Nonprofit Hospitals, Once For the Poor, Strike It Rich

With Tax Breaks, They Outperform For-Profit Rivals

By John Carreyrou And Barbara Martinez

Nonprofit hospitals, originally set up to serve the poor, have transformed themselves into profit machines. And as the money rolls in, the large tax breaks they receive are drawing fire.

Riding gains from investment portfolios and enjoying the pricing power that came from a decade of mergers, many nonprofit hospitals have seen earnings soar in recent years. The combined net income of the 50 largest nonprofit hospitals jumped nearly eight-fold to $4.27 billion between 2001 and 2006, according to a Wall Street Journal analysis of data from the American Hospital Directory. AHD, an information-service company, compiles data that hospitals report to the federal government.

The Cleveland Clinic swung from a loss to net income of $229 million during that period. No fewer than 25 nonprofit hospitals or hospital systems now earn more than $250 million a year. One nonprofit hospital system, Ascension Health, has a treasure chest of $7.4 billion—more than many large, publicly traded companies.

Nonprofits, which account for a majority of U.S. hospitals, are faring even better than their for-profit counterparts: 77% of the 2,033 U.S. nonprofit hospitals are in the black, while just 61% of for-profit hospitals are profitable, according to the AHD data.

At some nonprofits, the good times are reflected in new facilities and rich executive pay. Flush with cash, Northwestern Memorial Hospital in Chicago has rebuilt its entire campus since 1999 at a cost of more than $1 billion. In October, it opened a new women's hospital that features marble in the lobby, birthing rooms with flat-screen televisions, 1,000 works of art and a roof topped with 10,000 square feet of gardens. In 2006, Northwestern Memorial's former chief executive officer, Gary Mecklenburg, received a $16.4 million payout.

But Northwestern Memorial has been frugal in its spending on charity care, the free treatment for poor patients that nonprofit hospitals are expected to provide in return for the federal and state tax breaks they receive. In 2006, Northwestern Memorial spent $20.8 million on charity care—less than 2% of its revenues and a fraction of what it received in tax breaks. By comparison, the hospitals run by Cook County, where Northwestern Memorial is located, spent 14% of revenues on charity care.

Northwestern Memorial says that in addition to charity care, it provides other benefits to its community, such as pioneering research in obstetrics and other areas that improve standards of care nationally.

To be sure, some nonprofit hospitals, particularly ones in inner cities that handle large numbers of uninsured patients, remain under financial strain and are struggling to keep their doors open.

But the growing gap between many nonprofit hospitals' wealth and what they give back to their communities is raising questions about the billions of dollars in tax exemptions they receive.

"Some nonprofit hospitals

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Healthy Returns

Many nonprofit hospitals, such as Northwestern Memorial in Chicago, below, have flourished recently amid strong growth in income.

Source: American Hospital Directory, based on the hospitals' Medicare cost reports

Nonprofit Hospitals, Once for the Poor, Strike It Rich

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seem to forget that their operations are subsidized with generous tax breaks. They allow their priorities to get out of whack," says Sen. Charles Grassley. The senior Republican on the Senate Finance Committee threatened last year to introduce legislation forcing nonprofit hospitals to provide a minimum amount of charity care.

Nonprofit hospitals account for about 60% of the more than 3,400 hospitals in the U.S. The rest are either for-profit or government-owned.

In a report issued in December 2006, the Congressional Budget Office estimated nonprofit hospitals receive $12.6 billion in annual tax exemptions, on top of the $32 billion in federal, state and local subsidies the hospital industry as a whole receives each year.

Community Benefit

In return for not paying taxes, nonprofit hospitals are supposed to provide a "community benefit," a loosely defined requirement whose most important component is charity care. But many hospitals include other expenses in their community-benefit accounting to the Internal Revenue Service, including unpaid patient bills. Often, hospitals also include the difference between the list prices of treatment they provide and what they are paid by Medicaid and Medicare, the government programs for the poor, disabled and elderly. Excluding those other expenses, many hospitals spend less on charity care than they get in tax breaks, studies by various counties and states show.

One nonprofit hospital system, St. Louis-based BJC HealthCare, counts the salaries of its employees as a community benefit. BJC, which runs 14 hospitals in Missouri and Illinois, says on its Web site that it provided more than $1.8 billion in benefits to various communities in 2004. Its payroll, including its CEO's $1.8 million compensation, accounted for $937 million of that figure, while charity care represented $35 million, according to BJC.

"The impact that any organization that's job-producing and buying goods has on a community is of benefit to that community," says BJC HealthCare spokeswoman June Fowler. However, she says BJC won't count its payroll as a community benefit in the future because of new standards adopted by the IRS.

The new standards, due to take full effect in 2009, will require nonprofit hospitals to break out specifics of their community-benefit contributions. But they won't require the hospitals to provide any minimum amount of charity care.

The size of nonprofit hospitals' tax exemptions is coming under scrutiny in part because their incomes have risen so sharply in recent years, and because they represent such a big chunk of America's health-care spending. Thirty-one cents of every dollar spent on medical care is spent on hospitals.

One reason for hospitals' soaring profits is a gradual increase in Medicare reimbursements after federal budget cutbacks during the 1990s. By merging and gaining scale, many hospitals also gained leverage in price negotiations with health insurers.

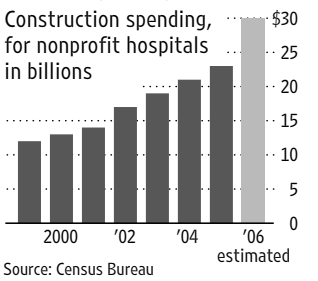
However, much of the industry's profit growth comes from strategies it honed to increase profits. Among them: demanding upfront payments from patients; hiking list prices for procedures and services to several times their actual cost; selling patients' debts to collection companies; focusing on expensive procedures; and issuing tax-exempt bonds and investing the proceeds in higher-yielding securities.

Untaxed investment gains have greatly increased some hospitals' cash piles. Ascension Health, a Catholic nonprofit system that runs 65 hospitals, mostly in the Midwest and Northeast, reported net income of $1.2 billion in its fiscal year ended June 30, 2007, and cash and investments of $7.4 billion. That's more cash than Walt Disney Co. has.

Ascension says it needs to maintain a sufficient amount of cash to pay for charity care, to keep the interest rates it pays on its debt low, to provide retirement benefits to its 106,000 employees, and to make capital and technology investments at its hospitals.

At the University of Pittsburgh Medical Center, which runs 20 facilities, cash and investments totaled $3.35 billion at the end of last year. UPMC says the money goes toward producing "world-class health care, education and research," citing the $1 billion it spent over five years to create electronic medical records for patients and an additional $500 million to build a children's hospital and a network of cancer centers.

Building Binge



Source: Census Bureau

But some of UPMC's expenses are only tenuously related to medicine. In its 2006 fiscal year, UPMC also spent $10 million on advertising, including $1 million on ads in the New York Times. Wendy Zellner, a spokeswoman for the hospital, says the ads enable UPMC "to better compete with other leading hospitals."

UPMC paid its CEO, Jeffrey Romoff, $3.3 million in fiscal 2006. Mr. Romoff also received $36,995 from the hospital to cover a car allowance, spousal travel and legal and financial counseling. Ms. Zellner says what UPMC pays Mr. Romoff is in line with "nonprofit and for-profit organizations of comparable scope and complexity."

Some nonprofit hospital executives enjoy other perks. Royal Oak, Mich.-based Beaumont Hospitals says it paid $10,795 for the country-club membership of the president of its foundation last year. A spokeswoman for Beaumont says it pays for the membership to provide the executive "a venue with access to potential donors."

The Cleveland Clinic continued to pay its former CEO, Floyd Loop, more than $1 million a year for two years after he retired in April 2005. The Cleveland Clinic says part of that was deferred compensation and vacation pay and the rest was for consulting services.

Hospitable Pay

Some of the best paid nonprofit hospital CEOs

CEO	Hospital	Total accrued compensation, in millions	Year
Gary Mecklenburg*	Northwestern Memorial Hospital	**$16.4**	2006
Floyd Loop†	Cleveland Clinic	**7.5**	2006
Mark Neaman	Evanston Northwestern Healthcare	**5.4**	2006
Lloyd Dean	Catholic Healthcare West	**5.3**	2006
Philip Incarnati	McLaren Health Care Corp.	**5.2**	2006
Joseph Trunfio	AHS Hospital Corp.	**5.0**	2005
Alan Brass	ProMedica	**4.1**	2005
Herbert Pardes	New York-Presbyterian	**3.5**	2006
Jeffrey Romoff	UPMC	**3.3**	2006
Douglas French‡	Ascension Health	**3.3**	2004

*Retired on Sept. 1, 2006, total includes a retirement payout and deferred compensation †Retired in April 2005; $6.4 million of the $7.5 million is a split-dollar life insurance policy, the rest is deferred compensation, vacation pay and consulting fees ‡Resigned in May 2004

Sources: Forms 990 filed to the IRS; the hospitals

The University of California San Francisco Medical Center provided its CEO and chief operating officer low-interest mortgage loans of more than $1 million each, according to the University of California's executive compensation reports. A UCSF spokeswoman says such loans help recruit and retain executives, given the area's high cost of housing.

Catholic Healthcare West, a hospital system based in San Francisco, forgave a $782,541 housing loan it made to its CEO, Lloyd Dean. Counting the forgiven loan, Mr. Dean's total accrued compensation in 2005 was $5.8 million. Catholic Healthcare West says his compensation reflects his skill in turning the hospital system around financially.

One nonprofit hospital executive who has benefited from the industry's good fortunes is Mr. Mecklenburg, the former CEO of Chicago's Northwestern Memorial. The hospital says it paid him $5.45 million in salary, bonus and deferred compensation in its fiscal year ended Aug. 31, 2006, and an additional $10.95 million when he retired the next day. The hospital also awarded five other executives a combined $13.3 million in total compensation in fiscal 2006, according to its filings to the IRS.

Mr. Mecklenburg, now a partner at Chicago private-equity firm Waud Capital Partners LLC, declined to comment, referring questions to the hospital and to the former chairman of its compensation committee, James Denny.

Stellar Results

Northwestern Memorial says a big part of Mr. Mecklenburg's $16.4 million payout represents retirement benefits and deferred compensation accrued over his 21-year tenure. Mr. Denny, who chaired the hospital's compensation committee from 1995 to January 2008, says Mr. Mecklenburg delivered stellar results, nearly quintupling the hospital's patient revenues. "Our view of it is: This is the best deal we've ever made," he says.

Critics argue that Mr. Mecklenburg's compensation is excessive for a charity organization that gets tens of millions of dollars a year in tax breaks. Northwestern Memorial sits on property on the Gold Coast, Chicago's most affluent neighborhood, abutting Lake Michigan. The Center for Tax and Budget Accountability, a Chicago nonprofit organization, estimates the value of the hospital's annual property-tax exemption at $37.5 million. Northwestern Memorial is also exempt from $12.5 million in sales tax for a total of $50 million in annual tax exemptions, not counting the taxes it doesn't pay on its investment gains, the center estimates.

"The hospital's tax benefit is more than two times greater than the charity care provided," says Heather O'Donnell, the center's health-care policy director.

Northwestern Memorial says it hasn't calculated the value of its tax exemptions. Robert Christie, the hospital's vice president for government relations, notes that the Center for Tax and Budget Accountability receives funding from the Service Employees International Union, which represents numerous hospital employees and frequently clashes with hospitals in labor disputes. Ms. O'Donnell says her organization receives funding from many foundations besides SEIU.

Peter McCanna, Northwestern Memorial's chief financial officer, says the hospital's contribution to its community should be judged more broadly. "We fundamentally disagree with narrowing [the definition of] our community-benefit contribution to charity care," he says. He says Northwestern Memorial's research and education expenses should also be counted. The hospital is the primary teaching hospital for Northwestern University's Feinberg School of Medicine.

Taking into account educational and other expenses, such as bad debt and unreimbursed Medicaid costs, Northwestern Memorial values its total community-benefit contribution at $230 million for fiscal 2006.

Room Service

Around Chicago, Northwestern Memorial is known as a hospital that attracts the well-heeled. It's a short walk from the Magnificent Mile, the famous thoroughfare lined with expensive shops and restaurants. At Northwestern Memorial's new Prentice Women's Hospital, expectant mothers can watch TV or browse the Internet on 42-inch flat-screen televisions, order room service 24 hours a day and page nurses and doctors via a wireless system. Some birthing rooms have views of Lake Michigan. Only 6% of Northwestern Memorial's patient revenues come from Medicaid.

By comparison, Sacred Heart Hospital, a small for-profit hospital in a poor neighborhood on the west side of the city, gets 62% of its revenues from Medicaid and pays several million dollars a year in taxes, according to its president, Edward Novak. Parts of Sacred Heart date back to 1928, when the hospital was founded. Another wing was built in 1950. Mr. Novak says he would like to replace the aging hospital with a new facility, but is struggling to figure out how to pay for it. He says his compensation is less than $220,000 a year.

At John H. Stroger Jr. Hospital—formerly known as Cook County Hospital—56% of patients don't have any insurance when they are admitted, says John Cookinham, the hospital's chief financial officer. At Northwestern Memorial, the percentage of uninsured patients is less than 5%. Stroger's chief operating officer earned $204,485 in 2007, according to Cook County budget records.

In recent years, some nonprofit hospitals have decided to stop using the courts to collect from patients who owe them money. But Northwestern Memorial pursues patients such as Iris Ayala who haven't paid their bills. While running an errand for her employer, the 50-year-old Ms. Ayala fainted and collapsed in the street one day in 2006. A friend rushed her to Northwestern Memorial's emergency room.

Ms. Ayala says her insurer paid for the bulk of her 24-hour hospital stay, but she was responsible for a $1,035.39 co-pay. Working only part-time because of health issues and with a daughter in college, she says she couldn't afford her portion of the bill.

After representatives for Northwestern Memorial repeatedly called her to ask for payment, Ms. Ayala says she promised she would settle the bill once she got her annual tax refund. But Northwestern Memorial sued her in Cook County Circuit Court in July 2007. To make the lawsuit go away, Ms. Ayala says she borrowed the money and paid the hospital. "They didn't want to hear my sob story," she says.

Northwestern Memorial declined to discuss Ms. Ayala's case, citing patient privacy laws. Mr. McCanna says the hospital sued only 82 patients in 2006 and 2007, a number he says is small compared with the more than one million accounts it billed over that period. He says the hospital tries to determine whether patients who are behind on bills qualify for assistance, but some can't be reached or refuse to volunteer information about their finances. "Absent of information, a lawsuit is sometimes the only recourse," he says. Mr. McCanna adds that, in some cases, the hospital has waived patients' bills after later learning that they did qualify for aid.

Northwestern Memorial says its strong balance sheet allows it to provide outstanding care and conduct innovative research. As of Aug. 31, 2007, its cash and investments totaled $1.82 billion, making it one of richest individual nonprofit hospitals in the country. With such a treasure chest, it could operate for a year and two months without any revenue—a gauge of financial strength Mr. McCanna highlights in presentations to bond investors and analysts.

"Nonprofit is a misnomer—it's nontaxable," says Sacred Heart Hospital's Mr. Novak. "When you're making hundreds of millions of dollars a year, how can you call yourself a not-for-profit?"

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ONLINE TODAY: John Carreyrou provides a tour of Northwestern Memorial Hospital, which just underwent a renovation costing more than $1 billion, at **WSJ.com/Video**. Plus, see more data on hospital funding and spending, at **WSJ.com/OnlineToday**.

From Charity and Tax Breaks to Healthy Profits

Historically, most hospitals in America have been recognized as "charitable organizations" exempt from taxes under Section 501(c)(3) of the U.S. Tax Code. In return for their tax exemptions, the Internal Revenue Service used to require that nonprofit hospitals provide a substantial amount of care for the poor, also known as charity care.

But after Medicare and Medicaid were created in 1965, the hospital industry contended that there would no longer be enough demand for charity care to satisfy the IRS's tax-exemption standards. Most Americans, it argued, would be covered either by the new government programs for the poor and elderly or by private health insurance. The industry pushed for a more flexible exemption standard that became known as the "community benefit" standard. The IRS adopted it in 1969.

Some charity care has continued to be expected of nonprofit hospitals as part of their contributions to their communities, but no minimum amount has been required.

Today, about 60% of the 3,400 hospitals in the U.S. are nonprofit. About 23% of hospitals are for-profit, and another 17% are run by counties, states or the federal government.

Like other nonprofit organizations, nonprofit hospitals don't have shareholders or owners to whom any profits can be distributed. Rather, any money they earn from their operations or from financial investments must be channeled back into the organization in some way. Many nonprofit hospitals have used their growing surpluses to pay for expensive new facilities and equipment, to reward their executives with large pay packages and to increase their treasure chests.

Cash Before Chemo: Hospitals Get Tough

By Barbara Martinez

LAKE JACKSON, Texas—When Lisa Kelly learned she had leukemia in late 2006, her doctor advised her to seek urgent care at M.D. Anderson Cancer Center in Houston. But the nonprofit hospital refused to accept Mrs. Kelly's limited insurance. It asked for $105,000 in cash before it would admit her.

Sitting in the hospital's business office, Mrs. Kelly says she told M.D. Anderson's representatives that she had some money to pay for treatment, but couldn't get all the cash they asked for that day. "Are they going to send me home?" she recalls thinking. "Am I going to die?"

Hospitals are adopting a policy to improve their finances: making medical care contingent on upfront payments. Typically, hospitals have billed people after they receive care. But now, pointing to their burgeoning bad-debt and charity-care costs, hospitals are asking patients for money before they get treated.

Hospitals say they have turned to the practice because of a spike in patients who don't pay their bills. Uncompensated care cost the hospital industry $31.2 billion in 2006, up 44% from $21.6 billion in 2000, according to the American Hospital Association.

The bad debt is driven by a larger number of Americans who are uninsured or who don't have enough insurance to cover medical costs if catastrophe strikes. Even among those with adequate insurance, deductibles and co-payments are growing so big that insured patients also have trouble paying hospitals.

Letting bad debt balloon unchecked would threaten hospitals' finances and their ability to provide care, says Richard Umbdenstock, president of the American Hospital Association. Hospitals would rather discuss costs with patients upfront, he says. "After, when it's an ugly surprise or becomes contentious, it doesn't work for anybody."

M.D. Anderson says it went to a new upfront-collection system for initial visits in 2005 after its

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Bad Debts Prompt Hospitals to Demand Patients' Cash Upfront

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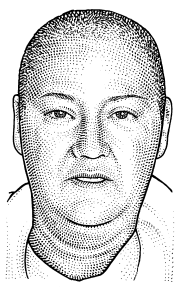
unpaid patient bills jumped by $18 million to $52 million that year. The hospital said its increasing bad-debt load threatened its mission to cure cancer, a goal on which it spends hundreds of millions of dollars a year.

The change had the desired effect: The hospital's bad debt fell to $33 million the following year.

Asking patients to pay after they've received treatment is "like asking someone to pay for the car after they've driven off the lot," says John Tietjen, vice president for patient financial services at M.D. Anderson. "The time that the patient is most receptive is before the care is delivered."

M.D. Anderson says it provides assistance or free care to poor patients who can't afford treatment. It says it acted appropriately in Mrs. Kelly's case because she wasn't indigent, but underinsured. The hospital says it wouldn't accept her insurance because the payout, a maximum of $37,000 a year, would be less than 30% of the estimated costs of her care.



Lisa Kelly

Tenet Healthcare and HCA, two big, for-profit hospital chains, say they have also been asking patients for upfront payments before admitting them. While the practice has received little notice, some patient advocates and health-care experts find it harder to justify at nonprofit hospitals, given their benevolent mission and improving financial fortunes.

In the Black

An Ohio State University study found net income per bed nearly tripled at nonprofit hospitals to $146,273 in 2005 from $50,669 in 2000. According to the American Hospital Directory, 77% of nonprofit hospitals are in the black, compared with 61% of for-profit hospitals. Nonprofit hospitals are exempt from taxes and are supposed to channel the income they generate back into their operations. Many have used their growing surpluses to reward their executives with rich pay packages, build new wings and accumulate large cash reserves.

M.D. Anderson, which is part of the University of Texas, is a nonprofit institution exempt from taxes. (Please see article below.) In 2007, it recorded net income of $310 million, bringing its cash, investments and endowment to nearly $1.9 billion.

"When you have that much money in the till and that much profit, it's kind of hard to say no" to sick patients by asking for money upfront, says Uwe Reinhardt, a health-care economist at Princeton University, who thinks all hospitals should pay taxes. Nonprofit organizations "shouldn't behave this way," he says.

It isn't clear how many of the nation's 2,033 nonprofit hospitals require upfront payments. A voluntary 2006 survey by the Internal Revenue Service found 14% of 481 nonprofit hospitals required patients to pay or make an arrangement to pay before being admitted. It was the first time the agency asked that question.

Nataline Sarkisyan, a 17-year-old cancer patient who died in December waiting for a liver transplant, drew national attention when former presidential candidate John Edwards lambasted her health insurer for refusing to pay for the operation. But what went largely unnoticed is that Ms. Sarkisyan's hospital, UCLA Medical Center, a nonprofit hospital that is part of the University of California system, refused to do the procedure after the insurance denial unless the family paid it $75,000 upfront, according to the family's lawyer, Tamar Arminak.

The family got that money together, but then the hospital demanded $300,000 to cover costs of caring for Nataline after surgery, Ms. Arminak says.

UCLA says it can't comment on the case because the family hasn't given its consent. A spokeswoman says UCLA doesn't have a specific policy regarding upfront payments, but works with patients on a case-by-case basis.

Federal law requires hospitals to treat emergencies, such as heart attacks or injuries from accidents. But the law doesn't cover conditions that aren't immediately life-threatening.

At the American Cancer Society, which runs call centers to help patients navigate financial problems, more people are saying they're being asked for large upfront payments by hospitals that they can't afford. "My greatest concern is that there are substantial numbers of people who need cancer care" who don't get it, "usually for financial reasons," says Otis Brawley, chief medical officer.

Mrs. Kelly's ordeal began in 2006, when she started bruising easily and was often tired. Her husband, Sam, nagged her to see a doctor.

A specialist in Lake Jackson, a town 50 miles from Houston, diagnosed Mrs. Kelly with acute leukemia, a cancer of the blood that can quickly turn fatal. The small cancer center in Lake Jackson refers acute leukemia patients to M.D. Anderson.

When Mrs. Kelly called M.D. Anderson to make an appointment, the hospital told her it wouldn't accept her insurance, a type called limited-benefit.

"When an insurer is going to pay the small amounts, we don't feel financially able to assume the risk," says M.D. Anderson's Mr. Tietjen.

An estimated one million Americans have limited-benefit plans. Usually less expensive than traditional plans, such insurance is popular among people like Mrs. Kelly who don't have health insurance through an employer.

Mrs. Kelly, 52, signed up for AARP's Medical Advantage plan, underwritten by UnitedHealth Group Inc., three years ago after she quit her job as a school-bus driver to help care for her mother. Her husband was retired after a career as a heavy-equipment operator. She says that at the time, she hardly ever went to the doctor. "I just thought I needed some kind of insurance policy because you never know what's going to happen," says Mrs. Kelly. She paid premiums of $185 a month.

A spokeswoman for UnitedHealth, one of the country's largest marketers of limited-benefit plans, says the plan is "meant to be a bridge or a gap filler." She says UnitedHealth has reimbursed Mrs. Kelly $38,478.36 for her medical costs. Because the hospital wouldn't accept her insurance, Mrs. Kelly paid bills herself, and submitted them to her insurer to get reimbursed.

M.D. Anderson viewed Mrs. Kelly as uninsured and told her she could get an appointment only if she brought a certified check for $45,000. The Kellys live comfortably, but didn't have that kind of cash on hand. They own an apartment building and a rental house that generate about $11,000 a month before taxes and maintenance costs. They also earn interest income of about $35,000 a year from two retirement accounts funded by inheritances left by Mrs. Kelly's mother and Mr. Kelly's father.

Mr. Kelly arranged to borrow the money from his father's trust, which was in probate proceedings. Mrs. Kelly says she told the hospital she had money for treatment, but didn't realize how high her medical costs would get.

The Kellys arrived at M.D. Anderson with a check for $45,000 on Dec. 6, 2006. After having blood drawn and a bone-marrow biopsy, the hospital oncologist wanted to admit Mrs. Kelly right away.

But the hospital demanded an additional $60,000 on the spot. It told her the $45,000 had paid for the lab tests, and it needed the additional cash as a down payment for her actual treatment.

In the hospital business office, Mrs. Kelly says she was crying, exhausted and confused.

The hospital eventually lowered its demand to $30,000. Mr. Kelly lost his cool. "What part don't you understand?" he recalls saying. "We don't have any more money today. Are you going to admit her or not?" The hospital says it was trying to work with Mrs. Kelly, to find an amount she could pay.

Mrs. Kelly was granted an "override" and admitted at 7 p.m.

Appointment 'Blocked'

After eight days, she emerged from the hospital. Chemotherapy would continue for more than a year, as would requests for upfront payments. At times, she arrived at the hospital and learned her appointment was "blocked." That meant she needed to go to the business office first and make a payment.

One day, Mrs. Kelly says, nurses wouldn't change the chemotherapy bag in her pump until her husband made a new payment. She says she sat for an hour hooked up to a pump that beeped that it was out of medicine, until he returned with proof of payment.

A hospital spokesperson says "it is very difficult to imagine that a nursing staff would allow a patient to sit with a beeping pump until a receipt is presented." The hospital regrets if patients are inconvenienced by blocked appointments, she says, but it "is a necessary process to keep patients informed of their mounting bills and to continue dialog about financial obligations." She says appointments aren't blocked for patients who require urgent care.

Once, Mrs. Kelly says she was on an exam table awaiting her doctor, when he walked in with a representative from the business office. After arguing about money, she says the representative suggested moving her to another facility.

But the cancer center in Lake Jackson wouldn't take her back because it didn't have a blood bank or an infectious-disease specialist. "It risks a person's life by doing that [type of chemotherapy] at a small institution," says Emerardo Falcon Jr., of the Brazosport Cancer Center in Lake Jackson.

Ron Walters, an M.D. Anderson physician who gets involved in financial decisions about patients, says Mrs. Kelly's subsequent chemotherapy could have been handled locally. He says he is sorry if she was offended that the payment representative accompanied the doctor into the exam room, but it was an example of "a coordinated teamwork approach."

On TV one night, Mrs. Kelly saw a news segment about people who try to get patients' bills reduced. She contacted Holly Wallack, who is part of a group that works on contingency to reduce patients' bills; she keeps one-third of what she saves clients.

Ms. Wallack began firing off complaints to M.D. Anderson. She said Mrs. Kelly had been billed more than $360 for blood tests that most insurers pay $20 or less for, and up to $120 for saline pouches that cost less than $2 at retail.

On one bill, Mrs. Kelly was charged $20 for a pair of latex gloves. On another itemized bill, Ms. Wallack found this: CTH SIL 2M 7FX 25CM CLAMP A4356, for $314. It turned out to be a penis clamp, used to control incontinence.

M.D. Anderson's prices are reasonable compared with other hospitals, Mr. Tietjen says. The $20 price for the latex gloves, for example, takes into account the costs of acquiring and storing gloves, ones that are ripped and not used and ones used for patients who don't pay at all, he says. The charge for the penis clamp was a "clerical error" he says; a different type of catheter was used, but the hospital waived the charge. The hospital didn't reduce or waive other charges on Mrs. Kelly's bills.

Continuing Treatment

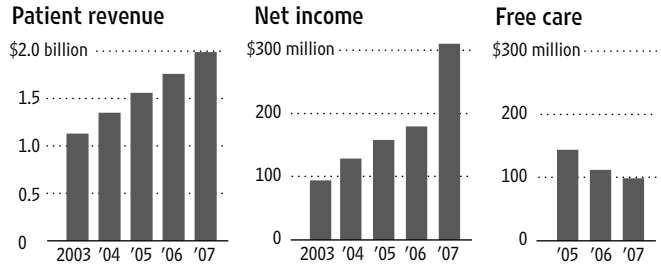
Mrs. Kelly is continuing her treatment at M.D. Anderson. In February, a new, more comprehensive insurance plan from Blue Cross Blue Shield that she has switched to started paying most of her new M.D. Anderson bills. But she is still personally responsible for $145,155.65 in bills incurred before February. She is paying $2,000 a month toward those. Last week, she learned that after being in remission for more than a year, her leukemia has returned.

M.D. Anderson is giving Blue Cross Blue Shield a 25% discount on the new bills. This month, the hospital offered Mrs. Kelly a 10% discount on her balance, but only if she pays $130,640.08 by this Wednesday, April 30. She is still hoping to get a bigger discount, though numerous requests have been denied. The hospital says it gives commercial insurers a bigger discount because they bring volume and they are less risky than people who pay on their own.

The hospital has urged Mrs. Kelly to sell assets. But she worries about losing her family's income and retirement savings. Mrs. Kelly says she wants to pay, but, suspicious of the charges she's seen, she says, "I want to pay what's fair."

Giving Care

While M.D. Anderson Cancer Center has become increasingly profitable, its free care for indigent patients has been declining



Source: the hospital

Financial Health

❖ **The Issue:** Hospitals are asking patients for payment before receiving treatment.

❖ **The Background:** Hospitals say the practice is needed because of an increase in the number of people not paying their bills.

❖ **The Bottom Line:** While hospitals provide care to the poor, uninsured and underinsured people are likely to be hardest hit.

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ONLINE TODAY: See documents from Mrs. Kelly's case, at **WSJ.com/OnlineToday**.

Healthy Funding At M.D. Anderson

M.D. Anderson Cancer Center is part of the University of Texas System. It was created by pledges of $173.6 million, including $50 million from oil baron T. Boone Pickens.

Nonprofit Hospitals Flex Pricing Power

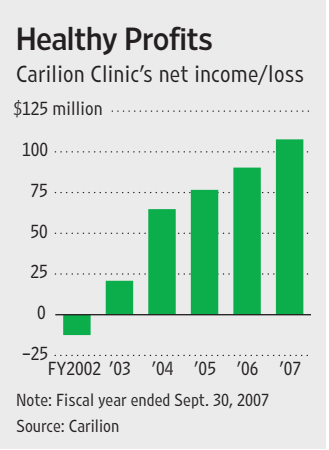
In Roanoke, Va., Carilion's Fees Exceed Those of Competitors; the $4,727 Colonoscopy

By John Carreyrou

ROANOKE, Va.—In 1989, the U.S. Department of Justice tried but failed to prevent a merger between nonprofit Carilion Health System and this former railroad town's other hospital. The merger, it warned in an unsuccessful antitrust lawsuit, would create a monopoly over medical care in the area.

Nearly two decades later, the cost of health care in the Roanoke Valley—a region in southwestern Virginia with a population of 300,000—is soaring. Health-insurance rates in Roanoke have gone from being the lowest in the state to the highest.

That's partly a reflection of Carilion's prices. Carilion charges $4,727 for a colonoscopy, four to 10 times what a local endoscopy center charges for the procedure. Carilion bills $1,606 for a neck CT scan, compared with the $675 charged by a local imaging center.



Carilion's market clout is manifest in other ways. With eight hospitals, 11,000 employees and $1 billion in assets, the tax-exempt hospital system has become one of the dominant players in the Roanoke Valley's economy. Its dozens of subsidiaries include businesses ranging from athletic clubs to a venture-capital fund.

The power of nonprofit hospital systems like Carilion over their regional communities has increased in recent years as their incomes have surged. Critics charge this is creating untaxed local health-care monopolies that drive the costs of care higher for patients and businesses.

"It's a one-market town here in terms of health care," says Sam Lionberger, who owns a local construction firm. "Carilion has the leverage."

Carilion acknowledges its influence in the local community but says there is nothing untoward about it. The hospital says it doesn't have a monopoly over the Roanoke Valley health-care market because it faces robust competition from Lewis-Gale Medical Center, a hospital located in nearby Salem, Va., and owned by for-profit chain HCA Inc.

Carilion says it charges more for certain procedures because it has to subsidize operations such as an emergency department and treatment for the uninsured. Edward Murphy, Carilion's CEO, says the high cost of health care in Roanoke reflects the national increase in such costs, which he says is driven by overutilization of medical services. Carilion is converting to a clinic model, in which doctors are employees of the hospital system and work more closely together to coordinate care, in an effort to cut down on unnecessary tests and procedures, he says. "Fragmentation is the enemy of quality" and affordable care, Dr. Murphy says.

However, the clinic project

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Nonprofit Hospitals Flex Their Pricing Power

Continued from Page One

has provoked a backlash from a group of local independent doctors, who say it is designed to stifle competition.

Originally set up to serve the poor, nonprofit hospitals account for the majority of U.S. hospitals. They are exempt from taxes and are supposed to channel income they generate back into operations, while providing benefits to their communities. But they have come under fire from patient advocates and members of Congress for stinting on charity care even as they amass large cash hoards, build new facilities and award big paychecks to their executives.

Fueled by large, untaxed investment gains, Carilion's profits have risen over the past five years, reaching $107 million last year. Over the same period, the total annual compensation of its chief executive, Dr. Murphy, nearly tripled to $2.07 million. His predecessor, Thomas Robertson, received a lump-sum pension from Carilion of $7.4 million in 2003, on top of more than $2 million in previous pension payouts.

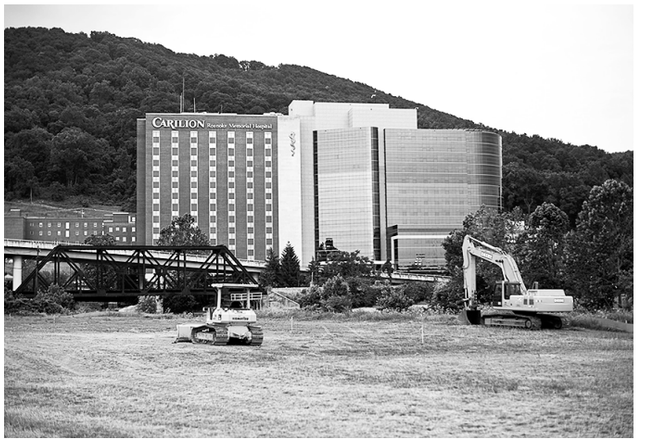
Carilion says Dr. Murphy's compensation is in line with comparable health-care organizations and notes he doesn't receive car allowances, a spousal allowance or club memberships. It says Mr. Robertson's pension accrued over a 32-year career at Carilion.

Carilion estimates it receives about $50 million a year in tax exemptions. It dispensed $42 million in charity care in 2007 and $30 million in 2006.

After the 1989 merger, Carilion continued to operate Roanoke's two hospitals separately. It later consolidated the hospital boards and in 2006, transferred most of Roanoke Community Hospital's staff and services to a renovated and enlarged Roanoke Memorial Hospital.

The moves eliminated any hospital competition in Roanoke proper, enabling Carilion to raise its prices and contributing to a spike in health-insurance rates in the region, one of the least affluent parts of the state, according to local doctors and health-insurance brokers.

Alan Bayse, founder of a local benefits-consulting firm who has sold health insurance in the area for 30 years, says health-insurance rates in the Roanoke Valley used to be 20% lower than in Richmond, Virginia's capital, and the lowest in the state. Today, he says, they are the highest in the state and 25% higher than in Richmond, citing rate information from insurer Cigna Corp. Anthem, another health insurer, says its rates are 6% higher in Roanoke than in Richmond.



Stephen Voss/WpN for The Wall Street Journal

Carilion is building a state-of-the-art **new medical campus** in Roanoke.

Mr. Lionberger, whose construction company has about 100 employees, says his health-care costs have risen 50% over the past three years, hampering his ability to compete with contractors from other parts of the state. "It's frustrating," he says.

While Carilion strengthened its power in the hospital market, Roanoke continued to be home to a community of independent doctors numbering in the hundreds.

Taking the Helm

In 2001, Dr. Murphy took the nonprofit hospital system's helm. Dr. Murphy, who has a medical degree from Harvard but doesn't practice medicine, says he was convinced that the cost and quality of care in Roanoke could be improved if doctors worked in a more centralized system. In June 2006, he announced a seven-year, $100 million plan to transform Carilion into a multispecialty clinic, like the Mayo Clinic.

Carilion began approaching private physician groups, offering to buy their practices and pay their salaries. Some accepted, but others balked. Some doctors who chose to remain independent say the number of patients referred to them by Carilion physicians plummeted. Carilion controls a large proportion of Roanoke's referrals because it employs a majority of doctors who make them, such as family practitioners, pediatricians and emergency physicians.

Joseph Alhadeff, an orthopedic surgeon who is a member of a private practice called Roanoke Orthopedic Center, says the number of joint replacements he performed dropped off sharply after he stopped getting such referrals from Carilion doctors, prompting him to plan to relocate to Pennsylvania. "I spent seven years building up a practice and watched it evaporate in six months," he says.

Set up to serve the poor, nonprofit hospitals are exempt from taxes.

Carilion spokesman Eric Earnhart says the hospital system didn't engage "in any activity to reduce or divert" referrals from Dr. Alhadeff. Mr. Earnhart adds that Carilion continues to refer numerous cases to Roanoke Orthopedic Center.

Geoffrey Harter, an ear, nose and throat doctor at another Roanoke private practice, Jefferson Surgical Clinic, says Carilion-employed colleagues told him the hospital system asked them not to refer patients to doctors it didn't employ, calling such referrals "leakage." Keeping referrals within Carilion is lucrative for the hospital system because it ensures tests and procedures performed on patients take place at Carilion facilities.

Dr. Murphy says Carilion uses the term "leakage" in internal marketing discussions and that he would rather see its doctors refer patients to other Carilion doctors to optimize their care. But he says Carilion doesn't require its doctors to keep referrals in-house even though it would be legal to do so.

As tension between Carilion and Roanoke's independent doctors grew in 2006, a group of 200 doctors formed an organization called the Coalition for Responsible Healthcare to protest the Carilion Clinic plan. The group posted a petition on its Web site and put up billboards around Roanoke that read: "Carilion Clinic. Big Dream. Big Questions." The local newspaper, the Roanoke Times, covered the controversy in a series of articles written by its health-care reporter, Jeff Sturgeon.

A few months later, in March 2007, the Roanoke Times moved Mr. Sturgeon off the health-care beat after Carilion complained repeatedly about his coverage. Carilion says it communicated its displeasure to the paper's editors, but never asked that Mr. Sturgeon be reassigned. Carilion withdrew most of its advertising from the paper, but says it did that as part of a reallocation of its ad budget. "Any friction that exists between an organization like us and the media is entirely appropriate," Mr. Earnhart says.

Mr. Sturgeon, who now covers transportation, declined requests for comment. Carole Tarrant, the Roanoke Times's editor, said: "We're covering Carilion like we always have and always will, and have no plans to change how we cover Carilion." She declined to elaborate.

New Campus

A large part of the clinic conversion's costs have involved the construction of a new medical campus around Roanoke Memorial Hospital that began several years earlier.

The lead contractor building the site is Swedish construction giant Skanska. But one of the project's biggest beneficiaries has been J.M. Turner & Co., which is owned by Carilion board member Jay Turner. Carilion says it paid J.M. Turner a total of $14.9 million in direct contracting work from 2004 to 2007.

Dr. Murphy says Carilion's board authorized "arm's length work" with J.M. Turner, but adds that "a case could be made that we shouldn't award work to J.M. Turner to avoid the appearance of impropriety."

Carilion also paid Skanska, the lead contractor, a total of $120.8 million from 2003 to 2007. Some of that money flowed back to J.M. Turner as subcontracting work, according to Skanska and J.M. Turner. The companies and Carilion declined to say how much.

In an email, Mr. Turner said he recuses himself from all Carilion board decisions that involve his company. He added that his firm passed on much of the $14.9 million in direct contracting work it received from Carilion to other subcontractors.

Mr. Turner isn't the only Carilion board member with a financial stake in the new medical campus. Another board member, Warner Dalhouse, has invested in a hotel being built on the campus to accommodate patients and their families. HomeTown Bank, a local bank Mr. Dalhouse founded and of which he was until recently chairman, is financing the hotel's construction. Dr. Murphy and Mr. Turner sit on HomeTown Bank's board.

Edward Murphy

Carilion and Mr. Dalhouse say he didn't make his $130,000 investment in the hotel until after Carilion sold the parcel to Texas developers in early 2006. "I wasn't dealing with Carilion. I was dealing with the new owners of that land who had paid fair market value for it," Mr. Dalhouse says.

Carilion says its transformation into a multispecialty clinic will eventually lower local health-care costs. But many patients say they have yet to see relief from Carilion medical bills.

The Roanoke City General District Court devotes one morning a week to cases filed by Carilion. In its fiscal year ended Sept. 30, Carilion says it sued 9,888 patients, garnished the wages of 5,478 people and placed liens on 3,920 homes. Carilion says the people it takes to court have the means to pay their bills.

On a Thursday morning in June, a Carilion representative waited outside a courtroom to intercept the half-dozen patients who had responded to summonses to appear in court. She took them to a side room to work out payment plans. A judge later called out names of close to 100 patients who didn't show and, one-by-one, entered judgments against them.

One of the patients who came to court, a 32-year-old housewife named Christie Masellis, faced a $12,137.12 bill. She had gastric bypass surgery at a Carilion facility in 2005. After developing complications, she required two more surgeries. She says her insurer covered the first surgery but not the two follow-ups because it changed its coverage policy.

Mrs. Masellis has two children. Her husband, Mark, earns about $49,000 a year working for an auto-parts distributor. Mrs. Masellis says she inquired about qualifying for hospital financial assistance, but the Carilion representative told her she was no longer eligible for charity care because her account was past due. The representative agreed to put her account on hold until Sept. 30 but offered her no discount. The bill included $2,514.82 in interest charges Carilion added to the original debt of $9,622.30.

Carilion's Mr. Earnhart says Mrs. Masellis had already received more than $15,000 in charity-care discounts. The suit Carilion filed is "for the remainder of the bill," he says.

Mr. and Mrs. Masellis have begun the process of filing for personal bankruptcy. Mr. Masellis says the hospital bill was a big factor in the decision, though the couple has other debts, including a $68,000 mortgage.

When some patients don't pay their bills, Carilion places liens on their homes. Carilion says it doesn't track how many liens it has outstanding, but the close to 4,000 it filed in 2007 "is representative of a typical year," Mr. Earnhart says. Carilion doesn't foreclose on homes and only collects when properties are sold, he says.

Dr. Murphy says Carilion only sues patients and places liens on their homes if it believes they have the ability to pay. "If you're asking me if it's right in a right-and-wrong sense, it's not," he says. But Carilion can't be blamed for the country's "broken" health-care system, he says.

Nonprofit Hospitals Leave The City for Greener Pastures

By Barbara Martinez

DETROIT—Ascension Health, the country's largest nonprofit hospital system, says its mission is to serve all, "with special attention to those who are poor and vulnerable." But in this city, where one in four people don't have health insurance, it's become harder for the poor and vulnerable to find Ascension.

Last year, Ascension's local subsidiary closed Riverview Hospital, the third hospital it has shut down in Detroit in the past 10 years and the only hospital that remained on the city's blighted east side. Meanwhile, 30 miles away, in a suburb of multimillion-dollar homes, Ascension is opening a new $224 million hospital.

Ascension's approach to the Detroit market is an increasingly common strategy among nonprofit hospital systems: Close money-losing facilities in poor areas where a large share of patients are uninsured, and build or refurbish hospitals in affluent places where people have private insurance coverage.

Nonprofit hospital systems have shuttered facilities from Los Angeles to Chicago to Newark, N.J., while spending billions on suburban expansions. This all comes as large nonprofit chains have been enjoying some of their most prosperous times ever.

Net income at Ascension, which owns 67 hospitals located mostly in the Midwest, South and Northeast, nearly tripled to $1.2 billion between 2004 and 2007 thanks largely to investment gains. With financial markets struggling over the past year, Ascension reported net income of $351 million for the year ended June 30.

Shutting down unprofitable operations and expanding profitable ones is a common business maneuver, but nonprofit hospital systems aren't ordinary businesses. They're required to provide benefits to their communities, such as free care for the indigent, in exchange for the billions of dollars in annual tax exemptions they receive.

Ascension, which is affiliated with the Roman Catholic Church, says its more profitable subsidiaries can't be used to subsidize those that are struggling. "Such an approach would mean that needs in other communities may not be met," says Ascension spokeswoman Trudy Barthels. The 38 subsidiaries, which Ascension calls "health ministries," operate with a large degree of independence and have to be "self-sustaining," she says. Ascension adds that it ties how much capital it allocates each subsidiary, in part, to its profitability.

St. John Health System, Ascension's Michigan subsidiary, says Riverview lost $16 million in 2006, just before it announced the closing. Uninsured patients were using Riverview's emergency room for non-emergencies—an expensive and inefficient way to deliver routine care, says Robert Hoban, St. John's chief strategy officer. The neighborhood's real need, he says, is not for a hospital but for more primary-care doctors. He says St. John is studying ways to provide more of that kind of care there.

But critics of the closure, including neighborhood residents

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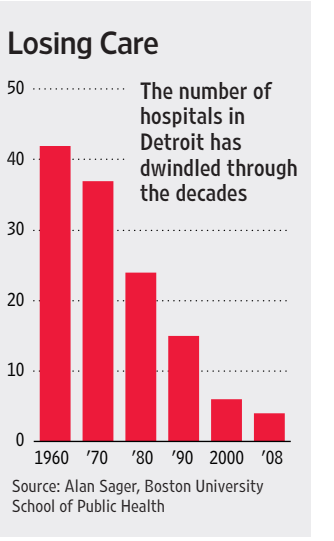


Nonprofit Hospitals Leave the City for Greener Pastures

Continued from Page One

and former employees, say shutting down Riverview had the effect of driving doctors away. Of the 50 doctors who worked in office buildings on the Riverview campus, at least a third have left or cut back their office hours since the hospital closed, including all but one of the pediatricians and the sole oncologist.

Malaz Alatassi, an internal-medicine doctor who had office hours once a week at Riverview, has since cut down to twice a month and is considering leaving the area for good. "The message patients got was that all doctors have left," said Dr. Alatassi. "It was a bad thing for the community. I feel bad giving up my patients."

St. John officials say that there hasn't been a large-scale exodus and that they are finalizing negotiations to add another primary-care doctor to the campus.

Ascension traces its roots to 17th-century France, where a group of nuns known as the Daughters of Charity traveled from city to city to care for the poor. In the early 1800s, the order found its way to the U.S., creating one of its first hospitals in a three-room log cabin in St. Louis.

In 1999, the Daughters of Charity National Health System and the Sisters of St. Joseph Health System merged to create Ascension, a nonprofit giant with facilities in 20 states and the District of Columbia.

Many Ascension meetings still begin with a prayer and nuns hold some management roles. Ascension is also a well-oiled money machine with sterling credit ratings. Its cash and investments totaled $7.3 billion for the year ended June 30, including about $1 billion restricted to self-insurance trust funds or limited by donors for specific uses or to be maintained in perpetuity. Ascension's chief executive, Anthony Tersigni, earned $2.4 million in total compensation in 2006, according to the hospital system's latest filing with the Internal Revenue Service. Ascension declined to provide more recent compensation figures.

Ascension spent $320 million on charity care in its hospitals in the year ended June 30, or 2.5% of its patient revenue—the highest percentage among the nation's five largest nonprofit hospital systems. But its St. John subsidiary devotes a much smaller percentage to traditional charity care, with 0.8% going to it in the 2008 fiscal year.

Ascension and St. John say their traditional charity care numbers don't take into account all the other money they spend on helping the poor in the community, such as health education, writing off bad debts and their losses on Medicaid, the government health-insurance program for the poor.

A St. John spokeswoman said it's unfair to compare St. John's figures to Ascension's because more patients in Michigan qualify for Medicaid than some of the other states where Ascension operates. In those states, more people receive charity care because fewer people are eligible for Medicaid.

Before its closing, Riverview was one of the few remaining hospitals in the Detroit city limits. Of the 42 hospitals that dotted this 139-square-mile city in 1960, only four are now left. At the same time Detroit's hospitals have dwindled, its number of uninsured has grown. An estimated 200,000 of the city's 800,000 residents have no health insurance.

Located in one of Detroit's poorest wards, Riverview sits among empty buildings on East Jefferson Avenue, a thoroughfare sprinkled with subsidized senior housing, empty and overgrown lots, partially burned homes, and graffiti-stained shops.

Even in a struggling city, Riverview's neighborhood stands out for its abysmal statistics: Thirty-four percent of the population lives below the poverty line, infant mortality is more than double the national average and the rate of AIDS deaths is five times higher, according to Richard Lichtenstein, an associate professor at the University of Michigan's School of Public Health. Its poor patient base made Riverview a perennial money-loser.

In 2003, St. John executives campaigned to persuade local regulators to let it build a new hospital in the wealthy suburb of Novi (pronounced no-vie), 30 miles to the northwest. The new facility's profits, they said, would help ensure the survival of St. John's operations in Detroit by subsidizing their losses.

"We are very, very committed to staying in Detroit," St. John's Mr. Hoban said at a public hearing on the new hospital plan, according to a transcript. "We wouldn't be here today if we weren't committed to staying in Detroit."

Approval for the Novi hospital was granted. That year, St. John shut down its hospital in northeast Detroit, reducing its presence in the city proper to Riverview and St. John Hospital and Medical Center. St. John had already closed another Detroit hospital, Saratoga Hospital, in 1998.

Mr. Hoban says today that even with the closure of those hospitals and Riverview, "we still have the same number of beds per population" in the city after a recent expansion of St. John Hospital and Medical Center.

Riverview continued to be a drag on St. John's financial performance. Nearly 50% of its patients were uninsured or on Medicaid and another 42% were on Medicare, the federal program for the elderly. Unlike Medicare, Medicaid reimburses hospitals at much lower rates than private insurance plans and often not enough to cover costs.

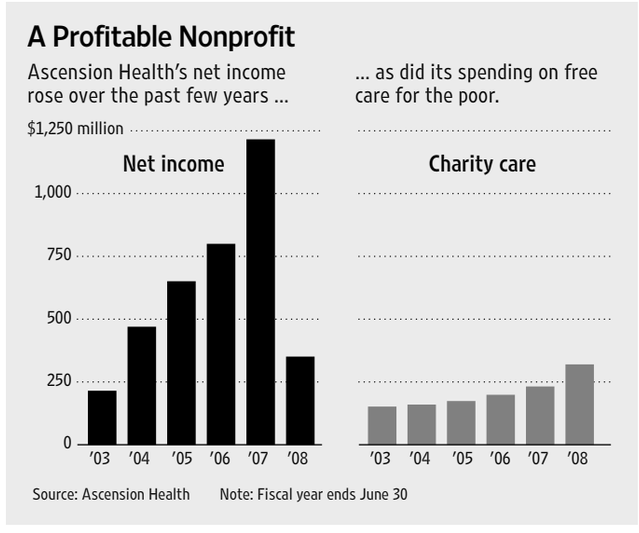
In 2006, Dr. Cheryl Gibson-Fountain, Riverview's former chief of staff, says she was told by St. John that the hospital could not afford the less than $5,000 Riverview was planning to spend on its annual health-and-immunization fair. The point of the fair was to screen area residents for early signs of disease. A spokeswoman for St. John said the hospital participated in other health fairs.

Even as it eliminated the fair, St. John spent $9 million in design and architecture fees for its new construction projects in the year ended June 30, 2006, according to its IRS filings.

In February 2007, a potential lifeline materialized for Riverview. St. John officials were in talks with Michigan State University about making it one of the university's teaching hospitals, Riverview's president told employees in a letter. Under the proposed deal, the state would have taken ownership of the hospital with St. John receiving a fee to manage it. But the deal fell through when Michigan State chose to link up with another hospital.

"We were looking for teaching space for our students," said Randy Hillard, the university's associate provost for human health. "They wanted to give us the whole hospital, and we needed to pay them a $10 million management fee on a hospital that was losing millions of dollars."

St. John closed Riverview in June 2007. That year, St. John paid then-Chief Executive Elliot Joseph $1 million. Mr. Joseph defends the closing of the hospital, pointing out that the population of the metro areas had shifted from the shrinking city to the growing suburbs.



"At the time we closed Riverview, the state of Michigan said that there were an excess of 1,200 hospital beds in the city of Detroit," Mr. Joseph said through a spokesman. "We believed, accurately, that the best way to improve the health of the community in the Riverview area was by helping people establish relationships with primary-care physicians."

Shortly after Riverview closed, St. John's critics seized on renovations at the system's lone remaining city hospital as a symbol of their anger. St. John moved the lobby of St. John Hospital and Medical Center to overlook the wealthy, almost exclusively white suburb of Grosse Pointe Woods rather than Detroit, which it had faced for more than 50 years.

William Anderson, who was director of medical education at Riverview, says he believes St. John was saying, "We do not want to be in Detroit where there are so many poor, black people."

St. John denies that race and wealth had anything to do with it; the change was dictated by simple geography. The lobby-moving project was part of a $163 million upgrade to the hospital that added 144 private-room beds and more parking. Maureen Petrella, a St. John spokeswoman, says the expansion was added "to the north part of the property because that is the only space that was available on this landlocked site." Patients can still enter the Detroit side of the hospital.

To ease the impact of Riverview's closure, St. John maintained a bare-bones emergency room there for 12 months. The hospital's ER had always been bustling, handling 30,000 patient visits a year.

In February, a 60-year-old barber named Alfred Gaut was on his routine exercise walk in nearby Belle Isle Park when he was shot in the leg by teenagers playing with a gun. The police took Mr. Gaut to the shrunken Riverview ER, his daughter and two of his sisters say. Mr. Gaut, who was on Medicaid, was told he had flesh wounds and sent home with crutches and painkillers, the family says.

Mr. Gaut had been training to become a barber instructor. When he didn't show up for a ceremony at which he was to receive his instructor's license two weeks later, his family and friends went looking for him. They discovered his badly decomposed body in his apartment. The medical examiner's office listed the cause of death as "indeterminate."

Tia Gaut, Mr. Gaut's 38-year-old daughter, wonders if things might have turned out differently if there had been a hospital to admit him. "I want to know, why did they release him?" she asks.

Ascension and St. John declined to comment about Mr. Gaut, citing patient-privacy laws. But Ascension notes that every 52 seconds one of its hospitals nationwide treats an uninsured patient, and it provides care for many Medicaid patients.

St. John shut Riverview's ER for good on June 30. It's now an "urgent care" center only equipped to handle small emergencies such as cuts or burns. Unlike full-fledged emergency departments, urgent-care clinics aren't required to treat all patients regardless of their ability to pay.

A sign at the reception desk reads: "Attention all Riverview urgent care patients: There is a $50 charge if you do not have insurance." Ms. Petrella says patients who say they can't pay can "request free care or installment payments." St. John wouldn't say how many people request such accommodations nor how many get them.

Sister Mary Ellen Howard, the executive director of the Cabrini Clinic, a free clinic located just a few miles away that treats about 1,600 uninsured patients, says the health-care situation in Detroit is desperate. Even before Riverview closed, her clinic periodically limited the number of new patients it accepts. Another nearby free clinic for the uninsured says it continues to turn away about 30 callers a day looking for help.

A few months ago, Sister Howard met with Cynthia Taueg, vice president of community health for St. John, to ask if she could send a few of her uninsured patients to a St. John hospital for minor procedures or surgery. The Cabrini Clinic operates only with volunteer family-medicine doctors. The nun says she was turned down. "We're doing enough already," she says Ms. Taueg told her. St. John and Ascension donated $43,000 to the Cabrini Clinic last year.

In an email, Ms. Taueg said Sister Howard's account of the meeting "is not entirely accurate," but she didn't respond to subsequent emails and phone messages asking her to elaborate. Ms. Petrella says St. John only makes its specialists available to uninsured patients within its own network of affiliated hospitals and clinics "due to limited resources."

While East Detroit adjusts to the reality of not having a hospital, Ascension's state-of-the-art Providence Park Hospital opened last month in Novi with private rooms that feature flat-screen televisions and large windows for viewing what the St. John Web site describes as "green space, wetlands, foliage and wildlife habitat" on a campus "rich in natural beauty."

Doing a Volume Business in Liver Transplants

By John Carreyrou

PITTSBURGH—The University of Pittsburgh Medical Center once dominated the lucrative business of liver transplants. But as the procedure grew more common, competition from other hospitals eroded its monopoly.

Earlier this decade, UPMC made an aggressive bid to reclaim its leadership by hiring an innovative surgeon named Amadeo Marcos, who promised to double the number of liver transplants the hospital did.

Dr. Marcos delivered on his pledge. In doing so, however, he resorted to practices that some colleagues found questionable. To overcome a perennial shortage of organs, he used more livers from older donors. He transplanted some of these into relatively healthy patients for whom the risk-reward calculation was less certain. He used partial livers from living donors, and then understated complications from the controversial procedure.

UPMC is a nonprofit hospital system whose income is largely exempt from taxes. Yet, it is increasingly run like a for-profit company, paying its executives high salaries, jumping into new activities and expanding abroad. Its quest to ramp up its transplant business shows how a drive for higher revenue, now common at nonprofit hospitals, could risk compromising patient care.

UPMC asked Dr. Marcos to resign in March for what it says was a code-of-conduct breach unrelated to patient care. It says it

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A Nonprofit Hospital Ramps Up Its Liver-Transplant Business

Continued from Page One

stands by his clinical work, noting that one-year survival rates for liver-transplant recipients improved in the three full years of his tenure as head of its program.

"It would be incorrect to insinuate that financial motives drove" the transplant program under Dr. Marcos, said a UPMC spokesman, though he acknowledged that stepping up transplant volume was one reason the surgeon was recruited. "Our core mission is nothing less than providing the best and most appropriate care for patients," said the spokesman, Paul Wood.

Dr. Marcos, 46 years old when he left UPMC, did not respond to numerous attempts to reach him, including a letter sent to his home. A lawyer who represented him in a court case last year said he hadn't been in contact with Dr. Marcos for months.

Dr. Marcos's nearly six years at UPMC coincided with rapid growth at the medical center. UPMC is one of the nation's most financially successful nonprofit hospital systems, with operations ranging from Pennsylvania to Ireland and Qatar. Even though three-quarters of its $7 billion in annual revenue is exempt from federal and local taxes, UPMC has acquired many of the trappings of large, for-profit corporations.

Its chief executive, Jeffrey Romoff, earned $4 million in the fiscal year ended June 30, 2007, and 13 other employees earned in the roughly $1 million to $2 million range. For their transportation, UPMC leases a corporate jet. Earlier this year, UPMC relocated its headquarters into Pittsburgh's tallest skyscraper, the 62-story U.S. Steel Tower.

The transplant program is a source of both profits and prestige that UPMC leverages to attract star doctors and build its other businesses, which include a health-insurance arm. Hospitals charge $400,000 to $500,000 for a liver transplant. UPMC's transplant program produced $130 million of revenue in its latest fiscal year.

UPMC became a leader in the field in 1981 by hiring Thomas Starzl, the first surgeon to successfully transplant a human liver. He turned Pittsburgh into the world's transplantation capital. At its peak in the mid-1980s, UPMC was performing about 600 liver transplants a year.

It took the franchise abroad, creating, for instance, a center in Sicily. But as many other U.S. hospitals began doing the procedure, the annual total UPMC performed fell to 132 in 2001.

Amadeo Marcos

The next year, UPMC set out to hire a surgeon who could restore the program to its former glory. It settled on Dr. Marcos, a dashing Venezuelan with a taste for Ferraris and Porsches, who specialized in the emerging field of transplants from living donors.

He promised to double liver-transplant volume in his first year and to bring with him pairs of living donors and recipients from where he then worked, the University of Rochester (N.Y.) Medical Center, say people familiar with his recruitment. In a May 14, 2002, email to UPMC's chief executive, a top UPMC official said Dr. Marcos had boasted "he can do five liver transplantations per week."

But he carried some baggage. In March 2000, Dr. Marcos had been pressured to resign from the Virginia Commonwealth University School of Medicine after a colleague there filed a complaint with the Equal Employment Opportunity Commission alleging he sexually assaulted her, a letter the state's Board of Medicine later sent to Dr. Marcos shows. The woman, a post-doctoral fellow in the medical school's psychiatry department, also filed a federal suit against Dr. Marcos and the university that was later dismissed.

UPMC officials learned of the allegation during the vetting process, says John Fung, a surgeon who then headed the transplant program. Dr. Fung says the CEO, Mr. Romoff, played down the concerns it raised and that Mr. Romoff and Dr. Marcos "saw eye-to-eye on volume and profit."

UPMC declined to make Mr. Romoff available for an interview. Mr. Wood, the spokesman, said that Dr. Marcos denied the sexual-assault allegations and "there were no court findings to support them."

Mr. Wood acknowledged that transplant volume was a consideration in the hiring. He said "UPMC was just trying to claw back" volume it had lost.

UPMC offered Dr. Marcos $500,000 a year and "additional incentive payments," a letter dated June 21, 2002, shows. Dr. Marcos came aboard as director of clinical transplantation, reporting to Dr. Fung.

Liver-transplant volume in Dr. Marcos's first full year there jumped to more than double the volume in the year before he came, according to data from the United Network for Organ Sharing, or UNOS. But the way he boosted it raised questions for some colleagues.

A shortage of transplantable organs from cadavers is a perennial constraint on the number of liver transplants. Dr. Marcos overcame this in part by using organs from so-called expanded-criteria donors—deceased people who had been older or sicker than preferred liver donors.

In the 2½ years before Dr. Marcos joined UPMC, the average age of its deceased liver donors was 41, according to UNOS. By 2003, it was 47, or nine years above the national average.

And while in 2000 and 2001, UPMC used an average of only 10 livers a year from patients older than 65, it used 45 in 2003.

Dr. Marcos put some of these organs into patients who were in the early stages of liver disease, say Dr. Fung and Howard Doyle, who then worked in UPMC's transplant intensive-care unit. These were patients, they say, who sometimes didn't need a transplant.

"For the first time in years, we had people dying on the operating table or in the ICU," says Dr. Doyle, now director of surgical critical care at Montefiore Medical Center in New York. At times, according to him, patients healthy enough to walk into the hospital before being transplanted died "because they had a high-risk liver put into them."

Data from the Scientific Registry of Transplant Recipients show that during Dr. Marcos's time at UPMC, 30 liver recipients died within two days of surgery. That was a death rate of 2.4%, versus a national average of 1.6%. UPMC's Mr. Wood counters that in 2005-2007, the three complete years Dr. Marcos headed the transplant program, one-year survival rates for liver recipients improved to 84.1% from 81.2%.

Mr. Wood says UPMC used only 3% of the expanded-criteria organs that became available. "If our motivation was strictly financial, this percent would be much greater," he said.

Liver patients are ranked by how advanced their disease is. Based on a series of blood tests called MELD, scores range from 40 for the sickest to six for the healthiest. Most experts now believe the risks of a transplant generally outweigh the benefits for patients with MELD scores of 14 or lower.

During Dr. Marcos's nearly six years at UPMC, it performed 441 liver transplants on patients with scores of 14 or lower, according to UNOS. That was 35% of the liver transplants performed during his tenure, and compares with fewer than 7% in the 2½ years before he arrived.

Mr. Wood says it wasn't until 2006 that the transplant community coalesced around a score of 15 as a cutoff to allocate organs. "It would be unrealistic to expect a physician to practice according to yet-to-be-discovered criteria," he said.

Drs. Fung and Doyle say they became increasingly uncomfortable with what they considered the UPMC transplant program's relentless pursuit of volume and revenue. Both left in 2004.

Mr. Wood says Dr. Fung never raised his concerns with his superiors and gave Dr. Marcos good performance reviews. Dr. Fung says that he did raise them and that he once told Mr. Romoff that UPMC was paying a penalty with the use of bad organs.

"I couldn't square my own ethics with what was going on," said Dr. Fung, now chief of surgery at the Cleveland Clinic. "I didn't feel like the decisions that were being taken had the patient's best interest at heart."

In 2004, the New York State Department of Health fined Dr. Marcos's former employer, the University of Rochester Medical Center, for circumventing state organ-allocation rules between 2000 and 2003, during much of which time Dr. Marcos had been in charge of the program. The news didn't affect his standing at UPMC. He became head of the transplant program after Dr. Fung left that year.

Besides using more expanded-criteria livers, Dr. Marcos sharply increased the number of transplants from living donors. In these, part of the liver of a healthy person is cut off and grafted into a sick patient. If all goes well, both pieces eventually grow to normal size. The procedure is controversial because it could be risky for the otherwise healthy donor.

UPMC did 150 such surgeries while Dr. Marcos was there, according to UNOS. No donors died. However, in 69% of the cases, the recipient had a MELD score of 14 or lower—suggesting that UPMC was putting some living donors at risk to do transplants on patients in which the risks of the operation may have outweighed the benefits.

UPMC's answer is that Dr. Marcos's use of organs from living donors saved lives, because about 50 patients on UPMC's waiting list die each year for lack of a transplantable organ.

Dr. Starzl, the pioneering surgeon for whom UPMC's transplant program is named, had long been wary of the safety of the living-donor procedure. Though long retired, the 83-year-old doctor continues to do research from an office on campus.

In early 2007, he became suspicious of the low complication rates Dr. Marcos was reporting in adult living-donor liver transplants, say people familiar with the matter. In a textbook Dr. Marcos co-wrote, he said UPMC's rate of serious complications was zero for donors and 34% among a subset of recipients.

Dr. Starzl reviewed the 121 transplants UPMC had done involving removal of the donor's right lobe, a typical procedure in adult-to-adult living-donor liver transplants. Dr. Starzl's finding, according to people with knowledge of it: Though recipients' survival rate was only slightly lower than the national average, 60% of the recipients suffered life-threatening complications, ranging from bile-duct leaks to blood-supply problems—nearly double the rate Dr. Marcos reported.

Dr. Starzl raised his concerns with UPMC chief Mr. Romoff and other officials, including the head of the department of surgery, Timothy Billiar, say the people familiar with the situation.

A tense six-month standoff ensued. Dr. Starzl, worried that UPMC was covering the matter up, sent his findings to a medical journal, according to people familiar with the events. Dr. Billiar asked it not to publish, on the ground that Dr. Starzl hadn't obtained patient authorization to collect the data. Dr. Billiar says that Dr. Starzl's paper would have jumped the gun on a peer-reviewed internal study he had requested from another surgeon, Wallis Marsh.

UPMC and Dr. Starzl compromised: Dr. Starzl would wait for the internal study, which would be reviewed by Pierre-Alain Clavien, a Zurich surgeon who pioneered a scale to measure complications in living-donor liver transplants. UPMC's final conclusions would be published.

In January, Dr. Marsh and Dr. Clavien confirmed Dr. Starzl's finding of a 60% rate of serious complications among recipients, documents seen by The Wall Street Journal show. The review also concluded that about 10% of the living donors had suffered serious complications, belying Dr. Marcos's claim that this number was zero.

By then, Dr. Marcos was on thin ice at UPMC for another reason: He was having affairs with co-workers. A social worker who met him during an assignment at UPMC and dated him says Dr. Marcos beat her in front of her house one night in June 2007 after an argument, and police passing in a car arrested him.

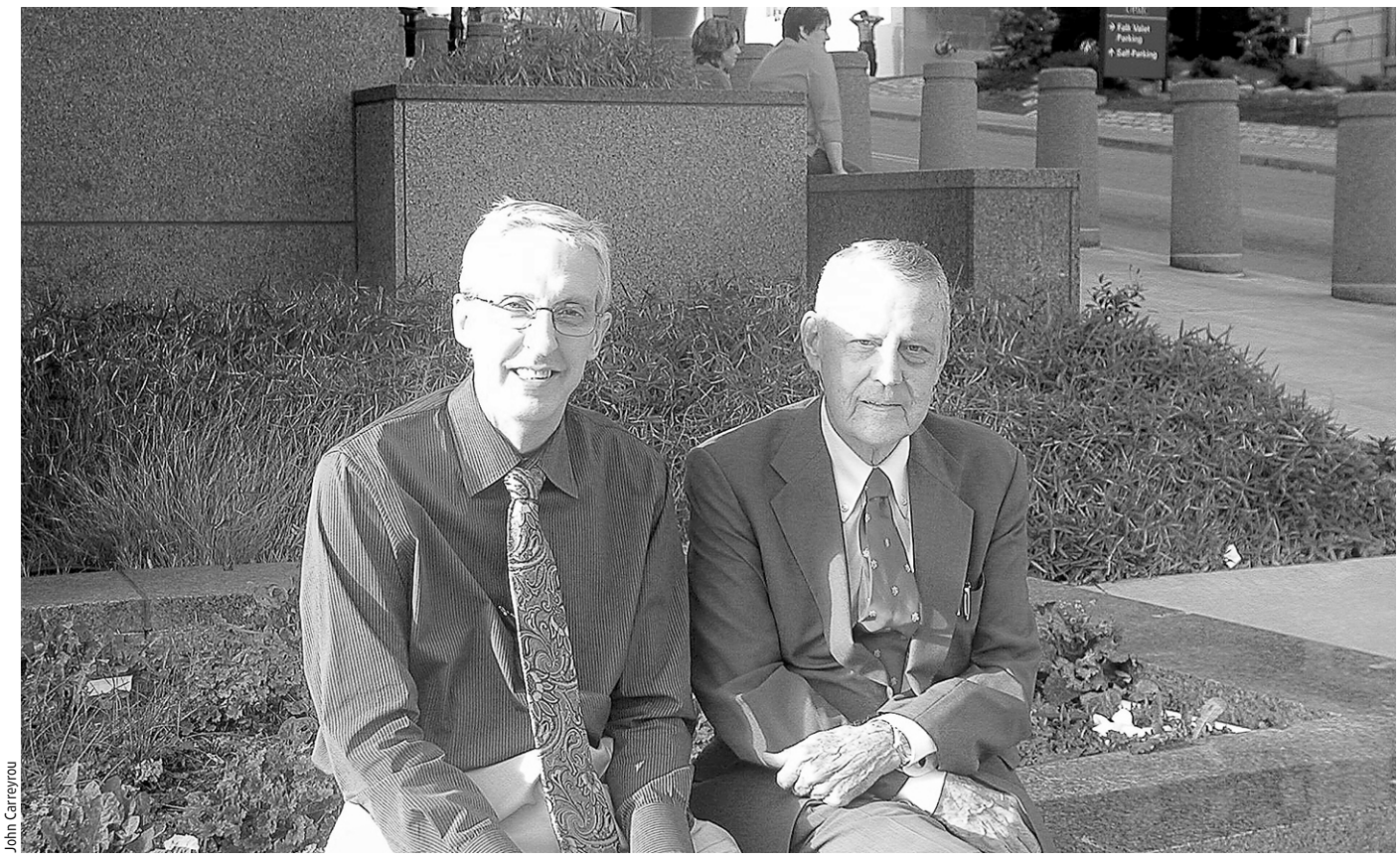
A Pittsburgh Post-Gazette article described the arrest, citing court records. The records later were expunged after Dr. Marcos completed anger-management classes, according to his attorney in the case, Robert Del Greco. The woman recounted the incident in an interview.

By the fall of 2007, the married Dr. Marcos had started dating another woman, a physician's assistant on the kidney-transplant team, four people with knowledge of the relationship say. After it soured early this year, the woman filed a complaint against Dr. Marcos with a top transplant-program official. She didn't return calls seeking comment. UPMC says it won't discuss personnel issues.

UPMC asked Dr. Marcos to resign in early March for what it referred to as a violation of its code of conduct. It declines to elaborate on the nature of the violation. Mr. Wood, the spokesman, said the dismissal had "nothing to do with patient care or surgical issues."

Randy Juhl, the University of Pittsburgh's vice chancellor for research conduct and compliance, referring to Dr. Marcos's relationships and reporting of surgery complications, said the university is "very disappointed" in him. "He did give himself and us a big black mark."

UPMC says Dr. Marsh, whom it has since named interim head of the transplant program, and Dr. Starzl now are working together on a paper about complication rates in living-donor transplants and will submit it to a scientific journal. Adult living-donor liver transplants at UPMC have ground to a halt, although UPMC says it hasn't abandoned the procedure.

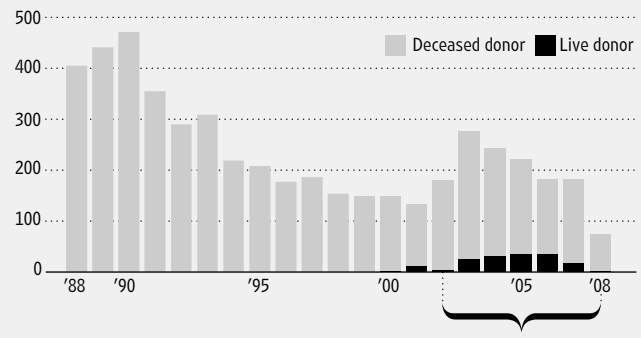


John Carreyrou

Dr. Wallis Marsh (left) and **Dr. Thomas Starzl**, outside UPMC's transplant center in Pittsburgh, are working on a paper about complication rates in living-donor transplants.

Surgery Caseload

Liver transplants at the University of Pittsburgh Medical Center, after a decline, surged when surgeon Amadeo Marcos came aboard.



Dr. Marcos worked at UPMC from mid-2002 through March 2008 and headed its transplant program from mid-2004 until his departure.

Note: 2008 data are through Aug. 31 Source: United Network for Organ Sharing