Nonprofit or For-profit? Hospital Conversion Considerations

By Rebecca Bales, MPA, ASA, Kelly Tiberio, and Tara Tesch, MHSA
I. Summary

Purpose

This white paper was prepared by The Camden Group to provide an overview of the following topics relating to nonprofit hospitals:

- Key nonprofit hospital characteristics that differ from that of a for-profit hospital, including requirements for maintaining nonprofit status.
- How nonprofit and for-profit hospitals are reacting to the changing environment, including shifts in corporate structure and arrangements that will ensure their survival.
- Potential reasons driving for-profit conversions, trends in the formation of health conversion foundations, and considerations and implications for conversion.

Background

By definition, a nonprofit hospital is one that exists to serve the healthcare needs of the community. Many nonprofit hospitals are mission-driven, culturally rich organizations with century-old beginnings. While some are rooted in religious values and follow directives from their religious sponsors, many others formed as community start-ups by entrepreneurial humanitarians, nurses, and doctors. Regardless of its religious or secular mission, however, a nonprofit hospital bears a unique responsibility to the community it serves.

In some cases, nonprofit hospitals are “safety net” providers, whereby they take on a substantial responsibility in serving the uninsured, Medicaid enrollees, and vulnerable populations facing a variety of barriers to healthcare access. These hospitals serve large numbers of racial and ethnic groups, and some serve people in remote rural areas who have few other alternatives for care.

Both safety net and non-safety net nonprofit hospitals must adhere to a number of regulatory statutes at the federal and state levels in order to maintain exempt from federal, state, and county taxation. This relationship improves healthcare access to the underinsured and uninsured while relieving nonprofit hospitals from substantial tax liability.

Of recent debate in Illinois is the uncertain legislation surrounding the criteria for determining tax-exempt status. An overview of the current situation is summarized within, including the potential implications for denial of tax-exempt status.
I. Summary

With increasing pressures to compete in the marketplace, collaborate with other providers, and provide stronger, evidence-based care, nonprofit hospitals across the country are exploring a number of solutions to remain solvent and viable. Of the many arrangements being brokered between healthcare corporations, nonprofit hospital conversion has become a growing trend over the last several decades. Conversions are highly complex, politically sensitive transactions requiring thorough investigation and analysis.

The matrix on the following page provides an at-a-glance summary of the key characteristics addressed in this paper and their applicability to nonprofit and/or for-profit hospitals.
## I. Summary

### Comparison of Nonprofit vs. For-profit Requirements

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<tr>
<th>Description</th>
<th>Nonprofit Only</th>
<th>For-profit and Nonprofit</th>
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<tbody>
<tr>
<td><strong>Community Health Needs Assessment</strong></td>
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<tr>
<td>Hospitals are required to file a Community Health Needs Assessment with the IRS every three years starting with 2012.</td>
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<td><strong>Sole Community Hospital (&quot;SCH&quot;) Status or Critical Access Hospital (&quot;CAH&quot;) Status</strong></td>
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<td><strong>Excess Benefit</strong></td>
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<td>Arrangements between hospitals and private individuals and companies are required to be commercially reasonable and have a prudent business purpose.</td>
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<td><strong>Stark Law</strong></td>
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I. Summary

As a reminder, state departments of health regulations, licensure and certification requirements, and government payer regulations apply to both nonprofit and for-profit hospitals equally. These fundamental requirements underscore that, on an operations level, nonprofit and for-profit hospitals are more similar than they are different.

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<td>State and Local Licensure Requirements</td>
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<td>Medicaid Rules</td>
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II. What Does It Mean to Be a Nonprofit Hospital?

Introduction
To maintain their tax-exempt 501(c)(3) status, nonprofit hospitals must comply with a number of federal and state regulations. This section aims to highlight several of those key regulations and designations, some of which are applicable to both nonprofit and for-profit hospitals.

Federal Regulations
Community Health Needs Assessment
Issue: Hospitals are required to file a Community Health Needs Assessment (“CHNA”) with the IRS every three years starting with 2012.

Applicability: Nonprofits only; not required of for-profit hospitals.

Background: Buried within the Patient Protection and Affordable Care Act (“PPACA”) enacted in March 2010 are four new requirements for 501(c)(3) hospitals. Specifically, the PPACA imposes new reporting requirements on 501(c)(3) hospital organizations for tax years beginning after March 23, 2012. The law added four new mandates identified below:

- Conduct a Community Health Needs Assessment.
- Adopt and implement written financial assistance and emergency medical care policies.
- Limit charges for emergency or other necessary medical care.
- Comply with new billing and collection restrictions.

The most significant requirement, the Community Health Needs Assessment, will necessitate a well-defined approach and process from hospitals to ensure a successful completion of this IRS mandate.

Beginning in 2012, the CHNA is required every three years. Hospital organizations not in compliance with this mandate will be penalized up to $50,000 per year and can be at risk of losing nonprofit status. The assessment will be shared with local government agencies and other healthcare entities in order to coordinate the allocation of both public and private resources.
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The IRS also requires a communication of results. Hospital organizations that conduct the CHNA must make the report widely available by posting the written results on a website. Hospitals must also attach their Form 990 (from the IRS).

Federal Designations Designed to Assist Rural Safety Net Hospitals

**Issue:** Hospitals that meet certain requirements can receive a designation as a Sole Community Hospital (“SCH”) or Critical Access Hospital (“CAH”), which allows them to receive enhanced reimbursement for Medicare patients.

**Applicability:** SCHs can be nonprofit or for-profit. CAHs must be nonprofit.

**Background:** There are 436 SCHs in the United States that meet certain location and/or access requirements. Hospitals in this category that are paid under the Medicare Acute Care Hospital Inpatient Prospective Payment System (“IPPS”) can receive higher payments for Medicare patients. The enhanced reimbursement is not cost based, but in general terms, the reimbursement calculation is more heavily weighted for the hospital-specific rates than are the rates paid to a non-SCH. This status, primarily applicable to rural hospitals, was established in Section 1833 of Title XVIII of the Social Security Act.

The CAH Program was created by the 1997 federal Balanced Budget Act as a safety net device, to assure Medicare beneficiaries access to healthcare services in rural areas. It was designed to allow more flexible staffing options relative to community need, simplify billing methods, and create incentives to develop local integrated health delivery systems. There are currently 1,330 CAH hospitals in the United States. CAHs also have location and access requirements, but have broader operating criteria than the SCH, including: the hospital must 1) have fewer than 25 beds, 2) have an average length-of-stay of fewer than 96 hours, and 3) adhere to other requirements regarding oversight of transfer agreements and credentialing, etc. CAHs have onerous cost report requirements since the reimbursement is partially cost based.

Both SCH and CAH will also receive enhanced reimbursement in Medicaid reform. This varies by state and the mechanisms are not yet defined.
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Excess Benefits Regulations

**Issue:** Hospitals cannot pay more than fair market value in transactions with private individuals and companies.

**Applicability:** Nonprofits only; there are no limitations for for-profit hospitals.

**Background:** Since the mid-1990s, the IRS has been addressing the problem of improper payments from nonprofit organizations to private individuals and companies. Prior to 2002, the only penalty the IRS could impose on a 501(c)(3) organization for an excess benefit transaction was to revoke its exemption, which was considered to be a harsh punishment, especially for hospitals serving the public benefit. In 2002, the Intermediate Sanctions penalties were established through the US Tax Code Section 4958. This code gives the IRS the power to impose excise taxes on hospital managers that knowingly participate in excess benefit transactions. An excess benefit transaction is generally described as a transaction that results in payments that exceed fair market value.

Through the Intermediate Sanction statute, the IRS can now place an “intermediate” sanction (an excise tax) on a hospital without putting them out of business or forcing them to convert to for-profit status. Additionally, the receiver of the excess benefit must pay the “excess” amount back to the hospital. So, this penalty can be imposed on the source of the excess benefit (the hospital and manager) and the receiver (a physician, for example).

The “hospital manager” is not just the hospital CEO, but may also include other "disqualified persons" such as:

- Management company
- Senior management team
- Leader of or major admitter in a major department
- Board members (and their families)
- Other physician leadership positions
- Other individuals that have substantial influence over the affairs of the organization
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A tax can also be imposed upon board members who approved the transaction knowing it was an excess benefit transaction.

There are multiple definitions of fair market value that establish standards for determining value, but the most simple and widely accepted definition is from IRS Revenue Ruling 59-60:

“the price at which a business or business interest would change hands between a willing buyer and a willing seller, neither being under compulsion to buy or sell and both having reasonable knowledge of all relevant facts as of the applicable valuation date.”

To avoid penalties, the hospital must document that they do not pay more than fair market value for 1) a private enterprise such as a medical group, 2) compensation to any private individual or management company, or 3) an interest in a joint venture with a private company. Likewise, the hospital may not provide services to a private individual or company, such as rent or office space, for anything less than fair market value. The need and qualifications for independent valuations and fairness opinions are described in the intermediate sanctions code.

**Commercial Reasonableness**

**Issue:** In addition to having compensation terms that meet fair market value standards, arrangements between hospitals and private individuals and companies are also required to be commercially reasonable. In other words, the arrangement must have a prudent business purpose.

**Applicability:** Applies to both nonprofits and for-profits.

**Background:** Commercially reasonable is defined by the Department of Health and Human Services (“HHS”) as:

“An arrangement which appears to be a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals.”

This definition according to Stark Law commentary states that:

“An arrangement will be considered ‘commercially reasonable’ in the absence of referrals if the arrangement would make commercial sense if entered into by a
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*reasonable entity of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential designated health services (“DHS”) referrals."

Given the above definitions, agreements that are considered commercially reasonable will demonstrate that:

- The scope of the services in the Agreement is clear, appropriate, and aligned to the specialty and skill level of the participating physicians or other contracting individuals.
- Sufficient demand exists in the Service Area for the services provided in the Agreement.
- The hospital is prudent in its oversight of the services performed in the Agreement.
- The parties involved can articulate meaningful benefits to the Hospital.
- The hospital is not paying another party for the same or overlapping services.

**Stark Law**

**Issue:** A physician may not refer a patient for certain services to be reimbursed by federal healthcare programs to an entity with which the physician has an ownership interest or compensation arrangement.

**Applicability:** Applies to both nonprofit and for-profit hospitals and their employed or affiliated physicians.

**Background:** Also known as the physician self-referral law, Stark Law was enacted in 1989 and is part of Section 1877 of the Social Security Act. At the time it was enacted, the legislation was narrowly focused and only prohibited physicians from self-referring for clinical laboratory services. Since then, Stark has expanded to include many other “designated health services” as defined by the Centers for Medicaid and Medicare, including:

1. Clinical laboratory services
2. Physical therapy services
3. Occupational therapy services
4. Outpatient speech-language pathology services
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5. Radiology and certain other imaging services
6. Radiation therapy services and supplies
7. Durable medical equipment and supplies
8. Parenteral and enteral nutrients, equipment, and supplies
9. Prosthetics, orthotics, and prosthetic devices and supplies
10. Home health services
11. Outpatient prescription drugs
12. Inpatient and outpatient hospital services

While some carefully monitored exceptions to the law exist—such as rental of office space, physician recruitment, and risk-sharing arrangements—hospitals must be very cautious about the type and scope of compensation arrangements they negotiate with physicians. Violation of Stark may result in significant civil monetary penalties and denial of reimbursement from government payers.

**Anti-Kickback Statute**

**Issue:** Hospitals may not compensate physicians or suppliers in a way that promotes referrals back to the hospital.

**Applicability:** Applies to both nonprofit and for-profit hospitals.

**Background:** The Medicare Anti-Kickback Statute, Section 1128B of the Social Security Act, is a means to govern how hospitals structure their financial relationships with physicians. The statute “prohibits knowingly offering or receiving payment to induce referrals of items or services.” Examples of compensation arrangements that are at risk of violating the statute are providing free services or staff to a physician practice, paying for unneeded services, providing discounts to practices, paying physicians different amounts than what their contract states, certain marketing practices, and certain recruitment arrangements. Payments to physicians must be commercially reasonable and at fair market value to comply with the statute.

Under the statute’s health reform revisions, the government is no longer required to prove that a physician or other claimant had a specific intent to violate the law. This makes prosecution of
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physicians easier and in some cases more aggressive with broader definitions of fraud. Violation of Anti-Kickback is a felony offense, with significant per-violation fines, imprisonment, and exclusion from government healthcare programs.

Additionally, Anti-Kickback violations can spur false claims, further increasing physician liability exposure. The statute now classifies claims for items or services resulting from a violation of the Anti-Kickback statute as “false or fraudulent claims.” If the government can prove a connection between a kickback and a referral, the referral becomes a false claim subject to recoupment and penalties.

EMTALA

**Issue:** The Emergency Medical Treatment and Labor Act ("EMTALA") requires any Medicare-participating hospital with an emergency department ("ED") to provide a medical screening examination to any individual who presents at the ED, and prohibits hospitals with EDs from refusing to examine or treat individuals with an emergency medical condition.

**Applicability:** Applies to both nonprofit and for-profit hospitals with EDs, including Critical Access Hospitals.

**Background:** Passed by Congress in 1986, EMTALA ensures non-discriminatory access to emergency medical care regardless of a patient’s ability to pay. EMTALA also prevents “patient dumping,” an act in which an uninsured patient is transferred solely for financial reasons from a private to a public hospital without consideration of patient medical condition or stability of transfer.

Under EMTALA, hospitals with “specialized capabilities or facilities” (e.g., burn units, trauma, neonatal intensive care, etc.) or those considered “regional referral centers” in rural markets cannot refuse an appropriate patient transfer from other hospitals lacking those capabilities. In 2003, this rule was further refined to reflect that this obligation ends either when the patient is “stabilized” or when the hospital “in good faith” admits the patient to the hospital in order to “provide stabilizing treatment.”

Hospitals that negligently violate this statute may be subject to a per-violation civil monetary penalty (without criminal implications). On-call physicians and those physicians that are responsible for examining and/or treating the patient that presents at the ED may also face
similar charges if they are found to have negligently violated this statute. In addition, violation of EMTALA could result in the hospital having its Medicare provider agreement revoked.

**State Regulations**

Regulatory oversight of nonprofit hospitals varies by state, as do the governing bodies through which regulations are enforced. Nonprofit hospitals may be required to report and comply with regulations set forth by a state’s Department of Health, Health Commission, Attorney General, and/or Department of Revenue. Some nonprofit hospitals participate in voluntary reporting to state hospital associations or other trade organizations to which they belong.

As of March 2008, the US Government Accountability Office reported that 15 states require hospitals to provide community benefits in order to receive tax exemption or achieve nonprofit status. How each of those states defines “community benefit” differs, as do the penalties associated with failure to comply.

For example, Illinois is currently one of the most active states regarding oversight of nonprofit status. The activities included in the State of Illinois’ definition of “community benefit” include: charity care; language assistance services; government-sponsored indigent healthcare; donations; volunteer services; education; government-sponsored program services; research; subsidized health services; and bad debt. Community benefit activities do not include the cost of paying taxes or other governmental assessments.

The State of Illinois enforces the following community benefit requirements for nonprofit hospitals (under the Illinois Community Benefits Act), some of which are duplicative of those enforced through the IRS. A nonprofit hospital must furnish to the Attorney General:

- Its mission statement
- A Community Benefits Plan (“CBP”)
- An annual report of the CBP
- A statement noting that the annual report is public information
- The annual report as a matter of community information
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Current Issues

Complicating tax-exempt status in Illinois is the ongoing debate about exactly how much of a hospital’s net patient revenue should be spent on free/charity care (community benefits) in order to maintain tax-exempt status. In August 2011, the Illinois Revenue Department (“IRD”) stripped three hospitals of their charitable status because less than two percent of their patient revenue was spent on free care. This denial caused immediate controversy over the ambiguity and unfairness of the existing legislation, because the law does not specifically quantify the percent of patient revenue to be attributed to charity care.

In response to the statewide uprising, Governor Pat Quinn ceased the IRD’s reviews of nonprofit hospitals’ property tax-exemption applications in September 2011. Ensuing discussions between the Governor, IRD, Attorney General, State legislators, Illinois Hospital Association, and other interest groups were expected to result in recommendations and revised legislation that would be announced March 1, 2012. The deadline passed without resolution and the State’s review of tax-exempt applications has since resumed.

The Illinois Hospital Association (“IHA”) has lobbied heavily to protect nonprofit hospitals’ tax-exempt status by proposing an overturn of a 2010 Supreme Court decision that tightened the requirements for nonprofit hospitals to be exempt from property taxes. The IHA’s new proposal—which has bipartisan Congressional support—recommends that nonprofit hospitals must provide community benefits that are equal to or greater than the value of their exemptions. This break-even formula would ensure an equitable trade of providing free care to the community in exchange for exemption from property taxes. The IHA is further proposing that the definition of charity care be expanded to include “not only free medical care to the indigent, but also programs and losses that hospitals incur treating patients under Medicaid, whose reimbursement fees are well below market rates.”

Opponents of the current legislation claim that property and sales taxation of nonprofit hospitals will result in a damaged healthcare system, significant loss of jobs, higher healthcare costs, and severely weakened economies across the state. Proponents of the legislation see the potential additional tax revenue that could be gained from tightening the restrictions on tax-exempt status. A 2006 estimate of taxation on Cook County nonprofit hospitals alone found approximately $241 million in additional tax revenue.
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Meanwhile, five nonprofit hospitals in Illinois withdrew their tax-exempt applications from the IRD in April 2012. While this action is not being encouraged by the Illinois Hospital Association, it has been presented as an option to Illinois hospitals in light of the potential risk for denial of tax-exempt status. Those hospitals will now be subject to property tax at the discretion of their county taxing authorities. One hospital is pursuing a civil action suit to achieve its property tax exemption in Circuit Court. As of early April 2012, 17 other nonprofit hospitals still have their tax-exemption applications in for IRD review, the results of which are unknown at this time.

**Legislative update as of August 2012:** At the time this paper was initially written, there was no legislative resolution in Illinois to further define tax-exempt status criteria for nonprofit hospitals. However, on June 14, 2012, Governor Quinn signed a bill into law that both clarified the definition of charitable activities (those that benefit the health of low-income individuals and that relieve the burden of government with regard to the provision of healthcare for those individuals) and the value of charitable activities required to be eligible for tax exemption. The new legislation stipulates that the value of a hospital's charitable activities must be equal to or greater than the estimated value of a hospital’s property tax exemption.

**Implications: Reality versus Perception**

Perhaps the most significant immediate result of converting from nonprofit to for-profit status relates to the taxation issue. Those hospitals that convert will no longer be exempt from taxation, nor will they be required to meet community benefit requirements. For many nonprofit hospitals, the additional tax liability would create a substantial burden on their already strained financial resources.

Rating agencies, including Fitch and Moody’s, have also issued reports expressing their view that the denial of property tax exemption for nonprofit hospitals will result in a “negative credit development” that will “further strain” the financial performance of many hospital providers in Illinois. This action could then “negatively affect” those hospitals’ ratings.

**Perception:** In the public’s eye, conversion to for-profit status may skew community perception that quality or accessibility of care will be negatively affected. By definition, a nonprofit hospital exists for charitable purposes, and as such, puts the needs of the community as its first priority. However, this can also be true of for-profit hospitals. While they may have varying corporate
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missions or values, they are still charged with delivering high-quality healthcare to the communities they serve.

In reality, there is research showing that a hospital’s tax structure makes little difference in the quality of care provided for patients or in the community benefit or charity care it offers. For example:

“Two decades of research has failed to provide definitive empirical evidence on the differences between for-profit and nonprofit healthcare facilities and on the social consequences of changes in ownership.” – D. Blumenthal, Health Affairs, 2000

“It is worth noting that much of the research into the continued provision of care to the indigent after hospital conversions has found little to no impact.” – “Community Considerations for Hospital Transactions,” published by the Governance Institute, Sept. 2011

Regardless of these findings, the Board and leadership of a nonprofit hospital must consider the negative public perception in the context of a for-profit conversion.
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The Nonprofit Hospital Landscape

According to the American Hospital Association’s 2010 annual survey, 2,904 of the 5,754 hospitals in the US are nongovernment, nonprofit community hospitals. Essentially, 50 percent of our nation’s hospitals operate under federal and state requirements for nonprofit status.

In Illinois, 156 nonprofit community and non-community hospitals make up the State’s total of 225 facilities (70 percent). Ownership status of those nonprofit hospitals is categorized as “Church” (62) or “Other” (94). The Illinois Hospital Association reported in its 2011 Community Benefits Report that 109 of its nonprofit hospitals filed annual reports with the Attorney General’s office, and that their community benefits equaled over $4.6 billion in 2010. These contributions to the community represent a 26 percent increase from 2005 to 2010.

However, according to the IHA, hospitals in Illinois contributed $2.23 billion in government-sponsored care in 2010, representing the greatest portion of total community benefits and far exceeding all other categories of contributions such as bad debt, charity care, education, and language assistance services. Government-sponsored care is defined by the Attorney General as the “unreimbursed cost of Medicare, Medicaid, and other federal, state, or local indigent healthcare programs, eligibility for which is based on financial need.” As stated earlier, nonprofit hospitals provide these benefits in exchange for tax exemption from federal, state, and local taxation authorities. The symbiotic relationship of nonprofit hospitals and the government keeps nonprofit hospitals’ operating costs down while ensuring healthcare access to millions of Americans.

Even though nonprofit hospitals represent the largest cohort of US hospitals, their survival in the current healthcare landscape has become increasingly challenging and has forced hospital leaders to develop innovative and sometimes unconventional strategies to remain viable.

National Hospital Trends: Retooling and Restructuring

According to Becker’s Hospital Review, 2011 was the most active year for mergers, acquisitions, and affiliations of US hospitals in more than a decade. It was estimated that by year end, 95 merger and acquisition (M&A) deals would be struck, up from 77 and 52 in 2010 and 2009, respectively. These transactions represent a variety of arrangements between hospitals, health systems, physician practices, health plans, and others. While it is unknown how many of the total transactions account for nonprofit hospital conversions in 2011, it is likely
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that a number of them involved nonprofit hospitals changing or retooling their corporate structure in one form or another.

By May of 2011, more than half of the hospitals in the US were operating from within a multihospital healthcare system, according to the American Hospital Association (AHA). Becoming part of a multihospital system often involves a change of ownership, governance structure, and bylaws. According to the AHA 2012 Guide, 3,461 hospitals were in a multihospital system in 2011, including: 1,261 that were in investor owned systems; 1,331 that were in secular nonprofit systems; 655 that were in church related systems, and 214 that were government operated. The AHA Guide also identifies 414 multihospital systems, of which 82 are investor owned.

When a for-profit hospital or health system acquires a nonprofit hospital or health system, a change in the nonprofit's ownership status occurs (this also is true in the reverse situation). This is considered a conversion. On the simpler end of the spectrum, a singular nonprofit hospital may file a change of its articles of incorporation to for-profit without a sale or merger transaction. On the more complex (and common) end, nonprofit hospitals can be purchased by another nonprofit or for-profit corporation, thus igniting a formal merger, acquisition, or joint venture transaction.

Because nonprofit hospitals are charitable organizations, they must legally protect their charitable assets in for-profit conversion transactions. In other words, once-philanthropic assets donated to the hospital must not be liquidated into the reserves of for-profit shareholders. This has led to the formation of health conversion foundations, endowed with assets generated by the conversion and charged with funding only health-related activities for the benefit of the community. The IRS classifies these entities as public charities, private foundations, or social welfare organizations.

Since not all conversion transactions are in the public domain, it is difficult to enumerate the number of nonprofit conversions that occur annually in the US. However, a potential indicator of conversion activity may be the creation of health conversion foundations. In 2009, Grant Makers in Health conducted a survey of health foundations created as a result of sales, transfers, or mergers of assets of nonprofit health organizations (up to 2004). The survey found that since the first health conversion foundation was formed in 1973, 197 new foundations have formed.
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The majority of these (53 percent) were formed between 1994 and 1998. Approximately two-thirds of the 197 foundations were created through hospital conversions, with the remaining accounting for conversions of health plans, health systems, and the less common conversion of nursing homes.

Geographically, conversion foundations are found in 37 states and the District of Columbia. California represents the greatest number of foundations formed (20), with assets totaling $5.8 billion. Other leading states include Ohio (17), Pennsylvania (15), Florida (10), and Missouri (10). When the survey was conducted, Illinois had six conversion foundations. On the aggregate, all 197 foundations reported approximately $18.3 billion in assets.

This provides some level of understanding of health conversion foundations relative to the total number of hospitals in the US, roughly four percent. However, not every nonprofit conversion results in the formation of a health conversion foundation—and no two conversion transactions are alike.

What Is Driving Mergers, Affiliations, and Conversions?

It is important to understand the external forces driving hospitals and health systems to consider new relationships and synergies with other corporations, including conversions to for-profit status. For a struggling nonprofit hospital or health system, for-profit conversion can offer a means to gain access to capital and improve its position in the market. Other reasons for conversion and affiliations include, in some combination:

- Healthcare reform, i.e., increased pressure to collaborate and achieve economies of scale
- Self-interest of Board and/or Leadership
- Mission fulfillment
- Burdensome debt service
- Unfunded pension liability
- Reduced payer reimbursements
- Lack of physician loyalty and inability to successfully recruit new physicians
- Loss of market position
- Unfavorable community reputation
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- Difficulties in staff recruitment and retention
- Aging plants and dated infrastructures
- Exclusion from managed care contracts

Even thriving nonprofit hospitals may consider a for-profit conversion in order to secure maximum assets and competitive positioning in their market.

In light of the PPACA’s aim to increase access to health coverage for millions of Americans, it is anticipated that nonprofits will see a reduction in their overall bad debt and charity care. While this is a positive in many respects, it will also have a detrimental effect on certain organizations. A significant reduction in community benefits may put an organization at risk for taxation depending on state legislation.

Conversion Considerations

When pursuing conversion as a solution to solvency, a number of issues come to bear on the hospital’s leadership and their strategy for successful implementation. Legal and regulatory approval is just one facet of conversion; it can be a very complex process, which varies from state to state.

In many states, attorneys general can exercise their authority to oversee and monitor conversion activities through common law and nonprofit corporation law. In fact, according to the Government Accountability Office, at least 24 states have enacted legislation regarding nonprofit hospital conversions to for-profit entities. Generally, these laws include provisions for public disclosure of the transaction, fair valuation of the charitable assets of the hospital, and assurances that the proceeds of the transactions will continue to be used to provide community benefits.

However, not every state has specific conversion legislation, leaving many of the nuances of conversion open to interpretation and controversy. At the federal level, taxation and anti-trust considerations relative to nonprofit conversions are the jurisdiction of the IRS, Federal Trade Commission, and Department of Justice.

Mechanically speaking, a nonprofit conversion will force leadership to make good on its charitable assets by forming a health conversion foundation. This is one way for a hospital to
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maintain its reputation as a reliable community provider post-conversion. Some services that will no longer be provided by the new for-profit structure can be funded by the newly formed foundation.

All bureaucratic considerations aside, the party who is most at-risk in a conversion (or any corporate restructuring transaction) is the patient. A hospital’s ability to continue delivering quality care to its patient population is its first priority. Conversions can change patient and community perception of a hospital (and subsequent market share). Careful branding and community messaging can allay fears and even strengthen perception, but marketing maneuvers must be supported by patient-oriented solutions.
IV. Case Studies

Case Study Examples

The following conversion examples were taken from a 2001 report by the Commonwealth Fund, *The For-Profit Conversion of Nonprofit Hospitals in the U.S. Health Care System: Eight Case Studies.* The study examined the long-term effects of nonprofit hospital conversion on community and financial performance. A variety of hospitals and situations were chosen for the study, in order to provide a broad spectrum of circumstances and outcomes. Researchers specifically chose transactions that took place around 1990, so that long-term impact could be analyzed.

The case studies below are not statistically representative of the entire conversion hospital universe. Of the 1,261 hospitals operating in investor owned systems, more than one third have been for-profit for more than 20 years, are financially stable, and have not undergone a subsequent change in ownership. Further, for many nonprofit hospitals, the conversion or sale to a for-profit is often a last-ditch effort to rescue an already struggling, distressed entity. According to the American Hospital Association, over the last 30 years, more than 800 hospitals have closed throughout the US.

**Burbank Community Hospital - Burbank, California**
- 100-bed hospital purchased by local physicians in 1991, and sold again to an independent investor in 1995
- Lost Medicare license and closed in 1997
- Sold to Vencor, Inc. in 1997, which opened it briefly in 1998 and closed it again that same year

**Palo Verde Hospital - Blythe, California**
- 55-bed hospital, leased by Brim, Inc. with an option to buy from a district board in 1992
- Sole community provider in an isolated desert town of 10,000
- Currently financially stable and has community support

**Victoria Hospital - Miami, Florida**
- 200-bed hospital, sold to Columbia Hospital Corporation and physician investors in 1988
- Located in a low-income community in Miami’s Little Havana, near Jackson Memorial, a sprawling public hospital
- Columbia bought nearby Cedars Medical Center in 1993, consolidated the two hospitals, and closed Victoria Hospital later that year

**Doctors’ Hospital - Coral Gables, Florida**
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- 157-bed hospital, sold to Healthsouth Corporation in 1992
- Located in an affluent neighborhood
- Post-conversion expansion of sports medicine services, financially stable

**Metropolitan General - Pinellas Park, Florida**
- 155-bed hospital, sold to Community Health Systems in 1992
- Flawed physical structure, over-bedded market, and financially unstable post-conversion
- Columbia/HCA acquired the hospital in a swap with CHS in 1996 and closed it

**Michael Reese Hospital - Chicago, Illinois**
- 600-bed teaching hospital on the near South Side, purchased by Humana in 1991 as part of a deal to purchase the hospital-owned HMO
- Operated as a 150-bed hospital with no teaching/research capabilities, financially distressed
- Ceased operations on June 30, 2009

**Doctors’ Hospital of Hyde Park - Chicago, Illinois**
- 200-bed South Side hospital purchased out of bankruptcy in 1992 by a controversial ophthalmologist and owner of eye surgery clinics
- Pursued community outreach as a strategy for survival, nursing home affiliations, home visit program, and chronic care services
- Paid $4.5 million to Medicare after whistleblower suit for DRG upcoding in 1999
- Declared bankruptcy in 2000 and closed

A full copy of the Commonwealth Fund report can be found at:


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