

May 15, 2008

By Electronic Filing

Internal Revenue Service
Draft 2008 Form 990 Instructions, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

**RE: COMMENTS ON DRAFT FORM 990, SCHEDULE H, AND SELECTED OTHER
INSTRUCTIONS**

On behalf of our nearly 5,000 member hospitals, health care systems, networks and other health care providers, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit comments on the draft instructions for Form 990, Schedule H for Hospitals, and selected other sections of the draft instructions.

We recognize the work that the Internal Revenue Service (IRS or Service) has put into the draft instructions, particularly those for Schedule H, and the Service's willingness to address questions from the hospital community. We particularly want to acknowledge the efforts of IRS officials who met with AHA and other associations representing tax-exempt hospitals to discuss the draft instructions, and who participated in a conference call with our members.

The instructions, like the form itself, need to be crafted to meet the Service's original goals. We encourage the Service to continue to improve the draft instructions with these goals in mind:

- **Enhancing transparency**
- **Promoting compliance**
- **Minimizing the burden** on filing organizations [which] means asking questions in a manner that makes it relatively easy to fill out the form, and that do not impose unwarranted additional recordkeeping or information gathering burdens to obtain and substantiate the reported information.

Our comments focus on Schedule H, but also raise issues with several aspects of the draft instructions for Form 990, Schedule J, Compensation Information, and Schedule K, Supplemental Information on Tax-Exempt Bonds.



SCHEDULE H

We very much appreciate the Service's efforts to minimize the considerable burden on hospitals associated with the new form and schedules, particularly Schedule H. As the Service is aware, many tax-exempt hospitals are small and many are financially strapped, which makes it particularly important that the Schedule H instructions be crafted with these organizations in mind. We believe that the Service has, in large measure, achieved that balance. However, there are some areas where the instructions need to be improved to further minimize burden and achieve greater clarity and consistency.

Who Must File

The draft instructions and highlights provide that an organization is not required or permitted to include foreign hospitals on Schedule H, except that foreign joint ventures and partnerships *must* be included in Part IV and information concerning foreign hospitals *may* be included in Part VI. Filers of Schedule H should be allowed to report data from foreign hospitals that are operated as an integral part of the filing organization.

Part I Charity Care and Certain Other Community Benefits

Many AHA members' corporate structures include multiple corporations, most of which provide some community benefit activities in addition to those conducted directly by the hospital. The draft instructions provide that Schedule H should aggregate information from disregarded entities and joint ventures, but does not provide a mechanism to capture activities from related corporations that operate within the hospital system or holding company structure. It is unclear from the draft instructions how organizations filing Schedule H should account for community benefit activities being provided by related foundations or tax-exempt organizations within a multi-entity health care system. AHA urges the IRS to clarify in the final instructions how such community benefit activities should be reported, since activity that would have been conducted by the hospital but for the corporate structure should be reportable activity. While Part VI permits an organization that is part of an affiliated health care system to describe the respective roles of the organization and its affiliates in promoting the health of the communities served, AHA does not believe this question adequately and appropriately addresses the issue presented.

To calculate amounts to be included in the charity care and other community benefit table, the draft instructions provide that organizations may use the worksheets provided with the instructions or other equivalent documentation that substantiates the information reported consistent with the methodology required in the worksheets. Many AHA member hospitals have developed or licensed software programs to capture information in connection with various state law community benefit reporting requirements. AHA urges the IRS to clarify in the instructions that such software created or purchased by health care organizations is considered "other equivalent documentation" whose use does not require an organization to duplicate effort by capturing equivalent information on the worksheets.

Grants

We commend the Service for its treatment of grants restricted for community benefit activities. That determination will encourage hospitals to seek such grants to support programs and services in their community that otherwise might not have been available.

The draft instructions do not require grants (whether restricted or not) that an organization receives and uses to provide community benefit to be counted as “Direct offsetting revenue” in computing “Net community benefit expense” on the charity care and other community benefit table. The draft instructions also provide that an organization may not report on Line 7(i) (Cash and in-kind contributions to community groups) any contributions that were funded in whole or in part by a restricted grant from a related organization. Moreover, the draft instructions provide that unrestricted grants or gifts to another organization that may, at the grantee organization’s discretion, be used other than to provide community benefit may not be reported on Line 7(i). Thus, it appears that if an organization makes a grant to a related organization, including to a foundation or other tax-exempt organization that is not required to file Schedule H, the organization should include such grant in Line 7(i), as long as it is restricted to be used to provide community benefit and was not funded by a restricted grant in the first place. This could also include a grant that was subsequently used by the related organization to fund in whole or in part a grant to another organization. Although this position can be discerned from the draft instructions as written, AHA requests that the IRS clarify this point in the final instructions.

Reporting Benefits

We support the IRS’ decision to remove bad debt expense from the total expense figure used in the denominator in Column (f) “Percent of total expense.” The accounting principles adopted by the American Institute of Certified Public Accountants (AICPA) instruct hospitals to treat charges written off as bad debt as an addition to expenses rather than a deduction from revenue. Backing out bad debt expense from the total expense figure recognizes that charges for bad debt are not an “expense” in the true sense of the word, but rather a way of accounting for the absence of revenue in the income statement. Leaving bad debt expense in the total expense figure would artificially inflate the denominator. The IRS should clarify that hospitals that follow other standards, such as those of the Government Accounting Standards Board (GASB), will not need to make this adjustment.

Under Line 7, Column (c) instructions, we suggest adding the words “if desired” to the end of the first sentence to ensure hospitals understand that these worksheets are optional.

Under Line 7, Column (f) instructions, the appropriate accounting term is “bad debt expense” throughout.

Medicaid Provider Taxes

The Service specifically has requested comments on how filing organizations should report the cost of Medicaid and provider taxes (Worksheet 1, Line 4) and revenue from uncompensated care pools or programs, including Medicaid Disproportionate Share Hospital (DSH) funds (Worksheet 1, Line 6), as costs and revenues associated with charity care (Worksheet 1) or with Medicaid and other means tested government programs (Worksheet 3). We have solicited input from hospital members and state hospital associations and believe the primary purpose requirement makes sense. This approach recognizes the variation across states in how provider tax programs are structured and funds are used, but does not create the undue burden of having to allocate the payments across multiple patient types.

The wording in the instructions for Worksheet 1, Line 4, however, is confusing, and results in a narrower-than-intended interpretation of what hospitals should report. We suggest the following changes:

Line 4: Enter the amount of Medicaid provider taxes paid by the organization, if payments received from an uncompensated care pool or Medicaid Disproportionate Share Hospital (DSH) program in the organization's home state are intended primarily to offset the cost of charity care. If such payments are primarily intended to offset the cost of Medicaid services, then report this amount in Worksheet 3, Line 4(A). "Medicaid provider taxes," sometimes termed a "fee" or "assessment," or "health care-related tax," means amounts paid or transferred by the organization to one or more states as a mechanism to generate federal Medicaid funds.

Note that we have suggested that the Service delete the last sentence because it does not add to the definition and creates the false impression that provider tax programs uniformly benefit individual providers.

On Worksheet 1, Line 4 and Worksheet 3, Line 4, delete the word "or."

Definition of Subsidized Services

Hospitals subsidize a range of services to meet the specific needs of their communities. These needs differ greatly based on demographic and geographic factors. For example, an inner-city hospital experiencing a high number of emergency department visits for uncontrolled asthma may establish a clinic offering free or reduced-fee services for children with asthma. A small rural hospital may need to subsidize physician on-call coverage to ensure the community has 24/7 access to emergency services.

The criteria that the IRS provides for "subsidized services" are clear and comprehensive and the examples cover a range of common service offerings. However, based on input from our hospital members on the unique circumstances that individual communities face, we believe it is inappropriate to exclude certain specific types of services provided that they meet the

criteria outlined. These include physician clinic services, skilled nursing services and ancillary services.

Hospital-subsidized physician clinics often provide a critical access point to care for low-income patients. The Center for Studying Health System Change has documented that the percentage of physicians providing charity care and serving Medicaid patients has been steadily declining over the past decade. Research also has documented the negative health effects associated with the inability to access physician care. Hospitals often sponsor physician clinics that offer free or reduced-fee physician care to fill this gap. Physician clinic services clearly provide a benefit to the community, and any subsidies required to operate these clinics should be reported.

Skilled nursing facilities (SNF) provide an important part of the continuum of care for patients who no longer require the intensity of service provided by a hospital but cannot be discharged safely to their homes. Small rural communities often do not have a large enough population to support a freestanding SNF, leaving patients either to remain in the hospital longer than necessary or be placed in a SNF that is far from their home and family. Other communities may not have sufficient capacity, especially to serve low-income populations. Hospitals frequently step in to meet this community need, but these services often generate a financial loss. When a SNF fills a documented community need, any subsidies required should be reported as a community benefit.

Hospitals are finding it increasingly difficult to ensure emergency access to specialty physician care. There is a shortage of neurosurgeons, orthopedic surgeons and other specialists willing and able to provide on-call coverage for hospital emergency departments. Anesthesiology (an “ancillary” service) also can be problematic. Providing emergency on-call services adds to the costs of medical liability coverage for physicians and often involves caring for patients who do not pay. More and more hospitals are paying for on-call coverage, guaranteeing payment for uninsured patients or otherwise supporting the costs of 24/7 physician coverage of their emergency departments and trauma units. When these costs meet the IRS criteria for subsidized services, they should be reported.

Part II Community Building Activities

Under Line 8 (Workforce development), the IRS should broaden the category to include other circumstances under which physician recruitment can be reported, such as the absence or shortage of a particular physician specialty. To that end, the IRS could amend the existing language to add after “underserved”: “or in other circumstances where there is an identified community need for a particular type of physician(s).”

Part III Bad Debt, Medicare & Collection Practices

We urge the Service to incorporate language from the original “Highlights” document into the instructions themselves, explicitly recognizing, as the Service did in the previous document that this section permits:

- important and uniform reporting of bad debt expense information and an explanation of why certain portions of bad debt should be considered community benefit; and
- important information regarding Medicare revenues and costs, shortfalls or surpluses and an explanation of why certain portions should be treated as community benefit.

This addition will help preserve the IRS' frequently publicly stated view of the importance of collecting this information and the opportunity it presents for the hospital community.

Section A

AHA commends the IRS for clarifying in the draft instructions that hospitals are not required to adopt or rely on the Healthcare Financial Management Association's Statement No. 15. AHA also appreciates the IRS' assurances that a "no" response to the related question at Line 1 in Part III, Section A will not reflect poorly on an organization or otherwise be used to target an organization for an audit.

Line 4 requires an organization to provide the text of the footnote to the organization's financial statements that describes bad debt expense. The draft instructions further provide that footnotes related to "accounts receivable," "allowance for doubtful accounts," or similar designations may satisfy this reporting requirement. We understand that many health care organizations' financial statements do not contain footnotes relating to bad debt expense or any noted or similar designations. AHA suggests that the IRS include language in the draft instructions to this question to clarify that, if this is the case, organizations are not required to create footnotes in financial statements to satisfy this question.

Section B

Under Section B-Medicare, Line 8, the Service has failed to provide any guidance to hospitals about the type of explanation it would find useful in better understanding which portions of Medicare underpayments constitute community benefit. To that end, we recommend that the Service incorporate the following language, or something similar, into the instructions:

An organization's rationale may have any reasonable basis, including the amount of the shortfall that might otherwise have been used to support the programs included in Parts I or II, an estimate of the income range of the organization's Medicare patients, an estimate of the number of Medicare patients also eligible for the Medicaid program (dual eligibles), or whether the organization reports the amount of Medicare shortfall to any state government authority identified in Part IV, Line 8, or any other government authority.

As the IRS is aware, this is an area in which hospitals have been provided little guidance in the past and in which guidance, like that suggested above, would be quite useful.

Under the introductory paragraph for Part III on page 9, we suggest that the IRS add the word “likely” after the word “who” in the first sentence to be consistent with the phrasing on the following page.

We urge the IRS to allow hospitals the same options for accounting for Medicare costs as are available for other parts of Schedule H. The current instructions are confusing and provide conflicting guidance. For example:

- By using the word “allowable cost” in Line 5, the IRS implies that hospitals should use Medicare cost reporting rules and accounting standards to calculate the Medicare shortfall. The inclusion of multiple choices on Line 8, however, implies that hospitals still have the ability to use the most accurate method available to them as they do elsewhere on Schedule H. The instructions provide no guidance on what those checkboxes mean.
- Line 5 of Part III says to “Enter total revenue received from Medicare (including DSH and IME),” and the instructions provide further guidance on what revenues to include or exclude. One item that is specifically *included* is Part B physician services. On the worksheet supporting Line 6, the IRS says to take Medicare allowable costs (from the Medicare Cost Report). The Medicare cost report does not account for the revenues and costs of Part B physician services because they are paid under a different payment system. Thus the IRS is including Part B physician services in revenues, but excluding them from costs.

Medicare cost report accounting is very different from Generally Accepted Accounting Principles (GAAP) standards and, as such, will be very different from what hospitals determine is the most accurate costing method to use elsewhere on Schedule H. The Medicare cost report is designed only to produce cost estimates for a specific subset of Medicare programs. It excludes parts of the Medicare program that may contribute to Medicare gains or losses for the hospital like Part B physician services, as mentioned above, and the revenues and costs associated with Medicare Advantage patients. Worksheet 3 specifically asks hospitals to include the revenues and costs associated with Medicaid managed care patients. The Kaiser Family Foundation’s Web site contains a useful fact sheet on the Medicare Advantage program: <http://www.kff.org/medicare/2052.cfm>.

To be consistent with the calculations on other parts of the form and provide a full accounting with respect to Medicare, Section B should capture the costs and revenues associated with *all* Medicare services and patients using the most accurate approach available.

Part V Facility Information

In the draft instructions, the IRS has proposed to adopt a definition of “facility” that is too broad. Under this broad definition, large health care systems that operate numerous hospitals will be required to report every building, structure, clinic, etc. Such a reporting requirement will amount to dozens of pages of information being submitted to satisfy this question. Thus, for large complex health care systems, such a broad definition would require details that are

not meaningful to understanding the hospital. Consequently, AHA urges the IRS to adopt a definition of “facility” that is confined to “an entity that is licensed and/or certified as a hospital.”

FORM 990 – KEY EMPLOYEE

Although the IRS has made many improvements to the Form 990 instructions, some concerns remain. Of immediate concern is the breadth of the definition of “key employee.” We have consistently advocated for a much more focused definition that would reduce the burden of providing this information. Hospitals and hospital systems can be large and complex organizations, and the new definition does too little to mitigate the burden associated with this new reporting requirement. We note that even within our own organization, the revised definition could capture Human Resource executives who have virtually no “responsibilities, powers or influence over the organization ... that is similar to those of officers, directors or trustees.” The same would be true for hospitals.

We agree with the American Society of Association Executives (ASAE) that the definition of “key employee,” even as revised by the draft instructions, remains too broad and sweeping and should be further refined. Both the percentage threshold (now 5 percent) and the control standard (management) need to be revised; a threshold well above 5 percent and a tighter control standard coupled with an upper limit on the number of employees to be reported – preferably limited to three – should replace the current definition. If experience with the new form ultimately suggests a more expansive definition, the Service should revise it at that time.

SCHEDULE J – DEFERRED COMPENSATION

The draft instructions to Schedule J require deferred compensation to be reported in the year earned, whether or not funded, vested or subject to substantial forfeiture, *and* in the year paid. Although final Schedule J includes column (F) for the reporting of amounts that were also reported in another year, AHA believes that this addition does not address the unfairness and misperception associated with reporting compensation that is not yet considered to be income to the recipient. Thus, AHA urges the IRS to require that amounts of unpaid, unvested deferred compensation be reported only in the year the compensation is paid to the recipient.

SCHEDULE K – SUPPLEMENTAL INFORMATION ON TAX-EXEMPT BONDS

The draft instructions to Schedule K require organizations to complete the Schedule for each outstanding tax-exempt bond that both had an outstanding principal amount in excess of \$100,000 as of the last day of the tax year and was issued after December 31, 2002. The draft instructions further provide that refundings after December 31, 2002 of pre-2003 issues must be treated as post-2002 issues and reported on Schedule K. AHA urges the IRS to clarify in the instructions that such reporting does not include information on expenditure and investment of proceeds or uses of bond-financed facilities occurring prior to 2003.

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We appreciate the opportunity to submit our comments, and we especially appreciate the IRS' efforts to reach out to the hospital community and better understand its concerns. We welcome the opportunity to help the IRS improve these instructions. If you have any further questions, please contact me at (202) 626-2336 or mhatton@aha.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Melinda Reid Hatton". The signature is stylized and includes a date "5/15/08" written at the end.

Melinda Reid Hatton
Senior Vice President and General Counsel