CLU | COMMUNITY LABOR UNITED

The NonProfit City:
The Impact of Boston's Teaching Hospitals on Our Community

A PUBLICATION OF COMMUNITY LABOR UNITED

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Community Labor United

Community Labor United (CLU) is a coalition of community and labor organizations that run joint campaigns to counteract the growing gap between rich and poor, while highlighting the connections between jobs and community issues. Our mission is to protect and promote the interests of working class communities in the Greater Boston region. CLU unites many of the strongest community organizations and unions in our region to drive forward policies that promote quality jobs, secure health care, affordable housing, job access, and environmental justice for the area's low and moderate-income people. Through collaborative research, leadership development and organizing, CLU unites our organizations and communities around a common vision and plan of action.

CLU carries out two types of research: campaign research that helps to frame and support our campaigns, and policy research on other issues of concern to working class communities in our region. In 2006, we published *The Hourglass Challenge: Creating a More Equitable Economy for Greater Boston*, which examines a range of policy and organizing opportunities for stemming this region's rapidly growing economic and racial inequality.

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Acronyms and Abbreviations Used in this Report

AMC ..... Academic Medical Center
BIDMC ..... Beth Israel Deaconess Medical Center
BWH ..... Brigham and Women's Hospital
BMC ..... Boston Medical Center
CEO ..... Chief Executive Officer
CHB ..... Children's Hospital Boston
COBTH ..... Conference of Boston Teaching Hospitals
DFCI ..... Dana Farber Cancer Institute
ER ..... Emergency Room
FESS ..... Family Economic Self-Sufficiency
FY ..... Fiscal Year
LPN ..... Licensed Practical Nurse
MH ..... MassHealth
MGH ..... Massachusetts General Hospital
PILOT ..... Payment in Lieu of Taxes
RN ..... Registered Nurse
StE ..... St. Elizabeth's Medical Center
TMC[1] ..... Tufts Medical Center
UCP ..... Uncompensated Care Pool

EXECUTIVE SUMMARY

Boston's health care industry comprises a unique cluster of world-class academic medical centers (AMCs) that train the nation's doctors and serve patients from across the country and around the world. These institutions are among the City's largest employers and are generally regarded positively, as an economic engine. At the same time, the tax-exemption AMCs enjoy on their extensive land holdings, along with their continued expansion, add to the pressures on Boston's working families.

Community Labor United is a coalition of community and labor groups whose mission is to protect and promote the interests of working class communities in the Greater Boston region. We believe that it is reasonable to ask whether the pressures of providing extensive tax exemptions to these institutions are balanced by the benefits a prosperous health care industry is bringing to Boston's residents—whether the industry makes a fair contribution to the people of Boston in return.

In this study, Community Labor United examines whether or not Boston's academic medical centers (AMCs), the core of the hospital sector, make a fair contribution to the City, its workers and its residents. Analyzing a range of information including property tax valuations, hospital financial filings, and employment data in Boston's health-care sector, this report addresses the following questions:

1. Are AMCs paying a fair share of revenue to the City of Boston?

2. Are AMCs providing their workers with good jobs at good wages?

3. Are AMCs providing an adequate level of charity care?

Our detailed examination of a wide range of data leads us to conclude that the answer to all three of these questions is 'No." We present evidence that the AMCs fail on all three criteria for contributing adequately to the City of Boston and its residents.

As a group, the Boston AMCs paid only one-quarter of their fair share of the cost of essential municipal services—and this share represents only a fraction of what residential and commercial taxpayers must pay. Further, the area labor market for hospitals and the health care sector in general is significantly inequitable, with almost two-thirds of the sector's occupations failing to pay wages high enough to provide for workers' basic self-sufficiency.

Finally, Boston's AMCs do not even provide an adequate level of charity care to the poor, one of the core purposes underpinning their nonprofit tax-exemption. They fall very far below the proposed federal standard of directing 5% of their revenues to provide uncompensated charity care for low-income patients. These failures cannot be attributed to a lack of resources: in Fiscal Year (FY) 2007, Boston's AMCs had profits—which they call surpluses—ranging from $9 million to $355 million, and

owned assets worth hundreds of millions of dollars. The property tax exemption AMCs enjoy as nonprofit institutions represents additional millions of dollars in public subsidies they receive every year in the form of tax exemptions. Ironically, this adds to the AMCs' capacity to buy more land and buildings, which takes even more land off the tax rolls and increases traffic and other burdens on adjoining neighborhoods.

1. Failure to Pay Fair Share Contribution Strains the Local Tax Base

Boston is home to a large number of medical institutions, nearly all of which are nonprofits. In Fiscal Year (FY) 2007, the 30 largest nonprofit medical institutions together owned *tax-exempt* properties with an assessed value of just under $3 billion ($2,997,377,626). (These institutions owned additional commercial, residential and industrial properties on which they pay taxes, which are not included in these figures or studied in this report). If these medical institutions' $3 billion in tax exempt properties were not exempt—if they were taxed at the commercial rate of $26.87 per $1000 in value that is paid by other businesses—they would bring in over $80.3 million in revenue. Subtracting the modest 'payments in lieu of taxes' (PILOT) that some of these institutions pay voluntarily, in 2007 the **City of Boston lost $76.3 million in revenue because these properties were exempt from taxation. Boston's large teaching hospitals, known as Academic Medical Centers (AMCs) accounted for most of this revenue loss, $60.2 million.**

Although they are tax-exempt, as large employers and owners of extensive properties the AMCs make significant use of essential City services—fire, police, and public works—and we believe that they should at the very least pay their fair share of the cost of providing these services. This assumption also governs the City's PILOT guidelines, which suggest that these nonprofit institutions should pay 25% of the commercial property tax obligation on their tax-exempt properties, since essential services represent approximately 25% of the City's budget. The City of Boston, under Mayor Menino's leadership, has earned a well-deserved reputation for the "most proactive PILOT program in the country."[2] Between 1993 and 2008, Mayor Menino succeeded in more than doubling total PILOT payments, bringing many new institutions into the PILOT program and significantly increasing the contributions of other institutions. However, the City is constrained by the fact that it cannot require PILOTs: a state statute dating back to 1830 grants these institutions tax-exempt status, and to date numerous attempts to amend this statute have failed.

Despite the City's intense efforts, the AMCs as a group paid only one quarter of the amount Mayor Menino and the City have designated as their fair-share contribution to the costs of essential municipal services; and this amount, in turn,

represents only a fraction of what residential and commercial property owners who are not tax-exempt must pay. Assuming that large nonprofit institutions should pay 25% of the commercial property tax obligation on their exempt properties to cover the cost of essential services, Boston nonprofit medical institutions as a group should pay $19.1 million in PILOT payments to cover the essential services the City provides, and the AMCs should pay $15.05 million of this. **In FY07, the AMCs paid just under $4 million in voluntary PILOT payments. The AMCs, then, paid only one-quarter of the PILOT goal—25%—and *just 6% of what the tax revenue would have been if the Academic Medical Centers were not exempted from taxation*.** This gap is even larger if you include all nonprofit medical institutions.

Nonpayment of taxes by the AMCs puts additional pressure on residential taxpayers to pay increased taxes, at the same time restricting the City's ability to provide services. In a city where more than half of the land is tax-exempt, this contributes significantly to the financial difficulties facing Boston and puts pressure on residential and commercial property taxes. Because of restrictions arising from Proposition 2½, and as a matter of political reality, the City of Boston cannot simply raise property tax rates as much as is needed to pay for essential—and other—services. As a result, wealthy nonprofit hospitals sitting on valuable real estate create a squeeze on City taxes and services.

2. Inadequate Hospital Wages Point to an Inequitable Labor Market and Shifting Employee Health Care Cost Burdens Taxpayers

The hospital labor market is not an equitable one. **Nearly two-thirds of its occupations fail to pay a "self-sufficiency wage**"—the wage a Boston family of three needs simply to pay for its basic needs, approximately $58,133.[3] This figure is very close to the 'mean occupational income' for both the Greater Boston region and for the 100 largest hospital occupations. If incomes were clustered around this mean, it would represent an 'equitable' labor market; but unfortunately a mapping of the City's hospital labor market shows that its occupations are NOT clustered around this mid-point. The hospital labor market is significantly inequitable. Executive salaries reflect this: in 2006, each of the AMC Chief Executive Officers (CEOs) was paid $1 million or more in compensation: about 50 times the median income for the AMCs' lowest-paid full-time occupations and 14 times the average salary for registered nurses. Low wages are exacerbated by other troubling features: a lack of training and advancement opportunities for lower-wage workers, and racial diversity found generally at only the lowest rungs of the occupational ladder.

Perhaps most disturbing, we also found that many AMC employees and their dependents themselves relied on charity care through the Uncompensated Care Pool and MassHealth, because they either did not receive or could not afford employer-sponsored health insurance. **In FY07, Massachusetts taxpayers absorbed the cost of providing health care for 8,000 Boston AMC employees and their dependents,**

totaling $9.4 million. We do not believe that this kind of 'cost shifting' is acceptable from the AMCs, which are making tens and often hundreds of millions of dollars in profit, institutions that are already subsidized by millions of dollars in tax exemptions.

3.Under-serving Poor Patients Creates a Strain on the Poor and on Taxpayers

One public benefit that most people expect from tax-exempt hospitals is that they provide adequate (or better) free care to the poor. The proposed federal standard is that a nonprofit hospital should spend a sum equal to at least 5% of its annual patient revenues or operating expenses—whichever is more—on uncompensated charity care.[4] T**he Boston AMCs do not come close to meeting this proposed standard: over the past six years, none of the teaching hospitals has provided even half of the level of charity care suggested by proposed federal goal. In 2007, none of the Boston teaching hospitals met even 10% of the proposed federal goal, and most were well below 5% of this goal—that is, they spent less than 1/3 of 1% of patient revenues on uncompensated charity care.** Not providing free health care to the needy creates a strain on poor people seeking health care, forces the government to pay more in health care costs, and ultimately imposes a burden on working families who pay increased taxes to cover these costs.

Conclusion

There is no credible evidence that the academic medical centers cannot afford to pay more equitable and self-sustaining wages for their workers and to provide more generous uncompensated charity care, just as there is no credible evidence that they cannot better support a fair share of essential municipal services. The tax exemptions that Boston is required to grant institutions such as the AMCs rest on an assumption that the exempt nonprofit institution is indeed fulfilling its exempt purpose in the activities that take place at each of its exempt properties. As the AMCs have grown into physically huge, legally complex, multi-billion dollar enterprises, new questions arise about whether this is in fact the case. The time may have come to reexamine this issue.

Community Labor United believes that our economy is shaped as much by creative public policy and broad civic participation as it is by the specific types of economic activity located here. The shift from a manufacturing-based economy to a service-based economy need not condemn us to low wages, high unemployment and shrinking public services. As in the past, organized communities, organized workers and innovative leadership can lead our region towards an economy where working people can support their families, where cities have the funds to pay for necessary services, and where residents and institutions share the revenue burden. Community Labor United is hopeful that Boston's academic medical centers can play a positive role in helping us to move in this direction.

I. INTRODUCTION

Health care is one of the most important sectors in the Boston economy. The City's health care industry comprises a unique cluster of world-class academic medical centers that train the nation's doctors and serve patients from across the country and around the world. These institutions are among the largest employers in the City and own significant amounts of land. The property tax exemption they enjoy as nonprofit institutions represents millions of dollars in public subsidies for them every year—yet these "nonprofits" make millions of dollars of profit ("surpluses") and own assets worth hundreds of millions of dollars. Nearly two-thirds of their workers do not make a wage sufficient to support a family in the City. And, perhaps most disappointing, they do not even provide an adequate level of charity care to the poor. Despite their importance to the Boston economy, Community Labor United is very concerned that these institutions do not make a fair contribution to the City or its workers.

Much has been written about the large nonprofit hospital sector in the Greater Boston region.[5] The research on this sector has largely examined the nonprofit hospitals from the traditional economic growth perspective. From this perspective, any job creation is considered to constitute a plus for the community, as well as a justification for continued public subsidies to large nonprofit employers. This economic growth perspective, however, fails to consider such issues as the quality of the jobs created, the impact of the subsidies that property tax exemption provides on the operation of the City of Boston, and the impact of the institutions' physical growth on surrounding neighborhoods. These are all important considerations for working people in Boston. The large hospitals accumulate a lot of wealth, yet they maintain inequitable wage scales in which executive and professional staff take home hundreds of thousands of dollars while workers struggle to earn self-sustaining wages. Community Labor United asks: "Don't we expect better from our nonprofit hospitals?"

In CLU's 2006 report *The Hourglass Challenge*, we recognized the importance of the nonprofit sector to the Greater Boston economy and to the region's employment landscape, with health care representing a significant piece of the nonprofit sector. Six out of every ten Boston workers are employed in the health care sector.[6] In Greater Boston there are over 1,600 health care establishments employing more than 100,000 people, with a combined annual payroll of over $4.6 billion. Taken together, twenty-one nonprofit hospitals have an annual payroll of over $2.7 billion and employ over 60,000 people. The Greater Boston Chamber of Commerce found that Health Care and Life Sciences is the largest employment sector in the region (252,500 employees), followed by Banking and Financial Services (132,600), High Technology (112,000), and Higher Education (85,900).[7]

In 2006, of the forty-eight largest employers in Boston (all of which have more than 1,000 workers), fifteen were medical facilities.[8]

This first report from Community Labor United's *Nonprofit City* research project focuses specifically on the City's large teaching hospitals, called Academic Medical Centers (AMCs). According to the Conference of Boston Teaching Hospitals (COBTH), the AMCs employ nearly 30,000 workers in the City itself and nearly 90,000 in Suffolk County and the adjacent counties of Middlesex, and Norfolk. Here we focus on seven of the leading teaching hospitals in Boston: Beth Israel Deaconess Medical Center (BIDMC); Boston Medical Center (BMC); Brigham & Women's Hospital (BWH); Children's Hospital Boston (CHB); Massachusetts General Hospital (MGH); St. Elizabeth's Hospital (StE); and Tufts Medical Center (TMC). Six of these seven AMCs are among the top ten largest employers in Boston.

Top Ten Largest Employers in Boston, 2007 (hospitals are bolded)

1. Massachusetts General Hospital
2. Brigham and Women's Hospital
3. Beth Israel Deaconess Medical Center
4. Boston University
5. Fidelity
6. Tufts Medical Center
7. Northeastern University
8. Boston Medical Center
9. Children's Hospital Boston
10. Harvard University

Source: Conference of Boston Teaching Hospitals, Driving Greater Boston and New England: The Impact of Greater Boston's Teaching Hospitals*, Boston, MA, 2007*

We focus on the Academic Medical Centers because they are the largest hospitals in Boston. They can be more easily compared (as a type) because they are all acute care facilities with active emergency rooms. Moreover, their relationships with universities, also nonprofit entities, suggest an even deeper public obligation. (Note, however, that for the employment analysis we had to rely on data about the Boston-area health care sector as a whole, as the individual hospitals do not provide independent public reports on their actual occupations, wage rates, and related data.)

Analyzing such data as property tax valuation, hospital financial filings, and employment and occupational data about the health care sector, this report asks whether the AMCs make a fair contribution to the City, its workers, and its residents. First, we examine the profit-making capacity of the AMCs. Then, we look in detail at the AMCs contribution in three areas:

(1) Are AMCs paying enough to the City of Boston to cover their fair share of the cost of essential municipal services?

(2) Are AMCs providing their workers with good jobs at good wages and helping to create an equitable labor market in the health care sector? and

(3) Are AMCs providing an adequate level of charity care for the poor?

In all three areas, the evidence leads us to conclude that Boston's large teaching hospitals are currently failing to meet even modest standards for a fair contribution to the city they call home.

Hospitals As Profit Generators

Nonprofit hospitals are legally classified as charitable institutions, and this is one of the primary reasons that the AMCs are exempt from taxation.[9] The exemption is given to allow the hospitals to operate and to perform their public mission. It can be surprising to learn, then, that these institutions can and do make profits. Nonprofit organizations can legally make a profit, but there are limitations on what they can do with it. For instance, nonprofits cannot pay out profits to individual owners or shareholders, as for-profit institutions do; but they can accumulate profit and use it in a variety of ways, including land purchase and facilities expansion. It might seem counter-intuitive that nonprofit hospitals would make any significant profit, but, they can and do. Boston's seven AMCs each made over $10 million in profit in fiscal year 2006. This profit is the amount by which their revenues exceed their costs. While the hospitals' accountants often refer to it as a "surplus," we refer to it by its more common name: **profit**.

Children's Hospital Boston (Children's) provides a useful illustration of how significant an AMC's profit can be. Children's is tax exempt, but made a voluntary 'payment in lieu of taxes' (PILOT) to the City of Boston totaling $593,750 in fiscal year 2007 (FY07).[10] That amount represents just over one-quarter (28%) of the City's PILOT goal for Children's, and less than 7% of what would be the hospital's tax obligation were there no exemption at all. While $593,750 is a very small amount to pay if you consider the assessed value of Children's tax-exempt properties, it nevertheless compares favorably to other PILOT-paying institutions. If Children's had been taxed on its more than $315 million of tax-exempt property that year, it would have paid an additional $7.88 million in property taxes. This means that Children's Hospital received almost $7.9 million in property tax relief in that one year—essentially, a $7.9 million subsidy from the City of Boston and its' taxpayers.

In FY07, Children's Hospital made a profit of just over $100 million. In other words, after accounting for the entire cost of the hospital's community benefit, community

Total Profit for 7 Boston AMCs, FY04-FY07

Hospital	FY04	FY05	FY06	FY07
Beth Israel Deaconess Medical Center	$40,813,000	$51,765,000	$64,609,000	$94,358,000
Boston Medical Center	$21,112,762	$54,219,000	$45,792,397	$52,128,472
Brigham and Women's Hospital	$42,708,000	$93,568,000	$68,070,000	$74,758,000
Children's Hospital Boston	$69,956,000	$110,133,000	$101,465,000	$112,544,000
Massachusetts General Hospital	$153,470,000	$245,415,000	$294,917,000	$354,657,000
Tufts Medical Center	-$21,260,000	$13,584,000	$10,099,000	$9,007,000
St. Elizabeth's Medical Center	$317,504	$10,488,482	$10,139,424	$15,853,820

Source: DHCFP Hospital Financial Reports

service, and charity care programs, and after paying its PILOT and whatever taxes it may have owed that year for for-profit uses of its property (such as a leased food-service facility), and after covering all operating expenses, Children's still had over $100 million left over for the year. The $7.9 million subsidy from the City of Boston, then, represents a mere 8% of Children's profit.[11]

There is nothing illegal or even inherently inappropriate about the AMCs making a surplus, or profit. But the magnitude of their profits does tell us something about the ability of these institutions to pay their fair share for essential city services, to provide their workers with good wages, and to provide charity care to the poor. We see in the next section that these profits are being generated at a time when their host city could certainly use additional revenue.

II. PAYING THEIR FAIR SHARE?

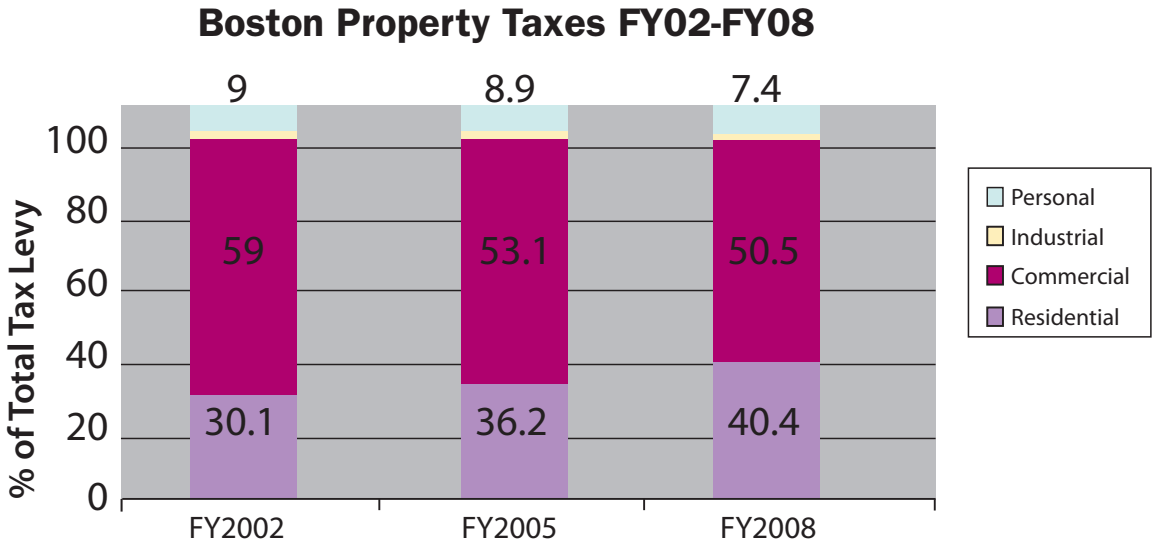
Local government depends on property taxes to provide the essential services on which residents and businesses rely every day. Police protection, fire and rescue services, trash pick-up, road maintenance and schools are functions of city government. Residents and businesses pay local taxes, primarily the property tax, to ensure that the City can function properly. AMCs do not.

Twin Problems: Overburdened Taxpayers, Underfunded Municipalities

The financial stress on Massachusetts' cities and towns is reaching critical proportions, and their fiscal difficulties are well documented.[12] A recent report from the Massachusetts Budget and Policy Center shows that while property tax collection has not changed much in fifteen years, overall state tax rates and receipts have fallen, meaning that the property tax represents an increasing share of total taxes paid.

> ". . .three factors may be contributing to heightened public concerns about property taxes: (i) property taxes, as a share of income, declined in the late 1990s, but began to climb due to local aid cuts beginning in FY 2002[;] (ii) there has been a trend towards greater reliance on residential property taxes relative to those from commercial and industrial sources; and (iii) income growth has been concentrated among high-income households in recent years, meaning that low-and moderate-income families' ability to pay their property taxes may not have risen at the same rate as those taxes."[13]

Residential taxpayers are shouldering an increasing share of the tax burden. This problem has been compounded by rising property value assessments, coupled with tax breaks for commercial and industrial uses.[14] This creates two problems—one for residents and one for municipalities. The problem for residents is evident:

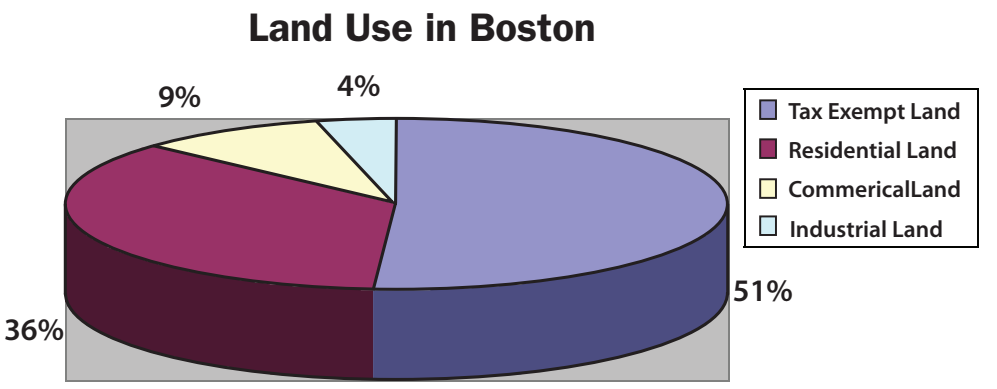


Source: City of Boston Property Tax Facts and Figures FY 2008. City of Boston Assessor's Database.

residential property taxes increase almost every year to support the annually increasing cost of providing the same, or an even lower level of government services, whether or not residents' incomes have increased.

For municipalities, the corresponding problem is inadequate revenue. Proposition 2½ limits the amount of revenue a city or town may raise, or levy, from local property taxes each year to fund municipal operations. First implemented in fiscal year 1982, Proposition 2½ limits the total levy a city or town can collect to no more than 2.5 percent of the total full cash value of all taxable property in the community. In addition, in a given fiscal year the total levy may increase no more than 2.5 percent.[15] Massachusetts cities and towns are up against a revenue ceiling: the Proposition 2½ tax cap. Their only way out of this is to have rising property values, to attract new construction, or to win state permission to enact new local taxes such as a meal tax. The Proposition 2½ tax cap puts increasing pressure on municipal officials to make land use decisions—for example, permitting new construction—for purely fiscal reasons, regardless of whether the uses are appropriate or reflect community desires. This "fiscalization" of land use decision-making has dire consequences for neighborhoods as pressure for increasing gentrification becomes a *de facto* municipal policy.

In Boston, one important squeeze on the City's ability to raise revenue is the fact that so much of its land is off the tax rolls. A total of 51% of Boston's land is tax exempt. Most of this land is used for open space; schools, government facilities and other public uses; and religious institutions. A small but significant amount of Boston land is owned by large tax-exempt nonprofit hospitals and universities. In 2005, tax-exempt nonprofit hospitals and universities owned 5.4% of all the land in Boston, which translated into almost $160 million of lost tax revenue.[16] This is equal to approximately 8% of the entire City budget or about one-third of the City's total state aid for that year.



Source: Perez, Yolanda et al, Residential Land Use in Boston, Boston Redevelopment Authority, 2/1/2004, p. 1.

PILOT: A Policy Tool to Address Nonprofit Tax Exemption

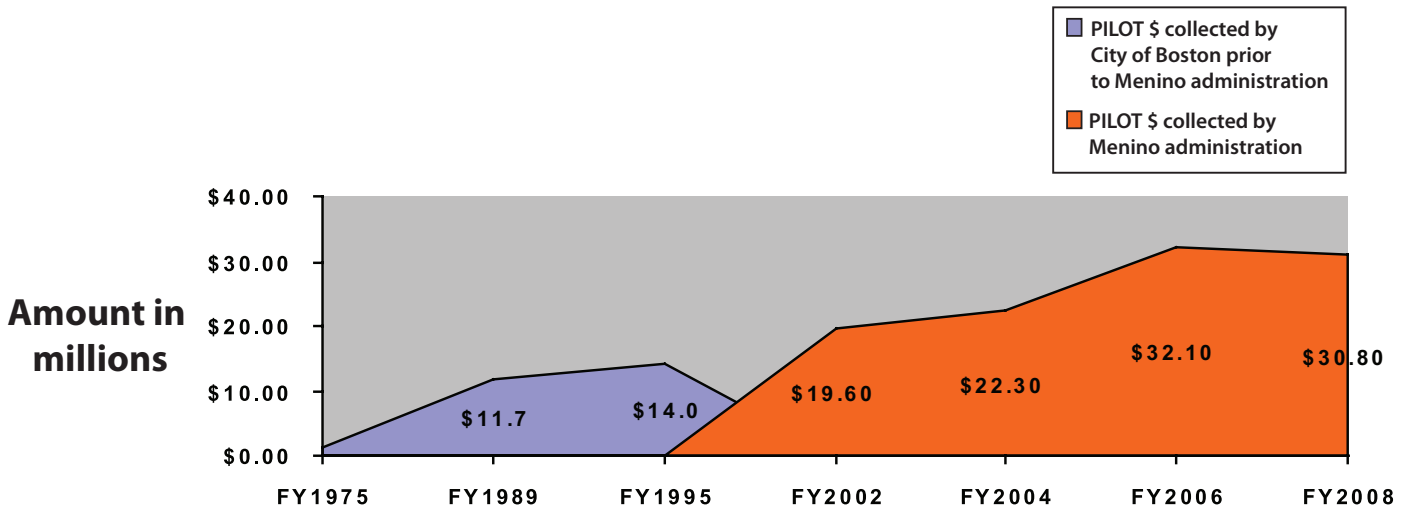
Although the Boston AMCs are exempt from corporate income tax under federal IRS law, it is state statute that grants them exemption from local property taxes. In 1830, Massachusetts granted tax-exempt status to land used for charitable purposes.[17] Given this state law, the City of Boston cannot legally require these institutions to pay property taxes on any property that is correctly used for their exempt purpose. Most states have laws similar to Massachusetts'. A recent review of state laws concerning property tax exemptions for nonprofit organizations found that forty-five states grant a property tax exemption to nonprofit organizations that serve a charitable purpose, although 'charitable purpose' is defined by only a few states and even these definitions are not uniform.[18] Most of these states also require that the organization be incorporated as a nonprofit, and most also exempt only property that is both owned by the nonprofit and used for a charitable purpose.

With mandated caps and political limits to residential property tax increases, the slim array of local revenue options, and the absence of available land for new development, Massachusetts municipalities are looking to large property-owning nonprofit institutions, such as the AMCs, to pay their fair share for essential local public services.[19] A PILOT is a *payment in lieu of taxes*: any voluntary, but contractual, payment made to a public agency instead of or supplementary to tax payments. PILOT agreements are used with nonprofit organizations or other governmental entities that are exempt from paying taxes to a local government.[20] To this end, in 1985 the City created a program to persuade nonprofit institutions to make *payments in lieu of taxes*, or PILOTs, to cover their fair share of the costs of essential city services.

The Country's Most Proactive PILOT Program

Mayor Menino and the City of Boston have earned a well-deserved reputation for the "most proactive PILOT program in the country."[21] Boston has an explicit PILOT policy and actively seeks out participation, which is unusual for a U.S. city. PILOT payments come from three major sources: 1) state and other government agencies (e.g. for open space); 2) Massachusetts Port Authority (Massport), which owns Logan Airport and other land; and 3) large tax-exempt nonprofit hospitals and universities. The City's largest PILOT agreement, $15 Million in FY07 or almost half of the PILOT total is with Massport. Massport's PILOT agreement was mandated in 1978 by state legislation, and the City periodically re-negotiates the terms. In addition to efforts to get nonprofit institutions to contribute to the cost of City services through PILOT payments, the City has also worked to get nonprofit colleges, universities and hospitals to directly address the needs of low-income residents by filling medical, educational or affordable housing service gaps.[22]

Boston Revenues From PILOTs 1975-2008



Sources: FY1989 data is from the City of Boston Assessors Department, reported in Zuckoff, Mitchell, Communities Ask Colleges for Financial Contributions, *Boston Globe, May 9, 1990, West Weekly p. 1. Data for FY 2002 is from Boston Redevelopment Report #562, T*ax Exempt Property in Boston, *December 2002, p. 11. Data for FY 2001 – FY 2007 is from City of Boston, Office of Budget Management,* Revenue Detail.[23]

Between 1993 and 2008, Mayor Menino succeeded in more than doubling total PILOT payments. The City reports that growth in PILOTs comes from three sources: new PILOT agreements, contract escalations that adjust the payments for inflation, or re-negotiation of a current contract.[24] Mayor Menino succeeded in negotiating PILOT agreements with many colleges, universities, hospitals and cultural institutions that had not previously paid, increasing the number of PILOT agreements from a dozen in the early 1990s to 44 in FY2006.[25]

Boston's "Fair Share Taxation" Approach

When the City learns that a large nonprofit property owner has acquired new property, or plans new construction or other expansion, the City attempts to negotiate a PILOT that will compensate the City for up to 25% of the lost taxes on that parcel.[26] The PILOT agreement also typically includes an escalator clause to keep up with inflation. The City does not currently ask nonprofits to pay a PILOT on property already off the tax roles as of 1985, the date of the policy's adoption. PILOT negotiations are accomplished either through the Boston Redevelopment Authority's permitting process, in which case the Mayor's Budget Office takes the lead; or through a change in tax status on a parcel, in which case the City Assessor's Office takes the lead.

The City of Boston's policy of seeking voluntary PILOT payments from nonprofits to the city incorporates a fair share methodology. The PILOT goal of 25% of lost revenue is based on the idea that all property owners should cover their share of the cost of "essential services," defined as police, fire, and public works, which together make up about 25% of the City budget. (For the purpose of setting PILOT goals, schools are not defined as an 'essential service.') The assumption is that this 25% essential services cost is shared relatively equally among all taxpayers.

Fair Share Taxation

Businesses, like residents, pay a "fair share" of the tax burden for city services that are part of our present-day municipal "commons." What does that mean? We do not consider it fair for property owners to opt out of paying taxes on the grounds that they use few or no city services. If we did, a wealthy childless couple living in a multimillion dollar townhouse on Beacon Hill would pay less than a working-class family with several school-age children living in a modest Mattapan home. In fact, these two property-owners are asked to pay the same residential tax rate, although the Beacon Hill couple pays more in taxes because their property is more valuable.

This is a fundamental principle of 'fair share' taxation, the method used for determining residential and commercial, as well as institutional, charges. (See sidebar on page 18.) There is no provision for hospitals, individually or collectively, to claim that they use more or less than this level of City services, even if they supplement City services with in-house trash collection or security.

Efforts to Legislate PILOT Increases

Over the past 20 years, City of Boston and state officials have tried a number of different approaches to require large nonprofit institutions to pay some kinds of standardized payments to municipalities to offset the costs of providing city services to these institutions. These include:

- In 1990, then-Mayor Flynn filed a bill with the state legislature that would require tax-exempt hospitals and universities to pay 25 percent of the amount they would have to pay if they were fully taxable. That bill died in the legislature in 1992.

- In 1993, Assessor Ron Rakow proposed a 'local option public safety tax whereby all large nonprofits, including hospitals, colleges and cultural institutions, would pay one-quarter the rate of businesses, to cover the cost of city services. This home rule legislation also died in the legislature.[27]

- In 2001, in response to Harvard University's purchase of a large commercial property in Watertown, the State legislature debated legislation that would have required schools and other nonprofit organizations to pay taxes when they bought large properties, thus removing them from the tax rolls. It would also have allowed communities to assess taxes on any property worth more than 1 percent of the tax base, even if used for tax-exempt purposes. The legislation offered a local option, so that communities could decide, for example, if they wanted to tax otherwise eligible open space.[28]

- The 2003 State budget crisis, when the City faced a $1.75 billion budget gap due to state aid cuts, prompted the Boston City Council to call for hearings to discuss charging colleges and universities a maintenance fee of $50 - $100 per

semester for each student who lives in the city, to help defray the cost of police, fire and other services.[29]

- In 2003, Mayor Thomas J. Menino intensified efforts to encourage tax-exempt institutions to increase their PILOTs, without waiting as the City usually did for nonprofits to come before the city for rezoning approval or other business before negotiating the voluntary payments. The Boston Globe editorial board supported the Mayor's initiative, and added that they believed "the system needs standardization" to even out contributions: "it's a fair bet that most nonprofits would rather work out a more rational, predictable payment system than have the Legislature do it for them."[30]

- In the spring of 2007 the Boston City Council held a hearing to consider reforming the PILOT program in order to collect more from large nonprofit institutions that can afford to pay more. On April 17 of this year, Councilor Stephen J. Murphy introduced a proposal to pressure colleges and universities to contribute more money to the City, asking the Legislature to end colleges' tax-exempt status.[31]

Despite all of these efforts, Boston's nonprofit institutions still fall far short of making payments in lieu of taxes that would offset the cost of the services the City of Boston provides to them. PILOT programs such as Boston's rest on an assumption that the exempt nonprofit institution is indeed fulfilling its exempt purpose in the activities that take place at each of its exempt properties. As the AMCs have grown into physically huge, legally complex, multi-billion dollar enterprises, new questions arise about whether this is in fact the case.

Property Tax Impacts of Boston Medical Facilities

Nearly all large medical facilities in Boston are nonprofits and have tax-exempt status.[32] For the City, the consequence is a loss of property tax revenue. Hence, tax exemption represents a form of public subsidy: the City forgoes collecting revenue from these institutions in order to facilitate their important charitable functions. This public subsidy implies several duties on behalf of the nonprofits. In a later section of this report we will look at whether the hospitals fulfill these charitable duties.

For its *Nonprofit City* project, CLU conducted a survey of all the *tax-exempt* parcels owned by the nonprofit hospitals and universities in the City of Boston in FY07. From this survey, we found that the FY07 Assessed Value of the 30 largest nonprofit medical facilities totaled over $2.99 billion. **If all of this property had been taxed at the commercial rate, it would have brought over $80.3 million into the City's coffers.** Subtracting the the $4 million in voluntary PILOT payments made by these institutions, the public **subsidy from the City to the hospitals for FY07 was approximately $76.3 million.** (Note: although most nonprofit institutions own additional properties that are classified by the tax assessor as commercial,

residential or industrial, we did not include these properties in this survey because the institutions pay taxes on these properties—they are not tax-exempt. This includes small portions of tax-exempt buildings that are used by for-profit businesses—for example, a commercial restaurant located in a hospital building.)

By far the largest share of this subsidy went to Boston's academic medical centers. In the table below, we include Dana-Farber Cancer Institute, which is an AMC, albeit one that does not provide emergency-room services, as the others all do. Subtracting the almost $4 million that they paid in voluntary PILOT payments, the AMCs account for **$60.2** million of the $76.3 million in property-tax revenue that Boston lost in FY07 due to the tax-exempt status of its nonprofit hospitals. **As a group, the AMCs paid only 6% of the amount they would have owed in property taxes were they not tax-exempt**.

Property Tax Subsidy FY07

All Nonprofit Medical Facilities

Total Value of Tax-Exempt Properties: $2.99 billion
Commercial Taxes would be: $80.3 million
25% 'PILOT' Goal would be: $20.1 million
$80.3 million minus PILOT payments (just under $4 million) = $76.3 million

Total Property Tax Subsidy to all Nonprofit Medical Facilities: $76.3 million

Seven AMCs and Dana Farber

Total Value of Tax-Exempt Properties: $2.4 billion
Commercial Taxes would be: $64.2 million
25% 'PILOT' Goal would be: $16 million
$64.2 million minus PILOT payments (almost $4 million) = $60.2 million

Total Property Tax Subsidy to the Seven AMCs and Dana Farber: $60.2 million

** Note that the actual tax payments are not in the table. In FY07, the seven AMCs plus Dana Farber paid $1,258,654 in property taxes to the City for unrelated for-profit uses.*

Source: City of Boston Assessing Department

The PILOT GAP

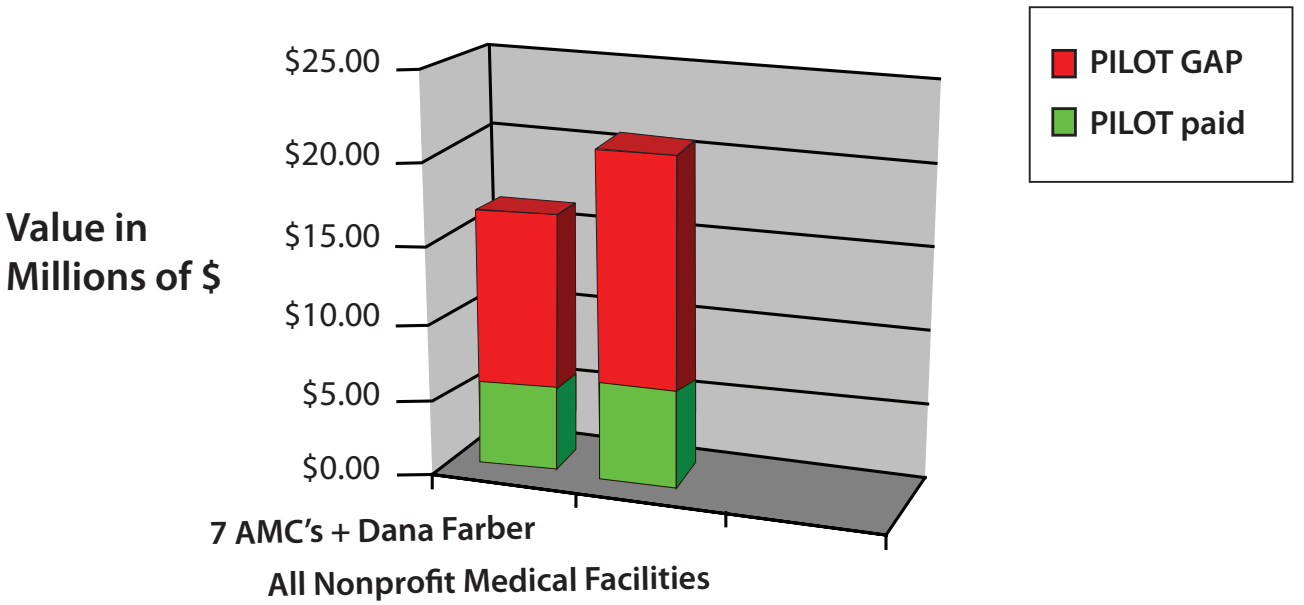
The PILOT goal is intended to compensate the City for "essential services" only, not for the full tax amount. So the PILOT goal for the AMCs would be $16 million (25% of the full assessed tax value of $64.2 million). **As the table below makes clear, however, even measured against that more limited standard the AMCs as a group paid only one-quarter of their expected contribution in FY07**. Their PILOTs totaled just under $4 million, 25% of the goal of about $16 million, leaving what we might call a **"PILOT gap" of about $12 million.** This is the amount that would go into the City's coffers if the AMCs, including DFCI, paid their fair share of the cost of essential city services.

Tax Exempt Property Values & PILOTs of AMCs (including Dana Farber) FY07

	Total Assessed Value of Exempt Land & Buildings	FY07 Property Tax if institution was not exempt (hypothetical)*	PILOT Goal = 25% of Hypothetical Tax	FY07 PILOT Payment	PILOT as % of Hypothetical Tax	PILOT as % of PILOT Goal (25% of assessment)
BIDMC	$281,247,023	$7,557,108	$1,889,277	$167,000	2%	9%
BMC	$262,022,400	$7,040,542	$1,760,135	$123,114	2%	7%
BWH	$133,672,600	$3,591,783	$897,946	$942,807	26%	105%
CHB	$315,456,500	$8,476,316	$2,119,079	$593,750	7%	28%
DFCI	$133,000,500	$3,573,723	$893,431	$87,895	2%	10%
MGH	$976,189,200	$26,230,204	$6,557,551	$1,275,579	5%	19%
St.E	$138,699,215	$3,726,848	$931,712	$-	0%	0%
TMC	$149,207,100	$4,009,195	$1,002,299	$791,271	20%	79%
Total	**$2,389,494,538**	**$64,205,718**	**$16,051,430**	**$3,982,098**	**6%**	**25%**

Sources: Assessed values from City of Boston Assessor Database FY07
PILOT Payments FY07 from City of Boston Budget Office
All figures rounded to the nearest dollar amount.
** At the commercial rate of $26.87 per $1000 in value*

Boston's Nonprofit Hospital PILOT "Gap"



In FY07, the AMCs as a group paid only one-quarter of their PILOT goal, the approximate amount it costs the City of Boston to provide them with essential services. They paid only 6% of what they would have owed in property taxes on their exempt properties if these properties were not tax exempt.

What Difference Could the Additional Revenue Make?

What difference could the additional revenues make? How could the City use these extra funds to support the essential public services it provides? The

The $12 million in lost "PILOT gap" revenue for essential services could pay for:

- 151 Teachers, or
- 115 Firefighters, or
- 96 Police Officers

Sources: Boston Municipal Research Bureau[33]

The $60.2 million in overall lost revenue opportunity could pay for:

- 761 Teachers, or
- 579 Firefighters, or
- 483 Police Officers

Sources: Boston Municipal Research Bureau[33]

figures in the left hand column above show how many teachers, police officers or firefighters could be hired with the $12 million "PILOT gap"—the difference between the amount that the PILOT program asks the AMCs to pay and the amount they actually do pay. The right hand column shows what the City could fund with the $60.2 million in total revenue that is lost due to the tax-exemptions the AMCs receive—the full property tax subsidies the AMCs receive.

As noted above, the burden on residential taxpayers is increasing; at the same time, municipal officials with ever-tightening budgets are proposing more Proposition 2½ override votes across the Commonwealth. The loss of tax revenue from valuable, otherwise taxable land in cities with few remaining undeveloped parcels puts a double squeeze on taxpayers and on consumers of public services. The addition of $60.2 million would help to relieve the burden borne by the City's residential taxpayers.

To sum up, in FY07 Boston's nonprofit hospitals as a whole made PILOT contributions that amounted to less than 20% of their fair share obligations. The AMCs as a sub-sector did slightly better—25%–primarily because these institutions were responsible for seven institutional PILOT payments made in that fiscal year. And AMC payments increased in FY07 due to increases in the relative payments made by two institutions—Brigham and Women's Hospital and Tufts Medical Center—for new construction that year. In other words, even in a year when two of the large teaching hospitals in Boston had the resources to undertake significant building projects, the AMCs as a group *still* contributed only one-quarter of the limited sum the PILOT program asks them to pay to cover essential municipal services.

It is a credit to Boston's proactive PILOT program that the City receives as much as it does from the City's large teaching hospitals. Overall, however, we can only conclude that these institutions do a poor job of meeting their obligation to contribute their fair share to the costs of the City's essential services.

III. PROVIDING GOOD JOBS AT GOOD WAGES?

So far, we have demonstrated that the Academic Medical Centers make significant profits, receive large amounts of public subsidy through tax exemption, and make up seven of the City's ten largest employers. These are wealthy, privileged, and large businesses; yet they also have very clear public missions. We would expect to see such institutions treat their workers well enough so that they could afford to live and support their families within the City. This does not seem to be an unreasonable expectation, given that the AMCs can afford it and that the public has invested heavily in them through tax exemption. When we examine their workforce, however, we see a different picture. Workers in fully two-thirds of the jobs available at Boston's AMCs do not earn enough money to support even a family of three in Boston.

What Would an Equitable Labor Market Look Like?

In an equitable economy, people who go to work every day should have incomes sufficient to provide for their families' basic needs. They should also have important benefits such as health insurance. A labor market, if equitable, should see incomes distributed broadly: when mapped, it should look like a barrel or football, with incomes clustered around a mid-point and relatively few outliers. By contrast, an *inequitable* labor market maps like an hour-glass or, more commonly, a teardrop or cylindrical flask, with jobs clustered at the high and low extremes (or else just clustered at the bottom), and relatively few jobs at the mid-point. Visually mapping the labor market helps to convey how our economy is organized and who benefits from it. CLU has analyzed that for our regional economy as a whole in *The Hourglass Challenge* (2006) and for the City of Boston's 2007 economy in *Earnings, Poverty and Income Inequality*. While in 2006 we found that the region had an hourglass-shaped economy, with few jobs clustered in the middle incomes, more recently we found that Boston's economy is coming more to resemble a teardrop, with many more jobs clustered at the bottom of the wage scale than at the middle or top.[34] Here, we will map the local hospital economy

equitable

inequitable

more inequitable

Hospitals and other health care and life sciences businesses are considered some of the most important employers in the so-called "knowledge economy." The knowledge economy comprises firms engaged in providing services and producing products that are the result of a substantial degree of research and

innovation, employing highly skilled and educated engineers, medical doctors, scientists, and others. Yet the jobs in these knowledge firms are by no means all white-collar, highly skilled ones. Many of these jobs are clerical, janitorial, personal service, or security. Many require no formal training, pay low wages with low or no benefits, and offer few or no advancement opportunities.

As Community Labor United demonstrated in *The Hourglass Challenge*, the biggest problem facing most of Boston's current workforce is inadequate wages. While it is common to hear public concern about a *skills gap*, the reality is that many jobs in the growing sectors of the economy require few skills. While there are no doubt certain jobs that are difficult to fill because they require skills that are in short supply among Boston residents seeking employment, there also exists a very real *wage gap*. And this is not a gap that can be met by additional skills alone. Hundreds of thousands of relatively low-skilled jobs that currently exist—and that must be done—are grossly underpaid. Skills training might help some individuals to prepare for other jobs, but it does nothing to alter the structural inequities manifested by the wage gap between occupations.

On January 1, 2008, the minimum wage for a Massachusetts worker increased to $8.00 an hour, or $16,640 a year for a full-time (40 hours a week) worker. How do families in Boston with one or even two minimum-wage workers fare? In an attempt to answer that question, researchers have developed the notion of a "family self-sufficiency wage," in other words, the income a family of a particular size would need to earn simply to pay for basic necessities such as food and shelter—no frills—without receiving any public assistance. We use here the Family Economic Self-Sufficiency standard (MASSFESS), a location and family-size-specific measure that has become a widely-used benchmark.[35] For a family of four in Boston, the self-sufficiency wage has been calculated to be about $62,000 a year. Compare that to the local median income for a family of four of about $43,000—which means that half of Boston's families of that size earn less than $43,000 per year, including families with two wage-earners each working 40 hours and earning the minimum wage. The unavoidable conclusion is that a significant number of Boston families who have at least one member working do not make enough money to pay for even bare-minimum living expenses. So how do people cope? Some don't pay for health care, while others make difficult and sometimes dangerous decisions about child care, forego a healthy and adequate diet, participate in the informal economy, live in substandard housing, turn to crime, or rely on public services for stopgap support when they can find and qualify for those.

Many families in Boston cannot make ends meet, yet most of them are not poor enough to qualify for an ever-shrinking welfare safety net. The best way to help these families is to ensure that every worker is paid a self-sufficiency wage. And this measure is how we will evaluate the hospitals' labor practices.

Boston's Hospital Labor Market: Troubling Features

Before we turn to look more specifically at wages in Boston's hospital sector, it is worth noting some of the general, and in some instances troubling, features of the hospital labor market.

Thirty-one percent of jobs in the City of Boston are in the field of health care and social assistance, and about half of these—approximately one in six jobs in the City—is in a hospital.[36] 1199 SEIU United Health Care Workers East—a large union that represents more than 300,000 health care workers and retirees in New York, Maryland, the District of Columbia and Massachusetts—has used worker surveys to identify health care workers' priority concerns. In addition to non-economic issues such as lack of respect, favoritism and the need for a voice in the workplace, there are many economic complaints, running the gamut from low pay, poor raises, the lack of high-quality, affordable health insurance, and lack of paid time off to limited promotion opportunities, overworked units and weak job security.

Racially Diverse Workforce Only in the Lower-Paid Positions

The hospital workforce in Boston is a racially and ethnically diverse one. One sign of this diversity was highlighted in a 2005 report from the Boston Redevelopment Authority, The New Bostonians, which noted that health and social services represents the single most common employment sector for Boston's foreign-born residents: 19% of them work in this sector. However, racial diversity in the hospital workforce declines as one moves up the skills and income ladder. Among Registered Nurses (RNs), a postion that requires an associate's degree and a license and often a bachelor's or master's degree as well, nearly all are white. Among the foreign-born workers in the lower-paid home health care sector, the largest share is Haitian. These non-white workers face significant barriers to obtaining the training and advancement opportunities that would allow them to ease the statewide shortage of RNs and shortages in other more highly skilled health care workforce positions.[37]

Racial Distribution of Nursing and Nursing Aid Workforce

- 90% of all RN's in Massachusetts are white.
- 78% of all Massachusetts License Practical Nurses (LPNs) are white (LPN requires a license and a credential from an accredited program)
- 55% of all nurses' aides and home health aides are white.

Source: US Census Bureau, Census 2000 Special Tabulation, EEO Data.

Few Training and Advancement Opportunities for Lower-Wage Workers

Given all of the public attention to the skill gap and recurrent shortages in certain more highly skilled health care occupations such as RNs, it seems reasonable to expect that Boston's large teaching hospitals would put resources toward providing relevant occupational training. The AMCs do have training programs for some career opportunities; and residencies and fellowships for new medical doctors represent another significant investment in training. For other health care occupations, one important program is the Health Careers Training Institute (HCTI). The HCTI brings together the AMCs and community organizations such as the Jamaica Plain and Fenway Community Development Corporations to provide residents of these neighborhoods with pre-employment training in patient care, science and technology, medical administration, targeted ESOL (English for Speakers of Other Languages), and other relevant skills.

In addition, AMCs run in-house training programs for incumbent workers, but there is no publicly available information on the number of workers they serve. What is known is that these programs include mostly graduate and professional training programs along with continuing education for doctors, nurses, and other health care professionals. There do not appear to be many training opportunities for technical, service, or maintenance workers. Worker surveys conducted by 1199 SEIU report that even when training programs exist, they are not accessible to all employees; participation is often at the pleasure of supervisors.

Moreover, other local educational institutions are providing insufficient training opportunities to help Boston health care workers move into more highly skilled jobs in the industry. In late 2005, despite widespread demand by health care workers for career ladder opportunities, over 8,500 health care jobs in greater Boston were unfilled.[38] Looking at just eleven hard-to-fill health care job categories[39], projections anticipate almost 14,000 new job openings by 2010 in the Boston area[40] that will require at least some form of post-secondary training.[41] While most of these will require at least an associate's degree, Boston-area institutions awarded only 816 associate's degrees in health care fields in 2002.[42]

Wages in Boston's AMCs Don't Meet Basic Needs for Two-Thirds of their Employees

We would have liked to perform an analysis of hospital workers' wages using data on the number and pay range of employees in each occupation from the hospitals themselves; however, none of this information is publicly available. As a result, we are forced to turn to the data that is publicly available— May 2007 wage data by occupation for Greater Boston employers from the federal Bureau of Labor Statistics (BLS).[43]

The data on the next two pages cover the 100 occupations found in the largest numbers in General Medical and Surgical Hospitals (NAICS code 622100). Together, these occupations make up most (94.3%) of the total hospital workforce.

Occupations clustering within $10,000 above and below the region's annual mean occupational income of $54,000 (from $44,000 to $64,000) are marked in grey.[44] This is what we consider to be the 'midpoint wage range,' which in this case stretches almost 20% above and below the mean wage. Occupations with a median annual income above the mean are marked in yellow. Occupations with a median annual income below that midpoint range are marked in pink. Note that the five highest paying of these 100 largest hospital occupations, physicians, surgeons and chief executives, are marked #, which indicates a median annual wage greater than $145,600 per year. It is also worth noting that the mean annual income for the 100 largest hospital occupations reviewed here was $53,748, very close to the $54,000 *regional* occupational mean.

Annual Median Income in Boston Hospital Occupations

Occupation		Annual Median Income
1	Physicians and surgeons, all other	#
2	Family and general practitioners	#
3	Internists, general	#
4	Chief executives	#
5	Surgeons	#
6	Computer and information systems managers	$118,840
7	Financial managers	$107,900
8	General and operations managers	$106,650
9	Health specialties teachers, postsecondary	$103,970
10	Medical and health services managers	$97,420
11	Managers, all other	$96,170
12	Pharmacists	$89,390
13	Management analysts	$86,820
14	Physician assistants	$83,150
15	Computer systems analysts	$82,600
16	Medical scientists, except epidemiologists	$82,350
17	Registered nurses	$78,480
18	Administrative services managers	$77,230
19	Network and computer systems administrators	$76,350
20	Radiation therapists	$74,180
21	Health diagnosing and treating practitioners, all other	$72,400
22	Nuclear medicine technologists	$72,270
23	Physical therapists	$68,850
24	Diagnostic medical sonographers	$68,150
25	Radiologic technologists and technicians	$67,140
26	Healthcare practitioners and technical workers, all other	$66,370
27	Occupational therapists	$66,210
28	Speech-language pathologists	$66,010
29	Human resources, training, and labor relations specialists, all other	$64,990
30	Business operations specialists, all other	$64,680
31	Accountants and auditors	$63,610
32	Purchasing agents, except wholesale, retail, and farm products	$62,520
33	Training and development specialists	$60,410
	SELF-SUFFICIENCY INCOME FOR 1 ADULT, 2 CHILDREN IN BOSTON	**$58,133**
34	Respiratory therapists	$58,480
35	Computer support specialists	$55,550
36	First-line supervisors/managers of office and administrative support workers	$54,300
	MEAN OCCUPATIONAL INCOME, BOSTON METRO REGION	**$54,000**
37	Medical and clinical laboratory technologists	$53,250
38	Employment, recruitment, and placement specialists	$53,220
39	Dietitians and nutritionists	$52,920
40	Medical and public health social workers	$51,700
41	Health educators	$50,200
42	Licensed practical and licensed vocational nurses	$49,840
43	Cardiovascular technologists and technicians	$49,820
44	Stationary engineers and boiler operators	$49,120

Note that for all occupations that have a listed median income of $145,600, there is no actual median. The data for these occupations show $145,600 as a minimum income for these occupations.

45	Production, planning, and expediting clerks	$46,360
46	Physical therapist assistants	$46,290
47	Executive secretaries and administrative assistants	$46,270
48	Occupational therapist assistants	$45,920
49	Clergy	$45,170
50	Health technologists and technicians, all other	$44,810
51	Surgical technologists	$42,730
52	Maintenance and repair workers, general	$40,460
53	Computer operators	$39,730
54	First-line supervisors/managers of housekeeping and janitorial workers	$39,470
55	Respiratory therapy technicians	$39,440
56	Human resources assistants, except payroll and timekeeping	$38,570
57	Bookkeeping, accounting, and auditing clerks	$38,200
58	Emergency medical technicians and paramedics	$37,760
59	Substance abuse and behavioral disorder counselors	$37,500
60	Office and administrative support workers, all other	$37,320
61	Psychiatric technicians	$37,030
62	Secretaries, except legal, medical, and executive	$37,020
63	Medical transcriptionists	$36,860
64	Customer service representatives	$36,850
65	Bill and account collectors	$36,760
66	All other information and record clerks	$36,630
67	Medical and clinical laboratory technicians	$35,550
68	Mental health counselors	$35,370
69	First-line supervisors/managers of food preparation and serving workers	$34,950
70	Billing and posting clerks and machine operators	$34,860
71	Medical secretaries	$34,710
72	Healthcare support workers, all other	$33,990
73	Medical assistants	$33,640
74	Interviewers, except eligibility and loan	$32,550
75	Medical records and health information technicians	$32,510
76	Medical equipment preparers	$31,520
77	Medical equipment repairers	$31,430
78	Pharmacy technicians	$30,360
79	Social and human service assistants	$30,070
80	Office clerks, general	$29,410
81	Cooks, institution and cafeteria	$29,320
82	Psychiatric aides	$29,240
83	Physical therapist aides	$29,200
84	Data entry keyers	$28,880
85	Nursing aides, orderlies, and attendants	$28,370
86	Switchboard operators, including answering service	$27,300
87	Janitors and cleaners, except maids and housekeeping cleaners	$26,190
88	Receptionists and information clerks	$26,030
89	Home health aides	$25,610
90	Security guards	$25,000
91	Couriers and messengers	$24,770
92	Dietetic technicians	$24,500
93	File clerks	$24,390
94	Maids and housekeeping cleaners	$24,030
95	Stock clerks and order fillers	$22,890
96	Food servers, nonrestaurant	$22,010
97	Food preparation workers	$20,290
98	Laundry and dry-cleaning workers	$20,160
99	Cashiers	$18,780
100	Combined food preparation and serving workers	$18,220

Source: List of 100 largest hospital occupations is from the Bureau of Labor Statistics May 2007 national industry data for NAICS 62-2100. Wage data is from Bureau of Labor Statistics May 2007data, Metropolitan Area Wages by Occupation, Boston-Cambridge,Quincy NECTA

As discussed above, Community Labor United believes that the appropriate standard by which to gauge workers' ability to escape poverty is the Family Economic Self Sufficiency (FESS) measure. In Massachusetts, this measure is published by the Crittenton Women's Union (formerly the Women's Education and Industrial Union).[45] The FESS "calculates the income necessary for working families to meet their most basic needs without public or private supports, depending on where they live and who is in their family."[46] It assesses the actual minimum income a family needs in order to cover only basic needs such as housing, food, child care, and clothing. It includes no money for entertainment or other non-necessities, but at the same time it does not require families to sacrifice one need to pay for another, as the federal poverty level does. For this reason, the FESS is significantly higher than the poverty level, yet it still marks an income level at which going to the movies or eating out are excluded luxuries.

The table below shows the 2007 Boston FESS income level for three different family configurations.

The Self-Sufficiency Standard for Boston, 2007

Family Type		Boston
1 adult & 1 preschool child	Self-Sufficiency Income	$49,797
1 adult, 1 preschool child & 1 school age child	**Self-Sufficiency Income**	**$58,133**
2 adults, 1 preschool child & 1 school age child	Self-Sufficiency Income	$62,095

Source: Crittenton Women's Union Self-Sufficiency Calculator http://www.liveworkthrive.org/calculator.php [October 2007]

Putting the Boston-area health care occupational wage data up against these self-sufficiency income standards reveals that **two-thirds of hospital occupations do not pay a wage that can support a family of three in Boston.** Of the 100 occupations that are found most often in hospitals, 67 (or 67%) have a median income below the Boston FESS income level for a family with one adult and two children: $58,133. **This means that the typical Boston worker in two-thirds of all hospital occupations cannot afford even a minimal, basic standard of living for one adult plus two children**.

Unfortunately, a mapping of the City's hospital labor market shows that its occupations are not equitable since they are not clustered around the region's

mid-point income, a generous $20,000 range that stretches $10,000 above and below the midpoint wage. In fact, only 30% of the occupations pay a median wage above the mid-point range and 20% pay within that range, while **fully half–50%–of the 100 largest hospital occupations have median incomes below the mid-point range**. Mapping these occupational wages ranges would give us a very inequitable teardrop shaped wage distribution, not the more desirable football shaped equitable one. And these data are only related for full-time work. Close to half the jobs in Boston's AMCs are part-time, with those workers earning less in terms of both salary and benefits.

We conclude that the internal labor markets at Boston's large nonprofit teaching hospitals reflect the more unequal teardrop shape that we have begun to see in the overall Boston economy. The hospital economy is not only inequitable; it has a significant degree of inequality. Next, we turn to one more measure of the quality of the jobs Boston's teaching hospitals provide: employee health coverage.

CEO Compensation

The table above does not list the compensation that the CEOs at Boston's teaching hospitals receive. In 2006, each of the AMC CEOs made $1 million or more in annual compensation, and CEO compensation continues to rise. To put that figure into perspective: $1 million could cover the basic needs of 17 Boston families for an entire year. It is almost 50 times the median income of the least-compensated occupation in the hospitals, and 14 times the median income for registered nurses.

No Health Care for Many Hospital Workers

A disturbing trend among Boston's hospital workforce concerns the unaffordable high cost of health coverage for a significant number of workers. As health insurance premiums and the employee share of those premiums rise, some hospital workers have been forced to forgo coverage. The result: far too many hospital workers unable to set foot in a hospital as a patient. When they are forced to seek emergency care, many hospital workers find themselves deeply in debt, unable to pay the huge hospital bills that result. Many have seen their meager savings wiped out and their credit ratings ruined. A 2004 report stated that half of all personal bankruptcies in the U.S. are related to medical debt.[47]

The Commonwealth of Massachusetts has begun to address the crisis of the uninsured through its universal health care legislation. Over time, the Commonwealth's unquestionably innovative policy may ease the situation. In the short run, however, low-income hospital workers may actually face more acute financial distress as the individual mandate to carry health coverage takes effect, requiring them to purchase the costly health plans offered by their hospital employers.

In the past year, Massachusetts has seen increases in both the number of hospital workers (and their dependents) who are enrolled in the Commonwealth's Medicaid program of health coverage for low-income residents, known as MassHealth, and in the total cost to MassHealth and the Uncompensated Care Pool for services provided to hospital employees:

- **In FY07, Massachusetts spent approximately $1,285 per user on MassHealth, Uncompensated Care Pool services and Commonwealth Care for hospital employees and their dependents. The total cost to the state was just over $23 million.**

- The state spent $9.4 million to provide health care for 8,000 employees of the Boston AMCs and their dependents.

- There were 4,493 hospital workers enrolled in MassHealth and 3,917 hospital workers who used the Uncompensated Care Pool in FY07. In addition, 693 hospital employees enrolled in the new Commonwealth Care program.

- Combined total costs for subsidized care (including MassHealth, the Uncompensated Care Pool, and Commonwealth Care) for hospital employees and their dependents increased 7% from 2006 to 2007.

- **These figures are significantly higher than what the state estimated before adopting new methodology in 2007 that better matches public health care spending to employer data.**

Source: Massachusetts Executive Office of Health and Human Services

AMC Employees Receiving Subsidized Healthcare, 2007

Employer	2007 Subsidized Care to Employees
Beth Israel Deaconess Medical Center	529
Boston Medical Center	448
Brigham & Women's Hospital	688
Children's Hospital Boston	350
Dana Farber Cancer Institute	81
Massachusetts General Hospital	1,132
Tufts Medical Center	203
St Elizabeth's Medical Center	219
Total	**3,650**

Source: Massachusetts Executive Office of Health and Human Services. Includes AMC Employees using MassHealth, Uncompensated Care Pool, and for 2007, Commonwealth Care.

CLU believes that large, wealthy institutions such as Boston's teaching hospitals should be expected to provide affordable health care coverage to their own employees. On that basis, the thousands of AMC workers who are enrolled in MassHealth or utilize the Uncompensated Care Pool—and the millions of dollars the Commonwealth spends on their health care—represent another taxpayer subsidy to these giant institutions.

In a truly equitable economy, no full-time worker would earn less than a basic self-sufficiency income. And institutions making millions of dollars in profit, receiving millions more in publicly subsidized tax exemptions, and paying their executives millions of dollars in compensation would have a workforce in which no one is unable to afford the basic needs of life, let alone live in poverty. We can only conclude that the employment practices of Boston's large teaching hospitals render the City's labor market and economy less equitable, not more.

IV. CHARITY CARE

When we consider how corporations can give back to the community, we often look at the core businesses they are engaged in. So, banks are asked to open branches in neglected neighborhoods or make loans to underserved populations. Supermarkets are asked to donate food for community events or hire from the neighborhood.

What about hospitals? Providing free medical care to the needy is an obvious contribution closely related to their core business. But the picture is not so simple. Hospital officials typically describe their institutions' direct contributions to their local communities as falling into two categories, uncompensated care and community benefits programs. These categories can be misleading. A report by the Consumers Union explains:

> A charity care discussion generally involves two opposing views with advocates arguing that charity care is an important requirement for nonprofit hospitals and the hospitals asserting that charity care is just one component of the 'uncompensated care' or 'community benefits' provided by the hospital. The problem with the term 'uncompensated care' is that because it typically includes bad debt (services provided to people who are able but refuse to pay for it), it does not accurately depict what a hospital provides to those who cannot afford to pay for their medical services. The term 'community benefits' is problematic because there are typically few restrictions on what qualifies as a 'community benefit', the term may be applied to hospital expenses that have no connection to the community's needs.[48]

"Community benefits" is a tricky label for hospitals' contributions because the idea means different things to different people. For some, it refers to medical programs specifically created to serve neighborhoods abutting the hospital or affected by its construction or operations. For others, it means conforming their physical and programmatic development to the needs or desires of local community planning. Traditionally—and this is directly related to their tax exemption—it means providing charity care, or free care to poor people.[49]

We use the level of uncompensated charity care as the criterion to evaluate the AMCs' direct contributions to the Boston community. (We stress "uncompensated" because historically, Massachusetts hospitals have been reimbursed for portions of their charity care through the Uncompensated Care Pool.) There are three reasons for this choice of criterion. First, it is the truest measure of a hospital's voluntary service to the poor. Second, in addition to being long accepted as a duty of nonprofit hospitals, the measure is easy to quantify and compare. Finally, Congress is currently considering legislation that

would establish a minimum uncompensated charity care threshold that nonprofit hospitals must meet. This proposal represents an external benchmark to which the records of Boston's teaching hospitals can be compared.[50]

The table below shows uncompensated charity care spending by the seven large Boston AMCs for the years 2001 to 2007.

Annual Charity Care Expenditures for Seven Boston Academic Medical Centers 2001-2006

AMC	2001	2002	2003	2004	2005	2006	2007
BIDMC	$ 2,970,604	$2,297,443	$9,112,416	$9,736,553	$9,624,747	$13,567,159	$3,358,307
BMC	$ 2,778,783	$2,234,199	$9,667,818	$25,228,627	$ -	$ -	$ -
BWH	$ 2,980,958	$2,627,941	$11,374,253	$10,944,452	$10,019,658	$8,095,832	$3,356,906
CHB	$ 1,610,846	$1,308,336	$5,413,498	$ -	$ -	$ -	$ -
MGH	$ 3,626,383	$3,200,479	$13,738,245	$24,177,467	$20,094,204	$19,749,641	$3,549,410
StE	$ 954,290	$823,725	$2,980,124	$2,024,173	$873,317	$429,175	$ -
TMC	$ 1,439,082	$1,315,979	$5,569,599	$5,322,913	$3,134,531	$ -	$2,542,531

Source: Uncompensated Charity Care Figures are taken from the amounts reported as "Shortfall Allocation" in each year's Uncompensated Care Pool Annual Report. Blanks reflect a full reimbursement from the UCP as discussed below. Uncompensated Charity Care amounts are reported 'at cost'—the amount they cost the institution to provide after reimbursement from the state .

We put these dollar figures into perspective by comparing them to the proposed federal goal for nonprofit hospitals' spending on charity care. The proposal originated in response to a June 2007 IRS report showing that a significant number of nonprofit hospitals around the country are failing in their responsibilities to the poor.[51] The IRS found that about one-quarter of nonprofit hospitals nationwide spend less than 1% of their revenue on charity care, and half spend only 3% or less. At the other end, nearly 20% of nonprofit hospitals nationwide spend 10% or more on uncompensated charity care. However, since such a large number of institutions spend so little on charity care, federal and state officials are increasingly questioning whether nonprofit hospitals provide enough charity care to qualify as charities and justify their tax exemptions.

Senator Charles Grassley of Iowa has proposed some changes to tax law to create specific criteria hospitals must meet in order to receive tax exemptions as nonprofits. His proposal includes:[52]

- Requiring nonprofit hospitals to spend 5% of annual patient revenues or operating expenses—whichever is more—on charity care.

- Limiting insiders on a hospital board to 25%, down from 49% today—and limiting doctors on the board and board committees to 25% as well, except for committees overseeing such matters as quality of care, credentialing, etc.

- Restricting hospitals to charging the indigent no more than either the actual cost of services or the amount the federal government would reimburse the hospital if federal coverage applied.

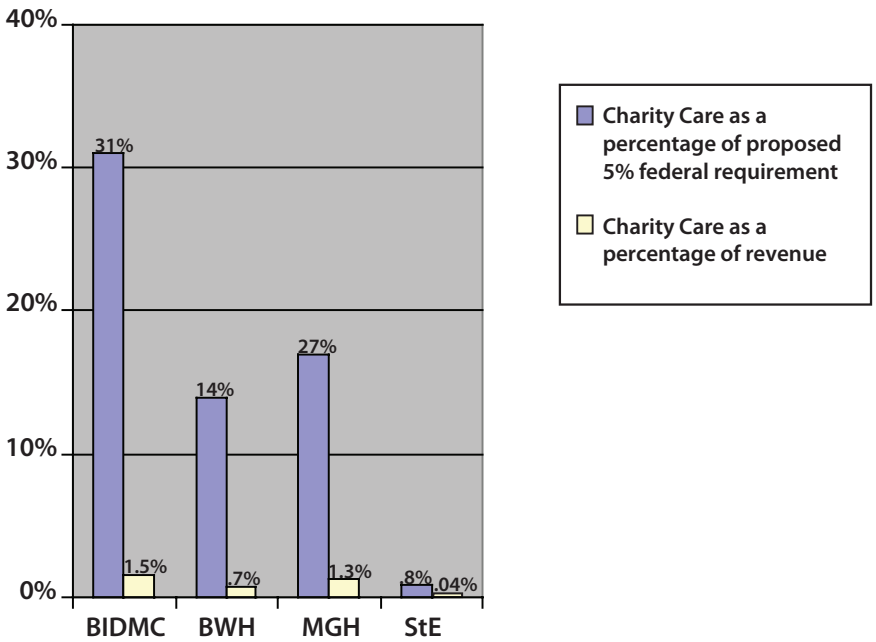
The tables on the next two pages show how much Boston's AMCs spent in 2006 and 2007 on uncompensated charity care as a percent of their revenue that year and as a percent of the federal goal. The same information is illustrated on the bar charts that follow the tables. We are presenting data for both years to demonstrate that the AMCs' low levels of uncompensated charity care spending have been ongoing and cannot be attributed solely to the Massachusetts Chapter 58 healthcare reform, which went into effect in 2007. This reform mandated health insurance coverage for all Massachusetts residents so that more of those who receive care at Massachusetts hospitals are insured and the hospitals are left with fewer unpaid bills, so they do provide less uncompensated charity care.

Boston AMC Uncompensated Charity Care as Percent of Revenue (left shaded column) and as a Percentage of Proposed Federal Goal (right shaded column)

2006	Uncompensated Charity Care (UCC) at cost*	Net Patient Service Revenue (NPSR)	UCC as a % of Net Revenue (NPSR)	Federal UCC Goal (5% of Net Revenue (NPSR)	UCC as % of Federal Goal
BIDMC	$13.6 M	$879.3 M	1.5%	$44 M	31%
BMC	$-	$733.5 M	-	$36.7 M	-
BWH	$8.1 M	$1,167.5 M	0.7%	$58.4 M	14%
CHB	$-	$747.1 M	-	$37.4 M	-
MGH	$19.7 M	$1,486.7 M	1.3%	$74.3 M	27%
StE	$.4 M	$235 M	.18%	$11.8 M	3.7%
TMC	$-	$510.3 M	-	$25.5 M	-

** Figures rounded to the nearest $.1M. Data from UCP Reports, audited AMC financial statements. Uncompensated Charity Care amounts are reported 'at cost'—the amount they cost the institution to provide.*

2006 AMC Charity Care Expenditures as a Percent of Revenue and as a Percentage of Proposed 5% Federal Requirement

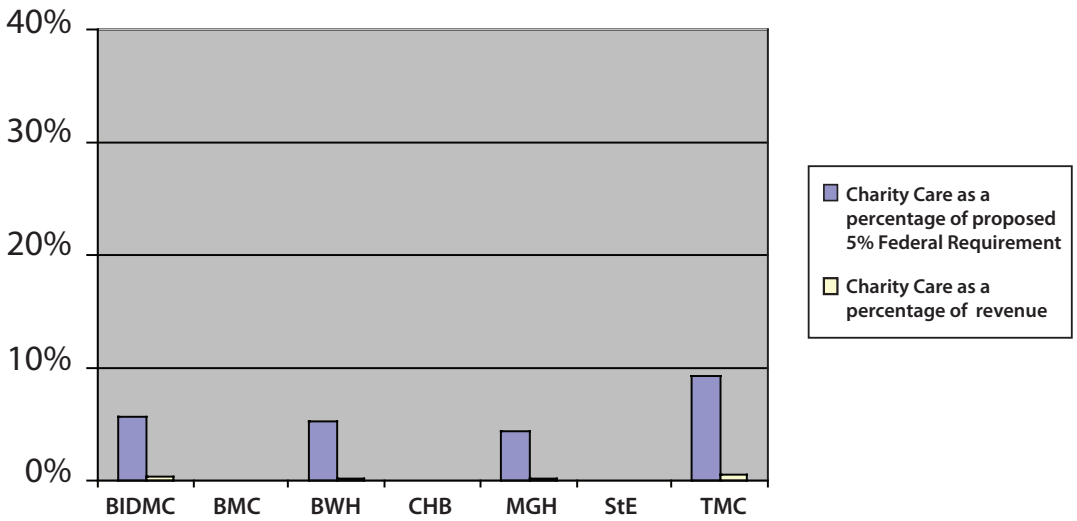


Boston AMC Uncompensated Charity Care as Percent of Revenue (left shaded column) and as a Percentage of Proposed Federal Goal (right shaded column)

2007	Uncompensated Charity Care (UCC) at cost*	Net Patient Service Revenue (NPSR)	UCC as a % of Net Revenue (NPSR)	Federal UCC Goal (5% of Net Revenue (NPSR)	UCC as % of Federal Goal
BIDMC	$3.4 M	$1,175.4 M	0.29%	$58.8 M	5.71%
BMC	$-	$823 M	-	$41.2 M	-
BWH	$3.4 M	$1,262.8	0.27%	$63.1 M	5.32%
CHB	$-	$801.1	-	$40.1 M	-
MGH	$3.5 M	$1,627.5	0.22%	$81.4 M	4.36%
StE	$-	$233.5	-	$11.7 M	-
TMC	$2.5 M	$546.9	0.46%	$27.3 M	9.30%

** Figures rounded to the nearest $.1M. Data from UCP Reports, audited AMC financial statements. Uncompensated Charity Care amounts are reported 'at cost'—the amount they cost the institution to provide..*

2007 AMC Charity Care Expenditures as a Percent of Revenue and as a Percentage of Proposed 5% Federal Requirement



In 2006, none of the Boston AMCs for which we have data spent even 2% of their revenue on uncompensated charity care. And none of them came within even 50% of the proposed federal standard that year or, in fact, in any year out of the past six. In 2007, when the health reform law was in effect, uncompensated charity care levels at the three largest Boston AMCs dropped sharply compared to 2006. Uncompensated charity care at MGH fell by fell by 82%; at BIDMC by 75%, and at BWH by 58%. In 2007, all three of these hospitals fell even more dramatically short of the proposed Federal 5% goal, spending less than .3%–one-third of one percent—of their earnings in uncompensated charity care.

Three of the seven Boston teaching hospitals (BMC, CHB and StE) had net charity care figures of zero for 2007. This reflects the fact that they were reimbursed by the Uncompensated Care Pool for all the costs they incurred providing free care to low-income individuals who were not covered by insurance. The Massachusetts legislature has enacted specific provisions to fully reimburse two of these hospitals, BMC and Children's, for the cost of their strong provision of free care. With nearly twice as many ER visits as the next busiest AMC, BMC's burden of emergency care is significant, and anecdotal evidence tells us that BMC is the hospital that Boston's low-income and underinsured residents turn to in order to be treated fairly and with respect when a health crisis strikes their households.[53]

Low rates of uncompensated charity care at Boston's teaching hospitals are a long-term trend that has intensified with the Chapter 58 healthcare reform. Over the past six years, none of the teaching hospitals has provided even half of the level of charity care suggested by proposed federal goal: that each hospital should spend 5% of its annual patient revenues or operating expenses—whichever is more—on charity care. In 2007, none of the Boston teaching hospitals met even 10% of the proposed federal goal, and most were well below 5% of this goal—that is, they spent less than 1/3 of 1% of patient revenues on uncompensated charity care. In 2007, only Tufts Medical Center came close to spending even ½ of 1% of revenues on uncompensated charity care. Overall, Boston's large teaching hospitals' extremely low and falling charity care contributions, together with their high profi ts, makes it hard to justify their continued charitable tax exemption.

More broadly, though, considering the amount of profit Boston's large teaching hospitals make, there appears to be no good reason they have been providing such consistently low rates of net charity care.

V. CONCLUSION: BOSTON'S NONPROFIT ACADEMIC MEDICAL CENTERS CAN—AND SHOULD—CONTRIBUTE MORE FAIRLY TO THE CITY THEY CALL HOME

This region's large health care sector is commonly portrayed as a positive economic engine. The size and expansion of Boston's health care sector is in part an outcome of public policies that allow hospital expansion and provide tax exemption. These policies unquestionably create additional economic pressures on Boston's taxpaying working families. So it is reasonable to ask whether those pressures are balanced by the benefits a prosperous health care industry is bringing to Boston's residents—whether the industry makes a fair contribution to the people of Boston in return. A detailed examination of one significant part of that sector, Boston's large academic medical centers, leads us to conclude that the answer is no.

At the outset we posed three tests:

1) Do the AMCs, as large property-owning institutions, pay a fair share of the cost of providing essential municipal services in the City of Boston?
2) As large employers that are influential in the City's labor market, do they help to make the labor market equitable and provide jobs with decent benefits and with wages that allow their workers to meet their families' basic needs?
3) And do they use their medical expertise and healthy financial surpluses to provide an adequate level of uncompensated charity care to poor Boston residents?

The evidence shows that Boston's AMCs fail all three of these tests.

- **NO FAIR SHARE TAX CONTRIBUTION:** Despite the City's intense efforts, the AMCs as a group paid only one-quarter of the sum that Mayor Menino and the City have designated as their fair-share contribution to the costs of essential municipal services; and this amount, in turn, represents only a fraction of what residential and commercial property-owners who are not tax-exempt must pay. The nonprofit property tax exemption creates the need for higher residential and commercial property taxes to compensate for the nonprofit hospitals' share of city services.

- **INEQUITABLE AND INADEQUATE HOSPITAL WAGES:** The labor market for hospitals and health care is significantly inequitable, with the median wage in fully two-thirds of its occupations insufficient to cover the cost of very basic necessities for a family of three in the City. The lowest paid AMC hospital CEO still makes enough money to support 17 Boston families for a year, while the lowest paid hospital worker will need three full-time jobs to support her or his family.

- **COST SHIFTING EMPLOYEE HEALTH CARE COSTS:** Boston's AMCs shift the

costs of providing health care for many of their employees to the general public, when these uninsured employees and their dependents use taxpayer-funded MassHealth and Uncompensated Care Pool services. In FY07, Massachusetts taxpayers spent $9.4 million on MassHealth, the Uncompensated Care Pool services and Commonwealth Care to provide health care for 8,000 employees of the Boston AMCs and their dependents.

- **INSUFFICIENT UNCOMPENSATED CHARITY CARE:** The Boston AMCs do not begin to meet the proposed federal standard of spending 5% of their revenue on uncompensated charity care for low-income patients. **Over the past six years, none of the Boston teaching hospitals has provided even half of the level of charity care suggested by proposed federal legislation. In 2007, none of them met even 10% of the proposed federal goal, spending less than 1/2 of 1% of patient revenues on uncompensated charity care.** Not providing free health care to needy patients creates undue pressures on those in need of affordable health care and ultimately costs working families whose tax dollars subsidize health care costs that are not covered as charity care.

- **HIGH AMC PROFITS:** Finally, these failures cannot be explained by a lack of resources: although they do not term them "profits," Boston's AMCs have annual surpluses totaling hundreds of millions of dollars. There is no credible evidence that the AMCs cannot afford to pay more equitable and self-sustaining wages for their workers and to provide more generous uncompensated charity care, just as there is no credible evidence that they cannot better support a fair share of essential municipal services.

The tax exemptions that Boston grants to institutions such as the Academic Medical Centers rests on an assumption that each institution is indeed fulfilling its exempt purpose. As the AMCs have grown into physically huge, legally complex, multi-billion dollar enterprises, new questions arise about whether this is in fact the case.

Community Labor United believes that our economy is shaped as much by creative public policy and broad civic participation as it is by the specific types of economic activity located here. The shift from a manufacturing-based economy to a service-based economy need not condemn us to low wages, high unemployment and shrinking public services. As in the past, organized communities, organized workers and innovative leadership can lead our region towards an economy where working people can support their families, where cities have the funds to pay for necessary services, and where residents and institutions share the revenue burden. Community Labor United is hopeful that Boston's Academic Medical Centers can play a positive role in helping us to move in this direction.

Appendix: Methodology

Hospital Profit

The sources for the data in this section of the research brief are all publicly and readily-available. The Community Benefit, Service, and Charity Care data are from the Massachusetts Attorney General's Office and the DHCFP UCP Annual Report. The PILOT data are from the City of Boston Assessor's Office. The asset and surplus (profit) data are from the Massachusetts Executive Office of Health and Human Services.

Municipal Finance

Using the City of Boston's Assessor's parcel database, we retrieved all practicably available tax-exempt parcels for 33 of the 34 nonprofit medical facilities listed by the Assessor's Office for fiscal year 2007. We omitted one facility—Mental Health Programs, Inc.—because it appeared to be a supported housing organization rather than a medical provider. For each parcel we found associated with one of the remaining 33 facilities, we collected the assessed value of the parcel (land plus building value), the net tax owed on the parcel, as well as the address, listed owner, property type, year (if any) that the parcel changed from a tax-paying type to exempt, and the parcel ID number. With this information we calculated the amount of tax that would be owed if the parcel was taxed at the FY07 commercial rate ($26.87 per $1,000 of assessed value. Using this number we calculated the PILOT goal (25% of the commercial tax amount). We used the commercial tax rate rather than the residential tax rate because the presumed functions on each parcel is commercial, even if it is exempt. Of course, the parcels we studied could be changed from nonprofit to residential uses, and then assume a residential tax rate, but this is speculative. The uses on these parcels right now is (almost entirely) analogous to commercial uses—the uses were they not exempt would currently be taxed at the commercial rate.

We reported only on parcels classified as 'Exempt.' Most institutions also own property that is classified as Commercial, Residential or (a few) Industrial, and they pay taxes on these parcels. Some of these are actually commercial uses within larger tax-exempt institutions, such as a commercial restaurant inside a hospital. We did NOT include these Commercial, Residential or Industrial parcels in our totals for institutional property values, because this report examines the value of the exempt properties only.

An important note about the parcels we analyzed: we cannot make any warranty that we uncovered all the parcels owned by the institutions we studied. The way in which ownership is listed varies, including through the use of limited liability subsidiaries, complicated our ability to be confident that we retrieved all the parcels. A more intensive research project could have been employed to uncover even more parcels; however, we believed that was not necessary. The results may be under-inclusive of the actual property value these institutions have; but that results in a conservative approach to the research. If one institution has a total assessment of $100 million from our approach, we know that it has at least $100 million of property value, but that it could have $150 million. Even if it paid taxes on the extra $50 million, that tax would not compensate for the lost tax revenue on the first $100 million.

An important caveat concerning the PILOT data: our reference to the "PILOT goal" in this research brief is to the monetary goal, not the property capture goal. Boston's PILOT criteria on property capture is that only new construction or expansion of existing construction triggers a negotiation over a PILOT agreement. However, we consider all parcels regardless of date of construction. Our task is to examine the lost revenue from tax exemption, and the property capture goal is unimportant to that task. We are not making an argument with this data that the City is not collecting enough money under its own PILOT criteria; we are showing the lost revenue on these parcels are a result of the tax exemption, taking PILOT payments into account.

A final note on this point: the PILOT monetary goal is useful to note for two reasons: (1) it theoretically represents the amount of direct impact any property has on the City's "essential services" and (2) under current policy it is the maximum the City would collect from exempt parcels assuming all construction is post-1985. This means the amount is an overestimation, not an underestimation of maximum collection; which in turn means we can conservatively estimate the lost revenue even if all parcels were subject to the maximum PILOT.

Wages and Labor Market

The research question for this section is: "Are the hospitals making a fair contribution to employment outcomes for their workers?" We approached this question by considering the following sub-questions: (1) are hospitals providing equitable labor markets? and (2) how would we know if they are?

An equitable distribution of wage data would be appear visually to be barrel-shaped around a mid-point wage that afforded workers means to pay for their basic needs. We map the distribution of wages by (1) identifying a wage mid-point in the regional labor market, (2) mapping the hospital labor market to see how it shapes around that mid-point, and (3) comparing that mid-point with a self-sustaining wage. One of our hypotheses is that the mid-point in the labor market should track fairly closely with the self-sustaining wage, and therefore the shape of the labor market is an accurate indicator of its equitable distribution.

We are limited by the data, and this presents us with some challenges. First, we cannot map the AMC wage data itself because we have no occupational income data for these specific institutions. Second, we cannot represent the number of employees on the map because even at the sector level, many of the occupations employed in the health care sector are not reported as health care jobs, but are reported in larger aggregates. For example, there are over 400,000 people employed in "office and administrative support occupations" in Greater Boston. These people are employed at all sorts of different kinds of workplaces, not just hospitals.

To answer the question we have posed about the shape of the hospital labor market, we had to create a methodology that would do so. Here is what we did.

- First, we collected median salary data on all occupations represented in hospitals from the Bureau of Labor Standards for its 2007 employment survey for the Boston-Cambridge-Quincy NECTA. This is the most recent publicly-available data at the smallest geographic area that includes the City of Boston.
- Second, we focused on the 100 occupations that are found in the largest numbers in the kind of hospitals that are most like Boston 's academic medical centers: General Medical and Surgical Hospitals (NAICS 4-digit code 62-2100). Taken together, these 100 largest hospital occupations make up almost 95% of all hospital employment (94.34%). This data on the percent of industry employment in the given occupation data is available for a total of 383 occupations ranging from those found most frequently to those found least frequently. This industry labor market data is available at only the national level. We analyzed the 100 occupations that had the highest percentage numbers, ranging from the Registered Nurses who comprise 28.3% of employees to several occupations that make up only .1% of hospital employment.
- Third, we found the mid-point wage for both the regional and the hospital labor markets by calculating a mean (not median) salary for all occupations. We used a mean because it better represents a qualitative mid-point to the market. A median, by definition, would have shown us a market in which half the occupations were higher and half lower—and, consequently, would tell us nothing of any significance about the labor market as a whole. We found that the mean salary for all occupations in the Boston-Cambridge-Quincy metro region was $54,000 in 2007. The mean annual salary for the 100 largest hospital occupations was very close to this–$53,748. In reality, the hospital mean is even closer to $54,000 because wages the 5 highest paying hospital occupations (Physicians and Surgeons and Chief Executives) were calculated at $145,600, which is in fact a lowest reported wage for these occupations.
- Fourth, we made an assumption about a mean area, in which all occupations in this area, while not actually hitting the mean point, could be fairly said to be in the middle of the market. We initially calculated that area as being within ten percent of the mean salary on either side (calculated as ten percent of the mean salary). This gave us an $11,000 area around the mean, which we then expanded to $20,000 ($10,000 on either side of the mean) in order to compensate for any error. This gave us a range $44,000 to $64,000,—an area we will call the 'mid-point wage range' of our hospital labor market.

From this we can see how many occupations pay a wage higher than the mean, and how many lower, and how many at it. This tells us how concentrated or non-concentrated the income distribution is.

We use the Family Economic Self-Sufficiency (FESS) measure as our self-sufficiency wage. The FESS was developed by the Crittenton Women's Union. This measure takes into account how much income is needed to pay for basic needs for families of certain sizes. We use the family with one adult, one preschooler and one school-age child to better approximate the buying power of one income on a family.

Below are the monthly self-sufficiency standards for Norfolk County (Brookline) and Suffolk County based on 1 Adults, 1 Preschool, and 1 School-age. The annual Self-Sufficiency Wage is $58,133.

Monthly Costs

Housing	$1,304
Child Care	$1,490
Food	$522
Transportation	$71
Health Care	$343
Miscellaneous	$373
Taxes	$1,009
Earned Income Tax Credit (-)	$0
Child Care Tax Credit (-)	$-100
Child Tax Credit (-)	$-167

Putting the Boston-area health care occupational wage data up against these self-sufficiency income standards reveals **that two-thirds of hospital occupations do not pay a wage that can support a family of three in Boston**. Of the 100 occupations that are found most often in hospitals, 67 (or 67%) have a median income below the Boston FESS income level for a family with one adult and two children: $58,133. **This means that the typical Boston worker in two-thirds of all hospital occupations cannot afford even a minimal, basic standard of living for himself or herself plus two children**.

Unfortunately, a mapping of the City's hospital labor market shows that its occupations are not equitable, are not clustered around the region's mid-point income, a generous $20,000 range that stretches $10,000 above and below the midpoint wage. In fact, only 30% of the occupations pay a median wage above the mid-point range and 20% pay within that range, while **fully half-50%–of the 100 largest hospital occupations have median incomes below the mid-point range**. Mapping these occupational wages ranges would give us a very inequitable teardrop shaped wage distribution, not the more desirable football shaped equitable one. And these data are only for full-time work. Close to half the jobs in Boston's AMCs are part-time, with those workers earning less in terms of both salary and benefits.

Summary of our findings:

- 30% of the occupations are above the mid-point wage range.
- 20% of the occupations fall within the mid-point wage range.
- 50% of the occupations are below the mid-point wage.
- The top tier occupations (highest paying 20%) range from $74,180 to above $145,600. This represents a range of over $70,000. About half of these top tier occupations are above $100,000.
- The bottom tier occupations (lowest paying 20%) range from $18,220 to $29,320, a range of only $11,100. The range for the entire 48 occupations below the midpoint is about $28,000.
- 67% of occupations have a median salary below the self-sufficiency wage for Boston.

Charity Care

In this section we make a straightforward comparison between the percentage of patient-related care that is spent on uncompensated charity care and the proposed federal standard of 5%. The AMCs' actual percentage is taken from their 2006 and 2007audited financial statements. The annual charity care expenditures (actual amounts, not percentages) are taken from the amounts reported as "Shortfall Allocation" in the Uncompensated Care Pool Annual Reports for the years 2001-2007.

Endnotes

[1] Formerly known as Tufts New England Medical Center, this AMC formally changed its' name to Tufts Medical Center in March 2008. We use the new name throughout this report.

[2] J.F. Ryan Associates, Springfield Financial Control Board Project Plan (2005).

[3] We use the Family Economic Self-Sufficiency (FESS) measure as our self-sufficiency wage. The FESS was developed by the Crittenton Women's Union. This measure takes into account how much income is needed to pay for basic needs for families of certain sizes. We use the family with one adult, one preschooler, and one school-age child to better approximate the buying power of one income on a family. It is widely used as a benchmark by Workforce Investment boards, social service agencies and legislators. Lassen, Mary, *Family Cost Index is Widely Accepted*, Boston Globe, May 29, 2001, p. A18.

[4] As reported by Senator Grassley at http://grassley.senate.gov/releases/2007/07182007.pdf

[5] See The Massachusetts Institute for a New Commonwealth, "The Massachusetts Nonprofit Sector: An Economic Profile," (2006); Conference of Boston Teaching Hospitals, "Driving Greater Boston & New England: The Impact of Greater Boston's Teaching Hospitals," (Tripp Umbach 2007).

[6] Community Labor United, *The Hourglass Challenge: Creating a More Equitable Economy for Greater Boston* (2006) pp. 25-27.

[7] Greater Boston Chamber of Commerce, "Leading Industries Report (March 2005)."

[8] Boston Redevelopment Authority, "The Boston Economy 2007: Steady Growth." p. 15.

[9] Some also qualify as academic, scientific and educational exempt entities. For example, St. Elizabeth's can claim tax exemption based on its status as a religious institution. Charitable status is very important, but not controlling here.

[10] PILOT data is from the City of Boston Budget Office.

[11] It is important to note that despite the above discussion, the hospitals are not making profit every year. Some, particularly the smaller ones, have several years of loss. Even a few of the larger ones had losses in one or two years over the four studied in the table above. The figures in the table above are not cumulative, but represent profit or loss in the fiscal year specified.

[12] Gabrielle Gurley, "Municipal Meltdown," CommonWealth Magazine (MassINC: Fall 2007), "The Massachusetts Nonprofit Sector: An Economic Profile," (2006); Massachusetts Budget and Policy Center, "Property Tax in Massachusetts: Trends and Options" (January 10, 2007); Boston Municipal Research Bureau, "Special Report: Boston's Property Taxes in Limbo," No. 07-4 (October 2, 2007); Boston Globe, "A Crisis in Cities and Towns," (Editorial: January 11, 2008).

[13] Massachusetts Budget and Policy Center, "Property Tax in Massachusetts: Trends and Options" (January 10, 2007), at p.1.

[14] This remains true despite the slight reduction in the property tax rate the City made for FY08.

[15] Proposition 2 $^{1/2}$ limits the amount of revenue a city or town may raise, or levy, from local property taxes each year to fund municipal operations. Proposition 2 $^{1/2}$ was approved by Massachusetts voters in 1980, and first implemented in fiscal year 1982. Massachusetts General Laws Chapter 59, Section 21C Source: http://staging.mma.org/index.php?option=com_content&task=category&sectionid=13&id=118&Itemid=315 Source: City of Boston Assessor's database. FY05 commercial tax rate was $32.68 per $1000 of value.

[16] This is 5.41% of the land by value.

[17] The original state statute was Chapter 151, Section 6 of the Statutes of 1830, signed into law February 28, 1831. The currently relevant statue is Massachusetts General Law, Chapter 59, Section 5. The historical statute was cited in Kocian, Lisa, *Officials Want Harvard to Pay Taxes Legislation Filed on Nonprofits*, Boston Globe June 10, 2001, Globe West p.1.

[18] Sjoquist, David L. and Rayna Stoycheva, *The Property Tax Exemption for Nonprofits*, Atlanta: Andrew Young School of Policy Studies Research Paper Series, Working Paper 08-15, July 2008, pp. 5-7.

[19] Noonan, Erica, *Should Nonprofits Chip In?*, Boston Globe, October 18, 2007. The cities of Boston, Cambridge, Somerville, Medford and Newton currently have PILOT programs, and a growing number of other municipalities in Massachusetts are beginning to consider PILOT programs to deal with their fiscal shortfalls.

[20] Greater Boston Cities that currently have at least one PILOT agreement include: Boston, Cambridge, Somerville, Medford and Newton.

[21] J.F. Ryan Associates, Springfield Financial Control Board Project Plan (2005).

[22] For example, in 2006, Mayor Menino got five colleges to make a $10 million commitment to building campus partnerships between the colleges and ten struggling public schools. Estes, Andrea, *City Talks of Donated Medical Care*, Boston Globe, April 12, 2006, p. B1. Grillo, Thomas, *Council Considers Fee for Off-Campus Students*, Boston Globe, March 19, 2000, p.B4. *Untapped Assets*, Boston Globe Editorial, September 9, 1993, p. 20. *A College Try for Boston*, Boston Globe Editorial, November 7, 2006, p. A10.

[23] City of Boston, Revenue Estimates and Analysis, FY08, p. 83

[24] City of Boston Assessor's Office

[25] City of Boston Assessor's Office

[26] Although the process is theoretically done on a parcel basis, data on PILOTs is not disseminated on a parcel basis, but on an institutional basis. Formal PILOT agreements may refer to parcel numbers or street addresses, but the City tends to disseminate PILOT information at an institutional level. (Interview with OBM staff.)

[27] *Untapped Assets,* Boston Globe Editorial, September 9, 1993, p. 20.

[28] Kocian, op cit. Kocian, Lisa, *Looking for a Deal on Taxes Harvard, Town in Talks Over Arsenal Complex*, Boston Globe, August 16, 2001, Globe West p. 1.

[29] Some versions of this counted only out-of-state students; others counted only students living off-campus. Slack, Donovan, *Council Mulls Budget Measures*, Boston Globe, January 30, 2003, p. B8. Dade, Corey, *Council Rivals Outline Goals*, Boston Globe, September 19, 2003, p. B8. *Councilor wants new fee for colleges*, Boston Globe, February 11, 2004, New England in Brief, p.B2.

[30] Greenberger, Scott S., *Hub Would Tax the Tax-Exempt*, Boston Globe, May 17, 2003, p. A1. *Tax-Exempt Fairness*, Boston Globe Editorial, June 7, 2003, p. A12.

[31] Drake, John C. *What price history?*, Boston Globe, April 17, 2008.

[32] It is also important to note that there is a personal property tax in Boston and the value of exempting such property (such as medical devices, office equipment, etc.) is significant. However, the personal property valuation information is, unlike real property valuation, private and not available to us for analysis.

[33] Boston Municipal Research Bureau, "Boston's Employee Earnings in 2006: Higher Earnings Put More Focus on the Affordability of Generous Benefits" (Special Reports, No. 07-2). In calendar year 2006 (which overlaps FY07 for half of that year), average compensation was reported as: $79,022 for Boston school teachers; $103,817 for all firefighters; $124,473 for uniformed police officers. These figures are the basis for calculating how many teachers, firefighters or police officers could be financed with the FY07 PILOT Gap revenues.

[34]Community Labor United, The Hourglass Challenge, op cit. Community Labor United, Earnings, Poverty and Income Inequality, Boston, MA: 2008, p. 11.

[35] This is based on the Massachusetts Family Economic Self-Sufficiency Standard (MASSFESS), developed by what is now Crittenton Women's Union. In the 10 years since its introduction, the MASSFESS has become a widely used benchmark. Note that in the employment section of this study we use a self-sufficiency wage for a family of three, not four. The reason we use a family of four in the passage above is to keep the data consistent with the median family income data. The reason we use a family of three in the employment section is to compare the purchasing power of a single income.

[36] US Bureau of the Census, 2002 Economic Census.

[37] Research conducted by SEIU 1199.

[38] Massachusetts Job Vacancy Surveys, Department of Workforce Development, 4th Quarter 2004 and 4th Quarter 2005.

[39] Cardiovascular Technologists and Technicians, Licensed Practical and Vocational Nurses, Medical and Clinical Technologists and Technicians, Medical Records and Health Information Technicians, Nuclear Medicine Technologists, Nursing Aides, Orderlies, and Attendants, Physical Therapist Aides and Assistants, Radiologic Technologists and Technicians, Registered Nurses, Respiratory Therapy Technicians, and Surgical Technologists.

[40] MA Division of Career Centers and Division of Unemployment Occupational Employment and Wage Statistics May 2005

[41] Massachusetts Division of Unemployment Insurance, "Commonwealth of Massachusetts Employment Projections 2000—2010."

[42] Center for Labor Market Studies, "Assessment of Postsecondary Education Needs and Participation by Working Adults in the Greater Boston RCC,"(Northeastern University: February 2004).

[43] Bureau of Labor Statistics Wages by Area and Occupation, Metropolitan Area Wage Data, Boston-Cambridge-Quincy MA NECTA Division, May 2007.

[44] $54,000 was the mean occupational annual wage for all occupations in the Boston/Cambridge/Quincy NECTA region for 2007. If we instead used the mean occupational annual wage for only Health Practitioner and Technical Occupations (all occupations in Occ Code 29 0000s) it would be much higher, $77.520. This would not, however, be an accurate comparison, since only 30% of the 100 occupations employed most in hospitals fall in this occupational cluster, while 70% fall under other occupational clusters. These include occupations at all points on the wage spectrum, from high to low, for example: Financial Managers, Accountants and Auditors, Janitors and Cleaners and Security Guards.

[45] Hourglass Challenge at pp. 30-31.

[46] H.B. Boyle et al, "Investing in Massachusetts Working Families: A Framework for Economic Prosperity," (Boston, MA: The Women's Union, The Massachusetts Family Economic Self-Sufficiency (MassFESS) Project, April 2004), page 39.

[47] Health Access and SEIU 250, "Your Money or Your Health: Discriminatory Pricing and Aggressive Debt Collection Practices by Sutter Health in San Francisco," (May 2004). See also, David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness And Injury As Contributors To Bankruptcy," Health Affairs 24 (2005).

[48] Leslie Bennett, "It's All in the Numbers: A Beginner's Guide to Charity Care Analysis" (Consumers Union of U.S., Inc. undated) at 1-2.

[49] Other ways that hospitals have argued they are providing their charitable services: through community service programs, in community benefits agreements with individual community groups (such as community development corporations), and payments such as Linkage and PILOTs. There is nothing wrong with any of these programs, but they are insufficient indicators of the community benefits hospitals should provide as large employers engaged in medical business and paying no taxes. Reasons for this are:

- Community Service programs—same concerns as stated in the text concerning community benefit programs.
- CBAs with CDCs—these are private agreements with organizations that are not legally representative of the community, they are not easily available to the public for review, they do not compensate for lost revenue to the city.
- Linkage—this is a requirement that all developers must pay if their developments meet certain criteria; it is neither voluntary nor a medical business community benefit.
- PILOT—these payments are not for community benefit but for compensation for essential services of the city.

[50] http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf

[51] http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf *Hospital Compliance Project Interim Report (Summary of Reported Data).* The completed report was issued in September 2008: Nonprofit Hospitals Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements. The report, which reviews data from Texas, Indiana and Massachusetts nonprofit hospitals, can be found at: http://www.gao.gov/new.items/d08880.pdf?source=ra. The GAO report found that the level of uncompensated charity care contributions by Massachusetts hospitals in 2006 averaged 1.9% for MA nonprofit hospitals, which echoes our findings that no Boston Academic Medical center contributed more even 2% of its net revenues to uncompensated charity care in that year. See GAO, 2008, page 43, Figure 7: *Average Percentages of Total Operating Expenses Devoted to the Unreimbursed Cost of Medicaid and to the Unreimbursed Cost of Medicaid Net of DSH Payments among Nonprofit Hospitals in Selected States, 2006)*.

[52] As reported by Senator Grassley at http://grassley.senate.gov/releases/2007/07182007.pdf

[53] Beginning in Fiscal year 2004, the Uncompensated Care Pool began using a prospective payment system that based current year payments on prior years' experience (plus several adjustments). Because of this change, it was possible for some hospitals to receive payments greater that their experience in that year. Additionally, certain hospitals (including BMC and CHB) receive guaranteed rates or amounts of payments to reflect their particular mission of serving large numbers of uninsured patients.

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