ReedSmith

lshi

Life Sciences Health Industry Alert

If you have questions or would like additional information on the material covered in this Alert, please contact the author:

Kristen M. Gurdin
Associate, Pittsburgh
+1 412 288 3198
kgurdin@reedsmith.com

Carolyn D. Duronio
Partner, Pittsburgh
+1 412 288 4106
cduronio@reedsmith.com

the Chair of the Life Sciences Health Industry Group,

Michael K. Brown
Partner, Los Angeles
+1 213 457 8018
mkbrown@reedsmith.com

…or the Reed Smith lawyer with whom you regularly work.

Client Alert 09-114

March 2009

reedsmith.com

IRS Final Hospital Study and its Implications for Tax Reporting

On February 12, 2009, the Internal Revenue Service (the "Service") released its long–awaited Hospital Compliance Project Final Report (the "Report"). The Service commenced the Hospital Compliance Project in 2006 by sending out comprehensive questionnaires to 544 tax-exempt hospitals. The questionnaires focused primarily on hospitals' current practices with respect to community benefits and executive compensation. The Report details the data the Service compiled from the 487 respondent hospitals and the 20 hospitals selected for examination from that group. The Report did not provide any conclusions on whether the federal tax rules regarding community benefits and executive compensation should be changed. IRS officials' and lawmakers' initial interpretation of the Report and its findings, however, suggests that exempt hospitals should expect significant scrutiny of the community benefit and compensation information that they provide on the revised IRS Form 990 and that stricter requirements may be forthcoming.

Community Benefits Data

Background. The requirements for tax-exempt hospitals have generally remained unchanged since 1969, when the Service issued Revenue Ruling 69-545, 1969-2 C.B. 117. The ruling provided that a hospital would qualify for tax-exempt status under section 501(c)(3) of the Internal Revenue Code (the "Code"), if in addition to satisfying the basic requirements for exemption under section 501(c)(3) of the Code, it demonstrated community benefit according to the following five factors: (i) an emergency room open to all regardless of ability to pay; (ii) a governing board made up of members of the community; (iii) use of surplus funds for patient care, improvement of facilities, education, and similar functions; (iv) inpatient care for everyone who can pay, including Medicare and Medicaid patients; and (v) an open medical staff. Satisfaction of all the factors is not necessary, with the Service instead basing its conclusions on a facts and circumstances analysis. A recent report by the Government Accounting Office (GAO) commissioned by Senator Charles Grassley, the Ranking Member of the Senate Finance Committee, noted that three of the five factors—maintaining an open medical staff, treating Medicare and Medicaid patients, and treating emergency room patients regardless of ability to pay—are common practices at both nonprofit and for-profit hospitals, and questioned the relevance of such factors in differentiating between tax-exempt and for-profit hospitals.[1] In 2006, Representative William Thomas, then Chair of the House Ways and Means Committee proposed legislation that would have required exempt hospitals to provide a minimum level of charity care to individuals with incomes below the federal poverty limit.[2] On July 18, 2007, the staff of Senator Grassley, introduced a discussion draft on hospital reform, which suggested replacing the community benefits facts and circumstances test with a bright-line test mandating that an exempt hospital expend no less than 5 percent of its annual patient operating budget or patient revenues on charity care, whichever is greater.

Report Data on Community Benefits. Against this backdrop, the Final Report indicated that there were tremendous disparities among hospitals in both the amount of total community benefit expenditures they reported and what they counted in arriving at those figures. The entire respondent group reported aggregate community benefit expenditures of $9.4 billion, with a small number of hospitals in the study accounting for the bulk of these expenditures. According to the Report, 19 percent of the hospitals reported 78 percent of the aggregate community benefit expenditures. Uncompensated care was the largest component category of community benefit expenditures, accounting for 56 percent of the total expenditures reported. (When data from the 15 respondent research hospitals was excluded, uncompensated care accounted for 71 percent of total community benefit expenditures.) Approximately 1/5 of hospitals in the study included in their calculations of uncompensated care the differences between hospital charges and Medicaid allowances ("Medicaid shortfalls"). In addition, 44 percent of all respondents included bad debt in their calculation of uncompensated care. The study indicated that hospitals that included Medicaid shortfalls and bad debt in their uncompensated care figures reported significantly higher amounts of uncompensated

care than respondents who did not include these amounts in calculating uncompensated care. For example, for hospitals including bad debt in uncompensated care, the median uncompensated care expenditure as a percentage of revenue was 6.7 percent, while the median expenditure for those hospitals that did not include bad debt in uncompensated care was 2 percent. This contrasts with the new Form 990 standards. On the new IRS Form 990 Schedule H, the Service takes the position that community benefits must be reported on a cost basis instead of on the basis of the hospital's charges and that bad debt expenses and Medicaid shortfalls are not included in the calculation of community benefit expenditures. (Schedule H does provide hospitals the opportunity to explain what amounts of these expenses they believe should be treated as legitimate community benefits, even though the Schedule does not permit such expenditures to be treated as community benefits at this time.)

The disparity between the definition of community benefit on Schedule H and the reporting methodologies employed by a significant portion of the Study respondents has lead some Service officials to suggest that community benefit expenditures in the Report may be inflated and that a large portion of exempt hospitals would be unable to satisfy a bright-line expenditure test in line with the proposals previously suggested. Since the Service released the Report, Senator Grassley and members of his staff have expressed continued interest in replacing the current community benefit test with a mandatory charity care requirement, despite the suggestion by some Service officials that a bright-line test might be unworkable and inequitable in light of the tremendous variation in exempt hospital care models and community circumstances. A memorandum from the Senator in response to the Report stated:

> The tremendous advantage of tax-exempt status, and the ability to raise capital through tax-deductible contributions and tax-exempt bonds, puts non-profit hospitals in a position to provide health care to people who otherwise can't afford it. In fact it's that public good that justifies the tax-exempt status. Neither the IRS nor Congress has done a very good job when it comes to establishing the criteria for enjoying this tax status since the IRS scrapped charity care for its community benefit standard in 1969. The Treasury Department could do a lot of good, and probably more quickly than Congress, by re-establishing those charity care requirements, and if it looks like that can't get done, then Congress will have to step in.

Practice Tip. Hospitals are not required to fill out the community benefits section of the new Form 990 Schedule H until 2010 (when they prepare the 2009 Form 990). We recommend, nevertheless that hospitals should assess their community benefits expenditures against the Service's definitions and categories now, taking into account the need to report expenditures on a cost (instead of charge basis) and the exclusion of bad debt and Medicaid shortfalls from the calculation of community benefits. In addition, hospitals would be prudent to consider ways in which they might expand their community benefit programs in accordance with the categories of community benefits provided on Schedule H in order to comply with any future changes to community benefit requirements.

Executive Compensation

Background. Section 4958 of the Code provides for the imposition of excise taxes on excess benefit transactions. An excess benefit transaction occurs when a disqualified person (a person with significant influence over the organization) receives an economic benefit from an exempt organization that exceeds the value he or she provides to the organization in return. The Treasury Regulations provide a three-pronged procedure for approving financial transactions with disqualified persons including the payment of compensation (the "rebuttable presumption process"). This process, if followed, establishes a rebuttable presumption that compensation paid to a disqualified person was reasonable. In general, the process requires approval by an authorized and independent body, reliance on comparability data, and adequate and contemporaneous documentation of the process.

Report Data on Executive Compensation. The Final Report also included extensive data on the executive compensation practices reported by respondents. The vast majority of respondents reported making use of the rebuttable process for approving executive compensation and 73 percent of respondents reported having a written compensation policy. The average total compensation for all respondents' top management official was $490,431. Out of the 487 respondents, the Service selected 20 respondents for examination on the basis of the level of compensation reported. Among the hospitals selected for examination, the average compensation for the top management official was $1,381,276. The Service reported that 85 percent of the examined hospitals employed the rebuttable presumption process to establish compensation, thereby placing the burden on the Service to establish that compensation was unreasonable. In all of these cases, the Service determined that it did not have sufficient evidence to rebut the presumption of reasonableness. In response to these findings, Service and Congressional officials have suggested that they believe

some hospital compensation may be excessive and that the rebuttable presumption process and the exception from section 4958 for initial contracts with disqualified persons may contribute to inflated compensation. Some officials have further suggested that the restrictions on executive compensation require tightening and expressed particular interest in learning the extent to which hospitals routinely approve compensation that is above the 50th percentile of the comparability data provided to them.

Practice Tip. It is clear from the Report that use of the rebuttable presumption process offers significant protection against the Service's potential assessment of section 4958 taxes. Hospitals should ensure that they satisfy rebuttable presumption process for compensation paid to each of their disqualified persons as long as the process remains available to them and that they have adopted and continue to follow a written compensation policy. Hospitals should further expect that the additional compensation data that they must report on the new IRS Form 990 for 2008 may be subject to intense scrutiny.

---

1 "NONPROFIT HOSPITALS: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefits Requirements" GAO-08-880

2 H.R. 6420, "Tax Exempt Hospitals Responsibility Act of 2006."

About Reed Smith

Reed Smith is a global relationship law firm with nearly 1,700 lawyers in 23 offices throughout the United States, Europe, Asia and the Middle East. Founded in 1877, the firm represents leading international businesses, from Fortune 100 corporations to mid-market and emerging enterprises. Its lawyers provide litigation services in multi-jurisdictional matters and other high-stakes disputes; deliver regulatory counsel; and execute the full range of strategic domestic and cross-border transactions. Reed Smith is a preeminent advisor to industries including financial services, life sciences, health care, advertising, technology, media, shipping, energy trade and commodities, real estate, manufacturing, and education. For more information, visit **reedsmith.com.**