VII. EXECUTIVE COMPENSATION

A. Overview

The executive compensation component of the study was twofold. It included an analysis of the results of the executive compensation questions included in the questionnaire. Section VII.B discusses these results. The executive compensation component of the project also included examination of 20 hospitals from the study selected based, in part, on responses provided to the questionnaire. These results are discussed in Section VII.C, below.

B. Summary of Compensation Practices as Reported by Responding Hospitals

This section summarizes respondent data from Part III – Compensation Practices of the questionnaire. Part III of the questionnaire requested information on the compensation practices of the respondents with respect to their officers, directors, trustees and key employees, and any business relationships with such persons.

Not every hospital answered every question, and much of the data is based on fewer than 489 responses. Throughout this section, the number of responses that underlie the particular data are included.[64]

Section 4958, the intermediate sanction on excess benefit transactions, provides that an excess benefit transaction occurs when a disqualified person (any person in a position to exercise substantial influence over the affairs of the tax exempt organization) receives an economic benefit from an exempt organization that exceeds the value of consideration received by the organization. Rather than revoking the charity's tax-exempt status, section 4958 allows the IRS to impose an excise tax against the disqualified person and possibly the organization manager. The section 4958 regulations provide a three-pronged rebuttable presumption process (independent governing body, reliance on comparable data, and adequate documentation) that public charities may use when establishing what appropriate compensation is for a disqualified person.[65]

While the questionnaire did not specifically ask about whether the hospitals were using the rebuttable presumption, Questions 3 through 8 asked for information relevant to the process. The responses to the questions asked (particularly Question 3 and Question 8) indicate that use of the rebuttable presumption appears to be widespread.

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[64] In some cases, the number of responses is not included to prevent potential identification of respondent hospitals.

[65] Treas. Reg. section 53.4958-6. See also, H. Rep. No. 104-506, 104th Cong., 2d Sess. at 56-57.

List and compensation of officers, directors, trustees, and key employees (Question 1)

Question 1 asked the hospital to provide the names and titles of the hospital's officers, directors, trustees and key employees, and the amounts of salary and other compensation paid to each. For this purpose, salary was described to include all forms of cash and non-cash compensation received whether paid currently or deferred. Other compensation was described to include contributions to employee benefit plans and deferred compensation plans and expense allowances from non-accountable plans.

There was some variation in the data reported on the questionnaires. While many did provide information concerning all of their officers, directors, trustees and key employees, others only provided information about some of those individuals and a few provided no information. Hospitals that were part of systems or had management companies frequently reported that some or all of the compensation for their officers, directors, trustees and key employees was paid by other entities, and in some instances reported those amounts and in others did not. Thus, there are instances where the hospital identified its officers, directors, trustees and key employees, but provided no compensation amounts. There were also instances where the hospital reported compensation data, but did not provide the individual's positions.

Much of this variation in reporting is consistent with certain problems the IRS has encountered generally with Form 990 reporting of executive compensation, in particular, a lack of clarity regarding which persons to report, and how to report compensation paid by certain other organizations. The changes made to the redesigned Form 990 executive compensation reporting, including clearer definitions of officer, director, trustee, and key employee, as well as reporting of compensation paid by related or by other organizations and management companies, will help improve uniform reporting in this area. The IRS will follow-up with certain of these organizations through review by our Review of Operations unit (ROO) after the redesigned Form 990 filings are received to determine whether improvements have been made to the reporting of compensation paid to top management officials and other executives.

While other compensation data was reviewed, such as Forms 990, to select organizations for examination, the following analysis only includes data reported on the questionnaire. The respondents' data was reviewed to determine the average and median reported salary, other compensation, and total compensation of the organizations' top management officials. The question regarding compensation amounts for officers, directors, trustees, and key employees did not ask the organizations to identify a top management official. For this purpose, however, persons listed in the responses as "CEO" or "Chief Executive Officer" were treated as the top management official. If no person was listed as CEO or Chief Executive Officer, persons listed in the questionnaire

responses as "President," "Executive Director," or "Administrator" were treated as the top management official.

Based on review of the responses, 421 of the respondents listed a person with a title that, under the convention described above, was regarded as a top management official and reported a compensation amount from all sources greater than zero for such person. In 352 (84%) of those cases, the identified top management official had the highest compensation reported on the questionnaire for that hospital. The average and median salary paid to the top management official were $408,927 and $323,858, respectively, while the average and median other compensation were $81,504 and $34,611. When looking at total compensation paid to the top management official, the average and median were $490,431 and $377,256, respectively.

The identified top management official had the highest compensation reported on the questionnaire for 75% of the critical access hospitals, compared to 85% for the other three community types. Across revenue size, the hospitals reported paying the identified top management official the highest compensation as follows:

Under $25 million	72%
$25 - $100 million	84%
$100 - $250 million	92%
$250 - $500 million	87%
Over $500 million	71%

The average and median salary, other compensation, and total compensation was lower for the rural hospitals (CAH and non-CAH) than for the suburban and urban hospitals (high population and other urban and suburban). Among the community types, critical access hospitals had the lowest average compensation amounts and the hospitals in the highest population areas had the highest average compensation amounts. The average and median salary, other compensation, and total compensation increased as revenue levels increased. The following charts show the average and median salary and other compensation reported for the top management official, by community type and then by revenue size.

Figure 96. Salary and Other Compensation Reported for the Top Management Official by Community Type (Average and Median)

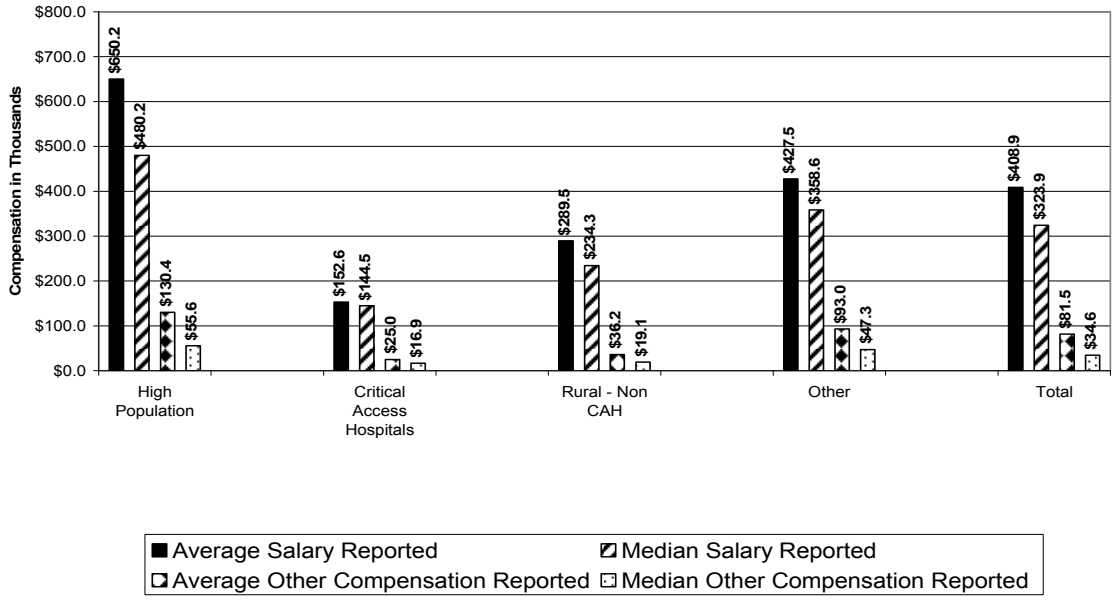
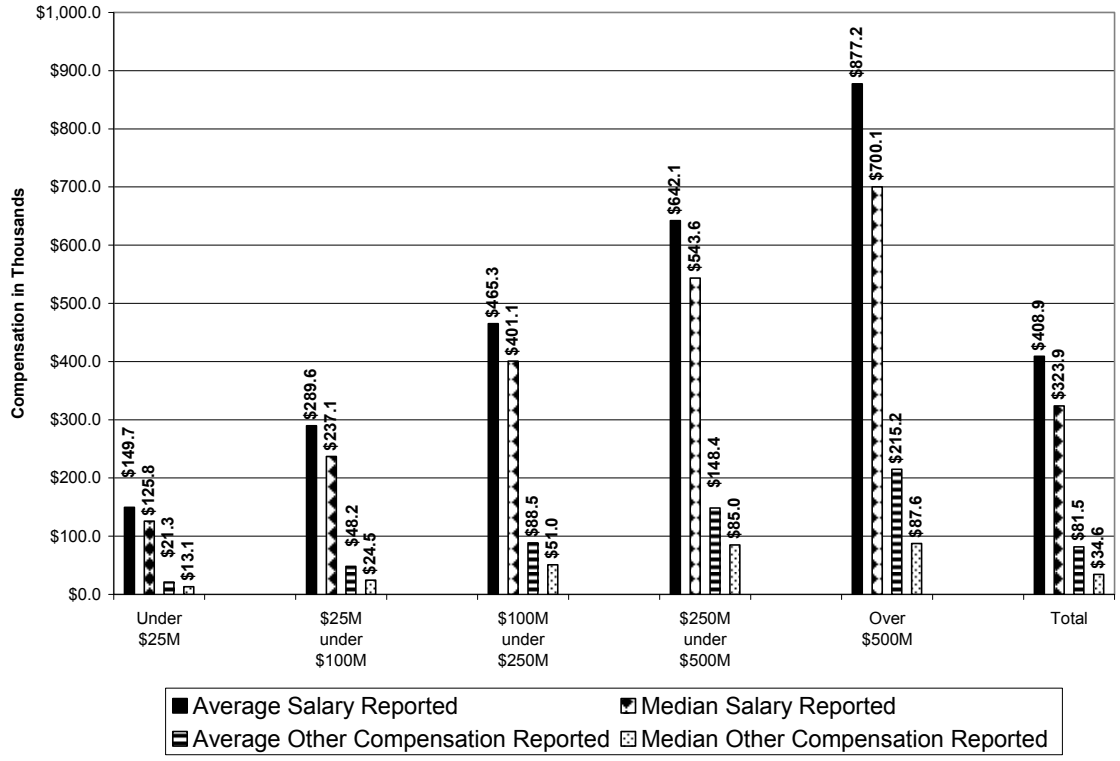


Figure 97. Salary and Other Compensation Reported for Top Management Official by Revenue Size (Average and Median)



The following charts show the average and median total compensation reported for the top management official, by community type and then by revenue size.

Figure 98. Total Compensation Reported for the Top Management Official by Community Type (Average and Median)

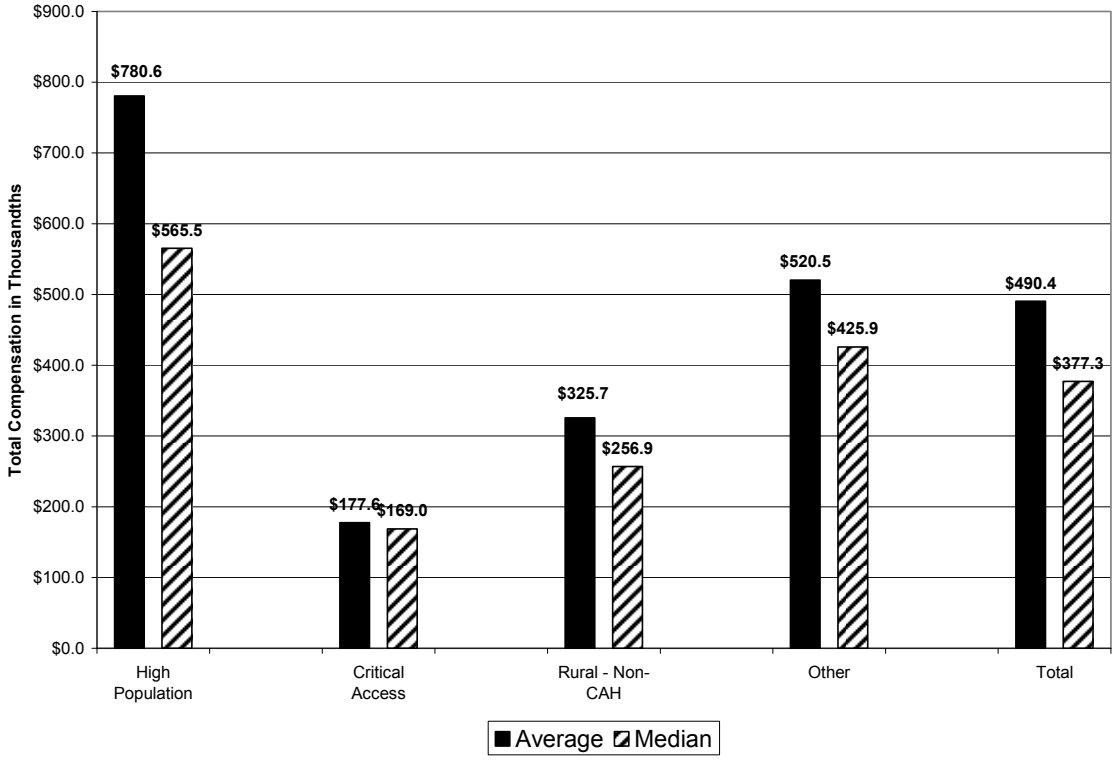
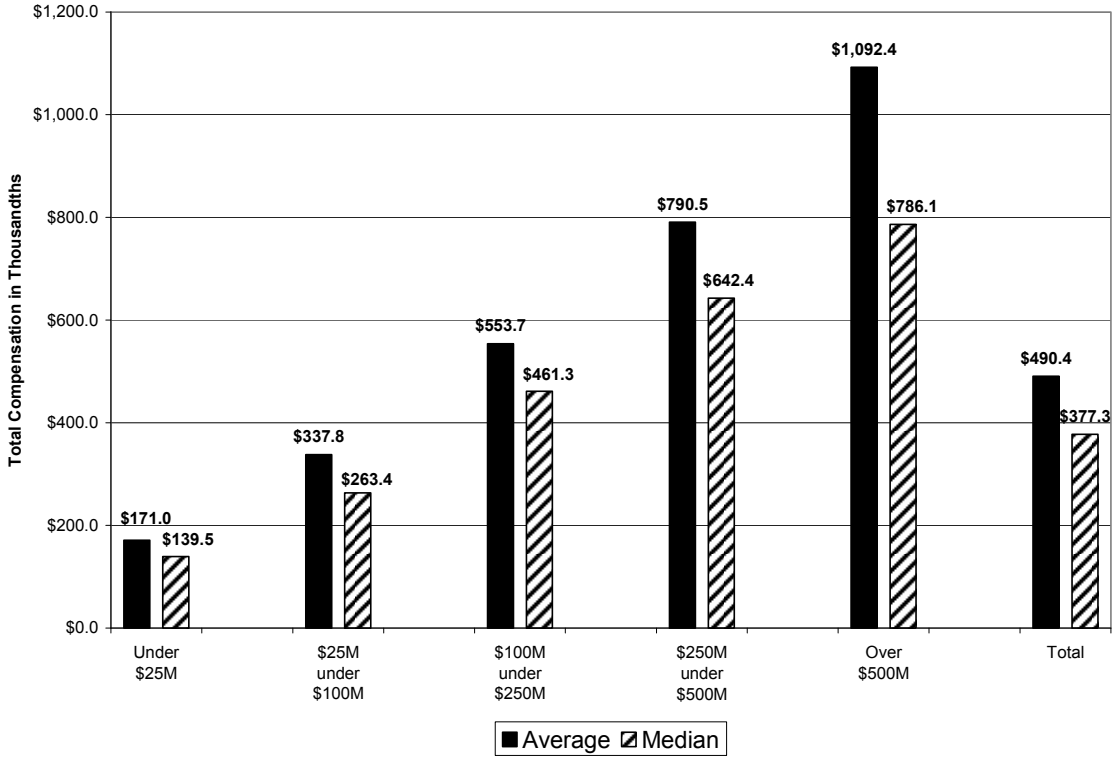


Figure 99. Total Compensation Reported for Top Management Official by Revenue Size (Average and Median)



Formal written compensation policy (Question 2)

Question 2 asked whether the hospital had a formal written compensation policy. 349 (73%) of 481 respondents reported having such a policy. This is generally consistent across community types, ranging from 64% to 79% of the hospitals having a formal written compensation policy. However, when looking at revenue size, only 54% of the hospitals with revenues under $25 million had a formal written compensation policy, while 87% of the hospitals with revenues between $250 million and $500 million did. The following charts show the percentage of hospitals that reported having a written compensation policy, first by community type and then by revenue size.

Figure 100. Percentage of Hospitals that Reported Having a Written Compensation Policy by Community Type

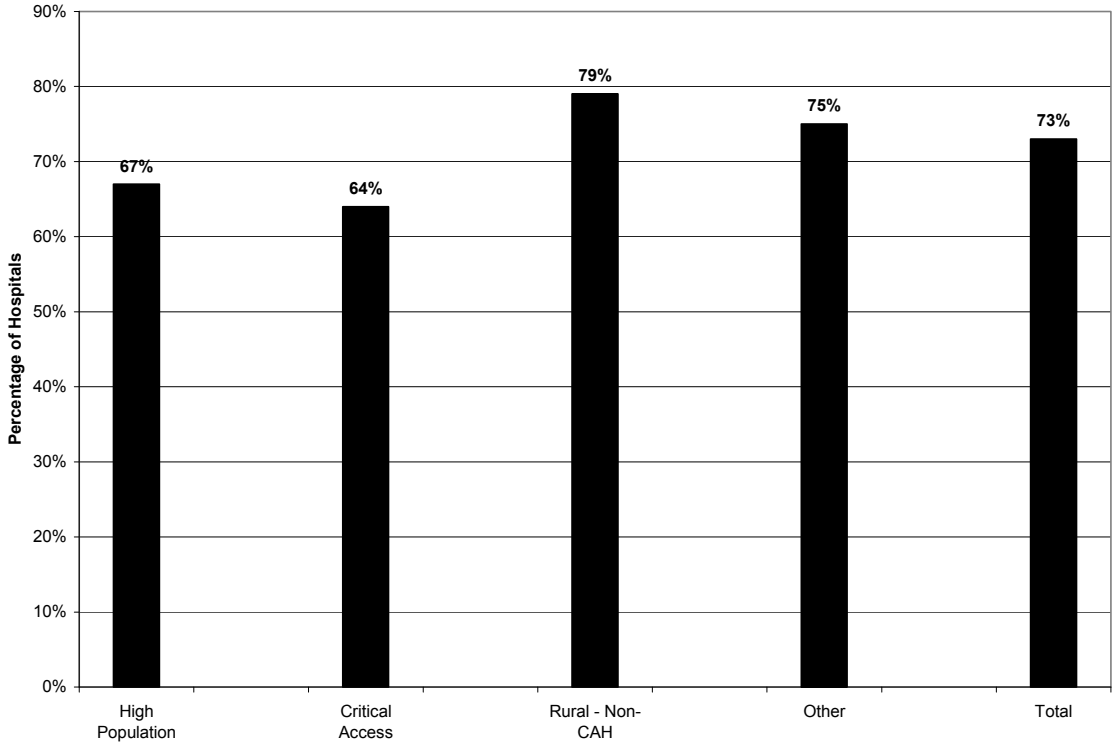
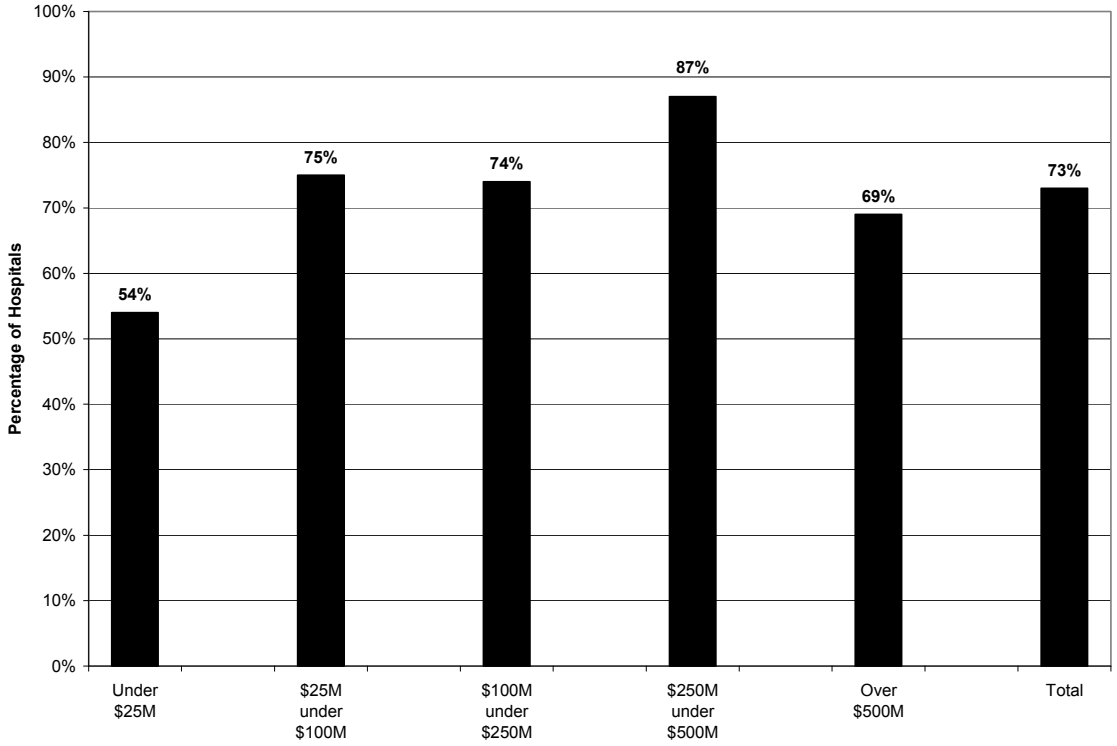


Figure 101. Percentage of Hospitals that Reported Having a Written Compensation Policy by Revenue Size



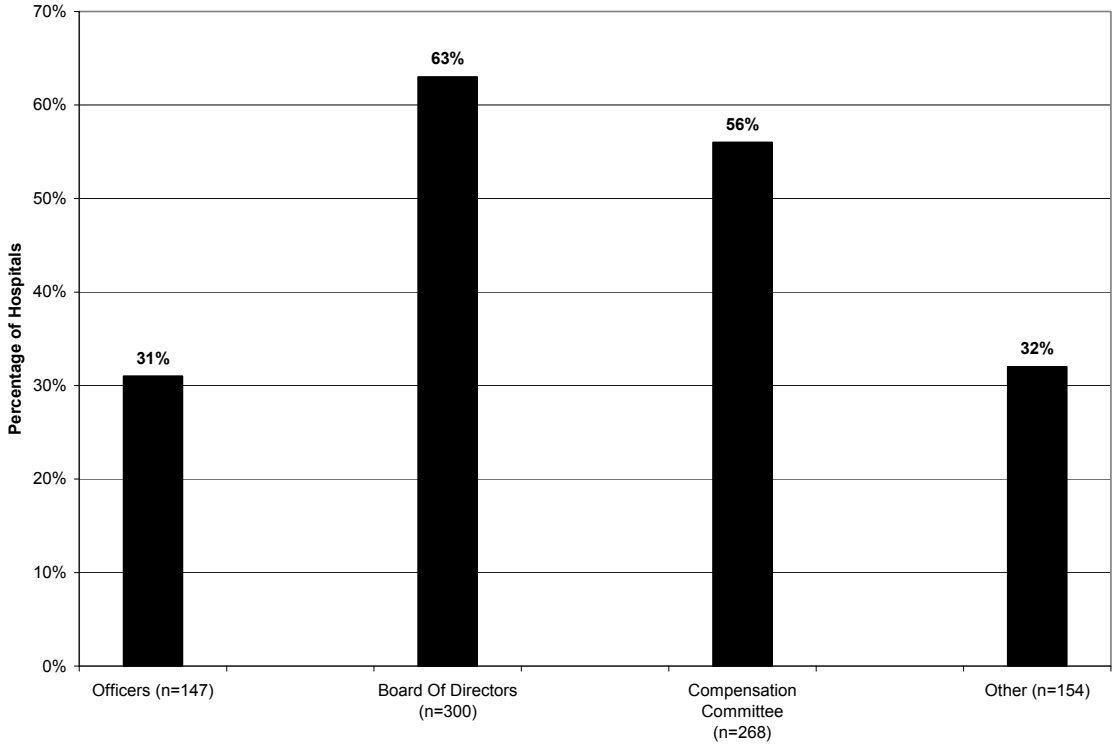
Approval of compensation in advance (Question 3)

Question 3 asked whether compensation was approved in advance by individuals that did not have a conflict of interest with the compensation arrangement being approved. 469 (98%) of 479 respondents reported that compensation was approved in advance by individuals that did not have a conflict of interest with the compensation arrangement being approved. Similar results were observed across community type and revenue size.

Organization officials responsible for establishing compensation (Question 4)

Question 4 asked who set the compensation for officers, directors, trustees, and key employees of the hospital – officers, the board of directors, a compensation committee, or others. The organization was instructed to check all that applied. For many respondents, compensation was determined by a combination of the categories.

Figure 102. Individual or Entity Reported to Determine Compensation (n=478)



Many of the organizations selecting "other" provided supplemental explanations which included one or more of the listed categories (for example, identifying specific officers that determined compensation). Also, some distinguished the Executive Committee of the Board as determining compensation, rather than the entire Board or a specific Compensation Committee. Some hospitals reported that the Human Resources Division determined compensation in a number of instances. Others reported that compensation was determined by the parent or another affiliated organization.

Compared to other community types, critical access hospitals reported the Board of Directors as setting compensation more often than the other groups (82% compared with 63% overall), while less than half of the hospitals located in the high population areas (48%) reported such. Of the community types, critical access hospitals reported the lowest incidence of the Compensation Committee setting compensation, while the urban and suburban hospitals (both those located in the high population areas and elsewhere) reported the highest. As the revenues increased for the hospitals, the percentage of hospitals that identified the Board of Directors as setting compensation generally decreased, while the percentage that identified the Compensation Committee significantly increased. Figure 103 and Figure 104, below, show the distribution of the individual or entity responsible for determining compensation, by community type and then by revenue size.

Figure 103. Distribution of Individual or Entity Reported to Determine Compensation by Community Type

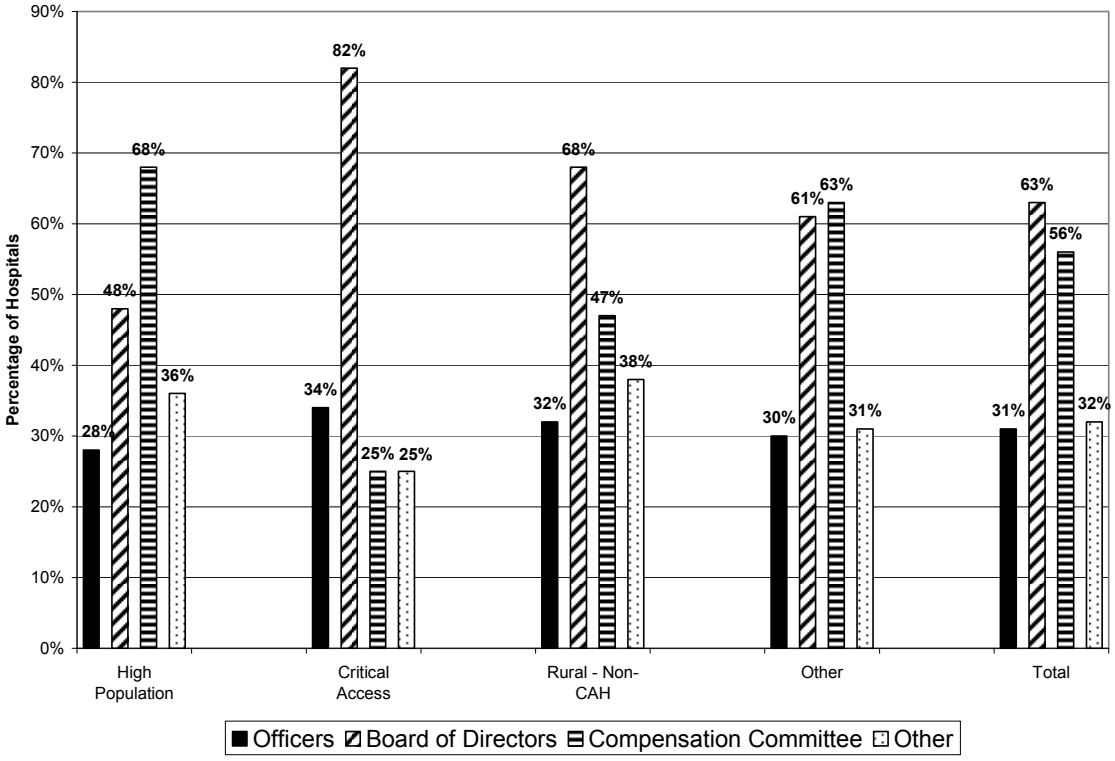
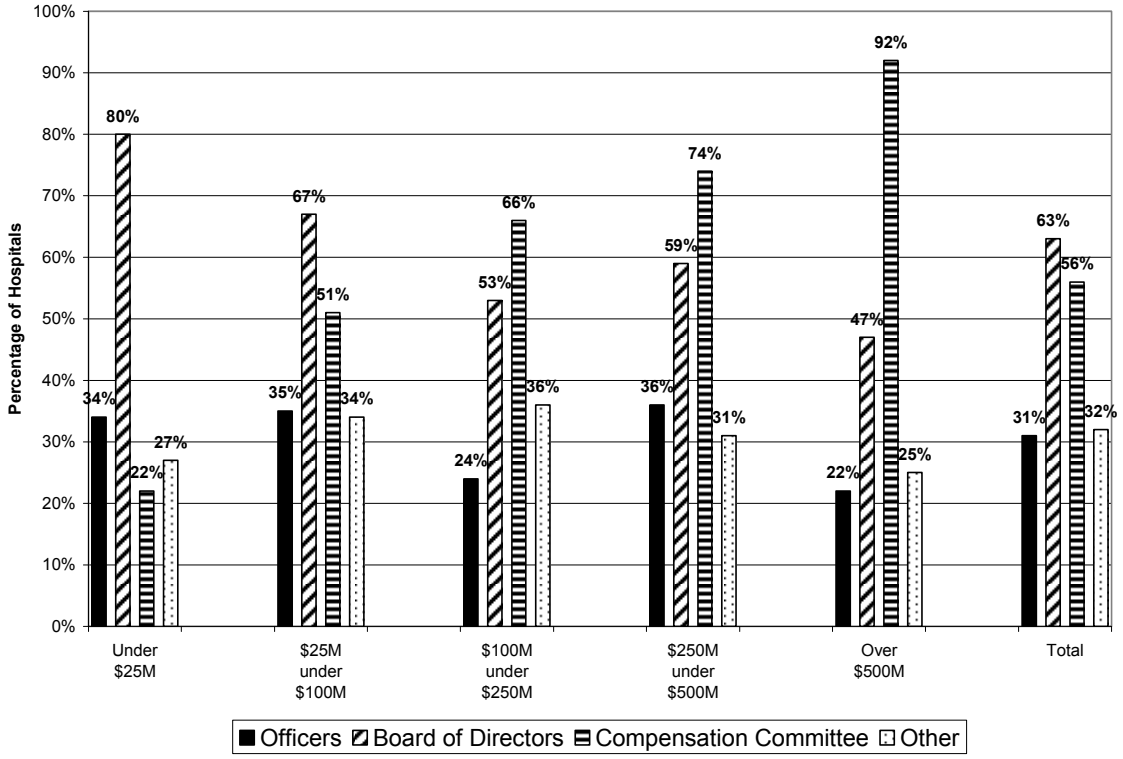
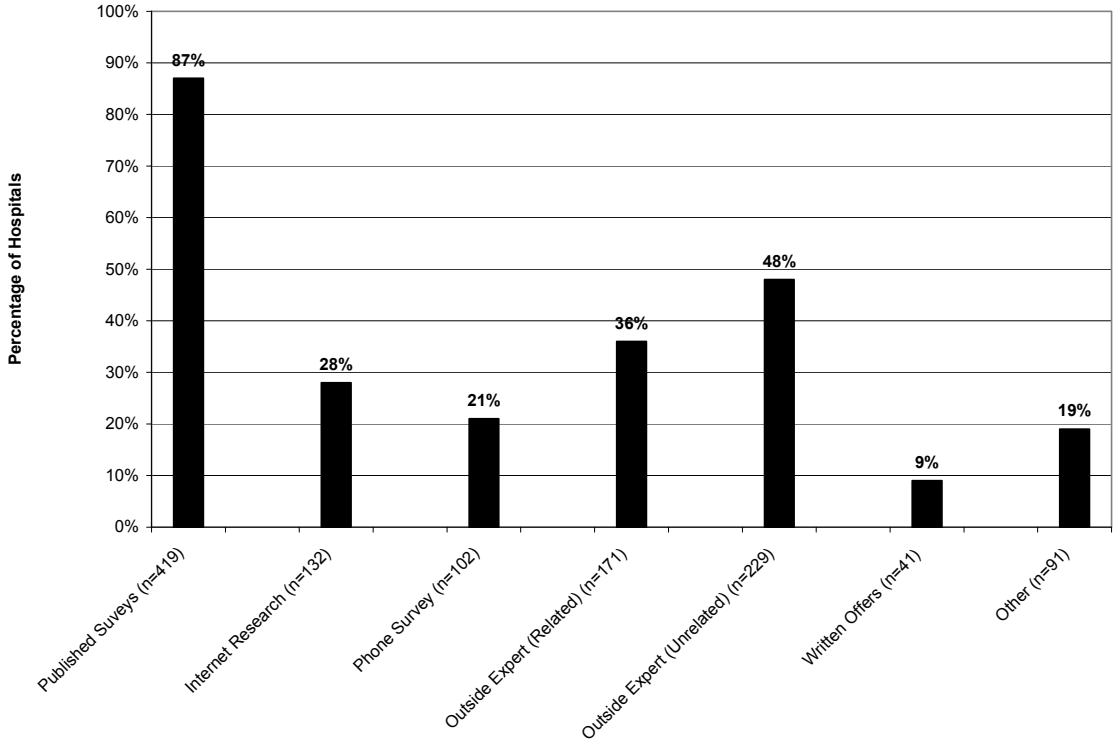


Figure 104. Distribution of Individual or Entity Reported to Determine Compensation by Revenue Size



Resources and methods used to establish compensation (Question 5)
Question 5 asked what resources and methods the hospital used to determine compensation amounts, identifying seven choices. 478 hospitals responded to this question. The chart below shows the percentage of respondents that indicated using each of the seven listed resources, with 87% of the respondents identifying the use of published surveys to determine compensation amounts and 9% identifying written offers. Published surveys was the most frequently reported tool, and written offers was the least frequently reported tool, across each community type and revenue size category.

Figure 105. Tools Used to Determine Compensation (n=478)



91 hospitals (19%) selected "other" and provided an additional explanation. In a number of instances, the hospital's additional explanation was to identify the particular survey or expert relied upon. For example, some hospitals relied upon Form 990 data.

The rural hospitals (both CAH and non-CAH) reported the highest percentages of hospitals using phone surveys to determine compensation amounts and the lowest percentages of use of an outside expert. Hospitals located in the high population areas reported the highest use of an outside expert report prepared by an expert employed by the hospital (referred to in the figures as "related"). The reported use of internet research and phone surveys generally declined as hospitals increased in revenue size, while the reported use of outside experts generally increased with revenue size.

Figure 106. Distribution of Reported Use of Tools to Determine Compensation Amounts by Community Type

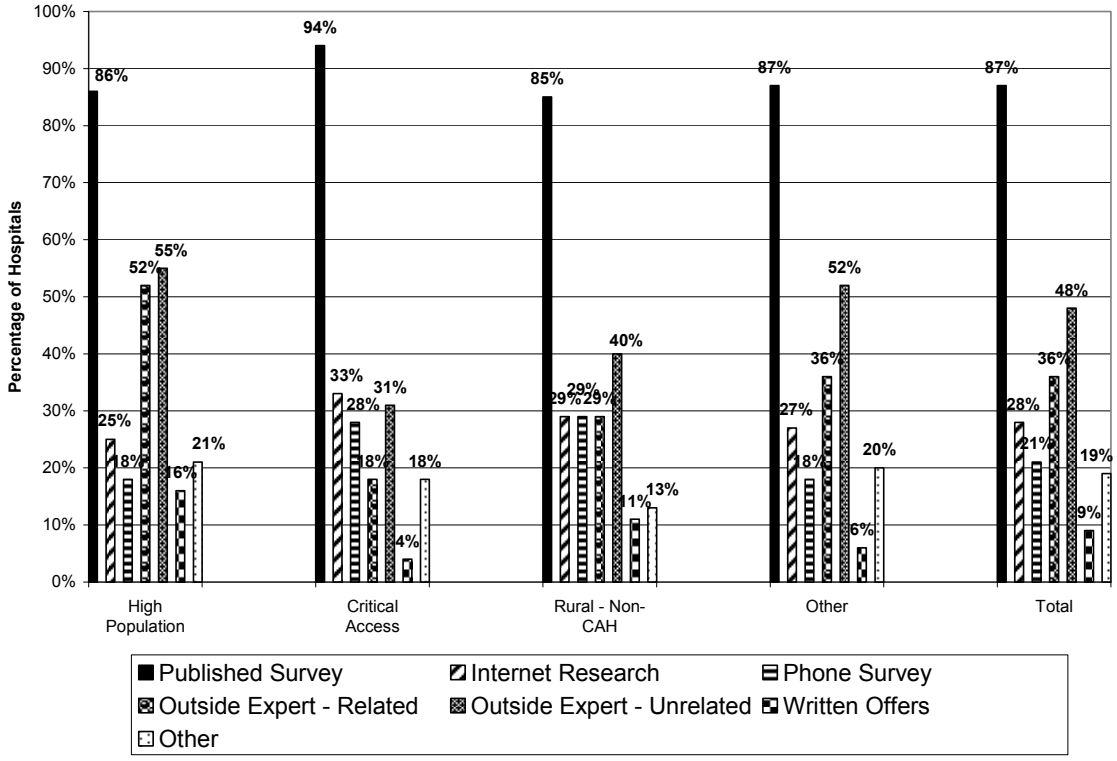
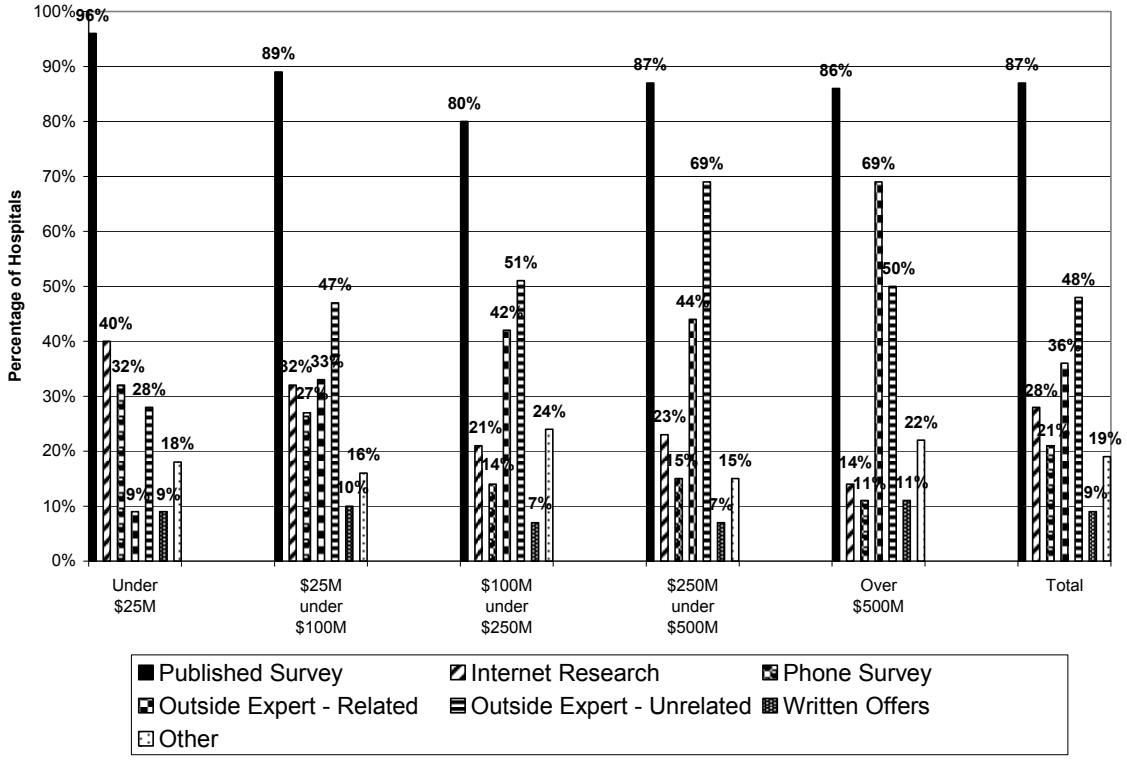


Figure 107. Distribution of Reported Use of Tools to Determine Compensation Amounts by Revenue Size

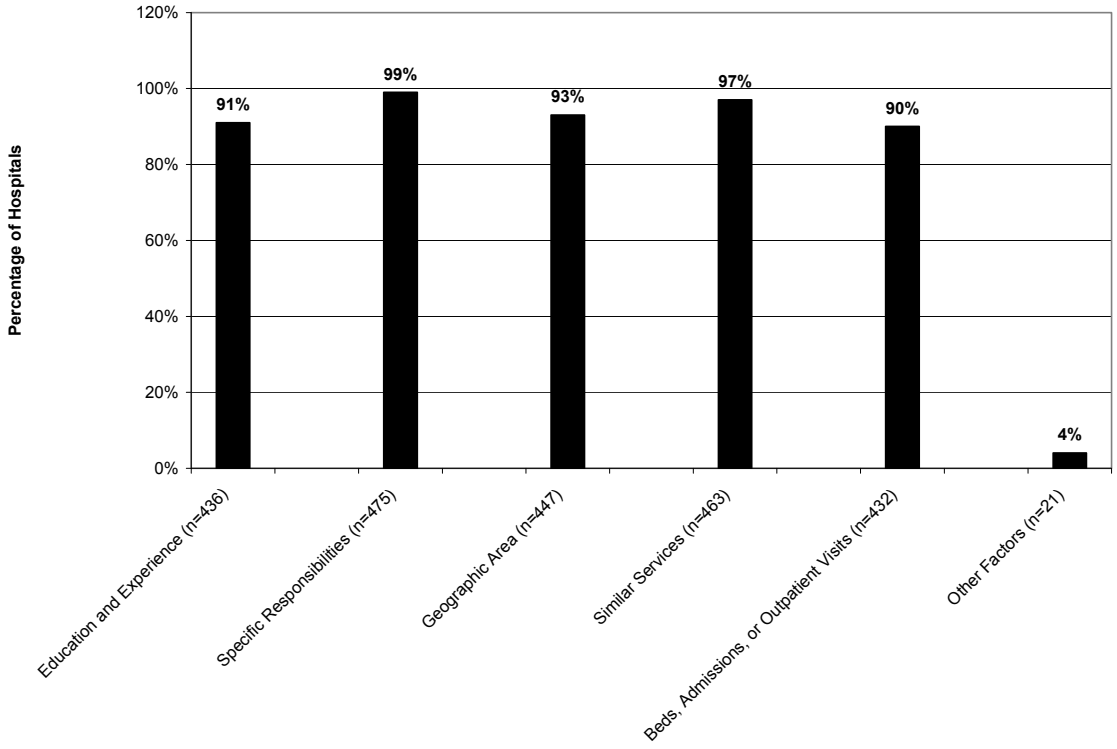


Factors included in comparability data used by the organization (Question 6)

Question 6 asked hospitals to show which of six identified factors were included in the comparability data used by the hospital. Respondents were also asked whether each factor was used for all employees described in section 4958(f)(1).[66] For each of the six identified factors, at least 90% of the respondents indicated they considered that factor, with 71% indicating that they considered all of the factors. The responses are summarized below.

[66] Section 4958(f)(1) defines disqualified persons subject to the excess benefit transaction tax.

Figure 108. Factors Included in Comparability Data



Hospitals that selected a given factor typically reported that they used that factor in their comparability analysis for all section 4958(f)(1) employees. Where hospitals indicated that other factors were considered that were not separately listed in the question, the most common explanation was that the hospital also considered entities with similar levels of revenue in determining comparability.

The most common explanation offered by hospitals for not considering factors was that the use of the factor depended upon whether the hospital was recruiting new hires or setting compensation for incumbents. For example, responses indicated that when recruiting new hires and using a national recruitment program, comparability might not be limited to entities in similar geographic areas, but when determining annual compensation for incumbents, education and experience might not be considered.

Among the community types, the rural non-critical access hospitals reported the lowest percentage of hospitals taking into account all of the identified factors, while those in the high population areas reported the highest, although the differences were modest. There was a slightly greater variation across revenue size, with the hospitals with revenue between $100 million and $250 million reporting the highest percentage considering all factors and the hospitals with revenue exceeding $500 million reporting the lowest.

Figure 109. Percentage of Hospitals that Considered all Comparability Factors by Community Type

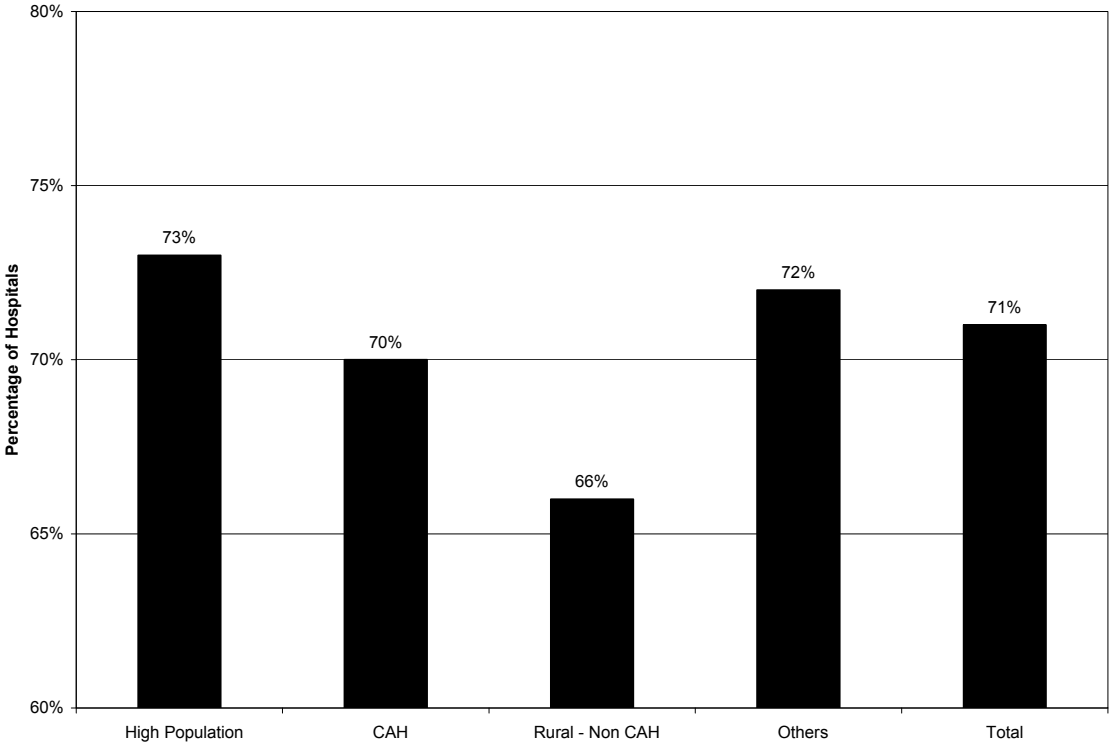
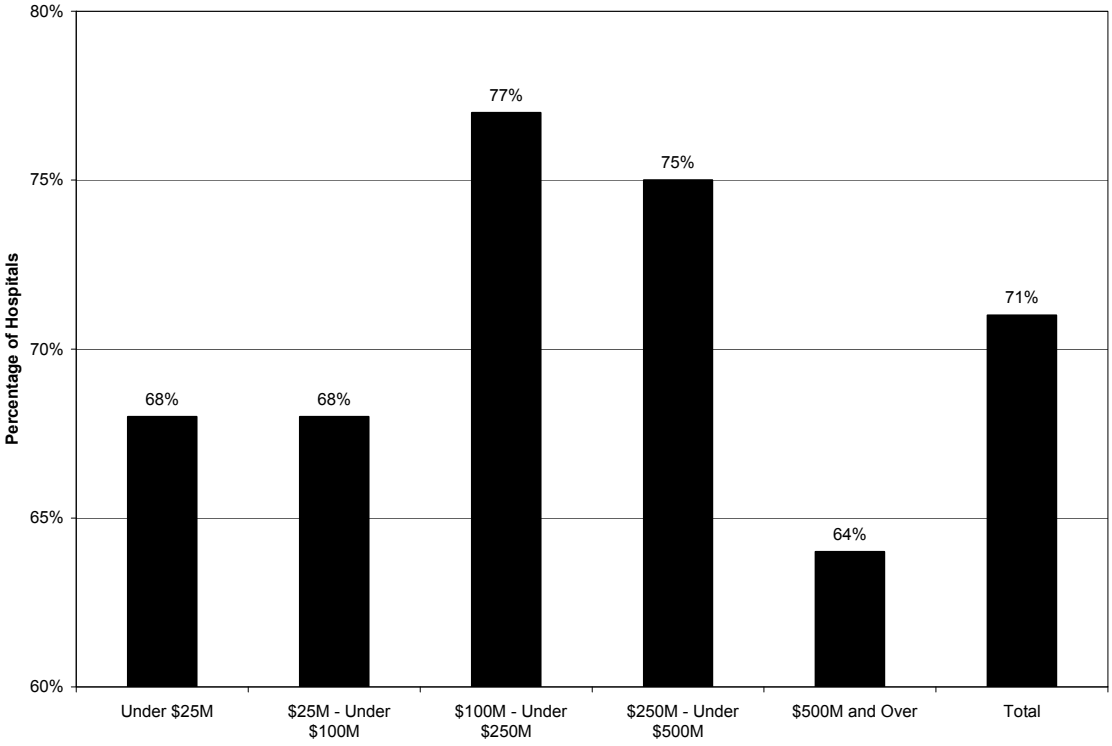


Figure 110. Percentage of Hospitals that Considered all Comparability Factors by Revenue Size



As Figure 111 and Figure 112 demonstrate, there was little variation in the consideration of specified factors across community types or revenue size groups.

Figure 111. Percentage of Hospitals that Considered Comparability Factors by Community Type

Community Type	Edu & Exp	Responsibility	Same Area	Similar Srvc	Similar Bed #
High Population	92%	100%	95%	97%	90%
CAH	93%	98%*	>95%	94%	91%
Rural - Non CAH	91%	98%*	94%	95%	91%
Others	91%	<100%	91%	98%	90%
Total (N = 479)	91%	99% *All rural hospitals	93%	97%	90%

*Both groups of rural hospitals (CAH and non-CAH) were combined to prevent potential identification of respondent hospitals.

Figure 112. Percentage of Hospitals that Considered Comparability Factors by Revenue Size

Revenue Size	Edu & Exp	Responsibility	Same Area	Similar Srvc	Similar Bed #
Under $25M	95%	98%*	95%	93%	88%
$25M - Under $100M	91%	98%*	97%	96%	91%
$100M - Under $250M	91%	100%	95%	98%*	92%
$250M - Under $500M	90%	100%	82%	98%*	88%
$500M and Over	89%	100%	83%	100%	89%
Total (N = 479)	91%	99% *Under $100M	93%	97% *$100M - <$500M	90%

*Revenue sizes were combined to prevent potential identification of respondent hospitals.

Use of other tax-exempt hospitals as comparability data (Question 7)
Question 7 asked whether the hospital's comparability data included information from other tax-exempt hospitals. 100% of 478 respondents indicated that their comparability data included information from other tax-exempt hospitals. The questionnaire did not ask about comparability data from for-profit hospitals.

Setting compensation within the range of comparability data (Question 8)
Question 8 asked whether the hospital set compensation within the range of comparability data. Nearly all of 478 respondents reported that compensation was set within the range of the comparability data.

Business relationships with officers, directors, trustees, and key employees (Question 9)
Question 9 asked whether the hospital had a business relationship with any of its officers, directors, trustees or key employees, other than through their position as officers, directors, trustees, or key employees, and to describe any such relationships. 303 (65%) of 468 reported having at least one such business relationship. Figure 113 and Figure 114 display the results by community type and revenue size. The two most commonly reported types of business relationships were the furnishing of goods, services or facilities by the officer,

director, trustee or key employee to the hospital and doing business with an entity in which the officer, director, trustee or key employee is a partner or investor.

Compared with rural hospitals (CAH and non-CAH), a higher percentage of urban and suburban hospitals (high population and other urban and suburban hospitals) reported having a business relationship with its officers, directors, trustees or key employees. The percentage of hospitals indicated having a business relationship with its officers, directors, trustees or key employees generally increased as revenue size increased, with less than half of the responding hospitals with less than $25 million in revenue indicating that they had such a relationship and over 80% of the hospitals with revenues exceeding $250 million doing so.

Figure 113. Percentage of Hospitals Reporting a Business Relationship with its Officers, Directors, Trustees, or Key Employees by Community Type

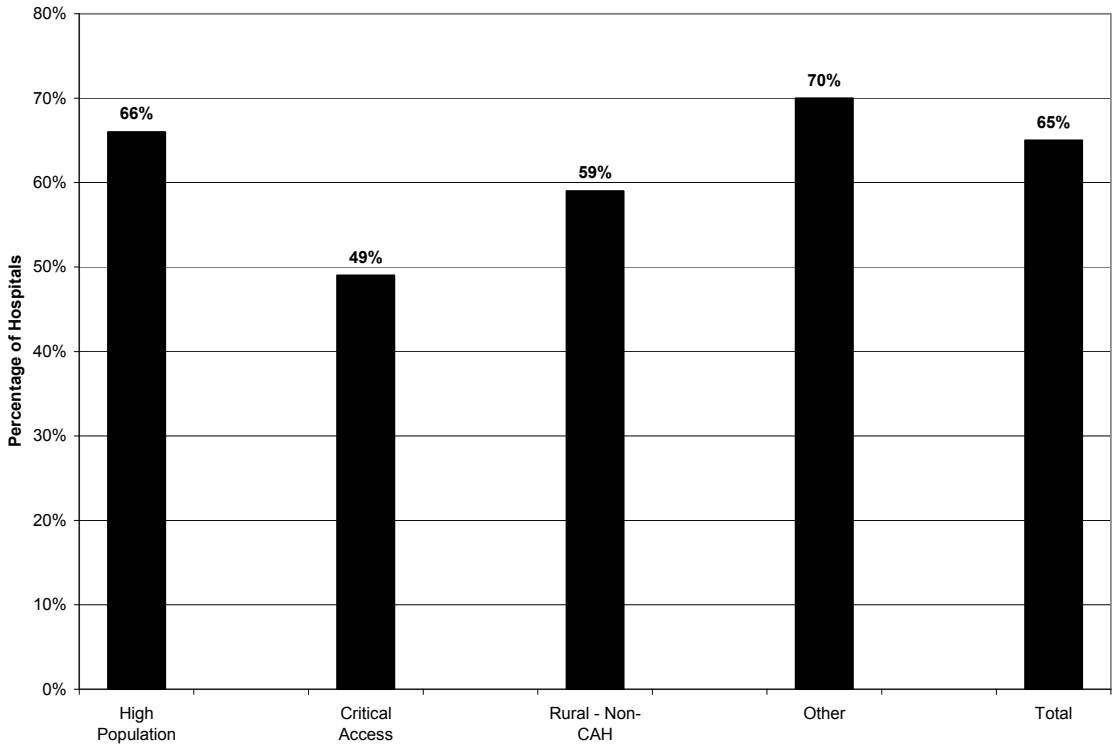
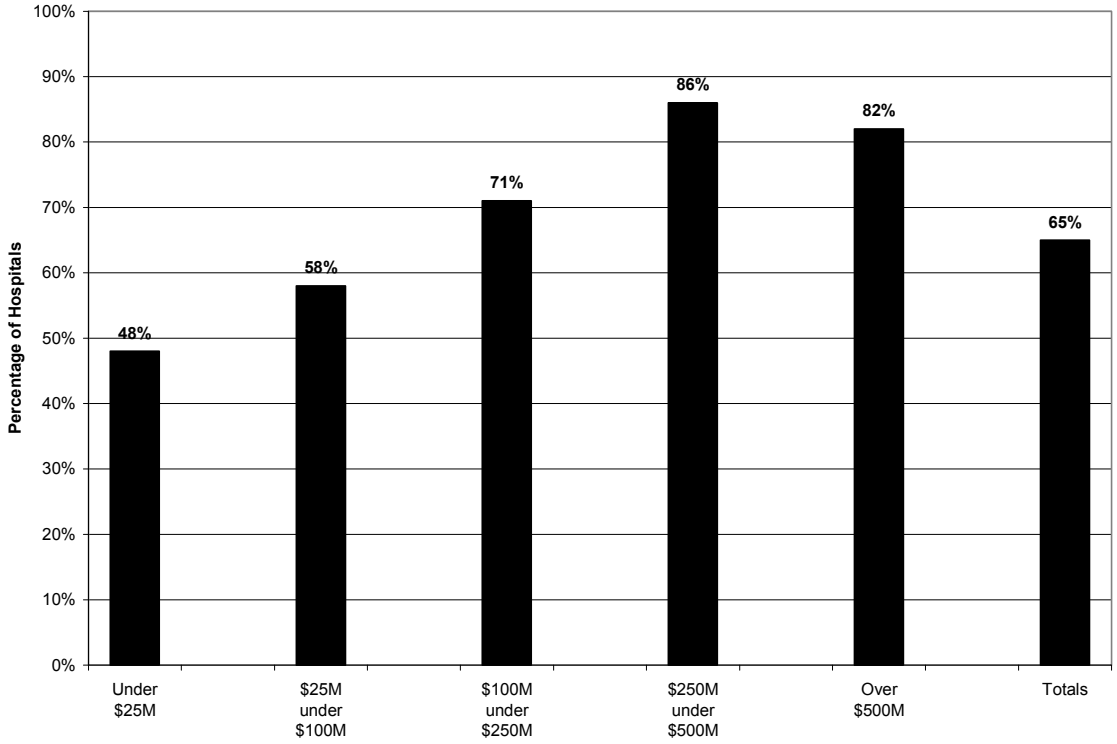


Figure 114. Percentage of Hospitals Reporting a Business Relationship with its Officers, Directors, Trustees, or Key Employees by Revenue Size



C. Summary of Examinations

1. Overview of Examination Component of the Project

The examination component of the Hospital Compliance Project is part of Exempt Organization's ongoing review of executive compensation in the tax-exempt sector.[67] In this study, the focus of the examinations was three-fold: (1) to follow up on the questionnaire responses regarding how organizations determined compensation, (2) to determine whether organizations were utilizing the rebuttable presumption, and (3) to determine whether the compensation so determined should be subject to tax as an excess benefit transaction under section 4958. Twenty hospitals from the study were selected for the examination component of the project.

To select the twenty hospitals to be included, IRS revenue agents and specialists reviewed the Forms 990, questionnaire responses, and other compensation information to identify the hospitals within the study that paid greater

[67] In 2007, EO issued its report on the Executive Compensation Compliance Initiative. Included in its recommendations were that future initiatives should focus on the correlation between satisfaction of the rebuttable presumption by an organization and the reasonableness of compensation paid to its disqualified persons by such an organization. Accordingly, this initiative included an executive compensation component focusing on these issues.

compensation amounts relative to the size and type of the organization. Their review focused on the highest paid and/or top management official, although in some cases they included up to four additional highly paid officials per organization in their review.

The process used to examine executive compensation of these twenty organizations was that regularly used to examine compensation paid by taxable and tax-exempt organizations to their officers, directors, trustees, key employees, and other high level officials. Accordingly, the examining agents used traditional risk analysis to assess whether they would request additional information from the organizations, conduct sampling of expense accounts and other compensation-related items, and seek the involvement of specialists to assist in conducting these examinations.

2. Examination Results

a. Overview

The twenty hospitals examined as part of this project constitute a small pool. Therefore, to prevent potential identification of examined hospitals, in many instances the findings below are discussed in generalities. Furthermore, the findings are not based on statistical sampling and cannot be applied to the general population. They merely reflect the organizations selected and are not representative of any portion of the hospital sector.

While the hospitals examined were selected based upon identifying highly paid individuals, consideration was given to the size and nature of the hospital. The twenty hospitals represent a reasonable cross section of the study's overall hospital group in terms of community type and revenue size. The hospitals are classified by community types and revenue size groups as follows:[68]

Community types:

- High population – 6 hospitals (30%)
- Rural (CAH and non-CAH) – 4 hospitals (20%)
- Other urban and suburban – 10 hospitals (50%)

Revenue sizes:

- Under $250 million – 8 hospitals (40%)
- $250 million - $500 million – 9 hospitals (45%)
- Over $500 million – 3 hospitals (15%).

In some instances, information concerning compensation was in the possession of another organization (e.g., a parent of the organization) so the organization

[68] Certain categories were combined to prevent potential identification of the examined hospitals.

that possessed such information was the entity examined, rather than the original respondent to the questionnaire.

b. Compensation amounts reported

As discussed above, the hospitals were selected for examination because they were identified as paying identified individuals greater compensation amounts, relative to the size and nature of the hospital. The examinations also reviewed compensation paid by other entities.

The total compensation paid by the twenty hospitals examined (including by related entities or common paymasters) to the individuals identified during the examination selection process is included in the table below. The twenty hospitals reported paying a total of $45.2 million, or 88% of the total of $51.3 million compensation paid to these individuals. The other 12% was paid by related entities, supporting organizations, or common paymasters. In those instances where compensation is paid by other entities, the average and median amount paid is 47% of the average and median amount paid by the hospitals examined.[69]

Figure 115. Total Compensation Paid to Identified Highly Compensated Individuals of Examined Hospitals

Description	Paid by Hospitals Examined	Paid by Other Entities	Total Paid by Examined Hospitals and Other Entities
Salaries	$30,704,177	$4,963,715	$35,667,892
Deferred Compensation	$6,333,625	$285,886	$6,619,511
Other Compensation	$8,190,340	$832,360	$9,022,700
Total Compensation	$45,228,142	$6,081,961	$51,310,103
Statistics of Total Compensation			
- Average	$753,802	$357,762	$801,720
- Median	$522,203	$246,402	$578,808

Total compensation paid to the CEO/President, the CFO/VP Finance, and all other identified highly compensated individuals is included in the following chart. These amounts include payments made by other entities. Primarily due to identifying relatively high paid individuals through the examination selection process, the average and median compensation paid to the CEO/President in the examined hospitals is substantially higher than the average and median salary reported for the top management officials on the questionnaires.

[69] The average and median compensation amounts paid by other entities are based on compensation paid to individuals reported to have received compensation from another entity. The calculation did not take into account cases in which no compensation was paid by another entity (thus, resulting in higher average and median amounts than if such cases had been taken into account).

Figure 116. Total Compensation to Identified Highly Compensated Individuals of Examined Hospitals by Position Title

	CEO/President	CFO/VP Finance	All Other Identified Individuals	Total
Salaries	$17,088,894	$12,070,679	$6,508,319	$35,667,892
Deferred Compensation	$5,022,047	$1,285,109	$312,355	$6,619,511
Other Compensation	$6,895,815	$1,494,154	$632,731	$9,022,700
Total Compensation	$29,006,756	$14,849,942	$7,453,405	$51,310,103
Statistics of Total Compensation				
- Average	$1,381,274	$571,152	$438,436	$801,720
- Median	$1,270,671	$549,347	$264,037	$578,808

c. How compensation was determined

The twenty examinations followed up on the questionnaire and looked at how compensation was determined, including review of the supporting documentation. The examinations confirmed that all twenty hospitals had a written conflict of interest policy that they adhered to.

85% of the hospitals examined had a written compensation policy, as compared to 73% of the hospitals that responded to the questionnaire. While in most cases if the hospital had a written compensation policy it followed that policy in all circumstances covered by its terms, there were a few instances where the hospital did not.

In all cases, compensation was approved in advance, nearly always by individuals that did not have a conflict of interest with the compensation arrangement being approved. This is comparable to the 98% of hospitals responding to the questionnaire that indicated that compensation was approved in advance by individuals that did not have a conflict of interest with the compensation arrangement being approved.

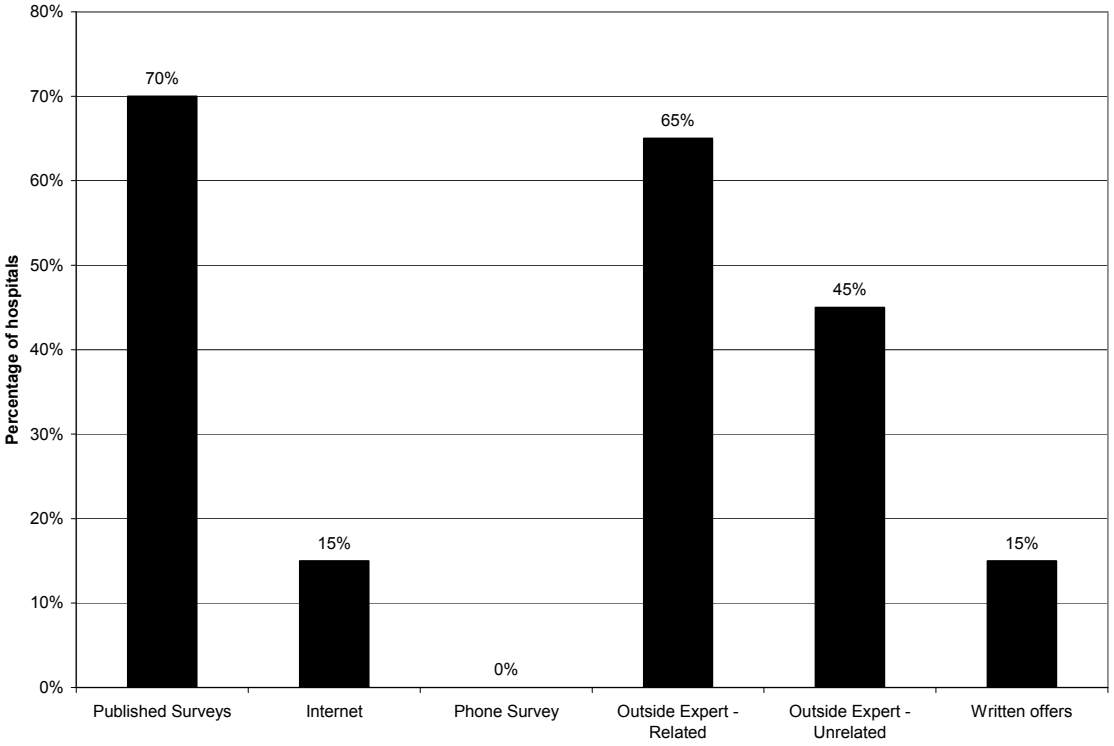
In 85% of the hospitals examined, hospitals had employment contracts with disqualified persons and in nearly all such cases the contract amount was found to be reasonable.

The amount of compensation was determined by the Compensation Committee at nearly all of the examined hospitals, with slightly over half of the examined hospitals also having compensation determined by the Board of Directors. This contrasts with the 56% of responding hospitals that indicated that the compensation was determined by the Compensation Committee on the questionnaire and compares similarly to the 63% of the questionnaire respondents that indicated the Board of Directors determined compensation. Few of the hospitals examined had compensation amounts determined by

officers. As was indicated in questionnaire responses, there were instances where the compensation was determined by an affiliated entity or by an Executive Committee.

70% of the examined hospitals used published surveys to establish compensation amounts (compared to 87% of the questionnaire respondents). 45% of the examined hospitals used an outside expert report prepared by an expert employed by an unrelated organization compared to 48% of the hospitals responding to the questionnaire. 65% of the examined hospitals used an outside expert report prepared specifically for the hospital by an expert employed by the hospital for that purpose (compared to 36% of the responding hospitals). None of the examined hospitals used phone surveys to determine compensation amounts (compared to 21% of the responding hospitals).

Figure 117. Examination Results - Tools Used to Determine Compensation



45% of the examined hospitals considered all of the identified factors included in comparability data, compared to 71% of the hospitals responding to the questionnaire. All of the examined hospitals used the specific responsibilities of the position, while only 60% used similar number of beds, admissions or out-patient visits in their comparability data. Although not all of the examined hospitals considered each of the remaining three identified factors, at least three-quarters of the examined hospitals considered each of them. As with the questionnaire responses, the most common factor considered other than the listed factors was similar levels of revenue. The factors were used consistently for all disqualified persons in 80% of the examined hospitals.

In all cases the examined organizations obtained comparability data involving tax-exempt hospitals, although not every examined hospital obtained comparability data regarding tax-exempt hospitals for all components of the compensation that was paid.

Nearly all of the examined hospitals set their actual compensation within the range of the comparability data.

Although 65% of the hospitals responding to the questionnaire indicated having a business relationship with any of its officers, directors, trustees or key employees, other than through their position as officers, directors, trustees, or key employees, a business relationship existed in only 40% of the hospitals examined. Most of these cases involved the furnishing of goods, services or facilities, although there were also instances involving loans and the sale or lease of property. In all cases where the business relationship was reviewed, no excess benefit transaction was found.

d. Rebuttable presumption analysis

After reviewing the process used by the hospital to establish compensation, the IRS then determined whether that process met the rebuttable presumption procedure described in Treasury Regulation section 53.4958-6.[70] This process involves three factors – an independent body to review and establish the amount of compensation in advance of actual payment, use of permissible comparability data to establish the compensation, and contemporaneous documentation of the process used to establish the compensation in the particular instance. Under the Regulations, compensation determined pursuant to a process that satisfies the rebuttable presumption requirements is presumed to be reasonable in amount, and the IRS has the burden of proving that the compensation is excessive for section 4958 excess benefit transaction tax purposes. If the rebuttable presumption is not met, the burden is on the organization to prove that the compensation is reasonable.

Organizations met the requirements of the rebuttable presumption process in 85% of the examined hospitals.

e. Information reporting and potential assessment of section 4958 excise tax

The compensation paid to the identified highly paid individuals was reviewed to determine whether the section 4958 excise tax should be assessed. In the case of the 85% of hospitals that met the rebuttable presumption, the burden of proof was on the IRS to show that compensation was not reasonable. This review included analysis of compensation data and surveys available to the IRS in addition to the comparables used by the organizations in setting compensation.

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[70] See H. Rep. No. 104-506, 104th Cong., 2d Sess. at 56-57.

The IRS determined that no excess benefit tax should be assessed in these instances. The IRS may assess 4958 excess tax in certain other case(s), but to prevent potential identification of examined hospitals, specific details cannot be provided.

The IRS also reviewed whether compensation paid to the identified highly compensated individuals was properly reported on various federal forms. Nearly all of the examined hospitals properly reported compensation on Form 990. For Forms 941 and W-2, all compensation was properly reported. The Forms 1040 for the identified highly compensated individuals were also reviewed where appropriate. In all cases where the Form 1040 was reviewed, compensation was reported correctly.