

## **IRS Exempt Organizations Hospital Study Executive Summary of Final Report (February 2009)**

**Background.** This report results from an IRS study of nonprofit hospitals begun in 2006. The study was conducted so that the IRS and other stakeholders could better understand nonprofit hospitals and their community benefit and executive compensation practices and reporting. The report is based on the responses to questionnaires the IRS sent to a sample of more than 500 nonprofit hospitals. As part of the study, the IRS also examined 20 nonprofit hospitals regarding their executive compensation practices.

The community benefit standard 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. This standard uses a facts and circumstances approach to assess whether a hospital is exempt or taxable. To obtain information about community benefit practices and reporting, the questionnaire requested information regarding the hospital's patient mix, emergency room, board of directors, medical staff privileges, and a variety of programs (specifically, its medical research, professional education and training, uncompensated care, and community programs).

Hospitals and other organizations described in section 501(c)(3) may pay no more than reasonable compensation to their officers, directors, trustees, and other disqualified persons. Current Code section 4958 excess benefit transaction rules allow exempt organizations to rely on a rebuttable presumption process to establish that compensation is reasonable. Under these rules, an organization may place the burden of proving excessive compensation on the IRS by using disinterested persons to review comparability data (including, in appropriate circumstances, that of for-profit organizations) to establish compensation, and by properly substantiating the process used to set compensation. The questionnaire requested information regarding the amounts of compensation paid to officers, directors, trustees and key employees, and about policies and practices used to establish executive compensation. The compensation examinations reviewed this information and the reasonableness of compensation paid to the hospital's executives.

In July 2007 the IRS released an [interim report](#) (and accompanying [executive summary](#)) summarizing the reported community benefit questionnaire data on an aggregate basis. A copy of the interim report and its accompanying executive summary are available on the IRS Web site.

The final report summarizes the reported community benefit and executive compensation data across various demographics, including the type of community in which the respondent hospital is located (community type) and the hospital's revenue size. The study also analyzed patient mix and excess

revenues across these demographics. The four community types, based on U.S. Census Bureau data and other information, are:

- High-population hospitals – hospitals located in the 26 largest urban areas in the United States
- 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 five groupings of the individual hospital's annual revenues:

- under \$25 million
- \$25 million to \$100 million
- \$100 million to \$250 million
- \$250 million to \$500 million
- over \$500 million.

**Summary of Community Benefit Findings.** In addition to analyzing community benefit expenditure data across the demographics described above, the study also analyzed reported community benefit expenditures by income and health insurance coverage levels of the areas surrounding the hospitals and by hospitals reporting large medical research expenditures.

The report's key community benefit findings are:

- There was considerable diversity in the demographics, community benefit activities, and financial resources among the respondent hospitals. In particular, significant differences were observed between the critical access hospitals and the high population hospitals, and between the smallest and largest hospitals based on revenue size.
- The average and median percentages of total revenues reported as spent on community benefit expenditures were 9% and 6%, respectively. Among the community types, these percentages were lowest for rural hospitals (both critical access and non critical access 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, other than for a group of 15 hospitals reporting large medical research expenditures (93% of all research expenditures reported by the study's respondents). Overall, the average and median percentages of uncompensated care as a percentage of total revenues were 7% and 4%, respectively. Uncompensated care accounted for 56% of aggregate community benefit expenditures reported by the hospitals in the study.

- After uncompensated care, the next largest categories of community benefit expenditures, ranked as a percentage of total community benefit expenditures, were medical education and training (23%), research (15%), and community programs (6%). The expenditure mix, however, varied both by community type and revenue size. Further, the group of 15 hospitals reporting large medical research expenditures materially impacted the overall numbers in this area. For example, when the research group is removed, the percentage of total community benefit expenditures reported as spent on uncompensated care increases from 56% to 71%, and that spent on medical research decreases from 15% to 1%.
- The overall group of hospitals reported excess revenues (total revenues less total expenses) of 5% of total revenues. Reported excess revenues varied across the community type and revenue size demographics, with large revenue size hospitals generally the most profitable and critical access hospitals the least profitable. 21% of the hospitals reported total expenses greater than total revenues; the percentage of hospitals reporting a deficit varied by community type and revenue size.
- Uncompensated care and community benefit expenditures were concentrated in certain hospitals and unevenly distributed. For example, 9% of the hospitals reported 60% of the aggregate community benefit expenditures of the overall group; 14% of the hospitals reported 63% of the aggregate uncompensated care expenditures.
- No correlation was found between community benefit expenditure levels and per capita income levels of the hospital's surrounding area. However, community benefit expenditure levels generally increased as uninsured rates of the hospital's surrounding area increased.

**Summary of Executive Compensation Findings.** The final report summarizes the executive compensation information arising from the questionnaires and compensation examinations conducted as part of the study. The reported data was analyzed based on community type and revenue size. The key findings are:

- Nearly all hospitals in the study reported complying with important elements of the rebuttable presumption procedure available to establish compensation of certain persons. The results did not vary materially by demographic. The examinations confirmed widespread use by the examined hospitals of comparability data and independent personnel to review and establish executive compensation amounts.
- The average and median total compensation amounts reported as paid to the top management official by respondents to the questionnaire were \$490,000 and \$377,000, respectively. By community type, 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 paid increased with revenue size.

- Hospitals were selected for examination based on high compensation amounts paid taking into account the size and circumstances of the hospital. The average and median total compensation amounts reported by the group of 20 examined hospitals were \$1.4 million and \$1.3 million, respectively.
- Although many of the compensation amounts reported may appear high to some, nearly all examined amounts were upheld as established pursuant to the rebuttable presumption process and within the range of reasonable compensation.

**Limitations of the Analysis.** The reported data has limitations and may not accurately reflect the respondent group or represent the nonprofit hospital sector as a whole. For example, although the IRS designated the general categories of activities that could be reported as community benefit for purposes of the study, determining what was treated as community benefit (for example, bad debt or Medicare shortfalls) and how to measure it (cost versus charges) was largely within the respondents' discretion. In addition, except for the compensation data reviewed in the examinations, the reported data was not independently tested or verified.

**Observations.** Both the community benefit and reasonable compensation standards have proved difficult for the IRS to administer. Both involve application of imprecise legal standards to complex, varied and evolving fact patterns. Some have suggested that these standards need to be revised. As these discussions occur, and despite the limitations described above, the study provides important information.

The size, complexity and importance of this segment will continue to be a challenge to those who consider refining or revising the exemption standard. The data suggests that any attempt to refine the standard will seriously impact the existing tax exempt hospital sector because of the hospitals' varying practices and financial capabilities. Put another way, any revised standard would affect the different types and sizes of hospitals depending upon the types of activities required to be taken into account as community benefit, the quantitative measure (if any) included in such a standard, and the extent the rule provides for exceptions or special rules (e.g., an exception from a quantitative standard if the hospital is the sole provider in the community or has a designation as a critical access hospital). As discussions about the community benefit standard continue, additional information may be available as more accurate and complete data on community benefit expenditures is expected to be available through Schedule H of the Form 990.

The area of executive compensation poses similar challenges. Amounts reported appear high but also appear supported under current law. For some, there may be a disconnect between what, as members of the public, they might consider reasonable, and what is permitted under the tax law. The IRS will

continue its enforcement work in this area through examinations and other compliance initiatives. As part of this work, the IRS will seek a better understanding of the impact of certain aspects of existing law, including the permitted use of for profit comparables, and the rule excepting the initial contract between the organization and the executive.