile of a community's capacities and resources. The Community Health Information System seeks to combine the two approaches into a single strategy that links needs to community assets. This resource is available on the Internet at the above Web address by selecting the "Assets" button.

Capacity-focused assets mapping emphasizes the development of policies and activities based on the capacities, skills and assets of people and their neighborhoods. Community development takes place when people are committed to investing themselves and their resources in the effort. Furthermore, in a time of budget constraint at all levels, and growing competition for federal and private foundation funding, the prospect for outside assistance is waning.

This electronic resource was developed by Carl H. Slater, MD, Associate Professor, Health Services Organization, University of Texas School of Public Health, Houston, Texas.

The Centers for Disease Control - "Consensus Set of Health Indicators for the General Assessment of Community Health Status - United States"

The Centers for Disease Control, catalyzed by Healthy People 2000 Objectives, convened a panel of experts in public health and developed a consensus set of 18 health status indicators "to assist communities in assessing their general health status and in focusing local, state, and national efforts in tracking the year 2000 objectives" (MMWR, 40, 27:449). Their list is as follows:

- Infant mortality rate per 1,000 live births
- Total deaths per 100,000 population
- Motor vehicle crash deaths per 100,000 population
- Work-related injury deaths per 100,000 population
- Suicides per 100,000 population
- Homicides per 100,000 population
- Lung cancer deaths per 100,000 population
- Female breast cancer deaths per 100,000 population
- Cardiovascular disease deaths per 100,000 population
- Reported incidence (per 100,000 population)
  - AIDS
  - Measles
  - Tuberculosis
  - Primary & secondary syphilis
- Percent of low birth weight infants
- Percent of mothers not receiving prenatal care in the first trimester
- Percent of children under 15 living in families at or below the poverty level
- Percent of people living in counties exceeding EPA standards for air quality

Subsequent to the development of this list of indicators, the National Center for Health Statistics specified the data sources, rationale, and latest national rates for each of the 18 indicators (NCHS, 1992). The Healthy People 2000 Review, 1993, provides updated national rates for each of the 18 indicators.

Institute of Medicine - Improving Health in the Community, 1997 Proposed Indicators for a Community Health Profile

Sociodemographic Characteristics

- Distribution of the population by age and race/ethnicity
- Number and proportion of persons in groups such as migrants, homeless, or the non-English speaking, for whom access to community services and resources may be a concern
- Number and proportion of persons aged 25 and older with less than a high school education
- Ratio of the number of students graduating from high school to the number of students who entered 9th grade three years previously
- Median household income
- Proportion of children less than 15 years of age living in families at or below the poverty level
- Unemployment rate

- Number and proportion of single-parent families
- Number and proportion of persons without health insurance

Health Status

- Infant mortality rate by race/ethnicity
- Numbers of deaths or age-adjusted death rates for motor vehicle crashes, work-related injuries, suicide, homicide, lung cancer, breast cancer, cardiovascular diseases, and all causes, by age, race, and gender as appropriate
- Reported incidence of AIDS, measles, tuberculosis, and primary and secondary syphilis, by age, race, and gender as appropriate
- Births to adolescents (ages 10-17) as a proportion of total live births
- Number and rate of confirmed abuse and neglect cases among children

Health Risk Factors

- Proportion of 2-year-old children who have received all age-appropriate vaccines, as recommended by the Advisory Committee on Immunization Practices
- Proportion of adults aged 65 and older who have ever been immunized for pneumococcal pneumonia: proportion who have been Immunized in the past 12 months for influenza
- Proportion of the population who smoke. by age, race, and gender as appropriate
- Proportion of the population aged 18 and older who are obese
- Number and type of U.S. Environmental Protection Agency air quality standards not met
- Proportion of assessed rivers. lakes. and estuaries that support beneficial uses (e.g.. fishing and swimming approved)

Health Care Resource Consumption

- Per capita health care spending for Medicare beneficiaries (the Medicare adjusted average per capita cost [AAPCC])

Functional Status

- Proportion of adults reporting that their general health is good to excellent
- During the past 30 days, average number of days for which adults report that their physical or mental health was not good

Quality of Life

- Proportion of adults satisfied with the health care system in the community
- Proportion of persons satisfied with the quality of life in the community

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Healthy Cities' Measures of Community Well-Being

The Healthy Cities initiative, which has followed the World Health Organization "Health for All by the Year 2000," has triggered interest and activity in the development of what would be called measures of community well-being. There is no consensus, nor is that the intent of the Healthy Cities initiative, on a set of community well-being measures. Each city is expected, through a broad-based, participative approach, to develop their own list of indicators. The U.S. Health Corporation has, however, attempted to facilitate this process by developing a "Healthy Community Assessment: Standard Indicators Menu." This "Menu" identifies 11 indicator areas and for each of them provides a menu of possible indicators. They have also taken the additional step of specifying "Basic Need Indicators," which might be interpreted as a minimum list for all

to consider, somewhat analogous to the CDC indicator list for the U.S. The 11 areas with the Basic Need Indicators, as well as some alternatives, are listed below:

Natural Environment
- Days with air quality in good range

Health Status
- % without health insurance
- % without emergency medical transport
- Infant mortality rate
- % low birth weight ratio

Food
- % reporting hunger
- % using food banks

Education
- % functionally illiterate adults

Economy
- Unemployment rate/# fulltime equivalent jobs
- Poverty/Equity
- % children living below poverty line
- Gini coefficient/distribution of income class

Housing
- Homeless rate
- Census of soup lines

Arts/Culture/Recreation
- City financial support per capita

Transportation
- % people commuting less than 25 minutes

Community Safety
- % people feeling safe walking alone at night
- % people reporting being victim of crime

Social Environment
- % people reporting less than 5 social contacts per week

Government/Politics
- % people registered who vote in municipal elections

Built Environment
- Perceived annoyance/urban stress index

Institute of Medicine - Access to Health Care in America, 1993

Promoting successful birth outcomes
- Percentage of pregnant women obtaining adequate care (u)*
- Children who die before first birthday (per 1,000 live births) (o)
- Percentage of infants born weighing less than 2,500 grams (o)
- Congenial syphilis cases per 100,000 population (o)

Reducing the incidence of vaccine-preventable childhood diseases
- Percentage of preschool children vaccinated (u)
- Incidence of preventable childhood communicable diseases (diphtheria, measles, mumps, pertussis, polio, rubella, and tetanus) cases per 100,000 population (o)

Early detection and diagnosis of treatable diseases
- Percentage of women undergoing procedure in given period (u)
  - Clinical breast exam
  - Mammogram
  - Pap test

- Percentage of tumors diagnosed at late stages (o)
  - Breast cancer
  - Cervical cancer

Reducing the effects of chronic diseases and prolonging life

- Average number of physician contacts annually by those in fair to poor health; proportion with no physician contacts in previous year (u)
- Admissions for referral-sensitive surgeries (u)
- Admissions for ambulatory-care-sensitive chronic conditions (o)
- Number of deaths per 100,000 population estimated to be due to access problems (o)

Reducing morbidity and pain through timely and appropriate treatment

- Percentage of individuals with acute illness who have no physician contact (u)
- Average number of dental visits per year (u)
- Admissions for ambulatory-care-sensitive conditions (o)

(u) utilization; (o) outcome.

APEXPH (Assessment Protocol for Excellence in Public Health) -- Part II -- The Community Process -- Health Data

Developed by the Centers for Disease Control and Prevention (USDHHS, CDC), and the National Association of City and Community Health Officials (NACCO).

Demographic profile: age and sex

- Male, Female, Total
- Age less than 1, 1-14, 15-24, 25- 44, 45- 64, 65- 74, 75& older, Total

Socioeconomic profile

- Percent of population below poverty level
- Percent of population unemployed
- Number of Food Stamp recipients
- Number of persons in the WIC program
- Number of Medicaid recipients
- Estimated number of homeless persons
- Percent with less than a high school education
- Percent with less than a college education
- Percent with a college or higher level of education

Demographic profile: race/ethnic distribution

Years of potential life lost (YPLL)

Access to primary health care profile

- Private providers
- Community and migrant health care centers
- Local health department
- Other sources
- Uninsured/underinsured

Occupational health and safety

- Work-related Injuries - Deaths
- Work-related Injuries - Nonfatal
- Cumulative Trauma Disorders
- Occupational Skin Disorders
- Occupational Disease (e.g., Hepatitis B)

Substance abuse

- Alcohol-related Accidents – Deaths
- Alcohol-related Accidents - Nonfatal
- Cirrhosis Deaths
- Drug-related Deaths
- Drug Abuse Emergency Room Visits
- Lung Cancer Deaths
- Current Smokers

Mental health/ mental retardation

- Suicides
- Teenage Suicides
- Child and Adolescent Mental Disorders
- Adult Mental Disorders
- Stress-related Health Effects
- Serious Mental Retardation - School-aged Children
- Serious Mental Retardation - Noninstitutionalized Population

Other risk factors

- Not Using Seat Belt
- Overweight
- Sedentary Lifestyle
- Ever Had Cholesterol Checked
- Diagnosed with Diabetes
- Being Treated for Hypertension
- Current Smokers

Perinatal indicators:
Live Births

- All ages
- Maternal age <18 years

Prenatal Care of Women

- First care in 3rd trimester
- Fewer than seven prenatal visits

Low Body Weight Live Births

- <2500 grams (low birth weight)
- <1500 grams (very low birth weight)

Live Births with Mortality or Birth Defects

- Perinatal mortality
- Fetal mortality
- Neonatal mortality
- Congenital anomalies

Other health indicators:
Leading causes of mortality

Estimated prevalence of disease

Leading causes of hospitalization

Environmental Profile

- Air Pollutants
- Water Contaminants
- Food Contaminants
- Land Pollution [human and industrial waste, pesticides, etc.]
- Other environmental hazards including work environment or conditions, radiation, climate, etc

Reaching out to neighbors

a celebration of innovative hospital-community initiatives

New Hampshire Hospital Association

To our community of hospital trustees

Congratulations!

At the end of a century of caring for families, friends and neighbors, your hospitals will set high water marks of accomplishment and community benefit as leading charitable and public service organizations in communities throughout New Hampshire. That's the wonderful legacy of decades of local, volunteer trustee leadership.

Few institutions impact people's lives in more personal or profound ways than hospitals. Journalist Charles Kuralt put it this way: "There is a precious tie that has lasted down through the years between towns and their hospitals. The very existence of hospitals is a promise that says, 'We're there when you need us.'"

The bedrock community benefit that hospitals provide is to simply continue being there to deliver hospital care for those who need it, all day, everyday, lifelong, locally and regionally, without regard to whether the patients are rich or poor, young or old, powerful or powerless. That's a tall order. The impact on people's lives and the local economy is substantial.

This year more than one in five people will cross a hospital threshold. That includes about 25,000 physicians, nurses, support personnel and volunteers who work in hospitals, about 250,000 patients who come for inpatient or outpatient care or rehabilitation, and countless friends and family members who come to help or visit patients.

Hospitals will be there to care in 500,000 emergencies, from a child's earache that flares up in the night to trauma cases where life hangs in the balance.

Hospitals will be there to help more than 14,000 mothers bring new life into the world. And hospitals will be there to comfort and care for about 4,000 of our friends and neighbors at the end of life as well.

Hospitals will continue to upgrade facilities and acquire the new technology needed to guarantee access to state-of-the-art care into the next millenium. They will continue to reach out and lead in the effort to achieve more integrated systems of care. And they will continue to collaborate through the Foundation for Healthy Communities to improve the processes, quality and outcomes of care.

Hospitals will continue to serve as a safety net for people who can't afford the care they need, but don't qualify for any other private or public assistance. This year hospitals will deliver more than $35 million worth of care at no charge for the benefit of about 90,000 people who can't pay. They will write off about $70 million more in uncompensated care for thousands of others who cannot pay in full, or can't cover their deductibles or copays, or simply don't pay. They will also sustain millions in losses representing the difference between what it costs to care for Medicare, Medicaid and other government program beneficiaries and what the government pays for that care.

Providing conventional hospital care for those who need it is our first responsibility. But hospitals do much more. In their zeal to make a difference hospitals are working to respond to community needs beyond traditional hospital boundaries. That's why hospitals are on the front lines delivering essential primary and preventive care, making a difference in children's lives in schools, in the work place, and in people's lives at home.

Trustees should be proud of what the institutions they govern are doing for their friends and neighbors. This publication offers just a glimpse at some innovative initiatives that show how hospitals reach out to improve health and healthcare in their communities. Would following any of these leads make a difference in your community?

Thank you for giving us wonderful accomplishments to celebrate. It's clear that trustee leadership can make great things happen for all of us!

Sincerely,



Robert Foster, Chairman

Robert Foster, Chairman
New Hampshire Hospital Association Board of Trustees
and Trustee, Huggins Hospital, Wolfeboro, New Hampshire

Mike Hill, President
New Hampshire Hospital Association, Concord, New Hampshire.



Mike Hill, President

Louis Chagnon, former trustee, Southern New Hampshire Medical Center

Peter Davis, Executive Vice President and Chief Operating Officer, Optima Health

Deanna Howard, CEO, Upper Connecticut Valley Hospital

Leslie MacLeod, President, Huggins Hospital

Donald Saunders, President, Androscoggin Valley Hospital

James Varnum, President, Mary Hitchcock Memorial Hospital

Community benefits steering committee

Access

ALICE PECK DAY MEMORIAL HOSPITAL & DARTMOUTH HITCHCOCK MEDICAL CENTER
Lebanon
Good Neighbors in the Upper Valley

LAKES REGION GENERAL HOSPITAL
Laconia
HealthLink

ANDROSCOGGIN VALLEY HOSPITAL
Berlin
A Community Effort to Attract Providers

CATHOLIC MEDICAL CENTER & ELLIOT HOSPITAL
Manchester
The Manchester Community Health Center

PARKLAND MEDICAL CENTER
Derry
The CHS Partnership:
Meeting the Needs of the Uninsured

WENTWORTH-DOUGLASS HOSPITAL
Dover
A Driving Factor in Improving Access to Healthcare

VALLEY REGIONAL HEALTHCARE
Claremont
A New Prescription for Medication Services

LITTLETON REGIONAL HOSPITAL
Littleton
Getting Patients on the Road to Good Care

Alice Peck Day Memorial Hospital Lebanon

Dartmouth Hitchcock Medical Center Lebanon

Good neighbors in the upper valley

In 1992, Alice Peck Day Memorial Hospital and Dartmouth Hitchcock Medical Center participated with the Upper Valley community to help create the Good Neighbor Health Clinic. Housed in the former rectory of St. Paul's Episcopal Church in White River Junction, VT, the Good Neighbor Health Clinic provides health care for New Hampshire and Vermont residents who do not have health insurance and cannot afford care.

In December 1990, a question about health care for the homeless at a League of Women Voters' forum sparked a discussion among doctors about what could be done in the Upper Valley to provide health care to those who couldn't afford to pay. The initial discussions led to the formation of a steering committee on which scores of volunteers, including physicians from both APD and DHMC, and others from various health and human service organizations got involved. The committee focused its efforts on creating a free health clinic.

The committee looked at different models, such as a rotating clinic that moves from town to town. But the committee members preferred the idea of a free-standing clinic so that people in need would know where to come. It was discovered that the pastor of St. Paul's church was moving to his own home and the rectory would soon be vacant. The committee worked with the church in developing it as the clinic's location.

The next step was financing. Committee members approached Mr. Robert Mesropian, President of APD, and Mr. James Varnum, President of Mary Hitchcock Memorial Hospital. Both supported the venture and were interested in helping with a solution. They were aware that an increasing number of people who weren't getting routine medical care were using emergency rooms. The hospitals were concerned with this situation and were interested in helping a free clinic get underway. Each hospital agreed to contribute enough money to offset the cost of the director's salary and the rent for the building.

The response for volunteers to work at the clinic was overwhelming. Today, the Good Neighbor Health Clinic has over 175 volunteers, including physicians, nurses, social workers, a dietitian, and administrative volunteers who help run the clinic on a day-to-day basis. Hartford High School students volunteer to do custodial work and many former patients also volunteer.

Alice Peck Day and Dartmouth Hitchcock have given their full support to the Good Neighbor Clinic, including equipment, furniture, supplies, and liability insurance. While the hospitals provided a stable foundation, the community has also given freely to cover the daily costs and helping with medications. Local organizations such as the Lions, Kiwanis, Rotaries, Sons of the American Legion, the Elks and other service clubs in the surrounding towns have made welcome donations. Churches and area merchants have also contributed.

In operation now for six years, the Good Neighbor Health Clinic has spawned the creation of eleven similar clinics in Vermont. Over the past couple of years, the clinic has been working with local dentists in establishing the Red Logan Dental Clinic for people who cannot afford dental care. Lack of affordable dental care was one of the highest needs identified in the local United Way's needs assessment.

It is probably safe to assume that the Good Neighbor Health Clinic might not have gotten started, or at least would have a much more difficult time sustaining itself, without the support of the two hospitals. However, without the volunteers and the community's collaboration, it is very likely that the Good Neighbor Health Clinic would not exist at all. It's an example of how all of us working together can create a stronger, healthier community.

Board Chair: Patricia Brown, Alice Peck Day Memorial Hospital
Donald E. Ross, Dartmouth Hitchcock Medical Center

Contact: Pam Gile, Vice President, Planning, Alice Peck Day Memorial Hospital, 448-3121
Eugenia Hamilton, Senior Vice President, The Hitchcock Alliance, 650-5336

Lakes Region
General Hospital
Laconia

Healthlink

When Jack Dexter was admitted to Lakes Region General Hospital for major surgery, he stayed for 8 1/2 weeks and incurred more than $150,000 in medical bills. But because of HealthLink, a unique program administered by the hospital, Dexter only had to pay a 5% copayment and $5.00 copay for prescriptions.

Dexter said that HealthLink made it possible for him to get the care he needed. "I don't want charity," he said. If he couldn't help pay for his care, he never would have gone to the doctor in the first place.

Over 600 individuals in Laconia are enrolled in HealthLink, a community-based program offering a full range of healthcare benefits to Lakes Region area residents who are uninsured and meet financial eligibility requirements. HealthLink covers preventive, primary and specialty care and includes a prescription drug program. Members pay a small co-payment for services.

"We link participants to the community's existing network of health care resources, which in turn guides them to social services or health education," explains Sheila Weeks, Director of Community Relations at LRGH. "We find that people will get the health care they need if they can contribute some payment. We offer a sliding scale based on a financial assessment which we repeat on a periodic basis."

HealthLink is funded in part by a special fund created by hospital trustees, and in part from Medicaid "disproportionate share" funds that were distributed to hospitals in the early 1990's. Blue Cross and Blue Shield of New Hampshire donates claims management and support with printed materials. HealthLink won the American Hospital Association's first Nova Award in 1994, which recognizes health care delivery networks that work with their communities to solve community health problems.

Lakes Region General Hospital is committed to HealthLink. "If HealthLink means that residents like Jack can get relief from physical illness because we are removing barriers to care, we're achieving our goal," says Sheila Weeks.

Board Chair: Gil Schohan

Contact: Sheila Weeks, Director of Community Affairs, 524 - 3211

Note: Jack Dexter's story was originally featured in NH Business Review, June 5-18, 1998 edition. He recently passed away, but during his illness, he received the best medical care available.

Androscoggin Valley Hospital Berlin

A community effort to attract providers

In 1994, a community needs assessment conducted by Androscoggin Valley Hospital (AVH) revealed that 24% of people living in the greater Berlin area reported having no primary care physician. Six physicians either retired or left the Berlin area between 1987 and 1994. Only four primary care physicians and three nurse practitioners remained to serve over 17,000 people in Berlin, Gorham, Shelburne and Randolph. Some didn't accept Medicare or Medicaid patients. The hospital was seeing an increase in the number of people seeking care at the Emergency Room. Fifty-four percent of the people surveyed reported that they received their primary care from the hospital, compared to 17% in a similar assessment conducted in 1987.

Hospital representatives began meeting with providers in-house and at the Coos County Family Health Services, a group that provided prenatal care but was contemplating the addition of physician services. The hospital met with numerous community groups, including women's groups and Motivated Elderly Self Help (MESH), which is a large senior citizen's organization. With the input of providers and community groups, AVH embarked on an aggressive recruitment campaign to help address the severe shortage of providers.

The first step was to take advantage of any federal programs. AVH worked with the Coos County Family Health Services to apply for federal designation as a "Medically Underserved Population." That enabled the hospital to access the National Health Service Program, which matched hospital funds for medical education loan repayments. Secondly, AVH helped community members having difficulty obtaining appointments with physicians. The third step was to keep the community informed of its recruitment efforts through a public relations campaign.

By 1997, the community successfully recruited 15 primary care providers (internists, family practitioners and mid-level providers.) Coos County Family Health Services became a federally qualified health clinic. That increased Medicare and Medicaid reimbursement and allowed the practice to expand into primary care services. Androscoggin Valley Hospital provides over $200,000 a year to cover medical education debt for providers who have relocated to the area.

Access to healthcare has improved significantly. All new providers accept Medicare and Medicaid patients. Residents can easily access the providers in their community. With this increase in providers, hospital ER visits dropped from 13,000 to 8,000 per year.

Board Chair: Michael O'Neil

Contact: Donald Saunders, President, 752-2200

Catholic Medical Center Manchester

Elliot Hospital Manchester

The manchester community health center

The Manchester Community Health Center opened its doors in 1993, filling a void in access to quality healthcare for low-income families. Originally intended to address the tremendous problem of low birth-weights in Manchester area babies, the program has grown into a full-service family health center.

The Community Center was started in 1993 with major grants from Catholic Medical Center and Elliot Hospital, with each hospital donating $150,000 from the Medicaid "disproportionate share funds." During the past five years, Optima Health has provided ongoing support to the Center. The past two years, Optima Healthcare's Healthy Community Golf Classic – a charity golf tournament – designated the Center as one its beneficiaries. In 1997, the Center received $23,443 and in 1998, received $23,500 for a total of $46,943 in direct funds from the golf tournament. Also in 1998, an additional $50,000 was provided to the Center for the "Healthy Baby Trust Fund." Other supporters of the Center include the federal government (via a 330 grant,) United Way of Greater Manchester, the City of Manchester and private foundations and corporations.

The Manchester Community Health Center's focus is to provide care to those who otherwise would not have access to primary healthcare services.

- *In its 5-year history, the Center has served more than 10,000 patients with more than 90,000 patient visits.*
- *Nearly 7,000 children have received their complete immunization series through the Center.*
- *Approximately 2,000 babies have been delivered to mothers who have been cared for by the Center.*
- *Forty to 45% of the patients served are uninsured, and 80-85% are underinsured or underserved.*
- *Approximately 20% of the Center's patients are non-English speaking.*
- *The Manchester Community Health Center is the first health center in New Hampshire to be accredited by the Joint Commission on Accreditation of Healthcare Organizations.*

"Many of the patients have complex medical concerns but have had no care outside the emergency departments for years," said Heather Davis, a Physician Assistant at the Community Health Center. "Language barriers, lack of food or housing, psychiatric illness, substance abuse and cultural differences are frequent concerns."

The Center is a federally qualified health center and employs a collaborative team of four family physicians, two nurse practitioners, a physician assistant, nurse midwife and nutritionist, as well as counselors, nurses, a translator and clinical support staff. Collaborative care management is especially important to the Center's prenatal population and the Positive Care Program, which serves individuals living with HIV.

"The Center services a key role in the health of thousands of people living in and around greater Manchester," said Edward G. George, President and CEO of the Manchester Community Health Center. "We are grateful to all of those organizations including Optima Health, the United Way, and the City of Manchester, as well as other organizations and individuals who have provided much needed support."

Board Chair: Patrick Duffy, Optima Health

Contact: Christopher Dugan, Director of Community Relations, Optima Healthcare, 663-8900

Parkland Medical Center Derry

Community partners in the greater Derry area have created a healthcare delivery system for residents who don't qualify for public assistance programs but can't afford health insurance. It's consumer-friendly, cost effective and stigma-free. It's called the Greater Derry Community Health Services (CHS.) It's made possible by ongoing support from Parkland Medical Center, The Alexander Eastman Foundation, the United Way and the NH Department of Health and Human Services.

CHS is a comprehensive service network that's intended to meet the needs of program participants as they arise. When residents enroll in the CHS program, they are issued a membership card, are assigned to a Health Care Manager and choose a primary care physician. The Health Care Manager performs an initial health status and risk assessment, develops a care plan and helps members access services from supporting agencies. A volunteer network of 95 members of Parkland Medical Center's medical staff provides primary care, specialty referrals and hospital-based services. CHS has its own pharmacy, and provides medications for a small copayment. In addition, CHS provides short-term mental health services.

The member makes a $5 copayment for each office visit. In the case of hospital-based services, the member pays a percentage of all charges based on personal income. This co-payment percentage is based on annual gross income and ranges from 10% - 25%, with Parkland Medical Center absorbing the balance of all charges. Parkland provides over $100,000 per year in direct support to CHS in the form of an outright donation.

"Greater Derry Community Health Services is a terrific example of how a community partnership can create a seamless system to meet the needs of uninsured community members," said Parkland's CEO Scott Goodspeed. "We're proud to be a part of this innovative program."

Board Chair: Dr. Ted Brooks

Contact: Scott Goodspeed, President & CEO, Parkland Medical Center, 432-1500

The chs partnership:
meeting the needs of the uninsured

Wentworth-Douglass Hospital Dover

A driving factor in improving access to healthcare

Sara is 19 years old, blind, and has a 6-month old baby. At least three times a week, the Community Connections van arrives at her apartment to take her to The Healthy Universal Beginnings (HUB) Family Support Center's teenage parent group, WIC program appointments and to The Clinic for well-child care and check-ups. The van is Sara's link to the outstanding community support she receives. Without this transportation, Sara and her baby would be unable to access the medical care and support they need.

Sara's situation is similar to many in the Seacoast area. Several community needs assessments conducted by Wentworth-Douglass Hospital and other community organizations showed that lack of transportation to medical care was a serious problem in Strafford County.

Wentworth-Douglass Hospital donated $60,000 to The HUB Family Support Center in Dover to purchase a 15-passenger van. The Community Connections van is on the road 25 hours a week. During the first months of operation, the van averaged 7.5 trips a day, and 122 trips per month. The van is available to a variety of agencies, including My Friends Place Homeless Shelter, The Clinic, area pediatricians, Community Action, Strafford Guidance, Dover Adult Learning Center, Dover Housing Authority and the hospital.

Robert DeColfmacker, President of McIntosh College in Dover and a hospital trustee, sees the donation for the van as part of the hospital's obligation to its community. "The community needs assessments showed us that many of the healthcare problems in the community were problems created outside the healthcare delivery system," said DeColfmacker. "As trustees, we are obligated to our communities to not only provide governance oversight to the hospital, but also to identify and create solutions for some of our more pressing healthcare needs."

Board Chair: Roger Evans, MD

Contact: Robert DeColfmacker, Immediate Past Chair, Board of Trustees, Wentworth-Douglass Hospital, 742-1234



Robert DeColfmacker, Trustee
Wentworth-Douglass Hospital

Valley Regional Healthcare Claremont

A new prescription for medication services

Access to healthcare means more than the ability to see a physician or nurse practitioner for preventive and primary care. It also means the ability to obtain necessary medications. No one knows that better than the practitioners at Valley Regional Healthcare's Partners In Health Center in Newport, NH.

Since 1995, the Partners In Health Center has provided primary care, preventive screenings and well child care to over 3,400 uninsured and underinsured residents of Sullivan County. But according to Nancy Szeto, Medications Coordinator at the Center, despite all their efforts to provide care, the physicians and nurse practitioners were seeing instances of acute illness because patients weren't taking their prescribed medications.

"We found that our patients – some of whom are indigent, and many of whom are elderly — simply could not afford to buy their prescription drugs," said Nancy. "Without the medications, it was inevitable that many of these people would become more seriously ill and eventually require hospitalization."

The Partners in Health Center took the problem into its own hands. Nancy Szeto contacted pharmaceutical companies to see if they could help. She found that many companies had programs to provide medications to low-income persons. The Center began assisting clients with the paperwork, which varies from company to company. To make this service work, the Center tracks the changes in each company's requirements, and works with physicians in a case management capacity. Over 500 clients have benefited from this Medication Assistance program.

"This concept works," Nancy says. "I receive calls from physician offices all over the state asking how their patients can access these programs. It's gratifying to see the relief of a low income elderly client, who formerly paid half of their fixed income on drugs, now paying only a minimal amount for a 3-three month supply of a necessary prescription."

Board Chair: John Lambert

Contact: Nancy Szeto, Partners in Health Center, 863-2273

Littleton Regional Hospital
Littleton

Getting patients on the road to good care

From winding mountain roads to blinding snowstorms, getting around in the North Country can be challenging. There's no public transportation system either. Littleton Regional Hospital recognized that transportation challenges often prevented residents from accessing routine healthcare services. Area healthcare agencies also agreed that many patients missed healthcare appointments and even necessary hospital visits because of lack of transportation. For some patients, their medical conditions deteriorated to the point that they needed ambulance transport for immediate medical care.

In 1994, an anonymous donor helped the hospital establish the Littleton Regional Hospital Care-A-Van shuttle service to bring patients to and from physician or hospital appointments. The hospital set up a toll-free phone number so that residents could call for the van free of charge. The van is in service five days a week and hundreds of individuals have taken advantage of the Care-A-Van on a routine basis for their healthcare needs.

While local transportation needs have been met through the Care-A-Van, the Hospice of the Littleton Area recently identified transportation for oncology patients as a major community need. Due to the frequency of radiation treatments for many oncology patients, cancer patients were finding it difficult to arrange transportation for the 60 to 90-minute trip to Dartmouth Hitchcock Medical Center in Lebanon, NH.

Littleton Regional Hospital, the Hospice of the Littleton Area and Dartmouth Hitchcock Medical Center joined efforts to make it easier for North Country patients to get to DHMC. A Radiation Oncology Van Service was established in January 1999 to take patients and family members to Lebanon. DHMC agreed to block schedule treatment times for North Country patients who use the van. While the program is still in its infancy, discussions have already begun with other North Country hospitals to join the Radiation Oncology Van Service, which would allow for more patients to be picked up on the route to Lebanon.

Board Chair: John Sauter, MD

Contact: Audrey Fogg, Director of Community Relations, 444-7731 ext. 304

Dental Programs

NEW LONDON HOSPITAL
New London
Rock Solid Dental Care

THE CHESHIRE MEDICAL CENTER
Keene
Putting On a Happy Smile

SPEARE MEMORIAL HOSPITAL
Plymouth
Reading, Writing and Brushing

CONCORD HOSPITAL
Concord
The Dental Clinic at Capital Region Family Health Center

New London Hospital
New London

Rock solid dental care

When a community health assessment surveyed the dental health of the Kearsarge Regional School District second grade class, it revealed that 20% of the children had 60% of the dental decay. To address the widespread, unmet dental needs of area school children, New London Hospital and area school nurses spearheaded the creation of a school-based dental program known as The Rock Dental Clinic. But you won't find the Clinic in an office building—this one is on wheels.

New London Hospital purchased mobile dental equipment to bring screenings, cleanings and fluoride treatments to the children in the schools. The mobile unit, staffed by a licensed dental hygienist, visits six area schools. The equipment is set up in administrative offices or even in stairwells.

Originally children in Grades 1 - 3 received preventive dental service and individual oral health education. In the 1996-1997 school year, the service expanded to Grade 4. During that year, 347 children received a free screening and 297 of those students qualified for additional services. In 1997-1998, children in grades K through 5 received the preventive dental care. The next step, according to the Hospital, is continuing the community health assessment process to see if restorative care and sealants could be added to the program.

Funding The Rock Dental Clinic is a community endeavor. New London Hospital, private contributions, grants and volunteers support the Rock Dental Clinic and the development of a dental health curriculum in the schools. Northeast Delta Dental donated the fluoride rinse program. New London Hospital provides administrative support services. The Community Health Institute has donated the services of a dental consultant to help develop protocols and report formats.

"As a school nurse and a health teacher, I have seen the effects of poor oral hygiene on student performance," says Tanya Wilkie, New London Hospital trustee. "Dental pain decreases the ability to concentrate in the classroom and leads to absences from school. The hospital has been proud to play a part in bringing The Rock Dental Clinic to students in the Kearsarge and Newport Schools."

Board Chair: Robert Bowers

Contact: Jeana Newbern, Director of Public Relations and Marketing, New London Hospital, 526-5270

The Cheshire Medical Center Keene

Putting on a happy smile

For elementary school children in the Monadnock Region, having a healthy smile is a reality, thanks to a collaborative effort called "Cheshire Smiles."

When a United Way survey identified dental health as one of the most unmet needs in the region, the Council for a Healthier Community decided to tackle the problem. The Council is a group of community stakeholders representing healthcare providers, human services organizations, businesses, government, schools, law enforcement, clergy and various community organizations. It is spearheaded by The Cheshire Medical Center.

Most, if not all, local dentists were not accepting Medicaid patients. While this access problem affected all age groups, the Council agreed it probably couldn't effectively meet everyone's needs. It decided to focus on the needs of children ages 5 to 8 years of age. A survey of school nurses in 19 area elementary schools indicated that about 25% of the children in this age group had unmet dental needs.

A school-based dental program called Cheshire Smiles was created with the help of seven area dentists and the Southwestern NH Hygienists Association. It's a 3-phase program which includes screenings, prophyllaxis (cleanings, flourides rinses and education) and restoration. Portable dentistry equipment was purchased with financial help from the Cheshire Health Foundation and the NH Healthcare Transition Fund. A public health hygienist was hired to coordinate the program and provide services for children in 19 area schools. PTOs, local service clubs and private donors provided additional funding.

Eighteen months after the hygienist/coordinator was hired, 786 children received dental screenings and 264 received preventive care services. Cheshire Smiles hosted its first ever Sealant Day in May 1998. Sixty-six children from 12 schools had 274 sealants placed on their teeth, free of charge. The effort of volunteer dentists, school nurses, hygienists, dental assistants and parents was instrumental in the success of this community health event.



Mary Burdett and Deb Albrecht, Public Health Dental Hygenist

As part of Cheshire Smiles, the Medical Center plans to open a dental operatory in the hospital in 1999 that will be used by volunteer dentists to treat children in need of basic restorative care. The program was expanded with the addition of a second hygienist in late 1998.

"The Cheshire Smiles program has been an excellent example of collaboration between the hospital, schools, the dental community, PTOs and service organizations," said H. Neil Berkson, Chairman of the Board of Trustees at The Cheshire Medical Center. "This shared vision and partnership with our community reflects the hospital board's commitment to improving the health of those we serve."

Board Chair: H. Neil Berkson

Contact: H. Neil Berkson, Chairman, Board of Trustees, 357-4800

Speare Memorial Hospital Plymouth

Reading, writing and brushing

For school children in SAU 48 and Ashland public schools, learning isn't limited to reading, writing and 'rithmatic. They're also learning about good dental hygiene and the proper use of a toothbrush and dental floss. While it may seem rather basic, there's a definite need. School nurses who were treating bumps and bruises and sore throats were discovering significant dental problems in young children in the district. Dental hygiene was inconsistent, and in some cases, non-existent.

In September 1998, Speare Memorial Hospital launched a program to screen schoolchildren for dental problems and make referrals to participating dentists. Participating youngsters receive one cleaning per year, a fluoride rinse and instruction in oral hygiene. The hospital purchased dental equipment and hired a full-time hygienist to visit nine elementary schools with a student population of 2,500. The program costs approximately $45,000 per year. Since its inception, over 400 students have been screened.

"It was evident that poor dental health in many of our school children was becoming a full blown community health problem," said Ann Blair, hospital trustee. "As a community resource, Speare Memorial hopes to heighten awareness that dental health is directly related to the overall health of the individual."

Board Chair: Sam Laverack

Contact: Ty Gagne, Director of Community Relations, Speare Memorial Hospital, 536-1120

Concord Hospital
Concord



Photo: Ken Williams, The Concord Monitor

The dental clinic at capital region family health center

"I look at this place as a life saver for me," says David Misner, a Concord resident in need of a liver transplant. Misner is talking about the Dental Clinic at Capital Region Family Health Center, a department of Concord Hospital.

Misner's rotted teeth could have undermined his immune system after a transplant. He could not become eligible for a liver transplant until his teeth were replaced. Dental health affects many less dramatic things than liver transplants, but important ones nonetheless — things like confidence for job interviews, and self esteem among one's peers.

The Dental Clinic opened in May 1998 with grants from the New Hampshire Health Care Transition Fund, Northeast Delta Dental and the Arthur Getz Charitable Trust. The Clinic was based on recommendations from a local Coalition for Dental Health, comprising Concord Hospital, Riverbend Community Mental Health, the Concord Dental Society, and the New Hampshire Technical Institute.

The goal of the Clinic is to provide basic dental health needs to adult low-income and uninsured people in the Concord area. In its first five months, there were 700 visits.

"We receive about 75 calls a week, and have about 200 names on our waiting list," says Deb Bergschneider, Coordinator of the Clinic. Six New Hampshire dentists work in the clinic in their free time for a small stipend, plus there is a paid part-time hygienist. "We see anywhere from 45 to 60 patients in the three days a week that the clinic is open. We're hiring a full-time dentist to help us expand our hours to five days a week."

The clinic accepts Medicaid payments, but also offers a sliding fee scale and provides services regardless of the patient's ability to pay. The clinic has provided more than $40,000 in free care in its first five months of operation. The majority of patients have fallen into the federal guidelines' 100% poverty level.

"We are clearly meeting a need," says Bergschneider. "It is gratifying to be able to do this work for the community."

Board Chair: Martin Gross, Esq.

Contact: Deb Bergschneider, Coordinator, Dental Clinic, 228-7200, Ext. 4461

Community outreach

CROTCHED MOUNTAIN FOUNDATION
Greenfield
Helping Local Schools Help Special Needs Students

FRISBIE MEMORIAL HOSPITAL
Rochester
Increasing Awareness About the Need for Mammograms

THE MEMORIAL HOSPITAL
North Conway
To Your Health-A Collaborative Health Education Initiative

EXETER HOSPITAL
Exeter
HEALTH*reach* Diabetes

ST. JOSEPH HOSPITAL
Nashua
Going Beyond Acute Care Needs: The St. Marguerite d' Youville Fund

THE FOUNDATION FOR HEALTHY COMMUNITIES
Concord
NH Prevention Guidelines

Crotched Mountain Foundation Greenfield



Nathan Piccuci and his father, Tom

When people think of the Crotched Mountain Foundation, they often think of the rehabilitation hospital and residential school designed to meet the needs of patients with serious injuries and young people with severe disabilities. The Greenfield, NH facility has a national reputation in a very specialized field. There is a concentration of medical and educational expertise "on the mountain" that's unparalleled in New Hampshire.

School districts across the state can tap that expertise through Crotched Mountain Foundation's School Partnership Program. Directed by developmental pediatrician Dr. Patricia A. Andrews, the Program provides support to public school professionals responsible for services to students with severe disabilities including neurological and genetic conditions. Members of a multidisciplinary team from Crotched Mountain's school and residential programs travel to schools throughout New Hampshire to provide clinical evaluations, consultation and training. Crotched Mountain discounts those services at approximately half the rate usually charged for such evaluations.

In the past two years, over 60 towns from throughout the state have contacted the Program Office for assistance. Crotched Mountain staff members conducted 87 different evaluations, attended 54 school staffings and 82 home visits or meetings with parents. A total of 64 different students were evaluated.

By conducting evaluations at the child's school rather than asking the child and family to travel to Crotched Mountain, team members get an accurate picture of the child's functioning in the school environment. Nathan Piccuci, a 4th grader in Jaffrey, is one of the students who was evaluated through the School Partnership Program. Nathan's parents, Charlene and Tom Piccuci agree that the meeting and report prepared by Dr. Andrews helped school staff members understand Nathan's needs.

"I think the Program is wonderful," said Mrs. Piccuci. "It has helped a lot."

Crotched Mountain Foundation's mission is "to assist children and adults with disabilities achieve optimal growth and independence." According to B. Cairbre McCann, MD, a Crotched Mountain Foundation trustee, providing this specialized expertise to school districts is very much in keeping with the institution's mission.

"We're proud of the School Partnership Program," says McCann, who chairs the Foundation's Programs and Services Committee. "We're helping New Hampshire's school districts serve their special needs students. It's a much-needed and greatly appreciated service to local school districts."

Board Chair: Benjamin F. Gayman, Esq.

Contact: B. Cairbre McCann, MD, Trustee, (207) 773-8521 or
Linda V. Smith, Assistant Director, School Partnership Program, 547-3311

Helping local schools help special needs students

Frisbie Memorial Hospital Rochester

Increasing awareness about the need for mammograms

Frisbie Memorial Hospital and its Auxiliary are working together to increase the number of women who get a first-time mammogram. The project was spurred on by some alarming statistics from the State of NH's 1993 Primary Care Access Study. The rate of late stage breast cancer diagnosis is 8% higher for Strafford Country than the state average. In addition, the rate of non-compliance with mammogram screening is 13.5% higher.

"Local experts, including our physicians, the American Cancer Society, the NH Breast Cancer Coalition and the Women's Life Imaging Center, say that many women tell them they don't get a mammogram because they have no money or insurance coverage, no transportation and are fearful of what the results might show," said Sheila Pierog, Chairperson of the Auxiliary's Breast Cancer Awareness Committee. "Our goal was to eliminate these barriers, so we developed an approach designed not only to provide a mammogram, but to make the patient feel good about the experience so she wouldn't hesitate to make an appointment the next time."

Frisbie's program is targeted for those who have not had a baseline mammogram. The Auxiliary schedules the appointments, provides transportation and covers the cost of the mammogram. What's more, an auxilian accompanies the patient at the time of the appointment and presents a small gift after the exam. The hospital promotes the services to the surrounding communities in order to heighten awareness of the need for this important screening.

"If we can make the first experience more comfortable emotionally by being supportive at the time of the appointment, and if we can relieve the burden of the cost, perhaps we can make a difference in the health of our community," said Pierog.

Board Chair: Gerard Gravel

Contact: Hilary Douglass, Director of Community Relations and Volunteers, 332-5211



Gerard Gravel, Chairman
Frisbie Memorial Hospital

The Memorial Hospital North Conway

To your health

a collaborative health education initiative

Northern Carroll County is a picturesque part of New Hampshire. Forests and rock ledges. Covered bridges and ski slopes. Tiny hamlets with steepled churches and whitewashed town halls. But the picture postcard scenes belie the challenging, rural lifestyle of the residents of this area. The tourism-based economy provides seasonal, part-time jobs and few, if any, employee benefits. That means that over 40% of the working population lack health insurance and access to information and education about health-related topics.

A 2-year Primary Care Feasibility Study, conducted by The Memorial Hospital and a group of area healthcare and social services agencies, found a lower health status than the rest of the state. Maternal smoking, low birthweight babies, lung cancer and chronic obstructive pulmonary disease, obesity and sedentary lifestyle were among the highest percentages when compared to other counties.

The report spurred the creation of the Community Health Education Coalition (CHEC) of Northern Carroll County. It's a group of 12 agencies whose goal was to create a community health education program that results in measurable changes to the community's health status and risk factor levels. The program, which is sponsored by and through The Memorial Hospital, is called "TO YOUR HEALTH." Collaborators include Visiting Nurse & Hospice Care Services, Carroll County Mental Health, Children's Health Center, Gibson Center for Senior Services, the UNH Cooperative Extension Service and several other agencies. The concept was to consolidate health activity information, conduct mutual event planning and on-going programs based upon risk-based themes and produce and distribute health information to the community that specifically targeted high-risk groups.

In its first two years, CHEC has successfully launched educational programs that followed quarterly themes, including women's wellness, men's health and healthy hearts, children's health and safety and senior health. A monthly lecture series based on those themes was held at The Memorial Hospital. A "To Your Health" community almanac featuring health-related activities, is inserted into area papers, posted at grocery stores and printed on grocery bags and paycheck stuffers. A local "To Your Health" TV show debuted on local access cable channels. Health screenings for diabetes, cholesterol and other problems were held at no charge.

"This goes beyond the routine health education programs that most hospitals offer," said Sharon Malenfant, community relations director at The Memorial Hospital. "This is a community partnership that is completely focused on raising awareness of health risk factors in our area and empowering residents to overcome those risks."

The community has responded. The health lectures attract up to 50 people. Over 700 people participated in the Women, Wellness & Wisdom Health Day at a local mall. Flu shots increased 28% after CHEC began its outreach efforts. More than 300 bike helmets were distributed to local children. Community surveys show a growing awareness of CHEC's collaborative efforts and requests for additional information have increased.

"It's too soon to see if we're actually affecting people's health status," said Malenfant. "But one thing is certain. Residents of Northern Carroll County are definitely beginning to pay attention to their health, and Memorial Hospital is committed to helping them."

Board Chair: Drew G. Smith, DDS

Contact: Sharon Malenfant, Asst. Administrator/Community Relations & Development, 356-5461, X198.

Exeter Hospital
Exeter

Healthreach diabetes

National statistics show that 3% of any given population is diagnosed with diabetes, and another 3% have the disease but are unaware of it. This means that by the year 2000, there will be 8,500 people in Rockingham County diagnosed with diabetes and an additional 8,500 who are symptomatic but not yet diagnosed. Diabetes can lead to other serious conditions, such as blindness, lower extremity amputation and renal disease. When a group of providers in the Exeter area was looking to create a model community health management program, they looked at state and national statistics, along with an analysis of hospital admissions. Diabetes was an obvious choice.

HEALTHreach Diabetes is a collaborative effort led by Exeter Hospital, area physicians, Exeter Healthcare, Rockingham VNA & Hospice, Lamprey Healthcare and the Exeter Hospital Associates. The program, which involves over 140 patients a month, combines prevention, education, early intervention and treatment as a way to prevent disease and manage the health of diabetics in the community. It was established as a community-based pilot program to provide a predictable, constant standard of care no matter where the service is provided.

Patients in the HEALTHreach program have the benefit of individual appointments and group education, a diabetes fitness program, free support groups and community awareness programs. Over 43% of the participants are in the 41- 65 age group, compared to national statistics that show diabetes is usually recognized in the 65 and over age group. "Because of HEALTHreach Diabetes, we're diagnosing the illness earlier in our community, and getting patients the information and treatment they need to prevent more serious conditions," said Mary Koenig, MS, PT, Director of Exeter Hospital's HEALTHreach Programs. "Compliance with key health assessments has improved dramatically. For example, between August 1997 and September 1998, compliance rates nearly doubled. Eighty-five percent of the HEALTHreach patients were having their blood tests regularly, 71% had eye exams and 92% were having their feet checked regularly."

"It's rewarding to begin to focus on prevention and look at decreasing the number of people with diabetes, rather than solely providing treatment for these community members," said Karen Brainard, MD, Medical Director for the HEALTHreach Diabetes program.

Board Chairman: E. Leigh Quinn, Sr.

Contact: Mary K. Koenig, MS PT, 773-6938

St. Joseph Hospital
Nashua

For Arthur and Jean, an elderly couple living in Nashua, each month's end brought a certain dilemma. Their monthly budget, based on a small pension and social security checks, was nearly depleted. They could buy groceries or get their prescriptions filled, they couldn't afford both.

St. Joseph Hospital's St. Marguerite d'Youville Fund is designed to help people like Arthur and Jean purchase prescriptions and other needs. In any given month, the fund services about 50 people throughout greater Nashua with medicine, rent and utility payments, furniture, clothing and food. About 600 people are served each year at an annual cost of approximately $106,000.

Many people who utilize the fund for assistance have been patients at St. Joseph Hospital or have been served in the Emergency Room on an outpatient basis. For those struck with a tragedy, the fund also provides temporary assistance on an emergency basis and, while respecting one's dignity and privacy, helps them become empowered to reach out to agencies that provide more long term assistance. In addition to the monetary grants, the fund seeks to offer compassionate concern and deal with the total person – physically, spiritually and psychologically.

Board Chair: Harold Acres

Contact: Mary Crooker, Director of Mission Effectiveness, St. Joseph Hospital, 595-3097

Going beyond acute care needs:

the St. Marguerite d' Youville Fund



Harold Acres, Chairman
St. Joseph Hospital

Foundation for Healthy Communities Concord

New hamphire prevention guidelines

When should you first begin cholesterol screenings? How often should you have a tetanus shot? How frequently should you have a routine physical? Thanks to the NH Prevention Guidelines, consumers have clear-cut advice about when to get physicals, diagnostic screenings and vaccinations.

The guidelines were developed by all the major health plans in New Hampshire through the Foundation for Healthy Communities. In April 1998, bright red and green posters were distributed to physicians, clinics and hospitals for display in exam rooms and waiting rooms. In December 1998, a NH Health Care Transition Fund Grant enabled the Foundation to adapt the poster into a direct-mail piece, with the goal of reaching as many households in the Granite State as possible. Hospitals and health plans will distribute half a million NH Prevention Guidelines flyers in early 1999. New Hampshire is the first state in the nation where health plans and providers have produced uniform prevention guidelines.

"These guidelines are a win-win for New Hampshire physicians, hospitals and patients," said Allen Hinkle, MD, Medical Director of Blue Cross and Blue Shield of New Hampshire. Blue Cross and the NH Medical Society were the joint recipients of the Health Care Transition Fund Grant that funded the printing of the direct mail flyer. "On one hand, they will simplify physician practice management by being a singular guideline adopted by all of New Hampshire's managed care organizations. For our patients, it focuses our collective efforts towards making prevention work, rather than providing multiple, inconsistent guidelines."

The Foundation is a collaborative effort involving hospitals, physicians, health plans, the NH Medical Society and the Home Care Association of New Hampshire. It was founded by the New Hampshire Hospital Association and is dedicated to collaborative partnerships that improve health and healthcare.

Board Chair: Alvin Felgar, President, Frisbie Memorial Hospital

Contact: Shawn LaFrance, Vice President, Planning and Development, 225-0900

Moms & Babies

DARTMOUTH HITCHCOCK MEDICAL CENTER
Lebanon
Bringing the Physician to the Patient

PORTSMOUTH REGIONAL HOSPITAL
Portsmouth
Prenatal Care Is a Top Priority in Portsmouth

THE FOUNDATION FOR HEALTHY COMMUNITIES
Concord
Mothers Know Best

Dartmouth Hitchcock Medical Center Lebanon

Bringing the physician to the patient

New Hampshire has one of the lowest infant mortality rates in the nation. In 1996, it was second lowest in the nation with 5.0 infant deaths per 1000 live births compared with the national average of 7.3 infant deaths per 1000 live births. One of the reasons for this success story is the 20-year old New Hampshire Perinatal Program of the Dartmouth Hitchcock Medical Center, which brings specialized perinatology services and education to over 30 hospitals in the region.

Barry Smith, MD, Chair of the DHMC's Department of Obstetrics and Gynecology, has been a strong advocate for taking this program on the road throughout New Hampshire. "The program is consistent with DHMC's mission and philosophy that care should be delivered locally when possible," says Smith. "Many DHMC Ob/Gyn and Pediatric specialists travel to several New Hampshire and Vermont sites to give onsite care, consultations or co-manage patients. These include a Reproductive Endocrinologist, Gynecologic Oncologists, Pediatric Cardiologists, Pediatric Surgeons, Pediatric Urologists and other subspecialists. In many situations, we can help manage up to a dozen patients a day with one of these visits."

"The primary goal of the program is to make optimal care available to all pregnant women and newborns in New Hampshire," says Judith Frank, MD, Professor of Pediatrics and longtime Chair of the Division of Neonatology. "We also collaborate with community hospitals in following up with annual on-site visits, discussions of referred cases of high risk obstetrical patients, and of premature and other critically ill infants delivered and treated at DHMC and later transferred back to their local hospitals. These conferences, to which we send a team consisting of a Neonatologist, a high risk Obstetrician, a Perinatal Clinical Nurse Specialist and often other specialists, provide for continuous improvement of maternal and child health services."



Susan Bassett, patient and Barry Smith, MD

One of the program's accomplishments is that it brings current and specialized educational programs directly to physicians and nurses in community hospitals. Dr. Frank says the program is able to tailor its education to the needs and requests of the perinatal providers at the community hospitals, thus maximizing the interest and participation in local educational sessions. In addition, these efforts have fostered a unique collaboration among all these healthcare facilities that has allowed for collaborative research that has gained national attention.

The program, which is unique in the nation, annually awards up to 10,000 credits of continuing education for doctors and nurses. In the past 10 years, it provided 98,576 hours of accredited education, Frank says. "But our greatest accomplishment is the improvement in the quality of medical care for both mothers and infants. Healthy moms and babies are our primary concern."

Board Chairman: Donald E. Ross

Contact: Judith Frank, MD, 650-5828 or Barry Smith, MD, 650-8163

Portsmouth
Regional Hospital
Portsmouth

Prenatal

care is a top priority in portsmouth

It's not a surprise that the number of low birthweight babies born in the Seacoast has declined significantly over the years. For over 15 years, Portsmouth Regional Hospital has made prenatal care a top priority in the community.

In the early 1980's, the hospital was seeing an increasing number of teen mothers, low birthweight babies and pregnant women with no prenatal care. In response to a clear need in the community, a coalition of nurses, physicians and the hospital founded the Portsmouth Prenatal Clinic in 1984. That year, the Prenatal Clinic served 25 women. In 1986, the Clinic incorporated as a non-profit agency, independent of the hospital, but with continued financial and in-kind support from the hospital and its obstetrical staff.

The program is now called Families First Health Center. It provides comprehensive primary care, maternal and child health services and community outreach, health education and care coordination. Last year, Families First served 1,301 individuals, provided 4,568 medical visits, saw 200 children in the Well Child program, served 147 pregnant women, including 41 teens and delivered 69 healthy infants.

Since 1987, when the new Portsmouth Regional Hospital was established by the former Hospital Corporation of America, the hospital has provided in-kind services, such as free space and utilities for the program, valued at approximately $400,000. The hospital donated over $350,000 in other monies to the program's building fund and family support programs. Each year, Families First is a major recipient at the hospital's Billy Cheverie Memorial Golf Tournament, receiving contributions of $20,000 to $25,000.

Board Chairman: Edward E. Bulmer

Contact: Richard Senger, Chief Financial Officer, 436-5110



Mothers and babies at the Families First Health Center

Foundation for Healthy Communities Concord

When 8,500 mothers share their opinion, hospitals listen. Through the Foundation for Healthy Communities' Maternal & Newborn Assessment Project, New Hampshire hospitals are gathering feedback from mothers of newborns and using the information to improve prenatal, childbirth and postpartum care. It's a collaborative effort involving all Granite State hospitals, physicians, nurses, the NH Medical Society, the Home Care Association of New Hampshire, all NH health plans, along with Public Service of New Hampshire and Citizens Bank.

Every mother of a newborn in the state is sent an 8-page survey asking about her perceptions and experience with prenatal, labor and delivery and postpartum care. In 1997, over 8,500 women responded. The Foundation for Healthy Communities learned that women in New Hampshire have outstanding access to prenatal care, are satisfied with pain management during labor and delivery and received a home care visit when they wanted one. Mothers also identified areas for improvement. They felt they needed more information during prenatal care to prepare them for labor and childbirth, including information about pain management options and cesarean sections. They also wanted to be better prepared to take care of their babies once they went home.

In direct response to patient feedback, the Foundation for Healthy Communities is working with clinicians, hospitals, home care agencies and health plans to publish a comprehensive guidebook called "Healthy Mom, Healthy Baby," that will be made available to every pregnant woman in the state. It's expected to be distributed in early 2000. Local hospitals are also making changes based on hospital-specific results of the research project.

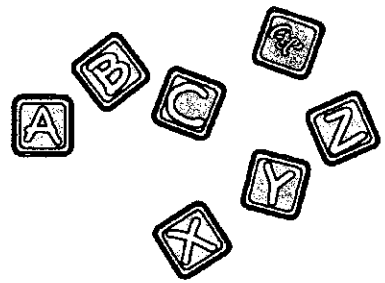
"The Foundation's goal is to see healthcare through patients' eyes, share those views with providers and help them make positive changes to better meet patients' needs," said Rachel Rowe, Executive Vice President of the Foundation. "This unique collaborative effort allows hospitals to share what works in the individual institutions in order to improve care throughout New Hampshire."

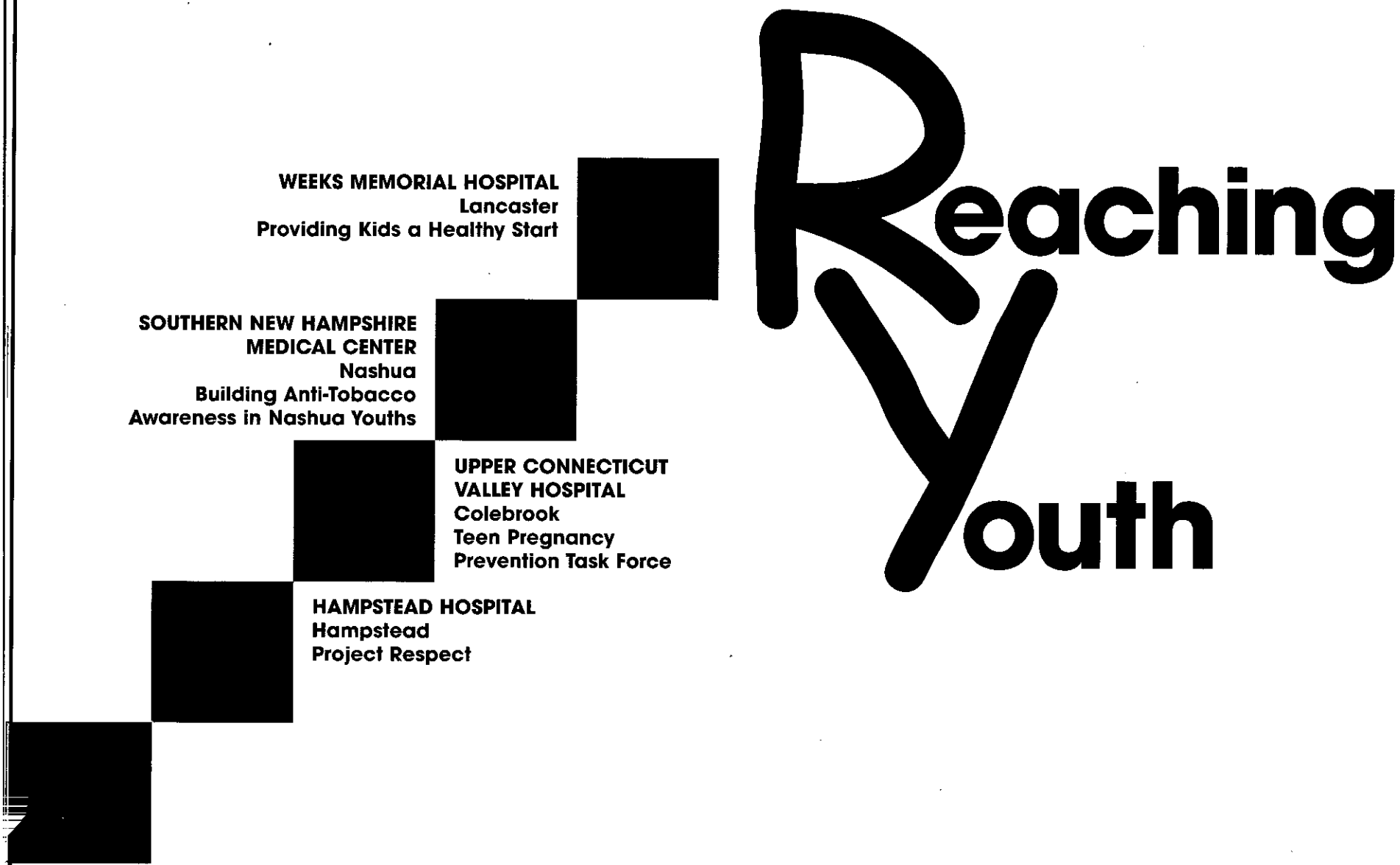
Chairman: Alvin Felgar, President, Frisbie Memorial Hospital

Contact: Rachel Rowe, Executive Vice President, 225-0900

Mothers **know best**

Maternal & Newborn Assessment Project




WEEKS MEMORIAL HOSPITAL
Lancaster
Providing Kids a Healthy Start
SOUTHERN NEW HAMPSHIRE
MEDICAL CENTER
Nashua
Building Anti-Tobacco
Awareness in Nashua Youths
UPPER CONNECTICUT
VALLEY HOSPITAL
Colebrook
Teen Pregnancy
Prevention Task Force
HAMPSTEAD HOSPITAL
Hampstead
Project Respect
Reaching
Youth

Weeks Memorial Hospital Lancaster

Providing

kids with a healthy start

Every Friday morning, Krissy Wheeler-McInvaile, a Certified Physician Assistant, gets in her car and drives to work. Depending on which Friday of the month it is, she heads to an elementary school in Lancaster, Whitefield, Jefferson, Groveton or Dalton. Throughout the day, she'll perform routine physicals, conduct health assessments, check for ear infections, strep throat and other common childhood maladies, answer parents' questions on growth and development and provide prescriptions when necessary.

"Sometimes, getting your child to the doctor for basic healthcare can be difficult," said Krissy. "Between parents' work schedules, school, busy doctors' offices, cost pressures, and sheer distance, it's easy to put off a physical or a visit for a stubborn stuffy nose. My job is to bring healthcare directly to kids right at their school."

Krissy works with Dr. Brian Beattie in Weeks Memorial Hospital's Healthy Start Program. These school-based clinics provide healthcare and health education for children in the White Mountains Regional School District. The clinics provide a convenient and comfortable setting, and they're free to children enrolled in the Healthy Start program. The program was funded originally by a NH Health Care Transition Fund Grant. When the grant expired, Weeks Memorial Hospital began fully funding the program.

Weeks began the Healthy Start Program because statistics for the region showed that families weren't accessing available health services and children were at risk. Since its inception in 1996, more than 500 children have been treated. The response from parents has been tremendous. "It's a great idea, especially if you need just a brief visit," said one parent. "It saved me the time and cost of a medical bill for a simple question about child growth," said another.

Weeks Memorial Hospital also provides school nurses for 7 area schools at no cost to the school district. They provide daily coverage for bumps, bruises and sudden illnesses at school, and they refer children to the Healthy Start program when necessary.

"The Board of Trustees of Weeks Hospital Association is totally committed to the school-based clinic concept," said Patrick Kelly, President of the Board of Trustees. "These clinics enhance overall community health and often give us a chance to tackle problems or concerns before they become major issues."

Board Chair: Patrick Kelly

Contact: Gail Tattan-Giampaolo,
Community Outreach Coordinator, 788-5005



Krissy Wheeler-McInvaille, PA-C with Groveton Elementary student, Dana Meunier

Southern New Hampshire Medical Center Nashua

Dear Mrs. Brackett,

Thank You very much for coming to our classroom! I learned a lot about smoking, like, I definately won't hang with people who smoke! Smoking causes lung cancer, and heart diseses! It can hurt your children and give them brain damage if you smoke when you are pregnant, and smoking isn't cool! Please come into the 6th grade next year! That information will be with me forever!

Thanks Again,
A Nashua area 5th Grader

Building anti-tobacco awareness in nashua youths

No Butts About It



The Granite State has one of the highest teen smoking rates in the country. In Nashua, according to the 1995 PRIDE survey, smoking was higher than the national average in grades 6 through 12.

This data was the impetus behind the creation of Nashua's Partnership for Tobacco-Free Youth. It's all part of the much larger community-focused Partnership for Healthier Communities initiative that was spearheaded by Southern New Hampshire Medical Center to inspire and assist the greater Nashua community to measure and improve the health status of area residents.

The Partnership for Tobacco-Free Youth includes representatives from the community dedicated to increasing the number of youth growing up smoke free in the greater Nashua area. It is sponsored by the NH Tobacco Prevention Program and the Smoke Free NH Alliance, which is funded through a cooperative agreement with the Centers for Disease Control and Prevention (CDC).

Since its inception in September 1995, the Partnership has successfully initiated a youth-focused anti-tobacco campaign. The American Lung Association of New Hampshire's "No Butts About It" anti-tobacco program has been implemented in 27 Nashua 5th Grade classrooms, reaching over 729 students. The Partnership offered the "No Butts About It" Facilitator Training Program and certified six facilitators, along with 31 junior and senior high students who were certified through a Peer Educator Training program. Each year, 9th grade students participate in a T-shirt design contest and the winning T-shirt is distributed to the students participating in the "No Butts About It" program.

The Partnership administers a yearly Tobacco Survey to monitor change in tobacco use and compare to state and local statistics. The survey was initially administered to 7th grade students in 1996 and 1997, and to all 8th grade students in 1998 to measure change in behavior. Compliance checks have also been conducted to monitor sale of tobacco products to youth. The Nashua Police Department has provided vendor education about the tobacco sales law and continues to conduct periodic checks.

Recently, clean indoor air has been placed in the foreground as a youth tobacco prevention strategy. This year, the Partnership looks forward to embarking on a new initiative – Tobacco-Free Restaurants.

Board Chair: Sidney Katz, MD

Contact: Marcy Brackett, Chair, Partnership for Tobacco-Free Youth, 577-2988

Upper Connecticut Valley Hospital Colebrook

Teen pregnancy prevention task force

A day at The Balsams Resort for eighth grade students. The food! The views! The topic—how to prevent teenage pregnancy.

In 1991, the Board of Directors at Upper Connecticut Valley Hospital (UCVH) decided to expand its vision of healthcare from acute care to illness prevention and wellness promotion. In surveying the service area, which extends west into Vermont, east into Maine, and north to Canada, the Board found that one of the biggest health problems was the high rate of teen pregnancy.

A Teen Task Force was formed, with its primary mission being the reduction of teen pregnancies in the service area. Each year, under the leadership of UCVH, the Teen Task Force holds a one day seminar at The Balsams Resort with educators, counselors, and healthcare providers to educate about 100 8th graders about behaviors, values and self-image issues that help prevent unwanted pregnancies. The program, entitled "Crossroads: Changes and Choices—North Country Youth Pregnancy Prevention," is headed into its sixth year.

"The Balsams Resort donates the facility and we finance the rest of the costs," explains David King, Chair of the Board of UCVH. "The program is now considered a rite of passage for North Country teens." The incidence of teenage pregnancy has declined in the UCVH service area since the inception of the program, but King quickly points out that the hospital has only just developed a formal assessment tool to relate the reduction to the educational program.

"We are constantly looking outside the hospital walls to see how we can promote health and wellness in this community," King says. "This program is one way we support a common community goal."

Board Chair: David King, Esq.

Contact: Francine Bigney, Coordinator, Community Health, 237-4971



UVCH Teen Task Force Pregnancy Prevention Conference

Hampstead Hospital
Hampstead

Project respect

Hampstead Hospital is a healthcare facility that serves psychiatric and chemical dependence treatment needs of patients from all backgrounds. However, it prides itself in its work with the Hampstead Middle School to help address the needs of its local adolescent population.

In 1994, representatives from Hampstead Hospital and the Hampstead Middle School designed the first annual "Project Respect" program. Its goal is to help teens and their families deal with the pressures of adolescence.

"We identified some critical areas of need facing our adolescents in Hampstead, such as substance abuse, violence, issues related to sex and other stresses of adolescence," explains Cindy Gove, the Director of Marketing and Contracts for Hampstead Hospital. "We devote time to help promote communication between parents and teens on these challenging issues. The common theme is self respect and respect for others."

Each year, over 300 Hampstead Middle School 7th graders and their parents attend various workshops over a two-day period at Hampstead Hospital. The collaboration has drawn support of experts from the local community — law enforcement, state healthcare agencies, education and healthcare delivery — to talk about community needs and provide critical information.

Project Respect is funded by a grant from Safe and Drug Free School Program, Hampstead Hospital and local businesses. "We are proud to continue to be a part of this very positive community effort," said Gove.

Board Chair: Henry Audess

Contact: Cindy Gove, Hampstead Hospital, 329-5311

Service To Seniors

FRANKLIN
REGIONAL HOSPITAL
Franklin
Healthy Older People

HUGGINS HOSPITAL
Wolfeboro
Daily Care for
Vulnerable Seniors

MONADNOCK
COMMUNITY HOSPITAL
Peterborough
A Gathering Place
for Seniors

Franklin Regional Hospital
Franklin

Healthy older people

A Kitchen Band comprised of elder citizens plays on improvised instruments. A cookie tin is used as a drum; wooden spoons serve as drumsticks. The band members play and sing for an audience made up of young and old, and some of the audience joins in the songs they know.

At the end of the concert, one woman in the audience cries. A band member consoles her. "I'm OK," she says. "I'm crying because I'm happy." Her husband, a nursing home patient who had not spoken a word in years, had been singing along with the band.

The Kitchen Band is part of HOP — Healthy Older People — a nationwide concept that Franklin Regional Hospital adopted in 1985. The program was created in recognition of the increased longevity of seniors, and the need to keep them healthy and active in their later years.

"The goal of the program," says coordinator Linda Hebert, "is to reach out to the older population in our service area with the message that it's important to stay healthy, active and engaged in what's going on in the community."

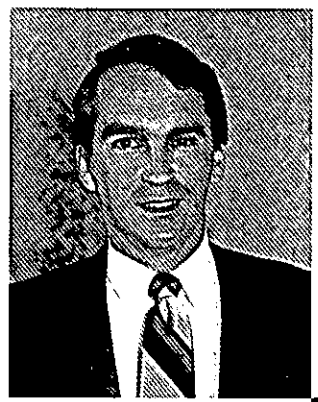
Franklin's HOP program includes social activities, such as the kitchen band, chair exercise tailored to older bodies, line dancing and education on everything from managing cold symptoms to disease management programs for asthma and diabetes. "HOP's exercise program is offered in Bristol on Mondays, in Sanbornton on Fridays, and in Franklin on Tuesdays and Thursdays. Interest in HOP's chair yoga program has grown so much that we have held a training session for six senior centers in the surrounding area," Hebert notes.

Many of these programs are offered at the Intergenerational Center which provides an opportunity for seniors to socialize with teens who use the facility for their smoke-free coffee house gatherings. Franklin Regional Hospital offers most of the programs free to seniors.

"With people living longer, Franklin Regional Hospital wants to enter the new century recognizing the importance of promoting the health and vitality of our senior generation," adds Hebert.

Board Chair: Stuart Trachy

Contact: Linda Hebert, RN, Educator/HOP Coordinator, 934-2060



Stuart Trachy, Chairman
Franklin Regional Hospital

Huggins Hospital
Wolfeboro

Daily care for vulnerable seniors

The Wolfeboro area is a mecca for retirees and senior citizens. While many of the seniors are volunteers at the Huggins Hospital, some are frail elderly who need care and supervision and the stimulation of social activities. Huggins Hospital's Adult Day Program provides a safe environment for elders in the Wolfeboro area, regardless of their ability to pay.

Huggins Hospital staffs the program with a registered nurse director, a professional social worker, a trained activity director and anywhere from 15 to 18 trained community volunteers. The program was designed with a grant from the New Hampshire Charitable Foundation, and ongoing costs are covered through private donations, client fees and state funding for participants with Alzheimer's or related diseases. The hospital provides financial assistance and transportation for those in need.

The program is open three days a week and offers homebound, impaired adults an opportunity for involvement in a community setting. The key feature to the program, according to the director, Cheryl White, RN, is the promotion of activity and society in a safe environment. While some adults play cards, others enjoy music and crafts, and field trips are organized for those whose medical conditions would permit outings. Volunteers read newspapers and discuss current events with the members, read books aloud, play games with participants, and help with meals and special projects, such as creating an Adult Day cookbook. Every other week, children from the Wolfeboro Area Children's Center visit the Adult Day Program to perform songs, play games, and to talk.

According to Joan Lovering of Huggins Hospital, over 70 people have participated in the program since it began in 1994. "Hundreds of family members have also benefited from the program indirectly, as they get some respite and time to do errands and chores without worrying about their loved one."

Board Chair: Robert Fournier

Contact: Joan Lovering, Community Affairs & Public Relations, 569-7500

Monadnock
Community Hospital
Peterborough

Over 600 seniors in the Monadnock Region have a place to turn to for daily support, social activities and a vigorous volunteer program, thanks to the generosity of Monadnock Community Hospital. For the past 7 years, the hospital has leased a building on its campus to Monadnock Family Services for its senior activities. The cost of the lease? $1.00 a year. The value of the lease is $33,000 a year.

The White Building, as it's known in the community, houses the Monadnock Adult Care Center, a day program for seniors with Alzheimers Disease. It's the home of Senior Focus, which offers social programs and evening events for older adults. It also houses the Retired Senior Volunteer Program (RSVP), which provides a network of volunteers to support those in need in the community.

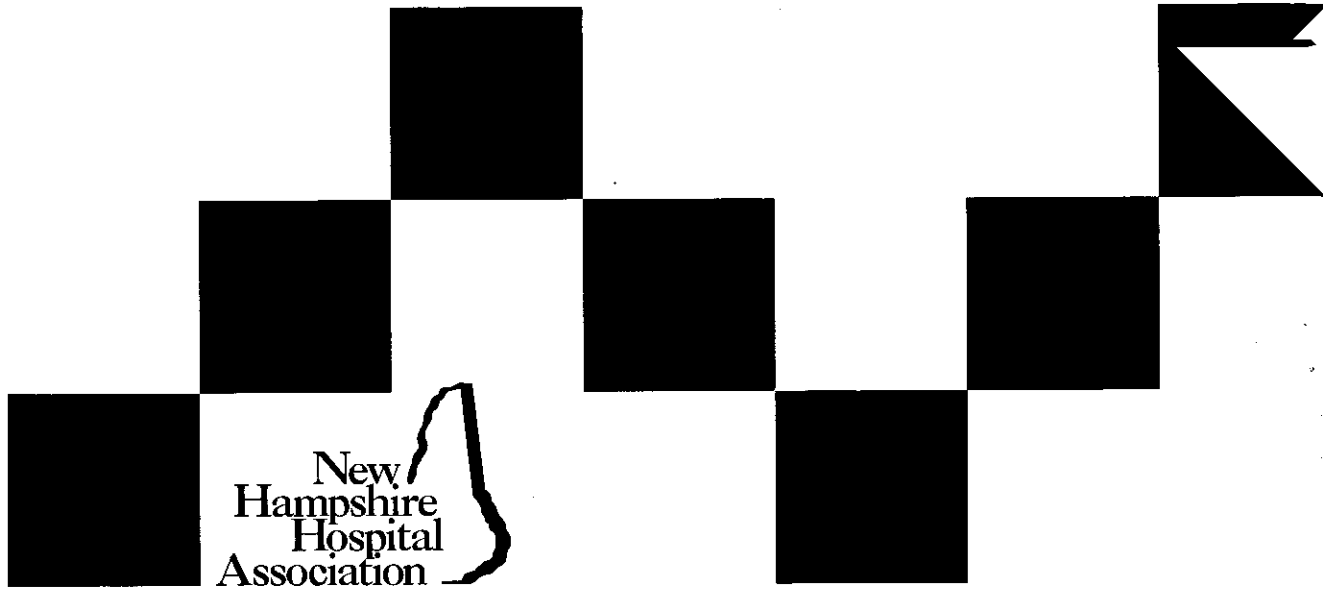
Finding space for these growing programs was critical to their success. The building's size and location in the community have proven effective in meeting the needs of the programs and the people they serve.

"Supporting programs and services on the hospital campus for our senior population has been a long-standing commitment of Monadnock Community Hospital, and is important to the health and welfare of the entire community," said Audrey White, President of the hospital's Board of Trustees.

Board Chair: Audrey White

Contact: Dana Jeanblanc, Director of Public Affairs, 924-7191, x1132

A gathering place for seniors



125 Airport Road, Concord, NH 03301
(603) 225-0900
http://www.nhha.org

City of Lebanon

51 North Park Street
Lebanon, New Hampshire 03766

April 27, 2000

Dear Municipal Government Committee Member:

Attached for your information, please find a copy of the City of Lebanon Spring/Summer 2000 Newsletter. The Newsletter contains a supplement that deals with a summary of information regarding the Dartmouth Hitchcock Medical Center (DHMC) lawsuit against the City. The newsletter is being distributed to approximately 7,800 Lebanon and West Lebanon residents and businesses, the Chamber of Commerce, and many state and local officials.

The City is being sued by DHMC because the Board of Assessors, a volunteer board of local and community business leaders, has determined, based on the information submitted to date by DHMC, that they do not meet the statutory requirements for a charitable tax exemption from New Hampshire real estate taxes.

While the supplement is out of the ordinary for a City Newsletter, the DHMC lawsuit is not the typical lawsuit. The lawsuit will potentially have national as well as statewide impact. There has been a substantial amount of interest in this matter, as you can well imagine. The City has prepared a summary of New Hampshire law that applies to the case, a factual history and a summary of facts it knows about DHMC based on public documents. Our goal is simply to keep our citizens and other interested members of the public informed.

There is a distinct possibility that your office may be contacted by individuals who may have an impact in this matter, and I thought it best to provide you with the facts as the City knows them at the present time.

If you have any questions, please feel free to contact Adele Fulton, Esq. at (603) 448-2221 or me (603) 448-4220 at any time.

Sincerely,

James A. McSweeney
City Manager

City of Lebanon

This Newsletter is being published by the City of Lebanon, New Hampshire in order to provide information to the residents of Lebanon on "What's Happening in Your City."

Spring - Summer 2000

Lebanon City Council

With City Elections behind us, the Members of the Lebanon City Council for the year March 2000 - March 2001 are:

Ralph Akins, Mayor	At Large
Albert "Bert" Leonard, Asst. Mayor	Ward 1
Cliff Desrosiers	At Large
Terri C. Dudley	At Large
Terry Grigsby	Ward 2
David Jescavage	Ward 3
John Lavigne	Ward 1
Frank Mastro	Ward 3
William Solari	Ward 2

The Lebanon City Council meets in regular session on the First and Third Wednesdays of each month at 7:00 p.m. in the Council Chambers Meeting Room on the third floor of City Hall. All meetings are open to the public.

For a complete list of City Councilors' addresses and phone numbers, please contact the City Manager's Office at 448-4220 or email: manager@lebcity.com.

Lebanon Opera House

A new and much improved Lebanon Opera House is on the way! The Lebanon Opera House is gearing up for a major Capital Campaign Fundraiser. Keep an eye out for upcoming information on how you can help to breath new life into the Lebanon Opera House. This historic facility serves as the **cultural center** for the City of Lebanon. Some improvements to this facility will be taking place during the renovations of the entire City Hall facility. However, much more funding will be needed for improvements such as; replacement of seats, rigging system for staging, and some infrastructure improvements. For more information, contact the Lebanon Opera House at 448-0400.

The Master Plan

What's New with the Lebanon Master Plan Update?

The Lebanon Planning Board has been updating our City's 1993 Master Plan, following up on the "Lebanon: A Look Ahead" forum that over 100 residents attended in March of '99.

The Master Plan is the major policy document for guiding the future growth of our City. Currently the Planning Board is working on the land-use chapter, which makes recommendations such as where development should or should not occur, what types of development should or should not occur, and how to transform policy into action. Based upon these recommendations, the Board plans to create a future land-use map to help our City guide development in an orderly and beneficial manner.

The Planning Board welcomes input on the Master Plan from anyone who lives, works, own property, or is otherwise interested in Lebanon. The meetings are open to the public. Planning sessions normally occur the fourth Monday of every month in City Hall beginning at 7:00 p.m. These and any additional public meetings about the Master Plan will be announced in the local newspaper and other local media.

For more information please contact City Planner Ken Niemczyk at 448-1457 or email at: ken.niemczyk@LebCity.com. The Planning Office will also be pleased to provide you with the names and phone numbers of your fellow citizens who serve on the Planning Board.

SPECIAL SUPPLEMENT.....

A Special Supplement has been prepared to provide information to residents regarding the City's decision to tax the Dartmouth Hitchcock Medical Center. See pages i-viii.

Please visit the City's web site (address below) to view the City's presentation to the Court regarding DHMC.

The City of Lebanon's Web Site has lots of information. Visit us at:

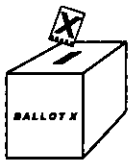
http://www.lebcity.com

News & Notes from the City Clerk



VOTING

The State Primary election will be held on September 12, 2000. Voting hours will be 8:00 am until 7:00 pm. A voter who will be out of town or unable to get to the polls due to a physical disability or religious observance may obtain an absentee ballot from the Clerk's Office approximately 3 weeks prior to and up until the day before the election. Completed absentees will be accepted by mail until 5:00 pm the day of the primary.



Eligible residents may register to vote at the City Clerk's Office Monday through Friday 8:00 am until 5:00 pm up until 10 days prior to an election. A resident who is not registered and physically unable to go before the Clerk or the Supervisors of the Checklist in person may register to vote by mail up until ten days before an election by calling the Clerk's Office for the appropriate forms. Potential voters not having an opportunity to register to vote at the Clerk's Office or with the Supervisors of the Voter Checklist within the ten day cutoff period prior to any election may do so on election day with proper documentation.

Voters who have not previously registered with a party, but wish to vote in a primary election must indicate their preference and receive that party's ballot. Any voter going into a primary with an Undeclared status may revert back to that status before leaving the polling place. Voters not taking the time to change back to an undeclared status will be registered with the party of their choice at the primary until they appear before the Supervisors or the Clerk's Office to complete a change in party affiliation form. **Those interested in changing their party affiliation** (republican or democrat) **for the September 12th State Primary may do so** with the City Clerk Monday - Friday 8:00 am to 5:00 pm until **June 6, 2000** or with the Supervisors of the Voter Checklists at their scheduled sessions until **June 6, 2000.**

A reminder to voters that the filing period for candidates for State Representatives to the General Court and Delegates to file with the City Clerk opens June 7th and closes June 16th. Candidates for State Representative must be registered voters and have resided in the state for at least two years preceding the election.

DOG LICENSES

Dog licenses are due May 1, 2000. Licenses issued June 1st and after will be charged a $1/month penalty fee. Proof of certificates of rabies vaccination (signed by a certified veterinarian) and neutering/spaying is required. Fee schedule:



~ Unaltered males & females = $9.00
~ Altered males & females = $6.50
~ Puppies (older than 3 months, but younger than 7 months) = $6.50 (After the initial license year, the dog owner must supply proof of spay/neutering in order to maintain the reduced fee).
~ Residents 65 years of age or older may register 1 dog at $2.00.

Historic District Commission to Study New Historic Districts

In 1996, the City Council created a historic district and the regulation which gives local control over certain exterior modifications of any building contained within the district. The first district encompasses the immediate area around Colburn Park and the Mall in downtown Lebanon. Since incorporation of the district, the Historic District Commission (HDC), the administrator of the regulations, reviewed one application.

The HDC is now considering two other areas for recommendation to the City Council for inclusion in a historic district: the neighborhoods east and southeast of Colburn Park and an area in West Lebanon encompassing Maple Street and extending west to Crafts Avenue and a small portion of Seminary Hill to include the Seminary Hill School.

The HDC will be walking or driving the areas to ensure that the areas are appropriate for a historic district. The HDC will also have discussions with the residents before any recommendation is sent to the City Council.

The City of Lebanon has a long history represented by a vast array of historical buildings. Many have been lost to "the march of progress". These historical buildings that remain contribute to Lebanon's character. It is the goal of the HDC to protect this character by protecting its historic resources.

How Can We Help You?

An often asked question is: "How many City Employees do we have?" Below is a chart of the number of employees for the past 6 years willing and able to serve the community.

	1995	1996	1997	1998	1999	2000
Full-time	160	161	155	154	156*	161**
Part-time	30	30	32	33	34	32
Net Positions	190	191	187	187	190	193



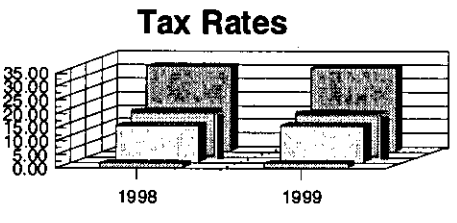
* Includes 2 new F.T. Police officers for traffic enforcement. ** Includes 4 new F.T. Firefighter/Medics for the Ambulance Service.

Tax Rate Information

FACT: *The municipal tax rate has been relatively stable over the last several years: 1998 = $13.30; 1999 = $13.52; Est. 2000 = $13.77.*

FACT: *Net property tax revenue, including school taxes, will have increased by about 18% during this same time period. An average of only 3.6% over the last 5 budget years. (1997 – $6,469,971 to projected 2000 – $7,638,401)*

The City's tax rate is an ad valorem tax which is based on the principle that the amount of tax paid should depend on the value of property owned. The property tax is the City's major source of revenue. The property tax levy is the total amount of money to be raised from the property tax as set forth in the budgets for the municipality, school and county. Property taxes billed and collected by the City include taxes levied for the school and county, which are remitted to these entities as required by law. These levies, whether higher or lower than the preceding year, is determined by the budget -making authority of each entity. Simply put, the amount of the property tax levy is the difference between the appropriated expenditure budgets and other non-property tax related revenue. The nominal tax rate is a mathematical expression of the relationship between the tax levy and the total assessments for the City: the levy amount is divided by the assessment amount to give the nominal tax rate.



Total	31.02	$30.89
School	$16.39	$15.70
Municipal	$13.30	$13.52
County	$1.33	$1.67

The tax rate is expressed as dollars per $1,000 of assessed value. The tax for each taxable parcel is calculated by multiplying the parcel's assessed value by the nominal tax rate so that tax for each parcel is at the same percentage of assessed value. The tax is, therefore, a tax according to value.

Prior to 1999, the City's total, or combined, tax rate was comprised of three components: municipal, school and county. Effective April 1, 1999, New Hampshire's property tax system includes a state education property tax to be assessed and collected by local municipalities. The state education property tax was enacted in response to the NH Supreme Court's ruling in the Claremont Case. The City's total, or combined, tax rate is now comprised of four components: municipal, school: local, school: state, and county. For 1999, of the total $15.70 school related tax rate component, $7.31 pertains to the State education tax.

Prior to 1998, the relationship between the two largest tax rate components -- municipal and school -- to the total, combined tax rate, was approximately 29% and 65%, respectively. Since 1998, these same relationships have been approximately 42% and 52%, respectively.

The reason for this is that the ultimate responsibility for the collection of property taxes rests with the City and is reflected in the municipal tax rate component. In other words, the school and county get their legally adopted property tax levies, notwithstanding whether these moneys are actually collected or more importantly when these moneys are collected. Each year, in connection with the setting of the tax rate by the New Hampshire Department of Revenue Administration (NHDRA), the City, with the review and approval of the NHDRA, establishes and raises through taxation an amount for abatements and refunds of property taxes known as overlay. This amount is reported as a reduction in tax revenue and is adjusted by the City for any tax reserves at year end. As an integral aspect of the overlay determination and estimation process, the City considers the nature of pending litigation; the progress of cases to date; how management of the City is responding or intends to respond to the litigation; and an evaluation of the likelihood of an unfavorable outcome and an estimate, if one can be made, of the amount or range of potential loss. Dartmouth Hitchcock Medical Center brought suit against the City in May, 1998, as the result of the Lebanon Board of Assessors denying the charitable tax exemption for the 1997 tax year of the Dartmouth Hitchcock Medical Center owned or used by DHMC, Mary Hitchcock Memorial Hospital, the Hitchcock Clinic and Dartmouth College. The entities have appealed the decision. DHMC paid taxes for the 1997, 1998 and first half of the 1999 tax years. As expressed and authorized by the Lebanon City Council by resolutions in 1998 and 1999, the City does not intend to employ these moneys received for property tax rate relief, support of ongoing operations or capital improvements until the litigation is resolved.

ASSESSMENT UPDATE 2000

Property taxes are based upon the local assessed valuation of all taxable property within the municipality, as of April 1 of each year. When a municipality conducts a revaluation, property is physically reviewed and valued based upon the analysis of sale prices of comparable properties or by other acceptable appraisal methods. Lebanon's last citywide revaluation occurred in 1995 and became effective in 1996.

The intent of a revaluation is to assess all property at its full and true value, often referred to as market value. A revaluation ensures that property within a municipality is assessed proportionally so that property owners bear their share of the property tax burden based upon the value of their property.

Each year the New Hampshire Department of Revenue Administration equalizes the property values for every city and town. Equalization is an adjustment of the municipality's local assessed values, either upward or downward, in order to approximate the full value of the municipality's property. Adjustments are not made to any individual properties.

CONTINUED. ..... Next page.

Assessment Update Continued.....

Rather, the total value of all property in the municipality is adjusted based upon the comparison of recent property sales with local property assessments. For example, if the comparison of recent sales indicates that on the average, a municipality is assessing property at 90% of market value, then the total local assessed value of the municipality would be increased by 10% in order to approximate the municipality's full value. If the comparison indicates that, on the average, the municipality is assessing at 105% of market value, then the total local assessed value would be decreased by 5%.

It is imperative, therefore, that a revaluation not be viewed as a one-time event, but rather a significant and meaningful starting point in an ongoing process. To this end, the Assessing Office has begun the process of reviewing and updating assessments for the 2000 tax year. The ultimate goal is to systematically strive to maintain property assessments as close as practicably possible to 100% of market value for all classes of property and to institute and maintain a consistent, ongoing reinspection program. Starting this year the plan is to inspect approximately 20% of improved properties yearly so that after five years all properties have been reinspected at least once. At the end of five years, the process would continue, thus elminating the need for another costly, involved and disruptive citywide revaluation.

Presently, Assessing Office staff are out in the community gathering required data and reinspecting properties. If you are not home when they visit your property, a door hanger will be left which provides contact information for a follow-up appointment. If interior access cannot be gained, staff is left with the task of estimating the condition, quality, number of rooms, et cetera, of your home. While at the property, exterior features of your home will be verified.

Another task associated with an update is to collect data on commercial and industrial property. An integral part of valuing this type of property is the rental income and expenses associated with a rental property. The Assessing Office maintains a large database of this type of information which is primarily confidential information. In April, the Assessing Office will be sending out questionnaires to commercial and industrial property owners asking them to complete the form so we can be as accurate and fair as possible in placing assessments on this class of property. If your commercial or industrial property is 100% owner occupied, relevant information would be the cost of any and all improvements made in the last few years. Please keep in mind we will also look at recent sales and building permit activity.

Property assessment information, including a recent sales report, is available online at www.lebcity.com Proceed to the government section and then Assessing Office for this information. If you have questions concerning the updating program, please contact the Assessing Office at 448-1499.

Lebanon Police Department & Community Activities

April 17~ ***The 8th Annual "Kids and Cops" Sports Cards Program*** will begin for youths in grades 3-6 with the distribution of sports cards to youths in the Upper Valley by local police dept. promoting anti-drug abuse messages through positive contacts w/ police officers. On May 21 a Sports Clinic will be held at Leverone Field House, Hanover.

April 29-30 ~ The LPD will be participating in the following activities, held at Lebanon High School:

o ***KIXX Kids Trade Show*** (10a-4p) ~ providing bicycle registrations and the annual bike auction on April 29.

o ***CHaD (Children's Hospital@ Dartmouth) Health & Safety Fair*** (10a-4p) ~ providing KidCare Photo ID's and the D.A.R.E. Information Booth on April 29 & 30.

May 14-20 ~ ***Bike Safety Week as part of Bike Safety Month***! The ***Annual Lebanon Police/Lions Club Bicycle Rodeo and Registration*** will be held at Hanover Street and Seminary Hill Schools. Dates and times TBA.

May 21st ~ ***Kids & Cops Sports Clinic*** at Leverone Field House in Hanover beginning at 11:00 a.m. with registration and lunch. Activities are from 12:30 – 3:30 p. m. The program concludes with prizes until 4:00 pm.

May 26 ~ The ***12th Annual Project Graduation BBQ*** in Colburn Park. Fundraiser for LHS senior class to promote a drug free graduation party. Last year 943 people were served steak, chicken & lobster dinners with a profit of over $4,000 for the Senior Class Substance Free Graduation Party. We hope to raise more this year! Join us in Colburn Park from 5-8 p.m.!!



May 27 ~ The ***West Lebanon Alumni Parade***. The Department motorcycle will be leading the parade, along with several other officers providing traffic control along the parade route of Dana St., Main St. & Maple St.



May 29 ~ The ***Lebanon Memorial Day Parade.*** Several officers will provide traffic control along the parade route - Hanover Street & around Colburn Park.

June 1 ~ Lebanon Police Dept. along with the Hanover Police Dept. will be participating in the ***Annual Law Enforcement Torch Run for Special Olympics***. The run will start near the Hanover Police Dept. and officers will run through Hanover and Lebanon to the Enfield town line and proceed with the run the full length of the event to Concord, where the torch ceremony will be held.

June 15 ~ Lebanon High School Graduation!

June 17 ~ ***Lebanon Alumni Parade***. Chief Laurie and several police officers and explorers will escort the parade and assist with traffic control along the parade route.

June 24 – June 30 ~ High School Members of the Lebanon Police Explorers Post will be attending the 27th Police Cadet Academy. The graduation ceremony will be held on June 30.

August ~ The ***9th Annual D.A.R.E. Golf Tournament*** will be held again this year. Date, time, location and tournament information will be announced at a later date.

THE DHMC LAWSUIT—WHAT EVERY TAXPAYER SHOULD KNOW

This special newsletter insert has been prepared as part of a continuing effort to keep the citizens and business community informed about the facts surrounding the lawsuit by DHMC against the City.

How Do Tax Exemptions Affect the Taxes I Pay?

As a general rule, all property owners are required to pay real estate taxes by law to support all local governmental services. These include maintenance of streets, fire and police services, recreation, planning and zoning enforcement, major infrastructure, as well as the City's schools and Grafton County services. The legislature has allowed few exceptions to the general rule that all property owners must pay taxes, because any exemption shifts the financial responsibility to pay for all local City, school and county services onto other taxpayers.

Real estate taxes are described as being "ad valorem," because the amount of the tax paid depends on the value of real estate owned. As budgets increase for specific school, municipal and county services each year, the anticipated expense is supported financially by spreading the cost evenly among all property within the City that can be taxed. The more real estate that can be taxed, the lower the taxes each landowner pays, because there is more property to pay for the cost of the same services.

In effect, then, tax exemptions for some landowners mean other landowners subsidize the businesses or activities on exempt real estate with additional real dollars. The cost of local school and City services does not decrease; the cost is just spread over fewer households and taxes must increase for the remaining taxpayers. For instance, if DHMC had agreed to pay its taxes instead of suing the City, the taxes owed by every resident and business in the City in 1999 could have been significantly decreased. For every home valued at $100,000, instead of taxes that were paid of $3,089, taxes could have been around $2,514 — a decrease of $575.

How Does the Board of Assessors Decide Which Real Estate Is Exempt from Paying Taxes?

New Hampshire law permits certain real estate to be exempt from paying taxes as a way to encourage certain types of activities beneficial to the general public. One exemption is real estate used for charitable purposes. Every year, organizations seeking charitable tax exemptions are required to give information they think is helpful to the City's Board of Assessors to prove that an exemption applies in any given case. Once the Board is familiar with the activities of each organization, it then decides each year whether the organization meets legal requirements for a tax exemption. Some of those legal requirements are:

1. The activities undertaken meet essential human needs of a substantial, or indefinite, segment of the general public.

2. The members of the organization (whether they are persons or related corporate entities) do not benefit financially from the activities.

3. The income and any profits are all used for charitable purposes, and the charitable use and occupancy of the real estate is not slight, negligible or insignificant.

4. The use of the real estate is substantively different than if the same property were used and occupied by a non-charitable or taxable organization.

5. The operations of the organization make it plain that there is an underlying motive of generosity towards the public as shown by activities that are very different from those of a taxable business operating as a commercial venture with a money-profit motive.

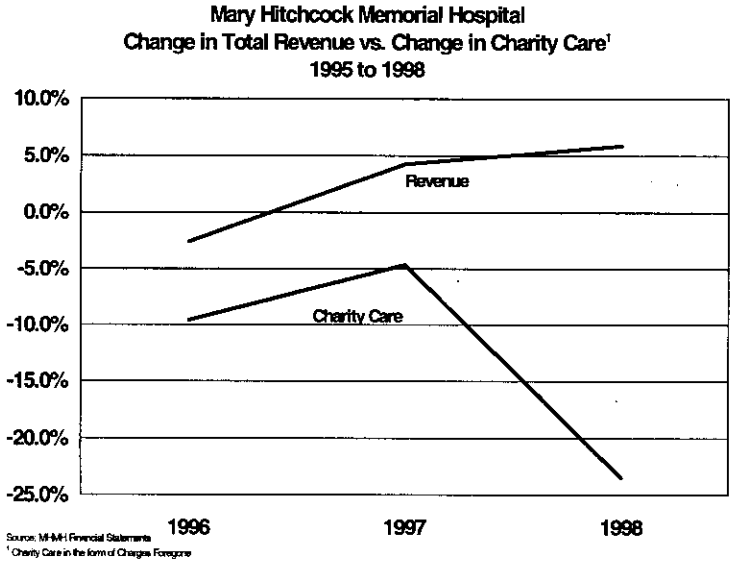


Fig. 1. Between 1995 and 1998, Mary Hitchcock Memorial Hospital's charity care declined sharply at the same time as its revenues were on the rise.

What Process Did the Board of Assessors Follow In Deciding to Tax DHMC?

As is legally required, the Board of Assessors reviews applications filed each year by every organization seeking an exemption. The all-volunteer Board of Assessors, made

up of local business and community leaders, normally grants or denies exemption requests at its regular meetings. Generally, most organizations that request exemptions are granted those exemptions. If the organization is new to Lebanon so that the Board is reviewing its activities for the first time, the Board may take extra time to understand more about the organization. Once the Board obtains the information it needs, it makes a decision either to grant or deny the exemption request. If the organization disputes the decision, the organization is permitted by law to file an appeal either to a state administrative board or to a court.

A recent example of this process occurred when the University Press of New England ("UPNE") moved to Lebanon in 1993. As it was new to Lebanon, the Board reviewed the application, learned about the nature of UPNE's activities and then concluded it did not qualify for the educational exemption sought. The Board denied the exemption, and similar to the current situation with DHMC, UPNE filed an appeal claiming it was entitled to the exemption. In 1995, the City was successful in defending its decision and UPNE has paid taxes since.

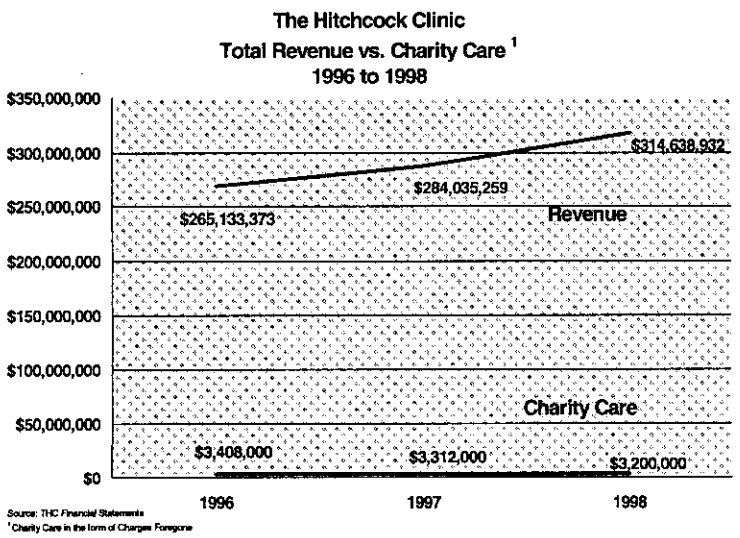


Fig. 2. Between 1996 and 1998, The Hitchcock Clinic saw a dramatic rise in its revenue while its level of charity care decreased.

Did the Board Unfairly Single DHMC Out in Reviewing and Denying Its Exemption, As DHMC Claims?

The short answer is an emphatic "no." Indeed, the City gave DHMC more time and more opportunity to prove its claims than is typical.

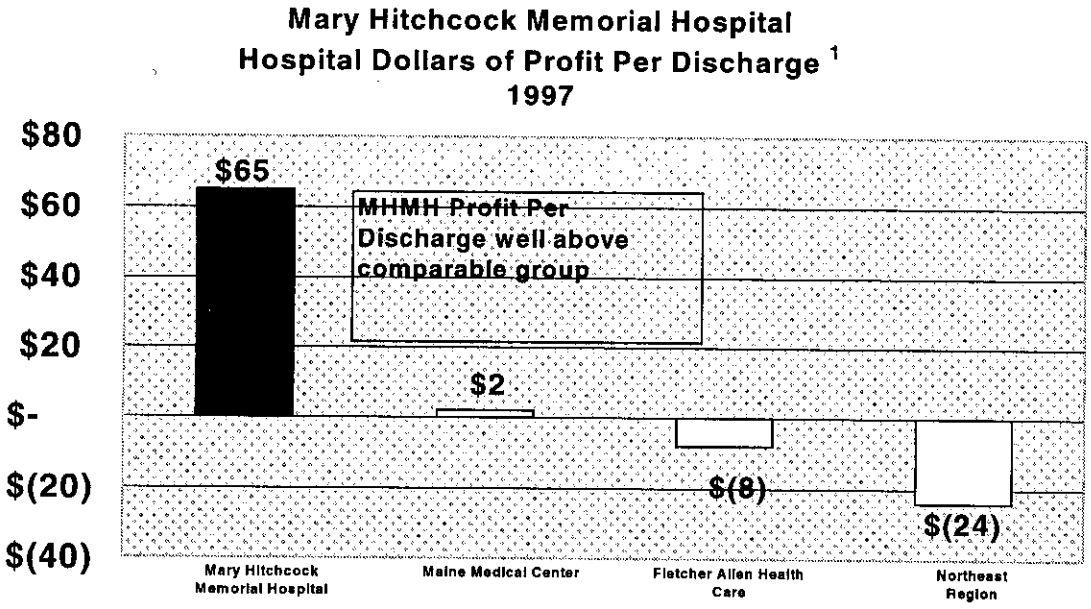
A little historical context is helpful: DHMC moved to Lebanon in late 1991 and immediately requested exempt status as a charity. The Board of Assessors was uncertain about DHMC's eligibility for exempt status, met with DHMC officials, and discussed the issue on several occasions over the next few years. Since the Board increasingly understood DHMC's operations to be more complex than usual, the City eventually retained special legal counsel with experience in the health care industry for advice.

In the meantime, the Board was presented with a request for an exemption by the newly-constructed Harvest Hill, APD's retirement community. The Board sought additional information from Harvest Hill and then sought a legal opinion as to its exempt status. After obtaining both, the Board denied Harvest Hill's exemption request in 1996. (The Board denied the exemption again in 1997 and 1998.) Harvest Hill disputed that decision and filed a lawsuit against the City. In that case, however, the parties were able to come to an amicable accommodation in 1999, and the trial never took place due to the settlement.

After having reviewed Harvest Hill's status, in January 1997 the Board sent a letter to DHMC asking it to provide more information to support its claim for an exemption. City representatives spoke on the phone and met with DHMC representatives on several occasions over the course of the year. Recognizing organizational complexity, the Board did not rush DHMC and gave it ample opportunity to provide any documents that would support its request for an exemption.

When DHMC finished providing documents to the City in late 1997, similar to Harvest Hill, the Board then sought a legal opinion. As there was a significant volume of information to analyze in accord with New Hampshire law, the Board did not receive a report from legal counsel until early March 1998, which was the last month of the 1997 tax year. After reviewing the report, the Board concluded that, to uphold State law, DHMC had to be taxed for the 1997 tax year.

Rather than treating DHMC unfairly, just the opposite occurred. The Board gave DHMC many months to provide additional support for its exemption and delayed making a decision just so that DHMC would have every opportunity to prove its case to the Board. Moreover, the Board then made sure that a careful review was conducted so as to avoid a hasty and uninformed decision. DHMC was unsuccessful in convincing Board members that it qualified for the exemption, but the Board acted appropriately and treated DHMC fairly. In the end, the Board merely concluded that DHMC, as any large business, should do its part to contribute its fair share to support the City's schools and services.



[1]Ratio data extracted from the 1998-99 Almanac of Hospital Financial & Operating Indicators, Wm. Cleverley, Ph.D
Hospital specific ratios obtained from The Center for Healthcare Industry Performance Studies.

Fig. 3. Mary Hitchcock Memorial Hospital's profit earned per patient discharged is much greater than its closest competitors and significantly higher than the average profit earned in the Northeast Region.

What Has the City Learned About DHMC's Activities?

The City has reviewed various public documents over the past two years, although more detailed documents concerning DHMC's operations have not been provided to the City yet. Some facts discovered are summarized below and reflect the activities of several private organizations doing business as "DHMC." With a combination of strong profits and significant cash reserves while working hard to increase market share to accumulate more profit, DHMC out-paced other private companies in New Hampshire in terms of gross revenue. At the same time, very little in the way of charity care was being provided to the public.

- Between 1994 and 1996, Mary Hitchcock Memorial Hospital ("Hospital"), one unit of DHMC, enjoyed profits annually ranging from a low of $12.2 million to a high of $18.5 million.

- In 1997, the profit earned per patient discharged from the Hospital was significantly higher than the average earned by other hospitals in the region. See Figure 3.

- In 1995, the Hospital gave $1.65 million from its profit to The Hitchcock Clinic ("Clinic"), another DHMC unit, to encourage the Clinic's statewide expansion efforts, thereby increasing market share for patient-based revenue.

- In 1995, the non-profit Clinic itself had a profit of $9.4 million and another profit of $5.2 million in 1996.

- These were the profits left over *after* the Hospital and Clinic gave Dartmouth College amounts ranging from $18 million to $20.2 million between 1994 through 1996. During the same time period, the College enjoyed an endowment which increased in market value by almost $340 million and was, by the end of the fiscal year in 1996, worth more than a *billion* dollars ($1,082,934,000).

- The Clinic, although a non-profit corporation claiming to be a charity, has close ties with a for-profit company owned by physician stockholders using a similar name (Hitchcock Clinic, Inc.), sharing some of the same top management-level personnel, and serving as the employer of all physicians working at the medical center.

- In the instances where the Clinic has expanded into other locations in New Hampshire, it has paid taxes for the real estate it uses.

- The Hospital, the Clinic, and the College paid combined annual amounts ranging from a low of $1.96 million to almost $6.4 million between 1994 and 1996 to a holding company which had no employees and provided no healthcare.

- "Dartmouth-Hitchcock Medical Center," this holding company with no employees, spent approximately $4.27 million for "fund-raising expenses" between 1996 and 1998, yet only raised a total of $2.8 million during the same period. See Figure 6.

- In 1997, combined compensation for just five individuals in senior management at the non-profit DHMC came close to two million dollars ($1,798,874).

- While new revenue at the Hospital increased by $20 million between 1996 and 1998, its level of patient charity care decreased by $2 million (and as a percentage of gross revenue, fell from 3.54% to 2.36%, a decrease of 33%). See Figure 1.

- Similarly, the Clinic's total revenues increased by $50 million during this same period but its percentage of charity care for patients went from a high of 1.29% down to 1.02% of its revenues, a decrease of 21%.

- In 1997, the Hospital had $332 million readily available to itself in cash and investments, representing almost two years (595 days) of its operating budget and far exceeding the reserves of community hospitals or even comparable health care facilities. See Figure 4.

- DHMC (including its affiliates) grossed almost a *billion* dollars statewide in 1997 and had the highest revenue of all privately-held businesses reported in the Business NH Magazine. The closest any other private business came to matching DHMC's sales revenue was the $288 million reported by the AutoFair Automotive Group headquartered in Manchester. As a private non-profit corporation seeking a tax exemption, DHMC's gross revenue more closely matched the revenue of Cabletron Systems, Inc. in 1997, a public company that reported sales of $1.4 billion.

dismiss the claim, which was granted by the court. Though DHMC has filed a motion for reconsideration of that decision, the City has been able to begin moving forward to defend its decision on the central issue of DHMC's charitable status.

Towards that end, the City's court filings include its response to DHMC's contention that the Hospital's legislative charter from 1889 automatically entitled it to a perpetual tax exemption as long as it existed. The City has vigorously argued that the 1889 legislative act was repealed, and even then, only related to real estate in Hanover, and did not (nor could not) mean that DHMC was entitled to an exemption without also being required to operate as a public charity as do all other organizations seeking exemptions.

In December 1999, the City began to request documents from DHMC regarding its management and operations to prepare for trial, and at this time, the City is still waiting for DHMC to produce the information. The facts described above are just the beginning of the real story of DHMC's business-like operations.

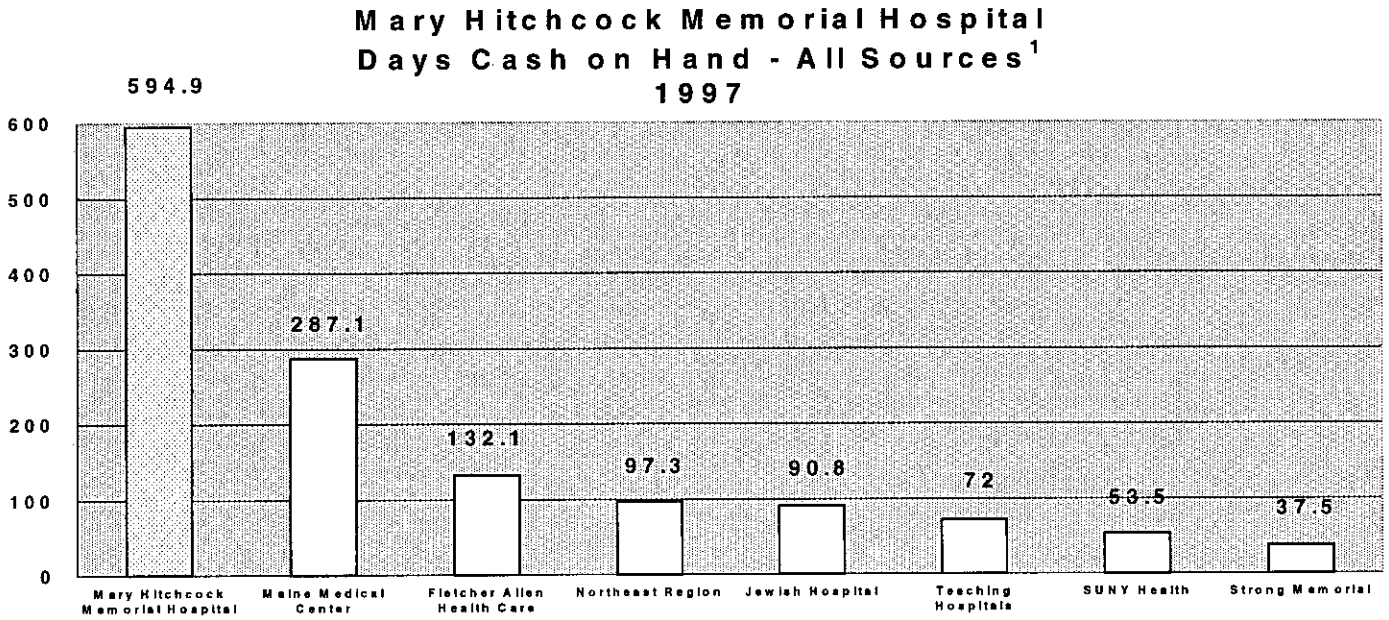


Fig. 4. In 1997, Mary Hitchcock Memorial Hospital maintained almost twice the amount of cash and investment reserves than its closest competitors.

What Is the Status of the Litigation?

The City won the first round of motions filed in court last year. DHMC had claimed on a procedural issue that the tax bill the City had sent for the 1997 tax year was illegal, because it had been sent "too late" in the tax year. The court denied DHMC's motion and the City, in order to remove that issue entirely from the case, filed a motion to

Some questions that still need answers are: Why did DHMC expand during the 1990s to compete with other hospitals and physicians in the area? Did this expansion have anything to do with the enormous expense associated with building the medical center? Why did it open up a new retail store in the heart of downtown Lebanon to compete with local optometrists who were already providing quality optical services? How did it make so

much profit? Why are DHMC's rates higher than most other facilities in the region? Why were charity care levels so low while revenues kept increasing during the 1990s? Why has DHMC never widely advertised free or low cost care despite its claims of being a charity while, at the same time, advertising heavily in local media to attract new patients? These and other questions should be answered by DHMC, and to date, the City has not seen any persuasive reason why DHMC should not be taxed like other businesses in the City.

The City's 1988 Agreement with DHMC Anticipated that DHMC Might, Someday, Be Taxed

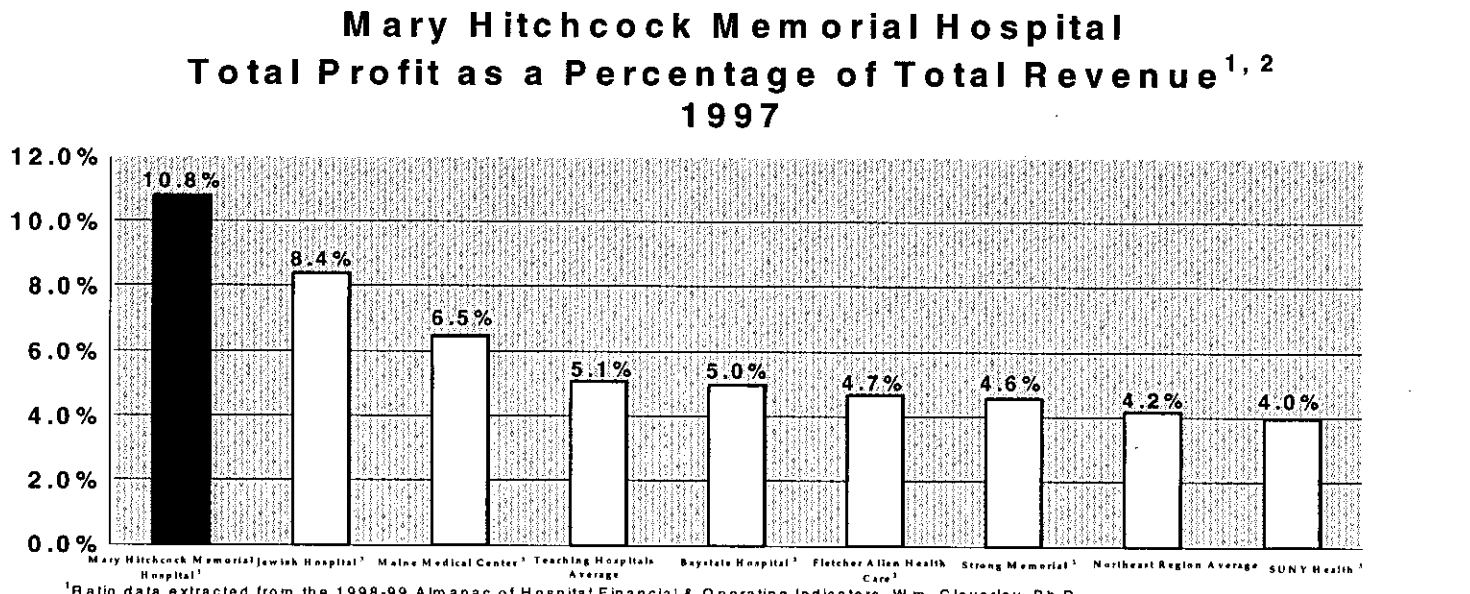
DHMC claims that the City has breached a 1988 agreement that, in fact, expressly states that both parties recognized DHMC might be taxed in the future.

After DHMC decided to move to Lebanon, its representatives met with several City officials in 1987 and 1988. DHMC hoped to encourage and coordinate all administrative permits and approvals needed from Lebanon for subdivision, site plan, zoning, and building issues in order to construct the new medical center.

Included in the arrangements was DHMC's agreement to pay for and construct all improvements needed in the previously-undeveloped area along Route 120 to support its medical facility, including paying for the cost of extending water and sewer services. These arrangements were not unusual. Any developer who had sought to construct a commercial complex or a large residential development in that area would have had to agree similarly, because City taxpayers should not have to pay for new infrastructure intended to serve only one developer's interests—in this case, DHMC.

There was discussion over whether DHMC might be tax exempt in Lebanon since DHMC was, at that time, tax exempt in Hanover. City officials negotiated a $2 million payment from DHMC to offset the cost of DHMC's exempt status on the City's taxpayers. That amount was an advance on annual payments estimated at $250,000 per year for a ten-year period and was a substantial increase over DHMC's first offer to the City of just $50,000 per year. However, the agreement explicitly contemplated that DHMC might be taxed before the end of the ten-year period.

The agreement reads: "In the event that such tax exemption is lost for any of the owners of any part of the [medical center] Project which were exempt from Lebanon real estate taxes on the date of initial occupancy, then all or a portion of the $2,000,000 shall be applied as a credit against the new property tax obligation. After the expiration of the ten year period, there shall be no further credit notwithstanding changes in what real estate is exempt from Lebanon real estate taxes."



[1]Ratio data extracted from the 1998-99 Almanac of Hospital Financial & Operating Indicators, Wm. Cleverley, Ph.D Hospital specific ratios obtained from The Center for Healthcare Industry Performance Studies.

[2]Total Revenue, for comparison purposes, is as defined by the 1998-99 Almanac of Hospital Financial & Operating Indicators, Wm. Cleverley, Ph.D This total revenue number differed slightly (less than 5%) from the published MHMH financial statements. This should not affect the relative comparison value.

[3]Mary Hitchcock Memorial Hospital, Jewish Hospital, Maine Medical Center, Baystate Hospital, Fletcher Allen Healthcare, Strong Memorial, and SUNY Health are all members of the AAMC Council of Teaching Hospitals and Health Systems

Fig. 5. In 1997, Mary Hitchcock Memorial Hospital's profit margin as a percentage of its gross revenue was higher than any of its competitors.

While the exemption issue was never specifically addressed by the Board of Assessors in 1988, the agreement clearly anticipated that DHMC might be taxed at some point in time. A more troubling issue for DHMC is that, even if the agreement had clearly spelled out the promise of a future tax exemption for an indeterminate period of time (which it did not), that portion of the agreement would have been illegal and unenforceable anyway under New Hampshire law.

Nevertheless, the agreement does not promise a tax exemption and the City has abided by the terms of the agreement. Should DHMC decide to accept its taxable status, the City would issue a credit to DHMC of a remaining portion of the initial $2 million payment which would reduce its taxes then due to the City.

Does Centerra Have Anything to Do With Whether DHMC Is Operating In a Charitable Manner?

DHMC has argued that one of the reasons it should not be taxed is due to the benefits already received by the City's taxpayers when it developed the Centerra "Marketplace." The problem with DHMC's argument is that the law relates only to activities taking place on the property DHMC wants to be tax exempt, namely, the medical center.

While most residents appreciate the services and amenities provided by the new Centerra development, Centerra is commercially-operated and intended to return a profit. While one might wonder how commercial development of an office/retail/hotel complex might be related to DHMC's stated health care objectives, new taxes paid by landowners in Centerra are simply irrelevant and do not relieve DHMC of its own responsibility to contribute its fair share to the support of City, school and county services. Certainly, new development places new and increased burdens on the City, but the only legal question concerning DHMC is whether the medical center itself is being operated in a charitable manner. The City has concluded that it is not.

How Does the Earlier Lawsuit Regarding DHMC's Daycare Center Relate to the Present Case?

After DHMC began construction of the medical center in 1989, one of the first buildings completed was a daycare center for its employees. The Board of Assessors did not challenge the taxable status of DHMC (which had not yet moved to Lebanon) but did deny a tax exemption for the daycare center on the basis that it was not being used for charitable (that is, public) purposes.

That issue alone was tested in court. A Superior Court judge eventually decided after a brief trial that the daycare center was reasonably necessary for DHMC to accomplish its "charitable" objectives and upheld a tax exemption for the daycare center alone.

Although DHMC argues that the litigation over the daycare center proves that it is entitled to a charitable exemption now, the issue whether DHMC itself was charitable was never addressed by the court. Moreover, that argument ignores New Hampshire law that establishes that each tax year creates new legal duties for the City to decide the eligibility of organizations for tax exemptions. The earlier case, therefore, simply has little to do with DHMC's most recent lawsuit and cannot be relied upon by DHMC to prove it is entitled to a charitable exemption. Unlike the earlier case, DHMC must prove now that it deserves an exemption on its own merits, or it must pay taxes like every other business in the City.

Has the City Tried to Settle DHMC's Lawsuit?

During 1998 and 1999, the City's representatives met with DHMC representatives on numerous occasions for many, *many* hours, sometimes going late into the night, in an effort to find common ground for settlement. The issues were complex and numerous, and the City made many offers in response to DHMC's demands. During these negotiations, though the discussions were wide-ranging and civil, DHMC moved little towards offering a fair contribution to the tax burden on the City's residents given the value of its real estate exemption and the profitability of its commercial enterprise. The City's representatives were mindful they had to be fair to all taxpayers and uphold legal principles, not only for 1999 and 2000, but into the future. And, while no agreement has been reached yet, both sides continue to talk.

Residents may have heard, in the meantime, that the Lebanon Chamber of Commerce has offered to initiate a public forum for more discussion. The central problem with the Chamber's call for a public forum is that the Board of Assessors' decision to tax DHMC was a legal determination made after a careful review of hundreds of documents from DHMC and the law. While a public forum sounds great, such an event may serve only to cause fractures in this community rather than aid discussion between the parties. At a minimum, it is unlikely to resolve a complicated dispute where lengthy private discussions have been unsuccessful.

Expense of the Lawsuit

Unlike DHMC which has millions of dollars to spend on both litigation and public relations, the City is mindful it has to be careful with its resources in a very complex case with millions of dollars at stake if it wins. Four large and wealthy corporations have sued the City and they have

four groups of lawyers working for them. In response, while the City continued to rely on its local legal counsel in the lawsuit, the City also chose to retain a Boston law firm in order to match the combined resources from the large New Hampshire law firms representing the medical center.

Despite the expense of this litigation to date, there is a great deal more money at stake for the City's taxpayers. If successful, the City will recover far more than its expense and should have millions of dollars left over to reduce future taxes.

Has DHMC's Lawsuit Affected the City's Education Funding?

As a result of the recent New Hampshire Supreme Court decision and legislative activity, the City benefited from increased State funding for education in 1999. But DHMC has raised the question whether the City is losing State money as a result of DHMC's lawsuit.

Beginning in 1999 under the new State law, a tax was assessed on all real estate for purposes of State funding of education. If a community's minimum education required more spending than the State's mandate, the State redistributed the "wealth" to communities that did not have as much taxable real estate.

So, for instance, Hanover was considered a "property-rich" town and its taxpayers were required to send money to the State to help pay for the costs of education in Lebanon and other "property-poor" communities. Even though Lebanon included DHMC's real estate in its taxable property base in 1999, it was still considered "property-poor-enough" to receive $1.4 million from the State, money which had been paid by taxpayers in other communities. Obviously, if DHMC had not been taxed, Lebanon would have been an even "poorer" community in terms of taxable real estate.

The City understands that any disadvantage is short-term and will last only so long as DHMC insists on challenging its tax status. Looking at the bottom line, DHMC should have paid approximately $4.8 million *without disputing it and* the City would have still received additional State funds for education in the approximate amount of $1.4 million. The net effect would have been increased funding from the State for education, despite a larger property tax base including DHMC.

Nevertheless, this "bottom line" approach was not the basis for the Board's decision to tax DHMC. The Board's considerations were not related to financial issues but based on legal principles the Board members felt duty-bound to uphold.

Moreover, City officials are mindful that the law requiring such education funding is under attack from numerous quarters and it may not survive in the long term. For this reason, the City has carefully avoided making decisions today based on assumptions about State education funding that may not exist in the not-too-distant future.

Despite this uncertainty, and despite the fact that all State funding actually comes from the pockets of individual taxpayers, DHMC has asked the City to grant a multi-million dollar annual tax exemption on the basis that the City would then receive even more money from other taxpayers through the new State law than it did in 1999. City officials, however, believe it is wrong to grant DHMC a tax exemption for no other reason than for the City to "get a larger piece of the pie."

Every dollar that the City might obtain from the State to protect DHMC from paying its fair share of taxes would actually require taxpayers from other municipalities, including Hanover, to absorb the difference. The City understands that some Hanover

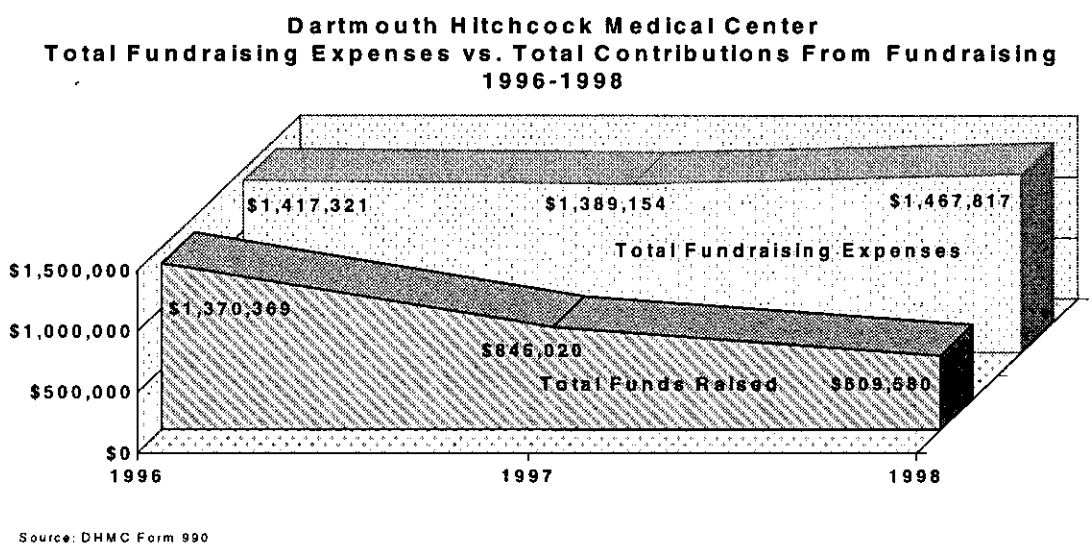


Fig. 6. Despite the fact that DHMC is only a holding company with no employees, it reported having spent $4.3 million between 1996 and 1998 for "fundraising expenses" while raising only $2.8 million during the same time period.

residents, particularly those on fixed incomes, have been hit hard and have struggled to pay the increased tax. The City's priority has been that all taxpayers be treated fairly under New Hampshire law.

If DHMC *should* be paying taxes to Lebanon, it would be unfair and illegal for the City to force Hanover or taxpayers in other communities to increase their financial support just so that DHMC could enjoy a tax exemption to which the City has already decided DHMC is not entitled.

Would A Declaratory Judgment Action Have Benefited the City's Taxpayers?

DHMC has publicly asked why the City did not choose to file a lawsuit against DHMC in the form of a petition for declaratory judgment rather than sending DHMC a tax bill to be paid. DHMC has claimed it would have been less expensive for the City if it had sued DHMC.

The reality is that a lawsuit is a lawsuit—regardless of its form or title—and the City would have incurred the same expense in a so-called declaratory judgment action. The major distinction, however, is that one form would have worked entirely in DHMC's favor: the declaratory judgment suit would have taken the same three or four years to reach a final decision, but DHMC would have paid no taxes in the meantime and the City could only have begun to tax DHMC once the lawsuit was over.

Obviously, DHMC wishes the City had chosen an alternative that would have allowed DHMC to escape paying the same taxes all residents and businesses have been paying. But that alternative would have required taxpayers to have borne the entire cost of the lawsuit themselves without providing an opportunity for them to enjoy the fruits of success at the end.

Other taxpayers, including UPNE and Harvest Hill whose exemptions were also denied, neither have asked for nor received such favorable treatment as DHMC has recently sought. Besides trying to treat DHMC the same as other taxpayers, the City will have a significant sum of money (potentially as much as $22 million) readily available to use at the end of this litigation, if successful, which will immediately enhance municipal and school services and reduce future taxes. Weighed fairly, a declaratory judgment action simply was not in the best interests of the City's taxpayers.

Is There A Slippery Slope? Does the City Plan to Tax Charities?

No. Contrary to concerns expressed by DHMC, charities in Lebanon which are still operating like charities will not be swept along on a tide of new taxable properties.

DHMC is in a league of its own. There is no other organization in the entire state, let alone in the City, like it in terms of gross sales and revenue, profits earned per patient, compensation paid to top management, competitive strength to increase its market share, business-like operations, cash reserves on hand, and the like. Since the Board of Assessors decided DHMC's exemption in 1997, other organizations operating like charities have not received tax bills. The law has not changed, and if these organizations continue to operate so as to meet the requirements of New Hampshire law for charitable exemptions, they will still qualify for the exemptions.

Does this mean that the Board of Assessors will not annually review the facts regarding other organizations? Of course not. Each year, the Board reviews the exemption applications filed by all organizations and decides whether to grant or deny them based on the facts. The Board (whose members are local business and community leaders with strong interest in the well-being of local organizations) has, on occasion, decided to deny exemptions, but it has always done so in a manner it believed to be fair and even-handed. The Board will continue to do so.

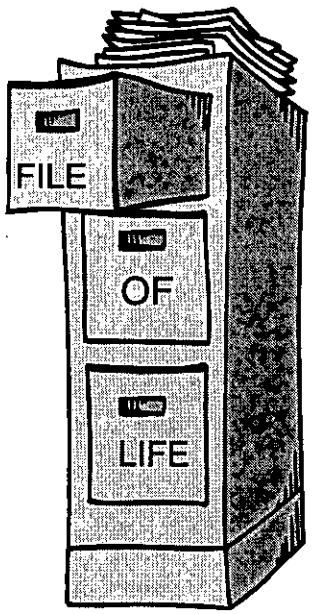
DHMC Needs to Accept An Obligation Shared By All Other Property Owners

Taxes are not penalties. They are contributions which landowners are expected to make to support the services and activities of local schools and government. Every resident and every parcel of property receives governmental services. Such services cost money. When one owner refuses to contribute its fair share of the cost for these services, other property owners must contribute a higher proportion of the total cost.

The City appreciates that the medical center is an excellent facility offering helpful services to many people. The City believes, however, that the medical center's success is similar to many other business enterprises in Lebanon. Other business enterprises recognize they owe an obligation to the community to support funding of our schools and the general services of the City and regularly pay their fair share. The City has only asked the medical center to do likewise.

More Information Available

Additional information is available (such as, the City's court filings responding to DHMC's legal and factual claims, and facts about DHMC) at the City Assessors' office. The City's website at www.lebcity.com will also be updated with information from time to time.



The File of Life Comes to Lebanon

The 911 ambulance phone rings at dispatch. The dispatcher answers "Ambulance dispatch, where is your emergency." The 911 operator replies "this is operator 1310 with a call in Lebanon at 1212 Your House Road. Unknown type medical call, no other information available." The dispatcher confirms the information and alerts the Lebanon Fire Department. A radio tone and alarm bells in the station are set off and the dispatcher broadcasts on both police and fire frequencies "Lebanon Fire, Ambulance Call, unknown type medical emergency at 1212 Your House Road, Lebanon, Time out 0832 hours."

Once we arrive on the scene, the ability of our firefighters/medics to function to their fullest is to have as much medical information about you as possible in order to treat you.

In order to better serve community needs, the Lebanon Fire Department, with funding from the Lebanon Riverside Rotary Club, in cooperation with the Upper Valley Senior Center and the Lebanon Housing Authority, is initiating a program to allow you to be heard even when you cannot speak. This national program is called the "***File of Life***."

The File of Life is a system that standardizes information about you that could be used in an emergency if you were unable to speak or answer questions for yourself. The File of Life consists of four standard components; a standard location, a standard container, a standard information form and a standard medications form.

~ Standard Location: The standard location for File of Life information is on the front of your refrigerator door. This is a highly visible location.

~ Standard Container: A red and clear plastic five by four inch pouch with a magnetic back marked with "File of Life" in white letters magnetically attaches to your refrigerator.

~ Standard Information Form: A two sided form that folds up and stores in the container. This form has spaces for information that facilitates prompt treatment to the best of our ability initially and the hospitals' once we arrive. Information such as name, date of birth, medical conditions, physician, hospital identification number and such information is on the card specific to you.

~ Standard Medications Form: One modification made to the system is the addition of a stand-alone medications form. By having an independent form, should medications change, then only this form need to be changed as opposed to redoing a whole new information form.

Can the "File of Life" make a difference? Absolutely! They already have in other communities and ours should be no different. Information allows definitive treatment instead of a non-specific approach. Information allows informed action in the emergency department instead of reaction to your condition without history, allergies, etc.

We are excited about bringing this program to Lebanon. Distribution should start in late April or early May. If you have any questions, do not hesitate to give the Lebanon Fire Department a call at 448-8810 or email Deputy Chief Brush at: Charlie.Brush@LebCity.com



Airport Master Plan/ Airport Business Park Study



An Airport Master Plan study of local general aviation services and a feasibility analysis of the Airport Business Park is currently in progress.

The Airport Master Plan Update will focus on both existing and future general aviation services at Lebanon Airport. With limited land available for general aviation development, the community and the airport must analyze several development alternatives and establish both short term and long range planning goals. The study will begin with an analysis of existing conditions followed by an estimate of future demand. The objective of the study will be to work with the community to identify feasible alternative development plans for the Airport. A development schedule with associated costs will be submitted as part of this task.

The Airport Business Park Feasibility Study will focus on the next scheduled phase of development (Phase IB) in the Airport Business Park. Phase IB is approximately 45 acres in size and is located immediately adjacent to the existing Business Park. An economic analysis and market overview will be conducted to include a recommendation for the overall development strategy of Phase IB. In addition to the above, the study will also consider conceptual plans for the development of Phases II and III of the business park located on the east side of the Airport.

Public participation is encouraged for each aspect of the master plan process. Public meetings will be held throughout the process in any effort to keep the community fully involved with the planning of future development at the Airport and in the Business Park.

For more information contact Tim Edwards, Airport Manager at 298-8878.

Lebanon Libraries

Programs for Children

Preschool Storytimes ~ Are for children ages 3-5. Held at the Lebanon Library every other Tuesday and at the West Lebanon Library every other Thursday at 10:15 am. Parents and care givers are welcome.

Time for Twos ~ Series of programs featuring simple stories, songs, and finger plays for children ages 2-3 with their parents and care givers. Each session is 6 weeks long and is held each Wednesday morning at the Lebanon Library beginning at 10:15 am. Programs last 20-30 minutes.

Vacation Specials

April 19 ~ **Sleepytime** musical stories with Mary Catherine Jones at West Lebanon. This program is especially for children 2 and up & their families. 7-8 pm.
April 20 ~ NH Audubon Society's program **Birds for Beginners**. This program is held at Lebanon from 1-2 pm and is especially designed for children ages 4 and older.

Reading Cats and Dogs ~ This is the theme of the year 2000 Summer Reading Program. Join us in the Children's Room for fun reading and programs. This program begins as soon as summer vacation does and lasts until the end of July. We guarantee you'll learn about the furry side of four-footed life right along with us. Details available from the Library in April. Call: 448-2459 (Lebanon) or 298-8544 (West Lebanon).





New Faces

You may notice a couple of new faces in the Lebanon Library Children's Room. We welcome Suzanne Winchester and Kristin Wisnewski to the staff at the Library. The Library is very pleased to have them on board!

Adult Programs

Many adult programs are held throughout the year. Please call 448-2459 for information about upcoming programs.

Happy Retirement Goes to Margaret Adams!

After 29 years of service to the West Lebanon community, Library Assistant Margaret Adams has retired. Margaret's caring ways and fabulous sense of humor will be missed by everyone! Best wishes for a healthy and happy retirement Margaret!

Kilton Fund Steering Committee

This volunteer committee made up of dedicated and interested members of the community has been meeting regularly in order to discuss the possibilities of expansion/renovation of the West Lebanon Branch Library on Main Street in West Lebanon. Co-chaired by John Bryar and Dan Smith, the committee plans to meet with city officials to discuss possible on-site expansion. The Committee will also be meeting with consultants in the library and architectural fields to investigate topics such as space planning, work flow analysis and community needs. There are no immediate plans for construction or renovation (which is what the funds are dedicated for) as both the Steering Committee and the Library Board of Trustees feel it imperative to carefully consider all options as well as getting feedback from the community before any decisions are made. If you have any suggestions for new programs, services, or changes to the library building in West Lebanon, please send them in writing to the West Lebanon Branch Library Steering Committee, c/o Susanne Robb, Library Director, 9 East Park Street, Lebanon, NH 03766

~ Notes from the ~
~ Public Works Department ~



Paving Schedule for 2000 – the following streets are scheduled to be paved this year :

West Lebanon	Lebanon
Maple Street & sidewalk	Storrs Hill
Pleasant Street & sidewalk	Buckingham Place
Farman Avenue	Centerra Parkway
South Main Street & sidewalk	Morgan Drive
Orcut Avenue	Poverty Lane

(schedule is subject to change)

Cemeteries



There have been some changes to City Ordinance #25 relating to the City's cemeteries. One of the changes is that the cemeteries are now closed from 10:00 p.m. to 6:00 a.m. Copies of the complete ordinance are available in the City Clerk's Office at City Hall.

Water Issues

With the onset of warm weather, tap water may run a little discolored. This is due to the water temperature changes. If this happens to you, we recommend that you run your tap for 15-20 minutes before calling Public Works. During the hours of 7am-3:30pm Mon. – Fri., call 448-3112, after hours call Dispatch at 448-1212.

Please be on the lookout for water main breaks. If you see water bubbling out of the ground where you know it shouldn't be, call Public Works or Lebanon Dispatch during the times listed above. Remember, water left running costs us all.

Lebanon Recreation Department News & Notes

The Recreation Department publishes a quarterly newsletter with a full listing of programs available. For information and brochures on programs, recreational facilities and parks, please contact the Recreation Department at 448-5121 or e-mail us at recreation@lebcity.com

ONGOING PROGRAMS
NYSCA Youth Coaches Clinics
4th-8th Boys/Girls Lacrosse
Nature Crafts
Junior High School Track
Upper Valley Adventures

UPCOMING PROGRAMS
Adult Outdoor Clinics
April Break-Away
Summer Baseball
Raiders Basketball Camp
Bookmaking and Beyond
Camp Kaleidoscope
Camp K on the Road
Summer Cheerleading
Summer Theater Workshop
Summer Gymnastics
Full Moon Hikes
Summer Hikes
Nickelodeon Clean-Up Day
Jr. High School Photo Club
PlaySoccer Camp
Adult Photography Workshop
Rock Climbing
Savvy Senior Programs
Advanced Scrapbooking
3rd-6th Grade Girls Softball
Adult Co-Rec Softball
Swim Lessons
Tennis Lessons
Thunder Soccer Camp
Summer Track and Field
Water World



LEBANON MEMORIAL OUTDOOR POOL

OPENING DATE: Monday, June 12
SWIM LESSONS: Complete information about swimming lessons will be in the Recreation Department's summer newsletter. Three 3-week sessions will be offered again this summer:
Session I — June 19 - July 7
Session II — July 10 - July 28
Session III — July 31 - August 18

CAMP KALEIDOSCOPE

Arts & crafts, games/sports, trips to State parks and area community recreation activities, environmental education and swimming lessons. Guaranteed fun with a qualified and enthusiastic staff. Join us!

DATES: June 26 - August 4
DAYS: Monday through Friday
LOCATIONS:
Ages 5-6 (Kindercamp) — Mt. Lebanon School
Ages 7-8 — Hanover Street School
Ages 9-12 — Lebanon High School
TIMES:
Basic Camp — 8:30 a.m. - 4:00 p.m.
Early Bird Camp — 7:30 - 8:30 a.m.
Sunset Camp — 4:00 - 5:00 p.m.



FEES:	Resident	Non-resident
Basic Camp	$75/week	$105/week
Early Bird/Sunset Camp	$ 5/week	$10/week

REGISTRATION:
Resident registration begins March 27th.
Non-resident registration begins April 10th.
Registration is on a first come, first serve basis. Registration packets will be available at the Lebanon Recreation Office or in the Lebanon and West Lebanon School guidance offices after March 15th.

HEALTH FORMS:
Just a reminder that children enrolled in Camp Kaleidoscope must have had a physical within two years prior to attending camp, and a physician must verify this information on the health form. We appreciate your cooperation in helping camp run smoothly by requiring that all health forms be submitted by Monday, May 1st.

JULY 4TH CELEBRATION

We need your help! Community organizations, school groups, anybody who is willing to help...we need your ideas to make this year's July 4th celebration one of the most memorable. The Lebanon Recreation Commission is making plans now. Please call the Recreation Office at 448-5121 for the date and time of the next meeting and plan to attend!



Other News & Notes



Colburn Park Events:

(Spring & Summer 2000)

Monday Evening Concerts (free):
June 19 - August 14 — 7:00 - 9:00 p.m.
(sponsored by the Lebanon Rec. Department)

Thursday Noon-Times in the Park (free):
June 22 - August 10 — Noon - 1:00 p.m.
(sponsored by the Lebanon Rec. Department)

May 26 – Project Graduation BBQ
June 3 – Upper Valley Crafters Craft Show
June 17 – Alumni Day Activities
July 22 – Upper Valley Crafters Craft Show
August 19 – Twin State Cruisers Car Show
September 16 – Upper Valley Crafters Craft Show



From the City Assessor:

A Change in Current Use Assessment

The State of New Hampshire Current Use Board enacted a change in their Rules regarding the documentation necessary to be assessed under the "Forestland With Documented Stewardship" (managed forestland category) effective April 1, 2000. Please contact the Assessing Office at 448-1499 or the Department of Revenue Administration at 271-2687 for more information. Or, access the Current Use Criteria Booklet online at http://webster.state.nh.us/revenue/forms/ curruse99.htm or http://www.lebcity.com/government/assessor



Thank You!

Very special thanks go to the following folks:

HARTFORD VOTECH – Thanks to the students and teachers at Hartford Area Career and Technical Center for all the work done during the past Holiday season in making lots of gifts to be given to the children in the area. The Lebanon Welfare Office was thrilled to receive these item and City employees enjoyed looking over these beautiful hand made gifts before they were given away to the children.



Thanks also goes to all the area businesses, churches, service organizations and private clubs for their contributions to the Holiday season. The Lebanon Welfare Office and the City of Lebanon appreciates these efforts.

DAVEY TREE SERVICE – Thanks to Davey Tree Service for volunteering their equipment and their employees, Charlie Chapman and Jamie McKinney to put lights up in the trees in Colburn Park for the Holiday season. We appreciate your efforts and the results were enjoyed by many.



STRYKER BIOMOLECULES – Thanks for your generous donation of equipment to go with the stretchers in the City's ambulances in connection with the City's assuming responsibility for the ambulance service.



NICKLEODEAN BIG HELP CLEAN-UP DAY

As part of Nickleodean's on-going commitment to connecting kids to their communities through volunteering, the Lebanon Recreation Department is pleased to organize Lebanon's Big Help Clean-Up Day. Open to children of all ages! Family members are welcome and encouraged to participate. Contact the Recreation Office if you have a specific park or area you would like to see cleaned up. Trash bags and some equipment will be provided. Bring gloves, rakes, shovels and a lot of energy! Don't forget to stay for FREE pizza at noon!



DATE: April 22
DAY: Saturday
TIME: 9:00 a.m. - Noon
KICKOFF LOCATION: Meet at Colburn Park

Holidays - City Hall and the Lebanon Landfill will be closed on the following dates from April '00 - September '00:

May 29 (Memorial Day)
July 4 (Independence Day)
September 4 (Labor Day)

City of Lebanon
51 North Park Street
Lebanon, NH 03766

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Voting Sheets

HOUSE COMMITTEE ON MUNICIPAL AND COUNTY GOVERNMENT

EXECUTIVE SESSION on HB 1144

BILL TITLE: **(New Title) establishing a committee to study the exemption from property taxes for not-for-profit hospitals.**

DATE: March 16, 2000

LOB ROOM: 301

Amendments:

Sponsor: Rep. Brundige/Kelley	OLS Document #:	2000	3764
Sponsor: Rep. Brundige/Hager	OLS Document #:	2000	3850
Sponsor: Rep.	OLS Document #:		

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. McGuirk

Seconded by Rep. Zerba

Vote: (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Brundige

Seconded by Rep. Hager

Vote: 15-0 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: 15-0

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Richard C. Leone, Clerk

Study Committee made reporting date Nov. 1, 2001

HOUSE COMMITTEE ON MUNICIPAL AND COUNTY GOVERNMENT

EXECUTIVE SESSION on HB 1144

BILL TITLE: **relative to the property tax exemption of not-for-profit hospitals.**

DATE: 3/16/00

LOB ROOM: 301

Amendments:

Sponsor: Rep. Brundige/Kelley OLS Document #: 2000-3764h Adopted/Failed — being removed

3/21/00 dk → Sponsor: Rep. Brundige/Nagle OLS Document #: 2000-3850h (Adopted)/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. McGuirk/Zerba Withdrawn

Seconded by Rep. _____

Vote: _____ (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, (Interim Study) (Please circle one.)

Moved by Rep. Brundige/Kelley Withdrawn

Seconded by Rep. _____

Vote: _____ (Please attach record of roll call vote.)

Final Motion → OTP/A ~~Interim Study~~ Brundige/Nagle

3/21/2000

CONSENT CALENDAR VOTE: 15-0 yes Consent

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Richard C. Leone, Clerk

OFFICE OF THE HOUSE CLERK 2000 SESSION

MUNICIPAL AND COUNTY GOVERNMENT

Bill #: HB 1144 **Title:** Relative to the property tax exemption of certain for-profit hospitals

PH Date: / / **Exec Session Date:** 3/24/00 ~~3/16/00~~

Motion: Ought to Study **Amendment #:** 2000-3850h

MEMBER	YEAS	NAYS
Hess, David W, Chairman	15	
Patten, Betsey L, V Chairman	1	
Cote, Patricia L		
Rice, Thomas E P	2	
Brundige, Robert W	3	
Sabella, Norma A		
Griffin, Mary E	4	
Leone, Richard C, Clerk	5	
Noyes, Richard A	6	
Hager, Elizabeth S	7	
Akins, Ralph L	8	
Lovejoy, Marian E		
Lockwood, Priscilla P	9	
Kelley, William J	10	
Fraser, Marilyn A		
McGuirk, Paul A	11	
Salatiello, Thomas B		
St Cyr, Gerard L		
Sarette, John C	12	
Simon, Anthony F	13	
Zerba, Roger T	14	
Rosenfield, Jay		
TOTAL VOTE:	15	0

Printed: 2/3/2000

Committee Report

COMMITTEE REPORT

COMMITTEE: **Municipal and County Government**

BILL NUMBER: **HB 1144-LOCAL**

TITLE: relative to the property tax exemption of not-for-profit hospitals.

DATE: March 21, 2000 CONSENT CALENDAR YES ☒ NO ☐

☐ OUGHT TO PASS

☒ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

This bill would require the legislative bodies of towns, cities and districts to authorize the tax exemption for not-for-profit hospitals at least every three years. Testimony revealed there is a wide discrepancy in the percentage of services which hospitals contribute for charitable purposes. The amendment established a committee to study the exemption from property taxes for not-for-profit hospitals.

Vote 15-0.

Rep. Robert W. Brundige
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

COMMITTEE REPORT

COMMITTEE: **Municipal and County Government**

BILL NUMBER: **HB 1144-LOCAL**

TITLE: relative to the property tax exemption of not-for-profit hospitals.

DATE: March 21, 2000 CONSENT CALENDAR YES ☒ NO ☐

☐ OUGHT TO PASS

☒ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

This bill would require the legislative bodies of towns, cities and districts to authorize the tax exemption for not-for-profit hospitals at least every three years. Testimony revealed there is a wide discrepancy in the percentage of services which hospitals contribute for charitable purposes. The amendment established a committee to study the exemption from property taxes for not-for-profit hospitals.

Vote 15-0.

Rep. Robert W. Brundige
FOR THE COMMITTEE

3/21
ok

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

CONSENT CALENDAR

Municipal and County Government

HB 1144-LOCAL, relative to the property tax exemption of not-for-profit hospitals. OUGHT TO PASS WITH AMENDMENT

Rep. Robert W. Brundige for Municipal and County Government: This bill would require the legislative bodies of towns, cities and districts to authorize the tax exemption for not-for-profit hospitals at least every three years. Testimony revealed there is a wide discrepancy in the percentage of services which hospitals contribute for charitable purposes. The amendment established a committee to study the exemption from property taxes for not-for-profit hospitals. Vote 15-0.

HB 1144-LOCAL

SUBJECT: RELATIVE TO THE PROPERTY TAX EXEMPTION ~~FOR~~ OF NOT-FOR-PROFIT HOSPITALS.

OTP-A 15-0

THIS BILL WOULD REQUIRE THE LEGISLATIVE BODIES OF TOWNS, CITIES AND DISTRICTS ~~TO AUTHORIZE~~ TO AUTHORIZE THE TAX EXEMPTION FOR NOT-FOR-PROFIT HOSPITALS AT LEAST EVERY 3 YEARS. THE AMENDMENT ESTABLISHES A ~~STUDY~~ COMMITTEE TO STUDY THE EXEMPTION FROM PROPERTY TAXES FOR NOT-FOR-PROFIT HOSPITALS. TESTIMONY REVEALED THERE IS A WIDE DISCREPENCY IN THE ~~AMOUNT~~ OF PERCENTAGE OF SERVICES WHICH HOSPITALS CONTRIBUTE FOR CHARITABLE PURPOSES.

Robert W Burridge