

Internal Revenue Service releases final report on tax-exempt hospital project: how do you compare?

Internal Revenue Service (IRS) officials recently released the final report on the tax-exempt hospital project initiated in 2006. The final report is based on responses to questionnaires the IRS received from more than 500 not-for-profit hospitals. The service implemented the tax-exempt hospital project to help it and the public better understand how not-for-profit hospitals benefit their communities. Community benefit is the basis of the hospitals' federal tax exemption. The project also examined executive compensation from a sample of 20 not-for-profit hospitals.

Community benefit

Community benefit is the legal standard for determining whether a nonprofit hospital is exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code. To learn about the hospitals' community benefit practices and reporting, the questionnaire asked about each hospital's patient mix, emergency room, medical staff privileges, board of directors, medical research, professional education and training, uncompensated care and community programs.

Executive compensation

Hospitals described in section 501(c)(3) may pay no more than reasonable to

their officers, directors, trustees and other disqualified persons. To demonstrate compensation amounts are reasonable, many organizations use what is commonly called the rebuttable presumption of reasonableness test. By meeting the criteria in this test, the exempt organization shifts the burden of proof for excessive compensation to the IRS. The IRS questionnaire requested information about the amount of compensation paid to officers, directors, trustees and key employees and about policies and practices used to establish executive compensation.

Final report

The final report summarizes the reported community benefit and executive compensation data across various demographics, including the type of community in which the hospital is located and the hospital's revenue size. The study analyzed reported community benefit expenditures by income and health insurance coverage levels in the areas surrounding the hospitals. It also analyzed hospitals reporting large medical research expenditures.

The four community types analyzed in the report included:

- High-population hospitals – hospitals located in the 26 largest urban areas in the U.S.
- Other urban and suburban hospitals – those hospitals located in urban and suburban areas other than the 26 largest urban areas
- Critical access hospitals – rural hospitals designated as such under federal law
- Other rural hospitals – rural hospitals not designated as critical access hospitals

The report also provides results based

on each hospital's annual revenues:

- Under \$25 million
- \$25 million to \$100 million
- \$100 million to \$250 million
- \$250 million to \$500 million and
- More than \$500 million

Community benefit findings

The report's key community benefit findings were the following:

- Considerable diversity in the demographics, community benefit activities and financial resources among the hospitals. Considerable differences observed between the critical access hospitals and the high population hospitals and between the smallest and largest hospitals based on revenue size.
- Average and median percentages of total revenues reported as spent on community benefit expenditures were 9% and 6%, respectively. These percentages were the lowest for rural hospitals and highest for high population hospitals. The percentage spent on reported community benefit expenditures generally increased with revenue size.
- Uncompensated care was the largest reported community benefit expenditure for each of the study's demographics, except for a group of 15 hospitals reporting large medical research expenditures. The average and median percentages of uncompensated care as a percentage of total revenues were 7% and 4%, respectively.
- Next largest categories of community benefit expenditures (after uncompensated care) ranked as a percentage of

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total community benefit expenditures were medical education and training (23%), research (15%) and community programs (6%). However, the expenditure mix varied by both community type and revenue size. The 15 hospitals reporting large medical research expenditures materially affected the overall numbers in this area.

- Overall, the group of hospitals reported excess revenues of 5% of total revenues. Excess revenues varied across the community type and revenue size demographics with large revenue size hospitals as the most profitable and critical access hospitals as the least profitable. Twenty-one percent of the hospitals reported total expenses greater than total revenues.
- Uncompensated care and community benefit expenditures were concentrated in certain hospitals and unevenly distributed.
- No correlation was found between community benefit expenditures and per capita income levels of the hospital's surrounding area. However, community benefit expenditure levels increased as uninsured rates of the hospital's surrounding area increased.

Executive compensation findings

The report's key executive compensation findings were the following:

- Most hospitals in the study reported complying with important elements of the rebuttable presumption proce-

cedure. The results did not vary much by demographic. The examinations confirmed widespread use of comparable data and independent personnel to review and establish executive compensation amounts.

- Average and median total compensation the hospitals paid to the top management official was \$490,000 and \$377,000, respectively. The largest amounts were reported by high population and other urban and suburban hospitals while critical access hospitals reported the smallest amounts paid. Average and median total compensation increased with revenue size.
- Hospitals were selected for examination based on high compensation amounts taking into account the size and circumstances of the hospital. The average and median total compensation amounts reported by the examined hospitals were \$1.4 million and \$1.3 million, respectively.
- Nearly all examined compensation amounts were upheld as established pursuant to the rebuttable presumption process and within the range of reasonable compensation.

Observations

The reported data has limitations and may not accurately reflect the respondent group or represent the not-for-profit hospital sector as a whole. Except for the compensation data reviewed in the examinations, the reported data was not independently tested or verified.

Community benefit reporting varied across the demographics for multiple reasons. The study observed differences in a demographic group's general treatment of an activity as community benefit and varying cost methods the hospitals used. These factors and limitations must be considered when reviewing the study's findings.

Beginning with the 2009 tax year, Schedule H of the Form 990 should promote more uniform and accurate reporting of quantitative and qualitative community benefit information by tax-exempt hospitals. Particular areas of inquiry are expected to include the following:

- Accuracy of costing methods used to measure community benefit
- Medical research funded by for-profit organizations or not will be made widely available to the public
- Amounts reported as bad debt that are actually attributable to charity care
- Treatment of portions of Medicare shortfalls or certain community building activities as community benefit
- Review of nonquantifiable aspects of community benefit

How does your organization compare?

Interested in how your organization compares with the IRS findings? Contact your BKD advisor or visit bkd.com for more information on how we can help you compare your results to those in the study. ■



ADDRESS SERVICE REQUESTED

Hammons Tower
901 E. St. Louis Street
P.O. Box 1900
Springfield, MO 65801-1900

