An April 4, 2008, article in The Wall Street Journal by John Carreyrou and Barbara Martinez painted much of the not-for-profit hospital industry in a negative light. There were a number of themes that ran throughout this article, but four received the majority of attention:

> Not-for-profit hospitals have high profit levels.
> Cash balances at many not-for-profit hospitals are high.
> Salaries of key executives are excessive.
> Not-for-profit hospitals do not give back enough charity care.

These four points are used as evidence to question the appropriateness of tax exemption for the not-for-profit hospital sector. Much of the article revolves around specific situations at a select number of not-for-profit hospitals and hospital systems.

It is my belief that the article has serious logic flaws that call into question the conclusions of the article. The authors seem to extrapolate from a very limited number of hospitals to reach conclusions about the entire not-for-profit hospital industry. The authors also cite financial metrics without putting them into a proper context.

**Profit Levels of Not-for-Profits**

The opening salvo of the article references an eight-fold increase in profits from the 50 largest not-for-profit hospitals from 2001-06. The data source was the American Hospital Directory, which uses filed Medicare Cost Reports. From our firm’s Medicare Cost Report databases, we also defined the 50 largest not-for-profit hospitals in 2006. We also discovered that the profit increase from 2001-06 was approximately eight-fold, as cited by the authors. Our top 50 acute care not-for-profit hospitals earned $4.6 billion in 2006, slightly above the $4.27 billion reported in the article.

Using an absolute level of profit for any firm or any industry is of limited value until it is related to underlying investment. Large capital-intensive firms clearly require larger levels of income to maintain operations. We calculated the return on equity (ROE) in 2006 for these 50 hospitals to be 12.8 percent. To put this in perspective, the average return on equity for the Standard & Poor’s 500 in the last five years was 19.6 percent after tax. The eight-fold increase has produced a current ROE that is not unreasonable by other industry standards, and furthermore does not recognize the base year performance in 2001. In 2001, these 50 hospitals had a collective ROE of only 2.4 percent.

Quite clearly, a ROE of 2.4 percent in 2001 was not sufficient to maintain the financial viability of these 50 hospitals. The critical question is not the eight-fold increase in net income, but rather, what level of profit is reasonable for not-for-profit hospitals? Not-for-profit hospitals are very capital-intensive businesses, and they are constantly replacing capital equipment at significantly higher costs. They cannot finance 100 percent of their capital needs with debt, so a positive return is required. Ultimately, a not-for-profit hospital must generate an ROE that is equal to its expected growth rate in assets to maintain sustainable growth. These top 50 not-for-profit hospitals have increased their total investment levels at about 8 percent per year, which would indicate a required ROE of 8 percent per year, very similar to the average ROE in 2001 and 2006, 7.6 percent.

The authors cite the Cleveland Clinic’s $229 million profit in 2006 as one example of excessive profit. We validated the accuracy of this number, but, again, the magnitude of the number is not as
relevant as the relationship to investment. The Cleveland Clinic is a large operation, and $229 million represented a 12.3 percent ROE in 2006, compared with a negative ROE of 0.4 percent in 2001. I cannot see how this example demonstrates profit gouging by the Cleveland Clinic. If the Cleveland Clinic operated at a loss or break-even level, the excellence of medical care for which the clinic is so well known would erode very quickly.

**Cash Balances at Not-for-Profits**

The article also implies that not-for-profit hospitals are holding excessive cash and investment positions. Ascension Health was singled out for having $7.4 billion in a “treasure chest,” which the authors described as more than that of many large publicly traded companies. We obtained Ascension’s 2007 audited financial statements and did validate the $7.4 billion cash and investment position. Although the number is large, Ascension’s total 2007 operating revenue was $12.3 billion, which is larger than any publicly traded hospital company.

The real question that should have been addressed is not the dollar amount, but the relationship of the cash amounts to the need. For not-for-profit hospitals, the primary purpose for cash and investments is replacement of fixed assets. In 2007 Ascension Health reported $11.9 billion of gross property and equipment in its 2007 audit. By contrast, in 2007 Microsoft had $23.4 billion in cash and investments, but only $9.4 billion in gross fixed assets. Ascension does have significant cash reserves, but more than likely, its cash position is dedicated for future replacement and renovation. Ascension Health does not have the luxury of issuing new equity shares to finance future capital needs, but must fund replace its capital from cash balances and new debt offerings.

**Salaries of Key Executives**

The third issue cited by the authors was excessive compensation levels of hospital executives. Ten individuals were cited with compensation levels running from $3.3 million to $16.4 million. On the surface, these numbers appear to be high because many people believe not-for-profit companies should not pay their executives at levels comparable with private industry. A review of CEO compensation figures for the five largest (by revenue) publicly traded hospital management firms in 2006 shows that the average 2006 compensation for these five investor-owned systems was $7.4 million. These compensation levels are quite large, but pale in comparison with some compensation levels of executives in other industries. Assuming that compensation for these firms is reasonable, it is important to recognize that many of the executives cited by the authors have been approached by investor-owned firms for executive positions. Not-for-profit hospitals are very large business entities that require the very best management talent to run them effectively. Although money is not the sole motivation for not-for-profits, those who work in not-for-profit hospitals do have options and are being courted frequently by private for-profit ventures. Not-for-profit hospitals must pay competitive wages to attract and retain nurses, physical therapists, and executive talent.

The *Wall Street Journal* authors have uncovered some of the highest compensation levels for not-for-profit executives, but these levels are still not out of line with compensation levels of publicly traded hospital firms. Recognize that the not-for-profit hospital firms cited are also very large. For example, Ascension’s $12.3 billion operating revenue exceeds the largest publicly traded hospital firm. Catholic Healthcare West, which was also singled out, had $7.5 billion of revenue in 2007, more than any of the public firms except Tenet.

The real question regarding compensation is whether the executives returned value commensurate with their compensation. The boards of the organizations cited have compensation committees and must believe that they have established reasonable levels of compensation.

**Charity Care Given by Not-for-Profits**

The final theme of the article is the key takeaway: The authors believe that many not-for-profit
hospitals are not giving back enough charity care to justify their tax-exempt status, but they cite only one hospital, Northwestern Memorial Hospital. The authors claim that Northwestern Memorial Hospital’s annual tax exemption is worth $50 million, more than two times its charity care. They further state that only 6 percent of the hospital’s revenues come from Medicaid. Northwestern Memorial Hospital’s CFO states that the community value provided is closer to $230 million annually.

Obviously, community value is a subjective concept at the present time, but it is possible to test a few of the points made by the authors regarding Northwestern Memorial Hospital. First, there is an implied understanding that Northwestern Memorial Hospital is making lots of money, but is it? In 2006, Northwestern Memorial Hospital realized income from patient services of $12.2 million on $981.2 million of net patient revenue, a margin of 1.2 percent. Total net income was $107.2 million, which, given unrestricted net assets of $1,684.8 million, yields a ROE of 6.4 percent.

The 2006 ROE of Northwestern Memorial Hospital is not excessive, and in fact is below U.S. averages. The article also stated Northwestern Memorial Hospital had a low percentage of Medicaid patients (6 percent, according to the article). Medicaid days at Northwestern Memorial Hospital in 2006 were 37,730 on total days of 232,583, or 16.2 percent. This level is very different from 6 percent and is above the U.S. median for Medicaid days. With this level of Medicaid patients, a sizable subsidy as measured by cost less payment was provided by Northwestern Memorial Hospital to the state of Illinois.

If Northwestern Memorial Hospital is the authors’ best case for questioning not-for-profit hospital tax exemption, they picked a poor example. A one-time observation of high executive compensation is not a compelling argument against Northwestern Memorial Hospitals, let alone the entire not-for-profit hospital industry. 


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