

Lessons to Nonprofits From the IRS Hospital Report

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Elizabeth M. Mills, Michael W. Peregrine, and Ralph DeJong, attorneys at McDermott Will & Emery LLP; in this article they discuss the results of an IRS study of tax-exempt hospitals that focused on community benefit and executive compensation.

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The recently released, comprehensive IRS report on its hospitals compliance project¹ is significant for all sophisticated nonprofit organizations, regardless of industry sector. This is principally because the report provides direction on how the IRS might address important tax issues arising throughout the nonprofit sector. It shows the rise of an evidence-based compliance approach, and a corresponding need to provide accurate and complete information to the IRS, on the Form 990 series or elsewhere.



Other issues raised by the report include the process by which executive compensation is determined, specific board composition matters, and the importance of tax law compliance. The lessons learned in the preparation of the report informed the development of the college and university compliance check now underway and presumably other planned compliance efforts. Further, the report has been released during a period of unprecedented public controversy regarding public subsidies (for example, tax exemptions) of corporations and industry groups. As such, it is worthy of consideration by nonprofit organization corporate and tax counsel.

Accordingly, this article will review the catalysts for the report's preparation, provide an overview of the report, and summarize its principal conclusions. Also, the article will comment on the implications of the report to the broader nonprofit sector, and provide a series of recommendations for proactive responses to those implications by nonprofit organizations.

1. The Origins of the Hospital Report

Any evaluation of the report must include an understanding of its origin, including the evolving IRS approach to evaluating compliance in the exempt organization universe, the 2006 compliance check questionnaire process, and the release of several related government publications that preceded the report's release.

¹ Available at <http://www.irs.gov/pub/irs-tege/frephospproj.pdf>.

Hospitals Compliance Project. The IRS Exempt Organizations Division, through its workplans and implementing guidelines for the last decade, has made known its plans to focus resources on exempt organizations likely to be noncompliant, as determined by data on noncompliance by sector -- an evidence-based approach. The fiscal 2003 implementing guidelines present the division's plan to initiate research studies (not examinations) on the hospital and college/university market segments as a preliminary step in profiling those segments. The hospital report represents the final aspect of this effort for hospitals: the hospitals compliance project. The project elicits information and draws conclusions about the way community benefit is provided by nonprofit hospitals and the manner in which such hospitals establish and report executive compensation.

A primary instrument of the project was the IRS's dissemination in 2006 of a comprehensive compliance check questionnaire to more than 500 tax-exempt hospitals, and a subsequent evaluation of the responses. The questionnaire requested information about the hospitals' activities, corporate governance, community benefit expenditures, and executive compensation processes. The hospitals that received the questionnaire were of varying sizes and types and were located in different regions and communities across the country. Responses were received from about 17 percent of all tax-exempt community hospitals in the United States, which appears from a nonstatistician's view to be a robust sample.

Compliance Check Questions. The executive compensation questions in the questionnaire asked about the compensation practices of hospitals, in particular the compensation of their officers, directors, trustees, and key employees, and any business relationships with those persons. The community benefit questions focused on patient mix by payer, charity care policies and procedures, means of publicizing the availability of charity care, billing and collection policies and procedures, amount of charity care, and amount of other categories of community benefit, as well as information relating to the factors enumerated in Rev. Rul. 69-545² (for example: community board, open medical staff, acceptance of all paying patients, emergency services).

Follow-Up Examinations. The project also included IRS examinations of 20 hospitals that responded to the questionnaire. The decision to conduct the follow-up examinations of those hospitals was based in part on the responses they provided to the questionnaire (in other words, they were identified as providing greater amounts of executive compensation relative to their size and nature than might be expected).

Interim Report. The IRS released an interim update on the project on July 19, 2007.³ The update addressed only information related to community benefit taken from the questionnaires, as the follow-up executive compensation examinations were still in progress. Although the interim report detailed aggregate responses to the community benefit questions, it did not analyze community benefit amounts in relation to hospital

² 1969-2 C.B. 117.

³ Available at http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf.

size or other factors because some data were still being cleaned up or were not yet available on the respondents' Forms 990.

Other Relevant Studies. The final report was also preceded by reports issued by the Congressional Budget Office and the U.S. Government Accountability Office on issues related to tax-exempt hospitals' executive compensation practices and their provision of charity care and community benefit, respectively.⁴ Also, the executive compensation portion of the report should be evaluated in context with a report the IRS published in 2007 that summarized the findings and conclusions from the IRS's 2004-2006 executive compensation compliance initiative.⁵

2. Core Focus of the Report

The primary focus of the hospital report was to address the series of next steps forecast by the interim report. Its purpose was to evaluate differences in the community benefit expenditures among the responding hospitals. A related focus of the report was to summarize the data provided by the responding hospitals in response to the questionnaire's compensation questions.

The report analyzes community benefit data according to (a) relevant geographic and revenue classifications and (b) income and health insurance coverage levels of the communities surrounding the hospitals and by hospitals reporting large medical research expenditures. A principal conclusion was that there is "considerable diversity" across hospital classifications in the demographics, community benefit activities, and financial resources of the responding hospitals. The report is thus unlikely to resolve the debate concerning the viability of the community benefit requirement for tax exemption set forth in Rev. Rul. 69-545. The report does not take a position on whether the present standard should be retained or modified. Nonetheless, the IRS recognizes that because of the variability between hospitals and the tight financial margins of some hospitals, any quantitative requirement for tax exemption could have disproportionate effects on hospitals, and some hospitals "could have a very difficult time meeting quantitative tests that key off of charity care or other community benefit expenditure levels."⁶

⁴ Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefit" (Dec. 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" (Sept. 2008).

⁵ Available at http://www.irs.gov/pub/irs-tege/exec._comp._final.pdf; Government Accountability Office, "Nonprofit Hospital Systems, Survey on Executive Compensation Policies and Practices" (June 2006).

⁶ Statement by Lois Lerner, director of the IRS Exempt Organizations Division, on the IRS Report on Nonprofit Hospitals, at a press briefing, Feb. 12, 2009.

Regarding executive compensation, the report reveals that almost all respondents reported high amounts of compensation as well as compliance with the key elements of the rebuttable presumption of reasonableness safe harbor provided by the section 4958 intermediate sanctions rules. The data did not vary by demographic information. Similar findings were made with the 20 hospitals subject to follow-up examinations, although some of those hospitals ultimately may be subject to intermediate sanctions penalty excise taxes because of their compensation arrangements.

3. Detailed Analysis of the Report

Project Methods

The report describes the methods for the study as follows. The IRS selected the hospitals to be contacted by reviewing its exempt organizations master file to identify section 501(c)(3) organizations with a hospital (section 170(b)(1)(A)(iii)) foundation classification and that had filed a Form 990 in their last two tax years. Initially, 6,002 organizations were identified. Five hundred of them were randomly selected and of those, approximately 265 organizations were identified as hospitals through their Web sites and other sources of information. A second group of 2,000 organizations was randomly selected and hospitals were isolated on this list as well. The final list included 544 organizations that had been confirmed as hospitals. An organization was not included in the list if it did not operate a hospital, was a governmental hospital, was a clinic or had more nursing home and assisted living beds than hospital beds, or was a medical research institute or grant-making organization. The IRS Exempt Organizations Compliance Unit sent the questionnaire to the selected hospitals.

Eleven hospitals did not respond to the questionnaire, and 46 recipients of the survey did not operate hospitals. Ultimately, 489 hospitals responded to the questionnaire and reported community benefit expenditures (although not every hospital answered every question and most of the data are based on fewer responses).

According to the report, the American Hospital Association⁷ reported that as of November 2008 there were 2,913 nongovernmental nonprofit community hospitals in the United States (59 percent of community hospitals), so the 489 that completed the survey represent about 17 percent of all nonprofit hospitals in the country.

Between the time the interim report was published and the time the final report came out, further review of the responses to the questionnaires was undertaken, data entry and transcription errors were corrected, and Form 990 revenue and expense information for the tax year corresponding to the year for which responses were provided was obtained.

The report focuses on how uncompensated care and community benefit vary among hospitals by location, size, and level of profitability. Hospitals were grouped in 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

⁷ Available at <http://www.aha.org/aha/content/2008/pdf/08-uncompensated-care.pdf>.

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.

Results -- Executive Compensation

The executive compensation portion of the report provides an analysis of the answers to the executive compensation questions and addresses the results of the follow-up examinations of 20 hospitals. The report reveals no smoking gun regarding compensation practices. Rather, it (indirectly) concludes that hospitals have been complying with the law as it has been made known to them; in other words, although the compensation reported was generally high, the vast majority of responding hospitals reported compliance with the rebuttable presumption of reasonableness safe harbor.⁸ Further, nearly all of the 20 hospitals that were examined similarly complied with the rebuttable presumption and had compensation within the range of reasonableness.

From a raw data perspective, the average and median compensation amounts reported as paid to the senior executive of the responding hospital were \$490,000 and \$377,000, respectively. Not surprisingly, the highest levels of compensation were reported paid by the high-population and other urban/suburban hospitals. The lowest compensation was paid by critical access hospitals. Similarly, compensation increased as hospital revenue size increased. Also, the average and median total compensation amounts for the senior executives of the 20 hospitals selected for follow-up examinations were \$1.4 million and \$1.3 million.

Regarding the core compensation questions, some of the more interesting results include the following:

- The reporting of officers, directors, trustees, and key employees varied, which is consistent with problems the IRS has been encountering in connection with Form 990 reporting of executive compensation. The IRS expects to follow up with some of the respondents after new Form 990 filings are received to determine whether the revised format has been helpful in reporting compensation payable to senior executives.
- Seventy-three percent of the hospitals reported that they apply a formal written compensation policy in their decision making. The percentage was notably less for hospitals with revenues under \$25 million.
- Almost all of the hospitals (93 percent) reported that compensation decisions were approved by persons who did not have a conflict of interest in the particular arrangement being approved.
- Hospitals located in high-population areas were more likely to use an outside compensation consultant. Although there was a wide variation in responses concerning resources and methods used to determine compensation, a high percentage (87 percent) reported use of published surveys.

⁸ Reg. section 53.4958-6.

- A high percentage of the hospitals reported consideration of five separate factors identified in the questionnaire in determining comparability data: education and experience; specific responsibilities; geographic area; similar services; and beds, admissions, or outpatient visits.
- Somewhat surprising was that 65 percent of the hospitals reported having at least one business relationship with an officer, board member, or key employee other than through the individual's position at the hospital. The most common relationships reported were the furnishing of goods, services, or facilities; and doing business with an entity of which the officer, board member, or key employee is a partner or investor.

The data derived from the 20 hospitals that underwent examinations generated similarly interesting results, including the following:

- a higher percentage of this group applied a written compensation policy than the larger group of questionnaire respondents;
- a smaller percentage of this group reported having one or more business relationships with an officer, board member, or key employee;
- eighty-five percent of the examined hospitals satisfied the rebuttable presumption of reasonableness, and the IRS decided not to impose intermediate sanctions excise taxes in those instances; and
- the compensation paid to the executives of the examined hospitals was properly reported on various applicable federal forms.

Results -- Community Benefit

The report concludes that considerable diversity exists in terms of the demographics, community benefit activities, and financial resources among the hospitals responding to the questionnaire. The most pronounced differences were between critical access hospitals and hospitals located in high-population areas, and between the smallest and largest hospitals as measured by revenues:

- The average and median percentages of total revenues allocable to community benefit expenditures were 9.2 percent and 5.5 percent. Rural hospitals reported the lowest percentages, while high-population hospitals reported the highest percentages. Community benefit expenditure percentages increased as revenue size increased.
- The largest classification of community benefit reported was uncompensated care, with average and median percentages of uncompensated care as a percentage of total revenue reported as 7 percent and 4 percent. As a whole, uncompensated care represented 56 percent of the aggregate community benefit expenditures reported. However, 15 academic medical centers reported large medical research expenditures, or 93 percent of total research expenditures. When those facilities are excluded from the calculation, uncompensated care represented 71 percent of reported community benefit expenditures.
- Other categories of reported community benefit expenditures were medical education and training (23 percent), research (15 percent), and community programs (6 percent). That mix varied substantially according to community type

and revenue size, and the research component was substantially affected by the reporting from the 15 academic medical centers.

- The hospitals reported aggregated excess revenues (total revenues less total expenses) of 4.6 percent of total revenues. The large revenue-size hospitals were the most profitable, and critical access hospitals the least profitable. Twenty-one percent of the hospitals reported total expenditures above total revenues. The percentage of excess revenue (or deficit) varied according to community type and revenue size.
- Uncompensated care and community benefit were unevenly distributed across hospitals, with substantial concentration of such care/benefit. Sixty percent of the aggregate community benefit expenditures of all of the respondents was provided by only 9 percent of the hospitals. Similarly, 14 percent of the hospitals reported 63 percent of the aggregate expenditures allocable to uncompensated care.
- Although no link was found between community benefit expenditure levels and per capita income levels of a hospital's service area, there was a general increase in such expenditure levels as the level of uninsured patients in the service area increased.

Validation of Community Benefit Results

The community benefit results were roughly consistent with those from other recent studies, taking into account the definitional issues in the various surveys.

According to the American Hospital Association, in 2007 hospitals provided uncompensated care (charity care and bad debt but not including Medicare or Medicaid shortfalls) with estimated cost equal to 5.8 percent of total expenses. That appears higher than the numbers found in the report, which may be due to a number of factors. One is that the denominator in the number cited in the report is total revenues, which are (for 79 percent of the reporting hospitals) greater than expenses. Another factor is that not all respondents to the survey included bad debt in uncompensated care and community benefit.

Other recent, relevant government studies on community benefit include studies conducted by the GAO and the CBO.

The GAO study, in 2005, obtained data on uncompensated care from hospitals in five states. Uncompensated care included charity care as well as bad debt. The study obtained uncompensated care charges from state reporting programs. The study then estimated uncompensated care costs by multiplying charges by the cost to charge ratios from Medicare cost reports. These were then computed as a percentage of total patient operating expenses from the Medicare cost reports.

The GAO found that the average percentage of patient operating expenses devoted to uncompensated care provided by nonprofit hospitals varied from 3.2 percent to 6.9 percent, while those for for-profit hospitals varied from 2 percent to 5.4 percent and for governmental hospitals from 3.7 percent to 18 percent. Uncompensated care was concentrated in a few hospitals in each state. Overall uncompensated care for nonprofit hospitals as a percentage of operating revenues was 4.7 percent. That is consistent with the IRS report, which indicated that median uncompensated care as a percentage

of total revenue was 4 percent. The number from the IRS report could be expected to be lower because the denominator was total revenues, not patient care expenses (which would be lower).

Also, more than half of the respondents to the IRS survey did not include bad debt in uncompensated care, while others did; the GAO study apparently included bad debt in uncompensated care uniformly. (It should be noted, however, that some respondents to the IRS report -- on the order of about 20 percent -- included Medicare and Medicaid shortfalls as uncompensated care.) On the other hand, the GAO study uniformly used estimated costs of uncompensated care, while the amounts in the IRS report may have been calculated using charges or costs.

The CBO study, released in 2006, used two data sets. One set was information from Medicare cost reports for 2003 from all United States hospitals and one set was the data from the 2005 GAO report. Overall, nonprofit hospitals on average provided higher levels of uncompensated care than similar for-profit hospitals, though the distributions largely overlapped. The CBO study compared levels of community benefits after adjusting for size of facility, income level of community, case mix, and state.

Limitations of the Report

The IRS acknowledges several limitations of the report. First, the questionnaire did not limit what could be included in a community benefit category or explain how things should be measured. Respondents differed as to what was included in uncompensated care; some included Medicare shortfalls or bad debt and some did not. The IRS did not test or verify the information provided. Also, the IRS acknowledged that the results are a snapshot of a single year's activity.⁹

The analysis in the 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. A factor not highlighted in the 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. Although 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 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.

⁹ Statement by Lois Lerner, director of the IRS Exempt Organizations Division, on the IRS Report on Nonprofit Hospitals, at a press briefing, Feb. 12, 2009.

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 using 2008 figures, the same analysis might produce very different results.

The report further observes that many of the survey's questions proved to be ambiguous or difficult to answer without a supplemental explanation. Further, incorporating narrative responses into the analysis was time-consuming. Also, to the extent they could have been determined ahead of time, demographic classification criteria for respondents (for example, location and size) should have been included in the questionnaire. The report says that in future initiatives, the IRS will try to work more closely with others in designing the survey questions.

Finally, the report observes that studies of this nature require a lot of personnel and that training for such personnel should be done at the beginning of the study.

Those lessons appear to have been incorporated in the college and university compliance check. In October 2008 the IRS sent compliance check questionnaires to approximately 400 public and private colleges and universities. The sample was designed to include a cross section of small, medium, and large institutions. The questionnaire asks for information about how the reporting institution reports various types of income and expenses on its Form 990, calculates and reports losses on Form 990-T, carries forward net operating losses, and allocates income and expenses in calculating unrelated business taxable income. It also requests information on how the institution invests its endowment funds and the rate and type of expenditures from endowment funds, and it seeks information on amounts and methods of determining executive compensation. It can be completed on paper or by submitting a compact disk. Although the college questionnaire is significantly longer than the hospital questionnaire -- 33 pages as opposed to 9 pages -- it provides for a lot more check-the-box responses. In that way, it is similar to the redesigned Form 990's hospital schedule, Schedule H, the development of which was influenced by the hospital study.

4. Evidence-Based Policy Development Concerning Tax-Exempt Organizations

The hospital study and the resulting report are an important advance in the IRS's development and use of empirical data to identify exempt organization compliance issues and to find solutions -- in other words, evidence-based exempt organization tax policy. However, that is not a new idea. Survey data were used to fashion some of the private foundation provisions of the Tax Reform Act of 1969. More recently, over the past decade the IRS Exempt Organizations Division has been moving toward this goal through its market segment specialization program. The problems identified in that program have informed the hospital study and the college and university study. We can expect further studies to take place on carefully selected topics.

5. Implications to Broader Nonprofit Sector

Both the scope of the project and the conclusions of the report provide useful guidance for the entire nonprofit sector, beyond hospitals. The currency of this guidance

is heightened by the economic crisis, new and anticipated legislative proposals, and the widening controversy regarding the provision of bailouts and subsidies to certain industry sectors (for example, the nonprofit sector).

One implication is that the IRS will continue its evidence-based approach to compliance with the college/university compliance check, data from the revised Form 990, and future studies. The IRS experience with the project indicates that progress on future compliance checks will be slow but will yield valuable information. Similarly, the information from the revised Form 990 will be valuable but will be slow in coming. A complete year of Forms 990 will not be filed until near the end of 2010, and even then several portions of schedules H and K will not need to be completed by filers until the filing year ending near the end of 2011. An open question is whether policy changes will wait for data.

Also, several of the report's conclusions about executive compensation may reasonably be interpreted as having implications for nonprofit corporations in industry sectors other than healthcare:

- The importance of adherence to the rebuttable presumption of reasonableness is underscored by the report. High levels of compensation are nevertheless justified by widespread compliance with the safe harbor. The broad application of the rebuttable presumption by the respondents suggests that nonprofits that fail to apply the safe harbor would be considered to be noncompliant.
- The data reflecting a relatively high degree of directors simultaneously serving as vendors to the responding hospitals are somewhat at odds with the IRS focus on director independence and conflicts of interest. Accordingly, the data may prompt follow-up scrutiny from the IRS, state charity officials, donors, media, and/or labor unions, which would likely spill over into the larger nonprofit sector.
- The expected criticism of the rebuttable presumption as enabling higher levels of compensation would not be limited to its application in the nonprofit hospital sector.
- The possibility of eliminating the initial contract exception to the intermediate sanctions excise tax rules, and prohibiting consideration of for-profit comparability data (both of which are mentioned in the report) would affect all nonprofits, not just hospitals.
- It is difficult to draw unflattering lessons of compensation practices in the nonprofit sector from the report. No pattern of unreasonable compensation or other compensation-related abuse arises from the responses to the questionnaires. This is a finding consistent with the separate, prior conclusion of the IRS in its March 1, 2007, report on its Executive Compensation Compliance Initiative. The absence of any smoking gun undermines the credibility of legislative proposals intended to place limitations on executive compensation in the nonprofit sector. The data just do not support such an effort (at least not until the results of the college and university compliance check questionnaires are analyzed, which probably will take a few years).
- Nevertheless, it would be imprudent for nonprofit organizations to proceed on a "business as usual" approach regarding executive compensation. The external environment relating to executive compensation is ignored at organizational and

executive peril. Senior IRS officials have commented on what they perceive to be a disconnect between hospital compensation as reflected in the report and what the public might perceive as reasonable compensation.¹⁰ Accordingly, future compensation decisions should be guided by common sense and proper business judgment, reflective of (a) the current economic circumstances, and (b) increasing taxpayer concern with tax subsidies to charitable, nonprofit corporations. Failure to do so could expose a nonprofit to reputation damage, decreased philanthropic support, and regulatory challenge.

- Intermediate sanctions still carry a sting. It should not be lost on the broader nonprofit sector that penalty excise taxes may be applied in circumstances involving one or more of the 20 hospitals subject to the follow-up examinations.
- Nonprofits also should recognize that state charity officials are not bound by the rebuttable presumption in evaluating allegations of excess executive compensation paid by a nonprofit.

6. Recommendations

Given the significance of the IRS hospital report, nonprofit organizations of all types should take the following actions, among others:

- prepare an appropriate briefing on the report for the full board, as well as key committees (for example: executive compensation, audit/finance, compliance);
- evaluate the extent of compliance with the rebuttable presumption of reasonableness in setting executive compensation amounts;
- reevaluate the extent of reliance on comparability data from for-profit companies;
- consider the implications of the broader economic environment in making executive compensation decisions, including those related to adjustments to existing arrangements;
- have the nonprofit's governance committee or a related committee review the extent of director-as-vendor relationships on the board and key committees, and have it evaluate the sufficiency of existing controls intended to prevent abuse arising from such arrangements; and
- complete the Form 990 or 990-PF accurately and pull together the best information available, which will be increasingly important as the IRS proceeds on its way to evidence-based compliance for exempt organizations.

¹⁰ Available at http://www.irs.gov/pub/irs-tege/miller_speech_011209.pdf.