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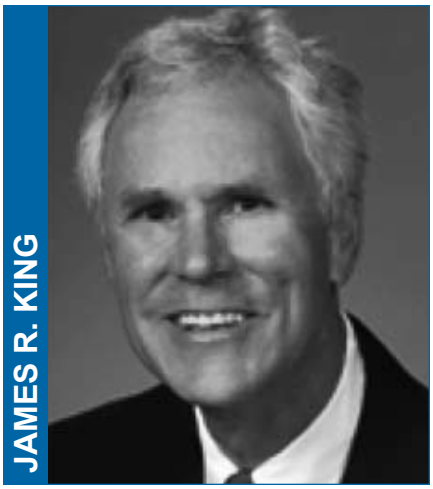
Earn CEU credit
SEE INSERT
Meet
Deann M. Baker
Corporate Compliance & Privacy Officer, Alaska Native Tribal Health Consortium
PAGE 14
Get Ready: RACs may be nationwide sooner than expected!
PAGE 4
Also:
Tax compliance for the new millennium: Redesigned Form 990—Part II
PAGE 46
Feature Focus:
Risk Assessments and Compliance
PAGE 22

Tax compliance for the new millennium: IRS releases Discussion Draft of redesigned Form 990—Part II

By James R. King, JD and Gerald M. Griffith, JD



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Part I of this two-part series on IRS Form 990 appeared in the September 2007 issue of Compliance Today.

The Discussion Draft of the redesigned Form 990 contains a Core Form and 15 Schedules. For a full list of the Schedules, please see Part 1 of the article.

Schedule H –Information for hospitals

Organizations that operate a facility that provides hospital or medical care must complete new Schedule H, which covers community benefit and other information for hospitals. This new Schedule has five parts:

- Part I – Community Benefit Report
- Part II – Billing and Collection Practices
- Part III – Management Companies and Joint Ventures
- Part IV – General Information
- Part V – Facility Information

Schedule H will, of course, be the key schedule for all hospitals. It is where the rubber hits the road for hospitals in telling their story about how they meet the community benefit standard for exemption. In that regard, the eight pages of instructions that accompany Schedule H provide readable and largely helpful definitions and clarifications for completing the schedule. In addition, the community benefit portion of Schedule H is accompanied by eight helpful Worksheets.[1] The Worksheets are not to be filed as a part of the Form 990 filing, but are to be retained to support the information provided on Schedule H.

IRS rationale and operating assumptions

The IRS explains some of its rationale in designing Schedule H in the materials accompanying the Schedule. The IRS notes, at one point, "In the hospital area, concerns continue to be raised about whether there are differences between for-profit and tax-exempt hospitals. While the health care sector has changed dramatically over the last forty years, the general tax rules governing this sector have not."[2]

Data gathering for policy makers. The inference here, of course, is that the data collected in Schedule H can be used not only to assist the IRS in enforcing the community benefit standard, but also to compare the operations of exempt hospitals with those of non-exempt hospitals. Policy makers can then use that data for future legislative efforts, if it reveals that no material behavioral differences exist to justify the current level of tax subsidy that exempt hospitals enjoy.

Increased transparency. The IRS also stated, "The proposed schedule is designed to combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care."[3] Regardless of whether a lack of transparency existed in the past, the IRS clearly advances transparency in the areas that Schedule H addresses. Additionally, Schedule H will make it possible to compare exempt hospitals with for-profit hospitals and also with other exempt hospitals of similar size and mission. (It is likely, however, that in the early years of reporting under the new regime, many "false positives" will occur as hospitals learn the in's and out's of how to consistently report all of the information that Schedule H requires.)

IRS view of the substantive law. The IRS then goes on to say that, "In drafting the

schedule, the Service tried to quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals."[4] While the Discussion Draft does not make, nor does it purport to make, any changes in substantive law, the inference here is that the IRS believes the factors cataloged in Schedule H are the "objective" metrics under the community benefit standard.

In that regard, Schedule H only sets forth the factors that the IRS believes indicate whether an organization is engaging in activities that advance community benefit. Schedule H does not express any view of how much community benefit is enough. That task will be left to the 20/20 hindsight judgment inherent in the overall facts and circumstances analysis of Revenue Ruling 69-545 and the courts. See, for example, *IHC Health Plans, Inc. v. Commissioner*,[5] in which the court summarized the community benefit standard and posited the following "plus" test for determining whether an organization provides sufficient benefits to merit § 501(c)(3) status:

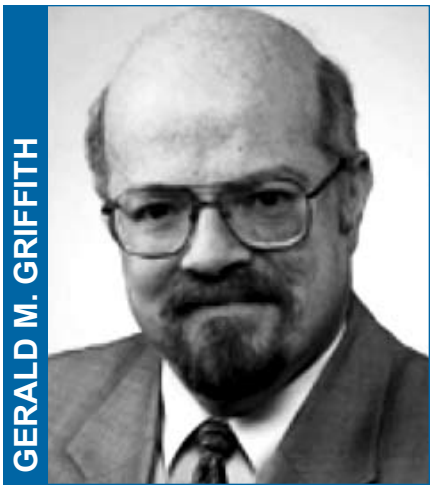
> In summary, under section 501(c)(3), a health-care provider must make its services available to all in the community plus provide additional community or public benefits. The benefit must either further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the subsidy. Further, the additional public benefit conferred must be sufficient to give rise to a strong inference that the public benefit is the primary purpose for which the organization operates. In conducting this inquiry, we consider the totality of the circumstances.[6]

Thus, under the IHC "plus" formulation, it is not enough to promote health, nor is it enough to offer care to the entire community for a fee. These are just the starting point for the analysis. In addition, the organization must demonstrate that it satisfies one or more otherwise unmet community needs or that it supplements or advances governmental programs aimed at meeting those same community needs. Moreover, the organization must engage these activities at a level that is substantial enough to allow the inference that furthering public benefit is the organization's primary purpose. Schedule H will assist the IRS and organizations in quantifying how well organizations address the various metrics involved.

Specific comment on the CHA approach to community benefit. Finally, the IRS states that,

> "For purposes of advancing the discussion in this area, the Service chose to utilize the Catholic Health Association's (CHA) community benefit reporting model. CHA is a respected leader in the area of charity care and community benefit reporting. The Service recognizes, however, that there will be alternative reporting models and welcomes comments in this area."[7]

This statement acknowledges the fine work the CHA has done over the past 15 years, but it also acknowledges that there is not complete agreement on all factors within the hospital community and that many respected members of the hospital community have different views in some areas. For example, while they agree on many points, CHA and the American Hospital Association (AHA) disagree on some points, such as whether to take the Medicare "shortfall" into account as an item of community benefit. IRS expressly acknowledges this disagreement among knowledgeable and respected members of the health care sector.[8] As a result, we can expect extensive comment on which portions of the CHA approach should be followed and where there should be deviation from the CHA approach.



Part I – The Community Benefit Report

According the Congressional Budget Office,[9] based on calendar year 2002 data (the most current data available), nonprofit hospitals receive, in aggregate, approximately $12.6 billion in governmental tax subsidies, broken down roughly evenly between the federal government and various state and local tax exemptions and benefits. This means that, in aggregate, tax-exempt hospitals receive an annual tax "subsidy" from the federal government of about $6.3 billion in the form of the basic exemption from paying income tax on net income, the ability to receive contributions that are deductible by the contributors, and the cost savings from the advantages of tax-exempt financings. They receive another roughly $6.3 billion from various state and local governmental entities in the form of sales and use tax exemptions, income tax exemptions, and real estate tax exemptions.

Quid pro quo information for tax benefits. Because of the substantial subsidies, the Community Benefit Report will be the first place that the IRS and state regulators look to see whether a filing organization provides enough "bang for the buck" – the community benefit it provides in comparison to the level of tax subsidy that it receives. This report will also be the first place that the news media will look,

Continued on page 50

and it will be a source of information for others in the community including unions, class-action plaintiffs lawyers, and tax whistleblowers. As a result, hospitals will want to pay very careful attention to the data reported here.

Unreimbursed cost of community benefits. The Community Benefit Report basically follows the CHA model for reporting community benefits, and it requires organizations to report, on a unreimbursed cost basis, the cost of providing "charity care" and "other benefits." The worksheets indicate that the cost data may be provided based either from the organization's own cost-accounting system or based on a costs-to-charges ratio from cost reports.

In the charity care category, the report asks for three categories of unreimbursed cost: (i) "traditional charity care"; (ii) the unreimbursed cost of providing Medicaid (the "Medicaid shortfall"); and (iii) the unreimbursed costs of providing benefits under other government programs. Worksheets that provide a methodology for computing the costs with respect to each category are included.

Although Schedule H is based on the CHA model, and, although CHA and AHA have disagreed on the treatment of the Medicare shortfall, it is not clear from the Instructions whether the Community Benefit Report actually takes sides in the CHA/AHA Medicare shortfall debate. The Instructions dealing with billing and collections clearly exclude Medicare and Medicaid from other government programs, but the Instructions in the Charity Care section are silent as to whether or not the Medicare shortfall could be included in the Other Government Programs category in some cases, depending on the organization's particular circumstances.[10] This should generate a significant amount of comment and continued debate because, for many organizations, Medicare shortfalls can be an important issue and may generate losses that will be material to the organization's financial status. In this area, the Healthcare Financial Management Association Statement 15 concludes that: ". . . each hospital should decide, based on its circumstances, whether Medicare shortfalls should be part of its community benefit disclosure."[11] Stay tuned.

In the "Other Benefits" category, the report asks for cost data regarding the costs of providing five additional categories of community benefit:

- Community health improvement services and community benefit operations
- Health professions education
- Subsidized health services
- Research
- Cash and in-kind contributions to community groups[12]

If a charitable hospital provides other additional benefits to its community that are not included as part of these five categories, those benefits presumably do not count for community benefit purposes in the view of the IRS. Many charitable hospitals have developed innovative ways to respond to community needs in the past, and hopefully those activities will continue, but Schedule H contains no place for a hospital to report them. As with the Charity Care category, there are worksheets for the Other Benefits category, and the Instructions provide largely useful definitions about the items that can be included in each category. As noted, these definitions and worksheets are based on the CHA's work product in this area.

Community benefit annual reports. In addition to the cost-based data computed using the worksheets, the Community Benefit Report section also asks whether the organization produces an annual community benefit report for its operations and, if so, whether the report is made available to the public (Part I, Lines 12a and 12b). The Instructions suggest some ways in which an organization can make its Community Benefit Report available to the public, including to post the report on the organization's Web site, to publish and distribute the report to the public, and to submit the report to a state agency or other organization that distributes the report to the public.[13]

Charity care policies. Schedule H also asks whether or not the organization has a charity care policy and then asks for a description of that policy (Part I, Lines 13a and 13b). The Instructions indicate that the organization's description of its charity care policy should include, but should not necessarily be limited to, the following five factors:

- Whether the organization determines eligibility for full or partial charity care on the basis of Federal Poverty Guidelines. For instance, if a patient's family income must be less than a certain percentage of the Federal Poverty Guidelines for the patient to qualify for free care, the organization is to indicate that percentage. Similarly, if a patient's family income must be within a certain income range to qualify for discounted care, the organization is to indicate that income range;
- Whether the organization determines eligibility for full or partial charity care on the basis of an asset test. For purposes of this question, "asset test" means a limit on the amount of total or liquid assets that a patient or the patient's family may own to qualify for free or discounted care;
- Whether the organization applies its charity care policy uniformly throughout all of its facilities, or whether the application of the policy varies from facility to facility based on socio-economic factors, local law, or other factors;
- Whether the amount of free or discounted care provided under the policy is limited by budget caps or other condi-

tions that may result in persons otherwise eligible under the policy not receiving free or discounted care;

- How and when the organization informs its patients of the terms and availability of the policy, such as posting the policy in admissions areas, emergency rooms and other areas of the organization's facilities in which eligible patients are likely to be present; providing a copy of the policy to patients with discharge materials, and including the policy or a summary of it in patient bills.[14]

These factors indicate that the IRS remains concerned about the publicity that the charitable hospital provides for its charity care policy and the results that the policy actually produces. For example, in 2001, the IRS issued a Field Service Advice Memorandum containing [14] questions designed to elicit facts regarding a hospital's charity care policy and its activities.[15] These questions included whether the hospital had a specific, written plan or policy to provide free or low-cost health services; what directives or instructions the hospital had provided to ambulance services regarding the transportation of poor or indigent patients to its emergency room, and whether the hospital maintained "detailed records" regarding the times and circumstances under which it provided free or reduced-cost care.[16] Despite these questions and the growing focus by the IRS, states attorney generals, plaintiffs attorneys, and potential tax whistleblowers with respect to charity care, no requirement exists under the community benefit standard as interpreted by courts or pursuant to Revenue Ruling 69-545 for a hospital to provide free care in exchange for exempt status under federal law.

Part II – Billing and collections

Part II of Schedule H asks for information regarding billing and collections. To the authors' knowledge, this represents the first time that the IRS has asked for information regarding these practices in any organized way. Indeed, Revenue Ruling 69-545, which sets forth the community benefit standard, does not mention billing and collection at all.[17]

Rationale for billing and collection information. The IRS's stated rationale for adding this request for billing and collection information is that it is needed "in order to better reflect the revenue stream of the organization and to enhance transparency regarding these practices."[18] Initially, the "revenue stream" concept seems valid for purposes of allowing the IRS to enforce the tax laws. The validity of this concept, however, depends on whether this section gives the IRS information regarding how organizations treat bad debt for charity care purposes and when the organization identifies an amount as either charity care (never entering into its revenue stream) or as bad debt (entering into its revenue stream, but ultimately not collectible). On the other hand, some of the information collected in this section seems to have little, if anything, to do with enforcing the tax laws. It may fall into the "transparency" category, which makes it nice to know, particularly for state regulators, the news media, and plaintiffs lawyers.

Section A – Insurance categories, discounts, and bad debt:

Insurance. Information is requested in a format that breaks patients out by the categories of insurance coverage as follows: (i) Medicare; (ii) Medicaid; (iii) Other Governmental Programs; (iv) Private Insurance; and (v) Uninsured. Section A then requests information regarding how the organization gets from the gross charge amount to the "net expected" and the "fees collected." In that regard, the Instructions contain a useful and instructive discussion of the "discounts" an organization uses in order to arrive at the "net expected" number.[19]

Discounts defined. According to the Instructions, "discounts" include "any and all billing or contractual discounts or allowances applied to the gross charges."[20] Thus, the Instructions say that organizations should include discounts, such as those negotiated with private insurance companies, discounts applied by government programs, early payment discounts, discounts granted automatically to persons without insurance, and discounts granted to charity care patients.[21] A discount may be any portion of a gross charge, including 100% of that charge, and more than one discount may apply to a given charge. For example, the Instructions note that a charge may be discounted by reason of a patient's insurance policy, and the co-pay may be further discounted through the organization's charity care policy.[22]

Calculation of bad debt expense.

Schedule H, Part II does not define the difference between charity care and bad debt, but it does ask the organization to explain how it calculates bad debt expenses (Part II, Line 5). In this regard, the Instructions make clear that the term "discounts" does not include "an allowance, reduction, or adjustment offered or provided to settle or collect an amount previously billed, such as to encourage collection of a past due amount."[23] In other words, discount does not include bad debt. Fair enough.

However, this does not address one of the more contentious and, in the authors' view, silly debates in this area – whether an organization can treat bad debt as charity care. In the authors' view, this is a semantic debate, not a substantive one. As a result, organizations should take care in answering this request to ensure that they accurately and carefully respond, taking into consideration the principles set forth in Healthcare Finan-

Continued on page 52

cial Management Association's Statement 15, which sets forth a basis for distinguishing bad debt from charity care for financial accounting purposes.[24]

In general terms, it is easy to tell the difference between charity care and bad debt. Charity care is an amount that the organization intends to "give away" because the person meets certain criteria. As a result, charity care never enters into the organization's revenue stream and is never a part of the organization's accounts receivable. Bad debt, on the other hand, is one key measure of an organization's revenue cycle effectiveness. It is an amount that initially enters into the revenue stream because the organization did not intend to give it away. It intended to get paid, but it made a bad credit underwriting judgment and, therefore, has an "unintended" operating expense.

The issue that arises here is not one of whether bad debt can be counted as charity care, but when the organization makes the determination that a particular patient is a charity care patient or a paying patient. Many, including the IRS in the St. David's case at the trial level, have taken the position that, if an amount ever enters the organization's revenue stream, it can never be accounted for as a charity care amount.[25] This is a position reminiscent of the old Will Rogers advice on picking stocks: "Don't gamble; take all your savings and buy some good stock and hold it till it goes up, then sell it. If it don't go up, don't buy it."

What Will Rogers said about picking stocks is equally true about deciding which patient is a charity care patient and which one is a paying patient. It is extremely difficult in many instances to tell whether a particular patient is eligible for charity care at the point of service, and it is often the case that the institution, despite its best efforts, cannot make that determination until some considerable period of time after the service is rendered. This includes, in some cases, waiting until after collection efforts have commenced and the information then becomes available. Indeed, on this point, the United States District Court in the St. David's case made the following colorful, but cogent, observation:

> The government attempts to quibble about how St. David's differentiates between free care that is charity and free care that is bad debt. The Court thinks that is a silly and meaningless distinction for purposes of this case. When all who need emergency care are treated regardless of willingness or ability to pay, the function is charitable regardless of what the accountants discover later. The government uses the alleged fact that St. David's attempts to collect payment from all patients before determining whether the care rendered was charity care or bad debt to show that St. David's actually provides no charity care. This implicitly attempts to require St. David's to determine before rendering care, whether to expect payment from that particular patient, a luxury allowed only to those privileged to live in a bubble constructed by theories without the rude pin prick of practicality that so frequently bursts such bubbles. Not surprisingly, the IRS offers no method by which that determination could be made, perhaps it could be based on skin color, the brand name of clothes worn by the patient upon entering the emergency room, or shaking a Magic 8-ball.[26]

It would be helpful if, in the final Instructions or in some other form of guidance, the IRS addressed this issue. In that regard, the authors urge the IRS to adopt the standards set forth in the Healthcare Financial Management Association's Statement 15, which sets forth a thoughtful and useful way of addressing this issue: requiring that the organization make every practical effort to make charity care eligibility determinations before or at the time of service, but recognizing that determinations can be made at any time during the revenue cycle and that there should be no rigid time limit for when determinations are made.[27] This is a much better approach than "shaking a Magic 8-ball."

Section B – Collection Practices. Schedule H, Part II, Section B asks whether the organization has a written collection policy and, if so, for a description of that policy. The Instructions note that the description should include a statement of how and when the organization informs patients of the terms of the policy as well as a description of how the organization collects debts from patients.[28] If the organization uses collection procedures or refers collections to third parties, the organization is to describe when such procedures are used or when such referrals take place. The Instructions also indicate that the organization should note whether amounts that are designated as charity care may be subject to collection procedures or referred for collection to a third party either before or after the charity care determination is made.[29]

As noted above, the charity care versus bad debt information seems relevant to the community benefit standard. However, much of the remaining request for information is a stretch, if the goal is enforcement of federal tax laws. The best theory would be that, under state charitable law concepts (under which the health care exemption qualifies as a tax-exempt purpose) there is a requirement that charitable hospitals follow some particular set of debt collection polices that are different from those of other organizations. While many plaintiffs lawyers, some attorneys general, and some state tax departments have

made such arguments, no general, underlying state charitable law concept requires a separate set of debt collection practices for charitable hospitals or specifies what those practices might be. While some states, such as Illinois, have enacted hospital-specific billing and collection legislation, the relevant compliance details are tied to the particular requirements of the statute and are not susceptible to uniform national reporting or, arguably, even within the jurisdiction of the IRS.

As a result, it seems strained to try to shoehorn this request into a category that ties directly to a federal tax law requirement. That said, the rules under IRC § 6033 and the Treasury Regulations thereunder clearly give the IRS the authority to promulgate forms and instructions requesting information of this kind. As a result, hospitals should carefully describe what they do and why.

Part III – Management companies and joint ventures

The Discussion Draft places overall emphasis on joint ventures outside of schedule H. Joint ventures have been a hot topic for the IRS and other regulators, the Senate Finance Committee and other legislative bodies, the media, and class-action plaintiffs lawyers. As a result, under both the enforcement and transparency prongs of the IRS's approach to the redesign of the Form 990, the Discussion Draft, in a number of places, requests a significant amount of new information regarding joint ventures.

Core Form 990 – Joint Venture Information. The Core Form 990, Part VII, Statement Regarding General Activities has a series of questions regarding joint ventures.

Line 7b asks whether the organization is related to any tax-exempt or taxable entity, and, if yes, requires the organization to complete Schedule R regarding related entities. Note that the definition of "related organizations" in the Glossary only includes parents, subsidiaries, brother-sister corporations, and supporting/supported organizations.[30] It does not appear to include any organization where the control (direct or indirect) is 50% or less, unless the filing organization is the managing partner or managing member of a partnership/ limited liability company (LLC) or a general partner in a limited partnership.

Line 8a asks whether during the tax year the filing organization conducted all or a substantial part of its exempt activities through or using a partnership, LLC, or corporation. The Instructions require organizations to answer "yes" if the organization conducted exempt activities through or using one or more partnerships, LLCs, or corporations and the aggregate exempt activities conducted through or by such entities involved a substantial portion of the organization's capital expenditures or operating budget or a discrete segment or activities of the organization that represent a substantial portion of the organization's assets, income, or expenses of the organization, as compared to the organization as a whole.[31] This question does not depend on the level of control over the other entity, but it does ask only about substantial activities. The Instructions do not define "substantial." However, based on other guidance in other areas, anything over 15% may be substantial.[32]

Line 8b further requires detailed information, including the primary activity of any partnership, LLC, or corporation in which the filing organization's ownership or control was 50% or less, based on vote or value. This question only applies if the joint venture is a substantial portion of overall activities of the filing organization. It represents, however, the first time that the IRS has asked specifically for disclosure on the Form 990 of joint venture arrangements where the exempt organization does not have more than 50% control, as well as the first time that the IRS has focused on ownership percentage. Through this question, the IRS will be able to identify potential targets for focused compliance checks or correspondence audits to assess compliance with the control test of St. David's, etc. In that regard, ownership percentages are also potentially relevant in analyzing whether control and other rights are proportionate to ownership. To date, however, the IRS has not expressed concern about exempt organizations that have lower ownership percentages than voting percentages in partnerships, LLCs, and corporations.

Line 8c seeks information about whether the organization was a partner in a partnership, member of an LLC, or shareholder of a corporation that was managed by a company that was controlled by taxable partners, members, or shareholders. This question does not depend on the level of control over the other entity, nor is it limited to substantial activities. Rather, it applies to even ancillary joint ventures. It is possible that this question signals an increased interest by the IRS in potential inurement and private benefit issues related to ancillary joint ventures, which may be reflected in future compliance checks.

Line 11 asks whether the organization has a written policy or procedure to review the organization's investments or participation in disregarded entities, joint ventures, or other affiliated organizations (exempt or non-exempt). Like question 8, this question may be part of a move to gather more information about nonprofit/for-profit joint ventures and may signal a future IRS compliance initiative.

Line 12 further asks whether the organization has a written policy that requires the

Continued on page 55

organization to safeguard its exempt status with respect to its transactions and arrangements with related organizations. The Instructions indicate that an organization is to answer "yes" if the organization has adopted a policy that requires the organization to negotiate in its transactions and arrangements with other organizations such terms and safeguards adequate to ensure that the organization's exempt status is protected. The safeguards include:

- control by the organization over a partnership sufficient to ensure that the partnership furthers the exempt purpose of the organization;
- requirements that a partnership in which the organization is a partner give priority to exempt purposes over maximizing profits for the partners;
- that the partnership not engage in any activities that would jeopardize the organization's exemption;
- that returns of capital, allocations and distributions be made in proportion to the partners' respective ownership interests; and
- that all contracts entered into by the partnership with the organization be on arm's-length terms, with prices at fair market value.

If a related organization does not substantially further the exempt purposes of the organization, safeguards might include steps taken to ensure that the related organization's activities will not be attributed to the organization, or if they are, will not be sufficient to threaten the organization's exempt status.

The Instructions are particularly clear about the safeguards the IRS expects to see in non-profit/for-profit joint ventures. Although the question is limited to related organizations, it is likely that the IRS will apply to same standards to 50/50 or minority control positions in assessing unrelated business income or, where the joint venture is substantial or involves insiders, determining whether there is a risk to tax-exempt status (e.g.,inurement, private benefit).

Schedule H – Joint ventures

Schedule H follows this overall trend in the Discussion Draft by requesting information specifically targeted at management companies and joint ventures in the health care areas. In that regard, Schedule H requires hospitals to identify all management companies and joint ventures in which the hospital is either a partner or shareholder if (a) current or former (within the past five years) directors, trustees, officers, or key employees ("Listed Persons") or physicians own in aggregate 5% or more of the profits, interest, or stock; and (b) either manages hospital or medical care operations for the filing organization or directly provides hospital or medical care, or owns any property used by the filing organization or others to provide hospital or medical care. The required information includes name of the entity, description of its primary activity, and a breakdown of percentage of ownership among the filing organization, Listed Persons, and physicians. The stated purpose of this disclosure, according to the Instructions, is to provide an "understanding [of] the structure of the [filing] organization and any inurement or private benefit issues."[33] Examples given in the Instructions of organizations to be reported include ancillary-services joint ventures, joint ventures that lease hospital facilities, and equipment-leasing joint ventures.[34]

Given the overall high level of interest in joint ventures, and the emphasis placed on joint ventures throughout the Discussion Draft, health care organizations will have to take care in describing their joint venture arrangements and, more importantly, in structuring them in the first instance. This is true, not only for the reasons discussed above, but also because FIN 48 will require organizations with joint ventures to make a judgment that their joint venture arrangements are structured in a manner that enables the organization to take a more-likely-than-not position that the tax structuring they have done works. Then they will need to make a second judgment as to the amount of reserve, if any, they need to cover any uncertainty in their position.

Schedule N – Transfer of assets

This new schedule will have the effect of exposing more of the formerly private business transactions of hospitals to public scrutiny and affect joint ventures and corporate restructurings. It also may have the effect of painting an unflattering and, arguably, inaccurate picture of the health of the organization. On this schedule, the IRS combined four distinct concepts into a single reporting regime – joint ventures, corporate restructurings, dissolutions, and transfer of ownership of assets to unrelated parties. If the organization is involved in a substantial contraction (defined as the sale, exchange or disposition or other transfer of more than 25% of its assets), it would be required to report the event on Schedule N. The cover page of the accompanying Instructions to Schedule N notes that this reporting requirement includes transfers to a joint venture or to a for-profit company, even if the organization receives fair market value in return as an equity interest in that other entity. For example, contributing capital to a joint venture or spinning off assets to a subsidiary would trigger reporting on Schedule N.

Part IV – General information

In Part IV, the IRS seeks information regard-

Continued on page 57

ing how the organization assesses the health care needs of the communities it serves. This is a very important portion of Schedule H. Part IV also seeks information about the organization's emergency room policies and procedures, including the hours of operation, if applicable, and it seeks any other information important to describing how the organization's hospital's facilities further its exempt purposes.

Community needs assessment process. The first step in satisfying the community benefit standard is likely conducting a community needs assessment. While some have criticized community needs assessments as, in effect, disguised market studies, it is clear that boards should be actively involved in determining what needs exist in the community and how the organization can best serve those needs, given its financial resources and charitable mission orientation. In this regard, all charitable hospitals operate with finite resources, and, under the community benefit standard, these hospitals may allocate their resources in a manner that, in their judgment, best suits the needs of the communities they serve. In many instances, this means a substantial dollar commitment to charity care spending and to other activities that further charitable health care activities.

In recognition of this fact, the community benefit standard permits a flexible approach to determining which services are best suited to a particular community and how best to allocate limited resources to meet the needs of a particular community. These objectives are generally served by the community needs assessment process, which involves the board actively (i) setting the organization's mission overall, including the role of charity care and other tax-exempt objectives in the mission; (ii) establishing systems to monitor and measure the organization's compliance with its policies; and (iii) allocating the resources of the organization in a manner that best serves the community. Needs assessments need not be developed unilaterally by each hospital, and many can rely on existing assessments prepared by local health departments and community based organizations. If assessments are not available, then developing such an analysis can be done together with community groups as one approach to engaging in productive dialog regarding needs and collaborative approaches to meet them.

Patient education regarding charity care and other assistance. Part IV also asks the organization to describe how the organization's patient intake process informs and educates patients about their eligibility for assistance under federal, state, or local government programs, or under the organization's charity care policy. Unlike the charity care and billing and collection portions of the Instructions, where the IRS suggests the content it would like to see, the Instructions here are silent. Organizations will have to come up with their own descriptions. This free-form approach will generate a lot of information, but, because each organization will be left to its own devices, the descriptions will vary widely. This will not facilitate easy comparison of practices from organization to organization given the wide variety of ways in which the information will be presented on Schedule H, although it may be the IRS's plan to sift through these data and generate specific criteria later.

Whatever the IRS's approach is here, it would seem that organizations will almost certainly include this kind of information along with the criteria for eligibility for charity care. Given the calculations of charity care as excluding other assistance, organizations will clearly have the information and the economic incentive to make patients aware of other organizations that will pay part or all of the patient's costs. In any event, organizations should review what they are doing in this regard, and take practical steps to ensure that the information provided to patients is in a "patient friendly" format.

Parts V – Facilities Information

Part V follows on the last question in Part IV by seeking specific information regarding activities and programs conducted at each facility. The Instructions then go on at some length defining what constitutes a "facility." For purposes of listing its facilities, a "facility that provides medical or hospital care" means a building, other structure, or campus that is dedicated to providing medical or hospital care. A facility that provides medical or hospital care does not include a component wing or department of a hospital, clinic, or other discrete facility.

The Instructions also define what constitutes "medical or hospital care" as provided by hospitals, rehabilitation institutions, outpatient clinics, skilled nursing facilities, and community mental health or drug treatment centers. A facility that provides medical or hospital care includes one that treats any physical or mental disability or condition, whether on an inpatient or outpatient basis. Such facilities also include those of non-medical institutions (e.g., colleges, prisons) that operate facilities that provide medical or hospital care. A facility that provides medical or hospital care does not include a convalescent home or home for children or the aged, a cooperative hospital service organization, or an institution whose principal purpose or function is to train handicapped individuals to pursue a vocation. Nor does it include a facility whose principal purpose or function is to provide medical education or medical research, unless it is also actively used in providing medical or hospital care to patients as an integral part of medical education or medical research.

Continued on page 58

Form 990—Part II ...continued from page 57

Conclusions and observations

The IRS Discussion Draft is a remarkable work product from an overstressed agency. It is not perfect by any stretch, but on an overall, tax policy basis, it is a good first (and giant) step forward. In the Discussion Draft format, Form 990 is not just for numbers any more. It has become a disclosure document containing a vast store of readily available information regarding the activities of an organization and the extent to which the organization engages in financial transactions with organization insiders.

From an enforcement prospective, this will not only give IRS ready access to hard factual data to make judgments about the need for enforcement actions, but it will also modify behaviors by managers of tax-exempt organizations. The fact that Form 990 is a public-domain document gives the IRS a boost in enforcement, because the eyes of IRS agents will be supplemented by the eyes of state attorneys general, legislative bodies, the news media, and other interested members of the general public – all of whom will be able to gain quick and easy access to a substantial amount of information. Welcome to the future.

1 It should be noted that while eight Worksheets are referenced in Schedule H, only seven of the eight are posted with the materials online. Worksheet 8 is missing in action, though one would imagine it will be located before the roll out of the final redesigned form.
2 Instructions to Schedule H, at p. 1.
3 Id.
4 Id.
5 325 F.3d 1188 (10th Cir. 2003).
6 Id. at 1198 (emphasis in original) (internal citations omitted).
7 Id.
8 Id.
9 Congressional Budget Office Nonprofit Hospitals and the Provision of Community Benefits paper dated December 2006, cited in Treasury Inspector General for Tax Administration Report, "Tax-Exempt Hospital Industry Compliance with Community Benefit and Compensation Practices (March 29, 2007).
10 Supra note 32, at p. 5.
11 Healthcare Financial Management Association, P&P Board Statement 15, Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers (Dec. 2006), at p. 11.
12 Supra note 32, at pgs. 3-4.
13 Id. at p. 4.
14 Id. at pgs. 4-5.
15 See Field Serv. Adv. Mem. 200110030 (Feb. 5, 2001).
16 Id.
17 See, e.g., Rev. Rul. 69-545, 1969-2 C.B. 117.
18 Supra note 32, at p. 1.
19 Id. at p. 6.
20 Id.
21 Id.
22 Id.
23 Id.
24 Supra note 41.
25 See, e.g., St David's Health Care System, Inc., 89 AFTR2d 2002-2998 (W.D. Tex. 2002), rev'd and rem'd 349 F.3d 232 (5th Cir. 2003).
26 Id. at 2002-3005. Magic 8-ball is a registered trademark of Tyco Toys Inc.
27 Supra note 41, at p. 5.
28 Supra note 32, at p. 6.
29 Id.
30 Glossary to Discussion Draft, at p. 8 (available at http://www.irs.gov/charities/article/0,,id=171213,00.html).
31 Instructions to Discussion Draft, at p. 42 (available at http://www.irs.gov/charities/article/0,,id=171213,00.html).
32 See Internal Revenue Manual [7.8.1] 27.10.1 (May 25, 1999) (withdrawn I.R.C. 501(m) commercial-type insurance audit guidelines).
33 Supra note 32, at p. 1.
34 Id. at p. 7.

Miami-Based Medicare Billing Company Charged with Fraud

On August 20, 2007, the U.S. Department of Justice announced that the owner of a Miami-based Medicare billing company has been charged with submitting $170 million worth of fraudulent bills to the Medicare program, Assistant Attorney General Alice S. Fisher of the Criminal Division and U.S. Attorney R. Alexander Acosta of the Southern District of Florida announced today.

Rita Campos Ramirez, owner of a Medicare billing company named R and I Medical Billing Inc., was charged in a two-count criminal information with conspiracy to commit health care fraud and submission of false claims to the Medicare program, stemming from a scheme to defraud Medicare of $170 million. The information also seeks forfeiture.

As charged, from October 2002 through April 2006, Campos was employed as a medical biller for approximately 75 Miami-based health clinics that purported to provide HIV infusion services to Medicare eligible beneficiaries. As part of the scheme, HIV clinic owners would provide Campos with bills stating that HIV patients were being infused with expensive HIV medications in amounts that Campos knew were medically impossible. In most instances, the Medicare program was being billed for the same HIV medications and services at each of the 75 HIV clinics. During the approximately three-and-a-half year conspiracy, Campos submitted $170 million in fraudulent medical bills to the U.S. Department of Health and Human Services on behalf of the 75 HIV clinics. Of the $170 million in fraudulent bills submitted by Campos, approximately $105 million was paid to the HIV clinics. Campos received a fee of approximately 5 percent of all claims paid by Medicare. For more: *http://www.usdoj.gov/opa/pr/2007/August/07_crm_635.html*

OIG Releases Advisory Opinion 07-09

On August 28, 2007, the Office of Inspector General released Advisory Opinion 07-09 concerning a reward program under which certain consumers receive an annual reward based on the amount spent on purchases, including purchases of items covered by Federal health care programs. For more: *http://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-09A.pdf*