

Follow the money.

Begin with compensation, surplus and charity care. Connect each decision to safe care, access and responsible stewardship. An urgent safety issue always takes priority.

1. Executive compensation

Ask: What changed in total executive pay and bonuses, which results earned the awards, and who independently approved them?

Request: Three years of total pay and Schedule J components; targets set before the year; results, payout formula, peer group, conflicts and approval record. Count related-organization pay once.

Route: Compensation committee or equivalent, with the board chair; quality leaders validate safety results.

2. Surplus and spending priorities

Ask: What was earned from operations, what came from investments or one-time events, and what funded staffing, equipment, wages, assistance and access?

Request: Same-scope audited statements; operating and total surplus or deficit; liquidity, donor restrictions, debt obligations, reserve targets and a three-year forecast.

Route: Finance and audit committees with the full board; quality committee identifies unmet safety needs.

3. Charity care and community reach

Ask: How does financial assistance at cost compare with a clearly defined national reference, our own trend and the number of patients who need help?

Request: Schedule H line 7a, its expense denominator, eligibility and application rules, approvals and denials, screening before collections, and access outcomes. Show other community benefits separately.

Route: Community-benefit and finance leaders, patient financial services and compliance; board reviews results.

Charity comparison: keep the labels visible

KFF reports a 2.2% national average for charity-care costs / operating expenses in 2023: general short-term hospitals, all ownership types, excluding U.S. territories. It is hospital cost-report data, not a same-year Schedule H peer average. The separate 2.3% campaign benchmark matches a historical 2018 nonprofit aggregate from Bai and colleagues. Neither is a universal legal minimum. Charity care is not total community benefit, bad debt or donations to other groups.

Use the filer name, year, covered hospitals and source. A parent return does not reveal each facility's share. Ask for a like-for-like local comparison before drawing conclusions.

Bring one question.

Choose one or several according to the risks. Ask for unit-level or local evidence, an accountable person and a return date.

1. Keep experienced staff

Could management provide a quarterly dashboard of turnover, vacancies, agency spending and incentive payments by unit?

Use stable definitions and denominators; include overtime, retention, safety concerns and worker feedback. Ask for trends, targets and corrective actions.

2. Connect staffing to patient harm

Could we review nurse-sensitive outcomes alongside staffing, skill mix and patient needs by unit?

Falls with injury, infections, medication harm and missed care; counts and rates, time period, risk adjustment where appropriate, and sustained improvement after action.

3. Make assistance reach patients

Could we see assistance use versus estimated eligibility, reasons for denial, accounts sent to collections and bad debt separately from charity care?

Application and approval counts; language and disability access; screening timeliness; appeals and corrected accounts. Explain uncertainty in eligibility estimates.

4. Close gaps in access

Could we track emergency visits by people without a primary-care clinician, and whether referrals lead to completed appointments?

Define how the measure is collected; show missing data, wait times, geography and barriers. Protect privacy in small groups and include patient feedback.

5. Match outside funding to needs

Could we see which external grants or partnerships address our documented local needs, who owns each application and the verified deadlines?

Eligibility, application status, matching funds, staffing requirements, ongoing costs and a plan after temporary funding ends. Check current state and federal notices.

6. Verify denial and recovery pressures

If insurance denials help explain proposed cuts, could we see initial denials, appeals, recoveries and final losses over time?

Use the same claims cohort and allow for recovery delays; show payer and service differences, prevention work and patient delays. Do not apply a national recovery rate to this hospital.

Close every request

Who owns this? What will be reported, by when, and to which committee? Could the request and expected date be recorded in the minutes and put on the next appropriate agenda?

Ask for proof and follow-through.

These are suggested meeting questions and replies, not findings about any hospital.

They say: The pay is competitive and was approved.

You can reply: Please show the peer group, independent review and documented results. Market comparison explains one part of the decision; how did patients and workers benefit?

They say: That surplus is not available cash.

You can reply: Agreed. Please separate recurring operations, noncash gains, restricted funds and committed cash, then show the options and trade-offs in the forecast.

They say: Our total community benefit is much higher.

You can reply: Please show both. Medicaid shortfall, research and other benefits matter, but they do not answer whether eligible patients actually received financial assistance.

They say: We already have a good quality rating.

You can reply: That is useful context. Which local risks remain, what changed, and what evidence shows the improvement lasted? A rating does not answer every unit-level question.

Know your role

The full governing board oversees strategy, finances, executive accountability and mission. A quality committee reviews safety, staffing-related risk and improvement, then refers pay or budget decisions through its charter. Community and advisory members request evidence and recommendations; they do not automatically have governing authority. Do not request patient-identifying records in a public meeting.

What ethical oversight should test

Are patients safer? Can people obtain care and financial help? Are staff concerns heard without retaliation? Are conflicts disclosed? Does spending address documented needs? Are corrective actions measured and sustained? CMS requires hospital QAPI; OIG provides oversight guidance. IRS compensation review is a process, not proof that every award is fair.

Sources and limits

[CMS hospital quality and safety responsibilities](#)

[HHS OIG board oversight guidance \(2015\)](#)

[IRS compensation review: independent approval, comparability and documentation](#)

[IRS community health needs and implementation strategy](#)

[IRS financial-assistance requirements](#)

[KFF national charity-care analysis: 2023 data](#)

[Bai and colleagues: historical 2018 nonprofit charity comparison](#)

[IRS Schedule H definitions](#)

Campaign pay caps and bonus gates are proposals, not the CMS or IRS requirements summarized here. Committee charters and applicable law determine authority. More questions and replies: cashpaymed.org/ledger/community/