



HANCOCK, DANIEL, JOHNSON & NAGLE, P.C.

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CLIENT ADVISORY

Community Benefit and Executive Compensation: IRS Releases the Final Report of Hospital Study

On February 12, 2009, the IRS issued its long awaited 191-page Exempt Organizations Hospital Compliance Final Report based upon the Hospital Compliance Project that began in May 2006. At that time, the IRS submitted a compliance check questionnaire to 544 nonprofit hospitals requesting information on each hospital's community benefit activities, governance, and executive compensation practices. A follow up examination was conducted on 20 of those hospitals that reported high levels of executive compensation.

In July 2007, the IRS released an interim report summarizing the aggregate data from that survey. The Final Report reviewed the executive compensation data reported and analyzed the community benefit data by type, size and location of hospital. Over eighteen months later the Final Report summarizes the community benefit and executive compensation data across various demographics. The report divides the hospitals into four groups based on the type of community served: high population hospitals serving the top 26 urban areas, other urban

and suburban hospitals, critical access hospitals, and other rural hospitals. Additionally, the hospitals were divided into five groups according to their annual revenues.

Community Benefit

The Final Report examined how hospitals categorized and reported community benefit, the revenue and profit of the hospitals in relation to the community benefit they reported, and how the data varied by hospital size, type and location. The IRS analyzed information based on four types of community benefit: uncompensated care, medical education, medical research, and other community programs. In order for a hospital to be exempt under Section 501(c)(3) of the Internal Revenue Code ("IRC"), it must demonstrate that it provides benefits to a class of persons broad enough to benefit the community and that it is operated to serve a public interest. This community benefit standard has been applied through a facts and circumstances approach and is based upon Revenue Ruling 69-545, which was published by the IRS in 1969. This Revenue Ruling describes five factors relevant to making this determination. These



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include: (i) use of a “community board,” (ii) an open medical staff, (iii) a full-time emergency department open to all regardless of ability to pay, (iv) admission of all types of patients, and (v) how excess funds are used (e.g., expansion, renovation, education, research).

As the reimbursement world has changed, these factors have become less helpful in drawing a clear line between for-profit and nonprofit hospitals. Open medical staffs, participation in Medicare, and treating all emergency patients are common characteristics among most hospitals. Use of excess funds remains a distinction and thus the types of community benefit expenditures will likely become more important moving forward (especially to Congress and the IRS). The IRS has indicated that this is the primary impetus behind Schedule H of the new Form 990, which requires more detail on the types of activities reported as community benefit. It attempts to create some standardization among hospital reports. It also requires that community benefit be reported at cost (rather than charges or otherwise) and that community benefit be reported by federal employer identification number, rather than by each hospital or health system. These last two requirements address the shortcomings of the compliance questionnaire and ultimately the Final Report, which admittedly left the specific activities included as community benefit (for example bad debt or Medicare shortfalls) and how to measure it (cost vs. charges) to each respondent’s discretion.

A summary of the key community benefit findings include:

1. Excess revenue increased as hospital size increased and thus larger organizations had a greater percentage of revenue going towards community benefit expenditures. 9% of hospitals

reported 60% of the aggregate community benefit expenditures and 19% of hospitals reported 78%.

2. Uncompensated care was the largest community benefit expenditure and accounted for 56% of aggregate community benefit expenditures. This figure jumped to 71% if the 15 leading research hospitals were removed.
3. Net revenues averaged 5%, and 21% of hospitals reported deficit. 47% of hospitals reported community benefit expenditures less than 5% of total revenues, while 21% of hospitals reported less than 2%.
4. No correlation existed between per capita income of the area surrounding the hospital and the community benefit expenditures of the hospital.

The IRS did not recommend specific changes on how community benefit should be defined or reported, but rather the Final Report simply described the information collected and indicated that a bright-line rule on community benefit would have a significant impact on the tax-exempt healthcare community based upon varying practices and financial capabilities. Since much of the community benefit data reported in the Final Report varied from hospital to hospital, the use of the new Form 990 may provide a more accurate comparison of various healthcare providers.

Executive Compensation

The compliance questionnaire included several questions about how exempt hospitals compensated their directors, officers and key employees. The Final Report indicated that the hospitals reported widespread compliance with key compensation practices, including the use of formal written compensation policies, the use of comparability data, and approval by persons without a conflict of interest.



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The study indicated that the average compensation paid to the top management official was \$490,000 with a median of \$377,000. However for the 20 hospitals selected (because of high compensation) for the compensation examination, the average compensation was \$1.4 million, with a median of \$1.3 million. The IRS also noted that there was widespread compliance with the IRC Section 4958 excess benefit transaction rules. The IRS stressed that even though the reported compensation appeared high, nearly all the examined amounts were upheld pursuant to the rebuttable presumption process and were within the range of reasonable compensation.

Observations

The IRS admitted that the community benefit and reasonable compensation standards have proven difficult to administer. Healthcare organizations have diverse structures, operate differently and have varying degrees of financial resources. There are imprecise legal standards that must be applied to these complex, varied and evolving fact patterns. The IRS indicated that attempts to refine the current standards will have a “serious impact” on the tax-exempt hospital community based on these diverse characteristics. As the debate continues in Congress on if and how the community benefit standard should be refined, the IRS looks forward to obtaining more accurate and complete data through the new Form 990 and will continue to monitor community benefit reporting.

Although the compensation practices reported were found to be compliant under the current law, the Final Report’s statement that compensation “appears to be high” may increase scrutiny from the public and Congress, especially in light of the current economic and political climate. The Final Report may

increase the likelihood that Congress may take action to ease the burden on the IRS in challenging instances of high compensation. This may involve revisiting the ability of tax-exempt hospitals to use for-profit comparables for setting reasonable compensation.

As community benefit issues continue to be closely examined by the IRS and Congress, the tax-exempt healthcare community should take steps to ensure that it is prepared to report community benefit in accordance with Schedule H of the new Form 990, to ensure that community benefit reporting practices are consistent with its charitable mission, and to evaluate the Final Report’s findings in light of the manner in which community benefit is reported. For executive compensation issues, exempt hospitals should ensure that a conflict of interest policy is maintained and followed, that they maintain and utilize clear policies or procedures for complying with the rebuttable presumption of reasonableness within the intermediate sanctions regulations, and that Executive Compensation Committees are briefed on the findings within the Final Report.

For more information on the Final Report please contact Jim Daniel or Mike Newby, by telephone at 804.967.9604, or by e-mail at jdaniel@hdjn.com or mnewby@hdjn.com. Additional information about Hancock, Daniel, Johnson & Nagle, P.C. is available on the firm’s website at www.hdjn.com.



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