Save Your Tax Exemption: Strategies for Survival

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Overview

- Why the Scary Title?
- Landscape; Bad Press
- Benefits of Charitable Status
- Bases for Tax Exemption in Senior Care
- Hospitals: A Cautionary Tale
- Social Accountability – The First 20 Years

Overview (cont.)

- Guiding Principles
- Recommendations
- Quantify, Quantify, Quantify
- Resources
- Q & A

Why the Scary Title?

- Premise of Presentation:
  - We are not prepared
  - Many of us are failing to take concrete action to save our tax exemptions
  - We are lulled into complacency by our good works, charitable pasts, & reputation for quality
  - Some of us have no real social accountability program; many of us fail to track it or publicize it
Landscape for Past Decade

- Climate of distrust in public and private sectors
- Calls for accountability
  - Sarbanes-Oxley Act
  - Nonprofit Integrity Act (CA)
    - Activism of State attorneys general
- Demands for transparency

Landscape (cont.)

- Efforts by State & local govs to enhance revenues
  - Property tax exemption; in lieu fees (PILOTs); affordable housing element
- Reforms in hospital arena (more to come)
- Criticism from consumer advocates
- Explosion of info. on line; Charity Navigator
- ACA, ACOs and focus on statistical performance

Bad Press

- Sr. care has received a lot of bad press recently:
  - GAO report
  - Wall Street Journal article
  - Noteworthy bankruptcies
  - Assisted living facility exposé
    - Resident lawsuits against high-end facilities
- Public starts to resent special status afforded charitable facilities, especially high-end ones
Tough Love

- Can you afford to lose your exemption?
- Our current social accountability efforts are inadequate and expose us to real risk
- We are not sufficiently focused on metrics
- We need to PROVE our nonprofit difference daily

Benefits of Charitable Status

- Tax-exempt income
- Deductible donations
- Access to private foundation and gov’t grants
- Cheaper access to capital (bonds)
- Property tax exemption – not all jurisdictions; not all provider types
- Potential exemptions from some sales, use taxes
- Presumed trustworthiness? Halo effect

Basis for Tax Exemption- CCRC, MLRC

- Rev. Rul. 72-124 recognized that the elderly were a charitable class with unique housing, healthcare, financial, and psychosocial needs. It allowed providers to charge for their services if they met various criteria, including three financial criteria:
  - operation at “lowest feasible cost” (but can have net revenues, set aside money for related uses)
  - affordability to a significant segment of community (not defined; 30% +/- may be enough)
Basis for Exemption (cont.)
— “no-eviction” policy, as long as:
 policy does not jeopardize provider’s sound financial operations (explicit condition); and
 resident does not deliberately impoverish himself to qualify for assistance (implied condition).

Would the IRS articulate this liberal standard today? I doubt it.

Other Bases for Exemption in Sr. Care
 Promotion of health – SNFs; assisted living (?)
 Relief of burdens on government, addressing poverty - affordable housing
 Providing services at or below cost – some home- and community-based services
 Meeting the unique needs of seniors, education – senior centers
 Presumed exemption v. affirmative IRS approval

What is Social Accountability?
 “A measure of an organization’s commitment to its mission, its stakeholders, and society…also a process for planning, budgeting, and reporting and evaluating these community benefits.”
LeadingAge

 “Programs or activities that promote health and healing as a response to identified community needs.” (Definition of community benefits.)
Catholic Health Association of the United States
What is Social Accountability? (cont.)

- “The art of giving back to the community.”
  American Baptist Homes of the West

- “What distinguishes charitable providers from their for-profit counterparts.”
  Anonymous

Other Terms

- Community benefit – favored term in hospital arena; analogous to social accountability; encompasses charity care and other benefits

- Charity care -- component of community benefit; may include uncompensated and under-compensated care (standards vary); quantitative; focus of hospital reforms

- Essential to define terms when measuring SA

LeadingAge’s Efforts – First 20 Years

- Launched first social accountability (SA) guide in collaboration with Catholic Health Association in 1993; latest edition was published in 2011

- Has since published and posted guidelines and members’ social accountability reports

- Focus has been on voluntary compliance, culture of social accountability, mission-driven values, and quality of care: a qualitative approach
New Call for Concrete Action

- Not-for-Profit Leadership Cabinet assembled (2012); Cory Kallheim, VP of Social Accountability, spoke at Annual Meeting in Oct. 2013
- Message:
  - Social accountability is no longer optional
  - We must look outside our communities
  - Share your story: make reporting a high priority; put faces and numbers on reports

Not-For-Profit Difference

- NFP Cabinet posed three questions:
  - Would you be missed if you were gone tomorrow?
  - Could you be replaced? By whom?
  - Do you have an impact beyond your walls?

Telling Our Stories

- Effort to humanize social accountability, obtain buy-in from smaller providers, and tailor SA to org
- Valuable if it inspires members to take next steps, but:
- We can become mesmerized by our own stories
- Stories are important but not sufficient
- We need to quantify!
2010 Social Accountability Report

- Joint LeadingAge/Holleran/Lyon Software effort
- Reported survey results re CCRC members’ awareness, adoption, recordation and tracking of social accountability activities
- Sample size of 150; skewed sample: respondents all have tracking and reporting mechanisms
- Results:
  - 60% of orgs include SA in strategic plan; 28% include it in budget, 25% in mission statement

Social Accountability Report (cont.)

- Results:
  - 55% of orgs produce SA report; of those, 53% independent, 47% embedded in annual report
  - 50% of orgs’ boards discuss SA goals
  - 52% agree that org has designated SA person
  - 63% state residents, staff know of SA efforts
  - 83% report successful community partnerships
    – schools, foundations, hospices, faith orgs: key

More Survey Results

- Free/subsidized activities are varied; list is in addition to any charity care or Medicaid shortfall
- Include (in declining order): free meeting space, food donations, lectures, workshops, student internships, event coordination, equipment donations, support groups, health fairs, community education (e.g., CPR), recreation, community health (e.g., screens), age-related research, self-help (e.g., smoking cessation), transportation, community revitalization, community rebuilding
Even More Survey Results

- Average spend on charity care: $568k for single-site providers and $2.89m for multi-site providers
- Average spend on Medicaid shortfall: $490k for single-site providers and $12.37m for multis
- Average spend on cash, in-kind, charity events: $84k for single-site providers and $247k for multis
- Total SA spend = 6% of revenues for single-site providers and 19% for multi-site providers

Most Troubling Statistic

- 44% of respondents (all of whom have the ability to track) report no significant tracking program
- 36% report use of spreadsheet program (e.g., Excel); 7%: Community Benefit Inventory for Social Accountability (CBISA) (Lyon) software; 3.5%: database program; 9%: “other”
- We don’t track our social accountability adequately
- Our good deeds and noble aspirations are lost without reliable tracking (if a tree falls, …)

Hospitals: A Cautionary Tale

- Evolution of hospital exemption is telling
- Early IRS and court rulings emphasized obligation to serve public without regard to its ability to pay. See Rev. Rul. 56-185.
- Landscape changed in late 1960s: Rev. Rul. 69-545 allowed hospitals to limit services to “paying customers” as long as emergency rooms were open without regard to patients’ ability to pay.
- Legal challenge of Rev. Rul. 69-545 was defeated
Hospitals: A History of Legal Challenges

- Round Two: Some states imposed limits on welfare exemption – e.g., operating rev’s cannot exceed operating exp. by 10% or more (CA)

- Round Three: Roybal and Donnelly challenged hospitals’ exemptions in the early 1990s.
  - Roybal would have required an open-door policy for Medicare and Medicaid patients.
  - Donnelly would have codified community benefit and added a charity care requirement
  - Both bills failed

Hospital Hearings; New Tax Law (cont.)

- Round Four: Baucus & Grassley distributed hospital questionnaire; called for Congressional hearings demanding that charitable hospitals show how they differed from for-profit hospitals
  - Data showed little difference in charity care

- Round Five: IRC Section 501(r) was passed as part of ACA; new hospital requirements included:
  - Community health needs assessment (must consider broad interests, be made widely available to public)

Section 501(r)

- Financial assistance policy (eligibility, type of assistance, basis for calculating charges, etc.)
- Restrictions on charges (limited to sums charged to patients with insurance)
- Billing and collection requirements (no extraordinary collection actions) (response to a few bad actors with predatory tactics)
- Created a record-keeping bureaucracy.
Schedule H to IRS Form 990
- Result of Section 501(r)
- 9 pages, 6 parts, 22 pages of instructions!
- Contains detailed questions about:
  - Finan. assistance, community benefits at cost
  - Community building activities (e.g., economic development, community support)
  - Bad debt, Medicare, collection practices
  - Management cos., joint ventures
  - Facility information

What's So Bad About 501(r) & Schedule H?
- They increase hospitals’ paper and filing burdens
- A community benefit analysis costs money and time, even if hospital already meets standards
- Schedule H costs money to prepare
- It is a public document
- The IRS is defining the rules for hospitals
- We should define our own rules within general charitable guidelines

Getting Down to Business
- Take control of your destiny
- Learn SA basics if you don’t already know them; SA Program on LeadingAge website is an excellent primer
- Accept that the IRS and other taxing bodies are likely to take a quantitative approach; stories and other subjective evidence will only get you so far
- Prepare for possible WA community benefit law.
- Understand guiding principles
State Legislation

- Two WA bills (SB 5557 and SB 5041) have died
- Both would have required Department of Revenue to create a document for “nonprofit homes for the sick or infirm” to report community benefit
- Report would have mirrored Schedule H to Form 990
- Community benefits include, without limitation:
  - Community health improvement services
  - Health professions education
  - Subsidized health services
  - Research
  - Financial & in-kind contributions
  - Community – building activities
  - Community benefit operations
  - Charity care, including Medicaid shortfall

State Legislation (cont.)

- Medicaid or HUD shortfall – subsidy by member
- Services at or below cost (free blood pressure screening, smoking cessation program at cost)
- Services beyond licensing or reimbursement req’ts (e.g., special palliative care program)
- Services of charity, not residents or staff (unless charity contributes items or services of value)
- Services designed to enhance access (e.g., free clinics for the underinsured, benefits enrollment)

What Counts – Some Guiding Principles
What Does NOT Count -Guiding Principles

- Bad debt
- Contractual allowances with third party payors
- Early payment discounts
- Costs of care in excess of Medicare payments
- Services designed to enhance revenue or increase market share
  - How to discern provider’s intent? Is a nurse hotline charitable outreach or marketing?

Recommendations

- Conduct a Self-Audit
  - Review articles, bylaws, mission statement, Form 1023, recent Forms 990, recent financial statements, annual reports, materials describing current charity care programs
- Identify unmet needs in community and ability to meet them; think broadly
  - Focus on what for-profit sector does NOT provide
  - Compare notes with other providers; assemble a LeadingAge WA taskforce

Recommendations (cont.)

- Secure a commitment from board and executive staff to support a social accountability program
- Pledge a portion of budget to program
- Commit to produce a social accountability report
- Record ALL community benefits (simple forms)
- Publicize social accountability
- Evaluate social accountability programs
**Quantify, Quantify, Quantify!**

- Reduce every element of SA to a number. ID $ value of all SA, number of people and populations served, and impact. Examples:
  - Dollar value of Medicaid or HUD shortfall, charity care, cash donations
  - Wage & benefit value of donated employee time
  - Fair rental value of space provided
  - FMV of donated equipment & supplies, free screenings, workshops, transportation, meals

**Shout it to the Rooftops**

- Annual reports
- Social accountability reports
- IRS Form 990
- Well-placed articles in local media
- Website; newsletters
- Press releases; letters to the editor
- Meetings with politicians

**Resources**

- Catholic Health Association of the U.S. ([www.chausa.org](http://www.chausa.org))
  - Guide for Planning and Reporting Community Benefit
  - detailed instructions for accounting for community benefits; guidelines for hospitals & LTC providers
- Alliance for Advancing Nonprofit Healthcare ([www.nonprofithealthcare.com](http://www.nonprofithealthcare.com))
- Lyon Software – Community Benefit Inventory for Social Accountability ([www.lyonsoftware.com](http://www.lyonsoftware.com))
Resources (cont.)

- Charitable Senior Care Providers’ Social Accountability Reports:
  - American Baptist Homes of the West (www.abhow.com/passion/accountability)
  - Episcopal Senior Communities (www.jtm-esc.org/ESC_Social_Accountability.pdf)

Q & A