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EXECUTIVE SUMMARY

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IRS Issues Hospital Industry Report

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On February 12, 2009, the IRS released its long awaited "Final Report" on the results of its hospital industry compliance check audits conducted in 2006.[1] The Final Report reviews and comments upon the executive compensation and community benefit data generated by those audits and by a limited number of follow-up examinations. As such, the Final Report is expected to have significant implications on public discussion about standards for hospital tax exemption. Furthermore, the Final Report is released in the midst of a highly charged political environment, with heightened taxpayer expectations of regulatory scrutiny when tax revenues or tax subsidies support a particular organization or industry sector. It is thus a development worthy of mention to the board and key operational committees (e.g., audit and executive compensation) of essentially all tax-exempt hospitals.

Brief Overview

With respect to executive compensation, the Final Report reveals high amounts of compensation and broad reliance on the three-part "Rebuttable Presumption of Reasonableness" safe harbor.[2] Senior IRS officials have expressed some concern that

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[1] IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report (henceforth, Final Report), February 12, 2009, *available at* www.irs.gov/pub/irs-tege/frepthospproj.pdf.
[2] Treas. Reg. § 53.4958-6 *et seq*.

application of the Rebuttable Presumption may be precluding the IRS from investigating instances of allegedly excess compensation, beyond the concept of “burden shifting” originally contemplated by the regulations. Thus, the Rebuttable Presumption may be a particular target of criticism, despite the fact that it incentivizes hospitals to follow prudent decision-making practices.

With respect to community benefit, the Final Report addresses three main issues: (1) what are the leading types of community benefit provided by hospitals; (2) which types of hospitals reported spending the most on community benefit; and (3) what are the revenues and profits of the hospitals responding to the compliance check. The Final Report does not take a position on what constitutes community benefit, or on whether (or how) the existing community benefit standard should be modified. It suggests a wide diversity in terms of community benefit provided by hospitals, as do the recent Government Accountability Office (GAO) and Congressional Budget Office (CBO) reports. As such, the Final Report is unlikely to resolve the debate concerning the viability of the community benefit standard of tax exemption.

Background: The Project

The Final Report arises from the IRS’ Hospital Compliance Project, initiated in May 2006 to provide the IRS and other stakeholders with a better understanding of hospital community benefit and executive compensation practices and reporting. The Project included the distribution of a comprehensive questionnaire to more than 500 nonprofit, tax-exempt hospitals.[3] The Final Report incorporates an analysis of the responses to these “compliance check questionnaires” and the results of a follow-up examination of the executive compensation practices of twenty nonprofit hospitals.

With respect to community benefit matters, the compliance check requested information related to the hospital’s patient mix, emergency room, governing board, medical staff privileges, and numerous programs (e.g., medical research, professional education and training, uncompensated care, and community outreach programs). With respect to

[3] A copy of the questionnaire is attached at Appendix B to the Final Report.

executive compensation, the information requested included the amounts of compensation paid to officers, directors, trustees, and key employees, and details regarding policies and practices involved in the executive compensation decision-making. In the twenty follow-up examinations, the responses to these questions and the reasonableness of individual compensation arrangements were reviewed.

In July 2007, the IRS issued an interim report (based on the same data) (Interim Report) which focused only on the community benefit aspects of the questionnaire and summarized data gathered from the questionnaire, and from certain information filed on Forms 990 by the responding hospitals. Executive compensation was not discussed in the Interim Report because the IRS was involved in the follow-up examinations at the time of the Interim Report's release. However, the IRS addressed tax-exempt organization executive compensation issues in a separately issued 2007 report.[4] The specific purpose of that report was to summarize the findings and conclusions from the IRS' Executive Compensation Compliance Initiative from 2004-2006. Other recent, relevant government studies include those conducted by the CBO and the GAO (all on community benefit),[5] and a separate GAO report on executive compensation.[6]

Executive Compensation Findings and Observations

Findings

There were two principal components to the executive compensation portion of the Final Report. The first component contained an analysis of the results of the executive compensation questions presented in the original compliance check questionnaire. The second component summarized the follow-up examinations of the twenty hospitals from the study selected, in part, by their respective answers to the questionnaire.

[4] *See* www.irs.gov/pub/irs-tege/exec._comp._final.pdf

[5] Congressional Budget Office, “Nonprofit Hospitals and the Provision of Community Benefit” (December 2006); Government Accountability Office, “Nonprofit, For-Profit and Government Hospitals, Uncompensated Care and Other Community Benefits” (May 2005); Government Accountability Office, “Nonprofit Hospitals, Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements” (September 2008).

[6] Government Accountability Office, “Nonprofit Hospital Systems, Survey on Executive Compensation Policies and Practices” (June 2006).

The Final Report contains several key executive compensation-related findings arising from the questionnaires and follow-up examinations:

1. Widespread use of the rebuttable presumption of reasonableness to establish the reasonableness of executive compensation arrangements.

2. Average CEO compensation of $490,000 and median CEO compensation of $377,000.

3. The highest amounts were reported by facilities located in high population areas and other suburban and urban hospitals, and the lowest amounts were reported by critical access hospitals.

4. The twenty hospitals selected for follow-up examination reported average and median compensation paid at $1.4 million and $1.3 million, respectively.

5. Despite the fact that many of the compensation amounts reported may appear high to some, nearly all amounts examined by the IRS were upheld as arrived at pursuant to the rebuttable presumption of reasonableness and within the range of reasonable compensation.

6. There was a notable element of diversity with respect to how certain classifications of hospitals responded to particular aspects of the rebuttable presumption criteria. For example, hospitals with annual revenues under $25 million were substantially less likely to have a written compensation policy than were hospitals with revenues between $250 million and $500 million. In addition, hospitals located in high population areas were far more likely to engage an independent compensation consultant than were rural hospitals.

7. A substantial majority (65%) of the hospitals participating in the study reported having one or more business relationships with its officers, directors, trustees, or key employees (other than through their positions as such), most commonly involving (1) the provision of goods, services, or facilities by the officer, director, trustee, or key

employee, and (2) doing business with an entity in which such an individual is a partner or investor.

8. Of the examined hospitals, 85% were determined to have met the rebuttable presumption, and in those instances the IRS did not assess excess benefit tax under Code § 4958. However, the Final Report implied that such tax may be assessed in certain other cases involving the examined hospitals.

Observations

Importantly, the IRS states that while the reported compensation arrangements “appear high,” they are also supported under applicable law. Nevertheless, the IRS acknowledges that there may exist a “disconnect” between the public perception of “reasonableness,” and what is allowed under tax law. In recent speeches, some senior IRS officials have also acknowledged the fact that state charity officials are not “burdened” by the rebuttable presumption of reasonableness with respect to evaluating nonprofit compensation decisions under state law. In that regard, it is notable that the potential exists that some of the follow-up examinations may yet result in the application of intermediate sanctions excise tax. Indeed, the examinations serve as a reminder that the IRS will pursue executive compensation arrangements where such arrangements appear disproportionate to the size and nature of the entity, and that such examinations will also review compensation paid to the selected individuals by other related entities. Furthermore, the information on the extent of "insider"/"director-as-vendor" relationships is particularly notable given the IRS' increasing focus on director independence. Interestingly, director-as-vendor relationships were more prevalent in the responding hospitals that were not selected for examination than those that were selected for examination. Nevertheless, it is entirely possible that this particular finding may receive substantial future attention from both the IRS and state charity officials given the related risk of self-dealing and increased disclosure on the Form 990.

Community Benefit Findings and Observations

The Interim Report, issued in 2007, reported the study's results in comparison to the factors listed in Rev. Rul. 69-545, including community board, emergency room, open medical staff, and conduct of scientific research available to the public. It also reported in some detail on the reporting hospitals' aggregate uncompensated care amounts and practices, billing and collection practices, and methods for publicizing the availability of uncompensated care. It also reviewed how many hospitals reported each type of enumerated community benefit, aside from uncompensated care (such as education) and the relative size of the reported community benefit expenditures in relation to revenues. The Interim Report did not attempt to analyze how these results varied between different types of hospitals.

The Final Report does not repeat the detailed findings of the Interim Report. Instead, the Final Report focuses on a broader view of how uncompensated care and community benefit vary across hospitals by location, size, and level of profitability. Hospitals were grouped into four types for the location variable: high population hospitals (those located in the most densely populated areas); other urban and suburban hospitals; critical access hospitals (as defined for Medicare purposes); and rural hospitals (again, as defined for Medicare purposes) that were not critical access hospitals. For the size variable, hospitals were grouped by total revenue, as shown on their Form 990. For level of profitability, hospitals were grouped according to the percentage resulting from dividing Form 990 revenues less expenses by Form 990 total revenues.

The average percentage of revenues expended for community benefit (including uncompensated care) was greatest in high population hospitals—a median of 9.84%. Critical access hospitals had the lowest—a median of 2.84% of revenues. Other rural hospitals and other urban and suburban hospitals fell within this range, with medians of 3.17% and 5.75%, respectively. The median percentage of revenue expended for uncompensated care alone followed the same pattern, ranging from a high of 4.82% at high population hospitals to a low of 2.14% at critical access hospitals. Aggregate

medians across all groups of hospitals were 3.88% for uncompensated care alone, and 5.50% for all measured community benefits.

The median percentage of revenues expended for community benefit (including uncompensated care) increased by hospital size, from 3.36% for hospitals with revenues under $25 million to 10.54% for hospitals with revenues of $500 million and over. The median percentage of revenues expended for uncompensated care alone generally followed the same pattern, ranging from 3.12% for hospitals with revenues under $25 million to 4.68% for hospitals with revenues of $500 million and over. The only anomaly between the two measures was that hospitals with revenues of $250 to $499 million had a somewhat larger median percentage of uncompensated care than larger hospitals, at 5.53%.

The overall group of surveyed hospitals reported excess revenues of 4.6% of total revenues (in the last fiscal year ending before June 2006), but 21% reported expenses in excess of revenues. The excess revenue percentage increased as hospital size increased. Community access hospitals had the lowest median percentage of excess revenues, while other rural hospitals had the highest.

The Final Report also compared the percentage of revenues expended for community benefit by the average per capita income of the area in which each hospital was located, but did not find a clear relationship. On the other hand, perhaps not surprisingly, the percentage of revenues expended for community benefit was higher for hospitals in areas with higher uninsured population percentages.

One of the significant findings of the Interim Report was that hospitals report uncompensated care and community benefit in many different ways (as an example, based on charges as opposed to hospitals' actual costs). This variance was an important driver in development of the Schedule H on the new Form 990. In fact, the Final Report includes a summary tracing questions from the Compliance Check questionnaire to the new Schedule H.

The new Schedule H and its instructions reflect intense cooperative effort between the IRS, hospitals, and tax practitioners to design questions that elicit clearly defined and consistent information. Thus, the Schedule H information can be expected to provide more reliable information to answer the questions that Congress, the IRS, and the public are asking about hospital activities. Unfortunately, a complete year of 990s with completed Schedules H will not be filed until near the end of 2011, given that completion of all portions of the Schedule H is not required until the return reporting for calendar year 2009 and after, and extensions permit filing up to ten and a half months after the end of the reporting period. Thus, any analysis of the information to inform public policy debate cannot occur until 2012 at the earliest.

The analysis in the Final Report is helpful but it is still limited by the data available and the "snapshot" nature of the report. As noted above, the uncompensated care and community benefit figures were collected without precise definitions, so the numbers are not necessarily comparable from one hospital to another. Perhaps more importantly and a factor not highlighted in the Final Report, is that the revenue, expense, and excess of revenue over expense figures used in the analysis are the total revenues and expenses shown on the Form 990 for the entity for the relevant year. While this may have been the best data available, it still leads to inconsistencies and extraneous factors confounding the analysis. For example, the total revenue figure includes contributions, grants, investment dividends and interest, and investment capital gains. Further, the reporting hospitals may not have reported their program service revenue on the same basis. For example, some may have used a gross revenue figure without reduction for contractual allowances, while others may have used net patient revenue. These differences could have a significant effect on the percentages of revenue that are expended for uncompensated care or other items. Finally, the inclusion of investment income in total revenue means that total revenue and the percentages of revenue that are expended for uncompensated care or other items will vary tremendously with the financial markets. If performed on 2008 figures, the same analysis might produce very different results.

What's Next

The Final Report may strengthen sentiment for legislative proposals to define "community benefit" for tax exemption purposes or otherwise to define standards for hospital tax exemption. While such proposals may be premature if they are to be based on solid data, proposals may not wait for the three years necessary to get information from the new Form 990. In the meantime, the uncompensated care and community benefit percentages can be expected to be used in policy debates. An interesting twist in the debate may be the Final Report's finding that critical access hospitals—the only hospitals in their community, by definition—provide a smaller percentage of community benefit. The Final Report suggests that such hospitals may be exempt simply because they are there serving the community.

Senator Charles Grassley (R-IA) has already issued a press release pointing out that the Final Report does not include the same analysis with respect to for-profit hospitals and suggested that this be done. The Final Report acknowledges that in areas where tax-exempt and for-profit hospitals co-exist, a deeper understanding of the for-profit organizations would be helpful and suggests that to the extent possible, future initiatives should attempt to take into account bodies of knowledge regarding such for-profit organizations. Of course, the IRS exempt organizations group may feel somewhat limited in its capacity to collect such information itself.

Along the same lines, the IRS is expected to evaluate the impact of current regulatory provisions that allow consideration of comparability data from for-profit organizations in satisfying the rebuttable presumption. The Final Report also reflects the IRS' willingness to re-evaluate the "initial contract exception" to the Intermediate Sanctions rules. Briefly stated, this exception provides that fixed (i.e., non-discretionary) payments under an initial contract with a disqualified person who was not a disqualified person when the contract was entered into are not subject to intermediate sanctions excise taxes. This exception was intended to apply to newly hired executives and to arrangements with management companies, and any revisions thereto could particularly create hurdles in negotiating employment contracts with new CEOs.

Practice Suggestions

The Final Report focuses on two issues critical to the governance and operations of tax-exempt hospitals—satisfaction of the community benefit standard and the manner in which corporate executives are compensated. Finally, the reported "high amounts" of compensation, given the broad adoption of the rebuttable presumption by the responding hospitals, may prompt some legislators to re-evaluate whether the rebuttable presumption should be revised to reduce the burden on the IRS in challenging instances of allegedly high compensation. This is despite the fact that the rebuttable presumption appears to have been very successful in incentivizing hospitals to adopt prudent business practices with respect to compensation decisions. In any event, the IRS will continue to focus on executive compensation through examinations and other compliance initiatives. Yet, the Final Report makes no suggestion that hospitals have not been "playing by the rules" or that any law has been violated.

That being said, the substance of the Final Report must be interpreted through the filter of current events and the firestorm of public concern with respect to whether exempt organizations should be expected to adhere to stricter governance expectations, and perhaps compensation guidelines, as a precondition to receiving federal tax subsidies. Accordingly, corporate leadership may wish to consider several internal governance responses to the Final Report.

Community Benefit

Tax-exempt hospitals are already acutely aware, because of the new Form 990 and many other reasons, that they must improve and standardize their reporting of community benefits. In today's financial environment, hospitals must balance their fiscal responsibility for the future of their institutions with the need to continue to meet community needs, which are exponentially increasing. For example, the resources needed to craft the best possible community benefit reporting system, or to meticulously distinguish charity care from bad debt when no payment will be forthcoming in any case, may not be available. As another example, hospitals under pressure for revenue to continue operations may feel pressure to step up efforts to collect amounts from

patients who cannot pay at the same time that public scrutiny of such collection practices is heightened. Boards should be briefed on the Final Report's findings and implications, and should reinforce from the top the hospital's commitment to community benefit.

Executive Compensation

As noted above, the Final Report has been released within a toxic environment as it relates to executive compensation, benefits, and "perks." The board and its compensation committee should not take false security from the otherwise favorable compensation conclusions of the Final Report. Rather, they should be encouraged to be sensitive to the external environment and to exercise "common sense" business judgment. Compliance with the rebuttable presumption should be confirmed and use of comparability data from for-profit companies should be re-evaluated. Furthermore, both the board and senior leadership should be aware of the continuing interest of the IRS—and of state charity officials—in assuring that only reasonable compensation is paid to executives of nonprofit, tax-exempt organizations, and that both sets of regulators will pursue examinations of and subsequent challenges to compensation arrangements that appear to be excessive.

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