The Law of Tax-Exempt Healthcare Organizations

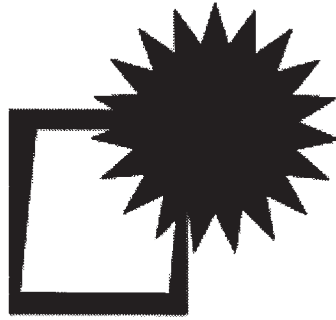
Third Edition

Thomas K. Hyatt
Bruce R. Hopkins

John Wiley & Sons, Inc.

The Law of Tax-Exempt Healthcare Organizations

Third Edition



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Thomas K. Hyatt
Bruce R. Hopkins

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To my boys, Sean and Conor
TKH

To my colleagues in the Health Care Practice Group at
Polsinelli Shalton Flanigan Suelthaus PC
BRH

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Mr. Hyatt is a member of the American Health Lawyers Association (AHLA) and is also a member of the American Bar Association and the District of Columbia Bar. He served as a member of AHLA's Board of Directors from 1992 to 1998. Tom is one of the inaugural Fellows of AHLA. In 2004, Mr. Hyatt received AHLA's David J. Greenburg Service Award. He is listed in the 2005–2008 editions of *Best Lawyers in America*. He is a licensed consultant for the Standards for Excellence Institute. He frequently lectures on business and tax planning issues for nonprofit health care providers and has written numerous articles for publication on tax-exempt organization topics. In addition to *The Law of Tax Exempt Healthcare Organizations, Third Edition*, he is the author of a chapter entitled "Tax Exemption Issues for Healthcare Organizations" in the *Health Law Practice Guide*, published by Thomson/West, New York, New York. He is also the general editor and a contributing author to *The Nonprofit Legal Landscape*, a guidebook for managers and directors published by BoardSource.

Mr. Hyatt is a 1979 *cum laude* graduate of Boston College, and received his law degree in 1982 from the University of Pittsburgh, where he served as Editor-in-Chief of the Journal of Law and Commerce.

Bruce R. Hopkins is a senior partner in the law firm of Polsinelli Shalton Flanigan Suelthaus PC, practicing in the firm's Kansas City, Missouri, and Washington, D.C., officies. He specializes in the field of healthcare and other tax-exempt organizations law. His practice ranges over the entirety of

tax matters involving tax-exempt organizations, with emphasis on the formation of nonprofit organizations, acquisition of recognition of tax-exempt status for them, the private inurement and private benefit doctrines, the intermediate sanctions rules, legislative and political campaign activities issues, public charity and private foundation rules, unrelated business planning, use of exempt and for-profit subsidiaries, joint venture planning, tax shelter involvement review of annual information returns, Internet communications developments, the law of charitable giving (including planned giving), and fundraising law issues.

Mr. Hopkins served as Chair of the Committee on Exempt Organizations, Tax Section, American Bar Association; Chair, Section of Taxation, National Association of College and University Attorneys; and President, Planned Giving Study Group of Greater Washington, D.C.

Mr. Hopkins is the series editor of Wiley's Nonprofit Law, Finance, and Management Series. In addition to *The Law of Tax-Exempt Healthcare Organizations, Third Edition,* he is the author of *The Law of Tax-Exempt Organizations, Ninth Edition; The Planning Guide for the Law of Tax-Exempt Organizations: Strategies and Commentaries; IRS Audits of Tax-Exempt Organizations: Policies, Practices, and Procedures; The Tax Law of Charitable Giving, Third Edition; The Law of Fundraising, Third Edition; The Tax Law of Associations; The Tax Law of Unrelated Business for Nonprofit Organizations; The Nonprofits' Guide to Internet Communications Law; The Law of Intermediate Sanctions: A Guide for Nonprofits; Starting and Managing a Nonprofit Organization: A Legal Guide, Fourth Edition; Nonprofit Law Made Easy; Charitable Giving Law Made Easy; 650 Essential Nonprofit Law Questions Answered; The First Legal Answer Book for Fund-Raisers; The Second Legal Answer Book for Fund-Raisers; The Legal Answer Book for Nonprofit Organizations; The Second Legal Answer Book for Nonprofit Organizations;* and *The Nonprofit Law Dictionary;* and is the co-author, with Jody Blazek, of *Private Foundations: Tax Law and Compliance, Second Edition;* also with Ms. Blazek, *The Legal Answer Book for Private Foundations;* and with David O. Middlebrook, *Nonprofit Law for Religious Organizations: Essential Questions and Answers.* He also writes *Bruce R. Hopkins' Nonprofit Counsel*, a monthly newsletter published by John Wiley & Sons.

Mr. Hopkins received the 2007 Outstanding Nonprofit Lawyer Award (Vanguard Lifetime Achievement Award) from the American Bar Association, Section of Business Law, Committee on Nonprofit Corporations. He is listed in *The Best Lawyers in America*, Nonprofit Organizations/Charity Law, 2007 and 2008.

Mr. Hopkins earned his J.D. and L.L.M. degrees at the George Washington University and his B.A. at the University of Michigan. He is a member of the bars of the District of Columbia and the state of Missouri.

Book Citations

Throughout this book, 8 books by Bruce R. Hopkins (in some cases as co-author), all published by John Wiley & Sons, Inc., are referenced in this way:

Book	Cited As
1. *IRS Audits of Tax-Exempt Organizations: Policies, Practices and Procedures* (2008)	IRS AUDITS
2. *The Law of Fundraising, Third Edition* (2002)	FUNDRAISING
3. *The Law of Intermediate Sanctions: A Guide for Nonprofits* (2003)	INTERMEDIATE SANCTIONS
4. *Planning Guide for The Law of Tax-Exempt Organizations: Strategies and Commentaries* (2004)	PLANNING GUIDE
5. *Private Foundations: Tax Law and Compliance, Second Edition* (2003)	PRIVATE FOUNDATIONS
6. *Starting and Managing a Nonprofit Organization: A Legal Guide, Fourth Edition* (2005)	STARTING AND MANAGING
7. *The Tax Law of Charitable Giving, Third Edition* (2005)	CHARITABLE GIVING
8. *The Tax Law of Unrelated Business for Nonprofit Organizations* (2005)	UNRELATED BUSINESS

The second, fifth, and seventh of these books are annually supplemented. Also, updates on all of the foregoing subjects (plus The Law of Tax-Exempt Healthcare Organizations) are available in Bruce R. Hopkins' Nonprofit Counsel, a monthly newsletter, also published by Wiley.

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Preface

This Third Edition of *The Law of Tax-Exempt Healthcare Organizations* chronicles some of the most remarkable tax law and policy developments ever witnessed by tax-exempt healthcare organizations. These developments are due in no small part to the tremendous growth of the nonprofit sector, both in number and in scope. From 1997 to 2007, the number of tax-exempt organizations on the Internal Revenue Service's master file increased by more than 350,000. The total number of exempt organizations now totals 1.6 million, which does not include most churches. According to the IRS, the value of the assets held by these organizations is more than three trillion dollars. The growth and increasing commercialization of the nonprofit sector have attracted the attention of the IRS, Congress, the courts, charity watchdog groups, the media, and the public. As a result, the seven years since the previous edition have seen intense scrutiny of the sector and a renewed vigor in efforts to regulate and govern it.

The primary focus of these forces has been to improve the governance of nonprofit organizations. The role of the board of directors, best governance practices, oversight of compensation and conflicts of interest, and transparency and accountability are critical issues for every nonprofit organization today. In recognition of these important developments, we have added a chapter to the book on governance. Clearly a catalyst for the new focus on governance was the Sarbanes-Oxley Act of 2002. While it applied primarily to publicly traded for-profit corporations and their accountants, its principles were promoted for use by nonprofits. The C-suite and boardroom scandals that brought about the Sarbanes-Oxley Act were not unique to for-profits; excess compensation, improper expenditures, and lax oversight by boards of directors occurred all too frequently on the nonprofit side.

Congress responded by holding several hearings to examine the validity of continuation of provision of the benefits of tax exemption to nonprofit organizations, with particular attention paid to healthcare organizations. The Senate Finance Committee, and in particular its ranking member Senator Charles Grassley, have used the bully pulpit of the Committee to ask hard questions of nonprofits and to demand quick, thorough, and public responses. The Senate Finance Committee's staff prepared a discussion draft of legislative reforms for the charitable sector which quickly became a rallying point for a sector that much preferred self-regulation. The Pension Protection Act of 2006 saw some of the proposed charitable reforms become law, primarily addressing abuses by supporting organizations. However, for the most part,

Congress has allowed the nonprofit sector to develop its own best practices and will watch carefully as it implements them.

As for the IRS, the most important and visible development resulting from this extensive scrutiny was the redesigning of Form 990. Until recently, this annual information return was primarily a vehicle for disclosing financial data. While still essential, reporting financial data has taken a back seat on the new Form 990. The chief focus of the new form is governance. The expressed intent of the IRS is to improve transparency and promote accountability for all exempt organizations. The new 990 also marks a shift in the IRS's efforts back to enforcement. In the last decade, most of the IRS's activity in the exempt organizations arena was in the area of education, guidance, and outreach. The IRS is now redeploying its resources to ensure that its investment in education results in greater compliance. It has employed several new tools in this regard, most notably the compliance check which provides data to the IRS to enable it to undertake more targeted examinations. The Form 1023 has also been reborn and now probes more deeply into the proposed activities of a nonprofit organization, particularly with regard to potential conflict of interest issues, compensation, and commercial activity.

A debate detailed in the last edition that continues to burn brightly in this edition is that of the level of charity care and community benefit that must be provided by tax-exempt healthcare organizations in exchange for recognition of their tax-exempt status. Some in Congress and in other corners have urged a return to a basis for exemption for healthcare organizations that relies primarily on the provision of charity care. However, the IRS's 1969 community benefit standard continues to be vital and has recently been validated in federal appellate court decisions. It is a dynamic standard which is still being defined, most notably in the new Schedule H for Form 990 which must be completed by tax-exempt hospitals.

Executive compensation in tax-exempt organizations has also been, to use a term coined by the IRS, a ''fertile area of inquiry.'' The GAO undertook a study of executive compensation in healthcare organizations and the IRS initiated a compliance check in this area as well. A wave of examinations has been launched as a result of these inquiries with particular attention being focused on loans by nonprofits.

We have seen since the last edition some settling of guidance in areas in which the IRS has apparently decided that it has said what it has to say. Prime examples are the topics of joint ventures and physician recruitment. However, in other areas, guidance is still wanting, most notably with regard to the application of the commercial-type insurance rules to health maintenance organizations. The IRS has indicated that it continues to consider regulations in this area and that its actions will be shaped by pending federal court cases.

Finally, we note the passing in 2006 of Bob Bromberg. To say that Bob was the dean of the healthcare tax bar is to understate the case. Bob founded

the National Health Lawyers Association tax program in 1975 and chaired it for 21 years. He served on the board of directors of NHLA and became its president in 1986. His treatise on tax exemption for hospitals was substantive and scholarly and was the only work in the field for many years. In addition to authoring seminal regulations and rulings at the IRS, Bob published more than 75 articles. He left his mark on the law of tax-exempt healthcare organizations, and it will be a lasting one.

We hope that you find the Third Edition useful to your practice. Given the pace of developments in this area, the next supplement cannot be far behind.

Thomas K. Hyatt
Bruce R. Hopkins
February, 2008

PART ONE

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CHAPTER ONE

Rationale for Tax-Exempt Healthcare Organizations

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The waxing and waning of tax policy, at the federal and state levels, has pushed nonprofit healthcare organizations to the fore of scrutiny and into the heart of the debate over eligibility for tax-exempt status. No category of tax-exempt organization has its tax exemption in greater jeopardy than hospitals, health maintenance organizations (HMOs), and other healthcare providers. Few other types of exempt organizations are raising as many unrelated income issues as these entities. Moreover, when it comes to the creation of new organizations and the triggering of new tax questions, no group of nonprofit organizations can top nonprofit healthcare organizations.

This high-profile position and the resulting predicament for healthcare entities are explicable on a very fundamental basis: government regulators, legislators, and the public are finding it increasingly difficult to differentiate the practice of healthcare by nonprofit organizations from that by for-profit organizations. Part of this confusion is attributable to the evolving forms of healthcare vehicles and the dramatic changes in the places where medicine is practiced and healthcare otherwise delivered. Other elements of the confusion are traceable to the alterations in the way healthcare is funded: the enactment of the Medicare and Medicaid programs greatly expanded the universe of individuals who could, directly or indirectly, "pay" for healthcare services; the injection of healthcare services into the realm of employment benefits forced greater funding of healthcare services by employers and shifted a large part of healthcare funding to commercial insurance companies.

Much of *health law* evolved from the regulatory frameworks built up around the government-financed healthcare benefits and the ways in which

the insurance companies set about to reduce the amounts paid out to, or for the care of, benefits claimants. As these bodies of regulation grew (typified by *anti-abuse* and *patient dumping* rules) and inequitable insurance practices (highlighted by denials of coverage because of ''preexisting conditions'' and changes of employers) became more commonplace, the nation's healthcare system became troubled.

Consumers became first perplexed and then angered by the rapidly evolving and shifting healthcare system's institutional look. The role of free-standing hospitals declined, and massive *systems* took their place. The intricacies of HMOs had to be parsed, traditional private practices gave way to mysterious combinations of physicians with their ever-more-focused subspecialties, and the modern patient saw his or her illness treated through something called an ''integrated delivery system.''

The last decade of the twentieth century brought much cacophony but little in the way of actual accomplishment as to healthcare legislation. Despite the frenetics of the healthcare marketplace, very little was translated into federal tax law. The Clinton Administration's massive effort to reform the healthcare delivery system failed. The 103d Congress (1993–1994) spent a major portion of its second session struggling with many versions of healthcare legislation; not much came of that. Subsequent years saw Congress talk much about healthcare delivery law revision, including a substantial focus on managed care; nothing, however, was enacted. As the debate in and out of Congress about the appropriateness, as a matter of tax policy, of tax exemption for nonprofit hospitals and similar entities has intensified,[1] greater attention is being given to the possibility of legislation on the topic. For example, legislation was introduced late in 2006 to deny exempt status and impose excise taxes on medical care providers that fail to provide a minimum level of charity medical care.[2]

Congress's inability to generate substantial healthcare legislation has not slowed the ongoing revision of and expansion in health law. Experiments at the state level and the forces of the marketplace are rapidly altering the way healthcare services are being provided in this country. Of great importance, the policymakers in the Department of the Treasury and in the Internal Revenue Service[3] are continuing to reshape the role of nonprofit, tax-exempt healthcare providers and funders in the healthcare delivery process.

This book concerns the *law of tax-exempt healthcare organizations*. For the most part, this law consists of federal health law and tax law requirements. Other relevant federal and state laws that apply to tax-exempt healthcare organizations are referenced throughout the book.

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1. See § Chapter 3.
2. Tax Exempt Hospitals Responsibility Act of 2006 (H.R. 6420, 109th Cong., 2 d Sess. 2006).
3. The Internal Revenue Service is referred to throughout this book as the ''IRS'' or occasionally the ''Service.'' The Internal Revenue Code is referred to as ''IRC,'' followed by the section (''§'') number(s).

§ 1.1 DEFINING *TAX-EXEMPT ORGANIZATIONS*

A *tax-exempt organization* is a unique entity.[4] Almost always, it is a *nonprofit organization*.[5] The concept of a nonprofit organization is usually a matter of state law[6]; the concept of a tax-exempt organization is principally a matter of the federal tax law.[7]

The universe of nonprofit organizations in the United States comprises the nation's *nonprofit sector*—a name that has not been a totally comfortable fit for those within the sector. Over the years, it has been called, among other appellations, the ''philanthropic sector,'' ''private sector,'' ''voluntary sector,'' ''third sector,'' and ''independent sector.'' In a sense, none of these terms is appropriate.[8]

Essentially, there are three *sectors* in a democratic or civil society: governmental, for-profit, and nonprofit. Governmental entities are the branches, departments, agencies, and the like, of the federal, state, and local governments. For-profit entities comprise the business or commercial sector of a society. Nonprofit organizations constitute the nonprofit sector,[9] which is critical for the maintenance of freedom and as a bulwark against the excesses of the other two sectors.

In addition to confining the organization's purpose to *nonprofit* endeavors, the rules of state law concerning the creation of nonprofit organizations usually address subjects such as the origin and composition of the organization's governing board, the functions of the officers, the nature of committees, voting and document amendment processes, and mergers, liquidations, and dissolutions.

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4. This body of law is discussed in detail in TAX-EXEMPT ORGANIZATIONS.
5. The term *nonprofit* organization is used throughout, rather than the term *not-for-profit* organization. The latter term is technically proper usage (e.g., in the federal tax setting) to describe activities (rather than organizations) the expenses of which do not qualify for the business expense deduction (IRC § 162) because they are not undertaken with the requisite ''profit'' motive (IRC § 183).
6. Nearly every state has a nonprofit corporation law; many have extensive laws pertaining to trusts and other unincorporated entities. Occasionally, a nonprofit organization is created by federal statute. *See*, in general, HOPKINS, STARTING AND MANAGING, Chapters 2–4.
7. Nearly every state's tax law makes provision for some forms of tax-exempt organizations (and charitable contribution deductions), but these laws tend to follow the federal approach.
8. An excellent compilation and discussion of these and other such terms are available in HODGKINSON, LYMAN, AND ASSOCIATES, THE FUTURE OF THE NONPROFIT SECTOR (1989).
9. This summary is substantially oversimplified; the roles of the sectors are rarely so orderly and functionally classifiable. Instead, there is much overlap of functions among the sectors, such as when a nonprofit organization engages in a commercial activity (an unrelated business (*see* Chapter 24)) or when a for-profit organization engages in an activity thought by some to be exclusively in the domain of the nonprofit sector (such as scientific research or community services). One of the sources of the confusion about healthcare organizations is the fact that, in the United States, these organizations are found in all three societal sectors.

There is a substantial conceptual difference between *nonprofit* organizations and *tax-exempt* organizations. Almost all tax-exempt organizations are nonprofit organizations, but some types of nonprofit organizations are ineligible for forms of federal and/or state tax exemptions. Thus, certain types of nonprofit healthcare organizations cannot qualify as tax-exempt organizations.

Indeed, there is considerable misunderstanding as to what the word *nonprofit* means. The use of that descriptive does *not* mean that a nonprofit organization cannot earn a ''profit''—an excess of revenue over expenses. Indeed, many nonprofit organizations—and the healthcare field is at the top of this list—generate considerable ''profits.'' Rather the essential difference between a nonprofit organization and a for-profit organization is embedded in the *private inurement doctrine*.[10] For the most part, this difference is rarely found in the organization's structure or operating characteristics: both categories of organizations require a legal form, almost always have directors and officers, pay compensation, face basically the same expenses, and are able to receive a ''profit,'' make investments, and produce goods and/or services.

The concept of a nonprofit organization is best understood by comparing it with a for-profit organization. A for-profit entity has owners—those who hold equity in the enterprise, such as stockholders in a corporation or partners in a partnership. A nonprofit organization rarely has owners[11]; however, both types of organizations have controlling persons or bodies. For-profit and nonprofit organizations are entitled to earn a profit, known as profit at the *entity level*. The chief feature differentiating these organizations is the purpose to which the entities' profits are directed.

The for-profit organization is operated for the purpose of generating a profit or benefit for its owners. The profits of the enterprise are passed through the organization to its owners for their private benefit and use, such as the payment of dividends to the stockholders of a corporation. This transfer of profits (the federal tax law defines them as *net earnings*) is termed *inurement* of the profits. A for-profit organization is intended to generate a profit for its owners. The passage of the profits from the for-profit organization to its owners is an inurement of net earnings to the owners in their private capacity.

In contrast, a nonprofit organization generally is not permitted to distribute its profits to those who control and/or financially support it; that is, most nonprofit organizations are not permitted to engage in forms of private inurement. (This prohibition on private inurement is reflected in the criteria of several categories of tax-exempt organizations, including nearly all types of exempt healthcare organizations.) The nonprofit organization usually seeks to devote its profits to some end that is beneficial to society. Consequently, the

10. *See* Chapter 4.
11. A few states allow nonprofit corporations to issue stock; this is done for control purposes only. The stock does not carry with it any *rights* to dividends.

private inurement doctrine is the substantive dividing line that separates, for law purposes, nonprofit organizations from for-profit organizations.

The private inurement doctrine is applicable to many types of tax-exempt organizations, but it is most pronounced and developed with respect to charitable organizations.[12]

Thus, there are subsets and subsubsets within the nonprofit sector. Tax-exempt organizations are subsets of nonprofit organizations. Charitable organizations are subsets of tax-exempt organizations. Many types of tax-exempt healthcare organizations are subsets of charitable organizations.[13]

These elements of the nonprofit sector may be visualized as a series of concentric circles, as shown in Exhibit 1.1.

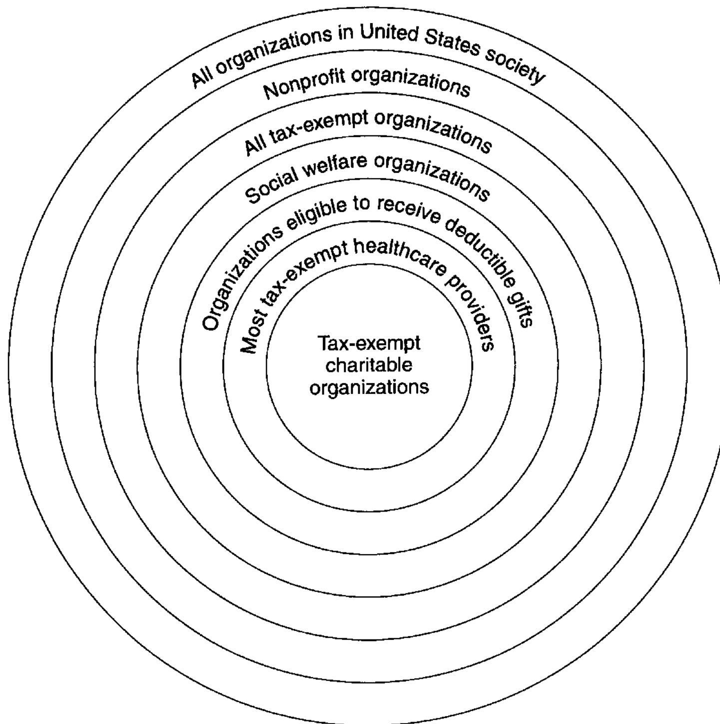

EXHIBIT 1.1

The Nonprofit Sector

12. The federal law of tax exemption for charitable organizations requires that each of these entities be organized and operated so that "no part of . . . [its] net earnings . . . inures to the benefit of any private shareholder or individual" (IRC § 501(c)(3)). *See*, in general, Chapter 4.
13. The complexity of the federal tax law is such that the charitable subsector is also divided into two segments: (1) charitable organizations that are *private foundations* and (2) those that are *public charities* (the latter being all charitable organizations that are not private foundations). (*See* Chapter 5.)

For a variety of reasons, the organizations comprising the nonprofit sector of the United States have been granted exemption from federal and state taxation and, in some instances, have been made eligible to receive contributions that are tax-deductible under federal and state law. Yet, despite the longevity of many of these exemptions and deductions, their underlying rationale is usually vague and varying. Nonetheless, the rationales for tax exemption (and the charitable contribution deduction) are long-standing public policy, an inherent tax theory, and unique and specific reasons that occasioned the enactment of a particular tax provision.

§ 1.2 RATIONALES FOR TAX EXEMPTION

One commentator astutely observed that the various categories of tax-exempt organizations ''are not the result of any planned legislative scheme'' but were ''enacted over a period of eighty [now nearly 100] years by a variety of legislators for a variety of reasons.''[14]

The federal income tax dates from 1913, when the Revenue Act of that year was passed, in the aftermath of ratification of the Sixteenth Amendment to the U.S. Constitution. Congress had attempted to create a corporate income tax in 1894; that enactment succumbed to a constitutional challenge.[15] Both measures contained some categories of tax-exempt organizations, including charitable, educational, and religious entities. (Prior to 1894, all customs and other tax legislation enacted by Congress specified the entities subject to taxation; thus, until that date, tax ''exemption'' existed by virtue of statutory omission.)

Although most of the legislative history accompanying the 1913 tax act and subsequent revenue acts is silent on the reasons for initiating and continuing tax exemptions (and, later, charitable contribution deductions), the rationale for tax exemption for charitable and similar organizations is relatively clear. It represented the extension of comparable practice throughout the whole of history. ''[The] history of mankind reflects that our early legislators were not setting precedent by exempting [from tax] religious or charitable organizations.''[16] Presumably, Congress simply believed that these organizations should not be taxed and found the proposition sufficiently obvious as to not warrant extensive explanation.

For the United States and other democratic nations, the community of nonprofit organizations is a necessary ingredient of a civil society. Through

14. McGovern, ''The Exemption Provisions of Subchapter F,'' 29 *Tax Lawyer* 523, 524 (1976).
15. *Pollock v. Farmers' Loan and Trust Co.*, 157 U.S. 429 (1895), *overruled on other grounds, State of South Carolina v. Baker*, 485 U.S. 505 (1988).
16. McGovern, *supra* note 14, at 527. Also, Hansmann, ''The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation,'' 91 *Yale L.J.* 69 (1981); Bittker and Rahdert, ''The Exemption of Nonprofit Organizations from Federal Income Taxation,'' 85 *Yale L.J.* 299 (1976).

these organizations, citizens can resolve societal problems and enhance the quality of life for all, without channeling all problem-solving efforts through government. In this sense, the nonprofit sector mirrors the traditional American wariness of the state; fear of ''big government'' is assuaged by the ''pluralism of institutions.''[17] Therefore, the thinking underlying the tax policy in this setting was and has been that taxation of most nonprofit organizations would be antithetical to and frustrative of the political philosophy on which the nation is based.

There is a related, albeit secondary, rationale to be considered. Clues to it are found in the federal tax regulations, where *charitable* activities are defined as including purposes such as the relief of the poor, advancement of education or science, erection or maintenance of public buildings, and lessening of the burdens of government.[18] The exemption for charitable organizations is, then, a derivative of the concept that they perform functions that, in the absence of the organizations, government would have to perform. Therefore, government is willing to forgo the tax revenues it would otherwise receive in return for the public services rendered by charitable organizations (and, to some extent, social welfare organizations[19]).

Since the founding of the United States and even in the earlier colonial period, tax exemption—particularly with respect to religious organizations—was common. Churches were openly and uniformly spared taxation. This practice has been sustained throughout the nation's history—not only at the federal but at the state and local levels as well, most significantly with property taxation. The U.S. Supreme Court, soon after the commencement of the nation's tax system, concluded that the foregoing rationalization was the basis for the federal tax exemption for charitable entities. In 1924, the Court noted that ''[e]vidently the exemption is made in recognition of the benefit which the public derives from corporate activities of the class named, and is intended to aid them when not conducted for private gain.''[20] Many years later, the Court, in upholding the constitutionality of the tax exemption for religious organizations, observed that ''[t]he State has an affirmative policy that considers these groups as beneficial and stabilizing influences in community life and finds this classification [tax exemption] useful, desirable, and in the public interest.''[21]

In respect to the exemption for charitable organizations, a federal court of appeals wrote that ''[o]ne stated reason for a deduction or exemption of this kind is that the favored entity performs a public service and benefits

17. Mill, *On Liberty* (1859).
18. Income Tax Regulations (''Reg.'') § 1.501(c)(3)-1(d)(2).
19. *See* § 1.8.
20. *Trinidad v. Sagrada Orden de Predicadores de la Provincia del Santisimo Rosario de Filipinas*, 263 U.S. 578, 581 (1924).
21. *Walz v. Tax Commission*, 397 U.S. 664, 673 (1970).

the public or relieves it of a burden which otherwise belongs to it.''[22] One federal court wrote that the reason for the charitable contribution deduction has ''historically been that by doing so, the Government relieves itself of the burden of meeting public needs which in the absence of charitable activity would fall on the shoulders of the Government.''[23]

One of the rare congressional pronouncements on this subject is further evidence of this public policy aspect of the rationale. In its committee report accompanying the Revenue Act of 1938, the House Committee on Ways and Means stated:

> The exemption from taxation of money or property devoted to charitable and other purposes is based upon the theory that government is compensated for the loss of revenue by its relief from financial burden which would otherwise have to be met by appropriations from public funds, and by the benefits resulting from the promotion of the general welfare.[24]

In testimony before the Committee in 1973, the then-Secretary of the Treasury observed:

> These [charitable] organizations are an important influence for diversity and a bulwark against over-reliance on big government. The tax privileges extended to these institutions were purged of abuse in 1969 and we believe the existing deductions for charitable gifts and bequests are an appropriate way to encourage those institutions. We believe the public accepts them as fair.[25]

One writer, focusing on what he termed ''voluntarism,'' stated:

> Voluntarism has been responsible for the creation and maintenance of churches, schools, colleges, universities, laboratories, hospitals, libraries, museums, and the performing arts; voluntarism has given rise to the private and public health and welfare systems and many other functions and services that are now an integral part of the American civilization. In no other country has private philanthropy become so vital a part of the national culture or so effective an instrument in prodding government to closer attention to social needs.[26]

The public policy justification for tax exemption (particularly for charitable organizations) was reexamined and reaffirmed by the Commission on Private Philanthropy and Public Needs in its findings and recommendations in 1975. The Commission offered this sketch of the function of and rationale for nonprofit organizations in America:

> Few aspects of American society are more characteristically, more famously American than the nation's array of voluntary organizations, and the support in both

22. *St. Louis Union Trust Company v. United States*, 374 F.2 d 427, 432 (8th Cir. 1967).
23. *McGlotten v. Connally*, 338 F. Supp. 448, 456 (D.D.C. 1972).
24. H. Rep. No. 1860, 75th Cong., 3 d Sess. 19 (1939).
25. ''Proposals for Tax Change,'' Department of the Treasury, Apr. 30, 1973, at 72.
26. Fink, ''Taxation and Philanthropy—A 1976 Perspective,'' 3 *J. Coll. & Univ. L.* 1, 6–7 (1975).

> time and money that is given to them by its citizens. . . . The practice of attending to community needs outside of government has profoundly shaped American society and its institutional framework. While in most other countries, major social institutions such as universities, hospitals, schools, libraries, museums and social welfare agencies are state-run and state-funded, in the United States many of the same organizations are privately controlled and voluntarily supported. The institutional landscape of America is, in fact, teeming with nongovernmental, noncommercial organizations. . . . This vast and varied array is, and has long been, widely recognized as part of the very fabric of American life. It reflects a national belief in the philosophy of pluralism and in the profound importance to society of individual initiative.[27]

There are other explanations for tax exemption, although they are not often pertinent to healthcare organizations, particularly healthcare providers. These rationales include the inherent tax theory, which holds that the operation of certain nonprofit organizations is not a *taxable event* and underlies the tax exemption for social clubs,[28] homeowners' associations,[29] and political organizations.[30] Tax exemption for some nonprofit membership organizations vests to some degree on the constitutionally protected right of association. Other provisions for tax-exempt status have been engrafted onto the federal tax law as a by-product of other legislative efforts or as the handiwork of "special interests."[31]

Thus, exemption from taxation for certain types of nonprofit organizations is a principle that is larger than the vicissitudes of taxation. The action of citizens in combating problems and reaching solutions on a collective, nongovernmental basis is inherent in the very nature of the American societal structure. Nonprofit entities are traditional in the United States, and their role and responsibility are not diminished in modern society. To tax nonprofit entities would be to flatly repudiate and contravene this public policy doctrine, which is so much a part of the nation's heritage and strength.

Consequently, it is erroneous to regard tax exemption (or, where appropriate, the charitable contribution deduction) as anything other than a reflection of this larger doctrine. Congress is not merely "giving" eligible nonprofit organizations "benefits"; this exemption from taxation (or charitable deduction) is not a "loophole," a "preference," or a "subsidy." Rather, this tax policy is reflective of the affirmative decision by government to not inhibit by taxation the beneficial activities of qualified tax-exempt organizations acting in community and other public interests.

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27. Commission on Private Philanthropy and Public Needs, Giving in America—Toward a Stronger Voluntary Sector 9–10 (1975).
28. Organizations that are tax-exempt under IRC § 501(a) by reason of description in IRC § 501(c)(7).
29. Organizations that are tax-exempt to the extent provided in IRC § 528.
30. Organizations that are tax-exempt to the extent provided in IRC § 527.
31. A more extensive analysis of these rationales is in Tax-Exempt Organizations §§ 1.3–1.6.

Yet, no constitutional law protects tax exemption for healthcare organizations or for any other type of tax-exempt entities. Congress is essentially free to structure the rules for federal tax exemption and the incentives for charitable giving as it wishes.

§ 1.3 CATEGORIES OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS

Of the many categories of tax-exempt healthcare organizations, the ones that are the deliverers of healthcare services—the healthcare providers—are usually *charitable organizations*. This classification has three meanings in the federal tax law[32]:

1. The charitable entity is tax-exempt because of its charitable focus—in contrast with other entities that are, for example, educational or religious.[33] These charitable organizations may have features of other exempt organizations, such as functions that are educational (teaching hospitals), religious (healthcare entities controlled by a church), or scientific (research entities).
2. The entity is charitable in the sense that it is subject to all of the general law pertaining to charitable, educational, religious, and similar entities.[34] (This general law includes the private inurement doctrine,[35] the distinction between public charities and private foundations,[36] the proscriptions on lobbying and political campaign activities,[37] the unrelated business rules,[38] and the federal and state laws regulating fundraising.[39])
3. The charitable entity is eligible to receive contributions that are tax-deductible as charitable gifts.[40]

Some tax-exempt healthcare organizations qualify for federal tax exemption as social welfare organizations, not as charitable entities.[41] In a given category of healthcare organizations, some may, under certain circumstances, constitute charitable organizations while others are social welfare organizations. The best case in point is the health maintenance organization.[42]

32. *See*, in general, § 1.4.
33. IRC § 501(c)(3).
34. *Id*.
35. *See* Chapter 4.
36. *See* Chapter 5.
37. *See* Chapter 7.
38. *See* Chapter 24.
39. *See* Chapter 31. *See*, in general, FUNDRAISING.
40. IRC § 170(c)(2). *See*, in general, CHARITABLE GIVING.
41. *See* § 1.8.
42. *See* § 2.9.

The realm of exempt healthcare organizations includes other nonprofit entities. Healthcare organizations are members of business associations and other forms of business leagues that serve their policy and their other interests.[43] Organizations serving physicians and other healthcare practitioners often have the same federal tax status.[44] A healthcare organization may have a tax-exempt parent (or holding) corporation,[45] one or more supporting organizations,[46] a development foundation,[47] a title-holding company,[48] and the right to utilize tax-exempt benefit funds[49] or be involved in a tax-exempt cooperative organization.[50]

§ 1.4 CHARITABLE HEALTHCARE ORGANIZATIONS

Most healthcare organizations that are tax-exempt under federal law have that status because they are charitable organizations.[51] The types of these organizations and the legal basis for their exemptions are discussed throughout the book; this section provides only a brief overview.

A tax-exempt charitable healthcare organization is likely to be a provider of healthcare services because, in large part, the *promotion of health* is one of the principal rationales for this category of tax exemption.[52] The organizations that are tax-exempt because they qualify for this classification include hospitals,[53] certain managed care organizations,[54] certain home health agencies,[55] qualifying homes for the aged,[56] a variety of ambulatory care providers,[57] and integrated delivery systems.[58] Another justification for this form of tax exemption may be that the entity is operating for the purpose of *relieving the poor*.[59]

43. *See* Chapter 18, particularly § 18.2.
44. *Id.*, particularly § 18.3, and Chapter 19.
45. *See* § 20.2.
46. *See* § 5.5.
47. *See* Chapter 14.
48. *See* Chapter 15.
49. *See* Chapter 28.
50. *See* Chapter 17.
51. *See* § 1.3.
52. *See* § 1.7.
53. *See* Chapter 8.
54. *See* Chapter 9.
55. *See* Chapter 10.
56. *See* Chapter 11.
57. *See* Chapter 12.
58. *See* Chapter 23.
59. See § 1.6. There are altogether at least 15 rationales by which organizations can be considered charitable for federal income tax purposes (*see* TAX-EXEMPT ORGANIZATIONS, Chapter 7); these other ways are infrequently utilized in the healthcare context. In one instance, arguments that an organization ostensibly providing exempt-purpose services to hospitals failed; the organization claimed tax exemption on the ground of advancement of education and lessening the burdens of government (*University Medical Resident Services, P.C. v. Commissioner*, 71 T.C.M. 3130 (1996)).

Other types of charitable healthcare organizations are tax-exempt, not because they are healthcare providers, but because they are facilitators for organizations that do deliver healthcare services. Among them are development foundations,[60] supporting organizations,[61] private foundations,[62] holding corporations,[63] and cooperative hospital service organizations.[64]

§ 1.5 THE LAW OF CHARITABLE TRUSTS

The federal tax law providing tax exemption for charitable organizations has as its antecedents the English common law of trusts. That law, over the centuries, evolved to a recognition that entities other than individuals are to be recognized as persons in the eyes of the law. The first of these persons was the *trust*, itself influenced by advances in the law of property. (Other persons, such as corporations and partnerships, came much later.)

The first of the charitable persons was the *charitable trust*. Today, the charitable trust remains as one of the three basic forms that a tax-exempt charitable organization can take (the other two are corporations and unincorporated membership associations).[65] Because of issues relating to personal liability for trustees, directors, and officers,[66] however, the contemporary tax-exempt charitable healthcare organization is likely to be a nonprofit corporation.

This use of the corporate form is particularly appropriate for an operating institution, such as a hospital or home for the aged. By contrast, the trust form may remain suitable for a development foundation, supporting organization, other separate endowment fund, scholarship or research fund, or private foundation.

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60. *See* Chapter 14.
61. *See* § 5.5.
62. *See* § 5.9.
63. *See* § 20.2.
64. *See* § 17.1. Despite decades of law development, there still is disagreement as to what the scope of the term *charitable* is, at the federal and state levels, in the healthcare context and in general. A case in point involved a public charity that operates a mental health center; it provides its services on an outpatient basis, principally to indigents. Its application for a real property tax exemption was denied by the state tax authorities, largely on the ground that the entity was not *charitable*, in that it received very little in the way of charitable gifts. This decision was overturned by a court, which held that ''significant private donations are not required [for an organization to be considered *charitable*] as a matter of law'' (*State Department of Assessments and Taxation v. North Baltimore Center, Inc*., 743 A.2 d 759 (Md. Ct. Spec. App. 1999)). At the federal law level, at least, the extent of charitable contributions is basically irrelevant in determining whether an organization is charitable. In this case, the organization is clearly *charitable* in nature, in that it provides relief to the poor (*see* § 1.6) and promotes health (*see* § 1.7)
65. *See* Tax-Exempt Organizations § 4.1(a).
66. *See* Planning Guide, Chapter 1.

§ 1.6 RELIEF OF POVERTY

The federal tax law provides income tax exemption for organizations that are organized and operated exclusively for charitable purposes. The term *charitable* is used in this context in its ''generally accepted legal sense'' and is, therefore, not to be construed as limited by other purposes that may fall within the broad outlines of *charity* as developed by the courts.[67] The most traditional of these definitions is embraced by the concept of *relief of poverty*. Many of the tax exemptions for healthcare organizations were initially based on this rationale; some still are.

The federal tax regulations define the term *charitable* as including ''[r]elief of the poor and distressed or of the underprivileged.''[68]

The relief of poverty is the most basic and historically founded form of charitable activity. Assistance to the poor (but not necessarily the absolutely destitute) is the common concept of giving *charity* or assisting by ''[distributing] money or goods among the poor, by letting land to them at low rent, by making loans to them, by assisting them to secure employment, by the establishment of a home or other institution, by providing soup kitchens and the like.''[69] The layperson's concept of charity (or philanthropy) is very much the money-dispensing or soup-kitchen approach to easing the burdens of the underprivileged.

As society progressed, organizations recognized as tax-exempt because they relieved the poor, distressed, or underprivileged began to emphasize the provision of services and to deemphasize the ''handout'' type of charitable work. Rulings by the IRS provide a wide range of illustrations of these organizations.[70]

Among the entities that are especially visible in the healthcare setting are those that perform the following activities: home delivery of meals to the elderly,[71] transportation services for the elderly and handicapped,[72] operation of a service center providing information, referral, and counseling services in the health field,[73] vacations for the elderly poor at a rest home,[74] and provision of rescue and emergency services to individuals suffering because of a disaster.[75]

The view that charity consists of assistance to the poor has had a major role in the formation of tax policy applicable to nonprofit healthcare organizations.

67. Reg. § 1.501(c)(3)-1(d)(2). Also Reg. § 1.501(c)(3)-1(d)(1)(i)(b).
68. Reg. § 1.501(c)(3)-1(d)(2).
69. Restatement of Trusts (2 d ed. 1959) § 369, comment a.
70. *See* Tax-Exempt Organizations, §§ 7.1, 7.2.
71. Rev. Rul. 76-244, 1976-1 C.B. 155.
72. Rev. Rul. 77-246, 1977-2 C.B. 190.
73. Rev. Rul. 75-198, 1975-1 C.B. 157.
74. Rev. Rul. 75-385, 1975-2 C.B. 205.
75. Rev. Rul. 69-174, 1969-1 C.B. 149.

Indeed, for years, the tax exemption for nonprofit hospitals and similar entities rested on that justification.[76] This rationale, which was resurrected in the 1990s, is termed the *charity care standard*.[77]

In 1969, however, the IRS issued revised criteria as to what constitutes a *charitable* hospital.[78] In that year, the IRS concluded that the *promotion of health* was itself a charitable purpose as long as the requisite charitable class was present; specifically, the ruling enabled a nonprofit hospital to qualify for tax exemption where it simply provided emergency room services to all individuals requiring healthcare, irrespective of their ability to pay. This standard became known as the *community benefit standard*.[79]

A lawsuit ensued, and a federal district court held that a hospital, to be tax-exempt as a charitable entity, must significantly serve—without full charge or with no charge—the poor.[80] The court concluded that ''Congress and the judiciary have consistently insisted that the application of . . . [the charity tax exemption and contribution deduction rules] to hospitals be conditioned upon a demonstration that ameliorative consideration be given poor people in need of hospitalization.''[81] To find otherwise, wrote the court, would be ''to disregard what has been held to be the underlying rationale for allowing charitable deductions.''[82]

This construction of the term *charitable* was, however, reversed.[83] On finding that the law of charitable trusts has promotion of health as a charitable purpose, the appellate court held that the term *charitable* is ''capable of a definition far broader than merely relief of the poor.''[84] After reviewing the changes in the financing of healthcare in the United States over past decades (including the advent of Medicare and Medicaid), the court found that the rationale by which the charitable status of hospitals is confined to the extent they provide for the poor ''has largely disappeared.''[85] The court observed that ''[t]oday, hospitals are the primary community health facility for both rich and poor.''[86]

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76. *See* § 26.1.
77. *See* § 26.3.
78. Rev. Rul. 69-545, 1969-2 C.B. 117.
79. *See* Chapter 6 and § 26.3.
80. *Eastern Kentucky Welfare Rights Organization v. Shultz*, 370 F. Supp. 325 (D.D.C. 1973).
81. *Id*. at 332.
82. *Id*. at 333.
83. *Eastern Kentucky Welfare Rights Organization v. Simon*, 506 F.2 d 1278 (D.C. Cir. 1974).
84. *Id*. at 1287.
85. *Id*. at 1288.
86. *Id*. The *Eastern Kentucky* case was heard by the U.S. Supreme Court, which never ruled on the substance of the case, holding only that the plaintiffs lacked standing to bring the action (*Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26 (1976)). This conclusion was subsequently reached by the court of appeals for the Sixth Circuit in *Lugo v. Miller*, 640 F.2 d 823 (6th Cir. 1981), *rev'g* (*on the issue*) *Lugo v. Simon*, 453 F. Supp. 677 (N.D. Ohio 1978).

In a similar development, the IRS based a finding of charitable status for an organization solely on the ground that it relieves the ''distressed,'' irrespective of whether they are also poor. The occasion was the consideration by the IRS of the tax treatment of a nonprofit hospice that operated on both inpatient and outpatient bases to assist individuals of all ages, who have been advised by a physician that they are terminally ill, in coping with the distress arising from their condition.''[87] Thus, the classification of the organization as a charitable entity was predicated on the fact that the hospice ''alleviat[ed] the mental and physical distress of persons terminally ill.''[88]

Thus, a charitable purpose is not necessarily dependent on a showing that the poor are being relieved. As one writer stated, it is ''a general rule in the construction of exemptions from taxation that the word 'charity' is not to be restricted to the relief of the sick or the poor, but extends to any form of philanthropic endeavor or public benefit.''[89] Previously, another commentator had observed that, ''[a]lthough the relief of the poor, or benefit to them is, in its popular sense a necessary ingredient in the charity, this is not so in the view of the law.''[90]

§ 1.7 PROMOTION OF HEALTH

As discussed, the promotion of health is recognized in the federal tax law as an independent basis for classification of a nonprofit organization as a charitable entity.[91] The promotion of health as a charitable purpose includes the establishment or maintenance of hospitals, clinics, homes for the aged, and the like; advancement of medical and similar knowledge through research; and the maintenance of conditions conducive to health.

Some of the various entities in the healthcare setting that are tax-exempt on this basis, as recognized by the IRS, include those with the following activities: assistance in securing a private room at a hospital[92]; facilitation of visits to hospital patients by family and friends[93]; operation of a health club for individuals in a community[94]; operation of a mobile cancer screening program[95]; sale of hearing aids by a hospital[96]; interpretation of diagnostic tests

87. Rev. Rul. 79-17, 1979-1 C.B. 193. A similar discussion, concerning comparable forms of distress facing the elderly, appeared in an IRS ruling concerning homes for the aged (see Chapter 11). An IRS analysis of the distress confronting the physically handicapped is contained in Rev. Rul. 79-19, 1979-1 C.B. 195.
88. Rev. Rul. 79-17, 1979-1 C.B. 193.
89. Black, A Treatise in the Law of Income Taxation 40 (2 d ed. 1950).
90. Zollman, American Law of Charity 135–136 (1924).
91. Rev. Rul. 69-545, 1969-2 C.B. 117. *See* Tax-Exempt Organizations § 7.6.
92. Rev. Rul. 79-358, 1979-2 C.B. 225.
93. Rev. Rul. 81-28, 1981-1 C.B. 328.
94. Tech. Adv. Mem. 8505002.
95. Priv. Ltr. Rul. 8749085.
96. Rev. Rul. 78-435, 1978-2 C.B. 181.

by one hospital for another, where the latter lacks the necessary resources[97]; sale of pharmaceuticals to a hospital's patients[98]; operation of a gift shop by a hospital[99]; operation of a cafeteria and coffee shop by a hospital[100]; and operation of a parking lot by a hospital.[101]

Health, for this purpose, includes ''mental health'' and would include, were it not for a separate enumeration in the federal tax law description of charitable organizations, the prevention of cruelty to children.[102] This rationale for tax-exempt status, particularly for hospitals, has, as discussed, become known as the community benefit standard.[103]

§ 1.8 SOCIAL WELFARE ORGANIZATIONS

Federal tax law provides exemption from income taxation for social welfare organizations.[104] This type of organization was originally conceived as a civic entity; thus, the exemption is for ''[c]ivic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare. . . .''[105]

There is no precise definition of the term *social welfare* for these purposes. The federal tax regulations accompanying this category of tax-exempt organization offer only these basic precepts: (1) social welfare is commensurate with the ''common good and general welfare'' and ''civic betterments and social improvements,''[106] and (2) the promotion of social welfare does not include activities that primarily constitute ''carrying on a business with the general public in a manner similar to organizations which are operated for profit.''[107]

97. Priv. Ltr. Rul. 8004011.
98. Rev. Rul. 68-375, 1968-2 C.B. 245.
99. Rev. Rul. 69-267, 1969-1 C.B. 160.
100. Rev. Rul. 69-268, 1969-1 C.B. 160.
101. Rev. Rul. 69-269, 1969-1 C.B. 160. Because promotion of health also occurs in the for-profit sector, for that activity to be sheltered from taxation by reason of being charitable, it must be in a nonprofit organization (*see* § 1.1). This reflects the fact that a healthcare activity in a for-profit entity can be made an exempt function simply by transferring it to a nonprofit entity (e.g., Priv. Ltr. Rul. 9710030, in which a transfer of activities from a physicians' group medical practice to an exempt charitable organization converted the activities to exempt functions, and, as explained in Priv. Ltr. Rul. 9747040, gave rise to a charitable contribution deduction).

    It should be noted, however, that the IRS has recognized for-profit professional corporations of physicians as tax-exempt charitable organizations where they are otherwise organized and operated for exempt purposes and state law requires that such practices be maintained in a professional corporation under the corporate practice of medicine doctrine. *See*, e.g., IRS determination letters issued to Saint Vincent Medical Education and Research Institute; North Shore Medical Specialists; Physicians Network, P.C.; and Marietta Health Care Physicians.
102. Restatement of Trusts (2 d ed. 1959) § 372, comment b.
103. *See* § 1.6, text accompanied by notes 78–79.
104. IRC § 501(a), for organizations described in IRC § 501(c)(4). *See*, in general, Tax-Exempt Organizations, Chapter 13.
105. Reg. § 1.501(c)(4)-1(a)(1).
106. Reg. § 1.501(c)(4)-1(a)(2)(i).
107. Reg. § 1.501(c)(4)-1(a)(2)(ii).

An exempt social welfare organization must function for the benefit of those in a *community*. Thus, for example, homeowners' associations that maintain common areas for the residents and enforce architectural covenants qualify as tax-exempt social welfare organizations.[108] Where there is significant benefit for the individual members, however, tax exemption may not be available.[109] Thus, an organization operating a vision care plan by contracting with subscribers was held to not qualify for tax-exempt status as a social welfare organization, in part because the membership-based structure caused the entity to not serve the requisite community.[110] An organization claiming to be an agency providing home healthcare services to residents of five facilities in various locations was found by the IRS to be merely a registry, matching the needs of residents with independent service providers for a fee; the organization was denied recognition of exemption as a social welfare entity primarily because it did not serve the requisite community.[111] Essentially, whether a particular community is being served is to be determined according to the facts and circumstances of each case.[112]

Historically, prepaid healthcare plans have been categorized as tax-exempt social welfare organizations.[113] Some health maintenance organizations can qualify as exempt charitable organizations; others are relegated to social welfare status.[114]

The experience with HMOs in this regard is illustrative. The concept of *social welfare* is broader than that of *charitable;* thus, any exempt charitable organization can qualify as an exempt social welfare organization, although the reverse is not the case. For this reason, many organizations that cannot qualify as tax-exempt charitable organizations become tax-exempt social welfare entities. For example, an organization that is precluded from charitable status solely because of excessive legislative activities[115] can constitute a social welfare organization because these entities are not circumscribed as to lobbying efforts. In short, these organizations can engage in more advocacy efforts than charitable ones. Exempt social welfare organizations, however, cannot attract charitable contributions that are deductible for federal income, estate, and gift tax purposes.

Consequently, the contemporary use of the social welfare organization category of tax exemption is generally for the healthcare organization that cannot qualify as a charitable entity or for the nonprofit organization that

108. Rev. Rul. 72-102, 1972-1 C.B. 149, modified by Rev. Rul. 76-147, 1976-1 C.B. 151.
109. Rev. Rul. 74-99, 1974-1 C.B. 131.
110. *Vision Service Plan v. United States*, 2006-1 U.S.T.C. ¶ 50,173 (E.D. Cal. 2005), on appeal to the U.S. Court of Appeals for the Ninth Circuit.
111. Priv. Ltr. Rul. 20544020.
112. Rev. Rul. 80-63, 1980-1 C.B. 116. The private inurement proscription (*see* Chapter 4) is expressly applicable to tax-exempt social welfare organizations (IRC § 501(c)(4)(B)).
113. For example, this was the tax exemption category for most Blue Cross and Blue Shield Associations (*see* § 13.1), until the enactment of IRC § 501(m) (*see* § 9.3).
114. *See* § 9.1.
115. *See* § 7.1.

could constitute an exempt charitable entity but for its extensive advocacy activities.

The IRS has a considerable propensity to import federal tax law principles applicable to tax-exempt charitable organizations to shape the law applicable to exempt social welfare organizations.[116] For example, the agency asserted that the private benefit doctrine[117] is applicable with respect to social welfare organizations, in denying recognition of exemption on this basis to an organization seeking to increase the number of women in public service and politics.[118] Likewise, the IRS is of the view that the commerciality doctrine[119] applies as part of the federal tax law concerning social welfare organizations;[120] for example, an organization that facilitated the sale of health insurance by for-profit insurance companies to participating employers and their employees, and provided administrative services to these companies for a fee, failed to be recognized as an exempt social welfare organization because it engaged in commercial activities.[121]

116. Congress is doing the same; an example is the treatment of both IRC § 501(c)(3) and (4) organizations as *applicable tax-exempt organizations* (*see* § 4.9).
117. *See* § 4.6.
118. Ex. Den. and Rev. Ltr. 20044008E.
119. *See* § 3.3.
120. The first time this was done was in Priv. Ltr. Rul. 200501020.
121. Priv. Ltr. Rul. 200512023.

CHAPTER TWO

Advantages and Disadvantages of Tax Exemption

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As subsequent chapters indicate, there are several varieties of tax-exempt healthcare organizations, and, accordingly, the advantages and disadvantages of tax exemption will differ, depending on the particular category.

§ 2.1 SOURCE OF TAX EXEMPTION

The Internal Revenue Code is, in so many respects, sweeping as to its scope. One section of the Code provides that ''[e]xcept as otherwise provided in this subtitle [Subtitle A—income taxes], gross income [received by a person] means all income from whatever source derived . . . ,'' including items such as interest, dividends, compensation for services, and receipts derived from business activities.[1] The Code provides for a variety of deductions, exclusions, and exemptions in computing taxable income. Many of these are contained in Code Subtitle A, Subchapter B, entitled ''Computation of Taxable Income.'' Of pertinence in the tax-exempt organizations context, however, is the body of exemption provisions contained in Subtitle A, Subchapter F, captioned ''Exempt Organizations.''

1. IRC § 61(a).

(a) Federal Tax Law in General

Exemption from federal income taxation is derived from a specific provision to that end in the Code; that is, whether a nonprofit healthcare or other organization qualifies as a tax-exempt entity under federal law is a function of its qualification in relation to the criteria stated in the particular exemption provision. More succinctly, Congress determines tax exemption at the federal level—not the IRS—as a matter of law. The function of the IRS is to *recognize* (issue a determination letter or ruling) an organization's tax-exempt status when the entity satisfies the requisite criteria. In some instances, tax exemption is a by-product of some other tax status (such as a cooperative or a state instrumentality).

A federal tax exemption is a privilege (a matter of legislative grace), not an entitlement,[2] and—being an exception to the norm of taxation—is often strictly construed. This type of exemption must be occasioned by an enactment of Congress and will not be granted by implication.[3] At the same time, provisions according tax exemption for charitable organizations are usually liberally construed.[4] Similarly, the charitable contribution deductions have been held to not be narrowly construed,[5] as opposed to other deductions.[6] These provisions respecting income destined for charity are accorded favorable construction since they are ''begotten from motives of public policy''[7] and any ambiguity in these rules has traditionally been resolved against taxation.[8]

The provision in the Internal Revenue Code that is the general source of the federal income tax exemption is section 501(a).[9] This provision states that ''[a]n organization described in subsection (c) [the locus of tax exemption for all nonprofit healthcare entities and most other nonprofit organizations] or (d) or section 401(a) shall be exempt from taxation under this subtitle [Subtitle A—income taxes] unless such exemption is denied under section 501 or 503.''

The U.S. Supreme Court characterized Code section 501 as the ''linchpin of the statutory benefit [read: exemption] system.''[10] The Court summarized this tax exemption as according ''advantageous treatment to several types of nonprofit corporations [sic], including exemption of their income from taxation

2. As discussed in § 1.2, the federal tax exemption for many nonprofit organizations (such as charitable ones) is a reflection of the heritage and evolved societal structure of the United States.
3. E.g., *Mescalero Apache Tribe v. Jones*, 411 U.S. 145 (1973).
4. E.g., *American Institute for Economic Research v. United States*, 302 F.2d 934 (Ct. Cl. 1962), *cert. denied*, 372 U.S. 976 (1963), *reh'g denied*, 373 U.S. 954 (1963); *Harrison v. Barker Annuity Fund*, 90 F.2d 286 (7th Cir. 1937).
5. E.g., *Sico Foundation v. United States*, 295 F.2d 924, 930, note 19 (Ct. Cl. 1962).
6. E.g., *White v. United States*, 305 U.S. 281, 292 (1938).
7. *Helvering v. Bliss*, 293 U.S. 144, 151 (1934).
8. E.g., *C.F. Mueller Co. v. Commissioner*, 190 F.2d 210 (3d Cir. 1951).
9. Also, IRC §§ 521 (farmers' cooperatives), 526 (shipowners' protection and indemnity associations), 527 (political organizations), and 528 (homeowners' associations).
10. *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26, 29, note 1 (1976).

and [for those entities that are also eligible charitable donees] deductibility by benefactors of the amounts of their donations.''[11]

Thus, to qualify as a tax-exempt organization under Code section 501(a), an organization must conform to the appropriate descriptive provisions of Code section 501(c) (where the exemption for healthcare organizations is located), 501(d), or 401(a). This exemption, however, does not extend to an organization's unrelated business taxable income.[12] Thus, the term *tax-exempt organization* is often not literally accurate, inasmuch as this type of organization may be subject to the tax on unrelated income as well as other federal taxes, such as those imposed on private foundations,[13] on organizations that engage in excessive lobbying,[14] on organizations that engage in certain political campaign activities,[15] or on the investment income of certain otherwise tax-exempt organizations.[16]

An organization that seeks to obtain tax-exempt status bears the burden of proving that it satisfies all of the requirements of the exemption status involved.[17]

An organization, to be tax-exempt as a charitable entity,[18] must be organized and operated primarily for one or more of the permissible exempt purposes. This requirement has given rise to an *organizational test* and an *operational test* for charitable organizations. If an organization fails to meet either test, it cannot qualify for exemption from federal income taxation as a charitable entity.[19] The organizational test requires the presence of certain provisions in an organization's articles of organization.[20] The operational test requires that an organization be operated primarily in the conduct of activities that accomplish one or more of its exempt purposes.[21]

(b) State Ad Valorem Tax

Although a discussion of state tax law is outside of the scope of this book, it should be noted that an issue of ongoing debate and litigation is whether various healthcare providers, who otherwise qualify for income tax exemption as charities under federal law, can qualify for tax exemption from real property

11. *Id*. at 28.
12. IRC § 501(b); Reg. § 1.501(a)-1(a)(1). *See* Chapter 24.
13. *See* § 5.9.
14. *See* § 7.1, text accompanied by notes 47–75.
15. *See* § 7.4, text accompanied by notes 131–171.
16. IRC § 512(a)(3).
17. E.g., *Harding Hospital v. United States*, 505 F.2d 1068, 1071 (6th Cir. 1974); *Haswell v. United States*, 500 F.2d 1133, 1140 (Ct. Cl. 1974).
18. That is, an organization described in IRC § 501(c)(3).
19. Reg. § 1.501(c)(3)-1(a).
20. Reg. § 1.501(c)(3)-1(b). The elements of this test are detailed in § 4.3 of Tax-Exempt Organizations.
21. Reg. § 1.501(c)(3)-1(c). The elements of this test are detailed in § 4.5 of Tax-Exempt Organizations.

taxes (also known as *ad valorem* taxes) under state law. Many states have statutes that define the term *charitable,* for state property tax exemption purposes, in a much more restrictive fashion than that applied by the IRS in federal income taxation cases. Often state statutes focus on the substantial provision of charity care as a sine qua non for granting property tax exemption. The following are some recent examples of this phenomenon:

- In Ohio, a tax examiner recommended that a Cleveland Clinic outpatient facility be denied exemption from local property taxation because it gave only a nominal amount of charity care.[22] The examiner based his recommendation on a recent Ohio Supreme Court ruling that a fitness facility owned by a nonprofit hospital was not entitled to property tax exemption because only a small number of people who used the facility did not have to pay membership dues.
- In Wisconsin, a child care center that was maintained by St. Joseph's Hospital of Marshfield in a nearby separate building was exempt from state property tax for the portion of the building allocated to children of its own employees, but whether the same treatment applied to an adjacent clinic depended on whether the employees provided diagnosis, treatment, or care to hospital patients.[23]
- In Michigan, an appeals court held that McLaren Regional Medical Center and two independent physician groups were properly denied charitable exemptions under state law because they did not qualify as hospitals serving public health needs or charitable institutions that would be eligible for exemption from ad valorem property tax assessments. The court ruled that the mere acceptance of Medicare and Medicaid patients was insufficient to warrant treatment of the facilities as charitable institutions, and the facilities' provision of only a negligible amount of free care undermined their position that they were charitable institutions serving a public health purpose.[24]
- In Pennsylvania, a court ruled that the nonprofit Alliance Home of Carlisle, which operates a skilled nursing home, an assisted living compound, and independent living apartments on the same property, was not entitled to a real estate tax exemption for the portion of the property upon which the independent living apartments were located, notwithstanding the tax-exempt status of the portions on which the nursing home and assisted living facilities were located.[25]
- In Massachusetts, the Sturdy Memorial Foundation, a charitable foundation that leased property for use by a medical clinic, was held to be

22. *BNA Health Law Reporter*, Oct. 7, 2004, at 1463.
23. *BNA Health Law Reporter*, Sept. 16, 2004, at 1354.
24. *BNA Health Law Reporter*, Sept. 2, 2004, at 1308.
25. *BNA Health Law Reporter*, June 24, 2004, at 949.

not entitled to exemption from real estate taxes assessed by the town of North Attleborough. The appeals court took the position that the foundation failed to demonstrate that its property qualified for exemption under a state law that exempts real estate owned by a charitable organization and occupied by another charitable organization. The court concluded that the medical clinic was not a charitable organization, taking into account the clinic's physician compensation arrangements and whether it was operated as a public charity.[26]

§ 2.2 ADVANTAGES OF TAX EXEMPTION

(a) Tax Relief

One advantage is shared by all categories of tax-exempt organizations, including healthcare entities: barring loss of exempt status, they are generally spared federal income taxation. In many instances, tax-exempt status under the federal income tax law will lead to comparable status under state and local income tax law; in other instances, additional requirements must be satisfied.[27]

Federal income tax exemption may also involve exemption from certain federal excise and employment taxes.[28] If a tax-exempt organization is deemed to be a private foundation, however, it will be subject to a special tax on net investment income and, if it chooses to dissolve, perhaps a termination tax.[29] Generally, the private foundation rules entail sanctions in the form of excise taxes.[30]

Many organizations that are tax-exempt under the federal income tax law also qualify for exemption from state and local taxes on purchases of items of property (sales tax), use of property (use tax), hotel occupancy, and the

26. *BNA Health Law Reporter*, Mar. 18, 2004, at 404.
27. For example, in the District of Columbia, the franchise (income) tax exemption is available to charitable (IRC § 501(c)(3)) organizations only where they are "organized and operated to a substantial extent" within the District of Columbia (9 D.C. Code, tit. 47, § 47-1802.1(4)).
28. For example, a lottery, raffle, drawing, or other form of "wagering" conducted by a tax-exempt organization (encompassed by IRC § 501 or 521) is excluded from the federal excise tax on wagers (IRC §§ 4401(a), 4411, and 4421) as long as no part of the net proceeds from the wagering inures to the benefit of an individual in his or her private capacity (Reg. § 44.4421-1(b)(2)(ii)).

    A similar exemption for charitable (IRC § 501(c)(3)) organizations exists as part of the Organized Crime Control Act (18 U.S.C. § 1955). That law, which prohibits certain gambling businesses, exempts bingo games, lotteries, and similar games of chance, as long as no part of the gross receipts derived from the gambling activity inures to the benefit of any private shareholder, member, or employee of the organization, except as compensation for actual expenses incurred in the conduct of the activity (e.g., *United States v. Hawes*, 529 F.2d 472, 481 (5th Cir. 1976)).
29. *See* § 5.9.
30. *Id*.

ownership of tangible personal property, intangible personal property, and real property.

(b) Deductibility of Contributions

Certain tax-exempt organizations, including charitable ones, are eligible to attract contributions that are deductible in computing the federal income tax liability of individual and corporate donors.[31] In many cases, deductibility of these types of contributions is allowable in computing state and local income tax liability.

In some instances, payments to a tax-exempt organization are deductible as a business expense.[32] A common illustration is the payment of dues to a trade, business, or professional association.[33] Some organizations that are not charitable ones can establish a related ''foundation'' and utilize the charitable contribution deduction by means of that subsidiary.[34]

(c) Grants

Many tax-exempt organizations are the likely recipients of grants from private foundations. This is especially the case with public charitable organizations, which can receive funds in satisfaction of the private foundation mandatory payout requirement, with the grantor able to avoid assumption of the expenditure responsibility requirements.[35] Also, some public charities are grantors.

In some instances, federal and state governmental agencies make grants only to, or enter into contracts only with, tax-exempt organizations—often, only those organizations that are charitable in nature.[36]

(d) Reduced Postal Rates

Many types of tax-exempt organizations are eligible for the preferential nonprofit postal rates. This body of law, however, excludes from the qualification for reduced mailing rates any mailings that are not in furtherance of the organizations' exempt purposes.[37]

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31. IRC § 170(c). *See*, in general, Charitable Giving.
32. IRC § 162.
33. *See* § 18.4.
34. *See* § 5.5, text accompanied by notes 218–222.
35. *See* § 5.9.
36. In one instance, an organization (unsuccessfully) sought categorization as a charitable entity so that its child day-care centers would qualify for the food reimbursement program administered by the U.S. Department of Agriculture (*Baltimore Regional Joint Board Health and Welfare Fund, Amalgamated Clothing and Textile Workers Union v. Commissioner*, 69 T.C. 554 (1978)).
37. *See* Fundraising § 5.18.

(e) Employee Benefits

The employees of a charitable organization may take advantage of special rules providing favorable tax treatment for contributions for certain annuity benefit programs.[38] There are unique rules concerning a variety of deferred compensation arrangements that exist for the benefit of employees of tax-exempt organizations.[39] Services performed for a tax-exempt organization may be exempt from federal unemployment taxation.[40] Churches and certain other church-controlled organizations can exclude from the social security tax base compensation for services performed for them (other than in unrelated businesses).[41]

(f) Other Advantages

Numerous other advantages to be derived from tax exemption may be available.

Several categories of nonprofit organizations are exempt from the Robinson–Patman Act, the federal price discrimination law.[42] Exempted from this law are nonprofit entities that purchase supplies for their own use at lower prices than can be obtained by other purchasers; this exemption is accorded to "schools, colleges, universities, public libraries, churches, hospitals, and [other] charitable institutions not operated for profit."[43] The purpose of this exemption is to enable these nonprofit institutions to operate as inexpensively as possible.[44]

Another federal tax advantage for certain tax-exempt organizations is an exemption from user fees on permits for the industrial use of specially denatured distilled spirits. This exemption is available for any "scientific university, college of learning, or institution of scientific research," where the entity is issued a permit and annually procures less than 25 gallons of the spirits for "experimental or research use but not for consumption (other than organoleptic tests) or sale."[45]

Nonetheless, an organization is not exempt from a statutory requirement solely on the basis of being a nonprofit entity. That is, in the absence of an express or implied exception in a statute, a nonprofit organization (irrespective of tax exemption) is required to comply with the statute in the same manner as a for-profit organization.[46]

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38. IRC § 403(b). *See* § 28.5, text accompanied by notes 167–172.
39. IRC § 457. *See* § 28.5, text accompanied by notes 161–166.
40. IRC § 3306(c).
41. IRC § 3121(b)(8)(B) and (w)(1), (2).
42. 15 U.S.C. § 13(a).
43. 15 U.S.C. § 13(c).
44. *Logan Lanes, Inc. v. Brunswick Corp.*, 378 F.2d 212 (9th Cir. 1967).
45. IRC § 5276(c).
46. E.g., *Tony and Susan Alamo Foundation v. Secretary of Labor*, 471 U.S. 290 (1985) (holding that a charitable organization must comply with the federal labor laws).

§ 2.3 DISADVANTAGES OF TAX EXEMPTION

In general, it may seem that an ability to avoid income taxation affords little opportunity for a disadvantage. Although this is often the case, the government usually imposes one or more operational limitations on a nonprofit organization in exchange for a tax-exempt status. The most common of these limitations is the rule that the exempt organization may not engage in forms of private inurement.[47]

This phenomenon of an operational limitation in exchange for tax exemption is most prevalent with respect to charitable organizations. These organizations are prohibited from engaging in substantial legislative activities[48] and any political campaign involvement.[49] If the charitable organization is a private foundation, qualification as a tax-exempt organization brings with it a host of additional limitations.[50]

Tax-exempt status can entail extensive disclosure and annual reporting requirements. Thus, nearly every tax-exempt organization is obligated to file an annual information return with the IRS[51] and a tax return for each year in which it has unrelated business taxable income.[52]

Tax-exempt noncharitable (principally social welfare) entities[53] are discouraged from engaging in public fundraising activities under circumstances where donors are likely to assume that the contributions are tax-deductible as charitable gifts, when in fact they are not. Under these rules, each *fundraising solicitation* by or on behalf of an exempt charitable organization must ''contain an express statement (in a conspicuous and easily recognizable format)'' that gifts to it are not deductible as charitable contributions for federal income tax purposes.[54] A fundraising solicitation that is in conformity with rules promulgated by the IRS (concerning the format of the disclosure statement in instances of use of print media, telephone, television, and radio), which include guidance in the form of ''safe harbor'' provisions, is deemed to satisfy these statutory requirements.[55] Failure to satisfy this disclosure requirement can result in imposition of penalties.[56]

A tax-exempt organization must pay a penalty if it fails to disclose that information or a service it is offering is available without charge from the federal government.[57]

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47. *See* Chapter 4.
48. *See* § 7.1.
49. *See* § 7.4.
50. *See* § 5.9.
51. *See* § 34.3, text accompanied by notes 35–36.
52. *Id.*, text accompanied by notes 95–96.
53. *See* § 1.8.
54. IRC § 6113.
55. IRS Notice 88-120, 1988-2 C.B. 454.
56. IRC § 6710.
57. IRC § 6711.

State law often requires similar annual reporting, particularly for nonprofit corporations and charitable trusts. The attorneys general of the states have parens patriae jurisdiction over many types of nonprofit entities, particularly those that are charitable ones. Nearly all states regulate the process by which charitable organizations solicit contributions from the general public.[58]

In some instances, the limitations and forms of regulation imposed on tax-exempt organizations are more extensive than comparable requirements imposed on for-profit organizations. In nearly all instances, however, the advantages of tax exemption seem to outweigh the disadvantages that may be caused by that status.

§ 2.4 ALTERNATIVES TO TAX-EXEMPT STATUS

A nonprofit organization may elect or be required to operate without formal recognition as a tax-exempt entity and yet achieve the same basic objective: the nonpayment of tax.[59] The legitimate alternatives to formal tax-exempt status, however, are few.

The simplest illustration of this principle is the organization (nonprofit or for-profit) that is operated so that its deductible expenses equal or exceed recognizable income in any taxable year. Having no taxable income, the organization is not required to pay tax. In essence, this is the basis on which cooperatives, other than formally tax-exempt ones, function without having to pay income tax.[60] A nonexempt cooperative (a ''corporation operating on a cooperative basis,'') escapes taxation because, in computing taxable income, a deduction is available for ''patronage dividends'' and qualified and nonqualified ''per unit retain allocations.''[61]

An organization that loses its tax-exempt status may continue to operate without taxation by conversion to the cooperative form.[62] Similarly, an organization that cannot qualify as a formal tax-exempt entity may choose to function as a cooperative.[63]

Another illustration of a type of conduit ''tax-exempt organization'' is the for-profit entity that is not taxable because the net (taxable) income is passed

58. *See* Chapter 31.
59. Of the many types of tax-exempt organizations, only two are required to have their tax exemption recognized by the IRS: (1) charitable (IRC § 501(c)(3)) organizations, by reason of IRC § 508(a), and (2) certain employee benefit (IRC § 501(c)(9), (17), and (20)) organizations, by reason of IRC § 505(c)(1). Two examples of tax-exempt organizations that are required to operate without formal recognition of exemption are charitable remainder trusts (as to which the IRS generally will not rule (IRC § 664)) and pooled income funds (as to which the IRS also generally will not rule (IRC § 642(c)(5)).
60. *See* Chapter 17.
61. IRC §§ 1382(b), 1388.
62. E.g., *A. Duda & Sons Cooperative Ass'n v. United States*, 504 F.2d 970 (5th Cir. 1975).
63. E.g., Rev. Rul. 69-633, 1969-2 C.B. 121.

along to others; these organizations include partnerships, other joint ventures, small business (S) corporations, and limited liability companies.[64]

If a nonexempt organization that does not operate on a cooperative basis seeks to avoid taxation by matching expenses and income, federal income tax law may foil the scheme if the organization is a membership organization, such as a trade or business association or a social club. In this situation, the expenses of furnishing services, goods, or other items of value (such as insurance) to members are deductible only to the extent of income from members (including income from institutes or trade shows conducted primarily for the education of members).[65] This means that any expenses attributable to membership activities in excess of membership income may not be deducted against nonmembership income (such as investment income), although the increment may be carried forward. Prior to the enactment of these rules, the courts had upheld contrary treatment.[66]

There is a line of law that permits nontaxation of an organization where it is merely a conduit for the expenditure of a fund established for a specific purpose. Thus, a soft drink manufacturer that received funds from bottlers for a national advertising fund was held to not be taxable on these monies because they were earmarked for advertising purposes; the manufacturer was considered to be merely the administrator of a trust fund.[67] Initially, the IRS took the position that this precept would be followed only where the recipient of the funds received them with the obligation to expend them solely for a particular purpose.[68] This position was, however, superseded by one in which the recipient organization is taxed on the amounts received and is allowed all related deductions, subject to the previously discussed expense allocation rules.[69] Also, the IRS has distinguished the above-described factual setting involving a soft drink manufacturer from that where the participants (such as the dealers and bottlers) form an unincorporated organization to conduct a national advertising program; the IRS ruled that the organization is separately taxable as a corporation.[70]

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64. *See* Chapter 22.
65. IRC § 277.
66. E.g., *Anaheim Union Water Company v. Commissioner*, 321 F.2d 253 (9th Cir. 1963). An application of IRC § 277 appears in *Boating Trade Association of Metropolitan Houston v. United States*, 75-1 U.S.T.C. (CCH) ¶ 9,398 (S.D. Tex. 1975).
67. *The Seven-Up Company v. Commissioner*, 14 T.C. 965 (1950). Also, Rev. Rul. 69-96, 1969-1 C.B. 32; *Ford Dealers Advertising Fund, Inc. v. Commissioner*, 55 T.C. 761 (1971), *aff'd*, 456 F.2d 255 (5th Cir. 1972); *Park Place, Inc. v. Commissioner*, 57 T.C. 767 (1972); *Greater Pittsburgh Chrysler Dealers Association of Western Pennsylvania v. United States*, 77-1 U.S.T.C. (CCH) ¶ 9,293 (W.D. Pa. 1977); *Insty-Prints, Inc. National Advertising Trust Fund v. Commissioner*, 44 T.C.M. 556 (1982); *Broadcast Measurement Bureau v. Commissioner*, 16 T.C. 988 (1951).
68. Rev. Rul. 58-209, 1958-1 C.B. 19.
69. Rev. Rul. 74-318, 1974-2 C.B. 14.
70. Rev. Rul. 74-319, 1974-2 C.B. 15. *See also Michigan Retailers Association v. United States*, 676 F. Supp. 151 (W.D. Mich. 1988); *Dri-Power Distributors Association Trust v. Commissioner*,

If formal tax-exempt status is not desired, is unavailable, or is revoked, and if deductible expenses do not or cannot equal or exceed income, and if the organization is not incorporated, perhaps the entity can legitimately escape taxation by contending that it is nonexistent for tax purposes. Admittedly, this is generally unlikely, if only by reason of the authority of the IRS to treat an unincorporated entity as a corporation for income tax purposes.[71] Yet, this is what political campaign committees did for many years, and the IRS failed or refused to assert tax liability in that context. Eventually, the IRS ruled that campaign committees are to be regarded as taxable corporations,[72] although that position was superseded by the enactment of statutory law on the point.[73] Yet, thereafter, the IRS continued to uphold the per-donee gift tax exclusion for separate fundraising campaign committees,[74] despite opposition in the courts.[75] Congress subsequently exempted contributions to political parties and political campaign committees from the gift tax.[76]

To be exempt from federal income taxation, an organization generally must formally qualify as a tax-exempt organization (by means of recognition or otherwise), operate on a cooperative basis, or legally marshal deductible expenses against income. Otherwise, it is nearly certain that the entity will be treated as a taxable entity, even if it is organized as a nonprofit organization. In the realm of healthcare, it is highly unlikely that any approach, other than one or more of these alternatives, will be successful.

§ 2.5 NO CONTRACT, THIRD-PARTY BENEFICIARIES, RIGHT OF ACTION, OR CHARITABLE TRUST

Tax exemption as a healthcare entity does not create an express or implied contract with the federal government, third-party beneficiaries of such a contract, a private right of action, or any form of charitable trust.

(a) Tax Exemption Does Not Create Contract

Litigants have asserted, without success in the courts, that an express or implied contract arises between an organization and the federal government once the IRS recognizes the tax-exempt status of the organization as a charitable[77] entity. The principal contention in this regard has been that tax exemption

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54 T.C. 460 (1970); *N.Y. State Ass'n Real Est. Bd. Group Ins. Fund v. Commissioner*, 54 T.C. 1325 (1970); *Angelus Funeral Home v. Commissioner*, 47 T.C. 391 (1967), *aff'd*, 407 F.2d 210 (9th Cir. 1969), *cert. denied*, 396 U.S. 824 (1969).

71. IRC § 7701.
72. Rev. Rul. 74-21, 1974-1 C.B. 14.
73. IRC §§ 41 (amended), 84, 527, and 2501(a)(5).
74. Rev. Rul. 74-199, 1974-1 C.B. 285; Rev. Rul. 72-355, 1972-2 C.B. 532.
75. *Tax Analysts and Advocates v. Shultz*, 376 F. Supp. 889 (D.D.C. 1974), *aff'd*, 75-1 U.S.T.C. (CCH) ¶ 13,052 (D.C. Cir. 1975).
76. IRC § 2501(a)(5).
77. That is, an organization described in IRC § 501(c)(3).

accorded to hospitals gives rise to a contract obligating the exempt hospital to provide medical care to uninsured patients without regard to their ability to pay for the care. This assertion, however, has been uniformly rejected.[78]

In general, absent express language to the contrary, the presumption is that statutes are not, and do not create, contracts. As the U.S. Supreme Court stated, this ''well-established presumption is grounded in the elementary proposition that the principal function of a legislature is not to make contracts, but to make laws that establish the policy of the state'' and ''[p]olicies, unlike contracts, are inherently subject to revision and repeal, and so to construe laws as contracts when the obligation is not clearly and unequivocally expressed would be to limit drastically the essential powers of a legislative body.''[79] Specifically, as to the tax law, the ''notion that the Federal Income Tax is contractual or otherwise

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78. *Burton v. William Beaumont Hosp.*, 347 F. Supp. 2d 486 (E.D. Mich. 2004); *Kizzire v. Baptist Health System, Inc.*, 343 F. Supp. 2d 1074 (N.D. Ala. 2004); *Darr v. Sutter Health*, 2004 WL 2873068 (N.D. Cal. 2004); *Ferguson v. Centura Health Corp.*, 358 F. Supp. 2d 1014 (D. Col. 2004); *Hudson v. Central Georgia Health Services*, 04-CV-301 (M.D. Ga., Jan. 13, 2005); *Washington v. Medical Center of Central Georgia, Inc.*, 04-CV-185 (M.D. Ga., Jan. 21, 2005); *Hogland v. Athens Regional Health Services, Inc.*, 04-CV-50 (M.D. Ga., Jan. 21, 2005); *Daly v. Baptist Health*, 04-CV-789 (E.D. Ark., Jan. 31, 2005); *Peterson v. Fairview Health Services*, 2005 WL 226168 (D. Minn. 2005); *Hagedorn v. St. Thomas Hosp., Inc.*, 04-0526 (M.D. Tenn., Feb. 7, 2005); *River v. Yale New Haven Hosp., Inc.*, 04-CV-1414 (D. Conn., Feb. 9, 2005); *Schmitt v. Protestant Memorial Medical Center, Inc.*, 04-00577 (S.D. Ill., Feb. 23, 2005); *Sabeta v. Baptist Hospital of Miami, Inc.*, 04-21437 (S.D. Fla., Feb. 23, 2005); *Wright v. St. Dominic Health Services, Inc.*, 04-CV-521 (S.D. Miss., Mar. 1, 2005); *Quinn v. BJC Health System*, 364 F. Supp. 2d 1046 (E.D. Mo. 2005); *Carlson v. Long Island Jewish Medical Center*, 378 F. Supp. 2d 128 (E.D. N.Y. 2005); *Jellison v. Florida Hosp. Healthcare Systems, Inc.*, 04-CV-1021 (M.D. Fla., Mar. 14, 2005); *Valencia v. Miss. Baptist Medical Center, Inc.*, 363 F. Supp. 2d 867 (S.D. Miss. 2005); *Fields v. Banner Health*, 04-CV-1297 (D. Ariz., Mar. 23, 2005); *Ellis v. Phoebe Putney Health System, Inc.*, 04-CV-80 (M.D. Ga., Apr. 8, 2005); *Bobo v. Christus Health*, 227 F.R.D. 479 (E.D. Tex. 2005); *Watts v. Advocate Health Care Network*, 04-CV-4062 (N.D. Ill., Mar. 30, 2005); *Corely v. John D. Archibold Memorial Hosp., Inc.*, 04-CV-110 (M.D. Ga., Mar. 31, 2005); *Kolari v. New York-Presbyterian Hosp.*, 2005 WL 710452 (S.D. N.Y. 2005); *Lorens v. Catholic Health Care Partners*, 356 F. Supp. 2d 827 (N.D. Ohio 2005); *Shriner v. ProMedica Health System, Inc.*, 2005 WL 139128 (N.D. Ohio 2005); *Amato v. UPMC*, 371 F. Supp. 2d 752 (W.D. Pa. 2005); *Gardner v. North Miss. Health Serv., Inc.*, 2005 WL 1312753 (N.D. Miss. 2005); *McCoy v. East Texas Medical Center*, 2005 WL 2105966 (E.D. Tex. 2005); *Jakublec v. Sacred Heart Health System*, 1261443 (N.D. Fla., May 27, 2005); *Feliciano v. Thomas Jefferson Univ. Hosp.*, 04-CV-04177 (E.D. Pa. 2005, Sept. 28, 2005); *Hutt v. Albert Einstein Med. Center*, 04-CV-03440 (Sept. 28, 2005); *Grant v. Trinity Health-Michigan*, 04-CV-72734-DT (E.D. Mich., Sept. 30, 2005).

    Other cases have been voluntarily dismissed prior to a ruling on a motion to dismiss. E.g., *Shipman v. Inova Health Care Services et al.*, 04-CV-910 (E.D. Va.); *Woodrum v. Integris Health Care, Inc.*, 04-CV-00835 (W.D. Okla.); *Kelly v. Northeast Georgia Med. Center*, 04-CV-00139 (N.D. Ga.); *Frimpong v. DeKalb Med. Center*, 04-CV-01745 (N.D. Ga.); *Maldonado v. Ochsner Clinic Found.*, 04-CV-01987 (E.D. La.).

    Attorneys' fees may be awarded in these cases (e.g., *Woodrum v. Integris Health Care, Inc., supra*).
79. *Nat'l R.R. Passenger Corp. v. Atchison, Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465–466 (1985).

consensual in nature is not only utterly without foundation but . . . has been repeatedly rejected by the courts.''[80] Thus, although the Internal Revenue Code contains a list of the types of organizations that may qualify for tax-exempt status, there is no language there that demonstrates any intention by Congress to create contractual rights; the Code merely establishes a legislative policy of not taxing the income of qualifying entities.[81]

(b) Tax Exemption Does Not Create Third-Party Beneficiaries

Those who contend that recognition of tax-exempt status creates a contract between the federal government and the exempt organization[82] then contend that they are third-party beneficiaries of this contract. This argument has been made, without success in the courts, by uninsured plaintiffs who claim that they were denied medical care by exempt hospitals, that this denial of care was a breach of this contract, and that they are entitled to relief as third-party beneficiaries of this contract.[83]

(c) Tax Exemption Does Not Create Private Right of Action

Courts have held that the recognition of tax exemption of an organization as a charitable entity does not create a private right of action.[84] As has been noted,[85] Congress has established private rights of action pursuant to the federal tax law in other settings.[86] The creation of this tax exemption did not establish an implied private cause of action[87] (and even if there were a contract and an implied cause of action, this type of plaintiff lacks standing to sue[88]).

(d) Tax Exemption Does Not Create Charitable Trust

Courts also have repeatedly held that the recognition of an organization by the IRS as a charitable entity does not create a form of charitable trust. This assertion was made, and has been unsuccessful in the courts, by individuals who claimed that exemption of a hospital from federal income tax gave rise to a charitable trust to provide affordable medical care to the hospital's uninsured patients.[89] This argument continues with the contention that the exempt hospital overcharged its patients, that this constitutes a breach of the trust, and that the uninsured patients are entitled to relief as intended beneficiaries of the

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80. *McLaughlin v. Commissioner*, 832 F.2d 986, 987 (7th Cir. 1987).
81. E.g., *Grant v. Trinity Health-Michigan*, 04-CV-72734-DT (E.D. Mich., Sept. 30, 2005).
82. *See* § 2.5(a).
83. *See* cases collected at *supra* note 78.
84. *Id*.
85. E.g., *Burton v. William Beaumont Hosp.*, 347 F. Supp. 2d 486 (E.D. Mich., 2004).
86. E.g., IRC §§ 7431(a)(1), 7433.
87. E.g., *Lorens v. Catholic Health Partners*, 365 F. Supp. 2d 827 (N.D. Ohio 2005)
88. E.g., *Grant v. Trinity Health-Michigan*, 04-CV-72734-DT (E.D. Mich., Sept. 30, 2005).
89. *See* cases collected at *supra* note 78.

trust. Courts have held that charitable trusts require the presence of language demonstrating a specific intent to create the trust and that, in any event, the only proper party to enforce the trust is the state's attorney general.

A companion argument also consistently rejected by the courts is that tax exemption as a charitable entity creates a constructive trust, from which individuals may derive relief.[90] It has been noted that this type of assertion of unjust enrichment and entitlement to relief is ''essentially a collateral attack on the IRS's decision'' to recognize the exempt status of the hospital.[91]

90. E.g., *Peterson v. Fairview Health Services,* 2005 WL 22616 (D. Minn. 2005).
91. E.g., *Grant v. Trinity Health-Michigan*.

CHAPTER THREE

Criticisms of Tax Exemption

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Despite its philosophical basis and the nurturing it often receives from the federal tax law,[1] the concept of tax exemption (and its frequent companion, the charitable contribution deduction) receives considerable ongoing attention and review, and recurring criticism. The sharpest focus is on charitable organizations[2]; in recent years, critics have concentrated on public charities—quite frequently, healthcare organizations.

Today, there is widespread reexamination of the approaches to and assumptions underlying tax-exempt status in the contemporary political and economic context. This process of testing the concept of tax exemption against modern needs and expectations is leading to the possibility of new criteria for tax exemption for a wide variety of organizations and institutions. In recent years, nonprofit healthcare organizations—more so than any other category of tax-exempt organization—have become primary subjects of this evaluation. As healthcare reform evolves, they are seeing a dramatic shift in the ground rules for their exemption.

The technicalities of federal tax law provisions aside, what is at stake in this continuing tax policy dialogue is the social role of charitable and other forms of tax-exempt organizations in the United States. The outcomes of this process may well reshape the contours of American society and life in the coming decades, by revising the roles played in the governmental, for-profit, and nonprofit sectors. If the role of the nonprofit sector is diminished as a consequence of policies antithetical to tax exemption (and deductible charitable

1. *See* § 1.2.
2. These are the organizations that are tax-exempt under IRC § 501(a) by reason of description in IRC § 501(c)(3), and are entitled to attract contributions that are deductible for income tax (IRC § 170(c)(2)), estate tax (IRC § 2055(a)(2)), and gift tax (IRC § 2522(a)(2)) purposes.

giving), the status of the United States as a democracy will undoubtedly be lessened.

§ 3.1 CRITICISMS IN GENERAL

Contemporary federal, state, and local governments are engaged in a near-desperate search for revenue to satisfy public demands for more services and to balance growing deficits. Politically, an increase in existing tax rates and/or the imposition of new taxes is generally not feasible. Thus, to extract additional revenues from an existing tax system, legislatures must make adjustments in tax features that constitute *exemptions, deductions, exclusions*, and *credits*.

Tax exemption and tax deductibility shrink the income tax base, forcing the remaining taxpayers to bear increasing tax burdens as the demand for governmental programs (and tax relief) rises. For example, in metropolitan centers, which are often highly dependent on the real property tax, hundreds of acres of valuable real estate are owned by tax-exempt (and government) organizations. Other parcels of land must then be taxed at higher rates. The public, feeling taxed to the maximum these days, is often not sympathetic to *tax-exempt* entities. The flat tax movement educated the populace well: when person one does not pay taxes, person two pays that much more.

Tax exemptions for nonprofit organizations are not escaping this severe scrutiny (nor are charitable contribution deductions). Political philosophies of pluralism, voluntarism, and a thriving independent sector tend to wither when politicians are eager to ferret out tax revenues from any possible source.

Among the nation's policymakers, some attack tax exemptions as *loopholes*, as though the legislatures created them inadvertently. Others laud them in theory but maintain they can no longer be *afforded*,[3] or contend that there are too many abuses of exemptions to warrant their continuation.[4] Still others assert that one or more forms of tax exemption are outmoded, anachronistic relics of a simpler, bygone era. This last argument pits those who want more government against those who want less.

As noted, the flat tax debate has greatly increased the sophistication of the taxpaying public. It is now generally recognized that deductions, credits, and the like carry a price tag in the form of *revenues forgone*.[5] (The peril in this

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3. An illustration was the inability of Congress to financially justify continuation of the tax exemption for group legal services organizations (IRC § 501(c)(20) entities); that tax exemption was allowed to expire as of June 30, 1992.
4. One of the best examples of this attitude was the widely held view of private foundations in the years preceding the reforms in 1969. *See* PRIVATE FOUNDATIONS, § 1.3.
5. Those who fervently espouse this concept see tax exemptions and the like as forms of *back-door spending*, arguing that the tax system is being inappropriately used in place of the direct appropriations process. There is nothing innovative about this view; more than seventy years ago, a court wrote that ''[t]o exempt from taxation is akin to appropriating the amount of the tax'' (*State v. Alabama Education Foundation*, 163 So. 527, 531 (Sup. Ct. Ala. 1935)).

reasoning is that it is predicated on the view that all revenues from all sources inherently belong initially to government, and government simply decides which persons are to be permitted to retain monies that they earn, and to what extent. Overlooked is the fact that sometimes the privately spent dollars are used for public ends more efficiently than the governmentally spent dollars. Further, this reasoning assumes that all relevant behavior taking place while the tax exemption is in place would remain after it is repealed; this assumption, often false, leads to high estimates of ''revenue losses'' that prove very tempting to legislatures eager to wring tax dollars out of an otherwise dry tax system.)

The development that has most singlehandedly directed attention to these *revenue losses* and threatens present-day tax exemptions and deductions is the concept of *tax expenditures*, which is a part of the federal budget law and process. Each annual budget submitted by the President contains a listing of these ''expenditures.'' The rationale underlying tax expenditures is that economists can ascertain the revenue that a government has forgone by category of tax exemption, tax deduction, and the like. The table of tax expenditures in each federal budget reveals the significant amount (usually in the millions and sometimes in the billions) of revenue ''lost'' by tax preferences for that fiscal year. The staff of the Joint Committee on Taxation also estimates tax expenditures; this analysis is of a five-year period. For example, for fiscal years 2007–2011, the tax expenditure (revenue loss) figure assigned to the charitable contribution deduction overall is $250.8 billion and for gifts to healthcare organizations is $27 billion.[6]

The U.S. Supreme Court has unanimously embraced the thought that charitable contribution deductions (and tax exemptions) are tax expenditures. This conclusion came as part of the rationale for deciding that Congress

6. Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2007–2011* (JCS-3-07).

Tax exemptions for nonprofit organizations technically are not tax expenditures. In part, this is because that tax benefit is available to any entity that chooses to organize itself and operate in the required manner. Also, in the case of charitable organizations and similar entities, tax-exempt status is not a tax expenditure because the nonbusiness activities of these organizations must predominate and their unrelated business activities generally are taxable (see Chapter 24).

Although the tax expenditures concept is a useful budgetary evaluation and planning tool, it generates much misunderstanding when applied to charitable organizations. The tax revenues ostensibly ''lost'' by reason of these tax exemptions and deductions are not ''lost'' at all; they are devoted to public ends. Moreover, as noted, those revenues can be allocated more efficiently than by using the federal government's expenditure approach. Research undertaken for the Commission on Private Philanthropy and Public Needs (see Chapter 1, text accompanied by note 25) showed that, for each $1.00 that the federal government ''loses'' because of the income tax charitable contribution deduction, the charitable sector gains between $1.15 and $1.29. Ultimately, this matter comes down to a political/philosophical view (which is, as discussed in § 1.2, what tax exemption and the charitable contribution deduction is based on): which sector should be entrusted with the expenditures—the nonprofit one or the governmental one?

has ample authority to restrict legislative activities by tax-exempt charitable organizations, while allowing tax-exempt veterans' organizations to lobby without limitation.[7] The Court wrote:

> Both tax exemptions and tax-deductibility are a form of subsidy that is administered through the tax system. A tax exemption has much the same effect as a cash grant to the organization of the amount of tax it would have to pay on its income. Deductible contributions are similar to cash grants of the amount of a portion of the individual's contributions. . . . The system Congress has enacted provides this kind of subsidy to non profit civic welfare organizations generally, and an additional subsidy to those charitable organizations that do not engage in substantial lobbying. In short, Congress chose not to subsidize lobbying as extensively as it chose to subsidize other activities that non profit organizations undertake to promote the public welfare.[8]

From a policy perspective, it becomes easier to repeal or trim the scope of a tax exemption (or tax deduction) when it is characterized merely as a *subsidy*.

Another set of criticisms of tax-exempt organizations—again, particularly public charities—emphasizes their misuse and manipulation. There are repeated surges of efforts to attack various forms (perceived or real) of *private inurement* or *private benefit*,[9] usually fueled by a scandal such as the ignominy involving the United Way of America.[10] The most recent of these efforts is the scheme of federal tax penalties enacted in 1996 and imposed on disqualified persons engaging in excess benefit transactions with public charities and social welfare organizations, in the form of *intermediate sanctions*.[11]

It is nonetheless unusual to repeal tax exemptions, particularly those in the federal income tax law. Despite a variety of philosophical and economic objections, the tax exemptions for most nonprofit organizations are secure. There are, however, two arguments that can prove quite successful in eliminating or narrowing the scope of a tax exemption. One is the *practical* argument: the original justification for the tax exemption no longer exists, so it is appropriate to repeal the exemption or rewrite the criteria for it.[12] The other is the *equitable* argument: certain activities (programs or fundraising) of the tax-exempt

7. Tax-exempt charitable organizations are limited as to the amount of permissible lobbying (see § 7.1). By contrast, veterans' organizations, while also tax-exempt (by reason of either IRC § 501(c)(4) or IRC § 501(c)(19)) and beneficiaries of deductible charitable gifts (IRC § 170(c)(3)), are allowed to engage in unlimited legislative activities. Organizations that are described in IRC § 501(c)(4) and that engage in lobbying activities, however, are ineligible for federal grants or other support (Lobbying Disclosure Act of 1995, Pub. L. No. 104-65, 104th Cong., 1st Sess. (1995), § 18).
8. *Regan v. Taxation With Representation of Washington*, 461 U.S. 540, 544 (1983). In a footnote, the Court cryptically added that, "[i]n stating that exemptions and deductions, on one hand, are like cash subsidies, on the other, we of course do not mean to assert that they are in all respects identical" (*id.*, at 544, n. 5).
9. See Chapter 4.
10. *See* Glaser, An Insider's Account of The United Way Scandal: What Went Wrong and Why (1994).
11. The components of this tax regime are the subject of §§ 4.9 and 28.2(b).
12. *See, e.g.*, § 13.1.

organization are considered to be unfairly ''competitive'' with similar activities of for-profit organizations.[13]

Healthcare organizations are finding themselves the brunt of all of these arguments and others, and each objection is forcefully held.

§ 3.2 CRITICISMS OF TAX EXEMPTION FOR HEALTHCARE ORGANIZATIONS

As noted above, one of the compelling arguments for the elimination or adjustment of a tax exemption is that the original justification for the exemption no longer exists, and therefore it is appropriate to repeal the exemption or rewrite the criteria for it. This contention has been at the heart of a forceful debate over the role of tax exemption for healthcare organizations in contemporary circumstances.

The debate started when opponents of the healthcare tax exemption asserted that today's charitable hospitals look no different from and function the same as today's for-profit hospitals. This is a modern-day application of the commerciality doctrine.[14] The consequence has been a vigorous analysis of the appropriateness of programs of tax-exempt hospitals and other healthcare entities—an analysis that reached a new high in media attention as Congress struggled throughout 1994 with proposed reform of the healthcare delivery system.

For years, the IRS has had to grapple with applications of the law of tax-exempt organizations, particularly with respect to organizations that are charitable entities, in relation to exploding changes in the field of healthcare. Controversy has been ongoing since the IRS launched use of the doctrine of *promotion of health*, as an independent basis for tax exemption for charitable entities, in 1969.[15] Keeping its tax policy applications in pace with the rush of new healthcare providers and other organizations has proved daunting for the IRS—although, to its credit, it has kept up and shows no sign of letting up as new healthcare tax pronouncements evolve. Yet this onslaught of new and changing nonprofit healthcare forms is straining present-day perceptions of appropriate tax policy—at the IRS and on Capitol Hill.

For a while, these policy disputes—most dramatically, over tax exemption for nonprofit hospitals—were confined to the courts. But, as the 1990s began, the focus on the appropriate characteristics of a tax-exempt hospital became more concentrated, and the controversy shifted from the courts to Congress. In the ensuing debate, one side asserted that the *community benefit* standard was adequate, and the other contended that the time had come (or perhaps

13. *See, e.g.*, § 9.3.
14. *See* § 3.3.
15. *See* § 1.7.

had returned) for utilization of a *charity care* standard. In essence, the two positions were:

1. *Community benefit standard:* The community benefit standard is the contemporary rationale for the federal tax law exemption for nonprofit hospitals and other healthcare providers. This standard is predicated on the fact that one of the definitions of the term *charitable* is the *promotion of health*. Thus, to be tax-exempt under this standard, a provider must promote the health of a class of persons broadly enough to benefit a community, and must be operated to serve a public, rather than a private, interest. It is not necessary that the provider base its tax exemption on some other rationale, such as *relief of the poor*.[16]
2. *Charity care standard:* Once the law, and desired in many quarters to again be the law, the rationale underlying the charity care standard was the basis for the federal tax law exemption for nonprofit hospitals and other healthcare providers. This standard is predicated on a view that, because the community benefit standard is inadequate to differentiate tax-exempt from taxable providers, tax exemption should be based on a definition of the term *charitable* that emphasizes *relief of the poor*. Under this standard, a provider, to be tax-exempt, must provide a substantial portion of its healthcare services without cost or on a reduced-cost basis.[17]

The beginnings of historical developments of this magnitude can rarely be identified with precision, but one of the principal events that brought this conflict to the fore was the hearings on the tax-exempt status of nonprofit hospitals before the House Committee on Ways and Means (Committee) in 1991.[18] In the press release announcing the hearings, the then-Chairman of the Committee, Rep. Dan Rostenkowski (D-Ill.), said that ''changes in the organization, structure, and activities of hospitals, as well as in the hospital financing system, suggest that a review of these issues is appropriate.''[19]

Earlier in the year, legislation in this field had been introduced by two prominent members of the House of Representatives. The first bill was introduced by Rep. Edward Roybal (D-Cal.), Chairman of the House Select Committee on Aging[20]; the second, by Rep. Brian Donnelly (D-Mass.), a member of the Committee.[21] The Roybal bill was heavily influenced by a report, on the matter of tax exemption for hospitals, issued in 1990 by the General Accounting Office (GAO).

16. *See* § 1.6.
17. These principles are discussed more fully in Chapter 30.
18. ''Tax-Exempt Status of Hospitals and Establishment of Charity Care Standards'' (Serial No. 102-73, July 10, 1991), House Committee on Ways and Means, U.S. House of Representatives, 102 d Cong., 1st Sess. 1991.
19. House Committee on Ways and Means press release No. 11, June 4, 1991.
20. H.R. 790, 103 d Cong., 1st Sess. (1991). A summary of this legislation is in § 26.6(a).
21. H.R. 1374, 103 d Cong., 1st Sess. (1991). A summary of this legislation is in § 26.6(b).

The Committee heard testimony on the Roybal and Donnelly proposals from spokespersons for the Department of the Treasury, the Department of Health and Human Resources (DHHS), the GAO, and the IRS, and from various other witnesses. The issues explored at this hearing were (1) the need for standards of charity care, particularly in light of the tax policy reasons for providing tax exemption to nonprofit hospitals; (2) estimates and background data concerning the value of the tax benefits provided to nonprofit hospitals; and (3) IRS administration of current laws applicable to tax-exempt hospitals, including the private inurement and private benefit rules,[22] the unrelated business income rules,[23] and the rules relating to the operation of taxable subsidiaries.[24]

The Committee also received testimony from government and private sector witnesses about the current operations of tax-exempt hospitals, including the extent to which nonprofit hospitals distinguish themselves from other hospitals with respect to provision of uncompensated care for patients who are unable to pay, programs and services that benefit the community, and day-to-day operations.

The essence of the testimony presented by the Treasury Department was that the present-law standard—the community benefit standard—is appropriate, and the extent of charity care should not be the prevailing test as to healthcare entities. The testimony contained a substantive history of the law of tax exemption for hospitals and similar organizations.[25]

Treasury's testimony stated that the community benefit standard ''reflects the basic economic rationale for the public policy underlying tax exemption for nonprofit hospitals.'' This point was amplified: ''Although the nature of hospitals and their role in the healthcare system have undergone several fundamental shifts since the adoption of the income tax, nonprofit hospitals' economic activities provide a continuing rationale for their tax exemption under the Internal [Revenue] Code.''

The Treasury view was that ''[a]n economic rationale for tax exemption is that nonprofit hospitals are able to provide services that are not provided or are inadequately provided by for-profit hospitals because the market prices charged by hospitals do not reflect the benefit the hospitals' services confer on the community as a whole.'' These services include research and innovation, medical teaching, care for low-income patients, and other community services. Treasury stated that a community benefit standard ''encourages pluralistic alternatives to government activities—the *raison d'être* for tax exemption.''

The Treasury testimony criticized a specific charity care standard on grounds that it would provide hospitals with an ''incentive to divert their free or reduced cost services to the form of care that best protects their tax-exempt

22. *See* Chapter 4.
23. *See* Chapter 24.
24. *See* Chapter 16.
25. This history is the subject of §§ 1.2, 1.4, and 1.5.

status.'' The testimony continued: ''Thus, a specific charity-care requirement may bias the healthcare system toward providing services to low-income persons in the form of hospital care rather than preventive and other less costly forms of medical care. It also might decrease nonprofit hospitals' expenditures for other activities, such as research and teaching, that contribute to the well-being of the community. Neither tax nor health policy would be advanced if nonprofit hospitals were simply to substitute one set of activities for another with no net increase in their overall provision of community benefits.''

Following a criticism of the Roybal and Donnelly bills, the Treasury Department testimony observed that the ''sole sanction for noncompliance under current law—loss of tax-exempt status—may merit reexamination.'' However, the spokesperson pointed out that this state of affairs is not limited to hospitals ''but rather applies to tax-exempt institutions generally.''

The testimony on behalf of the IRS also reviewed the historical development of standards for tax exemption for hospitals, then sketched out for the Committee the work of the IRS in this field during the previous five years. The IRS has audited over 3,800 annual information returns of hospitals and other healthcare organizations (such as nursing homes, hospices, and clinics). Of all of the examinations of public charities conducted during this period, approximately one-fifth were audits of hospitals or other healthcare organizations. These audits were largely based on the organizations' information returns (Form 990), were performed by a single revenue agent auditing a single entity, and often resulted in proposed adjustments in the unrelated business income area and, more recently, employment tax liability.[26] According to this testimony, ''only in a few instances'' did an audit result in a proposal to revoke tax-exempt status.

Looking ahead, the IRS stated that it knows it must adopt a ''more comprehensive and more penetrating approach'' to the audits of systems of hospitals, and thus has been implementing its plan by which these audits are conducted on the basis of ''coordinated examination procedures.'' This type of audit activity, which is used by the IRS in its examination of the largest corporate (business) taxpayers, is based on the team audit concept (teams include computer audit specialists, engineers, appraisers, and lawyers who are specialists in employment taxes, partnership issues, and corporate and individual income tax matters, as well as exempt organization specialists), which brings together the ''necessary and appropriate technical skills to conduct an examination effectively and efficiently.''[27]

The IRS's testimony emphasized three points:

1. The ''nonprofit hospital environment is extremely complicated and fast-changing; it demands considerable interpretative and enforcement resources.''

26. *See* Chapter 27.
27. *See* Chapter 35.

2. ''[W]hether the issue is community benefit, reorganizations, joint ventures, physician recruiting and compensation, or the unrelated business income tax, there are difficult interpretative and administrative challenges.''
3. ''[W]ithin available resources, we are making significant efforts to meet those challenges.''

The GAO testimony was based largely on the agency's 1990 report on the matter of tax exemption for hospitals. The essential position of the GAO in this regard was that the ''link between tax-exempt status and the provision of charitable activities for the poor or underserved is weak for many nonprofit hospitals.''

In the view of the GAO, large urban teaching/public hospitals provide a ''disproportionate share'' of charity and other unreimbursed care, while nonprofit hospitals provide the lowest level of charity care, serve the fewest Medicaid patients, and often have the highest profits. One of the GAO's most significant (and well-publicized) findings was that 57 percent of nonprofit hospitals provided less charity care (including bad debt) than the estimated value of their income tax liability.

Further, the GAO said that it was not uncommon for nonprofit hospitals' strategic goals (such as admissions policy and marketing) to resemble those of for-profit institutions. The position of the GAO in this regard is: ''If one goal of the tax exemption is to recognize the charitable role of hospitals and encourage them to continue or expand current levels of charity care and other services to the poor, changes in tax policy may be needed.''

The DHHS testimony concurred with Treasury ''on the issue of the administration of tax policy and precedents it may set.'' The department added that ''charity care and anti-dumping [of unwanted patients] are a high priority'' at the DHHS. This testimony contained slight criticism of the nonprofit hospital community for its level of charity care. DHHS said that the nonprofit hospitals take the position that they, as a group, ''provided more uncompensated care than the estimated value of their income tax liability.'' But, DHHS also said, these ''group statistics'' mask the fact that over one-half of the nonprofit hospitals provided less charity care than the estimated value of their income tax liability, with the bulk of the uncompensated care being concentrated in a ''small number'' of hospitals. The department observed that ''if non-profit hospitals were to provide additional charity care that could help provide additional services to the uninsured,'' but that the matter of charity care is ''but one small part of the larger context of health reform.''

When the American Hospital Association (AHA) testified at this hearing, its basic position was: (1) the current federal tax law requirements ensure that tax-exempt hospitals remain ''oriented and responsive'' to the needs of their communities, and (2) the problem of medical indigence must be considered

within the context of general healthcare law reform, because the needs in this area are ''too great'' for hospitals to meet alone.

As to the first position, the AHA said: ''Exemption should continue to be based on the tradition of supporting those organizations that serve a public purpose, and hospitals should be evaluated against whether they are meeting the needs of their communities.'' It also said that ''defining a charitable hospital solely in terms of the care it provides the poor does not begin to recognize the full range of public good that hospitals provide in their communities.''

The AHA added that ''[f]ocusing only on free care is an unreasonably narrow application of the concept of charitability.'' The establishment of a ''required amount of free care'' was pronounced ''arbitrary,'' and ''likely to lead to unintended and adverse consequences.'' The AHA warned: ''Setting a required amount will result in IRS second-guessing the hospital administrator and the community board of directors about which community needs should be met, in what priority, and with what amount of resources.'' The AHA ''believes that the definition of charity should be broad enough to accommodate the changing needs of society and the disparate needs of communities.''

The AHA addressed the problem of medical indigence. Using 1989 data, it estimated that over 34 million individuals in the United States are uninsured and that millions more have inadequate insurance. The AHA said that, in 1989, hospitals provided $8.9 billion in care—nearly 5 percent of total expenses—for which they received no payment. In that year, continued the AHA, hospitals provided to Medicaid patients $4.2 billion in care for which they were not paid, and provided other services for the poor, such as preschool immunizations, meals on wheels, elderly day care, and shelters for the abused and homeless. Moreover, said the AHA, while ''unsponsored care costs'' are growing, hospitals ''are becoming less able to absorb these costs.''

The AHA observed that the Roybal and Donnelly proposals, which would require tax-exempt hospitals to provide minimum levels of charity care, ''suggest that the problem of medical indigence is a hospital problem.'' Disagreeing with this view, the AHA stated that ''[o]nly if the problem of medical indigence is considered in the context of healthcare reform is there potential for producing the national commitment necessary to address the problem.''

Thus, the AHA asserted its belief that the ''community benefit standard strikes an appropriate balance between the need for a norm against which hospitals can be evaluated and the need for a norm that allows hospitals to be responsive to the unique needs of their individual communities.'' Urging the Committee to continue the community benefit standard, and not legislate charity care rules for exempt hospitals, the AHA noted that the ''principle underlying the [community benefit] standard is that the promotion of health in a manner that benefits a large enough part of a community to be of benefit to the community as a whole serves a public purpose that merits tax exemption.''

The Healthcare Financial Management Association (HFMA) also opposed the Roybal and Donnelly proposals. The HFMA said: ''[T]he debate should focus on the central question of the standard used to determine whether a hospital qualifies as tax-exempt. . . . HFMA believes that hospital tax-exempt status should be based on the broad array of community benefits hospitals provide. Charity care is one of those benefits—a major one—but it should not be the sole criterion.''

In supporting the community benefit standard, the HFMA said that it ''strongly disagrees with the philosophical basis of the Donnelly and Roybal proposals: the view that charity care, not the current standard of community benefit, should be made the determining factor in granting tax-exempt status to hospitals.'' It stated that ''efforts to base tax exemption solely on levels of charity care fail to recognize that it is not just the poor, but the entire community, that depends on a hospital.''

The HFMA had a task force prepare a report on the attributes or characteristics of tax-exempt healthcare organizations that may be used by hospitals in justifying their tax-exempt status. These attributes of the entity are its mission, use of financial surpluses, accountability, charity services, reduced government burden, essential healthcare services, unprofitable services, educational programs, contribution to healthcare, and provision of services that no other community entity is willing or able to provide. These criteria, urged the HFMA, should be used to assess the tax exemption for hospitals.

The HFMA, like the AHA, contended that qualification for tax-exempt status is a tax policy issue: ''[The] awarding of tax-exempt status should not be used as a national strategy for providing care to the indigent.'' That, concluded the HFMA, is a health policy issue that ''must be addressed by all parties, not just hospitals.''

The Association of American Medical Colleges (AAMC), testifying on behalf of the nation's teaching hospitals, said that these entities have a three-pronged mission: (1) comprehensive patient care, (2) education of health professionals, and (3) provision of an environment for biomedical research.

The AAMC reiterated a point made by many of the other witnesses: ''Charity care is only one dimension of a hospital's community mission.'' The AAMC added that ''it is appropriate to expect not-for-profit hospitals, enjoying the advantage of tax-exempt status, to make a contribution to the public welfare beyond merely providing medical services to those who can pay for them.'' The AAMC pointed out that two of the requirements of the Donnelly legislation are already being met by virtually all teaching hospitals: (1) provision of a full-time emergency room for all members of the community regardless of their ability to pay, and (2) participation in the Medicaid program. The AAMC said: ''In fact, teaching hospitals are the largest Medicaid providers in most states.''

The essence of this next portion of the AAMC testimony is worth quoting. The association said that it was before the Committee

> . . . to express the concern that the present tax [exemption] debate, which considers the issue largely in the context of charity care, is too narrowly focused. However, it is in arriving at a definition of what constitutes an acceptable community contribution, in lieu thereof, which is troublesome. There is, as of now, no widely accepted tally of what not-for-profit hospitals contribute to community welfare, nor even an agreed upon definition of what ought to be included in one. Without such data, it is difficult to conclude that the contribution is inadequate or even to develop a reasonable relevant standard for what ought to be expected. Although the GAO data suggest that some not-for-profit hospitals are contributing little to charity care and are prospering, nothing is known about the capacity of others to increase their contribution in the face of shrinking profit margins or what services they might have to curtail in order to do so. In the absence of a reliable method of measuring community benefits more broadly, . . . [the AAMC] believe[s] it is premature to consider changing tax status based on a formulaic approach.

The AAMC concluded:

> Teaching hospitals are working within their communities to determine appropriate and necessary community benefits. Their achievements and non-profit status should be measured against a yardstick which encompasses the whole range of benefits they provide.

Testimony on behalf of the United Hospital Fund of New York (UHF) revealed that it is ''unabashed in . . . [its] support of voluntary hospitals and the private, nonprofit healthcare sector as a crucial component of our nation's pluralistic health system.'' This testimony urged two points: (1) from 1981 to 1989, the voluntary hospitals' ''share of uncompensated care costs increased dramatically'' and (2) ''nonprofit, tax-exempt providers of healthcare services systematically behave differently from for-profit taxable corporations.'' As to this second point, the testimony continued, nonprofit hospitals ''are more likely to locate in, or remain in, poor communities; they are more committed to education and research; they provide more services to the poor and more unprofitable services, such as neonatal intensive care or burn care; and they encourage and use more volunteers.''

Contending against the need for more law in this area, the UHF spoke of the ''antidumping'' provisions in the Medicare and Medicaid laws, New York's guidelines for nonprofit hospitals, and the development of community benefit certification processes, and called for greater enforcement of the laws concerning private inurement and operation of unrelated businesses. This testimony concluded: ''One can only begin to imagine the costs of effective enforcement of the complex formulaic regulatory schemes contemplated by the legislation proposed by either Congressman Donnelly or Roybal. Maybe better use could be made of scarce enforcement dollars by focusing attention on existing laws.''

The Daughters of Charity National Health System (DCNHS), the largest nonprofit healthcare system in the United States, testified. Although not supportive of the Donnelly legislation as presently written, the DCNHS believed that the ''valued tradition of tax exemption is an enormous benefit to not-for-profit hospitals and it is entirely reasonable and proper for Congress to ask these institutions to provide and document charity care and community services.'' The organizations believed that nonprofit hospitals ''should be responsive to their communities, to public officials, and others, by demonstrating that their tax-exempt purpose is being fulfilled and that they deserve special tax treatment by relieving a government burden.'' The DCNHS cautioned the Committee to ''not set standards so strict and inflexible that we inadvertently harm those that we set out to provide for and protect.''

The president of the Delaware Valley Hospital Council, testifying on behalf of itself and some hospital systems and medical centers, urged the Committee to ''avoid wholesale, universal changes in the legislative treatment of tax-exempt hospitals.'' He supported the community benefit standard, observing that ''[t]here is no clear relationship between a quantitative level of charity care/community benefit and the quality of service provided to a hospital's community.'' The Roybal and Donnelly bills were criticized as embodying a ''lack of clear definitional guidance'' and lacking acknowledgment of the ''genuinely beneficial activities America's nonprofit hospitals routinely perform.'' Indeed, these proposals, which would set minimum standards for charity care and community benefits, were portrayed as establishing a ceiling for indigent care, under which ''nonprofit hospitals providing more than their 'required' share may be encouraged to scale back indigent care.''

The American Protestant Health Association (APHA) testified that the Donnelly and Roybal approaches are ''unnecessary.'' This testimony observed, however, that a ''substantial number of APHA members are Medicare disproportionate share hospitals and major teaching institutions. Moreover, we support the concept that all nonprofits have an open emergency room service component, and that all nonprofits should not discriminate against Medicare and Medicaid patients.'' The APHA ''firmly believe[s], however, that this issue, however critical, cannot be viewed in isolation from the rest of the healthcare delivery system. Our system needs reform, and this charity care issue is only one component. . . . Access, coverage, financing, malpractice reform—the list is quite long, as this Committee well knows. All of these issues need to be addressed comprehensively, and not in a vacuum.''

The Metropolitan Chicago Healthcare Council (MCHC) testified that the community benefit standard is an ''appropriate and fair standard'' by which nonprofit hospitals qualify for tax-exempt status, and that the policy underlying the Donnelly and Roybal bills ''will result in unnecessary hardships for hospitals and their surrounding communities.'' The MCHC criticized the GAO analysis for its examination of only five states, and for being based on

''outdated data and . . . conclusions that we do not believe are supported by the data in the study.'' The testimony concluded:

> The imposition of a monetary charity care requirement on . . . [tax-exempt] hospitals will do little to address the overall problem of our nation's healthcare system and could well undermine extensive community benefit currently provided by hospitals to their communities. . . . [We] believe everyone in this room is in agreement that any problems associated with healthcare have hit crisis proportion. . . . Comprehensive reform is the answer to this crisis rather than piecemeal revision as proposed in the Donnelly and Roybal legislation.

A deputy attorney general of the State of Texas testified, at the hearing, that ''tax-exempt hospitals have both a moral and a legal duty to provide charity care.'' This position resulted from a ''major study'' on charity care in Texas, undertaken in response to ''numerous calls from individuals who were denied medical care because they could not pay.'' This deputy attorney general stated that his office's ''sense of responsibility for protecting the public interest in charities springs from two sources: the desperate lack of healthcare in many communities and the implicit responsibilities to those communities that tax-exempt, nonprofit hospitals undertake.''

Echoing the GAO testimony, he said his office had ''found a tragic failure on the part of certain wealthy hospitals to provide their fair share of indigent healthcare.'' He concluded with this rejoinder to the previous testimony: ''We are not asking tax-exempt hospitals to solve the national healthcare crisis. We simply ask that they shoulder their fair share of the burden.''

The Catholic Health Association of the United States testified that it was ''very concerned that the proposed standards in some of the legislation before the Committee rely too heavily on those activities which can be easily counted and monetarized and ignore the many community benefits which cannot be so readily quantified but which are equally important.'' The association added: ''There is a grave danger that incentives will be inadvertently created that will drive hospitals to abandon many critical services they now provide in their communities in order to meet standards focused on high-cost activities.''

The Shriners Hospitals testified that both the Donnelly and Roybal bills would create law that would ''penalize a totally free hospital system such as ours, focused on children in need, because we do not service Medicare patients as such and we operate without the federal subsidies and controls embedded in the Social Security Act.'' This legislation would, said the Shriners, ''deny us the very tax benefits and tax incentives which Congress enacted to support truly charitable programs to patients in need.'' The organization asked that, if a charity care standard is adopted, then forms of free care other than that offered through the Medicare and Medicaid programs should be recognized.

The Hermann Hospital in Houston testified that ''[t]o impose one major policy change [a charity care standard] in the tax-exempt arena without

integrating such change with a larger reform of the healthcare system would be a grievous error.'' The spokesperson added: ''[T]he very large part of our society that has no healthcare coverage is neither the making of nor the responsibility of the hospitals of America. Society itself must deal with this need. We hospitals are part of the solution but are not the totality of the solution.''

The National Association of Counties applauded the Donnelly and Roybal bills, and testified: ''By no means will stronger charity care measures solve all the health access problems. But it will force those hospitals which have blurred their mission to serve everyone in the community.''

This set of hearings and the testimony it adduced constitute a full compendium of criticisms of the current state of the federal tax law as it applies to healthcare organizations. A distillation of the testimony of representatives of the nonprofit hospital field yields the following:

- The nation's nonprofit hospitals are quite satisfied with the community benefit standard and wish it to remain as the basis for determining their tax-exempt status.
- With regard to an appropriate measure, as the AHA testified, ''hospitals should be evaluated against whether they are meeting the needs of their communities.''
- They are in opposition to the Donnelly and Roybal bills and endorse the testimony of the HFMA, which ''strongly disagrees with the philosophical basis of the Donnelly and Roybal proposals: the view that charity care, not the current standard of community benefit, should be made the determining factor in granting tax-exempt status to hospitals.''
- They believe, as the AAMC testified: ''Charity care is only one dimension of a hospital's community mission.''
- They recognize the problem of healthcare for the indigent but pronounce it society's problem, not hospitals' problem, and they assert that, as the Metropolitan Chicago Healthcare Council stated, ''[c]omprehensive reform is the answer to this crisis [of lack of charity care] rather than piecemeal revision as proposed in the Donnelly and Roybal legislation.''

As is so often the case in the legislative process, neither side overwhelmed the other. Many representatives of government, from the GAO to the Texas Attorney General's office, remain convinced that the country's tax-exempt hospitals can do more by way of providing charity care and that the burden of charity care is distributed unevenly over the charitable hospital system. The tax policymakers asserted, however, that the present system is adequate for modern-day needs. With the shift from the Bush Administration to the Clinton Administration, there was some alteration in that thinking. But the IRS

can develop policy only to a limited extent. Ultimately, Congress will have to distill these criticisms and decide whether reforms are warranted.[28]

The battle has been joined anew by members of the 109th and 110th Congress, although the content of the debate has not varied much since the 1991 hearings. Both the House Ways and Means Committee and the Senate Finance Committee held hearings to reexamine the basis for tax exemption of charitable healthcare providers. The catalyst appears to be the point of view held by no less than the Commissioner of Internal Revenue: ''What's the difference between a profit making hospital and a not-for-profit hospital these days? Not a lot.''[29]

Representative William Thomas (R-CA), then Chairman of the House Ways and Means Committee, framed the issues as he saw them at the outset of his Committee's hearings in 2005:

> I think an appropriate question to ask is what does the current standard require of hospitals? Is there adequate oversight of the so-called community benefit standard? . . . Given the size of the Federal benefit and the competitive advantages given to tax-exempt entities—and we may attempt to place a ballpark dollar figure on those—I believe it is incumbent upon these Committees to ensure that the taxpayers are given at least some commensurate relationship of benefit for the tax exemption amounts. Fourteen years ago, this Committee held a hearing on this same topic, and yet today we still face many of the same questions because Congress has failed to act.[30]

Thus, Chairman Thomas asserted the position that the community benefit standard might no longer be appropriate and the charity care standard should again be the basis for tax exemption for hospitals.[31]

The Senate Finance Committee, and in particular its former Chair and now Ranking Member Senator Charles Grassley (R-IA), has been even more critical of the community benefit standard. The Committee's minority staff went so far as to propose for discussion a replacement for the community benefit standard, although stopping short of proposing specific legislation.[32] It cited

28. *See*, generally, Copeland, ''Nonprofit Versus For-Profit Hospitals,'' 18 *Exempt Orgs. Tax Rev*. (No. 1) 35 (1997).
29. Remarks of IRS Commissioner Mark Everson at *Representing and Managing Tax-Exempt Organizations Conference*, Georgetown University Law Center, *BNA Daily Tax Report* at G-9, April 29, 2005. Everson has also stated, however, that the burden of making this differentiation lies with the hospital board of directors. "More and more, the IRS looks to the independent board exercising its fiduciary duty to operate for the benefit of the community to differentiate the tax-exempt hospital from a for-profit operation." Statement of Mark Everson, Testimony Before the House Committee on Ways and Means, May 26, 2005.
30. Statement of Rep. William Thomas, hearings on the Tax-Exempt Hospital Sector, House Committee on Ways and Means, May 26, 2005.
31. Chairman Thomas later introduced legislation that would reinstitute a charity care-based standard. See § 26.6.
32. See Tax Exempt Hospitals: Discussion Draft, http://www.senate.gov/~finance/press/Gpress/2007/prg071907a.pdf (''Discussion Draft'') and discussion at § 6.3.

as its primary concern the same issue identified by Chairman Thomas: that many nonprofit hospitals receive substantial federal income tax benefits and subsidies without providing commensurate benefits to society.[33]

The Discussion Draft also noted the Congressional Budget Office study that concluded that nonprofit hospitals provide only slightly more uncompensated care than for-profit hospitals and that there are significant differences between individual nonprofit hospitals in terms of the amount of uncompensated care or charity care each hospital provides.[34] The Discussion Draft summed up the discrepancy this way: "some nonprofit hospitals are helping pull the wagon when it comes to charity care but far too many nonprofit hospitals are sitting in the wagon—receiving significant tax breaks but providing little to nothing in the way of charity care for those in need in our society."[35]

§ 3.3 THE COMMERCIALITY DOCTRINE

The *commerciality doctrine* is the single most important general element of the law of tax-exempt organizations today. Applications of the doctrine are transforming the law stating the bases for tax exemption (and, moreover, are significantly rewriting the law of unrelated business income taxation). The doctrine is having a major impact on the shaping of tax law applicable to nonprofit healthcare organizations, in as much as many critics are of the view that hospitals and other healthcare providers are operating in a *commercial* manner—another manifestation of the difficulty some are having in differentiating between the two types of healthcare providers.

The origins of the commerciality doctrine are obscure; it has been and is being formulated by the courts, not by Congress. With one exception, the word *commercial* does not appear in the federal statutory law of tax-exempt organizations.[36] Moreover, with one mostly irrelevant exception,[37] the term is not found in the applicable income tax regulations.

(a) Introduction

The commerciality doctrine, as it relates to the activities of tax-exempt healthcare providers and other tax-exempt organizations, is an overlay body of law that the courts have been gratuitously engrafting onto the statutory and

33. *Id*., Citing testimony of Nancy Kane before the Senate Finance Committee, September 13, 2006 (several studies have shown that the majority of tax-exempt hospitals do not provide charity care commensurate with the value of their tax exemptions).
34. Congressional Budget Office Report, *Nonprofit Hospitals and the Provision of Community Benefits*, Dec. 2006.
35. See supra note 32, at p 2.
36. The exception is IRC § 501(m), which denies tax exemption to certain organizations that provide *commercial-type insurance. See* § 9.3.
37. Reg. § 1.513-1(c)(1) (articulation of the requirement that a taxable unrelated business be *regularly carried on*). *See* § 24.3.

regulatory rules. When and if Congress enacts reforms in this area as part of enactment of national health system reform legislation, it is likely to codify one or more law principles previously configured by courts.

The consequence of application of the commerciality doctrine, as the IRS asserts, is this: A tax-exempt organization is engaged in a nonexempt activity when that activity is engaged in a manner that is considered *commercial*. An act is a *commercial* one if it has an analog in the for-profit organizations sector. (In practice, this doctrine is unevenly applied.)

The United States is essentially a capitalist society, so the business sector is, in several ways, the preferred of the three sectors.[38] Although entities in the business sector are operated for *private* objectives (to generate profits for their owners), the nonprofit sector is generally expected to be operated for *public* purposes (the good of society). Many today still perceive nonprofit organizations as entities that do not and should not generate a *profit*, are operated largely by volunteers, and are not and should not be ''run like a business.'' Out of these precepts (some of which are false) is emanating the view that organizations in the nonprofit sector should not *compete* (engage in similar activity) with organizations in the for-profit sector.[39] This is a form of *counterpart* test that labels a competitive activity of a nonprofit organization a *commercial* undertaking. This conclusion then leads to a finding that the commercial activity is a *nonexempt* or *unrelated* one, with adverse consequences in law for the nonprofit organization, either as respects tax-exempt status or unrelated business income taxation.

The ongoing debate as to whether nonprofit credit unions should continue to be tax-exempt is a classic illustration of this counterpart test—the ''counterparts'' being for-profit financial institutions. A report from the Congressional Research Service (CRS) referred to the fact that ''many believe that an economically neutral tax system requires that financial institutions engaged in similar activities should have the same tax treatment.''[40]

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38. *See* § 1.1.
39. In 1987, the then-Deputy Assistant Secretary (Tax Policy), Department of the Treasury, testified before the House Subcommittee on Oversight as follows: the ''role of the quasi-governmental, not-for-profit sector should . . . be restricted to that of supplementing, and not supplanting, the activities of for-profit businesses'' (*Unrelated Business Income Tax*, Statement of O. Donaldson Chapeton, *Hearings Before the Subcomm. on Oversight, House Comm. on Ways and Means*, 100th Cong., 1st Sess. 35 (1987)).
40. ''Should Credit Unions Be Taxed?,'' Congressional Research Service Analysis No. I B 89066 (Sept. 18, 1990).

Another illustration of the point is the question of the ongoing tax exemption for fraternal beneficiary societies (IRC § 501(c)(10)). A study conducted by the Department of the Treasury (*Report to the Congress on Fraternal Beneficiary Societies*, Jan. 15, 1993) concluded that the insurance products offered by these organizations are essentially the same as those provided by commercial insurers. The study observed that the large fraternal beneficiary societies ''conduct their insurance operations in a manner similar to commercial insurers.'' Oddly, in contravention of contemporary court opinions and

It is from this perspective that some argue that the *community benefit standard* for healthcare providers is inadequate, in that it serves merely as a rationale for allowing nonprofit hospitals to operate in a commercial (that is, competitive) manner. The *charity care standard* is advocated as a means of forcing tax-exempt healthcare providers to make services available in a noncompetitive fashion (that is, in a way that is different from that of their for-profit counterparts). These advocates would paraphrase the CRS: Many believe that an economically neutral tax system requires that healthcare providers engaged in similar activities should have the same tax treatment. Congress has espoused that view, legislating operational criteria to differentiate charitable healthcare providers from taxable providers. Thus, nonprofit providers that do not conform to these criteria will be taxed the same as for-profit providers.[41]

(b) Judicial Origins of the Doctrine

The commerciality doctrine is traceable to dicta in a U.S. Supreme Court opinion written over 75 years ago.[42] The case concerned a nonprofit religious order that engaged in some nonexempt activities (real estate and securities investments, and some incidental sales) that the government alleged destroyed the basis for its tax exemption. The Supreme Court concluded that the order was tax-exempt as a religious entity, and dismissed its investment and business efforts on the ground that ''[s]uch [religious] activities cannot be carried on without money.''[43] In this case, the Court did not articulate any commerciality doctrine; rather, it characterized the government's argument as being that the order ''is operated also for business and *commercial* purposes.''[44] Nonetheless, although the Court wrote that there was no ''competition'' and that while the ''transactions yield some profit [it] is in the circumstances a negligible factor,''[45] by using the word in describing the government's position, the ''commerciality doctrine'' was launched.

About 20 years later, the Court came the closest it has ever come to expressly enunciating the commerciality doctrine, in a case concerning the tax exemption of a chapter of a nonprofit ''better business'' bureau, which was seeking tax-exempt status as an educational organization.[46] On that occasion, the Court wrote that the requirement that an exempt educational

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IRS policy, the report dismissed this commerciality, stating that these societies ''do not use their exemption to compete unfairly with commercial insurers in terms of price or to operate inefficiently.''

41. This approach is a broader manifestation of that underlying the commercial-type insurance rules (*see* § 9.3).
42. *Trinidad v. Sagrada Orden de Predicadores de la Provincia del Santisimo Rosario de Filipinas*, 263 U.S. 578 (1924).
43. *Id*. at 581.
44. *Id*. (emphasis added).
45. *Id*. at 582.
46. *Better Business Bureau of Washington, D.C. v. United States*, 326 U.S. 279 (1945).

entity be operated ''exclusively'' for exempt purposes ''plainly means that the presence of a single non-educational purpose, if substantial in nature, will destroy the exemption regardless of the number or importance of truly educational purposes.''[47] The Court found a noneducational purpose in the promotion of a profitable business community: the organization was said to have a ''commercial hue'' in that its ''activities are largely animated by this commercial purpose.''[48]

The commerciality doctrine flourished during a period in the early 1960s, in the context of the courts' scrutiny of nonprofit publishing organizations. In one instance, a nonprofit organization that published and sold religious literature, with the purpose of upgrading the quality of teaching materials for Bible instruction in Sunday schools, was found to have generated ''very substantial'' profits.[49] The court rejected the government's argument that profits alone preclude tax exemption. The court wrote: ''If the defendant [IRS] seeks by this distinction ['slight' rather than 'very substantial' profits] to suggest that where an organization's profits are very large a conclusion that the organization is noncharitable must follow, we reject such a suggestion.''[50] But then the court added: ''If, however, defendant means only to suggest that it ['very substantial' profits] is at least some evidence indicative of a *commercial* character we are inclined to agree.''[51]

This court found the organization to be directly involved in the conduct of a business for profit, with religious objectives ''incidental.''[52] Application of the counterpart concept was articulated in a footnote, where the court observed ''that there are many commercial concerns which sell Bibles, scrolls, and other religious and semi-religious literature which have not been granted [tax] exemption as to that part of their businesses.''[53] Consequently, the court found that the organization's activities were of a ''nonexempt character.''[54] In as much as the court declined to apply the unrelated business income tax rules to the facts, its opinion is devoid of any discussion of ''related'' and ''unrelated'' activities. The court thought that the organization's primary activities were unrelated ones, since the tax exemption was revoked, but the word *commercial* was used rather than the word *unrelated*. This opinion offered no definition of the term *commercial* and does not contain any indication as to why the court used the word.

In a subsequent nonprofit publishing organization case before the same court, involving an entity that disseminated publications containing investment

47. *Id*. at 283.
48. *Id*. at 283–284.
49. *Scripture Press Foundation v. United States*, 285 F.2 d 800, 803 (Ct. Cl. 1961).
50. *Id*.
51. *Id*. (emphasis added).
52. *Id*. at 805.
53. *Id*. at 806, note 11.
54. *Id*. at 807.

advice to subscribers and others, the court ruled that the organization was not qualified for tax exemption because ''its purpose is primarily a business one.''[55] Rather than use the term *unrelated business*, the court elucidated as follows: the organization was ''in competition with other commercial organizations providing similar services,'' the organization's ''investment service in all its ramifications may be educational, but its purpose is primarily a business one,'' and the ''totality of these activities is indicative of a business, and . . . [the organization's] purpose is thus a commercial purpose and nonexempt.''[56]

In 1963, a court rejected the government's contention that the publication and sale of religious books, magazines, pamphlets, records, tapes, and photographs by a nonprofit organization amounted to commercial activity.[57] In 1964, this court was confronted with another case involving the operation of alleged commercial enterprises, this time litigation concerning a nonprofit religious organization that conducted training projects. The court refused to apply the commerciality doctrine, observing that ''we regard consistent nonprofitability as evidence of the absence of commercial purposes.''[58]

Another case involving a nonprofit religious publishing organization was considered by a federal district court in 1967. This court refined the commerciality doctrine by distinguishing between organizations that have commercial activities as only a portion of their overall activities and those that have commercial activities as their principal or sole activity.[59] Organizations that retained their tax exemption in the prior cases were grouped in the first category[60]; the other organizations were placed in the second category. The court thus relied on the other cases[61] in concluding that the publishing company did not qualify for tax exemption. The nonexempt purpose was portrayed as the ''publication and sale of religious literature at a profit.''[62] The court said its conclusion could not be otherwise: ''If it were, every publishing house would be entitled to an exemption on the ground that it furthers the education of the public.''[63]

In 1968, another federal district court reached the identical conclusion. A nonprofit publisher of religious materials was denied tax exemption because it ''was clearly engaged primarily in a business activity, and it conducted its

55. *American Institute for Economic Research v. United States*, 302 F.2 d 934, 938 (Ct. Cl. 1962).
56. *Id*. at 937–938.
57. *A.A. Allen Revivals, Inc. v. Commissioner*, 22 T.C. 1435 (1963).
58. *The Golden Rule Church Association v. Commissioner*, 41 T.C. 719, 731 (1964).
59. *Fides Publishers Association v. United States*, 263 F. Supp. 924 (N.D. Ind. 1967).
60. E.g., *Saint Germain Foundation v. Commissioner*, 26 T.C. 648 (1956); *The Golden Rule Church Association v. Commissioner*, 41 T.C. 719 (1964); *A.A. Allen Revivals, Inc. v. Commissioner, 22 T.C. 1435 (1963)*.
61. *Scripture Press Foundation v. United States*, 283 F. 2 d 800 (Ct. Cl. 1961); *American Institute for Economic Research v. United States*, 302 F. 2 d 934 (Ct. Cl. 1962).
62. *Fides Publishers Association v. United States*, 263 F. Supp. 924, 935 (N.D. Ind. 1967).
63. *Id*.

operations, although on a small scale, in the same way as any commercial publisher of religious books for profit would have done.''[64] This finding was reversed on appeal, however, with the appellate court concluding that the organization did not have ''operational profits.''[65] The court concluded that the ''deficit operation reflects not poor business planning nor ill fortune but rather the fact that profits were not the goal of the operation.''[66] Still, although the nonprofit organization in this case prevailed, this opinion went a long way in enshrining the point that the existence of profit is highly suggestive of commerciality.

Thus, the 1960s brought court cases that fundamentally created, solidified, and refined the commerciality doctrine. By this point, the courts were taking into account three elements in deciding whether to invoke the doctrine: the extent to which the organization had net profits, accumulated surplus revenue (capital), and made expenditures for exempt functions. Following this flurry of interest in publishing organizations, little happened with respect to the doctrine for nearly a decade. Then, in 1978, a court decided the first of what would become a bundle of contemporary commerciality doctrine cases.

In that year, a court reviewed the case of a nonprofit religious publishing organization whose program was the dissemination of sermons to ministers for the purpose of improving their religious teachings. The court allowed the organization to be tax-exempt on the ground that the sale of religious literature was an ''integral part of and incidental to'' the entity's religious objectives.[67] During that year, the same court was called on to determine whether a nonprofit organization that purchased, imported, and sold artists' crafts could be tax-exempt as a charitable entity. The IRS argued that the organization was a ''commercial import firm''; the organization asserted that its purposes were to assist disadvantaged artisans in poverty-stricken countries to subsist and preserve their craft, and to provide the stores of tax-exempt museums handicrafts representative of these countries.[68] Once again, the court declined to apply the commerciality doctrine, finding that the purchase, import, and sale activities were means of accomplishing exempt purposes.

Months later, however, this court concluded that the primary purpose of a nonprofit organization was the publication and sale of books written by its founder. In concluding that this organization was primarily commercial in nature, the court concentrated on the entity's annual profits, and its distribution and marketing practices.[69] Soon thereafter, the court analyzed the facts involving a nonprofit organization formed to purchase and sell

64. *Elisian Guild, Inc. v. United States*, 292 F. Supp. 219, 221 (D. Mass. 1968).
65. *Elisian Guild, Inc. v. United States*, 412 F.2 d 121, 125 (1st Cir. 1969).
66. *Id*. at 125.
67. *Pulpit Resource v. Commissioner*, 70 T.C. 594, 611 (1978).
68. *Aid to Artisans, Inc. v. Commissioner*, 71 T.C. 202, 208 (1978).
69. *Christian Manner International v. Commissioner*, 71 T.C. 661 (1979).

products manufactured by blind individuals. Holding that the principal purpose of the organization was to assist the blind in obtaining employment, thereby alleviating the hardships that these persons experience in securing and retaining employment, the court ruled that the entity was not a commercial one.[70] The court disregarded the fact that the organization generated a profit.

In 1980, the same court considered the case of a nonprofit organization that assisted in the organization and operation of businesses owned by or employing certain impoverished Native Americans. A substantial portion of the organization's revenue was derived from the leasing of oil well drilling equipment; the court ruled that the entity was disqualified from tax exemption because it was operated primarily for commercial purposes. The court wrote: ''Profits may be realized or other nonexempt purposes may be necessarily advanced incidental to the conduct of the commercial activity, but the existence of such nonexempt purposes does not require denial of exempt status so long as the organization's dominant purpose for conducting the activity is an exempt purpose, and so long as the nonexempt activity is merely incidental to the exempt purpose.''[71]

The next year, a federal district court concluded that a nonprofit organization, which published religious literature, properly had its tax exemption revoked because it evolved into a commercial entity. Originally formed as a missionary organization, it had, according to the court, become imbued with a ''commercial hue'' and transmuted into a ''highly efficient business venture.''[72] The court noted that the organization emulated the publishing and sales practices of commercial publishers, enjoyed expanding profits in recent years, experienced a growth in accumulated capital, and compensated its top employees in substantially increasing amounts.

In 1982, this court again contemplated the status of a nonprofit religious publishing company and again agreed with the IRS that its tax exemption should be revoked. The court found the entity to be too profitable and thus commercial, its ''commercial hue'' being derived from wide profit margins, development of a professional staff, and competition with for-profit commercial publishers.[73] On appeal, however, this conclusion was reversed because the appellate court was ''troubled by the inflexibility'' of the criteria invoked by the lower court.[74] As to these standards, the court of appeals did not proffer any clarity; although bothered by the facts, it was not prepared to sustain revocation of the organization's tax exemption. Thus, the appellate court wrote that ''success in terms of audience reached and influence exerted,

70. *Industrial Aid for the Blind v. Commissioner*, 73 T.C. 96 (1979).
71. *Greater United Navajo Development Enterprises, Inc. v. Commissioner*, 74 T.C. 69, 79 (1980).
72. *Incorporated Trustees of Gospel Worker Society v. United States*, 510 F. Supp. 374, 381 (D.D.C. 1981).
73. *Presbyterian and Reformed Publishing Co. v. Commissioner*, 79 T.C. 1070, 1083 (1982).
74. *Presbyterian and Reformed Publishing Co. v. Commissioner*, 743 F.2 d 148, 152 (3 d Cir. 1984).

in and of itself, should not jeopardize the tax-exempt status of organizations which remain true to their stated goals.''[75] At the same time, the court cautioned that, if an exempt organization's ''management decisions replicate those of commercial enterprises, it is a fair inference that at least one purpose is commercial.''[76]

In 1983, a court concluded that a nonprofit organization, ostensibly established for religious purposes, could not qualify for tax exemption because its principal purpose was ''tax avoidance'' counseling.[77] The court noted that the information provided by the organization was ''no different from that furnished by a commercial tax service.''[78] About three years went by before a court considered another commerciality case, this one in connection with an organization that was formed to assist in the process of ''technology transfer'' from colleges, universities, and other research institutions to industry. The court concluded that the major activity of the entity was the provision of patenting and licensing services—undertakings deemed primarily commercial in nature.[79] In 1986, a court held that a religious retreat center was not an organization that is commercial in nature, because it did not compete with for-profit entities.[80] This organization was found to have constructed housing on its property to promote religious activity; the fact that the entity charged fair market prices for the housing was rationalized as necessary to avoidance of charges of private inurement.

(c) The Contemporary View

Not until 1990 was the commerciality doctrine spelled out in detail by a court. The case concerned a nonprofit organization associated with a church that operated, in advancement of church precepts, vegetarian restaurants and health food stores. The organization regarded itself as having charitable and educational purposes; the court was of the view that the entity ''was conducted as a business and was in direct competition with other restaurants and health food stores.''[81] The court added: ''Competition with commercial firms is strong evidence of a substantial nonexempt purpose.''[82]

This decision was affirmed on appeal[83]; of significance was the appellate court's specific statement of the factors it relied on to find commerciality, thus

75. *Id*. at 158.
76. *Id*. at 155.
77. *The Ecclesiastical Order of the Ism of Am, Inc. v. Commissioner*, 80 T.C. 833, 843 (1983).
78. *Id*. at 839.
79. *Washington Research Foundation v. Commissioner*, 50 T.C.M. 1457 (1985). This holding by the court was, however, superseded by legislation providing tax exemption for the organization (Tax Reform Act of 1986 § 1605; H.R. Rep. No. 99-841, 99th Cong., 2 d Sess. II-827 (1986)).
80. *Junaluska Assembly Housing, Inc. v. Commissioner*, 86 T.C. 1114 (1986).
81. *Living Faith, Inc. v. Commissioner*, 60 T.C.M. 710, 713 (1990).
82. *Id*.
83. *Living Faith, Inc. v. Commissioner*, 950 F.2 d 365 (7th Cir. 1991).

offering the best contemporary explication of the commerciality doctrine to date. These factors were stated to be the following:

- The organization sold goods and services to the public.[84]
- The organization was in ''direct competition'' with for-profit restaurants and food stores.[85]
- The prices set by the organization were based on pricing formulas common in the retail food business.[86]
- The organization utilized promotional materials and ''commercial catch phrases'' to enhance sales.[87]
- The organization advertised its services and food.[88]
- The organization's hours of operation were basically the same as those of for-profit enterprises.
- The guidelines by which the organization operated required that its management have ''business ability'' and six months' training.[89]
- The organization did not utilize volunteers; it paid salaries.[90]
- The organization did not receive charitable contributions.

No other court has articulated the commerciality doctrine more fully. Since the issuance of these criteria, it has been held that a nonprofit organization selling religious tapes is a nonexempt commercial entity,[91] a nonprofit organization operating prisoner rehabilitation programs is not eligible for tax exemption because of commercial activities,[92] and a nonprofit organization that had as its principal activity the ''operation of a number of canteen-style lunch trucks'' (innately, a commercial activity) properly had its tax-exempt status revoked.[93]

In a dramatic application of the commerciality doctrine, a federal district court in 2003 ruled that an organization operating a conference center could not be tax-exempt as a charitable or educational organization because of the distinctively commercial hue associated with its operations.[94] The court applied the same commerciality doctrine criteria utilized by the federal appellate court in 1991.[95]

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84. This factor alone was said to make the operations of the nonprofit organization ''presumptively commercial'' (*id*. at 373).
85. *Id*.
86. The ''profit-making price structure loom[ed] large'' in the court's analysis and the court criticized the organization for not having ''below-cost pricing'' (*id*.).
87. *Id*.
88. This was based on the expenditure of $15,500 for advertising over two years.
89. *Living Faith, Inc. v. Commissioner*, 950 F. 2 d 365, 375 (7th Cir. 1991).
90. This was based on the payment of salaries of $63,000 in one year and more than $25,000 in another year.
91. *United Missionary Aviation, Inc. v. Commissioner*, 60 T.C.M. 1626 (1991).
92. *Public Industries, Inc. v. Commissioner*, 61 T.C.M. 1626 (1991).
93. *New Faith, Inc. v. Commissioner*, 64 T.C.M. 1050 (1992).
94. *Airlie Foundation v. Internal Revenue Service*, 283 F. Supp. 2 d 58 (D.D.C. 2003).
95. *See* text accompanied by *supra* notes 76–83.

Thus, the commerciality doctrine has come to be widely accepted in the courts, despite its peculiar beginnings. As unfolding tax law policy concerning healthcare organizations so aptly illustrates, the commerciality doctrine is finding its way into the statutory law of tax-exempt organizations.

(d) Commerciality Doctrine and Healthcare Organizations

One of the principal concerns today is whether the typical nonprofit hospital or other healthcare provider is operating in a *commercial* manner—that is, looks and functions too much like its for-profit counterparts. As discussed throughout, that is one of the criticisms of the community benefit standard: it allegedly allows these entities to operate in ways that do not appear sufficiently *charitable* in nature.

Calls for return to a charity care standard are reflective of an application of the commerciality doctrine. They are efforts to force on nonprofit healthcare providers operational requirements that will make them more different from for-profit providers. Congress is not likely, at least in the foreseeable future, to heed these calls.

Had Congress enacted national healthcare system reform legislation in 1994, it would have amply engrafted the commerciality doctrine onto the statutory law of tax-exempt healthcare organizations.[96] It would have done so by enacting a series of requirements that essentially would have restored a form of *charity care* standard and neutered the *community benefit* standard, as a means of differentiating between tax-exempt charitable healthcare organizations and other tax-exempt and taxable healthcare organizations. The IRS is making strides in that direction administratively, but only Congress can construct a new scheme of criteria for tax exemption for charitable healthcare providers.

Congress, one of these years, may do just that. If it does, it may transform the law in this area, reworking the rationale for federal tax exemption to make nonprofit providers and other healthcare entities function in a less commercial manner. What Congress does in this regard may have a great impact on the law of tax-exempt healthcare organizations.

(e) Commerciality Doctrine and Unrelated Business Rules

Historically, the commerciality doctrine and the unrelated business rules have evolved along parallel tracks. These two bodies of law, however, are beginning to converge. For example, the IRS ruled that a tax-exempt charitable organization operated an unrelated business in the form of a small restaurant used to attract visitors to its exempt gift shop.[97]

96. *See* § 26.6.
97. Tech. Adv. Mem. 200021056, where the IRS applied the law as stated in *Living Faith, Inc. v. Commissioner*, 950 F.2 d 365 (7th Cir. 1991).

PART TWO

Fundamental Exempt Organization Principles Applied to Healthcare Organizations

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CHAPTER FOUR

Private Inurement, Private Benefit, and Excess Benefit Transactions

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A healthcare organization, to be qualified as a tax-exempt, charitable entity,[1] must be organized and operated so that "no part of . . . [its] net earnings . . . inures to the benefit of any private shareholder or individual."[2] That is, aside from being organized and operated exclusively for an exempt purpose

1. That is, an organization that is tax-exempt under IRC § 501(a) by reason of being an organization described in IRC § 501(c)(3).
2. IRC § 501(c)(3).

and otherwise meeting the appropriate statutory requirements,[3] a charitable healthcare organization must be in compliance with the federal tax law proscribing *private inurement* and forms of *private benefit*.[4]

In the healthcare setting, an organization may qualify as a tax-exempt business league, such as a business or professional organization.[5] Likewise, an organization may qualify as a tax-exempt social welfare organization.[6] The private inurement doctrine is applicable to both types of these organizations.[7]

§ 4.1 ESSENCE OF PRIVATE INUREMENT

The concept of private inurement is broad and wide-ranging.[8] The word *inure* means to gravitate toward, flow to, or transfer to something. The word *private* is used in this setting to mean *nonpublic* or *nonexempt* (usually, noncharitable) purposes or activities. Thus, the private inurement doctrine forbids ways of causing the income or assets of a healthcare organization (or other tax-exempt organization that is subject to the doctrine) from flowing away from the organization and to or for the benefit of one or more persons (usually individuals) with some significant relationship to the organization, for noncharitable purposes.

(a) Private Inurement Defined

The Office of the Chief Counsel of the IRS stated that private ''[i]nurement is likely to arise where the financial benefit represents a transfer of the organization's financial resources to an individual solely by virtue of the individual's relationship with the organization, and without regard to accomplishing exempt purposes.''[9] The IRS Chief Counsel also observed that the ''inurement issue . . . focuses on benefits conferred on an organization's insiders through the use or distribution of the organization's financial resources''[10] and that the ''inurement prohibition serves to prevent anyone in a position to do so from siphoning off any of a charity's income or assets for personal use.''[11]

3. *See* §§ 1.4–1.7.
4. *See* §§ 4.6 and 4.7, as to private benefit.
5. *See* Chapter 18.
6. *See* § 1.8.
7. IRC § 501(c)(4)(B), 501(c)(6). Overall, the private inurement doctrine is a statutory criterion for federal income tax exemption for 13 categories of exempt organizations (see TAX-EXEMPT ORGANIZATIONS, Chapter 20, text accompanied by notes 2–14).
8. The U.S. Tax Court stated: ''The boundaries of the term 'inures' have thus far defied precise definition'' (*Variety Club Tent No. 6 Charities, Inc. v. Commissioner*, 74 T.C.M. 1485, 1494 (1997)).
9. Gen. Couns. Mem. 38459. A private inurement transaction must, as discussed in § 4.2, involve one or more *insiders*.
10. *Id*.
11. Gen. Couns. Mem. 39862.

The contemporary meaning of the private inurement doctrine—which is barely reflected in the statutory language and transcends the nearly century-old formulation of the doctrine—is that none of the income or assets of a tax-exempt organization subject to the doctrine may be permitted to directly or indirectly unduly benefit an individual or other person who has a close relationship with the organization when he, she, or it is in a position to exercise a significant degree of control over it.

The essence of the concept is to ensure that a tax-exempt healthcare organization (or certain other exempt organizations) is serving a public interest and not a private interest.[12] That is, to be tax-exempt, the organization must establish that it is not organized and operated for the benefit of private interests such as designated individuals, the founder of the entity or his or her family, shareholders of the organization, persons controlled (directly or indirectly) by private interests,[13] or any other persons having a personal and private interest in the activities of the organization.[14] Private inurement is in many ways a doctrine that is parallel to the intermediate sanctions rules[15] and is somewhat akin to self-dealing in the private foundation field.[16]

In determining the presence of any proscribed private inurement, the law looks to the ultimate purpose of the tax-exempt healthcare organization: if the basic purpose of the organization is to benefit individuals in their private capacity, then it cannot be tax-exempt, even though exempt activities may also be performed; conversely, incidental benefits to private individuals may not defeat tax exemption if the organization otherwise qualifies.[17]

The private inurement doctrine does not prohibit transactions between a charitable organization and its *insiders*; rather, it requires that these transactions be tested against a standard of *reasonableness*.[18] This standard looks to

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12. *Ginsburg v. Commissioner*, 46 T.C. 47 (1966); Rev. Rul. 76-206, 1976-1 C.B. 154.
13. Reg. § 1.501(c)(3)-1(c)(1)(ii).
14. Reg. §§ 1.501(a)-1(c) and 1.501(c)(3)-1(c)(2).
15. *See* § 4.9.
16. *See* § 5.9, text accompanied by notes 237–238. The match between the two doctrines is not always perfect, however, as illustrated by a private letter ruling in which the provision by a private foundation of a below-commercial-interest-rate home mortgage loan to a disqualified person was ruled to be an act of self-dealing—yet the same transaction, when the charitable organization was a public charity, was ruled not to be private inurement because the loan arrangement was considered part of a reasonable compensation package (Priv. Ltr. Rul. 9530032). In general, *see* PRIVATE FOUNDATIONS, Chapter 5.
17. Reg. § 1.501(c)(3)-1(d)(1)(ii).
18. E.g., in a private letter ruling, the IRS observed that "[t]here is no absolute prohibition against an exempt section 501(c)(3) organization dealing with its founders, members, or officers in conducting its economic affairs" (Priv. Ltr. Rul. 8234084). This fact is to be contrasted with the self-dealing rules applicable to transactions between private foundations and their disqualified persons, where generally the very existence of the transaction amounts to self-dealing, irrespective of the extent of "reasonableness" (see *supra* note 15).

comparables, that is, to how similar organizations, acting prudently, transact their affairs in similar circumstances.[19] For example, in the instance of a loan, the factors to be considered are the duration of the indebtedness, the rate of interest to be paid, the security underlying the loan, and the repayment amount—all in relation to similar circumstances in the community. If the matter is a rental arrangement, the factors to be considered are the duration of the lease, the amount and frequency of the rent payments, and other elements of the rental arrangement in relation to comparable situations in the community. Usually, the terms of these transactions are tested against ordinary commercial practices; an overarching test is whether these and like transactions were negotiated on an arm's-length basis.

The private inurement doctrine embodies the unique difference between nonprofit and for-profit organizations. For the most part, the characteristics of both categories of organizations are identical: both require a legal form, pay compensation, face essentially the same expenses, are able to receive a profit and make investments, and produce goods and services. But, unlike the for-profit entity, the nonprofit healthcare organization cannot distribute its profits (''net earnings'') to those who control it and/or financially support it; there may not be any authentic equity ownership in a nonprofit organization.[20] Thus, the private inurement doctrine—elsewhere termed the *nondistribution* constraint[21] or the *charitable leakage doctrine*—is the substantive dividing line in law between the nonprofit organization and the for-profit organization.[22]

Occasionally, the IRS revokes the tax-exempt status of an organization for engaging in a form of private inurement.[23]

(b) Net Earnings

The statutory language proscribing private inurement contains a reference to an organization's *net earnings*. Technically, that term refers to gross earnings less expenses; literally, then, private inurement would be confined to transfers of net equity, such as by means of dividends.[24] (Some of the initial

19. *See* § 4.4.
20. A few states permit a nonprofit corporation to issue stock, but these situations involve securities that do not carry any dividend rights and are used solely for ownership purposes. These circumstances are not in conflict with the federal tax law requirements imposed on tax-exempt organizations.
21. Hansmann, ''The Role of Nonprofit Enterprise,'' 89 *Yale Law J*. 835, 838 (1980).
22. *See* § 1.1.
23. E.g., Exemption Denial and Revocation Letter (''Ex. Den. and Rev. Ltr.'') 20042703E.
24. E.g., in one of the early court opinions, it was stated that, because the term *private inurement* is not defined in the tax law, it ''must be given its usual and ordinary meaning of what is left of earnings after deducting necessary and legitimate items of expense incident to the corporate business'' (*Bank of Commerce & Trust Co. v. Senter*, 260 S. W. 144, 151 (Sup. Ct. Tenn. 1924). Also, *Southern Coal Co. v. McCanless*, 129 S.W.2d 1003, 1005 (Sup. Ct. Tenn. 1946); *National Life & Accident Ins. Co. v. Dempster*, 79 S.W.2d 564, 567 (Sup. Ct. Tenn. 1935).

court decisions applied the term in this manner, particularly where the facts lent themselves to this approach.[25]) The term, however, has been expanded considerably in recent years by the courts and the IRS.

An early proponent of this expansive approach was a court reviewing the prospects of private inurement in the healthcare context. This court observed that the *net earnings* phraseology ''should not be given a strictly literal construction, as in the accountant's sense,'' and that the ''substance should control the form,'' so that tax exemption should be denied where private inurement is taking place, ''irrespective of the means by which the result is accomplished.''[26] Likewise, another court held that the term ''may include more than the term net profits as shown by the books of the organization or than the difference between the gross receipts and disbursements in dollars'' and that ''[p]rofits may inure to the benefit of shareholders in ways other than dividends.''[27]

Thus, as discussed below,[28] the contemporary concept of private inurement, in the setting of healthcare and other tax-exempt organizations, goes far beyond the literal computation and dissemination of *net earnings*, and embraces a wide range of transactions and other activities. Indeed, the law has developed to the point where this aspect of the phraseology in the definition of the private inurement doctrine is superfluous and is to be disregarded.

(c) Incidental Private Inurement

The rule that private inurement with respect to insiders may not take place when charitable organizations are involved is not, in the view of the IRS and some courts, subject to a *de minimis* threshold. According to this view, any element of private inurement can cause a charitable organization to lose or be deprived of tax exemption.[29] Thus, one court stated that ''even if the benefit inuring to the members is small, it is still impermissible.''[30] This interpretation of the law is reflected in other court opinions[31] and represents the formal position of the IRS.[32] By contrast, there have been suggestions from the courts, from time to time, that a threshold of ''insubstantiality'' in the private inurement setting is practical and unavoidable. In one instance, a federal court of appeals observed that ''[w]e have grave doubts that the de

25. E.g., *Birmingham Business College, Inc. v. Commissioner*, 276 F.2d 476, 480–481 (5th Cir. 1960); *Gemological Institute of America v. Commissioner*, 17 T.C. 1604, 1609 (1952), *aff'd*, 212 F.2d 205 (9th Cir. 1954); *Putnam v. Commissioner*, 6 T.C. 702, 706 (1946).
26. *Virginia Mason Hospital Ass'n v. Larson*, 114 P.2d 978, 983 (Sup. Ct. Wash. 1941).
27. *Northwestern Municipal Ass'n v. United States*, 99 F.2d 460, 463 (8th Cir. 1938).
28. *See* § 4.4.
29. As discussed below, by contrast, the private benefit doctrine embodies a standard wherein an incidental benefit is disregarded. *See* §§ 4.6 and 4.7.
30. *McGahen v. Commissioner*, 76 T.C. 468, 482 (1981), *aff'd*, 720 F.2d 664 (3d Cir. 1983).
31. E.g., *Unitary Mission Church of Long Island v. Commissioner*, 74 T.C. 507 (1980), *aff'd*, 647 F.2d 163 (2d Cir. 1981); *Beth-El Ministries, Inc. v. United States*, 79-2 U.S.T.C. ¶ 9412 (D.D.C. 1979).
32. E.g., Gen. Couns. Mem. 35855.

minimis doctrine, which is so generally applicable, would not apply in this situation'' (that is, in the private inurement setting).[33]

Today, however, the existence of *incidental private inurement*, in the sense of acts of private inurement that will not give rise to revocation (or denial) of tax-exempt status, is clear. This concept is manifest in the relationship between the doctrine of private inurement and the intermediate sanctions rules.[34] The IRS is in the process of developing regulations that will state the criteria the IRS will apply, in instances of private inurement, in deciding whether to apply the intermediate sanctions penalties in lieu of revocation (or denial) of exemption,[35] thereby evidencing the fact that an act of private inurement will not necessarily adversely affect an organization's exemption.

(d) Private Inurement Doctrine in Context

The private inurement doctrine is not always applied in accordance with the foregoing principles. The courts and the IRS have been known to confuse the concepts of private inurement and private benefit,[36] to apply the private inurement doctrine even in the absence of benefits to insiders,[37] and to find private inurement without first testing the transactions against the standard of *reasonableness*.[38]

Today, the IRS maintains an extremely broad stance with respect to the doctrine of private inurement. In the view of the IRS, ''all persons performing services for . . . [a tax-exempt, charitable organization] have a personal and private interest [in the organization] and therefore possess the requisite relationship necessary to find private . . . inurement.''[39] This obvious overstatement[40] is the basis for the view, at the IRS, that all physicians

33. *Carter v. United States*, 973 F.2d 1479, 1486 (9th Cir. 1992). In an instance suggesting recognition of the concept of incidental private inurement, the IRS, in determining that the provision of tickets and/or admission passes to an exempt organization's shareholders to enable them to attend an agricultural fair conducted by the organization did not rise to the level of private inurement, emphasized the fact that only 3 percent of the free passes were given to shareholders (Tech. Adv. Mem. 9835003).
34. *See* § 4.9.
35. These regulations were issued in proposed form on September 8, 2005 (REG-111257-05).
36. This usually is done by finding private inurement in the absence of one or more insiders.
37. E.g., *Columbia Park and Recreation Association, Inc. v. Commissioner*, 88 T.C. 1 (1987), *aff'd*, 838 F.2d 465 (4th Cir. 1988), where an association of homeowners was found to be engaging in private inurement transactions by ''providing comfort and convenience'' to its members, who, by reason of being the ''intended beneficiaries'' of the organization's facilities and services, were found to have a ''personal interest'' in the activities of the organization (88 T.C. at 24, 26).
38. E.g., *Airlie Foundation, Inc. v. United States*, 826 F. Supp. 537 (D.D.C. 1993), where a charitable organization was found to have engaged in acts of private inurement with its founder, even though each transaction satisfied the test of reasonableness; the court was influenced by the founder's conviction for tax offenses.
39. Gen. Couns. Mem. 39670.
40. This statement is an overly expanded view of the private inurement doctrine because, otherwise, every lawyer, accountant, fund-raiser, other service provider, and vendor

practicing in a tax-exempt, charitable hospital are ''insiders'' with respect to the hospital.[41]

The doctrine of private inurement is separate from other, similar requirements of law: healthcare and other charitable organizations (1) must be operated *exclusively* for tax-exempt purposes, (2) must be operated *primarily* for public rather than private purposes, (3) may not be operated for a noncharitable (other than insubstantial) purpose, (4) must not be operated principally for *commercial* purposes,[42] and (5) must not transgress the doctrine of *private benefit*.

§ 4.2 THE REQUISITE *INSIDER*

The concept of private inurement contemplates a type of transaction between a tax-exempt charitable (or perhaps other type of) organization and an individual (or other person) in the nature of an *insider*—one who is able to cause the application of the organization's net earnings for private purposes as the result of his or her exercise of control or influence over the organization. Thus, the statute speaks of inurement to the benefit of ''any private shareholder or individual.''[43]

(a) Definition of *Insider*

The federal tax law has borrowed the term *insider* from the federal securities laws (which prohibit, among other uses of the term, *insider trading*) and applies it to describe persons of this nature.[44] Generally, then, an insider is a person who, because of a unique, close, or otherwise special relationship to the organization involved, can cause the application of the organization's funds or other resources for his or her private purposes, by reason of his or her exercise of control of or influence over the organization. For this reason, the analogy to the self-dealing and excess benefit transactions rules is useful: certain types of transactions are proscribed, being between the charitable organization and one or more insiders (termed *disqualified persons* in the private foundation context[45] and in the intermediate sanctions context[46]).[47]

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serving a charitable organization would be an insider with respect to the organization, by reason of that relationship alone, which is clearly not the law.

41. *See* § 4.3.
42. *See* § 3.3.
43. It is rare for a tax-exempt healthcare organization or other exempt entity to have shareholders. *See supra* note 19. When shareholders exist, presumably they must be insiders in order for the private inurement doctrine to apply, although an IRS ruling suggests that the status of a person as a shareholder automatically makes the person an insider (Priv. Ltr. Rul. 9835001).
44. *Deluxe Corporation v. United States*, 885 F.2d 848 (Fed. Cir. 1989), *rev'g*, 88-1 U.S.T.C. (CCH) ¶ 9311 (Ct. Cl. 1988).
45. IRC § 4946.
46. IRC § 4958(f)(1).
47. *See* § 4.4.

The IRS wrote that the "concept of private inurement contemplates a transaction between the exempt organization and an individual who is an insider," noting that an insider, "by virtue of his or her position within the organization, has the ability to influence or control application of the organization's net earnings."[48] The agency added that, "when the interests of the charity are sacrificed to the private interests of the founder or those in control, exemption is precluded because the organization is serving private interests."[49]

Thus, impermissible private inurement involves two components: (1) the private person (insider) to whom the benefit inures has the ability to control or otherwise influence the actions of the tax-exempt organization so as to cause the benefit, and (2) the benefit that is conferred was intentionally conferred by the influenced tax-exempt organization and did not result merely by happenstance or as a by-product of an exempt function.

For years, the IRS declined to publicly concede that the private inurement doctrine can be applied only in instances of involvement of tax-exempt organizations with insiders. In a healthcare case decided in 1978, however, a court expressly held that the "concept of private benefit [inurement] . . . [is] limited to the situation in which an organization's *insiders* . . . [are] benefited."[50] The IRS subsequently agreed, writing that the "inurement issue . . . focuses on benefits conferred on an organization's insiders through the use or distribution of the organization's financial resources."[51]

(b) Early Law

Even prior to the 1978 court opinion, the law on this point was quite clear. One of the principal cases involved private inurement between a church and its founder and his family. The creator of the religion involved was the founder of the church, and he and his wife were two of its three trustees.[52] The church disbursed substantial sums to the founder and members of his family, in payments denominated as fees, commissions, royalties, compensation for services, rent, and reimbursement of expenditures made on behalf of the church. The church maintained a personal residence for the founder, paid him a percentage of its earnings, and made loans to him and his family members. The court observed that "[w]hat emerges from these facts is the inference that the . . . [founder's] family was entitled to make ready personal

48. Internal Revenue Manual, Part 4, Chapter 76 (IRS Exempt Organizations Examination Guidelines), 3.11.2 § 2.
49. *Id.* § 3.
50. *Sound Health Association v. Commissioner*, 71 T.C. 158, 185 (1978) (emphasis in original). Also, *Leon A. Beeghly Fund v. Commissioner*, 35 T.C. 490 (1960).
51. Gen. Couns. Mem. 38459.
52. *Founding Church of Scientology v. United States*, 412 F.2d 1197 (Ct. Cl. 1969), *cert. denied*, 397 U.S. 1009 (1970).

use of the corporate earnings. . . . [N]othing we have found in the record dispels the substantial doubts the court entertains concerning the receipt of benefit by . . . [this family] from . . . [the church's] net earnings.''[53] It was obvious that the court regarded these various disbursements as inurement of the church's net earnings to individuals in their private capacity; with respect to certain of these disbursements, the court wrote that the ''logical inference can be drawn that these payments were disguised and unjustified distributions of . . . [the church's net] earnings.''[54]

Prior private inurement cases involved colleges and schools. One court denied tax exemption to a college, in part because its net earnings were distributed to its shareholders for their personal benefit.[55] The founder of the college and his two sisters were the only shareholders of the institution and were, along with two of their spouses, the trustees of the college. The court, concerned about the ''constant commingling of the funds of the shareholders and the [c]ollege,''[56] found that the college ''was operated as a business producing, or ultimately producing, substantial revenues for its operators [;] . . . the net earnings, or substantial portions, were to be, and were in fact, distributed to those shareholders for their own personal benefit.''[57] The college's charter limited compensation so that it could not exceed a ratable distribution based on stock ownership; ''[i]t was, and was intended to be, a means by which to assure an equal distribution of the earnings.''[58]

Another of these early private inurement cases involved a school and its officers.[59] Five individuals leased property to the school, and the institution constructed improvements on property owned by these lessors. Of this group, one was president of the school, two were vice presidents, and one was secretary-treasurer; these four individuals constituted the executive committee of the school and were among its nine directors. The rents paid by the school were found to be ''excessive and unreasonable.''[60] The court found that ''as a result of these excessive rent payments part of the net earnings of . . . [the school] inured to the benefit of the members of the . . . group . . . and that part of the net earnings of . . . [the school] also inured to their benefit because of the construction at its expense of buildings and improvements on real estate owned by them.''[61]

In a case involving a foundation and its creator, a court declined to accord the foundation charitable status because of the private gain derived by

53. *Id*. at 1202.
54. *Id*. at 1201.
55. *Birmingham Business College, Inc. v. Commissioner*, 276 F.2d 476 (5th Cir. 1960).
56. *Id*. at 479.
57. *Id*. at 480.
58. *Id*.
59. *Texas Trade School v. Commissioner*, 30 T.C. 642 (1958), *aff'd*, 272 F.2d 168 (5th Cir. 1959).
60. *Id*., 30 T.C. at 647.
61. *Id*.

its founder (a popular entertainer) from the organization.[62] The foundation was established to provide musical instruction, living quarters, and medical assistance to ''young people interested in the entertainment field and who were featured in . . . [the founder's] shows.''[63] The court found that, ''[i]n these circumstances . . . [this individual] received a great benefit by establishing an organization whereby the recipients of the organization's charitable services were in his employ and benefiting him'' and ''it was to . . . [his] advantage as a director of a radio program and as an employer to provide these services.''[64]

In another case, a court declined to accord a foundation tax-exempt status as a charitable organization because part of its net earnings was found to have inured to its creator and controller.[65] The foundation made loans for the personal benefit of the founder and his family members and friends, made research expenditures to advance one of his hobbies, and purchased stock in a corporation owned by one of his friends. The court concluded that the foundation ''was organized in such a fashion that . . . [its creator] held control of its activities and expenditures; it was operated to carry out projects in which . . . [he] was interested and some of its funds were expended for . . . [his] benefit . . . or [for the benefit of] members of his family.''[66]

In still another of these instances, the organization engaged in several transactions with its founder, including receiving property from his mother and paying her an annuity and reimbursement for his (her son's) college education; paying the founder's personal expenses; and purchasing and leasing real property owned by the founder. A court concluded that the organization's income inured to the benefit of the founder in his private capacity and that the IRS had properly revoked its tax-exempt status.[67] The same result was occasioned upon a court's finding that a tax-exempt organization purchased real estate and life insurance, obtained a mortgage, and paid other personal expenses of its founders.[68]

(c) Subsequent Law

Subsequent (that is, post-1978) law on the point is equally clear. One of the principal cases concerned private inurement between a church and its founder and his family.[69] Indicia of this private inurement referenced by the court included unreasonable increases in salaries, directors' fees, management fees, and payments in support of this family. The court also labeled as private

62. *Horace Heidt Foundation v. United States*, 170 F. Supp. 634 (Ct. Cl. 1959).
63. *Id*. at 637.
64. *Id*. at 638.
65. *Best Lock Corp. v. Commissioner*, 31 T.C. 1217 (1959).
66. *Id*. at 1236.
67. *Rueckwald Foundation, Inc. v. Commissioner*, 33 T.C.M. 1383 (1974).
68. *Human Engineering Institute v. Commissioner*, 37 T.C.M. 619 (1978).
69. *Church of Scientology of California v. Commissioner*, 83 T.C. 381 (1984), *aff'd*, 823 F.2d 1310 (9th Cir. 1987).

inurement the founder's practice of aggressively marketing books and other church items in the name of the church, and being paid royalties for the sales (most of which were to the church's branches and other churches in the same religion) and for the literary efforts of other employees of the church. Still other forms of private inurement were determined by the court, including ''repayment of alleged debts in unspecified amounts and unfettered control over millions of dollars in funds'' belonging to entities affiliated with the church.[70] Private inurement was further found in the facts that the founder was paid a percentage of the church's gross income for his past services in establishing the religion and that he received interest-free loans from a nonexempt subsidiary of the church.

In another case involving a church, a court found that the organization failed to qualify as a religious entity because of inurement of net earnings to its founder.[71] The founder (its minister) and his wife and daughter comprised the organization's board of directors. The church's primary activity was seen by the court as the making of investments to accumulate money for a building fund. The church lacked a place of worship and did not hold any public religious services. It conducted some ministry through its founder, who was also its principal donor, and distributed some grants to needy individuals, who were selected by the founder. The court concluded that the founder's ''activities were more personal than church-oriented.''[72]

In similar circumstances, a court rejected an organization's claim of tax exemption, because the organization provided its creator and his family with ''housing, food, transportation, clothing and other proper needs as may from time to time arise.''[73]

An organization operated to provide educational tours had its tax-exempt status revoked because the founder of the organization consistently used his travel agency to make the travel arrangements.[74]

In the most far-reaching opinion yet concerning the scope of the term *insider*, the court held that the term embraces any person who has ''significant control'' over the activities of the tax-exempt organization.[75] The case concerned a service provider entity (a fundraising company) whose relationship with the exempt charitable organization was structured by contract. The fundraising

70. *Id.*, 83 T.C. at 492.
71. *Western Catholic Church v. Commissioner*, 73 T.C. 196 (1979), *aff'd*, 631 F.2d 736 (7th Cir. 1980), *cert. denied*, 450 U.S. 981 (1981).
72. *Id.*, 73 T.C. at 211.
73. *Parshall Christian Order v. Commissioner*, 45 T.C.M. 488, 492 (1983).
74. *International Postgraduate Medical Foundation v. Commissioner*, 56 T.C.M. 1140 (1989).
75. *United Cancer Council, Inc. v. Commissioner*, 109 T.C. 326 (1997). Elsewhere in the opinion, the court used the phrases ''substantial control'' and ''extensive control.'' It was subsequently stated that the ''case law appears to have drawn a line between those who have significant control over the organization's activities and those who are unrelated third parties'' (*Variety Club Tent No. 6 Charities, Inc. v. Commissioner*, 74 T.C.M. 1485, 1492 (1997)).

company ''heavily financed''[76] the charity and kept it in existence by means of the fundraising arrangement. The company was, wrote the court, ''in many ways analogous to that of a founder and major contributor to a new organization''[77] (although the charity had been in existence for 21 years before entering into the fundraising contract).

This decision was, however, reversed. The appellate court found that the fundraising company in the case was *not* an insider, and thus ruled that there was no private inurement. The case was remanded for a determination as to whether the charitable organization was operated, to an unwarranted extent, for the private benefit of the fundraising company.[78]

The court of appeals grounded its findings on the premise that the lower court's ''classification of [the fundraising company] as an insider of [the charity] was based on the fundraising contract.''[79] That is, the focus was on the contract's terms. The trial court and the IRS were characterized as contending that the ''contract was so advantageous to [the fundraiser] and so disadvantageous to [the charity] that the charity must be deemed to have surrendered the control of its operations and earnings to the noncharitable enterprise that it had hired to raise money for it.''[80]

The appellate court wrote that ''[f]undraising has become a specialized professional activity and many charities hire specialists in it.''[81] It continued: ''If the charity's contract with the fundraiser makes the latter an insider, triggering the inurement clause of section 501(c)(3) and so destroying the charity's tax exemption, the charitable sector of the economy is in trouble.''[82]

The charitable organization's ''sound judgment'' in entering into the contract with the fund-raising company was questioned by the court.[83] The court wrote that the charity ''drove (so far as the record shows) the best bargain that it could, but it was not a good bargain.''[84] Nonetheless, the court continued, the private inurement proscription ''is designed to prevent the siphoning of charitable receipts to insiders of charity, not to empower the IRS to monitor the terms of arm's length contracts made by charitable organizations with the firms that supply them with essential inputs, whether premises, paper, computers, legal advice, or fundraising services.''[85] The Tax Court's and IRS's position ''threatens to unsettle the charitable sector by empowering the IRS to

76. *Id*. at 387.
77. *Id*.
78. *See* § 4.6. Also *see infra* note 91.
79. *United Cancer Council, Inc. v. Commissioner*, 165 F.3d 1173, 1176 (7th Cir. 1999).
80. *Id*. at 1175.
81. *Id*. at 1176.
82. *Id*.
83. *Id*. at 1178.
84. *Id*.
85. *Id*. at 1176.

yank a charity's tax exemption simply because the Service thinks the charity's contract with its major fundraiser too one-sided in favor of the fundraiser, even though the charity has not been found to have violated any duty of faithful and careful management that the law of nonprofit corporations may have laid upon it.''[86]

The court said it could not find anything in the facts to support the ''theory'' that the fundraiser ''seized control of [the charity] and by doing so became an insider.''[87] Said the court: ''There is nothing that corporate or agency law would recognize as control.''[88] It wrote that the Tax Court used the word *control* ''in a special sense not used elsewhere, so far as we can determine, in the law, including the federal tax law.''[89]

The appellate court concluded that ''[t]here was no diversion of charitable revenues to an insider here, nothing that smacks of self-dealing, disloyalty, breach of fiduciary obligation or other misconduct of the type aimed at by a provision of law that forbids a charity to divert its earnings to members of the board or other insiders.''[90]

As to the remand, the court wrote that the ''board of a charity has a duty of care . . . and a violation of that duty which involved the dissipation of the charity's assets might (we need not decide whether it would—we leave that issue to the Tax Court in the first instance) support a finding that the charity was conferring a private benefit, even if the contracting party did not control, or exercise undue influence over, the charity. This, for all we know, may be such a case.''[91]

§ 4.3 PHYSICIANS AS *INSIDERS*

As the foregoing discussion indicates, the concept of insiders with respect to healthcare organizations includes the entities' directors, trustees, officers, and perhaps key employees, vendors, and contributors. It is also the view of the IRS, however, that the insiders with respect to a tax-exempt hospital include the physicians who practice at the institution.[92] This stance was foreshadowed by holdings in the courts reaching the same conclusion.[93]

86. *Id*. at 1179.
87. *Id*. at 1178.
88. *Id*.
89. *Id*. *See*, however, § 28.2(b)(iii).
90. 165 F.3d at 1179.
91. *Id*. at 1180. The Tax Court previously held that an act of private inurement is also an act of private benefit (*American Campaign Academy v. Commissioner*, 92 T.C. 1053, 1068 (1989)). The United Cancer Council case, which almost assuredly would have led to a significant private benefit opinion if considered by the Tax Court, was, however, settled.
92. E.g., Gen. Couns. Mem. 39498.
93. *Maynard Hospital, Inc. v. Commissioner*, 52 T.C. 1006 (1969), *The Lorain Avenue Clinic v. Commissioner*, 31 T.C. 141 (1958); *Sonora Community Hospital v. Commissioner*, 46 T.C. 519 (1966), *aff'd*, 397 F.2d 814 (9th Cir. 1968).

In one of the first court cases on the subject, a foundation was found to not qualify as a tax-exempt charitable organization because of inurement of its net earnings to a physician.[94] The foundation was established by the physician, who was one of its three trustees (his father was another). The foundation's principal activities were the treatment of patients (chiefly the physician's) and the conduct of scientific research. A nurse employed by the foundation was used by the physician in his private practice without additional compensation or any reimbursement to the foundation. The court concluded that the physician was benefited in his private capacity by reason of activities of the foundation. The foundation's laboratory (located next to the physician's office) was, according to the IRS, used ''on numerous occasions in his practice''; the court accepted the IRS's charge that the physician's ''practice and the income therefrom were materially enhanced by the establishment of the laboratory.''[95] This physician received consultation fees from patients making use of the laboratory.

In one instance, the IRS concluded that there was no private inurement in a situation where a tax-exempt hospital compensated a hospital-based radiologist on the basis of a fixed percentage of the income of the hospital's radiology department.[96] This conclusion was arrived at, in part, because, observed the IRS, the ''radiologist did not control the organization.''[97]

In another case, the tax exemption of a nonprofit hospital was barred by a court, in part because of the advantages that the physicians, who organized the hospital, obtained from its operation.[98] Most of the patients admitted by the hospital were attended by the founding physicians. The court was concerned about the arrangement for management services and the lease of office space. As to the concentration of these physicians' patients in the hospital, which the court found to be the ''primary source of the doctors' professional income,'' the court held that (even though net earnings were not paid to them) ''this virtual monopoly by the . . . [physicians] permitted benefits to inure to . . . [them] within the intendment of the statute.''[99] The court concluded that an agreement between the physicians and the hospital, by which they were paid to supervise the institution, was another form of private inurement to the physicians.

Likewise, the IRS revoked the tax-exempt status of a hospital organized and operated by a physician.[100] The hospital distributed its earnings to the physician in the form of direct payments, improvements to property in his professional corporation, and the free use of its facilities. The physician was regarded as an insider with respect to the hospital, and the court upheld the

94. *Cranley v. Commissioner*, 20 T.C.M. 20 (1961).
95. *Id*. at 25.
96. Rev. Rul. 69-383, 1969-2 C.B. 113.
97. *Id*. at 114.
98. *Harding Hospital, Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1974).
99. *Id*. at 1078.
100. *Kenner v. Commissioner*, 33 T.C.M. 1239 (1974).

revocation of the hospital's tax exemption. Similarly, a chiropractor established a nonprofit organization to study chiropractic methods; the organization was recognized by the IRS as qualifying as a tax-exempt charitable organization. The chiropractor then engaged in various transactions with the organization, including the sale of his home, automobile, and medical equipment to it, and caused it to pay some of his personal expenses and a salary while he conducted his practice. The organization did not engage in research or grant scholarships, as was its purpose; the court agreed with the IRS that revocation of the organization's tax-exempt status was appropriate.[101]

The foregoing state of the law, however, was dramatically altered in 1996, when Congress, as part of the creation of a statute levying taxes in connection with excess benefit transactions, wrote a definition of the term *disqualified person* that is applicable to nearly all healthcare entities.[102] The legislative history underlying this definition stated that, although it has been the view of the IRS that all physicians who are on the medical staff of a hospital or similar organization are insiders for purposes of the private inurement proscription,[103] a physician is a disqualified person under the intermediate sanctions rules only when he or she is in a position to exercise substantial influence over the affairs of the organization.[104]

§ 4.4 PRIVATE INUREMENT—SCOPE AND TYPES

Under current federal tax law governing tax-exempt, charitable healthcare (and certain other types of exempt) organizations, an organization may not be organized and/or operated for the benefit of an individual (or other person) in his or her private capacity. Because individuals can be privately benefited in many ways, the concept of *private inurement* has many manifestations.

Although the elements of private inurement and self-dealing in the private foundation setting are by no means precisely the same, the following summary of self-dealing transactions offers a useful sketch of the scope of transactions that may, in appropriate circumstances, amount to instances of private inurement:

1. Sale or exchange, or leasing, of property between an organization and a person, when the latter is in a private capacity
2. Lending of money or other extension of credit between an organization and a private person
3. Furnishing of goods, services, or facilities between an organization and a private person

101. *The Labrenz Foundation, Inc. v. Commissioner*, 33 T.C.M. 1374 (1974).
102. *See* § 28.2(b).
103. Gen. Couns. Mem. 39862.
104. H.R. Rep. No. 104-506, 104th Cong., 2d Sess. 58, note 12 (1996).

4. Payment of compensation (or payment or reimbursement of expenses) by an organization to a private person
5. Transfer to, or use by or for the benefit of, a private person of the income or assets of an organization[105]

The IRS publicly invoked the self-dealing analogy in only one situation involving a charitable organization that is not a private foundation.[106] The context was an IRS discussion as to when a nonprofit school, which is a successor to a for-profit school, is regarded as substantially serving the private interests of the directors of the school. The IRS determined that the school was not operating to serve a private interest where it purchased the personal property of the for-profit school at fair market value in an arm's-length transaction, paid a fair rental value for use of the land and buildings, and paid the former owners of the for-profit school (who were retained to provide supervision and care of the students) reasonable compensation for their services. By contrast, in a situation where a nonprofit organization, which had received all of the stock in a for-profit school as a gift, took over the former school's assets and assumed all of its liabilities, including notes owed to the former owners, the IRS denied the organization qualification as a tax-exempt charitable entity, holding that it was operated for the directors' (the former school's stockholders) private interests because the liabilities assumed by the organization exceeded the fair market value of the for-profit school's assets. The IRS stated: "The directors were, in fact, dealing with themselves and will benefit financially from the transaction."[107]

One court likewise embraced the self-dealing rationale in the non-private-foundation context, holding in one instance that a church was not entitled to tax-exempt status because it regularly participated in dealings with businesses owned by its ministers.[108] As a result of the "entire network of arrangements and relationships" among the church, the businesses, and the ministers, and the expenses and salaries paid, the court concluded that the business dealings were "for the substantial non-exempt purpose of filling the pockets of . . . [the ministers and their families] with monies intended by the donors for 'God's work.'"[109] Therefore, based on the "extent of the integration between . . . [the ministers'] activities and those of its related entities, the control of those entities by . . . [the ministers], the substantial current as well as potential abuse through manipulation of the arrangements between those entities and the obviously large amounts of current and direct financial benefits (to say nothing of the potential for future benefits) derived from the operations of those entities

105. IRC § 4941(d)(1)(A)–(E).
106. Rev. Rul. 76-441, 1976-1 C.B. 147.
107. *Id*. at 148.
108. *Church By Mail, Inc. v. Commissioner*, 48 T.C.M. 471 (1984).
109. *Id*. at 477, 479 (emphasis in original).

by . . . [the ministers] and their families,''[110] the court refused to find that the principal purpose of the organization was religious.[111]

(a) Equity Distributions

With the emphasis of the federal tax law, in the private inurement area, on *net earnings* and the reference to *private shareholders*, the most literal and obvious form of private inurement would be the division of an organization's net earnings among those akin to shareholders, such as members of the board of directors. Rarely does such a blatant form of private inurement occur. In the one instance where this type of private inurement was the subject of a court opinion, however, the organization involved was a hospital.[112]

In that case, the assets of an exempt hospital relating to a pharmacy were sold to an organization, which then sold pharmaceuticals to the hospital at higher prices. The court held that the practice amounted to a ''siphoning off'' of the hospital's income for the benefit of its stockholders.[113] Thereafter, apparently according to a preconceived plan, the corporation was dissolved and the sales proceeds were distributed to its shareholders. While the court's reasoning is far from clear, the court observed that ''[i]t is doubtful, too, whether an organization's operation can be 'exclusively' for charitable purposes . . . when its income is being accumulated to increase directly the value of the interests of the stockholders which they expect, eventually, to receive beneficially.''[114] This separation of the pharmacy from the hospital resulted in the retroactive revocation of the tax-exempt status of the hospital. Moreover, the shareholders were held to have received capital gain on the transaction, because of the proprietary rights in the hospital evidenced by the stock.[115]

110. *Id*. at 480.
111. On appeal, an appellate court found that the church was ''operated for the substantial non-exempt purpose of providing a market for . . . [the] services'' of businesses owned by the church's ministers and thus affirmed the opinion (765 F.2d 1387, 1392 (9th Cir. 1985)). A subsequent attempt by this organization to secure tax-exempt status by court order failed, again on the grounds of private inurement (*Church By Mail, Inc. v. United States*, 88-2 U.S.T.C. (CCH) ¶ 9625 (D.D.C. 1988), *aff'd*, unpub. opin. (D.C. Cir. 1990)).
112. *Maynard Hospital, Inc. v. Commissioner*, 52 T.C. 1006 (1969).
113. *Id*. at 1027, 1032.
114. *Id*. at 1031.
115. In another case, memberships in a tax-exempt charitable hospital were found to not entitle the members to a beneficial interest in the capital or earnings of the hospital because the law of the state prohibited the corporation from paying any part of its income to members and required transfer of the assets upon dissolution for charitable purposes (*Estate of Grace M. Scharf v. Commissioner*, 316 F.2d 625 (7th Cir. 1963), *aff'd* 38 T.C. 15 (1962)).

Again, these features are integral to the definition of a tax-exempt, nonprofit, charitable entity (*see* § 1.1). By contrast, a tax-exempt social club (an IRC § 501(c)(7) entity) may make liquidating distributions to its members following a sale of assets (*Mill Lane Club, Inc. v. Commissioner*, 23 T.C. 433 (1954)).

The most common forms of private inurement do not entail the parceling out of an organization's assets or net earnings to those in control of it but, rather, conventional transactions where the amount transferred by an organization to, or received by an organization from, one or more insiders is not *reasonable*. These transactions are forms of compensation, loans, and rentals.

(b) Compensation for Services

The payment of reasonable compensation by a healthcare organization for services rendered, whether by employees or independent contractors, does not result in the inurement of net earnings to the benefit of private persons.[116] Conversely, the payment of excessive compensation can result in private inurement.[117] Thus, the matter comes down to one of balance (reason); as one court observed, ''[t]he law places no duty on individuals operating charitable organizations to donate their services; they are entitled to reasonable compensation for their efforts.''[118]

Whether the compensation paid is reasonable is a question of fact, to be decided in the context of each case.[119] Thus, the factors to be considered include the size of the organization, the scope of responsibilities of the position, the cost of living in the particular community, the experience and talents of the holder of the position, and the amount paid to similar individuals in similar circumstances. Determining reasonableness in this setting is, then, an exercise in comparison of similar circumstances. Although the point is not clear, the comparables to be used probably are those of other charitable organizations, and not for-profit organizations.[120] The prevailing view seems to be that it is

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116. The reasonable compensation standard is discussed further in § 28.2.
117. E.g., *Harding Hospital, Inc. v. United States* 276 F. 2d 476 (5th Cir. 1960) 505 F. 2d 1068 (6th Cir. 1974); *Birmingham Business College, Inc. v. Commissioner*, 276 F.2d 476 (5th Cir. 1960); *Mabee Petroleum Corp. v. United States*, 203 F.2d 872 (5th Cir. 1953); *Texas Trade School v. Commissioner*, 30 T.C. 642 (1958), *aff'd*, 27 F. 2d 168 (5th Cir. 1959); *Northern Illinois College of Optometry v. Commissioner*, 2 T.C.M. 664 (1943).
118. *World Family Corporation v. Commissioner*, 81 T.C. 958 (1983).
119. E.g., *Jones Bros. Bakery, Inc. v. United States*, 411 F.2d 1282 (Ct. Cl. 1969); *Home Oil Mill v. Willingham*, 68 F. Supp. 525 (N.D. Ala. 1945), *aff'd*, 181 F.2d 9 (5th Cir. 1950), *cert. denied*, 340 U.S. 852 (1950).
120. In the intermediate sanctions setting, however, comparisons of this nature can include taxable as well as exempt entities (*see* § 4.9(a)(iii)). This approach to determining the reasonableness of compensation is known as the *multifactor test*. A trend appears to be developing, however, prompted by decisions in the federal circuit courts of appeal, by which that test is being replaced in the for-profit setting by an *independent investo*r test. The first of these decisions to openly embrace this approach was written by the U.S. Court of Appeals for the Second Circuit (*Dexsil Corporation v. Commissioner*, 147 F.3d 96 (2d Cir. 1998)). The most recent discussion of the point emanated from the U.S. Court of Appeals for the Seventh Circuit (*Exacto Spring Corporation v. Commissioner*, 196 F.3d 833 (7th Cir. 1999)).

    The multifactor test is being deemed flawed because the ''judges of the Tax Court are not equipped by training or experience to determine the salaries of corporate officers;

appropriate for employees and others serving charitable organizations to be paid less than their counterparts in the commercial sector.

A court, then, can find private inurement where the salary, wage, or other form of compensation of an insider (such as an employee, consultant, vendor, or other type of service provider) is perceived to be ''large,'' ''excessive,'' or ''unreasonable'' in terms of an absolute dollar amount. This is particularly the case where the insider/employee is concurrently receiving other forms of compensation from the organization (such as fees, commissions, or royalties) and/or more than one member of the same family are compensated employees.[121] Thus, where the control of an organization was in two ministers who contributed all of its receipts, all of which were paid to them as housing allowances, the tax exemption of the organization was revoked; yet the court wrote that the compensation was not ''reasonable'' although it may not be

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no judges are'' (*id*. at 835). This test is perceived to be ''redundant, incomplete, and unclear''; it ''does not provide adequate guidance to a rational decision'' (*id*. at 838). The independent investor test is based on the return on investment expected by the company's investors (real or hypothetical)—a percentage determined by an expert witness. When these investors are obtaining a ''far higher return than they had any reason to expect,'' the executive's salary is ''presumptively reasonable,'' even if the compensation may otherwise be considered ''exorbitant'' (*id*. at 839). Under this approach, the presumption can be rebutted by a showing by the government that, although the executive's salary was reasonable, the company ''did not in fact intend to pay him [or her] that amount as salary, that his [or her] salary really did include a concealed dividend though it need not have'' (*id*.). Also, according to the Seventh Circuit, if the executive's salary is approved by the other owners of the corporation, who are independent of the executive—that is, who had no incentive to disguise a dividend salary—that approval ''goes far'' to rebut any evidence of ''bad faith'' (*id*.).

Nonetheless, the two tests are becoming entangled. For example, the U.S. Tax Court held that the compensation paid by a for-profit company to its executive satisfied the independent investor test, so that the rebuttable presumption that the compensation is reasonable was created. The court then held that two-thirds of the compensation was excessive because the compensation was approved by a board of related individuals and was substantially higher than compensation paid by comparable publicly traded corporations to their executives; essentially, the court employed the multifactor test to defeat the presumption (*Menard, Inc. v. Commissioner*, 89 T.C.M. 656 (2005)). In general, Note, ''What Is Reasonable Compensation for Deduction Purposes? Two Tests Exist But Neither Paints a Clear Picture, as Evidenced in *Devine Brothers v. Commissioner*,'' 57 *Tax Law*. (No. 3) 793 (2004). Whatever the substance and progress of the independent investor test in the context of closely held corporations are, the test does not have much if anything to do with tax-exempt organizations, which do not have investors. So, the law in this regard as established by the courts may be evolving to the point where the tests for determining the reasonableness of compensation are different for tax-exempt organizations and for-profit organizations. If this is the outcome, the former will use the multifactor test, and the latter, the independent investor test.

121. E.g., *Founding Church of Scientology v. United States*, 412 F. 2d 1197 (Ct. Cl. 1969), *cert. denied*, 397 U.S. 1009 (1970); *Bubbling Well Church of Universal Love, Inc. v. Commissioner*, 74 T.C. 531 (1980), *aff'd*, 670 F.2d 104 (9th Cir. 1981); *Unitary Mission Church of Long Island v. Commissioner*, 74 T.C. 507 (1980), *aff'd*, 647 F.2d 163 (2d Cir. 1981).

''excessive.''[122] Likewise, a charitable organization was deprived of its tax exemption for paying excessive compensation to a fund-raising company (the charity netted less than 10 percent of the contributions), where the company also made valuable use of the charity's mailing list.[123]

The IRS has come around to the view that charitable organizations may establish profit-sharing and similar compensation plans without causing private inurement,[124] having previously taken the position that the establishment of qualified profit-sharing plans resulted in private inurement per se.[125] This alteration of position was based on the reasoning that the principles of qualification of pension and profit-sharing plans,[126] and Title I of the Employee Retirement Income Security Act of 1974 (ERISA), are sufficient to ensure that operation of these plans would not jeopardize the tax-exempt status of the nonprofit organizations involved. Thereafter, legislation enacted in 1986 amended the employee plan rules to make it clear that tax-exempt organizations can maintain qualified profit-sharing plans,[127] and extended certain deferred compensation rules to make them applicable to tax-exempt organizations.[128]

Tax-exempt organizations may maintain the qualified cash or deferral arrangements known as *401(k) plans*.[129] A charitable organization may maintain a *tax-sheltered annuity program*[130] for its employees. Tax-exempt organizations may pay reasonable pensions to retired employees without adversely affecting their tax-exempt status.[131]

Despite the factors enumerated above as to reasonableness, many of the determinations in this area are based on ''perception.'' For example, a court considered a case where three executives of a tax-exempt organization had salaries in 1970 of $25,000, $16,153, and $5,790, and in 1978 of $100,000, $72,377, and $42,896, respectively. This was held to be an ''abrupt increase'' in the salaries and a ''substantial amount'' of compensation, leading to the conclusion that the salaries ''are at least suggestive of a commercial rather than nonprofit

122. *Church of the Transfiguring Spirit, Inc. v. Commissioner*, 76 T.C. 1, 6 (1981). Cf. *Universal Church of Scientific Truth, Inc. v. United States*, 74-1 U.S.T.C. (CCH) ¶ 9360 (N.D. Ala. 1973) (the organization retained tax exemption in part because its revenues were derived from charges for published materials and the expenses were not entirely for the compensation of its ministers).
123. *United Cancer Council, Inc. v. Commissioner*, 109 T.C. 326 (1997), albeit reversed, 165 F. 3d 1173 (7th Cir. 1999).
124. Gen. Couns. Mem. 39674.
125. Gen. Couns. Mem. 35869. *See*, in general, § 28.4.
126. IRC § 401.
127. IRC § 401(a)(27).
128. IRC § 457. *See*, in general, § 28.5, text accompanied by notes 161–166.
129. IRC § 401(k)(4)(B)(i).
130. IRC § 403(b). *See*, in general, § 28.5, text accompanied by notes 167–171.
131. In the event of an IRS examination, the agency will review, in addition to salaries, ''employee contracts'' and ''other financial transactions'' to determine if private inurement is present (IRS Exempt Organizations Examination Guidelines 2.3.1 §1).

operation.''[132] By contrast, large salaries and noncash benefits received by a tax-exempt organization's employees can be reasonable, considering the nature of their services and skills, such as payments to physicians by a nonprofit organization that is an incorporated department of anesthesiology of a hospital.[133]

Reasonableness can also be tested against a standard of the basis by which an individual is compensated; this is particularly the case where the compensation is determined by a percentage of the payor organization's receipts. This is a sensitive area; a percentage of net receipts is difficult to rationalize in light of the proscription against distributions of ''net earnings,'' yet the IRS has approved of arrangements where the compensation is based on a percentage of gross earnings.[134] A healthcare organization might, for example, decide to compensate one or more persons in its department of development, in whole or in part, on the basis of the extent of charitable contributions received.

In one instance, a compensation arrangement based on a percentage of gross receipts was held by a court to constitute private inurement, where no upper limit was placed on the amount of total compensation.[135] This court, however, subsequently restricted the reach of this decision by holding that private inurement did not occur when a tax-exempt organization pays its president a commission determined by a percentage of contributions procured by him.[136] The court held that the standard is whether the compensation is reasonable, rather than the manner in which it is ascertained. Fundraising commissions that ''are directly contingent on success in procuring funds'' were held to be an ''incentive well suited to the budget of a fledgling organization.''[137] In reaching this conclusion, the court reviewed the states' charitable solicitation acts governing payments to professional solicitors, which the court characterized as ''sanction[ing] such commissions and in many cases endorse[ing] percentage commissions higher than'' the commission paid by the organization involved in the case.[138] Another court subsequently introduced even more uncertainty on the point when it wrote that ''there is nothing insidious or evil about a commission-based compensation system'' and, thus, an arrangement by which

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132. *The Incorporated Trustees of the Gospel Worker Society v. United States*, 510 F. Supp. 374, 379 (D.D.C. 1981), *aff'd*, 672 F.2d 894 (D.C. Cir. 1981), *cert. denied*, 456 U.S. 944 (1982).
133. *B.H.W. Anesthesia Foundation, Inc. v. Commissioner*, 72 T.C. 681 (1979). Also *University of Massachusetts Medical School Group Practice v. Commissioner*, 74 T.C. 1299 (1980).
134. Rev. Rul. 69-383, 1969-2 C.B. 113. One court injected additional confusion into this area when it held that ''paying over a portion of gross earnings to those vested with the control of a charitable organization constitutes private inurement as well,'' adding that ''[a]ll in all, taking a slice off the top should be no less prohibited than a slice out of net'' (*People of God Community v. Commissioner*, 75 T.C. 127, 133 (1980) (emphasis in original). *See*, in general, § 4.5.
135. *People of God Community v. Commissioner*, 75 T.C 127, 132 (1980).
136. *World Family Corporation v. Commissioner*, 81 T.C. 958 (1983).
137. *Id*. at 970.
138. *Id*. at 969. For a more detailed analysis of percentage compensation arrangements in the fundraising setting, see FUNDRAISING § 6.12.

those who successfully procure contributions to a charitable organization are paid a percentage of the gift amounts is ''reasonable,'' despite the absence of any limit as to an absolute amount of compensation (and despite the fact that the law requires the *compensation* to be reasonable, not the percentage by which it is determined).[139]

Hospital audit guidelines issued by the IRS in 1992 contain a substantive review of the body of law concerning the form of private inurement known as *unreasonable compensation*.[140] These guidelines specifically address private inurement transactions between hospitals and their physicians and senior executives. They reflect the fact that contemporary concerns at the IRS in this regard embrace incentive compensation plans, recruiting and retention incentives, purchases of physicians' practices, open-ended employment contracts, and compensation based on a percentage of the institution's profits. IRS agents have been urged to review compensation contracts to determine whether they were negotiated at arm's length; where this is not the case (such as where a physician is also a member of the hospital's board of trustees or is a department head), the contracts are said to require ''closer scrutiny.''[141]

In some instances, an individual receives compensation (including fringe benefits) and/or other payments from more than one organization, whether or not tax-exempt. A determination as to the reasonableness of this compensation or other payments is made in the aggregate. Thus, for example, in the college and university examination guidelines propounded by the IRS, auditing agents are advised that, ''[i]f one employee is compensated by several entities, even if the entities have independent boards or representatives, the examiner should examine the total compensation paid to such person by all entities in which the college or university has significant control or influence.''[142]

The IRS will closely scrutinize compensation programs of healthcare and other tax-exempt charitable organizations that are predicated on an incentive feature by which compensation is a function of revenues received by the organization, is guaranteed, or is outside the boundaries of conventional compensation arrangements.[143] These programs occur most frequently in the healthcare organization context. For example, the IRS has concluded that the

139. *National Foundation, Inc. v. United States*, 87-2 U.S.T.C. (CCH) ¶ 9602 (Cl. Ct. 1987). *See*, in general, Steinberg, ''Profits and Incentive Compensation in Nonprofit Firms,'' 1 *Nonprofit Man. & Leadership* (No. 2) 137 (1990).

140. Exempt Organizations Examinations Guidelines Handbook, Internal Revenue Manual 7(10)69 § 333 (hereinafter, ''Hospital Audit Guidelines''), reproduced by the IRS for broader dissemination in Ann. 92-83, 1992-42 I.R.B. 59, §§ 333.2 and 333.3. *See*, in general, § 35.2; Flynn, ''Audit Guidelines Send Agents to All Corners of Hospital Operations,'' 4 *J. Tax. Exempt Orgs*. 31 (Nov./Dec. 1992).

141. Hospital Audit Guidelines, *supra* note 140, § 333.2(2).

142. Exempt Organizations Examinations Guidelines Handbook, Internal Revenue Manual 7(10)69 § 342, reproduced by the IRS for broader dissemination in Ann. 94-111, 1994-37 I.R.B. 36, § 342.(15)(2).

143. *See*, in general, Chapter 29.

establishment of incentive compensation plans for the employees of a hospital, with payments determined as a percentage of the excess of revenues over the budgeted level, does not constitute private inurement, where the plans are not devices to distribute profits to principals, are the result of arm's-length bargaining, and do not yield unreasonable compensation.[144] Using similar reasoning, the IRS approved of guaranteed minimum annual salary contracts under which physicians' compensation was subsidized in order to induce them to commence employment at a hospital.[145]

IRS review of compensation arrangements based on the extent of the revenues of a healthcare entity is likely to be caused by a body of statutory law enacted in 1996. Congress, in creating a package of intermediate sanctions rules,[146] wrote an extensive definition of the term *excess benefit transaction*, which includes—to the extent to be provided in tax regulations—any transaction in which the amount of any economic benefit provided to or for the use of a disqualified person is determined in whole or in part by the revenues of one or more activities of the organization, but only if the transaction results in impermissible private inurement.[147] The legislative history underlying this phraseology reflects an understanding by members of Congress that, under existing law, "certain revenue sharing arrangements have been determined not to constitute private inurement" and they "expect that it would continue to be the case that not all revenue sharing arrangements would be improper private inurement."[148] It was also stated, however, that they "intend no reference that Treasury or the Internal Revenue Service are bound by any particular prior rulings in this area" and that the Department of the Treasury "will issue prompt guidance providing examples of revenue sharing arrangements that violate the private inurement prohibition and that such guidance will be applicable on a prospective basis."[149]

The IRS has explored other forms of productivity incentive programs[150] and contingent compensation plans.[151] Outside the healthcare setting, for example, the IRS concluded that a package of compensation arrangements for the benefit of sports coaches for schools, colleges, and universities, including deferred compensation plans, payment of life insurance premiums, bonuses, and moving expenses, did not amount to impermissible private inurement.[152]

144. Gen. Couns. Mem. 39674.
145. Gen. Couns. Mem. 39498. *See*, in general, Chapter 25.
146. *See* § 28.2(b).
147. IRC § 4958(c)(2).
148. H.R. Rep. No. 104-506, 104th Cong., 2d Sess. 56, note 4 (1996) (citing, *inter alia*, Gen. Couns. Mem. 39674).
149. *Id*. at 56. As of 12 years later, however, no such guidance has been provided.
150. E.g., Gen. Couns. Mem. 36918.
151. E.g., Gen. Couns. Mem. 32453.
152. Gen. Couns. Mem. 39670. Cf. *Copperweld Steel Company's Warren Employees' Trust v. Commissioner*, 61 T.C.M. 1642 (1991) (an organization was denied tax-exempt status by

Recent years have brought considerable scrutiny by the IRS of the compensation policies and practices of public charities and other tax-exempt organizations. The IRS, in mid-2004, launched a compliance check project[153] in this context—the Executive Compensation Compliance Initiative—stating that its intention is to ''identify and halt'' practices by exempt organizations of paying excessive compensation and other benefits to insiders.[154] The purposes of this project are to address the compensation of specific individuals or instances of questionable compensation practices, increase awareness of the tax law issues involved as organizations establish amounts and types of compensation in the future, and enable the IRS to learn more about the practices that exempt organizations are following as they set compensation and report it on their annual information returns. The IRS sent compliance check letters to 1,223 organizations.

These compliance checks, while uncovering significant reporting errors and omissions in specific areas, particularly in connection with excess benefit transactions and foundation transactions with disqualified persons, indicated that the organizations selected for review generally were compliant with the federal tax law as to compensation paid by tax-exempt organizations. One of the findings of this compliance check project was that, ''[a]lthough high compensation amounts were found in many cases, generally they were substantiated based on appropriate comparability data.''

The IRS, in 2006, initiated a Hospital Compliance Project, the purpose of which is to study nonprofit hospitals and assess how these institutions believe they are providing a community benefit,[155] as well as to determine how exempt hospitals establish and report executive compensation.[156] Although the IRS published an interim report based on data gathered from questionnaires and annual information returns, the executive compensation component of this project was not addressed in this report inasmuch as examinations in that area are ongoing.

(c) Loans

A charitable organization generally may make loans, to insiders and others, as part of an investment program.[157] A loan arrangement involving the transfer of the income or assets of a healthcare organization (or other charitable entity) to an insider, however, will always be skeptically reviewed. The terms of this type of loan must, to avoid being private inurement, be

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reason of IRC § 501(c)(3) because its primary purpose was the provision of compensatory fringe benefits).

153. The concept of compliance check projects in general is the subject of IRS Audits § 4.1.
154. IR-2004-106. This project is summarized in IRS Audits § 4.3.
155. *See* Chapter 6.
156. This project is summarized in IRS Audits § 4.5.
157. A loan arrangement between a private foundation and a disqualified person may constitute self-dealing (IRC § 4941(d)(1)(B)).

''reasonable''—that is, financially advantageous to the organization (since it is a form of investment)—or otherwise be commensurate with the purpose of the organization.[158] The factors to be considered in determining the reasonableness of a loan are, again, comparables, including the sum lent, the rate of interest, the amount and nature of the security underlying the loan, and the term of the loan.

If a loan is not timely repaid, questions of private inurement may be raised.[159] Indeed, as one court noted, the ''very existence of a private source of loan credit from an organization's earnings may itself amount to inurement of benefit.''[160] Thus, for example, the tax exemption of a school was revoked in part because two of its officers were provided by the school with interest-free, unsecured loans that subjected the school to uncompensated risks for no business purpose.[161]

A court found private inurement as the result of a loan where a nonprofit corporation, formed to take over the operations of a school conducted up to that time by a for-profit corporation, required parents of its students to make interest-free loans to the for-profit corporation. Private inurement was detected in the fact that the property to be improved by the loan proceeds would revert to the for-profit corporation after a 15-year term and that the interest-free feature of the loans was an unwarranted private benefit to private individuals.[162]

Private inurement was found in a case involving a tax-exempt hospital and its founder, a physician who operated a clinic located in the hospital building.[163] The hospital and the clinic shared supplies and services, and most of the patients of the hospital also were patients of the physician and his partner. The hospital made a substantial number of unsecured loans, at below-market interest rates, to a nursing home owned by the physician and to a trust for his children. The court held that there was private inurement to the physician because this use of the hospital's funds reduced his personal financial risk in and lowered the interest costs for the nursing home. The court also found private inurement in the fact that the hospital was the principal source of financing for the nursing home, since an equivalent risk incurred for a similar duration could be expected to produce higher earnings elsewhere. In general, the court observed, ''[w]here a doctor or group of doctors dominate the affairs of a corporate hospital otherwise exempt from tax, the courts have closely scrutinized the underlying relationship to insure that the arrangements

158. *Griswold v. Commissioner*, 39 T.C. 620 (1962).
159. *Best Lock Corp. v. Commissioner*, 31 T.C. 1217 (1959); Rev. Rul. 67-5, 1967-1 C.B. 123.
160. *Founding Church of Scientology v. United States*, 412 F. 2d 1197, 1202 (Ct. Cl. 1969), *cert. denied*, 397 U.S. 1009 (1970). Also *Unitary Mission Church of Long Island v. Commissioner*, 74 T.C. 507 (1980), *aff'd*, 647 F. 2d 163 (2d Cir. 1981); *Western Catholic Church v. Commissioner*, 73 T.C. 196 (1979), *aff'd*, 631 F. 2d 736 (7th Cir. 1980), *cert. denied*, 450 U.S. 981 (1981); *Church in Boston v. Commissioner*, 71 T.C. 102, 106–107 (1978).
161. *John Marshall Law School v. United States*, 81-2 U.S.T.C. (CCH) ¶ 9514 (Ct. Cl. 1981).
162. *Hancock Academy of Savannah, Inc. v. Commissioner*, 69 T.C. 488 (1977).
163. *Lowry Hospital Association v. Commissioner*, 66 T.C. 850 (1976).

permit a conclusion that the corporate hospital is organized and operated *exclusively* for charitable purposes without any private inurement.''[164]

The IRS's hospital audit guidelines state that a form of private inurement is ''inadequately secured loans,''[165] and that a loan used as a recruiting subsidy is appropriate (assuming the requisite need for the physician in the first instance) as long as the recruitment contract ''require[s] full repayment (at prevailing interest rates).''[166] These guidelines recommend that the IRS consider the following factors in determining whether a loan made to an insider is reasonable: (1) generally, the loan agreement should specify a reasonable rate of interest (the prime rate of interest plus one or two percent) and provide for adequate security; (2) the loan decision should be reviewed by the board of directors of the tax-exempt healthcare organization and should include consideration of the history of repayment of prior loans by the insider; and (3) even if determined reasonable, any favorable variance from the loan terms that the borrower could obtain from a typical lending institution must be treated, and appropriately reported, as compensation.[167]

(d) Rentals

A charitable organization generally may lease property and make rental payments for the use of the property, to insiders and others.[168] To avoid private inurement, however, the rental payments must be reasonable (once again, using comparables), and the arrangement must be beneficial and desirable to the organization. Inflated rental rates may well amount to private inurement, to the detriment of the charitable organization/lessee and to the benefit of the lessor.[169]

The hospital audit guidelines point out that a form of private inurement is ''payment of excessive rent''[170] and state that ''[a] reason of concern'' includes ''below market leases.''[171] The guidelines observe that auditing agents should be alert to the existence of ''rent subsidies,'' noting that ''[o]ffice space in the hospital/medical office building for use in the physician's private practice generally must be provided at a reasonable rental rate gauged by market data and by actual rental charges to other tenants in the same facility.''[172]

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164. *Id*. at 859 (emphasis in the original).
165. Hospital Audit Guidelines, § 333.2(1).
166. *Id*. at § 333.3(4).
167. *Id*. at § 333.3(10).
168. A rental arrangement between a private foundation and a disqualified person may constitute an act of self-dealing. *See* IRC § 4941(d)(1)(C).
169. *Founding Church of Scientology v. United States*, 412 F.2d 1197, 1202 (Ct. Cl. 1969), *cert. denied*, I397 U.S. 1009 (1970); *Texas Trade School v. Commissioner*, 30 T.C. 642 (1958), *aff'd*, 272 F.2d 168 (5th Cir. 1959).
170. Hospital Audit Guidelines, *supra* note 140, at § 333.2(1).
171. *Id*. at § 333.3(1).
172. *Id*. at § 333.3(7)(b).

These guidelines state that it is permissible for a physician to use an exempt organization's facility for both hospital duties and private practice, as long as the ''time/use of [the] office . . . [is] apportioned between hospital activities and private practice activities and a reasonable rent . . . [is] charged for the private practice activities.''[173]

Thus, a healthcare organization can lease property to one or more of its insiders; however, unreasonable rental payments will constitute private inurement.

(e) Assumption of Liability

As a general proposition, a charitable organization can incur debt to purchase, from an insider or another, an asset at its fair market value and subsequently retire the debt with its receipts, and not thereby violate the private inurement proscription.[174] If the purchase price for the asset is in excess of the fair market value of the property, however, private inurement may result.[175]

In one instance, a nonprofit corporation was formed to take over the operations of a school conducted up to that time by a for-profit corporation. The nonprofit organization assumed a liability for goodwill that, in the judgment of the court involved, was an excessive amount. The court held that this assumption of liability was a violation of the prohibition on private inurement because it benefited the private interests of the owners of the for-profit corporation.[176] Further, the court strongly suggested that any payment by a charitable organization for goodwill constitutes a private inurement, because goodwill is generally a measure of the profit advantage in an established business, and the profit motive is, by definition, not supposed to be a factor in the operation of a charitable organization.[177]

It is becoming increasingly common for a tax-exempt hospital to guarantee a debt of one or more other entities, some of which may involve insiders. This is usually done in advancement of a charitable purpose of the hospital or of a business venture in which the hospital is a participant or otherwise has an interest.

(f) Partnerships and Joint Ventures

There is a growing propensity for tax-exempt charitable healthcare organizations to become involved in partnerships, limited liability companies, or

173. *Id*.
174. *Shiffman v. Commissioner*, 32 T.C. 1073 (1959); *Estate of Howes v. Commissioner*, 30 T.C. 909 (1958), *aff'd sub nom. Commissioner v. Johnson*, 267 F.2d 382 (1st Cir. 1959); *Ohio Furnace Co., Inc. v. Commissioner*, 25 T.C. 179 (1955), *appeal dismissed* (6th Cir. 1956). Nonetheless, the acquisition of property by means of debt-financing may generate unrelated business income (*see* § 24.17).
175. *Kolkey v. Commissioner*, 27 T.C. 37 (1956), *aff'd*, 254 F.2d 51 (7th Cir. 1958).
176. *Hancock Academy of Savannah, Inc. v. Commissioner*, 69 T.C. 488 (1977).
177. *Id*. at 494, note 6.

other joint ventures with individuals and/or nonexempt entities.[178] Real estate ventures, with the charitable organization as the general partner (or one of them) in a limited partnership, are a common manifestation of this practice. The IRS is concerned that some of these ventures may be a means for conferring unwarranted benefit on the private participants (particularly where they are insiders).

Tax-exempt healthcare organizations are at the forefront of these developments. Exempt hospitals and other healthcare providers frequently function as general partners of limited partnerships, in which physicians practicing at the institutions are involved as limited partners. Often, these healthcare institutions are in these partnerships as a means to further their healthcare delivery functions or as investments. In some instances, a hospital will seek to minimize its tax difficulties (and other liabilities) by causing a for-profit subsidiary (usually one created for the purpose) to be a partner in the partnership. On occasion, a hospital will loan money to, or guarantee a loan to, such a partnership. These participations can raise a host of private inurement concerns.

Private inurement is less likely in the context of joint ventures. In one instance, the IRS approved of a joint undertaking between a blood plasma fractionation facility and a commercial laboratory, by which the parties would acquire a building site and construct a blood fractionation facility on it. This arrangement enabled the facility to become self-sufficient in its production of blood fractions, to reduce the costs of fractionating blood, and thus to be more effective in carrying out its charitable blood program. Each party had an equal ownership of the facility and shared equally in its production capacity. The IRS concluded that the participation by the organization in the joint undertaking was substantially related to its charitable purposes and thus that the involvement in the joint venture was not inconsistent with the ongoing tax-exempt status of the organization.[179]

(g) Asset Sales to Insiders

Another application of the private inurement doctrine involves sales of assets by charitable organizations to one or more of their insiders. It is becoming common for a charitable organization to decide to sell assets relating to a particular program activity, when the organization no longer wishes to engage in that activity. Sometimes, for a variety of reasons, these assets are sold to one or more individuals who are directors, officers, and/or other types of insiders with respect to the organization.

A case in point entailed a charitable organization that operated a hospital and had other research and educational functions.[180] The board of directors

178. *See* Chapter 22.
179. Priv. Ltr. Rul. 7921018.
180. Priv. Ltr. Rul. 9130002.

of the organization decided to sell the hospital to gain income for the other program activities. Because of the highly specialized nature of the hospital facility, there was a limited market for its sale. Thus, the hospital was sold to a for-profit entity controlled by its directors.

The organization secured a valuation of the hospital from a qualified independent appraiser, who used a single method of valuation. The property was sold at that value ($8.3 million, principally in cash and notes). There were no loan abatements or other special concessions offered to the directors as purchasers of the hospital facility. The organization took steps to ensure that it would use arm's-length standards in future dealings with the hospital. A ruling from the IRS was obtained to the effect that the transaction would not adversely affect the tax exemption of the organization.[181] Soon after the sale, the purchasing organization began receiving inquiries as to resale of the facility. It added beds to the hospital and obtained a certificate of need for additional beds. Less than two years after the initial sale of the hospital facility, it was resold (for $29.6 million). Each member of the board of the selling organization received in excess of $2.3 million as his or her personal share of the sales proceeds.

A state court ruled that the second sales price was not reasonable and that the directors acted with a lack of due diligence. At trial, the facilities were appraised using five appraisal methodologies; the conclusion was that the value of the assets at the time of the initial sale was $18 to $21 million. A subsequent analysis by the IRS set the value of the facility at $24 million. The IRS conceded that "no single valuation method is necessarily the best indicator of value in a given case." But, the agency argued, "it would be logical to assume that an appraisal that has considered and applied a variety of approaches in reaching its 'bottom line' is more likely to result in an accurate valuation than an appraisal that focused on a single valuation method." The IRS concluded that the organization, in selling the hospital facility for substantially less than its fair market value, contravened the private inurement doctrine. Accordingly, the tax-exempt status of the organization was revoked, effective as of the date of the initial sale of the facility.

In its private letter ruling, the IRS observed: "There is no absolute prohibition against an exempt section 501(c)(3) organization dealing with its founders, members, or officers in conducting its economic affairs." Transactions of this nature will be subject to special scrutiny, however, with the IRS concerned about (in the language of the ruling) a "disproportionate share of the benefits of the exchange" flowing to the insiders.

A Tax Court opinion issued in 1998 also illustrates some of the difficulties and complexities that can arise in this context. The matter addressed in the opinion was the sale of the assets of an exempt hospital to an entity controlled by insiders of the hospital; the court concluded that the transaction gave rise to

181. Priv. Ltr. Rul. 8234084.

private inurement because the sale was not conducted at arm's length, which caused the assets to be sold for less than their fair market value.

An appraiser determined that the fair market value of the hospital in 1981 was between $3.5 and $4.3 million. The IRS issued a private letter ruling in 1982, holding that the sale would be on an arm's-length basis and would not jeopardize the organization's tax-exempt status. The sale closed in 1983 with a purchase price (as ultimately determined by the court) of $6.6 million. The hospital expanded over the ensuing months and obtained a certificate of need for additional beds. The operating assets were sold in 1985 for $29.6 million to a large healthcare provider. In 1990, the hospital was sold for $4.3 million.

The court found that the lawyers who negotiated this sale, ''as far as the legal as distinguished from the financial aspects of the sale were concerned, acted independently and in good faith and sought to protect the interests'' of their clients.[182] Continued the court, however, ''there are serious questions as to the extent to which the negotiations adequately took into account certain financial aspects of the transaction which may cause the negotiations and the resulting sale price to be categorized as not being at arm's length and therefore giving rise to inurement.''[183]

The court noted an array of elements that were either not taken into account or inadequately taken into account in arriving at the price, including various changes in the values of assets between 1981 and 1983, valuations of adjacent properties that were transferred in the deal, the value of a certificate of need, the impact of changes in Medicare reimbursement policy, and the sales of the hospital in 1985 and 1990. By factoring in these elements, the court concluded that the fair market value of the assets transferred in 1983 was $7.8 million.

The court was not unmindful of the subsequent sales, particularly the one in 1985. Summarizing the law on this point, the court said that ''evidence as to [a] later category of events may be admitted because of its potential relevance even though it may ultimately be determined that such evidence does not have an impact on the determination of fair market value.''[184] As to this case, the court cryptically wrote that ''other evidence could provide a basis for concluding that the elements which impacted the 1985 sale may have been sufficiently known or anticipated at the time of the 1983 sale.''[185]

The difference of about $1.2 million was found to be ''substantial.''[186] The value of $7.8 million was found to ''fall outside the upper limit of any reasonable range of fair market values.''[187]

The negotiations between the lawyers were found to be ''fatally flawed because of their apparent failure to take into account the obvious and

182. *Anclote Psychiatric Center, Inc. v. Commissioner*, 76 T.C. 175, 182 (1998).
183. *Id*. at 183.
184. *Id*.
185. *Id*.
186. *Id*. at 186.
187. *Id*.

substantial'' increases in asset values in the period 1981 to 1983.[188] The court rejected reliance on the independent appraisal in that, by the time of closing, it was more than 18 months old.

This opinion is neither a model of clarity nor a model of consistency. The opinion opens with the court's statement that the issue of revocation ''turns on the question whether petitioner's sale of its hospital in May 1983 was for less than fair market value.''[189] But later the court wrote that ''fair market value plays an important role but is not determinative herein.''[190] In this case, then, the blame for causing private inurement rested more on the negotiators of the deal than on the appraiser of the transferred assets.

The lessons derived from this opinion include one that is relatively obvious: parties in these types of transactions should not rely on stale appraisals. Another is that lawyers or others negotiating this type of transaction should not blindly rely on a current appraisal but instead must independently assure themselves that all relevant items are valued. A third lesson (illustrated by the case above) is that an IRS favorable ruling is not necessarily protection for a subsequent transaction.

The fourth lesson—perhaps the most disturbing one—is that the IRS and the courts can take into account events and actions that occur *after* the sale. Apparently, it is not enough to value items that are ''known''—consideration must also be accorded those that may be ''anticipated.''

This opinion is not, however, completely adverse to the interests of tax-exempt organizations. The court specifically rejected the IRS's claim that it is necessary to determine a ''precise amount'' representing the fair market value of property in a private inurement case.[191] All that is required is an amount that is ''sufficiently close to the fair market value of the property at the time of the sale.''[192] The court wrote that, when the amount was within a ''reasonable range'' of what could be considered fair market values, there is no private inurement.[193]

§ 4.5 PRIVATE INUREMENT PER SE

Most instances of private inurement arise where the facts show that the payment—such as compensation for services, interest, or rent—to one or more insiders is not *reasonable* or is *excessive*. The IRS, however, recognizes forms of *private inurement per se*. This means that the structure of the transaction is inherently deficient; private inurement is found in the very nature of the

188. *Id*. at 187.
189. *Id*. at 176.
190. *Id*. at 182.
191. *Id*.
192. *Id*.
193. *Id*. It was not surprising, when the first of the intermediate sanctions cases were filed, to learn that they involved the sale of assets to insiders (*see* § 4.9(b)).

transaction. Thus, it is irrelevant (according to this view) that the benefit conferred on the insiders in some way also furthers the exempt purpose of the charitable organization and/or that the amount transferred is reasonable. This doctrine is usually inapplicable to elements of compensation.

The doctrine of private inurement per se was most fully articulated when the IRS made known the view of its Chief Counsel's office on the impact on the tax-exempt status of a hospital involved in a joint venture with members of its medical staff. The joint venture purchased, from the hospital, the gross or net revenue stream derived from operation of a hospital department or service for a defined period of time. In the Chief Counsel's view, the hospital jeopardized its tax exemption, on the ground of private inurement, solely by reason of entering into the transaction.[194] In arriving at this conclusion, the Chief Counsel's office revisited the position taken in three private letter rulings issued in the 1980s.[195] Essentially, the facts in these cases involved the purchase, by a joint venture or partnership, of the revenue stream of a hospital program.

For example, in the facts underlying one of these rulings, a limited partnership purchased the net revenue stream of the outpatient surgical program and gastroenterology laboratory of a hospital.[196] The partnership consisted of a subsidiary of the hospital as the general partner, and limited partners who were members of the medical staff of the hospital. In the facts of another of these rulings, a limited partnership (involving a hospital and members of its medical staff) acquired the gross revenue stream derived from operation of the outpatient surgery facility of the hospital.[197] This was done to induce the physicians to use the facilities of the hospital; a for-profit venture had established a competing ambulatory surgery center less than five miles from the nonprofit hospital, and was offering physicians on the medical staff of the hospital ownership interests in the surgicenter to attract their business. In these situations, the hospital continued to own and operate the facilities, established the amounts charged patients for the use of them, and paid the partnership the net revenue from operation of the facilities. At the time of the ruling request, the surgical facility in the first of these cases was only 54 percent utilized. The arrangement was undertaken to allow the staff physicians of the hospital to participate, on an investment basis, in the technical or facility charge component of the outpatient surgery program and gastroenterology laboratory. The IRS was told that this arrangement would offer a financial incentive to the physicians to increase use of the hospital's facilities. The purchase price for these revenue streams was established at fair market value as the result of arm's-length negotiations and was discounted to present value.

194. Gen. Couns. Mem. 39862.
195. Priv. Ltr. Rul. 8942099, 8820093, and one unpublished 1984 ruling.
196. Priv. Ltr. Rul. 8820093.
197. Priv. Ltr. Rul. 8942099.

The IRS recognized that ''there often are multiple reasons why hospitals are willing to engage in joint ventures and other sophisticated financial arrangements with physicians.''[198] Two of these reasons are the ''need to raise capital and to give physicians a stake in the success of a new enterprise or service.'' The hospital, in addition ''to the hope for or expectation of additional admissions and referrals,'' may act ''out of fear that a physician will send patients elsewhere or, worse, establish a new competing provider.'' But, the IRS added: ''Whenever a charitable organization engages in unusual financial transactions with private parties, the arrangements must be evaluated in light of applicable tax law and other legal standards.''[199]

Its analysis of net revenue stream arrangements led the IRS to conclude that ''there appears to be little accomplished that directly furthers the hospitals' charitable purposes of promoting health.''[200] The reason the hospitals enter into these arrangements is noted above: to retain and reward the physicians. Wrote the IRS, however, ''[g]iving (or selling) medical staff physicians a proprietary interest in the net profits of a hospital under these circumstances creates a result that is indistinguishable from paying dividends on stock.'' Thus, the private inurement prohibition is violated because ''[p]rofit distributions are made to persons having a personal and private interest in the activities of the organization and are made out of the net earnings of the organization.'' The IRS added that, in these cases, the ''hospital's profit interests in those [charitable] assets have been carved out largely for the benefit of the physician-investors.'' The IRS's lawyers opined that ''[t]his is enough to constitute inurement and is per se inconsistent with exempt status.''[201]

With this legal advice, the IRS revoked the two private letter rulings that it had published,[202] saying in one that the earlier determination had been ''issued in error.''[203] In the other, the IRS observed:

> [T]he private benefits conferred on the physician-investors by the [revenue stream] arrangement described above are direct and substantial, not incidental. The investments were potentially extremely profitable. The public benefit resulting from this arrangement—increased physician loyalty and improved utilization of . . . [the] hospital facilities—bears only the most tenuous relationship to its charitable purpose of promoting the health of the community it serves. Obtaining referrals, avoiding new competition, and increasing . . . [the hospital's] market share may improve . . . [the hospital's] competitive position but that does not necessarily benefit the community served by . . . [the hospital].[204]

198. Gen. Couns. Mem. 39862.
199. *Id*.
200. *Id*.
201. *Id*.
202. *See supra* note 195.
203. Priv. Ltr. Rul. 9231047, revoking Priv. Ltr. Rul. 8820093.
204. Priv. Ltr. Rul. 9233037, revoking Priv. Ltr. Rul. 8942099.

In both instances, the revenue stream venture was held to further the private interests of the physician-investors.[205]

Private inurement per se thus cannot be defended with the argument that the amounts being paid (in the above cases, to physicians) are ''reasonable.'' (The hospitals' position was that the physicians are being paid for admitting or referring patients or for giving up the right to establish or invest in a competing provider, and that these payments are reasonable.)

A peculiar aspect of this IRS position on private inurement per se is the distinction the IRS has drawn between payments that are compensation and those that are return on investment. If the private inurement is per se (inherent or structural) inurement, what difference does this labeling make? If reasonableness is not the test in the investment return setting, why should it be in the payment-for-services setting, where net profits are being passed to insiders?

The answer quite likely is that the IRS had to take account of a revenue ruling that held permissible the payment to a hospital-based radiologist of a percentage of the adjusted gross revenues from the radiology department in return for management and professional services.[206] In finding this arrangement to not be private inurement, the IRS used a reasonable compensation analysis. This precedent may have forced the IRS to make this distinction in the context of its development of the doctrine of private inurement per se. Yet, it seems that private inurement can be inurement per se if the arrangement involves a prohibited structure, where net earnings are paid out as compensation. As noted, the distinction may not really offer up a legitimate difference. Perhaps what the IRS should have done is treat this revenue ruling as approving of distributions of gross revenue as compensation but conclude that distributions of net income as compensation (even if ''reasonable'') are forms of private inurement per se.

This doctrine of private inurement per se should be regarded every time there is a payment based on a percentage of a healthcare provider's (or other charitable organization's) revenue.[207]

§ 4.6 ESSENCE OF PRIVATE BENEFIT

An organization cannot qualify as a tax-exempt charitable organization where it transgresses the *private benefit doctrine*. The concept of private benefit is a derivative of the operational test: to be tax-exempt, the organization must be operated primarily for one or more charitable purposes.[208] If more than an

205. In general, Mancino, ''New GCM Suggests Rules for Ventures Between Nonprofit Hospitals and Doctors,'' 76 *J. Tax*. 164 (Mar. 1992); Bromberg, ''IRS Announces New Position on Hospital-Physician Joint Ventures,'' 5 *Exempt Org. Tax Rev*. (No. 1) 31 (1992).
206. Rev. Rul. 69-383, 1969-2 C.B. 113.
207. *See* § 4.4, text accompanying Supra notes 131–138.
208. Reg. § 1.501(c)(3)-1(c)(1). As a court stated the matter, the private benefit proscription ''inheres in the requirement that [a charitable] organization operate exclusively for

insubstantial part of an organization's operations is for noncharitable (that is, private) purposes, the private benefit doctrine is violated and the organization cannot qualify as a tax-exempt charitable entity. The doctrine is separate from the private inurement rule, yet is broader than and subsumes that rule.[209]

The private benefit doctrine was articulated by a court opinion issued in 1989.[210] The case concerned a school that otherwise qualified for tax exemption; it trained individuals for careers as political campaign consultants and similar professionals. The school was held disqualified for exemption, however, because nearly all of its graduates became employed by or consultants to entities of the Republican Party and its candidates. The court concluded that the school did not primarily engage in educational activities in that it benefited private interests (that is, these entities and candidates) to more than an insubstantial extent.

The court determined that the prohibition against private benefit is not limited to situations where the benefits accrue to an organization's insiders.[211] Instead, the proscription embraces benefits to those whom the court labeled ''disinterested persons.''[212] Having thus defined the bounds of the private benefit doctrine, the court ruled that it was violated in this case. The court wrote that the school ''conducted its educational activities with the partisan objective of benefiting Republican candidates and entities.''[213]

The heart of this opinion is the analysis of the concept of *primary* private benefit and *secondary* private benefit. In the case, the beneficiaries of the primary private benefit were the students; the beneficiaries of the secondary private benefit were the employers of the graduates. The provision of secondary private benefit caused the school to fail to acquire tax exemption.

The court accepted the argument of the IRS that ''where the training of individuals is focused on furthering a particular targeted private interest, the conferred secondary benefit ceases to be incidental to the providing organization's exempt purposes.''[214] The beneficiaries at the secondary level

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exempt purposes'' (*Redlands Surgical Services v. Commissioner*, 113 T.C. 47, 74 (1999), *aff'd*, 242 F.3d 904 (9th Cir. 2001)). The IRS has asserted, however, that the private benefit doctrine also is applicable to tax-exempt social welfare organizations (*see* § 1.8) (e.g., Ex. Den and Rev. Ltr. 20044008E); this position is incorrect, in that the private benefit doctrine is a derivative of the operational test in the tax regulations, which is applicable only with respect to IRC § 501(c)(3) entities (see TAX-EXEMPT ORGANIZATIONS § 4.5) and thus does not apply to IRC § 501(c)(4) organizations.

209. That is, every act of private inurement is an act of private benefit, but the reverse is not always the case. E.g., *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989); *Church of Ethereal Joy v. Commissioner*, 83 T.C. 20, 21 (1984); *Canada v. Commissioner*, 82 T.C. 973, 981 (1984); *Goldsboro Art League, Inc. v. Commissioner*, 75 T.C. 337, 345, note 10 (1980); *Aid to Artisans, Inc. v. Commissioner*, 71 T.C. 202, 215 (1978).
210. *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989).
211. *See* § 4.2.
212. *American Campaign Academy v. Commissioner*, 92 T.C. 1053, 1069 (1989).
213. *Id*. at 1070.
214. *Id*. at 1074.

were found to be a ''select group.''[215] The ''particular targeted private interest'' and the ''select group'' were, in the court's view, the Republican Party entities and candidates served by the school's graduates.

As noted, for a private benefit to not be a risk to tax exemption, it must be insubstantial—or incidental. The IRS is of the view that the benefit must be incidental both qualitatively and quantitatively; it has explained this test as follows:

> An organization described in section 501(c)(3) of the Code must serve a public rather than a private interest. Any private benefit arising from a particular activity must be ''incidental'' in both a qualitative and quantitative sense to the overall public benefit achieved by the activity. To be qualitatively incidental, a private benefit must occur as a necessary concomitant of the activity that benefits the public at large. Such benefits might also be characterized as indirect or unintentional. To be quantitatively incidental, a benefit must be insubstantial when viewed in relation to the public benefit conferred by the activity. The private benefit conferred by an activity or arrangement is balanced only against the public benefit conferred by that activity or arrangement, not the overall good accomplished by the organization.[216]

This is a narrow view of the *quantitatively incidental* private benefit test. It holds that the private benefit conferred by an activity is balanced only against the public benefit conferred by that activity, rather than the overall charitable accomplishments of the organization. This constricted interpretation does not appear to be supported by the regulations and relevant court decisions, however. The regulations underlying the test state that ''an organization'' must serve a public interest; the regulation does not focus on the discrete activities of the organization.[217] Further, the private benefit test looks to determine whether there is sufficient private benefit to demonstrate a single noncharitable purpose that is substantial in nature.[218] The determination of whether a purpose is *substantial* can only fairly be made when considering all of the purposes and activities of the organization, not merely the activity in question.

The IRS proposed regulations that include examples of application of the private benefit doctrine.[219] One example concerns an educational organization the purpose of which is to study history and immigration; the focus of this entity's studies is the genealogy of one family, tracing the descent of its present members. It solicits for membership only individuals who are members of this family. Its research is directed toward publishing a history of this family that will document the pedigrees of family members. A major objective of the research is to identify and locate living descendants of this family to enable them to become acquainted with each other. These educational activities primarily (according to the text of the example) serve the private interests of members of

215. *Id*. at 1076.
216. Priv. Ltr. Rul. 9231047.
217. Reg. § 1.501(c)(3)-1(d)(1)(ii).
218. *Better Business Bureau v. United States*, 326 U.S. 279 (1945).
219. REG-111257-05.

a single family. This is held to be a violation of the private benefit doctrine; thus, this organization does not qualify for exemption as an educational entity.[220]

Another example pertains to a museum the sole activity of which is exhibition of art created by a group of unknown but promising local artists. The museum's board members are unrelated to the artists whose work is exhibited. The art is for sale at prices set by the artist; the artists have a consignment agreement with the museum, pursuant to which the artist receives 90 percent of the sales price. This, too, is a transgression of the private benefit doctrine, precluding exemption.[221]

The third of these examples involves an educational organization the purpose of which is to train individuals in a program developed by its president. A for-profit company owned by this individual owns the rights to this program. Prior to the existence of the educational entity, the for-profit company conducted the training function. The educational organization licenses rights to the program in exchange for the payment of royalties. The educational entity may develop course materials but they must be assigned to the for-profit company without consideration if the license agreement is terminated. This arrangement is said to constitute substantial private benefit conferred on the organization's president and the for-profit company, barring tax exemption for the educational organization, even if the royalty amounts are reasonable.[222] The private benefit doctrine is applicable in the absence of undue benefit to insiders. A court noted that the doctrine embraces benefits provided to ''disinterested persons''[223] and that impermissible private benefit can be conferred on ''unrelated'' persons.[224] This lack of necessity that an insider be involved is what gives the private benefit doctrine its sweep.

The private benefit doctrine is boundless; its use by the IRS is pliant.[225] The agency can on occasion be generous in dismissing private benefit as incidental. For example, the IRS ruled that a tax-exempt hospital's investment in a for-profit medical malpractice insurance company, using funds paid to it by its staff physicians, furthered charitable purposes[226] and was deemed to not entail impermissible private benefit, because the investment was required for the writing of insurance for the physicians, the physicians needed the insurance to practice at the hospital, and the hospital needed the physicians to provide

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220. Prop. Reg. § 1.501(c)(3)-1(d)(1)(iii), Example 1. *See The Callaway Family Ass'n, Inc. v. Commissioner*, 71 T.C. 340 (1978).
221. *Id.*, Example 2. *See St. Louis Science Fiction Ltd. v. Commissioner*, 49 T.C.M. 1126 (1985).
222. *Id.*, Example 3.
223. *American Campaign Academy v. Commissioner*, 92 T.C. 1053, 1069 (1989).
224. *Redlands Surgical Services v. Commissioner*, 113 T.C. 47, 74, *aff'd*, 242 F.3d 904 (9th Cir. 2001). As the IRS characterized the point, the private benefit doctrine applies to ''all kinds of persons and groups'' (Priv. Ltr. Rul. 200635018).
225. For example, as noted, in its zeal to expand application of the private benefit doctrine, the IRS stated that the doctrine is applicable in the context of exempt social welfare organizations (*see* § 1.8) (e.g., Ex. Den. and Rev. Ltr. 20044008E).
226. *See* § 1.7.

healthcare services to its communities.[227] The IRS announced that it does not treat the benefits an exempt hospital provides to its medical staff physicians, in the form of electronic health records software and technical support services, as impermissible private benefit if the benefits fall within the range of electronic health records items and services that are permissible under Department of Health and Human Services regulations, and if the hospital operates in a certain manner.[228] Likewise, the IRS held that a supporting organization operating for the benefit of an exempt college[229] may make grants to a capital fund for advancement of a business incubator program, with the businesses thus created contributing importantly to the college's teaching program, with the benefit conferred to the companies by the incubator investments considered incidental to the advancement of the college's educational purposes.[230] Yet when the agency embarks on a massive campaign to eradicate tax exemption in a particular field, such as credit counseling organizations,[231] housing provider entities,[232] or down payment assistance organizations,[233] strict application of the private benefit doctrine is an inevitable component of the agency's denial-and-revocation offensive.[234]

§ 4.7 PRIVATE INUREMENT AND PRIVATE BENEFIT DISTINGUISHED

Private inurement is specifically prohibited by statute, applies only where there is an insider participating in the transaction, and lacks (at least in the view of the IRS) any threshold as to insubstantiality. Private benefit is a by-product

227. Priv. Ltr. Rul. 200606042.
228. Memorandum dated May 11, 2007, from the Director of the Exempt Organizations Division to the Directors of EO Examinations and EO Rulings and Agreements. The Department of Health and Human Services earlier promulgated regulations permitting hospitals to provide, within certain parameters, such electronic health records services to their medical staff physicians without violating the federal antikickback and physician self-referral laws.
229. *See* § 5.5.
230. Priv. Ltr. Rul. 200614030.
231. *See* Tax-Exempt Organizations § 7.3.
232. *Id*. § 7.4.
233. *Id*. § 7.5.
234. As another example of application of the private benefit doctrine, an organization providing healthcare services was denied recognition of exemption because it was "effectively controlled" by two medical practices and because the provision of the services "enhances these businesses [the medical practices] and improves their reputation in the community" (Priv. Ltr. Rul. 200635018). Likewise, the IRS refused to recognize exemption in a case of a nonprofit corporation with four directors who were also the directors of a for-profit entity; the IRS ruled that the nonprofit entity was "totally dependent upon your for-profit creator" and that it "ceded control" to the for-profit company (Priv. Ltr. Rul. 200702042). In an erroneous application of the doctrine, the IRS found private benefit inherent in the fact that the organization involved, formed as a nonprofit public benefit corporation in compliance with state law, had only two (related) directors (Priv. Ltr. Rul. 200736037).

of the organizational test, can be applied with respect to any transaction, and must, to cause loss or denial of tax exemption, be more than an incidental or tenuous benefit.

The private benefit doctrine is applied in the healthcare setting. Presumably, the stance of the IRS in the past—that an organization can be an educational one, even though it provides training to individuals in a particular profession or industry (such as physicians or nurses)—is still firm.[235] In any event, these persons are the recipients of the primary benefit (permissible because it occurs as part of the performance of an exempt function); exemption will not be disturbed as long as the secondary beneficiaries are not targeted. Thus, a court concluded that the past IRS rulings are still valid, in that the ''secondary benefit provided in each ruling was broadly spread among members of an industry . . . as opposed to being earmarked for a particular organization or person.''[236] The court said that the secondary benefit in each of these rulings was, by reason of the breadth of the spread, ''incidental to the providing organization's exempt purpose.''[237]

This doctrine is available for applicability in the healthcare context. For example, if the IRS did not take the position that physicians affiliated with a hospital are insiders with respect to the hospital,[238] it could have used the private benefit analysis to that end. Indeed, the IRS applied a private benefit analysis when it concluded that the sale by a tax-exempt hospital of a revenue stream of a department of the hospital to a joint venture involving its medical staff physicians endangered the hospital's tax exemption.[239]

§ 4.8 A CASE STUDY

The IRS is in the process of examining many healthcare institutions and systems. The tax-exempt status of one of them, LAC Facilities, Inc., in Miami (previously named Modern Health Care Services, Inc.) was revoked in 1994 on the grounds of private inurement and private benefit. The rationale for this action is summarized in a technical advice memorandum issued in that year.[240] The government's position in this case represents a virtual catalog of impermissible private transactions and activities.

The organization was one of six entities, some tax-exempt, some taxable, within a system, the parent of which was a supporting organization.[241] One of the taxable entities is an offshore captive insurance company; another serves as a general partner in various joint ventures, some with physicians.

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235. E.g., Rev. Rul. 75-196, 1975-1 C.B. 155; Rev. Rul. 72-101, 1972-1 C.B. 144; Rev. Rul. 68-504, 1968-2 C.B. 211; Rev. Rul. 67-72, 1967-1 C.B. 125.
236. *American Campaign Academy v. Commissioner*, 92 T.C. 1053, 1074 (1989).
237. *Id*.
238. *See supra* § 4.3.
239. *See* § 4.5.
240. Tech. Adv. Mem. 9451001.
241. *See* §§ 5.5 and 23.2.

Seven private physician practices were purchased in an 18-month period for about $17.4 million.[242] The entity entered into service agreements with the physicians who previously owned the practices. One medical practice was purchased for $6 million, after obtaining an appraisal that the value was $6.8 million. The total tangible assets of the practice had a value of $170,093; the practice had incurred losses in the previous two years. An appraisal for the IRS put the value of the practice at $2 million. Board minutes of the healthcare entity contain a statement that the physicians were consciously overpaid for the practice in order to gain their patients and credibility. The resulting service agreement in this instance involved $2 million in annual compensation to the physicians and office personnel.

Over a five-year period, the institution paid over $17 million for various medical assets. These were later sold for $4.5 million to an organization controlled by physicians previously employed by the institution. The grandson of the institution's president had an interest in the purchasing organization. The purchase was by means of a promissory note that has a present value, after allowances for doubtful collection, of $253,000.

The president and chief executive officer of the organization received a salary in the examination year of $267,000. He stated that his duties included ensuring that the organization complies with ''exempt organization regulations.'' He claimed to work 70 hours a week, with no vacations and without working weekends. The examining agent found that the majority of the salaries of chief executive officers of hospitals in the community was $236,000. The IRS noted that this salary was ''not determined by an independent compensation committee.''

This individual also received a lump-sum distribution of $1.8 million from the institution's executive staff retirement plan and $120,000 from the offshore insurance company. The institution is the only client of the insurance company, which handled 30 claims over a four-year period.

A law firm having a partner as an officer received $450,000 in legal fees from the institution for the year. This individual's spouse was paid by the insurance company for graphic arts services. Another trustee was paid $48,000 in medical consulting fees; this individual also received a lump-sum distribution of $755,000 from the institution's retirement plan. The executive vice president of the entity received a salary of $213,000, plus $60,000 from the insurance company.

Other expenditures by this healthcare organization were for spouse travel, theater tickets, crystal and china, liquor, and country club expenses. While the entity contended that most of these outlays were for exempt functions, it could not submit documents to substantiate its position.

A limited partnership was established to own and operate an adult congregate living facility.[243] Over a four-year period, two of the healthcare

242. *See* § 25.5.
243. *See* Chapter 22.

organization's trustees and officers, and one of its employees, held a financial interest in the partnership. One of the trustees and officers was the general partner; the other two individuals (one of which was the president and chief executive officer of the exempt organization) were limited partners. The exempt organization incurred expenses totaling more than $80,000 on behalf of the partnership; these were recorded as interest-free, unsecured loans. (About $64,000 of this loan was repaid, without interest.) The president of the exempt organization told the IRS that these expenses were paid because of ''sloppy bookkeeping.'' The general partner's view, however, was that the expenses were incurred because the organization was interested in establishing the facility. Subsequently, the president of the exempt organization assigned his interest in the partnership to a corporation in exchange for an amount from the partnership equal to 50 percent of the net profit from certain real property.

The IRS opened its analysis of this case with the observation that a public charity ''is not prohibited from dealing with its directors or officers in conducting its economic affairs.'' The Service added: ''However, transactions between a charitable organization and a private individual in which the individual appears to receive a disproportionate share of the benefits of the exchange relative to the charity served presents an inurement issue.''

The IRS reviewed the extensive periods of time that the individuals involved in this case (the insiders) were trustees, officers, key employees, and the like with respect to the exempt organization. It was noted that the two individuals who received compensation from the insurance company lacked expertise in the ''insurance or actuarial field that would qualify them to provide various services'' to the company. Further, the IRS found that the insurance company had contracted with various entities to provide services similar to those provided by these individuals. The IRS concluded that the exempt organization overpaid for the insurance coverage, some of these funds were passed to the individuals ''under the guise of salaries,'' and thus that private inurement occurred.

The lump-sum payments from the retirement plan were also found to be forms of private inurement, as were the unsecured and interest-free loans to the partnership, purchases of physicians' practices, sales of medical assets, payments for airfare for spouses, food and liquor charges at a country club, and payments for items such as china and perfume. These and other transactions—those not involving insiders—were found to be forms of private benefit.

This organization filed a lawsuit, challenging the revocation, in the U.S. Court of Federal Claims.[244] The case, however, was settled; thus, a potentially important private inurement court opinion did not develop.

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244. *LAC Facilities, Inc. v. United States* (No. 94-604 T). *See*, in general, Griffith, ''Compensation and Fraud Issues Trigger First Health Care Audit Revocation of the 1990s,'' 6 *J. Tax'n Exempt Orgs*. (No. 6) 259 (May/June 1995).

§ 4.9 EXCESS BENEFIT TRANSACTIONS

Enactment of the *intermediate sanctions* rules—an emphasis on the taxation of those engaging in impermissible transactions with healthcare and certain other tax-exempt organizations rather than revocation of the tax exemption of the organizations involved—is transforming the private inurement and the private benefit doctrines.

(a) General Rules

The intermediate sanctions rules[245] apply with respect to nearly all tax-exempt healthcare organizations, as well as many other types of tax-exempt organizations.[246]

(i) Exempt Organizations Involved. These sanctions apply with respect to tax-exempt public charities[247] and tax-exempt social welfare organizations.[248] These entities are collectively termed, for this purpose, *applicable tax-exempt organizations*.[249] Organizations of this nature include any organization

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245. These rules are the subject of IRC § 4958, enacted by § 1311(a) of the Taxpayer Bill of Rights 2 and signed into law on July 30, 1996, Pub. L. No. 104-168, 104th Cong., 2d Sess. (1996), 110 Stat. 1452 (for purposes of this § 4.9, Act).

The Senate, on July 11, 1996, adopted the legislation as passed by the House of Representatives on April 16, 1996, without change. The House vote was 425–0; the Senate voted by unanimous consent. There was no report prepared by the Senate Committee on Finance and no conference report. Thus, the report of the House Committee on Ways and Means, dated March 28, 1996 (H. R. Rep. No. 104-506, 104th Cong., 2d Sess. (1996)) (for purposes of this § 4.9, House Report), constitutes the totality of the legislative history of the intermediate sanctions rules.

The intermediate sanctions rules are the subject of INTERMEDIATE SANCTIONS. The IRS provided a brief summary of these rules in Notice 96-46, 1996-2 C.B. 212. The lawyers for the IRS wrote that the primary purpose of the intermediate sanctions rules is to ‘‘require insiders who are receiving excess benefits to make their exempt organizations whole, with the goal of keeping them operating for the benefit of the public’’ (Chief Counsel Adv. Mem. 200431023).

246. The IRS issued proposed regulations explaining and amplifying these rules on July 30, 1998 (REG-246256-96). Hearings on these regulations occurred on March 16 and 17, 1999. The IRS issued temporary regulations on January 8, 2001 (T.D. 8920), which were initially set to be effective through January 8, 2004. The IRS, however, promulgated final regulations concerning the intermediate sanctions rules on January 21, 2002 (T.D. 8978).

247. A *public charity* is an organization that is tax-exempt for federal income tax purposes (IRC § 501(a)) because it is a charitable, educational, scientific, and/or like organization (i.e., it is described in IRC § 501(c)(3)); this type of charitable organization is not (by reason of IRC § 509(a)) a private foundation. The law as to public charities and private foundations is the subject of Chapter 5.

248. A *social welfare organization* is an organization that is tax-exempt for federal income tax purposes (IRC § 501(a)) because it is described in IRC § 501(c)(4). The law of social welfare organizations is the subject of § 1.8.

249. IRC § 4958(e)(1); Reg. § 53.4958-2(a)(1).

described in either of these two categories of exempt organizations at any time during the five-year period ending on the date of the transaction.[250]

A social welfare organization is covered by these rules if it has received recognition of tax exemption from the IRS, has filed an application for recognition of exemption, has filed an information return with the IRS as a social welfare organization, or has otherwise held itself out as a social welfare organization.[251] (These distinctions are required because, unlike nearly all public charities, an entity can be a tax-exempt social welfare organization without receiving recognition of exemption.[252])

There are no exemptions from these rules.[253] That is, all tax-exempt public charities and all tax-exempt social welfare organizations are applicable tax-exempt organizations.[254] A foreign organization that receives substantially all of its support from sources outside the United States, however, is not an applicable tax-exempt organization.[255]

(ii) Disqualified Persons. For these purposes,[256] the term *disqualified person* means (1) any person who was, at any time during the five-year period ending on the date of the transaction involved, in a position to exercise substantial influence over the affairs of the applicable tax-exempt organization (whether by virtue of being an organization manager or otherwise),[257] (2) a member of the family of an individual described in the preceding category,[258] and (3) an entity in which individuals described in the preceding two categories own more than a 35 percent interest.[259]

As to the first of these categories, a person can be in a position to exercise substantial influence over a tax-exempt organization despite the fact that the person is not an employee of (and does not receive any compensation directly from) the organization but is formally an employee of (and is directly compensated by) a subsidiary—including a taxable subsidiary—controlled by the parent tax-exempt organization.[260]

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250. IRC § 4958(e)(2); Reg. § 53.4958-2(b)(1). In the case of a transaction occurring before September 14, 2000, this lookback period began on September 14, 1995 (*see* § 4.9(a)(x)) and ends on the date of the transaction (Reg. § 53.4958-2(b)(1)).
251. Reg. § 53.4958-2(a)(3).
252. *See* Chapter 33, text accompanied by note 10.
253. In other areas of the law of tax-exempt organizations, by contrast, there are exemptions from the rules for entities such as, for example, small organizations and religious organizations (e.g., §§ 33.2(e), 34.3(b)).
254. Private foundations (*see* Chapter 5, text accompanied by notes 8–11) are not included in this tax regime because a somewhat similar body of law—that involving self-dealing rules (IRC § 4941)—is applicable to them. The self-dealing rules are summarized in § 5.9.
255. Reg. § 53.4958-2(b)(2).
256. Cf. IRC § 4946. *See* § 11.2.
257. IRC § 4958(f)(1)(A); Reg. § 53.4958-3(a)(1).
258. IRC § 4958(f)(1)(B); Reg. § 53.4958-3(b)(1).
259. IRC § 4958(f)(1)(C); Reg. § 53.4958-3(b)(2).
260. House Report at 58, note 10.

A person is in a position to exercise substantial influence over the affairs of an applicable tax-exempt organization if that person is a voting member of the organization's governing body or is (or has the powers or responsibilities of) the organization's president, chief executive officer, chief operating officer, or chief financial officer.[261] Certain facts and circumstances tend to show this substantial influence, such as being the organization's founder, being a substantial contributor to it, having managerial control over a discrete segment of the organization, or receiving compensation primarily based on revenues derived from activities of the organization.[262] Certain facts and circumstances tend to show a lack of substantial influence, such as service as an independent contractor (e.g., a lawyer, accountant, or investment advisor).[263] Certain persons are deemed to not have the requisite substantial influence, such as an employee who receives economic benefits that are less than the compensation referenced for a highly compensated employee[264] and public charities.[265]

Although it has been the view of the IRS that all physicians who are on the medical staff of a tax-exempt hospital or similar organization are insiders for purposes of the private inurement proscription,[266] a physician is a disqualified person under the intermediate sanctions rules only when he or she is in a position to exercise substantial influence over the affairs of the organization.[267]

An *organization manager* is a trustee, director, or officer of the applicable tax-exempt organization, as well as an individual having powers or responsibilities similar to those of trustees, directors, or officers of the organization.[268]

The term *member of the family* is defined as being (1) spouses, ancestors, children, grandchildren, great-grandchildren, and the spouses of children, grandchildren, and great-grandchildren—namely, those individuals so classified under the private foundation rules,[269] and (2) any brothers and sisters (whether by whole or half blood) of the individual and their spouses.[270] Thus,

261. Reg. § 53.4958-3(c). The legislative history, however, states that an individual having the title of ''trustee,'' ''director,'' or ''officer'' is not automatically considered a disqualified person (House Report at 58, note 12).
262. Reg. § 53.4958-3(e)(2).
263. Reg. § 53.4958-3(e)(3).
264. IRC § 414(q)(1)(B)(i). An individual is a highly compensated employee in 2008 if he or she earned more than $100,000 in 2007.
265. Reg. § 53.4958-3(d). As to this last point, a social welfare organization is deemed to not have substantial influence over another social welfare organization; other types of tax-exempt organizations can be disqualified persons in this context, such as a membership association (*see* Chapter 18) in relation to a related foundation (*see* § 30.2(a)).
266. Gen. Couns. Mem. 39862. *See* § 4.3.
267. House Report at 58, note 12.
268. IRC § 4958(f)(2); Reg. § 53.4958-1(d)(2).
269. IRC § 4946(d).
270. IRC § 4958(f)(4); Reg. § 53.4958-3(b)(1).

this term is defined more broadly in the public charity setting than is the case with private foundations.

The entities that are disqualified persons because one or more disqualified persons own more than a 35 percent interest in them are termed *35 percent controlled entities*. These are (1) corporations in which one or more disqualified persons own more than 35 percent of the total combined voting power, (2) partnerships in which one or more disqualified persons own more than 35 percent of the profits interest, and (3) trusts or estates in which one or more disqualified persons own more than 35 percent of the beneficial interest.[271] The term *combined voting power* includes voting power represented by holdings of voting stock, actual or constructive, but does not include voting rights held only as a director or trustee.[272] In general, constructive ownership rules apply for purposes of determining whether an entity is a 35 percent controlled entity.[273]

(iii) Excess Benefit Transactions. This tax law regime has as its heart the excess benefit transaction. In the instance of one of these transactions, tax sanctions are imposed on the disqualified person or persons who improperly benefited from the transaction and perhaps on any organization manager or managers who participated in the transaction knowing that it was improper.

An *excess benefit transaction* is any transaction in which an economic benefit is provided by an applicable tax-exempt organization directly or indirectly to or for the use of any disqualified person, if the value of the economic benefit provided by the exempt organization exceeds the value of the consideration (including the performance of services) received for providing the benefit.[274] The IRS provided a more concise definition of the term: "An excess benefit transaction is one in which a tax-exempt organization provides an economic benefit to one or more of the organization's insiders . . . without receiving a

271. IRC § 4958(f)(3)(A); Reg. § 53.4958-3(b)(2).
272. Reg. § 53.4958-3(b)(2)(ii).
273. IRC § 4958(f)(3)(B); Reg. § 53.4958-3(b)(2)(iii).
274. IRC § 4958(c)(1)(A); Reg. § 53.4958-4(a)(1). The IRS ruled that an annual monetary award presented by a public charity was an exempt activity and did not involve an excess benefit transaction (Priv. Ltr. Rul. 9802045). The IRS concluded that a transaction did not amount to an excess benefit transaction because it did not entail provision of an economic benefit to any disqualified persons, yet the IRS did not evaluate the facts as to whether an economic benefit was provided for the use of any disqualified person (Priv. Ltr. Rul. 200335037).

Thus, the definition of *excess benefit transactions* encompasses not only transactions where a benefit is provided *to* a disqualified person but also where a benefit is provided to a person who is not disqualified yet there nonetheless is a benefit provided *for the use of* a disqualified person. This latter element is sometimes overlooked (and, if applied, may change the ultimate outcome); an illustration is an IRS ruling finding certain grants to not be excess benefit transactions, without taking into consideration the *for the use of* aspect of these rules (Priv. Ltr. Rul. 200335037).

commensurate economic benefit in return.''[275] This type of benefit is known as an *excess benefit*.[276]

Payment of compensation that is not reasonable by an applicable tax-exempt organization to a disqualified person is a type of excess benefit transaction. Compensation for the performance of services is reasonable if it is only such ''amount that would ordinarily be paid for like services by like enterprises under like circumstances.''[277] Generally, the circumstances to be taken into consideration are those existing at the date when the contract for services was made. When reasonableness cannot be determined on that basis, the determination is made based on all facts and circumstances, up to and including circumstances as of the date of payment. The IRS may not consider ''circumstances existing at the date when the payment is questioned'' in making a determination of the reasonableness of compensation.[278]

Compensation for these purposes means all items of compensation provided by an applicable tax-exempt organization in exchange for the performance of services. This includes (1) forms of cash and noncash compensation, such as salary, fees, bonuses, and severance payments; (2) forms of deferred compensation that are earned and vested, whether or not funded and whether or not the plan is a qualified one; (3) the amount of premiums paid for insurance coverage (including liability), as well as payment or reimbursement by the organization of charges, expenses, fees, or taxes not ultimately covered by the insurance coverage; (4) other compensatory benefits, whether or not included in income for tax purposes, including payments to welfare benefit plans on behalf of the individuals being compensated, such as plans providing medical, dental, life insurance, severance pay, and disability benefits, and taxable and nontaxable fringe benefits,[279] including expense allowances or reimbursements or forgone interest on loans that the recipient must report as income for tax purposes; and (5) any economic benefit provided by an applicable tax-exempt organization, either directly or through another entity owned, controlled by, or affiliated with the applicable tax-exempt organization, or through an intermediary.[280]

275. Priv. Ltr. Rul. 200247055. The IRS ruled that an office-sharing arrangement involving a charitable trust, a public charity, its supporting organization, and disqualified persons did not result in any excess benefit transaction (Priv. Ltr. Rul. 200421010).
276. IRC § 4958(c)(1)(B). The first technical advice memorandum issued by the IRS in the intermediate sanctions setting reflected a variety of excess benefit transactions (Tech. Adv. Mem. 200243057).
277. Reg. § 53.4958-4(b)(1)(ii)(A).
278. Reg. § 53.4958-4(b)(2)(i). By contrast, the U.S. Tax Court is of the view that, in the private inurement setting, circumstances occurring after the transaction in question can be considered in determining reasonableness (e.g., *Anclote Psychiatric Center, Inc. v. Commissioner*, 76 T.C. 175 (1998)).
279. This item, however, does not include working condition fringe benefits (IRC § 132(d)) or de minimis fringe benefits (IRC § 132(e)) (Reg. § 53.4958-4(a)(4)(i)).
280. Reg. § 53.4958-4(b)(1)(ii)(B). This type of arrangement is known as the *automatic excess benefit transaction*.

The criteria for determining the reasonableness of compensation and fair market value of property are not directly stated in the intermediate sanctions regulations. Preexisting law standards apply in determining reasonableness of this nature.[281] An individual need not necessarily accept reduced compensation merely because he or she renders services to a tax-exempt, as opposed to a taxable, organization.[282]

An economic benefit may not be treated as consideration for the performance of services unless the organization providing the benefit clearly indicates its intent to treat the benefit as compensation when the benefit is paid.[283] Items of this nature include the payment of personal expenses, transfers to or for the benefit of disqualified persons, and non–fair-market-value transactions benefiting these persons.[284] In determining whether payments or transactions of this nature are in fact forms of compensation, the relevant factors include whether (1) the appropriate decision-making body approved the transfer as compensation in accordance with established procedures and (2) the organization provided written substantiation that is contemporaneous with the transfer of the economic benefit at issue.[285] If an organization fails to provide this contemporaneous substantiation, any services provided by the disqualified person will not be treated as provided in consideration for the economic benefit for purposes of determining the reasonableness of the transaction.[286] These transactions are thus known as *automatic excess benefit transactions*. In connection with its examination of the practices of certain consumer credit counseling organizations,[287] the lawyers for the IRS have concluded that financial arrangements between these organizations and ‘‘back-office service providers’’ entail excessive compensation warranting application of the intermediate sanctions rules.[288] These rules do not apply to nontaxable fringe benefits[289] and certain other types of nontaxable transfers (such as employer-provided health benefits and contributions to qualified pension plans).[290]

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281. House Report at 56. *See* § 28.2(c).
282. *Id*., note 5.
283. IRC § 4958(c)(1)(A); Reg. § 53.4958-4(c)(1).
284. House Report at 57.
285. Reg. § 53.4958-4(c)(1). This substantiation should be provided on returns or forms such as the organization’s annual information return filed with the IRS (usually Form 990), the information return provided by the organization to the recipient (Form W-2 or Form 1099), and the individual’s income tax return (Form 1040) (House Report at 57; Reg. § 53.4958-4(c)(3)(i)(A)(1)).
286. Reg. § 53.4958-4(c)(1). An economic benefit that a disqualified person obtains by theft or fraud cannot be treated as consideration for the performance of services (*id*.). The IRS’s lawyers decided that provision by a charitable organization to disqualified persons with respect to it of residences, vehicles, charge accounts, cell phones, and a computer constituted forms of automatic excess benefit transactions (Tech. Adv. Mem. 200435018).
287. *See* TAX-EXEMPT ORGANIZATIONS § 7.3.
288. Chief Counsel Adv. Mem. 200431023.
289. IRC § 132. *See* § 28.3(b).
290. The first intermediate sanctions case concerning the issue of excessive compensation was filed in the U.S. Tax Court on August 3, 2000 (*Peters v. Commissioner* (Docket

A transaction can be an automatic excess benefit transaction even though its terms and conditions show that it is, in fact, reasonable. Transactions of this nature include the provision by an applicable tax-exempt organization to a disqualified person of, for personal purposes, residential real property, use of a vehicle, access to exempt organization charge accounts, use of a cellular telephone, and use of a computer.[291] Payment for the expenses of spousal travel and no-interest loans (resulting in imputed income[292]) can also constitute automatic excess benefit transactions.

If a supporting organization[293] makes a grant, loan, payment of compensation, or similar payment (such as an expense reimbursement) to a substantial contributor[294] or related person of the supporting organization, the substantial contributor is regarded, for purposes of the intermediate sanctions rules, as a disqualified person.[295] This type of payment is treated as an automatic excess benefit transaction—that is, the entire amount of the payment is treated as an excess benefit.[296]

Accordingly, a substantial contributor in this position is subject to the initial intermediate sanctions excise tax[297] on the amount of the payment. An organization manager[298] that knowingly participates in the making of the payment is also subject to an excise tax.[299] The second-tier taxes[300] and the other intermediate sanctions rules are also applicable to these payments.

Loans by a supporting organization to a disqualified person with respect to the supporting organization are treated as excess benefit transactions; the entire amount of this type of loan is regarded as an excess benefit.[301]

A grant, loan, compensation, or other similar payment from a donor-advised fund[302] to a person that, with respect to the fund, is a donor, a donor advisor, or a person related to a donor or donor advisor automatically is treated as an excess benefit transaction for intermediate sanctions law purposes.[303] Again, this means that the entire amount paid to any of these persons is an excess benefit.

No. 8446-00)); the case was settled. The IRS has ruled that an economic benefit is disregarded for these purposes if the benefit is incidental and tenuous (Priv. Ltr. Rul. 200335037).

291. E.g., Tech. Adv. Mem. 200435018.
292. IRC § 7872.
293. *See* § 5.5.
294. As defined in IRC § 4958(c)(3)(C).
295. IRC § 4958(f)(1)(D).
296. IRC § 4958(c)(3). The IRS provided guidance as to the applicability date of this rule (Notice 2006-109, 2006-51 I.R.B. 1121 § 4).
297. *See* text accompanied by *infra* note 334.
298. *See* text accompanied by *supra* note 268.
299. *See* text accompanied by *infra* note 338.
300. *See* text accompanied by *infra* notes 340–342.
301. IRC § 4958(c)(3)(A)(i)(I).
302. As defined in IRC § 4966(d)(2).
303. IRC § 4958(c)(2).

Donors and donor advisors with respect to a donor-advised fund, and related persons, are disqualified persons for intermediate sanctions law purposes with respect to transactions with the donor-advised fund (although not necessarily with respect to transactions with the sponsoring organization generally).[304]

The phraseology *directly or indirectly* means the provision of an economic benefit directly by the organization or indirectly by means of a controlled entity. Thus, an applicable tax-exempt organization cannot avoid involvement in an excess benefit transaction by causing a controlled entity to engage in the transaction.[305] An economic benefit may also be provided by an applicable tax-exempt organization indirectly to a disqualified person through an intermediary entity.[306] All consideration and benefits exchanged between a disqualified person and an applicable tax-exempt organization, and all entities the organization controls, are taken into account to determine whether an excess benefit transaction has occurred.

The following economic benefits are disregarded for these purposes: (1) the payment of reasonable expenses for members of the governing body of an organization to attend board meetings; (2) an economic benefit received by a disqualified person solely as a member of (if the membership fee does not exceed $75) or volunteer for the organization; and (3) an economic benefit provided to a disqualified person solely as a member of a charitable class.[307]

Also, to the extent to be provided in tax regulations, the term *excess benefit transaction* includes any transaction in which the amount of any economic benefit provided to or for the use of a disqualified person is determined in whole or in part by the revenues of one or more activities of the organization, but only if the transaction results in private inurement.[308] In this context, the excess benefit is the amount of the private inurement.[309] This type of arrangement is known as a *revenue-sharing arrangement*. The Department of the Treasury was instructed by Congress in 1996 to promptly issue guidance providing examples of revenue-sharing arrangements that violate the private inurement prohibition.[310] The tax regulations that were issued in 2002 are silent on the subject.[311]

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304. IRC § 4958(f)(1)(D), (E).
305. House Report at 56, note 3.
306. Reg. § 53.4958-4(a)(2).
307. Reg. § 53.4958-4(a)(4). Thus, physicians, being disqualified persons with respect to an applicable tax-exempt healthcare organization, who derived a benefit from the operation of a bus service operated by the organization for the benefit of patients who are distressed, were ruled to not receive excess benefits because the service was provided to the same extent to similarly situated members of the general public (Priv. Ltr. Rul. 200247055). The IRS subsequently informally invoked this charitable class exception (Priv. Ltr. Rul. 200332018).
308. IRC § 4958(c)(2).
309. *Id*.
310. House Report at 56.
311. A section in the regulations has been reserved for these rules (Reg. § 53.4958-5).

Under the law in existence before enactment of the intermediate sanctions rules, certain revenue-sharing arrangements have been determined by the IRS to not constitute private inurement.[312] It is to continue to be the case that not all revenue-sharing arrangements are private inurement transactions. The legislative history of the intermediate sanctions rules, however, stated that the IRS is not bound by any of its prior rulings in this area.[313]

The intermediate sanctions rules do not apply to any fixed payment made to a person pursuant to an initial contract.[314] A *fixed payment* is an amount of money or other property specified in the contract, or determined by a fixed formula specified in the contract, which is to be paid or transferred in exchange for the provision of specified services or property.[315] An *initial contract* is a binding written contract between an applicable tax-exempt organization and a person who was not a disqualified person immediately prior to entering into the contract.[316] A compensation package can be partially sheltered by this initial contract exception; for example, an individual can have a base salary that is a fixed payment pursuant to an initial contract and also have an annual performance-based bonus that is subject to excess benefit transaction analysis.[317]

The IRS ruled that economic benefits provided to disqualified persons that are ''incidental and tenuous'' are not violative of the excess benefit transactions rules.[318]

(iv) Rebuttable Presumption of Reasonableness. This body of law includes a *rebuttable presumption of reasonableness* with respect to compensation arrangements and other transactions between an applicable tax-exempt organization and a disqualified person.[319] This presumption arises where the transaction was approved by a board of directors or trustees (or a committee of the board) of an applicable tax-exempt organization that was composed entirely of individuals who were unrelated to and not subject to the control of the disqualified person or persons involved in the transaction, obtained and relied on appropriate data as to comparability, and adequately documented the basis for its determination.[320]

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312. E.g., Gen. Couns. Mem. 39674, 38905, and 38283. *See* House Report at 56, note 4.
313. House Report at 56, note 4.
314. Reg. § 53.4958-4(a)(3)(i).
315. Reg. § 53.4958-4(a)(3)(ii).
316. Reg. § 53.4958-4(a)(3)(iii).
317. In general, Jones, '' 'First Bite' and the Private Benefit Doctrine: A Comment on Temporary and Proposed Regulation 53-4958-4 T(a)(3),'' 62 *U. Pitt. L. Rev*. 715 (Summer 2001). This *initial contract exception* is informally known as the *first bite rule*.
318. Priv. Ltr. Rul. 200335037.
319. This rebuttable presumption is not provided for in the Internal Revenue Code; it was created by the legislative history (House Report at 56–57) and is reflected in and amplified by the regulations (Reg. § 58.4958-6).
320. Reg. § 53.4958-6(a).

The first of these criteria essentially requires an independent board. The standard as to independence, for governing bodies and committees, is based on the concept of an absence of a *conflict of interest*.[321] An individual is not regarded as a member of a governing body or committee when it is reviewing a transaction if that individual meets with the members only to answer questions, otherwise recuses himself or herself from the meeting, and is not present during debate and voting on the transaction.[322] A committee of a governing body may be composed of any individuals permitted under state law to serve on the committee and may act on behalf of the governing body to the extent permitted by state law.[323]

As to the second of these criteria, appropriate data includes compensation levels paid by similarly situated organizations, both tax-exempt and taxable, for functionally comparable positions; the location of the organization, including the availability of similar specialties in the geographical area; independent compensation surveys by nationally recognized independent firms; and written offers from similar institutions competing for the services of the disqualified person.[324]

In the case of an organization with annual gross receipts of less than $1 million, when reviewing compensation arrangements, the governing body or committee is considered to have appropriate data as to comparability if it has data on compensation paid by three comparable organizations in the same or similar communities for similar services.[325]

As to the third of these criteria, adequate documentation includes an evaluation of the individual whose compensation level and terms were being established, and the basis for the determination that the individual's compensation was reasonable in light of that evaluation and data.[326] The fact that a state or local legislative or agency body may have authorized or approved a particular compensation package paid to a disqualified person is not determinative of the reasonableness of the compensation paid.[327]

For a decision to be documented adequately, the written or electronic records of the governing body or committee must note the terms of the transaction that was approved, the date it was approved, the members of the governing body or committee who were present during debate on the

321. Reg. § 53.4958-6(c)(1)(iii).
322. Reg. § 53.4958-6(c)(1)(ii).
323. Reg. § 53.4958-6(c)(1)(i)(B).
324. House Report at 57; Reg. § 53.4958-6(c)(2)(i). A commercial competitive bidding process for independently determining a coupon rate on bonds was ruled to constitute an offer received as part of an open and competitive bidding process for purposes of this presumption (Priv. Ltr. Rul. 200413014).
325. Reg. § 53.4958-6(c)(2)(ii).
326. House Report at 57.
327. *Id.*, note 7. Likewise, this type of authorization or approval is not determinative of whether a revenue-sharing arrangement violates the private inurement proscription (*id.*).

transaction or arrangement that was approved and those who voted on it, the comparability data obtained and relied on by the governing body or committee and how it was obtained, and the actions taken with respect to consideration of the transaction by anyone who was otherwise a member of the governing body or committee but who had a conflict of interest with respect to the transaction or arrangement.[328] If the governing body or committee determines that reasonable compensation for a specific arrangement or fair market value in a specific transaction is higher or lower than the range of comparable data received, the governing body or committee must record the basis for the determination.[329]

The documentation must be made concurrently with the determination.[330] This means that records must be prepared by the next meeting of the governing body or committee occurring after the final action or actions of the body or committee are taken. Records must be reviewed and approved by the governing body or committee as reasonable, accurate, and complete within a reasonable time thereafter.[331]

If these three criteria are satisfied, penalty excise taxes can be imposed only if the IRS develops sufficient contrary evidence to rebut the probative value of the comparability data relied on by the authorized governing body.[332] For example, the IRS could establish that the compensation data relied on by the parties was not for functionally comparable positions or that the disqualified person in fact did not substantially perform the responsibilities of the position.[333]

(v) Tax Structure. A disqualified person who benefited from an excess benefit transaction is subject to and must pay an excise tax—termed the *initial tax*—equal to 25 percent of the amount of the excess benefit.[334] Again, the excess benefit is the amount by which a transaction differs from fair market

328. Reg. § 53.4958-6(c)(3)(i).
329. Reg. § 53.4958-6(c)(3)(ii).
330. *Id*.
331. *Id*. If reasonableness of compensation cannot be determined based on circumstances existing at the date when a contract for services was made, this rebuttable presumption cannot arise until circumstances exist so that reasonableness of compensation can be determined and the three requirements for the presumption are satisfied (Reg. § 53.4958-6(d)(1)).

The fact that a transaction between an applicable tax-exempt organization and a disqualified person does not qualify for this presumption does not create an inference that the transaction is an excess benefit transaction (Reg. § 53.4958-6(e)). The fact that a transaction qualifies for the presumption does not exempt or relieve any person from compliance with any federal or state law imposing any obligation, duty, responsibility, or other standard of conduct with respect to the operation or administration of any applicable tax-exempt organization (*id*.).
332. Reg. § 53.4958-6(b).
333. House Report at 57.
334. IRC § 4958(a)(1) Reg. § 53.4958-1(a), (c)(1).

value, the amount of compensation exceeding reasonable compensation, or (pursuant to tax regulations) the amount of impermissible private inurement resulting from a transaction based on the organization's gross or net income.[335] (In addition, the matter must be rectified—corrected—by a return of the excess benefit to the applicable tax-exempt organization.[336])

An organization manager who participated in an excess benefit transaction, knowing that it was such a transaction, is subject to and must pay an excise tax of 10 percent of the excess benefit (subject to a maximum amount of tax as to a transaction of $10,000[337]), where an initial tax is imposed on a disqualified person and if there was no correction of the excess benefit transaction within the taxable period.[338] This tax is not imposed, however, where the participation in the transaction was not willful and was due to reasonable cause.[339]

Another tax—the *additional tax*—may be imposed on a disqualified person where the initial tax was imposed and if there was no correction of the excess benefit within a specified period. This period is the *taxable period*, which means—with respect to an excess benefit transaction—the period beginning with the date on which the transaction occurred and ending on the earliest of (1) the date of mailing of a notice of deficiency[340] as to the initial tax or (2) the date on which the initial tax is assessed.[341] In this situation, the disqualified person is subject to and must pay a tax equal to 200 percent of the excess benefit involved.[342]

If more than one organization manager or other disqualified person is liable for one of these excise taxes, then all such persons involved in a transaction are jointly and severally liable for the tax.[343]

A three-year statute of limitations applies, except in the case of fraud.[344] The IRS has the authority to abate an intermediate sanctions excise tax penalty if it is established that the violation was due to reasonable cause and not due to willful neglect, and the transaction was corrected within the appropriate taxable period.[345]

(vi) Correction. The term *correction* means undoing the excess benefit transaction to the extent possible and taking any additional measures necessary to place the applicable tax-exempt organization in a financial position that is not

335. House Report at 58-59.
336. *See* § 4.9(a)(vi).
337. IRC § 4958(d)(2); Reg. § 53.4958-1(d)(7).
338. IRC § 4958(a)(2); Reg. § 53.4958-1(d)(1). The concepts of *participation* and *knowing* are the subject of Reg. § 53.4958-1(d)(3), (4).
339. IRC § 4958(a)(2); Reg. § 53.4958-1(d)(1). The concepts of *willful* and *reasonable cause* are the subject of Reg. § 53.4958-1(d)(5), (6).
340. IRC § 6212.
341. IRC § 4958(f)(5); Reg. § 53.4958-1(c)(2)(ii).
342. IRC § 4958(b); Reg. § 53.4958-1(c)(2)(i).
343. IRC § 4958(d)(1); Reg. § 53.4958-1(c)(1), (d)(8).
344. IRC § 6501; Reg. § 53.4958-1(e)(3).
345. IRC § 4962; Reg. § 53.4958-1(c)(2)(iii).

worse than that in which it would be if the disqualified person were dealing under the highest fiduciary standards.[346] The correction amount with respect to an excess benefit transaction is the sum of the excess benefit and interest (at a rate that at least equals the applicable federal rate, compounded annually) on that benefit; generally, the correction must be made using cash or cash equivalents.[347]

The IRS is of the view that payment of the initial excise tax and compliance with the correction requirement also requires a change in the policies or practices of the organization involved. That is, the IRS also wants some assurance that the infraction or infractions will not be repeated. For example, the then-director of the Exempt Organization Division said that the intent of this law is ''not simply about paying a 25-percent excise tax and then cutting another check back to the charity.'' He added: ''We will want to be assured that there will not be a continuation of the behavior that raised the excise tax in the first place.''[348] If that assurance is not forthcoming, the organization's tax-exempt status may be in jeopardy.[349]

(vii) Reimbursements and Insurance. Any reimbursement by an applicable tax-exempt organization of excise tax liability is treated as an excess benefit transaction itself, unless it is included in the disqualified person's compensation for the year in which the reimbursement is made.[350] The total compensation package, including the amount of any reimbursement, is subject to the requirement of reasonableness. Similarly, the payment by an applicable tax-exempt organization of premiums for an insurance policy providing liability insurance to a disqualified person for excess benefit taxes is an excess benefit transaction itself, unless the amounts of the premiums are treated as part of the compensation paid to the disqualified person and the total compensation, including the premiums, is reasonable.[351]

(viii) Returns for Payment of Excise Taxes. Under the law in existence prior to enactment of the excess benefit transactions rules, charitable organizations and other persons liable for certain excise taxes are required to file

346. IRC § 4958(f)(6); Reg. § 53.4958-7.
347. Reg. § 53.4958-7(c).
348. 12 *Chron. of Philanthropy* (No. 4) 37 (Dec. 2, 1999).
349. In a somewhat parallel situation, the IRS, having threatened to revoke the tax-exempt status of what was then termed the Kamehameha Schools Bernice Pauahi Bishop Estate in Hawaii, in part on the grounds of private inurement, refused to settle the matter with the estate (by entering into a closing agreement (*see* § 35.3) until and unless the trustees of the estate who imperiled the organization's tax exemption either resigned or were removed by the court overseeing the entity's operations (*see* XVII *Nonprofit Couns.* (No. 2) 1 (Feb. 2000)). These individuals were assessed intermediate sanctions penalties; the cases were settled.
350. House Report at 58.
351. *Id.*

returns—Form 4720—by which the taxes due are calculated and reported. These taxes are those imposed on public charities for excessive lobbying expenditures[352] and for political campaign expenditures,[353] and on private foundations and/or other persons for a range of impermissible activities.[354]

Disqualified persons and organization managers liable for payment of an intermediate sanctions excise tax are required to file Form 4720 as the return by which these taxes are paid.[355] In general, returns on Form 4720 for a disqualified person or organization manager liable for an excess benefit transaction tax are required to be filed on or before the 15th day of the fifth month following the close of the tax year of that person.[356]

(ix) Scope of the Sanctions. The intermediate sanctions penalties may be imposed by the IRS in lieu of or in addition to revocation of the tax-exempt status of an applicable tax-exempt organization.[357] In general, these sanctions are to be the sole penalty imposed in cases in which the excess benefit does not rise to such a level as to call into question whether, on the whole, the organization functions as an exempt charitable or social welfare organization.[358]

Revocation of tax-exempt status, with or without the imposition of intermediate sanctions taxes, is to occur only when the applicable tax-exempt organization no longer operates as an exempt charitable or social welfare organization.[359] Preexisting law principles apply in determining whether an applicable tax-exempt organization no longer operates as an exempt organization. For example, the loss of tax-exempt status would occur in a year, or as of a year, the entity was involved in a transaction constituting a substantial amount of private inurement.

A court concluded that ''both a revocation and the imposition of intermediate sanctions will be an unusual case.''[360] In the case, the court declined to permit revocation of tax-exempt status. The exempt entities involved were in a ''dormant state'' during the period involved, they had not ''since the transfers

352. IRC § 4911 or 4912. *See* § 7.1.
353. IRC § 4955. *See* § 7.4.
354. IRC §§ 4940–4948. *See* § 5.9.
355. Reg. § 53.6011-1(b).
356. Reg. § 53.6071-1(f)(1).
357. House Report at 59.
358. The tax regulations state the matter this way: The intermediate sanctions law does not affect the substantive standards for tax exemption for applicable tax-exempt organizations; these entities qualify for exemption only if no part of their net earnings inures to the benefit of insiders (Reg. § 53.4958-8(a)).
359. House Report at 59, note 15. Some versions of the intermediate sanctions rules contained a provision imposing a tax on tax-exempt organizations that terminate their exempt status (a so-called *exit tax*). This tax was not a part of the rules ultimately adopted; in its place is the five-year lookback rule (*see supra* note 250).
360. *Caracci v. Commissioner*, 118 T.C. 379, 417 (2002), *rev'd, on other grounds*, 456 F.3d 444 (5th Cir. 2006).

been operated contrary to their tax-exempt purpose,'' and maintenance of the exemptions may enable them to be involved in the correction process.[361]

(x) Effective Dates. The intermediate sanctions rules generally became effective with respect to excess benefit transactions occurring on or after September 14, 1995.[362] The sanctions do not apply to any benefits arising out of a transaction pursuant to a written contract that was binding on that date and continued in force through the time of the transaction, if the terms of the contract have not materially changed.[363]

(xi) Statute of Limitations. In general, the statute of limitations for assessing an intermediate sanctions excise tax is three years.[364] This statute begins to run on the later of the date the tax-exempt organization filed its annual information return or the due date for the return.[365] A six-year statute of limitations applies if the exempt organization's return omits more than 25 percent of the excise taxes reported on the return; this statute, however, does not apply to tax omitted that has been adequately disclosed in the return.[366]

(xii) Third-Party Summons. The IRS, when investigating the possibility of an excess benefit transaction, may send a summons to the applicable tax-exempt organization involved. In one case, such a third-party summons was sent after the three-year statute of limitations pertaining to the exempt organization had expired; the disqualified person under investigation sought to quash the summons on the basis of expiration of the statute and inapplicability of the six-year statute.

In denying the petition to quash, the court wrote that the disqualified person's argument ''proves inconsequential,'' in that the matter as to which statute of limitations may apply was ''irrelevant'' for purposes of enforcement of the summons.[367] The court relied on a Supreme Court pronouncement, which held that the IRS ''need not meet any standard of probable cause to obtain

361. *Id*. 118 T.C. at 417–418. It may be noted that the reason the exempt organizations were ''dormant'' and not operating contrary to exempt purposes is that they lacked any income or assets, all of which were transferred to entities created and controlled by the disqualified persons. In one instance, the IRS elected to impose the intermediate sanctions rather than revoke a charitable organization's tax-exempt status (Tech. Adv. Mem. 200437040).
362. Act § 1311(d)(1); Reg. § 53.4958-1(f)(1). In one instance, the transactions that gave rise to intermediate sanctions penalties were entered into about two weeks after this effective date (*Caracci v. Commissioner*, 118 T.C. 379 (2002). In another instance, some transactions were held to be protected against these penalties by reason of the effective date (*Dzina v. United States*, 345 F. Supp. 2d 818 (N.D. Ohio 2004)).
363. *Id*. § 1311(d)(2); Reg. § 53.4958-1(f)(2).
364. IRC § 6501(a); Reg. § 53.4958-1(e)(3).
365. IRC § 6501(b)(1), (4).
366. IRC § 6501(e)(3).
367. *Lintzenich v. United States*, 371 F. Supp. 2d 972, 975, 976 (S.D. Ind. 2005).

enforcement'' of a third-party summons, either before or after the three-year statute of limitations expired, but ''must show that the investigation will be conducted pursuant to a legitimate purpose, that the inquiry may be relevant to the purpose, that the information sought is not already within the [IRS's] possession, and that the administrative steps required by the [Internal Revenue] Code have been followed.''[368] The Court stated that the ''burden of showing an abuse of the court's process is on the taxpayer, and it is not met by a mere showing . . . that the statute of limitations for ordinary deficiencies has run.''[369]

Thus, it appears that the IRS can issue a summons to an applicable tax-exempt organization, seeking information about a possible excess benefit transaction, any time it wishes, as long as there is compliance with the Supreme Court criteria. This is not the same as proceeding directly against a disqualified person, but, presumably, this opinion means that the IRS can use information gained from its investigation of the exempt organization to assess one or more intermediate sanctions taxes even if the statute of limitations involving the disqualified person has run. Otherwise, granting enforcement of the IRS summons would be pointless.

(xiii) Interrelationship of Doctrines. The coming months and years will bring interpretations and amplification of the intermediate sanctions rules, with emphasis on what does and does not constitute an excess benefit transaction and whether a compensation package or a value assigned to property or its use is reasonable. At least in the short term, this process will draw heavily on existing law as shaped by the private inurement doctrine. Likewise, the application of the intermediate sanctions area will also meaningfully inform the substance and boundaries of the doctrines of private inurement and private benefit. Thus a development in one of these three bodies of law is likely to directly affect the development of the other two. The intermediate sanctions rules probably will be invoked more frequently than revocation of tax-exempt status by application of the private inurement doctrine to public charities and social welfare organizations.

The law concerning self-dealing in the private foundation context[370] also will be heavily interrelated with the intermediate sanctions rules. The very structure of these rules is, in many ways, patterned after the foundation rules. Of greater substance, however, is that a significant amount of the private foundation self-dealing law is directly usable in discerning the contours of the intermediate sanctions law. Likewise, a development in the intermediate sanctions area is likely to be applicable in the private foundation context.

Thus, as the years unfold, the law of tax-exempt organizations is going to be enriched by the process and outcomes resulting from the interrelationships and

368. *United States v. Powell*, 379 U.S. 48, 58 (1964).
369. *Id*. A federal court of appeals observed that ''[t]his isn't much of a hurdle'' (2121 *Arlington Heights Corp. v. Internal Revenue Service*, 109 F.3d 1221, 1224 (7th Cir. 1997)).
370. *See* § 5.9.

fertilization of the intermediate sanctions, private inurement, private benefit, and self-dealing rules.

Proposed regulations issued by the IRS[371] provide that, in determining whether to continue to recognize the tax exemption of a charitable entity that engages in an excess benefit transaction that violates the private inurement doctrine, the IRS will consider all relevant facts and circumstances, including (1) the size and scope of the organization's regular and ongoing activities that further exempt purposes before and after one or more excess benefit transactions occurred, (2) the size and scope of one or more excess benefit transactions in relation to the size and scope of the organization's regular and ongoing exempt functions, (3) whether the organization has been involved in repeated excess benefit transactions, (4) whether the organization has implemented safeguards that are reasonably calculated to prevent future violations, and (5) whether the excess benefit transaction has been corrected or the organization has made good-faith efforts to seek correction from the disqualified person or persons who benefited from the excess benefit transaction.[372]

The fourth and fifth of these factors "weigh more strongly" in favor of continuing exemption where the organization has discovered the excess benefit transaction and takes corrective action before the IRS learns of the matter. Correction of an excess benefit transaction, after the IRS discovers it, by itself, is, according to the proposal, never a sufficient basis for continuing recognition of exemption.[373]

An example concerns a newly created art museum (public charity) that, in its first two years, engaged in fundraising and preparation of its facilities. In its third year, a new board of trustees, consisting of local art dealers, was elected. Thereafter, the organization uses almost all of its funds to purchase art from its trustees at excessive prices. This organization exhibits and offers for sale all of the purchased art. The purchasing of art from its trustees was not disclosed in the organization's application for recognition of exemption. These transactions violate the private inurement doctrine and are excess benefit transactions. The above factors dictate that this museum is no longer tax-exempt, effective as of the third year.[374]

Continuing with this illustration, in the fourth year, the entire museum board resigns and is replaced by members of the community who have experience operating educational institutions. The museum discontinues the selling of exhibited art, ceases to purchase art from its trustees, adopts a conflict-of-interest policy, adopts art valuation guidelines, retains the services of a lawyer to recover the excess payments to the former trustees, and implements a program of educational activities. Even though the payments

371. REG-111257-05.
372. Prop. Reg. § 1.501(c)(3)-1(g)(2)(ii).
373. Prop. Reg. § 1.501(c)(3)-1(g)(2)(iii).
374. Prop. Reg. § 1.501(c)(3)-1(g)(2)(iv), Example 1.

were excess benefit transactions and private inurement, this implementation of safeguards and efforts to pursue correction enables the museum to remain exempt.[375]

As another example, a public charity conducts educational programs for the benefit of the public. In its fifth year, the organization's chief executive officer (CEO) begins causing the entity to divert substantial funds to the executive for personal use. The organization's board of directors did not authorize this practice, although some board members were aware of these diversions. The CEO claimed, despite a lack of documentation and no repayment amounts, that the diverted funds were loans. These diversions of funds were excess benefit transactions and private inurement. By application of the factors, this organization's tax exemption was lost in its fifth year.[376]

In a third example, the CEO of a public charity contracts with a for-profit company to construct an addition to the organization's building; this is a significant undertaking for the entity. The company, owned by the CEO, is paid an excessive amount for its work. At the time, the organization's board did not perform due diligence that would have made it aware of the excess payments. Thereafter (and before the IRS examination), the board concludes that the payments were excessive, fires the CEO, adopts a conflict-of-interest policy, adopts contract review procedures, and hires a lawyer to recover the excess payment amounts. Even though the payment to the company was private inurement and an excess benefit transaction, this organization continues to be tax-exempt.[377]

Another example concerns a large public charity that, during a year, paid $2,500 of the personal expenses of its chief financial officer. These payments constitute an automatic excess benefit transaction and private inurement. Inasmuch as only a *de minimis* portion of the organization's revenues were so diverted, this organization's tax exemption is not disturbed.[378]

(b) Healthcare Intermediate Sanctions Case

The intermediate sanctions rules are likely to be the subject of considerable litigation in the coming years. Not surprisingly, the first set of these court cases involved tax-exempt healthcare entities. In this instance, eight petitions were filed with the U.S. Tax Court on November 15, 1999, contesting the intermediate sanctions penalties that were levied.[379] The excise taxes assessed

375. *Id.*, Example 2.
376. *Id.*, Example 3.
377. *Id.*, Example 4.
378. *Id.*, Example 5. In general, Green, ''Effective Corporate Governance Requires Building an Effective Intermediate Sanctions Compliance Process,'' 41 *Exempt Org. Tax Rev.* (No. 1) 41 (July 2003).
379. These petitions included *Sta-Home Health Agency of Carthage, Inc. v. Commissioner* (Docket No. 17333-99); *Sta-Home Agency of Greenwood, Inc. v. Commissioner* (Docket No. 17334-99);

totaled about $240 million: $200 million on individuals and $40 million on corporations.

These cases concerned the transfer of the assets of three tax-exempt home healthcare agencies,[380] which are applicable tax-exempt organizations,[381] to three for-profit (Subchapter S) corporations. The transfers were effected by family members who own the agencies, in response to an anticipated change from a Medicare cost reimbursement system to a prospective payment system. (A transfer of an asset from a tax-exempt organization to an insider is not an uncommon practice.[382])

The for-profit corporations were disqualified persons[383] with respect to the tax-exempt organizations, as were the individuals who are members of the family involved. The individuals all were in a position to exercise substantial influence over the affairs of the charitable organizations. Collectively, these individuals owned all of the stock of the for-profit corporations. The IRS asserted that these transactions were excess benefit transactions.[384] The agreements of transfer were dated September 19, 1995, with an effective date of October 1, 1995.[385]

The heart of this dispute was the value of the transferred assets, in relation to the requirement that the value be reasonable. The disqualified persons took the view that the for-profit corporations assumed substantial liabilities; the assets were valued at minus amounts. The IRS, by contrast, asserted that the assets were worth millions of dollars. None of the disqualified persons made any attempt to correct the transactions.[386] Thus, the IRS assessed both the first-tier 25 percent tax and the second-tier 200 percent tax.[387]

The Court, in an extensive valuation analysis, concluded that the fair market value of the transferred assets was $18.7 million, that the assumed liabilities were $13.5 million, and thus that the net value of these assets was $5.2 million. The value of the exempt organizations' transferred assets, in the words of the court, ''far exceeded'' the consideration paid by the for-profit entities.[388]

Each of the disqualified persons was held to be jointly and severally liable for the initial and additional intermediate sanctions penalties. These transactions have not been corrected. The court did not decide the matter of abatement.

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and *Sta-Home Health Agency of Jackson, Inc. v. Commissioner* (Docket No. 342-99). The court opinion reflecting these petitions is *Caracci v. Commissioner*, 118 T.C. 379 (2002), *rev'd*, 456 F.3d 444 (5th Cir. 2006).

380. *See* § 10.1.
381. *See* § 4.9(a)(i).
382. E.g., *Anclote Psychiatric Center, Inc. v. Commissioner*, 76 T.C. 175 (1998). *See* § 4.4(g).
383. *See* § 4.9(a)(ii).
384. *See* § 4.9(a)(iii).
385. The effective date of the intermediate sanctions rules is September 14, 1995 (*see* § 4.9(a)(x)).
386. *See* § 4.9(a)(vi).
387. *See* § 4.9(a)(v).
388. *Caracci v. Commissioner*, 118 T.C. 379, 415 (2002).

The court elected not to revoke the tax-exempt status of the ''dormant'' healthcare entities.[389] The court observed that the correction process may require a transfer of the assets back to the exempt organizations. It was noted that, if the exempt status of these entities was to be revoked at this stage, they would not be able to receive the assets.

A federal court of appeals, blasting the IRS and the trial court for a ''cascade'' of legal and factual errors, reversed the lower court and threw out the case.[390] The deficiency notices issued by the IRS in this case were found to be inherently defective; at trial, the IRS conceded that the notices were ''excessive and erroneous.''[391] The trial court mistakenly failed to shift the burden of proof to the government, to prove the correct amount of any taxes owed. The trial court also, having rejected most of the testimony provided by the IRS's expert witness as to asset value, also erroneously failed to rule against the government. The lower court compounded its mistakes by making a ''number of errors in the valuation method it selected and in the facts it found in selecting and applying that method.''[392] Because the IRS could not meet its burden of proof, the trial court's judgment was reversed and judgment was rendered in favor of the petitioners. Thus, what started out as a potentially significant healthcare intermediate sanctions case fizzled; the case turned and (from the government's standpoint) flopped in the face of the factual and procedural errors that occurred prior to and during the trial.

389. *Id*. at 417.
390. *Caracci v. Commissioner*, 456 F.3d 444, 456 (5th Cir. 2006).
391. *Id*. at 457.
392. *Id*. at 458.

CHAPTER FIVE

Public Charities and Private Foundations

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Nearly all tax-exempt healthcare provider organizations are *public charities*. This federal tax law classification is expressly provided by statute for *hospitals*[1] and for *medical research organizations*.[2] Most other healthcare organizations are public charities because they are *publicly supported*.[3] Some are *supporting organizations*.[4] A few are *private foundations*.[5] Some tax-exempt organizations

1. IRC § 170(b)(1)(A)(iii). *See* § 5.1(a).
2. IRC § 170(b)(1)(A)(iii). *See* § 5.1(b).
3. *See* §§ 5.2–5.4.
4. *See* § 5.5.
5. *See* text accompanied by *infra* notes 8–11.

in the healthcare field, such as social welfare organizations[6] and business leagues,[7] are not charitable organizations and thus are not concerned with the distinctions between public charities and private foundations.

Under the federal tax law, a private foundation is any domestic or foreign charitable organization[8] that does not qualify in one of four categories of organizations (itemized below).[9] This body of law (1) includes a presumption that every tax-exempt charitable organization is a private foundation (a status to be avoided whenever possible[10]) and (2) places on the charitable organization the burden of demonstrating (if it can) that it is not a private foundation.

Despite the technicalities of the term *private foundation,* this type of organization essentially is a charitable organization that is funded from one source (usually an individual, family, or corporation), receives its ongoing funding from investment income (rather than a consistent flow of charitable contributions), and makes grants for charitable purposes to other persons rather than conducts its own programs. (In most instances, a private foundation functions much like an endowment fund.) The aspect of a private foundation embraced by the word *private* thus principally involves the nature of its financial support.

There are, in essence, three types of charitable organizations, relative to the field of healthcare, that are *not* private foundations:

1. The *public institutions*

2. The two types of *publicly supported organizations*

3. The *supporting organizations*[11]

§ 5.1 PUBLIC INSTITUTIONS

The federal tax law recognizes certain charitable institutions as not being private foundations.[12] These *public institutions* are entities that are not private foundations by reason of the nature of their exempt functions (rather than by reason of how they are funded[13] or their relationships with other tax-exempt charitable organizations[14]).

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6. *See* § 1.8.
7. *See* Chapter 18.
8. That is, an organization described in IRC § 501(c)(3) and exempt from federal income taxation under IRC § 501(a) by reason of that classification.
9. Reg. §§ 1.509(d)-(1) and 1.509(e)-1. This body of law is the subject of IRC § 509(a); the *public charities* that involve healthcare organizations are those described in IRC § 509(a)(1), (2), or (3). *See*, in general, Private Foundations, particularly Chapter 15.
10. *See* § 5.9.
11. Another category that is not a private foundation, but is irrelevant in the healthcare context, is the charitable organization that tests for public safety (IRC § 509(a)(4)).
12. IRC § 170(b)(1)(A)(i)-(v).
13. *See* §§ 5.2 and 5.3.
14. *See* § 5.5.

Among these public institutions are nonprofit hospitals, many other types of healthcare organizations, and medical research organizations. This category of nonprivate foundations also includes churches, conventions of churches, and associations of churches[15]; schools, colleges, and universities[16]; supporting organizations for governmentally operated colleges and universities[17]; and governmental units.[18]

(a) Healthcare Provider Organizations

The federal tax law extends public charity status to an ''organization the principal purpose or functions of which are the providing of medical or hospital care or medical education or medical research, if the organization is a hospital.''[19]

The general criteria for a tax-exempt hospital are discussed elsewhere.[20] For public charity classification purposes, the term *hospital* includes hospitals operated by the federal government; hospitals that are instrumentalities of state, county, and municipal governmental units; rehabilitation institutions; outpatient clinics; extended care facilities; community mental health or drug treatment centers; and cooperative hospital service organizations.[21] The term, however, does not include convalescent homes, homes for children or the aged, or institutions the principal purpose or function of which is to train handicapped individuals to pursue a vocation.[22] It also does not include free clinics for animals.[23]

For these purposes, the term *medical care* includes the treatment of any physical or mental disability or condition, whether on an inpatient or outpatient basis, as long as the cost of the treatment is deductible[24] by the individual who is treated.[25]

(b) Medical Research Organizations

An organization that is a ''medical research organization directly engaged in the continuous active conduct of medical research in conjunction with a

15. IRC § 170(b)(1)(A)(i).
16. IRC § 170(b)(1)(A)(ii).
17. IRC § 170(b)(1)(A)(iv).
18. IRC § 170(b)(1)(A)(v).
19. IRC § 170(b)(1)(A)(iii); Reg. § 1.170A-9(c)(1).
20. *See* § 8.1.
21. Reg. § 1.170A-9(c)(1). These and other exempt charitable entities are discussed in Chapters 18–12 and Chapter 20.
22. Reg. § 1.170A-9(c)(1).
23. Rev. Rul. 74-572, 1974-2 C.B. 82.
24. IRC § 213. This rule means expenses that are generally deductible, that is, without regard to the 7.5 percent floor on these deductions (IRC § 213(a)) or the overall limitation on itemized deductions (IRC § 68).
25. Reg. § 1.170A-9(c)(1).

hospital'' is a public charity.[26] The term *medical research* means the conduct of investigations, experiments, and studies to discover, develop, or verify knowledge relating to the causes, diagnosis, treatment, prevention, or control of physical or mental diseases and impairments of human beings.[27] Medical research encompasses the associated disciplines spanning the biological, social, and behavioral sciences.[28] To qualify, the organization must have, or have continuously available for its regular use, the appropriate equipment and professional personnel necessary to carry out its principal function.[29]

To be a public charity under these rules, an organization must have the conduct of medical research as its principal purpose or function[30] and must be primarily engaged directly in the continuous active conduct of medical research.[31] To meet this test, the organization must either devote a *substantial portion* of its assets to, or expend a *significant percentage* of its endowment for, these purposes—or both.[32] This is a *facts-and-circumstances test*.[33] An organization that, during the applicable computation period,[34] devoted more than one-half of its assets to the continuous active conduct of medical research is considered to meet the substantial portion requirement.[35] An organization that, during the appropriate computation period, expended funds equaling 3.5 percent or more of the fair market value of its endowment for the continuous active conduct of medical research is considered to meet the significant percentage requirement.[36] Engaging directly in the continuous active conduct of medical research does not include the disbursement of funds to other organizations for the conduct of research by them or the extending of grants or scholarships to others.[37]

This type of medical research organization must function *in conjunction with* a hospital.[38] The organization need not be formally affiliated with a hospital to

26. IRC § 170(b)(1)(A)(iii); Reg. § 1.170A-9(c)(2)(i).
27. Reg. § 1.70A-9(c)(2)(iii).
28. *Id*. These disciplines include chemistry (such as biochemistry, physical chemistry, and bio-organic chemistry), behavioral sciences (such as psychiatry, physiological psychology, neurophysiology, neurology, neurobiology, and social psychology), biomedical engineering (applied biophysics, medical physics, and medical electronics, e.g., developing pacemakers and other medically related electrical equipment), virology, immunology, biophysics, cell biology, molecular biology, pharmacology, toxicology, genetics, pathology, physiology, microbiology, parasitology, endocrinology, bacteriology, and epidemiology (*id*.).
29. *Id*.
30. Reg. § 1.170A-9(c)(2)(iv).
31. Reg. § 1.170A-9(c)(2)(v)(a).
32. *Id*.
33. *Id*. Some of the facts and circumstances to be considered are listed in Reg. § 1.170A-9(c)(2)(v)(a)(1)-(4).
34. Reg. § 1.170A-9(c)(2)(vi)(a).
35. Reg. § 1.170A-9(c)(2)(v)(b).
36. *Id*.
37. Reg. § 1.170A-9(c)(2)(v)(c).
38. IRC § 170(b)(1)(A)(iii); Reg. § 1.170A-9(c)(2)(i), (ii)(b).

be considered primarily engaged in the active conduct of medical research in conjunction with a hospital.[39] There must, however, be a joint effort on the part of the research organization and the hospital pursuant to an understanding that the two organizations will maintain continuing close cooperation in the active conduct of medical research.[40] For example, the necessary joint effort is normally found to exist if the activities of the medical research organization are carried on in space located within or adjacent to a hospital, the organization is permitted to utilize the facilities (including equipment and case studies) of the hospital on a continuing basis directly in the active conduct of medical research, and there is substantial evidence of the close cooperation of the members of the staff of the research organization and the members of the staff of the particular hospital or hospitals.[41]

§ 5.2 PUBLICLY SUPPORTED ORGANIZATIONS—DONATIVE ENTITIES

Most tax-exempt charitable organizations that achieve classification as public charitable organizations do so because they are *publicly supported*. A publicly supported charity is the antithesis of a private foundation: the latter basically derives its financial support from one source, while the publicly supported organization is, as the term reflects, primarily supported by the *public*. The law in this area concerns the definition of *public support,* including the process by which the requisite public support is determined.

There are essentially two ways by which a charitable organization can be publicly supported for federal tax law purposes. One way (the subject of this section) is to be an organization that is substantially supported by a range of contributions and grants; this is the *donative* publicly supported charity.[42] The other way is to be an organization that is primarily supported by an appropriate combination of fee-for-service (exempt function) revenue, gifts, and grants—the *service provider* charitable organization.[43]

Thus, the federal tax law contains two definitions of a publicly supported charitable organization. Although there are substantive differences between

39. Reg. § 1.170A-9(c)(2)(vii).
40. *Id*.
41. *Id*. This regulation adds: ''The active participation in medical research by members of the staff of the particular hospital or hospitals will be considered to be evidence of such close cooperation. Because medical research may involve substantial investigation, experimentation and study not immediately connected with hospital or medical care, the requisite joint effort will also normally be found to exist if there is an established relationship between the research organization and the hospital which provides that the cooperation of appropriate personnel and the use of facilities of the particular hospital or hospitals will be required whenever it would aid such research.''
42. IRC §§ 170(b)(1)(A)(vi) and 509(a)(1).
43. IRC § 509(a)(2). *See* § 5.3.

the two sets of rules, many charitable organizations are able to satisfy the requirements of both of them.[44]

(a) General Rules

An organization is a publicly supported organization if it is a charitable entity[45] that ''normally receives a substantial part of its support'' (other than income from the performance of an exempt function) from a governmental unit[46] or from direct or indirect contributions from the general public.[47]

Organizations that qualify as donative publicly supported charitable organizations generally are entities such as museums, libraries, arts promotion organizations, symphony orchestras, ballet organizations, the American Red Cross, and the United Givers Fund.[48] In the healthcare setting, publicly supported *foundations* that function as fundraising vehicles for hospitals and other healthcare provider entities[49] often are donative charitable organizations.

The principal way for an organization to be a publicly supported organization under these rules is for it to normally derive at least one-third of its financial support from qualifying contributions and grants.[50] Thus, an organization qualifying as a publicly supported entity under these rules must maintain a support fraction, the numerator of which is the amount of eligible public support received during the appropriate computation period[51] and the denominator of which is total eligible support for the period. The cash receipts and disbursement method of accounting[52] is used in determining the nature of an organization's support under these rules.[53]

In general, contributions and grants from individuals, trusts, corporations, and other for-profit and nonprofit organizations constitute public support to the extent that the total amount of support from a source during the computation period does not exceed an amount equal to 2 percent of the

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44. The *donative* type of publicly supported organization is generally perceived as preferred over the service provider type. For example, only a charitable entity that satisfies the requirements of the donative organization rules (or the rules pertaining to public institutions (*supra* § 5.1)) is able to maintain a pooled income fund (IRC § 642(c)(5)(A)). (The requirements as to pooled income funds in general are summarized in CHARITABLE GIVING, Chapter 13.) The donative category includes an organization that is formally classified as a service provider entity but nonetheless meets the public support test of the donative entity rules (e.g., Reg. § 1.642(c)-5(a)(5)(iv)). As to the service provider category, an organization that qualifies as a public institution may nonetheless also qualify as a donative publicly supported organization (Rev. Rul. 76-416, 1976-2 C.B. 57).
45. That is, an organization described in IRC § 170(c)(2).
46. That is, an entity described in IRC § 170(c)(1).
47. IRC § 170(b)(1)(A)(vi); Reg. § 1.170A-9(e)(1).
48. Reg. § 1.170A-9(e)(1).
49. *See* Chapter 17.
50. Reg. § 1.170A-9(e)(2).
51. *See* text accompanied by *infra* notes 73–76.
52. IRC § 446(c)(1).
53. Gen. Couns. Mem. 39109.

organization's total includable support for the period.[54] If a donor or grantor provides an amount that is in excess of the 2 percent limitation, the portion that does not exceed the limitation qualifies as public support.[55] Therefore, the total amount determined by application of the 2 percent limitation is included in the numerator of the support fraction and the total amount of support provided by donors and grantors (plus investment income and certain other items[56]) is included in full in the denominator of the support fraction.[57]

There are a variety of refinements to these rules. Donors and grantors who stand in a defined relationship to one another (such as spouses[58]) must be considered as one source, for purposes of computing the 2 percent limitation amount.[59] Support from most donors and grantors is received in the form of *direct* contributions from the general public. Support received as grants from other donative publicly supported organizations and governmental units is support in the form of *indirect* contributions from the general public (in that these grantors are considered conduits of direct public support).

Support in the form of grants from donative publicly supported organizations and governmental units is, in its entirety, public support (it is not limited by the 2 percent limitation rule).[60] Because a charitable entity can be classified as an organization other than a private foundation pursuant to a categorization other than as a donative publicly supported organization, and nonetheless meet the donative organization public support requirements,[61] the 2 percent limitation also generally does not apply to this type of support. For example, the 2 percent limitation does not apply to support received by a donative publicly supported organization from a church (one of the public institutions) because, ''[i]n general, churches derive substantial amounts of their support from the general public'' and, therefore, grants from a church are considered forms of public support.[62] Assistance from a foreign government may be considered public support without limitation in determining an organization's qualifications as a donative publicly supported entity.[63] By contrast, the 2 percent limitation is applicable to amounts received from a supporting organization.[64]

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54. Reg. § 1.170A-9(e)(6)(i). E.g., Rev. Rul. 77-255, 1977-2 C.B. 74 (holding that a grant from a business league (see Chapter 18) is subject to the 2 percent limitation).
55. *Id*.
56. Reg. § 1.170A-9(e)(7)(i). As to these other items, see the text accompanied by *infra* notes 67–69.
57. Reg. § 1.170A-9(e)(6)(i).
58. IRC § 4946(a)(1).
59. Reg. § 1.170A-9(e)(6)(i).
60. *Id*.
61. *See* text accompanying *supra* note 44.
62. Rev. Rul. 78-95, 1978-1 C.B. 71.
63. Rev. Rul. 75-435, 1975-2 C.B. 215.
64. Priv. Ltr. Rul. 9203040. The supporting organization requirements are the subject of § 5.5.

Nonetheless, the 2 percent limitation applies with respect to grant support from a donative publicly supported charitable organization or a governmental unit if the support represents an amount that was expressly or impliedly earmarked by a donor or grantor to the donative entity or unit of government as being for or for the benefit of the organization that is asserting status as a publicly supported charitable organization.[65] To the extent they are treated as contributions to the organization under the law concerning the charitable contribution deduction, earmarked contributions constitute support of the intermediary organization under these rules, except where the intermediary organization receives the grants or contributions as the agent for the grantor or contributor and delivers them to the ultimate recipient.[66]

The term *support* means amounts received as gifts, grants, contributions, net income from unrelated business activities, and gross investment income.[67] The term also includes tax revenues levied for the benefit of the organization and either paid to or expended on behalf of the organization, and the value of services or facilities (exclusive of services or facilities generally furnished to the public without charge) furnished by a unit of a government to the organization without charge.[68] All of these items are amounts that, if received by the organization, comprise the denominator of the support fraction. The term *support* does not include any gain from the disposition of property that would be considered gain from the sale or exchange of a capital asset, or the value of exemption from any federal, state, or local tax or any similar benefit.[69]

In constructing the support fraction, an organization must (in attempting to comply with these rules) exclude from both the numerator and the denominator of the fraction (1) amounts received as exempt function revenue (that is, amounts received from the exercise or performance of its exempt purpose or function) and (2) contributions of services for which a charitable contribution deduction is not allowable.[70] An organization will not be treated as meeting this support test, however, if it receives almost all of its support from gross receipts from related activities and an insignificant amount of its support directly or indirectly from the general public.[71] Also, the organization may exclude from both the numerator and the denominator of the support fraction an amount equal to one or more *unusual grants*.[72]

Computation of the support fraction requires a review of the support of the charitable organization that was *normally* received. This means that the

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65. Reg. § 1.170A-9(e)(6)(v).
66. Gen. Couns. Mem. 39748.
67. IRC § 509(d); Reg. § 1.170A-9(e)(7)(i).
68. *Id*.
69. IRC § 509(d).
70. Reg. § 1.170A-9(e)(7)(i).
71. Reg. § 1.170A-9(e)(7)(ii).
72. Reg. § 1.170A-9(e)(6)(ii) and (iii). E.g., Rev. Rul. 76-440, 1976-2 C.B. 58.

organization must meet the one-third support test for a multi-year period immediately preceding the year involved, on an aggregate basis. In computing public support under these rules, the IRS has traditionally used a four-year measuring period. Beginning with the 2008 tax year, however, the measuring period is the organization's most recent five years.[73] Where this is done, the organization is considered as meeting the one-third support test for its current tax year and for the tax year immediately succeeding its current tax year.[74] For example, if an organization's current tax year is calendar year 2009, the computation period for measuring public support pursuant to these rules is calendar years 2004–2008[75]; if the support fraction requirement is satisfied on the basis of the support received over this five-year period, the organization satisfies this support test for 2009 and 2010. (A five-year period for meeting this support test is available for organizations during the initial years of their existence.[76])

Several issues can arise in computing the public support component (the numerator) of the support fraction for donative publicly supported organizations. These issues include whether (1) an item of financial support is a contribution, grant, or form of exempt function revenue (such as a membership fee)[77]; (2) a grant is from a donative or otherwise qualifying publicly supported charity (for purposes of determining whether the 2 percent limitation should be applied); (3) a grant from a donative publicly supported charity or governmental unit is a pass-through transfer from a donor or another grantor; (4) support from a governmental unit is in the form of a grant or contract (the latter being exempt function revenue),[78] or (5) an organization is primarily dependent on gross receipts from related activities (and thus is unable to rely on the donative publicly supported charity rules).[79] As to the first issue, the financial support of a home for the aged is illustrative. Two courts have held that funds provided to a home for the aged as a condition of admission are forms of exempt function revenue, rather than contributions.[80]

The fourth issue is well illustrated in the healthcare context. One of the rules in this setting is that an amount paid by a governmental unit to a charitable organization is not regarded as received from the exercise or performance of its tax-exempt functions (that is, the amount is not exempt function revenue and thus can qualify as grant support) if the purpose of the payment is primarily

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73. This change was made in the context of the redesign by the IRS of the Form 990. See § 35.3; TAX-EXEMPT ORGANIZATIONS § 27.2A (2008 supplement).
74. Reg. § 1.170A-9(e)(4)(i).
75. See Form 990 (2008), Schedule A, Part II.
76. *See* § 34.3.
77. Reg. § 1.170A-9(e)(7)(iii).
78. Reg. § 1.170A-9(e)(8).
79. Reg. § 1.170A-9(e)(7)(ii).
80. *Williams Home, Inc. v. United States*, 540 F. Supp. 310 (W.D. Va. 1982); *The Home for Aged Men v. United States*, 80-2 U.S.T.C. (CCH) ¶ 9711 (N.D. W.Va. 1980), *aff'd unrep. dec.* (4th Cir. 1991).

to enable the organization to provide a service to the direct benefit of the public rather than to serve the direct and immediate needs of the payor.[81] In application of this rule, the IRS determined that payments by the U.S. Department of Health and Human Services to a professional standards review organization are not a form of exempt function revenue but are, instead, grant support, because the payments compensate the professional standards review organization for a function that promotes the health of the beneficiaries of government healthcare programs in the areas in which the organization operates, thus enabling the organization to be classified as a donative publicly supported organization.[82] By contrast, Medicare and Medicaid payments to tax-exempt healthcare organizations were ruled by the IRS to constitute exempt function revenue, and thus not public support as grants, because the patients control the ultimate recipients of the payments through their choice of a healthcare provider. The patients, rather than the governmental units, are the payors.[83]

(b) Facts-and-Circumstances Test

An alternative to the above general rules is the facts-and-circumstances test. This test may be met as long as the amount of support normally received from public sources is *substantial*.[84] This body of law is infrequently utilized in the healthcare setting because nearly all healthcare entities can achieve public charity status by other, easier means. Museums and libraries (usually heavily endowed) tend to rely on this test.

To meet this test, an organization must demonstrate the existence of three elements: (1) the total amount of public (including governmental) support normally received by the organization is at least 10 percent of the total support it normally receives; (2) the organization has a continuous and bona fide program for solicitation of funds from the general public, units of government, or public charities; and (3) all other facts and circumstances are pertinent, including the percentage of its support from public sources, the ‘‘public’’ nature of the organization’s governing board, the extent to which its facilities or programs are available to the public, its membership dues rates, and whether its activities are likely to appeal to persons having some broad common interest or purpose.[85] (The higher the percentage of support from public sources, the lesser the burden of establishing the publicly supported nature of the organization through the other factors; the converse is also the rule.)

81. Reg. § 1.170A-9(e)(8)(ii).
82. Rev. Rul. 81-276, 1981-2 C.B. 128.
83. Rev. Rul. 83-153, 1983-2 C.B. 48.
84. Reg. § 1.170A-9(e)(3).
85. *Id*.

As to the governing board factor, the organization's nonprivate foundation status will be enhanced where it has a governing body that represents the interests of the public, rather than the personal or private interests of a limited number of donors. This can be accomplished by electing board members by vote of a broadly based membership, or by having a board composed of public officials, individuals having particular expertise in the field or discipline involved, community leaders, and the like.

As noted, one of the important elements of the facts-and-circumstances test is the availability of facilities or services for the public. Examples of entities meeting this requirement are a museum that holds its building open to the general public, a symphony orchestra that gives public performances, a conservation organization that provides services to the public through the distribution of educational materials, and a home for the aged that provides domiciliary or nursing services for members of the general public.

(c) Community Foundations

There are special rules by which a community foundation can qualify as a donative publicly supported charitable organization. Although a community foundation is not a healthcare entity, it can be a source of funding for one.

A community trust or foundation can be a donative entity if it attracts, receives, and depends on financial support from members of the general public on a regular, recurring basis. Community foundations are designed primarily to attract large contributions of a capital or endowment nature from a small number of donors, with the gifts often received and maintained in the form of separate trusts or funds. The contributions are generally identified with a particular community and are controlled by a representative group of persons from that community. Individual donors relinquish control over the investment and distribution of their contributions and the income generated from them, although donors may designate the purposes for which the assets are to be used, subject to change by the governing body of the community trust.[86]

To qualify as a publicly supported organization, a community foundation must meet the support requirements of the general donative organization rules[87] or the facts-and-circumstances test for donative charitable entities.[88] As to the latter, the requirement of attraction of public support will generally be satisfied if a community foundation seeks gifts and bequests from a wide range of potential donors in the community served, through banks or trust companies, through lawyers or other professionals, or in other appropriate ways that call attention to the community foundation as a potential recipient

86. Reg. § 1.170A-9(e)(10).
87. *See* § 5.2(a).
88. *See* § 5.2(b).

of contributions and bequests made for the benefit of the community. A community foundation is not required to engage in periodic communitywide fundraising campaigns directed toward attracting a large number of small contributions in a manner similar to campaigns conducted by a community chest or united fund.[89]

A community foundation wants to be treated as a single entity, rather than as an aggregation of funds. To be regarded as a component part of a community foundation, a trust or fund must be created by gift or like transfer to a community foundation that is treated as a separate entity and may not be subjected by the transferor to any material restriction with respect to the transferred assets.[90] To be treated as a separate entity, a community foundation must be appropriately named, be so structured as to subject its funds to a common governing instrument, have a common governing body, and prepare periodic financial reports that treat all funds held by the community foundation as its own.[91] The governing body of a community foundation must (1) have the power to modify any restriction on the distribution of funds where it is inconsistent with the needs of the community, (2) commit itself to the exercise of its powers in the best interests of the community foundation, and (3) commit itself to seeing that the funds are invested pursuant to accepted standards of fiduciary conduct.[92]

§ 5.3 PUBLICLY SUPPORTED ORGANIZATIONS— SERVICE PROVIDER ORGANIZATIONS

An organization is not a private foundation if it is a charitable entity that is broadly, publicly supported and thus responsive to the general public rather than to the private interests of a limited number of donors or other persons.[93] Under these rules, eligible public support can be derived from a blend of contributions, grants, and/or revenue from the provision of a service or good (also known as exempt function revenue). In the healthcare setting, publicly supported service provider organizations include homes for the aged[94] and various clinics, treatment centers, and other ambulatory care providers.[95] (Hospitals and similar healthcare providers, being funded principally by fee-for-service revenue, would be classified as public charities under these rules, were it not for a specific provision for them as entities other than private foundations.[96])

89. Reg. § 1.170A-9(e)(10).
90. Reg. § 1.170A-9(e)(11)(ii).
91. Reg. § 1.170A-9(e)(11)(iii)-(vi).
92. Reg. § 1.170A-9(e)(11)(v).
93. IRC § 509(a)(2); Reg. § 1.509(a)-3(a)(4).
94. *See* Chapter 11.
95. *See* Chapter 12.
96. *See* § 5.1, text accompanied by *supra* notes 19–41.

(a) Public Support Test

For a charitable organization to achieve nonprivate foundation status as a service provider publicly supported entity, it must normally receive more than one-third of its support from any combination of (1) gifts, grants, contributions, or membership fees,[97] and (2) gross receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities in activities related to its tax-exempt purpose,[98] subject to certain limitations.[99] The support in either category must be from *permitted sources*. Thus, an organization seeking to qualify under this one-third support test must construct a *support fraction,* with the amount of support received from these two sources constituting the numerator of the fraction, and the total amount of support received, the denominator.[100]

Permitted sources are units of government,[101] certain public institutions,[102] donative publicly supported charitable organizations,[103] and other persons (other than disqualified persons[104] with respect to the organization). The latter category of entities is subject to certain limitations.[105] Thus, with one exception,[106] support (other than from disqualified persons) from another service provider publicly supported entity, a supporting organization,[107] any other tax-exempt organization (other than governmental units, public institutions, and donative publicly supported organizations), a for-profit organization, or an individual constitutes public support for the service provider publicly supported organization, albeit confined by these limitations. The cash receipts and disbursement method of accounting[108] is utilized to determine the nature of an organization's support under these rules.[109]

The term *support* means (in addition to the two categories of public support referenced above[110]) (1) net income from unrelated business activities,[111] (2) gross investment income,[112] (3) tax revenue levied for the benefit of the organization and either paid to or expended on behalf of the organization, and

97. IRC § 509(a)(2)(A)(i).
98. IRC § 509(a)(2)(A)(ii). Revenue derived from the sale of pickle cards (a form of gambling) is not public support (*Education Athletic Association v. Commissioner*, 77 T.C.M. 1525 (1999)).
99. *See* § 5.3(d).
100. IRC § 509(a)(2)(A); Reg. § 1.509(a)-3(a)(2).
101. That is, entities described in IRC § 170(c)(1).
102. *See* § 5.1.
103. *See* § 5.2.
104. IRC § 4946.
105. IRC § 509(a)(2)(A).
106. *See* § 5.3(d).
107. *See* § 5.5.
108. IRC § 446(c)(1).
109. Reg. § 1.509(a)-3(k).
110. *See* text accompanied by *supra* notes 97 and 98.
111. *See* Chapter 24.
112. IRC § 509(e).

(4) the value of services or facilities (exclusive of services or facilities generally furnished to the public without charge) furnished by a governmental unit to the organization without charge.[113] The term does not include any gain from the disposition of property that would be considered as gain from the sale or exchange of a capital asset, or the value of exemption from any federal, state, or local tax or similar benefit.[114] These six items of support are combined to constitute the denominator of the support fraction.

(b) Investment Income Test

To avoid private foundation classification by reason of being a service provider publicly supported entity, a charitable organization also must normally receive not more than one-third of its support from the sum of (1) gross investment income,[115] including interest, dividends, payments with respect to securities loans, rents, and royalties, and (2) any excess of the amount of unrelated business taxable income over the amount of the tax on that income.[116] To qualify under this test, an organization must construct a *gross investment income fraction,* with the amount of gross investment income and any unrelated income (less the tax paid on it) constituting the numerator of the fraction, and the total amount of support received, the denominator.[117] In certain instances, it may be necessary to distinguish between *gross receipts* and *gross investment income.*[118]

(c) Concept of *Normally*

These support and investment income tests are computed on the basis of the nature of the organization's *normal* sources of support. An organization is considered as *normally* receiving one-third of its support from permitted sources and not more than one-third of its support from gross investment income for its current tax year and immediately succeeding tax year if, over a multi-year period immediately preceding its current tax year, the aggregate amount of support received from permitted sources is more than one-third of its total support and the aggregate amount of support from gross investment income is not more than one-third of its total support.[119] In computing public support under these rules, the IRS has traditionally used a four-year measuring period. Beginning with the 2008 tax year, however, the measuring period is the organization's most recent five years.[120] For example,

113. IRC § 509(d).
114. *Id.*, last sentence.
115. IRC § 509(e).
116. IRC § 509(a)(2)(B).
117. Reg. § 1.509(a)-3(a)(3).
118. Reg. § 1.509(a)-3(m).
119. Reg. § 1.509(a)-3(c)(1)(i).
120. This change was made in the context of the redesign by the IRS of the Form 990. See § 35.3; TAX-EXEMPT ORGANIZATIONS § 27.2A (2008 supplement).

if an organization's current tax year is calendar year 2009, the computation period for measuring public support pursuant to these rules is calendar years 2004–2008[121]; if the support fraction requirement is satisfied on the basis of the support received over this five-year period, the organization satisfies this support test for 2009 and 2010. If, in an organization's current tax year, there are substantial and material changes in its sources of support (for example, an unusually large contribution or bequest), other than changes arising from *unusual grants,* the computation period is the tax year in which the substantial and material changes took place and the four tax years immediately preceding that year.[122]

A substantial and material change in an organization's support may cause it to no longer meet either the public support test or the investment income test, and thus no longer qualify as a service provider publicly supported charity. Nonetheless, its status as a publicly supported charity under these rules, with respect to a contributor or grantor, will not be adversely affected until notice of a change of status is communicated by the IRS to the public. If a contributor or grantor either was aware of or was responsible for the substantial and material change, or acquired knowledge that the IRS had given notice to the organization that it had lost its designation as a service provider publicly supported organization, however, then that status would be adversely affected.[123] Nonetheless, the foregoing rule does not apply if, under appropriate circumstances, the contributor or grantor acted in reliance on a written statement by the donee or grantee organization that the contribution or grant would not cause the organization to lose its non-private-foundation classification as a service provider entity.[124] This statement must be signed by a responsible officer of the organization and must set forth sufficient information to assure a reasonably prudent person that the contribution or grant will not cause loss of the organization's classification as a service provider publicly supported organization.

Under the *unusual grant* rule, contributions or grants may be excluded from the numerator of the one-third support fraction and from the denominator of both the one-third support and one-third gross investment income fractions. These will generally be substantial contributions (including bequests) and grants, originating from disinterested parties, which were attracted by reason of the publicly supported nature of the organization, were unusual or unexpected with respect to the amount, and would adversely affect the status of the organization in relation to the one-third support test.[125] Thus,

121. See Form 990 (2008), Schedule A, Part III.
122. Reg. § 1.509(a)-3(c)(1)(ii). The rules with respect to new organizations (those with less than four years of existence) are contained in Regs. §§ 1.509(a)-3(c)(1)(iv) and 1.509(a)-3(d), (e).
123. Reg. § 1.509(a)-3(c)(1)(iii)(a).
124. Reg. § 1.509(a)-3(c)(1)(iii)(b).
125. Reg. § 1.509(a)-3(c)(3). Similar rules for donative publicly supported organizations (§ 5.2) are the subject of Reg. § 1.170A-9(e)(6)(ii), (iii).

the receipt of an unusual grant will not cause the recipient service provider organization to experience a substantial and material change in its sources of financial support, for purposes of this one-third support test. An item of gross investment income may not be excluded under this exception for unusual grants.[126]

The IRS has promulgated ''safe-haven'' criteria that, if satisfied, automatically cause a contribution or grant to be considered *unusual,* if the gift or grant, by reason of its size, would otherwise adversely affect the status of a charitable entity as a service provider publicly supported organization. These guidelines, which entail six tests, are intended to provide advance assurance to contributors and grantors that they will not, as the result of an unusual gift or grant, be considered to be responsible for any substantial and material changes in the sources of an organization's financial support.[127]

(d) Limitations on Support

There is one limitation on the amount of support that may be taken into account in determining the numerator of the support fraction under these rules concerning gifts, grants, contributions, and membership fees: this support must come from permitted sources.[128] Transfers from a disqualified person cannot qualify as public support under the service provider organizations rules. Nonetheless, as discussed,[129] grants from units of government, certain public institutions, and donative publicly supported organizations are not subject to this limitation.

In computing the amount of support received from gross receipts that is allowable toward the one-third support requirement, however, gross receipts from related activities (other than from membership fees[130]) received from any person or from any bureau or similar agency of a governmental unit are includable in any tax year to the extent that the receipts do not exceed the greater of $5,000 or 1 percent of the organization's support for the year involved.[131] Thus, it is frequently significant to determine precisely the persons who are the actual payors (rather than a single entity/payor).

Of the two illustrations provided by the IRS regarding the $5,000 or 1 percent limitation, both involve healthcare organizations. In one instance, a nonprofit blood bank entered into agreements by which the hospitals it

126. An example of the unusual grant rule appears in Rev. Rul. 76-440, 1976-2 C.B. 58 (concerning a large gift of real property to a service provider organization).
127. Rev. Proc. 81-7, 1981-1 C.B. 621. These rules do not preclude a potential donee or grantee organization from requesting a ruling from the IRS as to whether a proposed gift or grant, with or without the six characteristics, will constitute an unusual gift or grant.
128. *See* text accompanied by *supra* notes 101–105.
129. *Id.*
130. *See* text accompanied by *infra* note 137.
131. Reg. § 1.509(a)-3(b)(1).

supplied with blood were responsible for collecting fees from the patients and reimbursing the blood bank. Because of the existence of an agency relationship, the amounts paid to the hospitals were treated for these purposes as though paid directly by the patients to the blood bank. Thus, each patient was considered a separate payor for purposes of the $5,000 or 1 percent limitation.[132] Similarly, because Medicare and Medicaid patients determine the recipients of their payments through their choice of a healthcare provider, each patient (rather than a unit of government) is a payor for purposes of this support test.[133]

The phrase *bureau or similar agency* of a government means a specialized operating (rather than policy-making or administrative) unit of the executive, judicial, or legislative branch of government, usually a subdivision of a department of government.[134] Therefore, an organization receiving gross receipts from both a policy-making or administrative unit and an operational unit of a department is treated as receiving gross receipts from two separate agencies, and the amount from each is separately subject to the $5,000 or 1 percent limitation.

The Treasury regulations define the various forms of support referenced in these rules: *gift*, *contribution*, or *gross receipts*[135]; *grant* or *gross receipts*[136]; *membership fees*,[137] *gross receipts* or *gross investment income*[138]; and *grant* or *indirect contribution*.[139] For example, gross receipts are amounts received from a related activity where a specific service, facility, or product is provided to serve the direct and immediate needs of the payor, and a grant is an amount paid to confer a direct benefit on the general public.[140] A payment of money or transfer of property without adequate consideration generally is considered a *gift* or *contribution*.[141] The furnishing of facilities for a rental fee or the making of loans as part of an exempt purpose will likely give rise to *gross receipts* rather than *gross investment income*.[142] The fact that a membership organization provides services, facilities, and the like to its members as part of its overall activities will not result in treatment of the fees received from members as gross receipts rather than the more favorable designation, membership fees.[143]

132. Rev. Rul. 75-387, 1975-2 C.B. 216.
133. Rev. Rul. 83-153, 1983-2 C.B. 48.
134. Reg. § 1.509(a)-3(i).
135. Reg. § 1.509(a)-3(f).
136. Reg. § 1.509(a)-3(g).
137. Reg. § 1.509(a)-3(h).
138. Reg. § 1.509(a)-3(m).
139. Reg. § 1.509(a)-3(j).
140. Thus, the IRS ruled that Medicare and Medicaid payments made to healthcare organizations constitute gross receipts from the conduct of a related activity rather than grants from the federal or state governments (Rev. Rul. 83-153, 1983-2 C.B. 48).
141. Reg. § 1.509(a)-3(f)(1).
142. Reg. § 1.509(a)-3(m).
143. Reg. § 1.509(a)-3(h)(1).

§ 5.4 COMPARATIVE ANALYSIS OF THE TWO CATEGORIES OF PUBLICLY SUPPORTED CHARITIES AS APPLIED TO HEALTHCARE ORGANIZATIONS

The principle underlying the two discrete categories of publicly supported organizations—(1) the donative and (2) the service provider entities—is much the same; to qualify, both types of organizations generally must receive at least one-third of their support from public sources. The principal difference is in the definition of what constitutes public support.

Conceptually, a donative publicly supported organization is principally funded with contributions and grants, and a service provider publicly supported organization is principally funded with exempt function revenue (such as income generated from the sale of publications and admissions to programs, and from membership fees). In actuality, there often is a significant overlap of these categories.

There are material differences, however, in the manner in which the one-third support fraction of the donative and service provider publicly supported organizations' rules is computed. Thus, a charitable organization that has significant receipts from the conduct of related activities will likely find it advantageous to select the service provider organization category, inasmuch as the first $5,000 of the receipts (or 1 percent of total support, if greater) will constitute public support; by contrast, these receipts are excluded from the donative organization support fraction altogether and can even preclude a non-private-foundation classification under the donative organization category.[144] Amounts from government contracts and/or membership fees are, at least in part, eligible public support under the service provider organization rules but not under the donative organization rules. Conversely, an organization that receives financial support from those who would be substantial contributors or other disqualified persons under the service provider organization rules may well find the donative organization classification preferable: at least the amount of support up to the 2 percent limitation constitutes qualifying public support, whereas none of the support from a disqualified person can be public support under the service provider organization rules. The amount of public support can be as low as 10 percent under the donative organization rules. Further, the service provider organization rules contain a specific limitation on the amount of allowable gross investment income; the donative organization rules do not.

Another distinction between the two types of organizations is that payments from a supporting organization to a service provider publicly supported organization will retain their character as investment income (where

144. *See* text accompanied by *supra* note 71.

applicable),[145] but the same payments to a donative publicly supported organization can be considered as grants (although likely subject to the 2 percent limitation).

Because of dues support, a charitable organization that has a broad membership base can, with ease, find non-private-foundation status under the service provider publicly supported organization rules. A charitable organization that has a wide-ranging base of donors is likely to qualify under the rules concerning either category of publicly supported organization.

§ 5.5 SUPPORTING ORGANIZATIONS

Another category of charitable organization that is deemed to not be a private foundation is the *supporting organization*,[146] a type of public charity that is prevalent in the healthcare context.

Organizations that are deemed to not be private foundations because they are supporting organizations usually are entities that are not themselves either public institutions or publicly supported organizations but are sufficiently related to one or more of these public charitable organizations so that the requisite degree of public control and involvement is considered present. Thus, a supported organization must be one of the public institutions, a donative publicly supported organization, a service provider publicly supported organization,[147] or certain tax-exempt noncharitable organizations[148]; an organization that is not a private foundation by virtue of these rules is characterized as a *supporting organization*.[149]

A supporting organization must be organized, and at all times thereafter operated, exclusively for the benefit of, to perform the functions of, or to carry out the charitable purposes of one or more public institutions, publicly supported organizations, or certain noncharitable exempt organizations.[150] This type of organization must be operated, supervised, or controlled by one or more qualified supported organizations,[151] supervised or controlled in connection with one or more such organizations, or operated in connection with one or more such organizations.[152] Thus, the relationship between a supporting organization and a supported organization must be one of three types: (1) *operated, supervised, or controlled by*, (2) *supervised or controlled in connection with*, or (3) *operated in connection with*.[153] These organizations are sometimes

145. Reg. § 1.509(a)-5(a).
146. This type of organization is described in IRC § 509(a)(3).
147. These two types of publicly supported charities are collectively referred to in this portion of the chapter as *publicly supported organizations*.
148. *See* § 5.5(g).
149. Reg. § 1.509(a)-4(a)(5).
150. 146 IRC § 509(a)(3)(A); Reg. § 1.509(a)-4(a)(2).
151. The term *supported organization* is defined in IRC § 509(f)(3).
152. IRC § 509(a)(3)(B).
153. Reg. §§ 1.509(a)-4(a)(3) and 1.509(a)-4(f)(2).

referred to as Type I, II, or III organizations, respectively.[154] Inasmuch as, however, Type III supporting organizations are classified as either functionally integrated Type III supporting organizations (a significant number of which are in the healthcare field) or other Type III supporting organizations,[155] there are four types of supporting organizations.[156] A supporting organization must not be controlled, directly or indirectly, by one or more disqualified persons (other than foundation managers or eligible supported organizations).[157] A supporting organization may evolve out of a supported organization.[158]

To qualify as a supporting organization, a charitable organization must meet an organizational test and an operational test.[159]

(a) Organizational Test

A supporting organization must be organized exclusively to support or benefit one or more specified[160] supported organizations, or certain tax-exempt noncharitable organizations.[161] Its articles of organization must limit its purposes to one or more of the purposes that are permissible for a supporting organization,[162] may not expressly empower the organization to engage in activities that are not in furtherance of these purposes, must state the specified supported organization (or institutions and/or organizations) on behalf of which it is to be operated, and may not expressly empower the organization to operate in support of or to benefit any other organizations.[163]

To qualify as a supporting organization, an organization's stated purpose may be as broad as, or more specific than, the purposes that are permissible for a supporting organization. Thus, an organization formed *for the benefit of* one or more public institutions and/or publicly supported organizations will meet this organizational test, assuming that the other requirements are satisfied. An organization that is *operated, supervised, or controlled by*[164] or *supervised or controlled in connection with*[165] one or more supported organizations to carry out their purposes will satisfy these requirements if the purposes as stated in its articles of organization are similar to, but no broader than, the purposes stated in the articles of organization of the supported organization or organizations.[166]

154. The Type III supporting organization is defined in IRC § 4943(f)(5)(A).
155. See text accompanied by *infra* note 225.
156. In general, Reg. §§ 1.509(a)-4(f)(4), (g)(1)(i).
157. IRC § 509(a)(3)(C); Reg. § 1.509(a)-4(a)(4).
158. E.g., Priv. Ltr. Rul. 8825116.
159. Reg. § 1.509(a)-4(b).
160. This *specification* requirement is the subject of § 5.5(c).
161. IRC § 509(a)(3)(A).
162. *Id*.
163. Reg. § 1.509(a)-4(c)(1).
164. *See* § 5.5(d)(i).
165. *See* § 5.5(d)(ii).
166. Reg. § 1.509(a)-4(c)(2).

An organization will not meet this organizational test if its articles of organization expressly permit it to operate to support or benefit any organization other than its specified supported organization or organizations. The fact that the actual operations of the organization have been exclusively for the benefit of one or more specified supported organizations is not sufficient to permit it to satisfy this operational test.[167]

(b) Operational Test

A supporting organization must be operated exclusively to support or benefit one or more specified public institutions, publicly supported organizations, or certain tax-exempt noncharitable organizations.[168] Unlike the definition of the term *exclusively* as applied in the context of charitable organizations generally (where it is interpreted to mean *primarily*), the term *exclusively* in this context means *solely*.[169]

A supporting organization is not considered to be operated in connection with a supported organization unless the supporting organization (1) annually provides to each supported organization sufficient information to ensure that the organization is responsive to the needs or demands of the supported organization(s) and (2) is not operated in connection with any supported organization that is not organized in the United States.[170] An organization is not considered to be operated, supervised, or controlled by a qualified supported organization or operated in connection with a supported organization if the organization accepts a contribution from a person (other than a qualified supported organization) who, directly or indirectly, controls, either alone or with family members or certain controlled entities, the governing body of a supported organization.[171]

The supporting organization must engage solely in activities that support or benefit one or more eligible supported organizations.[172] These activities may include making payments to or for the use of, or providing services or facilities for, individual members of the charitable class benefited by the eligible supported organization. A supporting organization may make a payment indirectly through another unrelated organization to a member of a charitable class

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167. Reg. § 1.509(a)-4(c)(3).
168. IRC § 509(a)(3)(A). *See*, however, § 5.5(h).
169. Reg. § 1.509(a)-4(e)(1).
170. IRC § 509(f)(1). If a Type III supporting organization was supporting a foreign-supported organization on August 17, 2006, the second of these rules does not apply until the first day of the third tax year of the organization beginning after that date (IRC § 509(f)(1)(B)(ii)).
171. IRC § 509(f)(2).
172. Reg. § 1.509(a)-4(e)(1), (2). A supporting organization may have as its functions investment activities and grant-making to one or more supported organizations but that does not cause debt-financed investing (*see* § 24.17) to become an exempt function (*Henry E. & Nancy Horton Bartels Trust for the Benefit of the University of New Haven v. United States*, 209 F.3 d 147 (2 d Cir. 2000)).

benefited by an eligible supported organization, but only where the payment constitutes a grant to an individual rather than a grant to the organization.

An organization is regarded as operated exclusively to support or benefit one or more eligible supported organizations even if it supports or benefits a charitable organization (other than a private foundation) that is operated, supervised, or controlled directly by or in connection with an eligible supported organization.[173] Consequently, it is possible for a supporting organization to ultimately support or benefit a public institution or publicly supported organization by supporting or benefiting another supporting organization.[174] An organization will not be regarded as being operated exclusively as a supporting organization, however, if any part of its activities is in furtherance of a purpose other than supporting or benefiting one or more eligible supported organizations.[175]

The concept of the supporting organization includes but is not confined to one that pays over a suitable amount of its income to one or more eligible supported organizations. A supporting organization may also carry on a discrete program that supports or benefits one or more supported organizations.[176] A supporting organization may engage in fundraising activities, such as solicitations of contributions and grants, special events, and unrelated business activities, for the purpose of generating funds for one or more supported organizations or for other permissible beneficiaries.[177]

(c) *Specified* Public Charities

As noted, a supporting organization must be organized and operated to support or benefit one or more *specified* public institutions or publicly supported

173. Reg. § 1.509(a)-4(e)(1).
174. In the view of the IRS Chief Counsel's office, however, this possibility was not intended by Congress and perhaps the federal tax regulations should be revised to preclude that possibility (Gen. Couns. Mem. 39508). *See* text accompanied by *infra* note 233 (concerning the ''superparent'' supporting organization).
175. Reg. § 1.509(a)-4(e)(1).
176. E.g., Priv. Ltr. Ruls. 9538026–9538031 (provision of medical services, financial support for the medically indigent, support for hospice patients, support of community outreach programs, making grants to tax-exempt medical and health programs, and support of healthcare education, all as a supporting organization of a public charity); Priv. Ltr. Rul. 9438013 (provision of employment opportunities for and an information center about handicapped individuals by a supporting organization with respect to a residential facility for the handicapped); Priv. Ltr. Rul. 9434041, superseded by Priv. Ltr. Rul. 9442025 (operation of a professional practice plan as a supporting organization of a medical school at a university). Nonetheless, Congress has mandated the promulgation of new regulations (*see* Reg. § 1.509(a)-4(i)(3)(iii)) requiring Type III supporting organizations that are not functionally integrated Type III supporting organizations to make distributions of a percentage of either income or assets to supported organizations (Pension Protection Act of 2006, Pub. L. No. 109-280 § 1241(d)). *See* Notice 2006-109, 2006-51 I.R.B. 1121.
177. Reg. § 1.509(a)-4(e)(2).

organizations.[178] This specification must be in the articles of organization of the supporting organization, although the manner of the specification depends on which of the three types of relationships with one or more eligible supported organizations[179] is involved.[180]

Generally, it is expected that the articles of organization of a supporting organization will designate (or *specify*) an eligible supported organization by referencing the name of the supported organization.[181] If, however, the relationship between a supporting organization and a supported organization is encompassed by the phrase *operated, supervised, or controlled by*[182] or *supervised or controlled in connection with,*[183] designation by name is not required as long as the articles of organization of the supporting organization require that it be operated to support or benefit one or more eligible supported organizations that are designated by class or purpose and that include one or more (1) eligible supported organizations with which one of these two relationships exists (without designating the organization or organizations by name) or (2) public institutions or publicly supported charities that are closely related in purpose or function to one or more eligible supported organizations with which one of these two relationships exists (again, without designating the organizations by name).[184] Therefore, if the relationship is described as *operated in connection with,*[185] the supporting organization must usually specify the eligible supported organization or organizations by name.[186]

Where the relationship is described as other than *operated in connection with,* the articles of organization of a supporting organization may permit (1) the substitution of one eligible organization within a designated class for another eligible organization either in the same class or in a different class designated in the articles of organization; (2) operation of the supporting organization for the benefit of new or additional eligible organizations of the same or a different class, as designated in the articles of organization; or (3) variation in

178. IRC § 509(a)(3)(A).
179. *See* § 5.5(d).
180. Reg. § 1.509(a)-4(c)(1).
181. Reg. § 1.509(a)-4(d)(2)(i).
182. *See* § 5.5(d)(i).
183. *See* § 5.5(d)(ii).
184. Reg. § 1.509(a)-4(d)(2). For example, a trust formed to hold an endowment for a publicly supported organization was ruled to be a supporting organization because the relationship between the entities was embraced by the phrase *operated, supervised, or controlled by* (Rev. Rul. 81-43, 1981-1 C.B. 350). The IRS denied an organization supporting organization/public charity classification where, after payment of a certain amount to eligible supported organizations, the support requirements would not be met (Rev. Rul. 79-197, 1979-2 C.B. 204).
185. *See* § 5.5(d)(iii).
186. Reg. § 1.509(a)-4(d)(4). In one instance, a court generally ignored these regulations and found compliance with this requirement of specificity merely by reading the statutory provision (IRC § 509(a)(3)(A)) in light of the facts of the case (*Warren M. Goodspeed Scholarship Fund v. Commissioner*, 70 T.C. 515 (1978)).

the amount of support the supporting organization gives to different eligible supported organizations within the class or classes of organizations designated by the articles of organization.[187]

An organization that is *operated in connection with* one or more eligible supported organizations can satisfy the specification requirement even if its articles of organization permit an eligible supported organization that is designated by class or purpose (rather than by name) to be substituted for the supported organizations designated by name in its articles, but only if the substitution is conditioned on the occurrence of an event that is beyond the control of the supporting organization.[188] This type of event would include loss of tax exemption by, substantial failure or abandonment of operations by, or dissolution of the eligible supported organization or organizations designated in the articles of organization.[189]

A supporting organization that has one or more public institutions and/or publicly supported organizations designated by name in its articles of organization is permitted to have in these articles a provision that permits it to operate for the benefit of an organization that is not an eligible supported organization, but only if the supporting organization is currently operating for the benefit of an eligible supported organization and the possibility that it is operating for the benefit of an organization other than a public institution or publicly supported organization is a remote contingency.[190] Should that contingency occur, however, the supporting organization would then fail to meet this operational test.[191] Also, under these circumstances, the articles of organization of a supporting organization can permit it to vary the amount of its support between different designated supported organizations as long as it meets the requirements of the *integral part test*[192] with respect to at least one supported organization.[193]

A grandfather provision in the federal tax regulations states that a supporting organization will be deemed to meet the *specification* requirement even though its articles of organization do not designate each supported organization by name—despite the nature of the relationship—if there has been a historic and continuing relationship between the supporting organization and the supported organizations and, by reason of the

187. Reg. § 1.509(a)-4(d)(3).
188. Reg. § 1.509(a)-4(d)(4)(i)(a).
189. *Id*. In one instance, a charitable organization was held to not meet this organizational test (and thus to be a private foundation) because the trustee of the entity had too much latitude in determining the circumstances by which supported organizations could be substituted (*William F., Mable E., and Margaret K. Quarrie Charitable Fund v. Commissioner*, 70 T.C. 182 (1978), *aff'd*, 603 F.2d 1274 (7th Cir. 1979)).
190. Reg. § 1.509(a)-4(d)(4)(i)(b).
191. Reg. § 1.509(a)-4(d)(4)(ii).
192. *See* text accompanied by *infra* notes 213–217.
193. Reg. § 1.509(a)-4(d)(i)(c).

relationship, there has developed a substantial identity of interests between the organizations.[194]

In general, the federal tax law is vague as to how a supported organization with respect to a supporting organization can be changed, without the loss of the supporting organization's public charity status. In a rare private letter ruling on the subject, the IRS ruled that a tax-exempt organization could retain its status as a supporting organization, notwithstanding a transaction in which a supported organization was substituted.[195] An exempt university caused a related support organization to become affiliated with another entity that also functions to support and benefit the university. This ruling is of limited utility in planning a supported organization substitution, however, because, under the facts of the ruling, the functions of the supporting organization remained essentially the same and it will continue to indirectly support the university.

(d) Required Relationships

As noted, to meet these requirements, an organization must be operated, supervised, or controlled by or in connection with one or more qualified supported organizations. Thus, if an organization does not stand in at least one of the three required relationships to one or more eligible supported organizations, it cannot qualify as a supporting organization.[196] Regardless of the applicable relationship, it must be assured that the supporting organization will be *responsive* to the needs or demands of one or more eligible supported organizations and that the supporting organization will constitute an *integral part* of or maintain a *significant involvement* in the operations of one or more public institutions or publicly supported organizations.[197]

(i) Operated, Supervised, or Controlled By. The distinguishing feature of the relationship between a supporting organization and one or more qualified supported organizations encompassed by the phrase *operated, supervised, or controlled by* is the presence of a substantial degree of direction by one or more eligible supported organizations over the policies, programs, and activities of the supporting organization—a relationship comparable to that of a parent and a subsidiary.[198] This is, as noted, also referred to as a Type I supporting organization.

This relationship is established when a majority of the officers, directors, or trustees of the supporting organization are either composed of representatives of the supported organizations or at least are appointed or elected by the

194. Reg. § 1.509(a)-4(d)(2)(iv). E.g., *Cockerline Memorial Fund v. Commissioner*, 86 T.C. 53 (1986) (this rule was applied in a case involving a charitable trust and a college).
195. Priv. Ltr. Rul. 200731034.
196. Reg. § 1.509(a)-4(f)(1).
197. Reg. § 1.509(a)-4(f)(3).
198. Reg. §§ 1.509(a)-4(f)(4) and 1.509(a)-4(g)(1)(i).

governing body, by officers acting in their official capacity, or by the membership of the supported organizations.[199] This relationship will be considered to exist with respect to one or more qualified organizations and a supporting organization considered to operate *for the benefit of* one or more different qualified supported organizations only where it can be demonstrated that the purposes of the former organizations are carried out by benefiting the latter organizations.[200]

(ii) Supervised or Controlled in Connection With. The distinguishing feature of the relationship between a supporting organization and one or more qualified supported organizations encompassed by the phrase *supervised or controlled in connection with* is the presence of common supervision or control by the persons supervising or controlling both the supporting organization and the eligible supported organizations to ensure that the supporting organization will be responsive to the needs and requirements of the supported organizations.[201] This is, as noted, also referred to as a Type II supporting organization. To meet this requirement, the control or management of the supporting organization must be vested in the same individuals who control or manage the supported organizations.[202]

A supporting organization will not be considered to be in this relationship with one or more eligible supported organizations if it merely makes payments (mandatory or discretionary) to one or more named qualified supported organizations, regardless of whether the obligation to make payments to the named supported organizations is enforceable under state law and the governing instrument of the supporting organization contains the private foundation rules provisions.[203] According to the federal tax regulations, this arrangement does not provide a sufficient connection between the supporting organization and the needs and requirements of the supported organizations to constitute supervision or control in connection with these organizations.[204]

(iii) Operated in Connection With. The distinguishing feature of the relationship between a supporting organization and one or more qualified supported organizations encompassed by the phrase *operated in connection with* is that the supporting organization is responsive to and significantly involved

199. Reg. § 1.509(a)-4(g)(1)(i).
200. Reg. § 1.509(a)-4(g)(1)(ii). In one instance, a charitable trust that granted scholarships to students graduating from a city's public high school was deemed to satisfy the requirements of this relationship because of the involvement of the city's council and treasurer (Rev. Rul. 75-436, 1975-2 C.B. 217). A set of facts somewhat to the contrary appears in Rev. Rul. 75-437, 1975-2 C.B. 218.
201. Reg. §§ 1.509(a)-4(f)(4) and 1.509(a)-4(h)(1).
202. Reg. § 1.509(a)-4(h)(1).
203. IRC § 508(e)(1)(A), (B).
204. Reg. § 1.509(a)-4(h)(2).

in the operations of the eligible supported organization or organizations.[205] This is, as noted, also referred to as a Type III supporting organization. Generally, to satisfy the criteria of this relationship, a supporting organization must meet both a *responsiveness test* and an *integral part test*.[206]

A supporting organization meets the responsiveness test when it is responsive to the needs or demands of one or more qualified supported organizations.[207] This test may be satisfied in either of two ways.

The test is met where the supporting organization and one or more eligible supported organizations are in close operational conjunction, as manifested by a showing that (1) one or more officers, directors, or trustees of the supporting organization are elected or appointed by the officers, directors, trustees, or membership of the supported organization(s); (2) one or more members of the governing bodies of the supported organization(s) are also officers, directors, or trustees of, or hold other important offices in, the supporting organization; or (3) the officers, directors, or trustees of the supporting organization maintain a close and continuous working relationship with the officers, directors, or trustees of the supported organization(s). Not only must at least one of these three subtests be met, but also it must be demonstrated that the officers, directors, or trustees of the supported organization(s) have a significant voice in the investment policies of the supporting organization, the timing of grants and the manner in which they are made, the selection of recipients by the supporting organization, and the decisions affecting use of the income or assets of the supporting organization.[208]

The responsiveness test was met where the supporting organization is a charitable trust under state law, each specified public institution or publicly supported organization is a named beneficiary under the governing instrument of the charitable trust, and the supported organization has the power to enforce the trust and to compel an accounting under state law.[209] This test, however, was eliminated as of August 17, 2007.[210] Consequently, as of that date, trusts previously classified as Type III supporting organizations may be classified as private foundations. (A trust will continue to qualify as a supporting organization if it meets the *significant voice test*,[211] and thus remains a Type III entity, or if it meets the requirements of a Type I or II supporting

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205. Reg. § 1.509(a)-4(f)(4). As the U.S. Tax Court nicely termed the point, the *operated in connection with* test is the ''least intimate'' of the three types of supporting organization relationships (*Christie E. Cuddeback and Lucille M. Cuddeback Memorial Fund v. Commissioner*, 84 T.C.M. 623 (2002)).
206. Reg. § 1.509(a)-4(i)(1)(i).
207. Reg. § 1.509(a)-4(i)(2)(i).
208. Reg. § 1.509(a)-4(i)(2)(ii). E.g., *Roe Foundation Charitable Trust v. Commissioner*, 58 T.C.M. 402 (1989) (holding that the organization did not have the requisite relationship with a public charity to satisfy the *in connection with* test).
209. Reg. § 1.509(a)-4(i)(2)(iii).
210. Pension Protection Act of 2006 (Pub. L. No. 109-280, 109th Cong., 2nd Sess. (2006) § 1241(c).
211. See text accompanied by *supra* note 208.

organization.) The IRS provided some transitional relief in this regard by stating that charitable trusts that became private foundations by reason of this law change could file the standard annual information return (Form 990) for tax years beginning before January 1, 2008, and begin filing the private foundation annual information return (Form 990-PF) for subsequent years.[212]

A supporting organization meets the integral part test when it maintains a significant involvement in the operations of one or more public institutions or publicly supported organizations, and these supported organizations are in turn dependent on the supporting organization for the type of support it provides.[213] This test may be satisfied in either of two ways.

The test is met where the activities engaged in by the supporting organization for or on behalf of the supported organization(s) are activities to perform the functions of, or to carry out the purposes of, the supported organization(s), and, but for the involvement of the supporting organization, would normally be engaged in by the supported organization(s) itself.[214]

The second way to meet the integral part test involves a considerably more complex set of requirements. This package of rules represents the furthest and least demanding reaches under which a charitable organization can avoid classification as a private foundation, particularly where it has met the responsiveness test by reason of being a charitable trust.[215]

In this second way of meeting the integral part test, the supporting organization makes payments of substantially all of its income to, or for the use of, one or more supported organizations, and the amount of support received by one or more of the supported organizations is sufficient to ensure the attentiveness of the organizations to the operations of the supporting organization.[216] In addition, a substantial amount of the total support of the supporting organization must go to those supported organizations that meet the attentiveness requirement with respect to the supporting organization. In general, the amount of support received by a supported organization must represent a sufficient part of its total support so as to ensure the necessary attentiveness. In applying this rule, if the supporting organization makes payments to, or for the use of, a particular department or school of a

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212. Notice 2008-6, 2008-3 I.R.B. 275.
213. Reg. §§ 1.509(a)-4(i)(3)(i) and 1.509(a)-4(i)(4). A special rule allows a supporting organization to, under certain circumstances, be considered as meeting the integral part test even though the test cannot be met for the current year (Reg. § 1.509(a)-4(i)(1)(iii)).
214. Reg. § 1.509(a)-4(i)(3)(ii).
215. *Nellie Callahan Scholarship Fund v. Commissioner*, 73 T.C. 626 (1980).
216. The IRS has ruled that the term *substantially all* means at least 85 percent (Rev. Rul. 76-208, 1976-1 C.B. 161).

The IRS has privately ruled that the phrase *for this purpose* does not include short-term or long-term capital gain (Priv. Ltr. Rul. 9021060).

Where the *attentiveness* component of this requirement is satisfied, it is not necessary that substantially all of the income of the supporting organization be distributed in the tax year in which it is earned, although there may not be an extended accumulation of income (Gen. Couns. Mem. 36523).

hospital, university, or church, the total support of the department or school is substituted for the total support of the supported organization.[217]

Even where the amount of support received by a supported organization does not represent a sufficient part of total support, however, the amount of support received from a supporting organization may be sufficient to meet the requirements of the integral part test if it can be demonstrated that, in order to avoid interruption of a particular ongoing function or activity, the supported organization will be sufficiently attentive to the operations of the supporting organization. This may be the case where either the supporting organization or the supported organization earmarks the support received from the supporting organization for a particular program or activity, even if the program or activity is not the supported organization's primary program or activity but is a substantial one.[218]

All of the pertinent factors, including the number of supported organizations, the length and nature of the relationship between the supported organization and supporting organization, and the purpose to which the funds are put—are considered in determining whether the amount of support received by a supported organization is sufficient to ensure its attentiveness to the operations of the supporting organization. Inasmuch as, in the view of the IRS, the attentiveness of a supported organization is motivated by reason of the amounts received from the supporting organization, the more substantial the amount involved (in terms of a percentage of the supported organization's total support), the greater the likelihood that the required degree of attentiveness will be present. In satisfaction of this test, however, evidence of actual attentiveness by the supported organization is of almost equal importance. The federal tax regulations provide, as an example of acceptable evidence in this regard, the imposition of a requirement that the supporting organization furnish reports at least annually to the supported organization to assist the beneficiary organization in ensuring that the supporting organization has invested its endowment in assets productive of a reasonable rate of return (taking appreciation into account) and has not engaged in any activity that would give rise to liability for any of the private foundation excise taxes if the supporting organization were a private foundation. The imposition of this requirement is, however, merely one of the factors used in determining whether a supporting organization is complying with the requirements of this test; the absence of the requirement will not necessarily preclude an organization from classification as a supporting organization based on other facts.[219]

Where none of the supported organizations is dependent on the supporting organization for a sufficient amount of the supporting organization's support

217. Reg. § 1.509(a)-4(i)(3)(iii)(a).
218. Reg. § 1.509(a)-4(i)(3)(iii)(b).
219. Reg. § 1.509(a)-4(i)(3)(iii)(d). The IRS has ruled that reports, submitted by a trustee to each of the beneficiaries of a charitable trust, will not alone satisfy the attentiveness requirement of the integral part test (Rev. Rul. 76-32, 1976-1 C.B. 160).

within the meaning of these requirements, however, this test will not be satisfied, even though the supported organizations have enforceable rights against the supporting organization under state law.[220]

One court opinion holds that an organization may qualify as a supporting organization, under the *operated in connection with* relationship, where it supports both a public institution or publicly supported organization and a private foundation.[221]

(e) Additional Type III Supporting Organizations Rules

The private foundation excess business holdings rules[222] are applicable to Type III supporting organizations, other than functionally integrated Type III supporting organizations.[223] A *functionally integrated Type III supporting organization* is a Type III supporting organization that is not required by the tax regulations[224] to make payments to supported organizations.[225] These business holdings rules also apply to a Type II supporting organization if the organization accepts a contribution from a person (other than a public charity, not a supporting organization) who controls, either alone or with family members and/or certain controlled entities, the governing body of a supported organization of the supporting organization.[226] Nonetheless, the IRS has the authority to not impose the excess business holdings rules on a

220. Reg. § 1.509(a)-4(i)(3)(iii)(e).
221. *Change-All Souls Housing Corporation v. United States*, 671 F.2 d 463 (Ct. Cl. 1982). Examples of organizations that have failed to qualify under these rules are in *Christie E. Cuddeback and Lucille M. Cuddeback Memorial Fund v. Commissioner*, 84 T.C.M. 623 (2002); *Lapham Foundation, Inc. v. Commissioner*, 84 T.C.M. 586 (2002), *aff'd*, 389 F.3d 606 (6th Cir. 2004).
222. *See* PRIVATE FOUNDATIONS, Chapter 7.
223. IRC § 4943(f)(1), 3(A).
224. See *infra* note 225.
225. IRC § 4943(f)(5)(B). The IRS, on August 1, 2007, stated that it is anticipating proposing rules concerning Type III supporting organizations, including a requirement that these organizations that are functionally integrated with one or more supported organizations will be required to meet (1) the present-day *but for* test in the regulations (*see* text accompanied by *supra* note 206), (2) an expenditure test that will resemble the qualifying distributions test for private operating foundations (see PRIVATE FOUNDATIONS § 3.1(a)), and (3) an assets test that will resemble the alternative assets test for operating foundations (*id*. § 3.1(e)) (REG-155929-06). It is also expected that a Type III supporting organization that is not functionally integrated will be required to meet a payout requirement equal to the qualified distribution requirement imposed on standard grant-making private foundations (see PRIVATE FOUNDATIONS, Chapter 6). The proposed regulations may be expected to provide that certain Type III supporting organizations that oversee or facilitate the operation of an integrated system that includes one or more charities and that may be unable to satisfy certain requirements of the operating foundations' expenditure and assets test, such as certain hospital systems, will nonetheless be classified as functionally integrated entities in the proposed regulations if they satisfy the existing ''but for'' test.
226. IRC § 4943(f)(1), (3)(B). Temporary standards for determining *control* in this context were provided by the IRS (Notice 2006-109, 2006-51 I.R.B. 1121 § 3.02).

supporting organization if the organization establishes that the holdings are consistent with the organization's tax-exempt status.[227]

An excise tax is imposed on disqualified persons if they engage in one or more excess benefit transactions with public charities and/or social welfare organizations.[228] A grant, loan, compensation, or other similar payment (e.g., an expense reimbursement) by any type of supporting organization to a substantial contributor or a person related to a substantial contributor, as well as a loan provided by a supporting organization to certain disqualified persons with respect to the supporting organization, is an automatic excess benefit transaction.[229] Thus, the entire amount paid to the substantial contributor, disqualified persons, and related parties is an excess benefit. The legislation enacting this law provides that these rules apply to transactions occurring after July 25, 2006.[230]

A nonoperating private foundation may not treat as a qualifying distribution[231] an amount paid to a Type III supporting organization that is not a functionally integrated Type III supporting organization or to any other type of supporting organization if a disqualified person with respect to the foundation directly or indirectly controls the supporting organization or a supported organization of the supporting organization.[232] An amount that does not count as a qualifying distribution under this rule is regarded as a taxable expenditure.[233]

(f) Limitation on Control

A supporting organization may not be controlled, directly or indirectly, by one or more disqualified persons, other than foundation managers and/or

227. IRC § 4943(f)(2).
228. IRC § 4958. See § 4.9.
229. IRC § 4958(c)(3). For purposes of the *similar payment* rule, the term *substantial contributor* does not include an eligible supported organization (other than a supporting organization) (IRC § 4958(c)(3)(C)(ii)). Likewise, for purposes of the loan rule, the term *disqualified person* does not include an eligible supported organization (other than a supporting organization) (IRC § 4958(c)(3)(A)(i)(II)). There was an anomaly here, in that, when these rules were originally written, these exclusions failed to include the types of noncharitable organizations that qualify as supported organizations (see § 5.5(h)) (Pension Protection Act of 2006, Pub. L. No. 109-280, 109th Cong., 2nd Sess. (2006) § 1242). This matter was remedied by subsequent legislation (Tax Technical Corrections Act of 2007, Pub. L. No. 110-172, 110th Cong., 1st Sess. (2007) § 3 (i)).
230. Pension Protection Act of 2006 § 1242(c)(2).
231. See PRIVATE FOUNDATIONS, Chapter 6.
232. IRC § 4942(g)(4). As to the second element of this rule, a payment also is not a qualifying distribution if the IRS determines by regulation that the distribution "otherwise is inappropriate" (IRC § 4942(g)(4)(ii)(II)).
233. IRC § 4945(d)(4). *See* PRIVATE FOUNDATIONS, Chapter 9. A supporting organization that wishes to avoid these rules may make application to the IRS, pursuant to special procedures, to change its public charity status (Ann. 2006-93, 2006-48 I.R.B. 1017).

one or more qualified supported organizations.[234] An individual who is a disqualified person with respect to a supporting organization (for example, a substantial contributor) does not lose that classification because a supported organization appoints or designates him or her as a foundation manager of the supporting organization to serve as the representative of the supported organization.[235]

A supporting organization is considered *controlled* if the disqualified persons, by aggregating their votes or positions of authority, may require the organization to perform any act that significantly affects its operations or may prevent the supporting organization from performing the act. Generally, a supporting organization is considered to be controlled, directly or indirectly, by one or more disqualified persons if the voting power of these persons is 50 percent or more of the total voting power of the organization's governing body, or if one or more disqualified persons have the right to exercise veto power over the actions of the organization. All pertinent facts and circumstances—the nature, diversity, and income yield of an organization's holdings; the length of time particular securities or other assets are retained; and the manner of exercising its voting rights with respect to securities in which members of its governing body also have some interest—are taken into consideration in determining whether a disqualified person does in fact indirectly control an organization.[236] Supporting organizations are permitted to establish to the satisfaction of the IRS that disqualified persons do not directly or indirectly control it.[237]

One court demonstrated a disposition to avoid a strict reading of these requirements. In finding a scholarship-granting charitable trust to be a supporting organization pursuant to the *operated in connection with* relationship, the court ruled that the trust satisfied the responsiveness test and the integral part test even though the supported organization, a school, was not a named beneficiary of the trust and the funds were paid directly to the graduates of the school rather than to the school or its system.[238] This decision, and a prior and subsequent holding from the same court,[239] indicate that the courts will

234. IRC § 509(a)(3)(C).
235. Reg. § 1.509(a)-4(j)(1).
236. *Id*.
237. Reg. § 1.509(a)-4(j)(2). For example, this control element may be the difference between the qualification of an organization as a supporting organization and as a common-fund private foundation, inasmuch as the right of the donors to designate the recipients of the organization's gifts can constitute control of it by disqualified persons (namely, substantial contributors) (Rev. Rul. 80-305, 1980-2 C.B. 71). In another instance, the IRS concluded that directors of an organization who were employees of a disqualified person corporation were elements of indirect control for this purpose (Rev. Rul. 80-207, 1980-2 C.B. 193).
238. *Nellie Callahan Scholarship Fund v. Commissioner*, 73 T.C. 626 (1980).
239. *Warren M. Goodspeed Scholarship Fund v. Commissioner*, 70 T.C. 515 (1978); *Cockerline Memorial Fund v. Commissioner*, 86 T.C. 53 (1986).

not give these complex regulations an overly technical interpretation but will apply them in an effort to effectuate the intent of the statutory law.

(g) Specific Applicability of Rules to Healthcare Organizations

Contemporary application of the supporting organization rules is most prevalent in the setting of healthcare organizations. One instance is in connection with reorganizations of hospitals and hospital systems. These reorganizations are occurring for a variety of reasons: facilitation of compliance with governmental reporting requirements, separation of assets to limit liability, enhancement of the ability to expand facilities, and development of a more flexible framework within which to conduct and expand management functions. Thus, many institutions that are perceived as hospitals are in fact an aggregation of organizations, including one or more entities that are technically qualified as hospitals,[240] one or more other types of charitable entities (including, perhaps, a related *foundation* used for fundraising purposes), and one or more for-profit entities (housing assets and functions such as a parking garage; and billing, collection, and land management activities).

Under emerging concepts, *control* is being shifted away from a true hospital organization, and all of these entities are instead coordinated by a multi-entity healthcare *system* (itself a charitable entity) and managed by a *parent* organization (also a charitable entity).[241] Although the hospital entity (or entities) remains in existence, its oversight functions are transferred to the parent organization, and the services it performs for other organizations in the system are transferred to an organization that provides centralized management and other support services for the system. The management entity, controlled by the parent, provides a variety of services—management of investments, fundraising, shared service arrangements, and data processing. The management entity of a hospital system (or similar collection of institutions) can qualify as a supporting organization, with the nexus to the other organizations in the system based on one of the three relationships required of supporting organizations. At the same time, other hospital (and similar) reorganizations are occurring without use of a supporting organization.

Following a study of the federal tax implications of the structure of systems of healthcare organizations, prompted by the many ruling requests concerning hospital reorganizations, the IRS Chief Counsel's office prepared a summary of its view of the law regarding the applicability of the supporting concept in this context.[242] The study concluded that a parent management organization of a system of hospitals and related healthcare entities can qualify as a supporting organization only (assuming that only the relationship embraced by the

240. *See* § 5.1, text accompanied by notes 19–25.
241. *See* § 20.2.
242. Gen. Couns. Mem. 39508.

phrase *supervised or controlled in connection with* applies) where the parent and each of the qualified supported organizations have management or control exercised by the same persons. According to this view, it is not sufficient that management or control is vested in representatives or appointees of the supported organization.[243]

The IRS was indicating its concern regarding a parent entity's being a supporting organization for a subordinate organization. Generally, in the view of the IRS, a supporting organization should be subordinate to, rather than the parent of, the supported organization or organizations. Nonetheless, hospital reorganizations have evolved to a point where, as a practical matter, the IRS cannot preclude an entity from achieving supporting organization classification simply because it is functioning as a parent organization.[244]

The concept of the *functionally integrated* Type III supporting organization is of immense importance in the healthcare setting—indeed the emergence of the distinction is largely due to the efforts of those advocating on behalf of healthcare institutions.

(h) Supporting Organizations of Noncharitable Entities

The federal tax law permits certain tax-exempt organizations that are not charitable entities to qualify as supported organizations; the charitable organization that is supportive of one or more of these noncharitable entities is then able to avoid classification as a private foundation on the ground that it is a supporting organization. This point of law is contained in a rather cryptic and dazzlingly elusive passage in the Internal Revenue Code, which states that, for purposes of the supporting organizations rules, ''an organization described in paragraph (2) shall be deemed to include an organization described in section 501(c)(4), (5), or (6) which would be described in paragraph (2) if it were an organization described in section 501(c)(3).''[245]

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243. This conclusion reflected a stringent reading of the rules. The relevant regulation states that, under this relationship, the ''distinguishing feature is the presence of common supervision or control among the governing bodies of all organizations involved, *such as* the presence of common directors . . .'' (emphasis added) (Reg. § 1.509(a)-4(f)(4)). The regulation also states that, in this situation, the ''control or management of the supporting organization must be *vested in* the same persons that control or manage the publicly supported organizations'' (emphasis added) (Reg. § 1.509(a)-4(h)(1)). Thus, there is indication that common control by the same persons is only one way to evidence the requisite supervision or control. Likewise, common control must be *vested in* the same persons, which is different than *exercised by;* the IRS tolerates some flexibility as to the use of representatives or appointees, rather than insisting on interlocking directorates as evidence of control.

244. One manifestation of this is the integrated delivery system (Chapter 23). Another is the ''superparent'' (or ''grandparent'') organization, where the supported organizations are hospitals two tiers below; this type of superparent is *operated in connection with* hospital systems.

245. IRC § 509(a), last sentence.

The references are as follows: ''an organization described in paragraph (2)'' is the rules concerning the service provider publicly supported organization[246]; ''an organization described in section 501(c)(4)'' is the tax-exempt social welfare organization[247]; a section 501(c)(5) organization is a tax-exempt agricultural, horticultural, and labor organization; and a section 501(c)(6) organization is a tax-exempt trade, business, or professional association and other forms of business leagues.[248]

This provision means that a tax-exempt charitable entity may be operated in conjunction with a social welfare organization, agricultural, horticultural, labor organization, or business league, and still qualify as a supporting organization if the supported organization(s) meets the one-third support test of the rules concerning the service provider organization.[249] These organizations frequently meet this support requirement simply because their membership pays dues. This rule is principally designed to preserve non-private-foundation status for related *foundations* and other charitable organizations such as endowment funds (for example, scholarship and research funds) operated by business and professional associations, other business leagues, social welfare groups, labor unions, and the like. This type of supporting organization is often in an awkward position: it must be charitable in function, to be tax-exempt; yet it must support a noncharitable entity, to avoid being considered a private foundation.

(i) Department of Treasury Study

The Department of the Treasury has been directed by Congress to undertake a study on the organization and operation of supporting organizations, to consider whether (1) the deductions allowed for income, estate, or gift taxes for charitable contributions to supporting organizations are appropriate in consideration of the use of contributed assets or the use of the assets of such organizations for the benefit of the person making the charitable contribution, and (2) these issues are also issues with respect to other forms of charitable organizations or charitable contributions.[250]

§ 5.6 RELATIONSHIPS CREATED FOR AVOIDANCE PURPOSES

The tax regulations seek to ensure that the requirements concerning service provider publicly supported organizations and supporting organizations

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246. *See* § 5.3.
247. *See* § 1.8.
248. *See* Chapter 18.
249. Reg. § 1.509(a)-4(k). *See* § 5.3, text accompanied by notes 95–111. E.g., Rev. Rul. 76-401, 1976-2 C.B. 175 (a charitable trust was held to have the requisite relationship with a supporting organization; *see* § 1.8).
250. Pension Protection Act of 2006, Pub. L. No. 109-280 § 1226.

are not manipulated to avoid private foundation classification for charitable organizations. Thus, if one of the purposes of a relationship between a putative service provider publicly supported organization and a putative supporting organization is to avoid, for either organization, categorization as a private foundation, the character and amount of support received by the ostensible supporting organization will be attributed to the putative service provider organization for purposes of determining whether the latter entity meets the one-third support test and/or the one-third gross investment income test.[251]

If an organization seeking qualification as a service provider publicly supported organization fails to meet either the one-third support test or the one-third gross investment income test by reason of the application of these rules or the rules with respect to the retained character of gross investment income, and the organization is one of the specified organizations[252] for whose support or benefit an organization seeking the qualification is operated, the putative supporting organization will not be considered to be operated exclusively to support or benefit one or more eligible public institutions or publicly supported organizations.[253]

§ 5.7 INCOME ATTRIBUTION RULES

For purposes of determining whether an organization meets the gross investment income test that is applicable with respect to service provider publicly supported organizations,[254] amounts received by the organization from an organization seeking classification as a supporting organization by reason of support of the putative service provider publicly supported organization retain their character as gross investment income (rather than being treated as grants) to the extent that the amounts are characterized as gross investment income in the possession of the distributing organization.[255] This rule is also applicable with respect to support of a putative service provider publicly supported organization from a charitable trust, corporation, fund, association, or similar organization, that is required to distribute or that normally does distribute at least 25 percent of its adjusted net income to the organization and the distribution normally comprises at least 5 percent of the distributee organization's adjusted net income.[256] (There is no similar rule in connection with donative publicly supported organizations.)

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251. Reg. § 1.509(a)-5(b).
252. *See* § 5.5(c).
253. Reg. § 1.509(a)-5(c).
254. *See* § 5.3(b).
255. Reg. § 1.509(a)-5(a).
256. *Id*.

§ 5.8 RELIANCE BY GRANTORS AND CONTRIBUTORS

Once a charitable organization has been determined by the IRS to be a public institution or a publicly supported entity, the treatment of grants and contributions, and the status of grantors and contributors to it, generally are not affected by reason of a subsequent revocation of the determination by the IRS until notice of the revocation is communicated to the general public. In general, a grantor or donor in this circumstance is able to rely on the IRS determination that the grantee or donee organization is a public charity. This reliance may be a significant feature of the transaction, such as when a private foundation grant is made without exercising expenditure responsibility as required (and thus becoming a taxable expenditure),[257] or when a contributor seeks the maximum allowable charitable contribution deduction for a year.

This is not the case, however, where the grantor or contributor had knowledge of the revocation or was in part responsible for or was aware of the act, the failure to act, or the substantial and material change on the part of the organization that gave rise to the revocation of status.[258]

A principal difficulty with these reliance rules is that a grantor or contributor may not in fact be able to rely on the ruling that the grantee or donee is a public institution or publicly supported organization (or private operating foundation). Instead, the grantor or donor must solicit information from the prospective grantee or donee and make an independent determination of the effect of the grant or gift on the grantee's or donee's non-private-foundation status. The grantor or donor is expected to obtain a written statement and pertinent financial data from the prospective grantee or donee, and to review the information under the constraints of a reasonably prudent person test. The concern is that the grant or gift may constitute a substantial and material change in the support of the recipient entity, thereby causing loss of its public charity (or private operating foundation) status, with the attendant adverse consequences to the grantor or donor.[259]

These requirements, by imposing the need for a potentially extensive investigation and analysis in advance of a major gift or grant, frequently eliminate any authentic *reliance* opportunity for grantors and contributors. Many of these grantors are private foundations that lack the resources to conduct the necessary inquiries and consequently confine their grants to entities that clearly are public charities, thereby avoiding the expenditure responsibility requirements. In some instances, the grantor or donor was required to seek a ruling that a transfer would be an *unusual grant* or the grantor would voluntarily undertake to exercise expenditure responsibility.

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257. IRC § 4945.
258. Reg. § 1.509(a)-7.
259. Reg. §§ 1.509(a)-3(c)(1)(iii), 1.170A-9(e)(4)(v). A shift from public charity status to private foundation status, caused by a substantial gift or grant, is informally known as *tipping*.

The IRS provided some relief in this regard when it promulgated guidelines for determining when a grantor or contributor will not be considered responsible for substantial and material changes in the sources of financial support for an organization that, as the result of the transfer, loses its classification as a publicly supported organization. The essence of these guidelines, which are designed to provide a ''safe-haven'' rule in this regard for grantors and donors to publicly supported charitable organizations, is this: a grantor or donor will not be considered responsible for a substantial and material change in a recipient organization's support if the total of the grants or gifts from a grantor or donor for a tax year is no more than 25 percent of the total support received by the recipient organization—other than the grant or gift from the grantor or donor, a foundation manager, or related parties—during the immediately preceding four years.[260]

To an extent, contributors can rely on the listing of an organization in an IRS publication that contains a cumulative list of charitable organizations.[261] Generally, a contribution by a contributor who is unaware of the recipient organization's loss of charitable status or public charity status will give rise to a charitable contribution deduction where made on or before the date of a public announcement (such as by publication in the *Internal Revenue Bulletin*) that the contributions are no longer deductible. The IRS reserves the authority, however, to disallow the charitable deduction where the donor (1) had knowledge of the revocation of status, (2) was aware that the revocation was imminent, or (3) was in part responsible for or was aware of the activities or deficiencies on the part of the organization that gave rise to the loss of qualification.[262]

The IRS, in 1989, issued guidelines in connection with this problem of reliance for private foundations. Under these rules, a private foundation's grant will not cause the grantor to be considered responsible for or aware of a substantial and material change in the recipient organization's sources of support that results in the loss of the grantee's status as a publicly supported organization, where three conditions are met at the time of the making of the grant. These conditions are: (1) the recipient organization has received a ruling or determination letter, or an advance ruling or determination letter, from the IRS, stating that it is a publicly supported organization; (2) notice of a change in the grantee's status as a publicly supported organization has not been made to the public, and the private foundation has not acquired knowledge that the

260. Rev. Proc. 81-6, 1981-1 C.B. 620. When an organization has been in existence for less than five tax years, the number of years of its existence immediately preceding the tax year at issue is substituted for the four-year period, as long as the organization has been in existence at least one tax year consisting of at least eight months.
261. Publication No. 78, ''Cumulative List of Organizations Described in Section 170(c) of the Internal Revenue Code.''
262. Rev. Proc. 82-39, 1982-2 C.B. 759.

IRS has given notice to the grantee that it will lose that status; and (3) the grantee is not controlled, directly or indirectly, by the private foundation.[263]

§ 5.9 PRIVATE FOUNDATION RULES

A battery of stringent and onerous rules is imposed on private foundations by the federal tax law. These rules—accompanied by the fact that charitable giving may be less deductible when the donees are private foundations, the private foundation annual reporting rules are more extensive, and private foundations rarely make grants to other private foundations—make private foundation status a classification of law to avoid where possible.[264] These rules are underlain with a tripartite system of excise taxes that may be imposed on the private foundation and/or its managers.

One set of rules concerns *self-dealing*,[265] or being party to a transaction that occurs, directly or indirectly, between a private foundation and one or more disqualified persons.[266] Generally, self-dealing transactions include the sale or exchange of property; lease of property; lending of money or other extension of credit; furnishing of goods, services, or facilities; payment of unreasonable compensation; and transfer to, or use by or for the benefit of, disqualified persons of the income or assets of a private foundation. There are many exceptions to the self-dealing rules.

A private foundation must annually expend for charitable purposes an amount equal to 5 percent of the value of its investment assets.[267] This *distributable amount* is determined by calculating the foundation's *minimum investment return*. If a private foundation does not achieve at least a 5 percent return on its principal, it must use part of its assets to satisfy this minimum payout requirement. The amounts expended must constitute *qualifying distributions,* which essentially are grants for charitable purposes (including *set-asides*) and reasonable qualifying expenses. The net investment assets of a private foundation (not including assets held for charitable purposes) must be valued.

Generally, a private foundation and its disqualified persons may not have combined holdings of more than 20 percent of a business enterprise.[268] The rule applies to voting stock in a corporation, units in a partnership, and other forms

263. Rev. Proc. 89-23, 1989-1 C.B. 844.
264. A complete summary of these rules is provided in PRIVATE FOUNDATIONS, Chapters 5–10.
265. IRC § 4941.
266. *Disqualified persons* are those persons who have a special relationship with the private foundation, such as its trustees, directors, officers, principal employees, substantial contributors, members of the families of these individuals, and entities controlled by them (IRC § 4946).
267. IRC § 4942.
268. IRC § 4943.

of holdings in a business venture. Allowable holdings are termed *permitted holdings*; unallowable holdings are *excess business holdings*. If effective control of a business rests with unrelated parties, however, a private foundation and its disqualified persons may hold up to 35 percent of a business enterprise. For these purposes, the term *business enterprise* does not include a *functionally related business* or a business that derives at least 95 percent of its income from passive sources.

A private foundation may not invest any amount in a manner that will jeopardize the fulfillment of any of its charitable purposes.[269] The term *jeopardizing investments* is not defined but essentially it means highly speculative investments. This rule does not apply to *program-related investments*.

A private foundation is expected to avoid making *taxable expenditures*.[270] Generally, taxable expenditures are amounts paid or incurred to carry on propaganda, influence legislation, promote or oppose political candidates, make a variety of grants to individuals or to organizations where the private foundation has failed to exercise *expenditure responsibility,* or for any other noncharitable purpose. These rules entail a range of exceptions; among them are voter registration drives, eligible scholarship and fellowship grants, and circulation of the results of nonpartisan analysis, study, or research.

A private foundation must pay an excise tax equal to 2 percent of its net investment income for each year.[271] The phrase *net investment income* means interest, dividends, rents, royalties, capital gain, and the like, less allowable deductions. Certain operating foundations are excused from the payment of this tax.

If a charitable organization was a private foundation on October 6, 1969, it will be treated as a private foundation for all subsequent periods (or until the private foundation status is terminated[272]), even though it may also qualify as some other type of tax-exempt organization.[273] Thus, for example, an organization cannot avoid private foundation status by claiming that it also qualifies as a tax-exempt social welfare organization.

If an organization was a private foundation on October 9, 1969, and it is subsequently determined that it no longer qualifies as a charitable entity, it will continue to be treated as a private foundation (again, until that status is terminated).[274] Thus, a charitable organization cannot avoid private foundation status by converting to a taxable entity.

269. IRC § 4944.
270. IRC § 4945.
271. IRC § 4940.
272. IRC § 507.
273. Reg. § 1.509(b)-1(a).
274. Reg. § 1.509(b)-1(b).

CHAPTER SIX

Community Benefit

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§ 6.1 COMMUNITY BENEFIT AND OPERATION FOR CHARITABLE PURPOSES

As discussed earlier, the concept of charity in the Internal Revenue Code is based on the English common law of charitable trusts.[1] In the late nineteenth century, Lord McNaghten provided this fundamental definition of charity:

> ''Charity'' in its legal sense comprises four principle divisions: trusts for the relief of poverty; trusts for the advancement of education; trusts for the advancement of religion; and trusts for other purposes beneficial to the community, not falling under any of the preceding heads.[2]

The fourth division of charity established by Lord McNaghten—trusts for purposes beneficial to the community—has been echoed in subsequent elucidations of the law of trusts. Among them is the classic statement that the ''common element of all charitable purposes is that they are designed to accomplish objects which are beneficial to the community.''[3] This principle was also noted by the United States Supreme Court. In a frequently cited case on this point, the Court stated: ''A charitable use, where neither law nor public policy forbids, may be applied to almost anything that tends to promote the well-doing and well-being of social man.''[4]

One factor is central to this principle of community benefit as the basis for charity: the charitable class of persons served must be large enough to truly

1. *See* § 1.5.
2. *Commissioners for Special Purposes of Income Tax v. Pemsel* (A.C. 531-592, 1891). *See also* Sol. Op. 159, III-1 C.B. 480, 482 (1924).
3. Restatement of Trusts (2d ed. 1959) § 368, comment a.
4. *Ould v. Washington Hospital for Foundlings*, 95 U.S. 303, 311 (1877). *See*, in general, Reiling, ''What Is a Charitable Organization?,'' 44 *A.B.A.J*. 528 (1958); Annot., 12 A.L.R. 2d 849, 855 (1950). *See also Peters v. Commissioner*, 21 T.C. 55, 59 (1953).

benefit the community.[5] Thus, ''[a] trust is not charitable if the persons who are to benefit are not of a sufficiently large or indefinite class so that the community is interested in the enforcement of the trust. This is true even though the purpose of the trust is to promote health.''[6] Basically, where a class of persons is involved as beneficiaries, the sufficiency of the class, for purposes of ascertaining what charitable activities are being engaged in, becomes a question of degree.[7]

On occasion, the IRS will attempt to use this requirement as a basis for denial of exemption, by characterizing the beneficiaries as being too small in number or too limited in interests, such as where benefits are confined to a provider's subscribers.[8] But there are reasonable limitations on the reach by the IRS in applying this doctrine. As one court has observed: ''To our knowledge no charity has ever succeeded in benefiting *every* member of the community. If to fail to so benefit *everyone* renders an organization noncharitable, then dire times must lie ahead for this nation's charities.''[9] Essentially, a limited number of purposes may be benefited as the result of an organization's activities and the assistance considered ''charitable'' in nature, as long as the effect is to benefit the community rather than merely individual recipients.

§ 6.2 THE TRADITIONAL COMMUNITY BENEFIT STANDARD

Although the federal tax law for charitable organizations borrows heavily from the English common law of charitable trusts and property, at one point in U.S. legal history, a principle emerged that the only way to be charitable was to aid the poor. This principle was embodied in the IRS's early view of the qualifications for hospitals to be recognized as charitable entities. In a 1956 revenue ruling, the IRS required hospitals to provide charity care to the extent of their financial ability to do so.[10] That principle was abandoned when the current tax regulations were finalized, and the present definition of ''charitable'' includes over a dozen ways to achieve that status. One way is through the ''promotion of health,''[11] a definition introduced in the courts (common law) and memorialized by the IRS in 1969 with the release of Revenue Ruling 69-545.[12] This now-famous revenue ruling eliminated the financial ability standard and, with it, reliance on the principle that the relief of poverty is the only basis for according charitable status to healthcare providers. It was asserted that the promotion of health is a charitable purpose that is sufficient by itself to warrant charitable status for hospitals.

5. Restatement of Trusts (2d ed. 1959), § 372, comment c.
6. Scott on Trusts (3d ed. 1967), § 372.2.
7. *Id*. at § 375. *See also* Bogert, Trusts and Trustees (2d ed. 1959), § 365; Rev. Rul. 57-449, 1957-2 C.B. 622; Rev. Rul. 67-325, 1976-2 C.B. 113.
8. *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3d Cir. 1993).
9. *Sound Health Association v. Commissioner*, 71 T.C. 158, 185 (1978) (emphasis in original).
10. Rev. Rul. 56-185, 1956-1 C.B. 202. *See* § 26.2.
11. *See* § 1.7.
12. Rev. Rul. 69-545, 1969-2 C.B. 117.

The author of this revenue ruling, in a comprehensive article on the basis of tax exemption for charitable hospitals, labeled the reliance on the promotion of health and the dismissal of reliance on the relief of poverty as a basis for exemption as the ''liberal'' approach of American jurisprudence in this area. He concluded:

> If one accepts the thesis that promotion of health is a charitable purpose and that all receipts must be applied to that charitable purpose of the hospital, there would seem to be no logical reason why a hospital could not accept only paying patients, charge each the full cost of care, remain entirely self-supporting, and still qualify as a charitable institution. That is the conclusion which one could draw from the liberal position. . . .[13]

The basis of the 1969 revenue ruling is not limited to the liberal approach; instead, it stems from what the author described as a third approach under American law, the ''community benefit approach.''[14] In describing this approach, he stated:

> One cannot ignore, however, an obligation imposed upon the charitable hospital under American law which is more specific than that imposed by the unqualified liberal position that the promotion of health is *per se* a charitable purpose. . . . In the case of a charitable hospital, however, something more is needed.[15]

The something more that is needed is a benefit to the community:

> (1) A charitable hospital must in fact benefit the community, and (2) the community may not be benefitted if its needs are not met, *i.e.*, if a substantial portion of its residents are turned away. This does not mean that we must return to demanding that a charitable hospital must render some minimum percentage of its services free of charge or that it may not recover the costs of its services from each patient. The community benefit approach is an existential one; in order to be meaningful, therefore, this approach *must* take account of the realities of each hospital's situation.[16]

The 1969 revenue ruling applies this community benefit approach to a hypothetical ''Hospital A,'' which is imbued with characteristics that the IRS finds essential to the principle of community benefit. Foremost among these characteristics are maintenance by the hospital of a full-time emergency room in which no one requiring emergency care is denied treatment, and the provision of care to all those who can afford to pay for the cost of their care, including beneficiaries of the Medicare and Medicaid programs. The revenue ruling states: ''By operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, Hospital A is promoting the health of a class of persons that is broad enough to benefit

13. Bromberg, ''The Charitable Hospital,'' 20 *Cath. Univ. L. Rev*. 237, 247 (1970).
14. *Id*. at 248.
15. *Id*.
16. *Id*. at 249.

the community.''[17] These two characteristics are held by the IRS to be so fundamental to recognition of charitable status for hospitals that it sought to have them codified in the Donnelly Charity Care Bill.[18]

Also fundamental to the IRS's conclusion that Hospital A adequately benefited the community were: the use by the hospital of its surplus funds to improve the quality of patient care, expand the hospital's facilities, and advance the hospital's medical training, education, and research programs; the control of the hospital by a board of trustees composed of independent civic leaders; and the maintenance of an open medical staff with privileges available to all qualified physicians.

The community benefit standard, as espoused in the 1969 revenue ruling, has stood the test of time. Its application has been extended beyond hospitals to other healthcare providers, such as health maintenance organizations (HMOs)[19] and home health agencies.[20] Little attention was paid to it during the 1970s and 1980s, but the standard was reasserted and scrutinized in the 1990s during the debate over whether hospitals should be required to provide specific amounts of charity care in order to retain their tax exemptions.[21] The community benefit standard was again held up as the benchmark for IRS analysis of hospital activities[22] when the IRS considered, *inter alia*, whether certain hospital–physician joint ventures provided benefit to the community. It is also noteworthy that under the revised Hospital Audit Guidelines issued by the IRS in March 1992, the first standard that examiners are instructed to consider is the community benefit standard.[23]

§ 6.3 THE NEW COMMUNITY BENEFIT STANDARD

In the 2000s, it is apparent that the IRS's traditional community benefit standard is in the process of ongoing refinement.[24] This refining is acceptable, even preferable, given that the community benefit standard was intended to be more flexible than its predecessor and to allow the IRS to modify the requirements for exemption as society's needs change.[25] Unfortunately, one troubling manipulation of the community benefit standard analysis came from

17. Rev. Rul. 69-545, 1969-2 C.B. at 118.
18. *See* § 26.8(b).
19. *Sound Health Association v. Commissioner, supra* note 9; *Geisinger Health Plan v. Commissioner, supra* note 8.
20. Rev. Rul. 72-209, 1972-1 C.B. 148.
21. *See* Chapter 26.
22. Gen. Couns. Mem. 39862.
23. Ann. 92-83, 1992-22 I.R.B. 59, at § 333.1. *See* Appendix E.
24. ''Colloquium Report: Tax Exemption and Community Benefit,'' National Health Lawyers Association (1996); Seay, ''Tax-Exemption for Hospitals: Towards an Understanding of Community Benefit,'' 7 *Exempt Org. Tax Rev.* 413 (1993).
25. Sullivan and Moore, ''A Critical Look at Recent Developments in Tax Exempt Hospitals,'' 23 *J. Health & Hosp. L.* 65 (Mar. 1990).

the IRS itself. In an examination of a series of hospital–physician transactions, the IRS weighed the public benefit achieved by the hospitals' entry into joint ventures with their physicians against the private benefit conferred on the physician-investors through the use of a sale of revenue stream joint-venture mechanism, and stated:

> The public benefit expected to result from these transactions—enhanced hospital financial health or greater efficiency achieved through improved utilization of their facilities—bears only the most tenuous relationship to the hospitals' charitable purposes of promoting the health of their communities. Obtaining referrals or avoiding new competition may improve the competitive position of an individual hospital, but that is not necessarily the same as benefitting its community.[26]

The premise that hospital benefit and community benefit are not always the same is unsound. If, in fact, the hospital is organized and operated for public charitable purposes, then any benefit that accrues to a hospital will necessarily further those charitable purposes. By strengthening the economic health of the hospital, business transactions help to ensure that the hospital can continue to properly benefit the community by providing unlimited indigent care in the emergency room and providing care to all others able to pay for the cost of their care. Improving the financial health of the hospital can only enhance its ability to provide services to a larger segment of the community, which is, after all, the primary objective of the community benefit standard.

What is happening to the community benefit standard in the private sector and on the legislative front is also important to observe. Beginning with the unrelated business income hearings in 1987[27] and continuing through the charity care hearings in 1991,[28] the charitable hospital sector began to develop some blueprints for identifying and measuring the community benefit that is provided by charitable hospitals. The American Hospital Association, Voluntary Hospitals of America, Inc., Catholic Health Association of the United States, and Kellogg Foundation–funded Hospital Community Benefit Standards Program at New York University all have sought to establish community benefit standards for voluntary hospitals.[29] The efforts of these organizations are an attempt to explain community benefit in specific and practical terms, to ''fill in the blanks so eloquently implied by Lord McNaghten and others over the years.''[30]

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26. Gen. Couns. Mem. 39862.
27. *Unrelated Business Income Tax: Hearings Before the Subcommittee on Oversight of the Committee on Ways and Means, House of Representatives*, 100th Cong., 1st Sess. (1987).
28. *See* §§ 3.2, 26.6.
29. Seay, ''From Pemsel's Case to Health Security: Community Benefit Comes of Age,'' 12 *J. Health Admin. Educ*. 373–382 (Summer 1994). The following are useful documents prepared by these organizations: American Hospital Association, ''AHA Guidance on Reporting of Community Benefit''; Voluntary Hospitals of America, ''Voluntary Standards: A Framework for Meeting Community Needs''; Catholic Health Association, ''A Guide for Planning and Reporting Community Benefit'').
30. Seay, *supra* note 29, at 375.

These efforts are particularly significant because they represent movement beyond the principles established in 1969. They address ''process and program qualities'' and ''leadership characteristics'' essential to community benefit. These are not addressed in the 1969 revenue ruling.[31]

With regard to defining ''process and program qualities,'' the Kellogg Foundation program suggests this standard: ''[T]he scope of the [community benefit] program includes hospital-sponsored projects for the designated community in each of the following areas: improving health status; addressing the health problems of minorities, the poor, and other medically under-served populations; and continued growth of community health care costs.''[32]

The Catholic Health Association (CHA) has been instrumental in shifting the debate to what should count as community benefit and how it should be measured. By working closely with the Senate Finance Committee and the IRS, CHA succeeded in establishing a standard metric for measuring and reporting community benefit. The redesigned Form 990's Schedule H, which requires hospitals to report community benefit, is substantially based on the CHA reporting tool.

The refining of the community benefit standard in the 1990s apparently contemplated an ''outreach'' component as an essential part of the overall mission of the hospitals. The concept of outreach as a function of community benefit was prevalent in the myriad approaches to national health reform in the 103d Congress. Perhaps the best example of the expansiveness with which the community benefit standard was approached was the health reform bill reported out by the Senate Finance Committee in 1994.[33] The bill stated in relevant part:

> **(a)** TREATMENT OF HOSPITALS AND OTHER ENTITIES PROVIDING HEALTH CARE SERVICES—Section 501 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:
>
> ''(n) QUALIFICATION OF HEALTH CARE ORGANIZATIONS AS EXEMPT ORGANIZATIONS—
>
> (1) IN GENERAL—An organization which is described in paragraph (3) or (4) of subsection (c) and the predominant activity of which is the provision of health care services shall be exempt from tax under subsection (a) only if—
>
> (A) such organization, with the participation of community representatives, annually—
>
> (i) assesses its community's needs for health care services and qualified out-reach services; and
>
> (ii) prepares a written plan to meet those needs,

31. *Id*. at 376.
32. *Id*. at 377.
33. S. 2351, § 741. 103d Cong., 2d Sess. (1994).

(B) pursuant to such plan, such organization provides (directly or indirectly) significant qualified outreach services,

(C) such organization does not discriminate against individuals in the provision of health care services on the basis of participation in a government-sponsored health plan, and

(D) such organization does not discriminate against individuals in the provision of emergency health care services on the basis of ability to pay.

(2) SPECIAL RULE FOR HEALTH MAINTENANCE ORGANIZATIONS—A health maintenance organization shall not be treated as described in subsection (c)(3) unless substantially all of its primary care health services are provided in subsection (m)(6)(A).

(3) DEFINITIONS AND SPECIAL RULE—For purposes of this subsection—

(A) QUALIFIED OUTREACH SERVICES—The term 'qualified outreach services' means health care services (or preventive care, educational, or social services programs related thereto) which are provided—

(i) in 1 or more medically underserved areas,

(ii) below cost to individuals who are otherwise unable to afford such services, or

(iii) at emergency care facilities which provide specialty services and which normally operate at a loss.

Such term shall not include insurance described in subparagraph (B)(iii) unless such insurance is provided on a subsidized basis.

(B) HEALTH CARE SERVICES—The term 'health care services' means—

(i) any activity which consists of providing medical care (as defined in section 213(d)(1)(A)) to individuals,

(ii) in the case of an organization described in subsection (c)(3), any activity which is treated as accomplishing an exempt purpose of the organization solely because it is carried on as part of an activity described in clause (i), and

(iii) insurance (other than commercial-type insurance, as defined in subsection (m)) for the activities described in clauses (i) and (ii).

(C) MEDICALLY UNDERSERVED AREA—The term 'medically underserved area' means, with respect to a health care service, any area reasonably determined by the organization (in a manner not inconsistent with regulations prescribed by the Secretary) to have—

(i) a shortage (relative to the number of individuals needing such service) of health professionals performing such service, or

(ii) a population group experiencing such a shortage.

Such term includes a health professional shortage area (as defined in section 332 of the Public Health Service Act).

(4) EXCEPTIONS—This subsection shall not apply to any organization which—

(A) demonstrates, in a manner not inconsistent with regulations prescribed by the Secretary, that one of its principal purposes is academic training or medical research, or

(B) provides health care services exclusively on an uncompensated basis, regardless of ability to pay.''

In summary, this bill would have required healthcare organizations recognized as exempt under the Code as charitable or social welfare organizations—for example, hospitals, clinics, homes for the aged, and HMOs—to annually assess the community's needs for healthcare services and ''qualified outreach services'' and to prepare a written plan to meet those needs; to provide significant qualified outreach services; to not discriminate against individuals, in the provision of healthcare services, on the basis of participation in a government-sponsored health plan; and to not discriminate against individuals, in the provision of emergency healthcare services, on the basis of ability to pay. The bill expressly stated that its requirements are in addition to, and not in lieu of, the requirements otherwise applicable to tax-exempt charitable and social welfare organizations. Accordingly, this is an expansion of the community benefit standard rather than a substitution of one standard for another.

The actions of the IRS since 1969, and in particular since the 1990s, make clear that the community benefit standard will remain the linchpin of the IRS's analysis of healthcare provider activities. However, it is equally apparent that this standard is a dynamic one and that its boundaries are expanding to encompass concepts of both the size of the class of persons in the community who are benefited and the manner in which they are benefited.[34]

The IRS has recently undertaken a major effort to determine the level of compliance by charitable hospitals with the Community Benefit Standard. In the spring of 2006, the IRS issued a Compliance Check Questionnaire for Tax-Exempt Hospitals (Form 13790), a nine-page questionnaire designed to derive information regarding the operations of charitable hospitals particularly with regard to their charity care and compensation practices. The questionnaire was sent out to 544 hospitals. The IRS has indicated that it does not anticipate launching new audits as a direct result of information provided in response to the questionnaire. Rather, it is trying to better understand the effectiveness of the standard for today's charitable hospitals.

34. The IRS occasionally denies tax-exempt status to a healthcare provider for failure to satisfy this standard (e.g., Ex. Den. and Rev. Ltr. 20042705E).

The American Hospital Association commissioned a study by Ernst & Young of responses to the questionnaire by member hospitals; 132 responses were collected and analyzed by E&Y.[35] The E&Y report concluded that hospitals are providing a broad range of programs that benefit the health of the communities they serve and hospitals are providing substantial charity care.

On July 19, 2007, the IRS released an interim report summarizing the responses received from the Compliance Check.[36] The Interim Report presented data received from 487 hospitals in response to the compliance questionnaire and from information reported on Forms 990 filed by those hospitals.

The IRS found that the hospitals reported similar information in different ways, and that there is variation in the level of expenditures hospitals report in furtherance of community benefit, particularly with regard to uncompensated care. Examples included use by hospitals of a range of income and asset criteria to establish eligibility for uncompensated care and variance in measurement of bad debt expense and shortfalls between actual costs and Medicare or Medicaid reimbursements. Variance was also found in the use of costs and charges in the measurements.

The IRS stated that further analysis of the data was needed and, as a result, it is premature to conclude that the reported community benefit expenditure amounts accurately portray the community benefit actually provided by the responding hospitals.

The Interim Report found that in the aggregate, uncompensated care accounted for 56 percent of the total community benefit expenditures reported by the hospitals; however, significant variations were found in how hospitals reported uncompensated care. It was reported that 97 percent of hospitals replied they had a written uncompensated care policy. The treatment of bad debt expense as uncompensated care was mixed: 56 percent of the hospitals reporting said they did not include bad debt expense as uncompensated care, and the remaining 44 percent included at least some bad debt expense as uncompensated care; 97 percent of the hospitals reported making uncompensated care available to at least some persons.

After uncompensated care, the next largest categories of expenditures reported as community benefit were medical education and training (23%), research (15%), and community programs (6%). More than 75 percent of the hospitals reported expenditures for producing publications and newsletters, medical screenings, and public educational programs. Hospitals also reported expenditures to study the unmet health needs of the community (28%), immunization programs (40%), programs to improve access to healthcare (54%), and other health promotion programs (32%).

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35. ''Community Benefit Information from Non-Profit Hospitals: Lessons Learned from the 2006 IRS Compliance Check Questionnaire,'' Ernst &Young, November 27, 2006. *See* http://www.aha.org/aha/content/2006/pdf/061127-ErnstYcombenreport.pdf.
36. http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf.

Of the hospitals that responded, 90 percent did not deny medical services to any individuals who lacked insurance; an even greater percentage did not deny medical services to any individuals who were covered by government programs or private insurance. All responding hospitals that operated an emergency room reported that their emergency room provided services to all regardless of their ability to pay.

The Interim Report also summarized reported data regarding governance matters and practices, billing and collection practices, medical staff privileges, and emergency room operations.

The Compliance Check informed the IRS's redesign of the Form 990, effective for the 2008 tax year, which now requires specific and detailed disclosures by hospitals regarding their community benefit activities. Schedule H of the Form 990 requires in Part I disclosure of charity care and other community benefits at cost. It inquires whether the hospital prepares an annual community benefits report. It requests quantification of a hospital's community health improvement services and community benefit operations; health professions education; subsidized health services; research; and cash and in-kind contributions to community groups. Part II of Schedule H adds a new category of hospital charitable activity that was championed by the Catholic Health Association: community-building activities. In this part, the Schedule asks for quantification of a hospital's activities in physical improvements and housing; economic development; community support; environmental improvements; leadership development and training for community members; coalition building; community health improvement advocacy; and workforce development. The IRS has never before taken the position that these types of activities are included as factors in determining whether a hospital is operated for charitable purposes or as a part of the community benefit standard and represent a significant expansion of the basis for exemption for hospitals as charitable organizations. The American Hospital Association led the lobbying charge to convince the IRS that the calculation of bad debt expense and Medicare shortfalls should be included in the community benefit calculation of Schedule H. However, the IRS elected instead to put this information in Part III of Schedule H as a separate disclosure rather than to include it in Part I of the schedule under community benefit.

Not to be outdone, Congress took its turn at the same time. On July 18, 2007, the minority staff of the Senate Finance Committee released a discussion draft of proposals regarding tax-exempt hospitals.[37] The document was intended to provide proposals for reform for tax-exempt hospitals based on staff investigation and research as well as on input from tax and healthcare attorneys and policy analysts. It was described as a ''work in progress'' meant to encourage additional discussion and was not intended to represent proposed legislation.

37. http://www.senate.gov/~finance/press/Gpress/2007/prg071907a.pdf.

The discussion draft detailed the minority staff's concerns as including establishment of charity care policies and the publication of those policies at nonprofit hospitals; the amount of charity care and other community benefits provided by nonprofit hospitals; the conversion of nonprofit hospital assets for use by for-profit entities; ensuring furtherance of exempt purposes by joint ventures between nonprofit hospitals and for-profits; transparency and accountability of nonprofit hospital governance and activities; and the use of unfair billing and aggressive collection practices by nonprofit hospitals.

The draft proposal recommended various alternatives for consideration in drafting legislation to reform the basis for tax-exempt status under federal law for nonprofit hospitals. The staff recommended the creation of an exemption structure that applies different requirements depending on whether the nonprofit hospital seeks classification as a charitable organization or as a social welfare organization. The staff believes that requirements for charitable status should be more stringent than the requirements for social welfare organization status because of the differing tax benefits for these organizations.

The draft proposal recommended setting standards for hospitals seeking recognition of exemption as charitable organizations including: (1) establishing a charity care policy and wide publication of that policy; (2) quantitative standards for charity care; (3) requirements for joint ventures between nonprofit hospitals and for-profit entities; (4) board composition and other governance requirements, including some regarding executive compensation; (5) limiting charges billed to the uninsured; (6) placing restrictions on conversions; (7) curtailing unfair billing and collection practices; (8) transparency and accountability requirements; and (9) sanctions for failure to comply with applicable requirements for charitable hospitals.

The draft proposal also recommended establishing standards for hospitals seeking exemption as social welfare organizations including: (1) a quantitative amount of community benefits annually; (2) limiting charges billed to the uninsured; (3) governance reforms; (4) restrictions on conversions; (5) curtailing unfair billing and collection practices; (6) heightened transparency; and (7) sanctions for failure to comply with applicable requirements.

The staff intended that these proposed rules would apply in addition to existing legal requirements for charitable and social welfare organizations but would replace the community benefit standard[38] and the emergency room exception standard[39] established by the IRS in prior guidance. A roundtable discussion of the proposals by invited panelists was subsequently convened by the minority staff; however, no legislation containing any of these proposals has yet been introduced.

Federal courts have weighed in on this issue as well; the community benefit standard was reexamined in two high-profile appellate cases. In the *IHC Health*

38. Rev. Rul. 69-545, 1969-2 C.B. 117.
39. Rev. Rul. 83-157, 1983-2 C.B. 94.

Plans case,[40] the Tenth Circuit Court of Appeals reviewed the community benefit standard in determining whether the promotion of health for the benefit of the community is a charitable purpose. The court noted the evolution of the community benefit standard and its early foundation on the provision of free or below-cost care. It noted further that late in the twentieth century, with the advent of Medicare and Medicaid and the increased availability of private insurance, nonprofit hospitals no longer relied on the relief of poverty as the basis for their charitable status. Accordingly, under the IRS's current interpretation of the Code regarding healthcare providers' ability to qualify as a charitable organization, the court found that it must determine whether the healthcare provider operates primarily for the benefit of the community. The court found the community benefit standard ''somewhat amorphous'' but nevertheless determined that it was a workable standard for determining charitable status.

The court stressed that in defining the community benefit standard, every activity that promotes health does not necessarily support tax exemption as a charitable organization. The court pointed out that many for-profit enterprises offer products or services that promote health. In addition, the court read the IRS guidance on the community benefit standard as demonstrating that organizations cannot satisfy the community benefit requirement solely by providing healthcare services to everyone in the community. Although providing healthcare products or services to a broad section of the community is necessary, it is insufficient by itself to enable an organization to qualify as a charitable organization. In the court's words, the organization desiring recognition of charitable status must provide ''some additional plus.''[41]

The court defined the ''plus'' as a benefit that supplements and advances the work of public institutions, for example, providing free care, maintaining an open emergency room without regard to ability to pay, and devoting operating surpluses to research, education, and training. It found that the primary manner in which healthcare organizations advance government endeavors is the provision of care to Medicare and Medicaid beneficiaries.

The court next tackled the problem of how best to quantify the required community benefit. Under the Code, the court stated that the existence of some incidental community benefit is not enough; rather, the community benefit must be of sufficient magnitude to support the strong inference that the healthcare provider operates primarily for the purpose of benefiting the community. In the court's view, its inquiry rests not on the nature of the activity but rather on the purpose accomplished by it. To determine purpose, the court stated that it must consider primarily the manner in which the healthcare provider carries on its activities. In undertaking this inquiry, it will consider the totality of the circumstances.

40. 325 F.3d 1188 (10th Cir. 2003).
41. *Id*. at 1197.

The community benefit standard was also examined at length by both the district court and the court of appeals in the *St. David's* case.[42] In both decisions, the courts indicated that they believed the community benefit standard was the appropriate benchmark for analysis. They also agreed that the proper application of this standard required balancing the relevant factors and that no one factor was determinative. In particular, these decisions focused on the importance of having an independent community board to oversee the operations of the healthcare provider. The district court and the court of appeals both agreed that although the existence of a community board is relevant in an inquiry regarding operation for charitable purposes, the community benefit standard does not require that a community board be present in order for the standard to be satisfied.[43]

42. 349 F.3d 232 (5th Cir. 2003).
43. *Id*. at 236, n. 4.

CHAPTER SEVEN

Lobbying and Political Activities

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Tax-exempt healthcare organizations and other charitable organizations are constrained, by reason of their federal tax status, as to the amount of lobbying and/or political campaign activities they may undertake. The tax law limits their lobbying activities to an amount that is not *substantial;* the limitation on their political campaign activities is essentially an absolute prohibition.

§ 7.1 LEGISLATIVE ACTIVITIES LIMITATION

The federal tax law states that, for an organization to qualify as a tax-exempt charitable entity, ''no substantial part of the activities'' of the organization may constitute ''carrying on propaganda, or otherwise attempting, to

influence legislation.''[1] This body of law contains two sets of rules (other than those applicable to private foundations[2]) concerning the extent of permissible lobbying by healthcare and other charitable organizations: the *substantial part test*,[3] including some other tax law provisions,[4] and the *expenditure test*.[5]

An eligible charitable organization[6] that desires to avail itself of the expenditure test must elect to come within these standards.[7] Charitable organizations that may not or choose not to make this election are governed by the substantial part test.[8] Churches, conventions or associations of churches, integrated auxiliaries of churches, certain supporting organizations of noncharitable entities,[9] and private foundations may not elect to come under these rules.[10] Private foundations are subject to stringent regulation in this regard under another body of law.[11]

Nearly all healthcare organizations that are tax-exempt charitable entities find it suitable to remain under the substantial part test. Rarely does a healthcare organization engage in the type and extent of lobbying that would warrant an election of the expenditure test. Nearly all healthcare organizations, however, are able to make the election should they wish to do so.

If a charitable organization receives a contribution that is earmarked for use in influencing specific legislation, the contribution is not deductible as a charitable gift.[12]

(a) Meaning of *Legislation*

(i) Substantial Part Test. The term *legislation*, as defined for purposes of the substantial part test, has several manifestations. They include action by Congress, a state legislative body, a local council or similar governing body, and the general public in a referendum, initiative, constitutional amendment, or similar procedure.[13] The term embraces both authorization and appropriations legislation, and it includes proposals for the making of foreign laws.[14]

1. IRC § 501(c)(3).
2. *See* § 5.6.
3. Reg. § 1.501(h)-1(a)(1). *See* text accompanied by *infra* notes 13–15, 23–24, 48–57, 76, and 80.
4. *See* text accompanied by *infra* notes 87–90.
5. Reg. § 1.501(h)-1(a)(2). *See* text accompanied by *infra* notes 16–22, 25–46, 58–75, 77–78, and 81–86.
6. Reg. § 1.501(h)-2(b), (e).
7. IRC § 501(h)(3), (4), and (6). This election, and any revocation or reelection of it, is made by filing Form 5768 with the IRS (Reg. § 1.501(h)-2(a), (c), and (d)).
8. Reg. § 1.501(h)-1(a)(4).
9. *See* § 5.4.
10. IRC § 501(h)(5).
11. IRC § 4945(d)(1), (e).
12. *See, e.g.*, Rev. Rul. 80-275, 1980-2 C.B. 69.
13. Reg. § 1.501(c)(3)-1(c)(3)(ii).
14. Rev. Rul. 73-440, 1973-2 C.B. 177.

For these purposes, the term generally does not include action by an executive branch of government, such as the promulgation of rules and regulations, or action by independent regulatory agencies.

In the view of the IRS, an attempt to influence the confirmation, by the U.S. Senate, of a federal judicial nominee constitutes, for these purposes, an attempt to influence legislation.[15]

(ii) Expenditure Test. Under the expenditure test, the term *legislation* includes ''action with respect to [a]cts, bills, resolutions, or similar items by the Congress, any State legislature, any local council, or similar governing body, or by the public in a referendum, initiative, constitutional amendment, or similar procedure.''[16]

The position of the IRS that an attempt to influence the confirmation, by the U.S. Senate, of a federal Cabinet-level, judicial, or other nominee constitutes an attempt to influence legislation is reflected in the expenditure test, in the tax regulations.[17]

(b) Legislative Activities

It is irrelevant, for purposes of classification of a healthcare or other organization as a charitable entity under the federal tax law, that the legislation advocated would advance the charitable purposes for which the organization was created and that it promotes.[18]

The tax law, particularly in connection with the expenditure test, differentiates between *direct* lobbying and *grassroots* lobbying. Direct lobbying includes the presentation of testimony at a public hearing held by a committee of a legislature; correspondence and conferences with legislators and their staffs; meeting(s) with the staff of a legislative committee; and publication of documents advocating one or more forms of legislative action. Grassroots lobbying consists of appeals to the general public, or segments of the general

15. IRS Notice 88-76, 1988-2 C.B. 392.
16. IRC § 4911(e)(2); Reg. § 56.4911-2(d)(1).
17. Reg. § 56.4911-2(b)(4)(ii)(B), example (6).
18. The Hospital Audit Guidelines (*see* § 35.2) are silent on this topic. The IRS's audit guidelines for colleges and universities (IRS Exempt Organizations Examination Guidelines Handbook (IRM 7(10)69), § 342 (reproduced by the IRS for broader dissemination in Ann. 94-112, 1994-37 I.R.B. 1), however, instruct the examining agents to thoroughly review the activities of a ''University Affairs'' division or similar office to determine whether any lobbying of more than an insubstantial nature has taken place (§ 342(12)(6)). Agents were reminded that many colleges and universities maintain an office in the Washington, DC, area and/or respective state capital areas, to lobby on behalf of the institution. These activities are to be reviewed to determine whether any legislative activities took place that went beyond the institution's ''self-preservation'' interests (see *infra* note 43). *Id.*, § 342(12)(7).

public, to contact legislators or take other specific action regarding legislative matters.[19]

For these purposes, the term *lobbying* does not include lobbying of individuals in an executive branch of government,[20] unless this type of lobbying is engaged in for the purpose of influencing individuals in a legislative branch. This definition of lobbying should be contrasted with that used in connection with the business expense deduction rules, where lobbying of members of the executive branch of the federal government is also *lobbying*.[21]

The law in this regard is developed far more extensively as part of the expenditure test. The interpretations accorded this concept under the expenditure test are not supposed to be used in applying the substantial part test.[22]

(i) Substantial Part Test. Under the substantial part test, an organization is regarded as attempting to influence legislation if it (1) contacts, or urges the public (or a segment of the public) to contact, members of a legislative body for the purpose of proposing, supporting, or opposing legislation; or (2) advocates the adoption or rejection of legislation.[23] The first of these categories is grassroots lobbying; the second is direct lobbying. If a substantial part of an organization's activities is directed toward attempts to influence legislation, the organization is denominated an *action organization* and hence cannot qualify as a charitable entity.[24]

(ii) Expenditure Test. Under the expenditure test, the term *influencing legislation* is defined in two ways:

1. Any attempt to influence legislation through communication with any member or any employee of a legislative body or with any other

19. *American Hardware and Equipment Co. v. Commissioner*, 202 F.2d 126 (4th Cir. 1953), *cert. denied*, 346 U.S. 814 (1953); *Roberts Dairy Co. v. Commissioner*, 195 F.2d 948 (8th Cir. 1952), *cert. denied*, 344 U.S. 865 (1952).
20. *See*, e.g., text accompanied by *infra* note 45.
21. *See* § 18.4, text accompanied by notes 84, 91–93.
22. IRC § 501(h)(7).
23. Reg. § 1.501(c)(3)-1(c)(3)(ii).
24. *Id*. A fund was held to be an action organization on the ground that it functioned in a partisan manner as part of its efforts to further the study of tax reform; the court emphasized the organization's focus on a flat tax system and not alternatives for tax reform, including retention of the present system (*The Fund for the Study of Economic Growth and Tax Reform v. Internal Revenue Service*, 997 F. Supp. 15 (D.D.C. 1998)). This decision was affirmed (161 F.3d 755) (D.C. Cir. 1999), with the appellate court emphasizing that its holding in this case is ''quite narrow.'' Wrote the court:

    We are not holding that any organization which studies an issue touching on legislation, reaches a conclusion with respect to that issue, and then argues the merits of that conclusion must necessarily be characterized as an ''action'' organization. We are simply holding that an organization which assumes a conclusion with respect to a highly public and controversial legislative issue and then goes into the business of selling that conclusion may properly be designated an ''action'' organization. *Id*. note 9.

government official or employee who may participate in the formulation of the legislation.[25] This is direct lobbying or, more technically, a *direct lobbying communication*.

2. Any attempt to influence legislation through an attempt to affect the opinions of the general public or any segment of the public.[26] This is grassroots lobbying or, more technically, a *grassroots lobbying communication*.

A communication with a legislator, employee of a legislative body, or government official is a direct lobbying communication only where the communication refers to *specific legislation* and reflects a view on the legislation.[27] Where a communication refers to and reflects a view on a measure that is the subject of a referendum, ballot initiative, or similar procedure, and is made to the members of the general public in the jurisdiction where the vote will occur, the communication is generally a direct lobbying communication.[28] A communication is regarded as a grassroots communication only where the communication refers to specific legislation, reflects a view on the legislation, and encourages the recipient of the communication to take action with respect to the legislation.[29]

Specific legislation is legislation that has already been introduced in a legislative body or a specific legislative proposal that the organization supports or opposes.[30] In the case of a referendum, ballot initiative, constitutional amendment, or other measure that is placed on a ballot by petitions, an item becomes specific legislation when the petition is first circulated among the voters for signature.[31] There is a presumption that certain mass media advertisements are forms of grassroots lobbying.[32] ''Advocacy communications and research materials'' that originate as nonlobbying communications can be subsequently characterized as grassroots lobbying communications if they are later used in a lobbying effort.[33]

A communication between an organization and any bona fide member of the organization, when made to directly encourage the member to engage in direct lobbying, is itself a form of direct lobbying.[34] A communication between an organization and any bona fide member of the organization, when made to directly encourage the member to urge persons other than members to

25. IRC § 4911(d)(1)(B); Reg. § 56.4911-2(b)(1)(i).
26. IRC § 4911(d)(1)(A); Reg. § 56.4911-2(b)(2)(i).
27. Reg. § 56.4911-2(b)(1)(ii).
28. Reg. § 56.4911-2(b)(1)(iii).
29. Reg. § 56.4911-2(b)(2)(ii).
30. Reg. § 56.4911-2(d)(1)(ii).
31. *Id*.
32. Reg. § 56.4911-2(b)(5).
33. Reg. § 56.4911-2(b)(2)(v).
34. IRC § 4911(d)(3)(A).

engage in direct lobbying or grassroots lobbying, is itself a form of grassroots lobbying.[35]

A transfer is a grassroots lobbying expenditure to the extent it is earmarked for grassroots lobbying purposes.[36] A transfer that is earmarked for direct lobbying purposes, or for direct lobbying and grassroots lobbying purposes, is regarded as a grassroots expenditure in full, unless the transferor can demonstrate that all or part of the amounts transferred were expended for direct lobbying purposes, in which case that part of the amounts transferred is a direct lobbying expenditure by the transferor.[37]

Some expense allocation rules that are part of the expenditure test are applicable to communications that have a lobbying or a bona fide nonlobbying purpose.

One rule requires that the allocation be *reasonable*. This rule applies primarily to the communications of the organization with its bona fide members. For this rule to apply, more than one-half of the recipients of the communication must be members of the charitable organization.[38] Another allocation rule governs nonmembership communications. Where a nonmembership lobbying communication also has a bona fide nonlobbying purpose, an organization must include as lobbying expenditures all costs attributable to those portions of the communication that are on the same specific subject as the lobbying message.[39] If a communication (other than one to an organization's members) is both a direct lobbying communication and a grassroots lobbying communication, the communication is treated as a grassroots lobbying expenditure, unless the charitable organization demonstrates that the communication was made primarily for direct lobbying purposes, in which case a reasonable allocation is permitted.[40]

For purposes of the expenditure test, six categories of activities are excluded from the concept of *influencing legislation*: (1) making available the results of nonpartisan analysis, study, or research[41]; (2) providing technical advice or assistance to a governmental body or legislative committee in response to a written request by the body or committee[42]; (3) appearing before or communicating with a legislative body with respect to a possible decision that might affect the existence of the organization, its powers and duties, its tax-exempt status, or the deduction of contributions to it[43]; (4) effecting communication between the organization and its bona fide members with respect to legislation or proposed legislation that is mutually of direct interest,

35. IRC § 4911(d)(3)(B).
36. Reg. § 56.4911-3(c)(1).
37. Reg. § 56.4911-3(c)(2).
38. Reg. § 56.4911-3(a)(2)(ii).
39. Reg. § 56.4911-3(a)(2)(i).
40. Reg. § 56.4911-3(a)(3).
41. IRC § 4911(d)(2)(A); Reg. § 56.4911-2(c)(1).
42. IRC § 4911(d)(2)(B); Reg. § 56.4911-2(c)(3).
43. IRC § 4911(d)(2)(C); Reg. § 56.4911-2(c)(4). This is the *self-defense exception*.

unless the communications directly encourage the members to influence legislation or to urge nonmembers to influence legislation[44]; (5) sending routine communications to government officials or employees[45]; and (6) examining and discussing broad social, economic, and similar problems, even if the problems are of a type with which government would be expected to deal ultimately.[46]

(c) Measuring Allowable Lobbying

Despite the importance of the meaning of the terms *legislation* and *legislative activities*, the most significant of the general concepts is that of determining what is a *substantial* part of a charitable organization's activities. It is relatively easy to ascertain what legislation is and when it is being influenced, but it is often difficult to calculate what amount of lobbying is, at any point in time, allowable without causing loss of tax exemption.[47]

(i) Substantial Part Test. A determination as to whether a specific activity or category of activities of a charitable organization is *substantial* must basically be a factual one and, until enactment of the expenditure test, the law did not offer any mechanical formula for computing *substantial* or *insubstantial* legislative undertakings.[48]

One approach to attempting to measure substantiality in this context is to determine what percentage of an organization's annual expenditures is devoted to efforts to influence legislation. (This essentially is the concept underlying the expenditure test.) Yet the limitation on influencing legislation involves more than a curb on certain expenditures; it restricts certain types of activities as well. The extent of an organization's efforts and activities devoted to the shaping of legislation may well be more important than the amount of the organization's expenditures for that purpose.[49] It was once suggested that when 5 percent of an organization's time and effort involves legislation, the amount is not substantial.[50]

The term *substantial* is not meaningfully defined, for these purposes, in other contexts of the law of tax-exempt organizations, although it is generally

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44. IRC § 4911(d)(2)(D).
45. IRC § 4911(d)(2)(E).
46. Reg. § 56.4911-2(c)(2).
47. The IRS's audit guidelines for colleges and universities (*supra* note 18) provide that amounts that exceed the institution's ''business interests'' are to be measured to determine whether they were ''substantial'' (in the case of applicability of the substantial part test) or exceeded the lobbying allowable amount (in the case of applicability of the expenditure test). *Id.*, § 342(12)(7).
48. *See* text accompanied by *infra* notes 58–75.
49. *League of Women Voters v. United States*, 180 F. Supp. 379 (Ct. Cl. 1960), *cert. denied*, 364 U.S. 822 (1960).
50. *Seasongood v. Commissioner*, 227 F.2d 907, 912 (6th Cir. 1955).

regarded as meaning *ample* or *considerable*.[51] The phrase *substantially all* is defined as being either 85 percent[52] or 90 percent.[53] (Presumably, *substantially all* is a somewhat more encompassing term than *substantial*.) Regarding any conclusion that the word *insubstantial* means something in the range of 10–15 percent, the contemporary thinking at the IRS rejects such a mechanical approach to application of the substantial part test.

In this setting, the use of a percentage standard may be inappropriate. A charitable organization enjoying considerable prestige and influence might be considered as having a substantial impact on a legislative process solely by reason of, for example, a single official position statement—a negligible activity when measured by the percentage of time or funds expended.[54] One of the problems with this type of a standard, however, is that, when applied retrospectively, it places undue emphasis on whether a particular legislative effort was successful.[55] The most expansive interpretation of these rules occurred when a federal court of appeals held that the legislative activities of an organization "must be balanced in the context of the objectives and circumstances of the organization to determine whether a substantial part of its activities was to influence or attempt to influence legislation."[56] Another court observed that "[w]hether an inquiry is substantial

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51. The term *substantial*, however, is used in other exempt organizations contexts. For example, in the rules defining the characteristics of a medical research organization, *substantial* is defined to mean more than 50 percent (*see* § 5.1, text accompanied by note 35). Also, in the rules defining a donative publicly supported charitable organization, *substantial* is defined to mean more than one-third (*see* § 5.2, text accompanied by note 50). These percentages are far too low to be of any utility in the measurement of allowable lobbying by charitable organizations.
52. In the rules concerning private operating foundations, the income test requires that the foundation annually expend, as qualifying distributions, an amount equal to substantially all of the lesser of its adjusted gross income or its minimum investment return (IRC § 4942(j)(3)(A); Reg. § 53.4942(b)-1(a)); the term is defined by the IRS to mean at least 85 percent (Reg. § 53.4942(b)-1(c)). In the rules concerning supporting organizations (*see* § 5.4), where the relationship between the entities is reflected by the phrase *in connection with* and where the integral part test is being used, the supporting organization may be required to make payments of substantially all of its income to or for the use of the supported organization (Reg. § 1.509(a)-4(i)(3)(iii)(a)); again, the IRS has defined the term to mean at least 85 percent (Rev. Rul. 76-208, 1976-1 C.B. 161).
53. In the rules by which certain associations are not required to make disclosure to their members of their lobbying amounts (*see* § 18.4), because substantially all of the organization's dues monies are paid by members not entitled to deduct the dues in computing their taxable income, the term means at least 90 percent. *Id.*, text accompanied by notes 125–126.
54. *See*, e.g., *Kuper v. Commissioner*, 332 F.2d 562 (3d Cir. 1964), *cert. denied*, 379 U.S. 920 (1964).
55. *See*, e.g., *Haswell v. United States*, 500 F.2d 1133, 1142 (Ct. Cl. 1974), *cert. denied*, 419 U.S. 1107 (1974); *Dulles v. Johnson*, 273 F.2d 362, 367 (2d Cir. 1959), *cert. denied*, 364 U.S. 834 (1960).
56. *Christian Echoes National Ministry, Inc. v. United States*, 470 F.2d 849, 855 (10th Cir. 1972), *cert. denied*, 414 U.S. 864 (1973).

is a facts-and-circumstances inquiry not always dependent upon time or expenditure percentages.''[57]

(ii) Expenditure Test. The expenditure test utilizes what are intended to be mechanical standards for measuring permissible and impermissible ranges of lobbying expenditures[58] by eligible charitable organizations, and it does so in terms of the expenditure of funds and sliding scales of percentages.

These standards are formulated in terms of declining percentages of total *exempt-purpose expenditures*.[59] In general, an expenditure is an exempt-purpose expenditure for a tax year if it is paid or incurred by an electing public charity to accomplish the organization's exempt purposes.[60] These expenditures include (1) those expended for one or more charitable purposes, including most grants made for charitable ends; (2) amounts paid as employee compensation (current or deferred) in furtherance of a charitable purpose; (3) the portion of administrative expenses allocable to a charitable purpose; (4) all lobbying expenditures; (5) amounts expended for nonpartisan analysis, study, or research; (6) amounts expended for examinations of broad social, economic, and similar problems; (7) amounts expended in response to requests for technical advice; (8) amounts expended pursuant to the self-defense exception[61]; (9) amounts expended for communications to members that do not involve lobbying; (10) a reasonable allowance for straight-line depreciation or amortization of charitable assets[62]; and (11) certain fund-raising expenditures.[63]

Exempt-function expenditures do not include (1) amounts expended that are not for purposes described in the preceding items (1) through (9) or item (11); (2) the amount of transfers to members of an affiliated group, made to artificially inflate the amount of exempt-purpose expenditures, or to certain noncharitable organizations; (3) amounts paid to or incurred for a ''separate fund-raising unit'' of the organization or an affiliated organization; (4) amounts paid to or incurred for any person who is not an employee or any organization that is not an affiliated organization, if paid primarily for fundraising, but only if the person or organization engages in fundraising, fundraising counseling, or the provision of similar advice or services; (5) amounts paid or incurred that are properly chargeable to a capital account with respect to an unrelated trade or business; (6) amounts paid or incurred for a tax that is not imposed in connection with the organization's efforts to accomplish charitable purposes

57. *The Nationalist Movement v. Commissioner*, 102 T.C. 558, 589 (1994), *aff'd*, 37 F.3d 216 (5th Cir. 1994). Also *Manning Association v. Commissioner*, 93 T.C. 596, 610–611 (1989); *Church in Boston v. Commissioner*, 71 T.C. 102, 108 (1978).
58. IRC § 4911(c)(1); Reg. § 1.501(h)-3(c)(1).
59. IRC § 4911(e)(1); Reg. § 56.4911-4(a).
60. IRC § 4911(e)(1)(A).
61. *See supra* note 43.
62. IRC § 4911(e)(4).
63. IRC § 4911(e)(1)(B); Reg. § 56.4911-4(b).

(such as the unrelated business income tax); and (7) amounts paid or incurred for the production of income, where the income-producing activity is not substantially related to exempt purposes (such as the costs of maintaining an endowment).[64]

The basic permitted annual level of expenditures for legislative efforts (the *lobbying nontaxable amount*[65]) is determined by using a sliding scale percentage of the organization's exempt-purpose expenditures, as follows: 20 percent of the first $500,000 of an organization's expenditures for an exempt purpose, plus 15 percent of the next $500,000, 10 percent of the next $500,000, and 5 percent of any remaining expenditures. However, the total amount spent for legislative activities in any one year by an eligible charitable organization may not exceed $1 million.[66] A separate limitation—amounting to 25 percent of the foregoing amounts—is imposed on attempts to influence the general public on legislative matters[67] (the *grassroots nontaxable amount*[68]).

A charitable organization that has elected the expenditure test and that exceeds either or both of these limitations becomes subject to an excise tax in the amount of 25 percent of the excess lobbying expenditures.[69] As respects these two limitations, the tax falls on the greater of the two excesses.[70] If an electing organization's lobbying expenditures normally (that is, on an average over a four-year period[71]) exceed 150 percent of either limitation (the *lobbying ceiling amount*[72] and the *grassroots ceiling amount*[73]), it will lose its tax-exempt status as a charitable entity.[74] A charitable organization in this circumstance is not able to convert to a tax-exempt social welfare organization.[75]

(d) Record-Keeping Requirements

Charitable organizations must keep records with respect to their legislative activities. The extent of this type of record keeping is dependent on whether the organization is subject to the substantial part test or the expenditure test.

(i) Substantial Part Test. A charitable organization that is subject to the substantial part test must keep whatever records are necessary to be able to comply with the reporting requirements.[76]

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64. IRC § 4911(e)(1)(C); Reg. § 56.4911-4(c).
65. Reg. §§ 1.501(h)-3(c)(2) and 56.4911-1(c)(1).
66. IRC § 4911(c)(2); Reg. § 56.4911-1(c)(1).
67. IRC § 4911(c)(3); Reg. §§ 56.4911-1(c)(2), 1.501(h)-3(c)(4).
68. IRC § 4911(c)(4); Reg. §§ 56.4911-1(c)(2), 1.501(h)-3(c)(5).
69. IRC § 4911(a); Reg. §§ 56.4911-1(a), 1.501(h)-1(a)(3).
70. IRC § 4911(b); Reg. § 56.4911-1(b).
71. Reg. § 1.501(h)-3(c)(7).
72. Reg. § 1.501(h)-3(c)(3).
73. Reg. § 1.501(h)-3(c)(6).
74. IRC § 501(h)(1), (2); Reg. § 1.501(h)-3(b).
75. IRC § 504; Reg. § 1.504-1, 2. *See* § 1.8.
76. *See* text accompanied by *infra* note 80.

(ii) Expenditure Test. A charitable organization that is governed by the expenditure test must keep a record of its lobbying expenditures for each tax year. These records must include (1) expenditures for grassroots lobbying; (2) amounts paid for direct lobbying; (3) the portion of amounts paid or incurred as compensation for an employee's services for direct lobbying; (4) amounts paid for out-of-pocket expenditures incurred on behalf of the organization and for direct lobbying; (5) the allocable portion of administrative, overhead, and other general expenditures attributable to direct lobbying; (6) expenditures for publications or for communications with members to the extent the expenditures are treated as expenditures for direct lobbying; and (7) expenditures for direct lobbying of a controlled organization to the extent included by a controlling organization in its lobbying expenditures.[77] Identical record-keeping requirements apply with respect to grassroots lobbying expenditures.[78]

(e) Reporting Requirements

Charitable organizations must make annual reports to the IRS with respect to their legislative activities. Lobbying expenditures must be included on the annual information return.[79] The extent of this type of reporting is dependent on whether the organization is subject to the substantial part test or the expenditure test.

(i) Substantial Part Test. Charitable organizations that are under the substantial part test must report on the use of volunteers; paid staff or management; media advertisements; mailings to members, legislators, or the public; publications or broadcast statements; grants to other organizations for lobbying purposes; direct contact with legislators, their staffs, government officials, or a legislative body; and rallies, demonstrations, seminars, conventions, speeches, lectures, or any other means.[80]

(ii) Expenditure Test. A charitable organization governed by the expenditure test must make a report of its legislative activities in its annual information return. It must disclose the amount of its lobbying expenditures, both direct and grassroots, as well as the amount that it could have spent for legislative purposes without becoming subject to the 25 percent excise tax.[81] An electing organization that is a member of an affiliated group[82]

77. Reg. § 56.4911-6(a).
78. Reg. § 56.4911-6(b).
79. Form 990, Schedule A, Part III, line 1. *See*, in general, § 34.3.
80. Form 990, Schedule A, Part VI-B.
81. Form 990, Schedule A, Part VI-A.
82. *See infra* note 84.

must provide this information with respect to both itself and the entire group.[83]

(f) Affiliated Groups

The substantial part test does not have any rules with respect to affiliated groups.

The expenditure test, however, contains methods of aggregating the expenditures of related organizations (so as to forestall the creation of numerous organizations for the purpose of avoiding the limitations of the test). Where two or more charitable organizations are members of an affiliated group[84] and at least one of the members has elected coverage under the expenditure test, the calculations of exempt-purpose expenditures and lobbying must be made by taking into account the expenditures of the group.[85] If these expenditures exceed the permitted limits, each of the electing member organizations must pay a proportionate share of the penalty excise tax, with the nonelecting members treated under the substantial part test.[86]

(g) Special Rules for Public Charities

There are special rules in this area for public charities, which include tax-exempt charitable hospitals, other healthcare providers, and publicly supported organizations.

If a public charitable organization loses its tax exemption because of attempts to influence legislation, a tax in the amount of 5 percent of the lobbying expenditures is to be imposed each year on the organization.[87] This tax is inapplicable, however, to any organization that has elected to be governed by the expenditure test[88] or is ineligible to make that election.[89] A *lobbying expenditure* is any amount paid or incurred by a charitable organization in carrying on propaganda or otherwise attempting to influence legislation.

A separate tax is applicable to each of the organization's managers (basically, its officers and directors) who agreed to the expenditures for lobbying (knowing that they were likely to result in revocation of the organization's

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83. IRC § 6033(b)(8).
84. Reg. § 56.4911-7(e). Generally, two organizations are deemed *affiliated* where one organization is bound by decisions of the other on legislative issues by direction of its governing instrument, or the governing board of one organization includes enough representatives of the other to cause or prevent action on legislative issues by the first organization (IRC § 4911(f)(2)).
85. IRC § 4911(f)(1); Reg. § 56.4911-8, 10.
86. IRC § 4911(f)(1)(B).
87. IRC § 4912(a).
88. IRC § 4912(c)(2)(A). *See* § 7.1, note 6.
89. IRC § 4912(c)(2)(B). *See* § 7.1, text accompanied by note 10.

exemption), unless the agreement was not willful and was due to reasonable cause.[90]

§ 7.2 BUSINESS EXPENSE DEDUCTION RULES AND LOBBYING

Another set of federal tax rules exists, with respect to the business expense deduction.[91] This body of law not only denies the business expense deduction for nearly all forms of outlays for lobbying,[92] but also disallows the portion of membership dues paid to associations that is allocable to the associations' lobbying.[93] Disclosure and reporting obligations on these associations are imposed,[94] as is a proxy tax that is levied under certain circumstances.[95]

Although these rules are not applicable with respect to charitable organizations[96] and are applicable with respect to social welfare organizations,[97] they are predominantly utilized in connection with business leagues and thus are discussed in that context.[98]

§ 7.3 FEDERAL DISCLOSURE OF LOBBYING

The lobbying of Congress is protected by the constitutional right of free speech, which provides that "Congress shall make no law . . . abridging the freedom of speech or of the press; or of the right of the people . . . to petition the Government for redress of grievances."[99] Nonetheless, lobbying in general is loosely regulated at the federal level by the Lobbying Disclosure Act (the Act).[100] Thus, the Act is potentially applicable to any healthcare organization, association of healthcare organizations, and lobbyists for these organizations who endeavor to lobby members of Congress, their staffs, or committee staffs.

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90. IRC § 4912(b). According to the legislative history of this provision, the burden of proof as to whether a manager knowingly participated in the lobbying expenditure is on the IRS, and the fact that the excise tax is imposed on an organization does not itself establish that any manager of the organization is subject to the excise tax. H. Rep. NO. 100-495, 100th Cong., 1st Sess. 1024 (1987).
91. IRC § 162.
92. IRC § 162(e)(1)(A), (C)-(D).
93. IRC § 162(e)(3).
94. IRC § 6033(e)(1).
95. IRC § 6033(e)(2).
96. IRC § 6033(e)(1)(B)(i).
97. *See* § 1.8.
98. *See* § 18.4. The General Accounting Office (GAO) studied the issue as to whether these various definitions of lobbying activities (those summarized in § 7.1 and this section) should be harmonized, in the interest of uniformity and consistency. In a report issued in 1999, the GAO, having observed that these different definitions are reflective of separate policy decisions made by Congress, recommended that these policies be revisited before the laws are revised. This development has substantially reduced the likelihood of any harmonization of these laws.
99. U.S. Constitution, First Amendment.
100. 2 U.S.C. §§ 1601 *et seq*.

As a general rule, a *lobbyist* is required to register with the Secretary of the Senate and/or the Clerk of the House of Representatives. This registration must occur no later than 45 days after a lobbyist first makes a *lobbying contact* or is employed or retained to make this type of a contact, whichever is earlier. An organization that has one or more employees who are lobbyists must file a single registration on behalf of the employees for each *client*.[101]

There are two exemptions from this registration requirement. One—available to eligible tax-exempt organizations—is for an entity that has total expenses in connection with *lobbying activities* (in the case of an organization the employees of which engage in lobbying activities on its own behalf) that do not exceed or are not expected to exceed $20,000 during the semiannual period in which the registration would otherwise be made. The other exemption is for a person whose total income for matters related to lobbying activities on behalf of a particular client (in the case of a lobbying firm) does not exceed and is not expected to exceed $5,000 during the semiannual period in which the registration would otherwise be made. These monetary thresholds, which are applicable with respect to the six-month periods from January 1 through June 30 and July 1 through December 31, are to be adjusted for inflation every four years (beginning in 2001).[102]

A public charity that has elected the expenditure test[103] may, for the purpose of determining qualification for this exemption, make a good faith estimate (by category of dollar value) of applicable amounts that would be required to be disclosed under the tax law annual reporting requirements for the appropriate semiannual period.[104] Organizations that are subject to the business expense nondeductibility rules[105] may utilize a similar rule.[106]

A *lobbyist* is any individual who is employed or retained by a client for compensation for services that include more than one lobbying contact, other than an individual whose *lobbying activities* constitute less than 20 percent of the time engaged in the services provided by the individual to the client over a six-month period.[107] A *client* is any person that employs or retains another person for compensation to conduct lobbying activities. In the case of a coalition or association that employs or retains a lobbyist, the client is the coalition or association, rather than its members.[108]

A *lobbying contact* is any oral or written communication to a *covered legislative branch official* or to a *covered executive branch official* that is made on behalf of a client with regard to the formulation, modification, or adoption of federal

101. 2 U.S.C. § 1603(a)(1), (2).
102. 2 U.S.C. § 1603(a)(3).
103. *See supra* note 7.
104. 2 U.S.C. § 1610(a)(1).
105. See § 7.2.
106. 2 U.S.C. § 1610(b)(1).
107. 2 U.S.C. § 1602(10).
108. 2 U.S.C. § 1602(2).

legislation (including legislative proposals); the formulation, modification, or adoption of a federal regulation, rule, executive order, or other federal government policy or position; the administration or execution of a federal program or policy (such as the negotiation of a federal grant, contract, or loan); or the nomination or confirmation of an individual for a position subject to confirmation by the Senate.[109]

A *covered legislative branch official* includes a member of Congress, an elected officer of the House of Representatives or Senate, any employee of a member of Congress, any employee of a committee of the House or Senate, any employee of the leadership staff of the House or Senate, and any employee of a working group or caucus organization providing legislative services to members of Congress.[110]

A *covered executive branch official* includes the President, Vice President, any officer or employee in the Executive Office of the President, any officer or employee serving in levels I–V of the executive schedule, and any officer or employee serving in a position of a confidential, policy-determining, policy-making, or policy-advocating character.[111]

The concept of the *lobbying contact*, however, does not embrace a communication that is made in a speech, article, publication, or other material that is distributed to the public or through the media (grassroots lobbying); a request for a meeting, a request for the status of an action, or any other similar administrative request, as long as the request does not include an attempt to influence a covered legislative branch or executive branch official; testimony given before a committee, subcommittee, or task force of Congress or submitted for inclusion in the public record of the hearing; information provided in writing in response to an oral or written request by a covered legislative or executive branch official for specific information; made in response to a notice in the *Federal Register* or similar publication soliciting communications from the public and directed to the agency official designated in the notice; a petition for agency action made in writing and required to be a matter of public record; or made by a church, its integrated auxiliary, a convention or association of churches, or a religious order that is not required to file an annual information return.[112]

Lobbying activities are lobbying contacts, as well as efforts in support of these contacts, such as preparation and planning activities, research, and other background work that is intended, at the time it is performed, for use in contacts, and coordination with the lobbying activities of others.[113]

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109. 2 U.S.C. § 1602(8)(A).
110. 2 U.S.C. § 1602(4).
111. 2 U.S.C. § 1602(3).
112. 2 U.S.C. § 1602(8)(B).
113. 2 U.S.C. § 1602(7).

A public charity that has elected the expenditure test may, however, instead of adhering to this definition of lobbying activities, consider as lobbying activities those activities that are treated as efforts to influence legislation under that test.[114] Likewise, an organization that is subject to the business expense disallowance rule for legislative expenditures may consider as lobbying activities those activities the cost of which are not deductible under those rules.[115]

The registration under this body of law must include the name, address, telephone number, place of business, and description of the business activities of the registrant and the registrant's client; a statement of the general issue areas in which the registrant expects to engage in lobbying or already has engaged in lobbying for the client; and the name of each employee of the registrant who has acted as a lobbyist on behalf of the client. Also, a registrant must report the name, address, and place of business of any organization, other than a client, that contributed more than $10,000 toward the lobbying activities of the registrant in each semiannual period and that supervises and controls any major part of these lobbying activities.[116]

For each semiannual period in which a registration is in effect, the registrant must file a report with the Secretary of the Senate and the Clerk of the House on its lobbying activities during the period. A separate report must be filed for each client. The report is due no later than 45 days after the end of the period.[117]

This report must include a list of the specific issues upon which a lobbyist is engaged in lobbying, including a list of bill numbers and reference to specific executive branch actions; a list of the houses of Congress and the federal agencies contacted by lobbyists for the registrant; a list of the employees of the registrant who acted as lobbyists on behalf of the client; in the case of a lobbying firm, a good faith estimate of the total amount of all income from the client that was paid for lobbying; and, in the case of a registrant engaged in lobbying on its own behalf, a good faith estimate of the total expenses that the registrant and its employees incurred in connection with lobbying.[118]

If income or expenses do not exceed $10,000, the registrant may simply make a statement to that effect. For lobbying income or expenses in excess of $10,000, the estimates are to be rounded to the nearest $20,000.[119]

The registration forms and semiannual lobbying reports are to be retained by the Secretary of the Senate and Clerk of the House for a period of six years. They are available for public inspection and photocopying.[120]

114. 2 U.S.C. § 1610(a)(2).
115. 2 U.S.C. § 1610(b)(2).
116. 2 U.S.C. § 1610(b).
117. 2 U.S.C. § 1604(a).
118. 2 U.S.C. § 1604(b).
119. 2 U.S.C. § 1604(c).
120. 2 U.S.C. § 1605.

Tax-exempt social welfare organizations that engage in lobbying activities are ineligible for the receipt of federal funds by means of a grant, contract, award, loan, and the like.[121]

Anyone knowingly failing to remedy a defective filing within 60 days after receiving notice of the defect or failing to comply with any provision of this law is subject to a civil fine of not more than $50,000.[122]

Nothing in the Act may be construed to prohibit or interfere with the right to petition the federal government for the redress of grievances, the right to express a personal opinion, or the right of association. These rights are protected by the First Amendment to the U.S. Constitution.[123]

§ 7.4 THE POLITICAL ACTIVITIES LIMITATION

The federal tax law states that, for an organization to qualify as a tax-exempt charitable entity, it must ''not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.''[124] This proscription thus applies with respect to all healthcare organizations that are tax-exempt charitable entities.

(a) Scope of Proscription

The prohibition on involvement by a tax-exempt charitable organization in a political campaign is asserted by the IRS to be an absolute one, although the tax regulations do not clarify the point.[125] The IRS stated that ''this is an absolute prohibition,'' adding that ''[t]here is no requirement that political campaigning be substantial.''[126] Thus, the Chief Counsel of the IRS opined that an exempt charitable organization ''is precluded from engaging in *any* political campaign activities.''[127]

Nonetheless, there undoubtedly is at least some form of insubstantiality standard. As the U.S. Supreme Court stated, ''a slight and comparatively unimportant deviation from the narrow furrow of tax approved activity is not fatal.''[128] Another court observed that ''courts recognize that a nonexempt purpose, even 'somewhat beyond a de minimis level,' may be permitted without

121. 2 U.S.C. § 1611.
122. 2 U.S.C. § 1606.
123. 2 U.S.C. § 1607(a). *See supra* note 99.
124. IRC § 501(c)(3).
125. Reg. §§ 1.501(c)(3)-1(b)(3)(ii) and 1(c)(iii).
126. IRS Exempt Organizations Handbook (IRM 7751), § 370(2). The reference to substantiality was to contrast the rule with the insubstantiality threshold applicable with respect to the limitation on legislative activities (*see* § 7.1, text accompanied by *supra* notes 44–70).
127. Gen. Couns. Mem. 39694 (emphasis supplied).
128. *St. Louis Union Trust Co. v. United States*, 374 F.2d 427, 431–432 (8th Cir. 1967).

loss of exemption.''[129] The then-Commissioner of Internal Revenue stated, in testimony before a congressional committee concerning this proscription: ''If political intervention is involved, the prohibition is absolute; however, some consideration may be given to whether, qualitatively or quantitatively, the organization is in the circumstance where the activity is so trivial it is without legal significance and, therefore, de minimis.''[130]

(b) *Participation or Intervention*

An organization that participates or intervenes, directly or indirectly, in any political campaign on behalf of or in opposition to any candidate for public office is a form of *action organization* and thus cannot qualify for tax exemption as a charitable entity.[131] The scope of this prohibition has infrequently been the subject of discussion in court opinions or IRS rulings.

The most obvious way for a charitable organization to participate or intervene in a political campaign would be to make a contribution to a candidate for public office; this is clearly forbidden.[132] Another way would be to make available the facilities or other resources of the organization for the benefit of a candidate in a political campaign.[133] Other proscribed activities of this nature include evaluation of the qualifications of potential candidates in a school board election, and support of particular slates in the campaign[134]; implementation of an orderly change of administration of the office of a state governor[135]; activities of an organization established with the dominant aim of bringing about world government[136]; and publications and broadcasts attacking and urging the defeat of political leaders.[137]

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129. *Living Faith, Inc. v. Commissioner*, 950 F.2d 365, 370 (7th Cir. 1991).
130. *Lobbying and Political Activities of Tax-Exempt Organizations, Hearings Before the Subcomm. on Oversight, House Comm. on Ways and Means*, H.R. Serial 100-5, 96–97, 100th Cong., 1st Sess. (1987) (statement of Lawrence B. Gibbs, Mar. 12, 1987). Yet a federal appellate court earlier wrote that, with respect to charitable organizations, ''exemption is lost . . . by participation in *any* political campaign on behalf of *any* candidate for public office'' (*United States v. Dykema*, 666 F.2d 1096, 1101 (7th Cir. 1981) (emphasis in original), *cert. denied*, 456 U.S. 983 (1982)).
131. Reg. § 1.501(c)(3)-1(c)(3)(iii).
132. E.g., *New Faith, Inc. v. Commissioner*, 64 T.C.M. 1050 (1992).
133. The IRS's Hospital Audit Guidelines are silent on this point (*see* § 35.2). However, the IRS's audit guidelines with respect to colleges and universities (*supra* note 18) state that the examining agents are to review any written policies on political campaign activity (including on-campus speeches or other appearances by candidates), student newspapers' reports on institutional activities, minutes of committee meetings, and the activities of a ''University Affairs'' division or similar office, to determine whether there have been any unwarranted participations or interventions in any political campaigns (§ 342.(12)(2)-(6)).
134. Rev. Rul. 67-71, 1967-1 C.B. 125.
135. Rev. Rul. 74-117, 1974-1 C.B. 128.
136. *Estate of Blaine v. Commissioner*, 22 T.C. 1195 (1954).
137. *Christian Echoes National Ministry, Inc. v. United States*, 470 F.2d 849 (10th Cir. 1972), *cert. denied*, 414 U.S. 864 (1973).

In one instance, the IRS concluded that statements in a public charity's fundraising letters, mailed contemporaneously with election periods, constituted intervention in political campaigns, because they created the impression that resulting contributions would help candidates for public office who maintain a certain political viewpoint.[138] As another illustration, the IRS determined that the use by a charitable organization of panels of citizens to review and rate political candidates is a form of intervention or participation in the candidates' campaigns. The organization viewed this activity as a form of issue education and means to stimulate public dialogue, but the IRS asserted that the candidate ratings provided ''political editorial opinions to the general public and went beyond the neutral forums'' that are permissible.[139] In certain circumstances, grassroots lobbying can also be political campaign activity.[140] The standard to apply in determining whether an organization is involved in a political campaign has recently been clarified by the IRS. There are essentially two choices when framing the standard: *express advocacy,* where participation in a political campaign by a charitable organization is considered to occur only where there is an explicit communication or other direct and obvious manifestation as to the organization's position with respect to a candidate, or a *facts-and-circumstances test*, where political campaign activity (or the absence of it) can be inferred from the particular circumstances.

By the close of 2005, the IRS or a court had yet to articulate a substantive view as to the appropriate standard for ascertaining the presence of an organization's participation in a political campaign, notwithstanding the agency's launch of several inquiries as to the behavior or ostensible behavior of charitable organizations during the course of the 2004 presidential campaign. Utilization of the facts-and-circumstances approach by the IRS in this context is reflected in revenue rulings issued in the voter education setting; for example, this statement appears in two of these rulings: ''Whether an organization is participating or intervening, directly or indirectly, in any political campaign on behalf of or in opposition to any candidate for public office depends upon all of the facts and circumstances of each case.''[141] In one instance, voter's guides were found to be violative of the rule inasmuch as they either emphasized ''one area of concern'' that indicated the purpose was not nonpartisan or some questions in a questionnaire ''evidence[d] a bias on certain issues.''[142] In the other instance, an organization's publication was held to be ''not neutral,'' yet

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138. Tech. Adv. Mem. 9609007.
139. Tech. Adv. Mem. 9635003. The IRS's lawyers concluded that administration of a payroll deduction plan by a public charity in support of a political action committee constituted prohibited participation or intervention in political campaigns, in that charitable organizations ''may not provide or solicit financial or other forms of support to political organizations'' (Tech. Adv. Mem. 200446033).
140. E.g., Priv. Ltr. Rul. 9652026.
141. Rev. Rul. 80-282, 1980-2 C.B. 178; Rev. Rul. 78-248, 1978-1 C.B. 154.
142. Rev Rul. 78-248, 1978-1 C.B. 154.

other factors led to the conclusion that distribution of the publication was not prohibited political campaign activity.[143] A fuller explication of the standard, however, was not provided.

Then in a private letter ruling made public at the outset of 2006, the IRS wrote that the ''determination of whether a public communication made by, or on behalf of, an organization constitutes intervention in a political campaign for purposes of section 501(c)(3) of the Code is made on the bases of all the surrounding facts and circumstances.''[144] In this informal guidance, the agency continued: ''This determination for purposes of section 501(c)(3) does not hinge on whether the communication constitutes 'express advocacy' for federal election law purposes.'' The IRS concluded: ''Rather, for purposes of section 501(c)(3), one looks to the effect of the communication as a whole, including whether support for, or opposition to, a candidate for public office is express or implied.''

Thereafter, the IRS issued more formal guidance on this subject, indicating whether, in 21 factual situations, a tax-exempt charitable organization violated the federal income tax law proscription on participation or intervention in a political campaign on behalf of or in opposition to a candidate for public office.[145] The agency observed that, in each of these situations, ''all the facts and circumstances are considered in determining whether an organization's activities result in political campaign intervention.'' (This guidance addresses voter education and registration, action by organizations' leaders, candidate appearances, issue advocacy, and activity on web sites.)

Certain voter education activities are permissible,[146] as are the publication of newsletters containing the voting records of congressional incumbents on selected issues[147]; the provision of equal air time to all electoral candidates in compliance with federal communications law[148]; the provision, by a university, of faculty advisors and facilities for a campus newspaper that publishes the students' editorial opinions on political matters[149]; and the conduct, by a university, of political science courses that require students' participation in political campaigns of their choice.[150]

Inasmuch as tax-exempt healthcare and other charitable organizations function only through individuals, who have the personal freedom to engage in political campaign activities, the law distinguishes between activities that are undertaken in conjunction with *official* responsibilities and those that are *personal;* only activities in the former category are relevant in assessing an

143. Rev. Rul. 80-282, 1980-2 C.B. 178.
144. Priv. Ltr. Rul. 200602042.
145. Rev. Rul. 2007-41, 2007-25 I.R.B. 1421.
146. Rev. Rul. 78-248, 1978-1 C.B. 154.
147. Rev. Rul. 80-282, 1980-2 C.B. 178.
148. Rev. Rul. 74-574, 1974-2 C.B. 160.
149. Rev. Rul. 72-513, 1972-2 C.B. 246.
150. Rev. Rul. 72-512, 1972-2 C.B. 246.

organization's qualification for tax exemption in the face of political campaign efforts.[151] The political campaign activities of individuals (such as officers or members) are, however, imputed to the organization if it has, directly or indirectly, authorized or ratified the acts.[152]

The IRS revoked the tax-exempt status of a church as a result of its involvement in a political campaign. This church intervened in the 1992 presidential election by means of newspaper advertisements questioning the position of one of the candidates on certain social issues. This revocation of exemption was upheld by a court.[153]

(c) Requirement of a *Candidate*

For the political campaign activity proscription to apply, there must be a *candidate*; the federal tax law does not provide a definition of that term. The tax regulations come the closest to the definition when referring to ''an individual who offers himself, or is proposed by others, as a contestant'' for an elective public office.[154] A glaring omission from this definition is the point in time at which an individual becomes a candidate; it presumably can be a time earlier than the date of a formal announcement.

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151. Gen. Couns. Mem. 34631. In guidance for churches and clergy, the IRS stated that, when a member of a clergy takes a position with respect to a political candidate, he or she is to make it clear to the congregation that the position is a personal one and not that of the church (Ann. 94-122, 1994-42 I.R.B. 20).
152. Gen. Couns. Mem. 33912.
153. *Branch Ministries, Inc. v. Rossotti*, 40 F. Supp. 2d 15 (D.D.C. 1999). One of the arguments of this church was that it was the victim of selective prosecution by the IRS. This contention was that the IRS penalizes churches on the right of the political spectrum when they engage in political campaign activity but ignores comparable activity by churches on the left. The court earlier held that the church made a ''colorable showing'' that the entity's ''political and/or religious beliefs may have played an impermissible role in the revocation of their [sic] tax-exempt status'' and thus that it was entitled to additional discovery on the issue of intent (*Branch Ministries, Inc. v. Richardson*, 970 F. Supp. 11, 17 (D.D.C. 1997)). (The church had tendered to the court 65 examples of political campaign activity in or by churches.) The court, however, ultimately rejected the selective prosecution argument, writing that the church's evidence related ''only to churches that have allowed political leaders to appear at religious services or churches that have used the pulpit to advocate a certain message'' (*Branch Ministries, Inc. v. Rossotti, supra* at 21). The court observed that the church was unable to point to any ''other instance in which a church so brazenly claimed responsibility for a political advertisement in a national newspaper and solicited tax-deductible donations for that political advertisement'' (*id*.). This decision was affirmed (211 F.3d 137 (D.C. Cir. 2000)). The staff of the Joint Committee on Taxation conducted a study as to whether the IRS is biased in its treatment of religious and other tax-exempt organizations engaged in political campaign activity. This study, issued in March 2000, concluded that there is no credible evidence that the IRS engaged in any activity (such as issuance of determination letters or selection of organizations for examination) that was politically motivated (*Report of Investigation of Allegations Relating to Internal Revenue Service Handling of Tax-Exempt Organizations Matters* (JCS-3-00)).
154. Reg. § 1.501(c)(3)-1(c)(3)(iii).

An analysis of these political campaign intervention rules by the staff of a committee of the U.S. Congress stated that ''[c]lear standards do not exist for determining precisely at what point an individual becomes a candidate for purposes of the rule.''[155] This analysis continued: ''On the one hand, once an individual declares his candidacy for a particular office, his status as a candidate is clear.''[156] The analysis added: ''On the other hand, the fact that an individual is a prominent political figure does not automatically make him a candidate, even if there is speculation regarding his possible future candidacy for particular offices.''[157]

The little law there is inconsistent with this analysis. In one case, the political campaign proscription was ruled to apply because of a set of activities that occurred immediately following the election of an individual to public office; the candidacy status clearly had passed.[158] In another instance, criticism of existing officeholders was held to be inappropriate under these rules.[159]

Where an individual is not a *candidate* in a *campaign*, the proscription on political campaign activity cannot apply.[160]

(d) Requirement of a *Campaign*

For the political campaign activity proscription to apply, there must be a *campaign*; the federal tax law does not provide a definition of that term.

A federal court of appeals observed that a ''campaign for a public office in a public election merely and simply means running for office, or candidacy for office, as the word is used in common parlance and as it is understood by the man in the street.''[161] As is the case with the requirement of a *candidate*, however, this limitation has been applied where a campaign was not in progress.[162]

(e) Requirement of a *Public Office*

The federal tax law does not define the term *public office* for purposes of the political campaign activity proscription applicable to tax-exempt charitable organizations.

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155. Joint Committee on Taxation, *Lobbying and Political Activities of Tax-Exempt Organizations* (JCS-5-87) 14 (Mar. 11, 1987).
156. *Id*.
157. *Id*.
158. Rev. Rul. 74-117, 1974-C.B., 128.
159. *Christian Echoes National Ministry, Inc. v. United States*, 470 F.2d 849 (10th Cir. 1972), *cert. denied*, 414 U.S. 864 (1973).
160. *See*, e.g., *Fulani v. League of Women Voters Education Fund*, 882 F.2d 621 (2d Cir. 1989), *aff'g* 684 F. Supp. 1185 (S.D.N.Y. 1988).
161. *Norris v. United States*, 86 F.2d 379, 382 (8th Cir. 1936), *rev'd on other grounds*, 300 U.S. 564 (1937).
162. *See* text accompanied by *supra* note 137.

The private foundation rules defining the term *disqualified persons*, however, make reference to the phrase *elective public office*.[163] The statute does not define the term *public office* in this context either, but the tax regulations state that the term "must be distinguished from mere public employment,"[164] and that the "essential element is whether a significant part of the activities of a public employee is the independent performance of policymaking functions." Among the factors to be considered are whether the office was created by a legislative body, and whether the duties to be discharged by the office are defined directly or indirectly by legislative authority.[165] In the law of tax-exempt organizations, the only other reference to the term *public office* is in the context of the rules concerning political organizations, where the term is used in the definition of an exempt function for a political organization.[166] The regulations accompanying this provision use the same definition of the term *public office* as is used in the setting of the private foundations rules defining disqualified persons.[167]

In one of the few interpretations of these rules, the IRS Chief Counsel's office, relying on state law, took the position that members of precinct committees in a state are holders of a public office.[168] This conclusion was reached in the process of advising that a charitable organization's tax exemption should be revoked because it encouraged its members to seek election to precinct committees and to support these candidacies. The IRS's lawyers conceded that if the above-noted tax regulations were applied in this case, the individuals comprising the precinct committees "would not be considered as holding public office because their duties entail no independent policymaking functions." Nonetheless, the IRS relied on the "additional factors to be considered as indicative of a public office . . . which are listed in the latter part of that regulation."[169]

A federal appellate court held that the phrase *candidate for office* is "used in common parlance and as it is understood by the man in the street."[170] Relying on this observation, the IRS Chief Counsel's office stated that, "[t]o the average person, the appearance of precinct candidates on the general election ballot indicates that the position is a public office."[171]

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163. IRC § 4946(c)(1), (5).
164. Reg. § 1.53.4946-1(g)(2)(i).
165. *Id*.
166. IRC § 527(e)(2).
167. Reg. § 1.527-2(d).
168. Gen. Couns. Mem. 39811.
169. A state court of appeals held that an individual who is a candidate for delegate to a county political convention is a *candidate* for state law purposes but is not a candidate for a *public office* (*Templin v. Oakland City Clerk*, 387 N.W.2d 156 (Mich. App. 1986)).
170. *Association of the Bar of the City of New York v. Commissioner*, 858 F.2d 876, 880 (2d Cir. 1988), *cert. denied*, 490 U.S. 1030 (1989).
171. Gen. Couns. Mem. 39811.

(f) Special Rules for Public Charities

There are special rules in this area for public charities, which include tax-exempt charitable hospitals, other healthcare providers, and publicly supported organizations.

Taxes can be imposed for the making of a *political expenditure*. One definition of this term covers amounts paid or incurred by a public charitable organization to participate or intervene in the political campaign of any candidate for public office.[172] Therefore, any political expenditure that would cause an organization that made it to be an *action organization* would be a political expenditure for this purpose.[173] The other definition of political expenditures includes certain outlays by organizations that are formed primarily for the purpose of promoting an individual's candidacy or are used primarily for that purpose and effectively controlled by the candidate.[174] In the instance of a political expenditure, there is a tax on the charitable organization.[175]

A separate tax is imposed on the agreement of an organization manager to the making of a political expenditure, knowing that it was a political expenditure, unless the agreement was not willful and was due to reasonable cause.[176] The IRS's lawyers wrote that these taxes were enacted ''not so much as an intermediate sanction to replace revocation, but primarily as an

172. IRC § 4955(d)(1). *See* text accompanied by *supra* note 124.
173. *See* text accompanied by *supra* note 131.
174. IRC § 4955(d)(2).
175. IRC § 4955(a)(1).
176. IRC § 4955(a)(2). *See supra* note 90. A second set of taxes applies where the political expenditure in question is not corrected within a prescribed period (IRC § 4955(b)). This correction requires recovery of the expenditure to the extent possible (IRC § 4955(f)(3)). This two-tiered tax system is akin to the private foundation tax structure (*see* § 5.9).

An immediate assessment of these taxes and income taxes against a charitable organization is authorized in the case of flagrant political expenditures by the organization (IRC § 6852). The IRS is empowered to seek an injunction against further political expenditures by a charitable organization after flagrant political intervention by the organization (IRC § 7409).

In addition, where a tax-exempt organization engages in a *political* activity, as that term is defined in IRC § 527(e)(2), it becomes liable for the tax imposed by IRC § 527(f)(1). In this setting, political activities are the functions of influencing or attempting to influence the selection, nomination, election, or appointment of any individual to any federal, state, or local public office or office in a political organization, or the election of presidential or vice-presidential electors.

The U.S. Supreme Court, late in 2003, found nearly all of the provisions of the Bipartisan Campaign Reform Act to be constitutional, thereby locking into place rules enacted in 2002 that restrict the use of soft money and campaign advertising in the latter stages of political campaigns (*McConnell v. Federal Election Commission*, 540 U.S. 93 (2003)). Conventional wisdom has it that political campaign funds that may not be used by political organizations in ways barred by the Act will flow to and be expended by other types of tax-exempt organizations.

additional tax, and secondarily, as a sanction to apply instead of revocation in certain limited instances.''[177] On that occasion, the tax was imposed on a tax-exempt church for engaging in political campaign activity, in the form of statements made in broadcasts during a presidential campaign, when the political statements were incidental in relation to the organization's overall activities and the general content of the broadcasts; revocation of exemption was not pursued. In another instance, the tax was imposed in lieu of exemption revocation when a public charity administered a payroll deduction plan that facilitated contributions by its employees to a political action committee maintained by an exempt association.[178]

(g) IRS's Recent Enforcement Efforts

After years of faint regulation in this area, the IRS suddenly made the political campaign proscription on charitable organizations a major enforcement priority. Various allegations of participation by charities in the 2004 political campaign caused the agency to launch its Political Activity Compliance Initiative, which entailed examination of 132 organizations, leading to, among other outcomes, 55 advisory letters and proposed revocation of tax exemption in three instances.[179] In early 2006, facing the election cycle for that year and armed with what it learned during the 2004 election cycle, the IRS announced that it was distributing and making widely available expanded educational material, started monitoring earlier in the election year to ensure consistent and timely referral selections and examinations, publicized this project in advance so charitable organizations would not be ''surprised,'' and augmented its dedicated team to assure prompt handling of the cases.[180] The IRS is currently working cases identified during the 2006 election cycle. Following up on the activities of certain organizations that were previously examined, the IRS is contacting over 300 charitable organizations (identified through state election databases) that may have violated the prohibition on political campaign intervention by contributing to political candidates and entities during 2004 and 2005, and reviewing state election databases in an effort to identify charitable organizations that may have made political contributions in 2006.[181]

The IRS is continuing with this initiative in 2008, investigating allegations of political campaign intervention by public charities. This project is being expanded to review public charities that made contributions to political action

177. Tech. Adv. Mem. 200437040.
178. Tech. Adv. Mem. 200446033.
179. IR-2006-36.
180. FS-2006-17.
181. IRS FY 2007 Exempt Organizations Implementing Guidelines.

committees and private foundations that contributed to a political campaign or made a payment to a ballot initiative committee.[182]

§ 7.5 BUSINESS EXPENSE DEDUCTION RULES AND POLITICAL ACTIVITIES

Another set of federal tax rules exists, with respect to the business expense deduction.[183] This body of law not only denies the business expense deduction for nearly all forms of outlays for political activities,[184] but also disallows the portion of membership dues paid to associations that is allocable to the associations' political activities.[185] Disclosure and reporting obligations on these associations are imposed,[186] as is a proxy tax that is levied under certain circumstances.[187]

Although these rules are not applicable with respect to charitable organizations[188] and are applicable with respect to social welfare organizations,[189] they are predominantly utilized in connection with business leagues and thus are discussed in that context.[190]

§ 7.6 INTERNET ACTIVITIES

Tax-exempt healthcare organizations, and other exempt entities, may engage in attempts to influence legislation and/or political campaign activities by means of the Internet. There is, however, almost no law on the point.

Lobbying and political campaign activities involve forms of communication; the Internet is a medium of communication. The federal tax law does not

182. IRS FY 2008 Exempt Organizations Implementing Guidelines. *See*, in general, Kennard, ''Charitable Organizations and Politics: Permitted, Restricted, and Prohibited Activities,'' 46 *Exempt Org. Tax Rev*. (No. 2) 155 (Nov. 2004); Rich, ''The Utilization of Section 501(c)(3) Organizations for Politically Motivated Activity,'' 22 *Exempt Org. Law Rev*. (No. 1) 45 (1998); Yablon and Coleman, ''Intent Is Not Relevant in Distinguishing Between Education and Politics,'' 9 *J. Tax'n Exempt Orgs*. (No. 4) 156 (Jan./Feb. 1998); Hill, ''The Role of Intent in Distinguishing Between Education and Politics,'' 9 *J. Tax'n Exempt Orgs*. (No. 1) 9 (July / Aug. 1997); Cerny and Lauber, Jr., ''Voter Guides Must Meet IRS Guides as Permissible Voter Education,'' 8 *J. Tax'n Exempt Orgs*. (No. 4) 147 (Jan. / Feb. 1997); Colvin, ''An Election-Year Guide to Exempt Organization Political Activities,'' 7 *J. Tax'n Exempt Orgs*. (No. 2) 74 (Sept./Oct. 1995); Washlick, ''Political Activities of Tax-Exempt Organizations,'' 3 *J. Tax. Exempt Orgs*. 4 (Spring 1991); Knight, Knight, and Marshall, ''Lobbying, Campaigning, and Section 501(c)(3)—What Is Allowed?'' 2 *J. Tax. Exempt Orgs*. 17 (Fall 1990).
183. IRC § 162.
184. IRC § 162(e)(1)(B).
185. IRC § 162(e)(3).
186. IRC § 6033(e)(1).
187. IRC § 6033(e)(2).
188. IRC § 6033(e)(1)(B)(i).
189. *See* § 1.8.
190. *See* § 18.4.

provide any unique treatment for transactions or activities of exempt organizations involving lobbying or political activities simply because the Internet is the communication medium utilized. The IRS saliently observed that the ''use of the Internet to accomplish a particular task does not change the way the tax laws apply to that task.''[191] The IRS continued: ''Advertising is still advertising and fundraising is still fundraising.''[192] The agency could have also said: ''Lobbying is still lobbying and political campaign activity is still political campaign activity.''

(a) Attempts to Influence Legislation

An e-mail communication from a tax-exempt organization clearly can constitute an attempt to influence legislation. If the lobbying message is sent to a legislator, a member of the staff of a legislator, a member of the staff of a legislative committee, or the like, it constitutes direct lobbying. Likewise, a lobbying message can amount to indirect (grassroots) lobbying when the elements of that definition are met.[193]

A tax-exempt organization may post a lobbying message on its web site. For public charities, it is not always clear whether such a posting is an attempt to influence legislation in the tax-law sense of the phrase. For charitable organizations under the substantial part test, the law is vague on the point. When a charitable organization posts a lobbying message on its web site and takes a position with respect to specific legislation, the message is not a direct lobbying communication for purposes of the expenditure test. The possibility that a legislator may visit the web site of a public charity and read a lobbying message that is intended for all site visitors should not convert the message into a form of direct lobbying for purposes of that test. This may involve grassroots lobbying, however, for purposes of that test, if the communication encourages readers to take action with respect to the pending legislation to which it refers and on which it reflects a view.

Substantially in the expenditure test context is, as noted, measured solely in terms of expenditures of funds. The Internet is far more cost-effective than other forms of communication. Consequently, it is obvious that a charitable organization that has elected the expenditure test is in a position to engage in considerably more lobbying activity when the attempts to influence legislation are made by means of the Internet.

The IRS issued an announcement in 2000, seeking public comment on a number of questions pertaining to use of the Internet, in the context of lobbying activity, by charitable organizations. On that occasion, the agency wrote that ''[w]hen a charitable organization engages in advocacy on the Internet,

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191. FISCAL YEAR 2000 IRS EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM TEXTBOOK, Topic I.
192. *Id*.
193. *See* § 7.1(b).

questions arise as to whether it is conducting . . . lobbying activity, and if so, to what extent.''[194] These questions included whether a web site maintained by an exempt organization constitutes a single publication or communication, the methodology to be used in allocating expenses, the feasibility of maintaining the information from prior versions of the organization's web site, and whether statements made by subscribers to a forum may be attributed to the sponsoring exempt organization.

More specifically, the IRS inquired as to the facts and circumstances that are relevant, in the case of charitable organizations that are subject to the substantial part test, in determining whether lobbying communications made on the Internet are a substantial part of the organization's activities; as to the facts and circumstances involved in determining whether a charitable organization, which has elected the expenditure test, engages in grassroots lobbying on the Internet because it made a call to action; and whether publication of a web page on the Internet by a charitable organization that has elected the expenditure test constitutes an appearance in the mass media.[195]

(b) Political Campaign Activities

An e-mail communication from a tax-exempt organization clearly can constitute a political campaign activity (i.e., an endorsement). If an exempt organization were to, in the setting of a campaign, send an e-mail message or messages urging the election of an individual to a public office, that would constitute political campaign activity. An exempt organization may post a political campaign message on its web site. That also would be political campaign activity.

(c) Provision of Links

In its announcement, the IRS asked: ''Does providing a hyperlink [by a charitable organization] to the web site of another organization that engages in lobbying activity constitute lobbying by [the] charitable organization?'' The agency subsequently seemingly answered that question in the negative, at least to the extent of automatic attribution.

The occasion for the provision of this answer—the only guidance from the IRS as to Internet activity by tax-exempt organizations to date—was

194. Ann. 2000-84, 2000-42 I.R.B. 385.
195. This last question is curious, in that the tax regulations state that the term *mass media* ''means television, radio, billboards and general circulation newspapers and magazines'' (Reg. § 56.4911-2(b)(5)(iii)(A)). The statute does not use the word *includes*. Thus, while Internet communications are generically mass media communications, they are not for tax purposes.

issuance of the corporate sponsorship regulations in final form.[196] In that body of law, the sponsorship revenue is not taxable as unrelated business income as long as the recipient tax-exempt organization merely *acknowledges* the support, by referencing only the corporation's name, logo, product lines, and similar items. Services in the nature of *advertising* may cause the sponsorship payments to be taxable. The question thus arose in this context as to whether the exempt organization receiving the payment goes beyond the bounds of gift acknowledgment by providing a link to the web site of the sponsor, thereby raising the prospects of taxation of the payment.

By means of two examples in these regulations, the IRS took the position that the mere presence of a link by a tax-exempt organization to the site of a corporate sponsor does not defeat characterization of the payment as a nontaxable sponsorship. In one of these examples, a music shop was a sponsor of a concert series presented by an exempt organization that had as its function the operation of a symphony orchestra. Inasmuch as the organization did not promote the shop or advertise its merchandise, the payment in its entirety was cast as a qualified sponsorship payment.[197] In the other example, however, a health-based charity had a link to its corporate sponsor, which was a pharmaceutical company that funded an educational initiative of the charity. The company manufactured a drug that was used in treating the medical condition that was the focus of the charity's programs. On the company's web site, there was a statement that the charity ''endorses the use of our drug'' and ''suggests that you ask your doctor for a prescription if you have this medical condition.'' The charity reviewed the endorsement (which was advertising) before it was posted and gave the company permission for the endorsement to appear. The payment may have been taxable as unrelated business income.[198]

These examples illustrate how a message on another entity's web site can be attributed to a tax-exempt organization for tax purposes. This analysis took into account not only the content of the message but also the intent of the parties in posting it. Had the exempt organization in the second example posted the communication on its site, it would have been advertising there; posting it on the sponsor's site, coupled with the link, led to the same result. Other factors that will likely be taken into account in this type of analysis are which organization created and/or initiated the link, why it was created, who clicked on it, and why.[199]

196. *See* § 24.16.
197. Reg. § 1.513-4(f), Example 11.
198. Reg. § 1.513-4(f), Example 12.
199. In general, *see* Hopkins, The Nonprofits' Guide to Internet Communications Law (John Wiley & Sons, 2003), particularly §§ 1.8(b), 5.5, and 6.5.

§ 7.7 PUBLIC POLICY ADVOCACY ACTIVITIES

An expenditure by a tax-exempt organization, other than a political organization,[200] for issue advertising may be a political expenditure (a political organization exempt function[201]). The IRS provided guidance for determining when an expenditure by a tax-exempt organization[202] for an advocacy communication relating to a public policy issue is for an exempt function.[203] When an advocacy communication explicitly advocates the election or defeat of an individual to public office, the expenditure for the communication obviously is for a political organization exempt function. Otherwise (i.e., where an advocacy communication is not so explicit as to a candidacy), all of the facts and circumstances must be considered in determining whether the expenditure is for an exempt function.

The IRS stated that factors that tend to show that an advocacy communication on a public policy issue is for an exempt function include, but are not limited to, the following: the (1) communication identifies a candidate for public office; (2) timing of the communication coincides with a political campaign; (3) communication targets voters in a particular election; (4) communication identifies that candidate's position on the public policy issue that is the subject of the communication; (5) position of the candidate on the public policy issue has been raised as distinguishing the candidate from others in the campaign, either in the communication involved or in other public communications; and (6) communication is not part of an ongoing series of substantially similar advocacy communications by the organization on the same issue.

Factors that tend to show that an advocacy communication on a public policy issue is not for an exempt function include, but are not limited to, the following: the (1) absence of any one or more of the foregoing six factors; (2) communication identifies specific legislation, or a specific event outside the control of the organization, that the organization hopes to influence; (3) timing of the communication coincides with a specific event outside the control of the organization that the organization hopes to influence, such as a vote on legislation or other major legislative action (such as a hearing before a legislative committee on the issue that is the subject of the communication); (4) communication identifies a candidate solely as a

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200. That is, an organization described in IRC § 527. *See* TAX-EXEMPT ORGANIZATIONS, Chapter 17.
201. *Exempt functions* of political organizations include attempts to cause individuals to be elected or not elected to a public office and to influence nominations and appointments by the President of the United States (*see supra* note 171, third paragraph).
202. This guidance focused on advocacy activities by exempt social welfare organizations (*see* § 1.8), labor organizations (IRC § 501(c)(5) entities), and business leagues (*see* Chapter 18). Its principles, however, are generally applicable to nearly any category of organization that is tax-exempt under IRC § 501(a) by reason of being described in IRC § 501(c).
203. Rev. Rul. 2004-6, 2004-1 C.B. 328.

governmental official who is in a position to act on the public policy issue in connection with the specific event (such as a legislator who is eligible to vote on the legislation); and (5) communication identifies a candidate solely in the list of key or principal sponsors of the legislation that is the subject of the communication.

This guidance posits six illustrations of these rules; in three of them, the amounts expended by the exempt organizations are not exempt function expenditures and, in the other three, the amounts expended are such expenditures (and thus are subject to tax). In all of these situations, the advocacy communication identifies a candidate in an election, appears shortly before that election, and targets the voters in that election.

Each of these situations assumes that all payments for the activity are from the general treasury of the organization (i.e., not from a separate fund), the organization would continue to be tax-exempt because the organization's activities continue to meet the appropriate primary purpose test, and all advocacy communications also include a solicitation of contributions to the organization.

§ 7.8 POLITICAL ACTIVITIES OF SOCIAL WELFARE ORGANIZATIONS

The Internal Revenue Code does not impose any restrictions on political activities by tax-exempt social welfare organizations.[204] The IRS ruled that exempt social welfare organizations may engage in political campaign activity as long as they engage primarily in activities that promote social welfare.[205] The agency subsequently observed that exempt social welfare organizations may engage in ''limited'' political campaign activity.[206]

The IRS is commencing, in response to what the agency perceives is an increase in political campaign activity by tax-exempt social welfare organizations, an outreach effort to educate these exempt organizations and the public as to the rules concerning political activity by social welfare organizations, and has stated that it will address allegations of wrongdoing in this context.[207]

204. *See* § 1.8.
205. Rev. Rul. 81-95, 1981-1 C.B. 332.
206. Rev. Rul. 2004-6, 2004-1 C.B. 328.
207. IRS FY 2008 Exempt Organizations Implementing Guidelines. In general, Tax-Exempt Organizations § 23.5.

PART THREE

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CHAPTER EIGHT

Hospitals

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§ 8.1 FEDERAL TAX LAW DEFINITION OF *HOSPITAL*

If 100 people were asked what a hospital is, each would likely give a similar response: an imposing building filled with rooms with beds in them, tile floors, a medicinal odor, lots of high-tech equipment, and nurses, doctors, and patients everywhere. Most people were born in a hospital and, fortunately or unfortunately, have had occasion to be admitted to a hospital at some point in their lives. Hospitals are the scene of amazing feats of heroism. They serve daily as hosts to the depths of despair, the heights of rejoicing, the miracle of life, and the mystery of death. Hospitals are the repositories of some of humankind's greatest technological achievements. And they are the source of some of television's most memorable dramas and most forgettable sitcoms.

Federal tax law, when it addresses the activities of hospitals, usually contemplates a definition of a hospital consistent with the one each of us holds to be true. In actuality, however, there are three different definitions of a hospital, depending on the tax purpose for which the definition is required.

For most tax purposes, the definition of a hospital is the traditional one. Yet, that traditional definition appears nowhere in the Internal Revenue Code. Indeed, the term *hospital*, while used in IRS positions, rulings, and determinations since the inception of the Code, is not defined in the Code at all. It is evidently assumed that everyone understands what a hospital is.

Perhaps the most accurate source of a ''traditional'' definition of a hospital is the Medicare Act. The IRS and Congress frequently refer to the Medicare statute when dealing with healthcare aspects of tax policy, in order to standardize concepts and principles. The full definition of a hospital in the Medicare Act runs to 1,330 words, and a restatement of all of them is unnecessary here.

The essence of the definition is contained in the first full paragraph of the statutory section. A *hospital* means an institution that:

> is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons[.][1]

Another helpful exposition of the traditional definition is advanced by the American Institute of Certified Public Accountants (AICPA) in an Audit and Accounting Guide entitled ''Health Care Organizations.'' This guide, used by the accounting profession to establish standards for the audit of healthcare providers, defines hospitals as follows:

> Hospitals provide short-term, acute-care services, although some specialize in long-term care, such as rehabilitative and psychiatric services. Health care services provided by hospitals include the following three levels of care:
>
> **a.** *Primary Care*—Rendered in an ambulatory fashion, such as in emergency rooms, outpatient clinics, and other outpatient departments.
>
> **b.** *Secondary Care*—Rendered to inpatients in hospitals that offer short-term, acute-care services of either a general or specialized nature.
>
> **c.** *Tertiary Care*—Rendered in hospitals that possess the personnel, equipment, and expertise to handle complex cases.[2]

Both of these definitions square with the concept of a hospital that is usually intended by the IRS and is referred to in such important forums as the Hospital Audit Guidelines.[3] Moreover, those sections of the Code (on exempt organizations) that specifically refer to hospitals—those pertaining to cooperative hospital service organizations and the provision of certain hospital services[4]—assume a definition of a hospital that is consistent with the Medicare and AICPA definitions, although neither statutory section defines the term *hospital*.

A different definition of a hospital is used, however, for purposes of defining public charities. The first substantive definition of a hospital, a

1. 42 U.S.C. § 1395x(e).
2. AICPA Audit and Accounting Guide, ''Health Care Organizations,'' ¶1.17 (2007).
3. *See* Appendix E.
4. IRC §§ 501(e), 513(e). IRC § 513(e) provides an exception to the definition of an unrelated trade or business for various services furnished by hospitals to certain other hospitals where each hospital is described in IRC § 170(b)(1)(A)(iii). Reg. § 1.513-6 goes on to expressly define *hospital*, for purposes of this provision, as a hospital described in IRC § 170(b)(1)(A)(iii). Both the statute and the regulation are incorrect on this point. Both refer to the provision of services to facilities that serve fewer than 100 inpatients, and the regulation, for its illustrative example, describes a ''large metropolitan hospital.'' It is apparent that the Code and the regulation actually refer to the traditional definition of a hospital and not the broader definition used in IRC § 170(b)(1)(A)(iii) and Reg. § 1.170A-9(c).

definition substantially broader than the traditional definition described above, is found in the implementing regulations to the Code section on charitable contributions and gifts.[5] The reference to a hospital in this section came out of the intense efforts to regulate private foundations in the Tax Reform Act of 1969. The statutory language is somewhat circular. It includes as a public charity ''an organization the principal purpose or functions of which are the providing of medical or hospital care or medical education or medical research, if the organization is a hospital. . . .''[6] Thus, although the statute refers to an organization that is providing medical or hospital care, such an organization is a public charity only if it is a hospital. The Code section does not define the word *hospital*. This is left to the regulations.

The implementing regulation first reiterates the statutory provision by stating that an organization is described in the Code section if it is a hospital and its principal purpose or function is the providing of medical or hospital care or medical education or medical research.[7] The regulation then goes on to define the term *hospital* as including federal hospitals and state, county, and municipal hospitals that are instrumentalities of governmental units and otherwise come within the definition.[8] Once again, the regulation does not define what a hospital is; it simply refers to it, and the reference appears to apply the traditional definition of a hospital as described above.

Significantly, however, the regulation then continues by adding to the definition of a hospital other categories of organizations that likely would fall outside the traditional definition. The regulation provides that ''[a] rehabilitation institution, outpatient clinic, or community mental health or drug treatment center may qualify as a 'hospital'. . . if its principal purpose or function is the providing of hospital or medical care.''[9] Medical care is then defined to include the ''treatment of any physical or mental disability or condition, whether on an inpatient or outpatient basis, provided the cost of such treatment is deductible under section 213 by the person treated.''[10]

This section of the Code, governing the deductibility of medical expenses, provides a more thorough definition of medical care. It states that medical care means amounts paid ''for the diagnosis, cure, medication, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. . . .''[11] The use of the term *medical* care sometimes connotes care

5. IRC § 170.
6. IRC § 170(b)(1)(A)(iii).
7. Reg. § 1.170A-9(c)(1).
8. *Id*.
9. *Id*.
10. *Id*.
11. IRC § 213(d)(1)(A). The definition also includes amounts paid for transportation essential to medical care and for insurance covering medical care (within the definition of the term).

that excludes surgical care, but that is clearly not the case in the context of this Code section and, accordingly, the Code section on charitable gifts. The Code section on medical expenses excludes cosmetic surgery from the definition of medical care, thereby, by inference, including other types of surgical services within the definition of medical care. Neither the Code section on charitable gifts nor its implementing regulation provides any clarification as to how hospital care and medical care are distinguished, even though both provide separately for these items.

The regulation then adds two more categories of organizations that qualify as ''hospitals'' within the meaning of the regulation and the statute: (1) a skilled nursing facility, and (2) a cooperative hospital service organization. The regulation refers back to the Medicare Act for the definition of a skilled nursing facility.[12] If a skilled nursing facility has as its principal purpose or function the provision of hospital and medical care, then it qualifies as a hospital under the regulatory definition. As discussed below, the regulation also includes within the definition of a hospital a cooperative hospital service organization that meets the requirements of the Code and regulations.

Thus, the public charity definition of a hospital includes several organizations that would fall outside of the traditional definition of a hospital: rehabilitation institutions, outpatient clinics, community mental health or drug treatment centers, skilled nursing facilities, and cooperative hospital service organizations. This broad definition may be helpful to healthcare organizations seeking to obtain recognition of exempt status as charitable organizations, by enabling them to qualify as charitable hospitals (and ''public institution'' public charities) even though they would not commonly be considered hospitals. As the form and extent of services of healthcare organizations change to accommodate updates in healthcare delivery and payment, this definition provides a relatively liberal opportunity for organizations to qualify for recognition of exempt status.

The public charity definition is further developed through the regulation's identification of organizations that do not fall within the definition: convalescent homes or homes for children or the aged, and institutions whose principal purpose or function is to train handicapped individuals to pursue some vocation.[13] Presumably, these organizations are excluded from the definition of a hospital because they do not provide services that include an element of hospital or medical care.

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12. 42 U.S.C. § 1395x(j).
13. Reg. § 1.170A-9(c)(1) also excludes from the definition of a hospital organizations whose principal purpose or function is the providing of medical education or medical research, unless they are also actively engaged in providing medical or hospital care to patients on their premises or in their facilities as an integral part of their medical education or medical research functions. *See* § 5.1.

In some instances, the IRS uses the traditional definition of a hospital when the public charity definition should have been used. For example, in Form 1023, the Application for Recognition of Exempt Status under Section 501(c), used by organizations seeking recognition of their exempt status from the IRS, Schedule C must be filled out by organizations claiming to be hospitals. The IRS instructions to this schedule define an organization as a ''hospital'' if its principal purpose or function is providing medical or hospital care or medical education or research. The Form 1023 instructions also contain a glossary which purports to define the term ''hospital.'' However, it defines hospital or medical *care*—following the public charity definition—rather than the institution itself. The ostensible purpose of Schedule C is to assist the IRS in determining whether the organization can qualify as a public charity as a hospital-type public institution. However, Schedule C does not solicit information consistent with determining whether the organization falls within the corresponding definition contained in the regulations. Instead, it solicits information that goes to the question of whether the organization can qualify for exemption as a charitable organization under the traditional definition of a hospital. Schedule C requests information as to whether the organization has an open medical staff, whether it maintains a full-time emergency room, whether it discriminates against Medicare or Medicaid patients, whether it provides charity care to patients, and whether it leases office space to physicians. This request for information clearly arises out of the criteria established in the 1969 revenue ruling for traditional charitable hospitals.[14] Nevertheless, an organization could presumably qualify as a hospital within the public charity regulatory definition while having few, if any, of the features established in the 1969 revenue ruling and elicited in Schedule C.

Still another direction is being taken by the IRS in its redesign of the Form 990. This form contains a new Schedule H to be completed by hospitals. The IRS has indicated that it intends to define *hospital* for the purposes of completing this schedule by reference to state licensing or certification. The IRS further stated that it is considering whether a second category of facilities will be identified in the new form's instructions to ensure reporting by all organizations that provide hospital or medical care.

A third definition of a hospital for federal tax purposes includes an organization that clearly is not a hospital at all: a cooperative hospital service organization. The Code provides for exempt status for organizations that operate on a cooperative basis and perform on a centralized basis certain enumerated services solely for two or more hospitals, each of which is itself exempt from taxation.[15] The Code further provides that any organization that

14. Rev. Rul. 69-545, 1969-2 C.B. 117. *See* § 6.2.
15. IRC § 501(e). *See* Chapter 17.

qualifies as a cooperative hospital service organization shall be treated as a hospital. This convention was used to enable cooperative hospital service organizations to provide services to other cooperative hospital service organizations. Because such organizations are not hospitals, they would not normally be permissible patrons of the cooperative. By treating such organizations as hospitals, however, the provision of services to them is consistent with exempt status as a cooperative. This treatment is supported by the regulations, which permit the provision of specified services between or among cooperative hospital service organizations that meet the requirements of the Code and the regulations.[16]

§ 8.2 PRIVATE CHARITABLE HOSPITALS

The Internal Revenue Code provides federal income tax exemption for entities that are organized and operated exclusively for ''charitable'' purposes. The term *charitable*, which has the most extensive history and the broadest meaning of any of the terms in Code section 501(c)(3), is used in the Code section in its ''generally accepted legal sense'' and is, therefore, not to be construed as limited by the other purposes stated in the section that may fall within the broad outlines of charity as developed by judicial decisions.[17] One purpose contemplated by the term *charitable* in the federal tax law is the primary basis for exemption for nearly every healthcare organization: the ''promotion of health.''[18]

The most common example of an organization established and operated for the promotion of health is a hospital.[19] To qualify for exemption as a charitable organization, however, a hospital must demonstrate that it serves a public rather than a private interest.[20] The U.S. Supreme Court has noted that ''[n]onprofit hospitals have never received these benefits [tax exemption and eligibility to receive deductible contributions] as a favored general category, but an individual nonprofit hospital has been able to claim them if it could qualify'' as a charitable entity.[21] The Court added: ''As the Code does not define the term charitable, the status of each nonprofit hospital is determined on a case-by-case basis by the IRS.''[22]

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16. Reg. § 1.501(e)-1(d)(3).
17. Reg. § 1.501(c)(3)-1(d)(2). *See also* Reg. § 1.501(c)(3)-1(d)(1)(i)(b).
18. *See* Chapter 1.
19. IRC § 170(b)(1)(A)(iii).
20. Reg. § 1.501(c)(3)-1(d)(1)(ii).
21. *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26, 29 (1976).
22. *Id*. at 29. Schaffer and Fox, ''Tax Administration as Health Policy: The Tax Exemption of Hospitals, 1969–1990,'' 4 *Exempt Orgs. Tax Rev*. 1185 (1991); Simpson and Strum, ''How Good a Samaritan? Federal Income Tax Exemption for Charitable Hospitals Reconsidered,'' 4 *Exempt Orgs. Tax Rev*. 1084 (1991); Peregrine and McNulty, ''Emerging Standards: The Impact of Medicare Law on Hospital Tax-Exempt Status,'' 4 *Exempt Org. Tax Rev*. 941 (1991); Bove, ''When Should a Hospital Be Treated as a Charity?,''

The initial position of the IRS in this regard was published in 1956. The IRS requirements for exemption included a rule requiring patient care without charge or below cost.[23] At that time, the IRS stated that a hospital, to be charitable, ''must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.''[24] This approach was a reflection of the charitable hospital as it once was: an almshouse, providing healthcare more for the poor than for the sick.

Today's hospital provides health services for the entire community, with a commensurate increase in patient care revenue (especially in relation to private contributions) and healthcare costs. Prepayment plans now cover hospital expenses for much of the citizenry, and reimbursement programs under Medicare and Medicaid have reduced the number of patients who lack an ability to ''pay'' for health services. Because of these changes in society, in 1969, the IRS modified its 1956 position by recognizing that the promotion of health is inherently a charitable purpose and is not obviated by the fact that the cost of services is borne by patients or third-party payors.[25] Under the 1969 ruling, to be exempt, a hospital must promote the health of a class of persons broad enough to benefit the community and must be operated to serve a public rather than a private interest. Basically, this means that the emergency room must be open to all, and that hospital care is provided to all who can pay, directly or indirectly. The hospital may generate a surplus of receipts over disbursements and nonetheless be exempt. The requirement that healthcare must be provided free or at reduced cost to the extent of the hospital's financial ability was abandoned.

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3 *J. Tax. Exempt Orgs*. 10 (Spring 1991); Sullivan and Moore, ''A Critical Look at Recent Developments in Tax-Exempt Hospitals,'' 23 *Jour. of Health and Hosp. Law* 65 (1990); Copeland and Rudney, ''Federal Tax Subsidies for Not-for-Profit Hospitals,'' 46 *Tax Notes* 1559 (1990); Barker, ''Reexamining the 501(c)(3) Exemption of Hospitals as Charitable Organizations,'' 48 *Tax Notes* 339 (1990); Szabat, ''Tax-Exempt Hospitals: Still Charitable After All These Years? A Comparative Legal Analysis of Federal, State and Local Law,'' 3 *Exempt Orgs. Tax Rev*. 735 (1990); Mancino, ''Income Tax Exemption of the Contemporary Nonprofit Hospital,'' 32 *St. Louis U.L.J*. 1015 (1988); Clark, ''Does the Nonprofit Form Fit the Hospital Industry?'' 93 *Harv. L. Rev*. 1417 (1980); Comment, ''Income Taxation—A Pauper a Day Keeps the Taxman Away: Qualification of Hospitals as Charitable Institutions under Section 501(c)(3),'' 54 *N. Car. L. Rev*. 1195 (1976); Congdon, ''With Charity for All: Did the I.R.S. Comply with the Administrative Procedure Act in Changing the Requirements for Charitable Exemptions of Hospitals?,'' I *ISL L. Rev*. 41 (1976); Dwyer, ''Income Tax–Section 501(c)(3)–Qualification of Hospitals for Tax Exempt Status as Charitable Organizations,'' 7 *Univ. of Toledo L. Rev*. 278 (1975); Bromberg, ''The Charitable Hospital,'' 20 *Cath. Univ. L. Rev*. 237 (1970); Note, ''Federal Income Tax Exemptions for Private Hospitals,'' 36 *Fordham L. Rev*. 747 (1968); Hyatt, '' The Role of the Modern Charitable Hospital,'' 2 Pitt. J. EnvH. and Pub. Health L. 33 (2008).

23. Rev. Rul. 56-185, 1956-1 C.B. 202. *See* Chapter 26.
24. Rev. Rul. 56-185, 1956-1 C.B. 202, at 203.
25. Rev. Rul. 69-545, 1969-2 C.B. 117. *See* Chapter 26.

Other factors that may indicate that a hospital is operating for the benefit of the public include control of the institution in a board of trustees composed of individuals who do not have any direct economic interest in the hospital; maintenance by the hospital of an open medical staff, with privileges available to all qualified physicians, consistent with the size and nature of the facilities; a hospital policy enabling any member of the medical staff to rent available office space; hospital programs of medical training, research, and education; and involvement by the hospital in various projects and programs to improve the health of the community.[26] These and similar factors are of particular help in the qualification for tax exemption of hospitals that do not operate an emergency room, either because the facility would be duplicative in relation to the services provided by other institutions or because the hospital is a specialized institution (e.g., an eye hospital or cancer center) that offers medical care under conditions unlikely to necessitate emergency care.[27]

Despite the foregoing federal tax law, and in what has become a mainstream view, one state supreme court held that a contemporary typical nonprofit hospital is not a charitable entity for state property tax exemption purposes, because it operates no differently from a for-profit hospital.[28] The case concerned a nonprofit organization that owned or leased and operated 21 hospitals, including one hospital that owned several subsidiaries, at least one of which was a for-profit organization. Most of the revenue of the organization was derived from patient charges (either directly or from third-party payors), with some receipts in the form of contributions. Finding against the hospital organization, the court concluded that the ''traditional assumptions'' about the charitable nature of nonprofit hospitals ''bear little relationship to the economics of the medical-industrial complex of the 1980's.''[29]

The court wrote that ''[n]onprofit hospitals were traditionally treated as tax-exempt charitable institutions because, until late in the 19th century, they were true charities providing custodial care for those who were both sick and poor.''[30] The income of these institutions, noted the court, was derived largely or entirely from gifts. Today, the court concluded, modern nonprofit hospitals are ''market institutions,'' financed principally out of payments from patients.[31] The orientation of these hospitals, said the court, shifted away

26. IRS Exempt Organizations Handbook (IRM 7751), § 343.5(2). *See also* Appendix E; Ann. 92-83, 1992-22 I.R.B. 59, § 333.1.
27. Rev. Rul. 83-157, 1983-2 C.B. 94. *See* Chapter 26.
28. *County Board of Utilization of Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Sup. Ct. Utah 1985); *Hospital Utilization Project v. Commonwealth*, 487 A.2d 1306 (Sup. Ct. Pa. 1985).
29. *County Board of Utilization of Utah County v. Intermountain Health Care, Inc., supra* note 26, at 270.
30. *Id*.
31. *Id*.

from the ''poor'' and ''charity,'' and toward ''business'' and ''professionals.''[32] The court was impressed by factors such as the growing number of paying patients, the change in the social composition of patients, the modifications in hospital architecture, the practice of allowing physicians to charge patients for their services in hospitals, the sheer number of hospitals, and the growth of for-profit hospitals. The consequence of all of this, from the court's viewpoint: ''[T]he gradual disappearance of the traditional charitable hospital for the poor.''[33]

This state supreme court conceptualized two types of nonprofit hospitals. One is the *physicians' cooperative* model—hospitals that ''operate primarily for the benefit of the participating physicians.''[34] This, the court said, could also be termed the ''exploitation hypothesis,'' because the physicians' ''income maximizing'' system is ''hidden behind the nonprofit facade of the hospital.''[35] The second type of nonprofit hospital envisioned by the court was the *poly-corporate enterprise* model[36]—''large groups of medical enterprises, containing both for-profit and nonprofit corporate entities.''[37] The court saved its harshest words for the second model: ''The emergence of hospital organizations with both for-profit and nonprofit components has increasingly destroyed the charitable pretentions of nonprofit organizations.''[38]

For this court, the pivotal element in the facts was the small amount of contributions received by the hospital or the holding company in relation to patient revenues. ''It is precisely because such a vast system of third-party payers has developed to meet the expense of modern hospital care that the historical distinction between for-profit and nonprofit hospitals has eroded.''[39] The court noted that, in its view, the primary care services of both types of hospitals are largely the same, the rates are similar, both types accumulate capital, and both types have comparable operations. Indeed, the nonprofit hospital was criticized for using its ''profits'' to acquire ''capital improvements and new, updated equipment.''[40]

Application of the concept that the term *charitable* embraces the function of promoting health continues to trouble the IRS as the courts persist in allowing various forms of the practice of medicine (generally, a for-profit endeavor) to lodge within its ambit. The practice of medicine occurs in hospitals but, as noted, the law has rationalized the classification of most nonprofit hospitals as charitable. Thereafter, also as noted, charitable entities have been determined

32. *Id*.
33. *Id*. at 271.
34. *Id*.
35. *Id*.
36. *Id*.
37. *Id*.
38. *Id*. at 272.
39. *Id*. at 274.
40. *Id*. at 275.

to include a variety of clinics, centers, research agencies, plans, and health maintenance organizations.

§ 8.3 PUBLIC HOSPITALS

It is not difficult to find the public hospital in most cities and towns. It is the hospital that takes the patients who have no insurance and no independent means to pay for their care. It has the most overcrowded emergency room, and it is often the hospital with the oldest buildings, the threadbare carpets, and something less than the latest in technological advances. Yet, by all standards, we would be lost without it. It is the caregiver of last resort in the American healthcare system, and, without it, many people would never receive vitally needed healthcare services.

Public hospitals play this role because they are governmental entities. They are owned and operated by federal, state, county, or municipal governments or by political subdivisions thereof. In some instances, the governmental entity leases hospital facilities to nonprofit corporations for purposes of operation.[41] Public hospitals represent approximately 25 percent of all hospitals in the United States.[42]

Hospitals that are owned and operated by a state or local government qualify for exemption from federal income taxation under a separate Code,[43] and are also exempt from the tax on unrelated business income and from federal income tax filing requirements.

In some instances, however, state or local governmental hospitals may also obtain recognition of tax-exempt status as charitable organizations.[44]

§ 8.4 RELIGIOUS HOSPITALS

The Internal Revenue Code provides that an organization may be exempt from federal income tax if it is organized and operated exclusively for a ''religious'' purpose.[45] The IRS and the courts have struggled to come up with a definition of a ''religious'' activity or organization for tax law purposes; the income tax regulations do not provide a definition of the term *religious*. Similarly, there is no federal tax law definition of the term *church*.

One way to bridge this gap is to consider the categories of entities that are eligible for designation as ''religious'' organizations. A hospital can be a church-run organization, which is a category of religious groups that have been treated by the IRS as entitled to recognition of exemption as charitable

41. Rev. Rul. 80-309, 1980-2 C.B. 183.
42. American Hospital Association, 2001 Hospital Statistics Guide.
43. IRC § 115.
44. Rev. Rul. 56-185, 1956-1 C.B. 202.
45. IRC § 501(c)(3); Reg. § 1.501(c)(3)-1(d)(1)(i)(a).

organizations. While a hospital may qualify for charitable status on its own through its promotion of health,[46] a church-run hospital is often recognized as exempt as a member of a religious group.

An important benefit of this route to exemption is that such a hospital can be recognized as exempt pursuant to a group exemption extended to its sponsoring church.[47] Organizations covered by a group exemption letter are relieved from filing their own application for recognition of tax exemption. In some cases, organizations included in a group exemption are also relieved of the obligation to file annual information returns on Form 990. This includes churches and integrated auxiliaries of churches. However, in January 1977, the IRS issued final regulations defining the term ''integrated auxiliaries of churches,'' and it did not include hospitals and homes for the aged in that definition.[48]

Religious hospitals are among the oldest and most familiar healthcare providers in the United States. Many churches consider the provision of healthcare services as fundamental to their mission. The Roman Catholic Church is the largest religious provider of hospital services and Methodist, Baptist, Presbyterian, Adventist, Episcopal, Lutheran, and Jewish-sponsored hospitals are also quite common.

An example of hospitals and other healthcare organizations qualifying as charitable organizations through the group exemption extended to their sponsoring church is the healthcare providers sponsored by the Roman Catholic Church. In a ruling dated March 25, 1946, the IRS held that the agencies and instrumentalities and all educational, charitable and religious institutions operated, supervised, or controlled by or in connection with the Roman Catholic Church in the United States appearing in the Official Catholic Directory (OCD) were entitled to exemption from federal income tax under the Internal Revenue Code. That ruling has been updated annually to cover the activities added to or deleted from the OCD.[49]

Diocesan officials are responsible for compiling OCD information. Organizations included in the OCD must be operated by the Roman Catholic Church and must meet the general requirements for recognition of charitable status and nonprivate foundation status. Hospitals are routinely included in the OCD.[50]

The IRS has not limited its recognition of tax exemption to religious hospitals that provide ''traditional'' hospital services where the tenets of the

46. *See* Chapter 1.
47. *See* Chapter 34.
48. Reg. § 1.6033-2(g)(5).
49. In 1970, the IRS issued to the United States Catholic Conference a letter affirming the public charity status of organizations listed in the OCD. This determination letter is not reissued annually because it is not limited to a particular edition of the OCD.
50. Other types of healthcare organizations listed in the OCD include parent holding corporations (*see*, e.g., Priv. Ltr. Rul. 8917055), charitable trusts and organizations that provide hospital support services and own real estate (*see*, e.g., Priv. Ltr. Rul. 8920021).

sponsoring religion require that the services be provided in a different manner. Thus, the IRS has recognized charitable status for a medical care facility operated by the First Church of Christ, Scientist, also known as the Christian Science Church.[51] The nonprofit facility provided care, comfort, and maintenance to persons seeking healing consistent with the teachings of the Christian Science Church. The Church teaches that all forms of mental or physical illness and injury are symptoms of spiritual disorder and persons suffering from such illness or injury can be completely cured only through prayer and faith. The medical care facility was staffed by state-licensed nurses who had graduated from a Church-approved nursing course and by individuals recognized by the Church as Christian Science practitioners. The facility complied with all state and local laws applicable to the operation of a nursing care facility. The Service noted that it had previously ruled that payments to Christian Science practitioners are deductible as expenses for medical care.[52] The Service found that the facility served the charitable purpose of promoting health and therefore was tax-exempt as a charitable organization.

Presumably, there are limits to the ability of an organization to obtain recognition of exemption as a hospital where the manner of its provision of services substantially varies from that seen in traditional medicine because of the requirements of its sponsoring church. Thus, a hospital that actually jeopardized the health of its patients through the application of its sponsoring church's religious beliefs would likely not be found to be promoting health and would be acting contrary to public policy. As a result, it would be unable to obtain recognition of tax exemption from the IRS.

§ 8.5 PROPRIETARY HOSPITALS

Even though an organization operates a hospital, it will not be exempt if it is a proprietary institution, is operated for the benefit of private individuals (for example, owners or physicians), is operated for benefit of a closed medical staff, enters into favorable rental agreements with a limited group of physicians, or limits its emergency room care and hospital admissions substantially to patients of a limited group of physicians.[53] Other factors that may indicate that a hospital is being operated for the benefit of private interests are: whether the hospital is controlled by members of the medical staff (or by the original owners of the institution, when in proprietary form); the hospital enters into contractual arrangements enabling the controlling physicians or

51. Rev. Rul. 78-427, 1978-2 C.B. 176.
52. Rev. Rul. 55-261, 1955-1 C.B. 307.
53. *Harding Hospital, Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1974); *Sonora Community Hospital v. Commissioner*, 46 T.C. 519 (1966), *aff'd*, 397 F.2d 814 (9th Cir. 1968); *Burgess v. Four States Memorial Hospital*, 465 S.W.2d 693 (Sup. Ct. Ark. 1971); *Maynard Hospital, Inc. v. Commissioner*, 52 T.C. 107 (1969). *See*, in general, Bromberg, ''Tax Problems of Nonprofit Hospitals,'' 47 *Taxes* 524 (1969).

original owners to realize direct economic benefits from the operation of certain of its departments; the hospital has a record of negligible uncollectible accounts and charity care; and, if a sale is involved, the purchase price paid for the proprietary hospital is less than the reasonable value of the facility to the nonprofit organization.[54] The prospects of private inurement will be of particular concern where a proprietary hospital or similar organization is transferred to a nonprofit, ostensibly tax-exempt, entity.[55]

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54. IRS Exempt Organizations Handbook (IRM 7751), § 343.5(3).
55. *State v. Wilmar Hospital*, 2 N.W.2d 564 (Sup. Ct. Minn. 1942).

CHAPTER NINE

Managed Care Organizations

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§ 9.1 INTRODUCTION

Managed care organizations are perhaps the most controversial healthcare organizations in existence today. Notwithstanding that variations of such organizations have been in existence since the 1920s, they have become the primary healthcare delivery and financing mechanism in the United States. The term *managed care* normally refers to management of healthcare services that are delivered to patients; however, it also represents management of the financing of the provision of healthcare services. The particular appeal of managed care organizations to individuals, employers, and legislators is the ability of such organizations to control the costs of the care being provided. Managed care generally involves the delivery of healthcare services through specified providers and offers incentives to (or imposes requirements on) patients to obtain their healthcare services through those specified providers. In most cases, managed care involves the provision of some type of health insurance in addition to utilization review and other patient care management activities.

This chapter focuses on the most prevalent types of managed care organizations in the American healthcare system: health maintenance organizations (HMOs) and preferred provider organizations (PPOs). HMOs are organizations that both underwrite insurance risks and provide or arrange for the provision of healthcare services through a specified delivery system. They typically provide services only to an enrolled population and are responsible

for ensuring the quality and appropriateness of the healthcare services they provide to their enrollees. HMOs are regulated by state and federal law and are commonly identified with one of four different models: (1) the staff model, (2) the group model (which includes as a subset the ''dedicated'' group model), (3) the IPA (individual practice association) model, and (4) the network model. Although these distinctions are widely recognized, it is increasingly difficult to categorize a particular HMO as representing only one of these models. Most HMOs today are hybrids of two or more models.[1]

Preferred provider organizations are defined as organizations of physicians and hospitals that contract with employers and third-party payors to provide comprehensive healthcare services to subscribers on a fee-for-service basis.[2]

HMOs are predominantly operated by for-profit entities: over 71 percent of all HMOs are organized in this manner.[3] Over the past thirty years, the IRS's position with respect to the tax exemption of HMOs has varied considerably. The progenitor to the HMO, the Blue Cross and Blue Shield service benefit plan, was recognized by the IRS as a tax-exempt social welfare organization,[4] even though the historical rationale and legal criteria for such a position were never fully articulated by the IRS.[5] As a result, most HMOs that were able to obtain recognition of tax-exempt status from the IRS were recognized as social welfare organizations because of their similarity to the Blue Cross/Blue Shield plans.

HMOs that requested tax exemption as charitable organizations were generally denied that classification because the IRS held, at the time, that HMOs were organized and operated to serve the private interests of their subscribers.[6] In a 1977 General Counsel Memorandum, the IRS applied the community benefit analysis, which it had established for hospitals,[7] to determine whether HMOs could qualify as charitable organizations.[8] In the memorandum, the IRS took the position that an HMO that seeks recognition of exemption as a charitable organization must demonstrate that it does not provide, other than incidentally, preferential services or benefits to its subscribers. In other words, the HMO must be organized and operated exclusively to serve public rather than private interests. In the IRS's view, the membership form of operation of an

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1. *See*, in general, Michaels, ''Managed Care Payment Systems,'' American Health Lawyers Association Health Law Practice Guide, ch. 23 (2000); Health Law Center/Aspen Publishers, Managed Care Law Manual (1994).
2. *See* Cowan, ''Preferred Provider Organizations: Planning, Structure, and Operation'' (1984); and sources in *supra* note 1.
3. 2002 AHIP Survey of Health Insurance Plans at 3.
4. IRC § 501(c)(4).
5. *See* Gen. Couns. Mem. 34709; McGovern, ''Federal Tax Exemption of Prepaid Health Care Plans,'' 7 *The Tax Adviser* (1976). *See also* Chapter 13.
6. FY 1992 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, ''Federal Tax Exemption of Prepaid Health Care Plans After IRC 501(m),'' at 266.
7. Rev. Rul. 69-545, 1969-2 C.B. 117.
8. Gen. Couns. Mem. 37043. *See also* Rev. Rul. 69-545, 1969-2 C.B. 117.

HMO did not satisfy the requirement of promoting the health of a sufficiently large class of the community to warrant recognition of charitable status. As a result, it took the ruling position that HMOs could not be recognized as charitable organizations.

The IRS was forced to modify its position after the issue was litigated in the Tax Court,[9] in which the Tax Court held that a staff model HMO was able to qualify for exemption as a charitable organization. The floodgates for this category of exemption did not open, however, and the IRS continued to develop its ruling position for HMOs in a piecemeal fashion until Congress barred tax exemption for HMOs that provide commercial-type insurance as a substantial part of their activities.[10] This legislation forced the IRS to crystallize its position on the proper exemption classification of HMOs and, as it developed, this ruling position was confirmed in the Tax Court and the Third Circuit Court of Appeals, which addressed tax exemption for non-staff-model HMOs.[11]

The end result of this process is that some HMOs organized as nonprofit organizations prior to 1986 are recognized as tax-exempt charitable entities, but most are recognized as tax-exempt social welfare entities, although anomalies do exist. For HMOs organized after 1986, few are recognized as charitable entities, but most can still obtain recognition as social welfare entities. To achieve a uniformity of determination for such organizations, applications for recognition of exemption for HMOs normally are sent to the National Office of the IRS for review.[12] Meanwhile, as the gap between HMOs and indemnity insurers continues to narrow, it seems likely that obtaining any type of tax-exempt status for such organizations will, if anything, grow more difficult.

§ 9.2 HEALTH MAINTENANCE ORGANIZATIONS

(a) IRS Analysis of Qualification for Exemption

As a result of its years of review of prepaid healthcare plans, and the litigation and legislation of the 1970s and 1980s, the IRS has developed an analysis and ruling position for determining whether an HMO can qualify as a tax-exempt organization. The IRS applies a two-part screening test to HMOs seeking exemption. First, the IRS determines whether the rules concerning commercial-type insurance prohibit exemption. If those rules do not prohibit exemption, the IRS goes on to determine whether the organization qualifies for exemption as a charitable entity, or a social welfare organization entity.[13]

Thus, the first step is to determine whether the commercial-type insurance rules would bar exemption for the HMO.[14] Under these rules, an HMO can

9. *See infra* § 9.2, especially text accompanied by note 32.
10. IRC § 501(m). *See infra* § 9.4.
11. *See infra* § 9.2, especially text accompanied by notes 41–51.
12. IRM § 7664.31(1).
13. Gen. Couns. Mem. 39829.
14. *See infra* § 9.3.

be recognized as tax-exempt as a charitable or social welfare entity only if no substantial part of its activities consists of providing *commercial-type insurance*. Accordingly, the IRS has indicated that two findings must be made in order to determine that tax-exempt status for an HMO is precluded. First, the HMO must be found to provide ''commercial-type insurance''; second, the provision of commercial-type insurance must be a substantial part of the activities of the entity.[15] With regard to the determination of whether the HMO provides commercial-type insurance, there is an exception to the definition: ''incidental'' health insurance provided by an HMO, of a kind customarily provided by HMOs, does not constitute commercial-type insurance.[16] The IRS has established a ''safe harbor'' for what constitutes the incidental provision of health insurance by an HMO:

> We believe that an HMO operating on one of the common, existing models that (1) compensates primary care physicians exclusively on a salary, capitation, or other fixed-fee basis, and (2) shifts to those physicians (or to HMO-affiliated specialists and hospitals) substantially all of the risk of excess utilization of specialists and hospitals, principally provides healthcare and provides only incidental health insurance. Such HMOs qualify for the section 501(m)(3)(B) exception. Other HMOs must be examined on a case-by-case basis, taking into consideration their risk sharing arrangements with primary care physicians, specialists, hospitals, and other providers. Where a substantial portion of the risk is shifted to the providers, or a substantial portion of the HMO's costs are otherwise fixed, the insurance aspects of the HMO's operations may be considered incidental.[17]

The next step in the IRS analysis is the determination of whether the HMO can qualify for exemption as a charitable organization. As discussed earlier, the initial position of the IRS was that HMOs could not qualify for exemption as charitable organizations. After this position was defeated in litigation, new criteria were established under which the IRS would recognize exemption for HMOs as charitable entities. Generally, only HMOs that follow the staff model are able to satisfy these criteria,[18] and many staff model HMOs will still flunk the test. As the author of the IRS analysis noted in a subsequent article, the IRS's standard for exemption as a charitable organization is ''nearly impossible for most HMOs to meet.''[19]

The essential criterion from the Tax Court decision[20] and the IRS's revised position[21] is that it must be shown that the HMO does not serve private interests—that is, the HMO must satisfy the same community benefit requirement that the IRS imposes on hospitals seeking exemption as charitable

15. Gen. Couns. Mem. 39703.
16. IRC § 501(m)(3)(B).
17. Gen. Couns. Mem. 39829.
18. *See* § 9.2(b).
19. Sullivan, ''The Tax Status of Nonprofit HMOs After Section 501(m),'' 50 *Tax Notes* 75, 79 (Jan. 7, 1991).
20. *See* note 32, *infra*.
21. Gen. Couns. Mem. 38735.

organizations. The IRS will examine the totality of the HMO's operations to determine whether the requisite community benefit is being provided. It has identified certain key factors, however, that will, in its view, establish sufficient community benefit. These key factors include: actual provision of healthcare services and maintenance of facilities and staff; provision of service to nonmembers on a fee-for-service basis; care and reduced rates for the indigent; care for those covered by Medicare, Medicaid, or other similar assistance programs; emergency room facilities available to the community without regard to ability to pay (and communication of this fact to the community); a meaningful subsidized membership program; a board of directors broadly representative of the community; health education programs open to the community; health research programs; healthcare providers who are paid on a fixed-fee basis; and the application of any surplus to improving facilities, equipment, patient care, or to any of the above programs.[22]

The IRS is quick to note that these factors are not all-inclusive, and that the absence of any one factor is not necessarily determinative of a lack of charitable operation.

HMOs are membership organizations; they generally provide services only to individuals who have paid membership fees to the HMO. As a result, the IRS is greatly concerned that such organizations may be operated for the benefit of their members rather than for the community at large. The IRS takes the position that there must be no meaningful restrictions on the HMO's enrollment that would preclude a finding that the HMO serves the community as a whole. Relevant factors in making such a determination include: whether the HMO's membership is composed of both groups and individuals (with the individuals constituting a substantial portion of the membership); whether there is an overt program to attract individual members; whether there is a community rating system that provides uniform rates for prepaid care; whether similar rates are charged to individuals and groups; and whether there are no substantive age or health barriers to eligibility for either individuals or groups.[23]

Many HMOs are subsidiaries of tax-exempt parent holding corporations and are affiliates of tax-exempt hospitals in a reorganized healthcare system.[24] Although they may be able to qualify as charitable organizations under the factors discussed above, it has also been argued that they should qualify for recognition of exemption under the integral part theory of exemption.[25] The integral part theory holds that an organization that is a subsidiary of an exempt entity may itself be exempt if its activities are an integral part of the exempt activities of the parent. Thus, the argument goes, the HMO is engaged in activities that are an integral part of the exempt activities of its parent or

22. Gen. Couns. Mem. 39828.
23. *Id*.
24. *See* Chapter 20.
25. *See* § 34.6.

its affiliate, both of which are involved in the promotion of health. The IRS was not persuaded by this argument and took the position that a separately incorporated non-staff-model HMO that is controlled by the tax-exempt parent of a nonprofit healthcare system, and that does not qualify on its own for recognition of exemption as a charitable organization, cannot qualify for exemption as an integral part of its exempt parent.[26] This position was upheld by the Third Circuit Court of Appeals and, accordingly, it does not appear that the IRS will warmly receive an application for recognition of exemption from an HMO that relies on the integral part theory as the basis for exemption.[27]

The third part of the IRS's analysis is the determination of whether the HMO can qualify for exemption as a social welfare organization. As discussed earlier, most HMOs seeking tax exemption were recognized as social welfare organizations, as a result of longstanding administrative practice and their similarity to Blue Cross/Blue Shield plans. However, given Congress's revocation of the ability of Blue Cross/Blue Shield plans to qualify for tax-exempt status, through enactment of Code section 501(m), these health plans are no longer a good role model for HMOs aspiring to qualify as social welfare organizations.

Subsequent to the enactment of the commercial-type insurance rules, however, the IRS developed a ruling position on whether HMOs may qualify for exemption as social welfare organizations. In the IRS's view, HMOs that qualify as social welfare organizations must still satisfy the community benefit standard; however, the IRS will require a showing of community benefit that is similar to, but less exacting than, the benefit required for charitable HMOs. Under the IRS's current ruling position, the community benefit analysis for such HMOs will focus on factors such as whether the membership is open to individuals and small groups (taking into consideration any examination requirements, coverage limitations, and conversion rights); whether the HMO serves low-income, high-risk, medically underserved, or elderly persons; and whether premiums are established on a community-related basis.[28] Under its facts-and-circumstances analysis, the IRS also considers as evidence of community benefit the fact that an HMO is federally qualified within the meaning of the Federal HMO Act or that the HMO has a Medicare risk-sharing contract. However, the absence of either of these factors would not create an inference that community benefit is not established.[29]

(b) Tax Status of HMO Models

As discussed earlier, it is generally recognized that HMOs are organized under four fundamental models: (1) the staff model, (2) the group model, (3) the IPA model, and (4) the network model. The utility of these classifications has

26. Gen. Couns. Mem. 39830.
27. *Geisinger Health Plan v. Commissioner*, 30 F.3d 494 (1994). *See* § 34.6.
28. Gen. Couns. Mem. 39839.
29. *Id*.

diminished, however, as HMOs have bridged several of these models in an effort to optimize the attractiveness of their product to subscribers. Moreover, the IRS does not rule on the exemption of an HMO based on the model under which it is organized; instead, it applies a facts-and-circumstances analysis to the organization and operations of the particular HMO seeking exemption. Nevertheless, it is useful to review the treatment of each of these models by the IRS and by the courts with regard to qualification for exemption.

(i) Staff Model. One of the earliest and most popular models of organization for HMOs was the staff model HMO. A staff model HMO is defined as an organized prepaid healthcare system that delivers health services through a salaried physician group that is employed by the HMO.[30] Healthcare facilities are typically owned and operated at a central location by the HMO. Staff model HMOs are considered by the IRS to be direct providers of healthcare services. Despite their early popularity, staff model HMOs are now clearly in the minority. At the end of 1993, only 10.5 percent of the 545 HMOs in existence were organized as staff model HMOs, and they accounted for only 11.4 percent of all enrollees in HMOs nationwide.[31] As discussed earlier, although the standard remains difficult to meet, the staff model HMO clearly has the greatest likelihood of successfully obtaining exemption as a charitable organization.

The ability of staff model HMOs to qualify as charitable organizations was established by the Tax Court.[32] The opinion by the Tax Court in that case began with an extensive review of the organization and operations of the staff model HMO. The opinion indicated that Sound Health Association was a nonprofit, nonstock corporation owned by its members, and its primary (but not sole) purpose was to provide comprehensive healthcare services to its members. The goal of the HMO was to provide comprehensive healthcare services to all members and to the community.

The opinion further noted that the HMO was itself a healthcare service provider through the employment of salaried physicians, nurses, and other health professionals who then provided healthcare services directly to its members. The HMO contracted with other basic healthcare service and supply providers—for example, hospitals, pharmacies, radiologists, and laboratories—to provide services and supplies to the HMO's members. Nearly all of the HMO's services were centered at its clinic.

The amount of compensation paid to physicians and secondary healthcare service providers was set by contract and did not vary in relation to the number of patients enrolled or treated, the nature of the services performed, the status of the patient as a member or nonmember of the HMO, or the receipt

30. Group Health Association of America, 1994 National Directory of HMOs.
31. *Id*. at 21.
32. *Sound Health Association v. Commissioner*, 71 T.C. 158 (1978), *acq.*, 1981-2 C.B. 2.

of free care. The HMO's membership fees were based on a community rating system; everyone who was accepted as a member paid the same rates. The HMO had both group and individual members. It treated nonmember patients on a fee-for-service basis and provided emergency care, within the clinic's capabilities and within normal clinic hours, to those who needed it, regardless of whether they were members or had the ability to pay for the services. The HMO also planned a subsidized dues program directed at individuals who would want to join the HMO but would not be members of a group, could not qualify for Medicaid enrollment, and would have insufficient funds to pay the full HMO dues. The record demonstrated that the HMO had free care programs and educational activities as well.

Applying the law to these facts, the Tax Court first noted that neither the furnishing of medical care nor the operation of a hospital or an HMO is specifically listed as a charitable activity. Accordingly, the court turned to the law of charity to determine whether the provision of medical services would constitute a charitable purpose. The court quickly concluded that the rendering of medical care is a charitable activity and that it was reasonable to conclude that the tests applied to determine the tax status of a hospital are relevant to the determination of the charitable status of an HMO.

The court pointed out that the Internal Revenue Code's definition of ''hospital'' included outpatient clinics and that the IRS had previously ruled that a nonprofit community healthcare system that provided outpatient medical and general healthcare services qualified as a ''hospital.''[33] The court stated that the analogy between an outpatient clinic and the services rendered by an HMO clinic seemed clear.

In applying the IRS's analysis of charitable status for hospitals, the court first dismissed the issue of whether the HMO had to provide services to all without regard to ability to pay. It found that, with the IRS's adoption of the promotion of health as the primary basis for according charitable status to hospitals, it was not necessary to find a ''donative element'' present in the operation of the HMO plan. Accordingly, the court turned its primary focus to the question of whether the HMO had a policy of ensuring that adequate healthcare services were actually delivered to those in the community who needed them—that is, whether the HMO satisfied the community benefit approach adopted by the IRS.[34]

Based on its extensive review of the record, the court held that the HMO readily passed the organizational test for qualification as a charitable organization. The court further held that there was sufficient evidence to show that the HMO, like the hypothetical Hospital A in the IRS's criteria, was operated for charitable purposes.

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33. Rev. Rul. 73-131, 1973-1 C.B. 446. *See* § 8.1.
34. Rev. Rul. 69-545, 1969-2 C.B. 117.

Overruling the IRS's objection to the HMO's membership form of organization, the court found that this HMO's particular form of membership organization was what most qualified it as an organization providing benefit to the community. The class of persons eligible for membership in the HMO was practically unlimited, and the class of possible members of the HMO was, for all practical purposes, the class of members of the community itself. In addressing the IRS's concern that the membership mode of operation would result in ''preferential treatment'' to the HMO's members, the court stated that any potentially preferential treatment was the treatment common to every charitable organization that benefits the community by benefiting a certain class of individuals, and no charity had ever succeeded in benefiting every member of the community. The court also did not find the existence of any private benefit that would further support the preferential treatment argument of the IRS. Thus, the Tax Court held that the Sound Health Association should have been granted status as a charitable organization.

The IRS decided to acquiesce in the decision, and reexamined its position regarding the ability of HMOs to qualify as charitable organizations.[35] Subsequently, the IRS modified its earlier position at least with regard to HMOs organized under the staff model.[36] The IRS has, however, strictly held to the specific facts of the case and has never liberalized its position to encompass all staff model HMOs simply because they are organized under the staff model.

Because most staff model HMOs are organizationally and operationally closer to satisfying the community benefit standard established by the IRS than are other models of HMO organization, it appears likely that most, if not all, staff model HMOs will also be recognized by the IRS as social welfare organizations. As the organization of HMOs strays beyond the staff model, the ability of these entities to qualify for charitable status becomes substantially more difficult.

(ii) Group Model. The next HMO in the continuum, the group model HMO, is defined as an organized prepaid health system that contracts with one independent group practice to provide health services.[37] Patient care is often substantially provided in a centralized location under the group model. HMOs organized under the group model are also in the minority. At the end of 1993, only 10.1 percent of all HMOs were organized in this fashion, although, with 24.1 percent of all enrollees, they accounted for more than double the enrollees of staff model HMOs.[38]

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35. 1981-2 C.B. 2.
36. Gen. Couns. Mem. 38735. The memorandum generally follows the fact pattern of *Sound Health* and cites factors for qualification described in § 9.2(b) above. The memorandum included a draft revenue ruling that would have given the IRS's position precedential effect; however, that revenue ruling was never issued.
37. Group Health Association of America, *supra* note 30.
38. *Id*. at 21.

Because group model HMOs do not satisfy the Tax Court's test in the IRS's view, they typically are not recognized by the IRS as exempt as charitable organizations. However, a subgenus of the group model—the ''dedicated group'' model, also referred to as the ''captive group'' model—may still be able to qualify for charitable status. In the dedicated group model, the group practice provides substantially all of its services only on behalf of the HMO, and typically at a centralized location. As a result, even though the physicians and health professionals are not employees of the HMO, the HMO more closely resembles a direct provider of services than do other non-staff-model HMOs. The IRS has left the door open to according charitable status to dedicated group model HMOs, and recent legislative efforts to modify the commercial-type insurance rules in the context of health reform legislation have likewise recognized the preferred status of the dedicated group model.[39]

With regard to the garden-variety group model HMO, it is clear that the IRS's ruling position is that group model HMOs are not charitable organizations because they do not meet the Tax Court's test and the requirements set forth in the IRS analysis, and they may also have as a substantial part of their activities the provision of insurance within the meaning of the commercial-type insurance rules.[40] The IRS's position in this regard was upheld in the early 1990s after lengthy litigation involving the Geisinger Health Plan.

In the first phase of the litigation, it appeared that the IRS's restrictive position on recognition of exemption as a charitable organization was again headed for defeat: the Tax Court ruled that the non-staff-model HMO was a charitable entity.[41] Geisinger Health Plan (GHP) was incorporated as a nonprofit corporation and operated an HMO under the Pennsylvania Health Maintenance Organization Act. GHP was one of nine related organizations (including one of the largest rural healthcare facilities in the United States) and it was the subsidiary of a parent foundation recognized as a public charity. The purpose of the Geisinger System was to provide healthcare services to residents of northeastern and north central Pennsylvania.

Another sister company of GHP, the Geisinger Clinic (the ''Clinic''), employed licensed physicians to perform medical services for the hospitals and other entities within the Geisinger System. The Clinic was also recognized

39. FY 1995 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, at 142.
40. Gen. Couns. Mem. 39828.
41. *Geisinger Health Plan v. Commissioner*, 62 T.C.M. (CCH) 1655 (1991). The Geisinger Health Plan is probably most accurately described as a group model HMO, although it has network model HMO features and has been described in congressional committee reports as a network model HMO. (*See*, e.g., H. Rep. No. 103-601, pt. I, 103d Cong., 2d Sess. 582 (1994).) It was also incorrectly described by the Third Circuit Court of Appeals, in its review of this case, as an IPA-model HMO. *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210, 1217 (3d Cir. 1993).

by the IRS as a public charity. All physician services were provided to GHP subscribers through a Medical Services Agreement between GHP and the Geisinger Clinic. GHP provided for the healthcare of its subscribers at 43 outpatient facilities through the Clinic, and at other locations through its affiliated hospitals, pursuant to contracts with those entities. For the physician services it provided to GHP's members, GHP compensated the Clinic in an amount that was fixed per member. To fulfill its obligations, the Clinic also contracted with other physicians in GHP's service area; however, more than 84 percent of the physician services provided to GHP were provided by physicians who were employees of the Clinic.

GHP's membership was open to residents of 17 out of the 27 counties of the Geisinger System's service area. GHP provided services in rural counties that were classified by the federal government as medically underserved. Enrollment in the HMO was available to both groups and individuals, although there was a significant rejection rate for individuals. Under a community rating system, individual members and group members paid the same premium to GHP for the healthcare services that they received. GHP enrolled a very small number of Medicaid recipients (which was a major issue for the IRS). It adopted a subsidized dues program that, in practice, was used to subsidize only a small number of its members' premiums.

In its final adverse ruling, the IRS determined that GHP was not operated exclusively for charitable purposes because it did not meet the criteria for exemption set forth by the Tax Court. In addition, the IRS took the position that GHP did not qualify for exemption as an integral part of its parent because it did not provide essential services to the parent. Both GHP and the IRS agreed that the issue of GHP's exemption was controlled by the Tax Court's decision; however, they disagreed as to how that analysis was to be applied to the facts in the case. The Tax Court determined that GHP's operations were substantially similar to those of Sound Health Association and that its class of possible members, like Sound Health Association's, was "practically unlimited." As a result, it rejected the IRS's contention that GHP's operations conferred a substantial private benefit on its subscribers.

The court then addressed the issues raised by the IRS regarding the critical differences between GHP and Sound Health Association. Specifically, the IRS pointed out that GHP was not a staff model HMO, that is, GHP did not provide healthcare directly to its subscribers, but rather arranged for the provision of such services. It argued that GHP did not own or operate any facility at which healthcare was provided, did not provide any services to nonsubscribers, and did not provide emergency care to anyone in the community without regard to their ability to pay.

In addressing the IRS's arguments, the Tax Court stated that there was no absolute requirement that an HMO had to provide healthcare services directly to its members at its own facilities. It further stated that the critical factor

is the HMO's ability to ensure that adequate healthcare services are actually delivered to a sufficiently large class in the community, rather than provision of any absolute amount of free care. The court also overruled the argument regarding the operation of an emergency room, relying on the IRS's position that it is not necessary for an organization to operate an emergency room to qualify for exemption as a charitable organization, where such services are adequately provided by other institutions in the community.[42] In the case at bar, GHP had contracted with a substantial number of hospitals that provided emergency room services to GHP's patients. The other differences between the two HMOs were not considered persuasive by the Tax Court.

The court stressed that whether GHP is a charitable organization must be determined by examining all of the facts and circumstances and not on the presence or absence of one or more of the factors it previously outlined for Sound Health Association. It held that GHP's exempt status was properly based on its ability to ensure that healthcare services were actually delivered to the community and not on its ability to deliver those services in a particular manner. The court stated that even if GHP's activities were properly described as ''arranging'' for the provision of healthcare services, the activity of arranging, even if not itself inherently charitable, furthers GHP's exclusively exempt purpose of promoting health. The Tax Court therefore concluded that GHP was a charitable organization.

After its major loss in the prior case, the IRS opted not to acquiesce in this decision. Instead, it looked to the Third Circuit Court of Appeals for salvation in the form of a ruling that would uphold its narrow reading of that decision. The Third Circuit did not disappoint. On appeal, it overruled the Tax Court and held that GHP, standing alone, did not qualify for tax-exempt status as a charitable organization because it did not demonstrate the community benefit required to satisfy the operational test.[43]

In the Third Circuit, the IRS argued that more than the mere promotion of health must be shown in order to qualify for tax exemption. The IRS argued that at least some ''indicia'' of charity, in the form of serving the public and providing free care, must be shown as well. Looking at the totality of the circumstances, and focusing on whether the HMO benefits the community in addition to its subscribers, the Third Circuit held that GHP did not merit tax-exempt status as a charitable organization. The court stated:

> GHP cannot say that it provides any healthcare services itself. Nor does it ensure that people who are not GHP subscribers have access to healthcare or information about healthcare. According to the record, it neither conducts research nor offers educational programs, much less educational programs open to the public. It benefits no one but its subscribers.[44]

42. Rev. Rul. 83-157, 1983-2 C.B. 94. *See* § 26.4.
43. *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3d Cir. 1993).
44. *Id*. at 1219.

The court criticized the Tax Court's decision, opining that the court went too far when it reasoned that the presence of a subsidized dues program meant that the HMO served a large enough class to benefit the community. The court believed that the relevant inquiry is not whether an HMO benefits the community at all, but rather whether the HMO primarily benefits the community. Because GHP provided services only to its subscribers, the Third Circuit found that the community benefit was limited to those subscribers. Absent any additional indicia of a charitable purpose, the court concluded that GHP primarily benefited itself by promoting subscribership throughout its service area.

In summary, the Third Circuit concluded that GHP did not qualify as a charitable organization because it merely *arranged* for the provision of healthcare services—and only to its subscribers. This was not necessarily a charitable activity, the court held, particularly where the HMO has arranged to provide free or subsidized care to only a small number of persons. At least in the Third Circuit, this decision effectively eliminated the ability of group model (and other non-staff-model) HMOs to independently qualify for exemption as charitable organizations.[45]

The matter did not end there. The Third Circuit remanded the case to the Tax Court to determine whether GHP was entitled to tax-exempt status as a charitable organization because it was an integral part of the Geisinger System. Thus, the IRS's established position that non-staff-model HMOs cannot qualify as charitable organizations under the integral part doctrine was put to the test.[46]

This time, the Tax Court agreed with the IRS and held that GHP was not entitled to exemption under the integral part doctrine.[47] Under the Tax Court's analysis, an organization can qualify under the integral part doctrine if it performs an essential service directly to its parent or to related tax-exempt entities, or if it performs a service on behalf of its parent directly to the class of beneficiaries of the charitable activities of its parent. The parties also agreed that an organization is entitled to exemption under the integral part doctrine as

45. The Third Circuit's decision is seriously flawed in at least two respects, independent of its result regarding HMOs. First, the court accepted the IRS's position that something more than the mere promotion of health is required for an organization to qualify for tax exemption. This is simply a misstatement of the law. Promotion of health, in and of itself, is a charitable activity. The law does not require some additional indicia of charity (such as the relief of the poor, or advancement of education) as the court intimated. Further, the court based its decision on the fact that the HMO only arranged for the provision of services rather than providing the services directly. This concern is unwarranted. An organization can promote health without being a healthcare provider and still be charitable, just as an organization can be charitable because it promotes social welfare, or promotes education (without being a school), religion (without being a church), or science (without being a research institute). *See* § 1.7.
46. Gen. Couns. Mem. 39830. *See generally* § 34.6.
47. *Geisinger Health Plan v. Commissioner*, 100 T.C. 394 (1993).

long as its activities could be carried out by the exempt organization without constituting an unrelated trade or business.[48]

The court rejected GHP's arguments that it was a natural extension of the Geisinger System and that GHP could have been operated directly by its affiliated hospitals or the tax-exempt Clinic without constituting an unrelated trade or business. The court was unable to determine from the record whether the instances in which GHP subscribers were served by unrelated hospitals were substantial or insubstantial. However, following the lead of the Third Circuit, it gave greater deference to the interpretation of the circumstances given by the IRS and stated that it could not conclude that GHP's operations were so substantially and closely related to the exempt purposes of its affiliates that GHP's substantial serving of the private interests of its subscribers could be disregarded.

The last salvo in this battle was the appeal by GHP of the Tax Court's decision to the Third Circuit Court of Appeals. Unfortunately for GHP, this route to exemption was a dead end as well: the Third Circuit affirmed the Tax Court's decision that GHP was not exempt as an integral part of the Geisinger System. The court held that GHP did not qualify for exemption because its charitable character was not enhanced by virtue of its association with the Geisinger System. In so doing, it reinvented the integral part doctrine by requiring that the parent organization's relationship with the subsidiary provide a ''boost'' to the subsidiary's own exempt character sufficient to enable the subsidiary to become entitled to charitable status.[49] The end result is that group (and other nonstaff) model HMOs are also barred from recognition of exemption as charitable organizations under the integral part doctrine.[50]

Group model HMOs should be able to meet a preponderance of the factors set forth by the IRS for recognition of exemption as social welfare organizations, and, in practice, the IRS has liberally recognized this status for HMOs organized under this model.[51]

(iii) IPA Model. The third model of organization for HMOs, the most prevalent, is the IPA model. An IPA model HMO is defined as an organized prepaid healthcare system that contracts directly with physicians in independent practice, with one or more associations of physicians in independent practice, and/or with one or more multispecialty group practices (but predominantly organized around solo/single specialty practices) to provide health services.[52]

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48. *See* § 24.2.
49. *Geisinger Health Plan v. Commissioner*, 30 F.3d 494 (1994). *See* § 34.5 for an in-depth discussion of this case.
50. The IRS has not taken a position on whether staff model HMOs may qualify for exemption under the integral part doctrine. *See* Gen. Couns. Mem. 39830.
51. FY 1995 Exempt Organizations Continuing Professional Educational Technical Instruction Program Textbook, ''Health Care Update,'' at 142.
52. Group Health Association of America, *supra* note 30, at 4–5.

At the end of 2001, IPA model HMOs accounted for 71.1 percent of all HMOs nationwide.[53] To understand the IRS's treatment of these organizations, three distinctions are necessary: (1) the IPA itself, (2) HMOs that are controlled by the IPA they contract with, and (3) HMOs that are not controlled by the IPA that they contract with.

An IPA is an organization composed of and controlled by physicians for the purpose of negotiating contracts to provide physician services. Typically, IPAs contract with HMOs to provide physician services to the HMOs' beneficiaries on a fee-for-service basis. Participating physicians continue to operate their own practices and generally do not share administrative services.

When it first addressed the issue of whether IPAs can qualify for tax exemption, in 1982,[54] the IRS examined whether a nonprofit IPA could qualify for exemption as a social welfare organization.[55] In its analysis, the IRS stated that an organization is not operated primarily for the promotion of social welfare if its primary activity is carrying on a business with the general public in a manner similar to organizations that are operated for profit. Another factor for the IRS is whether the organization is controlled by its members, viewing nonmember input into an organization as a positive factor for securing social welfare status. In addition, the organization may not channel private economic benefits to its members.

Based on the totality of the facts and circumstances, the IRS concluded that the IPAs at issue were not operated primarily for the promotion of social welfare and that their primary activity was conducting a business similar to organizations that are conducted for profit. In reaching this conclusion, the IRS noted that an IPA is similar to a commercial health insurance reimbursement program because it serves as an alternative method to the direct billing and collection of fees from patients. In its memorandum, the IRS stated that there is nothing inherently charitable or educational in the performance of administrative functions for physicians whose medical care delivery is not dependent on such services.[56]

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53. 2002 AHIP Survey of Health Insurance Plans at 3.
54. Gen. Couns. Mem. 38894.
55. The IRS implicitly concludes in the memorandum that an IPA organized as a for-profit corporation would not be entitled to exemption under IRC § 501(c)(4). This is consistent with the longstanding IRS interpretation of the Code's requirements for exemption. The IRS has also not formally addressed whether a nonprofit IPA may qualify for exemption as an organization described in IRC § 501(c)(3). Given the IRS's analysis of the ability of HMOs to qualify for exemption as charitable organizations, it may be presumed that the IRS would take the position that IPAs are operated primarily for the private benefit of their members, do not serve a charitable purpose, and would therefore not qualify for exemption under that section.
56. Similar arguments have been raised by the IRS—administratively, with regard to tax-exempt clinics; and in the Tax Court, with regard to faculty practice plans. In those cases, however, the taxpayers established that the organizations at issue were more than simply billing and collection agencies, and were dedicated to the promotion of health, to

The IRS subsequently formalized its position in 1986. The IRS examined whether a nonprofit IPA would qualify for exemption as a social welfare organization and, in addition, whether the IPA could qualify as a tax-exempt business league.[57] The IRS found that IPAs are akin to billing and collection services. In addition, IPAs do not provide, to HMO patients, access to medical care that would not have been available but for the establishment of the IPA, nor do they provide such care at fees below those normally charged by member physicians in their private practices. Accordingly, the IRS concluded that the IPAs operate in a manner similar to organizations carried on for profit, and their primary beneficiaries are the member physicians rather than the community as a whole. As a result, IPAs are not operated exclusively for the promotion of social welfare. In addition, because the billing and collections services provide a convenience to the IPAs' physicians relating to the operation of their private medical practices, the IPAs are primarily performing particular services for their members, and because of restricted membership, they do not improve conditions for all physicians in the particular community. Accordingly, the IPAs are not operated as a business league.

However, in one ruling, the IRS determined that a parent holding corporation in a health system could provide IPA-like services for its affiliates consistently with its charitable status.[58]

The organization was recognized by the IRS as tax-exempt as a charitable organization and a supporting organization public charity. It served as the parent of a healthcare system that included several tax-exempt hospitals, a tax-exempt physician clinic, and other healthcare related organizations. It did not provide any healthcare services directly other than in its capacity as a supporting organization to the members of its system.

The parent organization entered into global risk contracting arrangements with insurance companies under which it received payments on a percentage of premium, per member per month basis. The capitation payments represented approximately 5 to 20 percent of the health system's gross revenue. The parent organization contracted for and received the capitation payments on behalf of its affiliated healthcare providers and certain specialty care physicians.

The IRS found that the global capitation contracts and subcapitation contracts were essentially medical service contracts for the promotion of the health of the community and therefore consistent with the parent's exempt purposes.

The Service further concluded that the organization was not providing commercial-type insurance since other organizations were not shifting risk to

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the provision of care to indigents, and to medical education and research. In addition, the faculty practice plans had a close nexus with tax-exempt medical schools and hospitals. These factors distinguish these organizations from the IPAs discussed in Gen. Couns. Mem. 38894. *See* Chapter 12.

57. Rev. Rul. 86-98, 1986-2 C.B. 74, § 18.1.
58. Priv. Ltr. Rul. 200044039.

the parent. By performing the services on a capitated basis, the parent was not protecting any other organizations or individuals from economic loss. The negotiated rates shifted substantially all of the risk of the contract and the capitation arrangements to the providers.

The IRS concluded that the parent organization's agreement with insurance plans to provide necessary medical and hospital care to the plans' members was substantially related to the parent's exempt purpose of promoting health. The IRS distinguished its position in prior guidance that IPAs cannot qualify as exempt organizations because the organization in this case provided direct healthcare through the primary care physicians employed by its exempt affiliate providers and also did not serve as a collective bargaining representative between member physicians and HMOs.

A different issue is whether an HMO that is controlled by an IPA can qualify for exemption as a charitable entity. The topic here is the HMO entity rather than the IPA itself, albeit with members of the IPA controlling the governing body of the HMO. In 1983, the IRS issued a memorandum that considered whether a federally qualified HMO that arranged for, but did not directly provide, comprehensive health services through an affiliated individual practice association, in exchange for a prepaid premium from its subscribers, could obtain recognition of exemption as a charitable organization.[59] The HMO was a nonprofit organization, affiliated with an IPA. Its board of directors consisted of three IPA executives and three members of the IPA's board of directors (additional outside directors were to be added, but majority control would remain with the IPA). The HMO contracted with the IPA to provide or arrange for the provision of administrative and financial services, as well as health services, to the HMO's members. Pursuant to its contract, the IPA would then enter into agreements on behalf of the HMO to provide physician services, surgical services, in-hospital care, emergency care, and diagnostic laboratory and x-ray services. The HMO itself would not operate any of the healthcare facilities, but would conduct utilization review programs. Membership was open generally to groups, and it was anticipated that membership would ultimately be expanded to include individuals. There was no firm plan for the enrollment of Medicare and Medicaid beneficiaries, and HMO-sponsored services would not be available to nonmembers. The HMO did not intend to subsidize dues for members or nonmembers. The HMO and IPA did plan to develop health education programs for the general public as well as for HMO members.

The IRS applied the Tax Court's community benefit analysis to the organization, thereby expressly extending it to non-staff-model HMOs. The IRS concluded that the IPA model HMO was markedly different from the Sound Health Association model. In fact, it sounded the death knell for the IPA model HMO by comparing it to the dreaded Hospital B in the IRS's 1969 revenue

59. Gen. Couns. Mem. 39057.

ruling on the community benefit standard[60]—the ''bad'' hospital that did not qualify for tax-exempt charitable organization status. The IRS concluded that the IPA-controlled HMO was a shell organization that promoted the common business interests of the IPA, which in turn was controlled by healthcare providers. Because the HMO was organized and operated for the private benefit of IPA members rather than for the exclusive benefit of the public, the HMO was found not to be entitled to exemption as a charitable organization.

It is important to note that the IRS did not consider whether the IPA-controlled HMO would have qualified for exemption as a social welfare organization. The IRS has not as yet taken a formal position on that question, although it seems unlikely that an HMO organized in this manner could survive the analysis that doomed the IPA itself in the IRS's ruling on this issue.[61]

The third variation on this model is an IPA model HMO in which the HMO entity is not controlled by the IPA. This would occur, for example, where the HMO is freestanding, or where it is controlled exclusively by charitable organizations, such as parent holding corporations or hospitals. This type of HMO entity was not addressed by the IRS in its guidance on this issue, and the IRS has not published any further guidance on it to date. At least one IPA model HMO that is controlled by two charitable hospitals has obtained recognition of exemption as a charitable organization. If reviewed by the IRS today, such HMOs would be more likely to obtain recognition of exemption as social welfare organizations, and most such entities should be able to satisfy the IRS's ruling position for HMOs seeking exemption under this section, as described above.

(iv) Network Model. The final predominant model of HMO organization, the network model, is defined as an organized prepaid health system that contracts with two or more independent group practices to provide health services. Network model HMOs are the second-most-common mode of operation for HMOs (after the IPA model). They account for 17.2 percent of all HMOs and 17.5 percent of all HMO enrollees nationwide.[62] The IRS has taken no formal position on the qualification for exemption of a network model HMO. It is unlikely that a network model HMO would survive the IRS's ruling position on HMOs that qualify for exemption as charitable organizations. However, it appears that the IRS would recognize tax-exempt social welfare organization status for such organizations, although they would have a more difficult road to exemption than would a group model HMO.

(v) Open-Ended Plans. Each of the above-described HMO models may contain another feature of operation that is becoming increasingly popular and

60. Rev. Rul. 69-545, 1969-2 C.B. 117.
61. Rev. Rul. 86-98, 1986-2 C.B. 74.
62. Group Health Association of America, *supra* note 30, at 21.

that might, by itself, threaten the ability of the HMO to obtain recognition of exemption. This feature is commonly referred to as a "point-of-service" option, and plans that offer the option are referred to as "open-ended HMOs." The point-of-service option permits individuals who are enrolled in the HMO to self-refer to providers outside the HMO's network, typically with deductibles or extensive cost sharing required. Because the lock-in feature of HMOs often dissuades potential subscribers from joining HMOs (as subscribers, they would not be permitted to receive services from physicians with whom they already have a relationship), the point-of-service feature is a vital method of obtaining new subscribers. The feature substantially blurs the distinction between HMOs and traditional indemnity insurers.

In the IRS's view, Congress did not intend to exclude from the reach of the commercial-type insurance restriction HMOs that provide a point-of-service product. Because such services are provided on a true indemnity basis, they constitute the provision of commercial-type insurance. Accordingly, any revenues obtained from the provision of such services by a tax-exempt HMO must be treated as an unrelated trade or business subject to the special taxation provisions of the Code for such services.[63] If this type of activity is substantial, the IRS believes the organization providing these services would be precluded from exemption.[64]

(vi) Medicaid HMOs. In the fall of 1998, the IRS released its continuing professional education textbook for fiscal year 1999.[65] Included in the textbook is an article that clarifies the standards under which HMOs may qualify for exemption as charitable organizations.[66] In the case of Medicaid HMOs, the IRS offers a rare exception to its narrow interpretation of the Tax Court's test for charitable status by acknowledging that Medicaid HMOs that merely arrange for the provision of healthcare services (e.g., network model HMOs) may qualify for tax-exempt status. Rather than focus on the HMO's operational structure, the IRS has shifted its focus to the HMO's actual purpose and class of beneficiaries.[67] The IRS indicated that an HMO that primarily serves to benefit the community at large may qualify for tax-exempt status, irrespective of whether the HMO actually provides healthcare services or, as is now the norm, acts as a managed care administrator. To illustrate this position, the IRS analyzed three hypothetical examples in which network model HMOs qualify

63. IRC § 501(m)(2).
64. Gen. Couns. Mem. 39829. In general, Levine, "*Geisinger Health Plan* Likely to Adversely Affect HMOs and Other Health Organizations," 79 *J. Tax'n Exempt Orgs*. 2, 90 (Aug. 1993).
65. IRS FY 1999 Exempt Organization Continuing Professional Education Technical Instruction Program Textbook ("FY 1999 CPE Text").
66. Brauer and Friedlander, Chapter D, "Exemption of Medicaid HMOs and Medicaid Service Organizations Under IRC 501(c)(3)" ("Brauer and Friedlander"), in *id*. at 67.
67. *See* § 9.2(a), *supra*.

for tax-exempt status as charitable organizations by virtue of serving Medicaid beneficiaries exclusively.

Because none of the HMOs described in the article resemble the staff model that the IRS has historically accepted as the prototype for purposes of recognizing charitable status, the IRS opined that none qualified for charitable status by virtue of the ''direct provider'' analysis. Nor do they otherwise qualify under the ''integral part'' doctrine. Notwithstanding their operational configurations, however, because each HMO offered a service that provided a compelling benefit to the community at large (serving Medicaid beneficiaries), the IRS recognized that the HMOs would qualify as charitable organizations on other grounds, concluding that the Tax Court doctrines did not necessarily control in these limited instances. The examples used by the IRS are as follows:

Example 1. A nonprofit medical clinic (the ''Clinic''), exempt as a charitable organization, organized a separate nonprofit HMO to service Medicaid beneficiaries and their dependents, exclusively, on a managed care basis. The HMO arranged for the provision of services through the Clinic's panel of providers as well as through physicians who contracted directly with the HMO as independent contractors. The HMO provided hospital services on a contractual basis through hospitals unrelated to the HMO. The Clinic's board of directors was made up of members of the community; it implemented a conflict-of-interest policy that also applied to the HMO.

Example 2. A nonprofit membership corporation was organized and operated under state law as a Medicaid HMO to provide services exclusively to Medicaid beneficiaries in underserved areas of the state. Medicaid recipients automatically qualified to enroll in the HMO. The members of the HMO consisted of five tax-exempt charitable hospitals, each of which could appoint one director to serve on the HMO's board. The state paid the HMO a monthly capitated fee for each Medicaid recipient. The HMO arranged for the provision of primary and specialty care services through contracts with its member hospitals, which employed salaried physicians. The HMO also provided services through a panel of physicians who contracted with the HMO on an independent basis. In addition, the HMO implemented a substantial conflict-of-interest policy.

Example 3. A health services network (the ''Network'') was organized under state law as a nonprofit corporation. State law required the Department of Social Services in each county to provide medical benefits to persons eligible for Medicaid. State law

also required each county to contract with charitable organizations to provide certain services under the state's Medicaid program. A county's Department of Social Services contracted with the Network to perform the services required under the state Medicaid program. Specifically, the Network (1) established a network of primary care physicians who provided the healthcare services; (2) coordinated reimbursement and monitored utilization and quality of care; (3) instructed Medicaid beneficiaries how to use primary care physicians instead of the emergency room to obtain routine healthcare; and (4) trained teaching teams to enroll Medicaid-eligible persons to participate in the program. In exchange for these services, the Network was paid a monthly fee on a capitated basis. In turn, the Network allocated the capitated fee to its primary care physicians, less a predetermined amount that the Network retained as an administrative fee. The Network, a nonmembership corporation, adopted a substantial conflict-of-interest policy and maintained a board of community leaders.

In assessing whether each organization described above warranted charitable status, the IRS noted that there are essentially three rationales for the exemption of HMOs: (1) the promotion of health; (2) the relief of the poor and distressed; and (3) lessening the burdens of government. With respect to the promotion of health, the IRS reiterated that although the promotion of health has long been held to be a charitable purpose, it does not, in and of itself, warrant tax-exempt status. Amplifying the holding set forth by the Third Circuit,[68] the IRS opined that ''an organization that merely promotes health in the broad sense of the term, without more, does not qualify for recognition under IRC § 501(c)(3).'' Indeed, to the extent that an HMO's operations are geared only toward its membership population, it is more characteristic of a commercial insurance company than a charitable organization. In contrast, the IRS opined that a charitable purpose may be supported by serving Medicare or Medicaid beneficiaries, maintaining an emergency room for indigent patients, or any number of other activities that benefit more than the organization's membership, to wit: operating a free computerized donor authorization retrieval system to facilitate organ transplants; planning the effective provision of healthcare services within a specified geographical area; providing housing, transportation, and counseling to friends and family of hospital patients; or providing professional standards review services to Medicaid providers.[69]

With respect to the HMOs described in *Examples 1* and *2*, which enroll Medicaid beneficiaries exclusively, the IRS took the position that the activities

68. *See Geisinger II, supra* note 41.
69. Brauer and Friedlander at 72–73.

of each HMO reflect a charitable purpose. Specifically, each HMO arranges for the provision of healthcare services for low-income individuals who have special needs and thereby ensures that these individuals have access to appropriate care. Moreover, by operating on behalf of Medicaid beneficiaries exclusively, the IRS noted that the HMOs enable the state and federal governments to operate the Medicaid programs more efficiently, which in turn promotes the health of Medicare beneficiaries as well as the community at large.[70]

Separately, the IRS opined that the HMOs described in *Examples 1* and *2* may also qualify for charitable status by providing ''relief to the poor and distressed,'' which, as noted above, is also considered a charitable purpose.[71] In this context, the IRS predominantly analogized to the low-income housing rulings, which consistently hold that the provision of housing for underprivileged individuals is a charitable activity because it serves a special need of persons who ''cannot otherwise afford the necessities of life.''[72] Still other analogous rulings denote relieving the distress of the elderly or physically handicapped, or providing temporary housing or other social services to fire victims, as charitable activities.[73] Similarly, the provision of healthcare to Medicaid beneficiaries, who, by definition, are usually underprivileged, would be a charitable activity. The IRS noted that low-income individuals, who often require more healthcare than do more privileged individuals, are generally unable to pay for those services and are consequently left unattended. To this end, because both HMOs described in *Examples 1* and *2* are operated to serve the needs of the underprivileged exclusively, they each qualify for charitable status.

In contrast, the Network's operation as described in *Example 3* acts neither to promote health nor to relieve the poor and distressed. First, the IRS noted that because the Network does not actually enroll or provide services to Medicaid beneficiaries but merely aggregates the claims of downstream providers on behalf of the state Medicaid program, it is not actually providing (or arranging for the provision of) healthcare services in a manner that is distinguishable from other for-profit organizations. And second, to the extent that an organization merely enables a governmental body to perform its obligations as prescribed by law, it is not considered to be providing relief to the poor and distressed, even though such activities may qualify for charitable status on other grounds, as discussed below.[74]

Finally, noting that activities that ''lessen the burdens of government'' are expressly included within the realm of charitable activities, the IRS concluded

70. *See* Brauer and Friedlander at 77, citing *Professional Standards Review Organization of Queens County, Inc. v. Commissioner*, 74 T.C. 240 (1980).
71. *See* Reg. § 1.501(c)(3)-1(d)(2).
72. Brauer and Friedlander at 77.
73. *Id*. at 77–79.
74. *See* Rev. Rul. 77-3, 1977-1 C.B. 140 (the provision of low-income housing to the poor is a charitable activity).

that in certain instances HMOs may further such interests and thereby qualify for tax exemption.[75] Specifically, healthcare organizations that act to assist governmental bodies to satisfy their obligations under the Medicare and Medicaid statutes would likely satisfy this criterion. Pointing to professional standards review organizations (PSROs), which act as the agents of the Medicare and Medicaid programs, the IRS cited a litany of cases that suggest that organizations may qualify as charitable organizations by providing assistance to government programs.[76] For example, Congress created the PSRO program for the express purpose of saving the government the time and expense associated with Medicare and Medicaid program oversight by establishing quasi-governmental peer review organizations that would assume these responsibilities. Accordingly, the courts have consistently recognized that PSRO organizations further a charitable purpose by lessening the burdens of government. Yet, while the IRS has historically agreed with this premise,[77] it distinguishes between the complete abdication of governmental responsibility as required by law and purely voluntary arrangements whereby the state delegates certain responsibilities in exchange for a fee. State contracts with managed care organizations to provide healthcare services on a capitated basis, for example, are generally not considered to lessen the burdens of government even though the managed care organization provides services on behalf of the government. Thus, it would appear that the IRS requires more than a mere contractual arrangement with a governmental body (e.g., a legislative mandate requiring the delegation of governmental authority).

With respect to *Examples 1* and *2*, the IRS indicated that such organizations would not qualify for tax-exempt status on the basis of lessening the burdens of government insofar as ''there is no objective manifestation by a state, either administratively or in applicable legislation, of an intention that an HMO should assume any portion of the state's burden of providing health care for residents who are Medicaid beneficiaries.'' In contrast, the IRS reasoned that the Network in *Example 3* does qualify on that basis because in that instance the respective state law affirmatively requires each county to furnish Medicaid benefits through organizations that are tax-exempt as charitable organizations.

(c) HMO Case Study: *IHC Health Plans*

Much of the analysis found in the IRS's FY 1999 CPE Text article on Medicaid HMOs was reiterated in a Technical Advice Memorandum (TAM) regarding an HMO's continued qualification for exemption as a charitable

75. *See* Reg. § 1.501(c)(3)-1(d)(2).
76. *See generally Professional Standards Review Organization of Queens County, Inc. v. Commissioner*, 74 T.C. 240 (1980), and *Virginia Professional Standards Review Foundation v. Blumenthal*, 466 F.Supp. 1164 (D.D.C. 1979).
77. *See* Rev. Rul. 81-276, 1981-2 C.B. 128.

organization or, in the alternative, as a social welfare organization.[78] In this TAM, the IRS considered the case of an HMO that had been recognized as a charitable organization by the IRS since 1985. It was licensed as a third-party administrator but was not federally qualified. The HMO was a member of a larger nonprofit healthcare system. The parent of the system, which was the HMO's sole member, was also a charitable organization. In addition, it was the parent of another charitable organization, which owned or operated 25 acute care hospitals that provided inpatient and outpatient care to patients in three western states. The IRS concluded that because the HMO no longer provided the requisite community benefit identified in the Tax Court cases involving Sound Health Association and Geisinger Health Plan, did not satisfy the integral part doctrine as a basis for exemption, and, in addition, was substantially providing commercial-type insurance, it no longer qualified for exemption as a charitable organization and was also unable to qualify for exemption as a social welfare organization.

At the time of its initial application for exemption, the HMO was apparently structured as either a group or a network model HMO. It did not operate an emergency care facility, nor did it treat nonmember patients. In addition, it did not have a Medicare risk-sharing contract. The HMO paid its participating physicians on a fee-for-service basis. Beginning in 1988, it added a withhold feature and a bonus arrangement to its physician compensation mechanism but subsequently eliminated the withhold feature.

The HMO provided coverage only through accepted employer groups. Employer groups with fewer than 25 employees were accepted on a case-by-case basis, excluding coverage for some employees or conditions. Individuals apparently were not initially eligible for coverage. The HMO's board of directors included equal physician and hospital representation; the buyer/employer community had a plurality of seats on the board. All trustees were appointed, and subject to removal, by the parent corporation.

At the time that the technical advice was being considered, updated information was provided by the HMO. The bylaws of the HMO were revised to provide that the board would consist of a majority of persons who broadly represented the community and who were not financially interested persons or independently practicing physicians in a position to refer patients to organizations affiliated with the HMO. The HMO would arrange for the provision of various medical services for its enrollees, including inpatient and outpatient hospital care, as well as primary and specialty physician care. Approximately 91 percent of the HMO's hospital services would be provided through facilities owned by its parent corporation.

78. Internal Revenue Service National Office Technical Advice Memorandum (not published), 98 TNT 243-2 (Doc. 98-37129); Bureau of National Affairs Tax Core, Dec. 17, 1998.

The HMO provided primary and specialty physician care services through contracts with various physicians. These physicians either were employed by the parent corporation or maintained independent practices in their local communities. The parent corporation employed approximately 360 physicians, and the HMO contracts with approximately 2,170 other physicians. As of September 30, 1997, the HMO had paid 70.4 percent of its total professional expenditures to providers who were not employed by the parent corporation. For the same period, expenditures to professional providers represented approximately 53.4 percent of the HMO's total medical expenses.

Under the terms of its contracts with its physicians, the HMO compensated the physicians on a discounted fee-for-service basis, paying them the greater of a capitated fee or 85 percent of the physician's usual and customary billed charges. At the time, there was no provision in these agreements for a withhold of any portion of the fees. In some cases, physicians would be eligible for additional payments in the event of budget surpluses; however, in the event of budget deficits, the physicians would have no additional financial obligations. The HMO had 339,986 enrollees as of September 30, 1997. Of this total, 10 percent were individuals, 17 percent were small groups (25 or fewer employees), 63 percent were large groups, 0 percent were Medicare beneficiaries, and 10 percent were Medicaid beneficiaries. The HMO provided a point-of-service benefit and used an adjusted community rating methodology to determine its premiums.

In reaching its conclusions, the IRS applied the holdings of the Tax Court and the Third Circuit, as well as the analysis of the three GCMs it issued in 1990 on tax exemption for managed care organizations. In so doing, the IRS offered no relief from the overly restrictive and somewhat dated community benefit tests used by the Tax Court and also adopted the Third Circuit's view that services that primarily benefit an HMO's enrollees, no matter how much they may promote health, do not benefit the community as a whole.

In applying the Tax Court's test for community benefit, the IRS recited the now-familiar benchmarks of providing services through employed physicians, operating an emergency room open to all without regard to ability to pay, and owning facilities to provide healthcare. In the process, the IRS appeared to pull away from its general ruling position that an HMO organized under the captive or dedicated group model will also satisfy this test.

In the TAM, the IRS established a hierarchy of alternative routes to qualification for exemption as a charitable HMO: first, satisfying the direct provider community benefit test; second, satisfying the ''flexible'' community benefit standard; and third, satisfying the integral part test as explained and expanded by the Third Circuit.

Applying the direct provider community benefit test, the IRS simply stated that because the HMO did not provide medical services through employed physicians at its own facilities, did not operate an open emergency room, and

did not offer healthcare to all in the community who could not afford to pay, it did not satisfy the community benefit standard previously established by the IRS for hospitals[79] or the application of that standard to HMOs by the Tax Court. Unfortunately, this summary statement fails to acknowledge the many other methods of providing community benefit identified by the Tax Court. Furthermore, in suggesting that care must be provided to all persons in a community who cannot afford to pay (in addition to the open emergency room requirement), it contradicts the IRS's position on charity care in effect since 1969. As noted above, it also fails to acknowledge the IRS's previous recognition of charitable status for dedicated group model HMOs.

Under the flexible community benefit standard, the IRS considered whether the beneficiaries of the HMO's services were a broad enough segment of the community to constitute the requisite charitable class. While the HMO in question undoubtedly promoted health through its policy of nontermination solely for health reasons, free wellness programs, provision of prevention and education services at cost, and use of an adjusted community rating methodology, the IRS concluded that because these features applied almost exclusively to the HMO's enrollees, the community was not benefited as a whole.

Where neither the rigid community benefit test nor the flexible community benefit standard is met, then the application of the integral part doctrine is considered. Here, the IRS adopted the standard used by the Third Circuit that providing services to 20 percent or more of an HMO's enrollees through providers other than those facilities directly related to the HMO (i.e., those that are part of the same healthcare system) will result in failure to demonstrate that the charitable purposes of the HMO's related hospitals are being substantially furthered. Evidently because a significant number of ''nonpatients'' were being served by the HMO, the IRS also concluded that the HMO's activities would be an unrelated trade or business if carried on by the HMO's charitable parent organization. Accordingly, the IRS found that the HMO did not qualify for exemption as a charitable organization under the integral part doctrine.

In the TAM, the IRS did not address whether the organization could have qualified for tax exemption as a social welfare organization, which, under prior IRS guidance, requires a less exacting standard of community benefit (which is apparently still more flexible than the standard applied to Geisinger Health Plan). It seems likely under the IRS's ruling position to date that this HMO would be able to meet the community benefit standards applied to social welfare organizations.

Although guidance in this area is needed and welcome, this TAM does little more than reiterate the Tax Court's community benefit tests, and it applies them in a fairly restrictive fashion. It continues a flawed reliance on whether an HMO directly provides healthcare or merely arranges for it as the fundamental basis

79. Rev. Rul. 69-545, 1969-2 C.B. 117.

for exemption, and it fails to take into account the substantial changes in the manner in which HMOs benefit their communities—most notably outreach, public health, and patient advocacy—that have occurred in recent years.

The HMO that was the subject of the TAM filed a Petition for Declaratory Judgment alleging that the IRS erroneously revoked its status as a charitable organization. In that case, the U.S. Tax Court upheld the IRS's stringent views of the type of health maintenance organization that can qualify for tax exemption as a charitable organization. In so doing, it perpetuated the IRS standard that makes it exceedingly difficult (if not impossible) for an HMO organized as other than a staff model HMO to obtain recognition of charitable status.

In separate opinions, the Tax Court found that IHC Health Plans, Inc. (''Health Plans'') and its affiliates, IHC Group, Inc. (''Group'') and IHC Care, Inc. (''Care''), did not qualify as tax-exempt charitable organizations.[80] These decisions upheld the IRS's decisions to retroactively revoke recognition of Health Plans' tax-exempt status and to reject Group's and Care's applications for recognition of tax exemption.

Health Plans, Group, and Care operated HMOs and were part of a number of companies comprising Intermountain Health System. The Church of Jesus Christ of Latter Day Saints organized Intermountain Health Care, Inc. (IHC) as a Utah nonprofit corporation for the purpose of assuming ownership and control of its hospitals and to oversee its worldwide healthcare program. The Church of Jesus Christ of Latter Day Saints transferred control of IHC to an independent board of trustees in 1975; and in 1983, IHC restructured its operations with the IRS's approval of its corporate reorganization plan.

IHC transferred its hospitals and substantially all of its remaining operating assets, outstanding tax-exempt debt, and other liabilities to IHC Health Services, Inc. (''Health Services''), a newly formed nonprofit and federally tax-exempt affiliate. IHC became the sole member of Health Services. Health Services had two divisions: (1) the hospital division, comprised of 22 hospitals of which all but two were general acute care hospitals; and (2) the physician division, which employed approximately 400 physicians.

IHC organized Health Plans as a nonprofit affiliate to operate as a state-licensed HMO, and IHC was Health Plans' sole corporate member. In 1985, Health Plans organized Care as a nonprofit affiliate for the purpose of establishing a federally qualified direct-contract model HMO. In 1991, Health Plans organized Group as a nonprofit affiliate for the purpose of establishing a federally qualified medical-group model HMO. Health Plans was Care's and Group's sole corporate member.

The IRS did not dispute that Health Plans was organized for a tax-exempt purpose. The issue was whether Health Plans was operated exclusively for

80. *IHC Health Plans, Inc. v. Commissioner*, 82 T.C.M. 593 (2001); *IHC Group, Inc. v. Commissioner*, 82 T.C.M. (CCH) 606 (2001); *IHC Care, Inc. v. Commissioner*, 82 T.C.M. 617 (2001).

an exempt purpose, which includes charitable purposes. The promotion of health for the benefit of the community is a charitable purpose.[81] To prove its charitable purpose, an HMO seeking tax-exempt status must demonstrate that it provides a community benefit.[82]

Health Plans offered managed care to individuals, employees of large and small employers, and Medicaid recipients. It used an adjusted community rating methodology to determine premiums for individual and small employer group enrollees, adjusting its rates for risk factors such as age and gender. For large employer group enrollees, Health Plans relied on past claims experience to determine premiums.

Health Plans did not directly own or operate any healthcare facilities. Its hospital services were provided by contracting with a panel of hospitals, including Health Services' hospitals and a limited number of independent hospitals. Health Plans did not employ a significant number of physicians; it offered a majority of its physician services through 2,400 independent physicians with whom it contracted.

Health Plans provided preventive healthcare services to its enrollees at no additional charge, and during 1999, it conducted free comprehensive health screenings for local schools, municipalities, and nonprofit and civic organizations. Other than the free screenings in 1999, Health Plans did not provide any free healthcare services or any program in which individuals were permitted to become members at a reduced rate.

The Tax Court analyzed Health Plans under the community benefit test, comparing Health Plans to the organizations in the prior litigation.[83] The court opined that Health Plans, like these other entities, offered its health plans to a wide cross-section of the community. The court found, however, that Health Plans' operations differed ''materially'' from the operations of these other plans.[84] In particular, Health Plans did not own or operate its own medical facilities, did not employ (to a significant extent) its own physicians, and did not offer free medical care to the needy. In addition, Health Plans did not institute any programs in which enrollees could pay reduced premiums and, aside from free health screenings in 1999, Health Plans did not provide any free or low-cost healthcare services.

The court pointed out that the record did not reflect whether Health Plans applied surplus funds to improve facilities, equipment, or patient care, or to enhance medical training, education, and research.[85] The court found the

81. *See*, e.g., *Redlands Surgical Servs. v. Commissioner*, 113 T.C. 47, 73 (1999), *aff'd per curiam*, 242 F.2d 904 (9th Cir. 2001); *Sound Health Association v. Commissioner*, 71 T.C. 158, 177-81 (1978).

82. *Sound Health Association v. Commissioner*, 71 T.C. 158 (1978); *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3rd Cir. 1993).

83. *See supra* note 81.

84. *IHC Health Plans, Inc. v. Commissioner*, *supra* note 79, at 605.

85. *Id*. (citing Rev. Rul. 83-157, 1983-2 C.B. 94).

premium disparity issue—in which individual and small employer groups were rated one way and large employer groups another—to be important as a possible inference that Health Plans was benefiting larger employers. The court also noted that, unlike the board of one organization,[86] which was comprised of community members, Health Plans' board of trustees lacked representation from the community at large, which furthered the inference that Health Plans ''predominantly served the private interests of the larger employers participating in its plans.''[87]

The Tax Court then analyzed Health Plans under the integral part test. The court found that there was no dispute that Health Plans' activities were carried out under the supervision and control of IHC, a tax-exempt affiliate. Thus, the court needed only to consider whether Health Plans' activities would constitute an unrelated trade or business if conducted by a related tax-exempt entity.

According to the court and its prior holding,[88] Health Plans had to show that its overall operations were substantially related to the functions of its tax-exempt affiliate. Like the entity in this prior holding, Health Plans did not own or operate any medical facilities and did not employ a significant number of physicians or healthcare professionals. Health Plans contracted with physicians and hospitals to provide healthcare services to its enrollees. Unlike the prior case, Health Plans' enrollees received medical services from independent hospitals that were ''limited to situations where Health Services was unable to provide specialized hospital services or were due to geographical expediency, or both.''[89] The Tax Court was satisfied that Health Plans' method of providing its enrollees hospital services was substantially related to Health Services' exempt function.

However, in the Tax Court's analysis of Health Plans' use of independent physicians, the court found that 80 percent of physician services were provided by physicians with no direct link to one of Health Plans' tax-exempt facilities. Although Health Plans argued that whether it contracted with independent physicians was not relevant because such physicians were required to maintain privileges at one of Health Services' hospitals, the court disagreed. Because Health Plans did not provide free or low-cost health services, the court did not see how Health Plans' operations, including its heavy reliance on independent physicians, would be essential to or substantially related to Health Services' exempt functions. The court found that Health Plans' method of arranging for its enrollees to receive physician services ''suggests'' that Health Plans operated on a scale ''larger than is reasonably necessary to accomplish the purpose of exempt entities.''[90]

86. *Sound Health Association v. Commissioner*, *supra* note 81.
87. *Id*.
88. *Geisinger Health Plan v. Commissioner*, *supra* note 47.
89. *Id*. at 606.
90. *Id*. (citing *Geisinger Health Plan v. Commissioner*, *supra* note 47, at 406).

The court found that Health Plans did not provide the community benefit required to qualify as a charitable organization and its operations were not essential to or substantially related to Health Services' exempt function. Thus, the Tax Court found for the IRS.

The other two organizations, Group and Care, offered health plans to employers with more than 100 employees. Neither Group nor Care had medical facilities; they did not directly employ any physicians or healthcare professionals; and they relied on a community rating methodology to determine premiums. Both Group and Care offered a Core Wellness Program—free healthcare services at no charge—to their enrollees, and offered Medicare enrollees coverage until 1998, when they ceased offering coverage in part because of the financial loss of that program. Neither Group nor Care offered any program to encourage or assist low-income persons, medically high-risk persons, persons located in medically underserved areas, or elderly persons. Neither offered premium subsidies for those who were unable to afford coverage, and neither engaged in any medical, healthcare, or scientific research.

As with Health Plans, the IRS did not dispute that Group or Care was organized for an exempt purpose. The issue was whether they were operated exclusively for an exempt purpose.[91]

In its community benefit test analysis, the court found that neither Group nor Care offered its health plans to the general public; rather they limited their enrollment to large groups. They did not have subsidized premiums programs, research, or free educational programs for the public.[92] Both Group and Care were able to offer lower costs than other HMOs, but those savings were only for enrollees, not to benefit the general public.

Under the integral part test, the Tax Court found that there was no dispute that both Group's and Care's activities were carried out under the supervision and control of IHC, a tax-exempt affiliate; therefore, the court needed only to consider whether Group's and Care's activities would constitute an unrelated trade or business if conducted by a related tax-exempt entity.[93] As in *Health Plans*, the Tax Court in *Group* and *Care* found that, although their enrollees received medical services from independent hospitals, those services were limited to situations where Health Services was unable to provide the specialized hospital services or due to geographical considerations. The court was satisfied that both Group's and Care's methods of arranging hospital services for its enrollees were substantially related to Health Services' tax-exempt function.[94] In its analysis of Group's and Care's use of independent physician services, however, the Tax Court found, as it did in *Health Plans*, that

91. *See IHC Group, Inc. v. Commissioner*, *supra* note 80, at 612; *IHC Care, Inc. v. Commissioner*, *supra* note 80, at 622.
92. *See Group*, 82 T.C.M. at 615; *Care*, 82 T.C.M. at 625.
93. *Group*, 82 T.C.M. at 615; *Care*, 82 T.C.M. at 626.
94. *Id*.

80 percent of physician services were provided by physicians with no direct link to one of Group's and Care's tax-exempt affiliates.

As did Health Plans, Group and Care argued that whether they contracted with physicians was not relevant because such physicians were required to maintain privileges at one of Health Services' hospitals; however, the court again disagreed. Because Group and Care did not provide free or low-cost health services and given the termination of their plans for Medicare patients, the Tax Court did not see how Group's and Care's operations, including their heavy reliance on independent physicians, would be essential or substantially related to Health Services' exempt functions. The court found, as it did in *Health Plans*, that Group's and Care's method of arranging for their enrollees to receive physician services suggested that they operated on a scale that was "larger than is reasonably necessary to accomplish the purpose of the exempt entities."[95]

The Tax Court concluded by holding in *Group* and *Care* that neither entity provided the community benefit required for them to qualify as charitable organizations and their operations were not essential to or substantially related to Health Services' exempt function. Thus, the court found for the IRS.[96]

This decision of the Tax Court perpetuates the hard line the IRS has taken since the 1970s regarding the ability of HMOs to qualify as tax-exempt charitable organizations. At this time, very few HMOs are organized as staff model, or direct-provider–type, HMOs. The IRS has made respectable efforts over the years to extend the embrace of charitable organizations law to the ever-evolving species of healthcare organizations. However, the IRS clearly does not intend to modernize its view of the application of tax law to HMOs.

The decision of the Tax Court is also disappointing for what it does not do. It does not reach the arguments addressed by the parties regarding the application of the commercial-type insurance provisions of the Code, which denies exemption for charitable and social welfare entities that substantially engage in the provision of commercial-type insurance. The application of this statutory provision has been a mystery since its passage by Congress in 1986. A narrow reading and active enforcement of the provision stands to put many tax-exempt HMOs in jeopardy of losing their exemptions. By way of judicial restraint, the Tax Court found it unnecessary to reach this argument, and thus the mystery continues. This case is on appeal, with high hopes of greater resolution of these issues.

In the wake of this litigation, the IRS has proceeded to rein in its recognition of exemption for HMOs as social welfare organizations as well. In July 2002, the Service issued technical advice regarding whether a managed care organization (MCO) that had previously been recognized by the Service as a social welfare organization for its activities as an arranger for the provision of

95. *Group*, 82 T.C.M. at 616; *Care*, 82 T.C.M. at 626–27.
96. *Id*.

healthcare services to subscribers of a Health Plan could continue to qualify for exemption. The IRS also considered whether the MCO's provision of administrative services to self-insured employers and laboratory services to participating providers constituted an unrelated trade or business, thereby giving rise to unrelated business taxable income.

The IRS concluded that the MCO no longer qualified for exemption as a social welfare organization. It also determined that the provision of administrative services was substantially related to its provision of social welfare services prior to the revocation of exemption, but that its provision of laboratory services constituted an unrelated trade or business.[97]

Under the facts of this technical advice memorandum, the IRS considered the case of a nonprofit membership corporation that it had recognized as tax-exempt as a social welfare organization. The organization's principal activity consisted of contracting with employers, health maintenance organizations, insurance companies, and political subdivisions (collectively, its ''subscribers'') to arrange for the provision of healthcare services for the subscribers' employees or members by healthcare professionals with whom the organization contracted (otherwise known as *participating providers*). The MCO also operated a laboratory that provided various healthcare laboratory services.

The MCO also had several nonprofit affiliated organizations that provided substantially the same services, as well as ownership of for-profit subsidiaries that were engaged in similar activities.

The organization had two classes of members: director members and participating members. The director members were those who comprised the organization's board of directors. They also included public members who were neither providers nor employees of the organization nor persons who had any significant financial interest in the organization or in any entity providing services to it. Participating members were those licensed professionals who entered into provider contracts with the organization. Under the organization's bylaws, a majority of its board of directors consisted of participating members and/or physicians related to one of its affiliates. The remainder of the directors were public members.

The organization had two types of subscribers, full-risk subscribers and administrative service plan subscribers. The full-risk subscribers were those that paid the organization a per-enrollee per-month fixed amount in return for which their enrollees and their dependents were entitled to receive certain healthcare benefits from the organization's participating providers. Administrative service plan subscribers consisted of large self-insured organizations that paid the organization to provide administrative services only, including processing and paying claims.

97. Tech. Adv. Mem. 200245064.

The technical advice memorandum reported that the organization claimed that it engaged in community benefit activities in the following areas: the provisions of services to Medicare and Medicaid patients; the provision of services to low-income families; the operation of a child health assistance program that involved the reduction of fees for low-income children, regular checkups, and the distribution of educational materials; the publishing of a patient newsletter as part of an overall consumer awareness program; the operation of a disaster-relief program; and the collection and sharing of medical information with health plans and employer groups to assist with disease management programs and internal studies in research.

In addressing the ability of the MCO to continue to qualify as a social welfare organization, the IRS reviewed applicable law in the area, including a series of revenue rulings and federal case law. The federal case law reviewed by the IRS is perhaps best represented by a case involving a nonprofit membership corporation that purchased defense housing projects from the federal government and converted them to a cooperative nonprofit use as homes for its members. The court in that case concluded that the organization did not qualify as a social welfare organization after a lengthy discussion of what type of activity qualified as being ''civic'' in nature or promoting social welfare. In its decision, the court stated:

> Whatever the nature of the rights or privileges thus afforded persons other than members, it is a circumstance too insubstantial to qualify the entire activity of the corporation as in the social welfare. Size of membership in ratio to local population is not controlling on whether an organization is ''civic'' or ''social.'' The number affected is not the criterion. A private project may touch an appreciable segment of the people of a large physical area and yet, for want of the considerations mentioned, not be converted into a civic or social undertaking. *Classification as ''civic'' or ''social'' depends on the character—as public or private—of the benefits bestowed, of the beneficiary, and of the benefactor*. [emphasis added][98]

The IRS then applied the law and concluded that whether considered qualitatively or quantitatively, all of the community activities described by the organization represented only a minor part of its total activities and that its activities principally benefited its enrollees rather than persons who are medically underserved. The IRS stated that simply because the organization arranges healthcare services for a large number of persons in the community and engages in a small amount of social welfare activities, this does not establish that it is a social welfare organization as provided for in the Internal Revenue Code.

The IRS noted that the organization's social welfare activities during the years in question, regardless of whether they were considered in relation to the organization's total revenues, total expenses, accumulated surplus, or

98. *Commissioner v. Lake Forest, Inc.*, 305 F.2d 814, 818 (4th Cir. 1962).

total enrollment, were ''minor, incidental and insignificant.'' It concluded that based on any measure, it could not be said that the organization was primarily engaged in promoting the common good and general welfare of the people of the community as intended by federal regulations. It found that the organization had not established that these activities were significantly distinguishable from the same activities carried on by for-profit managed care service organizations.

The IRS, under authority provided under the Code, elected not to revoke the organization's tax exemption retroactively. Accordingly, it proceeded to consider whether the provision of administrative services and laboratory services constituted unrelated trades or businesses during the period prior to revocation.

The IRS determined that the provision of administrative services to self-insured employers constituted arranging for the provision of healthcare services that was a necessary and integral part of its overall activities of arranging for the provision of healthcare services for enrollees. Since these services contributed importantly to the accomplishment of its tax-exempt purposes, the IRS deemed them substantially related, and thereby not an unrelated trade or business.

With regard to laboratory services, however, the IRS noted that the organization was not a healthcare provider but was rather an arranger of healthcare services and that its provision of laboratory services to participating providers was no different from those provided by other commercial providers of services to the participating providers. Accordingly, the IRS found that these activities did not contribute importantly to the accomplishment of the organization's purported tax-exempt purposes. Therefore, the provision of laboratory services constituted an unrelated trade or business.

In April 2003, the Tenth Circuit closed the door on the hopes of IHC's health maintenance organizations for recognition of charitable status by upholding the Tax Court's decision denying such recognition.[99] The Court of Appeals reviewed applicable law and determined that the sole question that was required of it for consideration was whether the three HMOs operated exclusively for exempt purposes within the meaning of the Code. The court opined that such an inquiry required it to address two basic questions: (1) whether the purpose set forth by the HMOs qualifies as a charitable purpose; and (2) whether the HMOs in fact operated primarily for that purpose. The Tax Court had concluded that while the promotion of health for the benefit of the community is a charitable purpose, none of the HMOs operated primarily to benefit the community. The Court of Appeals agreed with this assessment.

The court examined at length the applicability of the Community Benefit Standard established by the IRS in 1969. The court stated that under the IRS's interpretation of the Code, and in the context of healthcare, it must

99. *IHC Health Plans, Inc. v. Commissioner*, 325 F.3d 1188 (10th Cir. 2003).

determine whether a nonprofit organization operates primarily for the benefit of the community. It noted that while the concept of community benefit is amorphous, it agrees with the IRS, the Tax Court, and the Third Circuit that it provides a workable standard for determining charitable status. In defining and quantifying community benefit in this context, the court concluded that in order to qualify as a charitable organization, a healthcare provider must make its services available to all in the community, *plus* it must provide additional community or public benefits. It stated that this benefit must either further the function of government-funded entities or provide a service that would not otherwise be provided within the community but for the tax subsidy. Moreover, this additional public benefit must be sufficient to create a strong inference that the public benefit is the primary purpose for which the organization operates under the totality of the circumstances. This ''plus'' test, along with the ''boost'' test established by the Third Circuit in applying the integral part theory of exemption, reflects the continuing efforts by courts to redefine decades-old legal interpretations so as to apply them to the increasingly commercial operations of modern healthcare providers.

The appellate court determined that the Tax Court had applied the correct legal test under the Code. Thus, it found that the Tax Court had correctly recognized that the promotion of health for the benefit of the community is a charitable purpose and that this determination is based on the totality of the circumstances. It further upheld the lower court's view that the HMOs did not operate primarily for the benefit of the community. It noted that these organizations do not provide healthcare services directly; rather, they furnish group insurance entitling their members to services from participating hospitals and physicians. It pointed out that the HMOs' premiums are determined using two methods: an adjusted community rating for individuals and small employers, and past claims experience for large employers. The court summed this up by stating that the HMOs primarily perform a risk-sharing function and that the commercial nature of this activity created doubt as to the HMOs' charitable purpose.

The court stated that the fact that a given activity traditionally is undertaken by commercial entities does not necessarily preclude tax-exempt status, particularly where the organization provides its services at or below cost. However, the court found that these HMOs provided virtually no free or below-cost healthcare services and that they did not subsidize dues for those who could not afford them. The court also pointed out that the HMOs did not conduct research or offer free educational programs to the public in a manner that would have supported the notion that they were promoting health for the benefit of the community. While it looked favorably on the adjusted community rating system as allowing members to obtain medical care at lower costs, the court opined that selling services at a discount says little about a provider's purpose, and that in evaluating price relative to an organization's purpose, there is a qualitative difference between selling at a discount and selling below cost.

The HMOs had argued that the class eligible to benefit from their services was quite broad. The appellate court was unimpressed by this, stating that the offering of products and services to a broad-based segment of the population is just as consistent with profit maximization as it is with charitable purposes. While the court examined the issue of whether the HMOs had a community board of trustees and the impact of this on demonstrating charitable purposes, it found it of little weight, given the lack of actual community benefit otherwise provided by the HMOs. Accordingly, the Fifth Circuit agreed with the Tax Court's conclusion that these HMOs, standing alone, did not qualify as charitable organizations.

The court also considered whether the HMOs could qualify for exempt status as an integral part of a charitable parent in the health system. It opined that qualification for exemption under the integral part doctrine is just as rigorous an inquiry as the determination of whether the organization qualifies for charitable status directly. However, the court did not reach the question of whether the HMOs provided services necessary to their exempt parent in conducting their exempt activities. Instead, it found that the required nexus between the activities of the HMOs and their parent was lacking in that the HMOs' enrollees received only about 20 percent of their physician services from physicians employed by or contracting with their exempt parent while contracting for the remaining 80 percent of physician services directly with independent physicians.

§ 9.3 COMMERCIAL-TYPE INSURANCE PROVIDERS

There was probably no more defining moment in the evolution of tax exemption for managed care organizations than the enactment of the commercial-type insurance restriction by Congress in the Tax Reform Act of 1986.[100] Because this provision acts as an absolute bar to exemption for certain types of managed care organizations, it added a new component to the IRS's analysis of whether such organizations can obtain recognition of exemption.[101] In so doing, it forced the IRS to reexamine its ruling positions and to refine them in a more deliberate manner.

The primary purpose of this legislation was to take away the tax exemption that had previously been available to Blue Cross/Blue Shield (''Blues'') plans. Congress determined that, notwithstanding these plans had fulfilled important societal needs, they had, over time, become identical to contemporary commercial insurers.[102] Congress therefore decided to take away the unfair

100. IRC § 501(m); Tax Reform Act of 1986, Pub. L. No. 99-514, § 1012 (Oct. 22, 1986).
101. FY 1992 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, ''Federal Tax Exemption of Prepaid Healthcare Plans after IRC 501(m),'' 258–283.
102. *See* Chapter 13.

competitive advantage of the Blues' tax exemption and to place them on a level playing field with other commercial insurers.[103] However, the reach of this legislation clearly extends far beyond the Blues' prepaid healthcare plans.[104] The IRS considered the application of the commercial-type insurance rules in another memorandum.[105]

Most HMOs would argue that they provide health services rather than insurance. In any event, an express exception for HMOs is contained in the language of the section. This exception provides that commercial-type insurance does not include ''incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations.''[106] In an effort to determine the intended scope of this exception, the IRS undertook a thorough analysis of the express terms of the exception and the legislative history of these rules.[107]

The IRS began its analysis by considering whether various types of HMOs provide insurance and what Congress meant when it used the terms *commercial-type insurance* and *incidental health insurance*. Congress did not define commercial-type insurance in the statute. The House Ways and Means Committee Report unhelpfully states that ''. . . commercial-type insurance generally is any insurance of the type provided by commercial insurance companies.''[108] The IRS concluded that, because the statute was intended to apply to Blue Cross/Blue Shield organizations, it is self-evident that health insurance is included within the meaning of commercial-type insurance.

The IRS looked to existing precedent concerning the definition of insurance and found that two elements of the definition of insurance are relied on consistently. These elements were established by the U.S. Supreme Court, which found that ''[h]istorically and commonly insurance involves risk shifting and risk distributing.''[109] The IRS noted that existing authorities were inconclusive regarding whether the various types of modern HMOs provide insurance. In its own consideration of the matter prior to the Tax Reform Act of 1986, the IRS found that an organization that issues medical service contracts to groups or individuals and furnishes direct medical services to subscribers by means of a

103. *See* Staff of the Joint Comm. on Taxation, 100th Cong., 1st Sess., ''General Explanation of the Tax Reform Act of 1986'' (Comm. Print 1987), at 583.
104. *See* § 19.3.
105. Gen. Couns. Mem. 39703. The IRS concluded that two findings must be made in order to determine whether IRC § 501(m) precludes tax exemption for a particular entity: (1) the entity must be found to provide ''commercial-type insurance,'' and (2) provision of commercial-type insurance must be found to constitute a substantial part of the organization's activities. The IRS stated that the analysis is based on all the facts and circumstances of a given case. The burning question for HMOs has been whether they are affected by IRC § 501(m). *See*, in general, Sullivan, *supra* note 18, at 75.
106. IRC § 501(m)(3)(B).
107. Gen. Couns. Mem. 39829.
108. H. Rep. No. 426, 99th Cong., 1st Sess. 665 (1985).
109. *Helvering v. LeGierse*, 312 U.S. 531, 539 (1941).

salaried staff is not an insurance company within the meaning of the Internal Revenue Code.[110] The memorandum went on to state that, notwithstanding the early precedents, a strong argument could be made that many modern HMOs provide insurance, even if they do not rise to the level of insurance companies under the Code. At the same time, it is apparent that, at least for some HMOs, their primary activities are the provision of health services. This is particularly true of staff model HMOs because they directly provide physician services through employees.

In examining the legislative history of these rules, the IRS found that the House Ways and Means Committee clearly intended to extend protection only to HMOs whose principal activity is providing healthcare. This raised the question of what types of HMOs would be covered by this section; as discussed above, many HMOs arrange for, but do not directly provide, healthcare services to their subscribers. After noting some confusing variation in the legislative history, the IRS concluded that the intended scope of the HMO exception to these rules is described in the Conference Committee Report for the 1986 Tax Reform Act. Regarding this exception, the Conference Report states:

> The conference agreement does not alter the tax-exempt status of health maintenance organizations (HMOs). HMOs provide physician services in a variety of practice settings primarily through physicians who are either employees or partners of the HMO or through contracts with individual physicians or one or more groups of physicians (organized in a group practice or individual practice basis).[111]

The IRS concluded that the language evinces an intent on the part of the Conference Committee that the commercial-type insurance rules would not affect the tax status of any of the common, existing types of HMOs (staff, group, network, or IPA model) as long as their principal activity is providing healthcare and any provision of insurance is incidental.

Upon completion of review of the legislative history, the IRS Chief Counsel opined that:

> [Code] section 501(m) was not intended to deny exemption to an HMO whose principal activity is providing healthcare services in the same manner as one of the common, existing types of HMOs solely because it also provides incidental health insurance. We do not read the legislative history to mean that any organization styled as an HMO will never be found to provide commercial-type insurance within the meaning of the statute. Where an HMO's principal activity is not providing

110. Rev. Rul. 68-27, 1968-1 C.B. 315; Gen. Couns. Mem. 33144. The IRS stated that, although Rev. Rul. 68-27 was frequently cited as establishing that HMOs do not provide insurance, it was based on the definition of the term *insurance company* rather than *providing commercial-type insurance* and, in any event, its holding would generally be limited to staff model HMOs. Accord, *Sound Health Association v. Commissioner*, 71 T.C. 158 (1978), and Gen. Couns. Mem. 38735.

111. H.R. Conf. Rep. No. 841, 99th Cong., 2d Sess. II-346 (1986).

> healthcare or where, notwithstanding that its principal activity is providing healthcare, it provides insurance that is not incidental to that activity, the organization may be found to provide commercial-type insurance. However . . . the determination of whether an HMO qualifies for the section 501(m)(3)(B) exception should be based on all the facts and circumstances surrounding its operations, and not solely on whether it operates on the staff, group, network, or IPA-model.[112]

The IRS then identified several relevant factors for determining whether an HMO's principal activity is providing healthcare or insurance. Those factors include whether and to what extent: an insurance risk is transferred and distributed; the entity operates in a manner similar to for-profit insurers or Blue Cross/Blue Shield plans; the organization markets a product similar to those offered by for-profit insurers or Blue Cross/Blue Shield plans; the organization provides healthcare services directly; the provider has shifted any risk of loss to the service providers through salary or fixed-fee compensation arrangements.

The IRS noted the difficulty in relying on traditional characteristics of HMOs at a time when HMOs are beginning to look more and more like commercial insurers, and commercial insurers are adopting HMO-like managed care characteristics in an effort to control costs. It concluded that the fact that an HMO employs its own staff and operates its own facilities, or otherwise fixes its costs by shifting a substantial portion of the risk to providers, may be the only practical way to distinguish it from commercial insurers or Blue Cross/Blue Shield plans. The IRS then took the position that it must be satisfied on the basis of all the facts and circumstances that any insurance element provided by an HMO is a necessary and normal consequence of the HMO's principal activity.[113] The IRS concluded its analysis by adopting a ''safe harbor'' for finding that an HMO principally provides healthcare and provides only incidental health insurance based on the manner in which it compensates its primary care physicians.[114]

A direction in which Congress and the IRS may choose to go in clarifying (and arguably extending) the reach of the commercial-type insurance rules was suggested by proposed revisions to these rules contained in the various health reform proposals that surfaced in the 103d Congress. An example was the provision contained in the House Ways and Means Committee's version of the Clinton Health Security Act (H.R. 3600), which would have revised Code

112. *Id*.
113. *See* discussion at § 9.2.
114. *See supra* § 9.2(a). IPA and network model HMOs that pay providers on a fee-for-service basis, even where subject to a percentage withhold or a reduction for overutilization, are comparable to traditional indemnity insurers in the IRS's view. The IRS has not, however, taken a position to date on whether these organizations provide insurance or services or whether they fall within the exception set forth in IRC § 501(m)(3)(B). *But see* HMO Audit Guidelines at Appendix N.

section 501(m) by identifying certain HMO activities that would not constitute the provision of commercial-type insurance.[115]

The intent of this proposed revision to Code section 501(m) is to more thoroughly define the section's application to commercial-type insurance providers by identifying specific types of activities contemplated by the statute. It is important to note that the identified activities are intended to be all-inclusive. Through the use of the language ''if (and only if),'' the proposed statute indicates that all other types of the provision (or arranging for the provision) of medical care on a prepaid basis by HMOs will be treated as commercial-type insurance.

An example of the type of care that would fall within the first identified activity would be staff or dedicated group model HMOs that hire healthcare providers (either as employees or as independent contractors) to provide medical care exclusively to HMO members at the HMO's facilities.[116]

An example of the second category of activity that does not qualify as commercial-type insurance is the provision of (or arranging for provision of) medical care by an HMO where the HMO pays healthcare professionals on a fixed or capitated basis, with the payments being based on the number of members served by the healthcare professional but not on the extent of

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115. This section of the proposed legislation provided in relevant part:

SEC. 11403. TREATMENT OF NONPROFIT HEALTH CARE ORGANIZATIONS.

(a) INSURANCE PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS.— Section 501(m) (relating to certain organizations providing commercial-type insurance not exempt from tax) is amended by adding at the end the following new paragraph:

''(6) CERTAIN ACTIVITIES PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS NOT TREATED AS COMMERCIAL-TYPE INSURANCE.— For purposes of this subsection, the provision of (or the arranging for the provision of) medical care on a prepaid basis by a health maintenance organization shall not be treated as commercial-type insurance if (and only if) such care is—

(A) care provided by such organization to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization,

(B) care provided by a health care professional to a member of such organization on a basis under which substantially all of the risks of the rates of utilization is assumed by the provider of such care,

(C) care (other than primary care) provided to a member of such organization pursuant to a referral by such organization,

(D) emergency care provided to a member of such organization at a location outside such member's area of residence, or

(E) care which the organization reasonably expected to be provided to a member as described in subparagraph (A), (B), or (C) but which was not so provided pursuant to section 2219(d) of the Social Security Act.''

H.R. 3600, 103d Cong.; 2d Sess. § 11403.

116. H. Rep. No. 103-601, pt. I, 103d Cong., 2d Sess. 591 (1994).

services provided to a member.[117] This example is based on the IRS's safe harbor, identified in its analysis in earlier guidance.[118]

The Committee's explanation of the provision offers the following example of how the second category would be applied. An HMO that is recognized as a tax-exempt social welfare organization and that makes capitated payments to a network of healthcare professionals in a particular area generally would not be treated as providing commercial-type insurance under the provision. However, if the HMO expands its operations to another area and does so by arranging to provide medical care via a network of physicians in that area on a fee-for-service basis, then the HMO would be treated as providing commercial-type insurance. Even if the commercial-type insurance activity is insubstantial, it would still result in unrelated trade or business income with respect to that activity for the HMO, and if it is substantial, the HMO would become ineligible for tax-exempt status.[119]

The third and fourth categories refer to traditional HMO practices of referring patients to specialists for care other than primary care or providing emergency care outside of the HMO member's area of residence.[120]

Under this provision, it appears that staff model and dedicated group model HMOs would likely not be barred from obtaining recognition of exemption as charitable or social welfare organizations by the requirements of the commercial-type insurance rules. Group, IPA, and network model HMOs, however, would only survive the application of these rules if they fall within the safe harbor created by the IRS for plans that shift substantially all of the risks and rates of utilization of care to the providers of that care through fixed or capitated payments to the providers for their services.

In its technical advice on the standards for an HMO to qualify for exemption,[121] the IRS examined the application of the commercial-type insurance rules, which precludes qualification for exemption as a charitable organization or as a social welfare organization for entities that substantially provide commercial-type insurance. Many commentators have criticized the IRS's efforts to apply this section of the Code to HMOs, arguing that the legislative history makes clear that it was never intended to apply to the types of services provided by these organizations.[122] Nevertheless, the IRS has consistently

117. *Id*.
118. Gen. Couns. Mem. 39829.
119. *Id*.
120. The fifth category was intended to reconcile the requirement of another provision of the bill that would obligate managed care plans, including HMOs, to offer an out-of-network option. This out-of-network option provision was not included in other versions of the Clinton Health Reform proposal that were considered in Congress.
121. Internal Revenue Service National Office Technical Advice Memorandum (not published), 98 TNT 243-2 (Doc. 98-37129); Bureau of National Affairs Tax Core, Dec. 17, 1998.
122. *See*, e.g., '' 'Trigon' Seen as Evidence Section 501(m) Not Intended by Congress to Apply to HMOs,'' Bureau of National Affairs, *Daily Tax Report*, Jan. 16, 2003 (citing *Trigon Insurance Company v. United States*, 215 F. Supp. 2d 687 (E.D. Va., 2002)).

taken the position since the passage of the Tax Reform Act of 1986 that these rules do apply to health maintenance organizations.

In the TAM, the IRS relied on the analysis that was earlier provided in the 1990 GCMs and, more recently, in the FY 1999 CPE Text article on Medicaid HMOs[123] to consider whether there was a sufficient shifting of risk of economic loss to others such that the exempt organization was not acting as an insurer and thereby providing commercial-type insurance. For the first time in published guidance, the IRS described various physician compensation models now common in the healthcare sector and considered under each model whether the risk of loss is shifted sufficiently such that qualification for exemption will not be precluded.

The physician compensation models reviewed include: (1) discounted fee-for-service; (2) discounted fee-for-service with a bonus; (3) discounted fee-for-service with a portion of the fees withheld based on meeting certain productivity and quality criteria; and (4) capitated fees. The IRS concluded that there is a shifting of risk of economic loss sufficient to permit qualification for exemption only in the models where the fees are capitated or where the fee-for-service arrangement includes a fee withhold based on achieving certain criteria. Under such models, compensation to the physicians is not guaranteed, and substantial risk of economic loss is borne by the physicians.

Under the straight fee-for-service, discounted fee-for-service, and discounted fee-for-service with a bonus models, it was the IRS's view that there was not a sufficient shifting of risk of loss to avoid the commercial-type insurance restrictions. Under these models, the physician is ensured of receiving income, albeit at a discounted rate, and there is no significant risk of loss being borne by the physicians. Accordingly, HMOs using the latter physician compensation models will not be able to qualify for recognition of exemption either as charitable organizations or as social welfare organizations.

Curiously, the IRS did not comment in the TAM about the consequence of the point-of-service benefit provided by the HMO. This has been an area of significant uncertainty in the managed care sector, particularly given the popularity of the point-of-service benefit with enrollees. The IRS has taken the position that a point-of-service product is commercial-type insurance, and, as a result, it has been unclear at what level the provision of such a product by an HMO becomes the substantial provision of commercial-type insurance, which would defeat qualification for exemption.

This guidance is useful to the managed care sector in establishing benchmarks for the effect on exemption of using particular physician compensation models. Unfortunately, the important question of the effect of offering a point-of-service benefit remains, at present, unanswered.

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123. *See supra* § 9.2(vi).

The IRS subsequently released HMO Audit Guidelines in a new chapter in the *Internal Revenue Manual*. While these Guidelines offer some useful benchmarks for determining the substantiality of affected activities, the Guidelines, like the analysis in the TAM, are based on a restatement of the seminal cases and do not recognize the ability of the newer HMO models to qualify for exemption except on the ''old'' terms.[124]

Under the HMO Audit Guidelines, whether an HMO is engaged in ''substantial'' commercial-type insurance activities is determined on a facts-and-circumstances basis. The IRS provides a safe harbor in this regard—if less than 15 percent of an HMO's activities consist of providing commercial-type insurance, then the HMO is not considered to be engaged in substantial commercial-type insurance activities.[125]

The IRS also offers further clarification of what constitutes a substantial shifting of risk such that the organization is not providing commercial-type insurance. To shift ''substantial'' economic risk, fee schedules must be discounted by at least 15 percent below the usual and customary fees charged by similarly situated providers for comparable services. Fee schedules that allow providers to recover the discount are not considered substantially discounted. Satisfactory withhold arrangements require the HMO to withhold at least 15 percent of the discounted fee paid. Providers may recover some or all of the withhold while still being considered to bear the risk of loss, so long as certain predetermined criteria are met, for example, budgetary goals, patient satisfaction standards, quality of care standards, or efficiency standards. Importantly, the IRS also noted that an HMO that compensates providers on a fee-for-service basis (presumably nondiscounted) may still share substantial economic risk by obtaining stop-loss insurance from an unrelated third party or otherwise sharing the operating deficit with its providers. Both arrangements would be assessed by the IRS on a facts-and-circumstances basis.[126]

The HMO Audit Guidelines go on to explain the application of the rule that ''incidental'' health insurance of a kind ''customarily provided by HMOs'' is not considered to be commercial-type insurance.[127] In this connection, the IRS acknowledged that point-of-service benefits relating to emergency healthcare services are considered to fall within this category. Other examples of ''incidental'' health insurance include (1) dental, vision, and mental healthcare services, and (2) inpatient and outpatient hospital services, specialist services, and ancillary services provided by the HMO as a result of a referral by a member's primary care provider under a managed care arrangement.[128]

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124. Internal Revenue Manual—Health Maintenance Organization Handbook (hereafter ''HMO Audit Guidelines''), IRM 7.8.1 ¶¶27.8.1 *et seq*.
125. HMO Audit Guidelines ¶27.10.1(1).
126. *See* generally *id*. ¶27.10.
127. *See* IRC § 501(m)(3)(B).
128. *See* generally HMO Audit Guidelines ¶27.10.3.

Providing healthcare benefits at substantially below cost to a class of charitable recipients is also an activity excluded from the scope of commercial-type insurance. Included within this exception are contracts with government agencies to directly provide or arrange for the provision of healthcare services to persons who have special healthcare needs, such as Medicaid beneficiaries, the indigent, the disabled, or substance abusers.[129]

Unfortunately, much of the utility of these Guidelines has now been rendered moot by the IRS's surprise withdrawal of the section of the Guidelines pertaining to the provision of commercial-type insurance.[130] The IRS announced that it intends to propose regulations defining the term ''commercial-type insurance'' and addressing the application of Code section 501(m) to charitable organizations and social welfare organizations, including HMOs. It also requested public comment on the content of these regulations. In light of this action, the IRS issued guidance to field agents instructing them not to revoke the exemption of a charitable HMO (or one recognized as a social welfare organization) on the basis that it substantially provides commercial-type insurance, for at least the next 18 months while the regulations project is under way.[131]

In October 2004, an IRS official stated that competing priorities have forced an extension of the IRS's deadline for issuing regulations implementing the commercial-type insurance provisions for at least one year.[132] The official predicted that the regulations would be out at least in draft form by October 2005. He also said it is unclear whether the IRS will extend the moratorium on issuing HMO determination letters for social welfare organizations, which was scheduled to expire November 7. As of February 2007, the regulations have yet to be issued.

§ 9.4 PREFERRED PROVIDER ORGANIZATIONS

Preferred provider organizations (PPOs) have some similarities to HMOs (in particular, non-staff-model HMOs), but there are also definite differences. PPOs are not direct providers of services; rather, they are in the business of arranging for the provision of healthcare services. Unlike most HMOs, they are not closed plans; that is, they do not prohibit enrollees from utilizing non-PPO providers, but they impose an economic disincentive to do so. Providers that participate in the PPO are normally paid on a fee-for-service basis and are subject to strict utilization review designed to control costs.

Not surprisingly, the IRS has taken a dim view of the ability of PPOs to qualify for tax exemption as charitable organizations. When the IRS formally

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129. *Id*. ¶27.10.3.1(2).
130. Notice 2003–31, 2003–21, I.R.B. 948 (May 27, 2003).
131. IRS Field Memorandum (May 7, 2003).
132. Comments of Marvin Friedlander, Chief of Technical Group 1 of the IRS TE/GE Division, at the American Health Lawyers Association program on Tax Issues for Healthcare Organizations, Oct. 21, 2004.

considered the question in a memorandum,[133] the issues involved did not focus directly on the ability of PPOs to qualify for tax exemption as charitable organizations. Rather, the IRS examined whether an entity controlled by other preferred provider organizations could qualify as a cooperative hospital service organization and whether the activities of such an entity constituted the provision of commercial-type insurance. The IRS concluded that the entity described in the memorandum did not qualify as this type of a cooperative because it was not organized and operated on a cooperative basis and was not organized and operated solely to perform the requisite services. It also did not provide services solely for tax-exempt hospitals.[134]

In the course of its analysis, however, the IRS examined whether a PPO could itself qualify for exemption. In so doing, it expressly extended its earlier analysis [135] to the activities of PPOs.

The IRS indicated its belief that the benefit flowing to the physician participants in the PPO equaled or exceeded that considered in its 1986 revenue ruling and that this private benefit is the primary reason why PPOs would not qualify for exemption as charitable organizations.[136] Its memorandum also stated that PPOs were typically organized by the physician and hospital members primarily to attract additional patients and revenues to the participating providers and to increase the providers' market share. Unlike HMOs, PPOs benefit participating physicians by attracting a larger volume of patients while preserving the concept of fee-for-service medicine and avoiding the assumption by physicians of financial risks for overutilization. The IRS concluded that, although the PPO's activities might benefit the tax-exempt hospitals that participate in them, they benefit, in more than an incidental manner, the private interests of the physicians who participate in the PPOs. Given the extension of the IRS's analysis to these organizations,[137] it seems likely that they would also have difficulty obtaining recognition of exemption as social welfare organizations.

§ 9.5 RECENT DEVELOPMENTS

In 2003, the IRS issued guidance reporting that it would undertake a project to write regulations under Code § 501(m).[138] It also withdrew the commercial-type insurance discussion in its HMO Audit Guidelines in light of the *Rush* decision.

133. Gen. Couns. Mem. 39799.
134. The office of the IRS Chief Counsel indicated that it did not have sufficient facts to reach a conclusion as to whether the entity was providing insurance within the meaning of IRC § 501(m).
135. *See* Gen. Couns. Mem. 38735; Rev. Rul. 69-545, 1969-2 C.B. 117.
136. Gen. Couns. Mem. 38735.
137. Rev. Rul. 86-98, 1986-2 C.B. 74.
138. Notice 2003-31, 2003-21 I.R.B.

The IRS has not issued guidance regarding HMO tax exemption since it rescinded its HMO Audit Guidelines in order to undertake greater study and to issue regulations regarding the Code's commercial-type insurance restrictions on exempt HMOs. The IRS is concerned about the ramifications of the *Rush* case, which held that ERISA does not preempt the Illinois HMO Act.[139] The case included a finding that HMOs provide insurance.

The head of the IRS EO Technical Division has reported that it is unlikely that the IRS will be issuing any regulations under Code § 501(m) in the foreseeable future.[140] With regard to the IRS ruling position in the interim, the official stated:

- The IRS will continue to recognize staff model HMOs as charitable organizations.
- As to HMOs that serve exclusively Medicaid beneficiaries, the IRS continues to recognize them as exempt charitable organizations on the basis that they provide relief to the poor and distressed.
- The IRS has been recognizing arranger-type HMOs as exempt social welfare organizations if they primarily benefit medically underserved classes, such as individuals, small-employer groups, and Medicare or Medicaid beneficiaries. However, the IRS is concerned with Blue Cross/Blue Shield organizations reclaiming exemption and language in the *Geisinger*[141] and *IHC*[142] decisions that casts doubt on the justification that serving some medically underserved groups warrants exemption.
- A 2005 U.S. District Court in California decision[143] concluded that a prepaid vision service plan did not qualify for exemption as a social welfare organization because it did not primarily benefit the community, but rather only its member-subscribers. This case did not involve Code § 501(m); however, if the government prevails in this appeal, that could have a broad impact on whether HMOs in general qualify as tax-exempt as social welfare organizations.
- A related issue is captive insurance companies. Many large hospital systems have created their own U.S.-based captive insurance companies to provide professional and general liability insurance exclusively for their member hospitals and their employees. The IRS has been exempting this type of organization under the integral part doctrine.[144] It has also concluded that this activity does not constitute commercial-type insurance.

139. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).
140. Remarks of Marvin R. Friedlander, Chief, EO Technical Branch, TE/GE Joint Council Meeting, February 2, 2007.
141. *Geisinger Health Plan v. Commissioner, 30 F. 3d 494 (3rd Cir. 1994)*
142. *IHC Health Plans, Inc. v. Commissioner, 325 F. 3d 1188 (10th Cir. 2003).*
143. *Vision Service Plan*, 2006-1 U.S. Tax Cas. (CCH) P50,173 *, on appeal to 9th CA*, No. 06-15269.
144. *See* Code § 1.502-1(b); Rev. Rul. 78-41.

With regard to the appellate case cited by the IRS as having potentially broad impact on its views at to whether an HMO can qualify as a tax-exempt social welfare organization, that case has now been decided. At the trial court level, the U.S. District Court for the Eastern District of California agreed with the IRS that the Vision Service Plan (''VSP'') did not qualify for exemption[145]. VSP is a corporation that contracts with empolyers, health maintenance organizations, insurance companies and political subdivisions (''subscribers'') to arrange for the provision of vision care services and vision supplies to the subscribers' employees or members (''enrollees''). It is not itself a health maintenance organization. In 1960, VSP was recognized as a tax-exempt social welfare organization. In 1999, the IRS began an examination of VSP and concluded that VSP was no longer entitled to recognition of tax-exempt status under this section of the Code.

The Internal Revenue Code provides federal tax exemption to social welfare organizations, described as ''organizations not organized for profit but operated exclusively for the promotion of social welfare[146].'' The Court noted that previous courts have interpreted the word ''exclusively'' to mean ''primarily.'' The tax regulations provide that an organization is not operated primarily for the promotion of social welfare if its primary activity is ''carrying on a business with the general public in a manner similar to organizations which are operated for profit.'' Thus, in order to qualify for exemption as a social welfare organization, an organization must establish (1) that it is not organized for profit, and (2) that it operates primarily for the promotion of social welfare.

VSP argued that it is operated primarily for the promotion of social welfare because it (1) provides services to a broad cross section of the California community; (2) provides free vision care services to non-enrollees; and (3) is involved in community education and community outreach.

VSP posited that its provision of services to employees of small and rural employers and Medicare, Medicaid and Health Families enrollees illustrates that VSP is primarily engaged in promoting social welfare. The Court disagreed and concluded that the benefits that VSP provides to the public are ''incidental'' and not the primary purpose of VSP. The court found that (1) the small employer or rural employers are still paying for VSP's services and VSP is making a profit from these contracts; (2) VSP competitively bid for the Medicare and Medicaid contracts and any losses that VSP claims under such contracts includes discounts given by participant doctors—which the Court points out are losses for the physicians and not losses for VSP; (3) VSP appears to make a profit from providing services to Medicare and Medicaid enrollees; and (4) the expenditures the VSP makes to provide the above services is a relatively small fraction of VSP's net income for 2003 and an even smaller fraction of VSP's gross income for 2003. Thus, the Court concludes, even if it the services provided

145. *Vision Service Plan v. U.S.,* 96 AFTR 2d (RIA) 2005-7440 (E.D. Cal. 2005).
146. IRC § 501(c)(4).

to these enrollees could constitute promoting social welfare, the fact that such enrollees make up less than half of VSP's enrollment undermines VSP's claim that it is ''primarily'' engaged in promoting social welfare. That is, the Court determined that the primary purpose of VSP is to serve VSP's paying members.

To further support its argument that it promotes social welfare, VSP cited its provision of vision care services to non-enrollees. The Court, after examining the two programs under which VSP provided such services, concluded that the total funds spent by VSP on these programs is ''minimal'' compared to VSP's net income or gross income.

With regard to the education and community outreach that VSP provides, the Court, while recognizing these programs as ''admirable and important,'' determined that they do not demonstrate that VSP is primarily involved in promoting social welfare—especially since the amounts VSP spent on these programs is a ''very small fraction'' of VSP's gross or net 2003 income.

Based on the above analysis, the Court determined the VSP's services are ''mostly beneficial to private paying members, the subscribers and the enrollees,'' and, therefore, VSP failed to illustrate that it meets the requirement that it operates primarily to promote social welfare.

The second element that an organization must demonstrate to qualify for tax exemption as a social welfare organization is that it is not operating for profit. The Court determined that VSP does not meet this criterion because VSP ''devotes much of its revenues to improving its ability to compete commercially through accumulation of large surpluses and expansions of its income producing facilities''. In support of this conclusion, the Court cited the following: (1) VSP's engaging in cost-cutting measures common to for-profit business—i.e., tying a portion of its bonus structure directly to reducing VSP's costs; and (2) VSP's striving to remain competitive in ways that do not appear to be consistent with the operations of a nonprofit—i.e., paying commissions to brokers who bring new clients. Additionally, the Court stated that it is unable to agree with VSP that no one profits from its activities, because of its executive compensation and bonus structures.

Thus, the Court determined that VSP is unable to meet the second requirement because it carries on business with the public ''in a manner similar to organizations which are operated for profit.'' Therefore, the Court held that VSP does not qualify for tax exemption as a social welfare organization.

The appellate decision by the 9th Circuit was brief and limited[147]. It held that VSP is not operated exclusively for the promotion of social welfare because it is not primarily engaged in promoting the common good and general welfare of the community. The court agreed that VSP offers some public benefits; however, they were not enough for the court to conclude that

147. *Vision Service Plan, Inc. v. U.S.*, Docket No. 06-15269 (9th CA, January 30, 2008). The court marked the opinion as not appropriate for publication and not precedent except as provided by 9th Cir. R. 36-3.

VSP is *primarily* engaged in promoting the common good and general welfare of the community. The court was critical of VSP's articles of incorporation which state that the primary purpose of the corporation is to establish a fund from payments by subscribers to defray and assume the costs of vision care for those subscribers. The court found that such a purpose benefits VSP's subscribers rather than the general welfare of the community. Since it found the failure of VSP to meet the criterion that it primarily promote the common good and general welfare of the community dispositive, the court did not address whether VSP carries on its business with the public in a manner similar to that of for-profit organizations.

This case brings back to the fore the commerciality doctrine and mixes in the 3rd Circuit's analysis for HMOs seeking charitable status in the *Geisinger Health Plan* case. It applies the higher standards for exemption used for charitable organizations, rather than the more relaxed standards applied by recent court decisions to social welfare organizations. The ball is now squarely in the IRS's court. It remains to be seen whether the Service will use this case to support a change in its ruling position and to cease recognizing tax exemption for HMOs as social welfare organizations that are operated similarly to VSP. Such a change could effectively eliminate tax exemption for nearly all HMOs now recognized as exempt as social welfare organizations. Given the thorough analysis of the 3rd and 10th Circuits regarding HMO qualification for exemption, the minimalist analysis of the 9th Circuit, and the stable track record of HMOs operating as social welfare organizations in satisfying a ''more flexible'' standard of community benefit, a change in the IRS's position would be unwarranted.

CHAPTER TEN

Home Health Agencies

§ 10.1 **Freestanding Home Health Agencies 277**
§ 10.2 **Hospital-Based Home Health Agencies 283**
§ 10.3 **Private Duty Nursing Companies 284**

Home health agencies are an essential resource in the American healthcare system. They provide a critical link between institutional care and total self-care by the patient. As administrators, employers, and insurers have come to recognize the high cost of providing institutional care, and as physicians have seen the therapeutic value to patients who receive care at home, the demand for home health services has skyrocketed and home health agencies have grown from mom-and-pop operations to multicorporate enterprises.

The traditional garden-variety nonprofit home health agency demonstrated its qualification as a charitable organization in 1972.[1] However, as home health agencies, like many other healthcare providers, expand and diversify, the IRS will no doubt increase its scrutiny of home health agencies and their affiliates, giving them the same attention it has given institutional providers. High-profile litigation against a group of home health agencies to enforce the intermediate sanctions penalties is ample testimony on this point.[2]

§ 10.1 FREESTANDING HOME HEALTH AGENCIES

The traditional home health agency is a freestanding—that is, an independent and unaffiliated—nonprofit corporation that provides a variety of health services to patients in their homes. The range of services includes part-time skilled nursing services; physical, speech, and occupational therapy; medical social services; and home health aide services. Home health agencies were originally and are traditionally known as visiting nurse associations. Services are provided by licensed nurses where necessary, but other types of health professionals with varying degrees of training and compensation are also employed. Much of the organization and service provision

1. Rev. Rul. 72-209, 1972-1 C.B. 148.
2. *See* § 4.9(b).

of home health agencies, both nonprofit and for-profit, has been shaped by the Medicare program. Medicare reimbursement for home health services rendered to eligible beneficiaries is the largest single source of income for nearly every home health agency. The Medicare Conditions of Participation therefore go a long way in determining how home health agencies will be operated.[3]

The only formal IRS position with regard to the tax exemption of home health agencies was issued in a 1972 revenue ruling.[4] In that ruling, the IRS considered whether a nonprofit organization that was formed to provide low-cost home healthcare for the community could qualify for exemption as a charitable organization. The ruling described an organization that was formed to provide low-cost home healthcare on a nonprofit basis to the community. Its professional nursing and other therapeutic services were available to the general public and were furnished to patients in their homes. These patients received the home health agency's services based on a course of treatment prescribed in writing by their physicians and subject to periodic review.

Most of the described organization's patients were elderly people who were confined to their homes because of their ill health. Importantly, the IRS noted that the organization was a qualified home health agency as defined in the Social Security Act[5] and that most of the agency's revenues came in the form of Medicare reimbursement. The ruling noted that the home health agency's disbursements were made for salaries, medical equipment and supplies, and various administrative expenses, and that any surplus was used to cover the cost of patients who could not afford to pay for services, and to expand the organization's services.

The ruling set forth the now-standard IRS position that, in the general law of charity, the promotion of health is considered to be a charitable purpose. It also referred to the IRS's landmark 1969 ruling,[6] in which the IRS took the position that a nonprofit organization whose purpose and activity was providing hospital care for members of the community was promoting health and therefore could qualify as being organized and operated in furtherance of a charitable purpose.

In reliance on those two positions, the IRS concluded that by providing home health services as described in the ruling, the home health agency was serving many of the same health needs of the community that were traditionally served by hospitals and, accordingly, the home health agency was also promoting health within the meaning of the general law of charity. The IRS thus concluded that the organization's activities were charitable and

3. 42 C.F.R. pt. 484 (1993).
4. *See supra* note 1.
5. 42 U.S.C. § 1861(O).
6. Rev. Rul. 69-545, 1969-2 C.B. 117.

that the organization was therefore exempt as a charitable organization under the Code.[7]

The IRS's 1972 ruling described a home health agency that is a Medicare-certified home health agency. Other IRS materials often refer to this factor as an underpinning of the ruling, but it is apparently not necessary for a home health agency to be Medicare-certified in order to be recognized as a charitable organization. This is certainly the case with regard to private duty nursing companies.[8] Thus, as long as a home health agency is organized as a nonprofit organization, makes its professional nursing and other therapeutic services available to the general public in their homes, makes its disbursements for exempt purposes, treats all patients able to pay for their care, and uses any surplus earned to pay for indigent care or otherwise to expand the organization's services, then it should qualify as a charitable organization.

Home health agencies by their nature are not institutions. They typically consist of a suite of offices and staff persons who are responsible for coordinating the provision of care to patients in their homes. The agencies do not have beds or provide any type of inpatient services, nor do they typically own much in the way of durable medical equipment or other supplies used in patient care. Home health agencies generally employ the majority of their caregivers; however, many arrange for the provision of services through temporary staffers and treat these individuals as independent contractors rather than as employees.[9] Accordingly, when employees are used, the home health agency can qualify as a provider of services (rather than an arranger) even though services are provided in patients' homes.

With regard to the public charity status of home health agencies, from analysis of the 1972 ruling,[10] it might appear that home health agencies would qualify as other than private foundations as public institutions and as hospitals because the ruling bases their exemption on the fact that they provide services that would typically be provided by hospitals. However, the IRS has never included home health agencies in its broad definition of hospitals for public charity status purposes, and most charitable home health agencies have been recognized as service provider–type public charities because of the substantial

7. In fact, the stage had already been set for the IRS to arrive at this conclusion. In Revenue Ruling 68-376, 1968-2 C.B. 246, which set forth the patient/nonpatient test of relatedness with regard to the business income of a hospital, the rendering of home health services was related to a hospital's exempt functions. Home health agencies are the subject of Priv. Ltr. Ruls. 199917084, 9735047, 9735048, 9857037, and 982052.
8. *See* discussion *infra* at § 10.3.
9. Medicare providers probably cannot treat nurses and home health aides as independent contractors because of the degree of control required under Medicare conditions of participation. *See* Chapter 27. Therapists may qualify as independent contractors, however, because that is how they have traditionally functioned.
10. *See supra* note 1.

nature of their exempt function income.[11] Some of these organizations may possibly qualify as publicly supported organizations as well.[12]

In the late 1970s and early 1980s, there was increased regulatory scrutiny of home health agencies with regard to certain administrative practices that became a problem in the industry. In 1979, the General Accounting Office (GAO) issued a report that reviewed these practices.[13] The particular areas of abuse noted were: inurement of net earnings, leasing of office space, franchising, and long-term contracts. The issues presented in each of these areas were: whether the home health agency's net earnings inured to the benefit of private shareholders or individuals, and whether the home health agency was operated for public purposes rather than private interests. Each of the home health agencies involved was not governed by an independent board; rather, it was governed by a board that had economic interests in the home health agency.

The IRS subsequently audited the home health agencies in question, determined that they were operating for other than tax-exempt purposes, and revoked their tax-exempt status. Ultimately, examination guidelines were issued in this area, and these types of abuses were brought to the attention of the field auditors. The examination guidelines list the following as examples of abusive and fraudulent schemes used by home health agencies:

(a) home health agencies that over-bill or submit fraudulent cost reimbursement reports to the government;

(b) home health agencies that siphon the Medicare program for goods and services never rendered;

(c) home health agencies that siphon Medicare dollars into for-profit enterprises with which the home health agency is directly or indirectly related, through management and consultant contracts that were not entered into at arm's length and do not have fair market value terms.[14]

Because these abuses occurred within the context of the Medicare program, the exempt organization (EO) examiners are instructed by the guidelines to secure and review the Medicare audit adjustment report of the home health agency in all home health agency examinations.[15] The EO specialists are then instructed to consider the adjustments entered in the audit adjustment report and to determine whether these adjustments indicate private inurement or the existence of a nonexempt purpose. Examples listed in the guidelines are: control

11. *See* IRC § 509(a)(2).
12. *See* IRC §§ 509(a)(2), 170(b)(1)(A)(vi).
13. GAO Report, Home Health Care Services—Tighter Fiscal Controls Needed (HRD-79-17, May 15, 1979).
14. IRS Exempt Organizations Examination Guidelines Handbook (IRM 7(10)69), § 336(4).
15. *Id*. at § 336(6)(a).

by another entity, unreported compensation, unreasonable management or consulting fees, and unsupported auto, travel, or entertainment expenses.[16]

The examination guidelines go on to explain that the audit of the home health agency's financial records is just as important as an audit of the organization's activities to determine whether there exists a nonexempt purpose or whether private inurement or impermissible private benefit exists. The guidelines instruct the EO specialist to consider the possibility of such grounds for revocation of exemption if the EO specialist finds:

> (a) compensation which appears excessive in relation to the nature and extent of duties performed, *e.g.*, the provision of leased cars for personal use, unsecured non-interest-bearing loans.
>
> (b) failure to keep records of the number of hours worked by employees, the nature of their duties, and the amount of compensation paid, particularly compensation paid to physicians who work on a part-time or consulting basis for the agency.
>
> (c) unnecessary or unreasonably costly management, consultant, or supply contracts. Provisions of such contracts which are subject to close scrutiny are:
>
> (1) where contracts to organize the home health agency are with a for-profit organization;
>
> (2) where services are contracted at a percentage of gross billings;
>
> (3) where there is an unduly lengthy term that eliminates competition for the purchase of services or supplies;
>
> (4) where the contract permits the for-profit organization to exert substantial management authority; and
>
> (5) the existence of a covenant not to compete binding upon the home health agency.
>
> (d) the existence of a for-profit organization that is controlled or owned by directors, administrators, or officers of the home health agency, particularly where the home health agency's facilities are used by the for-profit organization.
>
> (e) charges made by the home health agency for its services to patients which appear unreasonable, unnecessary, or unrelated to home health care to the patient.[17]

Where an auditor finds evidence of abuse, particularly in the Medicare and Medicaid reimbursement programs, which indicates the existence of private inurement or impermissible private benefit, exemption will be subject to revocation.

The IRS has made it clear in recent rulings that simply characterizing a nonprofit organization as a home health agency is insufficient to warrant

16. *Id*. at § 336(6)(b).
17. *Id*. at § 336(7).

recognition of its status as a tax-exempt organization. If an organization purporting to be a home health agency is in reality simply a conduit for the provision of services by others or is primarily a provider of management and liaison services between unrelated parties, it will be unable to qualify for tax-exempt status as a charitable organization or as a social welfare organization.

In one ruling, an organization was incorporated as a nonprofit organization to coordinate the delivery of home health services. It conducted three major activities: home health management, hospital liaison, and physician home call. It provided services to two for-profit home health agencies, two nonprofit home health agencies, and a tax-exempt hospital. Its management services consisted of traditional management and consulting services to unrelated home health organizations. These management services provided the majority of the organization's income. The liaison services, which were the second largest source of income for the organization, involved finding home health agencies or home health providers to care for patients after their discharge from the hospital. The organization also provided physician house call services to homebound patients; however, this was an insubstantial part of its overall activities.

The IRS concluded that by operating as a manager or facilitator for the provision of home health services in return for a fee, the organization was operating in a commercial manner and its activities were not charitable. The IRS noted, as it has in several other contexts, that activities promoting health, without more, do not further a charitable purpose. Accordingly, the IRS ruled that the organization did not qualify as a charitable tax-exempt organization.[18]

In another ruling, the IRS considered an application for recognition of exemption from federal income tax of an organization seeking to qualify as a tax-exempt social welfare organization. The organization was incorporated as a nonstock corporation for the purpose of establishing an agency for home healthcare services to be provided exclusively in particular residential communities. It served approximately 1,000 residents in five facilities in four locations. The organization described its activities in its exemption application as a liaison that arranges for independent contractors, through a registry, to be hired by independent and assisted living residents. When the organization received phone calls asking for assistance, it would collect relevant information, assess the need for care, and then match service providers from its registry to the client. The organization's revenue was derived entirely from fees that it charged for its services. When questioned about how it planned to use any budgeted excess of revenue over expenses, the organization stated that its goal was to establish a foundation or endowment for the benefit of the individuals residing in the residential communities.

18. Priv. Ltr. Rul. 200539027.

The IRS found that the organization did not qualify as a tax-exempt social welfare organization. In its ruling, it stated that a crucial element for qualifying for tax exemption as a social welfare organization is the promotion of social welfare for the people of the community. In the IRS's view, the fact that the organization was serving only residents of a small number of facilities in a small number of residential locations was insufficient. It noted the absence of the provision of services to a broader segment such as a government subdivision, and therefore concluded that it was not promoting the common good and general welfare of all the people in the community.

The IRS also found that the organization's primary activity was to act as a liaison by maintaining a registry. The IRS, relying on well-settled court decisions and guidance, concluded that this was a traditional business activity carried on by for-profit organizations and not charitable in nature. Applying a position commonly taken by the IRS in guidance regarding the tax-exempt status of health maintenance organizations, the IRS determined that the organization's activities were not charitable because it was an arranger of services and not a provider of charitable services. The IRS further pointed out that even if the organization's services were offered only to exempt organizations, they would still be regarded as a business. Thus, because its primary purpose was operating a business, rather than promoting the general welfare of the people of the community, the IRS ruled that the organization did not qualify for exemption as a social welfare organization.[19]

§ 10.2 HOSPITAL-BASED HOME HEALTH AGENCIES

Not all home health agencies are freestanding. Many are hospital based—that is, they are subject to the operating decisions of the hospital board of trustees. The Medicare and Medicaid reimbursement programs recognize this distinction among home health agencies. Where hospital-based home health agencies are not separately incorporated, they share the tax-exempt status of the hospital operating corporation. A hospital operating corporation is normally exempt as a charitable organization and as a public institution–type public charity. This activity will therefore be considered charitable in nature.

This exemption is further supported by the IRS's recognition of the relatedness of home healthcare to the charitable purposes of a hospital operating corporation.[20] Services provided to individuals by the professional staff of the hospital in a hospital-based home healthcare program are treated as services provided to patients of that hospital and do not generate unrelated business taxable income.

19. Priv. Ltr. Rul. 200544020.
20. Rev. Rul. 68-376, 1968-2 C.B. 246.

§ 10.3 PRIVATE DUTY NURSING COMPANIES

Many home health agencies have reorganized their corporate structures in order to maximize reimbursement under the Medicare program. In particular, because of the way the Medicare program allocates overhead and reimburses overhead costs, many home health agencies believe it desirable to create a separate corporation to provide private duty nursing services—services that are generally more long-term and custodial in nature and typically are not covered by the Medicare program.

The purpose of private duty nursing services is to assist patients in performing the activities of daily living so that they can remain in their own homes and enjoy the therapeutic benefits and less costly treatment available in that care setting. Skilled nursing services may be provided by registered or licensed practical nurses to ventilator-dependent patients or other patients who require skilled technical support in order to remain in their homes. In addition, a nonskilled level of private duty nursing services is provided, typically by home health aides, homemakers and housekeepers, and companions, who assist with baths, help patients to dress, prepare simple foods, do personal laundry and light housekeeping, and otherwise encourage patients to perform daily living activities.

At first blush, it is not immediately apparent why such organizations would be entitled to recognition of exempt status as charitable organizations. Such services would seem to be of the character of personal services rather than medical care. Moreover, private duty nursing companies do not provide services, for the most part, to Medicare and Medicaid patients, a fact that might otherwise be the death knell for their ability to obtain recognition of tax-exempt status as charitable organizations.

However, the reason private duty nursing companies do not provide a significant level of Medicare and Medicaid services is because their services are usually not covered by those programs, not because they refuse to treat such patients. Also, private duty nursing remains a type of ''hands-on'' healthcare provided by caregivers, an endeavor that has historically been looked on favorably by the IRS. Even though the services are of a more custodial nature, they are provided in accordance with a plan of treatment developed with the patient's physician and under the supervision of a licensed nurse.

Thus, as long as private duty nursing services are provided to all patients who are able to pay, some level of indigent care is provided, and any surplus is used to further the exempt purposes of the organization, private duty nursing companies should qualify for exemption as charitable organizations. The IRS has recognized such status in several private letter rulings.[21] However, when private duty nurses are supplied to the patients of related and unrelated

21. Priv. Ltr. Rul. 9405004; 8943049; 8601066; 8753052; 8837042.

healthcare entities, such activity may trigger complex issues regarding the unrelated business income tax.

In one IRS ruling,[22] a tax-exempt, charitable parent organization had three charitable affiliates (O, P, and Q), as well as one for-profit affiliate, N. N operated a service that supplied temporary nurses and private duty nurses to O and other unrelated exempt organizations in the community: 10 percent of N's services involved the provision of temporary nurses to O, 68 percent involved the provision of private duty nurses to O's inpatients, and 22 percent involved the provision of private duty nurses to unrelated exempt organizations. It was proposed that N transfer its nursing activity to Q and that Q carry on that activity in the same manner as N. Q's exempt purpose was the promotion of health through various program services, including weight loss, corporate physical examination, education classes, home care, and nutrition.

After reviewing the law pertaining to the unrelated business tax, the IRS concluded that income Q obtained from providing temporary nurses to O, its related organization, would not be subject to UBIT, because providing such nurses would "contribute importantly" to the provision of health in the community. In addition, the IRS ruled that income from providing private duty nurses to the inpatients of O would not trigger UBIT because the private duty nurses would be provided "primarily for the convenience of the patients of O," thus qualifying for exception to UBIT.[23] In reaching this second conclusion, the IRS seems to have expanded the definition of patients under the convenience exception to encompass not only an organization's own patients, but also the patients of any related tax-exempt organization. Finally, with respect to the provision of private duty nurses to other unrelated exempt organizations, the IRS did not even mention the convenience-of-patients exception as a possibility. Instead, the IRS summarily concluded that the provision of private duty nurses to unrelated exempt organizations did not contribute importantly to Q's exempt purpose because "such activity would be performed on a scale much larger than necessary for the performance of [Q's] exempt function." This conclusion is apparently based on IRS regulations,[24] which state that when income is realized by an exempt organization from activities that are in part related to the performance of its exempt functions, but that are conducted on a larger scale than is reasonably necessary, the income attributable to the excess activity constitutes unrelated business income.

Based on this ruling, it would appear that providing private duty nurses to related exempt organizations always qualifies for the convenience-of-patients exception to UBIT, whereas providing the same nurses to unrelated exempt organizations does not. The IRS also implies in the ruling that providing

22. E.g., Priv. Ltr. Rul. 9535023.
23. *See* § 24.15(a).
24. Reg. § 1.513-1(d)(3).

private duty nurses to related exempt organizations does not further an exempt purpose. Finally, the ruling suggests, somewhat inconsistently, that providing private duty nurses to any unrelated exempt organization might further the promotion of health, but only if such activity is not conducted ''on a scale larger than necessary.''[25]

25. For a detailed discussion of the unrelated business income rules, *see* Chapter 24.

CHAPTER ELEVEN

Homes for the Aged

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§ 11.1 INTRODUCTION

Prior to the 1970s, the IRS took the position that the aged were not a charitable class *per se*, but that the aged would be proper charitable beneficiaries if they were suffering from financial hardship. Since the 1970s, however, the IRS has softened its position and has recognized that the aged, apart from considerations of possible financial distress, also are highly susceptible to other forms of ''distress'' solely because of their advanced years and their special needs.[1] Consequently, organizations that conduct programs designed to relieve the distress and meet the special needs of the elderly, including various types of housing programs for the elderly, may readily qualify for tax exemption as charitable organizations.[2]

1. *See* in general, IRS Exempt Organizations Handbook (IRM 7751), § 343.5; Hopkins, The Law of Tax-Exempt Organizations (7th ed. 1998) at 101–102, 142–143; FY 1985 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, ''Housing for Senior Citizens'' (FY 1985 IRS CPE Text); FY 2004 IRS CPE Text, ''Elderly Housing.''
2. *See*, in the nonhousing context, Rev. Rul. 77-246, 1977-2 C.B. 190 (organization providing low-cost bus transportation to senior citizens and the handicapped, in a community where public transportation is unavailable or inadequate, qualifies for exemption under IRC § 501(c)(3)); Rev. Rul. 76-244, 1976-1 C.B. 205 (organization providing home delivery of meals to the elderly and handicapped, by volunteers, qualifies for IRC § 501(c)(3) status).

§ 11.2 OVERVIEW OF TAX EXEMPTION FOR HOMES FOR THE AGED

(a) General Criteria for Homes for the Aged

Prior to 1972, a tax-exempt charitable organization providing a home for the aged was required to provide free or below-cost services, in conformance with the early IRS view as to hospitals.[3] However, in 1972, the IRS changed its view, ruling that an organization that operates a home for the aged may be exempt from tax as a charitable organization if it operates in a manner designed to satisfy the three primary special needs of the elderly: (1) the need for housing, (2) the need for healthcare, and (3) the need for financial security.[4] In summary, the IRS stated that the need for housing is satisfied if the organization provides facilities that are specifically designed to meet some combination of the physical, emotional, recreational, social, religious, or similar needs of aged persons.[5]

The need for healthcare will generally be satisfied if the organization either directly provides some form of healthcare or maintains some continuing arrangement with other healthcare organizations, facilities, or personnel.

Finally, the IRS stated that the need for financial security is satisfied if two conditions exist. First, the organization is committed to maintaining in residence any persons who become unable to pay their regular charges. However, an organization required by reason of federal or state financing agreements to devote its facilities to housing only aged persons of low or moderate income and to recover operating costs from such residents is excused from this requirement. Second, the organization must operate so that it provides its services at the lowest feasible cost,[6] taking into account the payment of its indebtedness,

3. Rev. Rul. 56-185, 1956-1 C.B. 202; Rev. Rul. 57-467, 1957-2 C.B. 313. *See also* Rev. Rul. 70-585, 1975-2 C.B. 115, where the IRS reviewed four examples of housing provided to low- and moderate-income families (not involving the elderly). In the fourth example, the IRS concluded that an organization erecting housing to be rented ''at cost to moderate-income families'' because of a shortage of such housing in the community is *not* exempt from tax because its programs are not designed to provide relief to the poor or to carry out any other charitable purpose.
4. Rev. Rul. 72-124, 1972-1 C.B. 145.
5. Specially designed housing for the elderly can include units built with fire-resistant materials, skid-resistant floors, ramps, grab bars, wide doorways, 24-hour emergency call systems, and similar amenities. Rev. Rul. 79-18, 1979-1 C.B. 194.
6. The ''lowest feasible cost'' requirement is not one that can be neatly defined, but the IRS will take into consideration such necessary expenses as the payment of indebtedness, maintenance of adequate reserves sufficient to ensure the life care of each resident, and reserves for physical expansion commensurate with the needs of the community and the existing resources of the organization. Additional circumstances indicating the lowest feasible cost may include the fact that an organization makes some part of its facilities available to persons with income lower than its regular residents and at rates below its customary charges, although this is not required. Rev. Rul. 72-124, *supra* note 4. The

maintenance of adequate reserves to ensure life care of residents, and reserves for physical expansion commensurate with the needs of the community. The fact that the organization makes some of its services available at rates below its customary charges to persons of more limited means than its normal residents will constitute additional evidence that the entity is satisfying this second condition.[7]

In another significant ruling the IRS focused on the provision of rental housing for the elderly. In that ruling, the IRS held that an organization that provides specially designed apartment units for elderly persons at the lowest feasible cost and maintains in residence those tenants who subsequently become unable to pay the regular monthly fees is operated exclusively for charitable purposes.[8] However, the IRS also stated in the ruling that an organization must maintain in residence those unable to pay the facility's charges only to the extent that the facility is able to do so without jeopardizing its own financial condition.[9] The IRS also emphasized that the facility's fees should be such as to make the facility available to a ''significant segment'' of the community's elderly persons.

The IRS has subsequently stated that implicit in its 1972 ruling is the requirement that a facility for the elderly be ''reasonably available to the elderly in the community'' and that it not ''serve only an insignificant portion of that class.''[10] In a memorandum, the IRS elaborated further on this so-called ''community accessibility'' requirement, stating:

> We do not believe that the lavishness of the facility is the determinative factor [for community accessibility] . . . if the various fees charged are low enough so that a significant portion of the elderly community can avail itself of the facility, then the organization can qualify under Section 501(c)(3), assuming the other criteria are met. . . . Of course, this test [of community accessibility] must be performed on a case by case, community by community basis; charges that preclude sufficient availability in one community may not do so in another.[11]

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major factor in determining lowest feasible cost, however, is whether the organization's assets are dedicated to a charitable purpose with no private inurement, rather than whether less expensive methods could be used by the organization. *See* FY 1985 IRS CPE Text, *supra* note 1, at 177.

7. Rev. Rul. 72-124, *supra* note 4.
8. Rev. Rul. 79-18, *supra* note 5. *See also* Rev. Rul. 79-19, 1979-1 C.B. 195, reaching the same conclusion regarding an organization that provides housing to physically handicapped persons under the same circumstances.
9. The IRS has also stated, in a separate publication, that the requirement of maintaining in residence any persons who become unable to pay the regular charges can be satisfied in a number of ways, such as by finding a place for residents with another suitable agency or organization when the residents can no longer pay the regular charge. FY 1985 IRS CPE Text, *supra* note 1.
10. Priv. Ltr. Rul. 9001036.
11. Gen. Couns. Mem. 37101.

(b) Other IRS Rulings Regarding Housing for the Aged

Although the 1972 and 1979 rulings are its two most important pronouncements regarding homes for the aged, the IRS has issued a number of other noteworthy revenue rulings pertaining to housing or similar facilities for the elderly. For example, the IRS has ruled that a nonprofit, publicly supported organization that operated a rural rest home to provide, at a nominal charge, two-week vacations for elderly poor people from nearby metropolitan areas was recognized as exempt as a charitable organization.[12]

In another example, an organization that established a service center providing, among other things, information, referral, and counseling services relating to health and housing, and that provided a facility for specialized recreation for a community's senior citizens, was held to qualify for exemption as a charitable organization.[13]

In contrast, in a memorandum,[14] the IRS held that a life care facility in which residents purchased condominium living units and paid a monthly fee for a program of lifetime medical care, meals, housekeeping, recreational and social programs, and other services did not qualify for exemption where the sale of some units was financed by loans from third-party lenders and secured by mortgages on the units. The IRS stated that, under these circumstances, the nonprofit operator could not fulfill its no-eviction promise if a resident defaulted on a loan secured by the condominium. Additionally, a fee-simple sale could conflict with the community accessibility requirement because once the nonprofit organization sold the unit, it would lose control over accessibility. The memorandum distinguished this case from one described in another revenue ruling,[15] where the sale of housing in connection with a home for the aged was permissible because the tax-exempt organization controlled both the financing and the resale price.

The IRS has also ruled that the charitable tax-exempt status of a retirement home operator will not be jeopardized when it establishes a fee-for-services payment plan to accommodate those persons who would like to be residents of the retirement home without assigning their assets and income to it.[16]

Under the retirement home's prior method of operation, its occupants were all ''traditional'' residents who assigned to the retirement home all of their assets and income, including any and all gifts made by the residents within the last three years. The home was operating at less than half its capacity. The retirement home hoped to operate at full occupancy by filling its vacancies with fee residents. The proposed fee residents would be required to make a deposit with the retirement home upon entry. A resident who withdraws or

12. Rev. Rul. 75-385, 1975-2 C.B. 205.
13. Rev. Rul. 75-198, 1975-1 C.B. 157.
14. Gen. Couns. Mem. 38748.
15. Rev. Rul. 70-585, 1970-2 C.B. 115.
16. Priv. Ltr. Rul. 200150038.

passes away within 48 months of entry to the home would be refunded, or the estate would be refunded, the unearned portion of his or her entrance fee.

The retirement home planned to charge fees against the deposit at the rate of 5 percent the first month and 2 percent every month thereafter until the funds are depleted. In addition, it would charge a daily facility fee. The daily rates charged to the fee resident would be the same as that charged to a traditional resident. Each fee-based resident would have the same access to doctors and nurses that traditional residents have.

Fee residents would not be evicted if they became unable to pay the home's monthly fee. If a fee resident could no longer pay in accordance with the fee plan, the resident would have the option to transfer over to the traditional plan as long as he or she makes the required assignment of assets and income to the retirement home. No fee resident desiring to exercise the option would be denied admission under the traditional plan.

The fact that the organization charges an entrance fee and only accepts residents with the financial ability to pay its established rates does not hinder its exemption since it provides the security that if, subsequently, a resident could no longer pay, the home would incur all costs.

The IRS ruled that the retirement home satisfies the three primary criteria for homes for the aged that it developed in 1972, and is operating to provide its services to the aged at the lowest feasible cost. The Service determined that the retirement home's fee-for-services plan furthers the home's exempt purpose and is substantially related to the purpose for which it was recognized as exempt. As a result, implementation of the proposed fee for services plan would not jeopardize the home's charitable tax-exempt status and income derived from the retirement home's fee residents would not be classified as unrelated taxable business income.

§ 11.3 SPECIFIC TYPES OF HEALTHCARE FACILITIES FOR THE AGED

Tax-exempt healthcare entities may provide a wide variety of facilities for the aged. These facilities are given a number of different descriptives: ''continuing care,'' ''intermediate care,'' ''life care,'' ''residential care,'' ''congregate care,'' ''assisted living,'' ''independent living,'' ''skilled nursing care,'' and ''intermediate nursing care.'' More than one type of care may be provided at the same facility.

Two of the more common types of facilities for the elderly operated by tax-exempt healthcare entities are ''skilled nursing care'' facilities and ''assisted living'' facilities. A ''skilled nursing care facility'' is generally understood to mean a facility that provides, among other services, nursing care on an individualized basis utilizing registered nurses, licensed practical nurses,

and therapists.[17] Assisted living is generally understood to mean any group residential setting providing personal care and meeting the unscheduled needs of older disabled persons.[18]

(a) Skilled Nursing and Assisted Living Facilities

There is very little direct authority discussing the tax-exempt status of the various individual types of housing facilities for the elderly. However, in one private letter ruling, the IRS has analyzed, at least to a limited degree, the issue of whether an organization operating a combined skilled nursing facility and assisted living facility could qualify for tax exemption. In that ruling,[19] an organization that was already tax-exempt as a charitable organization sought to expand its activities to include constructing, owning, developing, and/or managing residential housing for the elderly. For unexplained reasons, the proposed housing would not meet HUD requirements for low-income housing. The housing project is described as consisting of ''independent living units, assisted living units, and skilled nursing care units.'' All of the units are designed to meet the special physical needs of the elderly. The project also includes the provision of specialized services for the elderly, including meals, housekeeping, laundry, transportation, social programs, and security. Although residents must be able to pay the monthly fee at the time of being accepted, any person subsequently unable to pay the regular charge will still be maintained in residence. The IRS concluded that the proposed project meets the three needs of the elderly, as described in its 1972 ruling,[20] and that the facilities would be reasonably available to a significant number of the elderly in the community. Therefore, the IRS ruled that the project would not jeopardize the organization's tax exemption.

In addition to the foregoing private letter ruling, numerous others mention skilled nursing and assisted living facilities in the context of a larger tax transaction. In each case, such facilities have already been recognized as tax-exempt charitable organizations, apparently because the IRS relied on the line of authority pertaining to homes for the aged.[21]

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17. American Association of Retired Persons, Assisted Living in the United States (1993) at 1.
18. E.g., Priv. Ltr. Rul. 9438039; 9405004; 9343024; 9318048. Registered nurses (RNs) generally provide nursing care under orders prescribed by the patient's physician; licensed practical nurses (LPNs) perform less complex treatment and work under the direction of registered nurses. Where nursing services are provided in an individual's home instead of in a separate skilled nursing facility, skilled home health aides and social workers are sometimes also used.
19. Priv. Ltr. Rul. 9001036. A similar organization is described in Priv. Ltr. Rul. 9735047.
20. Rev. Rul. 72-124, *supra* note 4.
21. E.g., Priv. Ltr. Rul. 9304035 (describing a tax-exempt, church-related retirement home that included ''facilities for assisted living . . . located in a mid-rise building, attached to a skilled nursing care facility''); Priv. Ltr. Rul. 8930024 (describing a tax-exempt

In one case, the details surrounding an IRS determination letter given to a ''continuing care retirement community'' was made public by the lawyers for that entity,[22] and those details shed some additional light on the extent to which skilled nursing and assisted living facilities may qualify for tax-exempt status.

The determination letter involved an application for recognition of exemption for a retirement community called Pacific LifeCare, and it was believed to be the first favorable IRS determination for a project in which the elderly residents *own* their own residential units (condominiums) and in which the exempt organization owns and operates all of the services. The organization, which began operations in 1996, provided its residents with a comprehensive life care package of services, including housekeeping, meals, transportation, assisted living, and skilled nursing care on a 66-acre site that accommodates 412 residential units, 16 Alzheimer's units, and an 84-bed skilled nursing facility. Residents have an option of purchasing a cooperative interest in their units or paying an entrance fee instead (in which case they acquire no equity interest). Additionally, residents are allowed to sell their units at any time, subject to certain sales restrictions.

The organization has a no-eviction policy, even though it is located near two of the wealthiest communities in its area. It has been able to establish with demographic data that 38.5 percent of the households over age 70 earn sufficient income to pay its monthly fees and that the average home sale prices in its service area are equivalent to 92 percent of the entry-level cooperative membership fee and 100 percent of the entry-level entrance fee that it is charging.[23]

The IRS was initially doubtful that a facility for the aged could qualify as charitable where housing was sold to people who were neither poor nor the victims of discrimination. The IRS also initially expressed concern about impermissible private benefit[24] to the residents of the community, resulting from the cooperative housing format and the residents' ability to

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incorporated retirement community that offered nursing care, assisted living care, and independent living, with fees calculated with respect to the cost of providing care to each resident and by projecting its future costs; although it reserves the right to dismiss assisted living residents for failure to pay fees, it never has done so); Priv. Ltr. Rul. 8752088 (describing a tax-exempt retirement and health center for the elderly providing ''independent living facilities, assisted living care and skilled and intermediate nursing care''); Priv. Ltr. Rul. 8620052 (discussing a tax-exempt organization desiring to receive a private foundation grant that will be ''earmarked for use in a program of construction of assisted living apartments for wheelchair-bound individuals'').

22. Gordon and Kaufman, ''IRS Grants Tax Exemption to Equity Continuing Care Retirement Community,'' 9 *Exempt Org. Tax Rev*. (No. 1), 123–130 (Jan. 1994).
23. The initial cooperative membership purchase prices (in 1990 dollars) were estimated to range from $250,000 to $450,000, and initial entrance fees ranged from $175,000 to $250,000.
24. *See*, in general, *supra* § 4.6.

sell their housing units. However, after two and one-half years of review, the IRS eventually issued the favorable Determination Letter granting the entity recognition of tax-exempt status as a charitable organization. However, it did so only after Pacific LifeCare agreed to several modifications in the way it would allow the units to be bought and sold.[25] For example, to avoid evictions from the facilities, Pacific LifeCare prohibited all third-party encumbrances of the living units, including mortgages, deeds of trust, liens, and security interests. Additionally, Pacific LifeCare ensured continued community accessibility of the units by reserving for itself the right to repurchase any units for any reasonable management purpose. Pacific LifeCare also agreed to an appreciation limit not to exceed 10 percent per year, to prevent residents from enjoying windfall profits upon the resale of their units.

Taken together, the above rulings suggest that any tax-exempt charitable organizations desiring to provide housing for the elderly, including skilled nursing care and assisted living facilities, must ensure that their facilities satisfy the three primary needs of the elderly (housing, healthcare, and financial security), and that in meeting the last of these needs, they must (1) have some form of no-eviction policy, (2) operate at the lowest feasible cost, and (3) have fees and charges that are not so high as to preclude a significant portion of the elderly in the local community from availing themselves of the facilities.[26] Where such facilities would include the sale of units to the elderly, however, compliance with the community accessibility and no-eviction requirements becomes much more difficult. Nevertheless, when properly structured, a skilled nursing care or assisted living facility can be constructed and operated by a tax-exempt entity.

On the other hand, where a nonprofit organization provides skilled nursing care or assisted living facilities that, because of high monthly fees or other charges, are not available to a significant portion of the local elderly community, or where sufficient safeguards have not been imposed to preclude elderly residents from obtaining an impermissible private benefit from the resale of their living units, obtaining recognition of tax-exempt status will be much more difficult.

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25. *See also* Gen. Couns. Mem. 38748.
26. A home for the aged may, in the alternative, qualify under prior IRS rulings for tax-exempt status if the home is primarily concerned with providing care and housing for financially distressed aged persons. Rev. Rul. 64-231, 1964-2 C.B. 139; Rev. Rul. 61-72, 1961-1 C.B. 188. In addition, it is possible for an organization that provides homes for the aged and also engages in extensive lobbying activities to qualify for tax exemption under IRC § 501(c)(4) as a social welfare organization, although such an organization would still need to satisfy the basic guidelines for homes for the aged set forth in Rev. Rul. 72-124 (*supra* note 4) and Rev. Rul. 79-18 (*supra* note 5). *See* FY 1985 IRS CPE Text, *supra* note 1.

§ 11.4 OTHER CONSIDERATIONS

Because the construction and operation of facilities for the aged never occur in isolation, all of the other restrictions applicable to tax-exempt charitable organizations and their activities must be considered. Three collateral issues are of particular importance to facilities for the aged. Although a full discussion of these issues is beyond the scope of this chapter, the issues are identified briefly below.

First, a charitable organization providing services to elderly citizens must consider whether any portion of the income from those services constitutes unrelated business taxable income (UBTI).[27] For example, if income is received from the elderly from their use of an on-site pharmacy, grocery store, beauty salon, or barber shop, is that income taxable or are those services related to the provider's exempt purpose? Although a good argument can be made that many of these services are related to the organization's exempt purpose because they provide the elderly with essential services that are not readily available to them because of their general lack of mobility, there is little IRS authority discussing these issues in the context of homes for the aged.[28]

Second, where facilities for the elderly are not constructed and operated by a charitable organization alone, but are instead owned and operated in a partnership or joint venture arrangement between nonprofit and for-profit entities, the nonprofit organization must ensure that the arrangement satisfies the various IRS restrictions on nonprofit involvement in joint ventures and partnerships.[29]

Finally, where such facilities are financed with tax-exempt bonds and managed by a for-profit entity, the nonprofit owner of the facility must ensure that the restrictions on private use of bond-financed facilities are complied with.[30]

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27. *See*, in general, *infra* Chapter 24.
28. Notably, FY 1985 Exempt Organizations . . . , *supra* note 1, does not even mention UBTI as a potential issue in transactions involving homes for the aged. However, one commentator has opined that the ''convenience exception'' to UBTI described in IRC § 513(a), which normally applies only to services provided to members, students, patients, officers, or employees of an exempt organization, may also be applicable to services provided to ''elderly residents'' of a tax-exempt housing facility for the aged. Harlan, ''Housing for the Elderly: Federal Income Tax Concerns,'' 5 *Exempt Org. Tax Rev.* (No. 1) 39, 41 (Jan. 1992).
29. *See*, in general, *infra* Chapter 22; FY 1985 IRS CPE Text, *supra* note 1; *also* Priv. Ltr. Rul. 8417054; 8449070; and 8943050.
30. *See*, in general, *infra* Chapter 30.

CHAPTER TWELVE

Tax-Exempt Physician Organizations

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Application of the concept that the term *charitable* embraces the function of promoting health continues to trouble the IRS as the courts persist in allowing various forms of the practice of medicine to lodge within its ambit. The practice of medicine occurs in hospitals, but, as noted, the law has rationalized the classification of most nonprofit hospitals as charitable. Thereafter, also as noted, charitable entities have been determined to include a variety of clinics, centers, research agencies, and health maintenance organizations.

The IRS has not been as hospitable toward physician organizations desirous of obtaining recognition of exempt status as charitable organizations, primarily because of its concerns over their inherent potential for creating private inurement or substantial private benefit (it would be difficult to argue with a straight face that such organizations are not engaged in the promotion of health).[1] Nevertheless, the IRS has grudgingly accepted the position that at least two types of physician organizations, when properly structured and operated, may obtain recognition of exempt status as charitable organizations: (1) physician clinics and (2) teaching hospital faculty organizations.

§ 12.1 TAX-EXEMPT CLINICS

The practice of medicine by physician groups is typically a for-profit endeavor. Group practices are not organized, nor are they operated, in a manner designed to obtain recognition of tax-exempt status as charitable organizations. Thinly veiled attempts at obtaining charitable status without actually observing the requirements for same have not been well received by

1. Columbo, ''Are Associations of Doctors Tax-Exempt? Analyzing Inconsistencies in the Tax Exemption of Health Care Providers,'' 9 *Va. Tax Rev*. 469 (1990).

the IRS.[2] However, it is not uncommon for some physician groups operating as clinics to seek recognition of tax-exempt status as charitable organizations; perhaps the best-known example is the Mayo Clinic. These types of physician organizations are organized and operated in a manner designed to secure charitable status, in many instances by carrying on activities that the IRS has approved for hospitals and other types of charitable healthcare providers.

Although the IRS has recognized charitable status for a significant number of physician clinics, as of yet there is no established guidance, formal or informal, specifying the conditions that must be satisfied in order for a physician clinic to obtain recognition of exemption. The closest thing to guidance in this area is the published IRS positions regarding faculty practice plans[3] and medical foundations in an integrated delivery system context.[4]

It is possible, however, to discern the IRS's views on tax exemption for physician clinics by reviewing treatment of physician clinics to date[5] and by considering the IRS's analysis of physician organizations in the context of integrated delivery systems. Historically, physician clinics that have been recognized by the IRS as charitable organizations have included within their activities medical education and training, medical research, charity care, community service, and a mechanism for ensuring reasonable physician compensation.[6] Many of these clinics were organized as professional corporations; their boards of directors consisted entirely of physicians employed by the professional corporation. This business form was often necessitated by the corporate practice of medicine doctrine of the state of incorporation, where only professional corporations of physicians are allowed to engage in the practice of medicine.

Other physician clinics were organized as nonprofit corporations. To effectuate this form of organization, the physicians voluntarily donated all of their assets to the nonprofit corporations, including their right to future profits of the clinics through dividends and appreciation of the assets, and received no consideration in return. Not surprisingly, these physicians sought total control of these organizations through the governing body, in return for their having relinquished their financial interests in their medical practices.

In reviewing the IRS's historical treatment of physician clinics seeking exemption, a leading healthcare tax practitioner compiled a list of eight factors considered by the IRS in reviewing exemption applications:

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2. Rev. Rul. 69-266, 1969-1 C.B. 151 (organization formed and controlled by individual physician who transferred assets to the organization and was employed by it to conduct ''research programs'' consisting of examining and treating patients unduly served private interests and was not entitled to exempt status).
3. *See* Gen. Couns. Mem. 38394 and *infra* § 12.2.
4. *See* Chapter 23.
5. *See*, in general, Bromberg, ''The Tax-Exempt Clinic,'' 8 *Exempt Orgs. Tax Rev*. 557 (Sept. 1993).
6. *Id*. at 562.

(1) a commitment to provide medical care in both an outpatient and inpatient setting to all patients seeking the clinic's services, without regard to ability to pay;

(2) in many cases, functioning as a regional medical center, and operating numerous satellite facilities, sometimes consisting of only one or two physicians, in rural medically underserved areas that would otherwise lack any physician in the community;

(3) an active role in medical education, with a substantial proportion of [the clinic's] medical staff holding faculty appointments at the nearest medical school;

(4) the active participation of some of the physicians on the clinic's medical staff in medical research, with many of these clinics making important contributions to medical science and the prevention, diagnosis or alleviation of disease;

(5) a compensation program that does not base compensation solely on a physician's billings, but rather on the physician's total contribution and productivity, including such elements as patient satisfaction, medical education, community service, etc. (which differs from the normal for-profit group practice approach, which generally bases compensation of physicians on the amount of the billings);

(6) a commitment to limit physician compensation to reasonable compensation through an annual review by an independent auditor using available surveys on physician compensation to insure that reasonable compensation is not exceeded;

(7) the establishment of some form of community or public advisory committee made up primarily of non-physician members of the community interested in the community's medical care, which committee is designed to provide input on the community's health care needs, as well as oversight on the reasonableness of the compensation paid by the clinic to its employees; and

(8) governing instruments that prohibit inurement through the payment of dividends or otherwise, and the realization of any appreciation on the disposition of any stock or interest held by the physician in the clinic (if in the form of a professional or stock corporation) and the dedication of all the clinic's net assets exclusively to charitable, educational and scientific purposes.[7]

Two developments concurrent with the IRS's review of tax-exempt physician organizations have caused the IRS to view differently the criteria for exemption for these organizations: (1) the completion of a two-year study by the IRS Office of Chief Counsel regarding the appropriate criteria for exemption of nonprofit clinics, and (2) the review by the IRS of requests for recognition of exemption by organizations using the foundation model integrated delivery system.[8] Three issues in particular have been raised by the IRS in reviews

7. Bromberg, ''Tax-Exempt Clinics Should Not Be Covered by Independent Board Requirements,'' 10 *Exempt Orgs. Tax Rev.* 361 (Aug. 1994).
8. Bromberg, *supra* note 5, at 557.

of matters pertaining to tax-exempt physician clinics: (1) the description of purposes in the physician organization's articles of incorporation, (2) the business structure of the physician clinic, and (3) the degree of physician control over the clinic's board of directors.[9]

The IRS is of the view that the traditional clause in a professional corporation's articles of incorporation—that its purposes are to engage in the practice of medicine—does not state a charitable purpose sufficient to satisfy the organizational test requirement of the Code. Evidently, the IRS prefers to see language that is broader in scope and that specifically limits the physician clinic to practicing medicine exclusively for charitable purposes in a manner that will benefit the community.

The IRS generally takes the position that a professional corporation is an inappropriate vehicle for a physician organization that wishes to obtain recognition of charitable status. The IRS's concern is that state corporation laws overly favor the physician shareholders of the professional corporation. This position makes sense, but it runs counter to the IRS's position permitting faculty practice plans organized as professional corporations to be recognized as tax-exempt.[10]

However, the IRS's views have apparently evolved in favor of a more flexible analysis. Presumably following its approach taken with regard to medical foundations established in integrated delivery systems, the IRS has issued determination letters recognizing tax-exempt status, as charitable organizations, for physician clinics.[11] They are noteworthy in that the IRS recognized exemption for the organizations even though they were organized as for-profit professional corporations or had governing boards consisting entirely of physicians.

In one determination letter, for example, the IRS recognized exemption for a for-profit professional corporation serving as the physician component of an integrated delivery system.[12] In the letter issued to Alliance Medical Group, P.C. (AMG), the IRS recognized that under the appropriate circumstances, a for-profit organization may be operated solely in furtherance of charitable interests notwithstanding its underlying operational structure. Specifically, AMG was organized by Memorial Health Alliance Inc. (MHA), a charitable parent company of an integrated delivery system that includes AMG as the physician component, and Memorial Hospital of Burlington County, also a charitable organization, as the hospital component.

9. *Id*. at 558–561.
10. *Id*. at 559. *See infra* § 12.2.
11. Marietta Health Care Physicians, Inc. (Oct. 3, 1995); C.H. Wilkinson Physician Network (June 19, 1996); Physicians Network P.C. (Oct. 28, 1996); North Shore Medical Specialists S.C. (Dec. 2, 1996). The IRS subsequently issued several favorable determination letters recognizing charitable status for physician clinics organized as for-profit professional corporations.
12. Determination letter issued to Alliance Medical Group P.C. (Dec. 10, 1998).

Under New Jersey law, AMG was limited to incorporating its medical practice as a for-profit professional corporation. Further statutory constraints included a corporate practice of medicine doctrine prohibiting MHA from owning stock in AMG as a professional corporation. To ensure that AMG operated exclusively in furtherance of a charitable purpose, AMG's charter was limited to activities and a business purpose that complied with IRC § 501(c)(3). In the same vein, AMG's bylaws restricted the shareholders' legal title in AMG to benefit MHA only and barred the distribution of any profits or dividends. Through a shareholder's agreement, AMG shareholders were obligated to appoint individuals named by MHA as AMG's officers, provide MHA advance notice of any intended actions, and refrain from voting until they received MHA's approval, among other things. These requirements also extended to a shareholder's voting rights as a board member. Still other restrictions were imposed through a conflict-of-interest policy as well as a management agreement between AMG and Alliance Medical Management Inc., a public charity designated to manage AMG's operations.

In light of these restrictions, the IRS reasoned that MHA's control over AMG was such that AMG would clearly operate in furtherance of a charitable purpose. Interestingly, although AMG's board composition was limited to physicians who were shareholders and employees of AMG, the IRS opined that AMG still achieved a broad community representation by virtue of MHA's board dynamic, which effectively controlled AMG's operations. Of course, the IRS included its standard caveat, conditioning the ruling on the absence of any violation of the federal antikickback statute and self-referral provisions of the Social Security Act.

The determination letters also shed light on the IRS's views regarding physician compensation plans. In the letter to Marietta Health Care Physicians, the IRS examined, among other things, the incentive compensation arrangements for the physicians. The IRS noted that the physicians' salaries were based on comparable compensation earned by physicians practicing in the community and that third-party surveys were used to determine the normal range of salaries for physicians in their given specialties. The physicians' compensation included a cap or ceiling based on reasonable compensation for the specialty. The physicians' employment agreements provided that the physicians received a base salary plus a productivity bonus. The bonus was calculated on total revenues generated by the physicians and any nurse practitioners working directly under the physicians' supervision.

In determining the amount of the bonus, the following factors were considered:

1. Quality of care being provided by the physician to the patient was not diminished during the period covered by the bonus.

2. The total compensation, the base, the bonus, and other physician benefits were reasonable.
3. Eligibility to receive incentive compensation was based on certain community benefit criteria such as the number of Medicare and Medicaid patients treated, number of charity care patients treated, participation in community education and scientific programs, plus traditional factors such as efficiency, quality of care, intensity of services required, patient satisfaction, hours worked, and level of experience and expertise required.

In the determination letter issued to the C.H. Wilkinson Network, which had a board comprised entirely of licensed physicians actively engaged in the practice of medicine, the IRS ruled that the Network qualified for exemption as a charitable organization. The IRS noted, of the Network's compensation for physicians, that the physician board employed a ''Network Board Physician Compensation Committee'' for the purpose of establishing, evaluating, and administering physician compensation. The committee consisted of at least one senior management representative of the Network's parent (a religious hospital operating company), as well as one representative of senior management from each of the parent's affiliated entities where it employed physicians from the Network, and other nonphysician representatives as selected by the board's president. The committee was responsible for evaluating and implementing appropriate compensation levels based on national surveys. It represented that all compensation—including base, benefits, and incentives—would be at fair market value and would be comparable to compensation received by other similar physicians in the geographical area.

The Network's physician employment contracts that contained incentive compensation also included caps in that compensation. In addition, contracts involving incentives based on revenues were based on revenues generated by the physician and/or medical personnel working directly under the physician's supervision. The organization represented that it would be careful in any compensation arrangement to have the criteria or standards measured so that they did not penalize physicians who perform charitable services that generate little or no revenues. The compensation program was structured to recognize charitable or community aspects of the physicians' employment with an exempt healthcare provider, such as serving Medicaid or charity care patients, and providing education programs.

In another determination letter recognizing status as a charitable organization for a physician clinic, the IRS concluded that the North Shore Medical Specialists clinic was operated for the benefit of and provided an essential service to a medical center that is a charitable organization. The IRS paid close attention to the physician employment agreements. Under the employment agreements, bonuses were a direct function of the physicians' productivity

and time devoted to providing medical care to their patients. The bonuses were determined regardless of the nature of the patient, the ultimate payor, or whether payment was ultimately received. Based on independent third-party surveys, the physicians' total current compensation was comparable to the compensation earned by other internal medicine physicians.

The impact of these determination letters is to reinforce the importance of those facets of an acceptable physician compensation plan previously identified by the IRS. These include caps on overall compensation to ensure reasonableness, the use of independent surveys as a benchmark, and recognition of services beyond provision of direct patient care (e.g., charity care, research, education, and other community benefit-oriented services).

In contrast, these determination letters also reinforce the ability of an exempt organization to include in its incentive compensation plans recognition of efficiency and productivity, quality of care, patient satisfaction, hours worked, and level of experience and expertise. It is also significant that these plans included bonuses calculated on total revenues generated by the physician. These determination letters provide continuing support for this type of revenue-sharing arrangement.

§ 12.2 TEACHING HOSPITAL FACULTY ORGANIZATIONS

An organization similar to a tax-exempt physician clinic is the teaching hospital faculty organization, commonly referred to as a ''faculty practice plan.'' Like tax-exempt clinics, teaching hospital faculty organizations are organized and operated for charitable, educational, and scientific purposes. They collect fees for the services of their physician members and disburse some portion of the fees collected to the physicians as salaries and benefits. The primary distinction between tax-exempt physician clinics and teaching hospital faculty organizations is that the latter have a close nexus with a university and hospital, each of which also qualifies as a charitable organization. In addition, a university official generally has significant input and/or control over the compensation paid to the physician members. The nexus between the teaching hospital faculty organization and the university and hospital enables these organizations to qualify for exemption through use of the integral part theory, which is unavailable for use by independent tax-exempt clinics.

The IRS generally concedes that faculty practice plans are engaged in activities that accomplish charitable, educational, and scientific purposes. It also generally concedes that such organizations promote health in the community. However, the IRS had refused to recognize exemption for these organizations as charitable entities because of the IRS's strongly held view that such organizations are operated for the private profit of their members and therefore cannot qualify for exemption. From 1979 through 1981, the IRS argued this position before the Tax Court in three separate cases involving

faculty practice plans organized (1) as a nonprofit corporation, (2) pursuant to state statute, and (3) as a professional service corporation. In each of these three cases, the Tax Court rejected the IRS's position and held that such organizations are entitled to recognition of exemption as charitable organizations.

In the first of these cases,[13] the petitioner was a nonprofit incorporation of the department of anesthesiology of the Boston Hospital for Women. The faculty practice plan was also affiliated with Harvard University Medical School, and both the hospital and the medical school were charitable organizations. The plan was composed of and controlled by its members, all of whom were staff physicians of the anesthesiology department as well as faculty members of the medical school. For the most part, however, control over the organization rested with the chairman of the department of anesthesiology.

The physician members of the organization provided to the department of anesthesiology all of their services, which included the conduct of research and the practice of anesthesiology as needed by the hospital's patients. They also provided clinical and classroom instruction to the medical school students and the hospital's interns and residents. The physicians served all hospital patients without regard to ability to pay; in fact, more than 10 percent of the patients they treated did not pay for their services.

The organization billed the hospital's patients or their insurance carriers directly for services rendered by the member physicians. A large percentage of the receipts was applied toward the physicians' salaries. In addition, the physicians received an academic salary paid by the hospital. The remainder of the receipts were used to cover departmental and hospital costs.

The distributions to the physicians were limited by the medical school to twice the maximum academic salary that the physicians could be paid. The court noted, however, that the physicians could earn considerably more in private practice. The court found no direct correlation between the gross receipts of the organization and the salaries paid to its physician members. The IRS, while conceding that the organization was engaged in charitable activities, contended that the organization was operated for the private benefit of its member physicians and therefore could not qualify for exemption.

The court stated that the payment of reasonable salaries does not defeat the exemption of an organization that otherwise qualifies for that status. In determining whether the salaries constituted reasonable compensation, the court instructed the IRS to look at all the facts and circumstances surrounding the organization's operations, including whether comparable services would cost the same if they were obtained from an outside source in an arm's-length transaction, and whether the salary would qualify as an expense deduction under the Code. The court also noted that it must be determined whether the physicians are receiving other private benefits from the organization, such as noncash benefits, which could also constitute impermissible private benefit.

13. *B.H.W. Anesthesia Foundation, Inc. v. Commissioner*, 72 T.C. 681 (1979).

The court concluded that, based on the administrative record, the salaries paid to the physicians were reasonable.

The court found that nothing in the record indicated that the organization was simply the incorporation of the private medical practice of the physician members. Rather, it was the incorporation of a department of an otherwise exempt hospital and it served the hospital's patients and benefited the hospital generally. As a result, the court held that the physician organization was not operated for the profit or private benefit of its members and that it qualified as a charitable organization.

The IRS did not take this defeat lying down. A year later, it came before the Tax Court in a similar case in which the physician organization was composed of all of the faculty members of the medical school, not merely a single department of a hospital.[14] Unlike the physician organization in the prior case, the University of Massachusetts group practice was created pursuant to state statute to serve as a component of the University of Massachusetts Medical School and its teaching hospital, the University of Massachusetts Hospital at Worcester. As in the earlier case, the Tax Court found that the organization was organized and operated as an integral part of the medical school and the hospital.

The physician members of the faculty practice plan devoted 60 percent of their time to teaching and research and 40 percent to clinical duties involving patient care. Even the patient care activities, however, were a part of the teaching function of the hospital. The physicians were treated as employees of the Commonwealth of Massachusetts and were thereby subject to state conflict-of-interest laws that prohibited them from directly billing patients or their insurers. Under the state law governing the creation of the faculty practice plan, the group practice billed patients for services rendered by the physicians, although all patients were treated without regard to their ability to pay.

The fees collected were deposited in a trust fund and could be disbursed only in accordance with purposes identified in the statute, for example, administrative costs, improvement and development of the medical school, and compensation and fringe benefits for physician members. The revenue generated from patient care through the clinical departments in the hospital was reallocated: departments that generated higher payments from patient care subsidized those that generated lower payments. Revenues were also used to support the medical school faculty, community programs, and scientific research.

In addition to the disbursements from the trust fund, the participating physicians received an annual base salary from the university. Total annual compensation was not permitted to exceed two and one-half times the maximum allowable base salary established for the appropriate faculty rank by

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14. *University of Massachusetts Medical School Group Practice v. Commissioner*, 74 T.C. 1299 (1980).

the university's board of trustees. The court noted that there was no direct correlation between patient care fees generated by the physicians and the salaries they received.

The IRS's primary argument was that the purpose of the group practice was to collect fees and return them to the physician members. As a result, the IRS contended, the group practice failed the organizational and operational test of the Code because the practice served private rather than public interests.

The Tax Court found that the total salary paid to the physicians was reasonable and that the fact that the trust fund was used for compensation purposes did not detract from the group practice's exempt purpose of enhancing the clinical education of the medical school. The court stated that:

> By organizing the clinical faculty of the medical school into a cohesive group, and by promoting an efficient mechanism for the collection of fees charged to the patients of the University hospital for services rendered by the clinical faculty, petitioner effectuates its exempt purpose of promoting and improving the education received by students of the medical school.[15]

The court formally followed its holding and reasoning in the prior case and found that, if anything, the facts of this case were even more supportive of tax-exempt status for the group practice because of the increased public scrutiny and outside control that resulted from the group practice's organization under a special act of the Massachusetts legislature as part of a state university.

Still not convinced, the IRS again argued its position before the Tax Court in a third case.[16] The primary distinction between this case and its predecessors was that the faculty practice plan at issue was organized as a professional service corporation. All of its stockholders (who were its employees) were physicians on the clinical staff of a teaching hospital operated by the University of Maryland and full-time members of the faculty of the university's School of Medicine. The corporation consisted of four departments of the medical school and—in addition to the provision of medical care—was empowered to provide academic and clinical instruction of medical students, medical research, and ancillary administrative services solely for the benefit of the medical school and the teaching hospital.

The financial support of the organization was derived from the receipt of fees for medical care performed by its physician employees at the teaching hospital; approximately 25 percent of the billable value of the services performed by the physicians was rendered to patients who were unable to pay and were not required to pay for the services.

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15. *Id*. at 1306.
16. *University of Maryland Physicians, P.A. v. Commissioner*, 41 T.C.M. 732 (1981). Curiously, the IRS refused to acquiesce in the *B.H.W. Anesthesia Foundation* case (1980-40 I.R.B. 5 (Oct. 6, 1980)), but it did acquiesce in the *University of Massachusetts Medical School* case (1980-52 I.R.B. 6 (Dec. 29, 1980)).

Rejecting the position of the IRS, the court found that the corporation was organized and operated for charitable, educational, and scientific purposes, in that it, in part, ''delivers health care to the general public.'' Other exempt activities were held to be the rendering of services without charge to the indigent; provision of clinical training to the students, interns, and residents of the medical school; and medical research for the advancement of the healing arts. The fact that the organization was authorized to engage in the general practice of medicine did not deter the court, in that the organization's activities were limited to serving the interests of the medical school and hospital involved; thus, it was not authorized to practice medicine for profit.

The court also excused the form of the professional corporation, rationalizing it as necessary because it is the only corporate entity permitted to practice medicine in Maryland. Further, the court tolerated the existence of stockholders and dismissed the fact that each shareholder was entitled to receive the par value of his or her single share ($1.00) in the event of dissolution as being insubstantial and thus not a violation of the rule requiring dedication of assets for a charitable purpose. Perhaps venting its frustration over the IRS's dogged pursuit of this issue, the court stated: ''[p]ut in perspective, and looking only at where the money goes, it is hard to see what troubles respondent about this case. . . . We just do not see the harm.''[17]

Consequently, on the basis of these decisions, it appears that teaching hospital faculty organizations are tax-exempt, even though they generate fees for the performance of medical care services and, in some cases, pay the resulting earnings to individuals who are their stockholders. Unlike freestanding tax-exempt physician clinics, they are able to rely on their close relationship with an exempt medical school and teaching hospital to strengthen their claim for tax exemption. The IRS may seek to require that these organizations be organized as nonprofit corporations (when they are separately incorporated) in the future, but, given the IRS's track record before the Tax Court on this issue, it seems unlikely that it would prevail if the issue were litigated.

17. 41 T.C.M. at 738.

C H A P T E R   T H I R T E E N

Other Provider and Supplier Organizations

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§ 13.1 BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

The Blue Cross and Blue Shield associations (Blues) and comparable organizations constitute a general category of entities known as *prepaid healthcare plans*. These are voluntary plans that provide individuals or groups with a vehicle by which medical expenses are prepaid. The individual or group pays a fixed fee with the understanding that, when the need for hospitalization or other medical services arises, the prepaid healthcare plan will either cover the costs or provide the needed service. The individuals who are served by these plans are known as *subscribers* or *members*; these plans do not provide benefits or services other than on a fee-for-service basis.

Historically, the Blues, as well as other prepaid healthcare plans, were categorized as tax-exempt social welfare organizations.[1] The history of how that status developed, and how Congress subsequently decided to repeal tax exemption of these entities and how several states intervened to prevent the conversion of these organizations to mutual insurance companies, is summarized below.[2]

1. *See* § 1.8.
2. *See*, in general, FY 1991 Internal Revenue Service Continuing Professional Education Technical Instruction Program Textbook, section L (hereinafter, ''FY 1991 IRS CPE Text'').

(a) Historical Background

The largest of the early prepaid healthcare plans, and a predecessor to the Blues, was created by Dr. Justin Ford Kimball, executive vice president of Baylor University in Texas, as part of an effort to resolve the problem of numerous unpaid medical bills of teachers at that university.[3] The Baylor Plan and other early prepaid healthcare plans soon faced inconsistent treatment by state insurance regulators. Some regulators believed that the plans were subject to the insurance laws; others ruled that the plans were service contracts and thus were not subject to the legal requirements of insurance.[4]

In response to these problems, the American Hospital Association (AHA) and other local hospital organizations sought, in various state legislatures, special enabling legislation that would treat prepaid healthcare plans differently from insurance companies. The AHA eventually acquired the special enabling legislation that provided certain prepaid healthcare plans with several privileges, including exemption from the general insurance laws of the state, status as charitable and benevolent organizations, and tax exemption. The justification for the special legislation was the promise that the prepaid healthcare plans would service the community[5]—in particular, low-income families.[6]

The best known of the early service benefit plans is Blue Cross, which was created by the AHA in response to the need for medical care during the Great Depression. During this period, there was a growing recognition of the need for some mechanism by which middle-income individuals could finance the extraordinary costs of hospitalization, particularly since hospital insurance was virtually nonexistent at the time.[7] This need to provide hospitalization coverage for people of moderate means, coupled with the need for a stable source of

3. ''Prepayment and Hospital,'' *Bull. AHA*, cited in LAW, BLUE CROSS: WHAT WENT WRONG? 7 (1974) (Law).
4. During the creation of the early prepaid healthcare plans, many commercial carriers did not believe that medical care coverage could satisfy the requirements for an insurable hazard and that any coverage provided would not be insurance. Law, *supra* note 3, at 11. To be classified as insurance, it has been customarily held that an insurance hazard should embody the following principles: (1) there should be a large and homogeneous group of risks; (2) the potential loss should be definite and measurable; (3) the loss should be fortuitous, unexpected, and uncontrolled; (4) the loss should be serious in nature; and (5) risks should be widely disbursed and not subject to catastrophic loss. The insurance industry was wary of hospitalization insurance during its initial stages because there was a question whether the medical expenses hazard could meet the second, third, and fifth principles. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 13 (1963), *cited in* FY 1991 IRS CPE Text at 261.
5. The earlier plans were community-rated, that is, they provided benefits to all members of the community at the same rate.
6. Law, *supra* note 3, at 7.
7. Richardson, ''The Origin and Development of Group Hospitalization in the United States, 1890–1940,'' 20 *Missouri Studies* (3), at 15–18 (1945), cited in Law, *supra* note 3, at 6.

income for hospitals, also served as the impetus for the creation of many other early prepaid healthcare plans.[8] The Blues and many other plans, however, were not charitable entities, principally because they confine the provision of their services to those who paid for them—their subscribers—rather than to any charitable class.

(b) Exemption as Social Welfare Organizations

In recognition of the fact that the Blues were operated on a nonprofit basis and were providing healthcare coverage that was then virtually nonexistent in the commercial field, the IRS determined that the Blues were exempt from federal taxation as social welfare organizations, although the rationale and criteria underlying this classification have never been fully articulated.[9]

The statutory basis for tax exemption for social welfare organizations[10] is somewhat of an anomaly. This is because the provision has been used by the IRS over the years as a catch-all category to provide tax exemption for organizations that seemingly warrant tax-exempt status but that do not fit any other exemption classification provision in the Internal Revenue Code.[11]

Consequently, the fact that a Blues organization, or any other prepaid healthcare plan, was once accorded designation as a social welfare organization should not be given too much weight in judging whether it had attributes of a social welfare nature. The rationale for tax exemption of prepaid healthcare plans was initiated in the 1930s, considerably before a variety of IRS rulings and court options introduced more specific requirements for exemption as a social welfare organization. One commentator speculated that the early plans, ''in an effort to accommodate the hospital organizations, were intentionally placed under a statute broad enough to encompass their activities.''[12]

Whatever the historical origins for tax exemption for the Blues and other prepaid healthcare plans as social welfare organizations, it is quite clear that, under the subsequently evolved law, they did not so qualify. This body of law is the tax regulations, IRS rulings, and court opinions issued after these plans began being treated as social welfare organizations and before the statutory elimination of tax exemption for these plans in 1986.[13]

Fundamentally, the tax regulations require that an exempt social welfare organization be ''primarily engaged in promoting in some way the

8. McGovern, ''Federal Tax Exemption of Prepaid Health Care Plans,'' 7 *Tax Advisor* 76 (1976).
9. *See* Gen. Couns. Mem. 39828.
10. *See* § 1.8.
11. ''This important exemption . . . is a catch-all provision . . .'' (Amdur, ''Tax Exemption of Social Welfare Organizations,'' 45 *Taxes* 292 (1967)); IRC § 501(c)(4) ''has long been recognized as a place to put organizations which really shouldn't be taxed, but which don't exactly fit under any other section of the Code'' (McGovern, *supra* note 8, at 77).
12. *Id*.
13. See § 13.1(c).

common good and general welfare of the people of the community.''[14] This is a type of community benefit standard, which posits a *community* as being somewhat akin to a political subdivision. A number of organizations that have been denied status as social welfare organizations, such as condominium associations and associations of residents of cooperatives, experienced that fate because the IRS determined that they failed to serve a requisite community.

Yet a Blues plan serves only its members—its subscribers who receive services because they paid for them. It is by no means clear that this type of grouping of individuals constitutes a requisite community. For example, a court in 1970 held that a trust established to provide group life insurance for members of an association could not qualify as an exempt social welfare organization.[15] Likewise, the IRS subsequently ruled that a mutual sick and death benefit society, which provided benefits to members of an ethnic group, could not be classified as an exempt social welfare organization because the benefits are ''limited to that organization's members (except for some minor and incidental benefit to the community as a whole).''[16]

This type of benefit, rather than being some form of community benefit, seems to be more akin to a form of private benefit.[17] As a general rule, tax-exempt status for organizations that principally provide services to their members is confined to trade and business associations,[18] social clubs,[19] veterans' organizations,[20] and homeowners' associations.[21] Indeed, the IRS ruled that a homeowner's association could not qualify for exemption as a social welfare organization unless it overcame a presumption that it was being operated for a private benefit.[22] A court concluded that tax exemption of a prepaid healthcare organization as a social welfare entity should be revoked, in part because it was not serving a community but rather only its subscribers/members.[23]

There is a third aspect of this matter of the Blues failing to meet the standards of social welfare organization status: *commerciality*.[24] A fundamental concept is that an entity cannot be a tax-exempt one if its primary functions

14. Reg. § 1.501(c)(4)-1(a)(2)(ii).
15. *New York State Association of Real Estate Boards Group Insurance Fund v. Commissioner*, 54 T.C. 1325 (1970).
16. Rev. Rul. 75-199, 1975-1 C.B. 160.
17. ''The community benefit concept is somewhat contradicted by a related concept of services to members'' (McGovern, *supra* note 8, at 77).
18. IRC § 501(c)(6) entities. *See* Chapter 18.
19. IRC § 501(c)(7) entities.
20. IRC § 501(c)(19) entities.
21. IRC § 528 entities.
22. Rev. Rul. 74-99, 1974-1 C.B. 131.
23. *Vision Services Plan v. United States*, 2006-1 U.S.T.C. ¶50,173 (E.D. Cal. 2005) (affirmed by to the U.S. Court of Appeals for the Ninth Circuit).
24. In general, *see* § 24.20.

are commercial and profit-making in nature.[25] Thus, in the social welfare organization context, the tax regulations state that an organization is not "operated primarily for the promotion of social welfare if its primary activity is . . . carrying on a business with the general public in a manner similar to organizations which are organized for profit."[26]

In 1986, Congress decreed that what the Blues and similar plans were doing was participation in the realm of commercial insurance.[27] This development obviously means that these plans were engaging in commercial activities in years prior to 1986. If these plans were engaging in commercial, competitive insurance operations, they were in violation of the rule prohibiting the carrying on of a business in a manner similar to for-profit organizations.

This matter of commerciality is another factor to be evaluated when considering the requirement of community benefit. If commerciality is the primary function and objective of a prepaid healthcare plan, any social welfare aspects of the operations are relegated to incidental activity. It would seem that for-profit operations and private benefit are the driving forces in this setting, not community benefit and social welfare.[28]

Therefore, the pigeonholing by the IRS of the Blues and like plans in the category of a tax-exempt social welfare organization is probably best viewed as a historical quirk, an administrative action taken by the federal tax authorities as a matter of convenience. It worked for a while because of an absence of pertinent law. In hindsight, this classification for tax purposes is difficult to justify.

This means that the fact a Blues organization was treated by the IRS for years as an exempt social welfare entity should not be given undue weight. That is, this classification for tax exemption purposes ought not to be used as a springboard to the conclusion that these organizations in fact were always tax-exempt social welfare organizations.

(c) Changes in Operations

Over the years, however, the Blues changed their mode of operation in two important respects. In the process, they erased two of the key characteristics that had at one time distinguished them from commercial insurance carriers.

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25. E.g., *Living Faith, Inc. v. Commissioner*, 950 F.2d 365 (7th Cir. 1991). To date, the courts have applied the commerciality doctrine only in connection with charitable organizations; the IRS, on one occasion, asserted that the doctrine is also applicable to tax-exempt social welfare organizations (Priv. Ltr. Rul. 200501020).
26. Reg. § 1.501(c)(4)-1(a)(2)(ii).
27. See § 13.1(d).
28. It has been argued that service benefit plans like the Blues were not promoting health in the traditional sense (*see* § 1.7) because they do not directly provide medical care but instead are merely responsible for the payment of bills received for medical services (FY 1991 IRS CPE Text, at 166). One IRS ruling noted that prepaid health plans can avoid classification as insurance companies for federal tax purposes because they issue service contracts rather than indemnities (Rev. Rul. 68-27, 1968-1 C.B. 315).

First, the Blues increasingly began to offer subscribers indemnity rather than service contracts.[29] Second, most of the Blues abandoned their commitment to community rating (in response to pressure from organized interests for experience rating) and began offering group experience–rated contracts that based the charges for medical care on the risk level of the group.[30] Based on this latter change, low-income persons and the aged were charged more because they were considered to be high-risk groups.

As the Blues and other service plans eliminated practices such as open enrollment and community rating, and thus became more like commercial insurance carriers, commercial insurance carriers began to object to the competitive cost advantage that tax exemption provided to the Blues. Over time, some commentators also began to question the tax-exempt status of the Blues and other prepaid healthcare plans, suggesting that many of these plans no longer met the requirements for tax exemption as social welfare entities.[31]

(d) Taxation under Insurance Rules

In light of their changes in operation and the complaints from commercial insurance carriers, Congress concluded that the Blues' operations paralleled those of commercial carriers and that they, along with other service benefit plans, should be subject to taxation to the same extent as commercial insurance carriers.

Congress's look at the Blue Cross and Blue Shield organizations' exemptions served as the impetus for the enactment, in 1986, of a provision subjecting the Blues and similar prepaid healthcare plans to taxation,[32] but made an express exception for HMOs. At the same time, Congress enacted another provision, which contains specific rules regarding the taxation of ''existing Blue Cross and Blue Shield organizations'' and certain other health insurance entities.[33]

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29. *See* Somers & Somers, Doctors, Patients, and Health Insurance 304 (1961).
30. Law, *supra* note 3, at 12.
31. McGovern, *supra* note 8.
32. IRC § 501(m). In general, Shill, ''Revocation of Blue Cross & Blue Shield's Tax-Exempt Status an Unhealthy Change? An Analysis of the Effect of the Tax Reform Act of 1986 on the Taxation of Blue Cross & Blue Shield and Health Insurance Activities,'' 6 *Boston U.J. Tax L.* 147 (1988); FY 1991 IRS CPE Text, at 269.
33. IRC § 833. An ''existing Blue Cross or Blue Shield organization'' means any Blue Cross or Blue Shield organization if (1) it was in existence on August 16, 1986; (2) it is determined to be exempt from tax for its last taxable year beginning before January 1, 1987; and (3) no material change has occurred in the operations of the organization after August 16, 1986 and before the close of the taxable year. IRC § 833(c)(2).

    On September 24, 1992, the IRS issued final regulations providing rules relating to the removal of the tax-exempt status of organizations described in IRC § 833 (T.D. 8438). These rules were needed because, as the result of the removal of tax-exempt status for these entities, they became includible corporations (IRC § 1504(b)). As a result of an IRC § 833 organization's becoming the new common parent of an existing consolidated group

In essence, these rules provide that an otherwise tax-exempt social welfare organization will lose or be denied tax exemption if a substantial part of its activities consists of the provision of *commercial-type insurance*.[34] Otherwise, the activity of providing commercial-type insurance is treated as the conduct of an unrelated trade or business[35] and is taxed under the rules pertaining to taxable insurance companies.[36] These rules are also applicable to tax-exempt charitable, educational, religious, and similar organizations.

The term *commercial-type insurance* generally refers to any insurance of a type provided by commercial insurance companies.[37] For example, an organization was held to not qualify as a tax-exempt social welfare organization because its sole activity was the provision of certain benefits to students in a school who are injured in the course of school-related activities. The coverage was declared similar to contingent or excess insurance coverage.[38] This term does not, however, include insurance provided substantially below cost to a class of charitable recipients; incidental health insurance, provided by an HMO, of a kind customarily provided by these organizations; property or casualty insurance provided (directly or through a qualified employer[39]) by a church or convention, or association of churches for the church or convention, or association of churches; and retirement or welfare benefits (or both) provided by a church or a convention, or association of churches (directly or through a qualified organization[40]) for the employees of the church or convention, or association of churches, or the beneficiaries of these employees.[41] This rule is also inapplicable to income from an insurance activity conducted by a political subdivision of a government.[42]

In 1990, the IRS endeavored to define the term *commercial-type insurance*, which is undefined in the statute. Following a review of tax cases defining the term *insurance*, the IRS Chief Counsel's office concluded that the definition of commercial-type insurance ''should include some form of risk-sharing and

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(Reg. § 1.1502-75(d)(1)), the old consolidated group terminated and a new affiliated group, with the organization as the new common parent, was created. Because there is no indication that Congress intended the termination of the old consolidated group and the creation of a new affiliated group as a consequence of the denial of tax-exempt status to IRC § 833 organizations, these regulations are designed to ameliorate the harsh results that would follow from termination of the old groups.

34. For a more complete discussion of IRC § 501(m), *see* § 9.3.
35. *See* Chapter 24.
36. IRC Subchapter L. The application of these rules may require organizations affected by them to change their accounting methods. The process for doing so is the subject of Rev. Proc. 87-51, 1987-2 C.B. 650.
37. H.R. Rep. No. 99-841, 99th Cong., 2d Sess. II-345 (1986).
38. Gen. Couns. Mem. 39703.
39. An organization described in IRC § 414(e)(3)(B)(ii).
40. An organization described in IRC § 414(e)(3)(A) or IRC § 414(e)(3)(B)(ii).
41. IRC § 501(m)(3).
42. Priv. Ltr. Rul. 8836038.

risk-distribution.''[43] The IRS's lawyers also said that, despite the statutory exception for HMO insurance, ''it is our opinion that in certain circumstances a health maintenance organization may be found to provide'' commercial-type insurance.''[44]

For these rules to apply, the underlying activity must be *insurance* in the first instance. For these purposes, the issuance of annuity contracts is considered the provision of insurance.[45] These rules do not apply, however, to a charitable gift annuity, which is defined for this purpose as an annuity where (1) a portion of the amount paid in connection with the issuance of the annuity is allowable as a charitable deduction for federal income or estate tax purposes, and (2) the annuity is described in the special rule for annuities in the unrelated debt-financed income provisions[46] (determined as if any amount paid in cash in connection with the issuance were property).[47]

(e) Conversions

Some Blues organizations have converted, or are in the process of converting, to for-profit entities, such as mutual insurance companies. Nonetheless, their basic operations do not change, in that they continue to provide health insurance to their policyholders in exchange for the payment of premiums. Their revenues continue to be used to provide or pay for hospital and physician services rendered to subscribers.

Various state attorneys general have asserted that the Blues organizations have been, over the decades, operating for *charitable* purposes, so that these entities are either inherently charitable entities or have assets that should be impressed with a charitable trust and thereby preserved for charitable purposes.[48] This position has been taken in an effort to block conversions or force the establishment of charitable foundations using some of the proceeds of the conversion. The approach of these attorneys general rests in part on a confusion of the concepts of *nonprofit* organizations and *tax-exempt* organizations,[49] coupled with a questionable admixture of different categories

43. Gen. Couns. Mem. 39828.
44. *Id*.
45. IRC § 501(m)(4).
46. IRC § 514(c)(5). In general, *see* § 24.17.
47. IRC § 501(m)(3)(E) and (m)(5). Charitable gift annuities are the subject of Chapter 14 of CHARITABLE GIVING.
48. The litigation concerning the conversion of charitable hospitals (*see* § 21.3) has superficial similarity to the cases involving the conversion of Blues entities, in that both sets of litigation concerned nonprofit organizations and both were in the healthcare context. The major difference, however, is that these hospitals clearly were charitable organizations under federal and state law, in terms of their programs and their practices of soliciting and receiving charitable contributions. Nonetheless, the states' successes in the charitable hospital conversion context appear to have been a major impetus for the initiation of litigation against the Blues organizations.
49. *See* § 1.1.

of exempt organizations. As to the latter, the attorneys general argued that, inasmuch as the organizations were *social welfare* organizations, they are also charitable organizations because the *promotion of social welfare* can be a charitable purpose.[50]

Notwithstanding the attorneys general litigating positions, state law was often clear that these plans were not charitable organizations. In one case, a court wrote that the organization (a hospital service association) was ''engaged in the insurance business for the advantage and convenience, if not profit, of the participating hospitals and the subscribers to said contracts'' and was ''not engaged in dispensing charity to anyone.''[51] In another instance, a court wrote that a Blue Cross/Blue Shield entity ''sold insurance to people who paid premiums to become policyholders'' and ''has not been operated exclusively for charitable purposes.''[52] Another court observed that a Blues organization ''was organized to benefit its members'' and ''not only has [the organization] never had a public charitable purpose, the evidence is undisputed that with only minor exceptions, all revenues generated by [this organization] have been used to benefit its policyholders or for its own corporate purposes.''[53] Still another Blues organization, where a court noted that it ''did not enroll subscribers for free,'' was found by the court to have ''never relied on philanthropy or carried out an explicitly charitable agenda.''[54] One court stated the matter thusly: ''The hundreds of Blue Cross and Blue Shield corporations located throughout the country are all non-profit but [are] not charitable.''[55]

Nonetheless, in a majority of the cases, the Blues organizations are being found by state courts to be charitable entities or be impressed with a charitable trust, by application of state, not federal, law. In many instances, these cases

50. Reg. § 1.501(c)(3)-1(d)(2). As an example, in one of these complaints, a state attorney general made reference to the ''long tradition of Blue Cross and Blue Shield's charitable social welfare operations'' (*Commonwealth of Kentucky v. Anthem Insurance Companies, Inc. et al*. (Case No. 97-CI-01566, Franklin Circuit Court)); from a federal tax law standpoint, that statement is incorrect. In another case, the attorney general repeatedly stated that the Blues organizations involved were formed ''exclusively'' for the purpose of ''promotion of social welfare'' (*Blumenthal v. Anthem Insurance Companies et al*. (Sup. Ct., Judicial District of Hartford)); while some of these organizations' documentation referenced ''social welfare,'' nowhere was the word ''promotion'' utilized, which the attorney general gratuitously inserted to make the phraseology read more like that of the IRC § 501(c)(3) rules.
51. *Hospital Service Association of Toledo v. Evatt*, 144 Ohio St. 179, 185, 57 N.E.2d 928 (Sup. Ct. Oh. 1944).
52. *ABC for Health, Inc. & Wisconsin Coalition for Advocacy v. Commissioner of Insurance*, 640 N.W.2d 510, 515-516 (Ct. App. Wis. 2001).
53. *Abbott v. Blue Cross & Blue Shield of Texas, Inc. et al.*, 113 S.W.3d 753, 766, 768 (Ct. App. Tex. 2003).
54. *Consumers Union of U.S., Inc. et al. v. State of New York et al.*, 840 N.E.2d 68, 84 (Ct. App. N.Y. 2005).
55. *Allison v. Mennonite Publications Board*, 123 F. Supp. 23, 28 (W.D. Pa. 1954).

are settled; a consequence of the settlement is the creation of a charitable foundation.[56] It may never be known whether the states' attorneys general proffered their argument, based on the words *social welfare*, because they were genuinely confused about the twofold meaning of these words in the federal tax law or whether the attorneys general fully understood the distinction and served up a disingenuous argument designed to bamboozle the courts.

§ 13.2 HIGH-RISK INDIVIDUALS HEALTHCARE COVERAGE ORGANIZATIONS

Enactment of the Health Insurance Portability and Accountability Act of 1996[57] brought another category of tax-exempt organizations. Exempt status is available for a membership organization established by a state exclusively to provide coverage for medical care[58] on a nonprofit basis to high-risk individuals through insurance issued by the organization or a health maintenance organization under an arrangement with the organization.[59]

The individuals, who must be residents of the state, must be—by reason of the existence or history of a medical condition—unable to acquire medical care coverage for the medical condition through insurance or from a health maintenance organization, or able to acquire the coverage only at a rate that is substantially in excess of the rate for the coverage through the membership organization.[60] The composition of the membership in the organization must be specified by the state.[61] For example, a state could mandate that all organizations that are subject to insurance regulation by the state must be members of the organization.[62] The private inurement doctrine[63] is applicable to this type of organization.[64]

56. *See* § 21.3(b), text accompanied by note 65.
57. Pub. L. No. 104-91, 104th Cong., 2d Sess. (1996).
58. This term is defined in IRC § 213(d). *See* § 8.1.
59. IRC § 501(c)(26)(A).
60. IRC § 501(c)(26)(B).
61. IRC § 501(c)(26)(C).
62. H.R. Rep. 104-736, 104th Cong., 2d Sess. (1996), at 36.
63. *See* Chapter 4.
64. IRC § 501(c)(26)(D).

PART FOUR

Tax Status of Health-Related Organizations

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CHAPTER FOURTEEN

Development Foundations

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One of the most difficult and perplexing decisions facing the manager or development professional of a tax-exempt hospital (or other healthcare entity) can be whether to utilize a separate ''foundation'' for purposes of fundraising (or development or advancement). A material question is almost always asked: Why should the hospital utilize a development foundation when the hospital itself qualifies as a tax-exempt, charitable organization?[1] The answer—or answers—lies in one word: bifurcation.

Bifurcation in this context means housing, in two tax-exempt organizations, functions that would otherwise be housed in one tax-exempt organization.[2] In some instances, bifurcation is dictated by considerations of law; in others, it is a management-oriented decision.

§ 14.1 BASIC CONCEPTS

(a) Introduction

The role of a development foundation for a nonprofit healthcare institution can be most starkly seen by comparison to a development foundation for a tax-exempt, yet noncharitable organization, such as a trade, business, or professional association.

In all cases, the development foundation will be a tax-exempt, charitable organization.[3] For purposes of this analysis, it will be presumed that the

1. *See* Part Three, particularly Chapter 8.
2. This principle is also applicable in connection with the use of for-profit subsidiaries, partnerships, joint ventures, and title-holding companies. *See* Chapters 15, 16, and 22.
3. An organization that is tax-exempt under IRC § 501(a) because it is described in IRC § 501(c)(3). *See*, e.g., § 1.4.

association is a business league.[4] (Nearly all medical and dental societies have these characteristics.)

The essential purpose of the association-related foundation is fundraising. Basically, it is formed to utilize the federal income tax charitable contribution deduction.[5] This type of foundation may also obtain the tax advantage of other federal and state benefits, such as state tax exemptions for income, sales, use, and/or property taxes, and preferential postal rate classification.

The fundraising is undertaken by the foundation to advance programs of interest to the association and its members. The general public may be the ultimate beneficiaries of the programs, although it is not necessary that this be the case. In fact, in many instances, the sole beneficiaries of the foundation's programs are the members of the association.

Because the foundation is a charitable organization (in the broadest sense of that term), its programs must primarily be those that qualify as charitable, educational, scientific, or similarly focused undertakings. Consequently, the foundation's programs may consist of conferences and seminars, research, publications, and scholarships, fellowships, or awards. These programs may be conducted directly by the foundation or may be undertaken by the association and funded by the foundation.

(b) Development Foundation

A charitable foundation for a noncharitable nonprofit organization has as its principal reason for being the utilization of the charitable contribution deduction. To return to the question posed at the outset: Why then should a charitable healthcare institution establish a separate development foundation?

For the most part, the reasons underlying the charitable foundation for a charitable parent organization are not based in tax law. Both organizations are tax-exempt and are eligible to attract deductible charitable contributions.

A principal reason for establishing a charitable foundation related to a charitable healthcare institution is to concentrate the fundraising function in one entity—the foundation. This approach (the practice of hospitals, colleges, universities, schools, and other entities for decades) enables the assembly of a board of directors that clearly understands that its basic mission is fundraising. Also, the foundation can serve as a vehicle for placing donors and those who provide access to them on a governing board, where it would be impractical or impolitic to place them on the board of the parent institution.

Another practical reason for establishing a development foundation is that, by use of the word *foundation* in its name, it can be made to sound more

4. An organization that is tax-exempt under IRC § 501(a) because it is described in IRC § 501(c)(6). *See* Chapter 18.
5. Generally, contributions to IRC § 501(c)(6) organizations are not deductible. The federal income tax charitable contribution deduction for gifts to tax-exempt charitable organizations is the subject of IRC § 170(c)(2). *See*, in general, CHARITABLE GIVING.

inherently charitable than its parent. Some individuals and corporations do not perceive of a hospital or other healthcare institution as a charity; the use of a separate foundation can eliminate any uncertainty of this nature and enhance the fundraising process.

Viability in segregating income and assets from those of the parent organization is another reason for use of a development foundation. In this sense, the foundation functions as an endowment; the focus is on investment and long-range planning, rather than on the immediate expenditure of all gifts for operating purposes.

There may be some tax law advantages to this type of foundation. For example, the development foundation may be able to maintain a pooled income fund, even when the parent entity may not be able to do so.[6]

The disadvantages to the use of a development foundation include some additional overhead, books and records, bank accounts, and IRS information returns.[7]

(c) Form

The legal form of the foundation is a matter for some consideration. The foundation may be a trust or other type of unincorporated entity. In most instances, however, the foundation should be a corporation—if only as a shield against personal liability for its officers and directors.[8]

Usually, the control feature (discussed next) is easier to implement when the development foundation is a corporation. The balance of the discussion in this chapter is based on the assumption that the development foundation is formed as a nonprofit corporation.[9]

(d) Control

One organization may control another organization (or, for that matter, two or more organizations) and two or more organizations may be under common control. This is the case irrespective of whether the organizations are tax-exempt or taxable.

A development foundation usually is a *controlled organization*. As discussed, the essential purpose of a development foundation is to raise funds for the parent institution; it would not be prudent for a healthcare institution to allow a foundation to raise charitable contributions in the name of the institution, if the institution were not controlling the foundation to ensure the timely and appropriate flow of funds. In some instances, the institution and foundation will

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6. *Id*.
7. *See* § 14.2.
8. A discussion of the liability of directors and officers of a development foundation is outside the scope of this work. *See*, however, STARTING AND MANAGING, Chapter 9.
9. A discussion of the various forms that a tax-exempt organization may take appears in TAX-EXEMPT ORGANIZATIONS, at § 4.1.

technically be under common control. In either circumstance, the development foundation is legally ''related'' to the ''parent'' healthcare institution.[10]

A tax-exempt organization is usually controlled by another tax-exempt organization by means of an interlocking directorate. This control mechanism can take many forms, such as by enabling the board of directors of the parent tax-exempt organization to name at least a majority of the board of directors of the subsidiary tax-exempt organization, or by causing at least a majority of the board of directors of the subsidiary tax-exempt organization to consist of individuals holding named offices (*ex officio* positions) in the parent tax-exempt organization (for example, president, past president, or treasurer). Any combination of these or other forms is permissible (assuming no state law prohibition); the mere fact of the majority overlap of directors vests the requisite control in the parent organization.

This type of control between a healthcare institution and a development foundation is most commonly achieved by means of interlocking directorates. Again, a majority overlap of board members is required to achieve formal control in this manner.[11]

A second general technique that can be used to achieve this form of control is the membership feature. In this situation, the development foundation is organized as a corporation with a membership. The healthcare institution becomes the sole member of that corporation,[12] and has the authority to select and remove directors (and perhaps officers).

Where a tax-exempt organization is formed pursuant to a nonprofit corporation act that allows the issuance of stock, the tax-exempt organization can be controlled by another tax-exempt organization by reason of ownership of at least a majority of the stock.[13] In this situation, because control is achieved by the element of stock ownership, the composition of the board of directors of the tax-exempt subsidiary is, in a sense, irrelevant (in that the stockholder can elect and remove directors). Nonetheless, many parent tax-exempt organizations will want more immediate control over the operations of the tax-exempt subsidiary than stock ownership can provide and thus will also have a substantial representation on the board of directors of the subsidiary. With this approach, the development foundation is organized as a corporation with authority to

10. The balance of this chapter uses the term *controlled* foundation to also encompass the type of foundation that is under common control with a healthcare institution.
11. The case study in § 14.3 offers a typical example of a control mechanism in this setting.
12. There rarely is a need or opportunity for the development foundation with this structure to have a member other than the parent healthcare institution.
13. Only a few states permit stock-based nonprofit organizations. If this approach is selected and the state involved lacks this statutory authority, the foundation may be created under the law of a state allowing stock and then qualified to conduct its activities in the state in which it is to primarily function (technically, do business). This type of stock is used for control purposes only; it is not the source of dividends.

issue stock. The healthcare institution becomes the sole stockholder[14] of that corporation, and has the authority to select and remove directors (and perhaps officers).

Once assembled, the foundation's board of directors can elect the foundation's officers. Or, the officers of the foundation can be appointed by the governing board of the parent organization.

Too frequently, charitable organizations that establish related foundations make the mistake of causing the foundation's board of directors to be comprised entirely of members of the board of directors of the parent organization. One of the problems with this approach is that it eliminates a fundraising potential: the ability to add to the foundation's board those individuals who are donors and/or can provide access to donors. This approach also reduces the likelihood that others will regard the foundation as something less than a viable, somewhat autonomous organization. The best approach, therefore, is to make provision for places on the foundation's board of directors for those who are not part of the leadership of the related parent organization.[15]

(e) Acquisition of Tax Statuses

The development foundation must obtain a ruling (usually, a determination letter) from the IRS as to its tax-exempt, charitable donee, and public charity status. This is done by submitting an application for recognition of tax-exempt status (Form 1023). As part of this process, the foundation describes its anticipated program activities, summarizes its fundraising program, identifies its officers and directors, provides a multiyear budget, and explains its relationship to the parent healthcare institution.[16]

A development foundation that expects to qualify as a publicly supported organization (see below) must be certain that its financial projections are in conformance with the public support requirements (that is, project at least one-third public support over the five-year measuring period). A foundation that is seeking qualification as a supporting organization must be certain that its financial projections demonstrate adequate support to the related healthcare institution.

A foundation that is seeking qualification as a publicly supported organization will (if successful) be issued an *advance ruling* as to its non-private-

14. As with the membership feature (*supra* note 11), there is rarely an opportunity or need for the development foundation to have more than one stockholder.
15. Where the parent and subsidiary organizations have differing tax statuses (different categories of tax exemption, or one is tax-exempt and the other is taxable), the greater the element of control, the greater the likelihood that the operations of the subsidiary will be attributed to the parent for tax purposes—an unwelcome outcome for the organizations (*see* § 16.2). In the instance of a healthcare institution and its development foundation, however, the potentiality of any such attribution is rarely of any tax consequence.
16. This application process is the subject of §§ 34.1 and 34.2.

foundation status. This ruling will generally remain in effect during the five-year *advance ruling period*. If the foundation is able to show the requisite public support during the advance ruling period, it will thereafter be issued by the IRS a *definitive ruling* as to its non-private-foundation status. Most other development foundations are able to obtain a definitive ruling at the outset.

(f) Public Charity Status

Every charitable organization is presumed to be a private foundation.[17] Because there is no advantage to having a development foundation categorized as a private foundation, it is important that the foundation be classified by the IRS as an entity other than a private foundation—that is, a public charity.[18]

Many development foundations are qualified as publicly supported organizations because their principal support is in the form of public gifts and grants[19] or an eligible combination of gifts, grants, and exempt function revenue (such as income generated by the sale of publications or admissions to seminars).[20]

Some related foundations are supporting organizations[21] and thus avoid private foundation status by reason of the provision of meaningful support to one or more aspects of the parent organization's programs. This is particularly the case where the supported organization is a nonprofit hospital—an entity that can clearly be the beneficiary of a supporting organization.[22] A hospital that is a governmental unit also can be the beneficiary of a supporting organization.[23] Any healthcare institution that is a public charity (other than a supporting organization)[24] qualifies as an entity that can be a supported organization.

A healthcare entity that has its public charity status predicated on its classification as a *service provider* publicly supported organization[25] should be cautious when establishing and operating a development foundation that is structured as a supporting organization. As discussed,[26] this type of public charity may not normally receive more than one-third of its gross income in the form of gross investment income.[27] Where one of the purposes of the creation of this type of relationship is to avoid private foundation classification

17. IRC § 508(b).
18. *See* Chapter 5.
19. *See* § 5.2.
20. *See* § 5.3.
21. *See* § 5.4.
22. As discussed in § 5.1, a nonprofit hospital is a public charity by reason of IRC § 170(b)(1)(A)(iii) and thus is not a private foundation (and, therefore, is a qualified supported organization) by application of IRC § 509(a)(1).
23. The hospital's public charity status in this instance is based on IRC §§ 170(b)(1)(A)(v) and 509(a)(1).
24. An organization described in IRC § 509(a)(1) or (a)(2).
25. That is, under IRC § 509(a)(2). *See* § 5.3.
26. *See* § 5.3.
27. IRC § 509(a)(2)(B).

for either organization, the character and amount of support received by the ostensible supporting organization will be attributed to the ostensible supported organization for purposes of determining whether the latter meets the one-third support test and the one-third gross investment income test.[28] That is, this form of support retains its character as gross investment income (rather than being treated as grants) to the extent that the amounts are characterized as gross investment income in the possession of the distributing organization. This outcome may cause the recipient organization to have difficulty satisfying the one-third gross investment income test. (There is no similar rule in connection with the donative publicly supported organization.)

§ 14.2 OTHER CONSIDERATIONS

A related developmental foundation is a separate legal entity. As such, it must have its own governing board, officers, governing instruments (including bylaws), and bank account. It must file an annual information return with the IRS, just as is the case with the related hospital (unless they are units of government). State law may also require an annual filing.

In nearly every instance, the healthcare institution and the development foundation will be at the same location. Therefore, some thought must be given to the extent to and manner in which the two organizations will be sharing space, personnel, equipment, and supplies. Whatever the arrangement, it should be in writing.

In some instances, it may be appropriate to term those who govern the foundation *trustees* rather than *directors*. This can serve to reduce confusion as to the identity of the two governing bodies (assuming, of course, that the members of the board of the healthcare institution are termed ''directors'') and help to accord the leadership of the foundation the status of fiduciaries of charitable assets.

Because the development foundation will be actively engaged in fundraising, consideration must be given to compliance with the states' charitable solicitation acts. These laws generally require registration and annual reporting by charitable organizations that solicit contributions within their jurisdictions.[29]

§ 14.3 CASE STUDY

The following case is based on the facts underlying the establishment of a development foundation for a tax-exempt hospital. The hospital was formed as a nonprofit corporation and has been recognized by the IRS as a tax-exempt charitable entity and a public charity.[30] The development foundation was also

28. Reg. § 1.509(a)-5(b).
29. *See*, in general, § 36.1.
30. That is, the hospital has been recognized by the IRS to qualify under IRC §§ 501(c)(3) (tax exemption), 170(c)(2) (charitable donee), 170(b)(1)(A)(iii) (charitable hospital), and 509(a)(1) (public charity).

formed as a nonprofit corporation and was recognized by the IRS to qualify as a supporting organization. This supporting organization is not a membership corporation and does not have the authority to issue stock.

The board of directors of the development foundation is comprised of fifteen individuals (termed trustees) with voting rights. The board is divided into three classes, each with a three-year term, to facilitate a staggered board of trustees (one-third elected each year). At each annual meeting of the board of trustees of the foundation, three of the five vacating trustee positions must be filled by act of the board of directors of the hospital. The other two positions are filled by a majority vote of the remaining (twelve) trustees. There is no limitation on the number of terms a trustee may serve.

A trustee of the foundation may be removed from office by a two-thirds vote of the other fourteen trustees. Vacancies on the board of trustees are to be filled in the same manner as that by which the vacating board member was previously elected.

Because the governing board of this development foundation is elected or appointed by the supported organization, the foundation has supporting organization status under the first of the three categories of that status, namely, that encompassed by the phrase *operated, supervised, or controlled by*.[31] Even though this relationship does not require that the supported organization be *specified* by name in the governing instruments of the foundation,[32] the hospital is identified as the sole beneficiary of the programs of the foundation.

The programs of this developmental foundation include—in addition to the fundraising function—a variety of community programs, such as a free lecture series, other educational and health forums, publications, and estate-planning seminars.

Every healthcare institution should give consideration to establishment of a development foundation. The advantages that flow to the institution consist of concentration of the fundraising function in a single entity for which that function is the sole or principal purpose, and the ability to attract and utilize the services of individuals whose interest or focus is fundraising. The foundation can be made to appear more ''charitable'' to the giving community than the parent organization.

It is not advisable to dismiss the idea of a development foundation on the ground that the parent healthcare institution has the requisite tax statuses. For the most part, this type of foundation is a management and development vehicle that can streamline the fundraising process and, most importantly, cause an increase in funding for the programs of the parent healthcare institution.

31. *See* § 5.5(d)(i).
32. *See* § 5.5(c).

CHAPTER FIFTEEN

Title-Holding Companies

§ 15.1 **Single-Parent Title-Holding Companies 330**

§ 15.2 **Multi-Parent Title-Holding Companies 333**

§ 15.3 **Unrelated Business Considerations 335**

The title-holding corporation is an entity that serves only one or more tax-exempt organizations, including healthcare organizations. Its purpose, as the name indicates, is to function as a subsidiary organization, holding title to property that would otherwise be held by the parent organization or organizations, and remitting any net income from the property to the parent or parents. Originally designed to circumvent state law restrictions on the holding of property by nonprofit organizations, the title-holding company today is used to house the title to property in the subsidiary, for the purpose of reducing the exposure of liability from use of the property by the parent entity, to otherwise facilitate administration, and to increase borrowing power.[1]

Should the organizations (or one of the organizations) to which a tax-exempt title-holding corporation makes income distributions cease to qualify for tax exemption, the holding company would in turn have its tax exemption revoked.[2]

Title-holding corporations are most useful in the healthcare setting. They are frequently found in a healthcare system, where—for management and/or law reasons—it is deemed appropriate that the title to a property be held in the name of another organization. There is no limitation on the type of property for which title may be held by a title-holding corporation; it may range from a medical office building to an item of capital equipment. As the IRS once observed, the title-holding corporation ''is by its nature responsive to the needs and purposes of its exempt parent which established it

1. IRS Exempt Organizations Handbook (IRM 7751), § 230.
2. Rev. Rul. 68-371, 1968-2 C.B. 204. A title-holding organization in this position could retain tax-exempt status by appropriately amending its articles of incorporation and other corporate documents.

mainly to facilitate the administration of properties.''[3] Wherever the administration of one or more healthcare organizations may be so served, the title-holding corporation is available as a useful tax-planning and management mechanism.

§ 15.1 SINGLE-PARENT TITLE-HOLDING COMPANIES

The federal tax law describes these entities, for the purpose of providing tax exemption, as ''[c]orporations organized for the exclusive purpose of holding title to property, collecting income therefrom, and turning over the entire amount thereof, less expenses, to an organization which itself is [tax-exempt].''[4] For this purpose, the term *expenses* includes a reasonable allowance for depreciation.[5]

This type of organization cannot accumulate income[6]; that is, as a general rule, it must turn over the entire amount of its income, less expenses, to a tax-exempt parent.[7] If the organization is not specifically organized to do this, it cannot qualify as a tax-exempt title-holding corporation.[8] Moreover, if the entity does not operate in this fashion, it cannot constitute this type of exempt organization.[9]

Despite the general prohibition on income accumulation, however, a tax-exempt title-holding organization may retain a portion of its income each year to apply to indebtedness on property to which it holds title.[10] This type of transaction is treated as if the income had been remitted to the parent entity, with the parent having then used the income to make a capital contribution to the title-holding corporation, which thereafter applied the contribution to reduction of the indebtedness. In rationalizing this flexibility, the IRS observed that the title-holding corporation should not ''be restricted in serving the needs of the parent in connection with the administration of properties.''[11]

The IRS ruled that an organization formed as a subsidiary of a tax-exempt title-holding corporation, organized for the exclusive purpose of holding title to investment property that would otherwise be held by the parent, itself qualified as a tax-exempt title-holding corporation because it collected the

3. Rev. Rul. 77-429, 1977-2 C.B. 189.
4. IRC § 501(c)(2). This type of organization is to be contrasted with the *feeder organization* of IRC § 502, which is an entity that carries on a trade or business for the benefit of a tax-exempt organization and is itself not tax-exempt.
5. Rev. Rul. 66-102, 1966-1 C.B. 133.
6. E.g., *Kanawha-Roane Lands v. United States*, 136 F. Supp. 631 (S.D. W.Va. 1955).
7. Reg. § 1.501(c)(2)-1(b).
8. E.g., *Banner Building Company, Inc. v. Commissioner*, 46 B.T.A. 857 (1942).
9. E.g., *Eddie Cigelman Corporation v. Commissioner*, 14 T.C.M. 1259 (1955); *The Davenport Foundation v. Commissioner*, 6 T.C.M. 1335 (1947).
10. Rev. Rul. 77-429, 1977-2 C.B. 189.
11. *Id*. at 189–190.

income from the property and turned it over to its parent (which was, of course, a tax-exempt organization).[12] In other words, an exempt title-holding organization can be the beneficiary of another exempt title-holding organization.

These organizations can be put to creative uses. In one instance, a title-holding corporation was utilized to hold and administer a scholarship and loan fund for a fraternity.[13] In another case, a stock corporation organized and operated to hold title to a chapter house of a college fraternity was held to qualify as a title-holding organization, even though the stock was owned by members of the fraternity.[14] (Where a tax-exempt organization has no control over the title-holding organization, however, the title-holding entity cannot qualify for tax-exempt status.[15])

Although the rental of real estate is generally treated as a business in the commercial context,[16] the IRS determined that income from the renting of realty is a permissible source of income for tax-exempt title-holding corporations[17]; that is, this rental activity is not an unrelated trade or business. The rental of personal property is treated as the conduct of unrelated business, however, unless it is leased in connection with real property.[18] Thus, title-holding organizations engaging in business activity—other than the rental of real property—may be denied or may lose their tax exemption.[19]

Consequently, the characterization (as real or personal) of the property being rented can be determinative of an organization's status as a title-holding corporation. In one instance, a corporation that otherwise qualified for tax exemption as a title-holding entity held a leasehold interest in an office building, with all of its income derived from the subleasing of space in the building to the general public. Even though a leasehold of real property is generally classified as personal property, income derived from subleasing an office building was treated by the IRS as income from the rental of real property.[20] The IRS reasoned that this type of income is similarly treated

12. Rev. Rul. 76-335, 1976-2 C.B. 141.
13. *N.P.E.F. Corp. v. Commissioner*, 5 T.C.M. 313 (1946).
14. Rev. Rul. 68-222, 1968-1 C.B. 243. This stock was the type that did not provide any rights to receive profits (either as dividends or liquidating distributions).
15. Rev. Rul. 71-544, 1971-2 C.B. 227; *Citizens Water Works, Inc. v. Commissioner*, 33 B.T.A. 201 (1935). *See also Return Realty Corp. v. Ranieri*, 359 N.Y.S.2d 611 (Sup. Ct. N.Y. Cty. 1974).
16. E.g., *Hazard v. Commissioner*, 7 T.C. 372 (1946). For many types of tax-exempt organizations, however, income from the rental of real estate is excluded from unrelated income taxation (IRC § 512(b)(3)). *See*, in general, § 24.17.
17. Rev. Rul. 69-381, 1969-2 C.B. 113. *See also* Reg. § 1.512(b)-1(c)(2); Rev. Rul. 66-295, 1966-2 C.B. 207.
18. Rev. Rul. 69-278, 1969-1 C.B. 148.
19. *See* § 15.3; *Stanford University Bookstore v. Commissioner*, 29 B.T.A. 1280 (1934); *Sand Springs Railway Co. v. Commissioner*, 21 B.T.A. 1291 (1931).
20. Rev. Rul. 81-108, 1981-1 C.B. 327.

as rental income from real property for purposes of qualification for tax exemption as a title-holding corporation.[21]

A title-holding corporation that derives income from the rental of real property to the general public is not precluded from tax exemption. In one instance, a corporation held title to a building containing offices that were rented on annual leases to the general public. It collected the rents, paid the expenses incident to operation and maintenance of the building, and turned over the balance of the income to its tax-exempt parent. The rents were not forms of unrelated business income, because there were no substantial services to the tenants.[22] The ''statutory language that requires them [tax-exempt title-holding corporations] to turn over the income from the property to an exempt organization contemplates that income will be received from parties other than the exempt organization for which they hold title.''[23]

A tax-exempt title-holding corporation is subject to the unrelated business income tax if one of its parent organizations is subject to the tax. In one instance, a title-holding entity with two parents—one subject to the tax, the other not—found itself in this position.[24]

Where a tax-exempt title-holding corporation holds title to property for the benefit of the parent tax-exempt organization, the property is encumbered with a debt, and the property is not utilized for the tax-exempt purposes of the parent organization, the title-holding corporation is subject to the tax on unrelated debt-financed income.[25]

As noted, to be tax-exempt, a title-holding corporation must not engage in any business other than that of holding title to property and collecting and remitting any resulting income.[26] For example, one organization that held

21. The reasoning of the IRS in this regard proceeded as follows: An IRC § 501(c)(2) corporation generally cannot have unrelated business income (Reg. § 1.501(c)(2)-1(a)). (However, as noted, that aspect of the law has been amended (*see* § 15.3)). For unrelated business income purposes, the term *real property* includes property described in IRC § 1250(c) (Reg. § 1.512(b)-1(c)(3)(i)). That provision encompasses certain real property that is or has been property of a character subject to the depreciation allowance rules (IRC § 167). Qualifying depreciable real property includes intangible real property, which in turn includes a leasehold of land of IRC § 1250 property. Accordingly, this type of leasehold constitutes IRC § 1250 property and thus is real property for purposes of IRC § 501(c)(2).
22. *See* § 24.17.
23. Rev. Rul. 69-381, 1962-2 C.B. 113.
24. Rev. Rul. 68-490, 1968-2 C.B. 241.
25. Priv. Ltr. Rul. 8145011. The unrelated debt-financed income rules are the subject of § 24.20. An instance of the use of these entities to hold title to property acquired with borrowed funds, prior to adoption of the unrelated debt-financed income rules, appears in Rev. Rul. 66-295, 1966-2 C.B. 207; the rationale was that this type of activity was not a trade or business engaged in for profit, under the approach adopted in court opinions such as *Bright Star Foundation, Inc. v. Campbell*, 191 F. Supp. 845 (N.D. Tex. 1960).
26. Reg. § 1.501(c)(2)-1(a).

title to a building housing its tax-exempt parent, maintained the property, and operated social facilities located in the building, was held to not qualify for tax exemption because the social activities were ''outside the scope of'' those allowed to an exempt title-holding entity.[27] Likewise, a title-holding corporation had its tax-exempt status revoked because it operated a bar and buffet in the building it maintained.[28]

A title-holding corporation may file a consolidated return with a parent entity for a tax year. When this occurs and the title-holding entity pays net income to the parent, or would pay net income but for the fact that the expenses of collecting the income exceed its income, the title-holding corporation is deemed, for purposes of the unrelated business income tax, as being organized and operated for the same purposes as the parent, as well as its title-holding purposes.[29]

Generally, contributions to a title-holding corporation are not deductible as charitable gifts for federal income tax purposes.[30] Where, however, a title-holding entity engages in a charitable activity, contributions to it for the express purpose of funding that activity are deductible as charitable gifts.[31]

It was the position of the IRS that a title-holding company is ineligible for tax exemption under these rules if it has two or more unrelated parent organizations, inasmuch as that is evidence of a pooling of assets for an active corporate venture, rather than a mere holding of title.[32] As discussed next, however, this matter was resolved by legislation enacted in 1986.

§ 15.2 MULTI-PARENT TITLE-HOLDING COMPANIES

The federal tax law describes (for the purpose of providing tax exemption to them) certain multi-parent title-holding organizations.[33] These are otherwise eligible corporations or trusts that are organized for the exclusive purposes of acquiring and holding title to real property, collecting income from the property, and remitting the entire amount of income from the property (less expenses) to one or more qualified tax-exempt organizations that are

27. Rev. Rul. 66-150, 1966-1 C.B. 147, 148.
28. *Knights of Columbus Building Association of Stamford, Connecticut, Inc. v. United States*, 88-1 U.S.T.C. (CCH) ¶ 9336 (D. Conn. 1988). Occasionally, the IRS or a court will not allow an organization to qualify under this category of exempt organization because of a violation of the private inurement doctrine (*see* Chapter 4) (e.g., Rev. Rul. 58-566, 1958-2 C.B. 261; *The Davenport Foundation v. Commissioner*, 6 T.C.M. 1335 (1947)).
29. IRC § 511(c).
30. This is because title-holding corporations are not among the charitable donees that are the subject of IRC § 170(c)(2).
31. Priv. Ltr. Rul. 8705041.
32. Gen. Couns. Mems. 39341 and 37351.
33. IRC § 501(c)(25).

shareholders of the title-holding corporation or beneficiaries of the title-holding trust.[34] For this purpose, the term *real property* does not include any interest as a tenant in common (or similar interest) and does not include any indirect interest. The title-holding entity must hold real property directly, rather than, for example, as a partner in a partnership.[35] The term *real property* also includes any personal property that is leased under, or in connection with, a lease of real property, although this rule applies only if the rent attributable to the leasing of the personal property for a year does not exceed 15 percent of the total rent for the year attributable to both the real and personal property under the lease.[36]

Tax exemption under this category is available only if the corporation or trust has no more than 35 shareholders or beneficiaries, and has only one class of stock or beneficial interest.[37] Also, to be tax-exempt as this type of title-holding organization, the corporation or trust must permit its shareholders or beneficiaries to (1) dismiss the corporation's or trust's investment advisor, following reasonable notice, upon a vote of the shareholders or beneficiaries holding a majority of interest in the corporation or trust, and (2) terminate their interest in the corporation or trust by either (or both, as determined by the corporation or trust) selling or exchanging their stock in the corporation or their interest in the trust (subject to any federal or state securities law) to any qualified organization so long as the sale or exchange does not increase the number of shareholders in the corporation or beneficiaries in the trust above 35, or having their stock or interest redeemed by the corporation or trust after the shareholder or beneficiary has provided 90 days' notice to the corporation or trust.[38]

Organizations that are eligible to acquire or hold interests in this type of title-holding organization are nonprofit healthcare organizations[39]; other

34. IRC § 501(c)(25)(A)(iii). The IRS, in 1988, modified and supplemented an earlier pronouncement (Notice 87-18, 1987-1 C.B. 455) concerning certain provisions that must be included in the articles of incorporation or trust document of an organization seeking recognition of federal tax exemption as an organization described in IRC § 501(c)(25) (Notice 88-121, 1988-2 C.B. 457). If state law prevents a corporation from including the required provisions in its articles of incorporation, the provisions must be included in the corporation's bylaws. A nonstock corporation may qualify under IRC § 501(c)(25) if its articles of incorporation or bylaws provide members with the same rights as required for other qualifying entities.

    This 1988 pronouncement also stated that a multi-parent title-holding organization may, under certain circumstances, acquire options to purchase real estate, hold reasonable cash reserves, and receive debt-financed income (*see* § 24.20) without loss of tax-exempt status.
35. IRC § 501(c)(25)(A).
36. IRC § 501(c)(25)(F).
37. IRC § 501(c)(25)(A)(i) and (A)(ii).
38. IRC § 501(c)(25)(D).
39. Healthcare organizations that are tax-exempt under IRC § 501(a) by reason of being described in IRC § 501(c)(3).

types of charitable organizations[40]; qualified pension, profit-sharing, or stock bonus plans[41]; governmental plans[42]; and governments and their agencies and instrumentalities.[43]

For these purposes, a corporation that is a *qualified subsidiary* (wholly owned) of a multi-parent title-holding organization is not treated as a separate organization.[44] In this instance, all assets, liabilities, items of income, deductions, and credits of the qualified subsidiary are treated as assets and other like items of the title-holding organization.[45] These rules allow a title-holding company to hold properties in separate corporations so as to limit liability with respect to each property.

As noted, this category of tax-exempt organization was created in response to the position of the IRS that a title-holding company otherwise eligible for tax exemption as a single-parent title-holding entity[46] cannot be tax-exempt if two or more of the parent organizations are unrelated.[47] This body of law does not modify the preexisting law concerning the tax-exempt status of single-parent title-holding organizations or related-parent title-holding organizations.[48]

§ 15.3 UNRELATED BUSINESS CONSIDERATIONS

Like any other category of tax-exempt organization, an exempt title-holding company can potentially conduct an unrelated trade or business.[49] Nonetheless, the IRS position has been that a title-holding company would have its tax exemption revoked if it generated any amount of certain types of unrelated business income.[50]

Congress interceded in this regard in 1993 by enacting legislation that somewhat superseded this stance of the IRS. Thus, for tax years beginning on or after January 1, 1994, a tax-exempt title-holding company is permitted to receive unrelated business taxable income (that would otherwise cause loss of the exemption) in an amount up to 10 percent of its gross income for the year, as long as the unrelated income is incidentally derived entirely from the holding of real property.[51] (This type of income is nonetheless taxable.)

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40. Organizations that are tax-exempt under IRC § 501(a) by reason of being described in IRC § 501(c)(3).
41. Plans that meet the requirements of IRC § 401(a).
42. Plans described in IRC § 414(d).
43. IRC § 501(c)(25)(C).
44. IRC § 501(c)(25)(E)(i)(I).
45. IRC § 501(c)(25)(E)(i)(II).
46. *See* § 15.1.
47. *See supra* note 32.
48. H.R. REP. No. 99-841, 99th Cong., 2 d Sess. II-824 (1986).
49. *See*, in general, Chapter 24.
50. IRS Notice 88-121, 1988-2 C.B. 457; Reg. § 1.501(c)(2)-1(a).
51. IRC §§ 501(c)(25)(G) and 501(c)(2) (last sentence). Even if the allowable unrelated business income is in excess of the 10 percent limitation, however, the tax exemption

For example, income generated from parking or operating vending machines located on real property owned by a title-holding company generally qualifies for this 10 percent *de minimis* rule, but income derived from an activity that is not incidental to the holding of real property (such as manufacturing) does not qualify.[52]

is not jeopardized where the organization is able to establish to the satisfaction of the IRS that the receipt of the excess unrelated income was ''inadvertent and reasonable steps are being taken to correct the circumstances giving rise to such income'' (IRC § 501(c)(25)(G)(ii)).

52. H.R. Rep. No. 103-213, 103d Cong., 1st Sess. 550 (1993).

CHAPTER SIXTEEN

For-Profit Subsidiaries

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Out of necessity, tax-exempt hospital systems and other exempt healthcare organizations commonly utilize one or more for-profit (and, thus, usually taxable) subsidiaries. (Indeed, this development is mirrored throughout the realm of tax-exempt organizations,[1] although nowhere is it more evident than with healthcare entities.)

The reasons for this phenomenon are manifold. In the typical situation, the activity housed in a taxable subsidiary is an unrelated one[2] and it is too extensive to be conducted within the exempt organization because of the threat to its tax-exempt status.[3] Specifically, in the healthcare context, a for-profit subsidiary is essential in facilitating the identification and independence of for-profit cost centers. Some managers of tax-exempt organizations do not want to report any unrelated business income and thus shift the income tax reporting responsibility to a subsidiary. Other reasons for a for-profit subsidiary include insulation of the assets of the parent exempt organization from potential liability, expansion of the sources of capital,[4] and use of the subsidiary in a partnership.[5] In some instances, the management of an

1. *See* TAX- EXEMPT ORGANIZATIONS, Chapter 29.
2. *See* Chapter 24.
3. In *Orange County Agricultural Society, Inc. v. Commissioner*, 893 F.2d 529 (2 d Cir. 1990), the court discussed the fact that the operation of a substantial unrelated business by a tax-exempt organization is likely to result in loss of the organization's tax exemption.
4. *See* SANDERS, JOINT VENTURES INVOLVING TAX-EXEMPT ORGANIZATIONS (2d ed. 2000), at 158.
5. *See* § 16.6.

exempt organization simply is enamored with the concept of a for-profit subsidiary.

As to the first of these reasons for a taxable subsidiary, an unrelated business may be operated as an activity within a tax-exempt organization, as long as the primary purpose of the organization is to carry out one or more exempt functions.[6] Generally, there is no fixed percentage of unrelated business activity that may be engaged in by a tax-exempt organization.[7] Usually, at least more than half of its activities must be in furtherance of exempt purposes; indeed, there cannot be a substantial nonexempt activity or set of activities.[8]

Therefore, if a tax-exempt healthcare organization is engaged in one or more unrelated activities where the activities are substantial in relation to exempt activities, the use of a taxable subsidiary is unavoidable, assuming tax exemption is to be retained.

§ 16.1 ESTABLISHING A SUBSIDIARY

The factors to be considered in determining whether a particular activity should be housed in a tax-exempt organization or a for-profit organization are essentially the same as those to be weighed when contemplating the commencement of a business that potentially may be conducted in either a tax-exempt or for-profit form. These factors are the value of or need for the tax exemption[9]; the true motives of those involved in the enterprise (such as a profit motive); the desirability of creating an asset (such as stock that is appreciating in value) for the equity owners of the enterprise (usually shareholders); and the forms and amounts of compensation for the employees.

The law is clear that a tax-exempt organization can have one or more tax-exempt (or at least nonprofit) subsidiaries and/or one or more for-profit subsidiaries.[10] Indeed, the IRS wrote that a tax-exempt organization ''can organize, capitalize and own, provide services and assets (real and personal, tangible and intangible) to a taxable entity without violating the requirements

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6. Reg. § 1.501(c)(3)-1(e)(1), 1(c)(1).
7. The one exception is a 10 percent limit on the unrelated business activities of title-holding companies (*see* § 15.3).
8. *Better Business Bureau of Washington, D.C. v. United States*, 326 U.S. 279 (1945). Nonetheless, on one occasion, the IRS permitted a charitable organization to remain tax-exempt, although two-thirds of its operations constituted unrelated business, inasmuch as the net revenue from the conduct of the unrelated businesses was used for achievement of charitable purposes; the IRS wrote that one way in which a business may be in furtherance of exempt purposes ''is to raise money for the exempt purpose of the organization, notwithstanding that the actual trade or business activity may be taxable'' (Tech. Adv. Mem. 200021056).
9. In the context of this book, it may be presumed that it is desired—indeed, may be essential—that the parent organization be or remain tax-exempt.
10. E.g., Priv. Ltr. Rul. 9016072 (where a tax-exempt organization owned a for-profit subsidiary and that subsidiary, in turn, owned a network of for-profit subsidiaries).

for exemption, regardless of whether the taxable entity is wholly or partially owned.''[11] The IRS also acknowledged that the ''number of subsidiaries or related entities an exempt organization can create for the purpose of conducting business activities is not set.''[12] With respect to for-profit subsidiaries, the tax-exempt parent can own some or all of the equity (usually stock) in the for-profit subsidiary.[13] For example, a public charity created a for-profit management corporation as a source of services to the public charity and two other exempt organizations, and provided it with operating funds in exchange for 100 percent of the subsidiary's stock.[14] Likewise, a healthcare organization providing programs of health treatment, research, and education established a for-profit subsidiary to engage in the development, manufacture, and commercialization (technology transfer) of pharmaceutical products for the treatment of patients.[15]

Several matters of structure must be taken into account when the use of a for-profit subsidiary by a tax-exempt healthcare organization is being contemplated. These include choice of form and the control mechanism.

This chapter is concerned with for-profit subsidiaries. When structuring these arrangements, consideration should be given to the possibility that a tax-exempt subsidiary could be used, rather than a taxable one. A likely candidate for this alternative approach, should it be available, is the supporting organization.[16]

(a) Choice of Form

Just as when forming a tax-exempt organization, consideration should be given to the choice of organizational form when establishing a for-profit subsidiary. Most for-profit subsidiaries will be for-profit corporations, inasmuch as that is the most common business form, it provides a shield against liability for management and the exempt parent, and it enables the parent to own the subsidiary by holding all or at least a majority of the stock.

Some for-profit businesses are organized as sole proprietorships; however, this approach is of no avail in the tax-exempt organizations context, where the unrelated business activity is to be in a separate entity. Business activity

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11. Priv. Ltr. Rul. 199938041.
12. Priv. Ltr. Rul. 8706012.
13. The extent of stock ownership may determine whether income from a subsidiary to a tax-exempt parent is taxable (*see* § 24.19). If the parent organization is a private foundation, special rules may apply to limit the extent of the holdings (*see* § 5.6). A transfer without consideration from a taxable corporation to a charitable organization, which is the corporation's sole stockholder, is a dividend rather than a charitable contribution (Rev. Rul. 68-296, 1968-1 C.B. 105).
14. Priv. Ltr. Rul. 9308047.
15. Priv. Ltr. Rul. 9722032.
16. *See* § 5.5.

conducted in the form of a sole proprietorship is an undertaking conducted directly by the exempt organization.

A for-profit business may be structured as a partnership or joint venture, but participation by a tax-exempt organization in either of those business forms can entail unique legal complications.[17]

Some states allow businesses to be conducted by means of business trusts—an approach potentially available to a tax-exempt organization. Yet, this form is unlikely to have any advantages over the corporate form.

In the general business context, those forming a corporation have an additional decision: Should they qualify the entity as an S corporation, which essentially is a for-profit corporation that is treated for federal income tax purposes the same as a partnership?[18] An S corporation is not subject to the federal income tax,[19] and its net income and losses (to the extent of the stockholders' basis in the corporation) are passed through to the shareholders for tax purposes. Charitable organizations are permitted to hold interests in S corporations, although other categories of tax-exempt organizations may not be shareholders in these entities.[20]

Another entity that may be considered is the limited liability company. These organizations are not taxable; that is, they are treated, for federal income tax purposes, as a partnership.[21] They also offer a shield against liability for their owners and managers. A single-member limited liability company is of little utility in this regard, however, in that it is a disregarded entity and is deemed to be a branch or division of its owner.[22]

In some instances, an activity can be placed in a taxable nonprofit organization.[23] This approach is a product of the distinction between a nonprofit organization (a state law concept) and a tax-exempt organization (essentially a federal tax concept).[24] Assuming state law permits (that is, an activity may be unrelated to the parent's tax-exempt functions, yet still be a ''nonprofit'' one), a business activity may be placed in a nonprofit, albeit taxable, corporation.[25] There may be some advantage (for example, in community relations) to this approach.

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17. *See* Chapter 22.
18. IRC § 1372.
19. *See* discussion of the partnership as a tax-exempt entity at § 22.1.
20. IRC § 1361(b)(1)(B), (c)(6).
21. Reg. § 301.7701-3.
22. Ann. 99-102, 1999-43 I.R.B. 545. This means, for example, that all of the financial and other activity of a disregarded limited liability company is deemed that of the tax-exempt organization member and must be reflected on the exempt organization's annual information return (*see* § 34.3).
23. The third main category of these approaches is the tax-exempt subsidiary. This technique is discussed throughout the book (e.g., §§ 5.5 and 17.1, and Chapters 14 and 15).
24. *See* § 1.1.
25. In this situation, the subsidiary is not a ''for-profit'' one.

(b) Control

Presumably, a tax-exempt healthcare organization will, when forming a for-profit subsidiary, intend to maintain control over this offspring. After capitalizing the enterprise,[26] nurturing its growth and success, and desiring to enjoy some profits from the business, the prudent exempt organization parent usually would not want to place the activity in a vehicle over which it cannot exercise control.

Where the for-profit subsidiary is structured as a corporation, the tax-exempt organization parent can own the entity and ultimately control it by means of stock (received in exchange for the capital contributed).[27] The exempt organization parent, as the stockholder, can thereafter select the board of directors and, if desired, the officers of the subsidiary.

If the taxable subsidiary is structured as a nonprofit corporation, two choices are available: (1) the subsidiary can be structured as a conventional nonprofit organization, in which case the tax-exempt organization parent would control the subsidiary by means of interlocking directorates; or (2) the entity can be organized as a nonprofit corporation that can issue stock, in which case the exempt organization parent would control the subsidiary by holding its stock. If the latter course is chosen and the nonprofit subsidiary is to be headquartered in a state where stock-based nonprofit organizations are not authorized, the subsidiary can be incorporated in a (foreign) state that allows nonprofit organizations to issue stock, and thereafter be qualified to do business in the home (domestic) state.

§ 16.2 FINANCIAL CONSIDERATIONS

(a) Capitalization

Assets of a tax-exempt healthcare organization that are currently being used in an unrelated business activity may, with little (if any) legal constraint, be spun off into a related, for-profit organization. The extent to which a for-profit corporation can be capitalized using tax-exempt assets (particularly charitable ones), however, is a matter involving more strenuous confines.

A tax-exempt organization can invest a portion of its assets and engage in a certain amount of unrelated business activities. At the same time, the governing board of a tax-exempt organization must act in conformity with basic fiduciary responsibilities, and the organization cannot (without jeopardizing its exemption) contravene the prohibitions on private inurement and private benefit.[28]

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26. *See* § 16.2, text accompanied by *infra* notes 28–32.
27. *See*, e.g., text accompanied by *supra* note 14.
28. *See* Chapter 4.

The only ''law'' on this point is contained in IRS private letter rulings, some of which suggest that perhaps only a very small percentage of an exempt charitable organization's resources ought to be transferred to a controlled subsidiary. (Many IRS rulings in this area do not state the amount of capital involved.[29]) The facts in these rulings, however, usually involve percentages of assets that are quite low and, in any event, principally pertain only to money. In some instances, a specific asset may—indeed, perhaps must—be best utilized in an unrelated business, even where its value represents a meaningful portion of the exempt organization's total resources.[30] Also, the exempt parent may want to make subsequent advances or loans to the subsidiary.

The best guiding standard in this regard is that of the prudent investor. In capitalizing a subsidiary, a tax-exempt organization (particularly a charitable one) should only part with an amount of resources that is reasonable under the circumstances and can be rationalized in relation to amounts devoted to programs and invested in other fashions. Relevant to all of these considerations is the projected return on the investment, in terms of both income and capital appreciation. If a contribution to a subsidiary's capital seems unwise, the putative parent should consider a loan (albeit one bearing a fair rate of interest and accompanied by adequate security).

In some circumstances, the capitalization of a for-profit subsidiary does not involve merely the transfer of funds; the capital can include appropriate operating assets. When this is done, any capital gain inherent in the transferred assets is excluded from unrelated business income.[31]

In all instances, it is preferable that the operation of the subsidiary furthers the exempt purpose of the parent[32]; circumstances where exempt purposes are thwarted by reason of operation of a for-profit subsidiary are to be avoided.

(b) Compensation

The structure of a tax-exempt parent and a for-profit subsidiary may generate questions and issues as to compensation of employees.

The compensation of an employee of a for-profit subsidiary is subject to the overarching requirement that the amounts paid may not exceed a reasonable and necessary salary or wage.[33] The compensation of an employee of a parent tax-exempt organization is subject to a similar limitation, by reason of the private inurement or private benefit doctrine.[34] If an individual is an employee

29. E.g., Priv. Ltr. Rul. 8709051.
30. In one instance, the amount of capital transferred was characterized by the IRS as ''substantial,'' although the exempt parent (a tax-exempt social welfare organization) was not a charitable entity (Priv. Ltr. Rul. 9245031).
31. This exclusion from income is provided by IRC § 512(b)(5) (*see* § 24.17(b), text accompanied by note 379) (e.g., Priv. Ltr. Rul. 9853034).
32. E.g., Priv. Ltr. Rul. 8709051.
33. IRC § 162.
34. *See* Chapter 4.

of both the parent and subsidiary organizations, a reasonable allocation of compensation between the entities is required.[35] If an officer, director, trustee, or key employee receives aggregate compensation of more than $100,000 from a tax-exempt organization and one or more of its related organizations, of which more than $10,000 was provided by a related organization, that fact must be reported and explained to the IRS.[36]

The employees of the tax-exempt parent organization may participate in deferred compensation, tax-sheltered annuity, profit-sharing, and retirement programs. Deferred salary, retirement, pension, and profit-sharing plans may also be utilized by the subsidiary organization.[37]

Use of a taxable subsidiary may facilitate the offering of stock options to employees, to enable them to share in the growth of the enterprise. The subsidiary similarly may offer an employee stock ownership plan that invests in the stock of the sponsoring company.[38] The subsidiary may issue unqualified options to buy stock or qualified incentive stock options.[39]

(c) Sharing of Resources

Generally, a tax-exempt organization and a for-profit subsidiary may share resources, such as office facilities, equipment, supplies, and the like, without adverse consequences to the exempt entity. Particularly where the exempt entity is a charitable one, however, all relevant costs must be allocated on the basis of actual use and each organization must pay fair market value for the resources used.[40]

It is generally preferable for the exempt organization to reimburse the for-profit entity for the exempt organization's use of resources, to avoid even a perception that the funds of a tax-exempt organization are being used to subsidize a for-profit organization. Nonetheless, this approach often is impractical where the exempt organization is the parent entity.

Another sharing of resources issue that continues to bedevil tax-exempt organizations is the proper characterization of income derived from a related taxable subsidiary. A strong argument can be made that income derived from activities of a wholly owned taxable subsidiary of an exempt parent should be characterized as related income where the activities further charitable purposes in collaboration with the other entities in the system. In most if not all cases, however, the IRS either has refused to issue such a ruling or has insisted that

35. The IRS ruled that the employees of a for-profit subsidiary or a tax-exempt parent organization may be included in the medical and dental plan of the parent, without endangering the parent's exempt status, as long as the costs of the plan are allocated among the two employers on a per-capita basis (Priv. Ltr. Rul. 9242039).
36. Form 990, Part V. *See*, in general, § 35.3.
37. *See*, in general, Chapter 28.
38. IRC § 4975(e)(7).
39. E.g., Priv. Ltr. Rul. 9242038.
40. E.g., Priv. Ltr. Rul. 9308047.

the taxable subsidiary be treated as if it were an unrelated entity. As a result, the IRS generally requires that transactions between an exempt parent and its taxable subsidiary be at arm's length and for fair market value, and that the income from the subsidiary be taxed as unrelated business income (assuming the income does not qualify for exclusion from the calculation of unrelated business income).

In this ruling, the IRS considered the case of a tax-exempt hospital recognized as a charitable organization and as a publicly supported organization.[41] The hospital had several charitable subsidiaries, one of which was a self-insurance trust. The hospital and its subsidiaries participate in this self-insurance trust. The request for rulings inquired about the effect of allowing a for-profit subsidiary of the hospital to also participate in the trust. The for-profit subsidiary operates a nursing home facility. Approximately 2 percent of the trust's total gross receipts would be derived from providing insurance to the for-profit subsidiary, and the risks of the for-profit subsidiary being insured by the trust would not exceed 5 percent of its total insured risks.

The IRS considered the unrelated business law and the requirement that activities have a causal relationship to the achievement of exempt purposes and be substantially related to those charitable purposes in order for income derived from the activities to escape taxation.[42] The IRS also cited its revenue ruling establishing the community benefit—standard,[43] regarding the promotion of health, and a revenue ruling that set forth the IRS's basis for recognizing tax exemption for self-insurance trusts.[44]

The IRS concluded that the provision of insurance by the trust for the risks of the for-profit subsidiary does not contribute importantly to the accomplishment of the trust's exempt purposes, even though the for-profit is a subsidiary of the exempt hospital. As a result, the IRS found that the income that the trust receives from the for-profit subsidiary for the provision of insurance constitutes unrelated business taxable income. The IRS found, however, that the activities were *de minimis* and would not jeopardize the tax-exempt status of the self-insurance trust, or its classification as a supporting organization.

This private letter ruling is disappointing in that it continues the IRS's failure to recognize that taxable subsidiaries within an integrated nonprofit system can carry on activities that further charitable purposes in a collaborative fashion with the other entities in the system. In so doing, particularly where the subsidiary is wholly owned and controlled by an exempt parent, the IRS's conclusion that the activity does not contribute importantly to the accomplishment of the trust's exempt purposes is invalid. The ruling will have some utility in that it establishes some benchmarks for a *de minimis* amount of

41. Priv. Ltr. Rul. 200501017.
42. *See* Chapter 24.
43. Rev. Rul. 69-545, 1969-2 C.B. 117.
44. Rev. Rul. 78-41, 1978-1 C.B. 148.

activity by a taxable subsidiary under the circumstances that would not affect the exempt status or the public charity status of an affiliate or a parent that transacts with it.

(d) Liquidations

The federal tax law causes recognition of gain or loss by a business corporation in an instance of a liquidating distribution of its assets (as if the corporation had sold the assets to the distributee at fair market value) and in the event of liquidating sales. There is an exception for liquidating transfers within an affiliated group (which is regarded as a single economic unit), so that the basis in the property is carried over from the distributor to the distributee in lieu of recognition of gain or loss.

For eligible liquidations in which an 80 percent corporate shareholder receives property with a carryover basis, this nonrecognition exception is modified to provide for nonrecognition of gain or loss with respect to any property actually distributed to that shareholder. Nonetheless, this nonrecognition rule under the exception for 80 percent corporate shareholders generally is not available where such a shareholder is a tax-exempt organization. This nonrecognition treatment is available in the tax-exempt organizations' setting where the property distributed is used by the tax-exempt organization in an unrelated business immediately after the distribution. If the property subsequently ceases to be used in an unrelated business, the tax-exempt organization will be taxed on the gain at that time.[45]

In one instance, a tax-exempt home health and hospice agency had formed a wholly owned for-profit subsidiary to provide home companion services and operate an assisted living facility. Years later, the parent organization expanded its programs and facilities, and determined that the activities conducted by the subsidiary could be undertaken by the parent without adversely affecting the parent's exempt status. The parent organization proceeded to liquidate the subsidiary and transfer to it all of the assets in the subsidiary, which had appreciated in value. The IRS ruled that the gain attributable to the distribution of the subsidiary's assets to the parent organization on liquidation would be excludable from taxation as unrelated business income by reason of the exclusion from taxation of capital gains.[46] In another instance, one of the

45. IRC § 337(b)(2). The liquidation rules of IRC § 337(c)(2)(A) were applied in the exempt organization context in *Centre for International Understanding v. Commissioner*, 62 T.C.M. 629 (1991).

46. Priv. Ltr. Rul. 9438029. This ruling did not utilize the liquidation rules of IRC §§ 332 and 337. It is not clear from this ruling whether the assets in the subsidiary were to be used in related or unrelated activities by the exempt parent after the liquidation. If the assets were to be used in related activities, the gain should have been recognized and taxable to the subsidiary (IRC § 337(b)(2)(A)).

The capital gain exclusion rule is the subject of IRC § 512(b)(5). *See* § 24.17, text accompanied by note 373.

functions of a charitable entity was the publication and circulation of religious materials. This organization had a for-profit subsidiary that engaged in both exempt and commercial printing activities. Once it was decided to discontinue the commercial printing operations, the exempt parent decided to liquidate the subsidiary and distribute its assets to the parent organization. The IRS ruled that any gain or loss must be recognized by the subsidiary on the distribution of its assets in liquidation (as if they were sold to the exempt parent at fair market value) to the extent the assets are to be used in related business activities.[47]

These rules as to liquidations may be contrasted with the rules as to tax-free distributions of securities (spin-offs) of controlled corporations,[48] where one of the requirements is that the transaction not be used principally as a device for distribution of the earnings and profits of the distributing corporation and/or the controlled corporation.[49] In one instance, a for-profit corporation, wholly owned by a supporting organization, distributed all of the stock of nine subsidiaries (an affiliated group) to the supporting organization, which subsequently transferred the stock to another supporting organization; both supporting organizations operated to benefit the same supported organization. The reason for this transfer was to enhance the success of the various for-profit businesses by eliminating control and management inefficiencies caused by the prior structure; the IRS ruled[50] that no gain or loss was recognized when the stock was distributed.[51]

§ 16.3 ATTRIBUTION OF SUBSIDIARY'S ACTIVITIES TO EXEMPT PARENT

A parent organization and its subsidiary are respected, for federal income tax purposes, as separate entities, as long as the purposes for which the subsidiary is formed are reflected in authentic business activities or the subsidiary subsequently carries on business activities.[52] That is, where an

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47. Priv. Ltr. Rul. 9645017. This ruling expressly addressed the point that, to the extent the assets were to be used by the parent in unrelated activities, any gain would not be recognized during the pendency of that type of use (IRC § 337(b)(2)(B)(ii)).

    The IRS issued final regulations, under authority of IRC § 337(d), concerning the liquidations of for-profit entities into tax-exempt organizations, where the relationship is other than that of parent and subsidiary; although the rules in this regard would be essentially the same as those that apply where a for-profit corporation converts to a tax-exempt entity (*see* § 21.4) (T.D. 8802). In general, Royalty, Tracy, Latkovic, and Levenson, ''Proposed Regulations Address Conversions and Other Transfers to Tax-Exempt Entities,'' 16 *Exempt Org. Tax Rev.* (No. 2) 207 (Feb. 1997).
48. IRC § 355.
49. IRC § 355(a)(1)(B).
50. Priv. Ltr. Rul. 200435005.
51. IRC § 355(c).
52. E.g., *Moline Properties, Inc. v. Commissioner*, 319 U.S. 436 (1943); *National Carbide Corp. v. Commissioner*, 336 U.S. 422 (1949). Also *Sly v. Commissioner*, 56 T.C.M. 209, 213 (1988)

organization is established with the bona fide intention that it will have some real and substantial business function, its existence generally will not be disregarded for tax purposes.[53] By contrast, where the parent organization so controls the affairs of the subsidiary that it is merely an instrumentality of the parent, the subsidiary may not be regarded as a separate entity, that is, the ostensible separate form is disregarded.[54] In an extreme situation (such as where the parent is involved in the day-to-day management of the subsidiary), the establishment and operation of an ostensibly separate subsidiary may be regarded as a sham perpetrated by the parties and ignored for tax purposes; with this outcome, the tax consequences are the same as if the two ''entities'' were one.[55]

This position of the IRS on the subject is traceable in three pronouncements by the office of the IRS Chief Counsel:

1. In 1968, the IRS was advised by its lawyers that an attempt to attribute the activities of a subsidiary to its parent ''should be made only where the evidence clearly shows that the subsidiary is merely a guise enabling the parent to carry out its . . . [disqualifying] activity or where it can be proven that the subsidiary is an arm, agent, or integral part of the parent.''[56]
2. In 1974, the IRS's legal counsel advised that ''[t]o disregard the corporate entity requires a finding that the corporation or transaction involved was a sham or fraud without any valid business purpose, or the finding of a true agency or trust relationship between the entities.''[57]
3. In 1984, the IRS's lawyers reviewed a situation where a separate for-profit corporation provided management and operations to several hospitals. Although the IRS's rulings division was inclined otherwise, its lawyers advised that where a subsidiary is organized for a bona fide business purpose and the tax-exempt parent organization is not involved in the day-to-day management of the subsidiary, the activities of the subsidiary cannot be attributed to the parent organization for purposes of determining the tax-exempt status of the parent.[58] This was the outcome, irrespective of the fact that the parent tax-exempt organization owned all of the stock of the subsidiary corporation.

(where an individual was held to have used two entities as a ''corporate pocketbook''); *Universal Church of Jesus Christ, Inc. v. Commissioner*, 55 T.C.M. 144, 153 (1988) (where a debt-collection business was said to be ''operating under the thinnest of veils in an attempt to give itself the appearance of a religious enterprise'').

53. E.g., *Britt v. United States*, 431 F.2d 227 (5th Cir. 1970).
54. E.g., *Krivo Industrial Supply Co. v. National Distillers and Chemical Corp*., 483 F.2d 1098 (5th Cir. 1973); *Orange County Agricultural Society, Inc. v. Commissioner*, 53 T.C.M. 1602 (1988).
55. Gen. Couns. Mem. 39598.
56. Gen. Couns. Mem. 33912.
57. Gen. Couns. Mem. 35719.
58. Gen. Couns. Mem. 39326.

Thus, the contemporary posture of the IRS in this regard can be distilled to two tests for whether the legitimacy of a for-profit subsidiary is to be respected: (1) it must engage in an independent, bona fide function, and (2) it cannot be a mere instrumentality of the exempt parent. As to the first test, the IRS's lawyers wrote:

> [T]he first aspect [in determining the authenticity of a for-profit subsidiary] is the requirement that the subsidiary be organized for some bona fide purpose of its own and not be a mere sham or instrumentality of the [exempt] parent. We do not believe that this requirement that the subsidiary have a bona fide business purpose should be considered to require that the subsidiary have an inherently commercial or for-profit activity. The term ''business'' . . . is not synonymous with ''trade or business'' in the sense of requiring a profit motive.[59]

As to the second test, the IRS's lawyers observed:

> [T]he second aspect of the test is the requirement that the parent not be so involved in, or in control of, the day-to-day operations of the subsidiary that the relationship between parent and subsidiary assumes the characteristics of the relationship of principal and agent, i.e., that the parent not be so in control of the affairs of the subsidiary that it is merely an instrumentality of the parent.[60]

At one point, the IRS demonstrated some proclivity to treat two organizations in this situation as one, where the entities' directors and officers are the same. For example, the IRS privately ruled that the activities of a for-profit subsidiary are to be attributed to its tax-exempt parent organization, for purposes of determining the ongoing tax exemption of the parent, where the officers and directors of the two organizations are identical.[61] The rationale underlying this ruling rested on the premise that, when the tax-exempt parent organization is involved in the day-to-day management of the subsidiary, the activities of the subsidiary are to be imputed to the parent organization for tax purposes. In this ruling, the IRS stated that an exempt parent is ''necessarily'' involved in the day-to-day management of the subsidiary simply because the officers and directors of the two organizations are the same individuals.

The applicable principles of law, however, do not lead to the conclusion of the IRS in this ruling, which is that an overlap of directors and officers of two organizations automatically leads to an attribution of the subsidiary's activities to the parent. The case law is instructive in that this can be the result where the facts show that the arrangement is a sham,[62] but that cannot be a mechanical and inexorable outcome. Indeed, in subsequent rulings, the IRS's rulings division has been guided by this advice from their lawyers:

> Control through ownership of stock, or power to appoint the board of directors, of the subsidiary will not cause the attribution of the subsidiary's activities to the

59. Gen. Couns. Mem. 39598.
60. *Id*.
61. Priv. Ltr. Rul. 8606056.
62. *See supra* notes 41–46.

> parent. We do not believe that . . . [a prior general counsel advice memorandum] should be read to suggest, by negative inference, that when the board of directors of a wholly owned subsidiary is made up entirely of board members, officers, or employees of the parent there must be attribution of the activities of the subsidiary to the parent.[63]

Contemporary rulings from the IRS evidence an abandonment of this rigid approach.[64]

Indeed, the IRS has evidenced a penchant for taking quite favorable positions, from the standpoint of tax-exempt organizations, on this point. For example, the agency ruled that a for-profit subsidiary of an exempt organization would not be disregarded for tax purposes and was not an instrumentality of the parent (that is, was not managed by the exempt organization on a day-to-day basis).[65] An exempt organization established a taxable subsidiary for the purpose of maximizing the business value of its web site, with the IRS taking essentially the same stance.[66] Indeed, the activities of a for-profit subsidiary were not attributed by the IRS to its tax-exempt parent because the subsidiary was organized for bona fide business purposes and there was an independent board of directors, even though there was a ''close working relationship'' between the organizations, they co-invested, and there was a sharing of office space and employees.[67]

Thus, the IRS is highly unlikely to attribute the activities of a for-profit subsidiary of a tax-exempt healthcare system or hospital, or other healthcare entity, to the parent entity, by reason of the foregoing elements of law. The use of for-profit subsidiaries in the contemporary healthcare setting has become too customary for this form of attribution to occur, absent the most egregious of facts.[68]

§ 16.4 ASSET ACCUMULATIONS

The IRS, in 2004, expressed concern about the undue accumulation of assets in a for-profit subsidiary of a tax-exempt organization. The issue is whether such an accumulation is evidence of a substantial nonexempt purpose.

The agency's lawyers wrote that, in cases involving exempt organizations, entities ''bear a very heavy burden'' to demonstrate, by ''contemporaneous and clear evidence,'' that they have plans to use the substantial assets in a subsidiary for exempt purposes.[69] In the case, the exempt organization

63. Gen. Couns. Mem. 39598.
64. E.g., Priv. Ltr. Rul. 9245031 (''[t]he activities of [the] [s]ubsidiary cannot be attributed to [the] [p]arent . . . '').
65. Priv. Ltr. Rul. 199938041.
66. Priv. Ltr. Rul. 200225046.
67. Priv. Ltr. Rul. 200232040.
68. This does not mean that revenue from a for-profit subsidiary to an exempt parent is not taxable; in fact, just the opposite is often the case (*see* § 24.19).
69. Tech. Adv. Mem. 200437040.

invested in a for-profit subsidiary, which grew rapidly. ''This growth presents a continuing obligation,'' the IRS wrote, on the organization to ''translate this valuable asset into funds,'' and use these funds for the ''expansion'' of its exempt activities. The IRS suggested that some of the subsidiary's assets be sold or a portion of the subsidiary's stock be sold, with the proceeds used to fund programs. The IRS's lawyers said that the organization ''cannot be allowed to focus its energies on expanding its subsidiary's commercial business and assets, and neglect to translate that financial success into specific, definite and feasible plans for the expansion of its'' tax-exempt activities.

The IRS on this occasion concluded that the ''fact that the assets are being accumulated in a for-profit company under the formal legal control of [a tax-exempt organization] does not excuse [the exempt organization] from using such assets'' for exempt purposes. This aspect of the analysis ended with this sweeping pronouncement: ''Excess accumulations maintained in a subsidiary entity under legal control of the exempt organization, but under the de facto control of the founder, are deemed to be for the founder's personal purposes if no exempt purpose is documented or implemented.''

As the foregoing indicates, the IRS is particularly concerned about asset accumulations in a subsidiary when the tax-exempt organization is a closely controlled entity. The IRS admonished the bar: ''[C]ounsel to closely held [that is, controlled] organizations should take care to ensure that for-profit subsidiaries are not being used to divert exempt organization financial assets, resources, and income to the founding families and other insiders.'' The agency said that it ''may examine ongoing activities to verify that there is a plan for using income and assets generated by subsidiaries for the organization's underlying exempt purposes.'' The IRS concluded: ''De minimis levels of exempt activities, millions of dollars in unsecured loans to closely controlled affiliates, with or without formal repayment arrangements, and/or failures to create and implement documented plans for asset accumulations to be used for exempt purposes are likely to be subject to further—and detailed—IRS scrutiny.''

§ 16.5 EFFECT OF FOR-PROFIT SUBSIDIARIES ON PUBLIC CHARITY STATUS

Just as it is possible for the existence of a for-profit subsidiary to have an adverse impact on the exempt status of a tax-exempt healthcare organization (by an attribution of activities for tax purposes[70]), so, too, the presence of a for-profit subsidiary could have a pernicious affect on the public charity status of the exempt charitable organization's parent organization.

70. *See* § 16.3.

(a) Publicly Supported Organizations

Any impact of a subsidiary organization on the status of a tax-exempt charitable organization that is its parent, where the parent is classified as a publicly supported organization, is derived from funding of the parent by the subsidiary. If the funding is in the form of a charitable contribution, it may be regarded for tax purposes as a dividend.

Where a parent charitable organization has its non-private-foundation status based on classification as a donative type of publicly supported charity,[71] a transfer of money or property to it by a subsidiary will, if treated as a dividend, not qualify as public support.[72] Moreover, where the item or items transferred to the publicly supported donative parent are considered gifts, they would not constitute public support to the extent the amount exceeded the 2 percent limitation threshold.[73]

If the parent organization is not a private foundation by reason of categorization as a service provider type of publicly supported charity,[74] any amount paid to it by a subsidiary would not be public support if the amount was regarded as a dividend.[75] Moreover, a payment of this nature, if accorded dividend treatment, would be investment income, on which there is a one-third limitation as to receipt.[76] If the item or items transferred to the publicly supported service provider parent are considered gifts, they would not constitute public support where the subsidiary is a disqualified person with respect to the parent organization.[77]

(b) Supporting Organizations

Some tax-exempt charitable organizations are able to become classified as public charities by virtue of the rules concerning supporting organizations[78]; this is common in the realm of exempt healthcare entities.

Because the public charity status of a supporting organization is not derived from the nature of its funding, the considerations pertaining to publicly supported organizations discussed above[79] are inapplicable (although a transfer from a taxable subsidiary to a supporting organization may nonetheless be considered a dividend).

The public charity classification of a charitable organization that is a supporting organization is rested on the rule that it must be ''operated

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71. *See* § 5.2.
72. Reg. § 1.170A-9(e)(2).
73. Reg. § 1.170A-9(e)(6)(i).
74. *See* § 5.3.
75. IRC § 509(a)(2)(A); Reg. § 1.509(a)-3(a)(2).
76. IRC § 509(a)(2)(B); Reg. § 1.509(a)-3(a)(3)(i).
77. IRC § 509(a)(2)(A); Reg. § 1.509(a)-3(b)(2).
78. *See* § 5.5.
79. *See* text accompanied by *supra* notes 70–76.

exclusively'' to support or benefit one or more eligible public charitable organizations.[80] For some time, it was unclear as to whether a supporting organization could have a for-profit subsidiary. The concern was that the use of such a subsidiary would be a violation of the rule that a supporting organization must be operated *exclusively* for the support or benefit of one or more supported organizations. The term *exclusively* means, in this setting, *solely*,[81] as opposed to its definition in the context of charitable organizations generally, where the term means *primarily*. The IRS ruled that, as long as a supporting organization does not actively participate in the day-to-day management of a for-profit subsidiary and both entities have a legitimate economic and business purpose and operations, the supporting organization can utilize a for-profit subsidiary without jeopardizing its *tax-exempt* status.[82] Nonetheless, the IRS subsequently ruled that a supporting organization can, without jeopardizing its *public charity* status, utilize a for-profit subsidiary.[83]

§ 16.6 SUBSIDIARIES IN PARTNERSHIPS

It is not uncommon for a tax-exempt healthcare organization to cause a for-profit subsidiary to become a partner in a partnership, rather than be the partner itself. This substitution of entity may be for the purpose of shielding the exempt parent from liability and/or may be done for federal tax reasons. As to the latter, a tax-exempt charitable organization that is contemplating becoming a general partner in a limited partnership may decline to endanger its exemption and may use a for-profit subsidiary instead.[84]

This can be an effective stratagem as long as all of the requirements of the law as to the bona fides of the subsidiary are satisfied, including the necessity that the subsidiary be an authentic business entity. As discussed,[85] however, if the tax-exempt parent organization is too intimately involved in the day-to-day management of the subsidiary, the IRS may impute the activities of the subsidiary to the parent for tax purposes, thereby endangering the exempt

80. IRC § 509(a)(3)(A). *See* § 5.5(b), text accompanied by notes 168 and 169.
81. Reg. § 1.509(a)-4(e)(1).
82. Priv. Ltr. Rul. 9305026. This ruling was silent, however, on the issue of the impact of the use of the subsidiary on the organization's *public charity* (supporting organization) status.
83. Priv. Ltr. Rul. 9637051.
84. E.g., Priv. Ltr. Rul. 9105029. One area of the federal tax law concerning tax-exempt organizations where the use of a for-profit subsidiary in a partnership, instead of an exempt organization, generally will not alter the tax outcome is the set of rules pertaining to tax-exempt entity leasing. *See* text accompanied by *infra* notes 90–93.

    On occasion, some or all of these results can be accomplished by the use of a tax-exempt subsidiary (e.g., Priv. Ltr. Rul. 8638131).
85. *See* § 16.3.

status of the parent entity by treating it as if it were directly involved as the (or a) general partner of the limited partnership.[86]

One commentator observed that, for this approach to be successful, ''it is preferable for the affiliate's [subsidiary's] participation to be funded through a source other than the hospital, because the IRS analyzes such transactions as if the hospital itself were participating directly in the venture to the extent of any funding traceable to it.''[87] This commentator inventoried the factors establishing the independent status of the subsidiary in the healthcare setting; they are: the hospital should refrain from active involvement in the day-to-day business affairs of the for-profit subsidiary; the subsidiary should be formed for a true business purpose and not as a mere instrumentality of the hospital; the terms of all transactions between the hospital and the subsidiary should be at arm's length; the costs of any shared assets, services, or facilities should be allocated according to actual use; and the subsidiary should maintain separate minutes and other formal documentation.[88]

Nonetheless, the IRS rules favorably on this matter of a tax-exempt organization and one or more for-profit subsidiaries on a regular basis.[89]

An illustration of this use of a partnership was presented in a private letter ruling made public at the close of 1993.[90] A community hospital wanted to expand its provision of medical rehabilitation services; a for-profit corporation that managed the rehabilitation program at the hospital was a subsidiary of the nation's largest independent provider of comprehensive rehabilitation services. The hospital, through this subsidiary, sought a joint venture with its for-profit parent to utilize its expertise and methodologies, and to operate the rehabilitation facility as a venture so that the expansion would not jeopardize the institution's role as a community hospital. The joint venture was structured so that it was between the hospital and a system of which it was a component, and a wholly owned for-profit subsidiary of the for-profit parent entity and its subsidiary. The IRS ruled favorably in the case, concluding that the hospital's participation in the venture was consistent with its purposes of promoting health.

The use of a for-profit subsidiary in a partnership by a parent tax-exempt organization can have implications with respect to the tax-exempt entity leasing

86. In one instance, the IRS, without explanation, expressly ignored the use of a for-profit subsidiary of a tax-exempt parent organization as the general partner in a partnership, reviewing the facts as though the exempt organization were directly involved in the partnership (Tech. Adv. Mem. 8939002).
87. Sanders, *supra* note 4, at § 4.6, citing Gen. Couns. Mems. 39598 and 39646, and Priv. Ltr. Ruls. 8604006, 8621059, and 9303030.
88. *Id*.
89. These rulings are collected in TAX-EXEMPT ORGANIZATIONS § 29.1(a), note 17. This observation is made with the understanding that the facts reflected in some of these rulings are altered at the request of the IRS and that some rulings requests in this area are withdrawn in anticipation of the issuance of an adverse ruling.
90. Priv. Ltr. Rul. 9352030.

rules. In essence, these rules require investors to compute their depreciation deductions over a longer recovery period where the property involved is *tax-exempt-use property*.[91] Tax-exempt-use property can include property, or an allocable portion of it, in a partnership where a tax-exempt organization is a partner.[92] Because of attempts to sidestep these rules by causing a taxable entity controlled by a tax-exempt organization to be a partner in a partnership (rather than the exempt organization), the law was altered to attribute the subsidiary's participation to the exempt partner organization. This was done by means of the concept of the *tax-exempt controlled entity*, a nonexempt corporation in which 50 percent or more of the stock is held by one or more tax-exempt organizations.[93]

The tax-exempt entity rules merely affect the amount of depreciation deductions. These enactments, however, make it clear that tax-exempt health-care (and other exempt) entities are entitled to participate in partnerships, either directly or by means of for-profit subsidiaries, without the threat of automatic revocation or denial of tax-exempt status.[94]

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91. These rules, contained in IRC § 168, are the subject of TAX-EXEMPT ORGANIZATIONS § 27.14.
92. IRC § 168(h)(6)(A).
93. IRC § 168(h)(6)(F)(iii)(I).
94. *See* discussion in § 2.3, text accompanied by notes 55–56. The tax treatment of revenue derived from for-profit subsidiaries is the subject of § 24.19.

CHAPTER SEVENTEEN

Exempt and Nonexempt Cooperatives

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§ 17.1 COOPERATIVE HOSPITAL SERVICE ORGANIZATIONS

Qualifying *cooperative hospital service organizations* are deemed to be charitable organizations[1] and are not private foundations.[2] These organizations must be organized and operated solely for two or more tax-exempt member hospitals and must be organized and operated on a cooperative basis. They must perform for their members certain specified services[3] on a centralized basis, namely, data processing, purchasing (including the purchasing of insurance on a group basis),[4] warehousing, billing and collection, (including the purchase of patron accounts receivable on a recourse basis) food, clinical, industrial engineering,[5] laboratory, printing, communications, records center, and personnel (including selection, testing, training, and education of personnel services). To qualify, these services must constitute exempt activities if performed on its own behalf by a participating hospital.[6] Although this type of cooperative must have hospitals as members (patrons), its membership may include comparable entities, such as the outpatient component of a county health department.[7]

1. IRC § 501(e).
2. IRC §§ 170(b)(1)(A)(iii) and 509(a)(1). *See* Chapter 5.
3. IRC § 501(e)(1)(A).
4. An organization performs the service of ''purchasing'' when it buys equipment for one of its patron hospitals, even though it holds legal title to the equipment, where that arrangement is used merely as a convenience to the hospital, which remains the beneficial owner of and solely responsible for paying for the equipment (Rev. Rul. 80-316, 1980-2 C.B. 172).
5. Rev. Rul. 74-443, 1974-2 C.B. 159.
6. Rev. Rul. 69-633, 1969-2 C.B. 121. *See*, in general, Tuthill, ''Qualifying as a Tax Exempt Cooperative Hospital Service Organization,'' 50 *Notre Dame L. Rev*. 448 (1975).
7. Gen. Couns. Mem. 39692.

The IRS takes the position that, to qualify as a cooperative hospital service organization, the organization may provide only the services listed in the specific authorizing legislation.[8] This position is based on the legislative history of the provision.[9] Thus, the IRS has ruled that a cooperative hospital laundry service cannot be tax-exempt as a ''charitable'' organization by reason of these specific rules, and has observed that such an entity may qualify as a tax-exempt cooperative.[10] However, it has been expressly held by a court that an organization that qualifies under the cooperative hospital service organization rules may nonetheless also qualify as a charitable organization.[11]

One court, in a case involving a centralized laundry service operated for tax-exempt hospitals, has held that the organization qualifies for status as a charitable entity, notwithstanding these specific rules.[12] The court maintained that the ''question of whether it [the plaintiff organization] is organized and operated for an exempt purpose is a question of fact for this Court to decide.''[13] Commenting on the rules for certain hospital cooperatives, the court said: ''The clearly expressed Congressional purpose behind the enactment of Section 501(e) was to enlarge the category of charitable organizations under Section 501(c)(3) to include certain cooperative hospital service organizations, and not to narrow or restrict the reach of Section 501(c)(3).''[14] Because the organization was operational prior to the enactment of these rules, the court, having concluded that it is charitable in nature, found the specific rules irrelevant to the case.[15]

The Senate Finance Committee's version of the Tax Reform Act of 1976 contained a provision[16] that would have inserted ''laundry'' services in the statutory enumeration of permissible services. The committee had observed that ''it is appropriate to encourage the creation and operation of cooperative service organizations by exempt hospitals because of the cost savings to the hospitals and their patients that result from providing certain services, such as laundry and clinical services, on a cooperative basis.''[17] However, this provision was defeated on the floor of the Senate.[18]

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8. Rev. Rul. 69-160, 1969-1 C.B. 147; Priv. Ltr. Rul. 200742025.
9. H. Rep. No. 1533, 90th Cong., 2d Sess. 1, 20 (1968). *See also* S. Rep. No. 744, 90th Cong., 1st Sess. 200–201(1967); H. Rep. No. 1030, 90th Cong., 1st Sess. 73 (1967).
10. Rev. Rul. 69-633, *supra note* 6. (The rules concerning cooperative organizations are at IRC §§ 1381–1383.) Services performed in the employ of a cooperative hospital service organization described in IRC § 501(e) are exempted from employment for purposes of the Federal Unemployment Tax Act (FUTA) (Rev. Rul. 74-493, 1974-2 C.B. 327).
11. *Chart, Inc. v. United States*, 491 F. Supp. 10 (D.D.C. 1979).
12. *United Hospital Services, Inc. v. United States*, 384 F. Supp. 776 (S.D. Ind. 1974).
13. *Id*. at 780.
14. *Id*. at 781.
15. *Id*. *See also Northern California Central Services, Inc. v. United States*, 591 F.2d 620 (Ct. Cl. 1979).
16. H.R. 10612 § 2509 (1976) (as reported by the Senate Committee on Finance).
17. S. Rep. No. 94-938, pt. 2, 94th Cong., 2d Sess. 76 (1976).
18. Amendment No. 315, 122 Cong. Rec. 25,915 (1976).

Since the enactment of these specific rules in 1968,[19] there has been considerable controversy as to the meaning and scope of the provision in relation to the general rules defining charitable entities.[20] In essence, there have been two competing views on why the hospital cooperative rules were enacted: (1) to provide the exclusive and controlling means by which a cooperative hospital service organization can achieve tax exemption, so that such an organization that fails to satisfy the requirements of the rules thereby fails to qualify as a charitable organization,[21] or (2) to enlarge the category of charitable organizations to include certain types of cooperative hospital service organizations, so that it does not narrow or restrict the reach of the rules defining charitable organizations generally.[22]

In a 1981 per curiam decision, the U.S. Supreme Court ruled that the first of these two views is the correct one.[23] In reaching this conclusion, the Court utilized a statutory construction rationale (namely, the rule that a specific statute controls over a general provision, particularly where the two are interrelated and closely positioned[24]), but principally relied on the legislative history underlying the rules for hospital cooperatives. The case involved a cooperative laundry organization service tax-exempt entity, and, as noted, laundry service is not specifically referenced in the rules despite efforts in 1968 and 1976 to include such a reference. The Court thus determined that:

> In view of all this, it seems to us beyond dispute that subsection (c)(1)(A) of § 501, despite the seemingly broad general language of subsection (c)(3), specifies the types of hospital service organizations that are encompassed within the scope of § 501 as charitable organizations. Inasmuch as laundry service was deliberately omitted from the statutory list and, indeed, specifically was refused inclusion in that list, it inevitably follows that petitioner is not entitled to tax-exempt status. The Congress easily can change the statute whenever it is so inclined.[25]

This decision was accompanied by a dissent that held that the proper analysis commences with an evaluation of the overall statutory scheme, without reference to any legislative history. The dissent noted that the rules for these cooperatives are not structured as an exception to the rules providing

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19. Pub. L. No. 90-374, § 109(a), 82 Stat. 269 (1968); 90th Cong., 2d Sess.
20. IRC § 501(c)(3).
21. E.g., *HCSC-Laundry v. United States*, 624 F.2d 428 (3d Cir. 1980), *rev'g* 473 F. Supp. 250 (E.D. Pa. 1979); *Metropolitan Detroit Area Hospital Services, Inc. v. United States*, 634 F.2d 330 (6th Cir. 1980), *rev'g* 445 F. Supp. 857 (E.D. Mich. 1978); *Community Hospital Services, Inc. v. United States*, 47 A.F.T.R.2d 81-999 (6th Cir. 1981), *rev'g* 43 A.F.T.R.2d 79-934 (E.D. Mich. 1979); *Hospital Central Services Assn. v. United States*, 623 F.2d 611 (9th Cir. 1980), *rev'g* 40 A.F.T.R.2d 77-5646 (W.D. Wash. 1977).
22. E.g., *Northern California Central Services, Inc. v. United States*, 591 F.2d 620 (Ct. Cl. 1979); *United Hospital Services, Inc. v. United States*, *supra* note 12; *Chart, Inc. v. United States*, *supra* note 11.
23. *HCSC-Laundry v. United States*, 450 U.S. 1 (1981), *aff'g* 624 F.2d 428 (3d Cir. 1980).
24. Citing *Bulova Watch Co. v. United States*, 365 U.S. 753, 761 (1961).
25. *HCSC-Laundry v. United States*, *supra* note 23, at 8.

tax exemption for charitable entities[26] and concluded that their purpose is to enlarge the category of charitable organizations. As regards the legislative history, the dissent concluded that enactment of these rules ''unambiguously granted a tax exemption to certain entities that arguably already were entitled to an exemption under § 501(c)(3)'' and that ''[t]here is absolutely no evidence that the 1968 statute was intended to withdraw any benefits that were already available under the 1954 Act.''[27] The dissent viewed the Congressional actions in 1968 and 1976 as meaning that hospital laundry cooperatives cannot qualify under these specific rules but not as establishing that they cannot qualify under the rules concerning charitable organizations in general.

The principal flaw in the Supreme Court majority opinion is its holding that these specific rules represent a determination by Congress as to the types of cooperative hospital organizations that can qualify for tax exemption as ''charitable'' entities. If that is, in fact, the law, then a cooperative hospital organization created before 1968 and recognized as having tax exemption would, if it cannot satisfy the specific rules, have its recognition of tax exemption revoked. There is no legislative history indicating that Congress intended this result.[28]

More significantly, the logic of this majority opinion is that Congress, in enacting the rules for hospital service cooperatives and educational service cooperatives, legislated as to the entire subject of the tax status of cooperative organizations and, thus, that a cooperative organization that cannot satisfy either set of rules for service cooperatives cannot qualify as a ''charitable'' entity. This result is clearly not the law. The fact is, Congress enacted the hospital cooperative rules solely in the hope of forestalling adverse IRS policy concerning hospital cooperatives, but did so in a way that enabled the IRS to circumvent the intent of Congress by devising a unique interpretation of the legislative history and then by convincing the appellate courts of the efficacy of this interpretation.[29]

The U.S. Tax Court ruled that three types of hospital membership funds do not qualify for tax exemption as charitable entities.[30] One of these funds was created to provide a vehicle for member hospitals to self-insure, on a group

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26. IRC §§ 501(a) and 501(c)(3). *See* IRC §§ 502 and 503.
27. *HCSC-Laundry v. United States*, *supra* note 23, at 20.
28. *United Hospital Services, Inc. v. United States*, *supra* note 12.
29. The decision in *HCSC-Laundry v. United States*, *supra* note 12, should be contrasted with another 1981 Supreme Court decision, where the Court went out of its way to ignore directly pertinent legislative history and to interpret a statute in a manner wholly inconsistent with Congressional intent, so as to avoid constitutional law difficulties, finding that approach ''simpler and more reasonable'' (*St. Martin Evangelical Lutheran Church v. South Dakota*, 451 U.S. 772, 782 (1981)). The IRS has, in reliance on the HCSC-Laundry decision, ruled that, if an organization fails to qualify under a specific category of tax exemption, it is therefore precluded from qualifying under a more general category of tax exemption (Rev. Rul. 83-166, 1983-2 C.B. 96).
30. *Florida Hospital Trust Fund et al. v. Commissioner*, 103 T.C. 140 (1994).

basis, against hospital professional liability, including injuries of patients. This fund and the second fund provide centralized cooperative insurance services to member hospitals through the employment of actuaries, risk managers, underwriters, accountants, and other insurance consultants; their purpose is to self-insure against liability arising from malpractice. The third fund was created as a vehicle for member hospital employers to self-insure on a group basis against workers' compensation claims.

The IRS refused to recognize tax-exempt status for these funds, on the grounds that they (1) are not cooperative hospital service organizations, (2) are precluded from exemption because a substantial part of their activities consists of the provision of commercial-type insurance, (3) are operated for a substantial nonexempt purpose, and (4) are feeder organizations. As to the first of these bases, the statute setting forth the range of permissible services includes ''the purchasing of insurance on a group basis.''[31]

The court concluded that the phrase ''purchasing of insurance on a group basis'' connotes a ''commercial transaction in which a cooperative hospital service organization negotiates and executes the purchase of insurance for its membership as a group.''[32] However, the court also found that the funds do not ''purchase'' insurance but ''have assumed the role of the insurer.''[33]

As to the argument that this interpretation renders this key phrase meaningless, the court disagreed: ''A cooperative hospital service organization that purchases insurance for its members on a group basis provides a valuable service to its member hospitals. Undoubtedly, member hospitals will realize direct savings due to the reduced need for in-house personnel required to handle insurance-related matters.''[34] Also: ''[M]ember hospitals will likely benefit in the form of lower insurance premiums as a result of the cooperative's ability to use its size to negotiate from a position of power.''[35] Any further policy considerations on this point, said the court, are the province of Congress.

The Tax Court's decision was upheld by the U.S. Court of Appeals for the Eleventh Circuit.[36] Unlike the Tax Court, however, the appellate court did not reach the commercial-type insurance issue, instead focusing on the issues presented under the cooperative hospital service organization rules. The court of appeals rejected the notion that the hospitals were purchasing insurance through the trusts or that they were self-insuring by means of the trusts. In the court's view, the hospitals were providing insurance to each other, on a reciprocal basis, using the trust vehicles as their chosen method. The court declined to interpret the cooperative hospital service organization rules to embrace this type of provision of insurance.

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31. IRC § 501(e)(1)(A).
32. *Florida Hospital Trust Fund et al. v. Commissioner*, *supra* note 30, at 153.
33. *Id*.
34. *Id*. at 155.
35. *Id*.
36. *Florida Hospital Trust Fund v. Commissioner*, 71 F.3d 808 (11th Cir. 1996).

This result is consistent with the narrow interpretation of Code section 501(e) given by the courts and the IRS, but, in some instances, the IRS has been more flexible in interpreting the statute, in an effort to apply it to current healthcare delivery mechanisms. A case in point is a Determination Letter issued to a cooperative seeking recognition of its status as an exempt cooperative hospital service organization, an organization described in Code section 501(e), because it is providing ''clinical'' services on a cooperative basis. This qualifying service would seem to be a natural for widespread use by cooperatives; however, the term *clinical* is not defined in the statute or in the regulations adopted by the IRS, and there have been no IRS rulings to shed light onto its intended application.

Congress added ''clinical'' services to the list of permitted activities for a cooperative hospital service organization in the Tax Reform Act of 1976.[37] The legislative history does not indicate that Congress intended any special or unusual meaning for ''clinical.'' The explanatory statement of the House and Senate conference committee simply indicates that the Senate amendment, which added clinical services to the specified services permitted to be performed by a tax-exempt cooperative service organization, was adopted by the conference agreement.[38] The Senate Finance Committee cited its reasons for the amendment as follows:

> The Committee believes that it is appropriate to encourage the creation and operation of cooperative service organizations by exempt hospitals because of the cost savings to the hospitals and their patients that result from providing certain services, such as laundry and clinical services, on a cooperative basis. . . .
>
> The Committee amendment adds the performance of laundry and clinical services to the types of services that can be performed on a cooperative basis by tax-exempt hospitals. Thus, it is permissible, under the Committee amendment, for tax-exempt hospitals to create a cooperative service organization to provide a laundry and clinical facilities to these hospitals.[39]

Finally, the Joint Committee on Taxation issued a report entitled *General Explanation of the Tax Reform Act of 1976*, in which it stated:

> The Congress believes that it is appropriate to encourage the creation and operation of cooperative service organizations by exempt hospitals because of the cost savings to the hospitals and their patients that result from providing certain services, such as clinical services, on a cooperative basis. Moreover, exemption from State taxation which this would facilitate in many cases would be particularly helpful in the case of clinical services, since they require relatively substantial investments in plant and equipment.[40]

37. Pub. L. No. 94-455, § 1312(a), 90 Stat. 1520, 1730 (1976).
38. H.R. Conf. Rep. No. 1515, 94th Cong., 2d Sess. 537 (1976).
39. S. Rep. No. 94-938, *supra* note 17, at 76–77.
40. Staff of Joint Comm. on Taxation, 94th Cong., 2d Sess., General Explanation of the Tax Reform Act of 1976, at 422 (Dec. 29, 1976).

The report went on to state that, as a result of the amendment, it would now be permissible for tax-exempt hospitals to create a cooperative service organization to provide clinical facilities to tax-exempt hospitals.[41]

The only appropriate understanding of the legislative history is that Congress added clinical services to the list of permitted services for these cooperatives in order to permit cost savings for hospitals and patients by encouraging the provision of clinical services on a cooperative basis. The legislative history's references to clinical facilities were exemplary and nonexclusive, because the term *facility* was not added to the statute by the amendment.

Because neither the statute nor the legislative history defines the term *clinical*, the IRS presumably must give that term its common meaning. As defined in a generally accepted medical dictionary, the term means: ''pertaining to or founded on actual observation and treatment of patients, as distinguished from theoretical or basic sciences.''[42] The definition is similar in other dictionaries.[43]

The cooperative seeking recognition of its tax-exempt status had charitable acute care hospitals as its members. It provided ''clinical'' services to patients of its member hospitals by providing home infusion and respiratory therapy services to patients in their homes. The individuals who received services either had been or likely would otherwise become inpatients of the member hospitals. The IRS accepted that these services fell within the definition of ''clinical'' and, evidently relying on its definition of patients contained in a revenue ruling,[44] accepted that the patients of the cooperative were also patients of the member hospitals.

Thus, the IRS has shown a willingness to interpret the cooperative hospital service organization rules favorably to providers in circumstances where the proper interpretation is open to question because of changes in healthcare delivery.

A public charity, formed to provide and maintain a variety of cooperatively planned hospital and health-related programs and facilities, performed services on a centralized basis for tax-exempt hospitals. The IRS reviewed these services to test them against the statutory requirements for cooperative hospital service organizations. Some of the services clearly qualified because they are expressly referenced in the statute, such as printing, warehousing of records, and purchasing. Some qualified because of interpretation of the law; thus, courier services and alarm installation and maintenance services were held to fall within the meaning of ''communications,'' whereas maintenance of biomedical equipment, environmental monitoring, and infectious waste disposal were found to be within the ambit of ''clinical'' or ''laboratory'' services.

41. *Id*. at 423.
42. Dorland's Illustrated Medical Dictionary (27th ed. 1988).
43. *See*, e.g., Stedman's Medical Dictionary (25th ed. 1990) (''relating to the bedside of a patient or to the course of his disease'').
44. Rev. Rul. 68-376, 1968-2 C.B. 246. *See*, *infra*, § 24.6.

However, the IRS rejected as nonqualifying services those for security, parking, and housekeeping and grounds maintenance; it also held that the organization cannot subcontract for impermissible services. Consequently, the organization was found not to be operating solely as a cooperative hospital entity and its tax-exempt status was revoked.[45]

In addition, the IRS opened the door, if just a crack, for another type of charitable consortium organization when it ruled that a healthcare organization formed by a group of unrelated charitable hospitals to provide lithotripsy services qualified as a public charity and could also manage a limited partnership and receive management fees without jeopardizing its exempt status.[46]

Under the facts of this ruling, A was incorporated as a nonprofit corporation as part of a joint undertaking between 10 charitable hospitals, including C, which was the primary teaching hospital affiliated with D, a state educational institution. A was formed to provide extracorporeal shock wave lithotripsy (ESWL) to residents of the state because the state limited the number of lithotripsy facilities that it would authorize under a certificate of need.

A was recognized as a charitable organization and classified as other than a private foundation as a hospital.[47] A formed a limited partnership (the Partnership), which owned and had the sole purpose of operating a lithotripsy center (the Center). The certificate of need was granted to the Center, conditioned on (1) having an open staff and allowing privileges to any urologist who successfully completed ESWL training, (2) treating all patients in need regardless of ability to pay, (3) providing care to any and all indigents with income eligibility determined by state income guidelines, (4) participating in the state Medicaid program and treating Medicaid recipients, and (5) accepting Medicare assignment.

A was the sole general partner of the Partnership, and the sale of limited partnership interests helped finance the acquisition of the lithotripter, the machine used to perform ESWL. The Partnership consisted of 37 partnership units, including 36 limited partnership units and one general partnership unit. Member hospitals owned six limited partnership units; physicians of member hospitals owned seven limited partnership units; board members, trustees, and other individuals owned 17 limited partnership units; and other organizations owned six limited partnership units. Limited partners owned 75 percent of the Partnership. A, the general partner, owned a 25 percent share of the Partnership. The partnership agreement provided that the purpose of the Partnership was research and the provision of healthcare through the acquisition of a lithotripter and operation of the Center. The partnership agreement also provided that A, as the general partner, would manage the

45. Tech. Adv. Mem. 9542002.
46. Tech. Adv. Mem. 200151045.
47. IRC § 170(b)(1)(A)(iii).

Partnership, decide matters of management and control over the Partnership, and assume direction of all of the Partnership's operations.

The IRS field agent who examined A concluded that A did not qualify for exemption as a charitable organization. In the agent's estimation, A was formed by two or more unrelated hospitals to operate on a centralized basis, which, in the agent's view, made the Code provisions regarding cooperative hospital service organizations controlling.[48] The agent further determined that management services performed by A for the Partnership did not come within the scope of any of the services enumerated as allowable under these Code provisions.

The IRS field review revealed that, from tax years 1995 through 1999, A's care to Medicare patients accounted for approximately 19 to 22 percent of all its patients; Medicaid patients accounted for approximately 1 to 2 percent of all patients; and indigent care accounted for approximately 1 to 2 percent of all patients. A established that the Center had never turned away any patient because of an inability to pay. The Center maintained open staff privileges—membership in the Partnership had no bearing on a physician's ability to obtain ESWL privileges. A maintained close ties with D, particularly with its urology residency program, and the Center also offered lithotripsy training to all interested urologists, regardless of their affiliation with D, and offered training to nonphysician staff. The Center also promoted various research studies and activities, particularly in connection with its affiliation with D, and it participated in the American Lithotripsy Society's lithotripsy database, which provides data about procedures to researchers.

A and the Partnership entered into a management agreement for A to manage the Center. The management agreement provided that the Partnership would compensate A on a calendar-year basis at a basic rate per year plus a set amount per procedure; the management agreement was later amended to provide compensation at a fixed annual rate. Under the terms of the agreement, A had the right and obligation at all times to operate the facility in accordance with its charitable purposes. A entered into a management services subcontract with C. C agreed to fulfill A's obligations under the management agreement to the Partnership. Any operating profit made in the management of the Partnership was to be divided equally between A and C.

The Code provides that an organization shall be treated as an organization organized and operated exclusively for charitable purposes if (1) such organization is organized and operated solely to perform for two or more exempt hospitals on a centralized basis certain specified services; (2) such organization is organized and operated on a cooperative basis; and (3) all of its stock is owned by patron hospitals.[49] A was created by 10 unrelated exempt hospitals

48. IRC § 501(e).
49. *Id*.

that joined in order to operate a lithotripter to provide ESWL services to the general public. According to the IRS National Office, A's services were not provided directly to the member hospitals as contemplated under this Code section; therefore, it was not controlling.

Because this Code section did not control, the question was whether A was organized and operated exclusively for charitable purposes. The National Office opined that the activities of a partnership or other joint venture are considered to be the activities of an exempt organization that is a partner in the Partnership when evaluating whether the exempt organization is operated exclusively for exempt purposes.

First, the IRS queried whether the Partnership furthered the charitable purpose of promoting health for a broad cross-section of the community (i.e., satisfied the community benefit standard).[50] The IRS found that the Partnership satisfied the community benefit standard by (1) allowing any physician or hospital to refer to the Center; (2) implementing the charity care policy that was advertised through the Center's financial forms; (3) serving Medicare, Medicaid, and indigent patients with the same services provided to any patient; (4) not refusing care to any patient because of an inability to pay; (5) having a community board representation by the member hospitals; and (6) participating in, and sponsoring, medical educational activities, community educational activities, and medical research projects.

Second, the IRS queried whether the Partnership arrangement permitted A to act exclusively in furtherance of its exempt purposes and only incidentally for the benefit of its nonexempt partners. The IRS found that A could ensure that the benefit to the for-profit limited partners was incidental to the accomplishment of its charitable purpose because (1) A had control over the policies of the Partnership and the day-to-day activities of the Center, and (2) A could ensure the assets it owned through the Partnership and the activities conducted by the Partnership would be used primarily to further exempt purposes. Thus, the IRS National Office found that A qualified for exemption as a charitable organization for the examination year.

This technical advice is unlikely to open the door to charitable status to all manner of consortium organizations. Clearly, the key to the IRS's analysis was the fact that the organization was itself a provider of care, a feature not common to most consortiums. Nonetheless, it offers hope for organizations that would not have been able to qualify as shared services cooperatives.

§ 17.2 SUBCHAPTER T COOPERATIVES

To qualify for tax treatment as a Subchapter T cooperative, the Code requires that an organization be ''operating on a cooperative basis.''[51] The

50. *See* § 6.1.
51. IRC § 1381(a).

phrase ''operating on a cooperative basis'' is not defined in the Code or Treasury Regulations. However, in the leading case in this area, the Tax Court interpreted this phrase as imposing three basic requirements: (1) democratic control, (2) subordination of capital, and (3) allocation of excess operating revenues in proportion to the patrons' participation in the cooperative endeavor.[52] The IRS and the courts have generally required that these factors be present in order for cooperative status to be recognized.

The IRS has uniformly ruled that a corporation seeking to be treated as a cooperative must be organized on a democratic model in which each member has one vote regardless of the size of its investment or the amount of business it does with the cooperative.[53] A nonexempt cooperative must also limit the financial return that it pays on its contributed capital.[54] The purpose of this restriction is to ensure that the cooperative's surplus revenue is returned to its patrons rather than to stockholders of the company.

In addition, the cooperative must return at least annually to its patrons the excess of its revenues over its related costs, in proportion to the volume or value of business done with each patron.[55] If the cooperative operates two or more different businesses on a cooperative basis, a separate accounting pool for each business can be established in order to separately determine the net earnings of each pool and to distribute the net earnings of each pool solely to the patrons that utilized the service for which the pool was formed.[56]

Although not stated in the Tax Court's decision, four additional factors are considered significant by the IRS and the courts in connection with qualifying as a cooperative. First, the cooperative must be engaged actively in some joint effort with, for, or on behalf of its members. Second, the IRS has taken the position that it is fundamental that a cooperative have ''sufficient membership to form a mutual joinder of interest in the risks and benefits'' of the cooperative effort,[57] and that membership consisting of ten patrons is sufficient to satisfy this requirement.[58] Third, the IRS has ruled that a cooperative must do a majority of its business with its member and nonmember patrons.[59] Finally, with respect to liquidating distributions, the IRS requires that a cooperative's articles of incorporation or bylaws obligate the cooperative to distribute its remaining assets, upon liquidation, to both its current and former members in proportion to the value or quantity of business that each did with the cooperative over some reasonable number of years.[60]

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52. *Puget Sound Plywood, Inc. v. Commissioner*, 44 T.C. 305, 308 (1965), *acq*. 1966-1 C.B. 3.
53. *See*, e.g., Priv. Ltr. Rul. 8803005; 8218070; 8037118; 7830100; 7731017. See also *Puget Sound Plywood*, *supra* note 47, at 308.
54. *Puget Sound Plywood, Inc. v. Commissioner*, *supra* note 47, at 308; Priv. Ltr. Rul. 9402012.
55. *Id*.
56. Rev. Rul. 74-567, 1974-2 C.B. 174.
57. Rev. Rul. 72-602, 1972-2 C.B. 510, 511.
58. *Id*.
59. Rev. Rul. 72-602, 1972-2 C.B. 510; *accord*, Priv. Ltr. Rul. 7746003; 8221111.
60. *See*, e.g., Priv. Ltr. Rul. 7726040.

Subchapter T cooperatives provide an alternative to consortium-type organizations otherwise unable to obtain recognition of exemption and tax-free operation. They have proven to be of particular value to healthcare organizations for group purchasing operations; other applications for this type of vehicle are being developed.

CHAPTER EIGHTEEN

Business Leagues

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Business leagues are important organizations in the constellation of tax-exempt entities that comprise the realm of nonprofit and for-profit healthcare. These entities, while themselves rarely healthcare providers, play a significant role in enabling healthcare organizations to act collectively for the improvement of their operating environments and the advocacy of their causes.

Business leagues can qualify as tax-exempt organizations under federal law,[1] as long as they are not organized for profit and do not violate the proscription against private inurement.[2] The more contemporaneous terminology for these organizations is trade, business, and professional associations, and professional societies; the term *trade association* is often used to describe all business leagues.

§ 18.1 BUSINESS LEAGUES IN GENERAL

A business league is an association of persons who have some common business interest, the purpose of which is to promote that common interest and not to engage in a regular business of a kind ordinarily carried on for profit.[3] The business league's activities must be directed to the improvement of business conditions of one or more lines of business, as distinguished from the performance of particular services for individual persons.[4] An organization, the

1. These organizations are tax-exempt under IRC § 501(a) by reason of description in IRC § 501(c)(6).
2. The concept of being organized *for profit* is the subject of § 1.1; the private inurement rules are the subject of Chapter 4.
3. Reg. § 1.501(c)(6)-1.
4. *Id*.

purpose of which is to engage in a regular business of a kind ordinarily carried on for profit, even though the business is conducted on a cooperative basis or produces only sufficient income to be self-sustaining, cannot be a tax-exempt business league.[5] Unlike some other forms of tax-exempt organizations, an exempt business league is not required to promote the general commercial welfare.[6]

The term *business* is broadly construed and includes nearly any activity carried on for the production of income,[7] including the professions[8] and consumer cooperatives.[9] Tax exemption as a business league has been denied for lack of a sufficient common business interest in situations involving an organization of individuals engaged in different trades or professions not in competition, who exchanged business information;[10] an association of motorists;[11] and an association of dog owners, where most of the members were not in the business of raising dogs.[12] Thus, organizations that promote the common interests of hobbyists do not qualify as tax-exempt business leagues, although tax exemption may be available as some other category of exempt organization.[13] At a minimum, to qualify as a tax-exempt business league, an organization must have some type of program directed to the improvement of business conditions; for example, the provision of bar and luncheon facilities alone is insufficient.[14]

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5. As the IRS stated, ''it is a well-established principle'' that this category of tax exemption is available ''only'' to organizations ''which are financed, at least in part, through membership dues''; an organization ''which is not in fact membership supported lacks the most significant characteristic common to'' business leagues (Priv. Ltr. Rul. 200020056). Thus, the general concept is that a tax-exempt business league will derive meaningful support in the form of members' dues and revenue from related activities. (This rule, however, does not preclude unrelated business undertakings by business leagues (see Chapter 24).)

   This definition of a business league has been given the ''imprimatur of Congress and thus is entitled to the effect of law'' (*Engineers Club of San Francisco v. United States*, 791 F.2d 686, 689 (9th Cir. 1986)). See also *Retailers Credit Association v. Commissioner*, 90 F.2d 47 (9th Cir. 1937). A discussion of the legislative history of this category of tax exemption appears in *National Muffler Dealers Association, Inc. v. United States*, 440 U.S. 472, 477–479 (1979), *aff'g* 565 F.2d 845 (2d Cir. 1977).
6. Rev. Rul. 59-391, 1959-2 C.B. 151; *Commissioner v. Chicago Graphic Arts Federation, Inc.*, 128 F.2d 424 (7th Cir. 1942).
7. See § 24.2.
8. Rev. Rul. 70-641, 1970-2 C.B. 119 (tax exemption as a business league held to be available because the organization increased the effectiveness of the interaction among various professions, developed greater efficiency in the professions, and solved problems common to the professions).
9. Rev. Rul. 67-264, 1967-2 C.B. 196.
10. Rev. Rul. 59-391, 1959-2 C.B. 151.
11. *American Automobile Association v. Commissioner*, 19 T.C. 1146 (1953).
12. *American Kennel Club v. Hoey*, 148 F.2d 920 (2d Cir. 1945).
13. Rev. Rul. 66-179, 1966-1 C.B. 144. The other categories of tax-exempt status are most likely to be social welfare organizations (IRC § 501(c)(4)), social clubs (IRC § 501(c)(7)), or some form of cooperative.
14. Rev. Rul. 70-244, 1970-1 C.B. 132.

In this context, a line of business is a ''trade or occupation, entry into which is not restricted by a patent, trademark, or similar device which would allow private parties to restrict the right to engage in the business.''[15] The provision of healthcare constitutes a line of business; a narrower line of business is the provision of healthcare on a nonprofit basis. Specialty healthcare providers may band together as a business league, as may physicians, vendors in the healthcare field, and lawyers who specialize in health law matters. The *line of business* can be narrowly drawn; the organization endeavoring to improve it will qualify for tax exemption as long as all persons functioning within the line of business are eligible to participate.

The U.S. Supreme Court upheld the *line of business requirement* (initiated by the tax regulations) as being consistent with the intent of Congress in according tax exemption to business leagues. The occasion for this holding of the Court was a case involving the tax-exempt status of an organization of muffler dealers that confined its membership to franchisees of a particular franchisor and that had as its principal activity the bargaining with the franchisor on behalf of its members. The Court held that the franchisees did not constitute a line of business, in that their efforts did not benefit a sufficiently broad segment of the business community, as would the endeavors of an association representing the entire muffler industry.[16] Thus, concluded the Court, tax exemption as a business league ''is not available to aid one group in competition with another within an industry.''[17]

Consequently, the *line of business rule* generally requires that a business league represent an industry.[18] One organization was held to not be entitled to tax exemption as a business league because ''[n]othing is done to advance the interests of the community or to improve the standards or conditions of a particular trade.''[19] The courts, however, have recognized as tax-exempt business leagues that represent all components of a line of business (industry) within a geographical area.[20]

With the requirement that a tax-exempt business league be an ''association of persons''[21] comes an assumption that the organization is a membership entity. Although this is usually the case, the IRS will recognize as tax-exempt, as a business league, nonmembership organizations that have a significant affiliation with one or more exempt business leagues. Members in a business

15. IRS Exempt Organizations Handbook (IRM 7751) at § 652(1).
16. *National Muffler Dealers Association, Inc. v. United States*, 440 U.S. 472 (1979).
17. *Id.*, 440 U.S. at 488. At the same time, a business league has, within the line of business it represents, persons who are competitors with one another.
18. E.g., *American Plywood Association v. United States*, 267 F. Supp. 830 (W.D. Wash. 1967); *National Leather & Shoe Finders Association v. Commissioner*, 9 T.C. 121 (1947).
19. *Produce Exchange Stock Clearing Association v. Helvering*, 71 F.2d 142, 144 (2d Cir. 1934).
20. E.g., *Commissioner v. Chicago Graphic Arts Federation, Inc.*, 128 F.2d 424 (7th Cir. 1942); *Crooks v. Kansas City Hay Dealers Association*, 37 F. 83 (8th Cir. 1929); *Washington State Apples, Inc. v. Commissioner*, 46 B.T.A. 64 (1942).
21. *See* text accompanied by *supra* note 3.

league may be individuals, business corporations and similar entities, and/or tax-exempt organizations. There may be more than one class of members.[22]

Where business leagues have a narrower range of purposes and/or membership base, classification as an exempt business league will not be forthcoming. For example, the IRS denied tax exemption to organizations composed of businesses that market a single brand of automobile[23] or bottle one type of soft drink.[24] In these and similar cases, the IRS reasoned that entities of this nature are not organized and operated to better conditions in an entire industrial line but rather are devoted to the promotion of a particular product at the expense of others in the same industry.[25] Thus, tax exemption as a business league is unavailable for organizations that endeavor to improve business conditions in only ''segments'' of lines of business.[26] As one court observed, the line of business requirement ''is well suited to assuring that an organization's efforts do indeed benefit a sufficiently broad segment of the business community.''[27]

Activities that promote a common business interest include the conduct of annual meetings, conferences, seminars, luncheon meetings,[28] and the like; publication programs, such as the issuance of professional journals, trade magazines, and newsletters[29]; presentation of information and opinions to agencies of government[30]; attempts to influence legislation germane to the members' common business interests[31]; designation of subsidies for litigation of interest to the membership[32]; and promotion of improved business standards, methods, and practices.[33]

In conclusion, as to this matter of membership, there can be as many as three components underlying eligibility for tax-exempt status. One is a *functional* one: the purposes and line of business served by the organization must be properly stated and followed. Another component is a *financial* one: the entity must be at least partially financed by membership dues. The third component may be *geographical*: membership may be limited on that basis.

An organization that is or that desires to qualify as a business league, however, must be somewhat cautious in the conduct of meetings and the like: it may

22. There may, however, be an unrelated business income issue in this connection (*see* text accompanied by *infra* notes 51–52).
23. Rev. Rul. 67-77, 1967-1 C.B. 138.
24. Rev. Rul. 68-182, 1968-1 C.B. 263.
25. Rev. Rul. 76-400, 1976-2 C.B. 153.
26. Rev. Rul. 83-164, 1983-2 C.B. 95.
27. *National Muffler Dealers Association, Inc. v. United States*, 565 F.2d 845, 847 (2d Cir. 1977).
28. Rev. Rul. 67-295, 1967-2 C.B. 197.
29. *National Leather & Shoe Finders Association v. Commissioner*, 9 T.C. 121 (1947).
30. *American Refractories Institute v. Commissioner*, 6 T.C.M. 1302 (1947); *Atlanta Master Printers Club v. Commissioner*, 1 T.C.M. 107 (1942).
31. Rev. Rul. 61-177, 1961-2 C.B. 117.
32. Rev. Rul. 67-175, 1967-1 C.B. 139.
33. Rev. Rul. 68-657, 1968-2 C.B. 218.

risk reclassification as a social club.[34] In one case, the IRS attempted to classify an engineering society as a social club, claiming that it was regularly engaged in substantial restaurant, beverage, and other social operations. This position, however, was rejected in litigation. The court concluded that the primary purpose of the organization was the promotion of the profession of engineering (through the conduct of professional education, training, and information dissemination activities) with the food, beverage, and social activities deemed either incidental or related to the professional activities.[35] Nonetheless, on appeal, the government prevailed, albeit on another argument—the society could not qualify as an exempt business league because the food and beverage service constituted a service performed for individual persons rather than the engineering profession in its entirety.[36]

As noted at the outset, an organization cannot qualify as a tax-exempt business league where its primary purpose is the performance of particular services for individual persons (as opposed to the entire membership). Generally, services are deemed to not be particular when they are supported by fees and assessments in approximate proportion to the benefits received.[37] For example, an independent practice association was ruled to not qualify as a tax-exempt business league, with the IRS portraying it as akin to a billing and collection service that provided an economy of convenience to its members relating to the operation of their private medical practices.[38] A nurses' registry was denied categorization as an exempt business league on a finding that it was merely an employment service for the benefit of its members.[39] The same fate befell an organization operating a telephone answering service for its member physicians.[40]

Often, it is difficult to determine whether an activity benefits the membership of an association as a group (and thus is a tax-exempt function) or is

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34. Tax-exempt social clubs are the subject of TAX-EXEMPT ORGANIZATIONS, Ch. 15. The principal disadvantage of categorization as a social club is that the investment income of these organizations is taxable (IRC § 512(a)(3)), which is not the case with respect to business leagues and most other exempt organizations.
35. *The Engineers Club of San Francisco v. United States*, 609 F. Supp. 519 (N.D. Cal. 1985).
36. *Engineers Club of San Francisco v. United States*, 791 F.2d 686 (9th Cir. 1986).
37. *MIB, Inc. v. Commissioner*, 734 F.2d 71 (1st Cir. 1984).
38. Rev. Rul. 86-98, 1986-2 C.B. 74. These types of organizations also fail to qualify for tax-exempt status on the ground that they are engaging in a business on a for-profit basis (*see* text accompanied by *supra* note 3). This line of law is parallel to one of the lines of law of, and precludes tax exemption by reason of, IRC § 501(c)(4), in that mutual, self-interest organizations cannot constitute exempt social welfare organizations (Rev. Rul. 81-58, 1981-1 C.B. 331).
39. Rev. Rul. 61-170, 1961-2 C.B. 112. *See* Rev. Rul. 55-656, 1955-2 C.B. 262 (community nursing bureau held exempt as a charitable organization in part because it received its principal financial support from community organizations and contributions).
40. Rev. Rul. 71-175, 1971-1 C.B. 153. *See* also Rev. Rul. 66-338, 1966-2 C.B. 226 (organization that advised its members in the operation of their individual businesses, and sold supplies and equipment to them, held to not be a tax-exempt business league).

a package of particular services for individual persons. In one case, a court held that an association's membership was benefited where the organization provided a product or a service to its members for a fee, with the benefit not directly proportional to the fees (for example, seminars and legislative activities).[41] This court wrote that ''[s]ervices which render benefits according to the fee that is paid for them are taxable business activities, not tax-exempt services.''[42] The court added: ''Therefore, the activities that serve the interests of individual . . . [members] according to what they pay produce individual benefits insufficient to fulfill the substantial relationship test, since those activities generally do not generate inherent group benefits that inure to the advantage of its members as members.''[43]

Subsequently, the IRS grappled with these subtleties, differing between ''an industry-wide benefit or a particular service to members.'' The IRS held that activities that provide an industry-wide benefit ''usually possess certain characteristics,'' such as being an ''activity for which individual members could not be expected to bear the expense and thus lends itself to cooperative effort'' and the fact that the ''benefits are intangible and only indirectly related to the individual business.'' Activities constituting particular services ''can usually be characterized as either a 'means of bringing buyers and sellers together' or a 'convenience or economy' to members in conducting their business,'' wrote the IRS, which also cautioned that ''[f]ull participation by industry components does not guarantee that the activity provides an industry-wide benefit.''[44]

An association also cannot constitute an exempt business league when it is principally engaged in a trade or business for profit. Some organizations failed to qualify as exempt business leagues because they both engaged in for-profit business activities and rendered services to individual persons.[45] The private inurement doctrine is also applicable with respect to business leagues.[46]

The rules concerning unrelated business activities generally apply to business leagues.[47] Business leagues can become entangled in these rules by performing particular services for individual persons, where the extent of these services is less than substantial. For example, the IRS concluded that an executive referral service conducted by a tax-exempt professional association constituted the performance of particular services for individual persons but, because other activities were the association's primary ones, the IRS ruled

41. *Professional Insurance Agents of Michigan v. Commissioner*, 726 F.2d 1097 (6th Cir. 1984).
42. *Id*. at 1104.
43. *Id*.
44. Priv. Ltr. Rul. 8524006.
45. E.g., *Associated Master Barbers and Beauticians of America, Inc. v. Commissioner*, 69 T.C. 53 (1977); Rev. Rul. 81-175, 1981-1 C.B. 337; Rev. Rul. 81-174, 1981-1 C.B. 335.
46. *See* Chapter 4.
47. *See* Chapter 24.

that the service was an unrelated business.[48] Another instance of application of the unrelated business income rules in this setting is the effort of the IRS to tax the dues of associate members, where these members join the association for the principal purpose of gaining access to a program of the association (such as insurance)[49] or to the regular members (for marketing purposes).[50]

§ 18.2 HEALTHCARE TRADE ASSOCIATIONS

Various types of nonprofit organizations concerned with the provision of healthcare in the United States are classified as tax-exempt business leagues, notwithstanding the traditional view that the promotion of health is a charitable purpose.[51] As one illustration of this phenomenon, the healthcare field is replete with exempt business leagues, usually referred to generically as trade associations. Some of these associations have, as their membership, healthcare providers such as hospitals. Some of these associations' members are both tax-exempt and for-profit; others are one or the other. There are associations of hospitals, health maintenance organizations, nursing homes, homes for the aged, rehabilitation facilities, and many other similar entities. As noted above, there are collateral associations as well, such as those of development personnel who serve only healthcare institutions, vendors of products and services to these institutions, and lawyers who specialize in the healthcare field.

Another category of business league is the professional society: the type of business league the membership of which is healthcare professionals, such as physicians and dentists. Here again, these entities tend to be referred to as trade associations, despite the fact that their membership is comprised of professionals. These organizations operate for the benefit and advancement of the particular profession; the rules concerning business leagues serve as the basis for their tax exemption. Medical societies, dental societies, and the like are perceived by the IRS—generally backed up by the courts—as conducting activities that are directed primarily at the promotion of the profession involved and as operating to further the common business purpose of their members.

In the healthcare field (as in so many others), a tax-exempt professional society that is a business league engages in many activities that are charitable and educational. For example, a medical society is likely to conduct the following charitable and educational activities: meetings where technical papers

48. Priv. Ltr. Rul. 8524006.
49. Tech. Adv. Mem. 9416002 (taxation of associate member dues allegedly paid to gain access to automobile, health, dental, and farm owners' insurance plans; the IRS characterized the payments as ''access charges'' rather than dues). *See also, National Association of Postal Supervisors v. United States*, 91-2 U.S.T.C. (CCH) ¶ 50,446 (Fed. Cir. 1991); *American Postal Workers Union v. United States*, 925 F.2d 480 (D.C. Cir. 1991).
50. Tech. Adv. Mem. 9345004 (where the IRS taxed as advertising income the listings of associate members placed in a directory to make them more accessible to the association's regular members).
51. *See* § 1.7.

are presented, maintenance of a library, publication of a journal, provision of lecturers and counseling services at medical schools, and the support of public health programs. A medical society, however, is nearly certain to also undertake the following activities: programs concerned with the promotion and protection of the practice of medicine, maintenance of a grievance committee, operation of a patient referral service, attempts to influence legislation, and conduct of a public relations program. The position of the IRS is that these latter types of activities predominate, so that the business league endeavors are primary, with the charitable and educational activities secondary.[52]

Nonetheless, if a professional society's dominant activities are undertakings such as noncommercial research, maintenance of a library, and publication of a journal, it will qualify for tax exemption as being charitable, educational, and/or scientific in nature, as long as no substantial activities are directed at or are concerned with the protection or promotion of a professional practice or business interests of any of the professions represented by its membership.[53] In one instance, an organization of individuals from various public health and welfare professions (seemingly charitable in purpose) was ruled by the IRS to be a tax-exempt business league, for the reason that its "activities promote the business and professional interests of the members by increasing the effectiveness of the interaction of the various professions, by developing greater efficiency in the professions, and by solving problems common to the professions."[54]

A network of physicians that entered into contracts with self-insured employers for the provision of health benefits failed to qualify as an exempt business league, principally because it was performing particular services for individual persons.[55] By contrast, a certification function was held to benefit an industry in its entirety and not merely provide particular services to its members.[56]

§ 18.3 CERTIFICATION ORGANIZATIONS AND PEER REVIEW BOARDS

Where the primary purpose of a nonprofit organization is to provide benefits to members of a particular profession, its tax-exempt status is almost certain to be that of a business league.[57] Because of the potential of forms

52. Rev. Rul. 71-504, 1971-2 C.B. 231. The law is the same as respects bar associations and similar entities (e.g., Rev. Rul. 71-505, 1971-2 C.B. 232; *Hammerstein v. Kelly*, 349 F.2d 928 (8th Cir. 1965); *Colonial Trust Co. v. Commissioner*, 19 B.T.A. 174 (1930); Rev. Rul. 77-232, 1977-2 C.B. 71 (unrestricted contributions to state bar group held nondeductible as charitable gifts)).
53. Rev. Rul. 71-506, 1971-2 C.B. 233.
54. Rev. Rul. 70-641, 1970-2 C.B.119.
55. Priv. Ltr. Rul. 200522022.
56. Priv. Ltr. Rul. 200536023.
57. *See* text accompanied by *supra* notes 3-5.

of commensurate benefit to the participating physicians, the approach of the IRS to the categorization of these entities is manifested in its position on certification organizations. In general, the view of the IRS is that testing and certification programs are exempt functions of a business league, rather than a tax-exempt charitable, educational, or scientific organization, because these programs are designed and operated to achieve professional standing for the line of business represented and to enhance the respectability of those who are certified.[58] As to whether a certification program is appropriate for an exempt business league, the IRS's lawyers wrote that a certification program of one membership organization ''is designed and operated to achieve professional standing for . . . [its members] and to enhance the respectability of those who have been certified.''[59]

In a speech in 1973, the Commissioner of Internal Revenue, analogizing to organizations that accredit television repairpersons and automobile mechanics, commented that organizations that accredit physicians in their fields of specialization will be treated by the IRS as tax-exempt business leagues.[60] Thus, in the view of the IRS, enhancement of the medical profession, not delivery of healthcare services, is the primary objective of these organizations.[61]

This stance of the IRS is identical in the case of organizations that maintain codes of ethics in a particular professional field.[62] In the view of the IRS, the administration and enforcement of a code of ethics is a program designed to help achieve professional standing for the members of the profession involved and to enhance the respectability of those who have been certified.[63]

Similarly, the IRS ruled that an organization formed by physicians of a state medical society to operate peer review boards for the purpose of establishing and maintaining standards for quality, quantity, and reasonableness of the costs of medical services constituted a tax-exempt business league.[64]

58. Rev. Rul. 81-127, 1981-1 C.B. 357; Rev. Rul. 70-187, 1970-1 C.B. 131; Gen. Couns. Mem. 39721.
59. Gen. Couns. Mem. 39721. The term *certification* is not always confined to the credentialing of individuals. The term can also refer to certification of a process (e.g., Priv. Ltr. Rul. 200020056 (concerning certification of certain shipping documents)) or of organizations (although the latter function is usually referred to as *accreditation*).
60. Remarks of Commissioner Donald C. Alexander before the American Society of Association Executives (IR-1326, Aug. 29, 1973). This position does not extend to the certification of organizations and programs of organizations, which is, as noted, accreditation.
61. Likewise, Rev. Rul. 73-567, 1973-2 C.B. 178 (medical specialty board that devised and administered written examinations to physicians in a particular medical specialty and issued certificates to successful candidates held to be tax-exempt as a business league but not as a charitable organization).
62. Gen. Couns. Mem. 39721.
63. *Id*. In general, Hopkins, ''The Meaning of Tax-Exempt Status in the Work of Certification Organizations,'' Chapter 1 of Schoon and Smith (Eds.), The Licensure and Certification Mission (Forbes, Inc. 2000).
64. Rev. Rul. 74-553, 1974-2 C.B. 168 (where the primary objective was held to be the maintenance of the professional standards, prestige, and independence of the medical profession).

The IRS recognized that these organizations are established in response to concern over the increasing costs of medical care and in an effort to curb the expenses by reviewing medical procedures and utilization of medical facilities. Nonetheless, the IRS ruled, ''[a]lthough this activity may result in a measurable public benefit, its primary objective is to maintain the professional standards, prestige, and independence of the organized medical profession and thereby furthers the common business interest of the organization's members.''[65] The law is slightly divided on this point, however; some courts hold that improvement in the delivery of healthcare is a charitable function, even if the profession is otherwise benefited.[66] From this viewpoint, *utilization and quality control peer review organizations* (formerly known as *professional standards review organizations* (PSROs)) are classified as exempt charitable entities.

These peer review organizations, authorized by federal statute,[67] are qualified groups of physicians that establish mandatory cost and quality controls in connection with medical treatment rendered in hospitals and financed under Medicare and Medicaid, and that monitor the care given. They were conceived of as part of a larger effort to curb the rising costs of healthcare—in this instance, by minimizing or eliminating unnecessary services (overutilization) by assuring that payments under these governmental healthcare programs are made only when and to the extent that the healthcare services provided are medically necessary.

It is obvious that Congress viewed PSROs as organizations acting in the public interest, their purpose being to improve the quality of healthcare in the United States, thereby obtaining maximum value for every federal health dollar expended.[68] Assuming that the federal tax law requirements for exempt charitable organizations are otherwise satisfied,[69] this purpose would seem to constitute a charitable activity in that it promotes health, lessens the burdens of government, and promotes social welfare. A ''private'' purpose, however, may also be served by these peer review entities, namely, establishment of and enhancement in the medical profession (even though the organized medical community was bitterly opposed to this use of peer review).[70]

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65. *Id*. at 169.
66. E.g., *San Antonio District Dental Society v. United States*, 340 F. Supp. 11 (W.D. Tex. 1972); *Huron Clinic Foundation v. United States*, 212 F. Supp. 847 (S.D. 1962), *remanded*, 324 F.2d 43 (8th Cir. 1963) (lower court decision vacated because of settlement of case).
67. 42 U.S.C. § 1320c *et seq*.
68. The law states that the purpose of these organizations is to perform medicine and osteopathy peer reviews of the ''pattern of quality of care in an area of medical practice where actual performance is measured against objective criteria which define acceptable and adequate practice'' (42 U.S.C. § 1320c-1(2)).
69. *See* Part Two (Chapters 4–7).
70. The medical profession unsuccessfully sued to enjoin implementation of the PSRO law and to declare the authorizing legislation (Social Security Amendments of 1972, 86 Stat. 1429) unconstitutional (*Association of American Physicians & Surgeons v. Weinberger*, 395 F. Supp. 125 (N.D. Ill. 1975)).

The law requires these peer review organizations to be nonprofit organizations; they are reimbursed by the federal government for administrative costs. Members of these organizations must be licensed practitioners of medicine or osteopathy. Basically, therefore, the question must be—as respects tax-exempt charitable status—whether the peer review organization functions primarily to benefit the general public or to serve the interests of the medical profession. At the outset, the stance of the IRS was that the public benefits flowing from these peer review activities were overshadowed by the benefits accorded physicians professionally and that these entities could not qualify as tax-exempt charitable organizations.

During the period when this controversy was brewing, the IRS considered the tax-exempt status of another type of organization authorized by federal law[71] to establish and maintain a system of health planning and resources development aimed at providing adequate healthcare for a specified geographical area—the *health systems agency* (HSA). Among the functions of an HSA, which received planning and matching grants from the federal government, was the establishment of a health systems plan, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Department of Health and Human Services. The basis of the designation of the HSA as a charitable entity was the promotion of health. In so finding, the IRS observed that, ''[b]y establishing and maintaining a system of health planning and resources development aimed at providing adequate health care, the HSA is promoting the health of the residents of the area in which it functions.''[72]

The position of the IRS as to the basis of tax exemption for PSROs was litigated, in a case involving PSRO support centers.[73] Rejecting the IRS's arguments, the court held that the principal purpose of Congress in creating PSROs was to ensure the economical and effective delivery of healthcare services under Medicare and Medicaid, and that any benefits that physicians and others may derive (including reimbursement for services, limitation on tort liability, or promotion of esteem for the medical profession) have only a ''tenuous, incidental, and nonsubstantial connection with the PSRO scheme.''[74] On this point, the court added that the PSRO support centers do not engage ''in financial transactions designed to benefit the members of the organizations or the organizations themselves, activities in the nature of a patient referral service, or other potential money-making activities designed to benefit members or participants.''[75]

71. 42 U.S.C. § 300k *et seq.*, enacted as the National Health Planning and Resources Development Act of 1974 (88 Stat. 2225), subsequently repealed (100 Stat. 3799).
72. Rev. Rul. 77-69, 1977-1 C.B. 143, 144.
73. *Virginia Professional Standards Review Foundation v. Blumenthal*, 466 F. Supp. 1164 (D.D.C. 1979).
74. *Id*. at 1170.
75. *Id*. at 1173.

This court found it ''difficult to reconcile'' the position of the IRS against charitable status for PSROs and the ruling recognizing tax exemption, as charitable organizations, for HSAs.[76] The court observed that the ''similarity between HSAs and PSROs and PSRO support centers is obvious,'' in that ''PSROs collect and analyze data, establish regional norms and criteria of care, and coordinate activities with HSAs and other federal and state health planning entities.''[77]

As a result of these two court decisions,[78] the IRS altered its position concerning PSROs and concluded that, in certain circumstances, a PSRO is a charitable organization because it ''is promoting the health of the beneficiaries of governmental healthcare programs by preventing unnecessary hospitalization and surgery.''[79] The IRS, however, regards these factors as essential for exemption of a PSRO as a charitable entity: (1) membership in it is open by law to all physicians without charge; (2) it is an organization mandated by federal statute as the exclusive method of ensuring appropriate quality and utilization of care provided to Medicare and Medicaid patients; (3) the composition of the board of directors of the PSRO is not tied to any membership or association with any medical society; and (4) the PSRO has the authority to make final decisions regarding quality and utilization of medical care for purposes of payment under the Medicare and Medicaid programs. The fact that the activities of the PSRO ''may indirectly further the interests of the medical profession by promoting public esteem for the medical profession, and by allowing physicians to set their own standards for the review of Medicare and Medicaid claims and thus prevent outside regulation'' was dismissed as being ''incidental'' to the charitable benefits provided by the organizations.[80]

§ 18.4 LEGISLATIVE ACTIVITIES OF BUSINESS LEAGUES

There is no restriction, from the standpoint of tax exemption for business leagues, as to the amount of legislative activity in which these organizations may engage. As noted, the IRS recognized attempts to influence legislation as a valid function of a tax-exempt business league.[81]

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76. *Id*. at 1172.
77. *Id*. *See also, Professional Standards Review Organization of Queens County, Inc. v. Commissioner*, 74 T.C. 240 (1980).
78. *See supra* notes 71 and 75.
79. Rev. Rul. 81-276, 1981-2 C.B. 128.
80. *Id*. at 129. *See*, in general, GOSFIELD, PSROS: THE LAW AND THE HEALTH CONSUMER (1975); Bromberg, ''The Effect of Tax Policy on the Delivery and Cost of Health Care,'' 53 *Taxes* 452, 475–478 (1975); Welch, ''Professional Standards Review Organizations—Problems and Prospects,'' 289 *N. Eng. J. Med*. 291–295 (Aug. 1973); Somers, ''PSRO: Friend or Foe?,'' 289 *N. Eng. J. Med*. 321–322 (Aug. 1973).
81. Rev. Rul. 61-177, 1961-2 C.B. 117.

The federal tax law rules concerning deductible business expenses,[82] however, place extensive limitations with respect to the business expense deduction for lobbying expenses—limitations so broad and arduous as to essentially deny a business expense deduction for lobbying outlays altogether.[83] These rules potentially operate indirectly as a restriction on lobbying activities by business leagues because these associations are heavily dependent for their financial support on dues from members, who deduct the dues payments (in whole or in part) as business expenses; the matter thus can become one of membership relations. The restrictions on the use of the dues payments for legislative activities that attach by reason of the rules governing deductible business expenses thus potentially apply to the use of the funds by the business league.

(a) General Deduction Disallowance Rules

With two exceptions, there is no business expense deduction for any amount paid or incurred in connection with influencing legislation.[84] The definition of *influencing legislation*, for purposes of this rule, is similar to, yet broader than, the definition of expenditures to influence legislation under the expenditure test applicable with respect to electing public charities. This term means ''any attempt to influence any legislation through communication with any member or employee of a legislative body, or with any government official or employee who may participate in the formulation of legislation.''[85] Thus, a business expense deduction is not allowed for any amount paid or incurred in connection with any attempt to influence legislation through (1) communication with any member or employee of a federal or state legislative body (direct lobbying), (2) communication with the general public, or a segment of it, with respect to legislative matters, or (3) direct communication with a governmental official or employee (a covered executive branch official) who may participate in the formulation of legislation in an effort to influence the official actions or position of the official.[86] This deduction disallowance rule does not apply with respect to lobbying at the local level[87] or with respect to Indian tribal governments.[88] *Legislation* is broadly defined to include action with respect to acts, bills, resolutions, or similar items.[89]

82. IRC § 162.
83. IRC § 162(e).
84. IRC § 162(e)(1). The two exceptions are the subject of the text accompanied by *infra* notes 85 and 86.
85. IRC § 162(e)(4)(A). A discussion of this expenditure test is in § 7.1.
86. IRC § 162(e)(1)(A), (C), and (D). This disallowance rule also applies with respect to a participation or intervention in a political campaign on behalf of or in opposition to a candidate for public office (IRC § 162(e)(1)(B) (*see* § 7.2)).
87. IRC § 162(e)(2).
88. IRC § 162(e)(7).
89. IRC §§ 162(e)(4)(B) and 4911(e)(2).

The phrase *influencing legislation* includes various types of lobbying communications that refer to specific legislation and reflect a view on the legislation. A lobbying communication also is one that clarifies, amplifies, modifies, or provides support for various views reflected in a previous lobbying communication. This phrase also embraces all activities engaged in for a purpose of making or supporting a lobbying communication, even if not yet made; these activities include research, preparation, planning, and coordination, as well as deciding whether to make a lobbying communication. Whether an activity is engaged in for the requisite purpose is a determination to be based on all the facts and circumstances. These include whether (1) the activity and the lobbying communication are proximate in time; (2) the activity and the lobbying communication relate to similar subject matter; (3) the activity is performed at the request of, under the direction of, or on behalf of a person making the lobbying communication; (4) the results of activity are also used for a nonlobbying purpose; and (5) at the time the activity took place, there is specific legislation to which the activity relates.[90]

If an individual engages in an activity for both a lobbying purpose and a nonlobbying purpose, he or she must treat the activity as engaged in partially for each purpose. There must be a reasonable allocation of the costs for the two functions. An allocation with respect to multiple-purpose activities will, in general, not result in a reasonable allocation if it allocates to influencing legislation (1) only the incremental amount of costs that would not have been incurred but for the lobbying purpose or (2) an amount based solely on the number of purposes for engaging in that activity without regard to the relative importance of the purposes. The following activities are not considered to be lobbying: (1) before evidencing a purpose to influence an item of specific legislation, either determining the existence or procedural status of the legislation, or the time, place, and subject of any hearing to be held by a legislative body with respect to it, or preparing routine, brief summaries of the legislation; (2) performing an activity for purposes of complying with the requirements of a law (such as federal or state securities law filing requirements); (3) reading any publications available to the general public or viewing or listening to other mass media communications; and (4) attending a widely attended speech.[91]

If a person engages in activities for the purpose of supporting a lobbying communication to be made by another person (or group of persons), the person's activities are treated as influencing legislation. For example, if an employee of a corporation (as a volunteer or otherwise) that is a member of a business association engaged in an activity to assist the association in preparing a lobbying communication, that constitutes the influencing of legislation by the corporation, even if the lobbying communication is made by the

90. Reg. § 1.162-29.
91. *Id*.

association and not the corporation. This is not the outcome, however, when the employee acted as a volunteer outside the scope of his or her employment. The regulations include rules for activities engaged in for a lobbying purpose when the organization later concludes that no lobbying communication will be made regarding that activity. These activities are treated as if they had not been engaged in for a lobbying purpose if, as of the organization's timely filed return, it no longer expects, under any reasonably foreseeable circumstances, that a lobbying communication will be made that is supported by the activity. Thus, the amount allocated to that activity for the year would not be treated as a lobbying expenditure. If that conclusion is reached at a time after the filing date, the amount allocated to that activity is treated as an amount that is paid or incurred only at that time in connection with a nonlobbying activity. Exempt organizations reduce their lobbying expenditures by these amounts.[92]

This body of law disallows a business expense deduction for costs incurred in connection with any direct communication with a *covered executive branch official* in an attempt to influence the official actions or positions of the official.[93] A covered executive branch official means the President, the Vice President, any officer or employee of the White House Office of the Executive Office of the President, the two most senior-level officers of each of the other agencies within the Executive Office of the President, an individual serving in a position in level I of the Executive Schedule[94] (such as a member of the Cabinet) or any other individual designated by the President as having Cabinet-level status, and any immediate deputy of an individual in the preceding category.[95]

Any amount paid or incurred for research for, or preparation, planning, or coordination of, any lobbying activity subject to the general disallowance rule is treated as paid or incurred in connection with the lobbying activity.[96] The purpose of this rule is to convert what might otherwise be a function constituting nonpartisan analysis, study, or research[97] into a lobbying undertaking where the research is subsequently used in an attempt to influence legislation.

A *de minimis* rule exempts certain *in-house expenditures* for lobbying from the general disallowance rule, if an organization's total amount of these expenditures for a tax year does not exceed $2,000 (computed without taking into account general overhead costs otherwise allocable to lobbying).[98] *In-house expenditures* means expenditures for lobbying (such as labor and materials

92. *Id*.
93. IRC § 162(e)(1)(D).
94. 5 U.S.C. § 5312.
95. IRC § 162(e)(6).
96. IRC § 162(e)(5)(C).
97. *See* § 7.1(b)(ii), text accompanied by note 41.
98. IRC § 162(e)(5)(B)(i).

costs) other than payments to a professional lobbyist to conduct lobbying for the organization, and dues or other similar payments that are allocable to lobbying (such as association dues).[99]

There are no exceptions to these rules (other than the ones for lobbying at the local level). Any communication compelled by subpoena, or otherwise mandated by federal or state law, however, does not constitute an attempt to influence legislation or a government official's actions.[100] It is not clear whether an invitation from a legislative committee to provide testimony with respect to a legislative matter removes the expenses of preparing and delivering the testimony from the ambit of *lobbying* (as is the case in connection with the rules governing charitable organizations[101]).

(b) Cost Allocations

The conference report accompanying this legislation directed the IRS to provide guidance for distinguishing costs incurred in connection with attempts to influence legislation from mere monitoring of legislative activities where there is no attempt to influence the formulation or enactment of legislation.[102] Where a taxpayer or tax-exempt organization monitors legislation and subsequently attempts to influence the formulation or enactment of the same or similar legislation, the costs of the monitoring activities generally are treated as incurred in connection with nondeductible lobbying activity.[103]

The conference report expressed an intent that the IRS will ''permit taxpayers to adopt reasonable methods for allocating expenses to lobbying (and related research and other background) activities in order to reduce taxpayer record-keeping responsibilities.''[104]

There are three methods to use in allocating in-house expenses to direct lobbying activities for purposes of application of the rule disallowing a business expense deduction for outlays allocable to lobbying. These allocation rules are used, in determining the nondeductible amount of costs applicable to these lobbying activities, by both tax-exempt organizations and for-profit businesses. That is, a tax-exempt organization (covered by these rules) must follow these regulations in computing its in-house lobbying costs, which in turn are used to calculate the ratio by which a portion of the organization's dues is rendered nondeductible as business expenses.[105]

The cost allocation rules (inapplicable with respect to payments to independent professional lobbyists) do not require persons to maintain any particular

99. IRC § 162(e)(5)(B)(ii).
100. H.R. Rep. No. 103-213, 103 d Cong., 1st Sess. 607 (1993).
101. *See* e.g., § 7.1(b)(ii), text accompanied by notes 42 and 43.
102. H.R. Rep. No. 103-213, 103 d Cong., 1st sess. 606 (1993).
103. *Id*.
104. *Id*., note 63.
105. Reg. § 1.162-28.

records of costs of lobbying activities, such as daily time logs, other than those generally required by the law. The rules generally describe the costs that are properly allocable to lobbying activities; they permit the use of any reasonable method to allocate those costs between lobbying activities and other activities. To be *reasonable*, a method must be applied consistently, allocate a proper amount of costs (including labor costs and general and administrative costs) to lobbying activities, and be consistent with certain special rules.[106]

Labor costs allocable to lobbying activities include costs attributable to full-time, part-time, and contract employees. These costs include all elements of compensation, such as basic compensation, overtime pay, vacation pay, holiday pay, sick leave pay, payroll taxes, pension costs, other employee benefits, and payments to a supplemental unemployment benefit plan. For each year, general and administrative costs allocable to lobbying activities are depreciation, rent, utilities, insurance, maintenance costs, security costs, and other administrative department costs (such as payroll, personnel, and accounting).[107]

An organization can use the following methods of allocating costs to lobbying activities: the *ratio method*, the *gross-up method*, the *unicap method*, or any other reasonable method of cost allocation. (The third of these methods is an allocation method that applies the principles of the rules concerning capitalization and inclusion in inventory costs of certain expenses.[108])

(i) Ratio Method. Under the ratio method, an organization multiplies its ''total costs of operations'' (excluding third-party costs) by a fraction, the numerator of which is its ''lobbying labor hours'' and the denominator of which is its ''total labor hours.'' The entity adds the result of this calculation to its third-party costs to determine the costs properly allocable to direct lobbying activities. Thus, this method requires understanding of these terms:

- **Total costs of operations.** An organization's total costs of its program or business for a year (other than third-party costs).
- **Third-party costs.** Amounts paid or incurred for lobbying activities conducted by third parties (such as professional lobbyists' fees, and dues), amounts paid or incurred for travel (including meals and lodging while away from home), and entertainment relating to lobbying activities.
- **Lobbying labor hours.** The hours that the personnel of an organization spend on lobbying activities during a year.

106. *Id*.
107. *Id*.
108. IRC § 263A.

- **Total labor hours.** The total number of hours of labor that the personnel of an organization spend on its program or business during a tax year; an organization may make reasonable assumptions concerning total hours worked by its personnel during the year.

An entity using the ratio method is able to treat as zero the hours spent by personnel engaged in secretarial, maintenance, and similar activities. An organization treating these hours as zero must do so for determining both lobbying labor hours and total labor hours. Costs for these personnel would, however, have to be included in the total costs of operations.[109]

The following is an illustration of how the ratio method is applied.

Example 18.1: In 2001, three full-time employees—A, B, and C—of organization W engaged in both direct lobbying activities and nonlobbying activities. A spent 300 hours, B spent 1,700 hours, and C spent 1,000 hours on lobbying activities, for a total of 3,000 hours on lobbying for W. W reasonably assumed that each of these three employees spent 2,000 hours in the year on W's program activities. The total costs of operation for W for the year were $300,000. There were no third-party costs. The numerator of the fraction (lobbying labor hours) is 3,000; the denominator of the fraction (total labor hours) is 6,000. The resulting ratio (1/2) is multiplied against the total costs of operations to determine the costs allocable to direct lobbying activities ($150,000).

(ii) Gross-Up Method. Under the gross-up method, an organization allocates costs to lobbying activities by multiplying its ''basic labor costs'' for lobbying hours by 175 percent. For this purpose, the entity's basic labor costs are limited to wages or other similar costs of labor, such as guaranteed payments for services. Pension costs and other employee benefits are not included in basic labor costs. As with the ratio method, third-party costs are added to the result of the calculation to arrive at the total costs allocated to lobbying activities.

The following is an illustration of how the gross-up method is applied (imitating some of the facts of the previous example).

Example 18.2: In a year, three employees—A, B, and C—of organization X engaged in direct lobbying activities and nonlobbying activities. A spent 300 hours, B spent 1,700 hours, and C spent 1,000 hours on lobbying activities, for a total of 3,000 hours on lobbying for X. There were no third-party costs. X determined that its basic labor costs for the year were $20 per hour for A, $30 per hour for B, and $25 per hour for C. Thus, X's basic labor costs for the year were $82,000 (($20 × $300) + ($30 × $1,700) + ($25 × $1,000), or ($6,000 + $51,000 + $25,000)). $82,000 × $175 percent equals $143,500, which, under the gross-up method, is X's cost for direct lobbying activities for that year.

109. The regulation does not define an hour. An hour is 60 minutes, but, for example, is 45 minutes of lobbying to be rounded off and considered an hour or are records to be kept, totaling up minutes of lobbying, so that every 60-minute increment is an hour? As noted, the regulations do not require the maintenance of time logs, yet the requirement seems unavoidable, particularly with the ratio method of cost allocation.

(iii) Unicap Method. The third method is the unicap method.[110] As to use of the principles of this method and the accompanying regulations to determine costs properly allocable to lobbying activities, lobbying is considered a service department or function.

Organizations that do not pay or incur reasonable labor costs for persons engaged in lobbying activities cannot use the ratio method or the gross-up method. For example, a partnership or sole proprietorship—in which the lobbying activities are performed by the owners, who do not receive a salary or guaranteed payment for services—does not pay or incur reasonable labor costs for persons engaged in those activities, and thus would not be able to use either method.

There is a de minimis rule for labor hours spent by personnel on lobbying activities. Under this rule, an organization can treat time spent by personnel on lobbying activities as zero, if less than 5 percent of these persons' time was spent on lobbying activities.

This de minimis rule does not apply to ''direct contact lobbying'' with legislators and covered executive branch officials. An activity is this type of lobbying if it is a meeting, telephone conversation, letter, or similar means of communication with a legislator (other than a local one) or covered executive branch official, and otherwise qualifies as a lobbying activity. Thus, all hours spent by an individual on direct contact lobbying, as well as the hours he or she spends in connection with direct contact lobbying (such as background meetings), must be allocated to lobbying activities.

The hours spent in a meeting would not be treated as hours spent engaged in a lobbying activity if no substantial purpose of the meeting was a lobbying activity. Unless the facts and circumstances clearly indicate otherwise, it would be presumed that a substantial purpose of a meeting with a federal or state legislator, a member of the staff of such an individual, a member of the staff of a federal or state legislative joint committee or similar body, or a covered executive branch official was a lobbying activity. For example, an individual who is merely present for a widely attended speech by a legislator would not treat the hours attending the meeting as hours spent engaged in lobbying activity, absent unusual facts.

These regulations do not apply to the expenditures of persons who are engaged in the trade or business of conducting lobbying activities on behalf of another person.[111]

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110. IRC § 263A.
111. IRC § 162(e)(5)(A). (This reference is to the anticascading rule, summarized in § 18.4.) *See* generally, Pecarich and Primosch, ''Final Lobbying Regs. Ease the Tracking of Expenses, But Some Definitions Remain Vague,'' 83 *J. Tax'n Exempt Orgs*. (No. 5) 261 (Nov. 1995).

(c) Association Dues

Under a flow-through rule that is applicable to nearly all tax-exempt associations, the portion of membership dues (or voluntary payments or special assessments) paid to an organization that engages in lobbying activities is disallowed as a business expense deduction.[112] The disallowed amount of these payments is the portion applicable to lobbying expenditures incurred by the organization. For this purpose, lobbying expenditures incurred by an organization are allocated first to dues paid to the organization; any excess amount of lobbying expenditures is carried forward and allocated to dues paid to the organization in the following year.

Trade, business, and professional associations and similar organizations generally are required to disclose in an annual information return the total amount of their lobbying expenditures and the total amount of dues (or similar payments) allocable to these expenditures.[113] For this purpose, an organization's lobbying expenditures for a taxable year are allocated to the dues received during the taxable year.[114] Any excess amount of lobbying expenditures is carried forward and allocated to dues received in the following taxable year.[115]

The organization also generally is required to provide notice to each person paying dues (or similar payments), at the time of assessment or payment of the dues, of the portion of dues that the organization reasonably estimates will be allocable to the organization's lobbying expenditures during the year and that is, therefore, not deductible by the member.[116] This estimate must be reasonably calculated to provide the organization's members with adequate notice of the nondeductible amount. This notice must be provided in a conspicuous and easily recognizable format.[117]

(d) Proxy Tax

If, for a tax year, an organization does not provide its members with reasonable notice of anticipated lobbying expenditures allocable to dues, the organization is subject to a *proxy tax* on its aggregate lobbying expenditures for the year.[118] If an organization's actual lobbying expenditures for a tax year exceed the estimated allocable amount of the expenditures (either because of higher-than-anticipated lobbying expenses or lower-than-projected dues

112. IRC § 162(e)(3).
113. IRC § 6033(e)(1)(A)(i).
114. IRC § 6033(e)(1)(C)(i).
115. IRC § 6033(e)(1)(C)(ii).
116. IRC § 6033(c)(1)(A)(ii).
117. This format is the same as that of IRC § 6113, which requires disclosure of the nondeductibility of contributions to noncharitable organizations.
118. IRC § 6033(e)(2)(A)(ii). This tax is reported on Form 990-T (the tax return also used to report unrelated business income). *See* § 35.3(a)(iv).

receipts), the organization generally must pay the proxy tax on the excess amount or seek permission from the IRS to adjust the following year's notice of estimated expenditures.[119] The proxy tax rate is equal to the highest corporate rate in effect for the tax year.[120]

As an alternative to the disclosure requirements, an organization may elect to pay the proxy tax on the total amount of its lobbying expenditures (up to the amount of dues and other similar payments received by the organization) during the tax year.[121] In this instance, no portion of any dues or other similar payments made by members of the organization is rendered nondeductible because of the organization's lobbying activities. Thus, if the association pays the tax, the dues payments are fully deductible by the members as business expenses (assuming they otherwise qualify).

An organization that underreports the total amount of its lobbying expenses in any tax year is required to pay the proxy tax on any undisclosed or underreported amount.[122] This tax may be imposed regardless of whether the organization has elected disclosure of lobbying expenses to its members or payment of the proxy tax for the tax year—thus, this tax serves as a penalty, and it may be imposed in addition to interest charges and any other penalties that may apply.

(e) Exemptions

The disclosure requirement is not applicable with respect to an organization that incurs only de minimis amounts of in-house lobbying expenditures (or, as noted, elects to pay the proxy tax on its lobbying expenditures incurred during the tax year).[123] The concept of ''de minimis in-house expenditures'' in this setting is the same as that in the disallowance rules (including the $2,000 maximum).[124] Amounts paid to outside lobbyists or as dues to another organization that engages in lobbying do not qualify for this exception.

This annual information return disclosure requirement is not applicable to charitable organizations.[125]

The disclosure and proxy tax requirements are inapplicable with respect to an organization that establishes, pursuant to an IRS regulation or procedure, that substantially all of its dues moneys are paid by members who are not

119. IRC § 6033(e)(2)(B).
120. IRC § 6033(e)(2)(A). The highest corporate tax rate is 35 percent (IRC § 11).
121. IRC § 6033(e)(2)(A)(i).
122. IRC § 6033(e)(2)(A)(ii).
123. IRC § 6033(e)(1)(B)(ii).
124. *See supra* notes 98 and 99.
125. IRC § 6033(e)(1)(B)(1). The reference to charitable organizations is to those exempt by reason of IRC § 501(c)(3).

entitled in any event to deduct the dues in computing their taxable income.[126] In this context, *substantially all* means at least 90 percent.[127]

Three examples of organizations of this nature are (1) an organization that receives at least substantially all of its dues moneys from members that are tax-exempt charitable organizations; (2) an organization that receives at least substantially all of its dues moneys from members who are individuals not entitled to deduct the dues payments because the payments are not ordinary and necessary business expenses;[128] and (3) a union[129] or other organization that receives at least substantially all of its dues moneys from individuals who cannot deduct their dues because of the 2 percent floor on miscellaneous itemized deductions.[130]

In implementation of this exception, the IRS issued a revenue procedure containing the rules by which certain tax-exempt organizations are exempted from the lobbying activities disclosure and proxy tax requirements.[131] The rule defines *similar amounts* as including voluntary payments made by members, assessments made by the organization to cover basic operating costs, and special assessments imposed by the organization to conduct lobbying activities. The proxy tax requirements also are not applicable to these organizations.

The rule provides a complete exemption from these reporting and notice requirements for all tax-exempt organizations, other than social welfare organizations,[132] agricultural and horticultural organizations, and trade, business, and professional associations.[133] Thus, for example, labor unions and other tax-exempt labor organizations are given this blanket exemption.

Nonetheless, there are limited exemptions for these three categories of organizations:

1. Social welfare organizations are exempt from the requirements if (a) more than 90 percent of all annual dues (or similar amounts) are received from persons, families, or entities who each pay annual dues (or similar amounts) of less than $50 (indexed for inflation) or (b) more than 90 percent of all annual dues (or similar amounts) are received from charitable organizations, state governments, local governments, political subdivisions, or other tax-exempt organizations.
2. Agricultural and horticultural organizations have the same exemption as social welfare organizations.

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126. IRC § 6033(e)(3). The principal reason that this deduction would not be available is the 2 percent floor on the deductibility of miscellaneous business expenses (IRC § 67).
127. H.R. Rep. No. 103-213, 103d Cong., 1st Sess.
128. This rule is applicable to many tax-exempt social welfare organizations. *See* § 1.8.
129. One that is tax-exempt by reason of IRC § 501(c)(5).
130. H.R. Rep. No. 103-213, 609, note 68 (1993). This floor is the subject of IRC § 67.
131. Rev. Proc. 95-35, 1995-2 C.B. 391.
132. Organizations that are tax-exempt by reason of IRC § 501(c)(4).
133. Organizations that are tax-exempt by reason of IRC § 501(c)(6).

3. Trade, business, and professional organizations are exempt from the requirement where more than 90 percent of their members are charitable organizations.[134]

In any other set of circumstances, the tax-exempt organization may request and receive a private letter ruling from the IRS that this exception is available. The grounds for this request would be that at least 90 percent of the dues (or similar amounts) paid to the organization are not deductible as a business expense in any event.[135]

An organization that believes that this exemption is available because of the composition of its membership may obtain a waiver from the IRS (in the

134. These exemptions (both the blanket and the special ones) are available only to tax-exempt organizations that are recognized as such by (that is, having a ruling or determination letter from) the IRS.

135. E.g., Priv. Ltr. Rul. 9429016. Obtaining a private letter ruling waiver from the IRS is most difficult for trade, business, and professional associations (those classified under IRC § 501(c)(6)). For the most part, these dues are generally deductible as business expenses. In some cases, the deduction is not available to an individual because of the 2 percent floor on miscellaneous deductions (*see* text accompanied by *supra* note 125). Some individuals who are self-employed, however, may take the deduction as an expense in computing profit or loss from a sole proprietorship. Some individuals may have their dues paid by an employer, which is a tax-exempt organization (and thus there is no deduction). If the employer is a for-profit entity, presumably it will claim the deduction. Where organizations are members, the matter of the deduction will also depend—in part, anyway—on whether the entity is or is not tax-exempt.

This note requires an organization in this situation to provide ''evidence'' to the IRS as to the 90 percent threshold. It may prove arduous for an organization to canvass its membership to ascertain these details. Some organizations will be better off paying the proxy tax, rather than struggling with the reporting and notice exception. The business league/association community challenged the constitutionality of the rules by which the deductibility, as a business expense, of the dues paid by members of an association is limited as a consequence of lobbying (or political campaign activity) by the association. This challenge—on free speech and equal protection grounds—failed, and did so for the same basic reasons that the challenges in the charitable setting failed: Congress has broad latitude in creating classifications and distinctions in tax statutes, and Congress did not preclude associations from lobbying but instead lawfully eliminated a tax subsidy underlying the lobbying activity. As the court stated its conclusion, the ''challenged provisions do not impose 'penalties' on tax-exempt associations that engage in lobbying, but merely enforce the decision of Congress to eliminate the lobbying subsidy'' (*American Society of Association Executives v. United States*, 23 F. Supp. 2d 64 (D.D.C. 1998)). The speech about legislation was found to encompass the ''entire spectrum of possible viewpoints and is, therefore, viewpoint neutral'' (*id*. at 70)—a finding that blunted the claim that the challenged provisions discriminate on the basis of the content of the speech. These tax provisions were held to be rationally related to a legitimate government interest and thus constitutional, in relation to both free speech and equal protection principles. (*See also American Society of Association Executives v. Bentsen*, 848 F. Supp. 245 (D.D.C. 1994).) This opinion was affirmed on appeal (195 F.3d 47 (D.C. Cir. 1999)); the Supreme Court declined to formally review these opinions (120 S.Ct. 1961 (2000)).

form of a private letter ruling)[136] or may claim the exemption on its annual information return.[137]

(f) Anticascading Rule

This body of law contains an anti-avoidance rule, designed to prevent a ''cascading'' of the lobbying disallowance rule. The purpose of this rule is to ensure that, when multiple parties are involved, the general lobbying disallowance rule results in the denial of a business expense deduction at only one level.

Thus, in the case of an individual engaged in the trade or business of providing lobbying services or an individual who is an employee and receives employer reimbursements for lobbying expenses, the disallowance rule does not apply to expenditures of the individual in conducting the activities directly on behalf of a client or employer.[138] Instead, the lobbying payments made by the client or employer to the lobbyist or employee are nondeductible under the general disallowance rule.

This anticascading rule applies where there is a direct, one-on-one relationship between a person and the entity conducting the lobbying activity, such as a client or employment relationship. It does not apply to dues or other payments to taxable membership organizations that act to further the interests of all of their members rather than the interests of any one particular member. These organizations are themselves subject to the general disallowance rule based on the amount of their lobbying expenditures.[139]

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136. IRC § 6033(e)(3).
137. Form 990, line 85a.
138. IRC § 162(e)(5)(A).
139. H.R. Rep. No. 103-213, 103 d Con., 1st Sess. 610 (1993).

CHAPTER NINETEEN

Other Health-Related Organizations

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§ 19.1 PHYSICIAN REFERRAL SERVICES

Physician referral services consist of organizations that, for a modest fee, supply information to the public concerning the availability of various types of physician services, as well as healthcare supplies, equipment, and auxiliary services.

Despite the efforts by the IRS to deny tax-exempt status as charitable organizations to nearly all entities providing referral services,[1] the Tax Court has, on at least one occasion, held that an organization that was a ''medical and dental referral service'' qualified as a charitable entity because it promoted health.[2] Although that organization's primary activity was the operation of a referral service, it also conducted a variety of other activities, including the publication of a healthcare newsletter, sponsorship of a community health fair, and arrangements for speakers to discuss health-related matters with community groups. Subscribers to the referral service had to pay an annual fee (generally $12). Subscribers were then provided with a membership card and a booklet listing the costs of common medical and dental procedures and the availability of discounts on various health-related goods and services. Subscribers could also call the referral service to obtain the name of a physician or

1. E.g., Rev. Rul. 80-287, 1980-2 C.B. 186 (lawyers' referral service was not exempt under IRC § 501(c)(3), but was exempt as a business league under IRC § 501(c)(6)). In *Kentucky Bar Foundation, Inc. v. Commissioner*, 78 T.C. 921 (1982), the IRS's denial of exemption under IRC § 501(c)(3) to a lawyer referral service was reversed by the Tax Court, which ruled that the referral service in question was exempt from tax as a charitable organization.
2. *Fraternal Medical Specialist Services, Inc. v. Commissioner*, 49 T.C.M. 289 (1984).

dentist. Referrals were generally made on the basis of geographical proximity to a subscriber's residence. The organization screened the professional qualifications of its medical and dental providers, and providers had given an oral understanding that they would provide products and services at reduced rates to subscribers.

Service providers do not pay a listing fee to the organization, although the organization does solicit voluntary contributions from the providers. On average, 60 percent of the providers made a voluntary contribution ranging from $25 to $220. However, in making referrals, the organization does not discriminate in favor of those providers who have made contributions. The organization's sole sources of income are its subscriber fees and the donations received from service providers. In most years, its revenues exceeded expenses by only a few hundred dollars, and profits never exceeded 3 percent of gross receipts. Moreover, its executive director, who works 40 hours per week, was paid a salary of less than $5,000 annually, and two board members and the director of dentistry served without compensation.

Based on the foregoing facts, the IRS ruled that the organization was operated in furtherance of substantial commercial purposes and also served the private interests of the service providers.[3] However, the Tax Court disagreed, finding that the organization's referral service served charitable purposes by providing a resource whereby subscribers can be made aware of and referred to medical specialists who can serve their healthcare needs. The Tax Court noted that the organization's profits and salaries were quite modest, and that it did not compete with any commercial enterprise. These facts demonstrated, said the court, that the organization does not operate in furtherance of a substantial commercial purpose. The court also noted that the services of the service providers clearly further the organization's exempt purpose of promoting health, and that any benefit to the service providers is incidental, because they received no more than a minimal number of annual referrals from the organization.

Thus, at least under some narrowly defined circumstances, physician referral services apparently can be tax-exempt as charitable organizations, although the IRS is likely to closely scrutinize the Application for Recognition of Exemption (Form 1023) for these entities.

§ 19.2 NURSE REGISTRIES

Nurse registries generally consist of organizations that maintain a register of qualified nursing personnel, including registered nurses, unregistered nursing school graduates, licensed attendants, and practical nurses, who are

3. In support of these positions, the IRS cited *BSW Group, Inc. v. Commissioner*, 70 T.C. 352 (1978), and *Federation Pharmacy Services v. Commissioner*, 72 T.C. 687 (1979).

available to fill the temporary or long-term nursing needs of hospitals, nursing homes, other health agencies, doctors, and individuals.

(a) Exempt Nurse Registries

The IRS has ruled on one occasion that a nurse registry can qualify for tax-exempt status.[4] At that time, the IRS ruled that a ''community nursing bureau'' that maintained a nonprofit register of qualified nursing personnel for the benefit of hospitals, health agencies, doctors, and individuals, and that received its primary financial support from various community organizations and public contributions, qualified for exemption as a charitable organization. The organization in question was formed as a result of a study by the nursing council of a metropolitan area in cooperation with civic and professional groups. The organization's purpose was to broaden the scope of services rendered by existing nurses' registers, which was inadequate as a general community activity. It operated a central directory of both professional and nonprofessional qualified nursing personnel, and it was controlled by a board of directors drawn principally from public health and welfare organizations and the public at large. No part of the net earnings of the organization inured to the benefit of any private individual.

Based on the foregoing facts, the IRS concluded, without any legal analysis, that the ''purposes and activities of the organization are directed to the relief of conditions relating to the health of the community, which is a matter of public concern, rather than those of a professional society.''

(b) Taxable Nurse Registries

Most nurse registries do not qualify for tax exemption, however, because they essentially operate as an employment agency for the benefit of individuals. For example, the IRS has ruled that an association was not exempt from tax as a charitable organization where it consisted of professional private-duty nurses and practical nurses who operated a nurses' registry ''primarily to afford greater employment opportunities for its members.''[5] The association's bylaws specifically stated that its purposes were to provide employment for its members, as well as to organize an adequate and available nursing placement service for the community. The association was controlled by a board of directors composed of professional nurses, and its income was derived principally from membership dues, fees, and assessments.

Although no part of its net earnings inured to the benefit of any private individual, the IRS concluded that the association was ''primarily engaged in the performance of personal services by operating an employment service

4. Rev. Rul. 55-656, 1955-2 C.B. 262.
5. Rev. Rul. 61-170, 1961-2 C.B. 112.

principally for the benefits of its members.'' In addition, the IRS noted that public participation in the management and support of the organization was negligible. Based on the foregoing, the IRS was able to distinguish this nurse registry from the one that was found to be tax-exempt, and concluded that this registry was not organized and operated exclusively for charitable purposes.

Moreover, the above association did not qualify as a Code section 501(c)(6) business league because its primary purpose was the operation of a regular business of a kind ordinarily carried on for profit, and because it engaged in rendering employment services for individuals rather than promoting the general business conditions of the nursing profession.[6]

(c) Worker Classification Issues

The worker classification[7] of nurses working for nurse registries has long been a matter of dispute. Nurse registries often treat their nurses as independent contractors, rather than as employees, on the theory that the nurse registry does not exercise substantial control over the nurses or over their method of performing services for the service recipients. However, the IRS has consistently held that supplemental staffing nurses working for nurse registries and similar entities are employees.[8] The following factors are frequently cited by the IRS as the primary grounds for its conclusion:

1. The services of the nurses were integrated into the business operations of the agency.
2. The nurse was essential to the agency's being able to operate its nursing business.
3. The nurses did not subject themselves to a risk of loss.
4. The staffing agencies always had the right to exercise some degree of control over the nurses, and, often, that right was actually exercised (such as by the use of a ''coordinator'' to resolve work performance problems).
5. The nurses were required to perform their services personally, were generally paid on an hourly basis, and had a continuing relationship with the agency.

In one case,[9] the court held that nurses working for a nurse registry that provided nurses to hospitals were independent contractors and the registry did not have to pay any employment taxes or penalties. However, the

6. *Id*.
7. *See* Chapter 27.
8. Tech. Adv. Mem. 9135001; Tech. Adv. Mem. 8913002; Priv. Ltr. Rul. 9122020; Priv. Ltr. Rul. 9415001; Rev. Rul. 75-101, 1975-1 C.B. 318.
9. *Critical Care Registered Nursing, Inc. v. United States*, 91-2 U.S.T.C. (CCH) ¶ 50,481 (E.D. Pa. 1991).

Commissioner of the IRS announced, on August 8, 1994, that she "does not acquiesce" in the above decision.[10] Thus, it appears that the IRS will continue to classify most nurses working for nurse registries as employees.

§ 19.3 CHARITABLE RISK POOLS

A new category of charitable organizations, the *qualified charitable risk pool*, was added to the law in 1996.[11] This body of statutory law overrides otherwise applicable case law denying tax-exempt status to eligible charitable risk pools.[12]

A qualified charitable risk pool is an entity organized and operated solely to pool insurable risks of its members—including health and medical insurance (other than medical malpractice risks)—and to provide information to its members with respect to loss control and risk management.[13] No profit or other benefit may be accorded to any member of the organization other than through the provision of members with insurance coverage below the cost of comparable commercial coverage (and loss control and risk management information).[14] Only charitable organizations can be members of these pools.[15]

This type of pool is required to be organized as a nonprofit organization under state law authorizing risk pooling for charitable organizations; to be exempt from state income tax; to obtain at least $1 million in start-up capital[16] from nonmember charitable organizations[17]; to be controlled by a

10. 1994-32 I.R.B. 4. A nonacquiescence signifies that, although no further appeal was sought in the case, the IRS does not agree with the court's decision and generally will not follow the decision in disposing of cases involving other taxpayers.
11. IRC § 501(n)(1)(A).
12. The case law involved is based on IRC § 501(m) (*see* § 9.4). Courts have held that the insurance coverage provided by these risk pools, for the benefit of small charitable organizations that cannot obtain or afford (if it is available) one or more types of insurance (such as vehicle, general commercial, and professional liability insurance), constitutes commercial-type insurance, thus defeating tax exemption for the pool (*Paratransit Insurance Corporation v. Commissioner*, 102 T.C. 745 (1994); *Nonprofits' Insurance Alliance v. United States*, 94-2 U.S.T.C. (CCH) ¶ 50,593 (Fed. Cl. 1994)). Also *Florida Hospital Trust Fund v. Commissioner*, 103 T.C. 140 (1994), *aff'd*, 71 F.3d 808 (11th Cir. 1996). This outcome is clearly beyond the intended purpose of IRC § 501(m) yet was dictated by the sweeping scope of the language. Organizations described in IRC § 501(n) are not subject to IRC § 501(m).
13. IRC § 501(n)(2)(A).
14. H.R. Rep. No. 104-737, 104th Cong., 2d Sess. 189 (1996).
15. IRC § 501(n)(2)(B).
16. This term means any capital contributed to, and any program-related investments (*see* § 5.9) made in, the risk pool before the pool commences operations (IRC § 501(n)(4)(A)).
17. A "nonmember charitable organization" is a tax-exempt organization described in IRC § 501(c)(3), which is not a member of the risk pool and does not benefit, directly or indirectly, from the insurance coverage provided by the pool to its members (IRC § 501(n)(4)(B)).

board of directors elected by its members; and to provide three elements in its organizational documents: namely, that members must be tax-exempt charitable organizations at all times, that if a member loses that status it must immediately notify the organization, and that no insurance coverage applies to a member after the date of any final determination that the member no longer qualifies as a tax-exempt charitable organization.[18]

The rule that a charitable organization cannot be exempt from tax if a substantial part of its activities consists of providing commercial-type insurance is not applicable to charitable risk pools.[19] Because this category of tax exemption is based on qualification as a charitable organization, a risk pool must satisfy all of the other requirements for achievement of this tax-exempt status.[20]

§ 19.4 HOSPITAL MANAGEMENT SERVICES ORGANIZATIONS

Organizations that manage other healthcare organizations can qualify as charitable organizations as long as they do not run afoul of the IRS's position on the relatedness of the manager and the organizations it manages. This position was reasserted when the IRS released guidance that proposed to prospectively revoke the tax-exempt status of Great Plains Health Alliance (GPHA).[21] GPHA is a nonprofit Kansas corporation that manages and leases 26 small rural hospitals in Kansas and Nebraska. It has enjoyed IRS recognition of its charitable status for the past 48 years, with that status reconfirmed by the IRS as recently as 1984 when GPHA merged with another organization. However, when the IRS undertook a routine audit of GPHA's pension plans, it broadened its inquiry and ultimately issued an adverse determination letter. Although GPHA has since challenged the IRS decision in a petition seeking a declaratory judgment pending before the U.S. Tax Court, there is ample prior guidance to support the IRS's position. Nevertheless, this ruling will likely prompt many healthcare organizations to reassess their arrangements with unaffiliated exempt organizations.

The primary issue raised by the IRS guidance is whether GPHA's management and operational maintenance of a network of unaffiliated hospitals is in furtherance of a charitable activity. Specifically, the IRS looked at whether

18. IRC §§ 501(n)(2)(C), (3).
19. IRC § 501(n)(1)(B).
20. *See* Part Two. In general, Larue, Jr., ''Small Business Act Grants Exempt Status to Charitable Risk Pools,'' 8 *J. Tax'n Exempt Orgs*. (No. 3) 103 (Nov./Dec. 1996).
21. Tech. Adv. Mem. 9822004. *See generally*, Prescott, Jr., ''Management & Consulting Services: The Impact on Exempt status and UBIT,'' 2003 *Tax Notes Today* 232-23. The IRS revoked GPHA's tax exemption but later reinstate it in a settlement with the IRS. Ann. 2001-26, 2001-1 C.B. 896. *See generally*, Harris, ''IRS stipulates to Tax Court Decision Reinstating Health Care Organization's Exempt Status,'' 33 *Exempt Org. Tax Rev.* 20 (July 2001).

lease and management agreements between GPHA and the hospitals afforded GPHA such control over hospital operations as to be deemed a de facto provider of hospital services and, thereby, able to qualify as a charitable organization.

The governing documents (as amended in 1983) indicated that GPHA was organized to provide a continuum of services more closely related to the actual provision of medical care, including the establishment, management, and operation of hospitals and other healthcare facilities ''to provide diagnosis, care, and treatment for patients.'' In addition, GPHA was to provide educational services and promote scientific research, among other activities. Based on this representation, the IRS affirmed the exemption. Subsequent disclosures in GPHA's Form 990, however, reported activities far more limited in scope, specifically, the ''management of hospitals w/support services'' or ''administrative and shared service fees to hospitals.'' Although the IRS did not initially focus on GPHA's managerial activities, during an unrelated audit of GPHA's pension plan, the IRS took another look at the arrangements between GPHA and the respective hospitals, and ultimately determined that the management services were not in furtherance of a charitable purpose.

GPHA's operational history indicated that it had lease arrangements with 9 hospitals, management arrangements with 16 other hospitals, and other arrangements for miscellaneous services. GPHA employed hospital administrators and accounting personnel. However, professional personnel, including physicians and nurses, were exclusively employed by the hospitals. In addition, the hospitals provided medical services under their own names and corporate identities. GPHA did not operate out of the hospitals but rather maintained a centralized office where it provided the core administrative services. Regional senior vice presidents routinely visited the hospitals and supervised the local administrators.

In its ruling, the IRS focused on a lease and management agreement (LMA) between GPHA and a county hospital that it considered to be representative of GPHA's arrangements with the other hospitals. Although the terms of the LMA suggested that GPHA ''leased'' the county hospital, the actual scope of the GPHA's rights and obligations indicated otherwise. For example, although GPHA was obligated to provide certain administrative and financial services, the county hospital district remained responsible for all financial losses, the availability of medical facilities, and the actual provision and delivery of healthcare services. In contrast, GPHA's responsibilities were almost exclusively managerial, involving administrative services, financial management, reimbursement services, health information management, risk management, physician recruitment, and other similar activities. In addition, GPHA could engage in day-to-day transactions on behalf of the hospitals but not extraordinary transactions.

The IRS concluded that GPHA was not acting in furtherance of a charitable purpose. Although surprising insofar as GPHA has been operating in virtually

the same capacity for 48 years without incident, this determination by the IRS is not far afield from its previous guidance in this area. The IRS has fairly consistently taken the position that if a charitable organization provides management services to unrelated organizations—even those that are also tax exempt—those services will be regarded as unrelated business activities and will produce unrelated business income, which is taxable. The IRS opined that for an organization to qualify for tax-exempt status, it must be regarded as being ''operated exclusively'' for one or more exempt purposes. The IRS stated further that an organization will not be so regarded if a substantial portion of its activities involve a single noncharitable purpose. Thus, to the extent that unrelated business activity constitutes a substantial portion of an organization's activities, the organization stands to lose its tax exemption. Accordingly, if an organization's primary activity is to provide management services to organizations with which it is not affiliated, the IRS will likely challenge the organization's status as a charitable organization.

That is not to say that there are no exceptions to this general proposition. Indeed, the IRS noted that organizations providing ''commercial-type services'' to unrelated charitable organizations may still qualify for exempt status if the services are an essential function and are provided substantially below cost.

Likewise, in situations in which an organization exercises exclusive control over the hospital, including all the operational responsibilities (i.e., the provision of medical care) and benefits and burdens associated with the provision of medical care (i.e., the profits and losses), it may fulfill a charitable purpose even if it does not own the hospital facility. To this end, GPHA argued that it still provides hospital services by virtue of its lease arrangements with the hospitals. In essence, GPHA contended that it maintained such control over the provision of hospital services that it was a *de facto* hospital service provider and, therefore, acted in furtherance of a charitable purpose. In its ruling, it would appear that the IRS agreed with this rationale in principle, if not in fact. Indeed, the IRS opined that certain lease management arrangements may be structured to effect and further a charitable purpose, particularly if they elevate the lessee's obligations and activities to those of a provider. An arrangement vesting GPHA with authority to actually operate the hospitals on its own behalf rather than act as a mere agent of the hospitals would likely have fulfilled the requirements for charitable status.

In contrast, however, the IRS concluded that the typical GPHA lease management arrangement did not grant GPHA absolute control over the hospital operations but instead limited its scope of operations to purely managerial functions. GPHA did not employ or contract with medical professionals such as physicians and nurses, nor did it lend its identity to the hospital or otherwise hold itself out as a hospital. Accordingly, the IRS opined that hospital patients did not come to see GPHA's hospital administrators and accountants but rather the medical providers employed by the specific hospital. Thus, GPHA

cannot be said to serve the community, as is required of charitable hospitals. Instead, it is merely a managerial arm of the hospital. Clearly, such services may offer some indirect benefit to the provision of healthcare but overall are no different from the operations of commercial management organizations.

Bearing in mind that this ruling is targeted at an organization whose primary activity is providing management services to *unaffiliated* organizations, the IRS ruling still serves as a stark reminder that no tax-exempt entity is completely safe from the risk of revocation. Indeed, it would appear that the IRS is prepared to enforce the exempt organization rules against rural healthcare organizations that face challenges not shared by most other charitable healthcare entities because of the difficulties inherent in serving the medical needs of rural populations. Thus, managers must now confront the task of reassessing the ongoing viability of their operations. Specifically, management services–type organizations that offer *independent* hospitals certain operational efficiencies, but do not actually control the provision of hospital services, are at risk of losing their exempt status.

The guidance does not address, however, the status of exempt organizations in health systems that provide management services only to other organizations in the health system that are related by virtue of being controlled by or being under common control with the management organization. Such organizations should not be in jeopardy as a result of this ruling. In those situations, the IRS still considers organizations that provide administrative services to be charitable organizations so long as such services would not otherwise constitute an unrelated trade or business if performed by the exempt affiliate.

Accordingly, the IRS would appear to be extending its ''provider/nonprovider'' distinction beyond the managed care arena. Historically, the IRS required HMOs desiring recognition as a tax-exempt entity to be organized as a staff or dedicated group model HMO because, in the IRS's view, only these types of HMOs are actual providers of care—other models only arrange for the provision of care.[22] Similarly, in this instance, the IRS distinguished between organizations that provide hospital services and those that manage such services. Although the IRS recognized that there are instances in which an organization may assume the role of a hospital provider without actually owning the hospital infrastructure, to stand up to IRS scrutiny the organization must apparently bear full responsibility for, and have control over, the provision of hospital services.

Organizations should not assume that their exemption ruling (or subsequent reaffirmation) offers blanket protection from a revocation. In this particular instance, GPHA had a stated purpose that seemingly comported with the obligations of charitable status, and, therefore, it was recognized as tax exempt. However, based on the facts as presented by the IRS, GPHA's stated

22. *See* § 9.2.

purpose depicted a scope of operations much broader than, if not different from, the services actually rendered.

In another ruling, the IRS held that a charitable hospital system would not jeopardize its tax-exempt status by transferring assets and leasing real property to a newly organized tax-exempt hospital.[23] In the ruling, A, a tax-exempt hospital system, provided both inpatient and outpatient hospital services through two operating divisions. A entered a joint operating agreement (JOA) with G, a nonprofit governmental hospital, which effectively created an integrated delivery system. Pursuant to the JOA, A and G capitalized B, a newly organized tax-exempt entity, with their operating assets. Following A's divestiture of assets to B, A continued to serve solely in furtherance of B's exempt purpose by advising B on budgetary, staffing, and other operating issues as well as providing strategic direction important to B's overall performance. B's governing board was made up of 15 directors. A and G, as holders of certain membership rights in B, were entitled to nominate, elect, and remove five directors each. Three directors could be appointed and removed through the vote of the directors in office, while the remaining two positions were filled by the chief executive officer and president of B, who is also A's chief executive officer. The IRS opined that the transfer of assets and the lease of real property to B did "not prevent A from achieving charitable purposes." Building on the integral part doctrine, the IRS recognized that A served a charitable purpose through its continuing involvement in B's operations by providing strategic oversight and advice integral to B's operations. Board composition also played a key role in the determination. As distinguished from Great Plains, which serviced a number of unaffiliated entities, A maintained strong corporate ties to B by virtue of its membership interest and board representation.

23. Priv. Ltr. Rul. 9837037; *see also* Priv. Ltr. Rul. 9828032 (reorganization of elder care system did not jeopardize its tax exemption).

PART FIVE

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CHAPTER TWENTY

Healthcare Provider Reorganizations

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§ 20.1 SOME BASICS ABOUT REORGANIZATIONS

During the 1980s, one of the most significant developments in the healthcare field was the reorganization of freestanding hospital operating companies into multiorganization healthcare systems. This was caused by a number of factors, including escalating costs, changes in Medicare reimbursement policy, decreased availability of capital, increased regulation, and increased competition in both the public and private sectors.

Creation of a healthcare system would usually involve the organization of several new entities that would serve as affiliates of one or more hospitals exempt as charitable organizations. The hospital(s) in the system would "spin off" activities that were not directly involved with inpatient care and place them in the newly created entities. Typical of these types of organizations are development foundations charged with responsibility for fundraising for the system,[1] and title-holding companies designed to hold real estate outside of the highly regulated corporations in the system.[2] The system would also often contain one or more taxable subsidiaries conducting what would otherwise be unrelated business activities if performed by the hospital(s).[3]

1. *See* Chapter 14.
2. *See* Chapter 15.
3. *See* Chapter 16.

These reorganizations have continued into the 2000s, although the number of them is declining since most hospitals that wished to recognize have already done so.[4] At the same time, reorganizations in other healthcare contexts continue, such as nursing homes,[5] retirement facilities,[6] health maintenance organizations,[7] rehabilitation service providers,[8] and homes for the elderly.[9]

While reorganized healthcare systems are now the norm and have generally been successful at achieving the most important of the goals that were the reason for their creation, they have not been greeted with universal acclaim. Some critics have claimed that corporate reorganizations of hospitals were nothing more than sources of work for lawyers and accountants. Some hospital administrators and their boards went overboard, seemingly trying to cram as many boxes as possible onto an organizational chart without adequate consideration of the excessive costs and staffing consequences of doing so. Legislators and judges decried these unnecessarily complex corporate structures as prime examples of what was wrong with healthcare in America.

Nevertheless, most of these reorganized healthcare systems have prospered and endured, and the tax status of their component organizations has become fairly well settled. The most common organizational element of these systems is the assignment of oversight and coordination responsibilities for the system to a parent holding corporation.[10]

§ 20.2 PARENT HOLDING CORPORATIONS

Most reorganized healthcare systems are structured around an integrating parent corporation (the *parent holding corporation* or *parent*). All other entities are nonprofit or for-profit[11] subsidiaries of the parent. The parent usually provides strategic planning and management services for all of the subsidiaries, and it often allocates funds raised by a fundraising affiliate or generated by an operating affiliate in the system. It is the sole member or shareholder of each nonprofit or for-profit subsidiary in the system. The subsidiaries might consist

4. An illustration of a typical hospital system reorganization appears in Priv. Ltr. Rul. 9715042.
5. E.g., Priv. Ltr. Rul. 9637051.
6. E.g., Priv. Ltr. Rul. 9635037.
7. E.g., Priv. Ltr. Rul. 9726010.
8. E.g., Priv. Ltr. Rul. 9804054.
9. E.g., Priv. Ltr. Rul. 9814042.
10. A court case that could have had enormous adverse implications for these forms of restructuring had the IRS prevailed was decided in 1996. The government asserted six forms of private benefit in the arrangement, including the payment of rent, use of common employees, overlapping boards of directors, and similarity of organization names (*Bob Jones University Museum & Gallery, Inc. v. Commissioner*, 71 T.C.M. 3120 (1996)). In the case, a taxable nonprofit (*see* § 21.3(b)) university spun off a tax-exempt educational museum to be operated on the university's campus.
11. *See*, in general, Chapter 16.

of such organizations as a hospital, a home health agency, a physician clinic, a fundraising foundation, a radiology and laboratory services corporation, an entity providing third-party administrator and physician billing services, a real property holding company, and a health maintenance organization (HMO).

Once the decision is made to create a healthcare system centered around a parent holding corporation, two fundamental issues must be considered: (1) What is the basis for obtaining tax exemption for the parent? and (2) What is the parent's public charity status?

Each of these issues is discussed below.[12]

(a) Basis for Exemption

(i) The Integral Part Doctrine. The parent holding corporation in a healthcare system will generally only perform management, planning, and policy functions, rather than directly engage in charitable activities that could be said to be directly furthering the promotion of health.[13] Nevertheless, the IRS has consistently ruled that the parent qualifies for tax exemption as a charitable organization under the so-called *integral part doctrine*. In essence, this theory holds that, where an organization is engaged in an enterprise that bears a close and intimate relationship to the functioning of one or more charitable organizations, the entity is entitled to the same tax-exempt status.[14] Thus, because the hospital (and most of the other subsidiaries in the system) qualifies for exemption as a charitable entity, the parent should also qualify for exemption as a charitable entity by reason of being an *integral part* of the operation of the hospital and the other charitable entities in the system.[15] At one time, the IRS questioned the propriety of this type of ''derivative'' exemption for parent holding companies,[16] but the integral part doctrine is now readily accepted by the IRS for these entities.

12. Another issue that frequently arises is whether the creation of a healthcare system and the spinning off of activities from the hospital to newly created entities may generate unrelated business taxable income. *See* Chapter 24 for a detailed discussion of the unrelated business rules.
13. The promotion of health has long been recognized as a charitable purpose within the meaning of IRC § 501(c)(3), and organizations that promote health are able to obtain tax-exempt charity status on that ground alone. *See*, e.g., Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 83-157, 1983-2 C.B. 94.
14. E.g., *Hospital Bureau of Standards and Supplies, Inc. v. United States*, 58-1 U.S.T.C. (CCH) ¶ 9194 (1958); *Trustees of Graceland Cemetery Improvement Fund v. United States*, 515 F.2d 963 (Ct. Cl. 1975); *Monterey Public Parking Corp. v. United States*, 21 F. Supp. 972 (N.D. Cal. 1970); Rev. Rul. 63-235, 1963-2 C.B. 210; Rev. Rul. 68-16, 1968-1 C.B. 246; Rev. Rul. 78-310, 1978-2 C.B. 173.
15. E.g., Rev. Rul. 78-41, 1978-1 C.B. 148.
16. In Gen. Couns. Mem. 39508, the IRS raised the issue (but did not provide any answer) regarding whether it is appropriate for a supporting organization that is a parent holding company in a healthcare system to be tax-exempt under IRC § 501(c)(3) by means of the integral part theory. The IRS was troubled by the fact that the tax regulations under

Although the basis for tax exemption for parent holding companies is now well-established, a more difficult and historically controversial issue is whether the parent can qualify as a public charity rather than as a private foundation.[17]

(b) Public Charity Status Issues for Parent Holding Corporations

(i) Publicly Supported Organization Status. In the early years of hospital reorganizations, some parent holding corporations acted as development foundations,[18] performing essentially a fundraising function for the healthcare system. Because the bulk of the parent's income was from gifts, grants, and contributions from the general public, the parent could qualify as a publicly supported charity of the donative type.[19] These sections of the Code describe an organization that normally receives one-third or more of its support from governmental units, or direct or indirect contributions from the general public.[20]

(ii) Supporting Organization Status and Corporate Relationships. Where a parent holding corporation does not act as a development foundation, but, instead, formulates policy and provides management services to organizations in the healthcare system, it will not be capable of attracting the requisite gifts, grants, or contributions from government units or the general public to satisfy the donative organization support test set forth in the Code for donative entities. It will also fail to satisfy the public support test described in the Code for organizations receiving fees for the performance of exempt services.[21] Thus, because this type of parent cannot qualify for standalone public charity service under the Code, either as a donative-type publicly supported charity or a service provider publicly supported charity, its only realistic hope of escaping private foundation status is to satisfy the requirements of a supporting organization as described in the Code.[22]

IRC § 502 do not seem to allow a parent organization to derive its exemption from a subsidiary organization or organizations. Instead, the subsidiary normally derives its exempt status from a dominant parent organization by providing services integral to the parent. In addition, the IRS noted that "to allow a parent organization to simply derive its exception from more than one exempt subsidiary organization would be to sanction, in effect, the exemption of cooperative undertakings in the hospital service area whose claim to exemption under section 501(c)(3) the Service has consistently rejected." Nevertheless, the IRS now recognizes parent holding companies as exempt as organizations described in IRC § 501(c)(3), based on the integral part doctrine.

17. *See*, in general, IRS Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook(s) (hereinafter, "FY _ IRS CPE Text"): FY 1983, at 22–28; FY 1985, at 191–199; FY 1987, at 31–38; and FY 1995, at 145–149.
18. *See*, in general, Chapter 14.
19. IRC §§ 509(a)(1), 170(b)(1)(A)(vi).
20. *See* § 5.2.
21. *See* § 5.3.
22. IRC § 509(a)(3).

A supporting organization generally supports the activities of one or more *supported organizations* that are already established public charities as donative entities or service provider organizations.[23] In most reorganized healthcare systems, however, the relationship is reversed—the supported organizations are the *subsidiaries* and the supporting organization is the *parent*. Moreover, some healthcare systems in the 1980s sought not only to have the parent corporation declared a supporting organization but also to have a subsidiary in the system declared a supporting organization. These issues raised considerable concern for the IRS, and the result was a lengthy discussion of these issues in a 1986 memorandum.[24]

In this memorandum, the IRS noted that, in order to satisfy the requirements for supporting organizations, an organization must demonstrate that it stands in one of the following relationships: (1) *operated, supervised, or controlled by* a publicly supported organization; (2) *supervised or controlled in connection with* a publicly supported organization; or (3) *operated in connection with* a publicly supported organization.[25]

The IRS observed that a parent holding corporation could not satisfy the first test above (*operated, supervised, or controlled by*) because this test envisions the parent being the ''supported'' organization. Under the facts presented in the IRS Memorandum, the third relationship (*operated in connection with*) also was not available to the parent because it had not specifically listed the supported organizations by name in its articles of incorporation, as required by the tax regulations.[26] However, after a lengthy analysis, the IRS concluded that the second test above (*supervised or controlled in connection with*) could be satisfied by a parent holding corporation, but only under certain narrow circumstances. Specifically, the IRS stated:

> [I]t is our view that the Service is justified in requiring as a rule of thumb [under the second test] that no less than a majority of the persons who control or manage the supporting organization have the requisite commonality with persons performing the same functions for each publicly supported organization supported or benefited.

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23. *See* § 5.5.
24. *See also* Gen. Couns. Mem. 39598, issued a year after GCM 39508, for another discussion of the integral part doctrine for parent holding companies. GCM 39508 is a particularly complex and cumbersome analysis. As one IRS official dryly noted, years after its release, ''Talmudic scholars at the IRS are still trying to divine the true meaning of GCM 39508.'' Comments of Jack Reilly at ABA Section on Taxation Meeting, Washington, DC.
25. The IRS now labels such supporting organizations as Type I, Type II, and Type III, respectively.
26. Reg. § 1.509(a)-4(d) provides, with some exceptions, that in order to meet the organizational test under IRC § 509(a)(3), the articles of incorporation of the supporting organization must designate the supported organization by name, unless the supporting organization is ''operated, supervised, or controlled by'' or ''supervised in connection with'' one or more publicly supported organizations. As noted below, the ''operated in connection with'' test is the one used most frequently in modern healthcare systems.

> Where less than a majority is involved, the number of persons must be sufficient so that when considered together with all the facts and circumstances there is a clear showing that each publicly supported organization served or benefited can insure that the supporting organization will be responsive to its needs or demands and will constitute an integral part of, or maintain a significant involvement in, its operations.

The second issue in the IRS Memorandum pertained to whether a supporting organization in a healthcare system can have another supporting organization as its parent so that, in effect, the parent is supporting a publicly supported organization ''through'' another supporting organization. After another lengthy analysis, the IRS finally concluded that:

> A section 501(c)(3) organization within a hospital system is not necessarily precluded from classification as a section 509(a)(3) supporting organization because it is subordinate to a section 509(a)(3) parent within the system. However, a showing that the subordinate organization and each publicly supported organization to be supported have management or control vested in the same persons must be made to achieve this classification. This support through another section 509(a)(3) organization was probably never intended, but the ambiguity in the operational requirements of the [supporting organization] regulation makes application of an exclusivity argument difficult.

The IRS added that this issue may be referred for possible clarification in a future regulations project. To date, that has not occurred.

A third issue briefly raised in the IRS Memorandum but never resolved is whether a parent holding corporation in a healthcare system can still qualify as a supporting organization if one or more of the subsidiaries in the system are for-profit entities. This is problematic because the operational test for supporting organizations requires that a supporting organization be operated *exclusively* to support one or more specified publicly supported organizations, and this occurs only if it engages *solely* in activities that support or benefit the specified publicly supported organizations.[27] Thus, supporting a taxable subsidiary would not appear to satisfy the requirement to engage *solely* in activities in support of publicly supported organizations.[28]

Despite the fact that the IRS left unanswered the issue of whether a supporting organization can have for-profit subsidiaries, the existence of for-profit subsidiaries in healthcare systems has not proven to be an impediment to parent holding companies' obtaining supporting organization status.[29] Moreover, tax proposals submitted to Congress in connection with the Clinton

27. Reg. § 1.509(a)-4(e)(1).
28. Cf. the discussion at § 16.5.
29. In a 1993 speech, Fred Kluss, the IRS Exempt Organization Industry Specialist for Healthcare, noted that the IRS was considering revising its requirements for supporting organizations in a way that would preclude ownership of taxable subsidiaries by such organizations (6 *Exempt Org. Tax Rev.* (No. 1) 8 (July 1992)). The IRS National Office also encouraged development of this issue in the early round of Coordinated Examination

Adminstration's healthcare reform package contained a provision that, if enacted, would have statutorily classified such parent holding corporations as nonprivate foundations.[30]

Notwithstanding the concerns and limitations expressed in the IRS Memorandum, well over 1,000 private letter rulings have been issued in which the IRS has recognized supporting organization status for parent holding companies in reorganized healthcare systems containing both nonprofit and for-profit subsidiaries.[31] Today, most parent holding companies are able to obtain supporting organization status under the third relationship test outlined above (i.e., ''operated in connection with''),[32] as long as they have specified by name the publicly supported organizations in their governing instruments[33] and have at least one director in common with each of the publicly supported organizations in the system.[34] The use of the ''operated in connection with''

Program (CEP) audits. Two technical advice requests from the IRS Southwest Region were submitted to the National Office seeking advice on whether a parent organization of a hospital system that had taxable subsidiaries should be treated as a private foundation because it did not ''solely'' support specified publicly supported organizations. After a thorough consideration of the issue by senior National Office officials, however, a decision was made to seek an administrative or legislative solution. The two technical advice memoranda were returned to the field. *Exempt Org. Health Care ISP Digest*, 1994-1 at 9 (Mar. 10, 1994).

30. *See infra* note 21.
31. E.g., Priv. Ltr. Rul. 9408024; 8837016; 8222076.
32. In GCM 39508, the IRS expressed some reservations regarding whether parent holding companies could qualify as supporting organizations under the ''operated in connection with'' test under IRC § 509(a)(3), noting that such qualification ''may be difficult, particularly in the case of a parent whose activities are so sketchy that it is difficult to show the actual benefit to the supported organizations as a result of the parent's activities.'' Today, however, supporting organization status under the ''operated in connection with'' test is routinely recognized. *But see* note 35.
33. Typical language in the ''purposes'' clause of the articles of incorporation for a parent holding company might read as follows:

    ''To operate exclusively for the benefit of, to perform the functions of, and to carry out the purposes of [legal name of publicly supported subsidiary], so long as such organization is described in section 501(c)(3) and section 509(a)(1) or (2) of the Internal Revenue Code.''
34. Typical language that could be inserted in the portion of the parent corporation's articles of incorporation dealing with directors is as follows:

    ''The Board of Directors shall at all times include one director who also concurrently serves on the governing body of [legal name of publicly supported subsidiary].''

    Supporting organization status under either the ''operated, supervised, or controlled by'' test or the ''supervised or controlled in connection with'' test would require either a majority of interlocking board members between the supporting and supported organizations or at least a significant commonality of interlocking directors plus other facts and circumstances to show that each supporting organization will be responsive to the needs or demands of the supported organizations and will constitute an integral part of, or maintain a significant involvement in, their operations. *See* FY 1987 IRS CPE Text, at 36–38.

test and the requirement of only one overlapping director between the supporting and supported organizations seems prudent and reasonable in light of the management role played by parent holding companies in today's modern healthcare systems.

Supporting organization status has become particularly attractive in modern reorganized healthcare systems because it does not require that the parent corporation satisfy any specific public support tests such as those that apply under the Code to donative entities and service provider organizations. Consequently, many parent holding companies that originally obtained public charity status as donative entities converted to supporting organization status because of its ease of administration.[35]

Health reform legislation introduced in 1994 contained proposals to codify the IRS's practice of recognizing supporting organization status for parent holding companies. Specifically, President Clinton's Health Security Act (as well as other health reform proposals) would have created a new Code section that would have provided public charity status to ''an organization which is organized and operated for the benefit of, and which directly or indirectly controls, an organization described in section 170(b)(1)(A)(iii).''[36]

(c) Superparents

A twist on the parent holding corporation arrangement is the category of a *superparent*—an organization that is the parent of the parents of two or more formerly unrelated healthcare systems. On September 1, 1993, the IRS issued a favorable determination of tax-exempt charitable status to just such a *superparent*.[37] The organization in question, Northwestern Healthcare Network (NHN), was the parent of the parents of three different reorganized

35. Ironically, because of the restrictions imposed by the Pension Protection Act of 2006 (PPA) on Type III supporting organizations, some parents are converting back to public charity status as a donative or service-provider entity. The IRS provided a procedure for this transition in Announcement 2006-93. However, the PPA continues the preferred status of the Type III supporting organization (and most parent holding corporations in health systems are in the Type III category) if it is ''functionally integrated'' with its supported organization (typically, a hospital). The IRS has suggested in guidance that health system parents will likely be deemed to meet this standard under upcoming regulations. See Announcement 2007-87 and § 5.5, supra.
36. E.g., Health Security Act, H.R. 3600, Title VII, Subtitle F, § 7601(c).
37. IRS determination letter to Northwestern Healthcare Network, (Sept. 1, 1993), reprinted in 8 *Exempt Orgs. Tax Rev*. (No. 4) 799 (Oct. 1993); *see*, in general, Broccolo and Peregrine, ''IRS Issues 'Double Derivative' Exemption to Super Parent in Regional Health Network—A Glimmer of Hope for the Future of Integral Part Status?,'' 8 *Exempt Orgs. Tax Rev*. 731.

hospital systems and one freestanding hospital corporation (collectively called the ''Institutions''). Each of the three parent organizations was a supporting organization, and the individual hospital corporation was a donative-type publicly supported charity.

Under the superparent structure, NHN was the sole member of each of the Institutions. NHN had a Council of twenty-eight Governors, consisting of seven individuals appointed by each of the four Institutions. At least four of the seven individuals from each Institution had to be officers, directors, or medical staff physicians of the various hospitals in the system, and at least one of the seven had to be a medical staff physician of the hospitals. However, no more than 20 percent of the Council could consist of physicians who were affiliated with the superparent, the Institutions, or any hospitals or Institution Group members in the system. The Council had the authority to appoint and remove the directors of NHN. NHN's board of directors included the president of Northwestern University, the president and CEO of NHN, the chairman of the board of each of the Institutions, and one additional representative from the board of directors of each of the Institutions. The 20 percent limitation on physicians' serving on the Council was applied to the board as well.

The affiliation of the various hospital systems was intended to create a regional academic and research-oriented healthcare network affiliated with Northwestern University. The determination letter stated that the affiliation was specifically designed to accomplish the following:

1. Coordinate the provision of patient care services in order to reduce duplication of resources and allow delivery of more cost-efficient care.
2. Offer more specialized services to a larger patient base.
3. Provide participants of the network with enhanced clinical, research, marketing, planning, finance, and organizational services and expertise on a regional basis.
4. Improve and enhance the strategic planning for the affiliated hospital systems.
5. Enhance access to capital markets at lower costs for the affiliated hospital systems.
6. Provide access to the most recent technological and medical advances.
7. Promote the education of physicians and other healthcare professionals.
8. Advance science through research regarding the cure and treatment of human diseases and other medical and scientific matters by the affiliation of the hospitals with an academic institution.

The IRS relied on the integral part doctrine to reach its determination of charity status for the superparent.[38] Consistent with other parent holding corporation rulings, the superparent was also recognized as a public charity as a supporting organization.[39]

38. Although the determination letter itself does not specify the reason that the IRS recognized IRC § 501(c)(3) status, the IRS has acknowledged in other sources that the integral part theory was the basis of its ruling. *See* FY 1995 IRS CPE Text, at 149, noting that the integral part theory was found to exist because by providing the overall management and coordination services for the system, the superparent was serving an essential function of the supported organizations in the system.
39. Although the IRS determination letter does not specify the basis for the supporting organization ruling, the FY 1995 IRS CPE Text states that the superparent was ''supervised or controlled in connection with'' the supporting organizations because control and management of the superparent was vested in the same persons who control and manage the supported organizations. *Id*. at 149.

CHAPTER TWENTY-ONE

Mergers and Conversions

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The federal tax law of tax-exempt healthcare organizations, in its statutory form, is silent on the matter of mergers and conversions involving these entities.[1] In reflection of this paucity in the law, the income tax regulations and IRS revenue rulings likewise do not address the subject. Yet, mergers and other forms of reorganizations are commonplace in the realm of healthcare organizations.

These types of mergers and other consolidations are governed by state law—almost always by provisions on the subject in each state's nonprofit corporation act. The procedure (or procedures) to follow in legally accomplishing the transaction is stated in these laws.

§ 21.1 MERGERS AND CONSOLIDATIONS BETWEEN EXEMPT HEALTHCARE ORGANIZATIONS

The tax aspects of mergers, consolidations, and other reorganizations of *for-profit* organizations are formidable, with emphasis on attempts to make them tax-free transactions. Thus, these considerations can be implicated where the merging healthcare entities are all for-profit, taxable entities, although they are rarely brought into play in mergers involving tax-exempt organizations.

1. With one exception, this is the case with respect to the law of tax-exempt organizations generally. Tax-Exempt Organizations §§ 31.3, 31.7, 31.8. The exception is a set of rules concerning the mergers and other reorganizations of private foundations (IRC § 507(b)(2)) (in general, Private Foundations § 13.5).

Mergers involving tax-exempt healthcare entities usually entail mergers only of exempt entities. When the merging organizations are charitable entities, they usually are public charities, such as hospitals or hospital systems.

Mergers of exempt entities can raise important federal tax issues that are quite different from those raised by mergers of for-profit entities. These issues normally are (1) whether the surviving organization or organizations involved can, after the transaction, retain tax-exempt status (and, where appropriate, the ability to attract tax-deductible contributions); (2) whether these survivors can (where applicable) retain (or perhaps obtain) non-private-foundation status[2]; and (3) whether the organizations in the transaction can avoid the tax on unrelated business income.[3]

The rationale for these mergers varies. The most frequent reason is the obvious one: each of the parties to the transaction has a function or a resource that is of value to the other, and the parties believe that they can be more effective (programmatically, economically, or otherwise) in combination.[4] There are, of course, other reasons. One merger was undertaken to reduce the administrative burdens of operating two or more organizations.[5] In other instances, the merger was undertaken to eliminate what had become one or more superfluous organizations.[6] Another merger served to change the state of incorporation.[7]

Mergers of this nature do not have adverse tax consequences in relation to tax-exempt status—assuming that the surviving entity has some charitable program to pursue in the wake of the reorganization—because the assets and income transferred in the merger remain dedicated to charitable purposes.[8] As long as this occurs, the merger is consistent with the asset dissolution requirements imposed on charitable organizations.[9] If the merger leaves the

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2. *See* Chapter 5.
3. *See* Chapter 24. There also are likely to be some state income tax law exemption and taxation issues, and perhaps sales tax consequences.
4. For example, three cancer treatment and cancer research facilities merged so as to improve the provision of cancer treatment to patients, improve the efficacy of medical research, and achieve operational economies of scale (Priv. Ltr. Rul. 200348029).
5. Priv. Ltr. Rul. 9314059.
6. Priv. Ltr. Ruls. 9738055 and 9738056 (a hospital merged into an unrelated supporting organization (*see* § 5.5)); Priv. Ltr. Rul. 9303030 (a supporting organization merged into a supported organization); Priv. Ltr. Rul. 8941082 (a former tax-exempt hospital corporation and a nonexempt nonprofit corporation merged into a tax-exempt hospital corporation).
7. Priv. Ltr. Rul. 9309037. In one case, a supporting organization for a boys' school and a supporting organization for a girls' school merged to form a single supporting organization for the entity that was the product of a merger of the two schools (Priv. Ltr. Rul. 9317054).
8. In one instance, the IRS observed that this type of merger is "similar to a contribution of capital or a donation from one exempt section 501(c)(3) organization . . . to another exempt section 501(c)(3) organization . . ." (Priv. Ltr. Rul. 9303030).
9. Reg. § 1.501(c)(3)-1(b)(4).

surviving entity (or entities) with a material change in character, purpose, or method of operation, that fact should be communicated to the IRS on a timely basis.[10]

In one instance, a healthcare system included a tax-exempt, publicly supported parent organization, a tax-exempt hospital, a related foundation, and a for-profit corporation.[11] The parent was merged into the hospital, and the hospital assumed the parent's role of providing the overall direction for the system. The IRS approved the merger, found no adverse impact on the hospital's or foundation's tax-exempt status, and concluded that this ''rearrangement of capital'' was not the conduct of an unrelated trade or business.[12] As another illustration, an organization operating independent-living housing for the elderly merged into a publicly supported organization, followed by a consolidation with a home for the elderly, all for the purpose of promoting efficient management, facilitating long-term planning, and enhancing philanthropy for the neediest elderly.[13]

As noted, the non-private-foundation status of one or more charitable organizations may be involved. The federal tax characteristics of an entity after a merger may be different from its characteristics before the transaction. For example, before a merger, an entity operating a hospital clearly would be a public charity[14]; after the transaction, the organization has other activities that require it to acquire (if it can) public charity status on another basis, perhaps as a publicly supported organization.[15]

In nearly every one of the mergers noted above, only public charitable organizations were involved.[16] Occasionally, however, both of the merging organizations will be tax-exempt, but under differing categories. For example, a lobbying organization[17] related to a public charitable organization may merge into the public charity, or a foundation related to a trade or professional organization[18] may merge into the association.[19]

These mergers usually do not adversely affect the tax-exempt status or the public charity status of the surviving organization, or result in any unrelated trade or business income. There always is the potential for difficulty in this area, however, such as when an insider is involved and thus the private inurement

10. Reg. §§ 1.501(a)-1(a)(2) and 1.601.201(n)(3)(ii).
11. This organizational arrangement was approved by the IRS in Priv. Ltr. Rul. 8811015.
12. Priv. Ltr. Rul. 9303030.
13. Priv. Ltr. Rul. 199914051. Other examples of mergers (and acquisitions) in the healthcare setting are reflected in IRS private letter rulings, such as Priv. Ltr. Rul. 9635037.
14. IRC §§ 170(b)(1)(A)(iii) and 509(a)(1). *See* § 5.1, text accompanied by notes 19–25.
15. IRC §§ 170(b)(1)(A)(vi) and 509(a)(1) or 509(a)(2). *See* §§ 5.2–5.4.
16. The exception concerned a nonprofit entity that probably could have obtained tax-exempt charitable status had it applied for recognition of exempt status (see *supra* note 5).
17. An organization described in IRC § 501(c)(4) (*see* § 1.8).
18. An organization described in IRC § 501(c)(6) (*see* Chapter 18).
19. In the latter type of merger, the assets of the foundation would have to be preserved for charitable purposes, such as in a fund of the association.

doctrine may come into play.[20] (This likelihood is greater, however, where the reorganization involves entities other than tax-exempt organizations.)

§ 21.2 MERGERS AND CONSOLIDATIONS BETWEEN EXEMPT AND NONEXEMPT HEALTHCARE ORGANIZATIONS

An infrequent occurrence will be a merger of a for-profit organization into a tax-exempt organization. This type of transaction is possible only if permissible under state law. The laws of some states will not permit a merger between a for-profit organization and a nonprofit one.[21]

This type of merger can be accomplished without endangering the tax-exempt status of the surviving organization and generally without causing unrelated business income for the tax-exempt organization.[22] In one instance, a taxable corporation was merged into a tax-exempt social welfare organization; the activities of the corporation were consistent with the purposes of the exempt organization. The tax-exempt organization issued ''special notes'' to the shareholders of the for-profit corporation in exchange for their stock. Again, the rationale for the merger was that the resulting combination would reduce duplicative operations and expenses.[23]

At the same time, mergers and similar transactions involving both tax-exempt and nonexempt entities have an inherent capacity for instances of private inurement or private benefit.[24] Many of the considerations in this area

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20. *See* § 4.2.
21. The federal tax law generally does not tolerate the merger of a charitable organization into a for-profit one because the transaction would impermissibly cause the application of charitable assets for noncharitable purposes. In one case, two charitable hospitals were permitted to convert into for-profit entities only because fair value was paid for the charitable assets to the parent holding company of the hospitals; however, the facts of the case do not state the mechanics (merger or otherwise) by which the hospitals became for-profit organizations, although the transaction was approved by a state court (Priv. Ltr. Rul. 8446047). The parent organization was a supporting organization (*see* § 5.4); it was able to retain that status because it continued to support other public charities.

    Mergers involving for-profit healthcare institutions are essentially outside the scope of this book (although there may be some indirect impact if one or more of these taxable entities are part of a system otherwise involving only exempt organizations). An analysis of transactions involving only taxable healthcare entities is contained in Elrod, Jr., Shields, and Bergman, Merging Health Care Institutions: A Guidebook for Buyers and Sellers (1987), ch. 10.
22. *See*, however, Tax-Exempt Organizations § 29.8 (discussion of potential adverse federal tax consequences of liquidations of for-profit subsidiaries into tax-exempt parent organizations).
23. Priv. Ltr. Rul. 9317054. In another instance, a defunct taxable nonprofit entity was merged into a tax-exempt hospital; the nonprofit entity probably could have qualified as an exempt charitable organization had it applied for recognition of exempt status (Priv. Ltr. Rul. 8941082).
24. *See* Chapter 4, particularly § 4.4.

are the same as those pertaining to the acquisition and retention of taxable subsidiaries by tax-exempt healthcare organizations.[25]

In another of these instances, the operations of a tax-exempt hospital and those of a for-profit medical practice clinic were integrated, without adverse tax consequences to the hospital.[26] This was done to enhance the quality of the services provided and eliminate duplicate services (the clinic was located across the street from the hospital). This merger was effectuated with agreements as to assets transfer, licensing, real estate, and professional services. The governing board of the resulting organization will have as its majority representatives of the community.

In another case, the IRS approved a merger of a tax-exempt hospital and a for-profit medical practice clinic; this integration of operations was undertaken to enhance the quality of services provided and eliminate duplication of services.[27]

§ 21.3 CONVERSION FROM EXEMPT TO NONEXEMPT STATUS

As has been discussed throughout, healthcare organizations can be nonprofit, tax-exempt entities or for-profit entities. On occasion, an entity of one type is desirous of converting to an entity of the other type. Both conversions can be accomplished, but the federal and state law on the point is scant.[28]

The state law on the subject concerns form and procedure. Most states have separate nonprofit corporation acts and business (for-profit) corporation acts; mergers from one to the other are not always permissible. Thus, a change in form is often required, entailing liquidations and reformations. The federal tax law on the subject focuses primarily on the need for new determinations as to tax status and disclosure of certain facts as part of any new application for recognition of exempt status.[29]

A tax-exempt organization may decide to shed that status and convert to a for-profit entity. (There is no prohibition in law as to doing that.) In the healthcare field, for example, a hospital may determine that the rules for maintaining tax-exempt status as a charitable entity are too onerous, or those involved in its operations may wish to partake of its profits; operation as a for-profit entity may thus be more attractive. These decisions are by no means

25. *See* Chapter 16.
26. Priv. Ltr. Rul. 200305032.
27. Priv. Ltr. Rul. 200305032.
28. The law on this subject is most pronounced when it involves the termination of a charitable organization's status as a private foundation (IRC § 507). This is a separate body of law that is uniquely applicable to private foundations (*see supra* note 1); the discussion in this chapter assumes that the charitable organizations referred to in it are not private foundations.
29. The process for obtaining a determination or ruling as to recognition by the IRS of tax-exempt status is the subject of § 33.1.

confined to hospitals; they can be made by other healthcare providers, such as outpatient clinics, health maintenance organizations, nursing homes, and homes for the aged.

(a) State Law

Nearly every tax-exempt organization is a creature of the law of a state or the District of Columbia. (In a rare instance, an exempt organization is established by a specific state statute or, even less frequently, is created by federal law.) These organizations are shaped as one of three types of entity: unincorporated association, trust, or nonprofit corporation.

The unincorporated association is the least likely option for a healthcare entity. The articles of organization of this type of organization are termed a *constitution*. The organization will undoubtedly have bylaws and otherwise function much like a corporation.

Some healthcare organizations are formed as trusts, although this infrequent type of trust is likely to be a private foundation.[30] An example of a trust operating in the healthcare setting is a trust existing solely as a repository of funds set aside by a tax-exempt hospital for the payment of malpractice claims against the hospital and as a payor of those claims; this type of entity has been ruled by the IRS to be tax-exempt by virtue of being an integral part of the hospital.[31] The articles of organization of this type of entity will be a declaration of trust or a trust agreement. Trusts, particularly charitable ones, are uniquely treated under state law, and this treatment may vary from state to state.

The third form that a tax-exempt healthcare entity can assume, that of the nonprofit corporation, is the form most commonly used today. (Indeed, the balance of this chapter is predicated on the assumption that the nonprofit and for-profit entities involved are corporations.) The corporate form is advantageous because the law as to its formation and operation is usually quite clear, and because it can provide a shield against personal liability for those individuals who are its directors and officers.[32]

As noted, nearly every state has a nonprofit corporation act and a for-profit corporation act. These are separate statutes; the extent of any interplay between

30. *See* Chapter 5 and *supra* note 1.
31. Rev. Rul. 78-41, 1978-1 C.B. 148. This example may be suspect in view of certain subsequent developments in the law. The ability of a trust or other entity to be tax-exempt as a charitable organization by reason of the integral part doctrine has been narrowed as the result of *Geisinger Health Plan v. Commissioner*, 30 F.3d 494 (3d Cir. 1994) (*see* § 33.5, text accompanied by notes 211–229). Moreover, with the advent of IRC § 501(m) (*see* § 9.4), trusts of this nature with an insurance function may no longer qualify for tax-exempt status (*Florida Hospital Trust Fund et al. v. Commissioner*, 103 T.C. 140 (1994), *aff'd*, 71 F.3d 808 (11th Cir. 1996)).
32. The subject of personal liability in the nonprofit organization context is outside the scope of this book. *See*, however, PLANNING GUIDE, Chapter 11.

them is a matter of state law and can vary from state to state. It may not be possible for a nonprofit corporation in a particular state to amend its articles of organization so as to become a for-profit corporation under the law of that state, because of the fundamental difference between the two types of corporations. For example, the District of Columbia has a nonprofit corporation act[33] and a business corporation act.[34] This body of statutory law defines a nonprofit corporation as ''a corporation no part of the income of which is distributable to its members, directors, or officers. . . .''[35] An example in which the conversion of a nonprofit entity to a for-profit one was permitted under state law was provided by the IRS in a private letter ruling.[36]

Whether a nonprofit corporation can merge into a for-profit corporation can be problematic, particularly where the survivor of the merger is the for-profit entity. For example, under the law of the District of Columbia, a merger pursuant to the nonprofit corporation act can involve only two or more nonprofit corporations.[37] In any event, the transformation of a tax-exempt charitable organization can easily attract the attention of a state's attorney general.

Suppose a tax-exempt charitable hospital, organized as a nonprofit corporation, is desirous of becoming a for-profit organization, organized as a for-profit corporation. Theoretically, the easiest way to accomplish this is to amend the corporate documents and convert to the for-profit form. As noted, however, state law may not allow for this transformation[38] and it raises great problems under the federal tax law.

Another approach would be to create a for-profit corporation and then merge the nonprofit corporation into it. Again, state law may preclude the merger of a nonprofit and a for-profit organization.

A third approach would be to create the for-profit corporation, liquidate the nonprofit corporation, and transfer the remaining assets and income of the nonprofit corporation to the for-profit corporation. However, as discussed below, this type of transfer must, for federal tax reasons, entail a sale or exchange of the assets for fair market value.

(b) Federal Tax Law

There is no federal law procedure by which an exempt organization has its tax-exempt status withdrawn; the IRS recognizes the exempt status of nonprofit organizations, it does not ''de-recognize'' them.[39] Thus, the only

33. D.C. Code, Title 29, ch. 5.
34. *Id*. at ch. 3.
35. *Id*. at ch. 5, § 29-502(3).
36. Priv. Ltr. Rul. 9545014.
37. D.C. Code § 29-540.
38. *See* text accompanied by *supra* notes 30–34.
39. Moreover, once the IRS has recognized the tax-exempt status of an organization, the organization cannot voluntarily relinquish it (Priv. Ltr. Rul. 9141050). There is no provision in the federal tax law for voluntary termination of exempt status.

way for a tax-exempt healthcare entity or other tax-exempt organization to lose its tax exemption is to violate one or more aspects of the *organizational test* and/or the *operational test*. These tests find their origin in the language of the statute giving rise to the exemption, which speaks of an organization being both ''organized and operated'' for one or more exempt purposes.[40]

The organizational test focuses on the organizing instrument of the entity, to see whether all required provisions are in the document (such as a clause preserving the assets for charitable purposes upon dissolution) and to ensure that prohibited language is not present.[41] If, for example, the articles of organization[42] of a tax-exempt charitable organization are amended to allow its net earnings to inure to one or more persons in their private capacity,[43] the organization no longer is qualified for tax exemption.[44] In general, an organization's articles of organization must limit its purposes to one or more exempt ones and may not empower the organization to engage in nonexempt activities other than insubstantially.[45]

The operational test scrutinizes an organization's programs. In the case of a charitable organization, the entity must be operated at least primarily for exempt purposes.[46] For example, the rationale for tax exemption for a charitable organization might be that it is engaged in activities that primarily promote health.[47] Where the operational test is violated, however, so that the organization is no longer functioning primarily for exempt purposes (such as

40. IRC § 501(c)(3); Reg. § 1.501(c)(3)-1(a)(1). If an organization fails to meet either of these tests, it is not tax-exempt (*id*.). These tests thus are applicable with respect to tax-exempt charitable organizations. In a sense, most other categories of exempt organizations have organizational and operational tests as well, although none of them is as well-developed as those for charitable entities. By contrast, if, in error, the IRS issued a determination letter recognizing the tax-exempt status of an organization on a particular basis, that determination can be disregarded by the agency, even if exempt status is available on another basis (Tech. Adv. Mem. 200126032).
41. Reg. § 1.501(c)(3)-1(b)(1).
42. An organization's articles of organization is the document (articles of incorporation, constitution, trust agreement, and the like) by which an organization is created (Reg. § 1.501(c)(3)-1(b)(2)).
43. The private inurement doctrine is the subject of Chapter 4.
44. Reg. § 1.501(c)(3)-1(b)(4).
45. Reg. § 1.501(c)(3)-1(b)(1). Although the statute (IRC § 501(c)(3)) states that a charitable organization must be organized and operated exclusively for charitable purposes, the true state of the law is that the word *substantially* or *primarily* is substituted for the word *exclusively* (*Better Business Bureau v. United States*, 326 U.S. 279 (1945)). This construction of the terminology not only tolerates an incidental amount of nonexempt activity, it allows for a meshing of the unrelated business rules (*see* Chapter 24). (This is the case even though the U.S. Supreme Court articulated the principle five years before the unrelated business law was enacted.)
46. Reg. § 1.501(c)(3)-1(c)(1). The term *exempt purposes* means those charitable purposes for which the organization was organized and is operated (Reg. § 1.501(c)(3)-1(a)(2)).
47. Rev. Rul. 69-545, 1969-2 C.B. 117.

by engaging in one or more forms of private inurement), the organization is no longer qualified for tax exemption.[48]

In addition, an organization is not organized or operated exclusively for one or more exempt purposes unless it serves a public, rather than a private, interest.[49] This rule, like the private inurement prohibition, requires the absence of transactions that benefit *insiders* of the organization—directors, officers, substantial contributors—and persons controlled by insiders.[50] (Particularly where the membership is small, insiders can include members.) In the healthcare setting, it is the view of the IRS that physicians practicing at an exempt hospital are insiders,[51] as are nearly all persons performing services for the institution.[52]

When it transgresses either the organizational test or the operational test, the organization becomes a non-tax-exempt (that is, taxable) entity. Nonetheless, it remains a nonprofit organization under state law. Therefore, without additional action, the entity is a taxable nonprofit organization. Further steps under state law are usually required to convert the entity to a for-profit organization.[53]

Where the exempt organization is a charitable one, the most difficult problem to overcome is the proscription of the dissolution clause. The organization, to be initially recognized as a charitable entity, was required to have this clause in its articles of organization. This clause mandates that, on dissolution or liquidation, the net assets and remaining income of the organization must be preserved for charitable purposes.[54] A blatant violation of this rule would be transfer, on dissolution, of assets to an organization's members or shareholders.[55] This aspect of the organizational test prevents a charitable organization from accumulating assets and income in the tax-exempt charitable mode and then simply converting to a taxable entity.[56]

48. Reg. § 1.501(c)(3)-1(c)(2).
49. Reg. § 1.501(c)(3)-1(d)(1)(ii).
50. *Id*. The federal tax regulations do not specifically use the term *insider*; the phrase used is *private shareholder or individual* (Reg. § 1.501(a)-1(c)) or *private interests* (Reg. § 1.501(c)(3)-1(d)(1)(ii)).
51. Gen. Couns. Mem. 39498.
52. Gen. Couns. Mem. 39670.
53. As noted, there are differences between these two types of corporations, with the fundamental distinction rooted in the private inurement doctrine (*see* Chapter 4).
54. Reg. § 1.501(c)(3)-1(b)(4).
55. *Id*., last sentence.
56. In a sense, this statement is overly broad. A statement of law or a provision in articles of organization does not, in a literal sense, ''prevent'' an individual from doing anything. This form of violation of the organizational test would, from a federal tax standpoint, merely cause loss of the organization's tax-exempt status—a result that is to occur in any event because of the organization's conversion to a taxable entity. Nonetheless, this development would still leave the organization as a nonprofit one, with potential problems under state law (*see* text accompanied by *supra* note 50). Further, the attorney general of the particular state may intervene to preserve the assets for charitable

There may be conflict between federal and state law on this point. State law may allow certain liquidating distributions that are impermissible under federal tax precepts. For example, where the articles of organization of a church failed to contain the requisite dissolution clause, tax-exempt status was denied, particularly in light of the fact that the law in the state of organization permitted certain distributions of assets to members of nonprofit corporations.[57] In another case, a charitable contribution deduction was denied where, under state law, the donee organization could, upon dissolution, distribute its assets to its founders (in this instance, the donors).[58] As one appellate court stated: ''If there is substantial possibility that upon dissolution, accumulated assets will find their way into private hands, exemption is barred.''[59] That statement is equally applicable in the revocation context.

Suppose, for example, that a tax-exempt charitable hospital decides to convert to a taxable for-profit hospital. It cannot merely create a for-profit corporation and transfer all of the income and assets of the charitable entity to it.[60] The assets of the charitable organization may be transferred to the for-profit corporation, but the recipient corporation must pay fair market value for them. This outcome leaves the charitable entity with no assets other than an amount of funds equal to the fair value of the assets (property) it once had. The IRS issues rulings from time to time as to the tax consequences of these types of transactions.[61]

To continue with this example, the charitable organization will no longer function as a hospital (although it may continue to operate in a manner that promotes health). Thus, there will almost certainly be a material change in circumstances, requiring the charitable entity to report the development to the IRS[62] and perhaps submit another application for recognition of tax exemption. The surviving charitable organization may, as illustrations, become a freestanding medical research organization, a foundation operating in tandem with the newly formed for-profit organization, or an entity operating a gift shop in conjunction with the for-profit hospital.[63] This new mode of operation

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purposes. Additionally, with the advent of the intermediate sanctions rules (*see* § 28.2(b)), this violation of the organizational test (as a form of private inurement) may trigger federal excise taxation of one or more of the individuals responsible for the transaction.

For certain other categories of tax-exempt organizations, the federal tax law is not so stringent. For example, a social club (IRC § 501(c)(7)) may make liquidating distributions to its members (e.g., *Mill Lane Club, Inc. v. Commissioner*, 23 T.C. 433 (1954); Rev. Rul. 58-501, 1958-2 C.B. 262). Also, a fraternal beneficiary association (IRC § 501(c)(8)) may convert to a for-profit entity (Priv. Ltr. Rul. 8938072).

57. *General Conference of Free Church of America v. Commissioner*, 71 T.C. 920 (1979).
58. *Calvin K. of Oakknoll v. Commissioner*, 69 T.C. 770 (1978).
59. *Monterey Public Parking Corp. v. United States*, 27 A.F.T.R.2d 71-378, 380 (6th Cir. 1971).
60. *See* first paragraph of *supra* note 20.
61. E.g., Priv. Ltr. Rul. 9538026.
62. *See* § 34.1.
63. It is the position of the IRS that a nonprofit organization, the primary activity of which is the operation of a gift shop and a gift cart within a proprietary hospital for the purpose

may cause the charitable entity to become another type of public charity or a private foundation.[64]

These points are being illustrated by sales of or mergers entailing tax-exempt hospitals, healthcare systems, and health insurance plans to or with for-profit entities, with a consequence of the transactions the establishment of ''foundations.'' One analysis surveyed 139 of these conversion-type foundations created since 1973; the year in which the largest number of these transactions took place (24) was 1995. These entities' assets totaled $15.3 billion in 2001. About 45 percent of these conversion organizations are private foundations. Overall, there are more than 165 organizations created by conversion agreements or organizations that received assets as a result of conversions.[65]

This matter becomes more complex where the successor for-profit entity is controlled by physicians who are insiders with respect to the tax-exempt hospital. This general issue is discussed elsewhere,[66] but one case illustrates the point. In the case, a tax-exempt, charitable hospital transferred its pharmacy operations to an organization controlled by its trustees, to function on a for-profit basis. The for-profit entity sold pharmaceuticals to the hospital at prices higher than those previously paid by it. Subsequently, the assets of the pharmacy were sold to another charitable organization. The exemption of the hospital was retroactively revoked, on the grounds of private inurement.[67]

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of selling candy, flowers, newspapers, books, magazines, sundries, and other small gift items to patients, visitors, and employees of the hospital, is a charitable entity because the organization's activity primarily improves the physical comfort and mental well-being of the hospital's patients, thereby encouraging their recovery, and only incidentally benefits the proprietary hospital (Gen. Couns. Mem. 39762). (This rationale for tax exemption under IRC § 501(c)(3) is the subject of § 24.7, text accompanied by notes 208–209.) The IRS termed these ''recuperative sales of nonmedical items'' (*id*.) and found the private benefit derived by the for-profit hospital to be incidental in both a qualitative and a quantitative sense, in that the overall benefit to the general public substantially overrode any benefit to private individuals, and the private benefit was a necessary concomitant of the beneficial activity, following the criteria stated in Gen. Couns. Mem. 37789. (The doctrine of private benefit is the subject of § 4.7.)

64. If the entity became a freestanding medical research organization, it presumably would gain tax-exempt status by reason of IRC § 501(c)(3) as a scientific organization (*see* § 1.3) and become a publicly supported organization by reason of IRC §§ 170(b)(1)(A)(vi) and 509(a)(1) or 509(a)(2) (*see* §§ 5.2 and 5.3). (Examples where the successor public charity status, in these circumstances, was that of IRC § 509(a)(2) are in Priv. Ltr. Ruls. 9643036 and 8234085.) It could not, however, be a medical research organization as that term is used in IRC § 170(b)(1)(A)(iii) (*see* § 5.1(b)) because the required related hospital must be a tax-exempt one. (In one instance, the successor public charity was an educational institution, by reason of IRC §§ 170(b)(1)(A)(ii) and 509(a)(1) (Priv. Ltr. Rul. 9643039).) If the entity became a foundation in relation to the for-profit institution, it may well become a private foundation (*see* Chapter 5) as is the case with most company-related foundations.
65. This analysis is based on a survey conducted by Grantmakers in Health; it is summarized at XIV *Chron. of Phil*. (No. 14) 10 (May 2, 2002).
66. *See* § 4.3.
67. *See* Chapter 4.

The court declared the transaction merely a device to funnel profits from the exempt hospital to its trustees.[68]

Although it happens infrequently, a tax-exempt organization may decide to sell one or more of its operating assets. Generally, it can do so as long as fair value is received on the sale. For the most part, the status of the purchaser is irrelevant.[69] As illustrations, the IRS has approved the sale of assets from a tax-exempt hospital to another tax-exempt organization,[70] to a partnership formed by the board of directors of a hospital,[71] and to unrelated purchasers.[72]

Nonetheless, where the purchaser of assets from a tax-exempt charitable hospital is an organization that was created by individuals related to the hospital to an extent to be treated as insiders,[73] such as physicians practicing there or members of the hospital's governing board, the transaction will be accorded strict scrutiny. This type of transaction has several ramifications, other than the matter of tax exemption; they include the impact on the qualification for any tax-exempt bond financing[74] and conflicts of interest.

As to the bounds of this scrutiny, it is frequently advised in these circumstances that the services of one or more competent appraisers be obtained. The purpose is to be able to demonstrate that the fair market value of the transferred assets was obtained on an independent basis.[75] In one instance, however, discussed next, that act of prudence proved inadequate to preclude loss of the selling hospital's tax-exempt status.

In the case, a tax-exempt organization that operated a hospital, and had research and educational functions, determined to sell the hospital to gain

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68. *Maynard Hospital, Inc. v. Commissioner*, 52 T.C. 1006 (1969).
69. Again, the assumption of this chapter is that the selling organization is not a private foundation (*see supra* note 1). In instances where the selling organization is a private foundation and one or more of the purchasers are disqualified persons with respect to it, the sale would almost certainly be an act of self-dealing, with resultant adverse federal tax consequences (*see* § 5.6).
70. Priv. Ltr. Rul. 9010073.
71. Priv. Ltr. Rul. 8234084.
72. E.g., Priv. Ltr. Rul. 8219066.
73. *See* Chapter 4 § 3.
74. IR-90-60. In Rev. Rul. 77-416, 1977-2 C.B. 34, the IRS ruled that interest on municipal bonds continued to be excludable from gross income under IRC § 103 following the sale by a city of an electric system to a private utility company, where the sale proceeds were placed in an escrow account as substituted security for the system revenues originally pledged as security for the bonds. The full reasoning underlying this ruling is contained in Gen. Couns. Mem. 37158 (with heavy emphasis on the facts that considerable time passed before the facility was sold and other evidence that the transaction was ''legitimate,'' that is, ''non-prearranged''), and a somewhat similar situation is analyzed in Gen. Couns. Mem. 37783. Transactions of this nature involving tax-exempt hospitals are the subject of Priv. Ltr. Ruls. 8152099, 8313016, 8509094, 8740029, and 8951058. Comparable transactions outside the healthcare setting are the subject of Priv. Ltr. Ruls. 8008184, 8124019, 8236047, 8312123, 8430024, and 8747008.
75. This approach to sales to insiders has become even more critical because of the intermediate sanctions law (*see* § 28.2(b)).

income for the other exempt functions. Because of the highly specialized nature of the hospital facility, there was a limited market for its sale. Thus, the hospital was sold to a for-profit entity controlled by its board of directors. Basically, the organization went about this process in the appropriate manner. It secured a valuation from a qualified independent appraiser, and the property was sold at the appraised value of $8.3 million (principally in cash and notes). No loan abatements or other special concessions were offered to the directors as purchasers of the hospital facility. The exempt organization took steps to ensure that it would use arm's-length standards in future dealings with the hospital. A ruling was obtained from the IRS to the effect that the transaction would not adversely affect the tax exemption of the organization.[76]

Soon after the sale, the purchasing organization began receiving inquiries as to resale of the facility. The new organization added beds to the hospital and obtained a certificate of need for additional beds. Less than two years after the initial sale of the hospital facility by the exempt organization, it was resold; the resale price was $29.6 million.

Each member of the board of the for-profit selling organization received in excess of $2.3 million as his or her share of the sales proceeds. The attorney general of the state involved filed a lawsuit, alleging that the initial sale price was not fair and reasonable. The court agreed, and concluded that the directors of the exempt organization acted with a lack of due diligence. At trial, the facilities were appraised using five appraisal methodologies; the conclusion was that the value of the assets at the time of sale by the exempt organization was approximately $18 to $21 million. A subsequent analysis by the IRS set the value of the facility at $24 million.

The factual issue before the IRS was whether the tax-exempt organization received fair market value when it sold its hospital facility. A detailed analysis of the appraisals led the IRS to the conclusion that fair market value had not been received. The appraisals done for the court and the IRS were based on various appraisal methodologies; the appraisal relied on by the selling exempt organization used one. The IRS conceded that ''no single valuation method is necessarily the best indicator of value in a given case.''[77] But, added the IRS, ''it would be logical to assume that an appraisal that has considered and applied a variety of approaches in reaching its 'bottom line' is more likely to result in an accurate valuation than an appraisal that focused on a single valuation method.'' Having resolved that factual issue, the IRS concluded as a matter of law that the tax-exempt organization, in selling the hospital facility for substantially less than its fair market value, contravened

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76. Priv. Ltr. Rul. 8234085 (in which the IRS stated that the ''proposed sale as described will not benefit those in a controlling position with respect to you by virtue of the ability of such persons to unfairly manipulate the transaction''). In this ruling, the IRS observed that the transaction presented the converse of the situations presented in Rev. Rul. 76-441, 1976-2 C.B. 147 (*see* text accompanied by *infra* notes 82–83).
77. Priv. Ltr. Rul. 9130002.

the private inurement doctrine. Accordingly, the organization's tax-exempt status was revoked, effective as of the date of the sale of the facility.[78] In so doing, the IRS observed: ''There is no absolute prohibition against an exempt section 501(c)(3) organization dealing with its founders, members, or officers in conducting its economic affairs.'' There is no doubt, however, that transactions of this nature will be subject to special scrutiny, with the IRS concerned about (in the language of the ruling) ''[a] disproportionate share of the benefits of the exchange'' flowing to the insiders. Thus, in this case, there was nothing inherently improper about the organization's decision to cease being a hospital and to sell the appropriate assets to an organization controlled by its directors.

The organization in this case followed the correct approach in acquiring an independent appraisal. In most circumstances, this should have been enough.[79] When, however, the directors resold the hospital facility after approximately only a two-year period and experienced a $21.3 million profit and a lawsuit by the state's attorney general (with the court having found a breach of fiduciary responsibility), the IRS found private inurement.

This type of sale of assets, in whole or in part, does not give rise to taxable gain or loss under the unrelated trade or business tax rules.[80] The onetime sale of an asset, principal or otherwise, when used directly in furtherance of the selling organization's exempt function, lacks the frequency, continuity, and commercial manner to be considered as an unrelated trade or business.[81]

As an alternative to sale of assets and/or total conversion, a tax-exempt organization may lease assets to a nonexempt organization, particularly where doing so advances the lessor's exempt purposes.[82] In one instance, a tax-exempt hospital leased its clinic facilities to a for-profit corporation controlled by physicians formally employed by the clinic without endangering its exempt status.[83] Also, if a sale is not feasible, the tax-exempt organization may enter

78. *Id*.
79. For example, in the charitable contribution deduction context, gifts of property in excess of $5,000 in value are generally required to be the subject of a qualified appraisal by a qualified appraiser (Reg. § 1.170A-13(c)). There is no requirement for more than one appraisal nor is there a requirement that an appraisal be based on a ''variety of approaches.'' Indeed, these rules require a qualified appraisal to state ''the'' method of valuation (Reg. § 1.170A-13(c)(3)(ii)). Moreover, these rules allow a donor to obtain more than one appraisal and use the most desirous one in substantiating the charitable deduction (Reg. § 1.170A-13(c)(5)(iii)). *See*, in general, Charitable Giving, § 21.2.
80. *See*, in general, Chapter 24.
81. Reg. § 1.513-1(c)(1).
82. E.g., *Gundersen Medical Foundation, Ltd. v. United States*, 536 F. Supp. 556 (W.D. Wis. 1982).
83. Priv. Ltr. Rul. 8204057. As to the unrelated business income aspects of this type of a transaction, *see* § 24.17. In general, Fox IV and Kelly, ''Sales of Not-for-Profit Hospitals to For-Profit Corporations,'' 137 *Trusts & Estates* (No. 11) 38 (Oct. 1998); Hoyt, ''Creating Supporting Organizations of Community Foundations from Hospital Sales,'' 17 *Exempt Org. Tax Rev*. (No. 2) 265 (Aug. 1997); Mancino, ''Converting the Status of Exempt Hospitals and Health Care Organizations,'' 9 J. *Tax'n Exempt Orgs*. (No. 1) 16 (July/Aug.

into a contract with a for-profit organization by which the latter manages and operates the former by means of a management contract.[84]

§ 21.4 CONVERSION FROM NONEXEMPT TO EXEMPT STATUS

A for-profit organization may decide to convert to a tax-exempt organization. (Like the reverse, there is no prohibition in law as to doing that.) In the healthcare field, for example, a proprietary hospital may determine that tax-exempt status as a charitable entity is preferable to a for-profit classification. These decisions are by no means confined to hospitals, however; they can be made by other healthcare providers, such as outpatient clinics, health maintenance organizations, nursing homes, and homes for the aged.

(a) State Law

Nearly every for-profit organization is a creature of the law of a state or the District of Columbia, and is usually organized as a corporation. (Again, the balance of this chapter is predicated on the assumption that the nonprofit and for-profit entities involved are corporations.)

As noted, nearly every state has a nonprofit corporation act and a for-profit corporation act. These are separate statutes; the extent of any interplay between them is a matter of state law, which can vary from state to state. For example, it may not be possible for a for-profit corporation in a particular state to amend its articles of incorporation so as to become a nonprofit corporation under the law of that state. Likewise, it can be problematic as to whether a for-profit corporation can merge into a nonprofit corporation.[85]

Suppose a hospital, organized as a for-profit corporation, is desirous of becoming a tax-exempt organization, organized as a charitable entity. As is the case when the conversion is to be the reverse, theoretically, the easiest way to accomplish this is to amend the corporate documents and convert to the nonprofit form. However, as noted, state law may not allow for this transformation.

Another approach would be to create a nonprofit corporation and then merge the for-profit corporation into it. Again, state law may preclude the merger of a nonprofit and a for-profit organization.

A third approach would be to create the nonprofit corporation, transfer the assets and income of the for-profit corporation to the nonprofit corporation, and dissolve the for-profit corporation. Presumably, there would not be a state law prohibition as to this type of transaction.

1997); Silk, ''Conversions of Tax-Exempt Nonprofit Organizations: Federal Tax Law and State Charitable Law Issues,'' 13 *Exempt Org. Tax Rev*. (No. 5) 745 (May 1996).

84. E.g., Priv. Ltr. Rul. 9715031. *See*, however, the discussion at § 22.9 (concerning whole-hospital joint ventures).

85. *See* text accompanied by *supra* note 9.

(b) Federal Tax Law

Unlike the state of the law concerning the process by which a tax-exempt organization converts to a for-profit one, there are considerable guidelines at the federal tax level for converting a for-profit entity to an exempt one.

The essential principles in this area in the healthcare context are reflected in a revenue ruling published by the IRS in 1976.[86] The transaction in that ruling involved the purchase by a nonprofit hospital corporation of all of the assets of a for-profit hospital; the purchase was not at arm's length, in that the owners of the for-profit entity created the nonprofit organization and over one-half of the board of directors of the nonprofit entity were stockholders of the for-profit institution. The nonprofit entity was held to qualify as an exempt charitable organization; the IRS ruled that there was no private inurement.

The chief tax issue in a transaction of this nature is the appropriate selling price. In this case, the owners obtained an independent appraisal of the tangible assets and then computed the value of the intangible assets (which was substantial) by the capitalization of excess earnings formula.[87] The purchase was made using the price arrived at by this method. The nonprofit organization satisfied the IRS that the intangible assets had a direct and substantial relationship to the performance of the exempt functions of the hospital. These assets, in the case of a hospital, were said to include accreditation for an internship or residency program, good labor relations, an active medical staff, and a favorable location.

Another example of these principles is contained in a subsequent revenue ruling also published by the IRS in 1976.[88] One aspect of the ruling concerned an otherwise qualifying nonprofit organization that purchased or leased the assets of a former for-profit school and employed the former owners, who were not related to the directors of the nonprofit entity, at salaries commensurate with their responsibilities. The IRS determined that the nonprofit school operated to serve a public interest where it purchased the for-profit school's personal property at fair market value in an arm's-length transaction and paid a fair rental value for use of the land and buildings. In the ruling, the IRS concluded that the organization was operating exclusively for educational and charitable purposes.

The ruling, however, also discussed another situation concerning a nonprofit organization that, after receiving as a gift all of the stock of a for-profit school, dissolved the school and assumed all of its liabilities, which included notes owed to the former owners, all of whom comprised the board of directors of the recipient organization. Financial information showed that the liabilities of the school exceeded the fair market value of its assets; consequently,

86. Rev. Rul. 76-91, 1976-1 C.B. 149.
87. This formula is the subject of Rev. Rul. 68-609, 1968-2 C.B. 327.
88. Rev. Rul. 76-441, 1976-2 C.B. 147.

the IRS ruled that the nonprofit donee organization was substantially serving the directors' private interests in honoring the notes and thus that the organization failed to qualify for tax exemption. Said the IRS: ''The directors were, in fact, dealing with themselves and will benefit financially from the transaction.''[89]

In general, it is the view of the IRS that where an organization purchases assets from an independent party, a presumption exists that the purchase price (arrived at through negotiations) represents a fair market value. Where the purchaser is controlled by the seller (or there is a close relationship between the two) at the time of the sale, however, this presumption will not be made because the elements of an arm's-length transaction are not present.[90]

Although there are no regulations or rulings on the subject, the IRS, in the application for recognition of tax-exempt status as a charitable organization,[91] established an inventory of the items of information it must have concerning the predecessor and successor organizations in order to issue a favorable ruling or determination letter to the nonprofit organization. (This body of information is in addition to the information requested of all nonprofit organization applicants.) The form presupposes that the applicant nonprofit organization is an entity separate from the predecessor for-profit organization,[92] thus reflecting the presumption that a for-profit organization cannot be transformed into a nonprofit organization.[93]

The specific items of information a successor nonprofit organization must provide the IRS as part of the exemption recognition process are (1) the name of the predecessor organization; (2) the nature of the activities of the predecessor organization; (3) the names and addresses of the owners or principal stockholders of the predecessor organization; (4) their share or interest in the predecessor organization; (5) the business or family relationship between the owners or principal stockholders and principal employees of the predecessor organization and the officers, directors, and principal employees of the applicant nonprofit organization; (6) whether any property or equipment formerly used by the predecessor organization has been or will be rented to the successor organization (if so, copies of leases and like contracts must be attached); (7) whether the successor organization is or will be leasing or otherwise making available any space or equipment to the owners, principal stockholders, or principal employees of the predecessor organization (if so, a list of the tenants must be included, along with a copy of each lease);

89. *Id*. at 148.
90. Rev. Rul. 76-91, 1976-1 C.B. 149.
91. Form 1023, Schedule I.
92. For this purpose, a for-profit organization includes any organization in which a person may have a proprietary or partnership interest, hold corporate stock, or otherwise exercise an ownership interest (Form 1023, Schedule I, last sentence). The organization need not have operated for the purpose of making a profit (*id*.).
93. *See* text accompanied by *supra* notes 9, 56.

and (8) whether any new operating policies were initiated as a result of the transfer of assets from the for-profit organization to the nonprofit organization. Additionally, the applicant nonprofit organization must attach (1) a copy of the agreement of sale or other contract that sets forth the terms and conditions of the sale of the predecessor organization or of its assets to the nonprofit organization, and (2) an appraisal[94] by an independent qualified expert showing the fair market value at the time of sale of the facilities or property interest sold.

Likewise, if a for-profit organization is endeavoring to convert to a non-profit organization and be a tax-exempt social welfare organization[95] or a business league,[96] and is requesting a determination from the IRS as to recognition of tax-exempt status, it must reveal as part of the exemption application the name of the predecessor organization, the period during which it was in existence, and the reasons for its termination. It must also submit copies of all documents by which any transfer of assets was effected.[97]

If a for-profit organization sells assets to a nonprofit organization, the seller is liable for taxes on any gain, just as would be any other purchaser involved. If the transaction is structured as a tax-free reorganization, however, there would not be any taxation.

If assets and/or income are contributed to a tax-exempt charitable organization by a for-profit organization, a charitable contribution deduction would likely result. This deduction may be limited by one or more factors, such as the percentage limitation on annual corporate charitable deductions[98] and the restrictions on the deductibility of gifts of inventory by businesses.[99]

Recent law has added another tax consequence of a conversion of a for-profit organization to a tax-exempt organization. The IRS has finalized regulations concerning the liquidation of for-profit entities into exempt organizations.[100] These rules are essentially the same as those concerning liquidation of for-profit subsidiaries into tax-exempt parents.[101] That is, the general rule now is that the for-profit organization must recognize gain or loss in the transaction, unless the assets are used by the exempt organization in an unrelated business. Thus, for example, a taxable corporation that transfers all or substantially all of its assets, which have appreciated in value, to one or more tax-exempt organizations is required to recognize gain as if the assets transferred were sold at their fair market value. This gain or loss is to be recognized immediately before the transfer.

94. *See supra* notes 71–75.
95. *See* § 1.8.
96. *See* Chapter 18.
97. Form 1024, Part II, question 4.
98. IRC § 170(b)(2). *See*, in general, Charitable Giving § 7.18.
99. IRC § 170(e)(3). In general, Charitable Giving § 9.3.
100. T.D. 8802, issued under authority of IRC § 337(d).
101. *See* § 16.2(d).

No gain or loss, however, will be recognized on any of the assets transferred that are used by the tax-exempt organization in an unrelated business. At the same time, any gain on these assets will later be recognized as unrelated business income if the tax-exempt entity disposes of the assets or ceases to use the assets in an unrelated business.

In general, a taxable corporation's change in status to a tax-exempt entity is treated as if it transferred all of its assets to a tax-exempt organization immediately before the change in status becomes effective. These regulations are certain to have an impact on restructurings, in the healthcare and other contexts, where assets are being shifted from for-profit to exempt entities.[102]

§ 21.5 JOINT OPERATING AGREEMENTS

A technique for securing many of the benefits of a merger without actually merging is the *joint operating agreement* (JOA), sometimes referred to as a "virtual merger."[103] Simply put, a JOA is an agreement between various entities (most often tax-exempt healthcare entities) that allows them to operate more efficiently by coordinating and centralizing their key administrative, financial, and management activities, while still maintaining a certain amount of corporate autonomy that would not be possible in a true merger. They typically involve the creation of a joint operating company (JOC) to act as the coordinating entity. JOAs are especially useful for universities and religious healthcare organizations because such entities are often legally or ethically unable to give up absolute structural control to a common parent.[104]

JOAs raise significant tax issues because, as a general rule, an organization such as a JOC cannot qualify as a charitable organization if it is established

102. There is a third implication of these regulations. In general, appreciated property in a tax-exempt organization could be taxed where the exempt organization lost its exempt status and subsequently regains it. However, that would not be the outcome if the organization reacquired exempt status within three years. An IRS official characterized this proposed rule as an "atomic bomb" for tax-exempt organizations (5 *EOTR Weekly* (No. 5) 1 (Feb. 3, 1997)).

103. In general, Bruder, "Charting the JOA Waters: Joint Operating Agreements, Tax-Exempt Health Care Facilities, and a Proposed Safe Harbor," 18 *Exempt Org. Tax Rev.* (No. 2) 227 (Nov. 1997); Griffith, "When Is a True Parent-Subsidiary Structure a JOA?," 18 *Exempt Org. Tax Rev.* (No. 2) 219 (Nov. 1997); Griffith and Tomtishen, "IRS Adopts Facts-and-Circumstances Approach for JOAs—Part Two," 17 *Exempt Orgs. Tax Rev.* (No. 3) 391 (Sep. 1997); Tracy and Lewis, "Latest JOA Ruling Confirms IRS Flexibility on Parent-Subsidiary Relationship Issue," 16 *Exempt Org. Tax Rev.* (No. 3) 449 (Mar. 1997); *see* generally Peregrine and Capizzi, "New Developments in Tax Planning for Joint Operating Company Arrangements," 14 *Exempt Org. Tax Rev.* (No. 1) 101 (July 1996); Griffith and Tomtishen, "IRS Adopts Facts and Circumstances Approach for JOAs—Part One," 14 *Exempt Orgs. Tax Rev.* (No. 3) 403 (Sept. 1996); Peregrine, Broccolo, and Capizzi, "New Guidance on Tax Treatment of Joint Operating Agreements," 13 *Exempt Org. Tax Rev.* (No. 3) 439 (Mar. 1996).

104. Carson, "JOA Ruling Is Good News for Health Care Arrangements," 15 *Exempt Orgs. Tax Rev.* (No. 3) 335 (Dec. 1996).

solely to provide corporate services for a profit to unrelated tax-exempt organizations (except for certain cooperative hospital services). Providing services for other tax-exempt organizations can also sometimes result in the imposition of the unrelated business income tax[105] and could result in a private business use[106] of tax-exempt bond proceeds.[107] However, under the Third Circuit's analysis in the *Geisinger* case,[108] a subsidiary may be tax-exempt under the integral part test[109] if its activities are an integral part of the exempt activities of the parent organization and if its activities would not be an unrelated trade or business if carried on by the parent. Thus, key issues in any JOA arrangement are whether the entities have sufficient structural and financial integration so that they are in something analogous to a parent–subsidiary relationship and whether the activities being conducted are essential to the accomplishment of exempt purposes.

The IRS has been sending to hospital JOA applicants a checklist of structural and financial factors that it will consider in reviewing JOA arrangements.[110] Those factors look to (1) various aspects of long-range and day-to-day management decisions by the JOA governing body; (2) whether there are significant hindrances to terminating the JOA; (3) whether there are mechanisms in place to resolve disputes among the participating entities; and (4) the degrees of veto and reserved powers.[111] The IRS also has issued a short article on JOAs in its guidance for field agents,[112] which indicates the popularity of this strategy and the IRS's attitude toward it, which has generally been positive.

The early IRS rulings in this area established several ground rules for JOA operation. One ruling[113] involved ''Corporation A,'' a charitable organization that owns and operates Hospital A consisting of three acute care hospitals in three different cities, and ''Corporation B,'' a charitable organization that is the sole corporate member of Hospital B, an acute care hospital in another city. In response to healthcare reform and in an effort to enhance the quality and efficiency of healthcare services in the area, the foregoing hospitals desire to unify their operations. This unification will be accomplished through a JOA between A and B, their respective hospitals, and a new Corporation C, which is a charitable organization formed pursuant to the terms of the JOA to operate

105. *See*, generally, Chapter 24.
106. *See*, generally, Chapter 30.
107. For a discussion of both bond and unrelated income issues, *see* Griffith and Tomtishen, ''Exempt Hospital Affiliations: Bond and UBIT Issues,'' 11 *Exempt Org. Tax Rev*. (No. 4) 709 (Apr. 1995); Griffith and Tomtishen, ''Exempt Hospital Affiliations: Bond and UBIT Issues—Part Two,'' 13 *Exempt Org. Tax Rev*. (No. 2) 215 (Feb. 1995).
108. *Geisinger Health Plan v. United States*, 30 F.3d 494 (3d Cir. 1994).
109. *See* § 33.5.
110. Reprinted in 14 *Exempt Org. Tax Rev*. (No. 3) 471 (Sept. 1996).
111. The complete checklist is reproduced at Appendix I.
112. ''Virtual Mergers—Hospital Joint Operating Agreement Affiliations,'' Exempt Organizations Continuing Professional Education Technical Instruction Program for FY 1997, Ch. J.
113. Priv. Ltr. Rul. 9609012.

the network. C will support the integration of the hospitals and provide certain governance, administrative, financial, and consulting services to the hospitals. Thus, the JOA will result in the operation of all of the hospitals functioning as a single regional integrated healthcare network.

The specific powers of C's board of directors include (1) appointing the members of the board of directors of the hospitals; (2) determining the authority to be delegated to the foregoing boards; (3) appointing and removing the senior executives of the hospitals; (4) approving budgets and strategic plans; (5) appointing members of the hospitals' medical staffs; and (6) approving medical staff bylaws. No more than 20 percent of the directors of C can be physicians who actively practice medicine.

The JOA provides for the operation (but not the ownership) of the network facilities. The JOA also allows the hospitals to share the financial risks and rewards of providing key healthcare services to the community. A network member performing a service for another network member pursuant to the JOA does not receive any separate profit for the service.

All hospitals will collect their respective revenues, pay their respective expenses, and fund their respective capital expenditures. However, the hospitals effectively accomplish financial integration through two annual payments. First, the hospital realizing the larger amount of adjusted cash flow pays over one-half of the difference to the other hospital. Each hospital thus realizes an equal amount of adjusted cash flow. Second, so that each hospital makes equal capital expenditures, the hospital that incurs the smaller amount of nonfinanced capital expenditures makes a payment equal to one-half of the difference between the smaller and larger amounts to the hospital incurring the larger amount of nonfinanced capital expenditures.

Both hospitals have borrowed the proceeds of tax-exempt bonds to finance capital expenditures, and the JOA will not alter the obligations for these borrowings.

Based on the foregoing facts, the IRS found that the parties to the JOA will form a partnership. Although use of tax-exempt bond proceeds by a partnership can constitute private business use, the IRS ruled that the implementation of the JOA does not have the potential of transferring the benefits of tax-exempt financing to the partnership if the partnership is viewed as merely the aggregate of its tax-exempt partners. In addition, the JOA will not give rise to any unrelated trade or business income. Instead, the JOA creates an integrated regional healthcare delivery system with the patients of one hospital being treated as the patients of the other hospital. Thus, the IRS found that services are being performed as an integral part of the exempt charitable activities of organizations that are financially and structurally related as a regional integrated healthcare network, and these services further the network's exclusively charitable purposes related to the promotion of health in the community.

In another ruling (actually a series of three identical rulings),[114] the facts and issues were somewhat analogous to those in the ruling previously discussed. The second ruling involved ''Corporation A,'' a public charity that owns and operates two hospitals and other healthcare facilities in a state. Corporation A is also the sole corporate member of ''Corporation B,'' a public charity that owns and operates another hospital and other healthcare facilities in another part of the same state. Together the above entities comprise ''Group A.''

''Corporation C'' is also a public charity that owns and operates two acute care hospitals in the central part of the state. ''Corporation D'' is a public charity that is the sole member of Corporation C. Together the above entities comprise ''Group C.''

''Corporation E'' is a charitable entity that was formed by Corporation A and Corporation D. One-half of the board of Corporation E is appointed by Corporation A and one-half by Corporation D. No more than 20 percent of the directors of Corporation E will be physicians who actively practice medicine.

In response to the healthcare reform movement and to enhance quality and efficiency of services, Corporation A and Corporation C propose unifying their operations through a JOA that provides a single regional integrated healthcare network composed of Corporation A and Corporation C, their respective facilities, and Corporation E (which will operate the network pursuant to the terms of the JOA). The main function of the Corporation E board of directors will be the establishment of network policies and the coordination of services by the network participants.

After implementation of the JOA, each network participant will continue to collect its own revenues and pay its own operating expenses. Network participants effectively accomplish financial integration through annual payments between Group A and Group C. The amount of the payment will be based on a weighted average of two ratios, each determinable as of a certain date. One ratio is based on the fair market value of the assets of Group A and the assets of Group C, plus or minus certain specified assets or liabilities. The other ratio is based on the average excess of revenues over expenditures for the four most recently completed fiscal years of Group A and Group C prior to the execution of the JOA. The amount of weight given to each ratio will vary over a term of years, with a declining weight given to the income ratio and an increasing weight given to the asset ratio.

Once the JOA is effective, neither ratio will be adjusted because of the future performance of any network participant. Thus, there will be no financial incentive for any network participant to encourage the use of services at, or to make capital additions to, any particular facility, and a network participant performing a service pursuant to the JOA will not receive any separate profit or benefit for rendering the service. The JOA will not alter the obligations of

114. E.g., Priv. Ltr. Rul. 9623011.

the various corporations with regard to any tax-exempt bonds, and each of the bond-financed hospital facilities will continue to be used as a hospital.

Based on the foregoing facts, the IRS again concluded that the network created by the JOA constituted a partnership. However, using the same analysis as in the first ruling, the IRS concluded that the JOA does not have the potential of transferring the benefits of tax-exempt financing to the partnership and will not give rise to any unrelated trade or business income. Instead, the IRS found that services are being performed as an integral part of the exempt charitable activities of organizations that are financially and structurally related as a regional integrated healthcare network, and that these services further the network's exclusively charitable purposes related to the promotion of health in the community.

In a subsequent ruling,[115] the IRS ruled that a JOA between a charitable parent organization and five tax-exempt healthcare entities would not result in loss of tax-exempt status for any entity in the system, nor would the arrangement create any unrelated business taxable income. In the ruling, ''J'' was listed as the parent organization in a healthcare delivery system consisting of K, L, M, N, and O. All of the entities in the system are tax-exempt charitable organizations. J has a JOA with the other entities in the system. Pursuant to the JOA, J actively manages and operates the system. Specifically, J has the authority to develop and administer strategic and financial plans for the system; oversee, conduct, and carry out marketing and business development strategies; develop a centralized accounting system; consolidate management; conduct contract negotiations and implementation; analyze productivity; approve capital expenditures; and manage and oversee daily operations of the system.

J's chief executive officer (CEO) is also the CEO of each entity in the system. J has the authority to employ the persons necessary to carry out the JOA, including the CEO of J and certain other senior managers. However, each entity in the system maintains the authority to make and implement labor and employment relations policies with respect to its employees. Also, each entity in the system retains the authority to grant hospital staff privileges in order to facilitate accreditation.

J also has authority to set fees and prices for the system, to control the programs and services of the participating entities, to establish budgets for participating entities, and to enter into managed care agreements on behalf of the system. In addition, J will assume all present and future debt of the participating entities (except for outstanding tax-exempt bonds), will be responsible for future losses of the system, and will buy and sell assets of the system. However, each entity in the system will retain ownership of its property, plant, and equipment.

115. E.g., Priv. Ltr. Rul. 9651047.

The primary powers reserved to the participating entities in the system include extraordinary matters such as amendments to the JOA, amendment of J's governing instruments, matters involving default, and a few narrowly defined exceptions to J's authority to direct the provision of healthcare services. M and N also have reserved for themselves the power to approve any plan by J that would alter their ability to provide certain kinds of healthcare services.

If an entity fails to comply with any provision in the JOA, an event of default occurs if the failure continues for 30 days after written notice of default. The parties are required to attempt to resolve their dispute in good faith and to use negotiation in the event issues remain unresolved.

The entities sought a ruling that the arrangement would not jeopardize their tax-exempt status and that the arrangement would not result in unrelated business taxable income.

The IRS found that, under all the facts and circumstances, the JOA in question effectively binds K, L, M, N, and O under the common control of J so that the organizations are ''within a relationship analogous to that of a parent and subsidiary.'' In reaching this conclusion, the IRS found most important the fact that the entities in the system had ceded authority to J's governing body to establish their budgets, to direct the provision of healthcare services, and to monitor and audit their compliance with J's directives. In addition, the governing body and committees of J meet regularly to exercise overall responsibility for decisions involving day-to-day and long-range strategic management for the participating entities. Therefore, the IRS concluded that services provided among these previously unrelated organizations through the JOA are ''treated as other than an unrelated trade or business.''

This ruling demonstrates three important points for tax-exempt healthcare entities interested in using JOAs. First, the ruling demonstrates that when reviewing corporate service arrangements between exempt organizations that have previously been unrelated to each other, the IRS is willing to use a flexible facts-and-circumstances test to determine whether there are sufficient manifestations of control between the entities such that something analogous to a parent–subsidiary relationship exists. Second, if something analogous to a parent–subsidiary relationship does exist, the JOA should not adversely affect any entity's tax-exempt status or cause the imposition of unrelated business income tax as long as the services being performed for a fee involve management or other activities that further tax-exempt purposes. Third, an appropriately integrated arrangement does not necessarily preclude the reservation of certain powers over system operations, such as control over extraordinary transactions (e.g., the sale of assets in excess of $1 million).

In later rulings, the IRS has continued to use the facts-and-circumstances test but offers little practical guidance to further clarify its application. The IRS did reinforce the proposition, however, that ''structural integration'' does not necessarily require that the joint operating company have complete control

over the parties to the agreement.[116] Rather, it would appear that certain extraordinary powers may be reserved by a parent or affiliated companies without jeopardizing the parties' tax-exempt status or otherwise generating unrelated business income.

In a ruling involving the integration of two tax-exempt hospitals and an ambulatory service provider, for example, the IRS held that the JOA effectively created a parent–subsidiary relationship notwithstanding the reservation of several extraordinary powers by members of the hospital responsible for managing the system.[117] Specifically, two acute care hospitals, Q and T, integrated their operations through V, a limited liability company that provided physician and ambulatory care services. Pursuant to a joint operating agreement, Q provided centralized management by coordinating the allocation of system resources; developing and implementing strategic plans and marketing activities; setting fees, charges, and rates; developing a centralized accounting system; negotiating and executing managed care agreements; and managing the day-to-day operations of the integrated system.

Powers reserved by the members of Q, R, and U, included (1) the ability to approve amendments to the articles or bylaws of Q; (2) any action that would change the religious status of Q or T; or (3) the dissolution of Q. Moreover, although the reserved powers did not include powers over day-to-day operations, Q was required to obtain the approval of U before closing certain core services provided at the T hospital within the first five years of the JOA (i.e., obstetrics, cardiology, and oncology services) or otherwise ceasing T's operations as an acute care hospital. Finally, in the event that certain financial targets were not fulfilled, R and U could participate in a conference committee to discuss budgetary matters.

After applying the facts-and-circumstances test, the IRS concluded that there was ample control vested in Q by virtue of the JOA to impute a parent–subsidiary arrangement and thereby establish sufficient structural integration. Interestingly, the IRS did not reference the powers reserved by Q's parents in its application of the facts-and-circumstances test, which may be some indication that parties to JOAs may reserve even broader authority before prompting IRS scrutiny.[118]

Another ruling lends credence to this assertion. Pursuant to facts similar to those described above, the IRS approved the reservation of rights to (1) ratify strategic plans; (2) approve budgeted and unbudgeted capital and operating expenditures that exceed certain predetermined thresholds; (3) approve the creation or admission of any subsidiary that is inconsistent with a predetermined policy; (4) approve mergers and dissolutions or alienation of assets; (5) ratify recommendations that would significantly affect access

116. *See* generally, e.g., Priv. Ltr. Rul. 9814040.
117. Priv. Ltr. Rul. 9819049.
118. *Id*.

to local healthcare delivery; (6) appoint directors to serve on a joint operating company; and (7) ratify the appointment of hospital administrators, among other things.[119]

The IRS's approach to the exemption and unrelated business income issues raised by the use of JOAs is fairly flexible. JOAs are a popular strategy for combinations short of a true merger in an industry that continually pursues options for consolidation. They are a means of enabling nonprofit, tax-exempt systems to survive against a tide of proprietary acquisitions. The IRS's analysis of JOAs is consistent with the approach it has taken in hundreds of hospital reorganization and joint venture rulings that found that tax exemption could be preserved. Happily, the IRS did not apply the far more restrictive approach it has taken toward consortium organizations (requiring qualification as cooperative hospital service organizations[120]), which would have stopped JOAs dead in their tracks.[121]

119. Priv. Ltr Rul. 9839042.
120. *See* § 17.1.
121. Additional IRS private letter rulings consistent with this analysis include Priv. Ltr. Rul. 9714011.

CHAPTER TWENTY-TWO

Partnerships and Joint Ventures

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One of the most important phenomena involving tax-exempt organizations in the modern era is their utilization of related organizations. Unquestionably, exempt healthcare organizations have blazed this trail, with their simultaneous use of differing related entities—for-profit or nonprofit, taxable or tax-exempt.[1] Sometimes, these related organizations come into being for management and tax reasons, or more sophisticated managers and advisors bring exempt organizations to the use of related entities to facilitate and enhance what they would be doing in any event.

Healthcare organizations, in the pursuit of their tax-exempt and nonexempt functions, frequently use (i.e., participate in) partnerships and joint ventures. In fact, the nonprofit healthcare field utilizes partnerships and joint ventures more often than all other exempt organizations combined. These involvements can trigger myriad federal tax issues.

§ 22.1 THE TAX LAW FUNDAMENTALS

For the tax-exempt healthcare organization, in actual practice, there may be scant difference in the legal distinction between a *partnership* and a *joint*

1. This observation likewise pertains to the use of taxable and nontaxable subsidiaries (see Chapters 14–16, 20.2).

venture. The participation in either form of entity may appear and operate the same. The two terms, however, have separate tax law definitions and, in a few instances, some operational variations. A chief distinction is whether the entity is used as a financing vehicle; another consideration may be the range of activities conducted by means of the joint entity.

A *partnership* is defined in the federal tax law as including ''a syndicate, group, pool, joint venture, or other unincorporated organization, through or by means of which any business, financial operation, or venture is carried on, and which is not . . . a trust or estate or a corporation.''[2] A partnership usually entails a profit motive. Thus, one court defined a partnership as a ''contract of two or more persons to place their money, efforts, labor, and skill, or some or all of them, in lawful commerce or business, and to divide the profit and bear the loss in definite proportions.''[3]

This broad definition of a partnership is sufficiently sweeping to subsume the joint venture. Nonetheless, in one definition, a *joint venture* is an association of two or more persons with intent to carry out a single business venture for joint profit, for which purpose they combine their efforts, property, money, skill, and knowledge, but they do so without creating a formal partnership, trust, or corporation.[4] In another instance, the term was defined as a ''special combination of two or more persons, where in some specific venture a profit is jointly sought without any actual partnership or corporate designation'' and as ''an association of persons to carry out a single business enterprise for profit.''[5] Thus, two of the distinctions between the partnership form and the joint venture form are that the latter (1) usually has an operational focus that is narrower than that of the partnership and (2) is less ''formal'' than a partnership arrangement. Another difference can be the legal nature of the members of the venture.

The IRS Hospital Audit Guidelines[6] use the following definition:

> A joint venture may take a variety of forms: it may be a contractual agreement between two or more parties to cooperate in providing services, or it may involve the creation of a new legal entity by the parties, such as a limited partnership or closely held corporation, to undertake an activity or provide services.[7]

2. IRC § 7701(a)(2).
3. *Whiteford v. United States*, 61-1 U.S.T.C. (CCH) ¶ 9301, at 79,762 (D. Kan. 1960).
4. *Id*.
5. *Beck Chemical Equipment Corp. v. Commissioner*, 27 T.C. 840, 848–849 (1957). *See also Browning v. Payton*, 918 F.2d 1516, 1520 (11th Cir. 1990); *Podell v. Commissioner*, 55 T.C. 429, 431 (1970); *Perlmutter v. Commissioner*, 44 T.C. 382, 406 (1965), *aff'd*, 373 F.2d 45 (10th Cir. 1967).
6. IRS Exempt Organizations Examination Guidelines Handbook (IRM 7(10)69) § 333 (''Hospital Audit Guidelines''), reproduced by the IRS for broader dissemination in Ann. 92-83, 1992-22 I.R.B. 59. These guidelines are summarized in § 35.2.
7. *Id*. at § 333.4(1).

Thus, a partnership is a business form recognized in law as an entity, as is a corporation or a trust. It is usually evidenced by a document, a partnership agreement.[8] The agreement is between persons who are the partners; they may be individuals, corporations, and/or other partnerships. Each partner owns one or more interests, called *units*, in the partnership.

Partners are of two types: general and limited. The types are delineated principally by the extent of the partners' liability for the acts of the partnership. General liability for the consequences of the partnership's operations rests with the general partner (or each general partner); the exposure to liability for the functions of the partnership for the limited partners is confined to the amount of each limited partner's contribution to the partnership. A general partner is liable for satisfaction of the ongoing obligations of the partnership and can be called on to make additional contributions of capital to it. Every partnership must have at least one general partner. Where there is more than one general partner, one of them may be designated as the managing general partner.

Many partnerships have only general partners, who contribute cash, property, and/or services. This type of partnership, which frequently bears a strong resemblance to the joint venture, is termed a *general partnership*. The interests of the general partners may or may not be equal in value. A partnership with one or more limited partners is a *limited partnership*. Usually, the units held by limited partners are of equal value.

Some partnerships need or want to attract capital from sources other than the general partners. This capital comes from investors—essentially, the limited partners. Limited partners become involved for the purpose of obtaining a return on their investment and perhaps to procure some tax advantages.

A tax-exempt healthcare organization (and nearly any other type of tax-exempt organization) can be either a general partner or a limited partner in a partnership. When it is the latter, it is usually for investment purposes. Most of the arrangements of this nature entered into by healthcare organizations are general partnerships or joint ventures, and these stimulate most of the tax controversies.

A partnership is an entity that acquires property, develops it (if necessary), and sometimes continues to operate and maintain the property. (By contrast, a joint venture rarely entails the ownership or operation of property; it usually involves the blending of other assets, such as resources or services.) Where a tax-exempt organization is the (or a) general partner, it is not the owner of the property (the partnership is); nonetheless, it can have many of the incidents of ownership of property, such as participation in the cash flow generated by the

8. The word *usually* is used because, as discussed below (see text accompanied by *infra* notes 9–21), the law can treat an arrangement between persons as a partnership for tax purposes, even though the parties are insistent that their relationship is of another nature.

property, a preferential leasing arrangement, and/or the general perception by the outside world that the property is owned by the tax-exempt organization. The tax-exempt organization can lease space in real property owned by the partnership of which it is a partner. Often, the tax-exempt organization will have the option to purchase property from the partnership after a stated period of time.

Every partnership and joint venture is a tax-exempt organization. That term in this setting does not mean a nonprofit organization that is tax-exempt in the conventional sense of the nomenclature. (There is no such thing as a nonprofit partnership in the legal sense as an entity, although a partnership can be operated for exempt purposes. When a partnership functions in furtherance of the exempt objectives of one or more of the participating exempt organizations, it is likely to be a joint venture.) This characterization simply means that partnerships do not pay income taxes; they are conduits of net revenue to the partners, who have the responsibility for any resulting income tax liability. Partnerships can also be the conduits of the tax advantages of the ownership of property, and thus pass through preference items such as depreciation and interest deductions.

It was noted above that, on occasion, for tax purposes, the law will impose the partnership or joint venture form on a set of facts, irrespective of the parties' intent or desire.[9] This may occur, for example, where the parties intend a landlord and tenant relationship, a management relationship, a fundraising relationship, or the payment of royalties. Thus, in the unrelated income context, a tax-exempt organization may have intended to structure an income-producing relationship with one or more other parties so that the revenue to it is nontaxable, usually as rent or royalty income[10]; the IRS may be contending that the income was derived from an active participation in a partnership or joint venture.

The federal tax law is inconsistent in stating the criteria for determining whether a partnership is to be found as a matter of law. The U.S. Supreme Court stated:

> When the existence of an alleged partnership arrangement is challenged by outsiders, the question arises whether the partners really and truly intended to join together for the purpose of carrying on business and sharing in the profits or losses or both. And their intention is a question of fact, to be determined from testimony disclosed by their ''agreement, considered as a whole, and by their conduct in execution of its provisions.''[11]

Subsequently, the Court elaborated on the factors to be considered in determining the intent of persons to form a partnership; they are

9. *See supra* note 8.
10. *See* §§ 24.17(b)(ii) 24.17(b)(iii).
11. *Commissioner v. Tower*, 327 U.S. 280, 286–287 (1946) (citations omitted).

> . . . whether, considering all the facts—the agreement, the conduct of the parties in execution of its provisions, their statements, the testimony of disinterested persons, the relationship of the parties, their respective abilities and capital contributions, the actual control of income and the purposes for which it is used, and any other facts throwing light on their true intent—the parties in good faith and acting with a business purpose intended to join together in the present conduct of the enterprise.[12]

These principles articulated by the Supreme Court are equally applicable in determining the existence of a joint venture.[13]

In one instance, a court, following these principles, examined state law and concluded that the most important element in ascertaining whether a landlord–tenant relationship or joint venture agreement exists is the intention of the parties.[14] Another court did the same, painstakingly exploring the intent of and the agreements between the parties.[15] Yet, another court declared that ''it is well settled that neither local law nor the expressed intent of the parties is conclusive as to the existence or nonexistence of a partnership or joint venture for federal tax purposes.''[16] This latter court followed a definition articulated previously.[17]

The court wrote that the ''realities of the taxpayer's economic interest rather than the niceties of the conveyancer's art should determine the power to tax.''[18] The court added: ''Among the critical elements involved in this determination are the existence of controls over the venture and a risk of loss in the taxpayer.''[19] Finally, the court said that it is not bound by the ''nomenclature used by the parties,'' so that a document titled, for example, a lease, may in law be a partnership agreement.[20] A contemporary manifestation of these issues is collected in the case law concerning share-crop leasing arrangements, with the tax-exempt organization/landlord contending that the relationship was that of landlord–tenant (so that the rent would not be taxable), and the IRS asserting that the affiliation was a joint venture (so that the shared profits would be taxed). To date, the federal government has yet to prevail in any case on the point.[21]

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12. *Commissioner v. Culbertson*, 337 U.S. 733, 742 (1949).
13. *Luna v. Commissioner*, 42 T.C. 1067 (1964); *Estate of Smith v. Commissioner*, 313 F.2d 724, 729 (8th Cir. 1963), *aff'g in part, rev'g in part, and remanding* 33 T.C. 465 (1959); *Beck Chemical Equipment Corp. v. Commissioner*, 27 T.C. 840 (1957).
14. *Harlan E. Moore Charitable Trust v. United States*, 812 F. Supp. 130, 132 (C.D. Ill. 1993), *aff'd*, 9 F.3d 623 (7th Cir. 1993).
15. *Sierra Club, Inc. v. Commissioner*, 103 T.C. 307 (1994), *aff'd in part, rev'd in part & remanded*, 86 F.3d 1526 (9th Cir. 1996).
16. *Trust U/W Emily Oblinger v. Commissioner*, 100 T.C. 114, 118 (1993).
17. *See* text accompanied by *supra* note 12.
18. *Trust U/W Emily Oblinger v. Commissioner*, 100 T.C. 114, 118 (1993).
19. *Id*. at 118–119.
20. *Id*. at 119.
21. *Harlan E. Moore Charitable Trust v. United States*, 812 F. Supp. 130 (C.D. Ill. 1993), *aff'd* 9 F.3d 623 (7th Cir. 1993); *Trust U/W Emily Oblinger v. Commissioner*, 100 T.C. 114 (1993); *White's Iowa Manual Labor Institute v. Commissioner*, 66 T.C.M. 389 (1993); *Independent*

If an entity fails to qualify under the federal tax laws as a partnership, it will be treated as an *association*, which means taxed as a corporation.[22] When this happens, as a general rule the entity will have to pay taxes and the ability to pass through tax advantages to the entity owners is lost.[23] Moreover, the partnership must have effective ownership of the property for these pass-throughs to be available, rather than have the ownership be by a tax-exempt organization that is the (or a) general partner of the partnership.[24]

A partnership can be a very useful and beneficial way for persons to acquire, own, and operate one or more properties. There can be problems with this approach, however, in the tax-exempt organizations setting.[25]

§ 22.2 TAX-EXEMPT HEALTHCARE ENTITIES IN PARTNERSHIPS

The principal legitimate reason that a tax-exempt healthcare organization involves itself in a partnership is to facilitate—from a financial standpoint—the acquisition, ownership, and utilization of one or more major properties, namely, real estate or a significant item of tangible personal property (a capital asset). (As discussed below, there can be adverse tax consequences when the reason an exempt organization enters a partnership is to convey economic advantages and benefits to insiders in their private capacity, or when there is a perception that that is the reason.[26])

For example, managers of tax-exempt organizations in general are more frequently concluding that the organizations would be financially advantaged if they owned real estate for housing their offices and/or for generating income, or for some other reasons. An organization is likely to be in a preferable position if its occupancy costs are fixed rather than subject to the vagaries of the rental market. Also, it is usually advantageous to have real property among the assets of an organization. Further, the ownership of real property sometimes offers the opportunity for an organization to conduct program activities at its own location. If the property appreciates in value, the organization can sell it, receiving nontaxable gain. In many instances, among its membership, program beneficiaries, contributors, and, perhaps, the general public, prestige

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Order of Odd Fellows Grand Lodge of Iowa v. United States, 93-2 U.S.T.C. (CCH) ¶ 50,448 (S.D. Ia. 1993).

22. IRC § 7701(a)(3).
23. One significant exception is the S corporation, a small-business corporation that is treated for federal income tax purposes as a partnership (IRC §§ 1361–1379).
24. E.g., *Smith v. Commissioner*, 50 T.C.M. 1444 (1985).
25. The foregoing is, by necessity, the briefest and most simplistic of overviews of partnerships and joint ventures. For a far more comprehensive analysis of these entities (from a tax-exempt organizations perspective), *see* SANDERS, JOINT VENTURES INVOLVING TAX-EXEMPT ORGANIZATIONS (2d ed., 2000), particularly Chapters 1, 3, and 4.
26. *See* § 22.3.

is associated with an organization that owns its offices. For some categories of tax-exempt organizations, such as hospitals, all and more of these factors apply, and ownership of real property is commonplace.

Nonetheless, commonplace or not, there can be financial reasons why a tax-exempt organization may want to obtain and utilize property by means of a partnership. This approach is, after all, reduced to the ultimate in simplicity, a mechanism of acquiring and using property by means of the resources of others.[27]

There are several tax aspects of ownership of real estate or other major capital assets by tax-exempt healthcare (and other) organizations. As a general proposition, a tax-exempt organization will not jeopardize its exemption because of acquisition, ownership, and maintenance of real or other property. Also, as a general rule, there is no likelihood of tax exemption being impaired where a tax-exempt organization leases property that it owns, whether to other tax-exempt entities or to the general public. At the same time, a variety of potential private inurement, private benefit, and unrelated business tax consequences is associated with the acquisition, ownership, maintenance, and operation of property by tax-exempt organizations. This is particularly the case in the healthcare field, where partners other than one or more exempt entities tend to be physicians (usually as limited partners) practicing at the institution that also is, directly or indirectly, in the partnership.

In the most fundamental of circumstances, if a tax-exempt organization were to itself acquire property with no financing and use the property wholly for its exempt purposes, there would be no private inurement, private benefit, or unrelated business aspects of the matter. These tax considerations come into play where, among other reasons, the property is acquired with the assistance of others, financing is utilized, there is rental income involved, or the property is not used entirely for exempt purposes.

One observer nicely summarized the ''most frequently stated motivations'' stimulating healthcare organization involvement in partnerships (and joint ventures):

> [T]he need to raise capital; to grant physicians a stake in a new enterprise or service, thereby gaining physician loyalty and patient referrals; to bring a new service or medical facility to a needy area; to share the risk inherent in a new enterprise; to pool diverse areas of medical expertise; to attract new patient admissions and referrals; to persuade physicians not to refer patients elsewhere; and to ensure that physicians do not establish a competing health care provider.[28]

27. On more than one occasion, the IRS has observed that ''[t]here is nothing *per se* objectionable about an exempt organization entering into a limited partnership where it either lacks or does not wish to expend all of the funds necessary to build or purchase a facility which will further its exempt purposes'' (e.g., Priv. Ltr. Rul. 9105029).
28. Sanders, PARTNERSHIPS & JOINT VENTURES (1994), at 257.

It was added that ''[m]ost joint ventures between hospitals and physicians involve the construction, operation, or acquisition of a new medical facility or the purchase or rental of medical equipment.''[29] The IRS has recognized these factors as well.[30]

Thus, a common way for an organization (tax-exempt or not) to acquire a major item of property, where the organization is unable to do so or does not want to do so out of its own resources, is to utilize a partnership. For the tax-exempt healthcare entity, the property involved may be or may include properties such as a clinic, medical office building, or computerized tomography scanner. The partnership may be composed of the tax-exempt organization, the person or persons (such as a commercial financier) providing the financing, and, if a facility is involved, a construction company. The partnership may be a limited partnership, with the tax-exempt organization being the general partner or one of the general partners, and others participating as investors (the limited partners). The general pattern is that the partnership is the entity that acquires the property, develops it (if necessary), and operates and maintains it.

Suppose, as an illustration, that a tax-exempt hospital desires to own (directly or indirectly) a medical office building. Its options for gathering the funds necessary to acquire or construct the building are (1) use money it has accumulated and is investing, (2) borrow the money, (3) embark on a capital campaign and raise the money as gifts and grants, (4) utilize a bond-financing arrangement, (5) acquire the property by means of a real estate partnership, or (6) use some combination of these approaches.

The disadvantage in most of these choices is that the institution does not have the wherewithal to, cannot, or does not want to obtain the funding by means of one or more of the first four of these options. As noted, the advantages of the partnership approach include the ability of exempt organizations to acquire significant properties using the funds of others.

An abundance of IRS private letter rulings amply illustrate the uses of partnerships by tax-exempt healthcare institutions. These include (1) a limited partnership involving an exempt hospital and two physicians, formed to construct and maintain a medical office building, for the purpose of operating a center specializing in the performance of certain surgical procedures[31]; (2) a partnership formed to provide general lithotripsy services to hospitals in a region[32]; (3) a partnership formed to provide a second and more sophisticated mobile magnetic resonance scanner for two exempt hospitals and their system[33]; (4) a limited partnership involving two exempt

29. *Id*. at 259.
30. *See* § 22.6, text accompanied by note 70.
31. Priv. Ltr. Rul. 9147058. The topic of medical office buildings in the unrelated income setting is the subject of § 24.13.
32. Priv. Ltr. Rul. 9109066.
33. Priv. Ltr. Rul. 9105029.

hospitals, in the nature of a management agreement, for the purpose of enhancing community access to primary acute care hospital services[34]; (5) a limited partnership involving an exempt hospital and physicians on its medical staff to provide a variety of services, including the management of a diagnostic related group and services related to managed care programs[35]; (6) a limited partnership involving an exempt hospital, a for-profit corporation specializing in the administration of freestanding outpatient clinics, a medical professional corporation, and physicians, for the purpose of developing and operating a diagnostic imaging facility[36]; (7) a partnership involving an exempt hospital to own and operate a kidney dialysis and treatment center[37]; (8) a limited partnership to own and operate a surgical center[38]; (9) a limited partnership by which a clinical faculty office building and parking garage were constructed and operated[39]; and (10) a limited partnership for the purpose of constructing and operating a medical office building for affiliated physicians.[40]

After substantial litigation, myriad private letter rulings and general counsel memoranda, and the publication of revenue rulings, the IRS has apparently grown weary of putting forth guidance on joint venture transactions. In 2006, the IRS announced that it will generally no longer issue rulings on whether joint ventures between exempt organizations and for-profit entities will affect exempt status or generate unrelated business taxable income.[41]

§ 22.3 PARTNERSHIPS AND TAX EXEMPTION

The federal tax law concerning tax-exempt organizations in partnerships basically has two aspects: impact on the exempt organization's tax-exempt status and unrelated income considerations.[42] As to the former, the focus of the IRS is on private inurement and private benefit.[43]

In general, the IRS is not enamored with the thought of tax-exempt charitable organizations in partnerships (other than as limited partners in a prudent investment vehicle). The concern of the IRS is that substantial benefits can be provided to the for-profit participants in a partnership (usually the limited partners) with a tax-exempt organization where the exempt organization is the (or a) general partner. This apprehension has its origins in arrangements

34. Priv. Ltr. Rul. 9029034.
35. Priv. Ltr. Rul. 9027050.
36. Priv. Ltr. Rul. 9021050.
37. Priv. Ltr. Rul. 8705089.
38. Priv. Ltr. Rul. 8638131.
39. Priv. Ltr. Rul. 8508073.
40. Priv. Ltr. Rul. 8312129.
41. Rev. Proc. 2006-4, 2006-1 C.B. 132 § 6.12.
42. The latter aspect is discussed throughout Chapter 24; this portion of the chapter relates solely to exemption ramifications.
43. *See*, in general, Chapter 4.

involving hospitals and physicians, such as a limited partnership formed to build and manage a medical office building, with a hospital as the general partner and investing physicians as limited partners.[44] Yet the law is clear that a tax-exempt charitable organization may participate as a partner in a partnership.[45]

The position of the IRS is that a charitable organization will lose its federal income tax exemption if it participates as the (or a) general partner in a limited partnership, unless the principal purpose of the partnership is to further charitable purposes. Even where the partnership can so qualify, the exemption is to be revoked if the charitable organization/general partner is not adequately insulated from the day-to-day management responsibilities of the partnership and/or if the limited partners are to receive an undue economic return.[46] Despite some initial trepidation,[47] the IRS has evolved to the view that a tax-exempt charitable organization can be operated exclusively for exempt purposes, and simultaneously be a general partner and satisfy its fiduciary responsibility to the other partners.[48] To date, the IRS has yet to issue a private letter ruling revoking the tax-exempt status of a charitable organization because of its involvement as a general partner in a limited partnership; indeed, the IRS frequently concludes that an exempt charitable organization can participate as a general partner in a limited partnership without endangering its tax-exempt status.[49]

An instance of application of the IRS position in this regard appeared in an IRS private letter ruling made public in 1985.[50] In that case, a charitable organization became a general partner in a real estate limited partnership that leased all of the space in the property to the organization and a related organization. The IRS found that the partnership was serving charitable ends because both of the tenants were exempt charitable organizations. (The general counsel memorandum underlying this ruling[51] noted that, if the lessee organization that was not the general partner had not been a charitable entity, the general partner would have forfeited its tax exemption.) The IRS also found that the general partner was adequately insulated from the day-to-day management responsibilities of the partnership and that the limited partners'

44. The history of the position of the IRS in this regard is detailed in TAX-EXEMPT ORGANIZATIONS, § 30.2(a); also, Sanders, *supra* note 25, at § 11.3(b).
45. On one occasion, the IRS ruled that the tax-exempt status of a charitable organization should not be revoked because of its participation as a general partner in seven limited partnerships (Priv. Ltr. Rul. 8938001).
46. Gen. Couns. Mem. 39005.
47. *See supra* note 44.
48. Gen. Couns. Mem. 39546.
49. This observation is made with the understanding that the facts reflected in some of these rulings are altered at the request of the IRS and that some ruling requests in this area are withdrawn in anticipation of the issuance of an adverse ruling.
50. Priv. Ltr. Rul. 8541108.
51. Gen. Couns. Mem. 39444.

economic return was reasonable. As to the potential for private benefit, the IRS offered this guidance:

> If a private interest is served [by a limited partnership in which an exempt charitable organization is the (or a) general partner], it must be incidental in both a qualitative and quantitative sense. In order to be incidental in a qualitative sense, it must be a necessary concomitant of the activity which benefits the public at large. In other words, the activity can be accomplished only by benefiting certain private individuals. To be incidental in a quantitative sense, the private benefit must not be substantial after considering the overall public benefit conferred by the activity.

The IRS added: ''[I]f the [charitable] organization is serving a private interest, other than incidentally, then its participation in a limited partnership [as the (or a) general partner] will [adversely] affect its exempt status.''

As to means by which the requisite insulation may be created, one commentator has suggested one or more of nine provisions in a partnership agreement involving a tax-exempt hospital or other healthcare organization: (1) a requirement of income distributions to the organization at least in proportion to its capital contribution; (2) a ceiling on losses allocable to the organization equal to its share of total capital; (3) a requirement that all transactions between the partnership and other parties be at fair market value; (4) a limit on the exposure of the organization to liabilities of the joint venture and corresponding indemnification; (5) exoneration of the organization from repayments of amounts invested by the other partners; (6) a prohibition against loans by the organization to the partnership to finance operations (at least not without full security) or to the nonexempt partners to finance contributions; (7) options (puts, calls, or rights of first refusal) granted to the organization upon disposition of the partnership property or interests; (8) no such options in the nonexempt partners unless the exempt organization is to receive at least fair market value; and (9) powers in the organization to appoint a majority of the governing body of the partnership.[52]

This commentator also listed the types of private inurement that may occur in the partnership context, where a hospital or other healthcare entity and affiliated physicians are involved.[53] These include (1) payment of excessive compensation to the nonexempt partner or partners; (2) a disproportionate allocation of profits and losses to the nonexempt partner or partners; (3) payment of inadequate rent by a physician; (4) receipt by the healthcare entity of less than fair market value in sales or exchanges of property with

52. Sanders, *supra* note 28, at 266–267. If the tax-exempt organization/general partner is shielded too much, however, the partnership may lose its tax status as a partnership (i.e., as a nontaxable flow-through entity). Should that occur, the entity may become an association taxable as a corporation (IRC § 7701(a)(3)). The IRS's lawyers raised this issue for the benefit of the agency's reviewers (Gen. Couns. Mem. 39546).

53. For private inurement to take place, the nonexempt party to the transaction must be an *insider* (*see* § 4.2). In the view of the IRS, physicians on the medical staff of a hospital are insiders (*see* § 4.3).

the venture; (5) inadequately secured loans or other questionable loan transactions; (6) unreasonable payments for physician services; and (7) any other arrangements that amount to a form of distribution of net earnings.[54]

The matter of tax-exempt organizations (charitable and otherwise) in partnerships should be evaluated in a larger context. From that perspective, it is clear that Congress approves (or at least does not disapprove) of exempt organizations as partners in partnerships. For example, a federal law provision states that, in determining whether income received by a tax-exempt organization from a partnership is unrelated income, the partnership is looked through, and the ultimate source of the revenue is ascertained and reviewed.[55] This unrelated income rule would be wholly superfluous, at least for tax-exempt charitable organizations, if the mere participation as a general partner in a limited partnership would cost them their tax-exempt status.

Also, the tax-exempt entity leasing rules[56] recognize that tax-exempt organizations may be partners in partnerships. The federal tax law contains specific rules for cases where a tax-exempt organization leases property from a partnership in which it is a partner. In this connection, the law speaks of a ''partnership which has both a tax-exempt entity [including a charitable one] and a person who is not a tax-exempt entity as partners.''[57] There would have been no point in the writing of tax rules concerning partnerships with charitable partners if the charitable partners were to lose their tax exemption solely by reason of their participation in the partnership.

Moreover, as discussed below, information reporting rules again reflect Congress's view that it is quite acceptable for tax-exempt organizations (including charitable healthcare organizations) to be partners in partnerships.

§ 22.4 LIMITED LIABILITY COMPANIES AS EXEMPT ORGANIZATIONS

In 2000, the IRS initially addressed the tax treatment of limited liability companies (LLCs) and the extent to which LLCs may be treated as exempt organizations.[58] Although much of the discussion outlined basic information such as the history of LLCs and their fundamental business and tax attributes (as compared with other business entities such as corporations and limited partnerships), the IRS also touched upon the distinctions between single- and multiple-member LLCs as well as circumstances under which an LLC may qualify for tax-exempt status.

54. Sanders, *supra* note 25, at § 11.3(b)(iii).
55. IRC § 512(c).
56. *See* Tax-Exempt Organizations § 27.14.
57. IRC § 168(h)(6)(A)(i).
58. Fiscal Year 2000 IRS Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, Chapter H.

Thereafter, the IRS announced that a single-member LLC is to be regarded as a branch or division of its owner, which is to say that it is a disregarded entity for federal tax purposes.[59] This means that an LLC with a tax-exempt organization as its only member is not treated as a separate entity for tax purposes and that the exempt organization regards (including for reporting purposes) the economic activity of the LLC as its own.[60] The clear implication was that a single-member LLC, where the member is an exempt charitable organization, cannot itself obtain recognition of tax-exempt status as a charitable organization—because it is a disregarded entity in any event.

In 2001, the IRS revealed that it had concluded that an LLC, with two or more members that are charitable or governmental entities, can qualify for tax exemption as a charitable organization itself, if it satisfies 12 conditions[61]:

1. The LLC's organizational documents must include a specific statement limiting its activities to one or more exempt (charitable) purposes.
2. This organizational language must specify that the LLC is operated exclusively to further the charitable purposes of its members.
3. The organizational language must require that the LLC's members be charitable organizations, governmental units, or wholly owned instrumentalities of a state or political subdivision of a state.
4. The organizational language must prohibit any direct or indirect transfer of any membership interest in the LLC to a transferee other than a charitable organization, governmental unit, or instrumentality.
5. The organizational language must state that the LLC, interests in the LLC (other than a membership interest), or its assets may be availed of or transferred to, directly or indirectly, any nonmember (other than a charitable organization, governmental unit, or instrumentality) only in exchange for fair market value.
6. The organizational language must guarantee that, on any dissolution of the LLC, the assets devoted to the LLC's charitable purposes will continue to be devoted to appropriate exempt purposes.
7. The organizational language must require that any amendments to the LLC's articles of organization and operating agreement must be consistent with the general organizational test applicable to charitable organizations.[62]
8. The organizational language must prohibit the LLC from merging with, or converting into, a for-profit entity.

59. Ann. 99-102, 1999-43 I.R.B. 545.
60. *See* § 22.12.
61. Fiscal Year 2001 IRS Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, Part I, Topic B.
62. *See* § 2.1, text accompanied by note 20.

9. The organizational language must require that the LLC not distribute any assets to members who cease to be charitable organizations, governmental units, or instrumentalities.
10. The organizational language must contain an acceptable contingency plan in the event one or more members cease at any time to be a charitable organization, a governmental unit, or an instrumentality.
11. The organizational language must state that the LLC's exempt members will ''expeditiously and vigorously'' enforce all of their rights in the LLC and will pursue all legal and equitable remedies to protect their interests in the LLC.
12. The LLC must represent that all its organizing documents provisions are consistent with state LLC laws, and are enforceable at law and in equity.

Because of conflict and confusion among the states as to the role of an LLC's articles of organization and operating agreement, the IRS is requiring that both documents separately comply with the first 11 of these conditions. The last one is met in a separate written statement from the organization.

An LLC that meets these 12 conditions can qualify as a tax-exempt social welfare organization,[63] if it otherwise meets the requirements for that category of exemption. The IRS has yet to establish its position as to whether an LLC can qualify as any other type of exempt organization.

The IRS also addressed whether LLCs wholly owned by a single charitable organization and, therefore, ignored for federal tax purposes under the check-the-box regulations may obtain recognition of tax-exempt status. Offering no definitive guidance one way or the other, the IRS simply noted that this position is inconsistent with LLCs being *deemed* to have elected treatment as a corporation. Thereafter, however, the IRS decided that a single-member LLC is to be regarded as a branch or division of its owner, which is to say that it is a disregarded entity for tax purposes.[64] This means that an LLC with a tax-exempt organization as its only member is not treated as a separate entity for federal tax purposes and that the exempt organization reports the economic activity of the LLC as its own. The IRS has not issued guidance as to the tax-exempt status of LLCs that have more than one tax-exempt member.

Nonetheless, a group of tax-exempt organizations can utilize an LLC for the performance of exempt functions. These functions are in a separate entity, that entity does not pay federal income taxes, and any income that flows from the LLC to the tax-exempt organization shareholder is not taxable by reason of the partnership lookthrough rule. An illustration of these points was the use by a group of healthcare organizations in the United States of an LLC to partner

63. *See* § 1.8.
64. Ann. 99-102, 1999-43 I.R.B. 545.

with public hospitals in a foreign country to establish and operate a charitable hospital in that country; the hospital itself was operated by the LLC.[65]

§ 22.5 INFORMATION REPORTING

If a partnership in which a tax-exempt organization is a partner regularly carries on a trade or business that would constitute an unrelated trade or business if directly carried on by the exempt organization, the organization generally must include its share of the partnership income and deductions from the business activity in determining its unrelated income tax liability.[66]

A partnership generally must furnish to each partner a statement reflecting the information about the partnership that must be shown on the partner's federal income tax return.[67] The statement must set forth the partner's distributive share of the partnership's income, gain, losses, deductions, or credits required to be shown on the partnership return, along with any additional information as provided by IRS forms or instructions that may be required to apply particular provisions of the federal tax law to the partner with respect to items related to the partnership.[68]

The instructions accompanying the statement for partners require the partnership to identify whether the partner is a tax-exempt organization.[69] Also, the partnership must attach a statement furnishing any other information needed by the partner to file its return that is not shown elsewhere on the statement. In the case of a partnership that has one or more tax-exempt organization partners and that is regularly carrying on a trade or business, the partnership must furnish to the partners the information necessary to enable each partner to compute its distributive share of partnership income or loss from the business.[70] The conference report accompanying this provision states that it "will emphasize that the IRS should monitor and enforce the present-law reporting requirements and, where appropriate, should provide further guidance to partnerships through regulations or instructions as to how such information must be furnished" and that "information that must be furnished to tax-exempt partners under this provision is to be reflected by such organization on Form 990 [annual information return] or Form 990-T [unrelated business income tax return] in the manner prescribed by Treasury regulations or by the IRS instructions for such Forms."[71]

Partnerships of tax-exempt organizations, including those comprised entirely of exempt organizations, must annually file federal information

65. Priv. Ltr. Rul. 9839039.
66. IRC § 512(c).
67. IRC § 6031(b).
68. Temp. Reg. § 1.6031(b)-1T.
69. Schedule K-1, Form 1065.
70. IRC § 6031(d).
71. H. Rep. No. 100-1104, 100th Cong., 2d Sess. 130 (1988). As to these reporting requirements, *see* § 34.3.

returns.[72] It is not uncommon for this filing requirement to be overlooked, particularly where the partnership does not own property and is a joint venture.

§ 22.6 JOINT VENTURES

A tax-exempt healthcare organization may enter into a joint venture with one or more for-profit persons and/or one or more exempt organizations without adversely affecting its tax-exempt status. This type of joint venture does not present the private inurement problems that the IRS associates with participation by exempt charitable organizations in limited partnerships.[73] By contrast, involvement in a joint venture by a tax-exempt organization would lead to loss of tax exemption if the primary purpose of the exempt organization is to participate in the venture and if the function of the venture is unrelated to the exempt purposes of the tax-exempt organization.[74]

Usually, joint ventures of this type are with one or more for-profit persons in advancement of the healthcare organization's tax-exempt purpose of promoting health in the appropriate community. On one occasion, the IRS summed up the requirements as follows:

> Whether a proposed joint venture activity furthers exempt purposes may be determined by analyzing the ''community benefit'' to be achieved. Certain indicia of community benefit are (1) creation of a new provider of health care services; (2) expansion of community health care services; (3) improvement in treatment modalities; (4) reduction in health care costs; and (5) improved patient convenience and access to physicians.[75]

Once this primary test is satisfied, the IRS will scrutinize the transaction for any private inurement or private benefit.[76]

For example, a charitable organization participating in a venture with a for-profit entity to own and operate an ambulatory surgical center was determined by the IRS to be engaging in a related activity.[77] Likewise, the IRS ruled that a joint venture between a charitable organization and a for-profit one, for the purpose of organizing and operating a freestanding alcoholism/substance abuse treatment center, would not jeopardize the tax-exempt status of the

72. IRC § 6031. This return is Form 1065.
73. *See* § 22.3.
74. An illustration of the latter was a joint venture, involving only public charities, to operate an ambulatory surgery center (Priv. Ltr. Rul. 200117043).
75. Priv. Ltr. Rul. 9352030.
76. *See* § 22.7. In one instance, the IRS wrote that ''[w]hether participation in a joint venture with non-exempt entities to provide certain outpatient medical services will conflict with an exempt health care facility's ability to pursue its exclusively charitable purposes depends in great part on the specific structuring of the agreement(s)'' (Priv. Ltr. Rul. 9105029).
77. Priv. Ltr. Rul. 8817039.

charitable organization.[78] Still another illustration is the IRS ruling that a tax-exempt hospital may, without endangering its exempt status, participate with a for-profit organization for the purpose of providing magnetic resonance imaging services in an underserved community.[79] Other joint ventures of this nature have been formed for the purpose of operating a comprehensive rehabilitation hospital,[80] an acute care hospital,[81] a magnetic resonance scanner,[82] an acute medical rehabilitation hospital,[83] a gastroenterology laboratory and surgical facility,[84] an ambulatory surgical center,[85] and a computerized tomography scanner.[86]

Other instances of joint ventures of this nature abound. Tax-exempt healthcare providers formed an LLC to provide neonatal intensive care services.[87] A public charity and a rehabilitation center entered into a venture to provide rehabilitation services.[88] A community-based healthcare system and a group of physicians formed an LLC to own and operate an ambulatory surgery center.[89] The IRS ruled that a general acute care hospital and a supporting organization with respect to it can, without endangering the hospital's exempt status, enter into a joint venture with physicians to operate a cardiac catheterization laboratory using an LLC.[90]

The Hospital Audit Guidelines promulgated by the IRS[91] observe, in general, that some examples of the items or services provided by means of joint ventures ''are clinical diagnostic laboratory services, medical equipment leasing, durable medical equipment, and other outpatient medical or diagnostic services.''[92]

A joint venture of this nature may be structured as an LLC. In one instance, an acute care hospital participated in an LLC, the purpose of which was to provide dialysis services on an outpatient basis. The hospital planned to acquire an interest in the company, along with a tax-exempt healthcare system and three physicians. The resulting outpatient facility was to provide the community with a new state-of-the-art dialysis facility and enhance the community's need

78. Priv. Ltr. Rul. 8521055.
79. Priv. Ltr. Rul. 8833038.
80. Priv. Ltr. Rul. 9352030.
81. Priv. Ltr. Rul. 9308034.
82. Priv. Ltr. Rul. 8833038.
83. Priv. Ltr. Rul. 9035072.
84. Priv. Ltr. Rul. 8820093.
85. Priv. Ltr. Rul. 8709051.
86. Priv. Ltr. Rul. 8344099.
87. Priv. Ltr. Rul. 200044040. Likewise, Priv. Ltr. Ruls. 200325003, 200325004.
88. Priv. Ltr. Ruls. 200102052, 200102053.
89. Priv. Ltr. Rul. 200118054.
90. Priv. Ltr. Ruls. 200304041, 200304042. Outside the healthcare field, colleges and universities are using an LLC to maintain a multi-institution qualified prepaid tuition plan (IRC § 529) (Priv. Ltr. Rul. 200311034), and three trade associations used an LLC to conduct a single trade show (Priv. Ltr. Ruls. 200333031–200333033).
91. *Supra* note 6.
92. *Id*. at § 333.4(1).

for the services, without causing the hospital to bear the entire cost of the facility. The hospital would participate on a proportionate basis in any needed capital contributions and any financing incurred by the limited liability company. Finding that the venture would further the hospital's exempt purpose of promoting health, the IRS stated that the institution's involvement in this LLC would not jeopardize its tax-exempt status.[93] Similarly, tax-exempt hospitals used LLCs to provide diagnostic services to their patients, with the IRS ruling that the resulting revenue to the hospitals was not taxable.[94]

In a private letter ruling issued in July 1998, the IRS indicated that charitable organizations would not necessarily jeopardize their tax-exempt status by engaging in joint ventures with foreign entities.[95] Amplifying a prior revenue ruling,[96] the IRS opined that activities of an exempt organization that are provided in a foreign country are considered charitable to the same extent that they are considered charitable when provided in the United States. As described in the ruling, N, a tax-exempt academic medical center, sought to increase the number of organs available for transplant in both the United States and a foreign country. In furtherance of this goal, N, along with two foreign public hospitals, Z and R, organized a limited liability company, S, to operate a foreign transplant hospital. The facility was located in U, a country that instituted a national system of medicine akin to the Medicare and Medicaid programs of the United States, except that the public healthcare services were provided on a more comprehensive basis. Notwithstanding the location of the facility, the underpinnings of the concept of promotion of health as a charitable activity remained the same, such that the determinative factors were not where the transplant facility was located, but whether it would benefit the community serviced by N. Because the facility increased the number of organs available for patients of N as well as allowed N to expand its clinical research, the IRS concluded that the new facility was in furtherance of N's charitable purpose. Thus, this ruling is noteworthy for two reasons. First, it reaffirms that tax-exempt organizations may engage in joint ventures with foreign organizations without jeopardizing their tax-exempt status. Second, and perhaps more importantly, it is not clear that charitable organizations may actually operate foreign facilities, indicating that ''community benefit'' as required by the IRS is not necessarily limited by geographical parameters.

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93. Priv. Ltr. Rul. 9637050.
94. E.g., Priv. Ltr. Rul 9739036. In general, Friz, ''How to Handle Real Estate in Joint Ventures Between For-Profits and Nonprofits,'' 10 *J. Tax'n Exempt Orgs*. (No. 1) 29 (July/Aug. 1998); Friz, ''Structuring Joint Ventures Between For-Profit and Nonprofit Organizations,'' 9 *J. Tax'n Exempt Orgs*. (No. 6) 259 (May/June 1998); Sanders and Cobb, ''Recent IRS Rulings Provide New Standards for Joint Ventures Involving Charities,'' 18 *Exempt Org. Tax Rev*. (No. 2) 213 (Nov. 1997).
95. Priv. Ltr. Rul. 9839039.
96. Rev. Rul. 71-460, 1971-2 C.B. 231.

Likewise, a public charity (a fundraising vehicle for an exempt hospital and for medical research), two educational institutions (that operate medical schools and engage in scientific research), and a state university (that manages an entity that facilitates technology transfer and the general growth of advanced technology companies) formed a charitable organization that serves as a center of research, technology, and entrepreneurial expertise; to facilitate the acquisition of land for this center, the organizations (other than the center organization) created a limited liability company.[97]

§ 22.7 PARTNERSHIPS, JOINT VENTURES, AND PRIVATE INUREMENT

Much of the federal tax law concerning partnerships, joint ventures, and private inurement has developed as the result of innovative financing and income-distribution techniques, including partnerships, fashioned by or for the benefit of hospitals and other healthcare entities, and/or their affiliated physicians.

The Hospital Audit Guidelines[98] observe that ''[j]oint ventures between taxable and exempt parties must be carefully examined for [private] inurement and private benefit.''[99] These guidelines advise the examining agent to review the facts to determine whether the venture serves a charitable purpose, whether and how participation by the exempt entity furthers its exempt purpose, and whether the arrangement permits the exempt entity to act exclusively in furtherance of its exempt purposes.

The guidelines summarize possible fact situations in this setting that may cause private inurement to arise: (1) participation in the venture imposes on the tax-exempt healthcare organization obligations that conflict with its exempt purposes; (2) there is a disproportionate allocation of profits and losses to the nonexempt (usually limited) partners (usually physicians); (3) the exempt partner makes loans to the partnership that are commercially unreasonable (because of a low interest rate or inadequate security); (4) the exempt partner provides property or services to the partnership at less than fair market value; and/or (5) a nonexempt partner receives more than reasonable compensation for the sale of property or services to the joint venture.[100]

The IRS identified the following legitimate purposes (absent private inurement per se[101]) for involvement of a hospital in a partnership or joint venture: (1) the raising of needed capital; (2) the bringing of new services or a new provider to a community; (3) the sharing of a risk inherent in a new activity;

97. Priv. Ltr. Rul. 200411044.
98. *Supra* note 6.
99. *Id*. at § 333.4(2).
100. *Id*. at § 333.4(3).
101. *See* § 22.8.

and/or (4) the pooling of diverse areas of expertise.[102] Prior pronouncements from the IRS reflect the following factors favored by the IRS: a limited contractual liability of the tax-exempt partner; a limited (reasonable) rate of return on the investment by the limited partners; a right in the tax-exempt organization of first refusal on the disposition of an asset of the partnership; the involvement of other general partners obligated to protect the interests of the limited partners; and the absence of any obligation to return the limited partners' capital from the resources of the exempt partner.

The IRS will pursue a private inurement rationale where there is a "complete lack of symmetry in upside opportunities and downside risks for the physician-investors." At the same time, the position struck by the IRS in the context of hospitals and physicians in partnerships should not "be read to imply that a typical joint venture that involves true shared ownership, risks, responsibilities, and rewards and that demonstrably furthers a charitable purpose should be met automatically with suspicion or disapproved merely because physician-investors have an ownership interest."[103]

§ 22.8 PARTNERSHIPS, JOINT VENTURES, AND PER SE PRIVATE INUREMENT

The IRS has recently developed the concept of private inurement per se. This doctrine has evolved, to date, solely in the healthcare context.

The manifestation of this phenomenon is the IRS's position with respect to the sale of a hospital department's gross or net revenue stream to a limited partnership (or joint venture) involving the hospital and physicians practicing in the department. The IRS holds that this use of hospital assets is private inurement per se (that is, the amount of the funds flowing to the physicians is not evaluated against a standard of reasonableness), causing the hospital to lose its tax exemption.[104] In formulating its position in this regard, the office of the IRS Chief Counsel used the occasion (in late 1991) to restate and update the analysis the IRS uses in evaluating the participation of hospitals in a partnership.

The IRS's lawyers emphasized that the participation by a tax-exempt hospital as a general partner in a limited partnership is not inconsistent with tax exemption on a per se basis.[105] In each partnership situation, the IRS determines the presence or absence of private inurement or private benefit[106] by evaluating all of the facts and circumstances, applying a standard of review of "careful scrutiny," and using a three-part analysis.[107] In evaluating these

102. Gen. Couns. Mem. 39862.
103. *Id*.
104. These partnerships are discussed in greater detail in § 4.5.
105. Gen. Couns. Mem. 39862. *See* § 22.3.
106. E.g., Gen. Couns. Mem. 37789.
107. *Id*.

situations, the IRS looks to see ''what the hospital gets in return for the benefit conferred on the physician-investors.'' The IRS is least likely to find a basis for revocation of tax exemption because of hospital partnerships where a ''new health care provider or resource was made available to the community.''[108] Of importance also is whether the partnership itself became a ''property owner or service provider, subject to all the attendant risks, responsibilities, and potential rewards.''[109]

By contrast, in the net revenue stream partnerships, the IRS saw insufficient community benefit; the partnership was viewed as a ''shell type of arrangement where the hospital continues to own and operate the facilities in question and the joint venture invests only a profits interest.'' The arrangement was perceived as only incidentally promoting health; the IRS believed that ''hospitals engaged in these ventures largely as a means to retain and reward members of their medical staffs; to attract their admissions and referrals; and to pre-empt the physicians from investing in or creating a competing provider.''[110]

Another situation the IRS deplored is where the general partner (such as a hospital or a taxable subsidiary of a hospital) is liable for partnership losses and is required to maintain a loss reserve, while the limited partners are not burdened with much risk. The gross or net revenue stream arrangement did not result in ''improved patient convenience, greater accessibility of physicians, or any other direct benefit to the community.''[111]

§ 22.9 WHOLE-HOSPITAL JOINT VENTURES

As noted[112] a tax-exempt healthcare organization can participate in a joint venture with a for-profit person and not adversely affect the organization's tax-exempt status, as long as the purpose of involvement of the exempt organization in the venture is furtherance of exempt purposes. In this type of joint venture, the exempt entity continues to utilize its assets in furtherance of a charitable purpose.

A much different type of joint venture is emerging in the healthcare setting: the *whole-hospital joint venture*. With this approach, the hospital or other exempt entity transfers its assets to the joint venture, with the for-profit organization managing the day-to-day operations of the venture. For example, ownership of one or more hospitals might be transferred. The tax-exempt healthcare organization does not directly engage in healthcare activities; it receives income and other distributions attributable to its ownership interest in the venture. There usually is a board of directors of this joint venture.

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108. E.g., Gen. Couns. Mem. 39732.
109. Gen. Couns. Mem. 39862.
110. *Id*.
111. In general, Puryear, ''The Physician as Entrepreneur: State and Federal Restrictions on Physician Joint Ventures,'' 73 *N. Car. L. Rev*. (No. 1) 293 (Nov. 1994).
112. *See* § 22.6.

Technically, the venture vehicle is a partnership (general or limited)[113] or a limited liability company.[114]

Essentially, a whole-hospital joint venture is another form of hospital network; it is a way of integrating a nonprofit hospital into the activities of a large, for-profit entity. This can lead to access to managed care contracts, greater efficiency of operations, and additional funding of charitable programs. From the standpoint of the for-profit entity, the venture provides a means to ''acquire'' a hospital without having to engage in an outright purchase of the institution.

Thus, the fundamental distinction between joint ventures in general and whole-hospital joint ventures—one that may determine whether the tax-exempt organization is able to maintain its exemption—is that in the former, the exempt entity continues to engage in healthcare functions; in the latter, the entity is an owner of the venture that itself operates the assets underlying the healthcare activity. This raises the question of whether participation in a whole-hospital joint venture would cause the hospital or other healthcare organization to lose its exempt status. Other issues are the possibility of private benefit to the for-profit entity in the venture and the likelihood that income from the venture is unrelated business income to the exempt hospital.

In 1998, the IRS released its long-awaited guidance on whether charitable healthcare organizations may enter into whole-hospital joint ventures with for-profit organizations without jeopardizing their tax-exempt status.[115] The revenue ruling is only the second one issued by the IRS in the healthcare arena since 1986. It addresses a controversial technique for permitting for-profit organizations, often investor-owned chains, to operate hospitals owned by charitable healthcare organizations without purchasing the facility outright. Because the joint venture operates the ''whole hospital,'' as opposed to only a department or service of the hospital, the venture calls into question whether the entity that was operating the hospital can continue to qualify as a charitable organization and as a hospital for public charity classification purposes.

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113. *See* §§ 22.1 and 22.2.
114. *See* § 22.6, text accompanied by note 84.
115. Rev. Rul. 98-15, 1998-1 C.B. 718. *See generally* Russell-Ward, ''Joint Ventures Beware: Discrepancies Exist in Penalties for Inurement and Private Benefit Scenarios,'' 45 *Exempt Org. Tax Rev.* (No. 1) 95 (July 2004); Griffith and Jones, ''The Fifth Circuit Rules . . . Not: A Mock Opinion in *St. David's*,'' 40 *Exempt Org. Tax Rev.* (No. 3) 263 (June 2003); Louthian, III, ''Revenue Ruling Brings New Life to Joint Ventures but Kills Off a GCM,'' 10 *J. Tax'n Exempt Orgs.* (No. 1) 3 (July/Aug. 1998); Mancino, ''New Ruling Provides Guidance, Raises Questions for Joint Ventures Involving Exempt Organizations,'' 88 *J. Tax'n Exempt Orgs.* (No. 5) 294 (May 1998); Griffith, ''Revenue Ruling 98-15: Dimming the Future of All Nonprofit Joint Ventures?,'' 20 *Exempt Org. Tax Rev.* (No. 3) 405 (1998); Peregrine and Sullivan, ''Rev. Rul. 98-15 Confirms Traditional Tax Planning Approach for 'Typical' Joint Venture,'' 20 *Exempt Org. Tax Rev.* (No. 2) 220 (1998); Salias, Kindell, and Friedlander, Chapter A, ''Whole Hospital Joint Ventures,'' in FY 1999 CPE Text.

The ruling by the IRS is a mixed bag at best. Although it permits charitable healthcare organizations to participate in whole-hospital joint ventures without losing their tax exemption or favored public charity status, in order to achieve this goal it imposes restrictions that will be unacceptable to many. In addition, the revenue ruling leaves many questions unanswered, including the intended reach of the ruling to other joint ventures.

The issue raised by the ruling is whether a charitable organization that operates an acute care hospital continues to qualify as such when it forms a limited liability company (LLC) with a for-profit corporation and then contributes its hospital and all of its other operating assets to the LLC, which then operates the hospital.

The ruling considers two factual situations in addressing the issue. The first situation involves a nonprofit charitable hospital operating company, Organization A, which owns and operates an acute care hospital. It is also a public charity by virtue of the fact that it operates a hospital. Organization B is a for-profit corporation that owns and operates a number of hospitals.

Organization A believes that it can better serve its community by obtaining additional funding, and B is interested in providing financing for A as long as it can earn a reasonable rate of return. Accordingly, the parties form an LLC, C. A contributes all of its operating assets, including its hospital, to C, and B contributes assets to C as well. In return, A and B receive ownership interests in C proportional to their respective contributions. The governing documents of the LLC provide that it is to be managed by a governing board consisting of three individuals chosen by the charitable healthcare organization and two individuals chosen by the for-profit corporation. A intends to appoint knowledgeable community leaders who are not on the hospital's medical staff and do not otherwise have business relationships with the hospital. C's governing documents can be amended only with the approval of both owners, and a majority of the board must approve certain major decisions relating to the operation of the LLC, including annual capital and operating budgets; distribution of earnings; selection of key executives; acquisition or disposition of healthcare facilities; contracts in excess of a particular dollar amount each year; changes to the types of services to be offered by the hospital; and renewal or termination of management agreements.

Under the governing document, the LLC must operate any hospital it owns in a manner that furthers charitable purposes by promoting health for a broad cross section of its community. These documents explicitly state that the duty of the governing board to operate the LLC in furtherance of charitable purposes by promoting health for a broad cross section of the community overrides any duty that it may have to operate for the financial benefit of its owners. In the event of a conflict between these obligations, the governing board must satisfy the community benefit standard for a charitable hospital without regard to the consequences for maximizing profitability of the enterprise. All returns

of capital and any distributions must be made proportional to the ownership interest of the parties in C.

The LLC entered into a management agreement with an independent management company to provide day-to-day management services over a five-year term. The agreement is renewable for additional five-year periods by mutual consent of the parties. The management fee is based on the gross revenues of the LLC. The LLC is permitted to terminate the management agreement for cause. None of the officers, directors, or key employees of the charitable organization who were involved in making the decision to form the LLC was promised employment or any other incentive by the LLC or by the for-profit organization to approve the transaction.

A intends to use any distributions it receives from the LLC to provide grants to support activities that promote the health of A's community and to help the indigent obtain healthcare. Substantially all of A's grantmaking will be funded by distributions from the LLC. A's projected grantmaking program and its participation as an owner of the LLC will be its only activities.

The second factual situation considered by the revenue ruling is identical to the first, with the following exceptions. The governing documents of the LLC provide that it will be managed by a governing board consisting of an equal number of individuals chosen by the charitable organization and the for-profit organization. The decisions that require majority board approval include annual capital and operating budgets, distributions over a required minimum level, unusually large contracts, and selection of key individuals. The governing documents provide that the LLC's purpose is to construct, develop, own, manage, operate, and take other action in connection with operating the healthcare facility it owns and to engage in other healthcare-related activities.

Also in the second situation, the LLC enters into a management agreement with a wholly owned subsidiary of the for-profit organization to provide the day-to-day management services. This management agreement is renewable at the discretion of the for-profit subsidiary, and the LLC may terminate the agreement only for cause.

As part of the agreement to form the LLC, the charitable organization agrees to approve the selection of former employees of the for-profit organization as the chief executive officer and the chief financial officer because of their business expertise.

The revenue ruling then reviews the legal authorities that apply to these situations, including case law stating that an exempt organization may not be used as an instrument to further for-profit purposes. In analyzing these legal authorities, the revenue ruling states that the activities of an LLC treated as a partnership for federal income tax purposes are considered to be the activities of a nonprofit organization that is an owner of the LLC when evaluating whether the nonprofit organization is operated exclusively for charitable purposes.

The ruling states that a charitable organization may form and participate in a partnership, including an LLC treated as a partnership for tax purposes, and may meet the operational test required of charitable organizations if its participation in the partnership furthers a charitable purpose and the partnership arrangement permits it to act exclusively in furtherance of its charitable purposes and only incidentally for the benefit of the for-profit partners.

Similarly, the ruling states that a charitable organization may enter into a management contract with a private party giving that party authority to conduct activities on its behalf and to direct the use of its assets if the charitable organization retains ultimate authority over the assets and activities being managed and provided that the terms are reasonable, including reasonable compensation and length of term. If a for-profit organization controls or uses a nonprofit organization's assets for its benefit in a less than incidental manner, however, the organization will not continue to be recognized as a charitable organization.

Applying this analysis to the two factual situations, the IRS concluded that the hospital in the first fact pattern would continue to be recognized as a charitable organization and as a hospital-type public charity. In reaching this conclusion, the IRS noted that the governing documents of the LLC committed it to provide healthcare services for the benefit of the community as a whole and to give the achievement of charitable purposes priority over profit maximization. In addition, the charitable organization's appointees had voting control over the organization, including specifically enumerated powers over the primary activities of the LLC. The IRS concluded that because the charitable organization's grantmaking activities were contingent on receipt of distributions from the LLC, its principal activity would continue to be the provision of hospital care.

In examining the second situation, the IRS reached a different result. In the IRS's view, the charitable organization in this fact pattern would not be engaged primarily in activities that further charitable purposes. Because there was no binding obligation for the LLC to serve charitable purposes or otherwise provide services to the entire community, the LLC would be able to deny care to the indigent if it chose to do so. Also, because the exempt organization did not directly control the governing body of the LLC, it would not be able to initiate programs within the LLC to serve new health needs within the community without the agreement of at least one board member appointed by the for-profit organization.

The IRS feared that the for-profit organization would not necessarily give priority to the health needs of the community over its desire to maximize profits. The IRS was also concerned that the information relayed to the governing board in the second factual pattern would come from individuals with a prior relationship with the for-profit organization and from a management

company that was a subsidiary of the for-profit organization. It noted that the management company would have broad discretion over the activities of the LLC without always obtaining governing board input and approval. It also noted the ability of the management company to unilaterally renew their management agreement.

Based on these facts and circumstances, the IRS concluded that the charitable organization could not establish that the activities it conducted through the LLC would further its exempt purposes. It also found that the benefit to the for-profit organization resulting from the activities of the LLC would not be incidental to the furtherance of an exempt purpose. Accordingly, the exempt organization would fail the requisite test for continued recognition of its charitable status.

The provider community has waited for several years for guidance from the IRS in this area. The use of whole-hospital joint ventures has been controversial; segments of the nonprofit sector have railed against the use of this model as contrary to the public interest.

The issuance of guidance in the form of a revenue ruling, which is binding on the IRS and can be relied on by all taxpayers, is to be applauded. Unfortunately, the substance of the revenue ruling falls short of the mark. It is certainly a positive ruling in that the IRS could simply have said no; it could have decided that the use of whole-hospital joint ventures was *per se* at odds with operation for charitable purposes as it did with net revenue stream joint ventures in 1991. Instead, the IRS held that if properly structured, whole-hospital joint ventures are consistent with charitable operation.

It is also positive in that the ruling permits a hospital-operating corporation to continue to be recognized as both a charitable organization and a hospital-type public charity even though it no longer owns hospital assets and no longer actually operates a hospital.

The ruling is disappointing to some, however, in its apparent insistence that the charitable organization maintain majority control over the governing board of the joint venture. Many whole-hospital joint ventures were structured with equal representation on the board, with major decisions requiring a supermajority vote or with certain veto powers being reserved to the exempt organization participant. This is arguably sufficient control over the activities of the joint venture to ensure that it could not cause the charitable organization to act other than in furtherance of its exempt purposes.

The ruling also takes a peculiar position with regard to management contracts. It apparently requires that the management agreement for the operation of the joint venture be under commercially reasonable terms, including the right of the charitable organization to determine whether the contract will be renewed and the retention of major decision-making authority at the joint venture's governing board level. This is all well and good. However, the ruling then indicates that it would be improper for this management services

agreement to be extended to a subsidiary of the for-profit participant in the joint venture or to include former employees of the for-profit company as managers of the enterprise. Most whole-hospital joint ventures have been structured precisely to allow this type of arrangement. It is the expertise and success record of the for-profit companies that is being sought in these ventures. If, as required by the IRS, the governing board of the joint venture is controlled by the charitable organization participant and the terms of the management agreement are otherwise commercially reasonable, it should not matter whether the for-profit management company is independent or a subsidiary of the for-profit participant in the joint venture. In either case, the assets of the exempt organization will be appropriately protected through the board control and management agreement terms. To forbid this type of arrangement is to preclude one of the primary benefits to the charitable organization of venturing with an experienced for-profit partner.

Perhaps the greatest weakness of the revenue ruling, however, is what it does not address. For example, it is unclear whether these fact patterns are intended to operate as safe harbors. Must all of the criteria be adhered to in order for tax exemption to be continued? If all of the enumerated factors are not necessary, which are the most important ones? Do some factors have more weight in the analysis than others? It is also unclear whether the revenue ruling is intended to be applied retroactively. If so, this would upset a significant number of these ventures that were predicated on prior IRS guidance and were instructed during a period in which the IRS declined to issue guidance pending the release of this revenue ruling. Although in the past the IRS has been fairly flexible in offering ''amnesty'' for unwinding problematic ventures, this will still result in significant hardship for the parties involved in such transactions.

§ 22.10 PROVIDER-SPONSORED ORGANIZATION JOINT VENTURES

In the Balanced Budget Act of 1997, Congress expanded the Medicare program by adding Medicare Part C, which permits Medicare beneficiaries to receive services covered by Medicare from a new type of health entity called a Provider-Sponsored Organization (PSO). The Act defines a PSO as a public or private entity that is run by a healthcare provider or provider group; which provides a substantial proportion of the Medicare-covered services directly through the provider or provider group; and with which the providers have at least a majority financial interest and share substantial financial risk.

Congress recognized that the joint venture between charitable healthcare providers and the PSO contemplated by the Act might raise concern under the IRS's prevailing joint venture analysis. Accordingly, it added a new section to the Code, § 501(o), which expressly states that a charitable organization

will still be treated as organized and operated exclusively for charitable purposes if a hospital that it owns and operates participates in a PSO joint venture, regardless of whether the PSO is itself tax-exempt.[116] The new section further states that any person with a material financial interest in the PSO will be treated as an insider for purposes of applying the private inurement proscription.

It is unclear whether a hospital's assumption of risk in a PSO arrangement would run afoul of the Code's rules against the substantial provision of commercial-type insurance by charitable healthcare organizations.[117]

The analysis of this revenue ruling, and the IRS's fairly rigid application of it, has been put to the test in a case involving a whole-hospital joint venture between a Texas nonprofit, charitable health system and a major investor-owned health system.[118] In this case, the IRS revoked the charitable status of the nonprofit hospital, St. David's, retroactively to its formation of a whole-hospital joint venture partnership in 1996. The IRS took the position that when St. David's entered into the whole-hospital joint venture with the for-profit entity, HCA, it was no longer engaged in activities that primarily furthered a charitable purpose.

A federal court saw the matter differently and concluded that it was clear that St. David's qualified as a charitable organization as a matter of law and granted summary judgment for St. David's. In the view of the court, the bases for the IRS's revocation of St. David's charitable status were that the joint venture was not controlled by a community board and that HCA had received an impermissible private benefit from the venture. The court concluded that St. David's satisfied the requirement for community board control and that it did not provide an undue private benefit to HCA in the venture. With regard to the IRS's allegation of private benefit to HCA, the court stated that ''it is difficult to imagine a corporate structure more protective of an organization's charitable purpose than the one at issue in this case.''[119]

The St. David's decision contains harsh criticism for the Internal Revenue Service's position and strongly concludes that St. David's continues to qualify as a charitable organization. However, the decision is sparse in its description of the underlying facts of the transaction. Accordingly, the decision is best analyzed when the administrative review of the venture is first considered.

The IRS's initial review of this transaction appears in a technical advice memorandum issued in August 2002.[120] In this technical advice memorandum, the IRS considered whether St. David's Healthcare System jeopardized its charitable status when it entered into a joint venture arrangement with HCA,

116. Balanced Budget Act of 1997, §§ 4041 and 501(o), 111 Stat. 251, 360 (1997).
117. IRC § 501(m). *See* § 9.3.
118. *St. David's Health Care System, Inc. v. United States*, 2002-1 U.S.T.C. ¶ 50,452 (W.D. Tex. 2002).
119. *Id*. at 84,254.
120. Technical Advice Memorandum (unreleased), *BNA Daily Tax Report*, August 9, 2002.

and if it did not jeopardize its tax exemption, whether it was subject to the unrelated business income tax on its share of profits from the joint venture.

Because the analysis used in the IRS's whole-hospital joint venture revenue ruling is based on facts and circumstances, a review of the facts set forth in the technical advice memorandum is useful here. As reported in the memorandum, St. David's was incorporated as a Texas nonprofit corporation in 1925 for charitable purposes, which it accomplished by owning and operating an acute care hospital facility. St. David's was recognized by the IRS as a charitable organization and a public charity. St. David's also owned an interest in or controlled other tax-exempt and taxable entities.

After considering its strategic options, St. David's entered into a partnership with HCA, an investor-owned for-profit corporation. St. David's engaged an independent consulting and investment banking firm to prepare a fairness opinion as to the business enterprise value of its assets, as well as those proposed to be contributed to the partnership by HCA. The same firm was also hired to negotiate on St. David's behalf. The fairness opinion by the investment banking concern determined that the estimated acceptable range of fair market value for the operating assets was between $140,000,000 and $165,000,000, and the total consideration received by St. David's from HCA fell within this range.

The Texas State Attorney General, which has oversight authority with respect to charitable organizations operating in Texas, retained a national accounting firm to perform an independent evaluation of the partnership transaction. That accounting firm determined that St. David's had received fair consideration for its assets under the terms of the joint venture. The Attorney General ultimately decided to wait until a five-year period had expired before it fully assessed the propriety of the transaction.

St. David's also obtained the advice of counsel with respect to the legal implications of entering into a partnership with HCA. Counsel advised St. David's that it was highly probable that its tax-exempt charitable and public charity status would not be affected by the partnership transaction. After considering these strategic options, St. David's believed that it was in the best interest of the community to enter into the whole-hospital joint venture with HCA.

The venture, organized as a Texas limited partnership, was created in 1996. The partnership consisted of the contributed assets and operations of St. David's and of certain St. David's affiliates and of HCA and its affiliates in the Austin, Texas, market. Under the terms of the transaction, HCA held a 59 percent equity interest in the partnership, while St. David's held a 41 percent equity interest. Under the partnership agreement, a board of governors was required to govern the partnership. St. David's and HCA each had five representatives on the board. The partnership agreement provided that only a St. David's representative could chair the board. The board was not authorized to act on behalf of or bind the partnership; rather, the actions of the board were

to be carried out by the manager pursuant to a management services agreement. The board retained the authority to make 15 ''major decisions,'' which included amending the partnership agreement, management services agreement, and other major transaction agreements; the sale of all or substantially all of the assets of the partnership; the approval of annual operating and capital budgets; the hiring of the partnership's CEO; a change in the mission, values, or philosophy for the partnership; approval of the annual strategic and business plans of the partnership; and several other actions having significant impact upon operation of the partnership.

According to the partnership agreement, its purposes included increasing the ability of the facilities to provide healthcare services (including charitable care and community health services) in the service area; the provision of more efficient and cost-effective healthcare services; and the provision of the highest quality medical care available at competitive charges.

The agreement stated that in furtherance of these purposes, the manager was required to cause the facilities to conduct the business and operations of the joint venture in such a manner as to satisfy the community benefit standard generally required of charitable hospitals, including accepting Medicare and Medicaid patients; accepting all patients in emergency rooms without regard to their ability to pay; maintenance of an open medical staff; provision of public health programs and educational benefits to the community; and generally providing the services at a reasonable cost. The partnership agreement also stated that the partnership intended to operate its business so as not to generate unrelated business income for St. David's or to jeopardize its charitable status. It did not, however, state that charitable purposes have priority over profit-making goals.

The management services agreement was between the joint venture and a taxable, wholly owned subsidiary of HCA. Under the agreement, the manager was responsible for the day-to-day operation of the partnership.

The IRS reviewed applicable law, much as it did in the development of its 1998 revenue ruling on whole-hospital joint ventures, and determined that it agreed with the conclusion of its director of examination that St. David's was not operated exclusively for charitable purposes following the execution of the partnership agreement for the whole-hospital joint venture. In its view, St. David's participation in the partnership did not permit St. David's to act exclusively in furtherance of its charitable purposes and it allowed for greater than incidental benefit to HCA and its for-profit subsidiaries.

In the view of the IRS, the facts of the St. David's case more closely resembled the ''bad'' fact pattern of situation two in the 1998 revenue ruling than those listed in the ''good'' fact pattern in situation one in that ruling. The IRS stated that the structure of the partnership, as well as the ancillary agreements, prevented St. David's from having meaningful control over the joint venture's activities. Under the governance structure established,

St. David's could not initiate changes to enhance charitable care in the community, and the board of governors had authority only over certain specified matters. The IRS believed that the management agreement also limited St. David's ability to influence decisions. The IRS noted with significance the fact that the partnership agreement did not provide an express statement that establishes an obligation that charitable purposes take precedence over profit motives. It further believed that the management agreement under Texas law required the manager to operate the partnership as a profit-making business and did not bind it to charitable purposes. In addition, the alternative dispute resolution provision did not require the mediator to consider the accomplishment of exempt purposes to take precedence over the accomplishment of business purposes.

The IRS also noted that St. David's and HCA had equal voting rights regarding decisions to be undertaken by the partnership. While this might help to protect charitable interests from undue influence, there was no majority vote conferred upon the exempt partners in this situation. St. David's could exert influence by blocking actions proposed by HCA, but the IRS again stressed that St. David's could not initiate action without the consent of HCA board representatives. With regard to the fact that St. David's had the right to select the chairman of the board, the IRS minimized the significance of that right. It noted that the chair does not break a tie vote and that while the chair could set the agenda, he or she could not prevent HCA from swaying the partnership toward furthering their financial interests.

The IRS also noted that the governing board had no control over the changes to the types of services provided or over whether the manager should be terminated or over which executives would be selected to provide services. It also stressed the significance of the fact that HCA determined whether distributions would be made by the joint venture. The Service found that a substantial amount of control was provided to the management company, which was a subsidiary of HCA. It noted that the primary source of information for board members to make decisions would be HCA executives and that these executives exercise so much control that it was unlikely that any of them would insure that the charitable program took precedence over the business concerns of HCA. Accordingly, through the control exercised by HCA, the IRS determined that it was benefited more than incidentally.

The IRS also criticized the term and fee structure of the management services agreement. It noted that the agreement is effective for a period of almost 55 years and terminable prior to that period only for cause. It noted that long-term contracts that cede effective control over charitable activities impede the furtherance of exempt purposes. Indeed, the IRS concluded that the provisions of this management services agreement were similar to or worse than those listed in the management contract discussed in the bad fact pattern in the 1998 revenue ruling.

The IRS also pointed out that the noncompete provision of the partnership agreement provides that St. David's cannot operate a competing business in the service area without the consent of the HCA representatives on the governing board, while HCA could operate any business anywhere so long as it was not a healthcare facility located within their restricted area. It distinguished other case law finding that such ventures were consistent with charitable status by concluding that HCA had far more control over the joint venture than was present in those cases. The IRS also noted that following the implementation of the partnership, the priority and manner of tracking and accounting of indigent care by St. David's changed and that certain services that it had previously provided had been consolidated, reduced, or eliminated after the formation of the partnership.

The IRS concluded that the hospitals as operated by the joint venture were not operated in accordance with the community benefit standard for exempt hospitals that it established in 1969.[121] It found that the requirement for a community board was not met by the St. David's partnership governing board, which was 50 percent controlled by HCA and in light of the control of the day-to-day operations of the business by the HCA management company. It concluded further that charity care in the partnership was ''given short shrift.'' It further found that HCA exerted both direct and indirect control over the joint venture's activities so that the hospital facilities were operated for HCA's private benefit. The joint venture both structurally and operationally served private interests and did not exclusively further charitable purposes. Accordingly, St. David's itself furthered a private rather than a public interest, and the revocation of tax-exempt status was warranted in the IRS's view.

The district court took a decidedly different view of St. David's continued qualification as a charitable organization after its participation in the whole-hospital joint venture. It entered summary judgment in favor of St. David's, holding that St. David's continued to qualify as a charitable organization in that it satisfied the primary activities prong of the operational test by promoting health, operating a generally accessible emergency room without regard to the ability to pay, operating exclusively for charitable purposes and in the community interest and not for the benefit of private interests. The court concluded that in its view, a community board was not absolutely necessary under the IRS's community benefit standard; however, even if a community board were an absolute requirement for tax exemption as a charitable organization, St. David's satisfied this requirement.

The court first considered St. David's satisfaction of the operational test required of charitable organizations.[122] The court began with a critical view of

121. Rev. Rul. 69-545, 1969-2 C.B. 117.

122. The court expressed its exasperation with the language of the Code regarding the requirement that an organization will not be deemed to be operated exclusively for charitable purposes if ''more than an insubstantial part of its activities is not in furtherance

the IRS's revenue ruling that established the community benefit standard[123] and the IRS's inconsistent application of its standards in the case. In the court's view, the dispute between the IRS and St. David's could be resolved by answering two overlapping questions: first, whether St. David's is operated exclusively for charity, that is, only insubstantial portions of its activities benefit private purposes; and second, whether St. David's is operated for the community interest and not for a private interest, specifically, HCA. As analyzed by the court, the primary factors in the IRS's decision to revoke St. David's tax-exempt status were that St. David's is not controlled by a community board, as required by its community benefit standard revenue ruling, and that HCA received an impermissible private benefit in the joint venture. The court then proceeded to address each of these issues.

With regard to the community board requirement, the court considered whether the factor of a community board is an absolute requirement or merely one point in favor of qualification as a charitable organization. It noted that there is also dispute as to what constitutes a community board. The court found that as a matter of law, the presence of a community board was a point in favor of exemption but not an absolute requirement. It noted that the IRS's community benefit standard revenue ruling never stated that any one factor was an absolute requirement for exemption and that the language of the ruling suggests that the absence of any one factor is not absolutely dispositive of the issue of qualifying as a charitable organization.

The court then continued that even if it were correct that a community board is an absolute requirement, the St. David's board satisfied that requirement. The court was not troubled by the fact that only half of the board was appointed by St. David's with the remainder appointed by a for-profit entity. In the court's view, the purpose of a community board "is to ensure that the community's interests are given precedence over any private interest." If a board is structured to insure such protection, then in the court's view it qualifies as a community board. The court believed that the IRS's view that the St. David's board was not a community board because it could only vote a tie with the members appointed by the for-profit entity was erroneous. In the case of St. David's, it noted that the partnership agreement required all the hospitals owned by the joint venture to be operated in accordance with the community benefit standard and that should they fail to do so, St. David's could exercise a unilateral right to dissolve the joint venture. The court also noted with approval the fact that the chairman of the board could be appointed only by St. David's and that day-to-day operations of the joint venture were

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of an exempt purpose." As perhaps only a Texas court can, the opinion lambasted the language of the Code, noting that "[s]adly, the last sentence of the section is a horrible amalgamation of negatives arranged like an inside joke prompting laughter only from seasoned and sadistic bureaucrats."

123. Rev. Rul. 69-545, 1969-2 C.B. 117.

impacted disproportionately by the ability of St. David's to unilaterally remove the chief executive officer. The court instructed that voting strength is more than ''just a numbers game'' and that the other elements of control were just as important.

The court decision then tackled the issue of whether the joint venture provided excessive private benefit to HCA. Agreeing that a facts and circumstances analysis was the proper approach, the court concluded that the joint venture's structure appropriately protected St. David's charitable purposes. The court believed that the language used in the partnership agreement and the voting rules and rights of the exempt partner prevented any usurpation of the charitable purpose by the for-profit entity. The court again concluded that the nonvoting elements of control gave St. David's substantially more control than the for-profit partner notwithstanding the 50–50 split in voting rights on the board of directors.[124]

The United States Court of Appeals for the Fifth Circuit heard the appeal from the district court in this case. The Fifth Circuit concluded that the case raised genuine issues of material fact and that the district court erred in granting St. David's Health Care System's motion for summary judgment. Accordingly, it vacated the district court's decision and remanded the case for further proceedings. It also vacated the district court's award of attorneys' fees and costs to St. David's. [125]

In this case, the government claimed that the trial court had erred in concluding St. David's was entitled to recognition of charitable status. The burden was on St. David's to prove that it qualified for tax exemption. The court noted that St. David's was required to demonstrate that it met both the organizational and operational test of qualifying as a charitable organization[126] and that the parties had agreed that St. David's satisfied the organizational test. Satisfaction of the operational test remained at issue. Since St. David's contributed all of its assets to the partnership joint venture, the court looked to the activities of the partnership to determine whether St. David's satisfied the operational test.

The IRS asserted that because of its partnership with a for-profit enterprise, St. David's could not demonstrate that it engaged primarily in activities that accomplish its charitable purposes. The court noted that the government did not contend that a nonprofit organization should automatically lose its exempt status when it forms a partnership with a for-profit organization. Rather, the government argued that a nonprofit organization sacrifices its tax-exempt

124. The strength of the court's opinion was further demonstrated when it took the unusual step of awarding fees to St. David's, concluding that the IRS's position was not substantially justified and that St. David's was entitled to reasonable litigation costs. *St. David's Healthcare System, Inc. v. United States*, 2002-2 U.S.T.C. ¶ 50,745; 90 A.F.T.R. 2d (RIA) 68-78.
125. 349 F.3d 232 (5th Cir. 2003).
126. *See* Chapter 4.

status if it cedes control over the partnership to the for-profit entity. When it does so, in the IRS's view, it can no longer ensure that its activities primarily further its charitable purpose through the partnership. St. David's responded that the key issue in determining its tax-exempt status was not which entity *controls* the partnership, but, rather, what the *function* of the joint venture is, that is, whether the joint venture partnership engages in activities that further the charitable organization's exempt purposes. St. David's argued that it satisfied the operational test because its actual activities through the partnership furthered its charitable purpose of providing healthcare to all those who request it.

St. David's relied on the IRS's community benefit standard in asserting that it was acting primarily for charitable purposes.[127] The court noted that a hospital need not demonstrate that it meets all of the factors set forth in the community benefit standard in order to qualify for charitable status. Instead, a hospital must demonstrate based on the ''totality of the circumstances'' that it is entitled to tax-exempt status.[128] St. David's contended that its activities via the partnership more than adequately satisfy the community benefit standard. It pointed out that the joint venture not only provides free emergency room care but also provides the rest of its services and facilities to all persons without regard to their ability to pay.[129] The IRS argued that the partnership did not provide free care at the levels it indicated because it sought to collect payment from all patients. The court found, however, that the government conceded that collection efforts do not definitively determine whether care is charitable. The court concluded that the arguments made by the government regarding St. David's collection efforts did not create a genuine issue of fact as to whether the partnership facilities dispensed charity care.[130]

St. David's also asserted that the partnership hospitals maintained open medical staffs and that it used the profits that it received from the partnership to fund research grants and other health-related initiatives.

The court then considered the government's contention that the partnership hospitals did not satisfy the community benefit standard in that they lacked a community board. Half of the members of the partnership's governing body were appointed by the for-profit partner and two of the members appointed by St. David's were physicians at partnership hospitals. Thus, the government contended that they could not be deemed independent representatives of the community who could give high priority to charitable concerns. While the district court found that St. David's satisfied the community board requirement,

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127. *See* Chapter 6.
128. Citing *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3rd Cir. 1993).
129. The court in a footnote took a position in the longstanding debate over what types of care qualify as charity care. *See* discussion at § 26.1. It did not find attempts by the hospital to collect payment for services to have the effect of precluding treatment of unpaid care as charity care.
130. *St. David's Healthcare System, Inc. v. United States*, 349 F.3d 232, 236, note 3 (5th Cir. 2003).

the Fifth Circuit focused on a different point, agreeing with the district court that even if St. David's did not satisfy the community board provision, that did not mean that it failed to meet the community benefit standard, since every factor in that standard does not have to be met in order to qualify for tax exemption. Indeed, the court conclusively stated that the joint venture hospitals could satisfy the community benefit standard without regard to whether they are run by an independent community board.[131]

The court stated that it did not doubt that the joint venture partnership provided important medical services in the community and indicated that if the case hinged on whether the partnership performed any charitable functions, it would be likely to affirm the district court's grant of summary judgment in favor of St. David's. However, the court disagreed with St. David's position that the central issue was whether the partnership provided charitable services. Instead, it focused on the requirement that organizations desiring charitable status operate exclusively in furtherance of exempt purposes. Thus, the court determined that it must not only consider whether the organization's activities further charitable purposes, but it also must ensure that the organization's activities do not substantially further noncharitable purposes. As a result, even if St. David's performed important charitable functions, it could not qualify as a charitable organization if its activities through the partnership substantially furthered the private interests of its for-profit partner.

The court concluded that in order to determine whether an organization furthers private interests, it must examine the structure and management of the organization by looking to which individuals or entities control the organization. If private individuals or for-profit organizations have either formal or effective control, the court presumed in its analysis that the organization furthers the profit-seeking motivations of private individuals or entities, even when the organization is a partnership between a nonprofit and for-profit entity. The court then set forth its starkest assessment of the law on this point:

> When the non-profit organization cedes control over the partnership to the for-profit entity, we assume that the partnership's activities substantially further the for-profit's interests. As a result, we conclude that the non-profit's activities via the partnership are not exclusively or primarily in furtherance of its charitable purposes. Thus, the non-profit is not entitled to a tax exemption.[132]

The court believed that the present case illustrates why the court should be concerned about the relinquishment of control in such joint ventures. It noted the disparity in financial condition between St. David's and the for-profit partner, and the resultant impact on the relative bargaining strength of the parties.

131. *Id*.
132. *Id*. at 238.

The court used the IRS's approach set forth in its revenue ruling on whole-hospital joint ventures as the starting point for its analysis.[133] The court believed that the partnership documents in the present case, when examined using the IRS's approach, left it uncertain as to whether St. David's had conceded control to the for-profit organization. In applying this analysis, the court took issue with the IRS's narrow interpretation of its revenue ruling with regard to its requirement that the operational documents of the joint venture expressly require the manager to place charitable goals ahead of profit maximization. The court found that St. David's requirement in the management agreement between the partnership and the for-profit management company that the manager abide by the community benefit standard was sufficient.

St. David's further argued that it had provided significant protections in the partnership documents for its charitable purposes, that is, through appropriate expressions of charitable purpose in the partnership agreement, the power to terminate the management services agreement and the CEO, the ability to block proposed action by the governing body, and the power to dissolve the joint venture if charitable operation was not continued. The court, however, sided with the government and challenged the real-world efficacy of these protections. It questioned the value of St. David's ability to appoint the chairman of the board when the appointment power did not provide St. David's with any real authority, since the chair could not make decisions or initiate action without the approval of the rest of the board. It also challenged operation of the partnership by a management company on a day-to-day basis by a subsidiary of the for-profit partner. The court also found fault with the extraordinarily long term of the management agreement. It grew still more critical when it noted that the management fee was based on a percentage of the partnership's net revenues, finding that such a contingency could give the manager an incentive to maximize revenues and to neglect charitable goals. In particular, the court seemed troubled by the combination of the long term of the management agreement and the percentage of revenue-based management fee.[134]

St. David's also asserted that it can enforce compliance with the community benefit standard under the management agreement by taking legal action. However, the court again disputed the value of this right, noting the time and expense for judicial proceedings and that it was unlikely that litigation would be resorted to every time a manager's decision conflicted with the community benefit standard.

Finally, the court challenged the amount of control that St. David's exercises over the partnership's CEO, noting that the CEO already had failed to satisfy all of the requirements set forth in the management agreement regarding reporting

133. Rev. Rul. 98-15, 1998-1 C.B. 718.

134. *St. David's Healthcare System, Inc. v. United States*, 349 F.3d 232, 242, note 13 (5th Cir. 2003).

charity care. In addition, it questioned the degree to which St. David's could control the joint venture by threatening dissolution, since dissolution would be ''disastrous'' for St. David's and the community.

The appellate court remanded the case to the trial court for further proceedings. The trial court thereafter conducted a trial before a jury on the sole issue of whether the hospital operating corporation should retain its tax-exempt charitable status. The jury voted that the corporation should retain its exempt status.[135] The government subsequently appealed the jury decision, but later withdrew its appeal in exchange for the organization's agreement not to seek attorneys' fees in the case.[136]

The Fifth Circuit's decision is a strong affirmation of the IRS's ruling position regarding joint ventures as set forth in its whole-hospital joint venture revenue ruling and in the *Redlands* case. While it remains a facts-and-circumstances analysis, the court focused on the reality of control by the exempt organization over the for-profit organization in the real-world operation of the joint venture, and not merely paper protections that have little effective value. Most critical is the court's acceptance of and reliance on the IRS's position that the nonprofit participant's control over the joint venture in order to insure operation primarily in furtherance of charitable purposes is the key determination, rather than the actual track record of charitable activity by the joint venture and the nonprofit organization.

The focus on control above all else remains questionable. The potential threat to operation of a joint venture primarily in furtherance of its nonprofit participant's charitable purposes that arises from failure to maintain absolute control over decisions by the joint venture at all times is a theoretical one. When an organization can affirmatively and convincingly demonstrate through a pattern of activity that it is in fact operating in furtherance of charitable purposes, this should be sufficient to rebut the presumption that the absence of absolute control will prohibit this.

More important, however, is the impact of this decision on the IRS's position with respect to ancillary joint ventures, that is, those joint ventures that involve less than the entire operations and assets of the participating charitable organization. In this context, if the charitable organization does not control the ancillary joint venture, but the joint venture's activities are not substantial in nature relative to the other activities undertaken by the charitable organization, the activities cannot represent a substantial nonexempt purpose. Accordingly, they are, at worst, unrelated business activities, and the organization must pay tax on any income generated therefrom. Again, if an organization can show that the activities it carries on through the joint venture actually further charitable purposes and are related to its charitable mission, this should be

135. *St. David's Healthcare System, Inc. v. United States*, No. 101CV-046 (W.D. Tex., Mar. 4, 2004).

136. *BNA Daily Tax Report*, June 14, 2004, at G-1.

sufficient to show relatedness and thereby free the organization from having to pay tax on income generated by the activities, even if it does not have absolute control over the joint venture. Ancillary joint ventures are far more prevalent than whole-hospital joint ventures, and clearly this is the area in which IRS guidance is most needed. Such guidance is on the IRS's workplan for 2004.

Some indication that the IRS may take a more flexible position with regard to ancillary joint ventures may be found in a recently issued determination letter recognizing the charitable status of the John Gabriel Ryan Association.[137] The John Gabriel Ryan Association (JGR) is a nonprofit corporation organized and operating in the state of Washington. Its sole corporate member is the Providence Health System—Washington (PHS-W), which is itself a Washington nonprofit corporation recognized by the IRS as a charitable organization and as a public charity.[138] JGR's sole activity is its participation in five ancillary healthcare provider and medical office building joint ventures on behalf of the Providence Health System and the local hospitals that it operates. These joint ventures provide healthcare and related services on behalf of the Providence Health System to their local communities.

Three of these joint ventures involve the provision of diagnostic radiology services; the other two involve the operation of a medical office building. In one of the health services joint ventures, JGR is a co-general partner with its parent, PHS-W, and with another tax-exempt nonprofit hospital. JGR and its parent own 50 percent of the joint venture. The joint venture agreement requires that the joint venture at all times observe the Ethical and Religious Directives for Catholic Healthcare Facilities (ERDs). The joint venture agreement also requires that: the facilities will not deny services to patients solely on the basis of their inability to pay; JGR has the right to unilaterally dissolve the joint venture upon notice; and the management committee has equal representation from each participant with certain major decisions requiring approval by the board of directors of each participant. The joint venture was not subject to a management agreement with a for-profit entity. The record indicated that the joint venture provided significant charity care and community benefit.

In another joint venture, JGR is a co-general partner along with its parent and with a for-profit imaging corporation. The for-profit corporation owns a 1 percent interest, with JGR and its parent owning the remaining 99 percent interest. The joint venture is required to: observe ERDs; not deny services based solely on inability to pay; adhere to the local hospital's charity care policy; and permit JGR to unilaterally dissolve the joint venture upon notice. The joint venture is managed by a management committee with each participant appointing an equal number of representatives. Certain decisions must be approved by the board of directors of each participant. The joint venture is not

137. *BNA Daily Tax Report* (July 11, 2003) at p. G-2.

138. The corporation is recognized as a tax-exempt organization and a public charity described in IRC §§ 501(c)(3), 170(b)(1)(A) (iii), and 509(a)(1).

subject to a management agreement with a for-profit participant or any of its affiliates. The joint venture provides significant charity care and community benefit.

The third joint venture is similar in structure; however, a for-profit professional services corporation owns a 50 percent interest in the joint venture. There are similar requirements regarding adherence to the ERDs and the provision of charity care and community benefit.

The IRS initially issued an adverse ruling to JGR on the basis that it was not operated exclusively for exempt purposes and that its activities served to benefit private interests more than incidentally and did not exclusively further charitable purposes. JGR challenged the IRS's decision through a petition for declaratory judgment in the U.S. Tax Court.[139] Subsequently, on June 25, 2003, the IRS changed its position and recognized the charitable status of JGR.

Because the public record consists only of the taxpayer's petition and the determination letter, it is difficult to ascertain the rationale for the IRS's change of heart. Its decision was made prior to the issuance of the Fifth Circuit's decision in the *St. David's* case. Nonetheless, it suggests that the IRS in ancillary joint ventures will permit structures in which the exempt organization does not have majority voting control as long as appropriate protections are in place to ensure operation for charitable purposes. Under such circumstances, the joint venture's activities will be deemed related to the charity's exempt purposes and income generated by these activities will not be subject to the unrelated business income tax.

§ 22.11 ANCILLARY SERVICES JOINT VENTURES

Because the IRS's guidance[140] involved the ''extreme'' case of a joint venture in which the operation of the entire hospital was at issue, there remained an open question of whether the same criteria would be applied by the IRS to ancillary joint ventures—those joint ventures involving discrete services of the hospital rather than the operation of the entire hospital.[141]

139. *John Gabriel Ryan Association v. Commissioner*, T.C., No. 16811-02x, petition filed on October 25, 2002.
140. Rev. Rul. 98-15, 1998-1 C.B. 718.
141. Some explanation of terms is useful here. This section discusses *ancillary joint ventures* and compares them to *whole-hospital joint ventures*. The definition used in this section is that ancillary joint ventures are those that do not involve the contribution of all of the assets of the exempt hospital; they involve only discrete services of the hospital. It is used as a catchall to describe any joint venture involving less than the operation of the whole hospital, however structured. Other commentators, as well as the IRS, have sometimes used different definitions. To some, a whole-hospital joint venture means any venture in which the entire operational assets of the exempt participant are contributed to the joint venture (even when the participant is not a hospital). While the IRS's analysis in Rev. Rul. 98-15 would arguably be the same in those cases where the exempt entity is other than a hospital, the authors intend that the term *whole-hospital joint venture*

(a) Subsequent Litigation

That question was answered as to hospital subsidiary–type joint ventures in the litigation and ensuing decision in a high-profile case decided in 1999.[142] In this case, the Tax Court upheld the denial of recognition of exemption as a charitable organization for an organization whose sole purpose was to participate in a joint venture that operates an ambulatory surgical center. The IRS had taken the position that Redlands Surgical Services (RSS) does not qualify for charitable status, either independently or as an integral part of its charitable parent, because RSS's partnership activities generate an impermissible private benefit and RSS is not operated exclusively for exempt purposes within the meaning of the Internal Revenue Code.

The *Redlands* decision is clearly not a death knell for joint ventures between charitable organizations and for-profit enterprises; however, it does warrant reexamination of existing joint ventures and careful structuring of new ancillary joint ventures to ensure compliance with the standards set forth by the IRS and the Tax Court.

The facts of the case are as follows. Redlands Surgical Services is a membership corporation, with RHS Corporation as its sole member. RSS is also a partner in two partnerships—the Redlands Ambulatory Surgery Center (RASC) Partnership and Inland Surgery Center Limited Partnership (ISC LP). RHS is a nonprofit public benefit corporation, recognized as a tax-exempt public charity, and is the parent corporation of Redlands Community Hospital, which is also a tax-exempt charitable organization.

Surgical Care Affiliates Inc. (SCAI) is a for-profit, publicly held corporation that owns and manages 40 ambulatory surgery centers in the United States. Redlands-SCA Surgery Centers Inc. (R-SCA), the for-profit partner in the RASC partnership, is a wholly owned for-profit subsidiary of SCAI.

SCA Management, another for-profit subsidiary of SCAI, entered into a management agreement with ISC LP to manage Inland Surgery Center, which operates an ambulatory surgical center. RASC Partnership, a general

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describe only joint ventures involving the contribution of all of a hospital's assets. Ancillary joint ventures are a bit more slippery to define. The IRS breaks these ventures down into two types: hospital subsidiary joint ventures and hospital ancillary joint ventures. *See* Fiscal Year 1999 IRS Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, Ch. A, ''Whole Hospital Joint Ventures,'' pp. 7–10. The IRS considers the structure at issue in the *Redlands* case to be a hospital subsidiary joint venture and reserves comment on hospital ancillary joint ventures—those arrangements where an exempt organization that operates a hospital or healthcare facility directly participates (rather than through a subsidiary) in the joint venture to operate a particular service. The American Bar Association has attempted to seek clarification on the IRS's position regarding hospital ancillary joint ventures by proposing the issuance of a revenue ruling that posits a joint venture in which only an insubstantial portion of an exempt organization's activities, rather than its sole activity, is involved. *Tax Notes Today* (October 1, 2002), 2002 TNT 190-14.

142. *Redlands Surgical Services v. Commissioner*, 113 T.C. 47 (1999).

partnership between RSS and R-SCA, entered into ISC LP as the general partner, along with 32 limited partners (physicians on the hospital's medical staff).

RSS filed a Form 1023, applying for exempt status, in September 1990. The IRS issued an initial adverse determination in March 1995; a conference followed, and the Service issued a revised adverse determination letter in April 1996. The IRS issued a final adverse ruling in March 1997.

RSS's articles of incorporation describe RSS as a nonprofit, public benefit corporation, not organized for private gain. The IRS states that RSS ''was created for the purpose of owning a partnership interest . . . RASC Partnership'' and that, as of July 1991, RSS intended to have the Surgery Center as ''its only planned activity.''

RSS's sole paid employee is its president, who concurrently serves as president of the hospital. RSS's sole source of financial support is its share of the revenues from the Surgery Center.

Management of the RASC Partnership is vested in a management committee consisting of four managing directors. Two are chosen by RSS; the other two are chosen by for-profit partner R-SCA. Under the partnership agreement, decisions affecting the partnership's affairs and policies are decided by majority vote of the committee. The management committee holds certain reserved powers over the operations of the Surgery Center, including preparing an annual budget for ISC LP, approving capital expenditures, establishing fees for medical procedures, overseeing Surgery Center services, hiring and firing the facility manager, appointing advisory committee members, and accepting insurance contracts for the center.

Medical procedures are performed at the Surgery Center if they are minor enough that they don't have to be performed at Redlands Hospital. There is nearly a 100 percent overlap between the surgeons who operate at the hospital and those who operate at the Surgery Center. Charges at the Surgery Center are determined based on customary and usual charges for similar services provided at other facilities in the area. The Surgery Center's payor mix shows that Medicaid invoices for the last half of 1993 totaled less than 1 percent of all invoices.

The IRS argued that RSS ''has no meaningful control over the assets or activities of the general partnership (RASC)'' and has the liability of a general partner in ISC LP ''but cannot exercise control; instead the for-profit interests do.'' The Service also asserted that ISC LP's management contract with SCA Management confers substantial control over the Surgery Center's operations and ''locks ISC LP into an unreasonably long (25-year) arrangement'' that would be ''extremely difficult'' to terminate.

Pointing out that RSS has only one employee, who serves concurrently as the president of the hospital, the Service concluded that RSS ''conducts no activities itself, performs no oversight, exercises no effective vote in the

partnerships . . . and in reality exercises no control over either partnership.'' The IRS also contended that the operations of the partnerships, which constitute RSS's sole activity, confer substantial private benefit on RSS's for-profit partner, the management company, and the physician limited partners, and do not benefit a broad cross-section of the community.

Finally, the IRS argued that RSS does not qualify under Treasury regulations as an ''integral part'' of its parent (RHS Corp.) or of Redlands Hospital. The IRS noted that there is not much overlap between patients of ISC LP and the patients of the hospital, indicating that RSS's activities are not charitable and do not further the exempt purposes of its related organizations. Finally, the Service said that RSS's activities would generate unrelated business income if carried on by its exempt parent or the hospital.

The Tax Court held that the petitioner (RSS) had ceded effective control over the operations of the partnerships and the Surgery Center to private parties, thereby conferring an impermissible private benefit. Consequently, it concluded that the petitioner is not operated exclusively for exempt purposes within the meaning of the Internal Revenue Code. The Tax Court further determined that to the extent that the petitioner cedes control over its sole activity to for-profit parties having an independent economic interest in the same activity, and where it has no obligation to put charitable purposes ahead of profit-making objectives, it must conclude that the petitioner is not operated exclusively for charitable purposes.

The Tax Court began its analysis by reciting the applicable legal principles in this case. The court first recited the *operational test* imposed on organizations seeking to qualify for charitable status. It noted that under applicable case law, the operational test focuses on the ''actual purposes the organization advances by means of its activities, rather than on the organization's statement of purpose or the nature of its activities.'' The court further indicated that to determine if the operational test has been satisfied, one must look beyond the four corners of the organization's articles of incorporation to discover what actually motivates the organization. The court noted that while an organization might be engaged in a single activity, that single activity could be directed toward multiple purposes, both exempt and nonexempt. Citing well-established law, the court stated that if the nonexempt purpose is substantial in nature, the organization will not satisfy the operational test. Whether an organization has a substantial nonexempt purpose is a question of fact to be resolved on the basis of all the evidence in the administrative record, according to the court.

The court then examined the promotion of health as a charitable purpose. The court noted that the promotion of health for the benefit of the community is a charitable purpose. Citing one of its prior[143] decisions, the court noted that the definition of the term *charitable* has not been static and that the standard no longer requires that the care of indigent patients be the primary concern

143. *Sound Health Association v. Commissioner*, 71 T.C. 158 (1978).

of the hospital as distinguished from the care of paying patients. Rather, the standard reflects ''a policy of ensuring that adequate health care services are actually delivered to those in the community who need them.'' The court found that under this standard, healthcare providers need only meet a flexible community benefit test based upon various factors, one of which would be whether the organization provides free care to indigent patients.

The next principle examined by the court was the proscription against benefiting private interests. The court began by citing its decision in its premiere private benefit case[144] for an explanation of the private benefit proscription. In applying this proscription to joint ventures, the court stated that the ''mere fact that an organization seeking exemption enters into a partnership agreement with private parties that receive returns on their capital investments does not establish that the organization has impermissibly conferred private benefit. The question remains whether the organization has a substantial non-exempt purpose whereby it serves private interests.'' The court cited the familiar cases of *Plumstead Theater*,[145] *Housing Pioneers*,[146] and *est of Hawaii*[147] in support of its analysis.

The court then considered, when applying the aforementioned principles, whether Redlands Surgical Services could independently qualify as a charitable organization. The court first considered the relevance of control under the parties' respective positions. The court's opinion noted that the IRS asserted that RSS had ceded effective control over its sole activity to for-profit partners and that this was indicative of a substantial nonexempt purpose whereby RSS impermissibly benefited private interests. RSS, on the other hand, challenged the premise that the ability to control its activities determines its purposes. It argued that under the operational test, the critical issue is not whether a for-profit or a not-for-profit entity has control but rather the conduct in which the organization is actually engaged. The court noted that both parties had agreed that under an aggregate theory of partnership taxation, the partnership's activities are considered RSS's own activities.

The Tax Court disagreed with RSS's thesis. It found it patently clear that the operating partnership was not operated in an exclusively charitable manner regardless of the charitable benefits that it may produce. The court noted that taken to its logical conclusion, RSS's thesis would suggest that an organization whose main activity is passive participation in a for-profit healthcare enterprise could thereby be deemed to be operating exclusively for charitable purposes.

144. *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989).

145. *Plumstead Theatre Society, Inc. v. Commissioner,* 74 T.C. 1324 (1980). *aff'd* 675 F.2d 244 (9th Cir. 1995).

146. *Housing Pioneers v. Commissioner,* 65 T.C.M. (CCH) 2191 (1993), *aff'd* 49 F.3d 1395 (9th Cir. 1995), *amended*, 58 F.3d 401 (9th Cir. 1995).

147. *est of Hawaii v. Commissioner*, 71 T.C. 1067 (1979), *aff'd in unpublished opinion*, 647 F.2d 170 (9th Cir. 1981).

The court found that such a conclusion would be contrary to well-established principles of charitable trust law.

The court found it clear that there is something in common between the structure of RSS's sole activity and the nature of its purposes in engaging in it. According to the court, an organization's purposes may be inferred from its manner of operations. The court found that ''to the extent that petitioner cedes control over its sole activity to for-profit parties having an independent economic interest in the same activity and having no obligation to put charitable purposes ahead of profit making objectives, petitioner cannot be assured that the partnerships will in fact be operated in furtherance of charitable purposes. In such a circumstance we are led to the conclusion that petitioner is not operated exclusively for charitable purposes.''

The court then applied a facts-and-circumstances analysis and concluded, based on the totality of the factors in the record, that RSS had in fact ceded effective control of the joint venture's activities to for-profit parties and in so doing had conferred significant private benefits on them. As a result, the court concluded that RSS was not operated exclusively for charitable purposes.

The court found the following indicia of for-profit control over the partnership's activities determinative: in the first instance, the court found nothing in the general partnership agreement wherein any of the binding commitments related to the Surgery Center established any obligation that charitable purposes be put ahead of economic objectives in the Surgery Center's operation.

Next, the court found five areas in which there was a lack of formal control for RSS over the joint venture.

First, the court found fault with the 50–50 representation of RSS and the for-profit interests on the governing body of the joint venture. It noted that RSS could exert influence by blocking actions proposed to be taken by the Managing Directors but that RSS could not initiate action without approval of for-profit interests. In the absence of formal majority voting control, the court then looked to the other binding commitments of the parties to determine whether other specific powers or rights conferred upon RSS might mitigate or compensate for its lack of majority control.

Second, the court considered the arbitration process set forth in the general partnership agreement. It noted that under the agreement, arbitrators were not required to take into account any charitable or community benefit objective but only to apply substantive state law. The court found that the arbitration process provided RSS with no assurance that charitable objectives would govern the outcome and, accordingly, that the arbitration process did not significantly mitigate RSS's lack of majority control.

Third, the court looked to the management agreement between the operating partnership and the for-profit management company. It noted that the agreement conferred broad powers on the for-profit manager, reserving to the medical advisory group of the operating partnership only the authority to

make all medical decisions. The court also noted that the management agreement was based on a percentage-of-revenues compensation methodology that created an incentive to manage the Surgery Center so as to maximize profits; that the operating partnership was locked into the management agreement for at least 15 years; that RSS could not be assured of any remedy if the for-profit management company were managing the Surgery Center in a manner inconsistent with the charitable purposes; that there was no requirement in the management agreement that the manager will be guided by any charitable or community benefit, goal, policy, or objective; and that there was some question whether the management agreement was negotiated at arm's length.

Fourth, the court found fault with the composition of the medical advisory group of the joint venture. The court noted that the partnership agreement delegated authority for making decisions about care and treatment of patients and other medical matters to the medical advisory group and that only three of the six members were selected by the general partnership, with the other three selected by one of the limited partners. The court found it ''telling'' that the medical advisory group was composed entirely of limited partners of the operating partnership, virtually all of whom received common stock in the for-profit enterprise.

Fifth, the termination of quality assurance activities troubled the Tax Court. The court noted that RSS originally had an agreement to provide quality assurance services to the Surgery Center but that the agreement was terminated after the first year, and there was no evidence in the record that a new agreement was ever negotiated. The court took the position that the termination of the quality assurance agreement vividly evidenced RSS's lack of effective control over vital aspects of the Surgery Center's operations.

The court also found no basis in the administrative record for concluding that in the absence of formal control, RSS possessed significant informal control by which it exercised its influence over the Surgery Center's activities. The court noted that the administrative record did not establish that RSS had the resources or ability effectively to oversee or monitor the Surgery Center's operations. The court noted the near-total lack of resources and minimal staff of Redlands Surgical Services.

RSS argued that its influence in the partnership was evidenced by changes in the operation of the Surgery Center after the partnership agreement became effective. The court found, however, that the record did not support RSS's contentions. For example, RSS had asserted that after it acquired an interest in the operating partnership, the decision to perform surgery at the Surgery Center was changed from an economic to a medical decision and, as a result, RSS achieved its goal of providing complete access to freestanding ASC care for all members of the Redlands community without regard to their ability to pay. The court, however, found that the assertion was not supported by the record.

The court also noted with concern that the Medi-Cal patient load at the Surgery Center was only 0.8 percent of total procedures. The court was unconvinced that low-income individuals did not typically seek the types of services provided by the Surgery Center. It stated that this fact provided no independent basis for establishing RSS's charitable purposes in its involvement with the Surgery Center. The court stated that the ''activities of Redlands Hospital in effecting some negligible degree of Medi-Cal coverage at the Surgery Center and in increasing the number of managed care contracts do not provide a basis for establishing petitioner's exemption.''

Finally, with regard to RSS's assertion that there are a number of ways in which Redlands Hospital has integrated its activities with those of the Surgery Center, the Court found that while there may be cooperation between the Surgery Center and Redlands Hospital, there is nothing in the record that suggests that the cooperative activities were more than incidental to the for-profit orientation of the Surgery Center's activities.

After examining the indicia of control, the court also considered the competitive restrictions on RSS and the market advantages to the for-profit entities involved in the joint venture. The court stated that by entering into the general partnership agreement, Redlands Health Systems restricted its future ability to provide outpatient services at Redlands Hospital or anywhere else without the approval of the for-profit partner. In addition, the general partnership agreement restricted the parties and their affiliates from providing outpatient surgery services and procedures that were not specifically authorized to be provided at the Surgery Center by the agreement. As a result, the court found that Redlands Health Systems restricted its ability to assess and serve community needs for outpatient services until the year 2020. The court concluded that ''[i]t is difficult to conceive of a significant charitable purpose that would be furthered by such a restriction.''[148]

With regard to market advantages, the court found that both RSS and the for-profit enterprise realize mutual competitive benefits by availing themselves of each other's resources and eliminating sources of potential competition for patients. While noting that there is no *per se* proscription against the nonprofit organization's entering into contracts with private parties to further charitable purposes on mutually beneficial terms, the court found that by virtue of its effective control over the Surgery Center, the for-profit affiliates operated it as a profit-making business, with significantly reduced competitive pressures from Redlands Hospital and ''largely unfettered by charitable objectives that might conflict with purely commercial objectives.'' The court concluded that the net result to the for-profit enterprise was a non-incidental advantage that constituted a prohibited private benefit.

Based on all the facts and circumstances described above, the Tax Court held that RSS had not established that it operated exclusively for exempt

148. *Id*. at 89.

purposes within the meaning of the Code. The court noted that it did not view any one factor as crucial but that when all of the factors present were considered in their totality, they compel the conclusion that by ceding effective control over its operations to for-profit parties, RSS impermissibly served private interests.

The court concluded its opinion by examining RSS's claim that even if it didn't qualify for tax exemption on a stand-alone basis, it did qualify for exemption under the integral part doctrine. The court noted that the integral part doctrine is not codified but rather is an outgrowth of judicial opinions, rulings, and regulations and that its contours are not clearly defined. After reviewing relevant case law, including the *Geisinger Health Plan*[149] litigation, the court stated that RSS had failed to establish that the Surgery Center's patient population overlaps substantially with Redlands Hospital. The court pointed out that the Surgery Center performed ambulatory surgery on a for-profit basis for its own patients well before RSS was ever involved and that presumably it had continued to do so.

The court went on to state that even if the patient populations of the Surgery Center and Redlands Hospital did substantially overlap, this would not be sufficient to confer exemption on RSS under the integral part doctrine. The court stated that in all of the legal precedents it had cited, the organization had been under the supervision or control of an exempt affiliate or otherwise limited in its purposes to advancing the interests of the affiliated exempt entity and serving no private interests. By contrast, the court found that RSS's sole activity (the Surgery Center) was effectively controlled by for-profit parties. The court found that the operations of the Surgery Center were plainly not dedicated to advancing the interests of RSS's exempt affiliates other than as those interests might coincide with the commercial interests of the for-profit partners. The court found that RSS's activity was not so substantially and closely related to the exempt purposes of its affiliates that those private interests could be disregarded, and, accordingly, RSS was not entitled to exemption under the integral part doctrine.

Redlands Surgical Services appealed the decision of the Tax Court to the Ninth Circuit Court of Appeals. The appellate court denied the petition for review in a per curiam decision. It adopted the Tax Court's holding that Redlands Surgical Services had ceded effective control over the operations of the partnerships and the surgery center to private parties, thereby conferring impermissible private benefit. As a result, it held that Redlands was not operated exclusively for charitable purposes. It also affirmed the Tax Court's conclusion that the benefit conferred on private parties by the surgery center's operations prevents Redlands from qualifying for charitable tax-exempt status under the integral part doctrine.[150]

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149. *See* § 9.2, text accompanied by notes 39–49.
150. *Redlands Surgical Services v. Commissioner*, 242 F.3d 904 (9th Cir. 2001).

Redlands should not be read as the beginning of the end for ancillary joint ventures. The Tax Court, despite its conclusion that RSS fails to qualify for tax exemption as a charitable organization, expressly states that it is not turning thumbs down on all such ventures. In its opinion, the court states:

> There is no per se proscription against a nonprofit organization's entering into contracts with private parties to further its charitable purposes on mutually beneficial terms, so long as the nonprofit organization does not thereby impermissibly serve private interests.[151]

Recall also the statement contained in the IRS's benchmark GCM on joint ventures. After opining that certain types of joint ventures would result in *per se* private inurement, the Service made it clear that it did not intend to call into question all joint ventures between exempt organizations and private parties:

> Nothing herein should be read to imply that a typical joint venture that involves true shared ownership, risks, responsibilities, and rewards and that demonstrably furthers a charitable purpose should be met automatically with suspicion or disapproved merely because physician-investors have an ownership interest.[152]

The central theme of both the IRS's whole-hospital joint venture revenue ruling and the Tax Court's decision in *Redlands* is control. Control was critical because of its effect on the ability of the exempt organization to ensure that it is acting exclusively in furtherance of charitable purposes.

It is important to distinguish between the potential problems of impermissible private benefit and private inurement, and operation for a substantial nonexempt purpose. It is always necessary to ensure that a transaction between a charitable organization and private parties does not result in excessive private benefit or inurement of the charity's funds to the private parties. If either occurs, exemption is subject to denial or revocation. However, even if all of the terms of the deal are reasonable and at fair market value, it is still possible to operate for a substantial nonexempt purpose (e.g., the advancement of the interests of the private parties over and above the public interest served by the charitable organization). The Treasury regulations provide that an organization will be regarded as operated exclusively for one or more exempt purposes only if it engages primarily in activities that accomplish one or more of such exempt purposes specified in the Code for charitable organizations.[153] An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose. The United States Supreme Court has stated that "the presence of a single . . . [nonexempt] purpose, if substantial in

151. *Redlands Surgical Services v. Commissioner*, 113 T.C. 47, 92 (1999) (citing *Plumstead Theatre Society v. Commissioner*, 75 F.2d 244 (9th Cir. 1982), *Broadway Theatre League v. United States*, 293 F. Supp. 346 (W.D. Va. 1968)).
152. Gen. Couns. Mem. 39862.
153. Reg. § 1.501(c)(3)-(c)(1).

nature, will destroy the exemption regardless of the number or importance of truly . . . [exempt] purposes.''[154]

Two examples of the application of this principle were cited by the IRS and the Tax Court. In one case, the Tax Court concluded that an organization did not qualify as a charitable organization because its activities performed as co-general partner in for-profit limited partnerships substantially furthered a nonexempt purpose, and serving that purpose caused the organization to serve private interests.[155] The organization entered into partnerships as a 1 percent co-general partner of existing limited partnerships for the purpose of splitting the tax benefits with the for-profit partners. Under the management agreement, the organization's authority as co-general partner was narrowly circumscribed. It had no management responsibilities and could describe only a vague charitable function of surveying tenant needs.

In another case, several for-profit ''est'' organizations exerted significant indirect control over est of Hawaii, a nonprofit entity, through contractual arrangement. The Tax Court concluded that the for-profits were able to use the nonprofit as an ''instrument'' to further their for-profit purposes. Neither the fact that the for-profits lacked structural control over the organization nor the fact that amounts paid to the for-profit organizations under the contracts were reasonable affected the court's conclusion. Consequently, this organization was held to not qualify as a charitable entity.[156]

Thus, the element of control is important because without it, the organization cannot ensure that it will not be operated for a substantial nonexempt purpose. The key to this analysis is the question of substantiality. The approach used by both the IRS and the Tax Court involved a facts-and-circumstances analysis. There were no objective *per se* rules established. Based on the substantial body of IRS guidance prior to *Redlands* that approved joint ventures in which governance of the joint venture was by a group with 50–50 representation from the charitable and private parties, it appears that formal majority control may be necessary only in those cases where there is not sufficient charitable activity occurring in the nonprofit participant to counterbalance the effect of the presence of a nonexempt purpose.

The presence of a nonexempt purpose is not, by itself, fatal to exemption. The Code deals with this issue by taxing the income generated by the activity born of the nonexempt purpose. Thus, an activity based upon an insubstantial nonexempt purpose may generate unrelated business taxable income but not threaten exemption.

Based on the whole-hospital joint venture revenue ruling and *Redlands* approaches, then, the following spectrum of control rights (individually or in

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154. *Better Business Bureau v. United States*, 326 U.S. 279, 283 (1945).
155. *Housing Pioneers v. Commissioner*, 65 T.C.M. (CCH) 2191 (1993), *aff'd*, 49 F.3d 1395 (9th Cir. 1995), *amended*, 58 F.3d 401 (9th Cir. 1995).
156. *est of Hawaii v. Commissioner*, 71 T.C. 1067 (1979), *aff'd* in unpublished opinion, 647 F.2d 170 (9th Cir. 1981).

combination) should be considered for a joint venture between a charitable organization and private interests. Generally, the fewer and less substantial the other charitable activities carried on by the organization (other than the joint venture), the greater will be the need to maintain tighter control for the exempt organization.

- *Formal majority control*. This means that the charitable organization has at least a majority representation (greater than 50 percent) on the governing body of the joint venture and that this majority cannot be defeated by requiring supermajority voting or quorum counts such that the private interest can effectively block the acts of the charitable organization. This would likely be necessary in the case of an organization whose sole or principal activity is participation in the joint venture (assuming, after *Redlands*, that it could qualify for exemption in the first place).
- *50–50 representation with certain unilateral rights*. In joint ventures involving charitable organizations that already are recognized as tax-exempt and have an established track record of charitable activities other than the joint venture—e.g., a hospital, a home health agency, a university, a religious organization—it should be sufficient to have 50–50 voting representation with the for-profit party on the joint venture governing board as long as the charitable organization can cause certain actions to be carried out by the joint venture through its unilateral direction. This ensures that the organization could block any proposal by the for-profit party that might unduly benefit it or skew the joint venture away from the attainment of charitable objectives. It also ensures that the organization can unilaterally cause certain charitable activities to occur, just as it could if it had actual voting control. The Tax Court in *Redlands* suggested these unilateral powers could include the power to (1) cause the joint venture to respond to community needs for new health services; (2) modify the delivery or cost structure of its health services to better serve the community; and (3) terminate the management agreement if the manager were determined to be managing the joint venture in a manner inconsistent with charitable objectives.
- *Restrictions on management agreement*. Also important to the control equation is the degree of control the exempt organization has over the for-profit manager. Because the manager generally has day-to-day control over the joint venture's activities, the Service is concerned that the manager can effectively prevent the joint venture from furthering charitable objectives. The level of protections necessary will again vary depending upon the degree of substantiality of the joint venture relative to the organization's other charitable activities. Restrictions to consider include (1) *term limits*: 5- to 10-year initial term, terminable for cause,

renewable only through mutual agreement; (2) *selection of personnel*: right of exempt organization to select or veto choice of personnel to serve as manager; and (3) *fee mechanism*: payment by flat fee payment by percentage of revenues with a collar (decreasing percentage at higher revenue levels), or counting charity care as revenues for purpose of determining fee based on percentage of revenues. In order to terminate the management agreement for cause for failure to pursue charitable objectives, it is advisable to include objective performance benchmarks for the manager tied into the IRS's community benefit standards, with a legitimate opportunity to cure.

- *Dispute resolution*. Another mechanism for preventing the undue exercise of control by the for-profit party is a dispute resolution provision that permits the charitable organization to attempt to remedy grievances short of litigation. In the Tax Court's view, this provision should include language that gives priority to the fulfillment of charitable purposes in resolving the dispute. This should be coupled with a buy–sell or withdrawal right in the event that the charitable organization determines that the venture poses a threat to its tax exemption.
- *Quality assurance*. The ability of the charitable organization to ensure that the services being provided by the joint venture are appropriate and sufficient to meet the needs of the patients served was deemed significant by the Tax Court. This right could be effected through an agreement between the joint venture and the charitable organization under which the organization would be the provider of quality assurance services. It could also be a specific duty of the manager (subject to termination if breached), or it could be included in the duties of a medical director supplied by agreement with the charitable organization.
- *Covenants not to compete*. The Tax Court was troubled by the agreement of *Redlands* to restrict its ability to expand its existing services at Redlands Hospital or to acquire additional facilities without the approval of its for-profit partner and the consequent effect on its ability to serve community needs.[157] Accordingly, such covenants should be narrowly tailored to achieve the minimum protection necessary to make the joint venture viable.

As discussed above, the degree of substantiality of a joint venture activity will vary depending upon whether the joint venture participant is a newly organized nonprofit corporation seeking recognition of exemption, with its sole activity being participation in the joint venture (as was the case in *Redlands*), or whether the joint venture participant is an established charitable organization that carries on a broad program of charitable activity (such as an

157. *See supra* note 114 and accompanying text.

acute-care community hospital or a college), or whether it falls somewhere in between. At this time, greater risk levels are present when a new, sole-purpose organization is used, and in such cases, far greater control should be present in the exempt organization. Other alternatives include the use of a for-profit taxable subsidiary of the exempt organization as the joint venture participant (greater protection and greater flexibility at the price of having to pay taxes) or an LLC subsidiary of the exempt organization (offers liability protection, but activities will be attributed to the parent under the IRS's aggregate theory of partnerships; the IRS is also considering whether sole-member LLCs must independently seek exemption).

Both the IRS and the Tax Court made clear the necessity that the joint venture documents expressly state the charitable purposes sought to be obtained by the joint venture. Each took the position that the documents should establish an obligation that charitable purposes be put ahead of economic objectives. This is a particularly sensitive matter where, as was the case in *Redlands*, the joint venture is taking over operation of a preexisting facility that until that time had been owned and operated by private interests for purely pecuniary benefit and now will be operated in furtherance of charitable purposes. There remains some question whether this expectation is consistent with the fiduciary duties of partners in a partnership under state law.[158] Nevertheless, to satisfy this criterion, appropriate language should appear in at least the operating agreement and the management agreement.

The community benefit standard established by the IRS in 1969 is dynamic in nature, and charitable organizations will have a fair amount of leeway to demonstrate how the joint venture will satisfy the charitable purpose of the promotion of health. It will be helpful, however, to consider the community benefit benchmarks for joint ventures previously suggested by the IRS.[159] They are an expansion of healthcare resources, creation of a new provider, improvement in treatment modalities, or reduction in cost.

Also, in its FY 1999 CPE Text, the IRS included a chapter setting forth its analysis of whole-hospital joint ventures, based upon its approach in the 1998 revenue ruling. At the end of that chapter, the IRS poses 24 questions that it would ask to discern "whether the partnership furthers charitable purposes and whether private benefit to the for-profit partners and/or manager is greater than incidental." That list of 24 questions is a useful road map in planning any exempt organization joint venture transaction.[160] It is important to remember that this is a facts-and-circumstances approach, and as the Tax Court said in *Redlands*, no single factor is crucial.

Perhaps the best commentary on the status of ancillary joint ventures after Revenue Ruling 98-15 and the *Redlands* decision is the closing paragraph of

158. This issue was addressed previously by the IRS in Gen. Couns. Mem. 39546.
159. Gen. Couns. Mem. 39862.
160. *See* Appendix N.

the article on whole-hospital joint ventures contained in the IRS's FY 1999 CPE Text:

> Rev. Rul 98-15 does not seek to curb all joint ventures between for-profit and tax exempt hospitals. It allows tax exempt hospitals the flexibility to partner with another organization or corporation. However, it does require that charitable purposes supersede profit maximization purposes. It dictates that health care services benefit the community as a whole. It obliges exempt organizations that enter into such partnerships to ensure that the partnership furthers charitable purposes; and does not result in greater than incidental private benefit to the taxable partner nor to other private parties. Thus, while the factual scenarios discussed in the revenue ruling represent newly evolved developments, the reasoning of the revenue ruling is not a departure from existing law.

(b) Ambulatory Surgery Center Ruling

The IRS approved a proposed joint venture to operate an ambulatory surgery center involving a public charity and nonexempt entities (physicians), and it serves as an illustration of the types of ventures that will be found to not jeopardize the tax-exempt status of the charitable organization.[161]

The charitable organization involved was a supporting organization (SO) that operated a community-based healthcare system. SO and its affiliates provided hospital, physician, home health, hospice, nursing home, and other healthcare services. Other functions constituted the primary activities of SO.

In order to better serve community needs, SO and a group of local physicians formed a limited liability company (LLC) to own and operate an ambulatory surgery center. The ruling stated that SO formerly owned and operated the center but somehow the center became owned by a for-profit subsidiary of SO (FP). Inasmuch as involvement in the center was not the primary activity of SO, this is an *ancillary joint venture*.

SO acquired a 70 percent ownership interest in LLC. The physicians acquired the remaining 30 percent interest. SO was to reduce its percentage interest in LLC by selling membership interests to board-approved purchasers until its percentage interest was 51 percent. Profits and losses were to be allocated to the members based on membership percentage.

LLC leased the center from FP. It also so leased the equipment used in the center pursuant to a separate lease agreement. SO represented to the IRS that both of the lease agreements were negotiated at arm's length, and that they reflect the fair market rental value of the facilities and the fair market purchase value of the equipment.

The operations of LLC were conducted pursuant to the terms of an operating agreement. That agreement provided that the purpose of LLC is to lease and/or own and operate an ambulatory surgery center in furtherance

161. Priv. Ltr. Rul. 200118054.

of charitable purposes by promoting health for a broad cross section of the community. It further provided that LLC and its board of directors will at all times cause LLC to be operated for these purposes and that this duty overrides any duty to operate LLC for the benefit of its members. SO represented that this override is enforceable under state law.

LLC was managed on a day-to-day basis by a board of directors. The total number of directors was six. SO appointed two of the directors; the physician members elected four of the directors. Each director appointed by SO had three votes on all matters coming before the board. Each of the other directors had one vote. Board decisions were by majority vote. The directors appointed by SO were community leaders experienced in healthcare matters, were not on the medical staff of the hospital or on the medical staff of the center, and were not otherwise engaged in business transactions with SO, LLC, or the center.

LLC had a charity care policy that is consistent with SO's charity care policy. This policy will be made known to potential patients. Charity care will not be included in bad debt. The percentages of patients who were expected to be served by LLC, as to indigents, Medicare and Medicaid patients, self-pay patients, and the like, were approximately equivalent to the percentages of patients served at the center when it was owned by SO.

Physician privileges at LLC's facility were not dependent on ownership of a membership interest in LLC. Medical staff members apply for and are granted privileges at the facility based on credentialing criteria. LLC did not have any employees and no plans for any; SO provided support services to LLC. SO leased nursing, clinical, administrative, clerical, and other personnel to LLC. Medical staff members were independent practitioners. Professional services were billed separately by the independent practicing medical staff members providing the service.

The IRS began the analysis by emphasizing three fundamental points of law: the promotion of health is a charitable purpose, whether a healthcare organization promotes health in a charitable manner is determined under the community benefit standard, and the activities of a partnership are attributed to a tax-exempt member for purposes of application of the *operational test*.

The IRS said that a charitable organization may form and participate in a partnership, including a limited liability company, and meet the operational test if (1) participation in the partnership furthers a charitable purpose and (2) the partnership arrangement permits the exempt organization to act exclusively in furtherance of its exempt purposes and only incidentally for the benefit of for-profit partners. The agency also said that, based on its 1998 revenue ruling, whether a nonprofit organization, the principal activity of which is the ownership of a membership interest in a limited liability company that is engaged in healthcare activities, satisfies the community benefit standard depends on all of the facts and circumstances.

In this case, the IRS ruled that, following the formation and operation of LLC, SO will continue to be primarily involved in furthering the needs of the exempt hospital system and its tax-exempt entities. Also, its participation in this venture was ruled to further its exempt purposes. SO's participation in LLC and operation of the ambulatory surgery center was said to promote health for the community. The structure of LLC and operation of the center was said to allow SO to act exclusively in furtherance of charitable purposes with no undue private benefit to the physician members.

As is the case with other joint ventures, the IRS focused on *control*. As noted, SO will always own at least 51 percent of LLC. It will have 6 of the 10 votes on LLC's board of directors. Because a majority of votes is needed to approve decisions, SO will exercise effective control over the major decisions of LLC and over the operations of the center. This control will ensure that the assets SO will own through LLC and the activities it will conduct through LLC at the center will be used primarily to further tax-exempt purposes. Also, the IRS reiterated that the operating agreement of LLC provides that the duty of its members and board is to operate LLC in a manner that furthers charitable purposes and that this duty overrides any duty to operate LLC for the financial benefit of its members.

Similarly, the IRS ruled that a public charity could enter into an ancillary joint venture with for-profit corporations for the purpose of financing small businesses for the benefit of low-income individuals without jeopardizing its tax-exempt status or incurring unrelated business income.[162] The agency observed that the venture (structured as a limited liability company) will be operated in conformity with its whole-entity joint venture principles.[163]

(c) IRS Revenue Ruling

The IRS finally made good on its promise to issue precedential guidance regarding these types of joint ventures when, in 2004, it issued formal guidance as to the tax consequences of public charities' involvement in ancillary joint ventures, ruling that a public charity in this type of arrangement with a for-profit entity will not lose its tax-exempt status if the involvement is an insubstantial part of its total operations and will not be subject to unrelated business income taxation if the charity retains control over the partnership arrangement and operations that constitute one or more related businesses.[164] Although this revenue ruling did not specifically address a joint venture with a healthcare scenario, it provides ample guidance to healthcare providers on what the IRS will find acceptable in these ventures.

This guidance concerned a tax-exempt university that offered, as part of its educational programs, summer seminars to enhance the skill level of

162. Priv. Ltr. Rul. 200351033.
163. *See* § 22.9.
164. Rev. Rul. 2004-51, 2004-1 C.B. *See* Appendix P.

elementary and secondary school teachers. To expand the reach of these seminars, the university, along with a for-profit company, formed a limited liability company (LLC), classified as a partnership for federal tax purposes. The for-profit company specialized in the conduct of interactive video training programs. The sole purpose of LLC, as stated in its governing instruments, is to offer teacher training seminars at locations off the university's campus, using interactive video technology.

The university and the for-profit company each hold a 50 percent interest in LLC, which is proportionate to the value of their respective capital contributions to LLC. The governing documents of LLC provide that all returns of capital, allocations, and distributions are to be made in proportion to the members' respective ownership interests. The university's participation in LLC is an insubstantial part of its activities.

Its governing documents provided that LLC is managed by a governing board comprised of three directors selected by the university and three directors selected by the for-profit company. LLC arranges and conducts all aspects of the video teacher training seminars, including advertising, enrolling participants, arranging for the necessary facilities, distributing the course materials, and broadcasting the seminars to various locations. LLC's teacher training seminars cover the same content that is covered in the seminars that the university conducts on its campus. School teachers participate through an interactive video link at various locations, rather than in person.

LLC's governing documents grant the university the exclusive right to approve the curriculum, training materials, and instructors, and to determine the standards for successful completion of the seminars. The for-profit company is granted the exclusive right to select the locations where participants can receive a video link to the seminars and to approve other personnel (such as camera operators) necessary to conduct the video seminars. All other actions require the mutual consent of the university and the for-profit company.

The governing documents require that the terms of all contracts and transactions entered into by LLC, with the university, the for-profit company, or any other party, be at arm's length and that all contract and transaction prices be at fair market value determined by reference to the prices for comparable goods or services. These documents limit LLC's activities to the conduct of the teacher training seminars and require that LLC not engage in any activities that would jeopardize the tax-exempt status of the university. LLC operates, in all respects, in accordance with its governing documents.

The IRS ruled that the university's activities conducted through LLC constituted a business that was substantially related to the exercise and performance of the university's purposes and functions. Even though LLC arranges and conducts all aspects of the teacher training seminars, the university alone approves the curriculum, training materials, and instructors, and determines the standards for successful completion of the seminars. The fact that the

for-profit entity selects the seminar locations and approves the other personnel was held not to change the conclusion that the seminars are a related business.

The seminars are conducted using interactive video technology and embrace the same content as the seminars conducted by the university on its campus. LLC's activities expand the reach of the university's teacher training seminars. Therefore, the IRS concluded that the manner in which LLC conducts the seminars contributes importantly to the accomplishment of the university's educational purposes; the activities of LLC are substantially related to the university's educational purposes. Thus, the university was not required to pay any unrelated business income tax on its distributive share of LLC's income.

This ruling did not resolve all the federal tax issues as to public charities in ancillary joint ventures. It did demonstrate that the IRS agrees that an exempt organization in a joint venture can retain control over venture activities in ways other than by means of the composition of the joint venture vehicle. Inasmuch as the involvement of the university in LLC is insubstantial, there could not be an issue as to the presence of undue private benefit. Likewise, because the activities of LLC were deemed to be inherently educational, the income flowing to the university could not, under the general flow-through rules, be unrelated business income.

The question remains, therefore, as to the tax consequences when the primary operations of the exempt organization are in the venture (the second type of joint venture referenced above). Even if the activity in the venture is related, it would seem that, if the public charity ceded its authority to the for-profit co-venturer, exempt status would be an issue because of application of the private benefit doctrine. Also, the IRS seemed to say that if the public charity ceded control over the venture to the for-profit company, the business in the venture would be converted to an unrelated business, even if the business remained inherently related. Further developments in this area must be awaited as the tax policy regarding these types of ventures is being shaped.[165]

At the same time, a number of questions are left unanswered. First and foremost is the question of how to determine whether a joint venture's activities will be considered a substantial part of an exempt organization's overall activities. The definition of *substantial* in this context, as in other tax contexts, is unclear and open to debate. It is also unclear whether the IRS would permit an exempt organization to have less than 50 percent voting control over the governance of a joint venture as long as other protections were

165. The IRS ruled that a tax-exempt hospital may participate in a joint venture in furtherance of its healthcare purposes and thus without loss of exemption, because the partnership and management agreements involved provided that charitable purposes override other purposes (Priv. Ltr. Rul. 200436022).

in place to ensure that the organization would be operating in furtherance of its charitable purposes. Such a conclusion appears to be well supported by the analysis of the courts in the *Redlands* and *St. David's* cases[166]; however, this ruling fails to address such a scenario. A similar question arises when an exempt organization has a clear minority position, akin to an investment, in a joint venture. Arguably, the joint venture standards set forth in this ruling should not apply and the exempt organization would address this scenario as a prudent investor, just as it would with any other investment. Some commentators have also pondered whether, in a healthcare context, a joint venture's governing documents would have to require satisfaction of the community benefit standard or the provision of a particular level of charity care to ensure that the exempt organization's distributive share of income was not subject to UBI taxation.

§ 22.12 SINGLE-MEMBER LIMITED LIABILITY COMPANIES

Tax-exempt healthcare organizations, and tax-exempt organizations in general, are making many creative uses of single-member limited liability companies. As noted, a single-member liability company (SMLLC) is a disregarded entity for federal tax purposes, so an SMLLC with an exempt organization as the member is not treated as a separate entity for tax purposes and the exempt organization regards the economic activity of the SMLLC as its own.[167]

Instances of use of the SMLLC in the healthcare context follow:

- A tax-exempt healthcare system, which owns a noncharitable business, sponsors a 403(b) plan for the benefit of its employees; inasmuch as the business is operated in an SMLLC, the IRS ruled that the employees of the business are to be treated as employees of the system to facilitate their participation in the plan.[168]
- A tax-exempt hospital participated in a joint venture, by use of an SMLLC, in furtherance of its healthcare purposes.[169]

As guidance for other applications of this body of law in the healthcare context, the following are instances of use of the SMLLC in the tax-exempt organizations setting in general:

- A charitable organization established an SMLLC to acquire and operate parking facilities to be used to benefit a city, with operation of the

166. *See* § 22.9.
167. *See* § 22.4, text accompanied by *supra* note 60.
168. Priv. Ltr. Rul. 200341023. These tax-deferred annuity programs are available only to employees of charitable entities and governmental educational institutions (*see* § 28.5(b)).
169. Priv. Ltr. Rul. 200436022.

facilities considered by the IRS as a function of the organization that is relieving the burdens of government.[170]

- A charitable organization transferred parcels of real property, previously contributed to it, to SMLLCs, for the purpose of sheltering the organization and the other properties from any legal liability that may arise from any of the properties; the organization nonetheless reflects the gift properties on its annual information return as if it owned them directly.[171]
- A tax-exempt museum, organized as a private operating foundation,[172] owned and operated a racetrack and a campground; the IRS ruled that these activities were functionally related businesses.[173]
- A public charity, with the objective of constructing, owning, and leasing student housing for the benefit of a tax-exempt college, developed and operated the project through an SMLLC; in this fashion, it issued taxable and tax-exempt bonds and provided temporary construction jobs and permanent employment opportunities in the community.[174]
- A charitable organization that accorded educational opportunities (and housing) to low-income and other students provided facilities for various tax-exempt colleges; the ownership and operation of each facility were placed in separate SMLLCs.[175]
- A public charity established an SMLLC to finance small businesses for the benefit of low-income populations, to enable it to issue equity interests to investors.[176]
- A private operating foundation expanded its activities to include control over and management of, by means of an SMLLC, a school of a tax-exempt university.[177]
- A tax-exempt trade association conducted a series of trade shows; rather than conduct the shows itself (because of concerns about legal liability), the association operated the shows by means of an SMLLC.[178]

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170. Priv. Ltr. Rul. 200124022. Lessening the burdens of a government is a charitable purpose. *See* Tax-Exempt Organizations § 7.7.
171. Priv. Ltr. Rul. 200134025.
172. This is a form of private foundation described in IRC § 4942(j)(3). In general, *see* Private Foundations § 3.1.
173. Priv. Ltr. Rul. 200202077. *See* § 5.9, paragraph accompanied by note 257.
174. Priv. Ltr. Rul. 200249014.
175. Priv. Ltr. Rul. 200304036.
176. Priv. Ltr. Rul. 200351033.
177. Priv. Ltr. Rul. 200431018.
178. Priv. Ltr. Rul. 200510030.

- A public charity operating a mobile-home park, by means of an SMLLC, was held by the IRS to be engaging in charitable activities because it was providing affordable housing to the poor and distressed.[179]

179. Priv. Ltr. Rul. 200642009. *See* § 1.6.

CHAPTER TWENTY-THREE

Integrated Delivery Systems

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§ 23.1 INTRODUCTION

Integrated delivery systems (IDSs) are, simply stated, vehicles for the integration of hospital services with physician services in an effort to control the cost, accessibility, and quality of patient care. As with corporate reorganizations of hospitals in the 1980s, nearly every hospital and healthcare system in the country has likely considered or implemented some form of integration. The conceptualization and creation of physician clinics, managed care organizations, hospital–physician joint ventures, and corporate reorganizations have all had an impact on the development of the integrated delivery system strategy. However, the tax exemption problems that arose with those forms of healthcare delivery are present in integrated delivery systems as well.

Integrated delivery systems run the spectrum of integration. They range from a fully integrated delivery system, such as the foundation model, to a minimally integrated delivery system, such as a management services organization (MSO) that may perform only billing and collection services for an assortment of individual physicians. Regardless of the level of integration, the primary tax issue is essentially the same: Does the organization and operation of the integrated delivery system confer prohibited private inurement or impermissible private benefit on the physician participants, thereby jeopardizing the tax exemption of the hospitals or other exempt entities involved? Features of these systems that are most problematic include the compensation of physicians, the acquisition of the physicians' practice assets, and the control over the systems granted to physicians.

After a lengthy study, by the IRS's Office of Chief Counsel, of the proper treatment to be afforded to physician clinics seeking recognition of exemption as charitable organizations, the IRS received the application of the Friendly Hills Healthcare Foundation, a foundation-model integrated delivery system. Many of the same issues that concerned the IRS regarding physician clinics were raised, along with a host of new issues that had not yet been addressed. After reviewing an administrative file best measured in height rather than number of pages, the IRS concluded (in a form of determination letter replete with a thorough description of the facts, analysis of law, and caveats not to violate the Medicare antifraud and abuse laws) that the foundation at issue could qualify for exemption as a charitable organization.[1]

The IRS has not issued formal guidance in this area, but there are available a number of determination letters and internal IRS materials that explain in detail the IRS's analysis and ruling position on the qualification for exemption of various integrated delivery system entities.

§ 23.2 TAX STATUS OF IDS ORGANIZATIONS

(a) The Foundation Model

Under the foundation model of an IDS,[2] a single nonprofit corporation is created to obtain all the assets of a group medical practice or practices, and it may also acquire one or more hospitals. Assets may be acquired by purchase, lease, license, stock transfer, gift, or a combination of the foregoing. The assets would include land and buildings of the clinics and hospitals, fixtures, furnishings, equipment, and inventories, as well as intangible property rights, such as covenants not to compete, third-party payor contracts, an assembled work force, warranty rights, prepaid assets and deposits, utility rights, goodwill, and trademarks and trade names.[3] The services of physicians who will provide medical care are also obtained through either direct

1. Ironically, the Friendly Hills system reverted to for-profit operation a short time later. *Modern Healthcare*, Aug. 15, 1994, at 6.
2. *See*, in general, FY 1994 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook (hereinafter, ''FY 1994 IRS CPE Text''), ch. N; Bromberg, ''The Foundation Model,'' 8 *Exempt Org. Tax Rev*. 335 (Aug. 1993); Levine, ''The Tax Status of Vertically Integrated Health Care Delivery Systems,'' *J. Health & Hosp. L*. 257 (Sept. 1993). There are a variety of other models for integrated delivery systems, including the ''hospital controlled model,'' the ''clinic controlled model,'' and the ''horizontally integrated model'' (in which physicians and hospitals establish a new organization that is jointly owned and controlled by the physicians and the hospital). FY 1994 IRS CPE Text at 213–214. However, the IRS has issued the most detailed guidance for the foundation model. *See also* Peters, ''Healthcare Integration: A Legal Manual for Constructing Integrated Organizations,'' National Health Lawyers Association Focus Series (1995).
3. FY 1994 IRS CPE Text, *supra* note 2, at 215.

employment contracts or independent contractor arrangements, depending on whether state law prohibits lay corporations from practicing medicine.[4] The foundation then becomes the provider of all healthcare services—medical and hospital, outpatient and inpatient. It also enters into all payor contracts, provides all personnel for the system, maintains all assets, and collects all revenues for services rendered.[5]

(i) Tax-Exempt Status of the Foundation. If properly organized and operated, the foundation in an IDS will qualify for exemption from federal income tax as a charitable organization. The foundation will also avoid private foundation status because it will qualify as a public charity as either a public institution, a donative entity, a service provider organization, or a supporting organization.[6]

The current IRS guidelines for qualifying an IDS as a charitable organization are set forth in a lengthy article released as part of the IRS's guidance for its field agents for fiscal year 1994 (hereinafter, ''1994 IRS CPE Text''),[7] as updated by articles issued for fiscal years 1995 and 1996.[8]

In the 1994 IRS CPE Text, the IRS noted that it will look for facts showing that the operation of the foundation will provide sufficient ''community benefit'' rather than serving private interests. This *community benefit standard*[9] stems from the IRS's landmark 1969 ruling[10] and other IRS pronouncements[11]

4. In many states, under the ''corporate practice of medicine'' doctrine, state law will prohibit lay corporations' employment of physicians. Therefore, instead of employing physicians directly, the foundation in an IDS will have to contract with a medical group on an exclusive basis to provide all needed medical services for the entire IDS. The foundation will then compensate the medical group for its professional services by paying it a portion of the capitation it receives from insurers and HMOs. FY 1994 IRS CPE Text, *supra* note 2, at 215; Bromberg, *supra* note 2, at 336 (noting that in states that prohibit the corporate practice of medicine, the foundation model was intended to serve as a provider of medical care and not merely as a facilitator or arranger of care).
5. FY 1994 IRS CPE Text, *supra* note 2, at 213.
6. *See* Chapter 5.
7. FY 1994 IRS CPE Text, *supra* note 2; Peregrine and Broccolo, ''IRS Releases Detailed Position on Exempt Status of Integrated Delivery Systems,'' 8 *Exempt Org. Tax Rev*. 903 (Nov. 1993). Although the FY 1994 IRS CPE Text is prepared for IRS training purposes only and is not legal authority, it nevertheless provides exempt organizations and tax practitioners with useful guidance on those factors that the IRS considers when it analyzes an exemption application (Form 1023) from an IDS. See Appendix A.
8. FY 1995 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook (hereinafter, ''FY 1995 IRS CPE Text''), ch. L. *See*, in general, Peregrine and Broccolo, ''1995 'CPE' Text Provides Valuable Health Care Guidance,'' 10 *Exempt Org. Tax Rev*. 879 (1994). FY 1996 IRS CPE Text, ch. P, Integrated Delivery Systems and Healthcare Update (''FY 1996 IRS CPE Text'').
9. *See*, in general, Chapters 6 and 26.
10. Rev. Rul. 69-545, 1969-2 C.B. 117.
11. E.g., Rev. Rul. 83-157, 1983-2 C.B. 94; IRS Exempt Organizations Examination Guidelines Handbook (IRM 7(10)69) § 333.1 (''Hospital Audit Guidelines''); *see* Appendix E.

analyzing the promotion of health as a charitable purpose. The IRS looks at all the facts and circumstances in determining whether a sufficient community benefit is provided by the foundation, but some factors are particularly helpful in this regard.

First, the IRS will determine whether the IDS facilitates the integration of all medical functions and records for each individual patient. An integrated record-keeping system provides community benefit by eliminating duplication of tests, procedures, and treatments, and yielding greater efficiency and reduced cost to the public.[12]

A second important factor in determining community benefit is whether the IDS has an open medical staff that makes its services readily accessible to Medicaid and charity care patients.[13] The IDS should serve all patients able to pay the cost of their care, including Medicare and Medicaid patients. The emergency room must also be open to the public and must provide emergency care to everyone, without regard to ability to pay. Many of these provisions will be recited in a professional services agreement (PSA) between the foundation and a medical group contracting with it to provide services to the IDS (where the physicians are not employed by the foundation). The IRS will carefully review the contents of the PSA.[14]

A third factor that the IRS will look for in determining public benefit is whether the IDS has associated research and education functions, including health education programs open to the public.[15]

A fourth factor, applied by the IRS with particular strictness in the IDS area, is whether the IDS has a community-based board of directors.[16] For ease of administration, the IRS has established a safe harbor under which it will allow no more than 20 percent of the governing board members of the foundation to represent physicians or other interested parties.[17] For example, a ten-person

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12. FY 1994 IRS CPE Text, *supra* note 2, at 225.
13. *Id*.
14. The IRS has noted as a favorable factor the existence of provisions in a PSA whereby physicians in a medical group agree that they will not discriminate against individual patients, based on ability to pay, at any of the clinic sites or any of the hospitals in the IDS. Additionally, the physicians should agree in the PSA to treat any patient seeking urgent care at any of the IDS clinics, without regard to the patients' ability to pay. Some PSA provisions also require a substantial number of the physicians to render care in hospital emergency rooms without regard to the patients' ability to pay. FY 1994 IRS CPE Text, *supra* note 2, at 223.
15. FY 1994 IRS CPE Text, *supra* note 2, at 226.
16. *Id*. at 227. *See*, in general, Griffith, ''Physician 'Control' and Section 501(c)(3) Status: When a Minority Interest Equals a Majority Interest,'' 10 *Exempt Org. Tax Rev*. 121 (July 1994).
17. This 20 percent limitation appears to be derived from Rev. Proc. 93-19, 1993-11 I.R.B. 1, which provides safe-harbor guidelines where nonexempt entities are providing management services for a facility financed with tax-exempt bonds. Under that Revenue Procedure, not more than 20 percent of the voting power of the governing body of a qualified IRC § 501(c)(3) user of a bond-financed facility may be vested in a nonqualified

board of directors of a foundation should have at least eight community members and no more than two members selected by the medical group that provides physician services to the foundation. The IRS also noted that, to meet the above safe harbor, the bylaws of an IDS organization applying for exempt status should state that no more than 20 percent of its board members may be interested parties or financially related, directly or indirectly, to any owner, partner, shareholder, or employee of the medical group or of other physicians providing services in conjunction with the IRS.[18]

Additionally, any committees or subcommittees of the governing board created to consider the business or charitable aspects of the IDS's operations must be independent and broadly representative of the community, and the 20 percent safe harbor will apply to their membership as well. However, a foundation can create committees to consider solely clinical or professional aspects of the healthcare services to be provided, and these latter committees may contain unlimited physician representation.[19] Some providers have responded to this limit by providing greater physician representation opportunities in management-level committees that are subject to the ultimate authority of a board of directors that meets the 20 percent safe harbor.

In addition to community benefit, the IRS will ensure that the IDS satisfies the other requirements of tax exemption. In that regard, the IRS will review the exemption application to determine whether, under all the facts and circumstances, there is more than incidental private benefit or any private inurement.[20] These issues arise most often in the context of physicians' compensation arrangements with the IDS[21] or in the context of the purchase price paid for the assets or stock of the physicians' medical practice.[22]

Physicians' compensation should be comparable to payment arrangements adopted by other medical groups of similar size and composition in the same geographical area. In general, the IRS will view favorably arrangements establishing compensation as a percentage of the IDS's capitation or adjusted gross revenues, but not as a percentage of net revenues.[23] To avoid private inurement problems, the IRS also prefers that the fee schedule and

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service provider and its directors, officers, shareholders, and employees, and vice versa. This revenue procedure was superseded by Rev. Proc. 97-13, 1997-1 C.B. 632, which retained the 20 percent safe harbor. *See*, in general, § 30.3(d), *infra*.

18. FY 1994 IRS CPE Text, *supra* note 2, at 228. *See also* § 33.4, *supra*.
19. *Id*. at 227.
20. *See* Chapters 4 and 34.
21. FY 1994 IRS CPE Text, *supra* note 2, at 220–221; FY 1995 IRS CPE Text, *supra* note 8, at 161–162. Rev. Rul. 69-383, 1969-2 C.B. 113, lists the factors that the IRS will examine in testing whether a compensation plan results in prohibited inurement.
22. FY 1994 IRS CPE Text, *supra* note 2, at 229–238; FY 1995 IRS CPE Text, *supra* note 8, at 162–169.
23. FY 1994 IRS CPE Text, *supra* note 2, at 221.

physicians' compensation be determined by an independent committee, and that none of the compensation arrangements suggests any dividend-like sharing of charitable assets or expenditures for the benefit of private interests.[24] Physicians' recruitment and retention incentives will be closely scrutinized by the IRS, but may be permitted if they further charitable purposes and are reasonable.[25]

To avoid private inurement issues regarding the adequacy of consideration paid for the physicians' medical practice, the purchase price of assets or stock must result from arm's-length negotiations and must be at or below fair market value,[26] as supported by certified independent appraisals.[27] Determining exactly how to measure fair market value, however, particularly in the case of intangible assets,[28] continues to be a complex and somewhat unsettled issue.[29]

Finally, any recognition of tax-exempt status will be conditioned on the foundation's compliance with the antikickback restrictions contained in the Social Security Act (which prohibits payment of remuneration for the referral of Medicare or Medicaid patients), as well as on compliance with other federal laws.[30]

In the course of granting recognition of tax-exempt status to several integrated delivery systems that utilized the foundation model, the IRS has had occasion to review the foundation model of IDS in some detail and, in particular, to examine the community benefit and private inurement factors outlined above. The following systems received determinations that established the IRS's ruling position in this area. Because each was found to meet the general

24. FY 1994 IRS CPE Text, *supra* note 2, at 232.
25. *See*, in general, Chapter 25; Hyatt, ''Physician Recruitment and Retention for Charitable Hospitals: In the Midst of a Sea Change?'' 6 *Exempt Org. Tax Rev*. (No. 6) 1314 (Dec. 1992).
26. The IRS defines fair market value as the price on which a willing purchaser and a willing seller agree, neither being under any compulsion to buy or sell, and both having reasonable knowledge of the relevant facts. Rev. Rul. 59-60, 1959-1 C.B. 237.
27. FY 1994 IRS CPE Text, *supra* note 2, at 232.
28. *See*, in general, Bromberg, *supra* note 2, at 341–342; FY 1994 IRS CPE Text, *supra* note 2, at 243–236; Peregrine and Broccolo, ''New 'IDS' Determination Letter Offers Promise, Sparks Controversy,'' 7 *Exempt Org. Tax Rev*. (No. 5) 757 (May 1993); Peters, ''A Practical Examination of the IRS and OIG Rules for Integrated Delivery Systems,'' 7 *Exempt Org. Tax Rev*. 765 (No. 5) (May 1993). FY 1995 IRS CPE Text, *supra* note 8, at 176–181, takes the position that, given the impact of the Omnibus Budget Reconciliation Act of 1993, which amended the Ethics in Patient Referral Act (''Stark Law''), it is doubtful whether any substantial value can be placed on intangibles in connection with the acquisition of a physician's interest in a provider of designated health services.
29. For a detailed discussion of the various methods of valuing physician practices, see FY 1995 IRS CPE Text, *supra* note 8, at 162–181.
30. FY 1994 IRS CPE Text, *supra* note 2, at 232–234; FY 1995 IRS CPE Text, *supra* note 8, at 173–175. *See*, in general, Chapter 29; Levine, ''IRS Enforcement of Health Care Laws,'' 6 *Exempt Org. Tax Rev*. (No. 4) 921 (1992); Bureau of National Affairs, ''Anti-Kickback Questions Remain in Second IRS Tax Exempt Ruling for IDS,'' *Health L. Reporter* 429 (Apr. 8, 1993); ''HHS' Thornton Writes IRS' Sullivan,'' 7 *Exempt Org. Tax Rev*. (No. 4) 705 (Apr. 1993).

IDS guidelines established by the IRS, all were granted recognition of exemption as charitable organizations. As is evident in the following discussion, there are considerable similarities in structure and function among these integrated delivery systems.

Friendly Hills

The IRS first granted recognition of tax-exempt status for an IDS to the Friendly Hills Healthcare Foundation (Friendly Hills),[31] a California-based IDS that had as its sole and permanent corporate member the Loma Linda University Medical Center. Friendly Hills proposed to operate what it described as a ''vertically integrated, primary care–driven, regional health care delivery system in a managed care environment.'' To create this integrated system, it entered into an ''assets purchase and donation agreement'' by which it acquired, by bargain sale,[32] the assets of four partnerships and one corporation commonly owned by various partners of the Friendly Hills Medical Group. These assets included a 274-bed general acute care hospital, a medical center, and ten clinic facilities. The purchase of these assets involved a combination of tax-exempt bond proceeds and an installment note, and the purchase price was represented to be at or below fair market value. After the purchase, Friendly Hills proposed to contract with the Medical Group to provide all professional medical services for the IDS. Friendly Hills would provide all assets, management services, and nonphysician support personnel.

Friendly Hills planned to have a ten-member board of directors, of whom no more than two would represent the Medical Group. The remaining members of the board would be independent members of the community and unrelated to the physicians. Substantially all of the compensation to the medical group was to be established on a capitated basis and was represented by Friendly Hills to not exceed reasonable compensation.

Finally, the IRS noted that the medical center proposed to maintain an open medical staff, to continue to operate an emergency room open to the public, and to provide emergency care to anyone without regard to ability to pay. In addition, anyone in immediate need of care could receive treatment at any of the IDS clinics without regard to ability to pay. The IDS would also make a good-faith effort to participate in the federal Medicare and the California Medi-Cal programs in a nondiscriminatory manner.

Based on the foregoing description, the IRS determined that Friendly Hills would qualify as a charitable organization and would be a public

31. IRS Determination Letter issued to Friendly Hills Healthcare Foundation (Jan. 29, 1993). Grant, ''IRS Approves Exemption for Medical Group Practices in Integrated Delivery System,'' 5 *J. Tax. Exempt. Orgs*. 3 (July/Aug. 1993); Peregrine and Broccolo, ''IRS Issues Guidance on Integrated Delivery Systems,'' 7 *Exempt Org. Tax Rev*. 391 (Mar. 1993).
32. *See*, in general, Levine, ''Guidelines on Donations of Medical Practices to Tax-Exempt Hospitals,'' 6 *Exempt Org. Tax Rev*. (No. 6) 1303 (Dec. 1992).

charity.[33] However, this determination letter, like those that would be issued to other integrated delivery systems applying for tax exemption in the future, was conditioned on the applicant's not violating the federal antikickback restrictions contained in the Social Security Act.[34]

Facey Medical Foundation

In early 1993, the IRS granted recognition of tax-exempt status to the Facey Medical Foundation (the Foundation) and gave an advance ruling that the Foundation was expected to qualify as a public charity as a service provider organization.[35] The Foundation had as its sole corporate member UniHealth America (UHA), a tax-exempt charitable corporation. UHA is the sole corporate member of eleven tax-exempt acute care hospitals and one acute psychiatric care hospital. The Foundation's affiliate, a subsidiary of UHA, was to purchase the stock of an existing group medical practice at a price represented to be at or below fair market value, based on independent appraisals and arm's-length negotiations. The Foundation proposed to provide management services and all nonphysician support personnel for the IDS.

There was significant evidence of community benefit. For example, all of the hospitals at which the medical group physicians have admission privileges have open staff policies.[36] A substantial number of medical group physicians were to render emergency room care without regard to the patients' ability to pay. The physicians were to treat patients requiring urgent care at various urgent care centers, without regard to ability to pay. Moreover, the physicians agreed not to discriminate against patients at any of the clinic sites, based on their ability to pay. The Foundation agreed to participate in the federal Medicare and the California Medi-Cal programs in a nondiscriminatory manner. The Foundation also stated that it would provide up to $400,000 per year[37] of charity care during its first two years of operation, and would continue charity care in at least that amount in subsequent years as well. Finally, the Foundation

33. Exemption was based on IRC § 170(b)(1)(A)(iii), which describes entities whose principal purposes or functions are the providing of medical or hospital care or medical education or research.
34. 42 U.S.C. § 1320a-7b(1) and (2). This statute prohibits the payment of remuneration in return for the referral of Medicare or Medicaid patients. In its determination letter to Friendly Hills, the IRS also expressed no opinion concerning the marketability, reliability, or value of the tax-exempt bonds to be issued in the transaction.
35. IRS determination letter issued to Facey Medical Foundation (Mar. 31, 1993). *See*, in general, Peregrine and Broccolo, *supra* note 28.
36. The determination letter noted, however, that the foundation's clinic facilities were not required to have an open medical staff.
37. In determining how the $400,000 of charity care is computed, the foundation will rely on Statement No. 15 (''Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Health Care Providers''), issued by the Principles and Practices Board of the Healthcare Financial Management Association.

agreed to conduct significant programs of clinical research and public health education.

The Foundation will have a ten-member board, of whom two members will be designated by the physicians' medical group. The Foundation's bylaws also state that no more than 20 percent of its board members may be financially related, directly or indirectly, to any shareholder or employee of the medical group.

The medical group is to be compensated for its services with a fraction of the Foundation's adjusted gross revenue (primarily from capitated contracts) in the initial stages. Subsequently, the Foundation will form an ''advisory compensation committee'' to review the medical group's compensation. This committee will be appointed and removed entirely by the Foundation, and no members of this committee will be physicians presently or formerly affiliated with the medical group. Additionally, the IRS noted that physicians' compensation would be determined by arm's-length negotiations and would reflect competitive rates for medical services.

Finally, the IRS noted that a five-member Fee Committee would determine fees not derived from the capitated-basis contract, and would recommend a fee schedule for all services provided to patients. The IRS allowed two members of this Fee Committee to be designated by the physicians' medical group; the other three were designated by the Foundation. The final fee schedule recommended by this committee had to be approved by the Foundation's board of directors.

DMC Centers, Inc

Late in 1993, a Michigan IDS called DMC Centers, Inc., was granted recognition of exemption as a charitable organization and was determined qualified as a supporting organization public charity.[38] DMC Centers was controlled by the Detroit Medical Center, acting as the parent of the DMC healthcare system, which includes six tax-exempt general acute care hospitals and a rehabilitation institute serving an inner-city community with a significant number of uninsured individuals. DMC Centers was formed by Detroit Medical Center to operate various medical clinics previously owned by some of the taxable subsidiaries within the DMC healthcare system. The assets and liabilities of those clinics were transferred to DMC Centers. (The method of transfer was not disclosed.)

The clinics to be operated by DMC Centers have a policy of accepting all patients regardless of ability to pay. DMC Centers employs physicians and other healthcare professionals to staff its clinics. The physicians' employment agreement provides for a specific base compensation, as well as incentive compensation capped at 25 percent of the physicians' base compensation.

38. IRS determination letter issued to DMC Centers, Inc. (Dec. 8, 1993).

The board of directors consists of nine individuals representative of the community, with no more than 20 percent being persons who are compensated for providing services to the IDS.

The Determination Letter noted that DMC Centers will conduct programs of clinical research and public health education programs, in addition to having residents from the nearby graduate medical education programs rotate through the IDS's clinics.

Billings Clinic

In December 1993, the IRS issued a favorable determination letter to the Billings Clinic (the Clinic), recognizing it as a charitable organization that also qualifies as a supporting organization public charity.[39] Its sole corporate member is Deaconess Care Corporation, the tax-exempt holding company for a diversified healthcare system consisting of a charitable acute care hospital, a development foundation, a research organization, and a for-profit entity. The transaction was structured as a purchase of medical group assets and partly as a gift from the medical group to the Clinic.[40] The purchase price was financed by proceeds from tax-exempt bonds. The Clinic represented to the IRS that the purchase price did not exceed fair market value, and it submitted independent appraisals for real property, personal property, and capitalized assets (but not for inventories, accounts receivable, prepaid items, and cash equivalents, which collectively constituted 43 percent of the total purchase price).[41] Although the IRS determination letter contained few details about the Clinic, the attorney for the Clinic stated publicly[42] that it had agreed to a 20 percent limitation on physician directors and had also followed the other IDS informal guidelines issued to date.[43]

Harriman Jones Medical Foundation

The determination letter for the Harriman Jones Medical Foundation (''the Foundation''),[44] issued in February 1994, revealed that this IDS was essentially the same as the Facey Medical Foundation described above. In particular, this Foundation's sole corporate member was UniHealth America (UHA), a charitable corporation that was the sole corporate member of eleven tax-exempt acute care hospitals and one acute psychiatric care hospital. The Foundation

39. IRS determination letter issued to Billings Clinic (Dec. 21, 1993). *See*, in general, Peregrine and Broccolo, ''Billings Clinic and Harriman Jones: New Resources for 'IDS' Tax Planning,'' 9 *Exempt Org. Tax Rev*. 789 (Apr. 1994).
40. Peregrine and Broccolo, *supra* note 39, at 793.
41. *Id*. at 794.
42. Statement of Gerald R. Peters, reprinted in *Tax Notes Today* (Jan. 3, 1994). *See*, in general, Peregrine and Broccolo, *supra* note 39.
43. *See* FY 1994 IRS CPE Text, *supra* note 2.
44. IRS determination letter issued to Harriman Jones Medical Foundation (Feb. 3, 1994).

purchased the assets of the Harriman Jones Medical Group for cash and notes, and assumed certain existing liabilities. After the purchase, the medical group proposed to reorganize into a professional corporation and contract with the Foundation to provide all of its medical services. In turn, the Foundation was to provide all management services and nonphysician support personnel for the IDS.

This Foundation had the same evidence of community benefit as did the Facey Medical Foundation, except that the Foundation promised to provide up to $750,000 per year of charity care during its first two years of operation, and to continue such care at least at that level in subsequent years. The structure of its board of directors and Fee Committee was also identical to that of the Facey Medical Foundation.

Based on the foregoing description, the IRS determined that the Foundation would qualify as a charitable organization and would be a public institution–type public charity.

Rockford Medical Health Services

In April 1994, the IRS granted recognition of tax exemption as a charitable organization to the Rockford Memorial Health Services Corporation (RMHSC) in Illinois and determined that it would be a public institution–type public charity.[45] This IDS consisted of a parent organization (RMC), which was the sole corporate member of RMHSC, and three other entities: (1) Rockford Memorial Hospital; (2) The Rockford Group (which operates community education, healthcare, and other programs); and (3) the Rockford Memorial Development Foundation (which engages in fund-raising for the system). RMHSC created the system by purchasing the assets of the Rockford Clinic (the Clinic), which is owned by about 100 physicians who are all on the medical staff of Rockford Memorial Hospital. The Clinic also owns a taxable HMO called ''CliniCare.''

RMHSC offered significant evidence that it would provide a community benefit. For example, it will employ physicians who will provide medical care, including emergency services, to all segments of the community, without limit and without regard to ability to pay. It will make good-faith efforts to participate in all managed care initiatives of the Medicare and Medicaid programs in a nondiscriminatory manner. In addition, RMHSC will be involved in medical education and scientific research.

The board of RMHSC consisted of 15 persons, of whom 11 were community representatives, 3 were physician representatives, and 1 was the CEO of RMC. Thus, the 20 percent physician safe harbor was satisfied. However, in what may be a broadening of the 20 percent safe harbor rule, the IRS Determination Letter made the following statement pertaining to RMHSC:

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45. IRS determination letter issued to Rockford Memorial Health Services Corporation (Apr. 4, 1994).

> This ruling is based on our understanding that *neither you, your related exempt organizations, or CliniCare* will allow more than 20 percent of the directors on any of those boards of directors to be individuals employed by you or physicians currently or formerly employed or compensated by you or the Clinic. *It is also our understanding that the quorum and committee requirements of these organizations will include similar limitations on the involvement of such financially interested individuals.* (emphasis added)

In this statement, the IRS seemed to be requiring every organization in the IDS to ensure that all of their boards and committees not have more than 20 percent physician representation. Apparently, a quorum to conduct business in these committees must also consist of at least 80 percent community representation.

St. Luke's Medical Associates, Inc

On December 30, 1994, the IRS released another determination letter which recognized tax exemption for St. Luke's Medical Associates, Inc. (St. Luke's) as a charitable organization and as a public institution–type public charity.[46]

St. Luke's was a Missouri nonprofit corporation whose sole governing member was a charitable hospital. The hospital appointed a majority of St. Luke's ten directors and St. Luke's bylaws provided that 80 percent of St. Luke's governing board would at all times be persons with no present or past financial interest or financial relationship, directly or indirectly, with the physicians providing medical services as part of the organization.

St. Luke's operated as an outpatient clinic and it directly employed its physicians, all of whom were primary care physicians. Its physicians were paid no more than reasonable compensation for their services, with compensation levels established by a compensation committee appointed by St. Luke's board and comprised of individuals other than physicians or medical personnel who could benefit from the committee's decisions. St. Luke's board of directors controlled the setting of fees for the physicians' services.

The IDS entity purchased, at fair market value, only the tangible assets and accounts receivable of the physicians it employed; it did not purchase the intangible assets of the physicians' practices.

St. Luke's provided charity care to patients unable to pay, and its determination of charity care was in accordance with Statement 15, ''Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers'' issued by the Principles and Practices Board of the Healthcare Financial Management Association.

St. Luke's was involved with medical education programs, served Medicare and Medicaid patients in a nondiscriminatory manner, did not enter into covenants not to compete with its physicians (a pro-community benefit feature in the IRS's view), and was not a prepaid health plan.

46. IRS determination letter issued to St. Luke's Medical Associates, Inc. (Dec. 30, 1994).

The organization and operations of this IDS entity and the IRS's approval of it fits the pattern of the previously discussed Determination Letters. It suggests that healthcare providers now recognize the IRS's ruling position on exemption for IDS entities and that they are structuring their IDS enterprises accordingly.

Tobey Medical Associates, Inc

On March 15, 1995, the IRS released a determination letter recognizing tax exemption for Tobey Medical Associates, Inc. ("Tobey"), as a charitable organization and as a public charity, because it qualified as a supporting organization.[47]

Tobey was a Massachusetts nonprofit corporation whose single member was Tobey Health Systems, Inc., a tax-exempt parent holding corporation. It also had a sister corporation, Tobey Hospital, Inc., also a charitable organization. Tobey was formed to attract emergency room and other physicians to Tobey Hospital's service area and to manage the business functions of their practices. Although Tobey described itself as a multispecialty group practice, the determination letter indicated that Tobey would not purchase any physician practices. Tobey amended its bylaws to provide that no more than 20 percent of its governing board, and none of its executive committee or compensation committee, would consist of practicing physicians or other persons with a financial interest in Tobey. The main activity of Tobey was to provide physicians to Tobey Hospital. The community served by Tobey Hospital had historically experienced a shortage of physicians and there was a current shortage in several medical specialties. Tobey Hospital's service area qualified as a Health Professional Shortage Area under rules promulgated by the U.S. Department of Health and Human Services. The hospital paid a monthly fee for Tobey's provision of its employed physicians to Tobey Hospital. All Tobey's physician employees, emergency room physicians, and anesthesiologists devoted 100 percent of their time to Tobey Hospital patients; its other specialists devoted some of their time to Tobey Hospital patients and the balance to others. Tobey agreed to provide reasonable care to all persons needing treatment, whether or not patients of Tobey Hospital, regardless of their ability to pay, and agreed not to discriminate against Medicare and Medicaid patients. An independent compensation committee without physician representation would review Tobey's physician compensation arrangements. The physician employees were compensated on the basis of fixed salaries and bonuses that would not exceed 25 percent of total compensation. Bonuses were not based on gross or net revenue and were performance-related.

It is significant that the IRS recognized exemption for this physician corporation in an integrated delivery system. This determination letter also

47. IRS determination letter issued to Tobey Medical Associates, Inc. (Mar. 15, 1995).

offers further support for the ability of physician clinics to be recognized as tax exempt when structured properly. However, it is also important to note that this physician clinic was structured as a nonprofit corporation. The next quantum leap in recognition of exemption for physician clinics was taken by the IRS in a determination letter issued to Marietta Healthcare Physicians, Inc.

Marietta Healthcare Physicians, Inc

The IRS continued with the evolution of tax exemption for physician clinic components of integrated delivery systems when, on October 3, 1995, it issued a determination letter recognizing tax exemption for Marietta Healthcare Physicians, Inc. (''Marietta''), as a charitable organization and as a supporting organization.[48]

The most significant feature of Marietta is its structure. Marietta was incorporated under Ohio's For-Profit Professional Corporation Act. Under that act, a physician clinic must be created as a for-profit professional corporation that is physician controlled and owned in order to satisfy Ohio's corporate practice of medicine doctrine.[49] This requirement had been confirmed by an opinion issued by the Ohio Attorney General. Marietta had a five-person board of trustees comprised of two members of the board of trustees of Marietta Memorial Hospital (MMH), a charitable organization, and three individuals who were administrative personnel of MMH. All of Marietta's trustees were appointed by MMH. The articles of incorporation of Marietta included specific language limiting its activities to one or more exempt purposes sufficient to satisfy the organizational test applicable to charitable organizations. The articles further specified that Marietta was operated exclusively for charitable purposes, including furthering the charitable purposes of MMH. The articles also contained a conflict-of-interest policy, as well as a prohibition of the receipt by any of the physician shareholders of the corporation of any appreciation on the disposition of their stock.

Marietta's bylaws provided that no more than 20 percent of its trustees could be physicians employed by Marietta or who directly or indirectly receive compensation from Marietta for providing clinical services. Physicians were, however, permitted to serve on board committees that had authority over the clinical aspects of Marietta's activities.

Marietta was legally controlled by a single physician shareholder who owned all of the stock of the professional corporation. However, this physician shareholder, a longtime member of the MMH medical staff, entered into a stockholder control agreement in which he agreed to hold his stock in a

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48. IRS determination letter issued to Marietta Healthcare Physicians, Inc. (Oct. 3, 1995).
49. *See* § 23.2(a) note 4.

fiduciary capacity for the benefit of MMH. The Ohio Attorney General had rendered a legal opinion that the corporate practice of medicine doctrine in that state did not require that the *beneficial* ownership of the corporation rest in the hands of a physician.

Marietta also entered into physician employment agreements with its physicians, which stated that Marietta was formed to further MMH's charitable purposes, that Marietta would participate in Medicare and Medicaid, and that it would provide services to patients without discrimination as to their ability to pay. The employment agreements called for compensation comprised of a base salary, determined to be reasonable and subject to a ceiling, as well as a productivity bonus based on the total revenues generated by the physician and any nurse practitioners working under the physician's supervision. Marietta also adopted a specific charity care policy.

The IRS concluded that Marietta was organized as a for-profit professional corporation to comply with state law, but that it was, in fact, controlled by, operated for the benefit of, and provided an essential service to MMH, a charitable organization. As a controlled organization of MMH, the IRS determined that Marietta operated as an integral part of the hospital and its integrated delivery system. Because Marietta provided an essential service for MMH and was in effect controlled by it, Marietta's operations were found to further MMH's exempt purposes. Accordingly, the IRS recognized Marietta's exemption as a charitable organization.

This determination letter is consistent with the decision reached by the Tax Court in 1981 in a case involving[50] a faculty practice plan[51] organized as a for-profit professional service corporation. It reflects the Service's general inclination to be flexible regarding factors that might otherwise disqualify an organization for tax exemption when those factors are mandated by state law.

In a 2000 ruling, the IRS concluded that the mergers of a hospital, a home health agency, and a licensed home care services company to create an integrated delivery system would not adversely affect the tax-exempt status of the system or its subsidiaries.[52] After the mergers, the integrated system became the sole corporate member of various nonprofit tax-exempt organizations and the sole shareholder of several for-profit corporations. The integrated system was created for the purposes of broadening the healthcare services available in the community; enhancing administrative efficiencies within the healthcare system; and promoting efficiency and economy in the delivery of health care services. The IRS also ruled that the for-profit taxable subsidiaries' activities would not be imputed to the new system and that any

50. *University of Maryland Physicians, P.A. v. Commissioner*, 41 T.C.M. 732 (1981).
51. *See* § 12.2.
52. Priv. Ltr. Rul. 200025056.

dividends received by the system from its taxable subsidiaries would not be subject to the unrelated business income taxation.

(b) Physician–Hospital Organizations

Not all integrated delivery systems are as fully integrated as the foundation model. A simpler form of integration is the physician–hospital organization (PHO). The typical PHO is formed as a nonprofit membership organization controlled equally by a tax-exempt charitable hospital and a medical group, an individual practice association (IPA), or individual physicians who practice at, or are affiliated with, the hospital. The PHO provides no healthcare services itself. Instead, it plans and implements an efficient healthcare delivery system designed to ensure that all needed medical treatments and resources are available and that duplication of services is avoided. The PHO contracts with payors (such as insurance companies or employers), on behalf of the hospital and physicians, for the provision of healthcare services in the community. Thus, the PHO essentially serves as a joint marketing arrangement for the hospital and the physicians.[53]

As is evident from the foregoing description, a PHO is not a healthcare provider; it does not engage in the practice of medicine or operate a hospital. Instead, it merely negotiates managed care contracts on behalf of its members (i.e., the hospital, and individual physicians). Because the PHO's activities substantially serve the private interests of its member physicians, the PHO cannot avoid the proscription against more than incidental private benefit. Thus, tax exemption as a charitable organization is not available to the PHO.[54]

Even if the PHO were made a subsidiary of the tax-exempt hospital, the IRS takes the position that a PHO cannot use the integral part doctrine''[55] to qualify as a tax-exempt organization. The reason is that the primary services provided by the PHO (i.e., negotiating managed care contracts for member physicians) are not essential services to the hospital; thus, the integral part test is not satisfied.[56]

Whether a hospital's participation in a PHO, either as a member of a separately incorporated PHO or as a general or limited partner in a PHO partnership or joint venture, will adversely affect the hospital's charitable status is determined by the IRS under its requirements for investments and joint ventures.[57]

53. FY 1995 IRS CPE Text, *supra* note 8, at 154.
54. *Id*. at 154–155.
55. *See* § 34.6.
56. FY 1995 IRS CPE Text, *supra* note 8, at 155.
57. *See* FY 1993 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, ch. D; 1995 IRS CPE Text, *supra* note 8, at 155–158; Griffith, ''Impact of Taxable PHOs and MSOs on a Hospital's Tax-Exempt Status,'' 10 *Exempt Org. Tax Rev*. 887 (Oct. 1994). See also FY 1996 CPE Text, *supra* note 8, at 16.

There are a number of ways in which a hospital might jeopardize its tax exemption by participating in a PHO. One example is where the PHO is used as a vehicle for the hospital to share its net income with the medical staff. This can occur where the hospital's control or profit share in the PHO is smaller than its capital contribution, thus providing the member physicians with benefits disproportionately greater than their risk. To maintain the hospital's tax exemption, the IRS generally requires that the expenses of the PHO arrangement be paid by the hospital and the aggregate physician members in proportion to the benefit derived by each from the arrangement.[58]

Another way for a hospital to jeopardize its tax exemption is where the PHO is used as a vehicle for sharing capitated payments with the physicians, who are being paid more than reasonable compensation for their services; or, the hospital otherwise receives less than a fair portion of the income, thus resulting in private benefit or private inurement to the physicians.[59]

In a memorandum, the IRS cited various factors that it will scrutinize when an exempt organization is involved in a partnership with physicians, and it indicated that those same factors are applicable in analyzing whether a hospital's participation in a PHO with physicians would adversely affect the hospital's tax-exempt status.[60]

Finally, hospitals involved in PHOs must consider whether income received from PHO services will be subject to the unrelated business income tax (UBIT).[61] Generally, income from PHO services performed for the benefit of the hospital and its patients would be related income and not taxable.[62] However, PHO services provided to patients of the member physicians' private practices do not serve the hospital's exempt purposes and thus are subject to UBIT.[63]

On September 29, 1994, the IRS issued its first private letter ruling regarding the effect of participation by a charitable hospital in a PHO.[64] The IRS

58. FY 1995 IRS CPE Text, *supra* note 8, at 156.
59. *Id*.
60. Gen. Couns. Mem. 39732; *id*. at 156. The factors cited in Gen. Couns. Mem. 39732 include whether: (1) a disproportionate allocation of profit or loss is being made in favor of the for-profit partner; (2) there is a nominal or insufficient capital contribution by the for-profit partner; (3) new equipment or services are being brought into the partnership or such equipment and services are already available in the area; (4) existing hospital equipment or facilities are being sold or leased to the partnership; (5) any services being provided by the hospital are at less than fair market value; (6) a for-profit limited partner has significant influence and control over operations; (7) the exempt organization bears all risk or liability for the partnership losses; and (8) commercially unreasonable loans are being made to the partnership.
61. *See*, in general, Chapter 24.
62. FY 1995 IRS CPE Text, *supra* note 8, at 160, citing Reg. § 1.513-1(b).
63. FY 1995 IRS CPE Text, *supra* note 8, at 160; Rev. Rul. 68-374, 1968-2 C.B. 242; Rev. Rul. 78-145, 1978-1 C.B. 169.
64. Priv. Ltr. Rul. (unnumbered), reprinted in ''Participation in PHO Will Not Jeopardize Tax-Exempt Status,'' 10 *Exempt Org. Tax Rev*. 1323 (Dec. 1994).

ruled that the acute care hospital, tax-exempt as a charitable organization, could participate in a PHO without adversely affecting its tax-exempt status. However, it is important to note that the ruling did not recognize tax-exempt status for the PHO itself. As noted above, the IRS's position had uniformly been that a PHO would not qualify for tax-exempt status as a charitable organization.

Under the facts of the private letter ruling, the hospital would become a member of the PHO, which is organized as a limited liability company under the laws of the State of Delaware. Under an agreement between the hospital and members of its medical staff, the PHO would act as a vehicle through which the two parties could offer and respond to solicitations from large employers, insurers, and others, for managed care bids to provide healthcare. The PHO would provide a centralized framework for managed care contracting, credentialing, education of physicians, and monitoring and improving healthcare quality.

The agreement called for the hospital to receive a 50 percent member ownership interest in the PHO. Individual physicians who participate in the PHO would, on an aggregate, hold the remaining 50 percent membership interest. This interest would be divided on a per-capita basis, but would accommodate two subclasses: (1) primary care physicians and (2) specialists. The admission and withdrawal of individual physicians would dilute or increase the ownership interest of any given physician from time to time, but the overall aggregate percentage of 50 percent held by all physicians would not change. The agreement stated that initial capital contributions and future capital calls would be incurred 50 percent by the hospital and 50 percent by the physician members. Importantly, the agreement also provided that any profits, losses, or cash distributions would be allocated based on percentage of ownership.

Management of the business and affairs of the PHO was allocated based on the particular area of business in question. Generally, however, responsibility for day-to-day management was vested in either the board of directors of the PHO or a ''Price Negotiating Committee.'' The agreement provided that a supermajority vote of 75 percent of the PHO's total membership interest was required to authorize major actions by the PHO with respect to clinical matters, governance matters, legal matters, and scope-of-business matters.

The board of directors of the PHO was to have at least five directors elected on an annual basis by a vote of the members (according to their membership interest). The affirmative vote of members owning 75 percent of the total membership interest was required for election of any director to the board of directors. However, not more than 20 percent of the board of directors could be medical staff members, eligible parties or their affiliates, or any employee, former employee, or relative of the foregoing, or any recently retired medical staff member.

The agreement further provided that the role of collecting information, submitting bids, negotiating fee schedules and financial aspects of managed care contracts, and all other fee schedule and financial reimbursement issues would be delegated exclusively to the Price Negotiating Committee. Neither the members nor the board of directors would have any authority at all with respect to such issues. The Price Negotiating Committee could only act, however, in those situations where the members and the board of directors had authorized the negotiation of a managed care contract. The agreement provided that no member, eligible party, or affiliate of an eligible party or member would be eligible for membership in the Price Negotiating Committee. Medical staff members of the PHO were obligated to provide service under managed care contracts entered into by the PHO. The hospital retained the authority to submit its own fee schedule for the services it provided under managed care bids.

Based on the foregoing information, the IRS determined that the hospital's participation in the PHO would not jeopardize its tax-exempt status. It based its ruling on two facts: (1) the agreement ensured that member physicians would not exert control over the PHO's operations, and (2) the hospital's interest was proportionate with its share of capital contributions and calls, profits and losses, and cash distributions made by the PHO. The IRS also concluded that member physicians of the PHO would not receive benefits disproportionately greater than their risk, and that any private interest served by the PHO would be incidental.

This ruling is consistent with the IRS's general position regarding participation by tax-exempt hospitals in joint ventures. As long as there is not undue control by the physician members, and the profits, losses, and risks are proportionate to the ownership interests, the IRS's primary concerns have been addressed. It is also consistent with the IRS's published guidance regarding exemption for physician–hospital organizations and the effect of participation in them by tax-exempt hospitals.[65]

Notwithstanding the position taken by the IRS in that ruling, on February 17, 1995, the IRS issued a determination letter recognizing tax exemption as a charitable organization and public charity status as a service provider charity for a PHO wholly owned by tax-exempt organizations.[66] University Affiliated Healthcare, Inc., was a nonprofit corporation organized under Kansas law and operating as a preferred provider organization structured as a physician-hospital organization. Its corporate members were the University of Kansas Hospital and 14 clinical practices at the University of Kansas Medical Center. University of Kansas Hospital was recognized as a charitable organization, as were the clinical practices, which were organized as nonprofit faculty

65. FY 1995 IRS CPE Text, *supra* note 8.
66. IRS determination letter issued to University Affiliated Healthcare, Inc. (Feb. 17, 1995).

group practice associations.[67] All of the physicians employed by the clinical practices were on the faculty of the University of Kansas Medical Center. The governance structure of the PHO gave its hospital members veto power over significant actions by the PHO. The PHO was to commence operations after it negotiated contracts with third-party payors and providers of medical services. Each contract was to be negotiated to provide arm's-length terms, including reasonable compensation to the providers. The PHO would enhance the ability of its member clinical practices to attract a continuum of patients with diverse medical problems to the medical school. The determination letter further stated that the operation of the clinical practices contributed to the ability of the hospital and its faculty to teach medical students, thereby providing community benefit.

After issuing its determination letter, the IRS came under criticism by some that it had flipped-flopped on its PHO ruling position. The IRS quickly pointed out, however, that the PHO's members were solely other exempt organizations and that the PHO qualified for exemption under the integral part theory of exemption. The Service further noted that this PHO bore little resemblance to the typical PHO; the IRS continues to take the position that most PHOs are taxable under the rationale of its 1986 revenue ruling.[68]

(c) Management Services Organizations

As a way of collaborating with a hospital without substantial integration, a medical group or individual physicians with hospital staff privileges may ask the hospital to provide certain services for their private practices, such as billing, collection, and general management practices. In this case, the hospital takes on the characteristics of what is referred to as a management services organization (MSO).[69]

An MSO can assume one of several forms and can provide a wide variety of functions. For example, the MSO functions may be performed entirely as an activity within the hospital itself, they may be undertaken by a hospital subsidiary or affiliate, or the hospital and physicians may form a separate partnership, joint venture, or corporation in which the hospital (or its subsidiary) will be a partner, participant, or shareholder.[70] At the fullest extent of its services, the MSO would purchase the tangible assets of the physicians' private practices and would provide all management services and nonprofessional staffing for those private practices (this is referred to

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67. *See* § 12.2.
68. Rev. Rul. 86-98, 1986-2 C.B. 74. *See* § 9.2. *See also* Streckfus, "Tax-Exempt Physician-Hospital Organization Not Your Typical PHO, Says IRS," 95 *Tax Notes Today* 81–7 (Apr. 26, 1995); FY 1996 IRS CPE Text at 402.
69. *Id*. at 157.
70. *Id*. at 153 and 157.

as ''turnkey'' management services), in return for a portion of the practice revenues.

The composition of an MSO's board of directors can vary. Usually, the board will contain representatives of the hospital. It also would normally include representatives of the member medical group(s) or individual physicians who join the MSO.[71]

An MSO does not provide medical care; even if the physicians have sold their assets to the MSO, they still retain ownership of their clinical practices and their patients' medical records. Moreover, like a PHO, an MSO serves to a substantial degree the private interests of the participating physicians. Therefore, the IRS takes the position that an MSO will generally not qualify for tax exemption as a charitable organization.[72]

As for the issue of whether a hospital's involvement in an MSO will jeopardize the hospital's tax-exempt status, the analysis is essentially the same as for PHOs; that is, the IRS will analyze the factors regarding investments by charities in partnerships and joint ventures.[73] An MSO's purchase of physicians' assets raises an additional issue: if the hospital is found to have paid more than fair market value, the IRS is likely to find there was either substantial private benefit or private inurement to those physicians.

As in the case of a PHO, a hospital's involvement in an MSO may also raise UBIT issues.[74] Specifically, a hospital's revenues from MSO services would be taxable as unrelated business income because these services do not serve charitable purposes, are provided to nonpatients of the hospital and to entities outside of the hospital's exempt affiliated system, and are regularly carried on.[75]

(d) Clinics Without Walls

The clinic without walls (CWW)[76] represents a step down from the level of integration achieved through integrating an existing, traditional group practice with a hospital. It involves the creation of a new group practice and the integration of that new practice with a hospital.

A CWW is appropriate where the physicians affiliated with a hospital are not ready to move their individual offices to a single site. A hospital may also be motivated to form a CWW where there is no large group practice with which to contract to establish an IDS or an MSO. This is the case particularly

71. *Id*. at 157. One commentator has noted that it appears to be implicit in the FY 1995 IRS CPE Text that the IRS would accept 50 percent physician representation on the board of an MSO or PHO, with appropriate conflict of interest policies, but not more than 50 percent. Griffith, *supra* note 56, at 895.
72. FY 1995 IRS CPE Text, *supra* note 8, at 158; Levine, *supra* note 2, at note 199.
73. *See supra* note 56.
74. *See*, in general, Chapter 24.
75. FY 1995 IRS CPE Text, *supra* note 8, at 160.
76. Bromberg, ''Tax Considerations in Forming MSOs and Clinics Without Walls,'' 8 *Exempt Org. Tax Rev*. 887 (Nov. 1993).

for smaller hospitals and rural hospitals, which often do not have on their medical staffs a large multispecialty group practice or a large group practice of family practitioners.[77]

In a simple CWW, physicians at multiple sites become shareholders or employees of a network. The physicians centralize overhead but retain ownership of practice assets. The physicians may continue to perform their own billings and collections, pay their own rent, and buy their own office supplies. Collections are credited and expenditures are debited to individual practice accounts at both the practice level and the central organizational level.[78]

A common variation of the basic CWW structure involves the use of a CWW together with an MSO (the MSO-hospital controlled model). Typically, the hospital will first set up an MSO, which then negotiates the purchase of the tangible assets of the practices of the various individual physicians that the hospital wants to pull together as a prelude to fuller integration. A new professional corporation is also created to purchase the intangible physician practice assets in exchange for stock. The end result will be similar to the MSO described above, which was initially unavailable to the hospital because of the absence of an existing group practice to work with.[79] Thus, the activities of the resulting CWW include providing administrative, managerial, and support services—and sometimes recruitment services—to participating physicians.

As with an MSO, a CWW would generally not be exempt as a charitable organization because a principal purpose is to benefit the private practice of the participating physicians by providing them a vehicle that enables them to more effectively participate in managed care plans.[80] However, one commentator has noted that if a CWW is created by a hospital or healthcare system and its governing body satisfies the 20 percent safe haven for physician representation that has been applied to the foundation model of an IDS,[81] a reasonable argument can be made that developing a group practice by acquiring the practice assets of individual physicians provides a strong community benefit by enabling the hospital to take the first step toward a still greater degree of integration, once a cohesive group practice is in place.[82] Thus, exemption as a charitable organization should be available in such circumstances. On the other hand, a CWW controlled by physicians would not appear to qualify for tax exemption.

Finally, regardless of physician control over the CWW, an exempt hospital participating in and funding a CWW will need to ensure that any private

77. *Id*. at 892.
78. Levine, *supra* note 2, at note 4.
79. Bromberg, *supra* note 75, at 892.
80. *Id*.
81. *See supra* notes 16–18.
82. Bromberg, *supra* note 75, at 892–893.

benefit to the individual physicians is only incidental, thereby protecting its own tax exemption.

§ 23.3 PHYSICIAN PRACTICE ACQUISITIONS

An essential mechanism for creating the integrated delivery system is the acquisition of physician practices and the subsequent employment of the physicians by the health system or, as often happens in a state that recognizes the corporate practice of medicine doctrine, the execution of a professional services agreement with the physicians. These acquisitions are usually structured as an asset purchase involving both the tangible and the intangible (goodwill) assets of the practice. Intangible assets are a well-recognized element of a physician practice and often account for the bulk of the purchase price; however, they have been a source of controversy in the past between the Internal Revenue Service and the Health Human Services (HHS) Office of Inspector General (OIG). The OIG takes the position that if the purchase of intangible assets is intended as a surrogate for the purchase of a future patient referral stream, this will violate the federal antikickback statute. The IRS permits intangible assets to be acquired in the purchase of a physician's practice when properly valued. The entity purchasing the assets is usually a charitable hospital operating corporation, a tax-exempt affiliate of the hospital, or a taxable subsidiary of a tax-exempt parent holding corporation.

A tax-exempt healthcare organization should base its purchase price for the practice assets on an independent valuation performed by a professional appraiser. While the bargaining process would normally create the presumption that the agreed-upon purchase price represents fair market value, in this context the IRS is concerned that the transaction cannot occur at arms' length because of the interdependent relationship of the parties in the delivery of healthcare. As a result, the IRS insists on the use of a valuation to determine the fair market value of the practice and has published detailed instructions on the methodology it expects to be used for this purpose.[83] In light of IRS enforcement activity, close adherence to this methodology is advised.

In order to ensure that no private inurement or impermissible private benefit results from the compensation paid to a physician employee (or through a professional services agreement with a physician independent contractor), it must be demonstrated that the compensation level and mechanism for determining compensation ensures that the physician is paid reasonable compensation at fair market value for his or her services. Is it important to verify fair market value through objective evidence. This is commonly done in the healthcare industry through salary surveys by various organizations such as the Medical Group Management Association (MGMA), the American Medical Association (AMA), the Hay Group, Towers and Perrin, Mercer, Sullivan

83. *See* Appendix F.

Cotter, and similar organizations. The MGMA Physician Compensation and Production Survey is a well-established benchmark for physician compensation. Typically, the 50th to the 75th percentile MGMA salary based on region and size of institution, specialty, and level of productivity is used as the comparator for physician compensation. Salaries that are above the 75th percentile should be justified by demonstrating the presence of unique factors, such as strong need for the particular physician specialty in the community, particular experience of the physician, unusually high level of productivity, or other similar factors.

There are no set formulas or mechanisms that must be used by a tax-exempt healthcare organization to determine reasonable compensation for physicians. The IRS has recently indicated that it has made a shift over time in the direction of looking at process and safeguards, rather than trying to establish some kind of bright-line or per se test for evaluation compensation.

Increasingly, however, health systems are adding other criteria to the determination of compensation that provide some additional correlation with the charitable purposes of the exempt organizations in the system. Thus, for example, increased compensation could be derived not only from increased collections, but also based on measures of patient satisfaction, medical research and education, and the provision of charity care. These factors were present in compensation plans ruled on favorably by the IRS.[84]

Compensation systems that reward physician productivity have become the norm, particularly in integrated delivery systems. A cap on total compensation in conjunction with a productivity-based income feature is an important mechanism for protecting a provider's tax-exempt status in the IRS's view. It provides additional protection that the overall compensation earned by the physicians is reasonable. While this arguably should not be necessary in that a physician's compensation is inherently limited by the amount of services that the physician provides, nonetheless, the IRS prefers to avoid leaving the total opportunity for compensation unlimited so that fair market value will not be exceeded. In public remarks, the Director of the IRS's Exempt Organizations Division spoke in favor of the use of compensation caps, stating that if they are not used, a hospital's work "could too easily become the corporate practice of medicine and no longer a charitable activity."

The incurrence of losses from acquiring and operating physician practices in health systems is not a unique phenomenon. It has been reported that this has become a common experience in healthcare systems due to high operating expenses and decreased productivity by the employed physicians.[85] The report cited a study of 17 hospitals that, on average, incurred annual losses of $97,000 per acquired physician. In another study of more than 400 practice

84. *See* § 23.2.
85. *Wall Street Journal*, June 7, 1997.

transactions, it was found that hospitals routinely lose money in the operation of acquired practices due to payment of high initial salaries.[86]

No formal guidance has been issued by the IRS regarding the incurrence of losses by a tax-exempt healthcare system from the operation of physician practices intended to further the charitable purposes of the system. However, IRS officials have made public comments that indirectly impact on the issue. One IRS official stated that when a tax-exempt health system has a management services organization, owned by a tax-exempt entity, that continues to compile losses while providing management services to independent physicians on the health system's medical staff, the IRS will be concerned that these continued losses will result in substantial private benefit being provided to the physicians and that, at some point, the losses must cease. In a recent panel discussion, an IRS official indicated that a healthcare organization should have a system in place to try to reduce or eliminate losses once it has identified the source of the losses and where remedial action is possible. Accordingly, it is imprudent for an exempt healthcare organization to fail to take available steps to reduce its losses in compensating physicians where the charitable activity can still be carried on.

The experience of sustained losses and unrealized networking and reimbursement gains led many health systems to divest their physician practices. However, by 2007, this trend had changed and physician practice acquisitions were again on the upswing.

86. Center for Healthcare Industry Performance Studies (CHIPS), The 1997–1998 Physicians Practice Acquisition Sourcebook.

PART SIX

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CHAPTER TWENTY-FOUR

Tax Treatment of Unrelated Business Activities

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One of the most complex aspects of the federal tax law applicable to tax-exempt healthcare organizations is its treatment of unrelated business activities. The fundamental concept is deceptively simple: income generated by a tax-exempt healthcare organization from the conduct of one or more business activities that are undertaken for reasons other than the furtherance of the organization's exempt purposes[1] is taxed in the same manner as the income would have been if received by a taxable entity. (These activities are known as *unrelated business activities* and the income they yield is termed *unrelated business income*.) Stated otherwise, the unrelated business income tax imposed on a tax-exempt organization generally is applicable only with respect to active business income that arises from activities that are *unrelated* to the organization's tax-exempt objectives. Behind that grand generalization, however, lie a multitude of refinements and exceptions.

The primary objective of the unrelated business income tax is to eliminate a source of unfair competition between for-profit and nonprofit organizations by placing the unrelated business activities of tax-exempt organizations on the same tax basis as the nonexempt business endeavors with which they compete.[2] For example, the House Committee on Ways and Means report on the Revenue Act of 1950 observed that the ''problem at which the tax on unrelated business income is directed here is primarily that of unfair competition. The tax-free status of . . . [qualified nonprofit] organizations enables them to use their profits tax-free to expand operations, while their competitors can expand only with the profits remaining after taxes.''[3] The Senate Committee on Finance reaffirmed this position in the context of enactment of the Tax Reform Act of 1976 when it noted that one ''major purpose'' of the unrelated business income tax ''is to make certain that an exempt organization does not commercially exploit its exempt status for the purpose of unfairly competing with taxpaying organizations.''[4]

In recent years, however, this rationale for the unrelated business rules has begun to be supplanted by the view that other objectives are important—some equally so. For example, slippage of the original basis for creation of these rules was reflected in the musings of one federal appellate court, which stated that ''while the equalization of competition between taxable and tax-exempt entities was a major goal of the unrelated business income tax, it was by no means the statute's sole objective.''[5] These other ends are seen as the elimination of commercial activity by tax-exempt organizations and the raising of revenue. Thus, as another federal appellate court observed, ''although

1. *Exempt* is frequently used in this area of the federal tax law to mean the same as *tax-exempt*. Thus, for example, *tax-exempt purposes* and *exempt purposes* are synonymous.
2. Reg. § 1.513-1(b).
3. H.R. Rep. No. 2319, 81st Cong., 2d Sess. 36–37 (1950); S. Rep. No. 2375, 81st Cong., 2d Sess. 28–29 (1950).
4. S. Rep. No. 94-938, 94th Cong., 2d Sess. 601 (1976).
5. *American Medical Association v. United States*, 887 F.2d 760, 772 (7th Cir. 1989).

Congress enacted the . . . [unrelated business rules] to eliminate a perceived form of unfair competition, that aim existed as a corollary to the larger goals of producing revenue and achieving equity in the tax system.''[6]

§ 24.1 INTRODUCTION

Even though a nonprofit healthcare organization achieves general exemption from the federal income tax,[7] it nonetheless remains potentially taxable on any unrelated business income.[8] This tax[9] is generally levied at the corporate rates;[10] in the case of charitable trusts,[11] the tax is imposed using the individual rates.[12] The unrelated business income tax applies to nearly all categories of tax-exempt organizations, including healthcare organizations.

The taxation of unrelated business income, a feature of the federal tax law since 1950, is based on the tax policy determination that the approach is a more effective and workable sanction for the conduct of unrelated business activities than denial or revocation of tax-exempt status.[13] Nonetheless, the law of tax-exempt organizations is rested on a primary purpose test; if a substantial portion of an organization's income is from unrelated sources, the organization will not qualify for tax exemption.[14]

With one exception,[15] there is no mechanical definition of what, in this setting, constitutes *substantial* or *primary* activities. Incidental trade or business

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6. *Louisiana Credit Union League v. United States*, 693 F.2d 525, 540 (5th Cir. 1982).
7. IRC § 501(a), by reason of description in at least one of the provisions of IRC § 501(c).
8. IRC § 501(b).
9. IRC § 511(a)(1).
10. IRC § 11.
11. IRC § 511(b).
12. IRC § 1(d).
13. Denial or revocation of tax-exempt status usually has the consequence of harming the beneficiaries of the programs. Nonetheless, one of the difficulties with this body of law is that the competitive activities of an exempt organization are often related businesses. Further, the system of intermediate sanctions, which operates in the private inurement context (Chapter 4), imposes taxes on persons in the event of violation of one or more rules, rather than revocation of tax-exempt status.
14. E.g., *Indiana Retail Hardware Association v. United States*, 366 F.2d 998 (Ct. Cl. 1966); *People's Educational Camp Society, Inc. v. Commissioner*, 331 F.2d 923 (2d Cir. 1964), *cert. denied*, 379 U.S. 839 (1964); Rev. Rul. 69-220, 1969-1 C.B. 154.

    This statement of the law should be compared to that advanced in Tech. Adv. Mem. 200021056, where the IRS ruled that, although two activities were found to be unrelated businesses, these activities simultaneously were operated in furtherance of charitable purposes in the context of determining whether the organization remained tax-exempt. The IRS concluded that one way in which an activity can be in furtherance of exempt purposes is to raise money for the charitable ends of the organization, even though the business activity is taxable.
15. A tax-exempt title-holding company is permitted to receive unrelated business income in an amount up to 10 percent of its gross income for the year, as long as the unrelated income is incidentally derived entirely from the holding of real property (IRC §§ 501(c)(25)(G) and 501(c)(2), last sentence (*see* § 15.3)). Similar definitional issues

activity will not alone cause a nonprofit healthcare organization to lose or be denied tax exemption.[16] It is common to measure substantiality and insubstantiality in terms of percentages of time or expenditures. It is clear, however, that ''[w]hether an activity is substantial is a facts-and-circumstances inquiry not always dependent upon time or expenditure percentages.''[17]

The IRS, however, is likely to deny or revoke the tax-exempt status of an organization where it regularly and actively derives over one-half of its annual revenue from the conduct of unrelated activities.[18] In the only case on the point, a court barred an organization from achieving tax-exempt status where the organization received about one-third of its revenue from an unrelated business.[19] The law is likely to be more tolerant where a tax-exempt organization receives a significant portion of its income as the result of the expenditure of an insubstantial portion of its time on unrelated activities.[20]

The federal tax law envisions a tax-exempt entity as a bundle of activities. These activities may be related or unrelated, or may be a combination of the two. The law empowers the IRS and the courts to fragment an organization into its component business parts in search of unrelated business activity.[21]

Thus, the program activities of a tax-exempt healthcare organization are regarded by the tax law as *related* activities. More technically, an organization may satisfy the requirements of the rules pertaining to a category of exempt organizations, although it operates a trade or business as a substantial part of its activities, where the operation of the trade or business is in furtherance of the organization's tax-exempt purposes and where the organization is not organized or operated for the primary purpose of carrying on an unrelated trade or business. In this setting, in determining the existence of a primary purpose, all the circumstances must be considered, including the size and extent of the trade or business and of the activities that are in furtherance of one or more tax-exempt purposes.[22] For example, an organization that purchased and sold at retail products manufactured by blind individuals was held by a court to qualify as an exempt charitable organization because it

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pertain with respect to the limits on allowable lobbying by charitable organizations (*see* § 7.1, text accompanied by notes 51–53).

16. E.g., Rev. Rul. 66-221, 1966-2 C.B. 220 (a volunteer fire department was ruled to be tax-exempt notwithstanding an incidental amount of unrelated business activities).
17. *The Nationalist Movement v. Commissioner*, 102 T.C. 558, 589 (1994), *aff'd*, 37 F.3d 216 (5th Cir. 1994). *See also Manning Association v. Commissioner*, 93 T.C. 596, 610–611 (1989); *Church in Boston*, 71 T.C. 102, 108 (1978).
18. E.g., Gen. Couns. Mem. 39108.
19. *Orange County Agricultural Society, Inc. v. Commissioner*, 893 F.2d 647 (2d Cir. 1990), *aff'g* 55 T.C.M. 1602 (1988).
20. A charitable organization was allowed to retain its tax-exempt status while receiving 98 percent of its support from nontaxable unrelated business income, inasmuch as 41 percent of the organization's activities were charitable programs (Tech. Adv. Mem. 9711003).
21. IRC § 513(c). *See* text accompanied by *infra* notes 32–38.
22. Reg. § 1.501(c)(3)-1(e)(1).

resulted in employment for the blind, notwithstanding its receipt of net profits and its distribution of some of these profits to qualified workers.[23]

The term *unrelated trade or business* means any trade or business, the conduct of which is not substantially related to the exercise or performance, by the tax-exempt organization carrying on the trade or business, of an exempt purpose or function.[24] The conduct of a trade or business is not substantially related to an organization's tax-exempt purpose solely because the organization may need the income for program purposes or because of the actual use the organization makes of the profits derived from the business (such as for program, fundraising, or investment purposes).[25] There are special rules in this area for certain trusts.[26]

Absent one or more exceptions,[27] gross income of a tax-exempt organization (assuming it is subject to the tax on unrelated business income) is includable in the computation of unrelated business taxable income where three factors are present: (1) it is income from a *trade or business;* (2) the trade or business is *regularly carried on* by the organization; and (3) the conduct of the trade or business is not *substantially* related to the performance of the organization's tax-exempt functions.[28]

§ 24.2 DEFINITION OF *TRADE OR BUSINESS*

Gross income of a tax-exempt organization (assuming it is subject to the tax on unrelated business income) may be includable in the computation of unrelated business taxable income where it is income from a *trade or business*.

(a) General Principles

Generally, any activity that is carried on for the production of income from the sale of goods or the production of services and that otherwise possesses the characteristics required to constitute *trade or business* within the meaning of the rules underlying the business expense deduction[29] is a trade or business for purposes of the unrelated business income tax.[30] The case law contains illustrations of activities considered not trades or businesses.[31]

23. *Industrial Aid for the Blind v. Commissioner*, 73 T.C. 96 (1979).
24. IRC § 513(a). *Trade or business* is used to embrace unrelated activities that might not, under some terminologies, constitute a *business*. The term, which also sweeps in *professional* undertakings (such as the practice of medicine), is often referred to by means of the sole word *business*.
25. IRC § 513(a).
26. IRC § 513(b).
27. *See* §§ 24.14, 24.15.
28. Reg. § 1.513-1(a).
29. IRC § 162.
30. IRC § 513(c); Reg. § 1.513-1(b).
31. E.g., *Adirondack League Club v. Commissioner*, 55 T.C. 796 (1971), *aff'd*, 458 F.2d 506 (2d Cir. 1972) (certain membership activities were not businesses for purposes of the business

An activity ''does not lose identity as [a] trade or business merely because it is carried on within a larger aggregate of similar activities or within a larger complex of other endeavors which may, or may not, be related to the exempt purposes of the organization.''[32] This provision of law is a confirmation by Congress of the contention by the IRS that income from a particular activity can be taxed as unrelated business income even where the activity is an integral part of a larger activity that is in furtherance of a tax-exempt purpose. This provision was initially directed at, but is by no means confined to, activities of soliciting, selling, and publishing commercial advertising, even where the advertising appears in a publication of a tax-exempt organization that contains editorial material related to the exempt purposes of the organization.[33] The advertising functions constitute an unrelated trade or business even though the overall publishing function is a related trade or business; the advertising is an integral part of the larger publication activity. With this authority, the IRS is empowered to fragment the total and integrated operations of a tax-exempt organization into component parts, in search of an unrelated trade or business.

Other applications of the fragmentation rule abound. The use of a tax-exempt university's golf course by its students and employees was ruled not to be unrelated business, while use of the course by alumni of the university and major donors to it was found to be unrelated business.[34] The rule was applied to differentiate between related and unrelated travel tours conducted by an educational and religious organization.[35] An exempt organization established to benefit deserving women, in part by enabling them to sell foodstuffs and handicrafts, was held to operate a consignment shop as a related business but its retail gift shop and a small restaurant were found to be unrelated businesses.[36] An exempt monastery, the members of which made and sold caskets, was ruled to be engaged in a related business as long as the caskets were used in burial services conducted by churches that are part of the religious denomination supporting the monastery but was held to be conducting an unrelated business to the extent the caskets were used in services conducted by other churches.[37] An exempt charitable organization was held to be a dealer in certain parcels of real property and thus engaged in an unrelated business with respect to those properties, even though the principal impetus for the

expense deduction); and *The Marion Foundation v. Commissioner*, 19 T.C.M. 99 (1960) (certain investment activities were not businesses). *See* Rev. Rul. 69-278, 1969-1 C.B. 148 (a title-holding corporation cannot qualify for tax exemption because of its business activities; however, as to this point of law, *see* § 15.3).

32. IRC § 513(c).
33. *Id.*, caption.
34. Tech. Adv. Mem. 9645004.
35. Tech. Adv. Mem. 9702004.
36. Tech. Adv. Mem. 200021056.
37. Priv. Ltr. Rul. 200033049.

acquisition and sale of real property by the organization was achievement of exempt purposes.[38]

Additionally, ''[w]here an activity carried on for profit constitutes an unrelated trade or business, no part of such trade or business shall be excluded from such classification merely because it does not result in profit.''[39]

In some instances, an activity does not rise to the level of a trade or business, such as the investment activities a nonprofit organization undertakes for itself. Also, a tax-exempt organization may engage in a transaction that is not a business undertaking, such as the infrequent sale of an item of property.[40]

(b) Profit Motivation Requirement

For many years, it had been thought that it was not necessary, for an activity to be considered an unrelated trade or business, that a tax-exempt organization engage in the activity with a *profit objective* or a *profit motive*. This was, in part, because the criteria for imposition of the unrelated business income tax, as stated in the Internal Revenue Code and the federal tax regulations, do not include a profit motivation factor. Also, as noted, the statute specifically references ''an activity carried on for profit [that] constitutes an unrelated trade or business''[41]; that language, on its face, seems to contemplate an unrelated business that is not carried on for profit.

This changed, however, once the U.S. Supreme Court redefined the term *trade or business* in another federal tax setting (the business expense deduction).[42] This expanded definition of the term was quickly exported into the law of unrelated business income taxation. Thus, for example, one court held that,

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38. Priv. Ltr. Rul. 200119061.
39. IRC § 513(c).
40. E.g., Priv. Ltr. Rul. 9316032 (a sale of property was not taxable, under circumstances where the property was held primarily for sale to customers in the ordinary course of business, following the standard articulated in *Malat v. Riddell*, 383 U.S. 569 (1966)). This aspect of the federal tax law is closely analogous to the ''regularly carried on'' test (*see* § 24.3).
41. *See* text accompanied by *supra* note 39.
42. *Commissioner v. Groetzinger*, 480 U.S. 23 (1987). The Court held that a full-time gambler who made wagers solely for his own account was engaged in a ''trade or business'' for purposes of the business expense deduction (IRC § 162(a)) because the ''primary purpose for engaging in the activity . . . [was] for income or profit'' (at 35). The Court stated that this ''profit motive'' test was not a ''test for all situations'' (at 36), that its interpretation of the phrase ''trade or business'' was ''confined to the specific sections of the Code at issue here'' (at 27, note 8) (namely, the business expense deduction), and that ''[w]e do not purport to construe the phrase where it appears in other places'' (*id.*). Lower courts, however, ignored the confines that the Court placed on its own holding and promptly set about to engraft the *profit motive* element onto the law of unrelated business income taxation.

for an activity of a tax-exempt organization to be a trade or business, it must be conducted with a ''profit objective.''[43]

Even before the Supreme Court's ruling, some courts concluded that an activity was a ''trade or business'' because it generated a ''profit.'' For example, one federal court of appeals devised an ''objective profit motive test'' to ascertain whether an activity is a business; it wrote that ''there is no better objective measure of an organization's motive for conducting an activity than the ends [profits] it achieves.''[44] Subsequently, the same court held that a nonprofit organization's activity was an unrelated business because it ''received considerable financial benefits'' from performance of the activity, which was found to be ''persuasive evidence'' of a business endeavor.[45] On this latter occasion, the appellate court explicitly defined as a business the situation where ''a nonprofit entity performs comprehensive and essential business services in return for a fixed fee.''[46] (The court, however, did acknowledge that ''there are instances where some activities by some exempt organizations to earn income in a noncommercial manner will not amount to the conduct of a trade or business.''[47])

An illustration of this principle of law was furnished when a tax-exempt healthcare provider organization sold a building to another provider organization; it was used to operate a skilled nursing and personal care home. At the time of the sale, the purchasing organization was not prepared to provide food service for its patients. Therefore, the selling corporation provided the meals, doing so for about seven months. The IRS was of the view that the provision of the meals did not constitute a business because the operation was not conducted with the requisite profit motive, in that the activity generated a net loss.[48] The food service was seen as an ''accommodation'' to the purchasing organization during a brief period until that organization could arrange its own meals program; the IRS determined that the activity was not conducted in a manner characteristic of a commercial enterprise.[49]

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43. *West Virginia State Medical Association v. Commissioner*, 91 T.C. 651 (1988), *aff'd*, 882 F.2d 123 (4th Cir. 1989). *See also National Water Well Association, Inc. v. Commissioner*, 92 T.C. 75 (1989).
44. *Carolinas Farm & Power Equipment Dealers Ass'n, Inc. v. United States*, 699 F.2d 167, 170 (4th Cir. 1983).
45. *Steamship Trade Association of Baltimore, Inc. v. Commissioner*, 757 F.2d 1494, 1497 (4th Cir. 1985).
46. *Id*.
47. *Id*.
48. Tech. Adv. Mem. 9719002.
49. The organization providing the food service attempted to use the net loss as an offset against unrelated income from other sources (*see* § 24.22, text accompanied by *infra* 510). The IRS looked to these factors in making its judgment: (1) there was no evidence, such as a business plan, that a food service business was being started; (2) the organization did not take any steps to expand the food service to other unrelated organizations; (3) the organization did not actively solicit additional clientele for a meals (or food catering) business; (4) the organization did not take any steps to increase the per-meal

The profit motive element, then, has become an essential ingredient of the concept of an unrelated trade or business.

(c) Competition and Commerciality

The presence of ''unfair competition'' also is not among the technical criteria for assessing whether a particular activity is subject to the tax on unrelated business income, even though concern about competition between tax-exempt and for-profit organizations was the underpinning for the unrelated business rules.[50] Thus, it is possible for an activity of a tax-exempt organization to be wholly uncompetitive with any activity of a for-profit organization and nonetheless be treated as an unrelated trade or business.[51] For example, one federal appellate court wrote that the ''tax on unrelated business income is not limited to income earned by a trade or business that operates in competition with taxpaying entities.''[52]

Yet, on occasion, the IRS has taken the position that, where an activity constitutes a trade or business and is not sufficiently related to the performance of tax-exempt functions, there is sufficient likelihood (something akin to an irrebuttable presumption) that unfair competition is present. Also, as discussed,[53] the emerging commerciality doctrine is causing an activity of a tax-exempt organization to be considered an *unrelated* one solely by reason of having been found to have been conducted in a *commercial* manner.[54]

(d) Charging of Fees

For some who must adhere to the law of tax-exempt organizations, it has proved difficult to reconcile the consequences of receipt by them of fees for the performance of functions and the tax treatment of these fees. Although it borders on the absurd, there are those who are of the view that an activity that generates fees is, for that reason alone, an unrelated activity. This is the case even though it is amply clear that an exempt organization can be paid fees for the performance of one or more activities that are substantially related to

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charge, which was substantially below cost; and (5) there was no contract between the organizations.

50. *See* text accompanied by *supra* notes 2–4.
51. E.g., *Clarence LaBelle Post No. 217 v. United States*, 580 F.2d 270 (8th Cir. 1978) (the operation of a bingo game by an exempt social welfare organization gave rise to unrelated business income).
52. *Id*. at 272. Likewise *Henry E. & Nancy Horton Bartels Trust for the Benefit of the University of New Haven v. United States*, 209 F.3d 147 (2d Cir. 2000) (securities purchased on margin by a tax-exempt organization gave rise to unrelated business income in the form of unrelated debt-financed income (*see* § 24.18)).
53. *See* § 3.3.
54. *See, e.g.*, discussion of the tax treatment of hospital laboratory testing activities in § 24.11, text accompanied by *infra* 265–266.

exempt purposes; this type of income is often termed *exempt function revenue*.[55] Indeed, although it is obvious that a charitable organization may charge a fee for services and not jeopardize its tax exemption for that reason, the issue is raised from time to time by the IRS when it sees fit to contend that a nonprofit organization, to be charitable in nature, must provide its services and/or sell its goods without charge.

The charging of a fee by an organization is not a bar to categorization of it as a tax-exempt charitable organization.[56] The absence of a requirement in law that an organization, to qualify as a charitable entity, must provide its services without charge is manifested by many provisions of the federal tax regulations. For example, one regulation states that an educational organization includes an ''organization, such as a primary or secondary school, [or] a college . . . which has a regularly scheduled curriculum, a regular faculty, and a regularly enrolled body of students in attendance at a place where the educational activities are regularly carried on.''[57] It is generally understood and accepted that nonprofit schools, colleges, and universities do not have to provide teaching and other educational services to students without charge in order to obtain or maintain classification as tax-exempt educational institutions. As is well known, these institutions levy a variety of charges for their services, in amounts that are far from nominal; these charges, which range into tens of thousands of dollars annually, include those for tuition, room and board, and registration, laboratory, and other fees. The law does not suggest that the charges imposed for the services these institutions render lead to unrelated business income (or an endangering of the tax-exempt status of these entities).

These tax regulations also make it clear that classification as a tax-exempt educational organization extends to nonprofit entities such as ''[m]useums, planetariums, [and] symphony orchestras.''[58] These organizations frequently impose a charge for the services they provide, and they can do so without unrelated business income taxation (or detriment to their tax-exempt status).

55. E.g., IRC § 509(a)(2), which explicitly recognizes that a publicly supported charitable organization can receive fee-for-service revenue without adverse tax consequences.
56. E.g., Rev. Rul. 80-200, 1980-2 C.B. 173 (adoption agency ruled to be tax-exempt, notwithstanding that one of two primary sources of support was fees); Rev. Rul. 78-99, 1978-1 C.B. 152 (organization that provided counseling to widows ruled to be tax-exempt despite fee income); Rev. Rul. 77-365, 1977-2 C.B. 192 (fee-based community sports organization held to be tax-exempt); Rev. Rul. 77-246, 1977-2 C.B. 190 (fee-based organization that provided transportation for senior citizens and the handicapped held to be tax-exempt); Rev. Rul. 77-68, 1977-1 C.B. 142 (tax-exempt organization that provided services for children with learning disabilities relied on fees as the ''principal'' source of its income). Restatement (Second) of Trusts § 376 (1959) states: ''Charging fees. A trust to establish or maintain an educational institution or hospital or home for poor persons is charitable although it is provided that the pupils or patients or inmates shall pay fees or otherwise contribute to the expense of maintaining the institution if the income so derived is to be used only to maintain the institution or for some other charitable purpose.''
57. Reg. § 1.501(c)(3)-1(d)(3)(ii), Example (1).
58. Reg. § 1.501(c)(3)-1(d)(3)(ii), Example (4).

Thus, the IRS ruled that a nonprofit theater may charge admission for its performances and nonetheless qualify as a tax-exempt charitable or educational organization.[59]

The same may be said for unrelated business income (and tax-exempt status) of nonprofit healthcare institutions. For example, the tax exemption of a hospital, as a charitable organization, will not be discontinued solely because patients are charged for the services rendered, even though the charges can amount to hundreds of dollars per day.[60] Likewise, nonprofit institutions and organizations such as medical clinics, homes for the elderly, and blood banks impose charges for their services and are not subjected to unrelated income taxation (or loss of tax exemption) as a result.[61] For example, the revenue ruling discussing the tax-exempt status of homes for the elderly as charitable organizations expressly noted that the ''operating funds [of these homes] are derived principally from fees charged for residence in the home.''[62]

Congress has expressly recognized the tax-exempt status of healthcare and similar types of nonprofit organizations as charitable entities for purposes of non-private-foundation classification.[63] Thus, the instructional institutions are regarded as educational entities that are public charities;[64] hospitals and certain other healthcare organizations are also regarded as public charities.[65] Likewise, the federal tax regulations recognize museums, symphony orchestras, theaters, and the like as public charities.[66]

The foregoing types of nonprofit organizations are accorded classification as charitable entities notwithstanding the fact that they impose a charge for their services. Thus, there is nothing inherently inconsistent between categorization of an organization as a tax-exempt charitable entity and the charging of a fee. One set of commentators observed:

> [T]he test of a charitable institution in many jurisdictions is not the extent of the free services rendered . . . but whether those who operate it are doing so for private profit, directly or indirectly. . . . Free service is not a prerequisite to tax exemption, and the legal meaning of charitable purposes is not limited to care of the indigent.[67]

It would be a matter of illogical and unfair discrimination for the government to permit some categories of tax-exempt charitable organizations to charge substantial fees for their services and yet levy an unrelated business

59. Rev. Rul. 73-45, 1973-1 C.B. 220.
60. Rev. Rul. 69-545, 1969-2 C.B. 117.
61. E.g., Rev. Rul. 72-124, 1972-1 C.B. 145; Rev. Rul. 70-590, 1970-2 C.B. 116; Rev. Rul. 66-323, 1966-2 C.B. 216.
62. Rev. Rul. 72-124, 1972-1 C.B. 145.
63. *See* § 5.1, text accompanied by *supra* 19–41.
64. IRC § 170(b)(1)(A)(ii). *See* § 5.1, text accompanied by *supra* 16.
65. IRC § 170(b)(1)(A)(iii). *See* § 5.1, text accompanied by *supra* 19–25.
66. Reg. § 1.170A-9(e)(1)(ii).
67. Hayt, Hayt, and Groeschel, Law of Hospital, Physician, and Patient 65–69 (2d ed. 1952).

income tax on (or deny charitable status for) other categories of otherwise qualified organizations that do so. A case in point is nonprofit consumer credit counseling agencies, which provide charitable and educational services to individuals and families. These agencies instruct the public on subjects useful to individuals and beneficial to the community;[68] they provide information to the public on consumer credit and budgeting by means of speakers and publications, and otherwise advance education and promote social welfare.[69] A court rejected attempts by the IRS to deny these agencies classification as charitable entities because they charge a nominal fee for certain services, although the fee was waived in instances of economic hardship.[70] Subsequently, the IRS was advised by its Chief Counsel's office that ''[i]f the activity may be deemed to benefit the community as a whole, the fact that fees are charged for the organization's services will not detract from the exempt nature of the activity'' and that the ''presence of a fee is relevant only if it inhibits accomplishment of the desired result.''[71]

Notwithstanding its stance with respect to consumer credit counseling agencies and other organizations, the IRS ruled that a nonprofit organization that was operated to provide legal services to indigents may charge, for each hour of legal assistance provided, a ''nominal hourly fee determined by reference to the client's own hourly income.''[72] Also, as noted, tax-exempt healthcare institutions are allowed, without adverse tax consequences, to charge fees as a principal source of their revenue. This exception from its general anti-fee stance has been reiterated by the IRS in rulings providing classification as a charitable entity for a nonprofit hospice,[73] a nonprofit organization providing specially designed housing for the elderly,[74] and a nonprofit organization providing housing to the physically handicapped.[75]

There have been instances where the IRS has determined that a nonprofit organization is charitable because it provides services that are free to the recipients. This is, however, a separate and independent basis for defining a charitable activity, and it is usually invoked only where the services, assistance, or benefits are not inherently charitable, educational, or the like. An illustration of the use of this rationale is the public interest law firm that provides legal services (not inherently an exempt purpose), yet nonetheless qualifies for tax exemption as a charitable organization.[76]

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68. Reg. § 1.501(c)(3)-1(d)(3)(1)(d).
69. Reg. § 1.501(c)(3)-1(d)(2).
70. *Consumer Credit Counseling Service of Alabama, Inc. v. United States*, 78-2 U.S.T.C. (CCH) ¶ 9660 (D.D.C. 1978).
71. Gen. Couns. Mem. 38459.
72. Rev. Rul. 78-428, 1978-2 C.B. 177.
73. Rev. Rul. 79-17, 1979-1 C.B. 193.
74. Rev. Rul. 79-18, 1979-1 C.B. 194.
75. Rev. Rul. 79-19, 1979-1 C.B. 195.
76. E.g., Rev. Proc. 71-39, 1971-2 C.B. 575; Rev. Proc. 75-13, 1975-1 C.B. 662.

The federal tax law does not require, as a condition of avoiding unrelated business income taxation (or of qualification as a tax-exempt organization), that the organization provide services without charge.[77] Thus, it has been held that the ''position that the test of a charitable institution is the extent of free services rendered, is difficult of application and unsound in theory.''[78] The only fundamental requirement in this regard, in the federal statutory law and the income tax regulations, is that the organization not be operated for private interests.[79] The law looks to the benefits flowing to the general public in assessing the essence of a charitable purpose. The feature of an organization providing benefits without charge is an alternative rationale for tax exemption, applicable in the absence of an inherently exempt purpose.[80] Likewise, the fact that a tax-exempt organization charges a fee for the provision of goods and services, while a likely indicator that the activity is a *business*, should not lead to an automatic conclusion that the business is an unrelated one.[81]

(e) Other Definitions of *Business*

On occasion, a court will ignore the statutory definition of the term *trade or business*[82] and derive one of its own. In one case, a court held that the proceeds derived by a tax-exempt organization from gambling operations were not taxable as unrelated business income, inasmuch as the organization's functions in this regard were considered insufficiently ''extensive'' to warrant treatment as a business.[83] Another court simply concluded that an exempt organization's financial undertaking did not rise to the level of a business.[84]

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77. Were the law otherwise, the vast majority of nonprofit organizations presently tax-exempt as charitable, educational, and like entities would face revocation of tax exemption.
78. *Southern Methodist Hospital & Sanatorium of Tucson v. Wilson*, 77 P.2d 458, 462 (Sup. Ct. Ariz. 1943).
79. *See* Chapter 4.
80. The IRS was advised by the Office of the Chief Counsel that the fact that a charitable organization charges a fee for the provision of a good or service ''will be relevant in very few cases,'' that the ''only inquiry'' should be whether the charges ''significantly detract from the organization's charitable purposes,'' and that the cost issue is pertinent only where the activities involved are commercial in nature (Gen. Couns. Mem. 37257).
81. E.g., *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3rd Cir. 1993) (health maintenance organization held not to be tax-exempt by reason of IRC § 501(c)(3) because it was ''primarily benefiting itself . . . by promoting subscribership throughout the areas it serves'' (*id*. at 1219); the opinion contains the erroneous conclusion that the law ''require[s] more than mere promotion of health in order to qualify for tax exemption'' (*id*. at 1216) (*see* § 24.5).
82. *See* § 24.2(a).
83. *Vigilant Hose Company of Emmitsburg v. United States*, 2001-2 U.S.T.C. ¶ 50,458 (D. Md. 2001).
84. *Laborers' International Union of North America v. Commissioner*, 82 T.C.M. 158 (2001). The IRS ruled that a tax-exempt university is not engaged in unrelated business if it enables charitable remainder trusts (see CHARITABLE GIVING, Chapter 12), as to which it is trustee

Likewise, a court found that a tax-exempt organization's oversight activities with respect to an insurance program, consisting of the receipt of semiannual reports and maintenance of overall approval of insurance policies, did not involve sufficient ''administrative control'' to warrant the conclusion that a business was being conducted.[85]

§ 24.3 DEFINITION OF *REGULARLY CARRIED ON*

(a) General Principles

Gross income of a tax-exempt organization (assuming it is subject to the tax on unrelated business income) may be includable in the computation of unrelated business taxable income where the trade or business that produced the income is *regularly carried on* by the organization.

In determining whether a trade or business, from which an amount of gross income is derived by a tax-exempt organization, is regularly carried on,[86] attention must be given to the frequency and continuity with which the activities productive of the income are conducted, and the manner in which they are pursued.[87] This requirement is applied in light of the purpose of the unrelated business income tax, which is to place tax-exempt organization business activities on the same tax basis as the nonexempt business endeavors with which they may compete.[88] Thus, specific business activities of a tax-exempt organization will ordinarily be deemed to be regularly carried on if they manifest a frequency and continuity, and are pursued in a manner generally similar to comparable commercial activities conducted by for-profit organizations.[89]

An illustration of these principles was the case of a tax-exempt organization that published a yearbook for its membership. The publication contained advertising; the organization contracted on an annual basis with a commercial firm for the solicitation of advertising sales, printing, and collection of advertising charges. Although the editorial materials were prepared by the organization's staff, the organization, by reason of its contract with the commercial firm, was ruled to be ''engaging in an extensive campaign of advertising solicitation'' and thus to be ''conducting competitive and promotional efforts

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and remainder interest beneficiary, to participate in the investment return generated by the university's endowment fund, because the university is not receiving any economic return by reason of the arrangement (Priv. Ltr. Rul. 200703037). (These arrangements also do not give rise to unrelated business income because they entail transactions between related organizations (see § 24.14).)

85. *American Academy of Family Physicians v. United States*, 95-1 U.S.T.C. ¶ 50,240 (W.D. Mo. 1995), *aff'd*, 91 F.3d 1155 (8th Cir. 1996).
86. IRC § 512.
87. Reg. § 1.513-1(c)(1).
88. *Id*.
89. *Id*.

typical of commercial endeavors.''[90] Therefore, in this instance, the income derived by the organization from the sale of advertising in its yearbook was deemed to be unrelated business income.

By contrast, a onetime sale of property (as opposed to an ongoing income-producing activity) is not an activity that is regularly carried on; any income generated in that manner is not unrelated business income. For example, a tax-exempt organization that was formed to deliver diagnostic and medical healthcare, and that developed a series of computer programs concerning management and administrative matters (such as patient admissions and billings, payroll, purchases, inventory, and medical records), sold some or all of the programs to another tax-exempt organization composed of three teaching hospitals affiliated with a university. The income derived from the sale was held by the IRS to be from a ''onetime-only operation'' and thus not taxable as unrelated business income.[91]

Where income-producing activities are of a kind normally conducted by for-profit organizations on a year-round basis, the conduct of the same or identical activities by a tax-exempt organization over a period of only a few weeks does not constitute the regular carrying on of a trade or business.[92] For example, the operation of a sandwich stand by a tax-exempt hospital auxiliary organization for two weeks at a state fair would not be the regular conduct of a trade or business.[93] Similarly, if a charitable organization sponsored an occasional dance or comparable entertainment to which the public was admitted for a charge, the activity would not be a trade or business that is regularly carried on.[94]

At the same time, however, the conduct of year-round business activities for one day each week would constitute the regular carrying on of a trade or business.[95] Thus, the operation of a parking lot, on a commercial basis, on one day of each week would be the regular conduct of a trade or business.[96]

In determining whether intermittently conducted activities are regularly carried on, the manner of conduct of the activities must be compared with the manner in which commercial activities are normally pursued by nonexempt organizations.[97] In general, tax-exempt organization unrelated business activities that are engaged in only discontinuously or periodically are not

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90. Rev. Rul. 73-124, 1973-2 C.B. 190, 191.
91. Priv. Ltr. Rul. 7905129. A leasing arrangement that was ''one-time, completely fortuitous'' was held to involve a business not regularly carried on (*Museum of Flight Foundation v. United States*, 99-1 U.S.T.C. (CCH) ¶ 50,311 (W.D. Wash. 1999)), whereas a lease of extended duration can constitute a business that is regularly carried on (*Cooper Tire & Rubber Company Employees' Retirement Fund v. Commissioner*, 306 F.2d 20 (6th Cir. 1962)).
92. Reg. § 1.513-1(c)(2)(i).
93. *Id*.
94. S. Rep. No. 2375, 81st Con., 2d Sess. 106-107 (1950).
95. *Id*.
96. *Id*.
97. Reg. § 1.513-1(c)(1) and (c)(2)(ii).

considered regularly carried on if they are conducted without the competitive and promotional efforts of for-profit endeavors.[98] For example, the publication of advertising in programs for sports events or music or drama performances ordinarily are not deemed to be the regular carrying on of business.[99] Conversely, where the nonqualifying sales are not merely casual, but are systematically and consistently promoted and carried on by the organization, they are regularly carried on.[100] Even where an event occupies merely one or two days in a year, the IRS, in assessing whether the activity is regularly carried on, will take into consideration the time expended by the organization in preparing for the event,[101] as well as any time outlays directly connected with the aftermath of the event.

In determining whether an unrelated business is regularly carried on, the functions of a service provider, with which a tax-exempt organization has entered into a contract, may be attributed to the exempt organization on the ground that the provider organization was acting as an agent of the exempt organization. For example, the advertising and publishing activities of a for-profit organization were attributed to a tax-exempt organization for this purpose, largely because of provisions in a contract between the entities specifically identifying the for-profit organization as an agent of the exempt organization.[102]

(b) Seasonal Activities

Where income-producing activities are of a kind normally undertaken by for-profit organizations only on a seasonal basis, the conduct of the same or similar activities by a tax-exempt organization during a significant portion of the season ordinarily constitutes the regular conduct of trade or business.[103] For example, the operation of a track for horseracing for several weeks in a year would be considered the regular conduct of trade or business because it is usual to carry on the trade or business only during a particular season.[104] Likewise, where the distribution of certain greeting cards was deemed to be

98. Reg. § 1.513-1(c)(2)(ii). This is the closest the federal tax regulations come to articulation of the *commerciality doctrine* in general (*see* § 3.3).
99. *Id*.
100. *Id*.
101. The insistence by the IRS that *preparatory time* should be taken into account in assessing whether an activity was regularly carried on has been rejected by a federal court of appeals (*National Collegiate Athletic Association v. Commissioner*, 914 F.2d 1417 (10th Cir. 1990)). The IRS refuses to follow this holding, however (Action on Decision No. 1991-015; Tech. Adv. Mem. 9147007).
102. *National Collegiate Athletic Association v. Commissioner*, 92 T.C. 456 (1989), *aff'd*, 914 F.2d 1417 (10th Cir. 1990). (This issue was not considered on appeal.) *See also supra* note 96.
103. Reg. § 1.513-1(c)(2)(i).
104. *Id. See also* Rev. Rul. 68-505, 1968-2 C.B. 248 (a tax-exempt county fair association that conducted a horseracing meet with parimutuel betting during a season was held to conduct an unrelated trade or business).

an unrelated business, the IRS measured regularity in terms of the Christmas holiday season, inasmuch as the cards were commemorative of that holiday.[105]

(c) Fundraising Activities

Certain intermittent income-producing activities of tax-exempt organizations occur so infrequently that neither their recurrence nor the manner of their conduct will cause them to be regarded as trade or business that is regularly carried on.[106] For example, income-producing activities of an exempt entity lasting only a short period of time will not ordinarily be regarded as being regularly carried on if they recur only occasionally or sporadically.[107] Furthermore, activities will not be regarded as regularly carried on merely because they are conducted on an annually recurring basis.[108]

This doctrine is of particular importance in the context of the tax treatment of special events and certain other forms of fundraising for charitable organizations, such as dances, dinner and theater events, fairs, and auctions.[109] Because of this regularity doctrine, income from these events is spared taxation as unrelated business income.[110]

§ 24.4 DEFINITION OF *SUBSTANTIALLY RELATED*

Gross income of a tax-exempt organization (assuming it is subject to the tax on unrelated business income) may be includable of the computation of unrelated business taxable income where it is income from a trade or business that is regularly carried on and that is not substantially related to the exempt purpose of the organization.

(a) General Principles

Gross income is derived from an *unrelated trade or business* if the conduct of the business that generated the income was not substantially related to the exercise or performance of the functions on which the tax exemption of

105. E.g., Priv. Ltr. Rul. 8203134.
106. Reg. § 1.513-1(c)(2)(iii).
107. *Id*.
108. *Id*.
109. *See*, in general, Chapter 31.
110. *Id*. Occasionally, the IRS will apply the preparatory time rule (*see* text accompanied by *supra* note 101) to cause a fundraising undertaking to be a taxable business. Some fundraising events are also sheltered from unrelated business income taxation because the ''business'' activity is conducted substantially by volunteers (*see* § 24.15) and/or because the activity is the sale of contributed items (*id*.). The latter of these two exceptions is of particular applicability to the conduct of auctions and the maintenance of thrift shops. If the fundraising event is a related business, there is no unrelated business income taxation (e.g., *Orange County Builders Association, Inc. v. United States*, 65-2 U.S.T.C. (CCH) ¶ 9679 (S.D. Cal. 1965)).

an organization is based.[111] (The fact that the business produced income that was used directly to advance exempt purposes does not make the business a related one.[112]) This rule of law necessitates an examination of the relationship between the business activities that generated the income in question—that is, the activities of producing or distributing the goods or performing the services involved—and the accomplishment of one or more of the tax-exempt purposes of the organization.[113]

A trade or business is *related* to tax-exempt purposes only where the conduct of the business activity has a *causal* relationship to the achievement of a tax-exempt purpose (other than through the production of income), and it is *substantially related* only if the causal relationship is a substantial one.[114] For the conduct of a trade or business, from which an amount of gross income is derived, to be substantially related to purposes on which tax exemption is based, the production or distribution of the goods or the performance of the services from which the gross income was derived must contribute importantly to the accomplishment of these purposes.[115] Where the production or distribution of the goods or the performance of the services does not contribute importantly to the accomplishment of one or more of the tax-exempt purposes of an exempt organization, the income from the sale of the goods or the performance of the services cannot be regarded as income from the conduct of a related trade or business.[116]

Whether activities productive of gross income contribute importantly to the accomplishment of any purpose for which a nonprofit organization is granted tax exemption depends in each case on the facts and circumstances involved.[117] One appellate court wrote that resolution of the substantial relationship test requires an ''examination of the relationship between the business activities which generate the particular income in question . . . and the accomplishment of the organization's exempt purposes.''[118] Another court of appeals wrote that each of these instances requires a case-by-case identification of the exempt purpose involved and an analysis of how the activity contributed to the advancement of that purpose.[119]

For example, the sale (at a profit) of standard legal forms by a tax-exempt local bar association, which purchased the forms from the state bar association, to its member lawyers was determined to be an unrelated business because the activity did not contribute importantly to the accomplishment of the exempt

111. IRC § 513(a); Reg. § 1.513-1(a).
112. *Id*.
113. Reg. § 1.513-1(d)(1).
114. Reg. § 1.513-1(d)(2).
115. *Id*. E.g., Rev. Rul. 75-472, 1975-2 C.B. 208 (furniture shop operated by tax-exempt halfway house and staffed by its residents was held to be a related business).
116. Reg. § 1.513-1(d)(2).
117. *Id*. E.g., *Huron Clinic Foundation v. United States*, 212 F. Supp. 847 (D. S. Dak. 1962).
118. *Louisiana Credit Union League v. United States*, 693 F.2d 525, 534 (5th Cir. 1982).
119. *Hi-Plains Hospital v. United States*, 670 F.2d 528 (5th Cir. 1982).

functions of the association.[120] The same rationale was used to characterize as an unrelated business the publication and sale, by an exempt association of credit unions to its members, of a consumer-oriented magazine designed as a promotional device for distribution to the members' depositors.[121] Likewise, the presentation of commercial programs and the sale of air time were ruled to be activities not substantially related to the tax-exempt purposes of an exempt broadcasting station;[122] a charitable organization with the exempt purpose of promoting the physical fitness of young individuals was held to have unrelated activity by reason of operation of a health club, because the dues and fees charged were sufficiently high so as to restrict use of the club to a limited number of the members of the community;[123] and the operation of a miniature golf course, in a commercial manner, by a charitable organization providing for the welfare of young individuals, was determined by the IRS to constitute an unrelated business.[124] By contrast, an organization that promoted professional automobile racing was held to not receive unrelated business income from the conduct of a product certification program, inasmuch as the program was part of the organization's regulatory activities designed to prevent trade abuses in the auto racing business.[125]

In determining whether an activity contributes importantly to the accomplishment of a tax-exempt purpose, the size and extent of the activity must be considered in relation to the nature and extent of the tax-exempt function that it purports to serve.[126] Thus, where income is realized by a tax-exempt organization from an activity that is in part related to the performance of its exempt functions, but that is conducted on a scale larger than is reasonably necessary for performance of the functions, the gross income attributable to that portion of the activity in excess of the needs of tax-exempt functions constitutes gross income from the conduct of unrelated trade or business.[127] This rule was illustrated when the IRS ruled that the provision of private-duty nurses to unrelated exempt organizations, by a tax-exempt healthcare organization that provided temporary nurses as a related business, and private-duty nurses to patients of related organizations, was an activity performed on a scale ''much

120. Rev. Rul. 78-51, 1978-1 C.B. 165. A court, however, subsequently held that the sale at a profit of standard real estate legal forms to lawyers and law students by a tax-exempt bar association was not an unrelated business but rather was an exempt activity because it promoted the common business interests of the legal profession and improved the relationship among the bench, bar, and public (*San Antonio Bar Association v. United States*, 80-2 U.S.T.C. (CCH) ¶ 9594 (W.D. Tex. 1980)).
121. Rev. Rul. 78-52, 1978-1 C.B. 166.
122. Rev. Rul. 78-385, 1978-2 C.B. 174.
123. Rev. Rul. 79-360, 1979-2 C.B. 236.
124. Rev. Rul. 79-361, 1979-2 C.B. 237.
125. Priv. Ltr. Rul. 7922001.
126. Reg. § 1.513-1(d)(3). In *Hi-Plains Hospital v. United States*, 670 F.2d 528 (5th Cir. 1982), the appellate court also stated that, in search of unrelated activity, there should be an examination of the scale on which the activity is conducted.
127. Reg. § 1.513-1(d)(3).

larger'' than necessary for the achievement of exempt functions.[128] This type of income is not derived from the production or distribution of goods or the performance of services that contribute importantly to the accomplishment of any tax-exempt purpose of the organization.[129]

For example, an exempt trade association had a membership of for-profit businesses in a particular state; one of its activities was to supply to member and nonmember businesses, for a profit, employment injury histories on prospective employees. Despite the organization's contention that this service contributed to the accomplishment of its tax-exempt purposes, the IRS ruled that the operation was an unrelated business, in that the services went ''well beyond'' any mere development and promotion of efficient business practices.[130] The IRS adopted a similar posture in ruling that a retail grocery store operation, formed to sell food in a poverty area at abnormally low prices and to provide employment training for unemployed residents of the area, could not qualify for tax exemption because the operation was conducted ''on a much larger scale than reasonably necessary'' for the training program.[131] Yet a tax-exempt organization that was formed to provide a therapeutic program for emotionally disturbed adolescents was advised by the IRS that a retail grocery store operation, almost fully staffed by adolescents to secure their emotional rehabilitation, was not an unrelated business because it was operated on a scale no larger than reasonably necessary for its training and rehabilitation program.[132] A like finding was made in relation to the manufacture and marketing of toys, which was the means by which a tax-exempt organization accomplished its charitable purpose of training unemployed and underemployed individuals.[133]

Thus, gross income derived from charges for the performance of a tax-exempt function does not constitute revenue from the conduct of an unrelated trade or business.[134] This principle encompasses income generated by functions such as performances by students enrolled in an exempt school for training children in the performing arts, the conduct of refresher courses to improve the trade skills of members of an exempt trade union, and the presentation of a tradeshow for exhibiting industry products by an exempt trade association to stimulate demand for the products.[135]

128. Priv. Ltr. Rul. 9535023.
129. *Id*.
130. Rev. Rul. 73-386, 1973-2 C.B. 191, 192.
131. Rev. Rul. 73-127, 1973-1 C.B. 221, 222. Under similar facts, a nonprofit organization that operated restaurants and health-food stores in accordance with the tenets of a church was denied tax-exempt status on the ground that it was operated for substantially commercial purposes (*Living Faith, Inc. v. Commissioner*, 950 F.2d 365 (7th Cir. 1991), *aff'g* 60 T.C.M. 710 (1990)).
132. Rev. Rul. 76-94, 1976-1 C.B. 171.
133. Rev. Rul. 73-128, 1973-1 C.B. 222.
134. Reg. § 1.513-1(d)(4)(i).
135. *Id*.

Court opinions and public and private rulings from the IRS provide many examples of instances where a trade or business was deemed to be related to a purpose or function of a tax-exempt organization.[136] Likewise, opinions and rulings provide illustrations where a trade or business was considered an unrelated activity.[137]

(b) *Same State* Rule

Ordinarily, gross income from the sale of products that result from the performance of tax-exempt functions does not constitute gross income from the conduct of unrelated business if the product is sold in substantially the *same state* (or condition) it is in upon completion of the exempt functions.[138] For example, in the case of a charitable organization engaged in an exempt program of rehabilitation of handicapped individuals, income from the sale of articles made by these individuals as a part of their rehabilitation training would not be gross income from the conduct of an unrelated trade or business.[139] The income in this instance would be from the sale of products, the production of which contributed importantly to the accomplishment of purposes for which tax exemption was accorded the organization, namely, rehabilitation of the handicapped.[140]

Conversely, if a product resulting from the performance of a tax-exempt function is utilized or exploited in further business endeavors beyond those reasonably appropriate or necessary for the product's disposition in the state it is in upon completion of exempt functions, the gross income derived from these additional endeavors would be income from the conduct of unrelated business.[141] For example, in the case of an experimental dairy herd maintained for research purposes by a tax-exempt scientific organization, income from the sale of milk and cream produced in the ordinary course of operation of the program would not be gross income from conduct of an unrelated business.[142] Were the organization to utilize the milk and cream in the manufacture of food items, however, such as ice cream and pastries, the gross income from the sale of these enhanced products would be income from the conduct of unrelated trade or business—unless these manufacturing activities contributed importantly to the accomplishment of an exempt purpose of the organization.[143]

Similarly, a charitable organization that operated a salmon hatchery as an exempt function was able to sell a portion of its harvested salmon stock in an unprocessed condition to fish processors in an untaxed business. By

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136. These opinions and rulings are collected in TAX-EXEMPT ORGANIZATIONS § 24.4(f).
137. *Id*. at § 24.4(g).
138. Reg. § 1.513-1(d)(4)(ii).
139. *Id*.
140. *Id*.
141. *Id*.
142. *Id*.
143. *Id*.

contrast, when the entity converted the fish into salmon nuggets (fish that was seasoned, formed into nugget shape, and breaded), the sale of the fish in that state (condition) was ruled to be a taxable unrelated business.[144]

(c) *Dual Use* Rule

An asset or facility of a tax-exempt organization that is necessary to the conduct of exempt functions may also be employed in another endeavor; this is a *dual use* of assets or facilities. The mere fact of the use of the asset or facility in one or more exempt functions, however, does not alone make the income from the other endeavor gross income from a related trade or business. Instead, the test is whether the activities productive of the income from the contiguous activity contribute importantly to the accomplishment of tax-exempt purposes.[145]

For example, a tax-exempt museum has a program of public education in the arts and sciences, and a theater that is specially designed and equipped for the showing of educational films in connection with this program. The theater is a principal feature of the museum and is in continuous operation during the hours the museum is open to the public. If the organization were to operate the theater as an ordinary motion picture theater for the entertainment of the public during the evening hours when the museum was otherwise closed, gross income from the public entertainment activity would be gross income from the conduct of a related business.[146]

As another example, a tax-exempt university uses its athletic facilities primarily for educational (student) purposes, but also makes them available to members of the faculty, other of its employees, and the general public. Income derived from the use of the facilities by individuals other than the student may be income from the conduct of an unrelated business. Thus, the IRS ruled that the operation by a college of a ski facility for the general public was an unrelated business, but use of the facility by the students of the college, for recreational purposes and in its physical education program, constituted related activities.[147] A college that made available its facilities and personnel to an individual not associated with the institution, for the conduct of a summer tennis camp, was ruled to have conducted an unrelated business.[148] A school that used its tennis facilities, employed during the academic year in its educational program, in the summer as a public tennis club operated by employees of the school's athletic department, was held to have operated an

144. Priv. Ltr. Rul. 9320042.
145. Reg. § 1.513-1(d)(4)(iii).
146. *Id. See also* Rev. Rul. 68-550, 1968-2 C.B. 249 (a mailing service operated by a tax-exempt organization was ruled to be an unrelated trade or business even though the mailing equipment was also used for exempt purposes).
147. Rev. Rul. 78-98, 1978-1 C.B. 167.
148. Rev. Rul. 76-402, 1976-2 C.B. 177.

unrelated business.[149] Moreover, the IRS determined that, when a tax-exempt university leased its stadium to a professional football team for several months of the year and provided the utilities, grounds maintenance, and dressing room, linen, and stadium security services, it was engaged in an unrelated trade or business.[150]

By contrast, the provision of athletic or other facilities by a school, college, or university to the general public may be a tax-exempt undertaking, inasmuch as the instruction of individuals in sports can be an educational activity.[151] For example, the IRS held that a college's conduct of a summer hockey camp for youths was an exempt educational activity,[152] as were the conduct of four summer sports camps by a university[153] and the operation of a summer sports camp by a university-affiliated athletic association.[154] Similarly, the IRS determined that an unrelated business was not being undertaken when a college operated, on its campus, a professional repertory theater that is open to the general public[155] and when a college made its facilities available to outside organizations for the conduct of conferences.[156] Both activities were considered to be in furtherance of tax-exempt purposes.

(d) *Exploitation* Rule

Activities carried on by a tax-exempt organization in the performance of exempt functions may generate goodwill or one or more other intangibles that can be exploited in commercial endeavors.[157] Where a tax-exempt organization exploits this type of intangible in a commercial activity, the mere fact that the resultant income depended in part on an exempt function of the organization does not make it gross income from a related trade or business.[158] Unless the commercial activities contributed importantly to the accomplishment of a tax-exempt purpose, the income that is produced is gross income from the conduct of an unrelated trade or business.[159]

In one instance that is illustrative of this rule, the IRS considered the activities of a tax-exempt organization, the primary purpose of which was

149. Rev. Rul. 80-297, 1980-2 C.B. 196.
150. Rev. Rul. 80-298, 1980-2 C.B. 197. This *dual use* rule is, in some ways, another application of the *fragmentation rule* (*see* text accompanied by *supra* notes 32–38). Also, in some instances, unrelated business income taxation can be avoided, either rule notwithstanding, when the matter is structured so that the tax-exempt organization is merely passively receiving rent (*see* § 24.17(b)).
151. E.g., Rev. Rul. 77-365, 1977-2 C.B. 192.
152. Priv. Ltr. Rul. 8024001.
153. Priv. Ltr. Rul. 7908009.
154. Priv. Ltr. Rul. 7826003.
155. Priv. Ltr. Rul. 7840072.
156. Priv. Ltr. Rul. 8020010.
157. Reg. § 1.513-1(d)(4)(iv).
158. *Id*.
159. *Id*.

to retain and stimulate trade in a downtown area of a city where adequate parking facilities were lacking. This organization, formed by civic leaders and individuals in various businesses and professions, operated fringe parking facilities and a shuttle bus service to and from the downtown area. No merchants were specifically favored by the manner in which the fringe parking lot and bus service were operated or in the selection of pickup and discharge points, nor were they able to offer patrons free or discount parking or bus fares. The organization, as an insubstantial part of its activities, operated a park-and-shop plan by which patrons of particular downtown participating merchants were able to park free at certain parking lots. The merchants in this plan purchased parking stamps, which were distributed to their customers and subsequently surrendered to the parking lot management in lieu of money. The IRS ruled that the operation of the fringe parking lot and bus service contributed importantly to the accomplishment of the organization's tax-exempt purposes because it provided ''easy and convenient access to the downtown area and, thus, stimulates and improves business conditions in the downtown area generally.''[160] But the IRS ruled that the operation of the park-and-shop plan ''constitutes the provision of a particular service to individual members of the organization'' and was an unrelated business, in that it ''did not further and was exploitative of the organization's exempt purpose.''[161]

Likewise, the operation of athletic or other facilities by a college or university for other than instructional (related business) purposes may give rise to gross income from an unrelated trade or business—but by virtue of the *exploitation rule* rather than the *dual use rule*. (The law concerning taxation of advertising revenue received by tax-exempt organizations[162] treats advertising as an exploitation of exempt publication activity.[163]) Where access to athletic facilities by students is covered by a general student fee, outside use may amount to exploitation, whereas, if separate charges for use of the facilities are made of students, faculty, outsiders, and others, any unrelated business income is treated under the dual use rule.[164]

§ 24.5 APPLICATION OF *SUBSTANTIALLY RELATED* TEST TO HEALTHCARE ORGANIZATIONS

A variety of types of tax-exempt organizations, and activities of tax-exempt organizations, present special applications of the rules concerning the operation of *trades or businesses* that may or may not generate taxable unrelated

160. Rev. Rul. 79-31. 1979-1 C.B. 206, 207.
161. *Id*. at 207.
162. IRC § 513(c).
163. Reg. § 1.513-1(d)(4)(iv).
164. E.g., Priv. Ltr. Rul. 7823062.

business income. Nonetheless, the same general set of concepts that is applicable in the context of determining tax-exempt status is applicable in ascertaining whether an activity is a related one for purposes of the unrelated business income rules. In the healthcare setting, for charitable organizations, the threshold determination is whether the activity furthers the objective of promoting health.[165] For social welfare organizations, the test is whether some form of social welfare or civic betterment is being advanced.[166] For business leagues, the standard is whether there is promotion of a common business interest, by improving the business conditions of one or more lines of business.[167]

The scope of a tax-exempt organization's rationale for exemption can be critical in the realm of unrelated trade or business: the more encompassing the range of exempt activities, the greater the likelihood that an undertaking will be considered related rather than unrelated. For example, a court ruled that sales of pharmaceuticals by an exempt hospital to members of the general public gave rise to unrelated business taxable income.[168] Yet, another court concluded that sales of pharmaceuticals by an exempt hospital to nonhospital patients of physicians practicing at the hospital did not produce unrelated business income because the sales were important in attracting and holding physicians in a community that had lacked any medical services for several years prior to the establishment of the hospital.[169] The difference between the two outcomes in this regard was that, in the latter case, the court was persuaded that the organization's purpose was more than solely maintaining a hospital; another purpose was to attract physicians to the community and provide services to retain them.[170]

This principle of law is illustrated in other healthcare contexts. For example, one area of controversy has been the tax status of fitness centers and health clubs or, where this type of center or club is operated as a program of a hospital or other healthcare institution, whether the operation is an unrelated trade or business. In this setting, the IRS looks to the breadth of the group of individuals being served. If the fees for use of a health club are sufficiently high to restrict use of the club's facilities to a limited segment of a community, the club operation will be a nonexempt one or an unrelated business activity.[171] By contrast, where the health club provides a communitywide benefit for the community the organization serves, operation of the club is an exempt function

165. *See* § 1.7.
166. *See* § 1.8.
167. *See* Chapter 18.
168. *Carle Foundation v. United States*, 611 F.2d 1192 (7th Cir. 1979), *cert. denied*, 449 U.S. 824 (1980).
169. *Hi-Plains Hospital v. United States*, 670 F.2d 528 (5th Cir. 1982).
170. This identical dichotomy applies with respect to laboratory testing (*see* § 24.11), as has been discussed by the IRS in some detail (e.g., Priv. Ltr. Rul. 8246018).
171. Rev. Rul. 79-360, 1979-2 C.B. 236.

or a related business.[172] This latter position is predicated on the rule in the general law of charity that the promotion of the happiness and enjoyment of the members of the community is considered to be a charitable purpose.[173] In one instance, the IRS blended these two definitions of charity in finding that a health club was tax-exempt because its ''operations promote health in a manner which is collateral to the providing of recreational facilities which advances the well-being and happiness of the community in general.''[174] Similarly, a fitness center was held to be tax-exempt inasmuch as it furthered the accomplishment of certain of the other programs of the health organization that operated it (including an occupational and physical therapy program), its facilities and programs were specially designed for the needs of the handicapped and the treatment plans of patients in other programs, its fee structure was designed to make it available to the general public (its rates were comparable to those charged by other similar local fitness centers), and it offered a range of programs and activities that focused on wellness.[175] Likewise, a freestanding state-of-the-art cardiovascular rehabilitation and heart disease prevention center, which included a fitness facility, was found to be a related activity of an exempt hospital, with the IRS emphasizing a nutrition program and a scholarship plan for those who could not afford the programs and services of the center.[176]

The provision of ancillary healthcare services by charitable healthcare providers by means of a health maintenance organization (an exempt social welfare entity[177]), with income in the form of capitated payments for the services of employee/physicians and physicians who are independent contractors, was ruled to be a related business.[178] Designation of a healthcare provider as the preferred provider of services for patients of another charitable organization and its statewide affiliates was held not to be the creation of an unrelated business.[179] An exempt hospital was ruled to be operating, as a related business, outpatient clinics (faculty physician practices).[180] The

172. Tech. Adv. Mem. 8505002.
173. Restatement (Second) of Trusts § 374 (1959); IV Scott, The Law of Trusts § 374.10 (3d ed. 1967).
174. Tech. Adv. Mem. 8505002. The IRS also ruled, however, that an organization that operated a health club was thereby engaged in an unrelated trade or business because the annual fees were sufficiently high to restrict participation in the program to a limited number of members of the community; the health club facilities were operated under a two-tiered membership structure that made recreational facilities available to the general public at one rate and other facilities available only for a limited number of individuals at a higher rate (Rev. Rul. 79-360, 1979-2 C.B. 236).
175. Priv. Ltr. Rul. 9329041.
176. Priv. Ltr. Rul. 9736047. A like outcome with respect to a university-based fitness center was the subject of Priv. Ltr. Rul. 9732032.
177. *See* § 1.8.
178. Priv. Ltr. Rul. 9837031.
179. Priv. Ltr. Rul. 9839040.
180. Priv. Ltr. Rul. 200211051.

operation of a call center by an exempt ambulance service provider was ruled to be a related business.[181]

In another instance, a healthcare provider of rehabilitative services developed a full-service preventive healthcare and rehabilitation facility. It consisted of health resources, physical development and rehabilitation, outpatient services, physician offices, and a chapel. The facilities entailed a gymnasium, track, warm-water hydrotherapy pool, lap pool, natatorium, racquetball and squash courts, health resources library, physical development equipment, aerobic studio rooms, exercise areas, massage therapy area, and several areas dedicated to education classes, including a demonstration kitchen. The facility further included a pro shop and a café. The organization provides rehabilitation services to its patients, offers extensive community education and prevention programs, and has a pricing policy that enabled all segments of the community involved to be represented in its membership. The IRS ruled that these operations consisted of charitable and educational undertakings.[182]

Considerable attention in this area has been focused on nonprofit physical rehabilitation organizations, which often provide housing and other services that are generally available commercially. The IRS ruled that an organization that provided specially designed housing to physically handicapped individuals at the lowest feasible cost, and maintained in residence those tenants who subsequently became able to pay the monthly fees, was a tax-exempt charitable entity[183]. The IRS similarly ruled that the rental to individuals under the age of 25 and to low-income individuals of all ages of dormitory rooms and similar residential accommodations was a related business.[184] The IRS likewise ruled that a halfway house, organized to provide room, board, therapy, and counseling for individuals discharged from alcoholic treatment centers, was a tax-exempt charitable organization; its operation of a furniture shop to provide full-time employment for its residents was considered a related business.[185] Also, the IRS ruled that an organization that provided a residence facility and therapeutic ''group living program'' for individuals recently released from a mental institution was an exempt charitable organization.[186] An organization with the purpose of providing rehabilitative and prevocational counseling to the handicapped and developmentally disabled received a ruling that its residential and day-care facilities were related activities.[187] Another entity, a charitable organization that maintained nursing homes and ancillary and related health facilities, was ruled to be engaged in the following related businesses: programs offering physical therapy, occupational therapy, speech

181. Priv. Ltr. Rul. 200222031.
182. Priv. Ltr. Rul. 200101036.
183. Rev. Rul. 79-19, 1979-1 C.B. 195.
184. Rev. Rul. 76-33, 1976-1 C.B. 169.
185. Rev. Rul. 75-472, 1975-2 C.B. 208.
186. Rev. Rul. 72-16, 1972-1 C.B. 143.
187. Priv. Ltr. Rul. 9335061.

therapy, injury prevention, pediatric services, and adult day care, as well as the provision of day care for its employees.[188] The operation of adult foster care homes was ruled to be a charitable undertaking,[189] as was the operation of home health activities, certain temporary medical staffing activities, a fitness center, wellness programs, physical therapy programs, rehabilitation programs, occupational health activities, and the provision of certain durable medical equipment and infusion services.[190]

Lifestyle rehabilitation programs can also present this dichotomy. For example, the IRS ruled that the operation of a miniature golf course in a commercial manner by a tax-exempt organization, the purpose of which was to provide for the welfare of young people, constituted an unrelated trade or business.[191] The IRS also ruled, however, that a tax-exempt organization, formed to improve the life of abused and otherwise disadvantaged children by means of the sport and business of golf, did not conduct an unrelated activity in operation of a golf course because the opportunity to socialize and master skills through the playing of the game were ''essential to the building of self-esteem and the ultimate rehabilitation of the young people'' in the organization's programs.[192]

A charitable and educational organization that was engaged in a broad range of activities concentrating on the dissemination of medical information, information on health, and disease prevention advice, embarked on a program aimed at increasing public awareness of the possibilities for early detection of breast cancer through the use of mammography. To this end, the organization operated a mobile mammogram unit that toured the country offering free breast examinations at various locations adjacent to facilities such as hospitals, government offices, and factories. Additional mobile units were added as funding allowed. The IRS, noting that promotion of health is a charitable undertaking, ruled that the operation of these cancer screening units was a related activity.[193]

As another illustration, a tax-exempt medical society proposed to undertake a program by which allegations of medical malpractice made against its members were subjected to peer review by other members, and the results of that review were made available to the accused members' lawyers. As the program progressed, the organization would establish a database of

188. Priv. Ltr. Rul. 9241055.
189. Priv. Ltr. Rul. 199943053.
190. Priv. Ltr. Rul. 9750056.
191. Rev. Rul. 79-361, 1979-2 C.B. 237.
192. Priv. Ltr. Rul. 8626080. At the same time, the IRS ruled that the operation of a family golf center, including a driving range, miniature golf course, and other recreational activities, constituted an unrelated business by this organization. A charitable organization engaged in the rehabilitation of disabled individuals was found to be operating a related business in operating a placement service to provide these persons with sheltered employment (Priv. Ltr. Rul. 9728034).
193. Priv. Ltr. Rul. 8749085.

professional liability claims made against practitioners in a particular specialty, and would make the information available to members and to the interested public, ultimately including insurance companies and patients. The IRS ruled that the organization would be engaging in exempt functions by aiding the medical profession as a whole to control costs and provide better medical treatment to patients in general. The only reasonable way to obtain this data would be to review individual cases; the IRS found that any benefit to individual practitioners would be incidental.[194] Yet, a professional standards review organization was ruled to be engaged in an unrelated business because of its peer review activities with respect to hospitalizations other than those paid for by the Medicare and Medicaid programs.[195]

Reference was previously made to the rule that, where income is realized by a tax-exempt organization from an activity that is, in part, related to the performance of its exempt functions but is conducted on a scale larger than is reasonably necessary for performance of the functions, the income attributable to that portion of the activity in excess of the needs of tax-exempt functions constitutes income from the conduct of unrelated trade or business.[196] This is illustrated in the healthcare context by the law pertaining to the provision of services by one organization to another within the same hospital system.[197] In the view of the IRS, the provision of services to related institutions that are under common control is a related trade or business, but the provision of the same services to unrelated organizations is an unrelated trade or business because the activity performed is on a scale much larger than necessary for conduct of the exempt function.[198] As another example, the operation of a guest accommodation facility used primarily by visitors at a tertiary care hospital was ruled to be a related trade or business; use of the facilities by the general public would be an unrelated trade or business.[199] A professional standards review organization conducts a related trade or business when it provides healthcare services under a contract with a federal agency—and then only services provided under Medicare and Medicaid;[200] however, when this type of organization conducts peer review activities for the private sector, it is engaging in an unrelated trade or business.[201]

A trust created by a tax-exempt hospital for the sole purpose of accumulating and holding funds to be used to satisfy malpractice claims against the hospital, and from which the hospital directs the bank-trustee to make payments to claimants, is an entity operated exclusively for charitable purposes and

194. Priv. Ltr. Rul. 8730060.
195. Priv. Ltr. Rul. 8511082.
196. *See* § 24.4, text accompanied by *supra* notes 126–133.
197. *See* § 24.14.
198. E.g., Priv. Ltr. Rul. 8817017.
199. Priv. Ltr. Rul. 9404029.
200. Rev. Rul. 81-276, 1981-2 C.B. 129.
201. Priv. Ltr. Rul. 9408026.

thus is tax-exempt.[202] The IRS ruled, however, that the provision of insurance to a for-profit subsidiary of a public charity parent by an organization supporting the parent entity is an unrelated business of the supporting organization.[203]

In general, with regard to healthcare activities, certain relatedness tests have evolved through myriad rulings by the IRS. The use of these tests can help determine whether the IRS would consider the activities to be substantially related to the organization's exempt purposes in the related/unrelated business setting.

One of these tests is based on whether the beneficiary of a service is a *patient* of the provider institution.[204] If so, the activity is likely to be a related one or be sheltered by the convenience business exception.[205] Where there is a finding that the activity is related to a provider's tax-exempt purposes, the patient/nonpatient test is irrelevant.[206]

Closely related to the patient/nonpatient test is the "hands-on medical care" test: whether the services being provided by the exempt healthcare organization involve the provision of "hands-on" care by an employee or contractor of the exempt organization. This finding tends to support a conclusion that an activity is substantially related to exempt functions. This analysis is part of the rationale for including home-care services provided by a nonprofit hospital as related even though performed outside of the hospital, for individuals who are technically not inpatients or outpatients of the hospital.[207]

The IRS has generally followed a "commercial availability" test in reaching determinations of relatedness and unrelatedness. If a business activity undertaken by an exempt provider is also being undertaken by a commercial entity in the same geographical area and the activity is not otherwise related to the provider's exempt purposes, it will likely be determined an unrelated trade or business. If, however, that same service or product is provided in an area in which the service or product is not otherwise commercially available, it may escape taxation as an unrelated trade or business.[208] This test is particularly applicable with respect to sales by exempt hospitals of pharmaceuticals and laboratory testing services.[209]

§ 24.6 DEFINITION OF *PATIENT*

The determination as to whether a service provided to an individual by a tax-exempt hospital or other healthcare entity is a trade or business usually depends on whether the individual is a *patient* of the organization involved.

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202. Rev. Rul. 78-41, 1978-1 C.B. 148.
203. Priv. Ltr. Rul. 200501017.
204. *See* § 24.6.
205. *See* § 24.17(a), text accompanied by notes 360–365.
206. E.g., Priv. Ltr. Rul. 8013052.
207. Rev. Rul. 68-376, 1968-2 C.B. 246, Example 5.
208. E.g., Priv. Ltr. Rul. 8004011.
209. *See* §§ 24.10 and 24.11.

This is the case whether the business is a related one [210] or an activity sheltered by the convenience business exception.[211]

In this connection, the IRS set forth six relationships where an individual is considered a *patient* in a hospital.[212] These are:

1. An individual is admitted to a hospital as an inpatient, receiving a bed, meals, diagnostic services, and treatment for his or her illness.
2. An individual is taken to a hospital's emergency room for treatment of injuries sustained in an accident. He or she is treated in the emergency room and discharged, but is instructed to return to the outpatient clinic of the hospital for further treatment. The hospital maintains, during regularly scheduled hours, an outpatient clinic where medical services are provided on an outpatient basis. The governing authority of the hospital has full legal responsibility for the conduct of the clinic. This individual visits the clinic, is registered as a patient, and receives medical care. Treatment in either the emergency room or the outpatient clinic is sufficient to make this individual a *patient* of the hospital.
3. An individual's private physician refers him or her to the outpatient diagnostic facilities of a hospital for a specific diagnostic procedure. The procedure is administered by a hospital-based practitioner affiliated with the hospital. The availability of these diagnostic procedures is an integral part of the services offered by the hospital.
4. An individual was formerly a patient of a hospital. During his or her course of treatment, the attending staff physician gave this individual a prescription. This prescription was filled at the hospital pharmacy, which filed and retained it. After formal discharge as a patient, this individual finds it convenient to return to the hospital pharmacy to obtain a refill of the prescription. Because the prescription was written in the course of the hospital–patient relationship, this individual remains a patient of the hospital.
5. An individual receives medical services in his or her residence. The services are rendered by, and under the supervision of, the professional staff of a hospital as an extension of its inpatient and outpatient care. (This is known as a ''hospital-administered home-care program.'')
6. An individual is a patient in an extended-care facility qualified to participate in Medicare and other government-financed programs. The facility is affiliated with a hospital that, by agreement, is responsible for certain of its professional activities, especially those necessary to qualify the facility for participation in the Medicare program. While this

210. *See* § 24.4.
211. *See* § 24.17.
212. Rev. Rul. 68-376, 1968 C.B. 246.

individual is a patient in the facility, he or she is under the medical supervision of a member of the hospital's medical staff.

In one instance, the IRS ruled that the following individuals were patients of a hospital: (1) those admitted to the hospital; (2) those being treated in the hospital's emergency room; (3) those having day surgery at the hospital; (4) those receiving treatment at or through several women's day surgery units operated by the hospital; (5) those scheduled to be admitted to the hospital, for whom their private physicians had ordered preadmission laboratory or radiology work to be performed at the hospital; (6) those who had been in the hospital and subsequently were released, for whom their private physicians had ordered follow-up laboratory or radiology work to be performed at the hospital; (7) those in a home-care program in which the hospital participated; (8) those receiving medical treatment at or through clinics operated by the hospital at various locations, for whom laboratory or radiology work was needed; and (9) employees of the hospital, in connection with a required employment application physical, an annual physical, or an on-the-job illness or injury.[213] By contrast, the following categories of individuals were not considered patients of the hospital: (1) those receiving medical treatment at or through another hospital or clinic, whose laboratory or radiology work was performed by the hospital because necessary equipment or personnel were not available at the other hospital or clinic; (2) those whose laboratory or radiology work was sent or referred to the hospital from another radiologist, pathologist, or laboratory; and (3) those not in a previous category for whom their private physicians ordered laboratory or radiology work, including diagnostic work.[214]

§ 24.7 GIFT SHOPS, CAFETERIAS, AND COFFEE SHOPS

The typical tax-exempt hospital operates several related businesses in support of its exempt function of promoting health. There are many illustrations of these businesses, but gift shops, cafeterias, and coffee shops predominate. Generally, these functions are deemed to be for the convenience of employees, patients, and visitors.[215]

An exempt hospital may operate a gift shop that is patronized principally by visitors making purchases for patients (as well as by patients, employees

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213. Priv. Ltr. Rul. 8246018.

214. *Id*. The IRS expanded the range of this definition of *patient* to embrace any situation, irrespective of location, where the healthcare service provider is an employee of the hospital (Priv. Ltr. Rul. 9445024). This ruling enabled an exempt hospital to provide services by contract with various skilled nursing facilities in a community without unrelated business income taxation.

215. IRS Exempt Organizations Examination Guidelines Handbook (I.R.M. 7(10)69) at § 333.8(4) (''Hospital Audit Guidelines''), reproduced by the IRS for broader dissemination in Ann. 92-83, 1992-22 I.R.B. 59. *See* Appendix F.

of the hospital, and independent contractors with respect to the hospital). This type of enterprise is a related business[216] and has been described as follows: It is ''operated by a full-time, salaried manager assisted by members of the hospital auxiliary. The gift shop sells candy, newspapers, books, magazines, flowers, and other small gift items. It handles rental orders for television sets for patients. It also operates a 'gift cart' that is taken throughout the hospital.''[217]

The IRS, following the observation that one of the purposes of a hospital is to provide healthcare for members of the community, ruled that, ''[b]y providing a facility for the purchase of merchandise and services to improve the physical comfort and mental well-being of its patients, the hospital is carrying on an activity that encourages their recovery and therefore contributes importantly to its exempt purposes.''[218] The IRS added: ''Furthermore, since it is to the hospital's advantage to keep its employees and medical staff on its premises throughout their working days, the sale of reading materials, candy, and other personal effects by the gift shop to hospital personnel increases the hospital's efficiency and contributes importantly to its exempt purpose.''[219]

This rationale has been extended to the operation by a hospital of a cafeteria and coffee shop. These facilities have been described by the IRS as being in the main building of the hospital and as primarily serving its employees and medical staff.[220] The IRS added: ''This enables hospital personnel to eat on the premises in order for them to be available for emergency situations and other hospital duties. Persons visiting patients in the hospital are permitted to use the facilities; however, the general public is not encouraged to use them.''[221]

The rationale for the treatment of tax-exempt hospital cafeterias and coffee shops as related businesses is this: ''The maintenance of the cafeteria and coffee shop on its premises for its employees and medical staff enables the hospital to operate more efficiently and thus contributes importantly to its exempt purpose. Visitation of patients constitutes supportive therapy that assists in patient treatment and encourages their recovery. By permitting visitors to use the hospital cafeteria and coffee shop, the hospital enables them to spend

216. Rev. Rul. 69-267, 1969-1 C.B. 160.
217. *Id*.
218. *Id*.
219. *Id*. Using similar reasoning, the IRS found the operation of a guest accommodation facility to be a related activity (Priv. Ltr. Rul. 9404029: ''The visitation of patients contributes important supportive therapy that assists in patient treatment and encourages their recovery. The operation of . . . [the facility] will be a means to enhance the visitation of patients. [The facility] will provide a common space for families and friends to use for comfort and mutual support with other visitors with ill family members, providing a compassionate atmosphere of camaraderie''). The IRS used a somewhat similar rationale in ruling that museum gift shops are related businesses (Rev. Rul. 74-399, 1974-2 C.B. 172).
220. Rev. Rul. 69-268, 1969-1 C.B. 160.
221. *Id*.

more time with the patients. This also contributes importantly to the hospital's exempt purpose.''[222]

A nonprofit organization, the purpose of which is to operate a gift shop and a gift cart within a proprietary hospital, can qualify for tax exemption as a charitable entity because these activities primarily improve the physical comfort and mental well-being of the hospital's patients, thereby encouraging their recovery.[223] This will be the outcome, however, only where the activities of the organization only incidentally benefit the proprietary hospital.[224]

The IRS advised its auditing agents to check for these facilities in ''adjacent medical office buildings that primarily serve the private patients of doctors in the building''[225] as part of their search for unrelated business activities.

§ 24.8 PARKING FACILITIES

A tax-exempt hospital can operate a parking lot as a related business. The provision of parking facilities is generally considered to be either an exempt function[226] or for the convenience of patients and employees.

A typical fact pattern in this regard is as follows: ''The hospital was concerned with providing sufficient parking space for visitors because visitation is considered to be a supportive therapy and part of patient treatment. Because of a serious lack of adequate parking space, the hospital constructed adjacent to its main building a parking lot for patients and visitors only. The lot is not for general public utilization. A fee is charged for the use of these facilities and all profits are placed in the hospital's general operating fund.''[227]

The rationale for this conclusion was: ''One of the purposes of the hospital is to provide health care for members of the community. Visitation of patients constitutes supportive therapy that assists in patient treatment and encourages their recovery. Without adequate parking facilities for patients and visitors, the hospital could not operate with maximum effectiveness in serving the public.''[228]

In one instance, a tax-exempt hospital owned and maintained a multistory parking garage that also served students at a medical and dental school; use by patients, visitors, personnel, and students was 87 percent of the total, so the IRS ruled that the operation of the garage was a convenience business.[229]

222. *Id*.
223. Gen. Couns. Mem. 39762.
224. The IRS ruled that a nonprofit organization that ministers to the nonmedical needs of patients of a proprietary hospital was tax-exempt as a charitable entity, where any benefit to the hospital was incidental (Rev. Rul. 68-73, 1968-1 C.B. 251).
225. Hospital Audit Guidelines, *supra* note 215, at § 333.8(4).
226. E.g., Priv. Ltr. Rul. 9315021.
227. Rev. Rul. 69-269, 1969-1 C.B. 160.
228. *Id*. at 161.
229. Priv. Ltr. Rul. 8815031. Inasmuch as the remaining garage use was by the general public, normally that use would be an unrelated trade or business (e.g., Tech. Adv. Mem.

In another case, an exempt hospital that participated in the construction of a medical office building was advised by the IRS that the addition of parking spaces in its existing parking garage adjacent to the building would not jeopardize its tax exemption.[230] Likewise, tax-exempt hospitals, by means of affiliated entities, developed medical office and condominium projects, and in that connection the IRS ruled that construction and operation of associated parking facilities would not jeopardize the tax-exempt and public charity status of the hospitals or their affiliates.[231]

The operation of a parking facility itself may be a related business, in which case the parameters of the convenience doctrine need not apply.[232]

The IRS advised its auditing agents that, ''if the parking facility is primarily serving private patients of doctors in an adjacent office building,'' there may be an unrelated business taking place.[233]

§ 24.9 TEMPORARY RESIDENTIAL FACILITIES

Temporary residential facilities, for the use of patients and their relatives and friends, can be operated as related businesses or convenience businesses. In finding the operation of a motel adjacent to a medical center to be an exempt function, the IRS wrote: ''Providing patients with a temporary place to stay that is readily accessible to the hospital while they undergo treatment at the hospital is an activity that provides a convenience to the hospital's patients consistent with the'' convenience doctrine.[234] The IRS continued:

> It affords patients with a place that is close to the hospital where treatment is readily available. In addition, patients do not have to worry about how the hospital will locate them in the event of emergencies. It also encourages their comfort and

8735004); however, in this instance, that portion of use was a charitable activity because it lessened the burdens of a city government.

230. Priv. Ltr. Rul. 8817067.
231. E.g., Priv. Ltr. Rul. 9739041.
232. For example, a tax-exempt museum was found to be operating a parking facility as an exempt function, as a means of advancing education (Tech. Adv. Mem. 8735004). This finding was enhanced by the fact that the parking area served other educational organizations.

    The examining agent tried to fragment the parking operation, on the ground that the convenience exception (available because the IRS ruled that the term *member* is sufficiently broad to cover patrons of the museum) would not apply during the 30 percent of the time the museum was open. The IRS National Office thwarted this approach by ruling that the parking lot was an exempt function. The *convenience exception* is available where the activity is carried on primarily for the convenience of members and the like; use of the parking lot 70 percent of the time as a convenience business would seem adequate to satisfy the threshold of *primary*. The IRS so held where 87 percent of the use of a parking facility was made by personnel, patients, and visitors of a medical and dental school (Priv. Ltr. Rul. 8815031).
233. Hospital Audit Guidelines, *supra* note 215, at § 333.8(5).
234. Tech. Adv. Mem. 9847002.

> well-being since they know that they have a nearby place to stay during the time they are undergoing treatment at the hospital.[235]

As noted, this function can be nontaxable when provided to patients' friends and family members. The IRS continued: ''Equally important, their friends and relatives also can stay nearby to provide needed support. Providing a temporary living facility for patients and their friends or family members also advances one of the purposes of the hospital which is to provide health care for members of the community so that this activity also is excepted from constituting an unrelated trade or business'' because it is an exempt function.[236]

In this case, 75 percent of the motel's guests were patients and relatives and friends of patients. Thus, the operation of the motel was held to be in furtherance of the exempt purposes of the medical center. By application of the fragmentation rule,[237] the IRS ruled that the balance of the motel's activities was subject to unrelated business income taxation.

§ 24.10 PHARMACY, MEDICAL SUPPLIES, AND SERVICES SALES

(a) Pharmaceutical Sales

The sale of pharmaceuticals to patients, by a pharmacy operated by a tax-exempt hospital, is not the conduct of an unrelated trade or business.[238] This is another application of the convenience doctrine in the healthcare context.[239] By contrast, the sale of pharmaceuticals by a tax-exempt hospital to private patients of physicians who have offices in a medical building owned by the hospital is considered by the IRS to constitute the conduct of an unrelated business.[240]

The IRS outlined the circumstances in which, in its view, a tax-exempt hospital derives unrelated business income from the sale of pharmaceuticals to the general public.[241] A federal court of appeals considered this issue and also concluded that sales of pharmaceuticals by an exempt hospital to members of the general public gave rise to unrelated business taxable income.[242] Here, the concept of the *general public* encompassed the private patients of the hospital-based physicians, on the rationale that sales by the pharmacy to the patients were related to the purchaser's visit to his or her

235. *Id*.
236. *Id*.
237. *See* § 24.2(a).
238. Reg. § 1.513-1(c)(2)(ii); Rev. Rul. 68-376, 1968-2 C.B. 246.
239. *See* § 24.17(a), text accompanied by *infra* notes 360–365.
240. Rev. Rul. 68-375, 1968-2 C.B. 245.
241. Rev. Rul. 68-374, 1968-2 C.B. 242.
242. *Carle Foundation v. United States*, 611 F.2d 1192 (7th Cir. 1979), *cert. denied*, 449 U.S. 824 (1980).

private physician at offices rented from the hospital and were not related to the use of services provided by the hospital. Another consideration was that tax-exempt hospital-operated pharmacies unfairly compete with commercial pharmacies.[243]

By contrast, another federal court of appeals concluded that sales of pharmaceuticals by an exempt hospital to nonhospital private patients of physicians practicing at the hospital did not produce unrelated business income because the sales were important in attracting and holding physicians in a community that had lacked any medical services for several years prior to the establishment of the hospital.[244] This appellate court ruled that the lower court was in error in defining the organization's function solely as that of maintaining a hospital, and held that another purpose was to attract physicians to the community and provide facilities to retain them. This court of appeals concluded that the ''availability of the hospital's pharmacy for use by the doctors' private patients is causally related to inducing doctors to practice at the hospital.''[245] The appellate court distinguished this case from the holding of the other court of appeals, stating that the facts in the latter case ''give no indication that the hospital had any difficulty in attracting doctors to its staff.''[246] The court of appeals, however, remanded the case to the lower court for it to determine whether sales of pharmaceuticals by the hospital to the general public constituted an unrelated trade or business.[247]

The provision of medical drugs by a healthcare organization to the employees of a healthcare system and their dependents, at a discount (as a fringe benefit), is a business activity that is not taxed by reason of the exception for convenience businesses.[248]

The IRS instructed its auditing agents to note the locations of pharmacies in a hospital, and to determine whether there are ''satellite locations'' in one or more medical office buildings. It advised the agents that pharmacies that ''are located away from the hospital are more likely to engage in nonpatient sales.''[249] The agents are to be ''alert for newspaper and telephone yellow page ads for the pharmacy.''[250] They are also to (1) determine ''hospital policies regarding sales to non-patients, other hospitals, nursing homes, non-employee doctors, etc.'' and, if sales to outsiders occur, record the amount of sales; (2) check pharmacy department records, including sales registers and prescription logs, and compare these to patients' records; (3) interview pharmacy

243. *See* § 24.2(a).
244. *Hi-Plains Hospital v. United States*, 670 F.2d 528 (5th Cir. 1982).
245. *Id*. at 531.
246. *Id*. at 533.
247. The IRS does not accept this more expansive view of a hospital organization for unrelated trade or business purposes.
248. Priv. Ltr. Rul. 8736046.
249. Hospital Audit Guidelines, *supra* note 215, at § 333.8(3)(a).
250. *Id*. at § 333.8(3)(b).

personnel; and (4) determine whether the pharmacy ''sells items other than drugs.''[251]

(b) Medical Supplies Sales

The IRS considered a tax-exempt hospital that had as its primary activity the operation of a clinic that provided various rehabilitation services to handicapped individuals, including those with hearing deficiencies. The hospital tested and evaluated the hearing of its patients with these deficiencies, and recommended the types of hearing aid that were suitable in each case. The hospital sold hearing aids and fitted them, to ensure maximum assistance to the patients in the correction or alleviation of their hearing deficiencies. The IRS ruled that the sale of hearing aids as an integral part of this hospital's program was not an unrelated trade or business because it ''contributes importantly to the organization's purpose of promoting the health of such persons.''[252]

In one instance, a tax-exempt healthcare organization affiliated with a hospital system generated about 5 percent of its gross income from the sales and rentals of durable medical equipment. Approximately 98 percent of these sales and rentals were to patients who had been discharged by the hospital or who used the hospital's outpatient and diagnostic facilities. The remaining 2 percent of the sales and rentals were to nonpatients. The IRS ruled that the sales and rentals of the equipment to the patients of the system were not unrelated business; the sales and rentals to the nonpatients were unrelated business.[253] Sales of this nature to *patients* are often protected from federal income taxation by the convenience doctrine.[254]

As discussed below, in certain instances, a tax-exempt hospital can provide services to one or more other exempt hospitals without the services constituting one or more forms of unrelated business.[255]

IRS auditing agents are expected to determine whether the hospital ''sells medical supplies to outsiders such as nursing homes, private doctors, other hospitals, and commercial labs.''[256]

(c) Sales of Other Services

In the course of its operations, a tax-exempt hospital may provide a variety of services to inpatients, outpatients, students, and employees of unrelated organizations, without engaging in an unrelated trade or business. These services include ultrasound and general radiology, mammography, outpatient dialysis, acute dialysis, critical life support, rehabilitation, home health services,

251. *Id*. at § 333.8(3)(c)–(e).
252. Rev. Rul. 78-435, 1978-2 C.B. 181.
253. Priv. Ltr. Rul. 8736046.
254. *See* § 24.17(a).
255. *See* §§ 24.14 and 24.15.
256. Hospital Audit Guidelines, *supra* note 215, at § 333.8(9).

occupational health, bill collection (for a related hospital), transportation, electrocardiogram computer, wellness and prevention, employee physicals, storage of medical and administrative records, and the leasing of optometrists to an optical chain selling optical services, in part, to subscribers of a related health maintenance organization.[257] (The sale of laboratory testing services is discussed below.[258])

A hospital may be able to develop real estate, by constructing condominium residences to be used as short-term living quarters by its patients, as a related business.[259]

In other instances, the IRS has ruled that the rental of pagers to staff physicians by an exempt hospital is not an unrelated business[260]; the sale by a hospital of silver recovered from x-ray film is not an unrelated business[261]; and the leasing of space and the furnishing of services to physicians are not unrelated activities by the hospital.[262]

§ 24.11 LABORATORY TESTING SERVICES

A hospital, as well as other types of healthcare entities, has one or more laboratories in which diagnosis testing and similar activities occur. Some of these institutions provide these services only with respect to their own healthcare programs and/or directly related entities; others sell the services to outside parties.

The provision of laboratory services by a hospital to or for the benefit of its patients is a related business.[263] In one instance, a medical outpatient clinic operated an on-site licensed medical laboratory, in furtherance of its purpose of ''providing convenient, timely and complete emergency and diagnostic medical care''; the IRS held that the revenues generated by the laboratory did not constitute unrelated business income to the extent that they arose out of services performed for patients of the clinic.[264]

The provision of services to nonpatients raises questions as to whether the sales activities are unrelated businesses. The IRS instructed its examining agents, in ascertaining whether there is laboratory income from nonpatients (when laboratory specimens for patients of private physicians, nursing homes, other hospitals, and commercial laboratories are tested), that they may have to interview the director of the laboratory, asking whether there is a secondary record showing patient and nonpatient revenue, and whether blood from

257. E.g., Priv. Ltr. Rul. 8736046.
258. *See* § 24.11.
259. Priv. Ltr. Rul. 8427105.
260. Tech. Adv. Mem. 8452011.
261. Tech. Adv. Mem. 8452012.
262. Priv. Ltr. Rul. 8452099.
263. Priv. Ltr. Rul. 8809092; Hospital Audit Guidelines, *supra* note 215, at § 333.8(2)(a).
264. Priv. Ltr. Rul. 8809092.

the hospital blood bank is being sold to commercial laboratories.[265] Agents are also to determine ''whether salesmen are calling on physicians to solicit business, whether a pick-up service is provided to carry specimens, whether the hospital advertises its lab services on television or in the telephone yellow pages; etc.''[266]

In the view of the IRS, the performance of diagnostic laboratory testing, otherwise available in the community, by a tax-exempt hospital, upon referred specimens from private office patients of the physicians practicing at the hospital, constitutes an unrelated trade or business.[267] The IRS concluded that there was no substantial causal relationship between the achievement of a hospital's exempt purposes and the provision of the testing with respect to individuals who are not patients at the hospital, and that there are commercial laboratories that can perform the testing services on a timely basis.[268]

Nonetheless, the IRS has noted that ''unique circumstances'' may cause the testing to be a related activity, such as emergency laboratory diagnosis of blood samples from nonpatient drug overdose or poisoning victims in order to identify specific toxic agents, where referral of these specimens to other locations would be detrimental to the health of those who are not patients of the hospital, or in situations where other laboratories are not available within a reasonable distance from the community served by the hospital or are clearly unable or inadequate to conduct tests needed for these individuals.[269] In one instance, laboratory testing conducted for the benefit of nonpatients was ruled not to be an unrelated business where the hospital was in a rural area, there were no commercial laboratories within a 120-mile radius of its location, and several of the tests ''require highly sophisticated testing equipment not generally found in physicians' offices or in other hospitals in [the geographical area].''[270] In another instance, laboratory services by an acute care hospital and long-term care facility likely would have been an unrelated business, but for the fact that the laboratory was the only full-service laboratory in a geographically isolated area and it was over 100 miles to the nearest major metropolitan area.[271] In another instance, where the closest comparable laboratory was 20 miles away, the IRS ruled that diagnostic

265. Hospital Audit Guidelines, *supra* note 215, at § 333.8(2)(b).
266. *Id*. at § 333.8(2)(c).
267. Rev. Rul. 85-110, 1985-2 C.B. 166.
268. This is one of many illustrations of the competition factor and the commerciality doctrine in the healthcare context. *See* § 3.3.
269. Rev. Rul. 85-110, 1985-2 C.B. 166, 168. The Hospital Audit Guidelines (*supra* note 215) instruct an examining agent to determine whether the tests ''are available only at the hospital'' (§ 333.8(2)(d)(2)) or whether ''hospital lab is the only lab within a reasonable distance for outsiders to send specimens'' (§ 333.8(2)(d)(3)).
270. Priv. Ltr. Rul. 8941082.
271. Priv. Ltr. Rul. 8921091.

laboratory testing by a tax-exempt hospital upon specimens from private office patients of the hospital's staff physicians was not an unrelated business.[272] In still another case, the furnishing of laboratory services to the private patients of staff physicians was held not to be an unrelated business, not only because the nearest commercial laboratories were over 100 miles away, but also because those facilities were not available after hours and on weekends and holidays; the hospital laboratory provided 7-days-a-week, 24-hours-a-day, year-round services.[273] Likewise, laboratory testing services provided by a university's dental school, through a separate charitable organization, were held to be related activities because the testing (microbiological diagnosis of periodontal infections) was unique and not readily available elsewhere, and there were no commercial laboratories providing a comparable service; these activities were also found to be an integral part of the university's teaching program.[274]

Likewise, the IRS determined that an exempt hospital was not conducting an unrelated trade or business when it allowed its physicians and facilities to be used in reading and diagnosing electrocardiogram tests for a hospital that lacked the physicians and facilities to provide the service.[275]

A court held that income received by a tax-exempt teaching and research hospital for the performance of pathological diagnostic tests on samples submitted by physicians associated with the hospital was not unrelated business income.[276] The court found that the performance and interpretation of these outside tests by the hospital's pathology department were substantially related to the performance by the hospital of its exempt functions because the tests contributed importantly to the teaching functions of the hospital.[277] Further, the court concluded that the testing was a related activity because it increased the physicians' confidence in the quality of the work performed by the pathology department and it was convenient in the event of surgery, in that the pathologist who conducted the test could promptly interpret a biopsy.[278] Similarly, the IRS ruled that, where the laboratory testing services provided a supply of specimens needed in a hospital's teaching program, the services were a related business.[279]

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272. Priv. Ltr. Rul. 8721103.
273. Priv. Ltr. Rul. 9023041.
274. Priv. Ltr. Rul. 9739043.
275. Priv. Ltr. Rul. 8004011.
276. *St. Luke's Hospital of Kansas City v. United States*, 494 F. Supp. 85 (W.D. Mo. 1980).
277. The IRS agreed to follow this aspect of the decision (Rev. Rul. 85-109, 1985-2 C.B. 165). The IRS, however, refuses to follow the portion of this opinion that concluded that private patient specimen testing is for the convenience of the hospital's members (*see* § 24.16), because the IRS position is that hospital staff physicians are neither members nor employees of the hospital (Rev. Rul. 85-109, *supra*).
278. *See also Anateus Lineal 1948, Inc. v. United States*, 366 F. Supp. 118 (W.D. Ark. 1973).
279. Priv. Ltr. Rul. 9023041.

§ 24.12 MEDICAL RESEARCH

In general, the conduct of medical research is a business and it can often be an unrelated business that is conducted in a commercial manner and/or in a way that is competitive with taxable business enterprises. Certain types of medical research, however, are sheltered from unrelated business income taxation.

There are three statutory exceptions from the unrelated business rules for medical research:

1. In the case of a hospital, all income derived from research performed for any person is excluded from taxation.[280]
2. All income derived from research for the United States or any of its agencies or instrumentalities, and for any state or its political subdivisions, is excluded from unrelated business income taxation.[281]
3. The income derived from research performed for any person is excluded from taxation where the organization is operated primarily for the purpose of carrying on fundamental research and the results of the research are freely available to the general public.[282]

The term *research* includes ''not only fundamental research but also applied research such as testing and experimental construction and production.''[283] As respects the exemption for research performed by a hospital, it is clear that ''funds received for research by other institutions [do not] necessarily represent unrelated business income,'' such as a grant by a corporation to a foundation to finance scientific research if the results of the research were to be made freely available to the public.[284]

In applying the term in this context, the IRS generally looks to the body of law defining research in relation to what is considered tax-exempt *scientific* research.[285] The issue usually is whether the activity is being carried on incident to commercial or industrial operations, such as the testing or inspection of materials or products, or the designing or construction of equipment or buildings[286]; if it is, it will almost assuredly be regarded by the IRS as an unrelated trade or business.[287] Stated otherwise, it may be necessary to determine whether the organization is operated primarily for purposes of carrying on *fundamental,* as contrasted with *applied,* research.[288]

280. IRC § 512(b)(8).
281. IRC § 512(b)(7).
282. IRC § 512(b)(9).
283. H.R. Rep. No. 2319, 81st Cong., 2d Sess. 37 (1950).
284. S. Rep. No. 2375, 81st Cong., 2d Sess. 30 (1950).
285. IRC § 501(c)(3).
286. Reg. § 1.501(c)(3)-1(d)(5)(ii).
287. Rev. Rul. 68-373, 1968-2 C.B. 206 (clinical testing was incidental to the commercial operations of a pharmaceutical company and thus was not research).
288. Reg. § 1.501(c)(3)-1(d)(5)(i).

One court, writing of this distinction, stated that applied research is ''generally repetitive work done by scientifically unsophisticated employees for the purpose of determining whether the item tested met certain specifications, as distinguished from testing done to validate a scientific hypothesis.''[289]

For example, an organization that fostered the development of machinery in connection with a commercial operation, and was empowered to sell, assign, and grant licenses with respect to its copyrights, trademarks, trade names, or patent rights, was ruled by the IRS to not be engaged in scientific research.[290] Similarly, an organization that tested drugs for commercial pharmaceutical companies was held by the IRS to not qualify for tax exemption as a scientific organization because the testing was regarded as principally serving the private interests of the manufacturers.[291] Likewise, an organization that inspected, tested, and certified (for safety) shipping containers used in the transport of cargo was determined by the IRS to not be engaged in scientific research because these activities were incident to commercial or industrial operations.[292]

In one instance, the IRS found applicability of the exclusion because the studies undertaken by a tax-exempt medical college in the testing of pharmaceutical products under contracts with the manufacturer were held to be more than ''mere quality control programs or ordinary testing for certification purposes, as a final procedural step before marketing.''[293] In another instance, the exclusion was held applicable to contract work done, in the field of rocketry, by a tax-exempt educational institution for the federal government.[294]

Scientific research is regarded as carried on in the public interest if the results of the research (including any patents, copyrights, processes, or formulas) are made available to the public on a nondiscriminatory basis or if the research is directed toward benefiting the public.[295] Examples of scientific research that is considered as meeting these criteria include scientific research carried on for the purpose of aiding in the scientific education of college and university students; obtaining scientific information that is published in a form that is available to the interested public (the *publication test*); discovering a cure for a disease; or aiding a community or geographical area by attracting new industry to it or by encouraging the development of, or retention of, an industry in the community or area.[296] Publication of research results, consequently, is

289. *Midwest Research Institute v. United States*, 554 F. Supp. 1379, 1386 (W.D. Mo. 1983), *aff'd*, 744 F.2d 635 (7th Cir. 1984).
290. Rev. Rul. 65-1, 1965-1 C.B. 226.
291. Rev. Rul. 68-373, 1968-2 C.B. 206.
292. Rev. Rul. 78-246, 1978-2 C.B. 175.
293. Priv. Ltr. Rul. 7936006.
294. Priv. Ltr. Rul. 7924009.
295. Reg. § 1.501(c)(3)-1(d)(5)(iii).
296. In one instance, an organization that engaged in research projects for nongovernmental sponsors on a contract basis, in the fields of physics, chemistry, economic development, engineering, and biological sciences, was held to be a scientific entity, rather than engaged in commercial testing; it satisfied the public benefit test because the research

not the only means by which scientific research can be in the public interest.[297] Scientific research is regarded as carried on in the public interest even though research is performed pursuant to an agreement under which the sponsor of the research has the right to obtain ownership or control of any patents, copyrights, processes, or formulas resulting from the research.[298] Thus, for example, an organization formed by physicians to research heart disease was ruled by the IRS to be tax-exempt as a scientific organization.[299]

An institution may engage in *commercially sponsored scientific research*, which is scientific research undertaken pursuant to contracts with private businesses. Pursuant to these contracts, the sponsor pays for the research and receives the right to the results of the research and all the ownership rights in patents resulting from work on the project. These practices can raise issues as to taxability where there is reliance on the requirement that the research be made available to the public on a timely basis. In some instances, the results of the commercially sponsored projects are made available to the public as developments in the project warrant or within a reasonably short time after the project is completed. If patent rights are involved, publication may be delayed pending a reasonable opportunity to establish the rights, such as through the filing of an application for a patent. In these instances, the publication test will be satisfied.[300]

By contrast, the exempt organization may agree, at the request of the sponsor, to forgo publication of the results of a project in order to protect against disclosure of processes or technical data that the sponsor desires to keep secret for business reasons. Or, the organization may agree to extend delay in the publication of results in cases in which the sponsor desires to protect its patent rights under the project but also desires to defer initiation of patent procedures so as to delay or control the timing of public disclosure of the results of the project. In these instances, the publication test is not met and the activity is likely to be considered an unrelated trade or business.

The IRS accorded categorization as a tax-exempt scientific organization to a membership entity formed to encourage and assist in the establishment of nonprofit regional health data systems; to conduct scientific studies and propose improvements with regard to quality, utilization, and effectiveness of healthcare and healthcare agencies; and to educate those involved in furnishing, administering, and financing healthcare.[301] The IRS observed that ''[b]y improving and enlarging the body of knowledge concerning current

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was intended to attract and develop industry in a particular geographic area (i.e., the Midwest) (*Midwest Research Institute v. United States*, 554 F. Supp. 1379 (W.D. Mo. 1983), *aff'd* 744 F.2d 635 (7th Cir. 1984)).

297. *IIT Research Institute v. United States*, 85-2 U.S.T.C. (CCH) ¶9734 (Ct. Cl. 1985).
298. Reg. § 1.501(c)(3)-1(d)(5)(iii)(c)(4).
299. Rev. Rul. 69-526, 1969-2 C.B. 115.
300. Rev. Rul. 76-296, 1976-2 C.B. 141.
301. Rev. Rul. 76-455, 1976-2 C.B. 150.

usage of health facilities and methods of treatment, the organization seeks to create a more efficient use of the nation's health facilities, and to aid in the planning of better care for future health needs.''[302] The IRS also ruled that an organization formed to develop scientific methods for the diagnosis, prevention, and treatment of diseases, and to disseminate the results of its developmental work to members of the medical profession and the general public, qualified for tax exemption as a scientific entity.[303]

It is often difficult to ascertain whether a particular activity constitutes medical or scientific research or *commercial testing*.[304] The language used in the law concerning a tax credit for certain research expenditures defines the term *basic research* as ''any original investigation for the advancement of scientific knowledge not having a specific commercial objective, except that such term shall not include (i) basic research conducted outside of the United States, and (ii) basic research in the social sciences, arts, or humanities.''[305] The general principle in this regard has long been that this distinction is made on the basis of the facts of each case.[306]

The IRS instructed its auditing agents to (1) review contracts to determine whether the hospital is engaged in testing drugs for drug companies, (2) review grants awarded to physicians and medical school professors to determine the nature of sponsored research and the arrangement between the parties, (3) determine whether clinical testing of drugs principally serves the private interest of the manufacturer rather than the public interest, (4) determine whether the hospital is doing any other type of research and review any agreements, (5) determine whether the research activities are of a type ordinarily carried on as incident to commercial or industrial operations, and (6) determine whether the results of research are freely available to the public.[307]

§ 24.13 MEDICAL OFFICE BUILDINGS

It is common for a hospital or other healthcare facility to own a medical office building and lease space in it to physicians affiliated with the facility.

302. *Id*. at 150–151.
303. Rev. Rul. 65-298, 1965-2 C.B. 163. *See* Rev. Rul. 74-553, 1974-2 C.B. 168 (a nonprofit organization formed by members of a state medical association to operate peer review boards for the primary purpose of establishing and maintaining standards for quality, quantity, and reasonableness of costs of medical services qualified for tax exemption as a business league (*see* Chapter 18) but not by reason of IRC § 501(c)(3)).
304. E.g., *Indiana Crop Improvement Association, Inc. v. Commissioner*, 76 T.C. 394 (1981) (the IRS concluded that an organization that conducted scientific activities in seed technology was engaged in endeavors incident to commercial operations, but the court held that the activities were research conducted pursuant to its authority as the official seed certification agency for a state or in conjunction with the state's designated agency for agricultural research and experimentation).
305. IRC § 41(e)(7)(A).
306. Rev. Rul. 54-73, 1954-1 C.B. 160.
307. Hospital Audit Guidelines, *supra* note 215, at § 333.8(6).

These physicians see their patients at the facility at times when the physicians' offices are closed or where the location is more appropriate to the patient's physical condition. This arrangement is advantageous to the healthcare facility because it ensures the availability of specialists and follow-up services to the primary care provided at the facility, and it facilitates the establishment of an on-call roster necessary for accreditation. It is the position of the IRS that this form of leasing is a related function (as long as the rents are based on fair market value[308]).[309] In one instance, the IRS characterized this activity as enabling a tax-exempt healthcare facility to ''provide its community a total health package, that will promote health and meet changing health-care needs of the public, all in the most efficient and economic manner possible.''[310]

Another rationale for this type of adjacent office building is that it encourages members of the facility's medical staff to maintain their private medical practices near the facility. One hospital established that as a result of having members of its medical staff practice medicine in offices adjacent to the hospital, there was greater use of the diagnostic facilities of the hospital. Also, the physical presence of the staff physicians resulted in those physicians' being more readily available for inpatient and outpatient emergencies. Again, the IRS ruled that the leasing of adjacent office space to the staff physicians contributed importantly to the hospital's functions.[311]

§ 24.14 TRANSACTIONS BETWEEN RELATED ORGANIZATIONS

A general principle in the federal law of tax-exempt organizations is that the provision of a service by one exempt organization to another exempt organization (even where both entities have the same tax-exempt status) is not, for that reason alone, a related business.[312] In the healthcare setting, it generally is the position of the IRS that income derived by a tax-exempt hospital from the provision of services to other exempt hospitals constitutes unrelated business income to the provider of the services, on the ground that the providing of services to other exempt hospitals is not an activity that is substantially related to the exempt purpose of the hospital providing the services.[313]

The IRS, however, has taken a generous position in this regard in the case of healthcare systems and other aggregations of healthcare entities, where it is common for exempt entities within a system to provide services to other

308. *See* Chapter 4.
309. Rev. Rul. 69-463, 1969-2 C.B. 131.
310. Priv. Ltr. Rul. 8809092.
311. Rev. Rul. 69-464, 1969-2 C.B. 132. Under these facts, physicians without staff privileges in the hospital were not accepted as tenants, the usual term of the leases was five years, and a lease terminated if the physicians ceased being members of the hospital's staff.
312. E.g., Tax-Exempt Organizations, § 24.5(j).
313. Rev. Rul. 69-633, 1969-2 C.B. 121.

exempt and nonexempt entities in the system. Thus, the provision of services by and among organizations within a hospital or similar system generally will not give rise to unrelated business income.[314] The factor of common control among and between the entities provides the rationale for this position, which essentially is rested on the premise that the activities do not constitute an unrelated trade or business. The types of activities that are protected from taxation under this rationale include contributions of assets, sales of property, loan repayments and guarantees, lease payments, interest payments, and the sharing of assets, personnel, facilities, expenses, and services.

In one instance, the IRS ruled that the purpose of this type of sharing of services (and costs) ''is to take advantage of economies of scale and to best use the resources and management talents'' of the entities; the sharing was held to be ''in furtherance of their charitable purpose of providing health care and improving the health care environment.''[315]

The IRS clarified the tax rationale for its thinking in this regard in 1996 in a private letter ruling concerning the use of joint operating agreements as a basis for creation of a healthcare delivery system.[316] In the case, a supporting organization[317] functioned as the parent of the system, which also was comprised of five tax-exempt providers of healthcare. The healthcare providers ceded authority to the governing body of the supporting organization to establish their budgets, including major expenditures, debt, contracts, managed care agreements, and capital expenditures; to direct their provision of healthcare services; and to monitor and audit their compliance with its directives. The IRS focused on what it termed the provision of *corporate services* by and among the entities.[318]

The provision of these services was evaluated in light of a 1977 revenue ruling holding that indebtedness owed to an exempt labor union by its wholly owned tax-exempt subsidiary is not acquisition indebtedness, for purposes of the unrelated debt-financed income rules,[319] since the parent and subsidiary relationship shows the indebtedness to be merely a *matter of accounting*.[320] In this private letter ruling, the IRS stated: ''If the participating exempt organizations are in a parent-and-subsidiary relationship, then corporate services provided between them necessary to their being able to accomplish their exempt purposes are treated as other than an unrelated trade or business and the financial arrangements between them are viewed as merely a matter of accounting.'' Moreover, the IRS said that this would be the outcome where the relationship among organizations is ''analogous to'' that of a parent and

314. E.g., Priv. Ltr. Rul. 8626102 (supplemented by 8645064).
315. Priv. Ltr. Rul. 9404029.
316. In general, *see* § 21.5.
317. In general, *see* § 5.5.
318. Priv. Ltr. Rul. 9651047.
319. In general, *see* § 24.17.
320. Rev. Rul. 77-72, 1977-1 C.B. 157.

subsidiary. Thus, the provision of ''corporate services'' by and among exempt organizations where their relationship is at least ''analogous to'' that of parent and subsidiary will not be treated as an unrelated business but rather merely a ''matter of accounting.''[321]

As to arrangements where the relationship is analogous to that of parent and subsidiary, the first illustration was provided in the case of two charitable organizations that managed healthcare facilities; they entered into a management agreement with a third such organization. Each of these entities was independent of the others. By reason of the agreement, these two charitable organizations were found by the IRS to have ceded to the third organization ''significant financial, managerial and operational authority over their affairs, including exclusive authority over capital and operating budgets, strategic plans, managed care contracting, the ability to allocate or reallocate services among the health care facilities [they] manage, and the ability to monitor and audit compliance with directives.'' The agency ruled that these two organizations were ''effectively under the common control'' of the third organization. Therefore, the IRS held that these organizations were ''within a relationship analogous to that of a parent and subsidiary,'' so that the provision of these corporate services would not result in unrelated business income.[322]

Subsequently, the IRS reviewed an arrangement involving a tax-exempt hospital and an unrelated exempt hospital, where the institutions shared a physical connection and had a longstanding collaborative relationship. Both hospitals were affiliated with an exempt medical school. Pursuant to these facts, the IRS could have ruled that the provision of services by one of these hospitals to another was not an unrelated business, because the relationship between them is analogous to that of parent and subsidiary. The agency, however, ruled that one of the hospitals could lease a portion of its research building and provide other services to the other hospital, with the provision of the services considered to be in furtherance of the lessor hospital's exempt purpose.[323]

Notwithstanding this clarification in the joint operating agreement context, however, the law on this point in general remains confusing and inconsistent. The performance by a business league[324] of management services for a charitable organization was ruled to be an unrelated business.[325] Yet, a supporting organization was found to be engaged in related business activities in leasing a computer system to a professional partnership affiliated with a university's medical school and teaching hospital; the system was

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321. *See also* Priv. Ltr. Rul. 9641011. An example of unrelated business activity in this context appears in Tech. Adv. Mem. 9550001. *See also* Rev. Rul. 68-26, 1968-1 C.B. 272.
322. Priv. Ltr. Rul. 200108045.
323. Priv. Ltr. Rul. 200314031. *See* § 24.17(b)(ii), text accompanied by *infra* note 395.
324. In general, *see* § 18.1.
325. Priv. Ltr. Rul. 9811001.

used for billing, collections, and record-keeping.[326] Likewise, an educational institution was ruled to be engaged in related activities when it provided a variety of ''central programs and services,'' including telephone services, accounting services, and a risk and property insurance program, to a group of colleges.[327]

It is possible for an activity that is a related business when conducted by one type of tax-exempt organization to be an unrelated business when conducted by another type of exempt organization. For example, the IRS ruled that a certification program conducted by a tax-exempt educational and scientific organization was an unrelated business, because it primarily advanced the interests of individuals in a particular profession and only incidentally served the interests of the public.[328] The activity was said to be appropriate when conducted by an exempt business league,[329] but an activity promoting nonexempt purposes when conducted by a charitable organization.[330]

§ 24.15 SERVICES FOR SMALL HOSPITALS

Generally, it is the position of the IRS that income that a tax-exempt hospital derives from the provision of services to other exempt hospitals constitutes unrelated business income to the provider of the services, on the ground that the providing of services to other exempt hospitals is not an activity that is substantially related to the exempt purpose of the hospital providing the services.[331] There is a statutory exception in this regard, however, with respect to the performance of certain services for small hospitals.[332]

This special rule applies where a hospital furnishes services only to other tax-exempt hospitals, as long as each of the recipient hospitals has facilities to serve no more than 100 inpatients and the services would be consistent with the recipient hospitals' tax-exempt purposes if performed by them on their own behalf.[333] The services provided must be confined to: data processing, purchasing (including the purchasing of insurance on a group basis),

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326. Tech. Adv. Mem. 9847002.
327. Priv. Ltr. Rul. 9849027. In what may be the first time that this matter-of-accounting rationale has been applied outside the healthcare setting, the IRS ruled that payments of this nature by a charitable organization to a social welfare organization were not forms of unrelated business income (Priv. Ltr. Rul. 200022056); however, the rationale was taken from the feeder organization regulations (Reg. § 1.502-1(b)). In general, Prescott, Jr., ''Management and Consulting Services: The Impact on Exempt Status and UBIT,'' 42 *Exempt Org. Tax Rev.* (No. 2) 209 (Nov. 2003).
328. Priv. Ltr. Rul. 200439043.
329. *See* TAX-EXEMPT ORGANIZATIONS § 14.1(g).
330. *Id.*, e.g., §§ 7.6(g), 8.6, 24.5(o),
331. *See supra* note 312.
332. IRC § 513(e).
333. IRC § 513(e)(1), (2); Reg. § 1.513-6(a)(1), (2).

warehousing, billing and collection, food, clinical, industrial engineering, laboratory, printing, communications, record center, and personnel (including selection, testing, training, and education) services.[334]

This exception was created to enable a number of small hospitals to receive services from a single institution instead of providing them directly or creating a separate organization to provide them. The language in the legislative history underlying this exception, however, is somewhat broader than the specifics of the statutory rule. The Senate Finance Committee's explanation stated that ''a hospital is not engaged in an unrelated trade or business simply because it provides services to other hospitals if those services could have been provided on a tax-free basis, by a cooperative organization consisting of several tax-exempt hospitals.''[335]

Another requirement for the exception with respect to services provided to small hospitals is that a service must be provided for a fee or cost that is not in excess of the actual cost of providing the services, including straight-line depreciation and a reasonable rate of return on the capital goods used to provide the service.[336] The Medicare program formulations are a ''safe harbor'' for use in complying with these limitations on fees. A rate of return on capital goods will be considered reasonable as long as it does not exceed, on an annual basis, a percentage based on the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months included in the tax year of the hospital during which the capital goods are used in providing the service.[337] Determinations as to the cost of services and the applicable rate of return are to be made as prescribed in the Medicare rules,[338] which permit a healthcare facility to be reimbursed under the Medicare program for the reasonable cost of its services, including, in the case of certain proprietary facilities, a reasonable return on equity capital.[339]

In one instance, an organization provided a battery of healthcare services, albeit not within the ambit of this statutory exception. Nonetheless, the IRS ruled that these services were related activities because they were provided to other entities in a system[340] and that the failure to satisfy the requirements of this exception did not adversely affect the organization's tax exemption as a charitable entity.[341]

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334. IRC §§ 513(e); 501(e)(1)(A).
335. S. Rep. No. 94-938 (Part 2), 94th Cong., 2d Sess. 76 (1976).
336. IRC § 513(e)(3); Reg. § 1.513-6(a)(3).
337. Reg. § 1.513-6(a).
338. 42 U.S.C. § 1395x(v)(1)(A), (B).
339. Reg. § 1.513-6(a)(3).
340. *See* § 24.14.
341. Priv. Ltr. Rul. 8817017.

§ 24.16 CORPORATE SPONSORSHIPS

It has become common for charitable organizations to be supported by large transfers of money from for-profit companies. The charities, of course, wish to regard this support as tax-deductible contributions. At the same time, these companies want to be publicly thanked for this support. The issue often arises as to whether this public recognition is merely an *acknowledgment* of the transfer (in which case the status of the payments as contributions is not disturbed) or is sufficiently effusive to amount to *advertising* (in which case the transfer may be taxable as unrelated business income). Statutory rules, embodying the concept of the qualified sponsorship payment, were enacted in an effort to draw this distinction. Qualified sponsorship payments received by tax-exempt organizations are exempt from unrelated business income taxation. That is, the activity of soliciting and receiving these payments is not an unrelated business.[342]

The concept of the qualified sponsorship payment is a safe-harbor rule. Thus, if a payment is not *qualified*, it may still escape unrelated business income taxation if it is eligible for another exception from the unrelated business rules.[343]

A *qualified sponsorship payment* is a payment made by a person engaged in a for-profit business to a tax-exempt organization, with respect to which there is no arrangement or expectation that the person will receive any substantial return benefit.[344] In determining whether a payment is a qualified sponsorship payment, it is irrelevant whether the sponsored activity is related or unrelated to the recipient organization's exempt purpose. It is also irrelevant whether the sponsored activity is temporary or permanent. *Payment* means the payment of money, transfer of property, or performance of services.[345]

A *substantial return benefit* is any benefit other than certain uses or acknowledgments or certain disregarded benefits.[346] A substantial return benefit does not include the use or acknowledgment of the name or logo (or product lines) of the person's business in connection with the activities of the exempt organization. A use or acknowledgment may include certain exclusive sponsorship arrangements; logos and slogans that do not contain qualitative or comparative descriptions of the person's products, services, facilities, or company; a list of the person's locations, telephone numbers, or Internet address; value-neutral descriptions, including displays or visual depictions, of the person's product

342. IRC § 513(i).
343. *See* § 24.17.
344. IRC § 513(i)(2)(A); Reg. § 1.513-4(c)(1).
345. Reg. § 1.513-4(c)(1).
346. Reg. § 1.513-4(c)(2)(i).

line or services; and the person's brand or trade names and product or service listings.[347]

A use or acknowledgment does not include advertising. The term *advertising* means any message or other programming material that is broadcast or otherwise transmitted, published, displayed, or distributed, and that promotes or markets any trade or business, or any service, facility, or product. Advertising includes messages containing qualitative or comparative language, price information or other indications of savings or value, an endorsement, or an inducement to purchase, sell, or use any company, service, facility, or product. A single message that contains both advertising and an acknowledgment is advertising.[348]

Benefits are disregarded if the aggregate fair market value of all of the benefits provided to the person, or persons designated by the payor, in connection with the payment during the organization's tax year is not more than 2 percent of the amount of the payment. If the aggregate fair market value of the benefits exceeds 2 percent of the amount of the payment, then generally the entire fair market value of the benefits, not merely the excess amount, is a substantial return benefit.[349]

In one of the few examples of application of this law prior to development of the qualified corporate sponsorship rules, the IRS considered a situation where a pet food company was a major sponsor of an annually televised show conducted as the predominant activity of a tax-exempt organization operated to increase interest in a type of pet animal. In return for a cash payment, the exempt organization provided certain benefits to the company, including exhibition of its logo on a mailing to potential exhibitors, identification on the exhibitors' benches, and identification on the armbands worn by exhibitors in the ring. This package of benefits was ruled to be in the "nature of acknowledgments rather than advertising"; the exempt organization was cast as having "agreed to do nothing for [the company] that reaches the level of providing advertising services for it."[350]

A qualified sponsorship payment does not include any payment where the amount of the payment is contingent on the level of attendance at one or more events, broadcast ratings, or other factors indicating the degree of public exposure to one or more events.[351] The fact that a sponsorship payment is contingent on an event or activity actually being conducted, in and of itself, however, does not cause the payment to fail to qualify. Also, mere

347. Reg. § 1.513-4(c)(2)(iv). The use of a web site link in connection with what would otherwise be an acknowledgment does not necessarily change the character of a payment from a qualified (nontaxable) corporate sponsorship to (taxable) advertising (Reg. § 1.513-4(f), Examples 11 and 12).
348. Reg. § 1.513-4(c)(2)(v).
349. Reg. § 513-4(c)(2)(ii).
350. Tech. Adv. Mem. 9805001.
351. IRC § 513(i)(2)(B)(i); Reg. § 1.513-4(e)(2).

distribution or display of a sponsor's products by the sponsor or the exempt organization to the general public at a sponsored event, whether without charge or for remuneration, is considered a use or acknowledgment of the sponsor's product lines and not advertising.

The tax regulations address the matter of the import of Web site links by means of two examples. The essence of these examples is that the mere existence of a link, from a sponsored tax-exempt organization to the corporate sponsor, does not cause a payment to fail to be a qualified sponsorship payment, although material on the linked site can cause the payment to entail a substantial return benefit.[352]

This safe-harbor rule does not apply to income derived from the sale of advertising or acknowledgments in a periodical of a tax-exempt organization. A *periodical* is regularly scheduled and printed material published by or on behalf of the payee (sponsored) organization that is not related to and primarily distributed in connection with a specific event conducted by the payee organization.[353] For this purpose, *printed* material includes material that is published electronically.[354] Thus, the rule does not apply to payments that lead to acknowledgments in a monthly journal but does apply if a sponsor received an acknowledgment in a program or brochure distributed at a sponsored event. The term *qualified sponsorship payment* also does not include a payment made in connection with a qualified convention or trade show activity.[355]

To the extent that a portion of a payment would (if made as a separate payment) be a qualified sponsorship payment, that portion of the payment is treated as a separate payment.[356] That is, a single payment may be considered partially qualified and partially not qualified; this allocation is based on value. For example, if a sponsorship payment made to a tax-exempt organization entitles the sponsor to product advertising, as well as use or acknowledgment of the sponsor's name or logo by the organization, the unrelated business income tax does not apply to the amount of the payment that exceeds the fair market value of the product advertising provided to the sponsor.

The provision of facilities, services, or other privileges by an exempt organization to a sponsor or the sponsor's designees (such as complimentary tickets, pro-am playing spots in golf tournaments, or receptions for major donors) in connection with a sponsorship payment does not affect the determination as to whether the payment is a qualified one. Instead, the provision of the goods or services is evaluated as a separate transaction in determining whether the organization has unrelated business income from the event. In general, if the

352. Reg. § 1.513-4(f), Examples 11 and 12.
353. IRC § 513(i)(2)(B)(ii)(I); Reg. § 1.513-4(b).
354. Reg. § 1.513-4(b).
355. IRC § 513(i)(2)(B)(ii)(II); Reg. § 1.513-4(b).
356. IRC § 513(i)(3); Reg. § 1.513-4(d)(1).

services or facilities do not constitute a substantial return benefit (or if the provision of the services or facilities is a related business activity), the payments attributable to them are not subject to the tax on unrelated business income.

Likewise, a sponsor's receipt of a license to use an intangible asset (such as a trademark, logo, or designation) of the tax-exempt organization is treated as separate from the qualified sponsorship transaction in determining whether the organization has unrelated business income.

This statutory exemption from taxation for qualified sponsorship payments is in addition to other exceptions from the unrelated business tax. These exceptions include the one for activities substantially all the work for which is performed by volunteers[357] and for activities not regularly carried on.[358]

§ 24.17 OTHER EXCEPTIONS TO UNRELATED INCOME TAXATION

Although the general rule is that an unrelated trade or business, if regularly carried on and not substantially related to a tax-exempt organization's exempt purposes, gives rise to unrelated business income, there are exceptions to this rule. Some exceptions are for types of activities; others are for types of income.

(a) Exceptions for Activities

In instances involving healthcare organizations, several exceptions allow income from an undertaking to be excepted from the unrelated business income tax, notwithstanding the fact that the undertaking is an unrelated trade or business.

One exception for otherwise unrelated activities in the healthcare setting is granted for services provided for the benefit of small hospitals.[359]

Another exception, available to all tax-exempt charitable organizations (thus, available to most exempt healthcare entities), is for *convenience* businesses. This exception is applicable with respect to a business that is carried on by an organization primarily for the convenience of its members, students, patients, officers, or employees.[360] As an illustration, the provision by an exempt hospital of mobile services to its patients by means of specially designed vans was ruled to be a convenience business.[361] Given the reference

357. *See* § 24.17(a), text accompanied by *infra* note 366.
358. *See* § 24.3.
359. *See* § 24.15.
360. IRC § 513(a)(2). *See also* Rev. Rul. 69-268, 1969-1 C.B. 160 (operation by a tax-exempt hospital of a cafeteria and coffee shop primarily for its employees held not a taxable business), and Rev. Rul. 55-676, 1955-2 C.B. 266 (laundry operated by a tax-exempt university primarily for the convenience of its students and employees held not a taxable business).
361. Priv. Ltr. Rul. 9841049.

to, and rather broad definition of, the term *patient*, the convenience doctrine is of particular significance in the law of tax-exempt healthcare organizations.[362] A court expanded this concept by holding that physicians on the staff of a teaching hospital are ''members'' of the hospital, in that the term ''refers to any group of persons who are closely associated with the entity involved and who are necessary to the achievement of the organization's purposes.''[363] The IRS, however, in disagreement with this interpretation, is of the view that the ''hospital's staff physicians are neither 'members' nor 'employees' of the hospital in their capacities as private practitioners of medicine.''[364]

Read literally, this exception for convenience businesses pertains only to the classes of individuals who have the requisite relationship directly with the exempt organization; for example, it applies with respect to services carried on by a hospital for the convenience of *its* patients. The IRS ruled, however, that the doctrine was available when an exempt organization's activities were for the convenience of patients of another, albeit related, exempt entity.[365]

Another exception, made for businesses conducted by volunteers, is available to all tax-exempt organizations. Specifically, exempt from the scope of taxable unrelated trade or business is a business in which substantially all of the work of carrying on the business is performed for the exempt organization without compensation.[366]

Also, this exception enables tax-exempt organizations to conduct vehicle donation programs without being considered operating unrelated businesses (vehicle sales activities).[367]

Another exception is for unrelated trade or business activities that constitute the sale of merchandise, substantially all of which has been received by the organization as contributions.[368] Although this exception was created for thrift shops that sell donated clothing and other items to the general public,[369] it can be useful to charitable organizations generally. For example, this exception

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362. E.g., Priv. Ltr. Rul. 9735048 (holding that the sale of medical equipment and pharmaceutical supplies by a home health organization (*see* § 10.1) does not generate unrelated business income, inasmuch as the sales are to active and discharged patients of the organization).
363. *St. Luke's Hospital of Kansas City v. United States*, 494 F. Supp. 85, 92 (W.D. Mo. 1980).
364. Rev. Rul. 85-109, 1985-2 C.B. 165, 166.
365. Priv. Ltr. Rul. 9535023.
366. IRC § 513(a)(1). *See also* Rev. Rul. 56-152, 1956-1 C.B. 56 (brokers obligated to deposit commissions in a special fund for public purposes deemed volunteers for this purpose); *Executive Network Club v. Commissioner*, 69 T.C.M. 1680 (1995) (exception held not available, in the case of an exempt organization that regularly carried on gambling activities, because the dealers and other individuals involved with the games received gratuities from the patrons).
367. E.g., Priv. Ltr. Rul. 200230005.
368. IRC § 513(a)(3). *See Disabled Veterans Service Foundation v. Commissioner*, 29 T.C.M. 202 (1970) (organization that operated several thrift stores was separate and distinct from a charitable organization and thus was taxable as a feeder organization).
369. Rev. Rul. 71-581, 1971-2 C.B. 236.

can protect from unrelated business income taxation the receipts generated by auctions conducted by charitable organizations.

Another exception is available only for tax-exempt organizations that are eligible to receive tax-deductible charitable contributions. This exception is for activities relating to certain distributions of *low-cost articles* incidental to the solicitations of charitable contributions.[370] A low-cost article is any article (or aggregate of articles distributed to a single distributee in a year) that has a cost not in excess of $5 (indexed for inflation[371]) to the organization that distributed the item or on behalf of which the item is distributed.[372] These rules also require that the distribution of the items be unsolicited and accompanied by a statement that the distributee may retain the low-cost article irrespective of whether a charitable contribution is made.[373]

Another exception, available only to exempt organizations that are eligible to receive tax-deductible charitable contributions, is applicable to the renting or exchanging of membership or donor lists to or with other of these types of tax-exempt organizations.[374]

When this exception is unavailable, or when the parties are unable to successfully structure the arrangement so that the exempt organization receives royalties,[375] an exchange of mailing lists will, in the judgment of the IRS, constitute an unrelated business, with the gross income from the transaction being the value of the lists received.[376]

(b) Exceptions for Income

In several exceptions applicable in instances involving healthcare organizations, income can be excepted from the unrelated business income tax, notwithstanding the fact that it is derived from an unrelated trade or business.

(i) General Principles. In determining unrelated business taxable income, both gross income derived from an unrelated trade or business and business deductions are computed with certain euphemistically termed *modifications*.[377] At least some of these forms of excluded income are types of passive income; as such, they are not derived in a manner that is competitive with commercial businesses and are appropriately excluded from unrelated income

370. IRC § 513(h)(1)(A).
371. This amount is $9.10 for years beginning in 2008 (Rev. Proc. 2007-66, 2007-45 I.R.B. 970).
372. IRC § 513(h)(2).
373. IRC § 513(h)(3). This exception is unavailable where the solicitation is competitive with for-profit vendors and/or is illegal (Tech. Adv. Mem. 9652004).
374. IRC § 513(h)(1)(B). *See*, in general, Turner, ''Marketing Charity Mailing Lists: Clarifying a Clouded Issue,'' 67 *Taxes* 202 (1989).
375. *See* § 24.17(b)(iii).
376. Tech. Adv. Mem. 9502009. This position is inconsistent with the previous stance of the IRS (in Tech. Adv. Mem. 8128004), which was prospectively revoked by the IRS (Tech. Adv. Mem. 9635001).
377. IRC § 512(b).

taxation.[378] Therefore, income such as dividends, interest, payments with respect to securities loans, annuities, royalties, rent, income from certain option-writing activities, and gain from the disposition of property is generally excluded from unrelated business income taxation, along with directly connected deductions.[379] Unrelated debt-financed income[380] is not eligible for these exclusions.[381]

(ii) Rules Concerning Rent. Rent is a form of income that is received for the occupation or other use of property. The exclusion from unrelated business taxable income for *rent* principally involves rent from real property.[382] In general, this exclusion is available for rental income where the tax-exempt organization is not actively involved in the undertaking that generated the revenue, such as through the provision of services to tenants.

The exclusion for rent is surrounded by several qualifications. Where the tax-exempt organization carries on an activity that constitutes an enterprise carried on for trade or business, even though the enterprise involves the leasing of real estate,[383] the exclusion will not be available. For example, a tax-exempt organization may own a building and lease space in it; the income from this activity would be excludable rent even where the organization performs normal maintenance services, such as the furnishing of heat, air conditioning, and light; the cleaning of public entrances, exits, stairways, and lobbies; and the collection of trash.[384] Where, however, the organization undertakes functions beyond these maintenance services, such as services rendered primarily for the convenience of the occupants (such as provision of a cleaning service), the payments would be considered as being from an unrelated trade or business (assuming that the rental activity is regularly carried on and is not substantially related to the organization's tax-exempt purposes).[385]

As a general rule, the exclusion for rent will not be available where the relationship between the parties is a partnership or joint venture. Where there is no profit motive, however, even if the arrangement is a partnership or joint venture in the broad sense of ownership of property and sharing of

378. *See* text accompanied by *supra* notes 2–6.
379. IRC § 512(b)(1), (2), (3), and (5).
380. *See* § 24.20.
381. IRC § 512(b)(4).
382. IRC § 512(b)(3)(A)(i). In one instance, this provision sheltered from taxation rent derived by a tax-exempt healthcare organization under a ground lease (Priv. Ltr. Rul. 9315021).
383. In general, the rental of real estate constitutes the carrying on of a trade or business (e.g., *Hazard v. Commissioner*, 7 T.C. 372 (1946)).
384. Reg. § 1.512(b)-1(c)(5).
385. *Id.;* Rev. Rul. 69-69, 1969-1 C.B. 159 (leasing of studio apartments and operation of a dining hall by a tax-exempt organization ruled to be an unrelated trade or business where occupancy in the apartments was not primarily for the convenience of its members); Rev. Rul. 58-482, 1958-2 C.B. 273 (operation of orchards and farms by the employees of a trust yielded unrelated business income). The distinction between such permitted and impermissible services is discussed in Rev. Rul. 69-178, 1969-1 C.B. 158.

net rents, there presumably is no partnership or joint venture for federal tax purposes because of the lack of an intent of a return of profits and because the relationship does not involve a working interest or operational control of the ''business.'' Thus, where the income is authentically rent and where the involvement of the exempt organization is only that of an investor, the exclusion for rental income is available.[386]

The exclusion from unrelated business income taxation for rents of personal property leased with real property is limited to instances where the rent attributable to the personalty is incidental (that is, no more than 10 percent).[387] Moreover, the exclusion is not available where the rent attributable to personalty is tied into the user's income or profits or if more than 50 percent of the total rent is attributable to the personalty leased. Thus, where the rent attributable to personalty is between 10 and 50 percent of the total, only the exclusion with respect to personalty is unavailable.[388]

Notwithstanding these general rules, the exclusion for rent does not apply if the determination of the amount of the rent depends in whole or in part on the income or the profits derived by any person from the property leased (other than an amount based on a fixed percentage or percentages of receipts or sales).[389] This is the *passive rent test*.

An amount is not encompassed by the exclusion for rents from real property if, considering the lease and all of the surrounding circumstances, the arrangement does not conform with normal business practice and is in reality used as a means of basing the rent on income or profits.[390] This rule is intended to prevent avoidance of the unrelated business income tax where a profit-sharing arrangement would, in effect, make the lessor an active participant in the operation of the property.

As noted, an exception is provided for amounts based on a fixed percentage or percentages of sales. These amounts are customary in rental contracts and are generally considered to be different from the profit or loss of the lessee. Rents received from real property would not be disqualified solely by reason of the fact that the rent is based on a fixed percentage of total receipts or sales of the lessee. The fact that a lease is based on a percentage of total receipts, however, would not necessarily qualify the amount received or accrued as rent from real property. For example, an amount would not qualify as rent

386. *United States v. Myra Foundation*, 382 F.2d 107 (8th Cir. 1967) (a tax-exempt organization that was a lessor of farmland and received a portion of the crops produced by the tenant as rent was not subject to unrelated income taxation on the rent). *See also* Rev. Rul. 67-218, 1967-2 C.B. 213 (income derived from a lease of a pipeline system ruled to constitute rent from real property). *See* Reg. § 1.512(c)-1.

387. IRC § 512(b)(3).

388. Reg. § 1.512(b)-1(c)(2). *See also* Rev. Rul. 67-218, 1967-2 C.B. 213; Rev. Rul. 60-206, 1960-1 C.B. 201.

389. IRC § 512(b)(3)(B)(ii).

390. Reg. §§ 1.512(b)-1(c)(2)(iii)(b), 1.856-4(b)(3), (6) (other than (b)(6)(ii)). The latter set of regulations is part of the rules pertaining to real estate investment trusts.

from real property if the lease provided for an amount measured by varying percentages of receipts, and the arrangement, contrary to normal business practices, was in actuality used as a means of basing the rent on income or profits.[391]

Income passively received from the rental of real property, however, such as that from a valid landlord–tenant relationship where the landlord receives nothing more than net rental payments, is not taxable.[392]

In general, the contractual relationship between the parties, from which the ostensible rental income is derived, must be that as reflected in a *lease*, rather than a *license*, for the exclusion for rental income to be available. A lease ''confers upon a tenant exclusive possession of the subject premises as against all the world, including the owner.''[393] The difference is the conferring of a privilege to occupy the owner's property for a particular use, rather than general possession of the premises. Thus, a tax-exempt organization that conferred to an advertising agency the permission to maintain signs and other advertisements on the wall space in the organization's premises was held to receive income from a license arrangement, rather than a rental one, so that the exclusion for rental income was not available.[394]

On occasion, rental income is derived by a tax-exempt organization from the operation of a related business, so the revenue is nontaxable for that reason.[395] In one instance, a public charity with a training program shared office space with an exempt association that owned the building, in part because the tenants of the association provided volunteer teaching faculty to the charitable organization; the charity accorded the association the right to allow the tenants use of its research equipment in exchange for maintenance of the equipment; the IRS held that the value of the maintenance services constituted nontaxable phantom rent.[396] Similarly, the agency ruled that a tax-exempt hospital may lease facilities to another exempt hospital, with the leasing activity constituting an exempt function, because of a direct physical connection and close professional affiliation of the institutions.[397] Likewise, the IRS ruled that a charitable organization owning and operating nursing homes

391. Reg. § 1.856-4(b)(3). This passive rent test can be applied, for example, in determining whether income from share-crop leasing is excludable rent or taxable rental income; in this area of litigation, the courts are finding the exclusion to be applicable (e.g., *Harlan E. Moore Charitable Trust v. United States*, 812 F. Supp. 130 (C.D. Ill. 1993), *aff'd*, 9 F.3d 623 (7th Cir. 1993); *Trust U/W Emily Oblinger v. Commissioner*, 100 T.C. 114 (1993); *Independent Order of Odd Fellows Grand Lodge of Iowa v. United States*, 93-2 U.S.T.C. (CCH) ¶ 50,448 (S.D. Iowa 1993); *White's Iowa Manual Labor Institute v. Commissioner*, 66 T.C.M. 389 (1993)).

392. *The State National Bank of El Paso v. United States*, 75-2 U.S.T.C. (CCH) ¶ 9868 (W.D. Tex. 1975).

393. *Union Travel Associates, Inc. v. International Associates, Inc.*, 401 A.2d 105 (D.C. Ct. App. 1979).

394. Priv. Ltr. Rul. 9740032.

395. E.g., *Museum of Flight Foundation v. United States*, 63 F. Supp. 2d 1257 (W.D. Wash. 1999).

396. Priv. Ltr. Rul. 9615045.

397. Priv. Ltr. Rul. 200314031.

could lease, as a related business, a skilled nursing facility to another charitable organization that owns and operates nursing homes.[398] The leasing of a medical office building by a partnership involving a supporting organization was ruled by the IRS to be related to the organization's exempt purpose.[399]

(iii) Rules Concerning Royalties. Of all of these income exclusions in the unrelated trade or business setting, the one that is the cynosure is the exclusion for royalties. The term *royalty* has an uncertain expanse and a disorderly legislative and regulatory history.

In general, a royalty is a payment for the use of valuable intangible property rights.[400] It has been defined as a payment for the use of a valuable right, such as a trademark, trade name, service mark, or copyright, regardless of whether the property represented by the right is used; royalties also include the right to a share of production reserved to the owner of property for permitting another to work mines and quarries or to drill for oil or gas.[401] Royalties have also been characterized as payments that constitute passive income, such as the compensation paid by a licensee to a licensor for the use of the licensor's patented invention.[402]

There are two schools of thought as to the reach of this exclusion for royalties. The traditional one is that moneys characterized as royalties will be taxed where the tax-exempt organization is not merely passively involved in the business that generated the revenue, but rather is actively entangled in the venture such as through the provision of services.[403] Frequently, in this context, the IRS takes the position that the more accurate description of the relationship between the parties is that of partners or joint venturers. By contrast, there is a view that an item of income, once classified as a royalty (using the preceding definition), is excludable from unrelated business income taxation irrespective of whether it was passively or actively derived. Adherents of this view assert that a royalty under the general definition is a royalty for tax purposes.

This latter view has been that of the U.S. Tax Court. The issue has arisen in the course of consideration as to whether payments for the use of mailing lists of tax-exempt organizations constitute royalties. This court has recently held on seven occasions that these payments are royalties and thus are excludable

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398. Priv. Ltr. Rul. 200404057.
399. Priv. Ltr. Rul. 200717019.
400. *Disabled American Veterans v. Commissioner*, 94 T.C. 60 (1990), *rev'd on other grounds*, 942 F.2d 309 (6th Cir. 1991); *Sierra Club, Inc. v. Commissioner*, 65 T.C.M. 2582 (1993), *aff'd*, 86 F.3d 1526 (9th Cir. 1996).
401. *Fraternal Order of Police Illinois State Troopers Lodge No. 41 v. Commissioner*, 833 F.2d 717 (7th Cir. 1987).
402. *Disabled American Veterans v. United States*, 650 F.2d 1178 (Ct. Cl. 1981).
403. E.g., *Disabled American Veterans v. Commissioner*, 94 T.C. 60 (1990), rev'd on other grounds, 942 F.2d 309 (6th Cir. 1991); *National Water Well Association, Inc. v. Commissioner*, 92 T.C. 75 (1989).

even if they are not forms of passive income.[404] The court has also held in the case of affinity card program payments.[405] The essence of this view is that, although Congress believed these types of income to be passive,[406] that does not necessarily mean they always must be passive.[407] Stated in the reverse, this view holds that a statutorily classified item of excludable income remains excludable irrespective of whether the income is passive or is derived from the active conduct of a trade or business.

One federal court of appeals, however, is of the view that the Tax Court's definition of the term *royalty* for unrelated business income purposes is overbroad, in that a royalty ''cannot include compensation for services rendered by the owner of the property.''[408] Under this approach, an element of services as the (or a) basis for compensation of a tax-exempt organization causes the erstwhile royalty to be subject to tax as unrelated business income. This position, then, is a compromise between the approach of the Tax Court and that of the IRS on the point. Thus, this appellate court wrote that, to the extent the IRS ''claims that a tax-exempt organization can do nothing to acquire such fees,'' the agency is ''incorrect.''[409] Yet, the court continued, ''to the extent that . . . [the exempt organization involved] appears to argue that a 'royalty' is any payment for the use of a property right—such as a copyright—regardless of any additional services that are performed in addition to the owner simply permitting another to use the right at issue, we disagree.''[410] Applying this definition, the court of appeals affirmed the Tax Court's mailing list opinion[411] but reversed

404. *Sierra Club, Inc. v. Commissioner*, 65 T.C.M. 2582 (1993), *aff'd*, 86 F.3d 1526 (9th Cir. 1996); *Oregon State University Alumni Association, Inc. v. Commissioner*, 71 T.C.M. 1935 (1996), *aff'd*, 193 F.3d 1098 (9th Cir. 1999); *Alumni Association of the University of Oregon, Inc. v. Commissioner*, 71 T.C.M. 2093 (1996), *aff'd*, 193 F.3d 1098 (9th Cir. 1999); *Common Cause v. Commissioner*, 112 T.C. 332 (1999); *Planned Parenthood Federation of America, Inc. v. Commissioner*, 77 T.C.M. 2227 (1999). Also *Mississippi State University Alumni, Inc. v. Commissioner*, 74 T.C.M. 458 (1997).

405. *Sierra Club, Inc. v. Commissioner*, 103 T.C. 307 (1994), *aff'd in part, rev'd in part & remanded*, 86 F.3d 1526 (9th Cir. 1996).

406. In its report accompanying the legislation that included the unrelated business rules, the Senate Finance Committee stated that ''[d]ividends, interest, royalties, most rents, capital gains and losses and similar items are excluded from the base of the tax on unrelated income because your committee believes that they are 'passive' in character and are not likely to result in serious competition for taxable businesses having similar income'' (S. Rep. No. 2375, 81st Cong., 2d Sess. 30-31 (1950). *See also* H. Rep. No. 2319, 81st Cong. 2d Sess. 36-36 (1950).

407. This view is based on additional language in the committee reports indicating that the exception for dividends, interest, annuities, royalties, and the like ''applies not only to investment income [which is a broader concept than passive income] but also to such items as business interest on overdue open accounts receivable'' (S. Rep. No. 2375, 81st Cong., 2d Sess. 108 (1950). *See also* H.R. Rep. No. 2319, 81st Cong., 2d Sess. 110 (1950).

408. *Sierra Club, Inc. v. Commissioner*, 86 F.3d 1526, 1532 (9th Cir. 1996).

409. *Id*. at 1535.

410. *Id*.

411. *See Sierra Club, Inc. v. Commissioner*, 65 T.C.M. 2582 (1993), *aff'd*, 86 F.3d 1526 (9th Cir. 1996). Also *American Academy of Ophthalmology, Inc. v. Commissioner* (Tax Ct. No. 21657-94)

and remanded its affinity card opinion.[412] As to the latter, the appellate court disapproved of the way in which the Tax Court resolved certain factual issues (namely, in favor of the exempt organization). Nonetheless, even with this revised definition of the term *royalty*, the Tax Court again concluded that the organization's affinity card revenue was excludable as royalty income.[413]

During the pendency of this litigation, the IRS adhered to its view on the tax treatment of royalties in its letter ruling policies.[414] A common instance of this treatment was the insistence by the IRS that the funds an exempt organization receives for an endorsement are taxable, whereas the organization asserts that the monies are royalties for the use of its name and logo.[415] A growing practice accordingly evolved: to make partial use of the royalty exclusion by the use of two contracts—one for the taxable services and one for the royalty arrangement.[416]

By the close of 1999, the IRS realized that this series of defeats[417] was insurmountable—that the courts were not going to accept its narrow interpretation of the tax-excludable royalty. The IRS National Office communicated with its exempt organizations specialists in the field, essentially capitulating on the point; a memorandum bluntly stated that "[c]ases should be resolved in a manner consistent with the existing court cases."[418] This memorandum added that "it is now clear that courts will continue to find the income [generated by activities such as mailing list rentals and affinity card programs] to be excluded royalty income unless the factual record clearly reflects more than unsubstantial services being provided." Two factors were highlighted by the IRS as establishing nontaxable royalty income: where the involvement of the exempt organization is "relatively minimal" and where the organization "hired outside contractors to perform most services associated with exploitation of the use of intangible property."[419]

Mineral royalties, whether measured by production or by gross or taxable income from the mineral property, are excludable in computing unrelated business income under the general rules. Where a tax-exempt organization

(where the IRS abandoned its mailing list revenue taxation stance in the aftermath of the *Sierra Club* holding).

412. *See Sierra Club, Inc. v. Commissioner*, 103 T.C. 107 (1994), *aff'd in part and rev'd in part & remanded*, 86 F.3d 1526 (9th Cir. 1996).
413. *Sierra Club, Inc. v. Commissioner*, 77 T.C.M. 1569 (1999).
414. E.g., Tech. Adv. Mem. 9509002.
415. E.g., Priv. Ltr. Rul. 9450028.
416. There is some support for this approach in *Texas Farm Bureau, Inc. v. United States*, 53 F.3d 120 (5th Cir. 1995), in which the contracts involved did not expressly cast the revenues at issue as royalties.
417. *See* the cases collected at *supra* note 404.
418. Memorandum from Exempt Organization Division Director to IRS exempt organization managers, dated December 16, 1999.
419. An issue is whether there should be an allocation of a single payment between compensation for the use of intangible property and compensation for more than insubstantial services.

owns a working interest in a mineral property and is not relieved of its share of the development costs pursuant to an agreement with an operator, however, income received is not excludable.[420] The holder of a mineral interest is not liable for the expenses of development (or operations) for these purposes where the holder's interest is a net profit interest not subject to expenses that exceed gross profits. Thus, a tax-exempt university was ruled by the IRS to have excludable royalty interests, where the interests it held in various oil- and gas-producing properties were based on the gross profits from the properties reduced by all expenses of development and operations.[421]

The IRS ruled that patent development and management service fees, deducted from royalties collected from licensees by a tax-exempt charitable organization for distribution to the beneficial owners of the patents, were not within this exception for royalties; it said that ''although the amounts paid to the organization are derived from royalties, they do not retain the character of royalties in the organization's hands'' for these purposes.[422] Similarly, the IRS decided that income derived by a tax-exempt organization from the sale of advertising in publications produced by an independent firm was properly characterized as nonexcludable royalty income.[423] By contrast, the IRS determined that amounts received from licensees by a tax-exempt organization, which was the legal and beneficial owner of patents assigned to it by inventors for specified percentages of future royalties, constituted excludable royalty income.[424] A federal court of appeals held that income consisting of 100 percent of the net profits in certain oil properties, received by a tax-exempt organization from two corporations controlled by it, constituted income from overriding royalties and thus was excluded from unrelated business income taxation.[425]

A matter of some concern to the IRS has been the appropriate tax treatment of payments to a tax-exempt organization, the principal purpose of which is the development of a U.S. team for international amateur sports competition, in return for the right to commercially use the organization's name and logo. The organization entered into licensing agreements that, in

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420. Reg. § 1.512(b)-1(b).

421. Priv. Ltr. Rul. 7741004. This result presumably would have been different (namely, imposition of the unrelated business income tax) if the university was obligated to and did pay its pro rata share of expenses in excess of gross profits.

422. Rev. Rul. 73-193, 1973-1 C.B. 262, 263. *See also* Rev. Rul. 69-179, 1969-1 C.B. 158 (an exempt organization's income from a mineral interest ruled not an excludable royalty where the organization was liable for the operating expenses associated with its interest).

423. Priv. Ltr. Rul. 7926003.

424. Rev. Rul. 76-297, 1976-2 C.B. 178. *See also J.E. and L.E. Mabee Foundation, Inc. v. United States*, 533 F.2d 521 (10th Cir. 1976), *aff'g* 389 F. Supp. 673 (N.D. Okla. 1975).

425. *United States v. The Robert A. Welch Foundation*, 334 F.2d 774 (5th Cir. 1964), *aff'g* 228 F. Supp. 881 (S.D. Tex. 1963). The IRS does not follow this decision (Rev. Rul. 69-162, 1969-1 C.B. 158). *See*, in general, Holloman, ''Are Overriding Royalties Unrelated Business Income?,'' 24 *Oil & Gas Tax Q.* 1 (1975).

consideration of the annual payment of a stated sum, authorized use of the organization's name and logo in connection with the sale of products. The initial position of the IRS was that, to be characterized as a royalty and thus be excludable from unrelated business income taxation, payments must be measured according to the use made of a valuable right. The IRS became sufficiently persuaded, however, on the basis of case law precedent,[426] that fixed-sum payments for the right to use an asset qualify as excludable royalties, although it continues to adhere to the position that, absent the statutory exclusion, the income would be taxable as being from an unrelated trade or business.[427]

Subsequently, the IRS ruled that certain payments a tax-exempt labor organization received from various business enterprises for the use of its trademark and similar properties were royalties.[428] This conclusion was reached even though the organization retained the right to approve the quality or style of the licensed products and services, and the payments were sometimes set as fixed annual payments.[429]

§ 24.18 INTERNET ACTIVITIES

Recent years have brought extensive use of the Internet by tax-exempt organizations. There has not, however, been any guidance from the IRS providing answers to the many tax questions that this form of Internet use is generating. One aspect of this matter is nonetheless clear: the federal tax law does not provide any unique treatment to transactions or activities of tax-exempt organizations simply because the Internet is the medium. As the IRS quite saliently observed: "[T]he use of the Internet to accomplish a particular task does not change the way the tax laws apply to that task. Advertising is still advertising and fundraising is still fundraising."[430]

The Internet use that implicates the unrelated business income rules concerns marketing, merchandising, advertising, and the like. In general, as noted, it may be assumed that, as the IRS's position develops, it will remain

426. *Commissioner v. Affiliated Enterprises, Inc.*, 123 F.2d 665 (10th Cir. 1941), *cert. denied*, 315 U.S. 812 (1942). *See also Commissioner v. Wodehouse*, 337 U.S. 369 (1949); *Rohmer v. Commissioner*, 153 F.2d 61 (2d Cir. 1946), *cert. denied*, 328 U.S. 862 (1946); *Sabatini v. Commissioner*, 98 F.2d 753 (2d Cir. 1938).
427. Priv. Ltr. Rul. 8006005.
428. Rev. Rul. 81-178, 1981-2 C.B. 135. Other payments, however, were held not royalties because the personal services of members of the organization were required.
429. The IRS relied on the following cases (in addition to those cited in note 338) for its conclusion: *Cepeda v. Swift & Co.*, 415 F.2d 1205 (8th Cir. 1969); *Uhlaender v. Hendrickson*, 316 F. Supp. 1277 (D. Minn. 1970). *See generally* Izuel and Park, "The Application of the Royalty and Volunteer Exceptions to Unrelated Business Taxable Income," 44 *Exempt Org. Tax Rev.* (No. 3) 299 (June 2004); Schadler, "The Courts Point the Way to Royalty Treatment for UBIT Purposes," 9 *J. Tax'n Exempt Orgs.* (No. 6) 244 (May/June 1998).
430. IRS CONTINUING PROFESSIONAL EDUCATION TEXT FOR FY 2000.

consistent with its position with respect to advertising, merchandising, and publishing in the offline world.

A significant issue in this context is the subject of charity web site hypertext links to related or recommended sites. Link exchanges may be treated by the IRS the same as mailing list exchanges. Compensation for a linkage may be unrelated business income. The purpose of the link may be determinative: Is its purpose furtherance of exempt purposes (a referral of the site visitor to additional (educational) information), or is it part of an unrelated activity (including advertising)?[431]

Also involved are corporate sponsorships, inasmuch as exempt organizations may seek corporate support to underwrite the production of all or a portion of the organization's web site. These relationships may be short-term or continue on a long-term basis. The financial support may be acknowledged by means of display of a corporate logo, notation of the sponsor's web address and/or 800 number, a ''moving banner'' (a graphic advertisement, usually a moving image, measured in pixels), or a link. The issue here is: Is the support a qualified sponsorship payment,[432] in which case the revenue is not taxable, or is it advertising income, which generally is taxable as unrelated business income?[433]

There is a question as to whether the use of a link in an acknowledgment will change the character of a corporation's payment—convert it from corporate sponsorship to taxable advertising income. The IRS may adopt the view that the payment should retain its character as a mere acknowledgment since the web site visitor must take an affirmative action (click) to reach the corporation's web site. A moving banner is more likely to be considered advertising.

Another problem relates to the rule that qualified sponsorship payments do not include payments that entitle the sponsors to acknowledgments to regularly scheduled printed material published by or on behalf of the tax-exempt organization. Here, the issue is the characterization of web site materials. Most of the materials made available on exempt organization web sites are clearly prepared in a manner that is distinguishable from the methodology used in the preparation of periodicals.

Nonetheless, there can be an online publication that is treated as a periodical. (When this is the case, the special rules by which unrelated business income from periodical advertising is computed become available.) Some periodicals have online editions, and some print publications are reproduced online, sometimes on a subscription basis or in a members-only-access portion of a web site. These materials should be and generally are sufficiently segregated from the other traditional web site materials so that the methodology employed in the production and distribution methods are clearly ascertainable

431. *See*, however, § 24.16, text accompanied by *supra* note 352.
432. IRC § 513(i).
433. IRC § 513(c).

and the periodical income and costs can be independently and appropriately determined. Presumably, ''genuine'' periodicals have an editorial staff, marketing program, and budget independent of the organization's webmaster.

Then there is the matter of the ''virtual tradeshow,'' which generates income for trade associations and other exempt entities from ''virtual exhibitors.'' This brings into play the rules by which traditional tradeshow income is excluded from the unrelated business income tax.[434] The extent to which the traditional rules will apply to virtual tradeshow income will most likely depend in large part on whether the qualifying organization is able to demonstrate that its exhibits or displays are substantially similar to those traditionally carried on at a tradeshow.

This tax exclusion is not likely to be available for a mere listing of links to industry suppliers' web sites. Also, it is highly questionable whether income from a year-round virtual tradeshow is excludable from unrelated business income. Conversely, virtual tradeshows with displays including educational information related to issues of interest to industry members or those that are timed to coincide with the sponsoring organization's annual meeting or regular tradeshow may qualify for the exclusion.

Another set of issues pertains to online storefronts, complete with virtual shopping carts, on exempt organizations' web sites. Again, it may be anticipated that the IRS will use the same analysis that it applies in sales made through stores, catalogs, and other traditional vehicles, such as that applied in the context of museum gift shop sales.[435] In deciding whether the unrelated business income tax applies, the IRS looks to the nature, scope, and motivation for the particular sales activities. Merchandise is evaluated on an item-by-item basis (applying the fragmentation rule[436]) to determine whether the sales activity furthers the accomplishment of the organization's exempt purposes or is simply a way to increase revenue.

As to online auctions, the IRS will be concerned with charities' use of outside auction service providers. Although utilization of these providers may provide a larger audience for the auction and enable the organization to avoid credit card problems, the relationship might have tax implications.

Again, the focus is on control.[437] The IRS will be considering how much control the charity exercises over the marketing and conduct of the auction. The IRS will want the charity to have primary responsibility in this regard. Otherwise, the IRS may be more likely to view income from these auction activities as income from classified advertising rather than as income derived from the conduct of a fundraising event. These service providers are essentially

434. IRC § 513(d).
435. *See* Tax-Exempt Organizations § 24.5(c).
436. *See* § 24.1.
437. E.g., § 16.3.

professional fundraisers, and thus their functions and fees should be scrutinized using the doctrines of private inurement and private benefit.[438]

Still another issue is affiliate and other co-venture programs with merchants. Of particular note are arrangements with large online booksellers. Some tax-exempt organizations make book recommendations that are displayed on their web site; others have a link to the bookseller. The exempt organization earns a percentage of sales of recommended materials and perhaps also a commission on purchases sold through the referring link. The principal issue here is whether the resulting income is a tax-excludable royalty.[439]

In anticipation of the issuance of a request for comments on questions posed by it concerning application of the tax law to the Internet activities of tax-exempt organizations, the IRS wrote: ''It is hoped that all members of the exempt organizations [community] will be involved in the development of new policies which will build upon principles developed over time and adapt to allow exempt organizations to take advantage of the technological innovations of the new millennium.''[440] Thereafter, the IRS announced that it is seeking comment on a range of questions pertaining to Internet activities by tax-exempt organizations in the unrelated business income context (and others).[441] The IRS issued a private letter ruling holding that certain web-site listings and links by a tax-exempt organization are not businesses, that these listings and links do not cause licensing royalties to be taxable, and that a web-site link to a corporate sponsor is an acknowledgment rather than advertising, and explained the special rules as to offline and online periodicals.[442]

§ 24.19 REVENUE FROM CONTROLLED ORGANIZATIONS

Even though revenue is derived by a tax-exempt organization in a form that generally enables it to be exempt from unrelated business income taxation, there is an exception for revenue derived from a controlled organization.[443] This exception is applicable with respect to payments of interest, annuities, royalties, and rents (but not dividends).[444]

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438. *See* Chapter 4.
439. *See* § 24.17 (iii).
440. Continuing Professional Education Text, *supra* note 430. In the context of the issuance of the proposed regulations concerning corporate sponsorships (see § 24.16), the IRS requested comments on the application of the rules governing periodicals and trade shows (in IRC § 513(i)(2)(B)(ii)) to tax-exempt organizations' Internet sites, and on whether providing a link to a sponsor's Internet site is advertising (within the meaning of IRC § 513(i)(2)(A) and Prop. Reg. § 1.513-4(c)(2)(iv)).
441. Ann. 2000-84, 2000-42 I.R.B. 385.
442. Priv. Ltr. Rul. 200303062.
443. IRC § 512(b)(13); Reg. § 1.512(b)-1(1).
444. The reason for this distinction is that the payment of rents, interest, or royalties gives rise to a tax deduction for the payment of them for the payor organization (IRC §§ 162 and 163). However, there is no tax deduction for the payment of dividends; rather, the

(a) General Rules

The requisite control element can be manifested by stock or by an interlocking of directors, trustees, or other representatives of the two organizations.[445] Until 1997, one organization controlled another, for this purpose, when the controlling entity directly had at least an 80 percent interest in the controlled organization.[446] Where the subsidiary was a nonexempt organization, income paid to the tax-exempt parent organization was regarded as unrelated business taxable income to the extent it would have been unrelated business taxable income if earned directly by the exempt parent. In the case of an exempt subsidiary, the rules applied in the proportion that the subsidiary's income was unrelated business taxable income.[447]

The purpose of this rule is to prevent a tax-exempt organization from housing an unrelated business activity in a separate but controlled organization and receiving nontaxable income by reason of the *modification* rules (such as by renting property, as an unrelated business, to a subsidiary). If the subsidiary is a tax-exempt organization, these rules apply in the proportion that the subsidiary's income is unrelated business income; likewise, where the subsidiary is a taxable organization, income from an activity related to the parent's tax-exempt function can be treated as related income in proportion to the subsidiary's total receipts.[448]

The law in this regard was changed significantly in 1997.[449] The control test was revised, constructive ownership rules were added, and the rules for determining how income is taxed under this regime were altered. The law was changed because its purpose was frustrated, in that it was too narrowly written and easily circumvented.[450]

Under the new rules, the percentage threshold for determining control was considerably reduced, from 80 percent to a more-than-50-percent standard. Thus, in the case of a corporation, *control* means ownership by vote or value of more than 50 percent of the stock in the corporation.[451] In the case of a partnership, control is ownership of more than 50 percent of the profit interests

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earnings and profits of the distributing corporation are reduced (IRC § 312(a)). Thus, it would be inconsistent with fundamental tax principles to tax revenue received by a parent tax-exempt organization where it is not deductible by the taxable subsidiary.

445. Reg. § 1.512(b)-1(1)(4).
446. IRC § 368(c).
447. Reg. § 1.512(b)-1(1), (2), (3).
448. Reg. § 1.512(b)-1(1)(2).
449. Taxpayer Relief Act of 1997, § 1041(a).
450. H. Rep. No. 105-148, 105th Cong., 1st Sess. 491-492 (1997). For example, under prior law, a for-profit subsidiary of a tax-exempt organization (a first-tier subsidiary) could itself have a for-profit subsidiary (a second-tier subsidiary); rent and the like paid by the second-tier subsidiary to the exempt organization were not taxable as unrelated business income because the exempt organization was not considered to control the second-tier subsidiary.
451. IRC § 512(b)(13)(D)(i)(I).

or capital interests in the partnership.[452] In an instance of a trust or any other case, control is measured in terms of more than 50 percent of the beneficial interests in the entity.[453]

Preexisting constructive ownership rules have been engrafted onto this area for purposes of determining ownership of stock in a corporation.[454] Similar principles apply for purposes of determining ownership of interests in any other entity.[455] For example, if 50 percent or more in value of the stock in a corporation is owned, directly or indirectly, by or for any person, that person is considered as owning any stock owned, directly or indirectly, by or for the corporation, in the proportion that the value of the stock the person so owns bears to the value of all the stock in the corporation.[456] Likewise, if 50 percent or more in value of the stock in a corporation is owned, directly or indirectly, by or for any person, the corporation is considered as owning the stock owned, directly or indirectly, by or for that person.[457] There are attribution rules that apply with respect to stock owned by members of a family, partnerships, estates, and trusts.[458]

Thus, when a controlling organization receives, directly or indirectly, a specified payment from a controlled entity (whether or not tax-exempt), the controlling entity may have to treat that payment as income from an unrelated business.[459] The term *specified payment* means interest, annuity, royalties, or rent.[460] A specified payment must be treated as unrelated business income to the extent the payment reduces the net unrelated income of the controlled entity or increases any net unrelated loss of the controlled entity.[461] The controlling organization may deduct expenses that are directly connected with amounts that are treated as unrelated business income under this rule.[462]

In the case of a controlled entity that is not tax-exempt, the term *net unrelated income* means the portion of the entity's taxable income that would be unrelated business taxable income if the entity were exempt and had the same exempt

452. IRC § 512(b)(13)(D)(i)(II).
453. IRC § 512(b)(13)(D)(i)(III).
454. IRC §§ 512(b)(13)(D)(ii), 318. Applying these rules, the IRS held (in a controversial private letter ruling) that a tax-exempt hospital that constructively owns several professional medical corporations received unrelated business income from them (Priv. Ltr. Rul. 200716034).
455. IRC § 512(b)(13)(D)(ii). The IRS is directed to develop rules as may be necessary or appropriate to prevent avoidance of the purposes of this body of law through the use of related persons (IRC § 512(b)(13)(E)).
456. IRC § 313(a)(2)(C).
457. IRC § 313(a)(3)(C).
458. IRC § 313(a)(1), (2)(A), (B), (3)(A), (B).
459. IRC § 512(b)(13)(A). Examples of indirect payments appear in *J.E. & L.E. Mabee Foundation, Inc. v. United States*, 533 F.2d 521 (10th Cir. 1976), and Gen. Couns. Mem. 38878.
460. IRC § 512(b)(13)(C).
461. IRC § 512(b)(13)(A).
462. *Id*.

purposes as the controlling organization.[463] Where the controlled entity is tax exempt, net unrelated income means the amount of the unrelated business taxable income of the controlled entity.[464] The term *net unrelated loss* means the net operating loss adjusted under rules similar to those pertaining to net unrelated income.[465] Consequently, the allocation-of-income rule embodied in prior law has been replaced by this lookthrough approach.[466]

(b) Temporary Rule

Notwithstanding the foregoing, a temporary rule applies with respect to payments to controlling organizations received or accrued by them after December 31, 2005, and before January 1, 2008.[467] Pursuant to this rule, the general law—which causes interest, rent, annuity, or royalty payments made by a controlled entity to the controlling tax-exempt organization to be included in the latter organization's unrelated business income to the extent the payment reduces the net unrelated income (or increases the net unrelated loss) of the controlled entity—applies only to the portion of payments received or accrued in a tax year that exceeds the amount of the payment that would have been paid or accrued if the payment had been determined under the rules concerning the allocation of tax items among taxpayers.[468] Thus, if one of these four types of payments by a subsidiary to an exempt parent exceeds fair market value, the excess amount of the payment is included in the parent's unrelated business income, to the extent that the excess reduced the net unrelated income (or increased any net unrelated loss) of the controlled entity.

A 20 percent penalty is imposed on the larger of the excess determined without regard to any amendment or supplement to a tax return or the excess determined with regard to all such amendments and supplements.[469] A tax-exempt organization that receives interest, rent, annuity, and/or royalty payments from a controlled entity must report the payments on its annual information return,[470] as well as any loans made to a controlled entity and any transfers between such an organization and a controlled entity.[471]

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463. IRC § 512(b)(13)(B)(i)(I).
464. IRC § 512(b)(13)(B)(i)(II).
465. IRC § 512(b)(13)(B)(ii).
466. There is an argument that the policy underlying IRC § 512(b)(13) should apply only where the amounts paid out of the controlled entity are not based on fair market value considerations. For example, the House report accompanying the law change states that the provision was enacted "to prevent subsidiaries of tax-exempt organizations from reducing their otherwise taxable income by borrowing, leasing, or licensing assets from a tax-exempt parent organization at inflated levels" (H. Rep. 105-148, 105th Con., 1st Sess. 491 (1997)). Congress, however, has not adopted that approach.
467. IRC § 512(b)(13)(E).
468. IRC § 482.
469. IRC § 512(b)(13)(E)(ii).
470. *See* § 35.3.
471. IRC § 6033(h).

The Department of the Treasury is to submit, by January 1, 2009, a report to Congress on the effectiveness of the IRS in administering this revised law and on the extent to which payments by controlled entities to the controlling exempt organization meet the cost allocation requirements.[472]

§ 24.20 UNRELATED DEBT-FINANCED INCOME

In addition to the foregoing ways a tax-exempt healthcare organization can generate income from an unrelated trade or business, there are rules concerning unrelated debt-financed income.[473] As the term indicates, this income is traceable in one way or another to unrelated property acquired with borrowed funds. Often, this type of income is taxable even though it is received by the tax-exempt organization in one or more of the forms that would otherwise be excluded (most notably, interest).

In computing the unrelated business income of a tax-exempt organization, there must be included—with respect to each debt-financed property that is unrelated to the organization's exempt function, and as an item of gross income derived from an unrelated trade or business—an amount of income from the property, subject to tax in the proportion in which the property is financed by the debt.[474] Basically, deductions are allowed with respect to each debt-financed property in the same proportion.[475] The allowable deductions are those that are directly connected with the debt-financed property or its income, although any depreciation may only be computed on the straight-line method.[476] For example, if a commercial business property was acquired by a tax-exempt healthcare organization subject to a mortgage reflecting 80 percent of the purchase price, 80 percent of the income and 80 percent of the deductions are taken into account for these purposes. As the mortgage is paid, the percentage involved usually diminishes. Capital gains on the sale of unrelated debt-financed property are also taxes in the same proportions.[477]

(a) Debt-Financed Property

The term *debt-financed property* means, with certain exceptions, all property (such as rental real estate, tangible personalty, and corporate stock) that is held to produce income (such as rents, royalties, interest, and dividends) and with respect to which there is an "acquisition indebtedness"[478] at any time

472. Pension Protection Act of 2006 § 1205(b)(2).
473. IRC § 514.
474. IRC §§ 514(a)(1) and 512(b)(4).
475. IRC § 514(a)(2).
476. IRC § 514(a)(3).
477. Reg. § 1.514(a)-1.
478. *See* § 24.20(b).

during the tax year (or during the preceding twelve months, if the property is disposed of during the year).[479]

Exempted from debt-financed property are the following:

1. Property where substantially all (at least 85 percent) of its use is substantially related (aside from the need of the organization for revenue) to the exercise or performance by the organization of its tax-exempt purpose or, if less than substantially all of its use is related, to the extent that its use is related to the organization's exempt purpose.[480]
2. Property to the extent that its income is already subject to tax as income from the conduct of an unrelated trade or business.[481]
3. Property to the extent that the income is derived from research activities and therefore excluded from unrelated business taxable income.[482]
4. Property to the extent that its use is in a trade or business exempted from tax because substantially all of the work is performed without compensation; the business is carried on primarily for the convenience of members, students, patients, officers, or employees; or the business is the selling of merchandise, substantially all of which was received as contributions.[483]

For purposes of the first category of property: (1) the principles established under the general unrelated business rules[484] are applicable in determining whether there is a substantial relationship between the property and the tax-exempt purposes of the organization[485] and (2) substantially all of the use of the property is considered substantially related to the exercise or performance of an organization's tax-exempt purpose if the property is real property subject to a lease to a medical clinic, where the lease is entered into primarily for purposes that are substantially related to the exempt purposes of the lessor.[486] For purposes of the first, third, and fourth categories of property, the use of any property by a tax-exempt organization that is related to an organization is treated as use by the related organization.[487]

An illustration of a situation where property that is debt-financed does not yield unrelated debt-financed income, because the use of the property

479. IRC § 514(b)(1).
480. IRC § 514(b)(1)(A). For example, it is on this basis that the rent a hospital derives from a debt-financed medical office building (*see* § 24.13) is not unrelated debt-financed income (e.g., Priv. Ltr. Rul. 8452099).
481. IRC § 514(b)(1)(B). This rule does not apply in the case of income excluded under IRC § 512(b)(5) (principally, capital gain). *See* § 24.17(b)(i), text accompanied by *supra* note 379.
482. IRC §§ 512(b)(7), (8), or (9), 514(b)(1)(C). *See* § 24.12.
483. IRC § 514(b)(1)(D). *See* § 24.17(b)(i).
484. *See* §§ 24.4 and 24.5.
485. Reg. § 1.514(b)-1(b)(1).
486. Reg. § 1.514(b)-1(c)(1).
487. IRC § 514(b)(2).

was substantially related to a tax-exempt use, was provided in the case of a tax-exempt medical foundation that rented mortgaged property to a medical clinic that had a close working relationship with the foundation. Because the leased property was held to be related to the foundation's exempt purpose of providing medical training, the rental income was determined to be nontaxable.[488]

Property owned by a tax-exempt organization and used by a related tax-exempt organization (or by an exempt organization related to the related exempt organization) is not treated as debt-financed property to the extent that the property is used by either organization in furtherance of its tax-exempt purpose.[489] Two tax-exempt organizations are related to each other if more than 50 percent of the members of one organization are members of the other organization.[490]

The *neighborhood land rule* provides an exemption from the debt-financed property rules for interim income from neighborhood real property acquired for an exempt purpose. The tax on unrelated debt-financed income does not apply to income from real property that is located in the neighborhood of the tax-exempt organization and that it plans to devote to exempt uses within ten years of the time of acquisition.[491]

If debt-financed property is sold or otherwise disposed of, a percentage of the total gain or loss derived from the disposition is included in the computation of unrelated business income.[492] The IRS has recognized, however, that the unrelated debt-financed income rules do not render taxable a transaction that would not be taxable by virtue of a nonrecognition provision in the federal tax law if it were carried out by an entity that is not tax-exempt. The occasion was a transfer, subject to an existing mortgage, of an apartment complex that had appreciated in value by a tax-exempt hospital to its wholly owned taxable subsidiary in exchange for additional stock in the subsidiary. Because of the operation of federal tax rules that provide for the nonrecognition of gain or loss in certain circumstances,[493] including those involving this hospital, the transaction was ruled to not result in a taxable gain for the hospital.[494]

(b) Acquisition Indebtedness

Income-producing property is considered to be unrelated debt-financed property (making income from it, less deductions, taxable) only where an *acquisition indebtedness* is attributable to it.[495] Acquisition indebtedness, with

488. *Gundersen Medical Foundation, Ltd. v. United States*, 536 F. Supp. 556 (W.D. Wis. 1982).
489. Reg. § 1.514(b)-1(c)(2)(i).
490. Reg. § 1.514(b)-1(c)(2)(ii)(c).
491. IRC § 512(b)(2)(A)–(C).
492. Reg. § 1.514(a)-1(a)(1)(v).
493. IRC §§ 351 and 357.
494. Rev. Rul. 77-71, 1977-1 C.B. 156.
495. IRC § 514(c).

respect to debt-financed property, means the unpaid amount of (1) the indebtedness incurred by the tax-exempt organization in acquiring or improving the property; (2) the indebtedness incurred before any acquisition or improvement of the property, if the indebtedness would not have been incurred but for the acquisition or improvement; and (3) the indebtedness incurred after the acquisition or improvement of the property, if the indebtedness would not have been incurred but for the acquisition or improvement and the incurring of the indebtedness was reasonably foreseeable at the time of the acquisition or improvement.[496]

If property is acquired by a tax-exempt organization subject to a mortgage or other similar lien, the indebtedness secured in this manner is considered an acquisition indebtedness incurred by the organization when the property is acquired, even though the organization did not assume or agree to pay the indebtedness.[497] Some relief is provided, however, with respect to mortgaged property acquired as a result of a bequest or devise. That is, the indebtedness secured by this type of mortgage is not treated as acquisition indebtedness during the ten-year period following the date of acquisition.[498] A similar rule applies to mortgaged property received by gift, where the mortgage was placed on the property, and the property was held by the donor, more than five years before the gift.[499]

Other exemptions from the scope of acquisition indebtedness include the following:

1. The term does not include indebtedness that was necessarily incurred in the performance or exercise of an organization's tax-exempt purpose.[500]
2. The term does not include an obligation to pay an annuity that (a) is the sole consideration issued in exchange for property if, at the time of the exchange, the value of the annuity is less than 90 percent of the value of the property received in the exchange; (b) is payable over the life of one individual who is living at the time the annuity was issued, or over the lives of two individuals living at that time; and (c) is payable under a contract that does not guarantee a minimum amount of payments or specify a maximum amount of payments, and does not provide for any

496. IRC § 514(c)(1).
497. IRC § 514(c)(2)(A).
498. IRC § 514(c)(2)(B).
499. *Id*.
500. IRC § 514(c)(4). Unrelated debt-financed income is triggered to the extent that the financing occurred in connection with the acquisition of property used for an exempt purpose but the loan proceeds were instead invested (*Southwest Texas Electrical Cooperative, Inc. v. Commissioner*, 95-2 U.S.T.C. (CCH) ¶50,565 (5th Cir. 1995)). Income derived from securities purchased on margin is unrelated debt-financed income (*Henry E. & Nancy Horton Bartels Trust for the Benefit of the University of New Haven v. United States*, 209 F.3d 147 (2d Cir. 2000)).

adjustment of the amount of the annuity payments by reference to the income received from the transferred property or any other property.[501]

3. The term does not include a tax-exempt organization's obligation to return collateral security pursuant to a securities lending arrangement,[502] thereby making it clear that, in ordinary circumstances, payments on securities loans are not debt-financed income.[503]

Complex rules exclude from the concept of acquisition indebtedness several types of indebtedness incurred by a *qualified organization* in acquiring or improving any real property.[504] Generally, healthcare organizations are not qualified organizations and thus cannot avail themselves of this exception. Operating educational institutions are qualified organizations,[505] however, and a hospital or other healthcare entity that is an integral part of such an organization may qualify.

§ 24.21 SPECIFIC DEDUCTION

In computing unrelated business taxable income, there is a *specific deduction* of $1,000.[506] This deduction is intended to eliminate imposition of the unrelated business income tax in cases where the exaction of it would involve excessive costs of collection in relation to any payments received by the government.[507]

A tax-exempt organization is entitled to only one $1,000 deduction in computing its unrelated business taxable income, irrespective of the number of unrelated businesses in which it is engaged.[508]

§ 24.22 COMPUTATION OF UNRELATED BUSINESS TAXABLE INCOME

Unrelated business taxable income means the gross income derived by a tax-exempt organization from any unrelated trade or business that it regularly carries on, less deductions that are directly connected with the carrying on of the trade or business, subject to certain modifications.[509] To be deductible,

501. IRC § 514(c)(5). Because of this provision, the issuance of charitable gift annuities by charitable organizations does not cause unrelated debt-financed income (CHARITABLE GIVING, Chapter 15).
502. *See* § 24.17(b)(i), text accompanied by *supra* note 379.
503. IRC § 514(c)(8).
504. IRC § 514(c)(9)(A).
505. IRC § 514(c)(9)(C).
506. IRC § 512(b)(12); Reg. § 1.512(b)-1(h)(1).
507. H.R. REP. No. 2319, 81st Cong., 2d Sess. 37 (1950); S. REP. No. 2375, 81st Cong., 2d Sess. 30 (1950).
508. Rev. Rul. 68-536, 1968-2 C.B. 244.
509. IRC § 512(a)(1); Reg. § 1.512(a)-1(a). These modifications are the subject of § 24.17(b). In general, a tax-exempt organization must use a method of accounting which "clearly reflects income" (Reg. § 1.446-1(a)(2)).

expenses, depreciation, and similar items must qualify as business deductions generally and must be directly connected with the carrying on of the unrelated trade or business. The phrase *directly connected with* means the deduction must have a proximate and primary relationship to the carrying on of the unrelated trade or business. If the organization derives gross income from the regular carrying on of two or more unrelated business activities, the aggregate of gross income from all of the activities, less the aggregate of the allowed deductions, constitutes unrelated business taxable income.[510]

Expenses, depreciation, and similar items that are attributable solely to the conduct of an unrelated business activity are considered to be proximately and primarily related to that business activity and therefore qualify for deduction if they are otherwise allowable income tax deductions.[511] Thus, for example, the compensation of full-time personnel who operate an unrelated trade or business and the depreciation on a building used entirely in the operation of that unrelated business are deductible in full to the extent that they are otherwise allowable.

When facilities or personnel are used both to carry on exempt activities and to operate an unrelated trade or business,[512] the expenses, depreciation, and similar items attributable to the facilities or personnel must be allocated between the two uses on a reasonable basis.[513]

Gross income may be derived from an unrelated trade or business that exploits an exempt activity.[514] Generally, deductions attributable to the conduct of the exempt activity are not deductible in computing unrelated business taxable income because they are not directly connected with the unrelated trade or business.[515] If, however, (1) the unrelated trade or business is of the kind normally carried on for profit by a taxable organization and (2) the exempt activity being exploited is a type of activity that is normally conducted by taxable organizations in that business, the expenses, depreciation, and similar items attributable to the exempt activity can qualify as deductions against unrelated business income.[516]

A tax-exempt organization is not entitled to an expense deduction for funds transferred from one internal account to another (*Women of the Motion Picture Industry v. Commissioner*, 74 T.C.M. 1217).

510. Reg. § 1.512(a)-1(a). For this rule to apply, however, the activity must be a *trade or business* in the first instance (*see* § 24.2).
511. Reg. § 1.512(a)-1(b).
512. *See* § 24.4(c).
513. Reg. § 1.512(a)-1(c).
514. *See* § 24.4(d).
515. Reg. § 1.512(a)-1(d)(1).
516. Reg. § 1.512(a)-1(d)(2). One of the most common instances of this type of exploitation is the sale of advertising in an exempt organization's publication that otherwise contains editorial material that is substantially related to the accomplishment of the organization's exempt purposes; special rules for the determination of unrelated business taxable income of this nature are in Reg. § 1.512(a)-1(f).

The foregoing law is, of course, applicable to all tax-exempt healthcare organizations. There is, however, a unique aspect of this law applicable to tax-exempt hospitals: the interrelationship between the computation of unrelated business income and Medicare costs.[517] In general, an exempt hospital—like any exempt organization—must properly define, allocate, and report gross income and deductions using a method of accounting that clearly reflects income.[518] At the same time, an exempt hospital must define, analyze, accrue, and allocate Medicare costs in compliance with the specialized reporting requirements of the Health Care Financing Administration. Since the federal tax law and the Medicare rules often do not share common principles (such as definition, allocation, and timing), the costs reported to HCFA often diverge from deductions allowed for tax purposes. Therefore, if a hospital relies on Medicare costs as tax deductions, it is likely to fail to accurately report unrelated business taxable income.

The IRS extensively reviewed this matter and provided guidance.[519] The Service observed that the ''goal of Medicare cost reporting is to reimburse hospitals for their cost of services to Medicare beneficiaries (i.e., patients),'' while the ''goal of the Internal Revenue Code is the equitable collection of revenue.''[520] These goals are achieved, wrote the IRS, ''through different and sometimes incompatible reporting systems.''[521] These guidelines focus on items such as cost of capital items, depreciation, administrative and general outlays (including litigation costs), education of interns and residents, allocation of general service costs (including a discussion of the Medicare step-down method), and accounting for inventories. In accordance with the law reviewed above, the IRS advised that Medicare costs are deductible in computing unrelated taxable income only where the deductions are otherwise allowable, are directly connected to unrelated trade or business, and clearly reflect income.

A loss from an unrelated business can be offset against a gain from another unrelated business conducted by the same organization. If an unrelated activity that generates a loss does so consistently, however, the IRS is likely to take the view that the activity is not a business, because of an absence of a profit motive,[522] in which case the loss cannot be offset against gain from another unrelated business.

The unrelated business taxable income of most tax-exempt organizations is taxable at the regular corporate rates; trusts are taxed using the rates for individuals.[523]

517. As to the latter, *see* Chapter 29.
518. *See supra* note 513.
519. Gen. Couns. Mem. 39843.
520. *Id*.
521. *Id*.
522. *See* § 24.2(b).
523. IRC § 511.

§ 24.23 THE COMMERCIALITY DOCTRINE

The commerciality doctrine is a major portion of the law of tax-exempt organizations generally;[524] it has extensive application to tax-exempt healthcare entities, in the context of both tax exemption and unrelated business activities.

The commerciality doctrine is particularly applicable in the realms of sales of pharmaceuticals and other items,[525] sales of laboratory testing services,[526] medical research,[527] the provision of services to small hospitals,[528] and the various exceptions to unrelated income taxation.[529] The elements of the doctrine that are specifically applicable in those settings are discussed in the appropriate portions of this chapter.[530]

The IRS enthusiastically embraces the commerciality doctrine, utilizing its precepts in a wide variety of settings. For example, the agency's policy of denying recognition of tax exemption to or revoking the exempt status of credit counseling organizations entails frequent invocation of the doctrine.[531] Other instances of IRS utilization of the doctrine in its rulings include denial of exempt status to an organization that facilitates the sale of health insurance for for-profit insurance companies[532]; an organization that facilitates charitable contributions of boats and other items of tangible personal property to charitable organizations[533]; an organization that established a center to provide rest and relaxation to caregivers of chronically and terminally ill individuals (because the services to be provided are akin to those provided by a commercial inn)[534]; and an organization that provides management services to home healthcare agencies and home healthcare providers, and otherwise facilitates the provision of home health services, for a fee.[535] Additional private letter rulings address this point.[536]

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524. *See* § 3.3.
525. *See* § 24.10.
526. *See* § 24.11.
527. *See* § 24.12.
528. *See* § 24.15.
529. *See* § 24.17.
530. Generally, the unrelated income rules and the principles of the commerciality doctrine do not interrelate; an instance, however, where the IRS used the doctrine in rationalizing to a conclusion that an activity was an unrelated business is in Tech. Adv. Mem. 200021056.
531. E.g., Priv. Ltr. Rul. 200538040.
532. Priv. Ltr. Rul. 200512023.
533. Priv. Ltr. Rul. 200512027.
534. Priv. Ltr. Rul. 200525020.
535. Priv. Ltr. Rul. 200539027.
536. E.g., Priv. Ltr. Rul. *See*, in general, Mancino, ''The Unrelated Business Income Taxation of Nonprofit Hospitals,'' 4 *Exempt Org. Tax Rev*. 35 (1991); Kannry, ''How Hospitals Can Minimize Their Potential Exposure to the Unrelated Business Income Tax,'' 43 *J. Tax*. 166 (1975). As to the commerciality doctrine, *see* Colombo, ''Regulating Commercial Activity by Exempt Charities: Resurrecting the Commensurate-in-Scope Doctrine,'' 39 *Exempt Org. Tax Rev*. (No. 3) 341 (Mar. 2003).

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Physician Recruitment and Retention

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§ 25.1 INTRODUCTION

The impact of regulatory forces on hospital–physician relationships has been catalytic. The effect of changes in the Medicare reimbursement system, most notably the prospective payment system and the resource-based relative value system payment mechanisms, has been to force hospitals and physicians to acknowledge their interdependence and to find new ways to help each other in an effort to provide healthcare services more efficiently and cost-effectively. Meanwhile, the Office of Inspector General of the Department of Health and Human Services has challenged many common physician recruitment and retention techniques, and the IRS continues to carefully examine hospital–physician relationships, as evidenced in the Hospital Audit Guidelines, general counsel memoranda, and Coordinated Examination Program (CEP) and Form 1099 audits. Nevertheless, hospitals continue to recruit and retain needed physicians for their communities while attempting to stay in the regulators' good graces.

The two guiding principles under the Internal Revenue Code and its implementing regulations for analyzing hospital–physician relationships are private benefit and private inurement. As discussed in Chapter 4, private benefit, the broader concept of the two, is based on the operational test of the Code for charitable organizations, which requires that charitable organizations be engaged in activities that further public purposes rather than private interests.[1] Private inurement, which is expressly prohibited by the Code, involves the acquisition of an exempt organization's funds or other assets by a person with a personal and private interest in the activities of the exempt organization.

The IRS has limited the application of the private inurement proscription, for the most part, to ''insiders''—individuals who have a personal and private interest in the activities of the exempt organization and could thereby cause the organization to provide the benefit.[2]

When assessing the risk of a particular hospital–physician relationship, it is important to determine whether the physician constitutes an ''insider'' relative to the hospital for purposes of applying the private inurement proscription. Historically, the IRS had not found mere membership on a hospital's medical staff sufficient to constitute an ''insider'' relationship. Thus, as long as any private benefit conferred was incidental to the public benefit of having skilled physicians available in the community to treat patients, recruitment and retention devices were permitted. The private inurement proscription was usually applied in cases where a doctor founded or owned the hospital, or otherwise controlled it.[3]

In 1986, however, the IRS took a much narrower view. The general counsel stated:[4]

> In our opinion, the recruited physicians as employees or as individuals with a close professional working relationship with the Hospital are persons who have a personal and private interest in the activities of the Hospital. Thus, such physicians are subject to the inurement proscription.

Subsequently,[5] the IRS expanded the definition of *insider* to the extent that the concept was rendered almost meaningless. It stated that ''[i]t is our opinion that *all persons performing services for an organization* have a personal and private interest and therefore possess the requisite relationship necessary

1. Reg. § 1.501(c)(3)-1(d)(1)(ii).
2. *See*, e.g., *Sound Health Association v. Commissioner*, 71 T.C. 158, 185 (1978); *American Campaign Academy v. Commissioner*, 92 T.C. 1053, 1066 (1989).
3. *See*, e.g., *Lowry Hospital Association v. Commissioner*, 66 T.C. 850 (1976); *Maynard Hospital, Inc. v. Commissioner*, 52 T.C. 1006 (1969); *Sonora Community Hospital v. Commissioner*, 46 T.C. 519 (1966), *aff'd*, 397 F.2d 814 (9th Cir. 1968); *Lorain Avenue Clinic v. Commissioner*, 31 T.C. 141 (1958); *Harding Hospital, Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1974).
4. Gen. Couns. Mem. 39498.
5. Gen. Couns. Mem. 39670.

to find private benefit or inurement [emphasis added].'' This includes any employee of the organization, and all physicians on a hospital's medical staff.[6]

The better view would seem to be that mere membership on a medical staff is insufficient to create a control or insider relationship for purposes of applying the inurement proscription. Typically, membership alone does not confer sufficient control over the hospital to permit the physician to obtain improper benefits. This view is consistent, for example, with the IRS's position that physicians on a hospital's medical staff are not closely enough related to the hospital to constitute ''members'' for purposes of applying a ''primarily for the convenience of members'' exception to the unrelated business income rules.[7] Arrangements with medical staff members with other indicia of control—for example, officers, trustees, top admitters, and so on—would pose a greater risk of running afoul of the inurement proscription.

Given the IRS's revenue ruling on physician recruitment,[8] and its regulations implementing intermediate sanctions,[9] it is apparent that mere membership on the medical staff is no longer viewed by the IRS as cause for a physician to become an insider for private inurement purposes. Rather, the physician must be in a position to substantially influence the affairs of the exempt organization in order to be treated as an insider for private inurement purposes.

Unfortunately, the expansion of the definition of an ''insider'' has led to a blurring of the concepts of private benefit and private inurement. It is important to note that the tests derived from *both* concepts are being applied by the IRS to physician recruitment and retention questions. This was expressly acknowledged where the IRS stated:[10]

> The relationship between inurement and private benefit was clarified by the Tax Court in *American Campaign Academy v. Commissioner*.[11] There, the court explained that, ''while the prohibitions against private benefit and private inurement share common and overlapping elements, the two are distinct requirements which must independently be satisfied.'' The court stated that private inurement violates both prohibitions, but the absence of inurement does not mean the absence of private benefit. Inurement, then, may be viewed as a subset of private benefit. This is important to bear in mind in any hospital–physician relationship context, including the instant cases, because, should a particular physician be deemed, for whatever reason, not to be subject to or not to have violated the inurement prohibition, the Service still would apply a private benefit analysis to his or her relations with the hospital.[12]

6. Gen. Couns. Mem. 39862.
7. *See* Rev. Rul. 85-109, 1985-2 C.B. 165.
8. Rev. Rul. 97-21, 1997-1 C.B. 121.
9. Reg. § 53.4958.
10. Gen. Couns. Mem. 39862.
11. 92 T.C. 1053 (1989).
12. Gen. Couns. Mem. 39862.

§ 25.2 THE IRS POSITION

It is clear that physician recruitment and retention programs are consistent with exempt status as a charitable organization. In 1986, the IRS expressly acknowledged this position:

> In principle we agree that the Hospital must offer incentives or inducements to attract qualified physicians needed in a particular area of specialization to enable the Hospital to provide quality health care [citing Rev. Rul. 73-313, Gen. Couns. Mem. 35268 and 37789]. Further, we know that exempt organizations may offer reasonable compensation for services provided to them without violating the requirements for exemption either as respects exclusive operation for exempt purposes or the inurement prohibition.[13]

The key, then, is determining when the benefit that would accrue to the exempt hospital from an arrangement with a particular physician or group of physicians is overridden by substantial private benefit or private inurement that would result from the proposed arrangement. The balance between the two is far from clear, but guidance can be obtained from the body of IRS rulings, positions, and court decisions available, as well as from internal documents such as the Hospital Audit Guidelines.[14]

§ 25.3 THE OIG POSITION

In May 1992, the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) released the third in a series of ''interpretative'' memoranda called ''Special Fraud Alert.'' Each Special Fraud Alert is

13. Gen. Couns. Mem. 39498.
14. *See*, e.g., Gen. Couns. Mem. 39598, which details a wayward physician retention venture in which both substantial private benefit and private inurement were found. *See also* Woodhill & Jones, ''Hospital Recruitment Policies Can Endanger a Hospital's Exemption,'' 4 *J. Tax. Exempt Orgs*. 31 (Nov./Dec. 1992); Hyatt, ''Physician Recruitment and Retention for Charitable Hospitals: In the Midst of a Sea Change?'' 6 *Exempt Org. Tax Rev*. (No. 6) 1314 (1992); Washlick, ''Physician Recruitment Incentives and Tax Exemption—More Than the Code Is Involved,'' 7 *J. Tax. Exempt Orgs*. 212 (Nov./Dec. 1996); Mancino, ''How to Retain Both Physicians and Exemption,'' 7 *J. Tax. Exempt Orgs*. 57 (Sept./Oct. 1995); Kaufman & Curry, ''IRS Proposed Guidelines Allow for Reasonable Physician Recruitment Incentives,'' 83 *J. Tax*. (No. 3) 162 (Sept. 1995); Mancino, ''Diverse Physician Recruitment Incentives Involve Common Tax Exemption Issues,'' 6 *J. Tax. Exempt Orgs*. 243 (May/June 1995); Peregrine, ''The Proposed 'Physician Recruitment' Revenue Ruling: A Base Hit Instead of a Home Run,'' 11 *Exempt Org. Tax Rev*. 1025 (May 1995); Hyatt, ''The New Physician Recruitment Revenue Ruling: The Right Approach,'' 11 *Exempt Org. Tax Rev*. 725 (Apr. 1995); Griffith, ''IRS Guidance on Physician Recruitment: From the Seeds of Herrmann Hospital to the Proposed and Final Rulings and Beyond,'' *Journal of Health and Hospital Law*, Vol. 30, No. 2, p. 75 (1997); Griffith, ''Physician Recruitment and Retention: Reconciling Legal Tensions Between Tax Law and Fraud and Abuse,'' (American Health Lawyers Association, Practice Guide, 2nd Ed., 2000).

intended to illustrate the OIG's views on the application of the Medicare and Medicaid antikickback statute to particular situations. The Special Fraud Alert on Hospital Incentives to Physicians is far reaching (many would say overreaching) and calls into question many hospital–physician relationships that are in common use. The document lists ten hospital incentive arrangements that it pronounces ''often questionable.'' They are:

1. Payment of any sort of incentive by the hospital each time a physician refers a patient to the hospital
2. The use of free or significantly discounted office space or equipment (in facilities usually located close to the hospital)
3. Provision of free or significantly discounted billing, nursing, or other staff services
4. Free training for a physician's office staff in areas such as management techniques, procedure coding, and laboratory techniques
5. Guarantees that provide that, if the physician's income fails to reach a predetermined level, the hospital will supplement the remainder up to a certain amount
6. Low-interest or interest-free loans, or loans that may be ''forgiven'' if a physician refers patients (or some number of patients) to the hospital
7. Payment of the cost of a physician's travel and expenses for conferences
8. Payment for a physician's continuing education courses
9. Coverage on the hospital's group health insurance plans at an inappropriately low cost to a physician
10. Payment for services (perhaps including consultations at the hospital) that require few, if any, substantive duties by the physician, or payment for services in excess of the fair market value of services rendered

This Special Fraud Alert does not state that these practices are *per se* violations of the antikickback statute, and it does not have the force of law. However, this ''hit list'' is a matter of concern, given the position of the IRS that a violation of the antikickback statute would serve as an independent basis for the revocation of tax-exempt status.[15] All the more puzzling is that most of these practices have been explicitly or implicitly approved by the IRS in numerous rulings and memoranda. It will be necessary to examine ongoing OIG guidance for physician recruitment activities, as well as any future IRS guidance on physician recruitment, in order to properly reconcile this conflict in particular cases.[16]

15. *See* Gen. Couns. Mem. 39862; Rev. Rul. 97-21, 1997-1 C.B. 121.
16. In general, *see* Jedrey, ''Hospitals Acquiring Practices Must Comply with IRS and OIG Standards,'' 6 *J. Tax'n Exempt Orgs*. (No. 5) 203 (Mar./Apr. 1995).

Both the federal antikickback law[17] and the federal Stark self-referral statute[18] are implicated by physician recruitment arrangements. The antikickback law contains a safe harbor that protects recruitment arrangements.[19] The recruitment safe harbor is fairly narrow in scope and only affords protection to new and relocating practitioners who establish their primary place of practice in a Health Professional Shortage Area. Fortunately, failure to fit within an antikickback safe harbor does not make an arrangement illegal. The Stark exception for recruitment, on the other hand, is mandatory.[20] The Stark exception was clarified and expanded as part of the Stark II, Phase III regulations.[21]

§ 25.4 GUIDELINES FOR ANALYZING RECRUITMENT AND RETENTION TECHNIQUES

Boiled down to their essence, the myriad rulings, positions, decisions, and statements of the IRS suggest the following guidelines for analyzing hospital–physician relationships:

Private Inurement

1. Is the physician an "insider"? Can evidence be produced to show a lack of control or significant influence?
2. Is the compensation or other expenditure for the physician reasonable when measured against the public benefit or furtherance of exempt purposes attained by the hospital?
3. Is the compensation or other expenditure for the physician reasonable when compared with the benefits given by other hospitals under comparable circumstances?
4. Is the compensation or other expenditure the result of arm's-length bargaining?
5. Is the arrangement merely a device to distribute profits to the physician?
6. Does the arrangement involve the sale of all or part of the hospital's revenue stream to physicians on its medical staff?

Private Benefit

1. Is the private benefit incidental in a *qualitative sense*, i.e., is it a necessary result of hospital–physician activities that benefit the public at large? Can

17. 42 U.S.C. § 1320a-7b(b).
18. 42 U.S.C. § 1395 nn.
19. 42 C.F.R. § 1001.952(n).
20. 42 C.F.R. § 411.357(e).
21. 72 Fed. Reg. 51,012 (Sept. 5, 2007).

the desired activities be accomplished best by benefiting the physician in the manner proposed?

2. Is the private benefit incidental in a *quantitative sense*, i.e., is the benefit to the physician not substantial when measured in the context of the overall public benefit that would result from the arrangement?
3. Is there a clear community benefit resulting from the arrangement? Is the hospital–physician arrangement solely to increase utilization, preserve market share, or avoid new competition?

§ 25.5 SPECIFIC RECRUITMENT AND RETENTION TECHNIQUES

In a published survey, popular recruitment incentives included salary with bonus; income guarantee; relocation stipends; signing bonus; paying for CME; and educational loan forgiveness.[22] The methods of recruiting and retaining physicians are as varied and creative as the hospitals that undertake them, but a number of techniques have found common acceptance and have been considered by the IRS. A sampling of those techniques and a brief analysis of their risk to exemption are set forth below.

(a) Salaries

Historically, payment of salaries to physicians most often arose with regard to hospital based physicians. However, in the current healthcare environment, primary care physicians often become employees of a hospital (as might occur after the hospital's purchase of a physician's practice and in integrated delivery systems), in order to be freed from the burdens of running an office, high malpractice insurance costs, and long hours. The key to avoiding a loss of exemption is ensuring that the overall compensation package is reasonable.

It is well established that a hospital may pay a *reasonable* salary to physicians, even those who may be considered ''insiders,'' without creating private inurement or substantial private benefit and thereby losing exempt status.[23] The determination of a ''reasonable'' salary is based on a facts and circumstances test.

In determining reasonableness of compensation, the IRS has identified four specific factors drawn from various revenue rulings, court cases, and memoranda:

22. 2007 Review of Physician and CRNA Recruiting Incentives, Merritt Hawkins & Associates.
23. *See*, e.g., *Mabee Petroleum Corp. v. United States*, 203 F.2d 872 (5th Cir. 1953); *Birmingham Business College, Inc. v. Commissioner*, 276 F.2d 476 (5th Cir. 1960), *aff'g, modifying, and remanding*, 17 T.C.M. 816 (1958); *B.H.W. Anesthesia Foundation, Inc. v. Commissioner*, 72 T.C. 681 (1979).

1. Whether the agreed-on compensation has been the result of arm's-length negotiation between the parties
2. The extent of control, by the party receiving the compensation, over the exempt organization or over the compensation process
3. Whether the compensation received is reasonable in terms of the responsibilities and activities assumed under the contract, that is, the extent to which comparable services would have a similar cost if obtained from an outside source in an arm's-length negotiation
4. Whether the salary would qualify as an expense deduction under the Code

These factors are not considered all inclusive.[24]

The IRS has also discussed these criteria related to determining the reasonableness of compensation:[25]

1. Whether a completely arm's-length contractual relationship is present, with the employee having no participation in the management or control of the organization, that is, no control over compensation decisions
2. Whether the payments serve a real and discernible business purpose of the hospital system, independent of any purpose to operate the organization for the direct or indirect benefit of the employee
3. Whether the compensation is dependent principally on the incoming revenue of the exempt organization or on the accomplishment of the objective of the compensating contract
4. Whether a review of the actual operating results of the organization reveals any evidence of abuse or unwarranted benefits
5. Whether a ceiling or reasonable maximum is present, helping to avoid the possibility of a windfall benefit, especially one based on factors bearing no relationship to the level of service provided[26]

(i) Percentage of Revenue Contracts. If the facts and circumstances support a finding that the hospital's exempt purposes are being furthered, a contract based on a percentage of revenue can constitute reasonable compensation. A contract based on a percentage of *net* revenue is suspect because of the prohibition against inurement of the "net earnings" of a charitable organization, and the potential conflict between personal interests and the organization's exempt

24. FY 1987 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook (FY 1987 IRS CPE Text), at 39. *See also* Priv. Ltr. Rul. 8833009.
25. Gen. Couns. Mem. 38905.
26. *See* FY 1987 IRS CPE Text, at 42–44.

purposes that may result from such a compensation scheme. However, the IRS has noted:

> [A]lthough a percentage compensation arrangement based on net earnings is not *per se* improper, payments made pursuant to such an arrangement would constitute prohibited inurement where all the factors bearing upon the relationship between the parties indicate a conferral of private benefit without a corresponding achievement of an exempt purpose.[27]

In a 1969 revenue ruling, the IRS reviewed a fixed percentage of gross billings contract between a hospital and a radiologist.[28] The IRS found that: the overall compensation was reasonable in terms of the responsibilities and activities the physician assumed under the contract; the physician did not control the organization; and the agreement was negotiated at arm's length. Consequently, no private inurement was found.

Where, however, a percentage compensation agreement transforms the principal activity of the exempt organization into a joint venture between it and a group of physicians, or is merely a device for distributing profits to persons in control, it will destroy the organization's exemption.[29]

(b) Income Guarantees

There are different views among exempt hospitals, the IRS, and the OIG with regard to the legitimacy and proper use of income guarantees, which are an extremely popular recruitment tool. Unfortunately, the OIG has labeled their use ''often questionable.''

In a controversial 1986 Memorandum,[30] the issue raised was whether a hospital jeopardizes its exemption by contracting with physicians to provide a guaranteed minimum annual income for two years *with no obligation by the physicians to repay subsidies* out of income earned after the contract period. The IRS concluded:

> [T]he provisions of the revised guaranteed minimum annual income contract as part of the Hospital's physician recruitment program may result in the physicians' private interests being served other than incidentally, and inurement of the Hospital's net earnings to individuals having a personal and private interest in the Hospital's activities. Such a conclusion would provide a basis for revocation of the exemption of the Hospital.

In arriving at this conclusion, the IRS noted that the hospital had earlier received a letter ruling that concluded that a guaranteed minimum annual income contract under which the physician is *required unconditionally to repay*

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27. Gen. Couns. Mem. 38905.
28. Rev. Rul. 69-383, 1969-2 C.B. 113.
29. *See Lorain Avenue Clinic v. Commissioner, supra* note 3; *Birmingham Business College, Inc. v. Commissioner, supra* note 18 (1960).
30. Gen. Couns. Mem. 39498.

any subsidy paid by the hospital *would not* adversely affect the exempt status of the hospital, and that the question of subsidies is ''essentially a question of whether a given compensation arrangement comports with the requirements of exemption.'' The IRS stated, ''It has not been demonstrated, however, nor does it seem possible to demonstrate, that all possible subsidies paid under the hospital's recruitment program will constitute reasonable compensation.'' The IRS further opined that the absence of any ceiling on amounts of subsidies to be paid (other than the total guarantee itself) and the absence of any requirement to provide further services after the expiration of the contract, in exchange for the freedom from the obligation to repay the subsidy, might relate to the reasonableness of the compensation paid.

The analysis of this memorandum met with a great deal of criticism by the hospital industry. The IRS then attempted to mitigate that criticism by clarifying its position.[31] It stated:

> [W]e believe that whether a particular compensation plan adversely affects an organization's exempt status is an inherently factual question. So long as the compensation plan is not inconsistent with exempt status as discussed above, is the result of arm's-length bargaining, and the compensation under the plan, as well as all other compensation provided, is reasonable, the plan should not jeopardize the exempt status of the organization. However, whether compensation is reasonable is an inquiry which is best left to field examination.

The IRS concluded that:

> GCM 39498, however, was not intended to create a negative presumption with respect to whether the compensation provided under any particular plan of compensation is reasonable, nor did it intend to suggest that the Service will not issue advance rulings on issues other than the reasonableness of the compensation. On this issue, GCM 39498 simply stated that the Service cannot determine, in advance, whether compensation is reasonable.

Some conclusions may fairly be drawn from these memoranda. First, the IRS has left the door open to issuing advance rulings on the *procedures* established for an income guarantee program.[32] (That being said, the IRS rarely receives requests for such rulings.) Second, the use of income guarantees with no obligation to repay subsidies after the contract period, while not *per se* improper, remains a risky recruitment/retention device. With modification along the lines established by the IRS (e.g., subsidy caps, requirements for additional physician services), such guarantees may become acceptable.

The IRS has approved a physician salary guarantee program in which amounts paid to a physician by a hospital are forgiven if the physician

31. Gen. Couns. Mem. 39674.
32. *See*, in general, Bromberg, ''Protecting the Hospital's Physician Recruitment Program,'' *Healthcare Fin. Mgmt*. 70–71 (Oct. 1986).

maintains a practice in the hospital's service area for a certain number of years.[33]

The Hospital Audit Guidelines[34] support the use of income guarantees for a one- or two-year period for *recruitment* purposes. In addition, the IRS's physician recruitment revenue ruling describes a fact pattern in which a net income guarantee is deemed acceptable.[35]

(c) Incentive Compensation

Previously, the IRS took an extremely restrictive position with regard to incentive compensation. It argued that the establishment of deferred compensation plans and profit-sharing plans by exempt organizations resulted in *per se* private inurement and a loss of exemption.[36]

The IRS began to reverse its position, however, with the issuance of a 1980 memorandum.[37] The IRS concluded that a charitable organization can have an incentive plan for compensating its employees that qualifies as a profit-sharing plan under the Code. Also, a charitable organization will not violate the requirements of exemption by adopting and operating an incentive compensation plan in which profits are a factor in the compensation formula, if the plan is adequately limited and safeguarded. In this regard, the standards applicable to profit-sharing plans generally under federal law may prove sufficient.

The IRS reexamined the establishment, by a charitable organization, of a deferred compensation plan that provides for the crediting of fixed amounts plus investment earnings to accounts set up for the benefit of employees, both separately and in combination with additional amounts of current compensation.[38] The IRS applied traditional reasonable compensation analysis, stating:

> As we have discussed, we currently believe that, with respect to any compensation package, it is necessary to examine the entire compensation package (including current and deferred amounts) and determine (1) whether that compensation package is not merely a device to distribute profits to principals or transform the organization's principal activity into a joint venture, (2) whether the package is the result of arm's-length bargaining, and (3) whether the compensation constitutes reasonable compensation. If it is determined that the compensation package as a whole meets these tests, the mere form that it takes will not *per se* result in prohibited inurement or private benefit.
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33. 3 *Exempt Org. Tax Rev.* (No. 3) 330 (May 1990). *See also* IRS Exempt Organizations Examination Guidelines Handbook (IRM 7(10)69) § 337(7)(a) (Hospital Audit Guidelines), reproduced by the IRS for broader dissemination in Ann. 92-83, 1992-22 I.R.B. 59. *See* Appendix E.
34. Hospital Audit Guidelines, *supra* note 33, at § 333.3(7)(a).
35. See §25.7, *infra*.
36. *See*, e.g., Gen. Couns. Mem. 35865.
37. Gen. Couns. Mem. 38283.
38. Gen. Couns. Mem. 39670.

> In this case, the payment of fixed amounts of deferred compensation, together with income earned thereon, as well as additional amounts of current compensation . . . do not result in private benefit or prohibited inurement. . . .

In another memorandum,[39] the IRS specifically addressed the establishment of a ''profit-sharing'' incentive compensation plan for hospital employees. Applying the same analysis used in its earlier guidance, the IRS concluded:

> [T]he mere establishment of incentive compensation plans to pay a percentage of the ''profits'' of the hospitals as additional compensation is not inconsistent with exempt status, such as when the compensation transforms the activity into a joint venture or is a mere device to distribute profits to principals. Both Plan A and Plan B have been established to advance the exempt purpose of the hospital by improving the quality and efficiency of patient care and appear reasonably designed to accomplish the exempt purpose.
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> * * * *
>
> With respect to whether the compensation is reasonable, however, as stated previously, we will not determine in advance whether, under the facts and circumstances of this case, the compensation is reasonable.

Also of interest is a ruling in response to an exempt hospital's request for rulings on a plan in which the hospital's employees will share 50/50 in any gains realized through improved productivity, if the following conditions are satisfied: (1) there has been an actual dollar improvement in the hospital-wide cost per adjusted discharge; and (2) the employees' departmental productivity has improved.

Under the facts of the ruling, distributions to employees will not be based on a percentage of net earnings or profits. Rather, such distributions will be based on the reduction of cost achieved by employees' input in improving the hospital's productivity. The employees' payout will be treated as compensation subject to the usual withholding requirements. Distributions will be based on a percentage of employees' gross earnings for a given year.

The IRS ruled that the adoption and implementation of the plan would not adversely affect the hospital's charitable status. Contrary to the position taken in its memoranda, the IRS also ruled, or at least relied on the statement of the hospital, that the distributions made under the plan are considered to be reasonable compensation.[40]

In another ruling involving incentive compensation, the IRS considered a proposed plan that would aid four exempt organizations in achieving their exempt purposes by motivating employees to work more efficiently, to minimize costs, and to be more productive. The plan would be funded based on actual savings to the exempt organization. The cost savings generated by the plan would be shared by the employees based on annual predetermined flat dollar amounts, which would be approximately 20 percent to 50 percent

39. Gen. Couns. Mem. 39674.
40. Priv. Ltr. Rul. 8731032.

of the total overall savings. The savings would be shared with the employees on a 50/50 basis. The IRS ruled that the incentive compensation plan is not inconsistent with exempt status but, consistent with its established position, would not rule in advance with respect to whether the compensation was reasonable.[41]

The IRS has reaffirmed that properly structured incentive compensation plans for employees, in which profits are a factor in the compensation formula, are permissible for charitable hospitals.[42]

A cap on total compensation, in conjunction with incentive-based compensation, is an important mechanism for protecting a healthcare organization's tax-exempt status. It will provide additional proof that the overall compensation earned by the physician is reasonable. Though this arguably should not be necessary, in that a physician's compensation is inherently limited by the amount of services the physician provides, nonetheless, the IRS prefers to avoid leaving the total opportunity for compensation unlimited so that fair market value will not be exceeded.

The IRS devoted an article in its field guidance to the topic of physician incentive compensation.[43] The article provides an overview of the concepts of private inurement and impermissible private benefit. In doing so, the IRS surveyed persuasive and nonpersuasive legal guidance, including a number of court cases, revenue rulings, and general counsel memoranda, which should be considered when analyzing any compensation program.

Building on the fundamental principle that the Internal Revenue Code prohibits the inurement of net earnings to any private shareholder or individual, the IRS acknowledges that physicians are no longer necessarily characterized as ''insiders.'' In the wake of the *United Cancer Council* case,[44] the IRS applies a facts-and-circumstances test to determine whether a ''physician's relationship with the organization offers the physician the opportunity to make use of the organization's income or assets for personal gain.'' This test is largely functional, emphasizing the individual's ability to control the organization rather than his or her title or formal position with the organization.

In the context of revenue-sharing arrangements, the IRS acknowledges that certain net-revenue-based arrangements may be permissible so long as such arrangements further an organization's charitable purpose by keeping actual expenses within certain budgeted amounts, thereby reducing those amounts charged for charitable services.

The IRS also acknowledges that certain profit-sharing arrangements between HMOs and physicians may be permissible. Specifically, the IRS

41. Priv. Ltr. Rul. 8807081. *See also* Priv. Ltr. Rul. 9112006.
42. Gen. Couns. Mem. 39862.
43. FY 2000 IRS Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook, Chapter C (FY 2000 IRS CPE Text).
44. *United Cancer Council, Inc. v. Commissioner*, 165 F.3d 1173 (7th Cir. 1999), *rev'g* 109 T.C. 17 (1997).

addresses the propriety of certain risk pool arrangements whereby a percentage of a physician's fees is not distributed to the physician unless certain predetermined targets are satisfied. To the extent that such arrangements are based on the organization's profit margin, the IRS opined that they are not necessarily improper so long as such distributions are dependent on patient satisfaction, quality of care, and efficiency standards beneficial to the patient.

Finally, the IRS provides a list of factors that should be used to determine the existence of private inurement and impermissible private benefit when structuring incentive compensation plans.[45]

A somewhat controversial form of incentive compensation is a revenue-sharing program (or, more accurately, a cost-savings sharing program) known as *gainsharing*. Broadly defined as an arrangement in which physicians may share revenue with hospitals generated by the provision of cost-effective care, gainsharing arrangements have been the subject of increased IRS scrutiny. Such arrangements are attractive to hospitals and physicians alike because they encourage the efficient utilization of services while enabling physicians to benefit financially. If poorly planned, however, the IRS has voiced concerns that gainsharing arrangements may trigger the private inurement or excess benefit proscriptions and thereby jeopardize a hospital's tax-exempt status or may result in the imposition of intermediate sanctions.

In unreleased private letter rulings issued in early 1999, the IRS approved two such arrangements. As described in the rulings, a tax-exempt hospital and groups of cardiologists on the hospital's medical staff would enter into participating provider agreements in which the physician groups agreed to assist the hospital to develop and implement initiatives to improve both the utilization of hospital resources as well as the quality of care. If the physician groups satisfied certain utilization and quality of care initiatives, a percentage of cost savings experienced by the hospital on an annual basis would be used to fund an award pool. (If the initiatives were not satisfied, the award pool would not be funded.) Specific award amounts would then be analyzed by an independent third-party appraiser to ensure that they reflected fair market value.

The favorable IRS rulings were based on the following factors: (1) the physician groups provided valuable services needed by the hospital; (2) the arrangements resulted in cost savings to the hospital; and (3) the allocation of the awards was capped to reflect fair market value, as determined by an independent third-party appraiser.

After the release of these rulings, gainsharing arrangements came under fire. The Director of the Exempt Organizations Division of the IRS advised organizations to refrain from entering into gainsharing arrangements pending the release of the final intermediate sanction regulations. This caution is presumably no longer valid given the issuance of final regulations in January 2002.

45. *See infra* Appendix L.

With regard to the antikickback implications of gainsharing, the IRS has indicated that it may be more reluctant to issue favorable rulings in light of the OIG more restrictive position released in its Special Advisory Opinion on Gainsharing Arrangements. In that guidance, the OIG opined that gainsharing arrangements are impermissible as a matter of law, although it has since relaxed its position somewhat. In this regard, the IRS will explore two areas when a gainsharing ruling is sought. First, the IRS will ascertain whether the requesting party has planned the arrangement in light of the Special Advisory Opinion. Second, the IRS will consult with the HHS and obtain its feedback. If the arrangement is problematic under the Special Advisory Opinion, the IRS will likely abstain from rendering an opinion.

It seems likely, however, that the IRS may be more willing to issue favorable gainsharing rulings given the increasing willingness of the OIG to bless gainsharing arrangements now that it has reached a ''comfort'' level with some arrangements. In February 2005 alone, the OIG issued six favorable advisory opinions.[46] While the issuance of six favorable advisory opinions in one month may suggest a renaissance in gainsharing, caution is still warranted. The OIG found that virtually all of the elements of these six gainsharing arrangements implicated the civil monetary penalties law and the antikickback law. Nevertheless, in each advisory opinion, the OIG decided not to impose administrative sanctions based on the protections incorporated into the respective gainsharing arrangements. The analysis used by the OIG in examining these six gainsharing advisory opinions is identical to the analysis in the only prior gainsharing advisory opinion.[47] However, the facts of the various gain sharing arrangements have some minor variations, and the application of the OIG's analysis to the specific facts is instructive.

To select one example,[48] an agreement between a group of cardiac surgeons and a hospital provided that the group would share a maximum of 50 percent of the hospital's savings arising from the surgeons' implementation of 24 cost savings recommendations in certain cardiac surgery procedures. The recommendations were grouped into four categories: (1) opening certain packaged items, including disposable components of a cell saver unit, only as needed; (2) performing blood cross-matching only as needed; (3) substituting less costly items for items currently being used; and (4) product standardization of cardiac devices. Interestingly, the OIG concluded that the recommendation regarding opening packaged items (except the items used with the cell saver) did not implicate the civil monetary penalties law given that the only delay will be the insubstantial time to open a package that is readily available in the operating room. With regard to the product standardization, the OIG emphasized that

46. OIG Advisory Opinions 05-01–05-06.
47. OIG Advisory Opinion 01-01.
48. OIG Advisory Opinion 05-01.

individual surgeons would continue to make patient-by-patient determinations of the appropriate device and have the same selection of devices as before the gainsharing arrangements were implemented.

In January 2002, the Internal Revenue Service issued an Information Letter regarding a CMS Demonstration Program for cardiovascular services and certain orthopedic services, the ''Medicare Partnerships for Quality Services Demonstration.''[49] The goal of the Program is to use bundled payments for certain high-volume, high-cost procedures to align the incentives of hospitals and nonemployee (''staff'') physicians to work together to provide coordinated, cost-effective care. The Program's reasoning is that by giving hospitals and physicians the flexibility to allocate resources in a manner they determine most appropriate, services can be better coordinated to improve the quality of care provided to beneficiaries as well as achieve savings to the Medicare program.

The Program described in the letter was structured as follows: a participating hospital receives a global payment for all Part A and Part B services provided on an inpatient basis to certain fee-for-service Medicare beneficiaries. From this global payment, the hospital makes payments to the physicians involved in providing care to these patients. The hospital and the physicians determine how the global payment will be distributed. The global rate includes all inpatient hospital and associated physician services for the Medicare beneficiaries. In addition to the range of specialty services routinely associated with the particular Diagnosis Related Groups (DRGs) covered, all other specialty physician services that may be required are also included in the global rate. The hospital is permitted to make incentive payments to physicians who assist the hospital in improving the efficiency of inpatient care for Medicare beneficiaries as long as the hospitals and the physicians meet strictly monitored standards for quality of care.

Payment arrangements between a hospital and a staff physician providing services to Medicare beneficiaries under the Program meet the following five criteria:

1. The incentive payments or financial risk to an individual physician or to a group of physicians may be neither 25 percent more than, nor 25 percent less than, the amount the physician or group of physicians would have been paid under the traditional Medicare program for the services provided to beneficiaries covered under the Program, as determined on an annual basis.
2. Incentive payments are based on aggregate costs of all similarly covered beneficiaries, such as Medicare patients discharged under a given DRG and/or group of related DRGs, and do not reflect the experience of individual beneficiaries. For this purpose, a grouping includes not less than ten discharges.

49. INFO 2002-0021.

3. Incentive payments are not focused solely on lowering the volume and cost of services provided to beneficiaries. Incentive plans require that the hospital and physician meet specific quality standards approved by CMS. Quality standards are monitored by CMS. In addition, an independent organization conducts an evaluation of the Program that includes a review of the quality of care provided under the Program.
4. The hospital informs eligible beneficiaries, upon admission to the hospital as patients, about the Program and, upon request, provides nonproprietary information regarding any nontraditional payment arrangements involving incentives. The hospital and the participating physicians provide CMS, upon request, information regarding physician incentive plans under the Program and the distribution of incentive payments in any Program period.
5. Only physicians and other licensed healthcare providers who are fully credentialed at the hospital to perform the services for which payment is sought are included under the incentive payment plan. This includes independent physicians as well as salaried hospital staff who care for Program patients and who are eligible for Medicare reimbursement, either directly or as a member of a group or other organization.

The IRS noted that hospitals participating in the Program meet minimum procedure volume requirements, provide evidence of high-quality outcomes, and have the infrastructure in place to support continuous quality improvement efforts. In addition, participating hospitals and their physicians are able to deliver high-quality care in a cost-effective manner. Participating hospitals provide all of the covered services in the relevant specialty, such as cardiovascular services or total joint replacement services, and do not elect to provide only selected DRGs. In addition, all eligible fee-for-service Medicare beneficiaries who receive services from the participating hospitals under the Program DRGs are included in the Program.

Participating hospitals and their physicians are required to maintain appropriate internal quality improvement programs as well as to participate in any external quality assurance mechanism and data collection effort established by CMS and/or the Program evaluator.

The IRS applied the reasonable compensation facts-and-circumstances analysis it has developed for healthcare organizations in recent years. It identified 12 factors it takes into consideration in this analysis:

1. Was the compensation arrangement established by an independent board of directors or by an independent compensation committee?
2. Does the compensation arrangement with the physician result in total compensation that is reasonable?

3. Is there an arm's-length relationship between the healthcare organization and the physician, or does the physician participate impermissibly in the management or control of the organization in a manner that affects the compensation arrangement?
4. Does the compensation arrangement include a ceiling or reasonable maximum on the amount a physician may earn to protect against projection errors or substantial windfall benefits?
5. Does the compensation arrangement have the potential for reducing the charitable services or benefits that the organization would otherwise provide?
6. Does the compensation arrangement take into account data that measures quality of care and patient satisfaction?
7. If the amount a physician earns under the compensation arrangement depends on net revenues, does the arrangement accomplish the organization's charitable purposes, such as keeping actual expenses within budgeted amounts, where expenses determine the amounts the organization charges for charitable services?
8. Does the compensation arrangement transform the principal activity of the organization into a joint venture between it and a physician or a group of physicians?
9. Is the compensation arrangement merely a device to distribute all or a portion of the healthcare organization's profits to persons who are in control of the organization?
10. Does the compensation arrangement serve a real and discernible business purpose of the exempt organization, such as to achieve maximum efficiency and economy in operations, that is independent of any purpose to operate the organization for the impermissible direct or indirect benefit of the physicians?
11. Does the compensation arrangement result in no abuse or unwarranted benefits because, for example, prices and operating costs compare favorably with those of other similar organizations?
12. Does the compensation arrangement reward the physician based on services the physician actually performs, or is it based on performance in an area where the physician performs no significant functions?

The IRS concluded that "there is no prohibition or *per se* rule that prevents health care organizations from making incentive payments to physicians. In determining whether a health care organization utilizing an incentive compensation program for physicians complies with the proscriptions against private inurement and impermissible private benefit, the Internal Revenue Service will examine all the relevant incentive compensation factors. . . ."

These are the same 12 factors reported in the IRS's FY 2000 continuing professional education article on physician incentive compensation. They provide a useful checklist for reviewing any type of incentive compensation.

This IRS guidance does not have mass application at this time. It is limited to a particular project sanctioned by CMS. Nevertheless, it suggests a framework for developing an incentive compensation plan involving gainsharing that can pass muster with the IRS.

(d) Pay for Performance (P4P) Programs

The Centers for Medicare & Medicaid Services (CMS) is developing and implementing a set of pay-for-performance initiatives to support quality improvement in the care of Medicare beneficiaries. CMS has announced initiatives for hospitals, physicians, and physician groups, and is also exploring opportunities in nursing home care, home health, and dialysis providers. CMS is also pursuing pay-for-performance initiatives to support better care coordination for patients with chronic illnesses.

The purpose of the initial CMS demonstration project is to improve the quality of inpatient care for Medicare Beneficiaries by giving financial incentives to almost 300 hospitals for achieving high-quality standards. Under this demonstration, CMS is collecting data on 34 quality measures relating to five clinical conditions. Hospitals scoring in the top 10 percent for a given set of quality measures will receive a 2 percent bonus payment on top of the standard diagnosis-related group payment for the relevant discharges. Those scoring in the next highest 10 percent will receive a 1 percent bonus. In the third year of the demonstration, those hospitals that do not meet a predetermined threshold score on quality measures will be subject to reductions in payment.

The demonstration project will reward physicians for improving the quality and efficiency of healthcare services delivered to Medicare fee-for-service beneficiaries. The demonstration seeks to encourage coordination of Part A and Part B services, promote efficiency through investment in administrative structure and process, and reward physicians for improving health outcomes. Ten large group practices (2,001 physicians) across the country will be participating in this demonstration, scheduled to be operational in April 2005. The physician group practices will be able to earn performance-based payments after achieving savings in comparison to a control group. The performance payment is based largely on various quality results.

CMS will assess both quality performance and quality improvement under the demonstration. The quality measures that will be used focus on common chronic illnesses in the Medicare population, including congestive heart failure, coronary artery disease, diabetes mellitus, hypertension, as well as preventive services, such as influenza and pneumococcal vaccines and breast cancer and colorectal cancer screenings. Under the demonstration, physician groups will

continue to be paid on a fee-for-service basis. Physician groups will implement care management strategies designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve the quality of care. Depending on how well these strategies work in improving quality and avoiding costly complications, physician groups will be eligible for performance payments.

Hospital and physician groups are also independently creating and implementing P4P programs. It seems likely that the IRS will apply an analysis to P4P programs similar to that used to assess gainsharing programs. The Service will no doubt follow the lead of CMS and OIG in this area. P4P programs generally reward the very factors the IRS expects to see in reasonable compensation programs operated by charitable institutions. As long as P4P programs are consistent with fraud and abuse law and Medicare and Medicaid program requirements; do not create incentives to reduce services to indigent or Medicare or Medicaid patients; and do not, when aggregated with other compensation received by the provider, result in unreasonable compensation, the IRS should be comfortable with these programs as consistent with charitable operation. Future IRS guidance on these programs would be useful.

(e) Office Space/Ground Leases

The rental of office space by a hospital to the physicians on its medical staff at below-market rents may be sufficient to constitute substantial private benefit or private inurement, resulting in a loss of exemption.[50] Under proper circumstances, however, below-market rental of office space may not result in substantial private benefit or private inurement.[51] Rental of office space or ground leases for an office building at fair-market value to physicians is also consistent with exemption as a charitable organization.[52] The IRS's physician recruitment revenue ruling describes a fact pattern in which the offering by a hospital of below-market rent to a physician for a limited period was deemed acceptable.[53]

(f) Loans

Loans from exempt organizations to private individuals, including physicians, have traditionally attracted great scrutiny on audit. Absent special

50. *See*, e.g., Gen. Couns. Mem. 39598; Rev. Rul. 69-545, 1969-2 C.B. 117 (Situation 2); *Harding Hospital, Inc. v. United States, supra* note 3, at 1078.
51. *See*, e.g., Rev. Rul. 73-313, 1973-2 C.B. 174 (below-market rental of office space to induce physician to locate in isolated rural area did not jeopardize exemption); *Olney v. Commissioner*, 17 T.C.M. 982 (1958) (office space provided primarily for benefit and convenience of hospital, was justified by duties required by physician, overall compensation not excessive); Priv. Ltr. Rul. 8134021 (*but see* Gen. Couns. Mem. 37789).
52. *See* Rev. Rul. 69-545, 1969-2 C.B. 119; Gen. Couns. Mem. 37789; *Lowry Hospital Association v. Commissioner, supra* note 3.
53. See § 25.7, *infra*.

circumstances, the provision of loans by an exempt organization to an ''insider'' at below-market rates or without adequate security will constitute impermissible private inurement.[54]

If the loan is made to a physician at a market rate of interest, is adequately secured, is for a reasonable term given the size and purpose of the loan, and is made for reasons that primarily benefit the exempt organization, the loan should be consistent with exempt status as a charitable organization.

A loan guarantee made by a group of three unrelated hospitals to a radiologist in private practice, to induce the physician to establish a radiation treatment facility in an isolated area, did not adversely affect the hospitals' charitable status.[55]

A $12 million loan made by a hospital to a local physician practice group composed of physicians on its medical staff, to finance the renovation and expansion of an office building/clinic that would offer improved facilities and would be used to recruit additional specialists, did not adversely affect the hospital's exemption.[56]

Below-market-rate loans may, in certain circumstances, be used to induce needed physicians to join a hospital's medical staff.[57] However, a below-market interest rate must be treated as compensation and reported to the IRS as income.[58]

It is worth noting that the Hospital Audit Guidelines characterize a reasonable rate of interest as prime plus 1 or 2 percent.[59] The Applicable Federal Rate has also been accepted by the IRS as a reasonable rate of interest.[60]

The IRS's physician recruitment revenue ruling describes a fact pattern in which a hospital's guarantee of a physician's home mortgage is deemed acceptable.[61]

(g) Moving Expenses

The IRS has specifically considered the payment of moving expenses as an incentive device.[62] Applying traditional reasonable compensation analysis, the IRS opined that the payment of moving expenses does not result in private benefit or prohibited inurement if the payment is the result of arm's-length bargaining and the compensation package as a whole is reasonable. Implied

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54. *See Lowry Hospital Association v. Commissioner*, *supra* note 3.
55. Priv. Ltr. Rul. 8419071.
56. Priv. Ltr. Rul. 9023091.
57. *See*, e.g., Priv. Ltr. Rul. 8028011 and 8418003.
58. Hospital Audit Guidelines, *supra* note 33, at § 333.3(10)(c).
59. *Id*. at § 333.3(10).
60. See, e.g., Reg. 53.4958-7(c) (applies AFR, compounded annually, as interest to be included on correction of excess benefit transaction); Hermann Hospital Closing Agreement Hospital Physician Recruitment Guidelines at Appendix B (lists applicable federal rate as example of interest at a reasonable rate).
61. *See* § 25.7, *infra*.
62. Gen. Couns. Mem. 39670.

approval of a one-time recruitment bonus would also seem to support a payment for moving expenses.[63]

The IRS's physician recruitment revenue ruling describes a fact pattern in which payment of a physician's moving expenses is deemed acceptable.[64]

(h) Cash Assistance

The IRS stated with apparent approval that ''a hospital may offer a one-time recruitment bonus or incentive the amount of which is determined not by reference to services to be rendered, but by reference to the value assigned to recruiting a particular physician to its medical service area. . . .''[65]

If the overall compensation package is reasonable, the result of arm's-length bargaining, and not merely a device to distribute profits to the physician, cash assistance in the form of bonuses and payment of life insurance premiums would be consistent with exemption, in the IRS's view.[66]

The IRS's physician recruitment revenue ruling describes a fact pattern in which payment to a physician of a signing bonus is deemed acceptable.[67]

(i) Support Staff/Management Services

The provision of support staff and management services to provide record-keeping, billing and collection, and other office support services is a popular recruiting device for new physicians just starting up a practice, and a popular retention device for older physicians who are preparing to retire or are simply weary of the burden of running an office.

If the support services/management services are provided at fair market value, this benefit should not adversely affect the hospital's exemption. (Income received may constitute unrelated business income to the hospital, however.) If the services are provided at below fair market value, the hospital will need to demonstrate that such a benefit is necessary to induce needed physicians to practice in the community and that the overall compensation package is reasonable.

(j) Purchase of Equipment

Another popular recruitment/retention device involves the purchase by a hospital of specialized equipment for use by a physician to treat his or her private patients as well as patients of the hospital. The hospital must demonstrate that the benefit to the hospital of having the specialized equipment available to treat its patients, and the benefit of having the physician available

63. Gen. Couns. Mem. 39498.
64. *See* § 25.7, *infra*.
65. *Id*.
66. Gen. Couns. Mem. 39670.
67. *See* § 25.7, *infra*.

in the community to provide his or her specialized services, outweigh the private benefit conferred on the physician through the use of the equipment to treat his or her private patients.

Private benefit can be minimized by avoiding an outright gift of the equipment to the physician. For example, the hospital could own the equipment, granting the physician only a limited right of use; or ownership could be conveyed to the physician only over an extended period of time, with a reversionary interest if the physician leaves the staff too soon; or the hospital could extend a loan to enable the physician to buy the equipment subject to an acceleration clause if the physician leaves the staff prematurely.

The IRS has approved the provision of subsidies by a charitable hospital to physicians serving on the hospital's medical staff to acquire and implement software used predominantly to create, maintain, transmit, or receive electronic health records for their patients.[68] The IRS will not treat such benefits as impermissible private benefit or private inurement if they fall within the range of health IT items and services permitted by the Department of Health and Human Services' Electronic Health Record Regulations.

§ 25.6 HERMANN HOSPITAL CLOSING AGREEMENT

In 1993 and 1994, healthcare providers awaited an oft-promised general counsel memorandum on the issue of physician recruitment and retention. It was anticipated that this memorandum would provide significant guidance on the permissible types of recruitment and retention incentives and the IRS's views on the private inurement and private benefit issues that might arise from them. In addition, providers expected that some closing agreements[69] arising from the first round of coordinated examination procedure audits would be made public, as promised by the IRS. Again, it was anticipated that these closing agreements would shed some light on IRS thinking regarding various healthcare provider practices. The memorandum never materialized, apparently a victim of the broader Clinton Administration healthcare reform agenda. However, the IRS did not abandon its goal to provide guidance in the physician recruitment area, choosing this as the first topic on which a closing agreement would be made public.

(a) Background and Terms of Agreement

On October 14, 1994, Hermann Hospital, a 560-bed, tertiary care hospital located in Houston, Texas, voluntarily made public the text of a closing

68. IRS Memorandum from Lois Lerner, Director, Exempt Organizations (May 11, 2007). *See* Appendix P.
69. A closing agreement is a final agreement between the IRS and a taxpayer on a specific tax issue or liability. It is a voluntary agreement and has the effect of permanently closing the matters at issue for the tax years involved.

agreement between the hospital and the IRS regarding an audit by the IRS of its physician recruitment and retention activities. According to the text of the agreement, Hermann Hospital had investigated and voluntarily disclosed to the IRS certain physician recruitment and retention arrangements that it had engaged in during a four-year period. The arrangements had raised questions as to whether prohibited inurement and private benefit had been conferred on individuals in violation of the Code provisions applicable to charitable organizations.

In the closing agreement, the hospital acknowledged the lack of a legal and governing body's review, awareness of, and control over certain actions undertaken by the hospital during those four years, including: (1) incentives offered to newly recruited physicians, most of which required no repayment and, in many cases, no performance of specific duties in exchange for benefits received; (2) incentives provided to physicians already located in the community; (3) incentives provided to full-time faculty members of an affiliated university medical school in connection with their becoming full-time private practitioners in the community, most of which benefits were not required to be repaid; (4) the apparent operation of certain hospital outpatient departments in a manner resembling the private practice of the physicians providing services there; and (5) certain transactions that may have benefited certain former board members and other individuals. The agreement further noted that the hospital, on its own initiative, undertook substantial corrective and remedial actions, including pursuing restitution and establishing safeguards designed to prevent the recurrence of similar transactions.

After the preamble, which set forth these acknowledgments, the closing agreement established the terms of the agreement between the parties. The following significant accords were reached:

1. The hospital's exemption was not revoked as a result of these actions.
2. The hospital did not have to rescind the agreements that were negotiated or executed prior to the date of the closing agreement; however, it could not modify, extend, or renew any such agreement after the closing agreement, unless it conformed with Hospital Physician Recruitment Guidelines that were included as an exhibit to the closing agreement.
3. Physician service agreements other than recruitment agreements were required to be reviewed and approved by the hospital's legal counsel, the vice president, the medical director, and the CEO of the hospital, and, in cases of contracts in excess of $250,000 per year, the executive committee of the hospital's board of trustees.
4. The hospital agreed to adopt a conflict-of-interest policy to be signed by all officers, directors (including medical directors), and trustees of the hospital.

5. The hospital agreed to adopt verbatim, and to follow, the Hospital Physician Recruitment Guidelines attached to the agreement.
6. The hospital agreed to comply with all employment tax requirements of the Internal Revenue Code and its applicable regulations, and to report to the IRS, on amended Forms 1099 and W-2, incentives paid to individuals as disclosed in the closing agreement.
7. The hospital agreed to execute an incentives disclosure, pursuant to Code section 6103(c), that would permit the IRS to respond to inquiries regarding the closing agreement.
8. The hospital agreed to make a public announcement, within 45 days of signing the agreement, through one or more Houston-area newspapers of general circulation and through one or more tax services, describing its activities and disclosing the text of the closing agreement.
9. The hospital agreed to pay to the IRS:
   a. an amount equal to 100 percent of the federal income tax liability of the hospital for one fiscal year, as if it were a taxable entity for that year (the amount stipulated by the parties was $993,531)
   b. the sum of $9,720, which was the amount attributable to penalties for nonfiling or late filing of Forms 1099 and W-2 with respect to the incentives paid to individuals disclosed in the agreement

These accords were of interest to healthcare providers in that they revealed how the IRS enforced compliance with the Code, but the real significance of the closing agreement was the attachment that established the Hospital Physician Recruitment Guidelines. While answering many questions that had arisen with regard to specific recruitment and retention practices, and while consistent with IRS pronouncements in this area, these guidelines created several new positions that sent shockwaves through the healthcare community. However, in public remarks made shortly after the release of the closing agreement, the Assistant Commissioner for Employee Plans/Exempt Organizations (EP/EO) noted that the closing agreement does not have precedential effect and that the IRS does not intend to apply the recruiting guidelines in the agreement across the board to all hospitals. He noted that these guidelines may be more liberal or restrictive in specifics than the approach the IRS would take on different facts.[70]

(b) Hospital Physician Recruitment Guidelines

As an exhibit to the closing agreement, the IRS attached newly penned guidelines that offered a great deal of specific, substantive guidance in this area.

70. Remarks of James J. McGovern, Assistant Commissioner for Employee Plans/Exempt Organizations, before National Health Lawyers Association 20th Annual Tax Issues in Nonprofit Healthcare Organizations Program, Oct. 27, 1994.

The Hospital Physician Recruitment Guidelines (''the guidelines'') are presented in two sections. The first section provides definitions of the essential terms used in the guidelines, and the second section establishes which physician incentives are permissible and which are impermissible.

Section I contains only six definitions; however, they are at the heart of the application of the guidelines. Beginning with the types of physicians covered by the guidelines, these terms are enumerated here for easy reference.

1. *Existing physician.* A physician who already has medical staff privileges at the hospital.
2. *Newly recruited physician.* A physician who does not yet have medical staff privileges at the hospital. Significantly, both definitions refer only to nonemployees of the hospital. Because the guidelines do not apply to physicians who are employed by the hospital, it must be presumed that the IRS will apply a traditional reasonable compensation analysis to determine whether the employee benefits provided to those physicians constitute prohibited private inurement or impermissible private benefit.
3. *Permissible recruit.* A physician who either (a) is a recent graduate of a residency or fellowship program, whether or not in the hospital's service area, or (b) has not previously practiced in the hospital's service area or been affiliated with another hospital that serves all or part of the hospital's service area. This definition is critical to understanding the intent of the recruitment guidelines. A permissible recruit is only a physician who has had no prior medical practice (other than a medical school residency or fellowship) in the hospital's service area. The purpose of this definition is to carry out the IRS's strongly held position that it is inappropriate and inconsistent with exemption to use charitable assets to recruit a physician who is already serving the community. This ''stealing'' of doctors—often, an attempt to bring a ''marquee'' physician and a large volume of business to the hospital—has frequently been criticized by IRS officials. Through this definition, the guidelines represent the IRS's position that this practice is no longer permissible.
4. *Permissible incentive.* The type of incentive that the IRS believes is consistent with charitable operation. The provision by a hospital of ''cash, credit, goods, services, or other valuable rights to a physician'' in exchange for that physician's agreement to relocate into or remain within that hospital's service area will be permissible, as long as these incentives are provided in an amount and manner that do not confer prohibited inurement or more than incidental private benefit on the physician.

   The definition goes on to state that these incentives shall not be permissible and shall be ''presumed'' to confer prohibited private inurement

or impermissible private benefit unless they are provided in accordance with the specific rules set forth in Section II of the guidelines (see below). It is unclear from this language whether the IRS intended to create a *per se* inurement type of approach, as it did with regard to revenue-stream joint ventures,[71] or whether a finding of inurement or impermissible private benefit would be a presumption that could be rebutted by the provider. This latter approach is consistent with the IRS's approach in connection with determining whether a physician is an insider for purposes of applying the private inurement analysis.

5. *Community.* A geographical area that exists within the confines of the hospital's primary and secondary service areas, as defined by the hospital. This definition allows *the hospital* to determine its service area, and thereby, its community. The concept of community, an amorphous one at best, is often measured by a source or authority that has little or nothing to do with the manner in which patients are served—for example, the Bureau of the Census. By allowing the hospital to define its own community, the hospital can more practically and realistically demonstrate its need to recruit physicians in accordance with the unique circumstances it faces.

6. *Recruiting fees or costs.* Fees paid to recruiting companies, and travel, moving, and relocation expenses. So far, this coverage is consistent with the expected definition of recruiting fees. However, the definition goes on to include ''the dollar cost of any other incentives, provided to, or on behalf of, or in connection with, a permissible recruit.'' This catch-all clause seems to add in all other types of incentives, thereby rendering uncertain the intended application of this type of expenditure. The definition would have made more sense if this latter phrase simply had not been included.

With those definitions as foundation, the guidelines establish, in Section II, the IRS's position with regard to the various types of physician recruitment incentives.

Section II.A contains one of the most controversial requirements of the guidelines. It states, simply, that ''[r]etention incentives of any kind provided to existing physicians are not permissible incentives.'' It is not surprising that retention incentives are not favored by the IRS; for that matter, they are not favored by the Office of Inspector General of the Department of Health and Human Services with regard to fraud and abuse concerns. This statement of *per se* prohibition of retention incentives, however, is much stronger than most providers expected to see.

There may well be situations in which providing a retention incentive is critical to ensuring that a needed physician can remain in the community. For

71. Gen. Couns. Mem. 39862.

example, a hospital might purchase, for an existing physician, high-technology equipment for use in diagnostic techniques in which the physician has been specially trained. Because the physician could not otherwise afford to obtain the equipment, the hospital might seek to ensure that the physician-specialist's services, and the diagnostic advantage of the technology, remain within the community. In rural and inner-city urban areas, hospitals commonly provide additional retention incentives to make it more desirable for physicians to remain within the community. Thus, to the extent that this guideline would become a *per se* rule, it unnecessarily removes a valuable tool available to healthcare providers.

This guideline does not, even if read narrowly, prohibit the provision of retention incentives in all cases. It would still be permissible to include a retention type of incentive in the original recruitment agreement, for example, an income guarantee subsidy that is forgiven over a long period of time. As long as the retention-type incentives are part of a recruitment agreement with a newly recruited physician, they would still be permissible under the guidelines.

Section II.B provides that permissible incentives do not include recruitment or retention incentives that are provided to physicians who are already on the staff of the hospital or who are practicing in another hospital located within the recruiting hospital's service area. This guideline implements the IRS's position that ''stealing'' doctors is impermissible.

Section II.C is based on another fundamental criterion of physician recruitment policy that has been developed by the IRS in recent years. In order for recruitment of a physician to be consistent with exemption, the hospital must demonstrate community need for that physician. This echoes the IRS's notion that hospital benefit and community benefit may not be the same thing.[72]

Section II.C requires that community need be demonstrated by one or more of six different measures:

1. A showing that the population-to-physician ratio in the hospital's service area is deficient in the particular specialty of the physician who is being recruited. This ratio is to be drawn from a report prepared by the U.S. Department of Health and Human Services in 1980.[73] Although considered a reliable study of the appropriate physician balance relative to populations, this report has not been updated since 1980.
2. A demand for a particular medical service in the hospital's service area, combined with a documented lack of availability of that service or a scarcity that imposes long waiting periods.

72. *See* Gen. Couns. Mem. 39862.
73. Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services (Sept. 30, 1980), DHHS Publication No. (HRA) 81-651.

3. Designation of the hospital's service area, or that portion of the service area that would be served by the recruited physician, as a health professional shortage area (HPSA)[74] at the time the recruitment agreement is executed. HPSAs are a standard measure of personnel needs in the healthcare profession and are often relied on by Congress as the primary measure for determining the need for physicians and other health professionals. However, HPSAs have been criticized as being overly restrictive, and many hospital administrators have complained of urgent needs for physician and other health professional services even though their communities were not included within the confines of an HPSA.
4. A demonstrated reluctance by physicians to relocate in the hospital's service area because of its physical location. This useful measure was intended to be used by hospitals located in rural or ''economically disadvantaged'' inner-city areas.
5. An expected reduction in the number of active physicians in the specialty being recruited, as predicted by anticipated retirement, within three years of the agreement, of physicians who are presently practicing in that specialty in the community. This is a logical measure of community need, but the choice of a three-year period is questionable. It is not helpful to artificially draw that timeline.
6. A documented lack of physicians who serve indigent or Medicaid patients within the hospital's service area, as long as the newly recruited physicians agree to serve a substantial number of these patients. This measure is consistent with the IRS's oft-expressed view that indigent care should be a *quid pro quo* for incentives provided to physicians.

In **Section II.D**, the IRS identifies duties that may be required by the hospital of the physician as a precondition to the physician's receiving the incentive benefits. These are:

1. Relocation to the hospital service area
2. Establishment of a full-time private practice
3. Continued practice in the community for a period of time
4. Maintenance of medical license
5. Acceptance of Medicaid and charity patients
6. Emergency room or other rotational duty
7. Performance of community or medical teaching
8. Performance of necessary administrative duties

74. 42 C.F.R. §§ 5.1–5.4 (1993).

9. Maintenance of medical staff privileges at the hospital
10. Maintenance of the specialty practice for which the physician was recruited

These are common requirements in physician recruitment agreements. Under this guideline, they will not adversely affect the hospital's tax-exempt status, nor is it likely they will run afoul of the Medicare and Medicaid fraud and abuse laws, as long as they are properly structured.

Section II.E deals with a mutual concern of the OIG and the IRS: recruitment agreements that require a physician to refer or admit patients to the recruiting hospital or that prohibit the recruited physician from obtaining staff privileges at other hospitals. Under this section of the guidelines, these types of restrictions are impermissible. Presumably, this is a problem for the IRS because it would be a fraud and abuse violation; arguably, such requirements would otherwise promote the use of the recruiting hospital facility and enhance its charitable operations.

Section II.F provides that if a physician receives incentives other than loans and travel and moving expenses, then the physician must agree to a periodic accounting by the hospital and must allow the hospital the right to inspect his or her books and records. Before reimbursement for travel and moving expenses, the hospital must first obtain documentation of those expenses.

Section II.G begins by stating that permissible incentives include ''loans, lines of credit, or loan guarantees.'' This is useful guidance in that it specifically recognizes forms of incentives that many healthcare providers feared had fallen out of favor with the IRS. For these types of incentives to be permissible, however, they must be evidenced by an executed promissory note, adequately secured, and must bear interest at a reasonable rate reflecting market conditions, which the IRS defines as the prime rate plus 1 or 2 percent, or the applicable federal rate. These conditions are consistent with the guidance provided in the Hospital Audit Guidelines[75] as well as with informal comments by the IRS in recent years.

The IRS also implicitly recognizes the acceptability of loan forgiveness in this section. To be permissible, loan forgiveness must be conditioned on the continued medical practice of the physician in the community and must be rated for a period of not less than four years. The recognition that loan forgiveness is an acceptable technique is appropriate and helpful, but the requirement of rating it for a period of not less than four years in all cases is unsupportable. For example, this requirement draws no distinction between loan forgiveness of $10,000 and loan forgiveness of $100,000 with regard to the time period for repayment. It also fails to recognize the value of other services that the physician may be providing to the community, which could have an impact on the length of time used for loan forgiveness. It would make

75. *See* Appendix E.

more sense to leave this open and simply require that a reasonable forgiveness period be chosen based on the amount of the incentive and the conditions applicable to the recruitment of a particular physician. Finally, the section provides that demonstrated need for the particular physician and the amount of the particular incentive must be evidenced when loan forgiveness is used.

Section II.H suggests the use of another type of incentive, which many providers had believed at the time that the IRS would strike down. Income guarantees are one of the most common recruitment and retention tool used by hospitals across the country.[76] However, the IRS's earlier guidance[77] had cast significant doubt on whether the use of many popular types of income guarantees would be consistent with tax-exempt status.

This section takes the position that reasonable income guarantees are permissible if *all* of the following conditions are met:

1. They are for a period of two years or less.
2. No benefits are offered or provided that are outside of those specified in the agreement.
3. The terms of the income guarantee are agreed to in advance, in writing, and are not modified over the life of the agreement.
4. Periodic income guarantee advances must be structured as a loan bearing a reasonable rate of interest, and any loan terms or loan forgiveness must comply with **Section II.G** of the guidelines.
5. If the income guarantee is for a net income amount, a reasonable fixed ceiling amount must be placed on allowable expenses and on the amounts for which advances may be made.
6. The guarantee must represent all or part of a compensation package that is reasonable in its entirety.

Section II.I recognizes that permissible incentives may include subsidies paid to assist a physician in starting up a medical practice. These include subsidies for medical office space rent, overhead expenses, and rental of equipment, as long as such rental amounts are at fair market value and the subsidy does not extend beyond two years. If the hospital subsidizes equipment purchases or acquires equipment for a physician, the free or reduced cost for use by the physician may not exceed two years. If title is transferred to the physician, the hospital must receive fair-market-value payment for the equipment from the physician. The hospital may not enter into a transaction for acquiring equipment or space that utilizes the mechanism of a conveyance or lease of the equipment or space to the physician with a leaseback to the hospital. These provisions are consistent with earlier IRS guidance; however,

76. *See supra* note 22.
77. Gen. Couns. Mem. 39498.

it is again unclear why it is necessary to draw arbitrary timelines regarding the use of these subsidies. The conveyance of equipment to the physician should be a forgivable event, just as it would be if it were a loan or income guarantee.

It is important to note that this section recognizes these as permissible incentives only if no comparable and related value is provided to the physician through an alternative incentive mechanism, such as an income guarantee or loan forgiveness. Thus, combination recruitment packages that include not only income guarantees but also equipment and office space subsidies appear to be impermissible incentives—another example of an unnecessary restriction. As the IRS has noted,[78] the mere form of the compensation provided to an individual should not determine whether impermissible private benefit or private inurement is present. The appropriate analysis would be whether the overall package is reasonable, is based on community need for the physician's services, and is structured in a manner that will protect the hospital's assets, not whether some particular combination of incentives is present, especially when these incentives, by themselves, have been expressly approved by the IRS elsewhere in the guidelines.

Section II.J expresses the IRS's position that payment of moving expenses is a permissible incentive subject to reasonable limits. A reasonable fixed ceiling amount must also be established. This is unnecessary if the individual expenses are subject to reasonable limits by themselves; an additional aggregate cap would seem to serve no purpose. The section also notes that the hospital may require reimbursement to itself for payment of such expenses if a newly recruited physician does not remain in the hospital's service area for the stipulated period of time.

Section II.K states that reasonable interview travel expenses may be reimbursed to permissible recruits; however, under **Section II.L** permissible incentives do not include travel and continuing education expenses where those expenses are primarily related to the physician's private practice of medicine. Unfortunately, the latter restriction is counterproductive to the goal of providing the best physician services possible to the community. All recruitment incentives ultimately relate to the physician's private practice of medicine if the physician is not employed by the hospital, and forbidding payment for continuing education expenses seems to be a distinction without a difference. Recognizing popular practice, however, the IRS does permit educational expense reimbursement to nurses and nurse anesthetists in exchange for their future employment commitments, particularly if there is a documented nursing shortage.

Section II.M forbids the payment of practice start-up assistance if an income guarantee has been provided to the same physician. As with **Section II.I**, this restriction is apparently intended to prohibit "double dipping" by physicians. However, it disregards the questions of whether the income

78. Gen. Couns. Mem. 39670.

guarantee is provided on a gross or a net basis and whether the recruitment package in its entirety has been balanced so that the overall benefit provided to the physician, regardless of how it is apportioned, is reasonable, based on the services being provided.

Section II.N indicates that a hospital may not subsidize salary and benefit costs for a physician's support personnel used in his or her private practice. As with **Section II.K**, given the fact that other permissible recruitment and retention incentives benefit a physician in his or her private practice, drawing a distinction as to subsidization of salary and benefit costs for support personnel is inconsistent.

Section II.O provides that a hospital may not pay the malpractice insurance premiums of a physician for his or her current private practice. The hospital may make payment for malpractice coverage with respect to a physician's duties as a medical director for the hospital or any other activity undertaken for the benefit of the hospital that is distinct from his or her private practice. The hospital may also make reasonable payment for *tail coverage* in the case of a relocating physician. This is another example of the inconsistent restriction of incentives that benefit the physician's private practice. Moreover, payment of malpractice insurance premiums for physicians has a direct benefit to the hospital: it helps to protect the hospital's assets from exposure to malpractice liability. Given the widespread application of the doctrine of ostensible agency to hospitals,[79] in nearly every physician malpractice suit the hospital is added as a defendant. By ensuring that malpractice premiums are paid, coverage is adequate, and the insurer is reputable, the hospital can be certain that its assets will be protected from such liability even where it is arguably not a liable party.

This section also notes that a hospital may not appoint a medical director unless there is a ''legitimate and demonstrable business purpose for doing so.'' This provision would seem self-evident, but it apparently addresses a widespread abusive practice that the IRS has uncovered in its audits of hospitals.

Section II.P continues the restriction of private practice subsidies by noting that, except in connection with hospital activities, permissible incentives do not include ''subsidized parking; telephone allowances, including cellular car phones; car allowances; health insurance; or payment of medical society dues or licensing fees.''

Section II.Q provides that signing bonuses or other similar types of bonus payments are not permissible incentives. This *per se* type of prohibition is directly at odds with earlier advice, in which the IRS expressly stated:

> [A] hospital may offer a one-time recruitment bonus or incentive the amount of which is determined not by reference to services to be rendered, but by reference

79. *See*, e.g., *Thompson v. Nason Hospital*, 591 A. 2d 703 (1991).

> to the value assigned to recruiting a particular physician to its medical service area. . . .[80]

Section II.R contains another guideline that has come under criticism by healthcare providers: if a physician is recruited to enter an existing medical practice, the hospital may pay no more than 50 percent of the recruiting fees or costs associated with that physician. This is an extremely important issue to healthcare recruiters, because of widespread agreement that the easiest way to recruit a physician and to ensure that he or she will have a successful initiation of medical practice is to recruit into an existing medical group rather than as a solo practitioner. The premise of the restriction seems to be that the medical group is benefiting as well and, therefore, it should bear at least 50 percent of the costs of the recruitment. This guideline is inconsistent with other guidelines that allow a hospital to pay for 100 percent of the recruiting costs incurred by a search firm or needed to recruit a solo practitioner. The better view would be that, as long as the amount of the recruitment fees incurred by the medical practice is reasonable and the agreement is structured to ban any opportunity for a windfall of benefit to the medical practice, payment of all reasonable recruiting costs to an existing medical practice should be consistent with charitable operation.

Section II.S provides that a hospital may not convey a hospital outpatient department (such as a clinic or center) to a physician. It must maintain proper records of fees, as well as other safeguards, to ensure that the outpatient departments of the hospital are operated for the benefit of the hospital and the community and not effectively operated as the private practice of physicians. This guideline is a direct response to a practice discovered at Hermann Hospital by the IRS, although it is also consistent with earlier positions taken by the IRS, where a portion of a hospital's revenue stream for a particular department was sold to a joint venture consisting of physicians on the medical staff of the hospital.[81] (The IRS outlawed that arrangement as well.)

Section II.T forbids the payment of recruitment fees or costs to existing physicians, but permits payment of such fees or costs to outside search consultants. Again, the IRS appears to be throwing the baby out with the bathwater. In many situations, it makes more sense to pay an existing physician to recruit another physician; the likelihood of success can be substantially greater, and there appears to be no distinction vis à vis charitable operation with regard to payment to a physician or payment to a search consultant, as long as legitimate services are being provided by the physician for the fee.

Sections II.U–Z require review of recruitment packages by legal counsel or tax advisors, to determine: that incentives being provided to physicians are reported on Form W-2 or Form 1099 as appropriate; that the guidelines are applied not only to the hospital, but also to its subsidiaries or controlled

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80. Gen. Couns. Mem. 39498.
81. Gen. Couns. Mem. 39862.

affiliates or its parent; that incentive agreements are memorialized in writing and that no side deals or off-agreement incentives are provided; that all incentive agreements contain a clause allowing the hospital to terminate the agreement and recover incentive payments made to a physician, if a court or government agency determines the arrangement to be illegal or inconsistent with the hospital's tax-exempt status; and that the hospital is maintaining complete and accurate records—documenting the amounts paid, the other incentives provided, and the community need that supports the arrangement—in order to ensure compliance with the guidelines.

These guidelines represented the first attempt by the IRS to provide specific nuts-and-bolts guidance in this area. Because these guidelines were an effort to take corrective action with regard to the practices of a particular hospital, and because many of the provisions draw lines in the sand that had not previously existed, healthcare providers breathed a collective sigh of relief when the Assistant Commissioner announced that the IRS would not rigidly apply these guidelines, across the board, to all hospitals. The Hermann Hospital Closing Agreement continues to offer useful concepts for a compliant physician recruitment program. However, it was supplanted by precedential guidance issued by the IRS in 1997 that established the rules of the road now enforced by the Service.

§ 25.7 PHYSICIAN RECRUITMENT REVENUE RULING

In 1995, the IRS filled the formal guidance void in this area by issuing a precedential ruling, the first in the healthcare area since 1986. It published an announcement[82] that contained a proposed revenue ruling on the tax consequences of physician recruitment incentives provided by hospitals recognized as tax-exempt charitable organizations. This guidance set forth five physician recruitment scenarios and established the IRS's position that four of these scenarios involve activities consistent with charitable operation and one does not. After a public comment period, the IRS published the revenue ruling in final form with some minor but significant changes over the earlier proposed version.[83] The physician recruitment revenue ruling is somewhat limited in scope; however, it has importance greater than either the Hospital Audit Guidelines or the Hermann Hospital Closing Agreement: as a revenue ruling, it is designed to be relied on by all taxpayers and is binding on IRS officials.

The final revenue ruling supports nearly all of the mainstream physician recruitment techniques used by charitable hospitals today, including some techniques that providers believed had come into disfavor with the IRS. The factual situations set forth in the ruling have been narrowly tailored; nevertheless, this guidance lays to rest most of the fears of charitable hospitals in this

82. Announcement 95-25, I.R.B. 1995-14.
83. Rev. Rul. 97-21. *See* Appendix I.

area and permits them to move forward with greater certainty as they endeavor to provide for the best possible healthcare services for their communities.

The 1995 announcement, which set forth the text of the revenue ruling for the first time in a proposed form, provided notice that the IRS was considering the issuance of a revenue ruling that would address the question of whether a charitable hospital violates the requirement for exemption from federal income tax when it provides incentives to recruit private practice physicians (other than employed physicians) to join the hospital's medical staff or to provide services on behalf of the hospital. By way of background, the announcement noted that the IRS is often required to consider whether a hospital recognized as a charitable organization violates the requirements for exemption when it provides recruitment incentives to physicians in private practice. The announcement noted that the situations described in the proposed revenue ruling do not delineate the boundaries of either permissible or impermissible types of transactions and that the addition or deletion of any facts or circumstances not specifically set forth in an example may alter the outcome of the transaction described therein. The announcement also reminded exempt organizations that they must properly file Form 1099 information returns regarding benefits provided through recruitment incentive packages.

The IRS solicited public comment on the proposed revenue ruling. It sought comments not only on the situations described in the revenue ruling, but also on other issues, including whether and how physician retention arrangements comply with the standards for exemption, whether other mechanisms may appropriately be used as recruiting incentives, and whether the standards described in the proposed revenue ruling should apply to other tax-exempt healthcare organizations. Several comments were submitted, including those by large accounting firms, private practitioners, and bar associations.

The revenue ruling was published in final form in 1997. It sets forth the issue it addresses as follows: ''Whether, under the facts described below, a hospital violates the requirements for exemption from federal income tax as an organization described in Section 501(c)(3) of the Internal Revenue Code when it provides incentives to recruit private practice physicians to join its medical staff or to provide medical services in the community?''

The revenue ruling then set forth five factual physician recruitment situations involving hospitals recognized as exempt as charitable organizations and that operate in accordance with the standards for exemption set forth by the IRS in 1969.[84] For the purposes of the revenue ruling, the recruiting activities described in the first four situations are all deemed to be lawful. However, the IRS expressly states that it has no jurisdiction regarding the Medicare and Medicaid antikickback statute,[85] and that taxpayers may not rely on the facts or assumptions in the ruling for purposes related to the antikickback statute.

84. Rev. Rul. 69-545.
85. 42 U.S.C. § 1320a-7b(b).

Throughout the first four situations, there is a common structure to the physician recruitment arrangements. That is, each arrangement is the subject of a written agreement that has been negotiated at arm's length and has been approved by the hospital's board of trustees or its designees or is in accordance with guidelines approved and monitored by them. In addition, there are no benefits being provided to the physician by the hospital other than those expressly delineated in the agreement.

Situation 1. In the first situation, a hospital is located in a rural area and is the only hospital within a 100-mile radius. The county in which the hospital is located has been designated as a health professional shortage area for primary medical care professionals, including obstetricians and gynecologists. The hospital recruits a physician who has recently completed an OB/GYN residency, and is not currently on the hospital's medical staff, to establish and maintain a full-time private OB/GYN practice in the hospital's service area and to become a member of the hospital's medical staff. In the agreement with the physician, the hospital pays the physician a signing bonus, pays the physician's malpractice premium for a limited period, provides office space in a hospital-owned building for a limited number of years at a below-market rent (after which rent is charged at fair market value), and guarantees the physician's personal mortgage on his home in the hospital's service area. The hospital also provides the physician with start-up financial assistance for his or her private practice pursuant to an agreement that is properly documented and bears reasonable terms. The agreement is in accordance with guidelines established by the hospital's board of directors. The board monitors and reviews the guidelines regularly to ensure that its recruiting practices are consistent with the hospital's exempt purposes.

Situation 2. In the second situation, the hospital is located in an economically depressed inner-city area. The hospital has conducted a community needs assessment indicating that there is a shortage of pediatricians in the hospital's service area and that Medicaid patients are having difficulty obtaining pediatric services. The hospital recruits a pediatrician, one that currently does not practice in the hospital's service area and is not on the hospital's medical staff, to relocate to its city and to establish and maintain a full-time pediatric practice in the hospital's service area, to become a member of the hospital's medical staff, and to treat a reasonable number of Medicaid patients. In the recruitment incentive package, the hospital reimburses the physician for moving expenses as defined in the Code,[86] and professional liability ''tail'' coverage for his former practice, and guarantees his private

86. IRC § 217(b).

practice income for a limited number of years. The income guarantee is properly documented and bears commercially reasonable terms and is structured as a net income guarantee (after reasonable expenses of the practice). The amount of the net income guarantee falls within the range reflected in regional or national income surveys for physicians in the same specialty. The agreement is approved by the hospital's board of directors.

Situation 3. In the third situation, the hospital is located in an economically depressed inner-city area. It has conducted a community needs assessment that indicates that indigent patients are having difficulty obtaining access to care because of a shortage of obstetricians in the hospital's service area that are willing to treat Medicare and charity care patients. The hospital recruits an obstetrician that is already serving on its medical staff to treat a reasonable number of Medicaid and charity care patients for a one-year period. In exchange for those services, the hospital agrees to reimburse the physician for the cost of one year's malpractice insurance. The agreement was in accordance with recruitment guidelines established, monitored and reviewed by the board, and was approved by the officer designated by the board to enter into contracts with hospital medical staff.

Situation 4. In the fourth factual scenario, the hospital is located in a medium-to-large-size metropolitan area. The hospital requires a minimum of four diagnostic radiologists in order to provide adequate coverage and a high quality of care for its radiology department. Two of the four diagnostic radiologists that currently provide coverage for the hospital are relocating to other areas. The hospital initiates a physician search to fill these positions and determines that one of the top two candidates is a physician that is currently practicing in the same city in which the hospital is located. The physician is a member of the medical staff of a different hospital in that city and provides coverage for that hospital's radiology department. As a diagnostic radiologist, the physician does not refer patients to any hospitals in the area. The physician is not currently on the recruiting hospital's medical staff. The hospital recruits the same-city physician to join its medical staff and to provide coverage for its radiology department. Pursuant to the recruitment agreement, the hospital provides a net income guarantee for the physician's private practice for the first few years that the physician remains a member of the hospital's medical staff and provides coverage for its radiology department. The net income guarantee (after reasonable expenses of the practice) is an amount that falls within the range reflected in regional and national income surveys for physicians in the same specialty. The agreement is approved by the hospital's board of directors.

Situation 5. The fifth and final situation is the sole situation identified in the revenue ruling that the IRS deems to be unlawful and inconsistent with charitable operation. In this situation, the hospital is located in a medium-to-large-size metropolitan area. As a result of its physician recruitment practices, the hospital has been found guilty in a court of law of knowingly and willfully violating the Medicare and Medicaid antikickback statute for providing recruitment incentives that constitute payments for referrals. The activities resulting in the violations were substantial.

The revenue ruling then sets forth the law upon which its analysis is based. This section notes that the promotion of health has long been recognized as a charitable purpose; however, under the common law of charitable trusts, charitable organizations are subject to the requirement that their purposes may not be illegal. The ruling cites six revenue rulings pertinent to these types of healthcare organization activities.[87]

Finally, the revenue ruling sets forth its analysis of the law and applies it to the five factual situations discussed above. The ruling states that a hospital providing recruitment incentives to physicians must provide those incentives in a manner that does not cause the organization to violate the operational test of the Code.[88] Whether the hospital is providing those incentives in a manner that does not violate the operational test is a question that will be answered based on all of the relevant facts and circumstances.

If the charitable hospital recruits a physician to perform services for or on behalf of the hospital, it will meet the operational test by showing that, taking into account all of the benefits that it provides to the physician, it is paying reasonable compensation for the physician's services.

If the hospital is recruiting the physician to provide services in the community other than for or on behalf of the hospital, the IRS states that a somewhat different analysis must be applied. In these cases, a violation will result if

87. Rev. Rul. 69-545 (nonprofit hospital that benefits community by having open medical staff, broadly representative board of trustees, full-time emergency room open to all regardless of ability to pay, and otherwise admits all patients able to pay qualifies as IRC § 501(c)(3) organization); Rev. Rul. 72-559 (organization that provides subsidies to recent law school graduates to enable them to establish legal practices in economically depressed communities that have shortage of available legal services qualifies as IRC § 501(c)(3) organization); Rev. Rul. 73-313 (organization formed to attract physician to community that had no available medical services furthered the charitable purpose of promotion of health); Rev. Rul. 75-384 (organization whose primary activity is sponsoring anti war protest demonstrations that violate local ordinances and breach public order does not qualify as an IRC § 501(c)(3) organization because its activities demonstrate an illegal purpose); and Rev. Ruls. 80-278 and 80-279 (organizations that conduct environmental litigation and dispute mediation qualify as IRC § 501(c)(3) organizations where their purpose is charitable, their activities are not illegal or contrary to public policy, and are in furtherance of organization's exempt purposes).

88. Reg. § 1.501(c)(3)-1.

the hospital fails to comply with any of four fundamental requirements: first, the organization may not engage in activities that demonstrate a substantial nonexempt purpose and must engage in activities that appropriately further its exempt purposes; second, the organization may not engage in activities that result in private inurement, as may result when the recruitment activity is structured as a device to distribute the net earnings of the hospital; third, the organization may not engage in substantial activities that cause the hospital to be operated for private interests rather than for public interests; and fourth, the healthcare organization may not engage in substantial unlawful activities.

The final revenue ruling concludes by applying this analysis to each of the five factual situations set forth above. In Situation 1, the IRS concludes that the hospital had objective evidence that demonstrated a need for obstetricians and gynecologists in its service area and that its recruitment activities bore a reasonable relationship to promotion and protection of the health of the community. Thus, the payment of a bonus, the guarantee of a personal mortgage, the reimbursement of malpractice insurance, the provision of subsidized office space for a limited time, and the lending of start-up financial assistance as recruitment incentives were reasonably related to causing the physician to establish and maintain a full-time practice in the hospital's service area. Accordingly, provision of these incentives was found to be consistent with the requirements for exemption for charitable organizations under the Code.

In Situation 2, the hospital had objective evidence demonstrating a need for pediatricians in its service area and engaged in physician recruitment activity that bore a reasonable relationship to promoting and protecting the health of the community. Thus, the payment of moving expenses, the reimbursement of malpractice *tail* coverage, and the provision of a reasonable private practice income guarantee were found to be reasonably related to causing the physician to establish and maintain a full-time private pediatric practice in the hospital's service area, and as a result were consistent with the requirements for exemption as a charitable organization.

In Situation 3, the hospital admitted and treated Medicaid patients on a nondiscriminatory basis as required by the IRS.[89] The hospital had identified a shortage of obstetricians willing to treat Medicaid patients. Thus, the IRS concluded that the payment of the physician's malpractice insurance premiums in exchange for his agreement to treat a reasonable number of Medicaid and charity care patients was reasonably related to the accomplishment of the hospital's exempt purposes. The IRS concluded that any private benefit to the physician was outweighed by the public purpose served by the agreement and therefore the recruitment activity was consistent with the requirements for exemption for charitable organizations.

89. Rev. Rul. 69-545.

In Situation 4, the hospital provided objective evidence that demonstrated a need for diagnostic radiologists to provide coverage for its radiology department so that it could promote the health of the community. The provision of a reasonable income guarantee as a recruitment incentive, conditioned upon the physician obtaining staff privileges and providing coverage for the radiology department, was deemed to be reasonably related to the accomplishment of the charitable purposes served by the hospital. The significant fact supporting the IRS's conclusion that the community benefit provided by the activity outweighed the private benefit provided to the physician was the hospital's determination that it needed additional diagnostic radiologists to provide adequate coverage and to ensure a high quality of medical care. Thus, the IRS concluded that the recruitment activity at issue was consistent with the requirements for charitable operation.

Finally, in Situation 5, the IRS noted that the physician recruitment practices resulted in a criminal conviction and that the activities were intentional and criminal, and not isolated or inadvertent violations of a regulatory statute. Because the organization engaged in substantial unlawful activities, it does not qualify as a charitable organization.

The holding of the revenue ruling sums up the positions taken by the IRS in each of the five factual situations. Thus, the revenue ruling holds that the hospitals in Situations 1 through 4 did not violate the requirements for exemption from federal income tax for charitable organizations because the physician recruitment transactions furthered charitable purposes, did not result in inurement, did not result in the hospital serving a private rather than a public purpose, and were assumed to be lawful for purposes of the revenue ruling. The hospital in the fifth situation did not qualify as a charitable organization because its unlawful physician recruitment activities were inconsistent with charitable purposes. The ruling notes that it addresses only issues for charitable organizations in the described situations and that no inference is intended as to any other issue under any other provision of law.

The format of the revenue ruling has been used before by the IRS. The identification of factual situations common in the industry, to which a legal analysis is applied to determine the tax consequences of the activity, is found in other revenue rulings as well as in the Treasury regulations. Some providers and practitioners may have preferred more detailed item-by-item guidance, as with the format used in the Hermann Hospital Physician Recruitment Guidelines. Many others will find solace in the more general application of the factual situation format, which lends itself to use as a safe harbor and avoids the unnecessary application of *per se* rules when providers can more effectively benefit from positions based on reasonableness and the facts and circumstances of individual transactions.

It appears that the IRS permits healthcare organizations to use the factual situations as safe harbors for their physician recruitment programs. The

proposed form of the revenue ruling stated that the factual situations identified in the revenue ruling do not delineate the boundaries of either permissible or impermissible types of transactions. While this statement was deleted from the final version, it still appears that it is not the intent of the IRS to apply these factual situations as *per se*–type rules under which any activity that does not comply is strictly prohibited.

It is important to note that the final revenue ruling does not address efforts by hospitals to retain physicians already on their medical staffs and serving the community, nor does it address application of the standards contained in the revenue ruling to tax-exempt healthcare organizations other than hospitals. The IRS solicited public comment on these points; however, they were not addressed in the revenue ruling in its final form.

In addition, none of the five factual situations described in the revenue ruling apply to physicians who are employed by the hospital. The IRS explained (more explicitly in the final version of the ruling) that for physicians providing services *for or on behalf of the hospital* (presumably meaning employees or independent contractors), the hospital must show that, taking into account all of the benefits that it provides to the physician, it is paying reasonable compensation for the physicians' services.

Not surprisingly, the IRS notes as a threshold matter in its factual setup that each of the hospitals described in the revenue ruling operates in accordance with the standards for exemption set forth by the IRS in 1969. Given the IRS's analysis in 1992 regarding certain types of hospital–physician joint ventures,[90] the language contained in the charity care bills in the 102d Congress, the expansion of the community benefit standard by federal courts to include health maintenance organizations, and the IRS's call for disclosure of compliance and community benefit activities in the redesigned Form 990, there can be no question that the community benefit standard is the foundation of any IRS analysis of activities of charitable healthcare organizations. The fact patterns also reveal a clear sensitivity on the part of the IRS to communities in which Medicaid and indigent patients are unable to obtain access to care. Nondiscrimination in the provision of services to Medicaid patients is an essential component of the community benefit standard and it is apparent that healthcare organizations will be given a great deal of latitude by the IRS in their physician recruitment programs where the purpose of the incentive is to improve the ability of the hospital to serve Medicaid and charity care patients.

Much to the relief of charitable hospitals, the standards developed in the revenue ruling are considerably more flexible and liberal than those espoused in the Hospital Physician Recruitment Guidelines that were contained in the Hermann Hospital Closing Agreement. The IRS Assistant Commissioner publicly stated after the release of the Hermann Hospital Closing Agreement that it was not the intent of the IRS to apply those standards across the board

90. Gen. Couns. Mem. 39862.

to all providers, and the standards set forth in the revenue ruling bear out that statement. Several of the standards contained in the revenue ruling are squarely at odds with the restrictions set forth in the Hermann Hospital Closing Agreement and thus, it appears that those restrictions will, indeed, apply only to Hermann Hospital. Moreover, as discussed below, some of the standards contained in the revenue ruling are more liberal than those set forth in the Hospital Audit Guidelines. Since the revenue ruling has general applicability and binding effect, it will control over the standards contained in the Hospital Audit Guidelines and the more liberal positions will prevail.

The revenue ruling takes the position that the fundamental justification for providing physician recruitment incentives in each of the four lawful factual situations is objective evidence of a community need for the physician services being sought. Under the factual scenarios set forth, the objective evidence of need found acceptable to the IRS included operation in a rural area, operation in an economically depressed urban area, operation in a health professional shortage area, need demonstrated by a community needs assessment, hospital-specific shortages where specialty physicians have relocated outside of the hospital's service area, and areas in which Medicaid and charity care patients have difficulty obtaining needed physician services. While these are all legitimate indications of community need, there are other characteristics and situations that will satisfactorily demonstrate community need. In that regard, the types of evidence of community need set forth in the Hermann Hospital Physician Recruitment Guidelines would still be quite useful, although even this list is not exhaustive.

Unfortunately, providers must continue to serve two masters with different agendas in this area, namely, the IRS and the OIG. The revenue ruling permits no conclusion to be drawn as to whether the activities described in the four permitted factual situations are lawful under the Medicare antikickback statute. Moreover, as discussed below, several of the physician recruitment incentives deemed permissible by the IRS remain questionable activities with regard to compliance with the Medicare and Medicaid antikickback statute according to the Office of Inspector General.[91]

Drawing from the four situations in the revenue ruling deemed by the IRS to be lawful, there are four threshold requirements that must be satisfied in order for any physician recruitment incentive to be permissible. First, the agreement between the hospital and the physician must be in writing. This should come as no surprise, although it is not uncommon to find charitable hospitals that still provide some recruitment incentives on a handshake. In addition to the fact that putting such agreements in writing is simply good business sense and reduces exposure to liability, the IRS and the OIG have been instructing healthcare providers for years to put hospital–physician agreements in writing. This requirement is also found in the Hospital Audit

91. *See* § 25.3.

Guidelines, the Hermann Hospital Closing Agreement, the IRS rules for charitable hospitals that use tax-exempt bond financing, and the OIG safe harbor for physician recruitment activities. Written agreements also afford providers the opportunity to demonstrate charitable purposes and the lack of purpose or intent to induce referrals, both critical to maintaining charitable status and avoiding fines, exclusion from the Medicare and Medicaid programs, and jail time.

Second, the agreement must be negotiated at arm's length. Again, this has been a staple of the IRS position regarding hospital–physician relationships, indeed any arrangement between a charitable organization and an individual, for decades. The failure to do so makes it likely that private inurement or impermissible private benefit will occur. In this context, based on previous IRS guidance, this requirement means that a true negotiation should occur between the parties and evidence of that negotiation should be documented in the hospital's files. If the physician receiving the benefit is a member of the hospital's board of trustees (which will usually be the case only in a retention situation), the physician should follow the hospital's conflict-of-interest policy for interested trustee transactions and remove himself or herself from the deliberation and vote for the transaction.

Third, the agreement must be approved by the hospital's board of trustees or the board's designees, or it must comply with recruitment guidelines established by the board and monitored and reviewed by them to ensure consistency with the hospital's exempt purposes. This requirement reflects the problems identified in the Hermann Hospital Closing Agreement when physician recruitment programs go awry due to lack of adequate oversight by the hospital's governing body.

Fourth, the physician recruitment arrangement may not include any *off-agreement* benefits. This was also an express requirement of the Hermann Hospital Closing Agreement. This requirement is consistent with the first three, and certainly makes sense. The IRS has uniformly examined the *totality* of the recruitment package, and any off-agreement incentives would need to be disclosed and considered in determining whether private inurement or impermissible private benefit would result.

With these underlying requirements as foundation, the IRS then identifies eight different physician recruitment incentives that, under the factual situations set forth, it deemed consistent with the requirements for exemption for charitable organizations:

1. *Signing bonuses.* The first approved technique was the offering of a signing bonus. In the proposed version, an amount of $5,000 was used in the factual situation. However, the IRS deleted amounts and time periods used in the factual situations in the final version to avoid the unintended use of them as safe harbors. This is an important acknowledgment for the IRS given the contrary position it took in the Hermann Hospital Closing

Agreement, in which it flatly prohibited the use of signing bonuses. Signing bonuses are a popular and successful recruitment technique and hospitals were greatly concerned that this technique was no longer available to them after Hermann Hospital. However, the IRS Assistant Commissioner publicly stated that the IRS had approved of signing bonuses in the past under appropriate circumstances and that it would likely continue to do so. This had, in fact, been the express position of the IRS at least since 1986, when the IRS stated that ''a hospital may offer a one-time recruitment bonus or incentive the amount of which is determined not by reference to services to be rendered, but by reference to the value assigned to recruiting a particular physician to its medical service area. . . .''[92] Accordingly, it is now apparent that signing bonuses are permissible under appropriate circumstances.

2. *Malpractice insurance reimbursement.* The second approved technique was reimbursement by the hospital for a physician's malpractice insurance premium. This is a more liberal position than previously had been taken by the IRS in other guidance in this area. For example, in the Hermann Hospital Closing Agreement, the IRS expressly prohibited payment or provision, directly or indirectly, of malpractice insurance for the current private practice of a nonemployee physician. The revenue ruling's position also makes a great deal of sense. Payment of malpractice insurance premiums for physicians has a direct benefit for the hospital: it helps to protect the hospital's assets from exposure to malpractice liability. Given the widespread application of the doctrine of ostensible agency to hospitals, in nearly every physician malpractice suit the hospital is added as a defendant. By insuring that malpractice premiums are paid, coverage is adequate, and the insurer is reputable, the hospital can be certain that its assets will be protected from such liability even where it arguably is not a liable party.

3. *Tail coverage reimbursement.* The third technique deemed lawful by the IRS is reimbursement for a physician's professional liability *tail* coverage. This is an extension of the malpractice insurance technique discussed above. It involves the relocation of a physician to the hospital's service area and the need to protect both the physician and the hospital from liability resulting from his or her practice in a prior location. If the physician had professional liability insurance in his or her previous practice on a *claims-made* basis, then the physician is exposed to liability for claims of malpractice that are filed after the termination of his or her previous insurance policy but for acts that occurred while the physician was in his or her prior location. For the reasons discussed above, the acquisition of tail coverage enables the hospital to protect

92. Gen. Couns. Mem. 39498.

its investment by insuring that the physician's practice is not derailed through a malpractice claim for which there is no insurance. Likewise, it protects the hospital's assets in the event that it should somehow be determined a liable party. The IRS's position on this point is consistent with the position it took in the Hermann Hospital Closing Agreement in which it approved reasonable payment for tail coverage in the case of a newly recruited physician who was relocating to the hospital's service area.

4. *Office rental subsidies.* The fourth practice permitted by the IRS was the offering of below-market rent for a limited number of years by a hospital in a building that it owned, after which the rental rate returns to its fair market value rate. This is a very common practice of hospitals; it enables the physician to start up a new practice without bearing full financial responsibility for a market rate of rent at a time in which his or her income will be at its lowest levels. Without such an alternative, many physicians would simply be unable to afford to start up a new practice. The Hospital Audit Guidelines are not so liberally phrased. Under the Hospital Audit Guidelines, the general rule is that if a hospital provides office space to a physician for use in the physician's private practice, it must generally be provided at a reasonable rental rate gauged by market data.

5. *Guarantee of personal mortgage.* The fifth technique approved by the IRS was a guarantee of a physician's personal home mortgage for his or her residence in the hospital's service area. Again, this is a common hospital recruitment technique and often is the extra step that enables the physician to relocate to the hospital's service area. It is also directly related to the recruitment of the physician since, but for the relocation, the physician would not otherwise have needed the guarantee.

6. *Start-up financial assistance.* The sixth technique approved by the IRS is the extension by the hospital of start-up financial assistance to a physician with a written agreement bearing reasonable terms. This is a useful position for hospitals since start-up financial assistance is in widespread use. It is unclear, however, what the reach of this position is intended to be because it is limited to assistance under *reasonable terms*. This might include, for example, working capital loans at a market rate of interest and secured through a promissory note. This position does not address whether such start-up financial assistance could be subsidized, such as through a below-market rate of interest on the working capital loan. It seems likely that the IRS would approve of such a technique given its analysis that signing bonuses and subsidized rent are acceptable recruitment techniques. Also, the IRS had used the term

commercially reasonable in the proposed version, a change that suggests that *reasonable* here means *reasonable under the circumstances*. It may be that the IRS is simply saying that it is acceptable for a hospital to serve as a source of capital for start-up financial assistance for a physician in addition to using recruitment incentives that involve the provision of subsidies by the hospital.

7. *Moving expenses.* The seventh technique approved by the IRS is the reimbursement of a physician's moving expenses as defined by the Code. Reimbursement of moving expenses is a feature of nearly every physician recruitment package in which a physician is relocating to the hospital's service area. It is clearly directly related to the recruitment since, but for the relocation, the physician would not have incurred the moving expenses. The IRS has historically blessed the reimbursement of moving expenses. Even in the Hermann Hospital Closing Agreement, the hospital was permitted to pay actual moving expenses and relocation costs and reasonable interview travel expenses for permissible recruits.

The IRS's position in the revenue ruling is consistent with its prior positions; however, it adds a new wrinkle. Under the factual situation described, the moving expenses were as defined by section 217(b) of the Code. This reference has value by standardizing a definition of moving expenses and following the definition used by the Code for purposes of deductibility to individual taxpayers. However, this definition of moving expenses is significantly more limited in scope than the working definition of moving expenses used by most hospitals. Thus, for example, the Code definition would not include reimbursement for meals during the move, nor would it cover site visits and house-hunting trips, or temporary quarters used while searching for a home.

Given the IRS's more liberal definition of moving expenses in the Hermann Hospital Closing Agreement, it would seem unlikely that the IRS would require strict adherence to the Code definition in order for the reimbursement of moving expenses to be acceptable. As long as the individual expenses are reasonable, and are directly related to the relocation of the physician to the hospital's service area, reimbursement of moving expenses should remain consistent with the requirements for exemption.

8. *Net income guarantee.* The eighth technique deemed acceptable by the IRS is the provision of a net income guarantee (after reasonable expenses) for a limited number of years and in an amount consistent with relevant regional or national income surveys. This is a major step forward that answers the questions raised after IRS's 1986 memorandum on income

guarantees.[93] Income guarantees are the most popular recruitment technique in use by hospitals, and this position provides substantial comfort to hospitals that they may use such incentives.

One key to the IRS's position is that the expenses incurred by the physician must be reasonable. Otherwise, a guarantee structured as a net income guarantee runs the risk of providing a windfall benefit to the physician since the physician would have an incentive to run up expenses, thereby increasing the amount of subsidy to be paid by the hospital. While putting a cap on the total amount of subsidy that can be provided under a net income guarantee (or a cap on the amount of expenses that will be recognized for purposes of the net income guarantee) is an effective means of ensuring the guarantee will remain acceptable, it does not appear that it will be necessary to do so in all cases. The IRS has publicly stated that the key is whether the overall guarantee is reasonable, and that a cap is not the only means of achieving that goal. Since a gross income guarantee has an inherent cap on the subsidy to be provided (the expenses of the physician are not at issue), presumably this type of income guarantee would also be acceptable to the IRS under this analysis.

While the revenue ruling does not address repayment of the income guarantee subsidies, the IRS has historically required an unconditional obligation to repay any amount advanced by the hospital. This was the position taken by the IRS both in the Hermann Hospital Closing Agreement and in the Hospital Audit Guidelines. The ruling is also silent on the use of a forgiveness provision; however, this should remain acceptable, as evidenced by the IRS's position in the Hermann Hospital Closing Agreement and in the Hospital Audit Guidelines. This was also deemed acceptable in two unpublished private letter rulings.[94]

In sum, through these eight techniques, the IRS has approved the majority of the mainstream recruitment techniques in use by health systems. It is important to remember that the IRS will look at the totality of the physician recruitment package to determine whether it is reasonable, and the mere fact that any one technique is reasonable does not mean that the entire recruitment package will be viewed in the same fashion. In that regard, it is instructive to see how the IRS has combined particular techniques in the four factual situations since they implicitly suggest that those particular combinations of incentives would be acceptable by the IRS under the factual circumstances described therein.

93. Gen. Couns. Mem. 39498.
94. 3 *Exempt Org. Tax Rev*. 330 (May 1990); unreleased IRS Private Letter Ruling on Physician Recruitment Incentives, Bureau of National Affairs Tax Core, June 9, 1999.

It is also noteworthy that in the factual situations set forth, the IRS has approved of the use of physician recruitment incentives to recruit a physician either already serving the community served by the hospital or already practicing on the recruiting hospital's medical staff. In the first instance, in Situation 4, the IRS approved the use of incentives by a hospital to recruit a physician to cover its radiology department where the physician was already providing such services in the same community. The IRS has made it clear in its public comments that it will not look kindly upon the ''stealing'' of physicians and that it will not approve incentives used to recruit physicians simply because of their ''marquee'' value, where the community does not gain the advantage of any new physician services being provided. Under this narrowly defined factual situation, community need was established in that two of these specialists that had been at the hospital had relocated outside of the area. Without the recruitment of this particular physician, the hospital would have insufficient coverage of its radiology department and the quality of care in that department would have been at risk. Thus, in situations where community need is clearly demonstrated, it apparently will be acceptable for a hospital to provide incentives to a physician already located in the hospital's service area. An IRS official has also pointed out that the fact pattern involved a radiologist, a specialist who normally does not make referrals but only receives them, and therefore patient referral patterns would be unaffected by the recruitment.

In Situation 3, the hospital's community needs assessment indicated that indigent patients were having difficulty obtaining access to care because of the shortage of obstetricians that were willing to treat Medicaid and charity care patients in the hospital's service area. Under those circumstances, the hospital was permitted to provide an incentive to a physician already serving on its medical staff in exchange for that physician's agreement to treat a reasonable number of Medicaid and charity care patients. This is not a retention technique; rather, it is an effort by the hospital to further its charitable purposes of promoting the health of the community by securing needed physician services to treat Medicaid and charity care patients.

Finally, the IRS identified one scenario it deemed unacceptable and inconsistent with the requirements for exemption for charitable organizations. In Situation 5, the IRS described recruitment activities that violated the Medicare and Medicaid antikickback statute. The provider was found guilty in a court of law for having violated this federal statute. Under these circumstances, the activity was unlawful and contrary to public policy and therefore was inconsistent with charitable operation. This position follows directly from the IRS's extensive analysis of activity that violates the Medicare and Medicaid antikickback statute in a 1992 memorandum.[95] While no one can legitimately argue that such physician recruitment activities are consistent with exemption,

95. Gen. Couns. Mem. 39862.

this position would seem to have little utility in determining when physician recruitment activities are sufficiently contrary to the requirements of the antikickback statute to warrant being inconsistent with the requirements for exemption. Most healthcare provider activities that are allegedly in violation of the antikickback statute are not ultimately found to be so in a court of law. Rather, in the usual case, the parties enter into a settlement of the charges, and some fines may be paid by the provider. Thus, it remains to be seen when the line will be crossed that activities that are inconsistent with the antikickback statute will be deemed sufficiently contrary to public policy that they will not be consistent with charitable operation.

This is a real problem for healthcare providers because of their regulation by two very different agencies, the IRS and the OIG. As has been apparent from IRS guidance, and the public comments of officials from the two agencies, the IRS and the OIG are often at odds with regard to what constitutes permissible activity. Indeed, the IRS takes the position in this revenue ruling, as it has elsewhere, that it is not making any determination as to whether the activities it approves are lawful under the Medicare and Medicaid antikickback statute. Several of the physician recruitment incentives approved in the revenue ruling would constitute *questionable* practices under the analysis of the OIG Special Fraud Alert on hospital incentives to physicians. Thus, charitable healthcare organizations will have to continue walking the tightrope in trying to satisfy the competing agendas of these two agencies.

It is noteworthy that the IRS moved away from its prior ruling position that mere membership on a hospital's medical staff is sufficient to cause a physician to be treated as an *insider* for purposes of applying the private inurement proscription. In the factual background section of the revenue ruling, the IRS states that none of the physicians described in the ruling are disqualified persons or insiders. Yet in each case, the physician would be joining the medical staff of the hospital that is recruiting him or her. The IRS ultimately adopted the more liberal view espoused in the legislative history to the intermediate sanctions legislation that only physicians with substantial influence over the affairs of the hospital are *insiders* or disqualified persons.

Another area of concern for providers had been whether the board of directors is required to approve every recruitment arrangement, an arduous task in a large health system. The fact patterns of the ruling indicate that if the board has established guidelines for recruitment (which it regularly monitors and reviews) that ensure that the recruitment is consistent with the hospital's exempt purposes, and if the recruitment agreement is approved by an officer of the hospital authorized by the board to enter into a contract on the hospital's behalf, that will be sufficient.

Finally, it is interesting to note that the IRS had always cast aspersions on hospitals recruiting from other hospitals in the same community, arguing that no benefit accrued to the community from merely changing the location

of the same physician. In the proposed version of the physician recruitment revenue ruling, cross-town recruiting was permitted under a very narrow fact pattern involving a specialty care unit and IRS officials were quick to limit the availability of this scenario in their public comments. However, in the final version, the fact pattern was changed to cross-town recruiting for diagnostic radiologists, a mainstream area of physician practice. The indication is that cross-town recruiting, where there is objective evidence of need *for the recruiting facility*, is permissible. IRS officials and some commentators have pointed out that the use of a radiologist, a nonreferring physician, was an important part of the fact pattern because patient referral patterns would not be affected by the recruitment. However, this qualification seems irrelevant here. The effect on patient referral patterns presumably is an issue for the OIG and the antikickback statute, for which the IRS has expressly disclaimed any responsibility. Previously, the IRS had dwelled on the fact that there were no additional physician services being created in a cross-community recruitment. Thus, the real issue would seem to be the definition of *community*, and the reality that hospitals in the same city may serve very different communities.[96]

The IRS has applied the principles contained in its 1997 revenue ruling in subsequent guidance that reveals their flexibility. On July 31, 1998, the IRS issued a private letter ruling to a hospital regarding whether certain proposed physician recruitment activities would adversely affect the organization's exempt status as a charitable organization. This ruling was not published by the IRS but was later made public in several trade publications.[97] Under the facts of the ruling, the charitable organization was a nonprofit tertiary care hospital that focused on establishing a geographically dispersed integrated healthcare delivery and financing system. In May 1994, it had adopted strategic initiatives that called for the development of affiliations with networks or primary care physicians. The hospital developed a relationship with a certain group of primary care physicians who wished to be affiliated with the hospital but did not wish to sell or otherwise seek control over their medical practices to the hospital.

As a part of this relationship, the physician group committed to recruit additional primary care physicians to the community served by the hospital, and the hospital agreed to assist in those recruitment activities subject to compliance with the policies adopted by its board of directors. The hospital had performed a community needs assessment in 1997 that indicated that by 2000, its medical staff would need a large number of additional primary care physicians and other underrepresented physician specialists to serve its patient population.

96. *See* White, ''A New Revenue Ruling Brings Precedential Guidance to Physician Recruitment,'' 9 *J. Tax. Exempt Orgs*. (No. 3) 100 (Nov./Dec. 1997); Mancino, ''Final Physician Recruitment Ruling Provides Welcome Guidelines,'' 87 *J. Tax*. (No. 1) 50 (July 1997).

97. *See*, e.g., BNA, *Daily Tax Report*, June 9, 1999, at G-5.

In order to further its charitable objectives, the hospital's board approved and funded certain physician recruitment incentives. The board of directors limited its provision of recruitment incentives to physicians whose services were not currently available within its service area or who were graduates of a physician-training program (dubbed *new physicians*). Further, the board required documentation of demonstrable community need for the recruitment of such physicians. Authorized recruitment incentives included income guarantees not to exceed three years, relocation assistance, and signing bonuses, all under reasonable terms. Financial assistance provided to an existing physician practice that was recruiting a physician was limited to no more than 50 percent of the total assistance provided to the physician.

The hospital sought a ruling from the Internal Revenue Service because it wanted to broaden the scope of its physician recruitment activities to respond more fully to the need for additional physicians in the community. It wanted to recruit new physicians, regardless of whether they joined the group with which the hospital had a relationship or another established physician group. The hospital also wished to offer support to certain physicians who had maintained a practice in the hospital's service area for less than four years but who had not established a meaningful practice and had expressed an interest in relocating to a practice site in proximity to one of the hospital's community health centers.

Under the proposal, the physician recruitment agreements would be negotiated at arm's length and for fair market value. The hospital would provide an income guarantee for up to three years to new physicians, and for currently practicing physicians it would provide an income guarantee for one year commencing on the date of relocation of the practice site. New physicians could also receive a signing bonus, reimbursement of reasonable relocation expenses, a onetime marketing payment, and other incentives that were deemed reasonable taking into account all relevant facts and circumstances. Currently practicing physicians could also be given a financial incentive, loan, or advance to permit them to terminate any preexisting office space lease obligations. The income guarantees would be structured as net income guarantees (i.e., they covered monthly gross receipts for professional services, less certain actual and reasonable direct and indirect costs). The hospital represented that the guaranteed amount would be objectively reasonable falling within the range reflected in regional and national surveys regarding income earned by physicians in the same specialty. The physicians would agree to become and remain members of the medical staff and perform certain medical staff administrative duties. Nothing in the agreement would restrict or prevent the recruited physicians from obtaining staff privileges at other facilities or making referrals to other facilities.

Amounts advanced under the physician recruitment agreements would be treated as a loan and would bear interest at a fixed rate equal to the applicable

federal rates, compounded monthly. If the recruited physicians' net income exceeded the guaranteed amount in any calendar month, then to the extent there was a balance due under the loan, the recruited physician would be obligated to repay the difference. Each loan was to be evidenced by a written promissory note. Under the terms of these notes, the physicians would be required to repay the balance due at the end of the guarantee period over a 36-month term; however, some of the obligation could be discharged through the continued maintenance of a full-time medical practice in the community. The balance due would be forgiven on a prorata basis for each full month of medical practice.

The IRS ruled that the hospital's forgiveness of the entire amount used to recruit new physicians would not adversely affect its continuing status as a tax-exempt charitable organization and that the extension of the income guarantee and other recruitment incentives described above to physicians already practicing in the community under these unique circumstances would not adversely affect its continuing status as a tax-exempt charitable organization, provided that such payments also comply with the Medicare and Medicaid antikickback laws.

This private letter ruling substantially follows the facts-and-circumstances analysis set forth by the IRS in 1997 in its guidance on physician recruitment activities.[98] While it does not represent a sea change in the thinking of the IRS, it does fill in some of the gaps and provides concrete examples of the types of recruitment incentives that the IRS deems acceptable under appropriate factual circumstances. It is of particular interest in that retention benefits were approved by the IRS (i.e., benefits to physicians already serving in the community), albeit under a limited factual scenario. Also significant is the IRS's comfort level with recruitment activities carried out in conjunction with existing physician groups, a practice that the IRS was not enamored of in the Hermann Hospital Closing Agreement.[99] It should be noted, however, that as to providing recruitment benefits to physicians already practicing in the community, a hospital would face a substantial hurdle in overcoming the restrictions imposed by the Stark anti-self-referral law, which does not except benefits provided to physicians who have not geographically relocated to the community.

98. Rev. Rul. 97-21.
99. *See supra* § 25.6.

CHAPTER TWENTY-SIX

Charity Care

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§ 26.1 INTRODUCTION

Since their inception in this country in the eighteenth century, hospitals have been expected to care for the healthcare needs of the poor.[1] In an interpretation of the Internal Revenue Code, the Internal Revenue Service at one time administratively required that nonprofit hospitals provide charity care as a condition of recognizing them as charitable organizations. The Code has no express requirement for the provision of charity care, however, and the IRS ultimately eliminated charity care as a requirement for recognizing exemption. The *community benefit standard*, adopted in 1969, has served as the criterion instead.

Yet, as the healthcare needs of the indigent, the uninsured, and the underinsured grow, and the federal government (and, increasingly, state and

1. *See Eastern Kentucky Welfare Rights Organization v. Simon*, 506 F.2d 1278, 1288, note 19 (D.C. Cir. (1974), *vacated on other grounds*, 426 U.S. 26 (1976)).

local governments) grapple with ways to meet those needs, the debate over hospital charity care has returned to center stage.[2]

§ 26.2 THE FINANCIAL ABILITY STANDARD

The Internal Revenue Code does not expressly state that the provision of hospital services constitutes operation as a charitable organization. Not until 1956 did the IRS establish administrative standards to be used in determining whether to recognize hospitals as charitable tax-exempt entities. The following general requirements were established in a revenue ruling[3]:

(1) the hospital must be organized as a nonprofit charitable organization, the purpose of which is to operate a hospital which cares for the sick;

(2) the hospital must be operated so that services are provided, to the extent of its financial ability, to those who are not able to pay and not exclusively to those who are able and expected to pay;

(3) the use of the hospital's facilities must not be limited to a particular group of surgeons and physicians, such as a medical partnership or association, to the exclusion of all other qualified doctors; and

(4) the hospital's net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual.

In elaborating on the financial ability criterion (item 2 above), the IRS stated:

> It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and additions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from

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2. Some recent statistics (August 2006) are helpful in identifying the scope of the problem. In 2005, 46.6 million people were without health insurance coverage, up from 45.3 million people in 2004. The percentage of people without health insurance coverage increased from 15.6 percent in 2004 to 15.9 percent in 2005. The percentage and the number of children (people under 18 years old) without health insurance increased between 2004 and 2005, from 10.8 percent to 11.2 percent and from 7.9 million to 8.3 million, respectively. See DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-231, ''Income, Poverty, and Health Insurance Coverage in the United States: 2005'' (U.S. Government Printing Office, Washington, D.C.).
3. Rev. Rul. 56-185, 1956-1 C.B. 202.

all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.[4]

§ 26.3 THE COMMUNITY BENEFIT STANDARD

The IRS expressly eliminated the financial ability criterion[5] when it adopted the broader ''community benefit'' standard in 1969.[6] A revenue ruling used two examples to illustrate whether a nonprofit hospital claiming tax exemption as a charitable organization is operated to serve a public rather than a private interest:

Hospital A is a 250-bed community hospital. It provides hospital care on a nonprofit basis for members of its community, operates an open emergency room, and does not deny treatment to any person requiring emergency care. It limits hospital admissions, in general, to those persons able to pay for the cost of such care, either directly or through third-party reimbursement. The hospital uses its annual surplus of receipts to improve the quality of patient care; advance its medical training, education, and research programs; and expand its facilities. The hospital's board of trustees, consisting of independent civic leaders, controls the hospital. It maintains an open medical staff with privileges available for all qualified physicians consistent with the size and nature of its facilities. Members of the active medical staff can lease available space in the hospital's medical building at rates comparable to those of other commercial buildings in the area. Because these factors indicate that Hospital A is operated to serve public and not private interests, the IRS ruled that Hospital A is exempt from federal income tax as a charitable organization.

Hospital B is a 60-bed general hospital originally owned by five doctors. Its ownership has been transferred to a nonprofit organization. The hospital's original owners continue to exercise a significant amount of control over the hospital through their control of the board of trustees and the medical committee. They have used their control to restrict the number of doctors admitted to the medical staff, enter into favorable rental agreements with the hospital, and limit emergency room care and hospital admissions substantially to their own patients. Because of these factors, the IRS ruled that Hospital B is operated for the private benefit of its original owners and not for the exclusive benefit of the public. Therefore, it does not qualify for exemption from federal income tax as a charitable organization.

Significantly, the 1969 revenue ruling took the position that providing hospital care on a nonprofit basis for members of the community, operating an open emergency room, and providing hospital care to all persons in the community able to pay the cost of the services constitute the promotion of

4. *Id*. at 203.
5. Rev. Rul. 56-185 was modified but not superseded.
6. Rev. Rul. 69-545, 1969-2 C.B. 119.

health of a class of persons broad enough to benefit the community, which is a ''charitable'' purpose in the generally accepted legal sense of the term.[7] The ruling stated that qualification for exemption is based on the facts and circumstances of each case, and modified the 1956 revenue ruling to remove the requirements for exemption relating to caring for patients without charge or at rates below cost.

An attempt was made to invalidate the 1969 revenue ruling in federal court and to reinstate the financial ability standard.[8] The D.C. Circuit reversed the plaintiffs' District Court victory, however, and held that the definition of charity can be defined far more broadly than merely the relief of the poor.[9]

Notwithstanding its 1969 ruling, the IRS frequently in practice has asked hospitals to detail the amounts and manner in which they will provide charity care when they request IRS advice on transactions such as joint ventures or during field audits. In 2001, the IRS issued field service advice (FSA) to its agents on the issue of whether a hospital whose stated policies are to provide healthcare services to individuals regardless of their ability to pay satisfies the charity care requirement of the community benefit standard developed by the IRS in 1969.[10] The IRS concluded that a hospital's stated policies are not sufficient to satisfy the charity care requirement of the community benefit standard unless the hospital demonstrates that such policies actually result in the delivery of significant healthcare services to the indigent.

The FSA suggests the extent to which the IRS's interest has been piqued. In the FSA, the IRS offers the following 14 questions for field agents to ask of hospitals:

1. Does the hospital have a specific, written plan or policy to provide free or low-cost healthcare services to the poor or indigent?

2. Under what circumstances may, or has, the hospital deviated from its stated policies on providing free or low-cost healthcare services to the poor or indigent?

3. Does the hospital broadcast the terms and conditions of its charity care policy to the public?

4. Does the hospital maintain and operate a full-time emergency room open to all persons regardless of their ability to pay?

5. What directives or instructions does the hospital provide to ambulance services about bringing poor or indigent patients to its emergency room?

7. Restatement (Second) of Trusts § 368, comment b, and § 372, comments b and c; IV Scott on Trusts §§ 368 and 372.2 (3d ed. 1967).
8. *Eastern Kentucky Welfare Rights Organization v. Simon*, 370 F. Supp. 325 (D.D.C. 1973).
9. *Eastern Kentucky Welfare Rights Organization v. Simon, supra* note 1.
10. FSA 200110030.

6. What inpatient, outpatient, and diagnostic services does the hospital actually provide to the poor or indigent for free or for reduced charges?
7. Under what circumstances does the hospital deny healthcare services to the poor or indigent?
8. Does the hospital operate with the expectation of receiving full payment from all persons to whom it renders services?
9. How and when does the hospital ascertain whether a patient will be able to pay for the hospital's services?
10. What documents or agreements does the hospital require poor or indigent patients to sign before receiving care?
11. What is the hospital's policy on admitting poor or indigent patients as inpatients and outpatients?
12. Under what circumstances does the hospital refer poor or indigent individuals who require services to other hospitals in the area that do admit poor or indigent patients?
13. Does the hospital maintain separate and detailed records about the number of times, and circumstances under which, it actually provided free or reduced-cost care to the poor or indigent?
14. Does the hospital maintain a separate account on its books that segregates the costs of providing free or reduced-cost care to the poor or indigent? Does this account include any other items, such as write-offs for care to patients who were not poor or indigent?

§ 26.4 THE EMERGENCY ROOM EXCEPTION

The IRS pointed out in its 1969 revenue ruling that the absence of a particular factor set forth in the ruling as a basis for exemption would not necessarily be determinative. This was borne out in a subsequent revenue ruling,[11] in which the absence of an open emergency room was not *per se* fatal to exemption. The hospital in this ruling is identical to Hospital A described in the 1969 revenue ruling, except it does not operate an emergency room because the state health planning agency made an independent determination that providing such a facility would be duplicative and unnecessary. Although the hospital cannot show evidence of promoting the health of a significantly broad class of persons by operating an open emergency room, the hospital can prove it is operating exclusively to benefit the community by: (1) maintaining an open medical staff policy; (2) treating persons who pay their bills through Medicare and Medicaid; (3) applying any surplus receipts to improve patient care, facilities, equipment and medical training, education, and research; and

11. Rev. Rul. 83-157, 1983-2 C.B. 94.

(4) selecting its board of directors from the community. Because the hospital adheres to those policies, the IRS ruled that the nonprofit hospital in question qualifies for exemption from federal income tax as a charitable organization.

By also citing the example of specialty hospitals that typically do not have a demonstrated need for emergency care, the ruling suggests that there may be other circumstances where the lack of an open emergency room will not be fatal to exemption, but such circumstances are not likely to be found often by the IRS.

§ 26.5 LEGAL CHALLENGES TO HOSPITAL CHARITY CARE PRACTICES

The charity care debate returned to the courtroom in 2004. The issue was the centerpiece of lawsuits filed in federal courts across the country challenging the charity care policies and billing practices of charitable tax-exempt hospitals. The suits, for which class action status was sought, all contained roughly the same claims.[12] With regard to the claims predicated on the hospital's tax-exempt status, the suits alleged:

- Charitable hospitals have an express and/or implied contract with the federal and state governments to provide mutually affordable medical care to indigent patients and not to seek to collect outstanding debt from these patients through ''aggressive, abusive, and humiliating collection practices'' in exchange for their tax exemptions; when they fail to avoid such practices, they are in breach of that contract.
- Under the express and/or implied contract theory, charitable hospitals have an implied contractual obligation that they will charge indigent patients no more than a fair and reasonable charge for medical care.
- When charitable hospitals charge indigent patients the full undiscounted cost of medical care, they are in violation of their tax-exempt status.
- Charitable hospitals should use their financial resources to provide a greater amount of mutually affordable medical care to indigent patients as a result of their tax-exempt status.
- By accepting federal, state, and local tax exemptions, charitable hospitals entered into a public charitable trust to provide mutually affordable medical care to their uninsured patients. These hospitals are in breach of their charitable trust obligations by failing to provide emergency room medical care to indigent patients without regard to their ability to pay,

12. *See generally* Lisa W. Clark, Katherine M. Kelton, and David Flynn, ''What May Arrive in Tomorrow's Mail?: An Analysis of Class Action Lawsuits Concerning Hospital Billing of Uninsured Patients,'' 13 *BNA Health L. Rep*. No. 31 (July 29, 2004), at 1134.

by charging these patients the highest undiscounted cost of medical care, by charging these patients more than they charge insured patients for the same services, by failing to use their net assets and revenues to provide mutually affordable medical care to indigent patients, and by allowing noncharitable, for-profit entities (i.e., physicians) to derive a profit from use of the hospitals.

The principal legal theory behind these charity care suits has not been persuasive to the courts that have opined on it thus far. The federal courts that have weighed in on it have all found that the plaintiffs have failed to state causes of action, or at least no federal claim.[13] In a federal district court decision in Michigan, the court noted the defendant hospital's position that no court has ever held that a nonprofit organization enters into a contract with the United States when it qualifies for tax-exempt status as a charitable organization, and added that the court could not find such a case. The court distinguished claims made under the federal Hill-Burton program for providing charity care to uninsured patients. The court sided with the defendant hospital when the hospital raised as a defense its compliance with the community benefit standard, in response to the plaintiffs' claim that the hospital must provide mutually affordable medical care as a result of its status as a charitable organization:

> Beaumont also notes that Revenue Ruling 69-545 modified prior law to remove previous requirements "relating to caring for patients without charge or at rates below cost." Thus, Beaumont maintains, the Burtons' assertion that Beaumont must provide mutually affordable medical care as a § 501(c)(3) organization is without foundation and the Burtons therefore cannot maintain an action for third-party breach of contract. Beaumont is correct.[14]

The court also debunked the plaintiffs' allegations that the hospital entered into a public charitable trust to provide mutually affordable medical care to its uninsured patients when it attained its charitable tax-exempt status, and that the plaintiffs are the intended beneficiaries of the alleged charitable trust. The court found that the plaintiffs had not stated a claim to a private right of action to enforce an alleged contract flowing from the fact that the hospital is a charitable organization; thus, the claim had to be dismissed. Moreover, the court concluded that even if the plaintiffs were able to establish the existence

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13. *See*, e.g., *Burton v. William Beaumont Hospital*, No. 04-72735, 2004 WL 2790624 (E.D. Mich. Dec. 3, 2004); *Amato v. University of Pittsburgh Medical Center*, No. 04-1025 (W.D. Pa. Nov. 23, 2004); *Kizzire v. Baptist Health System, Inc.*, 343 F. Supp. 2d 1074 (N.D. Ala. 2004); *Darr v. Sutter Health*, No. 04-02624, 2004 WL 2873068 (N.D. Cal. Nov. 30, 2004); *Hudson v. Central Georgia Health Services*, No. 5:04CV301 (M.D. Ga. Jan. 13, 2005); *Lorens v. Catholic Health Care Partners*, No. 1:04CV1151 (N.D. Ohio Jan. 13, 2005); *Pollack v. Sutter Health*, No. 04-04263 (N.D. Cal. Jan. 7, 2005).
14. *Burton v. William Beaumont Hospital*, *supra* note 13.

of a charitable trust and a breach, they would not be the proper parties to prosecute the breach; rather, the attorney general would be the proper party.[15]

§ 26.6 DEFINITIONAL AND REPORTING ISSUES

In order to address the problem of indigent care, and to properly measure the charity care being provided by charitable hospitals, it would seem beyond debate that there must be a shared definition of what constitutes charity care. Regrettably, there is not. Indeed, not all parties agree that there should be a single definition, although consensus is closer than ever and discussion continues. The following are the current definitions of charity care and recommendations for reporting used by major participants in the effort:

(a) AICPA

The American Institute of Certified Public Accountants (AICPA)'s *Audit and Accounting Guide for Healthcare Organizations*[16] provides the following definition for charity care:

> *Charity care:* Health care services that never were expected to result in cash inflows. Charity results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria.

Chapter 10 of the *Guide on Revenue, Expenses, Gains, and Losses* offers the following discussion on distinguishing charity care from bad debt expense or allowance:

> 10.03 Charity care represents health care services that are provided but are never expected to result in cash flows. As a result, charity care does not quality for recognition as receivables or revenue in the financial statements. Distinguishing charity care from bad-debt expense (or allowance, for governmental health care entities) requires the exercise of judgment. Charity care is provided to a patient with demonstrated inability to pay. Each organization establishes its own criteria for charity care consistent with its mission statement and financial ability. Only the portion of a patient's account that meets the organization's charity care criteria is recognized as charity. Although it is not necessary for the entity to make this determination upon admission or registration of an individual, at some point the entity must determine that the individual meets the established criteria for charity care. (See paragraph 10.26 for disclosure requirements relating to charity care.)

With regard to reporting charity care, the *Guide* states:

> 10.27 As discussed in paragraph 10.03, patient service revenue does not include charity care. Management's policy for providing charity care, as well as the level of charity care provided, should be disclosed in the financial statements. Such

15. *Id.*
16. AICPA Audit and Accounting Guide—Healthcare Organizations (2004 ed.).

disclosure generally is made in the notes to the financial statements and is measured based on the provider's rates, costs, units of service, or other statistical measure.

(b) HFMA

The Healthcare Financial Management Association (HFMA) has been influential in developing standards for the proper treatment and reporting of charity care. HFMA's position on this issue[17] has been identified in IRS guidance as an appropriate benchmark for determining charity care.[18] HFMA approved a new version of this statement in 2006. Key principles in this version include the following:

Financial Reporting Disclosure

- Charity care disclosures should be based on cost, not charges.
- Revenue for patient services should be recognized only when it meets GAAP criteria, which include the existence of a payment agreement between the provider and the patient and reasonably assured collectibility.
- Bad debt should not be reported as charity care or community benefit.

Government Shortfalls

- Government shortfalls should not be included as a part of charity care.
- It is appropriate to report payment shortfalls in Medicaid or similar government programs for the indigent as a community benefit.
- Individual facilities must determine whether Medicare shortfalls are material to the facility's financial status and mission. If so, they should be separately reported, and may be included in the community benefits section.

Charity Care Determinations

- The patient's eligibility for charity care, including the timing of that eligibility, is based on the facility's charity care policy.
- Charity care eligibility decisions can be made at any time during the revenue cycle as pertinent information becomes available.
- Charity care policies should address how determinations should be made in the absence of financial information provided by the patient.

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17. Principles and Practices (P&P) Board's Statement No. 15: ''Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers.''
18. *See*, e.g., IRS determination letter issued to St. Luke's Medical Associates, Inc. (Dec. 30, 1994).

The statement also reinforces the P&P Board's longstanding position that although it is important to strive for comparability, efforts to standardize charity care criteria are unrealistic. In the P&P Board's view, each healthcare institution must establish its own criteria for charity care consistent with its mission, community needs, and resources, and with state law.

(c) GAO

The Government Accountability Office (GAO) has undertaken two broad studies of the provision of charity care by hospitals. The first study[19] was published in 1990. This study, at the request of the House Select Committee on Aging, was one of the first substantive efforts to reexamine the role of providing uncompensated care in qualifying for tax exemption since the IRS adopted its community benefit standard in 1969. The GAO found that in the five states it examined, government-owned hospitals provided a disproportionate amount of uncompensated care. Both nonprofit and for-profit hospitals provided a smaller share of the states' uncompensated care than they provided of general hospital services. The GAO also found that the burden of uncompensated care was not distributed equally among the nonprofit hospitals in those states. Large, urban teaching hospitals had a higher share of the uncompensated care expense than did other nonprofit hospitals. Among the rest of the nonprofit hospitals, the tendency was for those hospitals with the highest operating margins to have the lowest rates of uncompensated care. The GAO noted that variations in uncompensated costs can be attributed both to the hospitals' geographical locations and to their particular operating policies, such as admissions practices.

A second study, released in 2005,[20] was requested by the House Ways and Means Committee, which held hearings on the subject. The second study was largely an updating of the first and undertook a similar analysis. In this study, the GAO defined uncompensated care as the sum of charity care and bad debt costs as reported in the data of the five states they reviewed. To determine uncompensated care costs, the GAO multiplied uncompensated care charges by a hospital-specific cost-to-charge ratio. The GAO noted that although specific definitions of charity care varied, states generally defined it as charges for patients deemed unable to pay all or part of their bill, less any payments made by, or on behalf of, that specific patient. States generally defined bad debt as the uncollectible payment that a patient is expected to but does not pay. The GAO's definition of uncompensated care did not include any contractual allowances or cost shortfalls (with contractual allowances

19. ''Nonprofit Hospitals: Better Standards Needed for Tax Exemption,'' GAO/HRD-90-84 (May 30, 1990).
20. ''Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits,'' GAO-05-743 T (May 26, 2005).

defined as the difference between a hospital's full charges for a service and the payment it has agreed to accept for that service from a particular insurer, and cost shortfalls as the difference between the accepted payment for a service and the actual cost of that service, in the case that the payment is less than the cost). The GAO also did not subtract any charity care–specific block grants or donations a hospital may receive, as that information was not available for all states. The GAO again found that government hospitals generally devoted substantially larger shares of their patient operating expenses to uncompensated care than did nonprofit and for-profit hospitals. It also found that the nonprofit groups' share was higher than that of the for-profit groups in four of the five states, but that the difference was small relative to the difference found when making comparisons with the government hospital group. It also found again that the burden of uncompensated care costs was not evenly distributed among hospitals but instead was concentrated in a small number of hospitals. As a result, a small number of nonprofit hospitals accounted for substantially more of the uncompensated care burden than did other charitable hospitals.

(d) CHA/VHA

The Catholic Health Association and Volunteer Hospitals of America have undertaken a tremendous effort to assist charitable hospitals in identifying, measuring, and reporting community benefit, including charity care. They define charity care as follows:

> *Charity Care:* Free care and discounted care given to persons deemed unable to pay based on established financial assistance policies. Charity care does not include bad debt. It should be reported in terms of costs, not charges.
>
> *Bad Debt:* Uncollectible charges, excluding contractual adjustments, arising from the failure to pay by patients whose health care has not been classified as charity care. Bad debt is not community benefit.

CHA takes the position that charity care is properly reported on the basis of costs rather than charges because uncollected charges overstate the actual cost of providing care. In addition, reporting charges can distort comparisons of healthcare facilities because of differences in the ''markup'' of charges over costs.[21] The *Guide* provides a methodology for calculating the cost of charity care being provided. CHA also takes the position that only Medicaid cost shortfalls should count as charity care. Charge and cost shortfalls in other federal programs do not count.

21. *See* ''A Guide for Planning and Reporting Community Benefit,'' Catholic Health Association, developed in cooperation with VHA, Inc., 2006. Some portions of the guide are available on the CHA web site at www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/TheGuide/.

(e) AHA

The American Hospital Association (AHA) has issued a Statement of Principles and Guidelines on Hospital Billing and Collection Practices that it states have been adopted by over 4,200 hospitals. The statement provides as follows regarding charity care and patient billing practices:

Making Care More Affordable for Patients with Limited Means

- Hospitals should review all current charges and ensure that charges for services and procedures are reasonably related to both the cost of the service and to meeting all of the community's health care needs, including providing the necessary subsidies to maintain essential public services.
- Hospitals should have policies to offer discounts to patients who do not qualify under a charity care policy for free or reduced cost care and who, after receiving financial counseling from the hospital, are determined to be eligible under the hospital's criteria for such discounts (pending needed federal regulatory clarification). Policies should clearly state the eligibility criteria, amount of discount, and payment plan options.

Ensuring Fair Billing and Collection Practices

- Hospitals should ensure that patient accounts are pursued fairly and consistently, reflecting the public's high expectations of hospitals.
- Hospitals should define the standards and scope of practices to be used by outside collection agencies acting on their behalf and should obtain agreement to these standards in writing from such agencies.
- Hospitals should implement written policies about when and under whose authority patient debt is advanced for collection.[22]

In addition, in April 2006, the AHA Board of Trustees approved a new policy on Billing, Collection, and Tax-Exempt Status. The policy is aspirational in nature. The AHA states that it ''represent[s] AHA's strong statement of expectation—a more detailed direction in which the hospital and health system field can and should move on its own to address issues of billing, collection, increased accountability and tax-exempt status.''

The policy provides in relevant part:

Increased Financial Assistance for the Uninsured of Limited Means (Applies to All Hospitals)

- Provide financial assistance and counseling for uninsured people of limited means, without regard to race, ethnicity, gender, religion, or national origin.

22. Excerpted from ''Hospital Billing and Collection Practices,'' Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association (2004).

- Financial assistance provided by hospitals to uninsured people of limited means should in no way substitute for state efforts to provide or expand coverage to the uninsured. State Medicaid programs should be required, at a minimum, to sustain a ''maintenance of effort'' keeping programs' eligibility at least at their current levels. Further, state Medicaid programs also should be required to expand coverage to all individuals at or below the poverty level. Until that time, hospitals should have policies to provide services to uninsured patients below 100 percent of the federal poverty level at no charge. Existing clinical and geographical criteria used by hospitals to determine eligibility for certain services would apply.
- Provide financial assistance to all uninsured patients between 100 percent and 200 percent of the federal poverty level by asking them (based on a hospital's choice) to pay *no more than*:
  - A price paid to the hospital under contract by a public or private insurer; *or*
  - 125 percent of the Medicare rate for applicable services, given that in the aggregate today, Medicare pays less than the cost of care.

  For these patients, hospitals may choose to charge on a sliding scale up to the stated limits. Hospitals also may choose to provide greater assistance.
- May offer financial assistance to uninsured patients with incomes in excess of 200 percent of the federal poverty level at the discretion of the hospital.
- Hospital financial assistance is contingent upon the cooperation of a patient in providing the information necessary for a hospital to qualify that patient for its programs of assistance or for public or other coverage or assistance that may be available. Patients receiving financial assistance from hospitals shall have a responsibility to pay according to the terms of that policy.
- Cosmetic surgery and other nonmedically necessary services are exempt.
- Make information about a hospital's financial assistance policy easily available to the public.
- Hospitals that have financial assistance policies that meet or exceed those above shall have immunity from related class action lawsuits.

Ensuring Fair Debt Collection Practices (Applies to All Hospitals)

- If using outside debt collection organizations, obtain written assurances that the organization complies with the Fair Debt Collection Practices Act and the ACA International's Code of Ethics and Professional Responsibility.

- Have written policies as to when and under whose authority a patient account is advanced for collection. If a patient has completed a hospital's application for financial assistance, that account should not be advanced for collection pending determination of eligibility.
- Have written policies as to when and under whose authority a lien can be placed on a patient's primary residence.

Reporting Community Benefit (Applies to Nongovernment, Not-for-Profit Hospitals)

- Conduct a periodic community needs assessment, with a frequency to be determined by the hospital (can be done collaboratively with other community organizations).
- Assign responsibility for a community benefit plan to a hospital employee.
- Calculate community benefit for purposes of reporting using the Community Benefit Guidelines in CHA/VHA's *Community Benefit Reporting* document; when calculating community benefit for each category, however, hospitals should include direct and indirect costs of subsidized healthcare services, charity care, bad debt, and the unpaid costs of government-sponsored healthcare (including Medicaid, Medicare, and public and/or indigent care programs).
- Report community benefit, as calculated above, as an attachment to the Form 990.[23]

§ 26.7 IRS COMPLIANCE CHECK AND FORM 990 REDESIGN

The IRS has undertaken a major effort to determine the level of compliance by charitable hospitals with the community benefit standard, including the provision of charity care.[24] In the spring of 2006, the IRS issued a Compliance Check Questionnaire for Tax-Exempt Hospitals, a nine-page questionnaire designed to derive information regarding the operations of charitable hospitals particularly with regard to their charity care and compensation practices. Questions related to charity care included: how many patients had Medicare, Medicaid, insurance, or no insurance; did the hospital deny medical services to individuals; did the emergency room provide services to all members of the community regardless of their ability to pay; did the hospital have a written uncompensated care policy; how many individuals received uncompensated care; how much did the hospital spend on uncompensated care; did the hospital treat bad debts as uncompensated care; and various questions regarding the hospital's billing practices.

23. Excerpted from Special Bulletin, AHA Policy Statement, ''Hospital Billing, Collection and Tax-Exempt Status,'' May 1, 2006.
24. *See* § 6.3.

On July 19, 2007, the IRS released an interim report summarizing the responses received from the Compliance Check.[25] The IRS found that the hospitals reported similar information in different ways, and that there is variation in the level of expenditures hospitals report in furtherance of community benefit, particularly with regard to uncompensated care. Examples included use by hospitals of a range of income and asset criteria to establish eligibility for uncompensated care and variance in measurement of bad debt expense and shortfalls between actual costs and Medicare or Medicaid reimbursements. Variance was also found in the use of costs and charges in the measurements.

The Interim Report found that in the aggregate, uncompensated care accounted for 56 percent of the total community benefit expenditures reported by the hospitals; however, significant variations were found in how hospitals reported uncompensated care. It was reported that 97 percent of hospitals replied they had a written uncompensated care policy. The treatment of bad debt expense as uncompensated care was mixed: 56 percent of the hospitals reporting said they did not include bad debt expense as uncompensated care, and the remaining 44 percent included at least some bad debt expense as uncompensated care; 97 percent of the hospitals reported making uncompensated care available to at least some persons.

Of the hospitals that responded, 90 percent did not deny medical services to any individuals who lacked insurance; an even greater percentage did not deny medical services to any individuals who were covered by government programs or private insurance. All responding hospitals that operated an emergency room reported that their emergency room provided services to all regardless of their ability to pay.

The Compliance Check informed the IRS's redesign of the Form 990, effective for the 2008 tax year, which now requires specific and detailed disclosures by hospitals regarding their provision of charity care. Schedule H of the Form 990 requires in Part I the disclosure of charity care and other community benefits at cost. It inquires as to how charity care policies are applied across multiple hospitals; what level of federal poverty guidelines are used to determine eligibility for free or discounted care; how much is budgeted by the hospital for free or discounted care; and calculation of charity care, unreimbursed Medicaid, and other unreimbursed costs from means-tested government programs.

§ 26.8 FEDERAL LEGISLATIVE INITIATIVES

Congress occasionally seeks to establish a formal requirement for the provision of charity care by healthcare providers seeking tax-exempt status. The following bills, none of which were enacted into law, are typical of such efforts.

25. www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf.

(a) H.R. 790: The Roybal Bill

On February 4, 1991, Rep. Edward R. Roybal (D-CA) introduced the ''Charity Care and Hospital Tax-Exempt Status Reform Act of 1991'' (H.R. 790). This bill would require, as a condition of qualifying for tax-exempt status under Code section 501(c)(3), that hospitals have an open-door policy toward Medicare and Medicaid patients and that they serve a reasonable number (under the facts and circumstances) of Medicare and Medicaid patients on a nondiscriminatory basis and furnish documentation of same. These hospitals would also be required to furnish, in a nondiscriminatory manner, an amount of qualified charity care equal to at least 50 percent of the value of their tax-exempt status for the taxable year. Qualified charity care costs would include: (1) the amount of free or discounted care to those unable to pay; (2) the amount written off as bad debt; (3) Medicaid allowances; and (4) if the community has too few charity care patients, the amount incurred for furnishing healthcare and other health-related services for the purpose of improving the health of the medically disadvantaged or underserved in the community.

Hospitals would also be required to furnish and document, on an annual basis, other unreimbursed qualified community benefits equal to an amount that is at least 35 percent of the value of their tax-exempt status. The community benefits must be those that, for the most part, would not otherwise be provided by non-tax-exempt hospitals. Charity care costs in excess of 50 percent of the value of the hospital's exempt status could also be counted in this category.

The value of a hospital's tax-exempt status would be based on a *national target percentage* of gross revenues set at a level to allow at least 75 percent of private tax-exempt hospitals to meet the bill's requirements. (The 75 percent standard can be modified on a case-by-case basis.) To enforce these provisions, an excise tax would be imposed on hospitals found to be out of compliance with the provisions of the Act. When the IRS first determines that a tax-exempt nonprofit hospital has failed to comply with these requirements in the reported year, it must notify the hospital and publish a notice in the *Federal Register* indicating that the hospital has failed to comply. If the hospital fails to comply the following year, the IRS could impose a 100 percent excise tax on the amount by which the value of the hospital's tax-exempt status exceeds the value of charity care and other community benefits furnished. The IRS could also increase the amount of the excise tax to 1 percent of the amount of the hospital's total gross receipts, if there existed unusual circumstances warranting a higher sanction. The IRS could revoke the tax-exempt status of a hospital in the case of an *egregious failure* to meet the Act's requirements.

A hospital requesting IRS recognition of its tax-exempt status would be required to forward a complete copy of its request for tax exemption to the state in which it is located and to forward to the IRS the state's comments regarding the status of the hospital's compliance with the Act.

(b) H.R. 1374: The Donnelly Bill

On March 12, 1991, Rep. Brian Donnelly (D-MA) introduced a bill (H.R. 1374) that would create new requirements for the provision of charity care by tax-exempt hospitals. A hospital would not be recognized as exempt from federal income tax if a substantial portion of its activities consisted of operating a *nonqualified hospital*. To avoid such classification, a hospital would have to provide (1) an open emergency room, (2) service to Medicaid patients without discrimination, and (3) charity care or other community benefits.

More specifically, hospitals would be required to operate full-time emergency rooms and to provide emergency care to all patients requiring such care, regardless of their ability to pay for such services. A hospital would be excluded from this requirement if a state agency made an independent determination that operating an emergency room would be duplicative or unnecessary, or if the facility is a specialty hospital that does not operate an emergency room and is not a prospective payment hospital under Medicare.[26]

Hospitals would also be required to maintain a Medicaid provider agreement with the state in which they are located. This requirement would be violated if a hospital consistently refused to furnish covered services to persons eligible for services under Medicaid. Hospitals that have their Medicare or Medicaid provider agreements terminated or suspended, or that receive multiple civil monetary penalties for violation of the COBRA antidumping provisions, would be out of compliance with the above requirements.

In addition to these requirements, tax-exempt hospitals would have to meet at least one of the following criteria: (1) the hospital is a sole community hospital; (2) the hospital receives additional Medicare or Medicaid payments because of its disproportionate share of low-income patients; (3) the hospital's disproportionate patient percentage is within one standard deviation of the mean of all disproportionate patient percentages of all hospitals in the geographical area of the hospital used for the Medicare wage adjustment; (4) the hospital allots at least 5 percent of its gross revenues to charity care (charity care does not include contractual allowances or bad debt, but does include contributions to a charity care pool); or (5) the hospital allots at least 10 percent of its gross revenues to *qualified services and benefits*, including services provided by a community health center or a substance abuse clinic in a medically underserved area.

If a hospital becomes classified as a nonqualified hospital for failure to have an open emergency room or for failure to maintain a Medicaid provider agreement, it will lose its tax-exempt status for at least two years. The hospital could reapply for tax-exempt status after the later of (1) the earliest date on which the emergency care and Medicaid provider agreement requirements are once again met, or (2) two years after the hospital is first determined a nonqualified hospital.

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26. *Cf.* Rev. Rul. 83-157, 1983-2 C.B. 94.

A hospital that is declared a nonqualified hospital because of its failure to fulfill at least one of the criteria to make qualified expenditures for community benefits could choose, as an alternative to losing its tax-exempt status, a penalty equal to 10 percent of the amount by which 10 percent of the hospital's gross revenues for the taxable year exceeds the cost of charity care provided during the first year. A 100 percent rate would apply for each following year with respect to the same failure.

Additional consequences of losing tax-exempt status by becoming a nonqualified hospital include losing eligibility to receive deductible charitable contributions, and losing the ability to use tax-exempt financing in the future.

Detailed additional reporting requirements for tax-exempt hospitals are provided, such as requiring a hospital to include a description of the nature of, and the hospital's costs for, uncompensated care furnished by the hospital during the year, as well as a description of the hospital's activities that benefit the community.

(c) H.R. 6420: The Thomas Bill

On December 8, 2006, Representative Bill Thomas, Chairman of the House Ways and Means Committee, introduced a bill that would bring into law the Tax Exempt Hospitals Responsibility Act of 2006.[27] Under this bill, Federal excise taxes would be imposed on charitable providers of medical and hospital care for failure to provide medically necessary care to low-income, uninsured individuals; for overcharging for specified medically necessary care to such individuals; and for failure to disclose charitable medical care information and negotiated charges. This bill was the result of hearings held by the Ways and Means Committee in 2005 and 2006. Given the retirement of Representative Thomas, it remains to be seen whether another member of Congress will continue to push for this type of legislation.

(d) The Senate Finance Committee in the 109th–110th Congress

During the 109th Congress, the federal government scrutinized the nonprofit sector more intensely than at any point since the late 1960s (when sweeping rules restricting private foundations were passed). While the scrutiny is sector-wide, hospitals received a significant portion of the criticism, particularly with regard to the levels of charity care provided. The House Ways and Means Committee and the Senate Finance Committee each held hearings in this area.

The Ways and Means Committee drew first blood with a hearing dedicated to examining hospital pricing practices.[28] The Senate acted more aggressively, however, primarily through the unrelenting questioning of the Finance

27. H.R. 6420, 109th Cong., 2d Sess. (2006).
28. *See* http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=157.

Committee's Chairman, Senator Charles Grassley (R-IA), in letters to hospitals and their associations. In one letter, Senator Grassley asked 10 major healthcare systems a series of questions about their charitable activities and patient billing. The questioning was as or more onerous than an IRS audit, and responses were expected in 45 days.

Subsequently, Senator Grassley sent letters to the American Hospital Association (AHA) and the Catholic Healthcare Association (CHA) inquiring about the charity care policies of their members. Both groups responded. The AHA explained their hospitals' policies toward uninsured patients, and argued in favor of changes in federal policy to help such patients. The CHA provided detailed examples of the practices of several different charitable Catholic hospitals that offer significant charity care and discount policies for uninsured patients.[29]

Senator Grassley has made it clear that he intends to hold the IRS's feet to the fire as well in reexamining the importance of charity care in qualifying for tax exemption.[30]

On July 18, 2007, the minority staff of the Senate Finance Committee released a discussion draft of proposals regarding tax-exempt hospitals.[31] The document was intended to provide proposals for reform for tax-exempt hospitals based on staff investigation and research as well as on input from tax and healthcare attorneys and policy analysts. It was described as a ''work in progress'' meant to encourage additional discussion and was not intended to represent proposed legislation.

The discussion draft detailed the minority staff's concerns as including establishment of charity care policies and the publication of those policies at nonprofit hospitals; the amount of charity care and other community benefits provided by nonprofit hospitals; and the use of unfair billing and aggressive collection practices by nonprofit hospitals.

The draft proposal recommended setting new standards for hospitals seeking recognition of exemption as charitable organizations. On charity care, the proposed criteria included: (1) establishing a charity care policy and wide publication of that policy; (2) quantitative standards for charity care; (3) limiting charges billed to the uninsured; (4) curtailing unfair billing and collection practices; and (5) sanctions for failure to comply with applicable requirements for charitable hospitals.

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29. *See* generally *BNA Daily Tax Report* (April 28 and May 4, 2006).
30. At the nomination hearing of Eric Solomon for Deputy Treasury Secretary for Tax Policy, the Senator made the following statement: ''I want your commitment that the Treasury and IRS are going to look at the real facts—that there is a great need to help low-income people facing medical expenses—and that Treasury and IRS are going to put out new guidance during this administration that puts real teeth to charity care, community benefit, charges to the uninsured and other important issues in this area. Poor people shouldn't have to suffer because Treasury and IRS got the facts wrong in 1969.''
31. www.senate.gov/~finance/press/Gpress/2007/prg071907a.pdf.

The draft proposal also recommended establishing new standards for hospitals seeking exemption as social welfare organizations. As to charity care, the criteria included: (1) limiting charges billed to the uninsured; (2) curtailing unfair billing and collection practices; and (3) sanctions for failure to comply with applicable requirements. Under the proposal, any hospital that was unwilling or unable to provide sufficient charity care to meet the standards for charitable organizations could instead qualify for exemption under the more flexible social welfare organization standards.

The staff intended that these proposed rules would apply in addition to existing legal requirements for charitable and social welfare organizations but would replace the community benefit standard[32] and the emergency room exception standard[33] established by the IRS in prior guidance. Clearly, the intent of the proposals is to return to a basis for exemption that is more closely aligned with the relief of the poor and the IRS's former financial ability standard. A roundtable discussion of the proposals by invited panelists was subsequently convened by the minority staff; however, no legislation containing any of these proposals has yet been introduced.

§ 26.9 CHARITY CARE AND NATIONAL HEALTH REFORM

A frequently asked question in the debate over national health reform is whether there remains a legitimate reason for healthcare organizations to be treated as charitable tax-exempt organizations. Underlying this inquiry is the premise that, if a reformed healthcare system were to provide for universal coverage, presumably there would no longer be any need to provide charity care, and the primary policy basis for recognizing nonprofit healthcare organizations as tax-exempt would disappear. This premise, of course, ignores the distinction between charity care and community benefit that was drawn by the IRS in 1969, and the reliance on community benefit as the primary policy basis for exemption since that time.

Perhaps in recognition of that distinction, most congressional staffers and commentators have indicated that they would anticipate continuation of tax exemption for healthcare organizations even after passage of a national health program that includes universal coverage. The *quid pro quo* of this approach, however, seems to be the addition, to the Code, of new language that would require healthcare organizations to provide particular amounts, or at least types, of charity care. This is reminiscent of the approach taken in the Roybal, Donnelly, and Thomas bills (quantifying specific amounts of charity care to be provided) and in the minority staff discussion draft of the Senate Finance Committee.

32. Rev. Rul. 69-545, 1969-2 C.B. 117.
33. Rev. Rul. 83-157, 1983-2 C.B. 94.

CHAPTER TWENTY-SEVEN

Worker Classification and Employment Taxes

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Certainly one of the most troublesome issues for tax-exempt healthcare organizations is the proper classification of workers for purposes of employment taxation.[1] The healthcare field has routinely treated most physicians and healthcare professionals as independent contractors, often with little consideration of whether the arrangement was actually an employment relationship. Few of these classifications were challenged by the IRS. An effort by the IRS in the late 1960s to increase enforcement of the employment tax provisions of the Internal Revenue Code met with considerable protest and resulted in the creation of safe harbors for the protection of employers under the Revenue Act of 1978.[2]

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1. Congress has examined the problem of worker misclassification on many prior occasions. E.g., ''The Pros and Cons of Home-based Clerical Work,'' Subcommittee on Employment and Housing (1986); ''Rising Use of Part-time and Temporary Workers: Who Benefits and Who Loses?,'' Subcommittee on Employment and Housing (1991); ''Exploiting Workers by Misclassifying Them as Independent Contractors,'' Subcommittee on Employment and Housing (1991); ''Repeal of Section 530 of the Revenue Act of 1978,'' Subcommittee on Select Revenue Measures (Sept. 21, 1993); ''Contractor Games: Misclassifying Employees as Independent Contractors,'' Committee on Government Operations, H.R. Rep. No. 102-1053, 102d Cong., 2d Sess. 10 (Oct. 16, 1992); Joint Committee on Taxation Staff Description (JCX-26-07) of Present Law and Background Relating to Worker Classification for Federal Tax Purposes Scheduled for a Public Hearing before the Subcommittee on Select Revenue Measures and the Subcommittee on Income Security and Family Support of the House Committee on Ways and Means on May 8, 2007.
2. Revenue Act of 1978, Pub. L. No. 95-600, 95th Cong., 2d Sess. § 530 (Nov. 6, 1978).

In the 1990s, however, Congress began to look at worker misclassifications as a revenue matter,[3] and the IRS announced its intention to step up its enforcement of the federal employment tax provisions. The IRS is particularly interested in misclassification of workers in the healthcare field.

The rationale for characterizing a worker in the healthcare field as an independent contractor is not as clear as it was in the past. By treating a worker as an independent contractor, the exempt healthcare organization avoids an employment tax obligation for that worker, as well as the cost of providing employee benefits. In addition, it was generally believed that liability protection was gained by characterizing a worker as an independent contractor. It is apparent, however, that charitable healthcare organizations that classify a worker as an independent contractor often receive little or no liability protection from the negligent acts or omissions of the independent contractor.[4]

There are also benefits to classification of a worker as an employee. By classifying a worker as an employee, the healthcare organization can gain needed control over the actions of the worker, including control over the worker's hours, availability, methods of practice, and ability to compete against the healthcare organization. Finally, significant protection is available under the Medicare and Medicaid antikickback statute for bona fide employees of the organization.[5]

§ 27.1 FEDERAL EMPLOYMENT TAXES

Under the federal employment tax system, most exempt organizations are subject to three taxes: (1) the Federal Insurance Contributions Act (FICA) tax; (2) the Federal Unemployment Tax Act (FUTA) tax; and (3) the Collection of

3. The General Accounting Office (GAO) released a report in July 1992 that contained the IRS's estimate that the 1992 tax gap caused by self-employed individuals (including independent contractors) who do not report all of their income is $20.3 billion. GAO Report, Tax Administration: Approaches for Improving Independent Contractor Compliance, GAO/GGD-92-108 (July 1992) at 2. The Government Accounting Office's Associate Director of Tax Policy reported to the House Small Business Committee, on August 4, 1994, that misclassification of workers as independent contractors leads to lost tax revenue because contractors tend to underreport their income. According to the GAO, independent contractors owe 75 percent of the delinquent taxes owed to the IRS annually, even though contractors comprise only 6 percent of all the taxpayers. The GAO also estimates that about 15 percent of all businesses have misclassified 3.4 million employees as independent contractors. BNA Daily Tax Report, Aug. 5, 1994, at G-3. See also, Employee Misclassification-Improved Outreach Could Help Ensure Proper Worker Classification, GAO Report GAO-07-859 T (May, 2007). A study by the accounting firm of Coopers & Lybrand conservatively estimated that, even without taking into account the impact of healthcare reform, misclassification of workers as independent contractors will cost the federal government nearly $35 billion over a nine-year period. ''Projection of the Loss in Federal Tax Revenues Due to Misclassification of Workers,'' Coopers & Lybrand (July 1994).
4. *See*, e.g., *Thompson v. Nason Hospital*, 527 Pa. 330, 591 A.2d 703 (1991).
5. 42 U.S.C. § 1320a-7b(b).

Income Tax at Source on Wages Act tax, commonly referred to as the ''federal withholding tax.''[6] The FICA tax has two components—(1) the Social Security tax and (2) the Medicare tax—and it is imposed on both employees[7] and employers.[8] For 2008, the employee and the employer each pay tax in the amount of 6.2 percent of an indexed wage base for Social Security and 1.45 percent for Medicare.[9] The Code imposes the FUTA tax only on employers.[10] For 2008, this tax was computed as 6.2 percent of the first $7,000 in remuneration paid during the calendar year. However, organizations described in Code section 501(c)(3), including charitable healthcare organizations, are not liable for payment of the FUTA tax for services provided by workers in their employ.[11] Finally, exempt healthcare organizations are required to withhold federal income tax for their employees from each wage payment.[12]

§ 27.2 EMPLOYEES AND INDEPENDENT CONTRACTORS DISTINGUISHED

To determine whether the federal employment taxes apply to a given worker, it is generally the responsibility of the employer to determine whether the worker is properly classified as an employee or as an independent contractor.[13] FICA and FUTA define the term *employee* by reference to the common-law

6. *See*, in general, FY 1992 Exempt Organization Continuing Professional Education Technical Instruction Program Textbook (IRS CPE Text), at 284–317.
7. IRC § 3101.
8. IRC § 3111.
9. In 2008, the wage base for Social Security is $102,000. The wage base for Medicare is unlimited.
10. IRC § 3301.
11. IRC § 3306(c)(8).
12. IRC § 3402(a). When an employer has misclassified an employee as an independent contractor, the employer will have no doubt failed to withhold the foregoing taxes from the worker's wages. In that event, the IRS may, if the failure to withhold was intentional, retroactively impose the following taxes on the employer: regular withholding of income taxes; both the employer's and the employee's halves of FICA taxes; FUTA taxes; and penalties and interest on the foregoing.

    Employees misclassified as independent contractors may also be entitled to participation in employee benefit programs. *See Vizcaino v. Microsoft Corp.*, No. 94-35770 (9th Cir., Oct. 3, 1996).

    Employees have their wages reported at the end of each tax year on IRS Form W-2, whereas independent contractors have their compensation reported on IRS Form 1099. The IRS ruled that a company could issue corrected Forms W-2 and 1099 reporting amounts paid to a worker whom the company had treated as an employee, but whom a court later ruled to be an independent contractor. Priv. Ltr. Rul. 9546018. The IRS also ruled that a company could take corrective action regarding pension plans in which the worker erroneously participated, although the IRS is currently reconsidering its position regarding such pension plan corrective action. *Id*.
13. Workers who are automatically employees by operation of law are referred to as *statutory employees. See* IRC § 3121(d)(3). These statutory employees generally do not include healthcare professionals.

rules applicable in determining an employer–employee relationship.[14] The accompanying Treasury Regulations expand on this by providing a general definition drawn from the common-law rules. Thus, under the regulations, an employer–employee relationship exists when:

> the person for whom services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished but also as to the details and means by which that result is accomplished. . . . In this connection, it is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if he has the right to do so.[15]

This same definition goes on to state that ''physicians . . . engaged in the pursuit of an independent trade, business, or profession, in which they offer their services to the public, are independent contractors and not employees.''[16] The IRS has interpreted this definition as generally meaning that physicians are independent contractors as to services provided to their patients, and has not extended it to encompass all physician relationships with hospitals and other healthcare providers.

It is extremely important to note that the Treasury Regulations state that whether the parties describe a worker relationship as an independent contractor relationship is irrelevant if an employer–employee relationship, in fact, exists.[17] Many healthcare organizations erroneously believe that simply by including a boilerplate independent contractor clause in an agreement, the relationship will be upheld as an independent contractor relationship. However, the IRS's enforcement of the employment tax provisions underlines the fact that the IRS will not uphold form over substance merely because a contract includes an independent contractor clause, no matter how skillfully drafted. The particular terms of the arrangement will control whether it is an independent contractor or employer–employee relationship.

§ 27.3 THE COMMON-LAW FACTORS

In most cases, the determination of whether a worker is an employee or an independent contractor must be made based on the facts and circumstances of the relationship. This requires an analysis of twenty common-law factors developed by the courts in analyzing worker relationships. The IRS's heavy reliance on the application of these twenty common-law factors is evidenced by the analysis contained in myriad private letter rulings. These twenty factors are set forth in on IRS revenue ruling which is

14. IRC §§ 3121(d)(2) and 3306(i).
15. Reg. § 27.3121(d)-1(c)(2). *See also* Reg. §§ 31.3306(i)-1(b), 31.3401(c)-1(b).
16. *Id*.
17. Reg. §§ 31.3121(d)-1(a)(3), 31.3306(i)-1(d), 31.3401(c)-1(e).

included as Appendix C. Thorough review and understanding of these factors are necessary in order to properly develop a contract that will reflect the desired classification of the worker. No single factor of the twenty is controlling; rather, a preponderance of the factors is generally required to demonstrate that a worker is either an employee or an independent contractor.[18]

§ 27.4 SAFE HARBORS

In response to aggressive enforcement of the federal employment tax laws by the IRS in the late 1960s, and the resultant protests, Congress enacted section 530 of the Revenue Act of 1978 as an *interim* relief measure to protect employers from the effects of misclassifications under certain circumstances.[19] Section 530 does not change the status of the worker; rather, the worker retains classification as a common-law employee, and the employer is relieved from the application of the employment tax provisions.

Section 530(a)(2) established three safe harbors that, if applicable, create a *reasonable basis* for treating as an independent contractor a worker who would normally be classified as a common-law employee. The three reasonable-basis safe harbors allow reliance on:

> **(1)** judicial precedent, published rulings, technical advice with respect to the taxpayer or a letter ruling to the taxpayer; or
>
> **(2)** a past Internal Revenue Service audit of the taxpayer in which there was no assessment attributable to the treatment (for employment tax purposes) of the individuals holding positions substantially similar to the position held by this individual;[20] or

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18. Rev. Rul. 87-41, 1987-1 C.B. 296. Although the IRS generally asserts that all 20 common-law factors must be considered, one study reviewed IRS rulings and court cases and concluded that only about five to seven factors would be sufficient to classify most workers. *See* ''The 20-Factor Worker Status Test: Would Seven Factors Work Just as Well?,'' *Tax Notes*, Dec. 13, 1993. According to the study, the most important factors are: realization of profit or loss; significant investment in facilities used in performing services for another; making services available to the general public; and working for more than one firm at a time.
19. Revenue Act of 1978, § 530, *supra* note 2, extended indefinitely by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 97th Cong., 2d Sess. § 269 (Aug. 17, 1982). Section 530 also prohibits the IRS from promulgating regulations or issuing revenue rulings of general application with regard to the common-law status of employees.
20. Rather than initiating an employment tax audit, the IRS will sometimes utilize employment tax ''compliance checks,'' which are designed to be informal educational tools in which revenue officers or revenue agents ask taxpayers to confirm that they have properly completed the required employment tax forms. Because the ''prior audit'' safe harbor under § 530 presumably applies only to an ''audit'' and not to a ''compliance check,'' the IRS takes the position that the prior audit safe harbor is not triggered by a

(3) long-standing recognized practice of a significant segment of the industry in which such individual was engaged.[21]

Even if an employer is unable to meet one of these safe harbors, it may still be entitled to relief if it can demonstrate another reasonable basis for not treating an individual as an employee.[22] Employers must file all required federal tax returns, including information returns with respect to the worker, consistently treating the worker as not being an employee (the reporting consistency rule).[23]

As part of the move by the IRS and some employer groups to increase enforcement of the employment tax provisions, legislative efforts are launched periodically, in an effort to diminish the section 530 safe-harbor protections.[24]

In 1996, Congress also enacted the Small Business Job Protection Act of 1996 , which made some changes in the worker classification area by amending section 530. Specifically, the law, which generally applies to periods after December 31, 1996:

- Requires the IRS to provide a written notice of the section 530 safe-harbor requirements to taxpayers when employment tax issues are first raised during an audit.
- Makes the section 530 safe harbors available without a prior IRS determination that the worker in question is an employee.
- Limits the prior audit safe harbor to prior employment tax audits.
- Shifts the burden of proof to the IRS if the taxpayer has fully cooperated with reasonable requests of the IRS for information and the taxpayer has established a basis that is reasonable on its face for having not treated its workers as employees.
- Provides that a taxpayer who starts to treat workers as employees will not lose the protections of section 530 for earlier years.
- Provides that a significant segment of the taxpayer's industry under the *industry practice* safe harbor does *not* require a showing of the practice

compliance check in which no worker classification problems were identified. Statement of Marshall Washburn, Executive Director of the IRS Office of Specialty Tax, reported in BNA *Daily Tax Report*, Sept. 7, 1995, at G-4.

21. Revenue Act of 1978, § 530(a)(2). *See also* Internal Revenue Service Publication 1976 on Section 530 Worker Classification Relief Requirements for Employees, issued Oct. 30, 1996, *reprinted in* BNA *Daily Tax Report*, Oct. 31, 1996, at L-1.
22. Rev. Proc. 85-18, 1985-1 C.B. 518.
23. Section 530(a)(1)(B), Revenue Act of 1978; Rev. Proc. 85-18, 1985-1 C.B. 518. For an example of a case involving the reporting consistency rule, *see Crowd Management Services, Inc. v. United States*, No. 90-1093-MA (D. Or., Apr. 11, 1995) (no § 530 relief was available with respect to workers that a company reclassified as independent contractors after 1982, as workers remained in substantially similar positions to workers who were treated as employees prior to 1982).
24. *See*, e.g., H.R. 4216, 102d Cong., 2d Sess. (1992); H.R. 5011, 102d Cong., 2d Sess. (1992).

of more than 25 percent of an industry (i.e., a lower percentage may constitute a significant segment of an industry based on the facts and circumstances).

- Provides that an industry practice need *not* have continued for more than 10 years in order for the industry practice to be considered *longstanding* and clarifies that an industry practice will not fail to be treated as longstanding merely because such practice began after 1978.
- Provides that in determining whether a worker holds a *substantially similar position* to another worker, the relationship of the parties must be one of the factors taken into account (including the degree of supervision and control of the worker by the taxpayer).[25]

§ 27.5 CLASSIFICATION OF HEALTHCARE WORKERS

In determining whether to classify a worker as an employee or an independent contractor in the healthcare field, the twenty common-law factors must be applied. One useful application of these factors is set forth in a section of the *IRS Exempt Organizations Examination Guidelines Handbook*, that is commonly known as the ''Hospital Audit Guidelines.''[26] The Hospital Audit Guidelines reviews the aspects of a worker relationship that examination agents are to analyze in order to determine whether the healthcare professional is an employee or an independent contractor.[27] The Hospital Audit Guidelines state that:

> [i]f the following factors are present, the physician is most likely an employee even if the contract describes the physician as an independent contractor.
>
> (a) The physician does not have a private practice.
>
> (b) Hospital pays straight wage to physician.
>
> (c) Hospital provides supplies and professional support staff.
>
> (d) Hospital bills for physician services.

25. Pub.L. No. 104-188, 110 Stat. 1755 Subtitle C §§ 1301-1317.
26. IRM 7(10)69, § 333; reproduced in Ann. 92-83, 1992-22 I.R.B. 59. *See* Appendix E.
27. *Id*. at § 333.7. In the context of management services, *see Idaho Ambucare Center, Inc. v. United States*, 57 F.3d 752 (9th Cir. 1995) (doctor whose professional corporation contracted to provide his management services to an outpatient surgical facility was an employee of his professional corporation but an independent contractor of the surgical facility, whereas another physician hired directly by the surgical facility to perform similar management services was an employee of the surgical center).

    Worker classification can be an especially complex issue when a healthcare professional receives remuneration from more than one entity for the same work. E.g., Priv. Ltr. Rul. 9525001 (nurses and other temporary healthcare workers who were paid as employees by the clients of a medical personnel agency, but who also received bonuses and other payments from the medical personnel agency, were employees of that agency; thus, the agency should have withheld taxes from those bonuses and other payments).

(e) Percentage division of physician fees with the hospital or vice versa.

(f) Hospital regulation of, or right to control, physician.

(g) Physician on-duty at hospital during specified hours.

(h) Physician's uniform bearing hospital name or insignia.[28]

Further application of the twenty common-law factors comes in various rulings with regard to particular types of physicians and healthcare professionals. The type of practice maintained by the physician or healthcare professional is clearly not determinative of employee/independent contractor status. Thus, dependent on the terms of the arrangement, the IRS has determined that anesthesiologists,[29] pathologists,[30] associate physicians,[31] residents,[32] company physicians,[33] and medical workers[34] were either employees or independent contractors. The IRS has also indicated that it is examining hospitals' classification of emergency room physicians as independent contractors. The IRS's position is that, in most cases, emergency room physicians should be treated as employees.[35] The IRS also has long taken the position that supplemental staffing nurses are employees and not independent contractors,[36] although

28. *Id*. at § 333.7(5).
29. Rev. Rul. 57-380, 1957-2 C.B. 634 (independent contractor); Rev. Rul. 57-381, 1957-2 C.B. 636 (employee).
30. Rev. Rul. 66-274, 1966-2 C.B. 446 (independent contractor); Rev. Rul. 73-417, 1973-2 C.B. 332 (employee).
31. Rev. Rul. 70-629, 1970-2 C.B. 228 (employee); Rev. Rul. 72-203, 1972-1 C.B. 324 (employees of laboratory director).
32. Rev. Rul. 57-21, 1957-1 C.B. 317 (employee).
33. Rev. Rul. 84, 1953-1 C.B. 404 (independent contractor); Rev. Rul. 61–178, 1961-2 C.B. 153 (employee).
34. Rev. Rul. 75-41, 1975-1 C.B. 323 (employee).
35. BNA, *Daily Tax Report*, Oct. 8, 1992, at G-2. Most private letter rulings bear out the Service's predisposition to classify emergency room physicians as employees. E.g., Priv. Ltr. Rul. 7804002. On one rare occasion, the IRS reversed its earlier decision and determined that certain emergency room physicians were independent contractors. Priv. Ltr. Rul. 9410041, reversing Priv. Ltr. Rul. 9335055.

    When a hospital hires a company to provide emergency room physicians for the hospital, the physicians supplied by the company are most often determined to be employees of the company rather than the hospital. E.g., Priv. Ltr. Rul. 9541032 (physicians supplied by company to staff hospital's emergency room were employees of company); Priv. Ltr. Rul. 9541032 (emergency room physicians referred to hospital by placement agency were employees of agency). *But see* Tech. Adv. Mem. 9628001 (physicians who contracted with a general partnership that provides emergency room services were ruled *not* to be common-law employees of the partnership).
36. E.g., Rev. Rul. 75–101, 1975–1 C.B. 318. In these rulings, the following were primary grounds for the IRS's conclusion that supplemental staffing nurses were employees:

    - The services of the RNs were integrated into the business operations of the agency. (Integration of a worker's services into an agency's business operations generally shows that the worker is subject to direction and control. The nurse was also essential to the agency being able to operate its nursing business.)

courts have sometimes disagreed as to whether a section 530 safe harbor was applicable.[37] Because of ongoing developments in this area, practitioners should always check for current private letter rulings and other IRS policy positions with regard to the specific type of healthcare professional involved.[38]

- The RNs did not subject themselves to a risk of loss.
- The staffing agencies always had the right to exercise some degree of control over the RNs, and usually that right was actually exercised. In one case, this was done by the use of a ''coordinator'' to resolve problems with their work performance.
- The nurses were required to perform their services personally, were generally paid on an hourly basis, and had a continuing relationship with the agency.

37. In *Critical Care Registered Nursing, Inc. v. United States*, 91-2 U.S.T.C. (CCH) ¶50,481 (E.D. Pa. 1991), a jury held that the Critical Care nurse registry, an agency that provided nurses to hospitals and that classified its nurses as independent contractors, did not have to pay penalties because of the § 530 safe harbors. IRS officials have publicly stated that despite the *Critical Care* decision, the IRS intends to crack down on those who misclassify their workers. The Commissioner of the IRS also announced on August 8, 1994, that she ''does not acquiesce'' in the *Critical Care* decision. *See also Hospital Resource Personnel, Inc. v. United States*, No. 94-8924 (11th Cir., Nov. 3, 1995) (corporation that operated a nursing registry established a reasonable basis for treating its nurses as independent contractors and thus was entitled to a refund of employment taxes).
38. For many types of healthcare professionals, the overarching factor for worker classification in most IRS rulings is whether the healthcare entity in question has the right to control the workers, even if that right is not always exercised to a significant degree. E.g., Priv. Ltr. Rul. 9535001, a 50-page technical advice memorandum in which the IRS ruled that a § 501(c)(3) organization operating an outpatient surgery center and nursing home retained the right to exercise the necessary degree of control over physician EKG interpretation panel members, a nursing home administrator, and a nursing home's physician medical director so as to make each of them employees of the organization. Certain Utilization Review Committee physicians were not employees, however, because the organization did not retain the right to direct and control their activities.

    In Priv. Ltr. Rul. 9535002, a 25-page technical advice memorandum, the IRS ruled that a § 501(c)(3) hospital retained the right to exercise the necessary degree of control over healthcare test interpreters, a physician hired to provide professional and administrative services, a physician hired to provide health services for the employees of the hospital, and various Lamaze childbirth instructors so as to establish an employer–employee relationship with each of them. However, the hospital's medical records transcribers were not employees because they worked at home and furnished their own equipment. *See also* Priv. Ltr. Rul. 9502008 (workers performing nursing services were employees because healthcare entity exercised requisite degree of control over them); Priv. Ltr. Rul. 9503017 (nursing home nurses were employees due to nursing home's exercise of control and other factors); Priv. Ltr. Rul. 9508004 (mental health workers were employees of local government because of the control exercised over workers); Priv. Ltr. Rul. 9540029 (home care provider was an employee of a government agency because of that agency's exercise of control over caregiver); Priv. Ltr. Rul. 9517003 (chiropractors were holistic healthcare center's employees because of center's control over them); Priv. Ltr. Rul. 9443002 (radiologist, four physicians, and physical therapist were all hospital employees).

    In many of these rulings on worker classification, the IRS cites the case of *James v. Commissioner*, 25 T.C. 1296 (1956) for the proposition that the requisite degree of control

Where certainty as to the proper classification is desirable or necessary, a Form SS-8 should be filed with the IRS in order to obtain a private letter ruling that will specify the proper worker classification.

An assessment of a compensation arrangement used by a university and its faculty practice plan provides a good example of the application of the facts-and-circumstances test.[39] In a technical advice memorandum that reversed a position held by the IRS since 1978, the IRS opined that the interrelationship between the work of physicians participating in a faculty practice plan and their compensation indicated that the physicians were not merely independent contractors but were employees of the university that essentially sponsored the plan. As testament to the difficulty in applying the twenty-factor test, the IRS reversed its 1978 ruling based on an improper assessment of facts, which are as follows.

A tax-exempt charitable university (''University'') owned and operated a Medical Center, which included a School of Medicine. Faculty of the School of Medicine were also required to participate in a Faculty Practice Plan (the ''Plan''), an unincorporated entity that was part of the University and its School of Medicine. The physicians provided services at the School of Medicine, an affiliated hospital, and a clinic. Although the physicians received a base salary for services rendered as University faculty members, their agreement with the Plan set forth the *overall* compensation package. Pursuant to this arrangement, all professional income, including the base salary paid by the University and *supplemental* income generated through clinical work, was channeled through the Plan. The physicians were considered employees of the University for purposes of their base salary (and provided W-2s for that income) but were considered independent contractors for purposes of any supplemental income generated through the provision of clinical services. Thus, the issue was whether the supplemental income should also be considered University wages.

In support of its original determination in which the IRS concluded that the physicians were independent contractors, the IRS cited several factors, including, among other things, that the physicians (1) had little supervision, if any; (2) controlled the types of clinical services that they provided; (3) received a percentage of revenue generated from their clinical services; and (4) had a voice in the Plan's governance. Additionally, the IRS noted that the University and the Plan tracked the physicians' performance separately.

Categorically rejecting this earlier determination, the IRS surmised that the interrelationship between the physicians' work and their compensation

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can be more general for professional than nonprofessional employees. In that court case, the Tax Court ruled that a physician engaged by two hospitals to perform services as a pathologist and laboratory head was an employee, even though the hospitals exercised little control over matters within the physician's area of expertise.

39. Tech. Adv. Mem. 9808001.

was contrary to such an arrangement. Although, as noted previously, several factors weighed in favor of the initial determination, on balance the University's authority over the Plan and economic control over the physicians was highly probative of an employer–employee arrangement between the University and physicians, respectively. The IRS noted generally that (1) the arrangement set forth in the Plan agreement required that the physicians teach, research, and provide healthcare services; (2) the compensation package included both the physicians' teaching salary and the supplemental income; and (3) the Plan was actually part of the University—all factors that indicated that the physicians were employees and not merely independent contractors.

This ruling is representative of the complexity inherent in the facts-and-circumstances test. Arguably, it is for this reason that the IRS changed its position on a purely factual basis and not pursuant to an error in law; it would appear that it may be moving toward a more rigid application of the twenty-factor test.[40]

The IRS has also released guidance on the proper treatment of medical residents for FICA purposes.[41] The IRS asserts that whether medical residents are subject to the student FICA exception is subject to all of the facts and circumstances. The IRS noted that facts to be developed include whether the medical resident is enrolled at an educational institution, registered for credit, and required to pay tuition. The IRS noted further that the student FICA exception will not apply in the event that the ''medical resident is employed by an employer other than the educational institution.[42]

§ 27.6 COORDINATED ISSUE PAPERS

Determining the proper classification of workers in the healthcare field can often be tricky, especially because of the wide variety of delivery mechanisms for healthcare services. Two worker classification issues have arisen so frequently in the healthcare field that the IRS prepared proposed coordinated issue papers to address them. The issues are: (1) the employee status of hospital-based physicians, and (2) the student nurse exclusion from the definition of employment.[43]

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40. The IRS undertook a useful review of the law and current litigation in this area in 2003. *See* FY 2003 IRS CPE Text at Chapter D, Employment Tax Update-Review of Current Litigation. See also, Anning, Griffith, and Moroney, ''Classifying Physicians as Employees— IRS Keeps Winning,'' Tax & Finance Newsletter (AHLA 2002), Vol. 4, No. 1, p. 4.
41. FY 2000 IRS CPE Text, Chapter M, Employment Tax Issues Involving Educational Institutions; FY 2002 IRS CPE Text, Chapter A, Medical Residents Refund Claims Training.
42. *See also Minnesota v. Apfel*, 151 F.3d 742 (8th Cir. 1998), in which the Eighth Circuit held that medical residents of state-owned and -operated university medical schools fall within the student FICA exception.
43. 7 *Exempt Org. Tax Rev*. 1043–1048 (Jun. 1993).

Coordinated issue papers are designed to ensure that agents in the field will take a common position on a given issue. If they believe it is necessary to deviate from a position reached in a coordinated issue paper, they are required to obtain permission from their superiors. Thus, coordinated issue papers are a useful source of guidance for practitioners regarding the position they can expect the IRS to take on the issue involved.

(a) Hospital-Based Physicians

A thorny question for the IRS over the years has been whether hospital-based physicians are employees or independent contractors for employment tax purposes. Hospital-based physicians are different from other physicians in that they must provide all or nearly all of their services at the hospital itself because of the unique nature of their services. Radiologists, anesthesiologists, pathologists, and emergency room physicians are usually considered hospital-based physicians. The fact that each of these specialties must be performed on the hospital premises does not necessarily mean that these individuals are employees of the hospital. Indeed, a number of different arrangements have been entered into for the provision of these services.

In its coordinated issue paper on hospital-based physicians, the IRS begins by listing the twenty common-law factors that are used as guides for determining whether the control exercised by an employer is sufficient to establish an employer–employee relationship.[44] Thereafter, the IRS points out that the business structure and the intent of the parties in establishing their relationship can be relevant and may affect the status of the worker, particularly in the case of physicians, who often practice medicine through complex business forms such as partnerships, corporations, and joint ventures. The IRS notes that determining whether a hospital-based physician is an employee or an independent contractor is difficult under the twenty-factor test, mostly because the test operates less efficiently as the degree of independent judgment of the worker in performing the services increases. Application of the test is also more complicated because the hospital setting in which the physician performs services for the patient often involves additional parties.

The coordinated issue paper states that the pre-1987 rulings[45] on the employee status of physicians considered four main factors:

1. The manner in which the physician is integrated into the operations of the firm for which services were performed
2. The substantial nature, regularity, and continuity of the physician's work for the firm

44. *See supra* § 27.3 and Appendix C.
45. Rev. Rul. 61-178, 1961-2 C.B. 153; Rev. Rul. 66-274, 1966-2 C.B. 446.

3. The authority vested in or reserved by the firm to require compliance with general policies
4. The degree to which the physician has been afforded the rights and privileges (e.g., employee benefits) the firm has established for employees generally

The IRS concludes that notwithstanding the difficulty of application of the twenty-factor test, it remains a viable mechanism for determining the employment status of physicians; however, these factors should be weighted differently for physicians than for other workers, such as unskilled laborers.

The coordinated issue paper then discusses some factors unique to physicians in determining their employee status. First, the IRS indicates that the degree of independence, skill, and judgment that must be exercised by a physician in providing medical services to patients is theoretically the same whether the physician is an employee of a professional corporation, an employee of a hospital, or an independent contractor. Accordingly, the IRS believes that the factors in the twenty-factor test that focus on independence of judgment or the physician's skill in providing patient care are less important than the factors that focus on the independence of the physician's business operations from those of the business operations of the organization for which or in which the physician performs his or her services.

Second, the IRS notes that physicians operate in both a two-party and a multiple-party setting. A physician who practices medicine as an unincorporated sole proprietor offering services to the public is normally a self-employed independent contractor rather than an employee of his or her patients.[46] The issue paper indicates that if the lack of control over the manner in which the physician performs medical procedures were the main criterion, no physician would ever be deemed an employee. It then takes the position that the better approach should be whether someone other than the physician has the right to direct or control those components of the physician's medical practice that are not necessarily linked to the physician's independent medical judgment.

The issue paper states that a potential employer's control over the physician's business activities, rather than its control over the medical procedures provided by the physician, is the critical factor in determining a physician's status as an employee in a multiple-party setting.

The first setting identified is where the physician is the sole shareholder, director, and officer of a Medical Service Corporation. The corporation, rather than the doctor, agrees to provide licensed individuals to perform medical services for patients admitted to a hospital. Typically, the corporation is not restricted to offering its services exclusively to one hospital. The corporation hires a physician as an employee to perform medical services under contract with the hospital, and pays the physician a reasonable fixed salary. The fees for

46. Reg. §§ 31.3121(d)-1(c)(2), 31.3306(i)-1(b), 31.3401(c)-1(b).

the physician's medical services then belong to the corporation. In applying the twenty-factor test to this setting, the IRS concludes that the physician is an employee of the Medical Service Corporation and not of the hospital.

The coordinated issue paper next considers the setting of a hospital as employer. This occurs in cases in which the physician is a common-law employee of the hospital. The IRS notes that this arrangement is usually found in hospitals owned or operated by governments or tax-exempt organizations, particularly those that have affiliations with medical colleges or universities. The issue paper states that interns and residents are virtually always common-law employees of the entity that operates the hospital in which they are trained.

The coordinated issue paper also states that a physician who delivers medical care to patients as a member of the ''staff'' of a hospital also is generally a common-law employee of the institution—for example, a university that operates the hospital. This is common in cases in which the physician is a designated faculty member of the institution, works exclusively in the hospital or hospitals owned by or affiliated with the institution, receives a fixed salary without reference to fees collected by the institution, and is included as an employee for purposes of the institution's employee benefit programs.

In applying the twenty-factor test in this setting, examiners are instructed to focus on whether the institution has the right to direct and control the manner and means of the business aspects of the physician's medical practice. The IRS states that three major factors are normally present when a physician is an employee of the institution: (1) the institution reserves the right to specify the hours during which the physician must be present; (2) the institution is entitled to fees collected from medical services rendered to patients; and (3) the institution bears the risk and expenses associated with the delivery of medical care.

Finally, the coordinated issue paper delves into the question of hospital-based physicians. It begins by noting that a hospital-based physician can qualify as a self-employed individual.[47] The prominent feature of this type of relationship is that the physician has control over the business aspects of delivery of his or her medical services, notwithstanding the need to perform such services in a hospital setting. The issue paper proposes the example of an unincorporated sole practitioner who contracts with a hospital to perform specialized medical services. Under the contract, the physician determines when and how frequently the services are to be performed, is entitled to all fees for medical services rendered to patients, and is responsible for maintaining professional liability insurance and all other expenses of the medical practice. The physician offers similar services under similar conditions to other hospitals, and does, in fact, sign up several hospitals under those conditions. The IRS concludes that the combination of these factors strongly suggests that the physician in the example is an independent contractor.

47. Rev. Rul. 66-274, 1966-2 C.B. 446; Rev. Rul. 72-203, 1972-1 C.B. 324.

The coordinated issue paper warns that, when using the twenty-factor test, an examiner might be inclined to view procedural limits established by hospitals as sufficient control of the physician's work performance to cause the physician to become the hospital's employee. Although such limitations should be carefully examined, they should not be given excessive weight in determining employee status. The issue paper elaborates by showing that four factors are common to virtually all hospital–physician relationships, whether or not the physician is the hospital's employee: (1) a requirement that medical procedures be performed in accordance with hospital protocols; (2) a requirement that the physician comply with internal hospital accreditation requirements before privileges are granted; (3) the physician's use of hospital facilities; and (4) the reservation of the hospital's right to terminate the physician's privileges for cause.

The IRS also points out in the coordinated issue paper that some physicians establish medical practice relationships with a hospital that cause the physicians to be employees of the hospital for certain services but not for others. In an example, a physician might chair a hospital department while providing medical services to patients in the hospital through his or her own corporation. Such a physician may be an employee of the hospital for the compensation paid for services as chair of the department, yet the physician may not be an employee of the hospital for the patients' medical fees provided by the hospital to the physician. This dual status can also occur where a hospital segregates each medical department by specialty or incorporates faculty practice clinics. The IRS warns that a conclusion that a physician is an employee of the paying organization for *all* payments may not be appropriate where payments are made to a physician who functions in multiple capacities.

Based on the foregoing analysis, the coordinated issue paper recommends that examiners take the following approach. First, they are to begin with the twenty-factor facts-and-circumstances test that is used for other workers. However, examiners are to treat factors that demonstrate independence of a worker's trade or business from that of the service recipient as being more important than factors demonstrating the service recipient's lack of direct control over the worker's professional skills.

Applying this analysis to physicians, examiners are instructed that the first step in determining a physician's status is to identify all the parties to the transaction and how they interrelate. Normally, the physician is not the employee of the patient. However, a physician serving patients in a hospital can be an employee of his or her own professional corporation, an employee of the organization operating the hospital, an employee of both, or an independent contractor. Where the physician operates a medical practice through a professional corporation, the physician's relationship to that corporation is generally that of an employee. Where the physician is a salaried faculty member of a university hospital, the physician is generally an employee

of the university. The issue paper states that employment arrangements that reflect a high level of control by a university but attempt to treat the physician as a self-employed independent contractor should be scrutinized carefully. Where the physician is the head of a department yet also provides medical services to hospital patients through a professional corporation, the physician may be regarded both as an employee of the hospital and as an employee of the professional corporation.

The coordinated issue paper concludes that the mere fact that a physician performs medical services inside a hospital, using only hospital facilities, does not, in itself, cause the physician to be an employee of the hospital. The physician may be able to demonstrate a degree of independence necessary to establish an independent contractor relationship with the hospital, particularly where the physician performs services for patients in other hospitals and facilities.

(b) Student Nurse Exclusion

Another worker classification issue that has bedeviled hospital administrators has been the question of whether student nurses are properly excluded from the definition of employment for FICA and FUTA withholding purposes. The Code excepts from the definition of employment services performed as a student in the employ of a hospital or a nurses' training school by an individual who is enrolled and regularly attends classes in a nurses' training school charted or approved pursuant to state law. In creating this exception under the Code, Congress stated:

> The intent of the amendment is to exclude those purposes and those organizations in which the employment is part-time or intermittent and the total amount of earnings is only nominal and the payment of the tax is inconsequential and a nuisance. The benefit rights built up are also inconsequential. Many of those affected, such as students . . . will have other employment which enables them to develop insurance benefits.[48]

Thereafter, the IRS issued guidance,[49] in which it concluded that the statutory language and the legislative history indicated congressional intent to except services as a student nurse from the definition of employment only if a three-pronged test was satisfied. This test requires that: (1) the student nurse's employment be substantially less than full-time; (2) the student nurse's total amount of earnings be nominal; and (3) the only services performed by the student nurse for the employer are incidental parts of the student nurse's training toward a degree that will qualify him or her to practice as a nurse or in a specialized area of nursing. Thus, in the IRS's view, the exception serves

48. H.R. Rep. No. 728, 76th Cong., 1st Sess. 18 (1939).
49. Rev. Rul. 85-74, 1981-1 C.B. 331.

to exempt nominal compensation that the student nurses receive for part-time services they perform to satisfy their clinical training requirements.

This interpretation was challenged in a U.S. District Court in *Johnson City Medical Center Hospital v. United States.*[50] Johnson City Medical Center Hospital sought a refund of the FICA tax that it paid in connection with services rendered by its student nurses. The student nurses did not receive academic credit from their nursing school for the work they performed for the Medical Center Hospital, and their earnings were not considered nominal. The district court upheld the IRS's position and found that the services performed by these student nurses were not exempt from employment under the Code because they were not incidental to obtaining a degree and because the earnings of the student nurses were not nominal. The IRS has continued to observe and enforce the three-pronged test contained in Revenue Ruling 85-74.

After a review of the foregoing law, the proposed coordinated issue paper takes the position that if a hospital pays wages for nursing services performed at a hospital or nursing school to an individual who is enrolled and regularly attending classes in a nurses' training school, the services must be directly related to the individual's capacity as a nursing student in order for the services to qualify for exclusion from the definition of employment for FICA and FUTA tax withholding purposes. However, where the work is performed by the student nurse merely for compensation, and no academic credit toward a nursing degree is granted, the IRS's position is that the student nurse exception is not met, and all such compensation will be subject to withholding. If all three requirements of the IRS's three-pronged test are met, wages paid to a qualifying individual will not be subject to withholding of either FICA or FUTA tax.

50. 783 F. Supp. 1048 (E.D. Tenn. 1992).

CHAPTER TWENTY-EIGHT

Compensation and Employee Benefits

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Much of the law concerning executive and other compensation, and employee benefits, is the same irrespective of whether the employer is a tax-exempt organization or a taxable organization. Yet there are some important differences. The rules of both categories can apply, nonetheless, where compensation and benefits are being provided as part of operation of an unrelated business[1] or through a for-profit subsidiary.[2]

In the healthcare field, the compensation arrangements involving hospitals and physicians have been the most closely scrutinized. In this setting, the IRS will examine these arrangements for instances of private inurement or excessive private benefit.[3]

In recent years, however, the IRS and Congress have intensified their scrutiny of executive compensation as well and the IRS's redesigned Form 990 will require disclosure and explanation of the full range of executive compensation to an extent never before seen in the nonprofit world.

1. *See* Chapter 24.
2. *See* Chapter 16.
3. *See* Chapter 4.

§ 28.1 THE REASONABLE COMPENSATION STANDARD

(a) General Principles

One of the most fundamental federal tax rules applicable to nearly all categories of tax-exempt organizations—and certainly to all charitable ones—is that private inurement may not occur.[4] This rule is phrased in this manner: ''No part'' of the organization's ''net earnings'' may ''inure'' to the benefit of ''any private shareholder or individual.''[5] For a form of this prohibited inurement to occur, the recipient of the benefit must be an *insider* with respect to the organization, such as an officer, director, or key employee. Private inurement thus entails some form of transfer of a financial resource (or resources) of the exempt organization to a person solely by virtue of that person's relationship with the organization, where an exempt function is not being advanced.

The most common form of private inurement is excessive compensation. A tax-exempt organization subject to the private inurement doctrine may pay compensation to an employee in the form of a salary, an hourly wage, a bonus, a commission, and/or the like, or make payments to a vendor, consultant, or other independent contractor.[6] The dictate of the private inurement doctrine, however, is that this compensation be *reasonable*, although the process for determining what is ''reasonable'' is less than clear. It is, in any event, a facts-and-circumstances test.[7]

Private inurement can be found in the compensation setting by reason of the method by which the compensation is calculated. The most offensive method is revenue-based compensation, particularly where the amount paid under this type of arrangement is computed on the basis of an organization's ''net earnings.''[8] The *per se* private inurement rule is inapplicable in the compensation context.[9] Thus, mere mechanics are not employed in determining reasonableness.

The process for determining reasonable compensation is much like that for appraising a property: common factors that have a bearing on its value are evaluated. It is an exercise of comparing a mix of variables pertaining to the

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4. The private inurement rules are the subject of Chapter 4.
5. IRC § 501(c)(3).
6. The distinction between an employee and an independent contractor is discussed in § 27.2.
7. ''Because of the different and complex compensation arrangements that may be involved in hospital cases, the determination of what constitutes unreasonable compensation is a facts and circumstances test'' IRS Exempt Organizations Examination Guidelines Handbook (IRM 7(10)69) § 333 (''Hospital Audit Guidelines''), Appendix E, at § 333.3(9)).
8. IRC § 501(c)(3) contains the requirement that ''no part of the net earnings'' of a tax-exempt charitable organization may ''inure[] to the benefit of any private shareholder or individual.''
9. *See* § 4.5.

compensation of others; this alchemy is supposed to yield a determination as to whether a particular item of compensation is reasonable or excessive.

Present law is not particularly clear as to the procedure to be used in ascertaining the reasonableness of compensation. Some principles are relatively obvious—for example, that an exempt organization can compensate individuals for services rendered. One court observed that the ''law places no duty on individuals operating charitable organizations to donate their services; they are entitled to reasonable compensation for their efforts.''[10] Another principle is that whether compensation paid is reasonable is a question of fact, to be decided in the context of each case.[11] A third principle is that all forms of compensation paid to an individual by an exempt organization—bonuses, commissions, royalties, fringe benefits, retirement benefits, and the like—are aggregated for this purpose; compensation is not merely confined to salary or a wage. A fourth principle is that the amount of time an individual devotes to a task is a factor: an amount of compensation may be reasonable when paid to a full-time employee, yet be unreasonable when the employee is only providing services on a part-time basis.

(b) Determining Reasonableness

The legislative history of the intermediate sanctions rules makes it clear that existing standards of law are to be used in determining the reasonableness of compensation and the fair market value of property, rental and borrowing arrangements, and the like.[12] For the most part, this body of law has been and is being developed in connection with the business expense deduction, under which an expenditure, to be deductible, must be ''ordinary and necessary,'' which is close to the standard of ''reasonableness.''[13] (In that setting, when there is a payment of compensation or similar outlay containing an element that is excessive, the excessive portion is treated as a dividend, which is not deductible.[14])

One of the principal criteria used in determining the reasonableness of compensation is the element of comparability. This entails evaluation of compensation levels paid by similarly situated organizations, both tax-exempt and taxable, for functionally comparable positions. To this end, compensation surveys by nationally recognized (and independent) nonprofit associations

10. *World Family Corporation v. Commissioner*, 81 T.C. 958, 969 (1983).
11. E.g., *Jones Bros. Bakery, Inc. v. United States*, 411 F.2d 1282 (Ct. Cl. 1969); *Home Oil Mill v. Willingham*, 68 F. Supp. 525 (N.D. Ala. 1945), *aff'd*, 181 F.2d 9 (5th Cir. 1950), *cert. denied*, 340 U.S. 852 (1950).
12. *See* § 4.9.
13. IRC § 162.
14. E.g., *Elliotts, Inc. v. Commissioner*, 716 F.2d 1241 (9th Cir. 1983); *Rapco, Inc. v. Commissioner*, 85 F.3d 950 (2d Cir. 1996); *Leonard Pipeline Contractors, Ltd. v. Commissioner*, 72 T.C.M. 83 (1996).

and employee compensation and benefits firms may be utilized. Thus, the board of trustees of a hospital, in endeavoring to assess the reasonableness of compensation paid to the chief executive officer of the hospital, would properly evaluate the levels of compensation paid to other hospital CEOs. Another element of comparability is the location of the organization; a compensation package that is reasonable in one portion of the nation might be unreasonable in another locale.

Other factors are the individual's expertise and training, whether the institution is seeking (including competing for) the services of a particular individual, and the amount of time the individual is devoting to the position. As to the second of these elements, for example, the fact that a hospital is seeking the acquisition of a particular physician for its medical staff is relevant in determining the reasonableness of any compensation eventually paid to that physician by the hospital. As to the third of these elements, a compensation package that is reasonable when the individual involved is working for the employer on a full-time basis may not be reasonable if the individual is working on half-time basis.

Still another factor—accorded greater importance as the consequence of enactment of intermediate sanctions—is whether the compensation package for an insider or disqualified person was approved by an independent board. This is a board of directors or trustees composed entirely of individuals who are not related to and not subject to the control of the disqualified person(s) involved in the arrangement. In lieu of an independent board, the same result may be achieved by means of an independent committee of the board.

The criteria for determining reasonableness of other types of transactions, such as rental and loan arrangements, are discussed elsewhere.[15] One of the outcomes of the intermediate sanctions law is emphasis on the documentation of the reasonableness of a transaction; the rules underlying the availability of the intermediate sanctions rebuttable presumption are useful in this context.[16]

It should also be noted that if a tax-exempt charitable or social welfare organization pays benefits to any person who is in a position to exercise substantial influence over the affairs of the organization and does not clearly indicate its intent to treat the benefits as compensation when paid, the IRS will view it as an automatic excess benefit transaction under the intermediate sanctions law and it will be irrelevant whether or not the compensation is reasonable.[17]

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15. *See* § 4.4.
16. *See* § 4.9.
17. *Id*. *See also*, Fiscal Year 2004 Exempt Organizations Continuing Professional Education Technical Instruction Program, ''Automatic'' Excess Benefit Transactions Under IRC 4958.

§ 28.2 HOSPITAL–PHYSICIAN COMPENSATION ARRANGEMENTS

There are several ways in which a tax-exempt hospital may compensate the physicians on its medical staff.

The least complicated of these arrangements is fixed compensation—a salary. Usually, this mode of compensation is reflective of employee status for the physician (rather than independent contractor status).[18] Fixed compensation, which accords the hospital maximum control over the physician's compensation, is the most predictable arrangement, and it allows the hospital the greatest control over patient charges. By contrast, an income guarantee arrangement[19] (associated with independent contractor status) that guarantees private practice income in the form of loans or subsidies for a specific period is likely to be closely examined (for possible private inurement) by the IRS because it typically is not related to services provided to or on behalf of the hospital.[20]

Under a fee-for-service arrangement, the physician is compensated based on his or her charges or on a fee schedule establishing the fee per unit of professional service rendered. This arrangement may provide for either separate billing by the physician, in which case he or she may not receive any compensation at all from the hospital, or billing by the hospital, with separately identified physician charges to be collected and remitted to the physician. When the physician is an employee, the fees billed to patients are generally considered income of the hospital. When the physician is an independent contractor, the fees are generally considered income of the physician. A fee-for-service arrangement generally gives the hospital little control over the physician's compensation. In certain circumstances, an independent contractor may also receive fixed compensation (such as for part-time administrative duties) along with the fee-for-service income.[21]

Physician compensation may be a function of a predetermined percentage of gross revenue or adjusted gross revenue[22] of a department of a hospital. The revenue involved may be derived from combined charges for facility use and professional services. This arrangement once was common for determining compensation for hospital-based specialists, such as radiologists,[23] but is less frequent today because of third-party payor restrictions.[24]

18. *See* Chapter 27.
19. *See* Chapter 25.
20. Hospital Audit Guidelines, at § 333.3(6)(a).
21. *Id*. at § 333.3(6)(b).
22. For this purpose, *adjusted gross revenue* is often defined as total charges less bad debt, contractual allowances, and other charge adjustments. In some instances, it is the collections actually received by the billing office as payments for services rendered.
23. Rev. Rul. 69-383, 1969-2 C.B. 113.
24. Hospital Audit Guidelines, at § 333.3(6)(c).

Some additional items may be part of a physician's compensation package, irrespective of whether he or she is an employee or independent contractor.

One is a guarantee of private practice income. The IRS may find this acceptable as part of a physician recruitment arrangement, where: the physician is relocating his or her practice to the service area of the hospital; there is sufficient objective evidence of need for the physician in the community; the level of income guaranteed is reasonable;[25] there is a reasonable and explicit ceiling on total outlays by the hospital; and there is an unconditional obligation to repay any amounts advanced by the hospital. Any forgiveness arrangement must be demonstrably related to community benefit[26] and treated as part of the physician's compensation.[27]

Another compensation item is rent subsidies. The hospital may provide office space within its building, or in an adjacent medical office building, for use in providing services to the hospital. This type of office space, when used in the physician's private practice, generally must be provided at a reasonable rental rate as gauged by market data and by actual rental rate charges to other tenants in the facility. If the physician splits his or her professional activities between duties for the hospital and private practice, the same office may be used for both types of activities. However, this utilization of the office must be fairly apportioned between hospital activities and private practice activities, with a reasonable rent charged for the latter.[28]

The hospital may provide support staff when a physician is rendering services to the facility. Support staff for use in the physician's private practice generally must be provided at a reasonable rate as gauged by market data and by actual staffing costs for similar physician offices. If the physician splits his or her professional activities between duties for the hospital and private practice, the same support staff may be used for both types of activities. Again, however, this utilization of support staff should be fairly apportioned between hospital activities and private practice activities, with a reasonable charge for the latter.

Other compensation features may include: unfunded deferred compensation arrangements,[29] loans, rentals of facilities or equipment, provision of services, and a range of retirement programs.[30]

A question that always arises as to physician compensation is: How much is too much? An Iowa newspaper reported in 2005 that a charitable tax-exempt Iowa medical center had been criticized by a competitor for paying two of its employed physicians annual salaries of more than $2 million.[31]

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25. *See* § 25.4.
26. *See* Chapter 6.
27. Hospital Audit Guidelines, at § 333.3(7)(a).
28. *Id*. at § 333.3(7)(b).
29. *See infra* § 28.6(b).
30. *See infra* § 28.6.
31. Tony Leys, ''$2 Million a Year Salaries for 2 Waterloo Doctors Under Fire,'' *Des Moines Register*, May 26, 2005.

The medical center paid an orthopedic surgeon more than $2.1 million in 2003 and a gastroenterologist approximately $2.1 million that year, according to the article, which used data contained in the medical center's Form 990. The medical center indicated that the physicians in question worked very long hours and handled heavy caseloads. However, the leader of the competing medical practice said in the article that the $2 million salaries are much greater than the average national pay for the doctors' specialties. He complained that it was unfair that his taxable, for-profit group practice must compete against a tax-exempt hospital that can afford to pay that much to its staff physicians. The medical center stated in the article that the doctors' pay was based on a formula that takes the amount of business they brought to the institution and subtracts expenses.

The IRS has generally been accepting of higher levels of compensation to employed physicians where they are being compensated for work done at their own hands or under their direct supervision.[32] If a physician is working hours and performing procedures far in excess of his or her colleagues, the physician has earned the right to receive higher compensation. The IRS generally has not been receptive to compensation schemes whereby the physician receives some portion of compensation for work that the physician did not perform or supervise. While a credible argument can be made that there should be no limit to compensation that a physician receives from direct work, the IRS has suggested in the past that a cap or collar on income would nevertheless be appropriate. Certainly, when a physician is being compensated far in excess of the median for peer groups, there is a higher burden to demonstrate that the compensation is reasonable. Also, greater scrutiny can be expected from the IRS, competitors, and the local newspaper.

§ 28.3 EXECUTIVE COMPENSATION

(a) Introduction

At the core of most scrutiny of executive compensation packages by the IRS, Congress, state regulators, and charity watchdog groups is the simple question of whether the executive is being paid too much for his or her services.[33] This question was the central element of high-profile litigation between the New York Attorney General and the former head of the New York Stock Exchange, which serves as an apt introduction to this topic.[34]

32. For a discussion of physician incentive compensation, see § 25.5(c).
33. *See, e.g.*, *Final Report of the Panel*, Section III, Recommendations, at 66, Panel on the Nonprofit Sector (June 2005).
34. *People of the State of New York, by Eliot Spitzer v. Richard A. Grasso, Kenneth G. Langone, and the New York Stock Exchange, Inc.*, Index No. 401620/2004 (N.Y. Sup. Ct., filed May 24, 2004).

The New York Stock Exchange, Inc. (the ''NYSE'') was originally created as a New York Not-for-Profit Corporation. (It was not, however, recognized by the IRS as a charitable organization under federal tax law.)[35] Richard A. Grasso served as the chairman and chief executive officer of the NYSE from 1995 until his dismissal on September 25, 2003. Kenneth G. Langone joined the NYSE Board of Directors in June 1998, and served as chairman of the Compensation Committee until June 2003. On May 24, 2004, New York Attorney General Eliot Spitzer filed a lawsuit against Grasso, Langone, and the NYSE. Spitzer's lawsuit alleged that Grasso's compensation and benefits violated the New York Not-for-Profit Corporation Law. Grasso filed an Answer, Counterclaim and Crossclaim, against the NYSE and John S. Reed, then-interim chairman of the NYSE, respectively, for breach of contract and defamation.

The New York Not-for-Profit Corporation law provides that the compensation of officers of not-for-profit corporations must be ''reasonable'' and ''commensurate with the services performed.'' In the suit, Spitzer alleged that Grasso's compensation and benefits violated these principles because they were (1) objectively unreasonable; (2) the product of a process that permitted Grasso improperly to influence both the amounts awarded to him and the members of the NYSE Compensation Committee and the Board of Directors who were required to approve those awards; and (3) approved by the NYSE Board of Directors based on materially incomplete, inaccurate, and misleading information.

The Complaint alleged that the amount the NYSE expensed in connection with Grasso's compensation and benefits for 2000 through 2002 was equal to 99 percent of the NYSE's net income during those years, amounts in excess of what is allowable under the New York Not-for-Profit Law. In total, Grasso is alleged to have received between $144.5 million and $156.7 million in compensation and benefits over the course of his tenure as chairman of the NYSE.

The Complaint further alleged that inaccurate and misleading information in the form of incomplete and incorrect analyses were provided to board members regarding Grasso's compensation and benefits. It also alleged that Grasso had the ability to control and manipulate the assessment required to calculate the benchmark for Grasso's pay, in effect increasing his compensation. The complaint further stated that Grasso's dual role as regulator and NYSE employee raised a conflict of interest.

On October 19, 2006, the New York State Supreme Court ordered Mr. Grasso to repay a substantial portion of his compensation.[36] The court held that he failed in his duty to keep the board of directors updated on the increases in his compensation packages.

The issue of reasonable compensation for nonprofit executives is a major operational concern for tax-exempt organizations. Charitable organizations

35. In 2006, the NYSE became a publicly traded, for-profit company.
36. Index No. 401620/04 (N.Y. Sup. Ct., Oct. 19, 2006).

struggle to find the right balance in compensation arrangements that will motivate and fairly reward executives consistent with best practices and compliant with federal tax law. The compliance risks run mainly to the exempt organization, but in light of growing enforcement of intermediate sanctions law by the IRS, they increasingly run to the individuals being compensated.

(b) GAO Survey on Nonprofit Health System Executive Compensation

On June 30, 2006, the U.S. Government Accountability Office (GAO) issued a 63-page report on its survey of 100 nonprofit hospitals and health systems.[37] The report was commissioned by the House Ways and Means Committee and focused on three issues related to executive compensation issues in nonprofit organizations:

1. What governance is exercised over executive compensation?
2. What is the basis for the compensation and benefits paid to CEOs and the four top healthcare executives of each healthcare system?
3. What internal controls exist for the review and approval of executive travel and entertainment expenses, gifts, and other perquisites?

Notable survey results from the 65 hospitals responding included the following:

- Healthcare systems commonly have policies and practices for establishing executive compensation, such as having an executive compensation committee or the full Board with primary responsibility for approving the CEO's and top four executives' base salary, bonuses, and perquisites.
- All had conflict-of-interest policies that cover the body that awards executive compensation and 40 of 65 had a policy that requires compensation consultants be free of any conflicts as well.
- There is reliance upon comparable market data of total compensation and benefits prior to making compensation determinations.
- The healthcare systems surveyed commonly have policies and practices for travel and entertainment expenses and perquisites, such as written policies that address business travel and entertainment expenses, and written policies that provide payment of auto-related expense and/or the provision of company-paid automobile.
- Regarding membership in recreational or social clubs, 45 of 65 systems reported providing this fringe benefit to CEOs and 35 of 65 reported providing it for the other top four executives.

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37. GAO Report, ''Nonprofit Hospital Systems: Survey on Executive Compensation Policies and Practices,'' GAO-06-907 R (June 30 2006).

- 13 systems provide personal travel expenses for the spouse of the CEO.
- 28 systems report paying the CEO to attend sports events and 29 do so for the other top four executives.
- 17 systems report paying the CEO to attend theater performances and 16 do so for the other top four executives.
- 48 systems report paying the CEO and other top four executives a perquisite to attend meetings, retreats, and other offsite activities at resort locations or private exclusive clubs.
- Severance packages to CEOs and the top four executives are rare with only 7 of 41 systems making such payments when a high-level executive is voluntarily leaving the organization.
- 63 of 65 systems reported they do not make loans to the CEO or the other top four executives.

In addition to congressional interest in executive compensation, the IRS continues to increase its review of this area. In February 2005, the IRS issued its *Executive Compensation–Fringe Benefits Audit Techniques Guide*, an instruction manual for its agents on special areas to focus upon during field audits.[38] Travel and entertainment expense documentation, and appropriate use of listed property, such as proper documentation of cell phones and computers for business use and loans to executives, are all areas of increased scrutiny.

(c) IRS Executive Compensation Compliance Project

In 2004, the IRS commenced a new enforcement effort, the Executive Compensation Compliance Project, to identify and halt abuses by tax-exempt organizations that pay excessive compensation and benefits to their officers and other insiders.[39] The IRS contacted approximately 2,000 charities and foundations in order to obtain information about their compensation practices and procedures. The project consisted of examinations as well as other ‘‘soft contacts.’’

The IRS stated that the purposes of this project were to: address the compensation of specific individuals or instances of questionable compensation practices; increase awareness of tax issues as organizations set compensation in the future; and learn more about the practices organizations are following as they set compensation and report it to the IRS and the public on their annual Form 990 returns.

The IRS focused on compensation of officers, insider transactions, and the sale, exchange, or leasing of property to officers and others. The IRS also

38. IRS Executive Compensation–Fringe Benefits Audit Techniques Guide (02-2005).
39. IRS Information Release 2004-106.

focused on Form 990 reporting, particularly reporting practices regarding excess benefit transactions.

The IRS released in March 2007 a report on its Executive Compensation Compliance Project.[40] The report contained the following noteworthy findings:

- Significant reporting issues exist. Over 30 percent of compliance check recipients amended their Forms 990. Fifteen percent of the compliance check recipients were selected for examination.
- Examinations completed as of the date of the report did not evidence widespread concerns other than reporting. However, as this was not a statistical sample, no definitive statement could be made concerning the compliance level in this area.
- Where problems were found, significant dollars were being assessed (25 examinations resulted in proposed excise tax assessments under Chapter 42, aggregating in excess of $21 million, against 40 disqualified persons or organization managers.)
- Although high compensation amounts were found in many cases, generally they were substantiated based on appropriate comparability data.
- Additional education and guidance, as well as training for agents, are needed in the areas of reporting requirements and the ''rebuttable presumption'' procedure that may be relied upon by public charities to establish appropriate compensation.

(d) Loans to Executives

Loans from nonprofit corporations to their employees, particularly to executives, as a compensation device have fallen into disfavor. The Sarbanes–Oxley Act of 2002 led the way for this change with its restrictions on loans between publicly traded companies and their executives, and this principle has taken hold at the nonprofit level as well. Although some commentators believe it creates a conflict of interest for an executive, the IRS has not interpreted the Internal Revenue Code as prohibiting a nonprofit from providing a loan to an employee as a recruitment benefit or a form of compensation. The reason that loans are now discouraged is a direct result of the abuses that have occurred in the use of this benefit. Frequently, loans were used as a form of disguised compensation in which it was never truly intended that the loan be repaid and the forgiveness was not reported as income to the employee. Or, the loan was interest free or at a below market rate and this element of compensation was not reported as income. However, loans made for a legitimate

40. www.irs.gov/pub/irs-tege/exec._comp._final.pdf.

purpose such as to enable an executive to purchase a home or to make a transition to a new job have largely escaped criticism where they are reasonable in nature and treated as an arm's-length transaction between the parties.

The IRS Hospital Audit Guidelines directly address the issue of loans made to employees or insiders. They provide that the following factors should be considered to determine whether any loans made to a physician, employee, or other insider are reasonable: generally, the agreement should specify a reasonable rate of interest (prime plus 1 or 2%) and include adequate security; the decision should be reviewed by the board of directors and should include consideration of the history of payment on prior loans by the physician or employee; and even if determined reasonable, any variance in the terms of the loan from what the borrower could obtain from a typical lending institution must be treated as compensation, and reported at the appropriate time on form W-2 or 1099. [41]

Accordingly, if the loan is made under commercially reasonable terms and any below-market interest rate or forgiveness is reported as income to the employee, and if the employee's overall compensation is reasonable when this benefit is taken into account, the loan should not pose any significant risk of adverse tax exemption consequences.

As to the reasonableness of interest rates, the IRS has indicated in guidance that use of the appropriate applicable federal rate (AFR) (based on length of term and frequency of compounding) is acceptable proof of reasonableness. This is consistent with the fact that the AFR is the interest rate the IRS pays on its own obligations, and below that rate, the ''free'' interest component is imputed income to the borrower under the Internal Revenue Code. The IRS's Hospital Audit Guidelines suggest that prime plus 1 or 2 percent is a reasonable rate of interest; however, the Guidelines are not mandatory. Indeed, the IRS has frequently supported the use of below-market interest rates for physician recruitment purposes where there is objective evidence of community need for the physician's services.

The Pension Protection Act of 2006[42] changed the intermediate sanctions law to treat loans between supporting organizations and disqualified persons as automatic excess benefit transactions; this is a substantial change in the law. Under the new law, a loan by a supporting organization to a disqualified person would become an automatic excess benefit transaction and the executive would be required to repay the full amount of the loan and any interest accrued to the exempt organization and would potentially be subject to a penalty excise tax on top of that.

Additional explanation of this provision was provided in guidance by the IRS.[43] The IRS stated that it will not consider any payment made pursuant to

41. IRS Hospital Audit Guidelines, at § 333.3 (10).
42. Pub. L. 109–280, 120 Stat. 780.
43. IRS Notice 2006-109.

a written contract that was binding on August 17, 2006 as an excess benefit transaction provided that (1) such contract was binding at all times after August 17, 2006, and before payment is made, (2) the contract is not modified during such period, and (3) the payment under the contract is made on or before August 17, 2007. Termination of the contract does not constitute a modification for this purpose. Thus, under this guidance, the IRS would not consider loans made to a disqualified person as an excess benefit transaction if the loan was made prior to the effective date.

The application of this provision is clear: supporting organization–type public charities can no longer make loans to executives who fit the definition of a disqualified person under the IRS intermediate sanctions rules. Bear in mind that because this new restriction is automatic, it is irrelevant that there is a legitimate charitable purpose behind making the loans, or that their terms are at fair market value and otherwise commercially reasonable, or that the loan is (or is not) forgivable. If such a loan is made, it is an automatic excess benefit transaction; the loan must be immediately repaid in full including interest, it must be reported to the IRS on Form 990, and the recipient is liable for a tax equal to 25 percent of the full loan amount plus an additional 200 percent of the full loan amount if it is not timely repaid.

It will be extremely important to not modify any loan agreements between a supporting organization and disqualified persons that were written and binding before August 17, 2007 prior to their completion as this would likely cause the entire amount of such loans to become an automatic excess benefit transaction under the new law.

It is worthy of note that in some states there is an express statutory provision prohibiting loans from a nonprofit organization to its directors and officers. Typically, in those statutory provisions, members of the board that approve such a loan can be held individually liable for the repayment of the loan.

(e) Incentive Compensation

Incentive compensation for nonprofit executives is receiving increasing scrutiny as well, and IRS guidance on permissible methodologies has been scarce. However, in a 2006 ruling, the IRS considered an incentive compensation plan proposed by a tax-exempt publicly supported organization. The entity was a nonprofit educational organization designed to encourage creative research work and the making of discoveries and inventions in connection with other parties. The organization had a self-perpetuating board of directors and its bylaws provided for a standing compensation committee. The organization also had a conflict-of-interest policy that applied to all of its officers, members of the board, and members of any committee with board-delegated powers.

The organization proposed to adopt a long-term incentive bonus program in order to provide financial incentives to, and rewards for, eligible employees

who made key contributions to its core operations and to the development of commercial uses for its science and technology discoveries. Under the program, participants would include eligible senior management employees, executive officers, and the chief executive officer. Each year, the compensation committee would nominate individuals to be eligible to receive a bonus for that year to the full board. If a prospective participant was not an executive officer, then the executive officers would recommend individual performance objectives to the compensation committee for that participant. In the case of executive officers, the compensation committee would establish individual performance objectives; in the case of the chief executive officer, the board itself would establish the CEO's individual performance objectives.

Each participant's performance would be assigned a performance score reflecting the individual's level of achievement of the performance objectives. Based on the performance score, the compensation committee would determine a potential bonus award for each participant. The potential bonus award would be based on a percentage of the participant's base salary. The organization would not actually pay any bonus unless and until it received appropriate sources of revenue to fund the bonus program. The board, in its full discretion, could cancel or reduce potential bonus awards at the time of payment.

In its ruling, the IRS found that the bonus program was designed to ensure that the financial incentives would constitute reasonable compensation. It analogized the provisions of the program to those set forth in an earlier revenue ruling issued by the IRS in the area of physician recruitment benefits.[44] As a result, the IRS concluded that the organization's adoption and operation of the bonus program would not adversely affect its tax-exempt status as a charitable organization.[45]

§ 28.4 BOARD COMPENSATION

Historically, directors served on nonprofit boards without compensation. They typically received only payment for or reimbursement of their out-of-pocket expenses incurred in the course of their duties as directors (e.g., travel expenses and meeting costs).

As nonprofit organizations have matured—some healthcare providers are billion-dollar businesses—the need for skilled directors has intensified and the difficulty in recruiting and retaining competent directors has greatly increased. As a result, some nonprofits find it necessary to provide an honorarium or stipend to directors in exchange for their services.[46]

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44. *See* Rev. Rul. 97-21 at Appendix I.
45. Priv. Ltr. Rul. 200601030.
46. While payment of board compensation is on the rise, the trend is not without its detractors. The Panel on the Nonprofit Sector in its Final Report discourages payment of compensation to board members by charitable organizations. See *Final Report of the Panel*, Panel on the Nonprofit Sector (June 2005).

There is little data available on the magnitude of these payments. The proper analysis is the same as would be used for any other compensation to a service provider: Are the payments reasonable in consideration of the services provided? The determination is subject to greater scrutiny because the board of directors, which is charged with responsibility for ensuring that the organization pays only reasonable compensation for services rendered, is inherently conflicted; it will be determining its own compensation. Accordingly, the board and management should make every effort to obtain comparable data from independent consultants, similar but unrelated organizations, or published surveys. Since directors are disqualified persons for purposes of the intermediate sanctions rules, the penalty for a failure to perform appropriate due diligence here may be an intermediate sanctions excise tax on the director and the obligation to return any excess payment to the organization. At a minimum, boards should be sure that any director compensation passes the "front-page" test. This information must be reported on the organization's Form 990, which is a public record document and readily available on the Internet.[47]

Directors should also be wary of state law provisions for limiting liability for volunteers. Many states will limit the personal liability of directors for their acts taken in good faith on behalf of the nonprofit organization—if they are volunteers. Payment of stipends to directors for board service may have the undesirable consequence of removing these important protections for directors.

§ 28.5 OVERVIEW OF EMPLOYEE BENEFITS LAW

Basically, employees—whether of tax-exempt healthcare organizations, other nonprofit organizations, for-profit organizations, or governments—are individuals who provide services to an employer. That is, these individuals—who by definition are not independent contractors—are provided compensation in exchange for their services.[48] For the most part, the law in this regard—both tax law and non-tax law—is identical with respect to both nonprofit and for-profit employees and employers.

Compensation in general is provided in two forms: (1) current and (2) deferred (the latter includes retirement programs). Both of these forms of compensation are available to employees of nonprofit healthcare and other organizations. Compensation generally is includable in gross income when actually or constructively received. An amount is constructively received by an individual if it is made available to the individual or the individual has an election to receive the amount.

47. *See, e.g.,* www.guidestar.org.
48. *See*, in general, Chapter 27.

Under one exception to this general principle of constructive receipt, no amount is included in the gross income of a participant in a qualified cafeteria plan[49] solely because, under the plan, the participant may elect among cash and certain employer-provided qualified benefits. In general, a qualified benefit includes employer-provided accident or health coverage, group-term life insurance coverage (whether or not subject to tax by reason of being in excess of the dollar limit on the exclusion for the insurance), and benefits under dependent-care assistance programs. Employer contributions to the cafeteria plan are usually made pursuant to salary reduction agreements between the employer and the employee, in which the employee agrees to contribute a portion of his or her salary on a pretax basis to pay for the qualified benefits. This type of plan must be in writing, must include only employees (or former employees) as participants, and must satisfy certain nondiscrimination requirements. An annual return for the plan must be filed with the IRS.

Whatever the mode of compensation—wages, salaries, bonuses, commissions, fringe benefits, deferred compensation, and/or pension and retirement benefits—tax-exempt healthcare and most other exempt organizations are constrained by the private inurement doctrine.[50] This essentially means that nearly all compensation of nonprofit employees, no matter how determined or whatever the form, must—for the employer to be or remain tax-exempt—be ''reasonable.''[51]

(a) Current Compensation in General

A nonprofit healthcare organization may pay salaries and/or wages, as forms of ''current'' compensation. As noted, these payments must be reasonable. Current compensation that is reasonable includes appropriate salary increases based on merit and appropriate cost-of-living adjustments.

A nonprofit healthcare organization may pay bonuses—again, subject to the standard of what is reasonable. However, a bonus is likely to be more closely scrutinized by the IRS than regular current compensation, because it is additional compensation and thus more susceptible to the allegation that it is excessive compensation or an otherwise inappropriate payment that is a form of private inurement or private benefit. This sensitivity as to the potential for

49. That is, a plan described in IRC § 125.
50. *See* Chapter 4. In this regard, private foundations also must take into account the rules concerning self-dealing (§ 5.9).
51. The criteria for determining reasonableness of compensation are discussed in § 28.1, *supra*. In a sense, the same rule applies with respect to for-profit employers, in that, to be deductible as a business expense, a payment of compensation must be ''ordinary and necessary'' (IRC § 162). Moreover, this standard of reasonableness also applies to payments to independent contractors, consultants (such as lawyers, accountants, fund-raisers, appraisers, and management consultants), and vendors.

private gain is heightened where a bonus is paid to an individual who is a director, officer, or principal employee.

In many respects, commissions are subject to the same rules as bonuses. However, commissions and other forms of percentage-based compensation can result in particular analysis because they are computed using percentages and thus tend to approximate, if not constitute, private inurement.[52] The IRS is likely to carefully review compensation programs of tax-exempt healthcare organizations that are predicated on an incentive feature whereby compensation is a function of revenues received, is guaranteed, or is otherwise outside the boundaries of conventional compensation arrangements.

For example, the IRS has developed criteria for assessing compensation arrangements based on a percentage of a tax-exempt organization's gross revenues.[53] The factors the IRS uses in this regard are whether the compensation actually paid was reasonable, the agreement was completely negotiated at arm's length, the service provider participated in or had control over the operation of the organization, the ''contingent'' payments served a ''real discernable business purpose'' of the organization (that is, independent of any purpose to benefit the service provider), the amount of compensation is dependent on the accomplishment of the objectives of the compensatory arrangement, actual operating results revealed any evidence of abuse or unwarranted benefits to the service provider, and there is a ''ceiling or reasonable maximum limit'' in the compensation agreement to avoid a ''windfall benefit'' to the service provider based on factors ''which had no direct relationship to the level of services provided.''

In the healthcare field, the closest scrutiny visited by the IRS on exempt organizations occurs where the individuals being compensated are physicians. This phenomenon is manifested acutely in the area of physician recruitment and retention.[54]

Therefore, all forms of current compensation paid by tax-exempt healthcare organizations are basically subject to the rule of reasonableness, with the tax exemption of the employer at risk if the amount of compensation is determined to be unreasonable and/or excessive.

(b) Fringe Benefits

Federal tax and other law does not prohibit the payment of fringe benefits by tax-exempt healthcare organizations. A *fringe benefit* is any property or service (or money, under certain circumstances) that an employee receives from an employer in lieu of or in addition to regular taxable compensation. If a benefit is not specifically excluded from gross income under the federal tax

52. *See* § 4.4, text accompanied by notes 116–156.
53. These criteria have appeared in questions propounded to organizations by the IRS in the course of the authors' practice.
54. *See* Chapter 25.

law, its value must be treated as current compensation. Once again, a fringe benefit (or a package of them), paid by a tax-exempt employer to an employee, must be reasonable, to preserve the tax exemption of the employer.

Certain fringe benefits are excluded from an individual's gross income; these are no-additional-cost services, qualified employee discounts, working condition fringes, and *de minimis* fringes.[55] The latter two are the most likely in the tax-exempt organizations context. A *working condition fringe* is any service or item of property provided to an employee by an employer to the extent that, if the employee paid for the service or property, the payment would be allowable as a business expense or depreciation expense deduction.[56] A *de minimis fringe* means a service or item of property the value of which is so small as to make accounting for it unreasonable or administratively impracticable.[57] The operation by an employer of an eating facility for employees is treated as a *de minimis* fringe if the facility is located on or near the business premises of the employer and the revenue derived from the facility normally equals or exceeds the direct operating costs of the facility.[58] Generally, these fringe benefits are excludable by those who are employees, whether these individuals are compensated or working as volunteers (where the exempt organization has the right to direct or control the volunteers' services).

Typically, an employer that is a tax-exempt organization will pay for fringe benefits in the form of insurance programs, such as for health, major medical, dental, disability, life, and perhaps travel coverages. For the most part, exempt employers can pay for one or more of these benefits without tax law difficulties.

Other common forms of fringe benefits paid (either directly or by reimbursement) by employers in general include meals and entertainment costs, automobiles, moving expenses, costs of attending conventions and educational seminars, club memberships, awards and prizes, scholarships and fellowships, educational assistance, and the costs of certain professional fees (such as physicians' charges for physicals, financial planning fees, and stress management expenses). Parking benefits may also be provided to employees if they are provided through a qualified transportation fringe benefit plan.

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55. IRC § 132(a).
56. IRC § 132(d). One example of a working condition fringe benefit is the provision of officers' and directors' liability insurance. When a bona fide volunteer (including a director or officer) performs services for a tax-exempt organization, the law deems the volunteer to have a ''profit motive'' for purposes of the business expense deduction requirement (Reg. § 1.132-5(r)(1),(2)). For this purpose, an individual is a bona fide volunteer only if the total value of the benefits provided with respect to the volunteer services is substantially less than the total value of the volunteer services the individual provides to the organization (Reg. § 1.132-5(r)(3)(i)). *See*, in general, Cerny, ''D and O Insurance Premiums Paid by Charitable Organizations Are Not Taxable,'' 3 *J. Tax. Exempt Orgs*. 5 (Winter 1992).
57. IRC § 132(e)(1).
58. IRC § 132(e)(2).

These latter types of fringe benefits are likely to cause problems for the tax-exempt organizations that pay them. Some entities may be able to pay items such as moving expenses, continuing education expenses, and perhaps automobile and parking expenses, without attracting too much interest by the IRS. Generally, however, a tax-exempt organization will be suspect, in the eyes of the IRS and other regulators (and perhaps the general public)[59] if its employees are granted substantial benefits such as country club memberships, financial planning services, or sizeable travel and entertainment allowances.[60]

§ 28.6 DEFERRED COMPENSATION IN GENERAL

Tax-exempt healthcare organizations may provide ''deferred compensation'' to their employees. As with forms of current compensation, deferred compensation programs are subject to the rule of reasonableness.[61]

These programs are known as *plans*. A plan is manifested by a plan document, each of the individuals involved in a plan is a *participant*, each participant in a plan is assigned an *account* in a defined contribution plan or an accrued benefit in a defined benefit pension plan, the participants and/or those persons they may designate under various conditions are the *beneficiaries*, and for all qualified plans and some types of nonqualified deferred compensation plans, the plan is accompanied by a *trust* or other *fund* that holds the plan assets and makes the requisite distribution to the beneficiaries. In general, these underlying funds are tax-exempt organizations.[62] *Contributions* to these plans are made by the employer and, in some instances, by the employees. The plan document sets forth the manner in which the contributions are invested, the funds allocated to participants' accounts, and benefits distributed.

Deferred compensation programs embrace retirement, pension, and profit-sharing plans. A nonprofit organization can maintain a profit-sharing plan;[63]

59. It should always be remembered that the offices of the attorney general in the states have a parens patriae interest in the financial affairs of nonprofit organizations, particularly charitable ones.
60. The governing board of a nonprofit, particularly charitable, organization has fiduciary responsibilities that can be violated where excessive benefits and other compensation are paid or otherwise afforded to the organization's employees.
61. *See* § 28.1, *supra*.
62. The statutory basis for this tax exemption is IRC § 501(a) (the same as for most tax-exempt organizations). Most of these trusts are described in IRC § 401(a); others are in IRC § 501(c)(9), (11), (17), (18), (21), (22), and (24). However, in some instances, the underlying fund is not tax-exempt, such as that in connection with the group legal service organization (which operates prepaid legal services programs); the authorization for tax exemption that was once provided for these organizations (former IRC § 501(c)(20)) expired as of June 30, 1992. *See*, in general, Hopkins, The Law of Tax-Exempt Organizations (9th ed. 2007).
63. IRC § 401(a)(27).

in the plan document, the words ''excess of revenue over expenses'' are substituted for the word ''profit.'' These plans are usually subject to various laws, including the Employee Retirement Income Security Act (ERISA).[64] The laws in this field impose requirements regarding employee participation, coverage, vesting of interests, funding, nondiscrimination, portability of benefits, fiduciary responsibility, prohibited transactions, preparation of plan summaries, annual reporting and disclosure rules, and similar matters.

Government supervision of these plans is largely the responsibility of the IRS and the Department of Labor. The Pension Benefit Guaranty Corporation administers a program of plan termination insurance for some defined benefit pension plans.

These programs are basically divided into *qualified plans* and *nonqualified plans*.

(a) Qualified Plans

A qualified plan is a deferred compensation plan that is funded and is tax-exempt.[65] This type of plan must satisfy a variety of tax law and other qualification requirements, as to discrimination[66] in favor of highly compensated employees, limitations on contributions and benefits, coverage of employees, participation levels, vesting, funding, portability, holding of investments, and other requirements. The plan may, but is not required to, obtain a *determination letter* as to qualification from the IRS.

For for-profit organizations, it is desirable for a plan to be a qualified one, to enable employer contributions to the plan to be deductible as business expenses. (This tax feature, of course, is not relevant to tax-exempt organizations.) Other considerations of a qualified plan are that the income and capital gains from the assets underlying the plan are not subject to the federal income tax; they are held in a tax-exempt trust,[67] and the beneficiaries of the plan are usually not taxed on their benefits until they are actually received.

Qualified plans are either *defined benefit plans* or *defined contribution plans;* the latter are also referred to as individual account plans. A pension plan may fall into either category.

(i) Defined Benefit Plans. A *defined benefit plan* is a plan established and maintained by an employer primarily to systematically provide for the payment of definitely determinable benefits to its employees over a period of years, usually life, following their retirement. Retirement benefits under a

64. 88 Stat. 829 (1974).
65. IRC § 401(a).
66. In Notice 96-64, 1996-2 C.B. 229, as modified by Notice 99-40, 1999-35 I.R.B. 324, the IRS provided guidance on the application of nondiscrimination rules to qualified plans maintained by governments and organizations exempt under IRC § 501(a).
67. IRC §§ 501(a) and 401(a).

defined benefit plan are measured by and based on various factors, such as years of service rendered and compensation earned by the employee. The determination of the amount of benefits and the contributions made to the plan are not dependent on the profits of the employer. Under a defined benefit plan, the benefits are established in advance by a formula, and the employer contributions are treated as the variable factor.[68]

Any plan that is not a defined benefit plan is a defined contribution plan.

(ii) Defined Contribution Plans. A *defined contribution plan* is a plan that provides an individual account for each participant and bases benefits solely on the amount contributed to the participant's account and any expense, investment return, and forfeitures allocated to the account.

This type of plan defines the amount of contribution to be added to each participant's account: (1) by directly defining the amount the employer will contribute on behalf of each employee or (2) by leaving to the employer's discretion the amount of contribution but defining the method of allocation. The individual accounts must receive, at least annually, their share of the total investment return, including investment income received and realized, and unrealized gain unless the accounts are self-directed.

Ordinarily, the total plan assets are completely allocated to the individual accounts. If a participant terminates his or her employment before becoming vested, the nonvested portion of the account balance is forfeited and, depending on the type of plan, is applied either to reduce future employer contributions or to increase the accounts of other participants. When a participant becomes eligible to receive a benefit, his or her benefit equals the amount that can be provided by the account balance. The benefit may be paid in the form of a lump-sum distribution, a series of installments, or an annuity for the lifetime of the participant or for the joint lifetimes of the participant and one or more other beneficiaries.

Where the undertaking is to set aside periodic contributions according to a predetermined formula, the plan is referred to as a *money purchase pension plan*. Contributions are generally expressed as a percentage of covered payroll, with the rate sometimes varying with the employee's age at entry into the plan. A *target benefit plan* is a money purchase plan that sets a targeted benefit to be met by actually determined contributions. Special antidiscrimination rules apply to target benefit plans.

Another type of defined contribution plan is a *profit-sharing plan*. The plan must have a definite, predetermined formula for allocating contributions made pursuant to the plan among the participants, and for distributing the funds accumulated under the plan after a fixed number of years or the

68. *See*, generally, Rev. Proc. 95-51, 1995-2 C.B. 430, which provides approval for various changes in the funding methods used to determine minimum funding standards for defined benefit plans.

attainment of a stated age, or upon the prior occurrence of some event, such as layoff, other severance of employment, illness, disability, retirement, or death. A profit-sharing plan may, but is not required to, have a definite, predetermined formula for computing the amount of annual employer contributions.

Other defined contribution plans (some of which are profit-sharing plans) include stock bonus plans, employee stock ownership plans, thrift plans, simplified employee pension plans (which can be a form of individual retirement accounts), and so-called cash or deferred arrangements.

(iii) Funding Mechanism. The usual method of funding a pension or profit-sharing plan is by means of employer contributions, generally held in a tax-exempt trust. (In some cases, employees may also contribute.) A trusteed plan uses a trust to receive and invest the funds contributed under the plan and to distribute the benefits to participants and/or their beneficiaries. For a trust forming part of a pension, profit-sharing, or like plan to constitute a qualified trust: (1) the trust must be created or organized in the United States and must be maintained at all times as a domestic (U.S.) trust; (2) the trust must be part of a pension, profit-sharing, or similar plan established by the employer for the exclusive benefit of the employees and/or their beneficiaries; (3) the trust must be formed or availed of for the purpose of distributing to employees and/or their beneficiaries the corpus and income of the fund accumulated by the trust in accordance with the plan; (4) it must be impossible under the trust instrument, at any time before all liabilities with respect to employees and their beneficiaries are satisfied, for any part of the trust's corpus or income to be used for, or diverted to, purposes other than for the exclusive benefit of employees and/or their beneficiaries; (5) the trust must be part of a plan that benefits a nondiscriminatory classification of employees under IRS guidelines and provides nondiscriminatory benefits; and (6) if the trust is part of a pension plan, the plan must provide that forfeitures cannot be applied to increase the benefit of any participant.

The tax advantages of a qualified plan can be obtained without the use of a trust through an *annuity plan*, under which contributions are used to purchase retirement annuities directly from an insurance company. An annuity contract is treated as a qualified trust if it would, except for the fact that it is not a trust, satisfy all the requirements for qualification. In that case, the individual who is the beneficiary of the annuity is treated as if he or she were the trustee.

A segregated asset account of a life insurance company can be used as an investment medium for assets of a qualified pension, profit-sharing, or annuity plan. Assets of a qualified plan may be held in this type of account without the use of a trust.

Another form of nontrusteed plan is the use of a custodial account. Under this approach, the employer arranges with a qualified financial institution to

act as custodian of the plan funds placed in the account. Although a custodial account is not a trust, a qualifying custodial account is treated for tax purposes as a qualified trust.

(b) Nonqualified Plans

Nonqualified plans are used as a means to provide supplemental benefits and/or to avoid the technical requirements imposed on qualified plans. The employer's deduction is deferred until the amount attributable to the contribution is includable in the employee's income. Nonetheless, nonqualified plans are of considerable importance to tax-exempt employers.

The federal tax consequences of nonqualified plans vary, depending on whether the plan is funded or unfunded. Where the plan is funded, contributions by an employer to a nonexempt employees' trust or other person (such as an insurance company) are includable in an employee's gross income in the first tax year in which the rights of the individual having the beneficial interest in the trust are transferable and are not subject to a substantial risk of forfeiture. An unfunded plan is one where the participants have only a contractual promise from the employer that future payments will be made. The tax consequences to an employee under an unfunded arrangement are determined by application of the doctrines of constructive receipt or economic benefit.

Funds in these plans are reachable by general creditors of the employer.

CHAPTER TWENTY-NINE

Medicare and Medicaid Fraud and Abuse and Its Effect on Exemption

§ 29.1 The Conflict and Confluence of Tax Policy and Health Policy 723

§ 29.2 Fraud and Abuse Violations as a Basis for Revocation of Exemption 728

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§ 29.1 THE CONFLICT AND CONFLUENCE OF TAX POLICY AND HEALTH POLICY

At first blush, tax policy and health policy seem to have little to do with each other. Tax policy, presumably, is intended to bring dollars into the public fisc in a manner that is most fair to all. Health policy, presumably, is intended to ensure that the health of the public is promoted and protected to the greatest benefit of all. However, there is often a confluence of the two policies. For example, tax policy is a vehicle that has been used by Congress to promote the provision of healthcare services to the indigent. Thus, by reviving the notion that tax-exempt hospitals must provide charity care as a *quid pro quo* of their tax exemption,[1] Congress is using tax policy not as a means of collecting additional revenues, but rather as a means of ensuring that tax dollars are being properly spent (or more accurately, forgone) to secure the provision of healthcare services to the indigent.

With regard to the tax-exempt organization provisions of the Code and the Medicare and Medicaid programs, however, there is both confluence and conflict of tax and health policy. It is not difficult to understand why there is conflict between the two. Tax and health policy are necessarily brought together because of the nature of the provision of healthcare services

1. *See* § 26.8.

by tax-exempt providers. Nearly every tax-exempt healthcare provider is a participant in the Medicare and Medicaid programs. Indeed, the IRS's community benefit standard arguably requires as a condition of tax exemption that hospitals participate in the Medicare and Medicaid programs.[2] Thus, healthcare providers must satisfy both the requirements of the IRS with regard to continued recognition of their tax-exempt status and the requirements of the Department of Health and Human Services with regard to participation in the Medicare and Medicaid programs. However, the enabling statutes in each of these areas are entirely different and have different objectives.

Because of the massive size of the Medicare and Medicaid programs,[3] there is ever-present opportunity for widespread fraud and abuse unless adequate safeguards are in place. Accordingly, Congress has delegated substantial authority to the Department of Health and Human Services and the Department of Justice to protect against fraud and abuse in these programs. Most notably, in 1977, legislation was passed prohibiting the offer, solicitation, payment, or receipt of any remuneration, in cash or in kind, in return for or to induce the referral of a patient for any service that may be paid for by Medicare or Medicaid. This law is commonly referred to as the *Medicare and Medicaid antikickback statute*.[4]

The requirements of the antikickback statute created fundamental conflict between the objectives of Congress in the fraud and abuse arena and the objectives of Congress in the tax arena. In the fraud and abuse arena, the concern is twofold: First, will any economic incentive interfere with the physician-patient relationship? At best, a physician who has a financial interest in a provider of services that are needed by his or her patient may restrict the freedom of choice of that patient by referring the patient only to that provider. In the worst case, the financial interest may result in an incentive to order unnecessary or inappropriate services for the patient. Second, will a financial incentive inflate costs to the Medicare and Medicaid programs?

The objective of the fraud and abuse laws is clear: providers must not receive benefits (in the form of illegal remuneration) in exchange for the services that they render.

In the tax arena, the objective is quite the opposite. The goal of the tax laws is to ensure that assets of exempt organizations are protected, that they do not inure to the benefit of private individuals, and that public interests are served. Thus, a fundamental objective of the IRS is to ensure that exempt organizations receive and demonstrate a public benefit that is at least equal, both qualitatively and quantitatively, to the benefit that is conferred on private individuals by the exempt organizations.

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2. Rev. Rul. 69-545, 1969-2 C.B. 117.
3. Medicare and Medicaid accounted for an expenditure of approximately $653 billion in FY 2005. The Medicare and Medicaid programs are the largest sources of income for nearly every healthcare provider in the nation.
4. 42 U.S.C. § 1320a-7b(b).

Further compounding the problem is the fact that enforcement originates in two different agencies: the Internal Revenue Service and the Department of Health and Human Services (in particular, the Office of Inspector General). The divided responsibility involves different organizations and individuals with different agendas and different political responsibilities. At one time, in true Washington tradition, neither agency discussed with the other what each was doing, even though they were dealing with the same regulated industry. However, recognizing that they had the ability to help each other with their common agendas, the two agencies began a dialogue on areas of mutual interest.[5]

As a result of this inherent conflict, the two agencies sometimes have to agree to disagree. An example of this disagreement is the issue of payment for intangible assets in the acquisition of a physician's practice by a tax-exempt healthcare provider. The IRS had generally taken the position that payment for intangibles is acceptable as long as the amount of the payment is set at fair market value. However, in a 1992 letter from the Office of Inspector General (OIG) to the IRS Technical Assistant for Healthcare Industries, the OIG stated its concern that payment for intangibles might violate the Medicare and Medicaid antikickback statute.[6] The OIG letter described as ''suspect'' any amounts paid to a physician in the acquisition of his or her practice that exceed the fair market value of the tangible assets.

In response, the IRS concluded that as long as the courts and the OIG have not definitively determined the illegality of a particular remuneration, the IRS generally will not deny or revoke exemption. However, in recognition of this potential conflict between the two agencies in this area, the IRS includes caveats like the following in its exemption determination letters:

> This ruling is conditioned upon your not violating the federal anti-kickback restrictions contained in Section 1128(b) of the Social Security Act, 42 U.S.C. § 1320a-7(b)(1) and (2), which prohibit the payment of remuneration in return for the referral of Medicare or Medicaid patients. We express no opinion as to whether your planned purchase of a private group medical practice or your subsequent payment for physician services complies with these provisions.

It thus appears that healthcare providers are left to their own devices in trying to reconcile the often competing requirements of these two agencies and the statutes they enforce.

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5. FY 1994 IRS CPE Text, *supra* note 2, at 232–234; FY 1995 IRS CPE Text, *supra* note 8, at 173–175. *See*, in general, Chapter 29; Levine, ''IRS Enforcement of Health Care Laws,'' 6 *Exempt Org. Tax Rev*. (No. 4) 921 (Oct. 1992).
6. Bureau of National Affairs, ''Anti-Kickback Questions Remain in Second IRS Tax Exempt Ruling for IDS,'' *Health L. Reporter* 429 (Apr. 8, 1993); ''HHS 'Thornton Writes IRS' Sullivan,'' 7 *Exempt Org. Tax Rev*. (No. 4) 705 (Apr. 1993). FY 1994 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook (hereinafter, ''FY 1994 IRS CPE Text''), at 185.

In 2004, the Office of Inspector General (OIG) of the Department of Health and Human Services responded to a request for an advisory opinion from a charitable organization that provided grants to financially needy patients to enable them to pay for their prescription drug therapies.[7] The OIG concluded that the proposed program would not constitute grounds for the imposition of civil monetary penalties, and as long as intent to induce or reward referrals for federal healthcare program business was not present, it would also not impose administrative sanctions under the antikickback statute in connection with the proposed program.

The requestor was a tax-exempt, charitable organization that served as a liaison between patients and their insurers, employers, and creditors to resolve insurance, job retention, and debt crisis matters relative to the patients' diagnoses. The requestor provided professional case managers to individuals who were insured, uninsured, or underinsured, including to some Medicare beneficiaries. The requestor received donations from a variety of sources, including but not limited to providers and suppliers of healthcare services, pharmaceutical companies, and individuals. The requestor was not subject to control by any donor affiliated in any way with any pharmaceutical company. The requestor proposed to establish and operate a patient assistance program to defray the costs of expensive prescription drug therapies incurred by financially needy patients suffering from specific chronic or life-threatening diseases. Under the proposed program, the requestor would pay all or part of the patients' cost-sharing obligations for prescription drugs.

The OIG concluded that because the requestor interposed an independent charitable organization between donors and patients in a manner that effectively insulated beneficiary decision making from information attributing the funding of benefits to any donor, it was unlikely that donor contributions would influence Medicare beneficiaries in their selection of a particular provider. As a result, donor contributions to the requestor would not constitute grounds for the imposition of civil monetary penalties.

This opinion highlights the situation of an organization that had satisfied the IRS that it qualified for charitable tax-exempt status (and could thereby receive deductible donations from donors) through its provision of financial support to needy patients in connection with prescription drug therapies, but ran the risk of violating federal fraud abuse laws in the process. The opinion closed the loop by verifying that the OIG would not pursue civil monetary penalties or antikickback prosecution for the same activities. It further illustrates the premise that healthcare providers must satisfy both masters: the IRS and the OIG; satisfying only one master is not enough. By verifying that the organization's activities are not in violation of federal fraud and abuse law, the opinion also helps to protect the organization's tax-exempt status by supporting the conclusion that the organization is operating in

7. OIG Advisory Opinion No. 04–15 (Nov. 5, 2004).

conformance with the law of charitable trusts, which requires that it comply with federal law in undertaking its activities.[8]

The developing trend now appears to be that the IRS follows the lead of the Medicare and Medicaid programs in determining whether to pursue potential private inurement and impermissible private benefit issues. An example of this is the decision by the OIG for the Department of Health and Human Services to establish a safe harbor from prosecution under the antikickback statute for certain arrangements involving the provision of electronic prescribing technology. In August 2006, in implementing the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,[9] the OIG issued a final regulation that established a new safe harbor under the federal antikickback statute that would protect certain arrangements involving hospitals, group practices, and prescription drug plan sponsors and Medicare Advantage organizations that provide certain nonmonetary remuneration to recipients in the form of hardware, software, or information technology and training services that are necessary solely for the purpose of receiving and transmitting electronic prescription information.[10] The regulation also established a new safe harbor for certain arrangements involving the provision of nonmonetary remuneration in the form of electronic health records software or information technology and training services that are used primarily to create, maintain, transmit, or receive electronic health records. Under these rules, hospitals are permitted to donate or provide at substantially below cost certain technologies to physicians. Physicians are required to pay 15 percent or more of the donor's cost for the donated technology. The premise behind this is that hospitals contend that electronic health records systems can become truly useful only if their physicians also participate in the network. Hospitals believe that physicians would not make the needed expenditure to acquire this technology without a financial incentive to do so.

While the rule was well received by the healthcare community as an important step toward promoting the use of electronic health records and thereby improving patient care, it raised obvious private inurement and impermissible private benefit issues at the same time. Tax-exempt hospitals were left wondering whether the provision of electronic equipment and software at an 85 percent discount to private physicians would put them at risk of violating their obligations as charitable organizations.

The IRS resolved this issue in May 2007 through the use of informal guidance. It issued an internal memorandum providing a directive for handling examination and exemption application cases involving hospitals that provide their staff physicians with financial assistance to acquire and implement

8. *See*, e.g., Rev. Rul. 97-21, 1997-1 C.B. 121; GCM 39862.
9. P.L. 108–173.
10. 71 Fed. Reg. 45110 (August 8, 2007).

software used in connection with electronic health records of their patients.[11] The IRS concluded that it would not treat benefits that a hospital provides to its staff physicians as impermissible private benefit or private inurement as long as the benefits fall within the range of items and services that are permissible under the OIG regulations. The memorandum carefully limited its reach to health IT subsidy arrangements. Questions raised by the limited language of the memorandum were subsequently addressed in a frequently asked questions transmission by the IRS.[12]

While a compelling argument can be made that the public benefit of developing a functional electronic health record system outweighs the private benefit accruing to physicians from obtaining the needed technology at a substantial discount from a charitable organization, it nevertheless appears that this analysis was driven by the policy choice made by the OIG and Congress in the enabling statute. Without the acquiescence of the IRS, the electronic health record program would have been stopped dead in its tracks.

§ 29.2 FRAUD AND ABUSE VIOLATIONS AS A BASIS FOR REVOCATION OF EXEMPTION

The confluence of tax policy and health policy was highlighted in a clear and specific way by the IRS in a 1991 Memorandum on hospital–physician joint ventures.[13] The memorandum took the position that a hospital that enters into a certain type of joint venture transaction jeopardizes its tax-exempt status, *inter alia*, because the transaction may violate federal law—specifically, the Medicare and Medicaid antikickback statute. The IRS did not take this position because the potential violation of the antikickback statute under the facts at issue resulted in private inurement or impermissible private benefit. These were independent bases in the memorandum for a finding that the exemption of the hospital was jeopardized. Rather, it took the position that because the violation of federal law was an illegal act and was contrary to public policy, it jeopardized the exempt status of the hospital.

The principle that an illegal act or an act contrary to public policy can result in the loss of exemption for an organization is not unique to this memorandum or to the healthcare arena. A tenet of qualification for charitable status is that charitable organizations are not permitted to engage in activities that are illegal or that violate public policy. This ''illegality doctrine'' is derived from English charitable trust law, which is the legal foundation on which the Code's rules for charitable organizations were built.[14] According to charitable trust law, a trust

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11. IRS Memorandum of Lois Lerner, Director, Exempt Organizations, May 11, 2007. See www.irs.gov/pub/irs-tege/ehrdirective.pdf and Appendix P.
12. See www.irs.gov/pub/irs-tege/ehr_qa_062007.pdf and Appendix P.
13. Gen. Couns. Mem. 39862. *See* § 22.7.
14. FY 1993 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook (hereinafter, ''FY 1993 IRS CPE Text''), at 156.

that violates the law or commits acts contrary to public policy cannot qualify for charitable status.[15] The illegality doctrine thus encompasses both illegal activity and activity that is contrary to public policy. It is the IRS's position that illegal activity is one of the criteria by which an organization's activities will be evaluated to determine whether charitable status will be recognized. Thus, an exempt organization's activities must not be illegal, contrary to a clearly defined and established public policy, or in conflict with express statutory restrictions.[16]

The tax policy basis for the illegality doctrine is also derived from the principle that charitable organizations lessen the burdens of government. As a result, organizations that increase governmental burdens cannot justify their tax-exempt status.[17] Organizations that are engaged in illegal activity would increase the governmental burden of law enforcement, and activities that are inconsistent with public policy would increase governmental costs and burdens. Thus, the illegality doctrine acts as a check to ensure that the federal government does not support the tax exemption of organizations that are engaged in activities that the government is charged with preventing.[18] As the District Court for the District of Columbia noted, in an oft-cited 1971 case, ''Fagan's school for pickpockets would qualify for a charitable trust'' were it not for the illegality doctrine.[19]

In applying the illegality doctrine in the healthcare arena, the IRS has identified three areas of potential application.[20]

The first of these is transactions invoking the application of the Medicare and Medicaid antikickback statute. The IRS has provided an extensive analysis of the manner in which a violation of the antikickback statute would also result in the revocation of tax exemption.[21] It noted that nearly every hospital that is tax-exempt as a charitable organization participates in the Medicare and Medicaid programs, because doing so is a virtual requirement for exemption under the IRS's community benefit standard. As a result, the Medicare and Medicaid antifraud and -abuse laws, particularly the antikickback statute, apply to these organizations.

The memorandum notes that the antikickback statute is worded broadly and that it prohibits arrangements that might be acceptable business practices in other settings, absent the application of the Medicare and Medicaid laws. The memorandum also notes the expansive interpretation of the statute given by federal courts, citing cases that indicate that if a single purpose of payment is

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15. Restatement (Second) of Trusts § 377, comment c (1959); Scott, The Law of Trusts § 377 (4th ed. 1989).
16. Rev. Rul. 80-278, 1980-2 C.B. 175.
17. FY 1993 IRS CPE Text, at 157.
18. *Id*.
19. *Green v. Connally*, 330 F. Supp. 1150 (D.D.C. 1971).
20. FY 1993 IRS CPE Text, at 169.
21. Gen. Couns. Mem. 39862.

to induce referrals, then the statute has been violated even if other purposes are entirely permissible.[22] The memorandum concludes that the IRS believes ''that engaging in conduct or arrangements that violate the anti-kickback statute is inconsistent with continued exemption as a charitable hospital. No matter how economically rewarding, such activities cannot be viewed as furthering exempt purposes.''[23] The memorandum acknowledges that the IRS's role in enforcing health policy in this area is not immediately apparent: ''[A]t first blush, one might wonder whether there is any real harm in giving physicians a financial incentive to refer or admit patients to a particular hospital or why the Internal Revenue Service should care.''[24] The memorandum answers this question by pointing out Congress's reasons for enacting the antikickback statute—to prevent overutilization of Medicare and Medicaid services without achieving any public benefit, and to prevent harm to individual patients as a result of their being subject to unnecessary procedures or from losing their freedom of choice of treatment facilities. It continues:

> Joint venturing simply as a means to attract, retain, or reward physicians in order to attract the patients they will refer ought not, in the usual case, to be viewed as furthering a hospital's exempt purpose. We should focus on how an arrangement benefits the community, not just the individual hospital itself. Where participating in a joint venture does not demonstrably further the hospital's exempt purposes in some legitimate manner, the Service ought not rule favorably on the arrangement.[25]

Second, where a healthcare provider makes a false claim to the Medicare program, through the improper waiver of co-payments and deductibles, for example, and the activity is substantial, exemption can be lost.[26]

Third, a provider guilty of ''patient dumping'' (refusing to examine indigent patients or referring them to other hospitals in medically inappropriate situations) is guilty of an illegal act through violation of federal law.[27] Moreover, the provider has likely acted contrary to public policy and to the requirement that it provide community benefit. In either case, the hospital's tax exemption would be jeopardized.[28]

It is apparent that the IRS and the OIG are in complete agreement on this statement: where a healthcare provider violates Medicare and Medicaid fraud and abuse law by taking actions that result in increased costs for the Medicare and Medicaid program and inappropriate patient care, the provider is guilty

22. *United States v. Greber*, 760 F.2d 68 (3d Cir.), *cert. denied*, 474 U.S. 988 (1985); *United States v. Katz*, 871 F.2d 105 (9th Cir. 1989); *United States v. Baystate Ambulance and Hospital Rental Service, Inc.*, 874 F.2d 20 (1st Cir. 1989).
23. Gen. Couns. Mem. 39862.
24. *Id*.
25. *Id*.
26. 18 U.S.C. §§ 287 and 1001; 31 U.S.C. § 3729; 42 U.S.C. § 1320a-7a. FY 1993 IRS CPE Text, at 172.
27. 42 U.S.C. § 1395dd.
28. FY 1993 IRS CPE Text, at 173.

of illegal activity, and, in addition, is taking action that is contrary to public policy. In these circumstances, tax-exempt status for the organization as a charitable organization cannot stand.

§ 29.3 HOSPITAL INCENTIVES TO PHYSICIANS

As noted above, the public policies behind the Internal Revenue Code and the Medicare and Medicaid fraud and abuse laws are not always compatible. One area in which these policies often conflict is the provision of incentives by hospitals to physicians in order to recruit them to the hospitals' service area or to retain their services in the hospitals' community. As discussed earlier, the IRS has issued a number of Private Letter Rulings and General Counsel Memoranda on the topic of hospital incentives to physicians.[29] This guidance has generally taken the position that as long as incentives are structured to avoid windfall benefits to physicians that would constitute private inurement or impermissible private benefit, and as long as they are reasonable in quantity and quality and are the result of arm's-length negotiations, then hospital incentives to physicians are consistent with charitable operation.

Previously, the IRS focused on whether the overall compensation provided to a physician through the incentives was reasonable. The IRS now accords greater weight to whether community benefit results from the recruitment of the physician and whether that public benefit is at least as great as the private benefit conferred on the physician through the incentive.

Regarding Medicare and Medicaid fraud and abuse, however, the Office of Inspector General has a clear policy objective to avoid permitting physicians to receive anything of value in order to induce them to treat or refer patients for Medicare and Medicaid services. The conflict on this issue became readily apparent when the Office of Inspector General issued a ''Special Fraud Alert'' on hospital incentives to physicians in May 1992.[30] This third in a series of interpretive memoranda issued by the Office of Inspector General was intended to illustrate the OIG's views on the application of the Medicare and Medicaid antikickback statute to particular situations. The Special Fraud Alert called into question, from a fraud and abuse perspective, many recruitment and retention activities that are in common use today.

It is important to note that this Special Fraud Alert does not state that these practices are *per se* violations of the antikickback statute, and it does not have the force of law. However, this ''hit list'' is a matter of concern, given the IRS's position that a violation of the antikickback statute would serve as an independent basis for the revocation of tax-exempt status. Still more troublesome is the fact that most of these practices have been explicitly

29. *See* Chapter 25.
30. *See* § 25.3.

or implicitly approved by the IRS in numerous Private Letter Rulings and General Counsel Memoranda.

For example, income guarantees are the most popular physician recruitment incentive in use today. Although the IRS has expressly approved the use of income guarantees if properly structured, the Special Fraud Alert includes income guarantees as a questionable practice.

Additional evidence is found in the IRS's 1997 physician-recruitment revenue ruling.[31] In that revenue ruling, the IRS identified one scenario that it deemed unacceptable and inconsistent with the requirements for exemption as a charitable organization. In Situation 5, the IRS described recruitment activities that violated the Medicare and Medicaid antikickback statute. The provider was found guilty in a court of law of having violated this federal statute. Under these circumstances, the activity was unlawful and contrary to public policy and therefore was inconsistent with charitable operation. This position follows directly from the IRS's extensive analysis of activity that violates the Medicare and Medicaid antikickback statute.[32]

Although no one can legitimately argue that such physician-recruitment activities are consistent with exemption, this position would seem to have little utility in determining when physician-recruitment activities are sufficiently contrary to the requirements of the antikickback statute to warrant being inconsistent with the requirements for exemption. Most healthcare-provider activities that are allegedly in violation of the antikickback statute are not ultimately found to be so in a court of law. Rather, in the usual case, the parties enter into a settlement of the charges, and some fines may be paid by the provider, or the provider may be excluded from participating in government healthcare programs. Thus, it remains to be seen when the line will be crossed and activities that are inconsistent with the antikickback statute will be deemed sufficiently contrary to public policy that they will not be consistent with charitable operation.

31. Rev. Rul. 97-21, 1997-1 C.B. 121. *See* § 25.8.
32. Gen. Couns. Mem. 39862.

CHAPTER THIRTY

Tax-Exempt Bond Financing

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Tax-exempt healthcare organizations (and most other exempt organizations) frequently lack the resources needed to finance the facilities and activities that carry out their exempt purposes. In many cases, charitable contributions and grants cannot be relied on to completely fund healthcare facilities and programs. Moreover, healthcare organizations often find that there are limited federal funding resources, increased restrictions on federal financing, and a general unavailability of affordable conventional financing. Faced with this dilemma, charitable healthcare organizations often turn to *qualified 501(c)(3) bonds,* which not only are generally available but also carry an interest rate that is typically far below conventional market rates.[1] Thus, these bonds are a relatively less costly form of financing. The tax law pertaining to the issuance and use of these bonds is outlined below.[2]

1. Because the interest is exempt from federal income tax, investors in tax-exempt bonds are willing to accept an interest rate that is as much as 35 percent lower than the interest rate they would earn on taxable securities, although the average has been closer to 23 percent. *Public Administration Review* 42–48 (Jan./Feb. 1990).
2. *See, generally*, IRS Publication 4077, Tax-Exempt Bonds for 501(c)(3) Charitable Organizations. For an analysis of tax-exempt bond issues from an IRS perspective, see Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook (hereinafter, ''FY [year] IRS CPE Text.'') as follows: FY 1992,

§ 30.1 OVERVIEW OF QUALIFIED 501(c)(3) BONDS

(a) General Tax Exclusions

In response to high default rates on tax-exempt bonds and increasing utilization of such bonds for ''questionable'' purposes during the 1980s, Congress enacted much stricter tax-exempt bond rules as part of the Tax Reform Act of 1986. That Act also divided the universe of bonds into two broad categories: (1) governmental purpose bonds and (2) private activity bonds.

A governmental purpose bond is issued by a state or local governmental body on its own behalf; an example is municipal bonds to build city roads or schools. The issuing government is the user of the bond proceeds, and the tax laws clearly provide that interest on such state or local bonds[3] is not includable in gross income for federal income tax purposes.[4]

However, where the proceeds of state or local bonds are used by private parties, some caution must be exercised because the benefits of tax-free interest do not apply to *private activity bonds* (other than qualified private activity bonds as described herein).[5] Private activity bonds are generally defined as having these characteristics:

1. More than 10 percent of the proceeds is to be used in any trade or business carried on by any person other than a governmental unit; and
2. The payment of the principal or interest on more than 10 percent of the bond proceeds is secured by property used for a trade or business use or payments in respect of such property; or
3. The proceeds are used to make loans to nongovernmental persons exceeding the lesser of 5 percent of the proceeds or $5 million.[6]

Despite these private activity bond restrictions, the tax law does allow private parties to utilize the proceeds from a wide variety of tax-exempt state and local bonds, as long as those bonds constitute a special subset of private activity bonds referred to as *qualified private activity bonds.* The

''Tax-Exempt Bond Financing''; FY 1993, ''501(c)(3) Bonds—A Mini Test''; FY 1994, ''The First Book of Arbitrage''; FY 1995, ''Tax-Exempt Bonds Current Topics''; FY 1996, ''Understanding Bond Documents'' and ''Application of the Arbitrage Restrictions: An Example.''

3. A state or local bond means an obligation of a state (including the District of Columbia), any possession of the United States, and any political subdivision thereof (IRC § 103(c)).
4. IRC § 103(a).
5. Tax exemption is also not available to arbitrage bonds within the meaning of IRC § 148 or to bonds that do not meet the requirements of IRC § 149 regarding registration and the like (IRC § 103(b)(2) and (3)).
6. IRC § 103(b); IRC § 141(a), (b), and (c). In determining whether the $5 million or 5 percent ceiling is exceeded, the pertinent amount is the amount actually loaned, rather than the net present value of the loan repayments. Priv. Ltr. Rul. 9252007; *City of New York v. Commissioner*, 70 F.3d 142 (D.C. Cir 1995).

federal tax law specifies seven primary types of qualified bonds that may be used for private purposes and that pay interest that is excludable from gross income. Each of the seven types of qualified bonds has its own governing Internal Revenue Code section, although there are also general bond rules that apply to some extent as well. The seven categories of qualified bonds are: (1) exempt facility bonds,[7] (2) qualified mortgage bonds,[8] (3) qualified veterans mortgage bonds,[9] (4) qualified small issue bonds,[10] (5) qualified student loan bonds,[11] (6) qualified redevelopment bonds,[12] and (7) qualified 501(c)(3) bonds.[13] Of these, the type most commonly used by tax-exempt healthcare and other charitable organizations is the *qualified 501(c)(3) bond*.[14]

(b) Overview of Qualified 501(c)(3) Bonds

Qualified 501(c)(3) bonds are a form of tax-exempt financing issued by a political subdivision (such as a state, county, or city) on behalf of a tax-exempt charitable organization for certain charitable purposes.[15] As with other types of qualified bonds, interest paid on qualified 501(c)(3) bonds is exempt from federal income taxes and state and local taxes within the state of issue in accordance with state law. Purchasers of the bonds are therefore willing to accept a lower interest rate than would otherwise be acceptable for taxable investments.

The federal tax law provides two key requirements for qualified 501(c)(3) bonds. First, all property financed by a qualified 501(c)(3) bond issue must be owned by a charitable organization or a governmental unit.[16] Thus, qualified 501(c)(3) bonds cannot be used to finance property owned by a charitable organization in partnership with other investors, although, in some instances,

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7. IRC § 142(a) defines an exempt facility bond as any bond issued as part of an issue 95 percent or more of the net proceeds of which are to be used to provide: airports, docks and wharves, mass commuting facilities, facilities for the furnishing of water, sewage facilities, solid waste disposal facilities, qualified residential rental projects, facilities for the local furnishing of electric energy or gas, local district heating or cooling facilities, qualified hazardous waste facilities, high-speed intercity rail facilities, environmental enhancements of hydroelectric generating facilities, qualified public educational facilities, qualified green building and sustainable design projects, or qualified highway or surface freight transfer facilities. Of these (fifteen) categories, healthcare organizations may have occasion to use exempt facility bonds for qualified residential rental projects.
8. IRC § 143(a).
9. IRC § 143(b).
10. IRC § 144(a).
11. IRC § 144(b).
12. IRC § 144(c).
13. IRC § 145.
14. Healthcare organizations may also have occasion to use the proceeds from exempt facility bonds for building or purchasing residential rental projects.
15. IRC § 141(b)(9) and (e); IRC § 145.
16. IRC § 145(a)(1).

mixed use facilities or facilities with multiple users may be financed in part with qualified 501(c)(3) bonds and in part with other conventional financing.[17]

The second requirement imposed by the federal tax law is that at least 95 percent of the net bond proceeds must be used for the exempt activities of the charitable organization.[18] Thus, not more than 5 percent of the bond proceeds can be used in an unrelated trade or business or for some other nonexempt purpose.[19] For these purposes, net proceeds are equal to total bond proceeds minus amounts set aside in a reasonably required reserve fund; the reserve fund generally may not exceed 10 percent of the proceeds of the bonds.[20] Costs of issuing the bonds must be included in the 5 percent nonexempt limitation described above, because those amounts are not considered to be spent in furtherance of the exempt activities of the organization.[21] Moreover, the costs of bond issuance financed with bond proceeds must not exceed 2 percent of those bond proceeds.[22]

The federal tax law imposes a number of other restrictions on qualified 501(c)(3) bonds.[23] Among the more important restrictions are the following:

1. These bonds may not be used to finance any airplanes, skyboxes or other private luxury boxes, facilities primarily used for gambling, or stores the principal business of which is the sale of alcoholic beverages for consumption off-premises.[24]

2. The average maturity of these bonds may not exceed 120 percent of the average reasonably expected economic life of the facilities[25] being

17. Priv. Ltr. Rul. 8827065. *See also* Priv. Ltr. Rul. 9125050, where the IRS discussed four methods for allocating space to determine the portion of a mixed-use facility that may be financed with tax-exempt bonds. Those allocation methods are: (1) square footage, (2) fair market value, (3) the perprocedure method, and, if those methods are unworkable, (4) a revenue allocation method.
18. IRC § 145(a)(2).
19. *See infra* § 30.3(d), regarding the private business use issues raised by certain kinds of service contracts and management contracts.
20. IRC § 148(d)(2).
21. The General Explanation of the Tax Reform Act of 1986 (hereinafter, ''Blue Book''), at 1185.
22. IRC § 147(g). Costs of issuance generally include legal, publishing, financial advisor, rating agency, trustee, accountant, and underwriter fees and expenses.
23. IRC §§ 147, 148, and 150.
24. IRC § 147(e). It should be noted that, although private activity bonds may not be used to finance health clubs, this prohibition does not apply to qualified 501(c)(3) bonds (IRC § 147(h)(2)). Also, unlike other private activity bonds, qualified 501(c)(3) bonds may be owned by substantial users of the facility being financed or by a person related to a substantial user (*id.;* Reg. § 1.103-11(b)). Thus, for example, it would be permissible for physicians to purchase tax-exempt bonds and to work in a healthcare facility that was financed with the proceeds of those bonds.
25. The reasonably expected economic life of the facilities being financed with any bond issue shall be determined as of the later of the date on which the bonds are issued or the date on which the facility is placed in service (IRC § 147(b)(3)(A)).

financed with the net bond proceeds.[26] Generally, land is not to be taken into account in determining the economic life of a facility, except where 25 percent or more of the net proceeds of the bonds are used to finance land, in which case the land is treated as having an economic life of 30 years.[27]

3. These bonds are subject to a public approval and notice requirement.[28] Specifically, the issuance of these bonds must be approved by the applicable elected representative[29] of the governmental unit that proposes to issue the bonds after a public hearing held following reasonable public notice.[30] Generally, at least 14 days' notice must be given in order for notice to be considered reasonable. In lieu of approval by an elected representative, a voter referendum may be held.[31]
4. As discussed in more detail below,[32] these bonds are subject to tax arbitrage restrictions.[33] Tax arbitrage arises when tax-exempt bond proceeds, or funds replaced by these proceeds, are invested at materially higher yields than the bond borrowing rate, rather than being spent for the exempt purpose of the borrowing. In general, if tax arbitrage is earned, all investment earnings in excess of the bond yield must be rebated to the federal government.[34]
5. Unlike some kinds of bonds, these bonds may be issued for *pooled financing*, in which the bond proceeds are used to make loans to two or more entities. However, special rules apply to these types of financing regarding the necessity of a financing demand survey, the use of such bond proceeds, and the maturity of the bonds.[35]

In addition to these general restrictions, the aggregate amount of outstanding qualified 501(c)(3) bonds (except for hospital bonds) allocated to any Code section 501(c)(3) organization that is a *test period beneficiary* may not exceed

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26. IRC § 147(b). Proceeds of bonds used to finance working capital, however, are not subject to the above bond maturity limitation (Reg. § 1.147(b)-1).
27. IRC § 147(b)(3)(B).
28. IRC § 147(f). For an example of an organization that deviated from the notice given to the public under IRC § 147(f), *see* Priv. Ltr. Rul. 9452021 (use of a small portion of bond proceeds for a hospital's working capital was permissible, since it was an insubstantial deviation from information it had supplied in its public notice).
29. The term *applicable elected representative* means *either* an elected legislative body of a governmental unit, *or* the chief elected executive officer, the chief elected state legal officer of the executive branch, or any other elected official of a governmental unit designated by the chief elected executive officer or by state law (IRC § 147(f)(2)(E)).
30. IRC § 147(f)(2).
31. IRC § 147(f)(2)(B)(ii).
32. *See infra* § 30.1(c).
33. IRC § 148.
34. For a discussion of the arbitrage restrictions, *see infra* § 30.1(c).
35. IRC § 147(b)(4).

$150 million.[36] All charitable organizations under common management or control are treated as a single organization for purposes of this limitation.[37] Thus, with the broad affiliations among entities so common in today's healthcare integrated delivery systems, it is necessary to carefully monitor all the outstanding bonds in the system to ensure that the $150 million limitation is not exceeded.

A test period beneficiary is any person who is an owner or principal user of the financed facility at any time during the three-year period beginning on the later of the date the facility is placed in service or the date of issue of the bonds.[38] All related organizations are treated as one entity.[39] Any outstanding bond benefiting a test period beneficiary on the date when the qualified 501(c)(3) bonds are being issued must be counted against the $150 million limitation.[40]

This $150 million limitation was clarified in a private letter ruling in which two charitable organizations sought guidance regarding the implications of a joint venture affiliation that was capitalized with property financed by the parties' tax-exempt bond holdings.[41] The IRS held that aggregating nonhospital bonds in a joint venture will not necessarily cause the interest accrued on bonds to be included in the holders' gross income. Although, collectively, the parties to the joint venture had bond-financed property in excess of $150 million, the IRS applied the $150 million limitation only to bond-financed property actually transferred to the new entity, not to the holdings of the parties in the aggregate.

Separately, in two companion rulings, the IRS addressed whether a limited liability company created by two nonprofit healthcare organizations would cause their tax-exempt bonds to be treated as private activity bonds or otherwise cause the interest on the bonds to be included in gross income for federal tax purposes.[42] As described in the ruling, two public charities, A and B, became affiliated by forming a limited liability company (LLC) to improve their delivery of healthcare. The LLC served to increase the operational efficiencies of

36. IRC § 145(b). Congress repealed the $150 million limitation for bonds issued after August 5, 1997, where 95 percent or more of the net proceeds are used to finance capital expenditures incurred after that date. Taxpayer Relief Act of 1997, §§ 222 and 145(b)(5), 111 Stat. 788, 818 (1997). Accordingly, the $150 million cap still applies to bonds issued prior to August 5, 1997, for expenditures incurred prior to that date.
37. IRC § 145(b)(3).
38. IRC § 144(a)(10)(D).
39. A charitable organization is related to another organization if: (1) it owns more than 50 percent of the stock in the organization or more than 50 percent of the capital or profit interests in the organization, or (2) the two organizations have significant common purposes and substantial common membership, or if they directly or indirectly have substantial common direction (Blue Book, at 1186).
40. IRC § 144(a)(10)(b).
41. Priv. Ltr. Rul. 9816020.
42. Priv. Ltr. Rul. 9839016.

A and B by coordinating the provision of healthcare through a cooperative arrangement. Pursuant to the terms of a network services agreement, the LLC could review the strategic plans and annual budgets of A and B as well as take appropriate action to enhance their provision of care. Ostensibly, the LLC was also capable of indirectly affecting the use of bond-financed property owned by A and B, but only A and B actually used the property. With respect to this arrangement, the IRS opined that it had no effect on the disposition of tax-exempt bonds held by A and B. First, the IRS opined that the LLC's activity was in furtherance of both A's and B's charitable purpose and, therefore, did not give rise to unrelated business activity. And second, the IRS stated unequivocally that the implementation of the network agreement did not effectively transfer the bond-financed property to the LLC, and, therefore, the $150 million limitation was not triggered.[43]

Qualified hospital bonds are not subject to the $150 million limitation, however, if 95 percent or more of the proceeds are used with respect to a hospital.[44]

Although qualified 501(c)(3) bonds are generally subject to the $150 million limitation described above, they are not subject to state private activity bond volume cap limitations.[45] Thus, qualified 501(c)(3) bonds may be issued without an allocation of part of the state-by-state annual aggregate volume limitation that applies to most other kinds of private activity bonds.

(c) Overview of Arbitrage Limitations

Because qualified 501(c)(3) bonds carry a low interest rate, it would be quite tempting for nonprofit organizations (and sometimes bond issuers) to make a profit by using the proceeds of these bonds to purchase higher-yielding investments. However, the federal tax law precludes this sort of *arbitrage*.[46]

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43. *See also* Priv. Ltr. Rul. 9815048 (managerial control over bond-financed property does not impute ownership for purposes of the $150 million limitation).
44. IRC § 145(c). A ''hospital'' is defined in the Blue Book as a facility that meets the following requirements: (1) it is accredited by a hospital accrediting board; (2) it is primarily used to provide, by or under the supervision of a physician, inpatient diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons (including mentally ill); (3) each patient must be under the care of a physician; and (4) it provides 24-hour nursing services rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered nurse on duty at all times.
45. IRC § 146 sets forth certain tax-exempt bond volume cap restrictions applicable to state agencies and other bond issuers. In general, the aggregate face amount of the private activity bonds issued by a state for any calendar year is the greater of (1) an amount equal to $50 multiplied by the state population, or (2) $150 million (IRC § 146(d)).
46. IRC §§ 103(b)(2) and 148. For a helpful and very detailed discussion of the law of tax-exempt bond arbitrage restrictions, *see* FY 1994 IRS CPE Text, at 261–339; FY 1996 IRS CPE Text, at 283. Arbitrage can sometimes arise in unusual ways. For example, in *Harbor Bancorp v. Commissioner*, 105 T.C. 19 (1995), the Tax Court ruled that interest

Except as otherwise allowed in accordance with the code, bonds shall not be invested in investments with a yield higher than those of the bonds.

Moreover, where there are improper arbitrage profits, they must be rebated to the government.[47] However, there is an exception for qualified 501(c)(3) bonds if the proceeds thereof are completely spent within a designated time period, or the gross annual earnings in a bona fide debt service fund for such bonds is less than $100,000.[48] Another exception exists under certain circumstances for a *construction issue*, where specified portions of the bond proceeds are spent on construction. A construction issue is a bond issue in which:

1. At least 75 percent of the available construction proceeds are to be expended with respect to property that is to be owned by a governmental unit or a charitable organization.
2. All of the bonds are qualified 501(c)(3) bonds, bonds that are not private activity bonds, or private activity bonds to finance property to be owned by a governmental unit or a charitable organization.[49]

(d) Advance Refunding

Despite the above arbitrage restrictions, qualified 501(c)(3) bonds may, under some circumstances, be used for *advance refunding*, which involves refinancing one issue of bonds with a later issue of bonds.[50] This is generally permitted as long as the proceeds of the later refunding issue are applied to

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paid on revenue bonds issued by a county to finance the construction of multifamily housing was not tax exempt because the bonds were actually arbitrage bonds within the meaning of IRC § 148. In the case, the IRS successfully argued that the bond issuances lacked substance because the county used so-called *black box structures*, including cashless closing schemes and complex circular structures. In addition, the court found that guaranteed investment contracts (GICs) acquired with the bond proceeds were *nonpurpose* investments that were not acquired to carry out the governmental purpose for the issuance of the bonds.

47. The amount of the rebate must be equal to the sum of (1) the excess of the amount earned on all nonpurpose investments over the amount that would have been earned if such nonpurpose investments were invested at a rate equal to the yield on the issue; plus (2) any income attributable to the above-described excess (IRC § 148(f)(2)). The rebate is required to be paid to the United States by the bond issuer in installments at least once every five years (IRC § 148(f)(3)).
48. IRC § 148(e)(4)(A)(ii).
49. IRC § 148(f)(4)(B), 148(f)(4)(C)(iv).
50. Bonds issued after 1985 may be advance refunded only once (IRC § 149(d)(3)(A)). For a detailed discussion of advance funding, *see* 1997 IRS CPE Text, ch. L (Tax-Exempt Advance Refunding Bonds—Some Basics). *See also* IRS Notice 96-49 (Announcing Hearing and Inviting Public Comment on Closing Agreement Program for Advance Refunding Escrows of State and Local Bonds), *reprinted in* BNA *Daily Tax Report*, Sept. 19, 1996, at L-1; Rev. Proc. 96-41 (Closing Agreement Program for Advance Refunding Escrows of State and Local Bonds), *reprinted in* BNA *Daily Tax Report*, July 22, 1996, at

the payment of the earlier refunded issue more than 90 days after the date of the refunding issue. In advance refunding, bond issuers typically invest the proceeds of a refunding bond issue in an escrow that is used to redeem the prior bond issue. Because these investments are subject to the arbitrage yield restrictions outlined above, issuers must ensure that the yield on the investments in the escrow is not materially higher[51] than the yield on the refunding bond issue.

Beginning in 1999, the Internal Revenue Service undertook audits of several health systems with respect to bond transactions known as *acquisition financings*. Under these transactions, an acquired hospital uses the proceeds of the purchaser's tax-exempt bond issue to pay off its outstanding bonds or, alternatively, the purchaser uses the bond proceeds to refinance the debt that it assumed in connection with the acquisition of the hospital. The issue for the Service was to determine whether the bonds being audited were correctly categorized as being used to acquire new assets, known as *new money bonds*, or if they were more correctly classified as refunding bonds used to pay off existing tax-exempt debt. This characterization is critical in that a second advance refunding would not be eligible for tax-exempt treatment.[52] Healthcare associations have requested additional guidance from the IRS on how to structure such transactions in a manner that is compliant with IRS regulations.[53]

§ 30.2 OVERVIEW OF THE QUALIFIED 501(c)(3) BOND ISSUANCE PROCESS

In a qualified 501(c)(3) bond financing, the issuer of the bonds is a state, a political subdivision, or other authority that has been delegated the power to issue bonds.[54]

L-1 (providing a program under which issuers of state or local advance refunding bonds may request a closing agreement to keep their bonds tax exempt in cases where they have paid more than fair value for Treasury securities).

51. For advance refunding escrows, the term *materially higher* is defined as one thousandth of one percentage point (Reg. § 1.148-2(d)(2)). Typically, the Treasury Department issued state and local government series (SLGS) bonds to help state and local governments satisfy yield restrictions under IRC § 148. However, the Treasury Department announced in October 1995 that it would stop issuing SLGSs because the government was about to reach its debt limit. To assist state and local governments that need to purchase yield-restricted investments, the IRS issued Rev. Proc. 95-47, 1995-2 C.B. 417, which applies to investments purchased after October 17, 1995. Under this revenue procedure, an issuer of state and local bonds may now make payments to the United States to reduce the yield on investments purchased with the proceeds of advance refunding bonds, provided certain conditions are satisfied.
52. *BNA Daily Tax Report*, August 4, 2000, at p. J-1.
53. *BNA Daily Tax Report*, March 29, 2001, at p. G-7.
54. IRC § 103(a). In three circumstances, a tax-exempt organization can issue tax-exempt bonds in its own right, in which case such bonds would be government bonds that are outside the statutory scheme for qualified 501(c)(3) bonds.

The issuing public authority then finances the activities or facilities of the charitable organization either by lending the bond proceeds to the charity for use in its charitable activities or by using the bond proceeds to acquire the facilities in question, which are then leased to the charity or sold to it on an installment sale basis. Usually, qualified 501(c)(3) bonds are issued as revenue bonds whose repayment is secured by revenue produced by the bond-financed project itself. Payment on the debt is generally structured over a term of years,[55]

First, the organization could issue tax-exempt bonds if it qualified as a ''political subdivision,'' which depends on whether it has in significant measure one of the three standard governmental powers: (1) the power to tax, (2) the power of eminent domain, and (3) the police power. E.g., Rev. Rul. 77-164, 1977-1 C.B. 20; Rev. Rul. 77-165, 1977-2 C.B. 21; Priv. Ltr. Rul. 9117066.

Second, the organization can issue tax-exempt bonds if it is a so-called *63-20 Corporation*. In Rev. Rul. 63-20, 1963-1 C.B. 24, the IRS ruled that obligations of a nonprofit corporation organized pursuant to the general nonprofit corporation law of the state will be considered to be issued on behalf of the state or a political subdivision for purposes of IRC § 103 if each of the following requirements is met:

1. The corporation must engage in activities that are essentially public in nature.
2. The corporation must be one that is not organized for profit (except to the extent of retiring indebtedness).
3. The corporate income must not inure to any private person.
4. The state or a political subdivision thereof must have a beneficial interest in the corporation while the indebtedness remains outstanding and it must obtain full legal title to the property of the corporation with respect to which the indebtedness was incurred upon the retirement of such indebtedness.
5. The corporation must have been approved by the state or a political subdivision thereof, either of which must also have approved the specific obligations issued by the corporation.

Finally, a tax-exempt organization can issue tax-exempt bonds if it is a *constituted authority* within the meaning of Rev. Rul. 57-187, 1957-1 C.B. 65. To satisfy that ruling, the organization must have the following characteristics:

1. It has to have specific statutory authorization.
2. It has to have a public purpose.
3. It has to have a governing board controlled by a political subdivision.
4. It has to have the power to acquire, lease, sell property, and issue bonds payable solely out of the project.
5. There can be no inurement.
6. On dissolution, the property has to go to the political subdivision.

55. Most tax-exempt bond issues have roughly *level* debt service, which means that payments of principal and interest are approximately the same from year to year, much the same as a home mortgage. However, it is also possible for tax-exempt bonds to have *back-loaded debt*, where debt service payments are higher in later years. Zero-coupon bonds, for example, pay no interest or principal until maturity of the bonds. The IRS will generally

and the issuing governmental entity is not responsible for the repayment of the bonds.

The bond application process itself can be quite time-consuming and can vary somewhat from state to state. In general, however, the process is as outlined below.[56]

A Code section 501(c)(3) bond-financing applicant will generally be required to file an application with the state or local governmental agency[57] that has authority to issue the bonds. The application requests various facts, including information about the organization's management, the organization's eligibility to receive bond financing, and the proposed bond-financed project. As part of this process, a feasibility study is usually conducted on the facility in question to determine whether the proposed project can generate enough revenue to pay the bondholders. Also, an analysis will be conducted to determine whether a private placement of the bonds will be made or whether an underwriter will be involved in a public offering of the bonds.

If the application is approved, a bond resolution is developed that states that the governmental authority will issue the bonds in question. The resolution also outlines the basic terms of the transaction, including the issuance amount, the interest rate range, the maturity schedule, the project to be financed, and the security for the bonds. The resolution must then be adopted by the legislative body of the jurisdiction where the issuing agency is located.

Once the bond resolution is adopted, the proposed transaction must be publicly approved. At this hearing, members of the public are given the opportunity to express their views on the bond issuance. After the hearing, the proposed transaction must be approved by the elected representative of the governmental body proposing to issue the bonds or by a voter referendum.

Before bonds can be issued, a legal opinion must also be obtained from bond counsel, who must review numerous documents surrounding the proposed transaction. In part because of increased IRS enforcement of tax-exempt bond issues, the National Association of Bond Lawyers (NABL) announced that the standard for the opinions that bond counsel would render regarding tax-exempt bonds was being *amplified.* The NABL standard reads as follows:

> The opinion should be based upon a reasonably sufficient examination of material legal and factual sources and reasonable certainty as to the subjects addressed therein. As to subjects about which the opinion is unqualified, bond counsel should

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scrutinize back-loaded debt to look for the existence of ''arbitrage'' or similar abuse. *See supra* § 30.1(c); Rev. Rul. 94-42, 1994-27 I.R.B. 5.

56. *See*, in general, Kalick, ''Tax-Exempt Financing for Section 501(c)(3) Organizations,'' *J. Tax. Exempt Orgs*. (Vol. 3, No. 2, p. 9, 1991); Roady, ''Understanding Section 501(c)(3) Bonds,'' *8th Annual Conference on Representing & Managing Tax-Exempt Organizations*, Georgetown University Law Center (May 9–10, 1991); 1996 IRS CPE Text, ch. K (Understanding Bond Documents).
57. Although the bond issuing authority is often a permanent government agency, it is also possible for the authority to be created for one bond transaction.

> have concluded that it would be unreasonable for a court to hold to the contrary. Bond counsel may reach such a conclusion as to federal income tax issues addressed in the opinion by determining that there is no reasonable possibility that the Internal Revenue Service would not concur or acquiesce in the opinion, if it considered all material legal issues and relevant facts.[58]

As noted above, once issued, the bonds may be either sold in a public offering (usually involving institutional investors such as mutual bond funds) or sold as part of a private placement (which is usually limited to banks or other sophisticated investors). For a public offering, the bond underwriter generally agrees to purchase the entire bond issue for less than face value (the ''underwriter's discount'') and then sells the bonds to the public.[59] The issuer in turn loans the proceeds to the charitable organization by giving the proceeds from the underwriter to a bond trustee under a trust indenture for the use of the charitable organization on whose behalf the bonds were issued. Until the bonds are paid, the trustee keeps a security interest for the bondholders in the bond-financed property (and sometimes in other property of the charity) and/or the revenue stream of such organization. After the bonds are issued, the issuer has certain reporting requirements.[60]

§ 30.3 DISQUALIFICATION OF TAX-EXEMPT BONDS

(a) In General

There are a number of ways in which qualified 501(c)(3) bonds can lose their federal tax status. For example, as noted above, this can occur where more than 5 percent of the property is used for a private business use.[61] Certain kinds of management or service contracts with nonexempt parties may result in excessive private business use, such as where a department of a hospital is managed by a group of private physicians or the hospital cafeteria is managed by a for-profit company. Similarly, private business use problems could arise where a portion of the proceeds of a bond issue are used to build a hospital

58. Reprinted in BNA *Daily Tax Report* (Apr. 13, 1994), at G-9.
59. There are two basic ways an underwriter can market bonds. A negotiated sale involves, in most instances, one or two investors who are usually identified before the issuance. A price for the bonds is negotiated with them, and the bonds never reach the open market. The other method is by open bid: orders are taken from various investors who wish to participate, the underwriter's counsel will prepare the offering statement, and these investors will rely on that document for the disclosure of significant matters relating to the bond issuance.
60. The issuer (i.e., the governmental entity) of private activity bonds must file Form 8038 no later than the 15th day of the second calendar month following the calendar quarter in which the bonds were issued. If the reporting requirements are not satisfied, the bonds are technically not tax-exempt.
61. *See*, in general, Mancino, ''Nonexempt Uses of Tax-Exempt Hospital Bonds,'' 4 *Exempt Org. Tax Rev*. 1324 (Dec. 1991); Rev. Rul. 77-416, 1977-2 C.B. 34; Gen. Couns. Mem. 37158 (June 13, 1977).

but a portion is also used to build a medical office building for the private practice of the hospital's physicians.[62] Additionally, private business use can occur where some or all of the property financed with qualified 501(c)(3) bond proceeds changes from a qualified use to a nonqualified use. Also, private business use problems can arise where the property financed with the bonds is no longer owned by a governmental unit or charitable organization during a period when such an entity must be the owner. Qualified 501(c)(3) bonds will, of course, lose their tax-exempt status if the organization on whose behalf such bonds were issued loses its tax-exempt status. Moreover, it is possible for a tax-exempt hospital's establishment of, and participation in, a joint operating agreement[63] with other tax-exempt hospitals to result in a private business use of tax-exempt bond proceeds.[64]

(b) Consequences of Disqualification

When the requirements for tax exemption are no longer met, a number of consequences follow. First, interest earned on the bonds becomes taxable income to the bondholders, retroactive to the date of issuance.[65] Second, the public charity will be treated as earning income in an unrelated trade or business in an amount equal to at least the fair rental value of the property.[66] Third, interest on the bond financing is nondeductible against the income earned in the unrelated trade or business.[67] Finally, upon failing the 95 percent qualified use test, the bonds would be considered private activity bonds, which means that interest earned on such bonds is a preference item that must be considered under the individual and corporate alternative minimum taxes.[68]

(c) Avoiding Change of Use Problems

Under IRS regulations,[69] issuers of tax-exempt bonds who have a change in the property's use subsequent to issuance of the bonds (such as a sale of the property to a for-profit purchaser) are allowed to take certain remedial actions

62. The Blue Book indicates that a medical office building supplying private offices for doctors associated with a hospital would be considered a private use, even if the medical office building is considered a related activity within the meaning of IRC § 513. Thus, this is an area where the definitions of unrelated trade or business may not coincide between IRC §§ 513 and 145. *See*, in general, Chapter 24.
63. *See* § 21.5.
64. *See*, generally, Griffith & Tomtishen, "Exempt Hospital Affiliations: Bond and UBIT Issues," 11 *Exempt Org. Tax Rev.* (No. 4) Apr. 1995, 709; Griffith & Tomtishen, "Exempt Hospital Affiliations: Bond and UBIT Issues—Part Two," 13 *Exempt Org. Tax Rev.* (No. 2), Feb. 1996, 215.
65. IRC § 103(b).
66. IRC § 150(b)(3)(A). *See* Chapter 24.
67. IRC § 150(b)(3)(B). *See also* Rev. Rul. 77-352, 1977-2 C.B. 34.
68. IRC § 57.
69. *See, generally*, Reg. § 1.141-1, *et seq.*

to prevent the bonds from becoming taxable bonds. For example, the issuer is permitted to use the amount received on the disposition of a bond-financed facility for a use that would qualify for tax-exempt financing as qualified 501(c)(3) bonds. Similarly, in certain circumstances, if the transferred facility would itself continue to be eligible for tax-exempt bond financing, that use is treated as a qualifying remedial action. The regulations provide, however, that the exempt status of the bonds will not be allowed to continue if the possibility that the property would be transferred to a nongovernmental person after issuance of the bonds was more than a remote one.[70]

The IRS rules also state that ruling requests will be entertained for change in use questions where the change does not fit into one of the above safe harbors.[71]

(d) Avoiding Management Contract Problems

The private activity bond regulations and Revenue Procedure 97-13 were released on January 16, 1997, and become effective with respect to bonds issued on or after May 16, 1997.[72] In general, they substantially liberalize the

70. Treas. Reg. § 1.141-12(a)(1).
71. E.g., Priv. Ltr. Rul. 9437014 (transfer of ownership of a bond-financed facility by a parent holding company from one subsidiary to another will not adversely affect the tax-exempt status of the bonds); Priv. Ltr. Rul. 9438008 (sale by financially troubled healthcare providers of nursing homes shortly after issuance of tax-exempt bonds will not make the interest on those bonds taxable); Priv. Ltr. Rul. 9427025 (sale of hospital financed with exempt bonds will not cause the bonds to lose their qualification); Priv. Ltr. Rul. 9406028 (lease agreement and partnership participation by a charitable hospital will not cause tax-exempt bonds to violate IRC § 145(a)); Priv. Ltr. Rul. 9345031 (university's transfer of a hospital to a subsidiary entirely controlled by the university will not jeopardize the tax-exempt character of the university's bonds); Priv. Ltr. Rul. 9544077 (county hospital authority's lease of a hospital financed with debt certificates that were equivalent to qualified 501(c)(3) bonds will not cause certificates to be private activity bonds, provided that certain conditions are satisfied); Priv. Ltr. Rul. 9543016 (lease by a § 501(c)(3) subsidiary of parent's hospital and nursing facility does not constitute private business use); Priv. Ltr. Rul. 9543033 (sale of hospital, clinics, and related assets will not cause interest from outstanding tax-exempt bonds to become taxable, provided that remedial actions (including a tender offer and escrow arrangement) are taken); Priv. Ltr. Rul. 9535037 (sale of a tax-exempt hospital's assets will not cause interest on the hospital's tax-exempt bonds to become taxable); Priv. Ltr. Rul. 9547014 (lease of bond-financed county medical center to a charity for 30 years will not cause bonds to lose status as qualified § 501(c)(3) bonds); Priv. Ltr. Rul. 9623011 (execution and implementation of a joint operating agreement among five tax-exempt hospitals will not cause the hospitals to be treated as used for private business use and will not disqualify outstanding tax-exempt bonds); Priv. Ltr. Rul. 9639052 (HMO's plan to expand the types of services and products it offers will not disqualify outstanding tax-exempt bonds); Priv. Ltr. Rul. 9610013 (lease of medical center to charity for rent equal to debt service on bonds issued to finance the medical center will not disqualify the bonds).
72. TD 8712, Jan. 10, 1997, 62 Fed. Reg. 2275 (Jan. 16, 1997); Rev. Proc. 97-13, 1997-5 I.R.B. 1. (*See* Appendix D.)

criteria for a contract to be deemed a qualified management contract under prior guidance. The private activity bond regulations apply a general (and vague) facts-and-circumstances test to determine whether a management contract constitutes a private business use of bond-financed facilities (i.e., all the surrounding facts and circumstances of a particular transaction are taken into account in determining whether a management contract rises to the level of a proscribed private business use). While this test provides a tremendous degree of flexibility in resolving the private business use issue, at least on a theoretical level, it provides little in the way of concrete guidance for the everyday formulation of management contracts relative to bond-financed facilities. (Atypical management arrangements, which fall outside the parameters of the safe-harbor provisions established by the applicable revenue procedures are, therefore, not necessarily proscribed private business use, but their qualification as qualified management contracts would be a proper issue on which to seek private letter ruling guidance from the IRS.)

Revenue Procedure 97-13 fleshes out the details of what typically is a qualified management contract. This revenue procedure establishes *safe harbors* that, if met, assure that a given management contract is deemed to be a qualified management contract. A contract's compliance with certain term, termination, and compensation parameters will determine whether it is a qualified management contract. The maximum possible term is fifteen years (for certain longer-lived facilities) so long as the compensation called for under such a contract is at least 95 percent paid on a periodic fixed-fee basis. A qualified management contract with a term of ten years (for longer-lived facilities), is permissible so long as at least 80 percent of the compensation thereon is paid on a periodic fixed-fee basis. Payment of productivity awards to a manager based on either an increase in gross revenues of the managed facility or reductions in total expenses (but not both) is allowed, without threatening the classification of a contract as a qualified management contract. Finally, *evergreen contracts* (i.e., contracts that automatically renew for additional one-year terms when neither party affirmatively acts to terminate the contract at the end of its term) are allowable as a term to a qualified management contract.

The Revenue Procedure specifically addresses certain healthcare contracts. Section 3.03 provides that for purposes of the Revenue Procedure, a management contract means a management, service, or incentive payment contract between a hospital and a service provider under which the service provider provides services involving all or a portion of the facility. A contract for management services for a specific department of a hospital is included within this definition. Section 3.06 of the Revenue Procedure defines a *per-unit fee* as a fee based on a unit of service provided as specified in the contract or otherwise specifically determined by an independent third party, such as the Medicare program. The definition further provides that "[s]eparate

billing arrangement between physicians and hospitals generally are treated as per-unit fee arrangements.''[73]

In general, agreements under which private entities, including the federal government, sponsor research through charitable organizations that utilize tax-exempt bond financing may lead to a violation of the private business use tests. In a separate revenue procedure, the IRS has established safe harbors applicable to these types of research agreements.[74]

Schedule K of the redesigned Form 990, optional for an organization's 2008 tax year and required beginning with the 2009 tax year, will require disclosures regarding an organization's compliance with these two revenue procedures.

(e) Potentially Abusive Transactions

In its FY 1999 CPE Text, the IRS reiterated that it has intensified its efforts to identify potentially abusive transactions involving tax-exempt bonds.[75] Building on the premise that bondholders are willing to accept lower interest rates to avoid federal income taxes on the interest, the IRS opined that this attribute can both encourage charitable activities as well as foster abusive transactions. Insofar as there is no bright-line test that can definitively determine whether a transaction is abusive, the IRS set forth a litany of factors to weigh when assessing a tax-exempt bond-financed transaction. In general terms, the IRS noted four areas that require consideration when weighing the propriety of a transaction: (1) board composition; (2) the relationship of the parties to the transaction; (3) the relationship, if any, of the exempt organization to other exempt organizations, the government, banks, and guarantors; and (4) the management of the bond-financed facility.

Ostensibly, IRS specialists and agents will assess whether the bond-financed project is prone to inurement or substantial private benefit. Weighing in favor of the propriety of the transaction is evidence that, among other factors: (1) the governing board consists of independent civic leaders; (2) the organization is controlled by another charitable organization; (3) the organization is created by a local government to be the lessor in a leaseback transaction; (4) there is no improper financial influence or control over the charitable organization; (5) the projected rate of occupancy allows the organization to operate the facility in a charitable manner; (6) the income, market, and cost methods of valuation are used to estimate the facility's current business enterprise value; and (7) the organization has appropriate facility management.[76]

73. *Id*.
74. *See* Rev. Proc. 2007-47, I.R.B. 2007-29 (July 16, 2007), *modifying and superseding* Rev. Proc. 97-14, 1997-1 C.B. 634.
75. Gannett and Sack, Chapter H, ''Identifying Abusive Transactions Involving Section 501(c)(3) Organizations and Tax-Exempt Bonds,'' in FY 1999 CPE Text.
76. *Id*.

Weighing against the propriety of a transaction is evidence of, among other things: (1) governing board members with no discernible connection to the community; (2) control over the organization vested in a for-profit organization; (3) improper financial assistance extended by a for-profit organization involved in the bond-financed project; (4) substantial financial gains accrued by a for-profit organization by virtue of the transaction; (5) excessive control by a bank or other third-party lender over the organization's budget and fees; (6) profit sharing with a for-profit organization that manages the bond-financed facility.[77]

To the extent that an organization fails to present adequate evidence that its operations will not result in impermissible private benefit, it will not qualify for tax-exempt status as a charitable organization.

§ 30.4 INTERNAL REVENUE SERVICE DEVELOPMENTS

(a) Information and News Releases

The IRS issued a warning about several potentially abusive healthcare transactions in which charitable organizations purchase or sell facilities financed with tax-exempt bonds.[78] The IRS noted that certain transactions may result in impermissible private benefit or private inurement and the loss of an organization's tax-exempt status. If so, the interest paid on the bonds issued by the organization may be taxable. Additionally, in some cases, the charitable organization may not be considered the true owner of the healthcare facility for tax purposes, also resulting in interest on the bonds being taxable.

The IRS announcement identified three types of healthcare transactions that are potentially abusive:

1. A developer acquires a nursing home and resells it at a substantial profit to a new or existing charity over which the developer exercises control or influence. The developer may then agree to rehabilitate, manage, or operate the nursing home for an excessive fee.
2. A charitable organization leases or sells healthcare or similar facilities financed with tax-exempt bond proceeds to partnerships or other entities in which physicians or medical staff of the charitable organization have a financial interest.
3. A private healthcare corporation sells an unprofitable facility to a charitable organization. This could occur by having the private corporation set up a new charity to issue tax-exempt bonds and then use the bond proceeds, along with purchase money debt, to purchase the facility from the private corporation at an inflated price.

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77. *Id*.
78. IRS News Release IR-90-60.

In August 1990, the IRS released guidelines pertaining to the processing of applications for recognition of exemption submitted by organizations suspected of abusing the use of tax-exempt financing, such as healthcare organizations, nursing homes, retirement homes, and hospitals.[79]

(b) Tax-Exempt Bonds Compliance Check

Commencing in August 2007, the IRS is undertaking an effort to evaluate the policies and procedures used by charitable tax-exempt organizations to ensure the post-issuance tax compliance of their tax-exempt debt obligations.[80] The IRS is using compliance check questionnaires that are being sent to more than 200 exempt organizations that reported an outstanding balance of tax-exempt liabilities on their 2005 Form 990.[81]

The compliance project will measure the post-issuance compliance knowledge and practices of the organizations that are contacted. The compliance check questionnaire contains questions relating to: (1) record-retention requirements; (2) qualified use of bond-financed property requirements; (3) arbitrage yield restriction and rebate requirements; (4) debt management policies and procedures; and (5) awareness of voluntary compliance and educational resources.

The IRS is mailing a cover letter explaining the questionnaire to the charitable organizations, and is collecting the data for analysis. The IRS will then issue a report describing its findings and recommendations regarding the development of follow-up outreach or compliance initiatives.

(c) Form 990 Reporting

The redesigned Form 990 applicable for tax years beginning in 2008 contains a new Schedule K, Supplemental Information on Tax-Exempt Bonds, which brings a much higher level of transparency to tax-exempt bond financings.[82] The IRS indicated that it has found significant noncompliance with record-keeping and record-retention requirements relating to tax-exempt bonds issued by or for the benefit of charitable organizations, creating enforcement problems for the IRS. The Service also is concerned about the investment of proceeds in a manner that might circumvent existing arbitrage rebate requirements. The Schedule K was designed to address these issues.

Schedule K requires disclosure of outstanding bond issues, as well as disclosure of information and various representations regarding private business use and arbitrage. Part I of the Schedule K will be required for the 2008 tax year. Part I is a list of outstanding tax-exempt bond issues and requires summary

79. IRS News Release IR-90-107.
80. *See* www.irs.gov/pub/irs-tege/tebc3web_rev_2.pdf.
81. *See* www.irs.gov/pub/irs-tege/form_13907_teb_financing_questionnaire.pdf.
82. *See* § 35.4(b)(xviii).

information regarding such issues. Parts II through IV of the Schedule are optional for 2008 to enable organizations more time to undertake necessary data collection. The entire Schedule K must be completed beginning with an organization's 2009 tax year. The Schedule applies only to bonds issued in 2003 or later; bonds issued before 2003 need not be reported in 2008 or thereafter.

CHAPTER THIRTY-ONE

Fundraising Regulation

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Many tax-exempt charitable healthcare organizations solicit charitable contributions, or have these resources solicited on their behalf, in support of their program activities. This nearly universal funding technique for charitable organizations is subject to considerable regulation by federal and state governmental authorities.

The solicitation of charitable contributions involves practices that are recognized as forms of free speech protected by federal and state constitutional law. Thus, there are limitations on the extent to which fundraising for healthcare, other charitable, educational, scientific, religious, and like organizations can be regulated by government. Also, some of these laws at the state level provide exemptions, in whole or in part, for fundraising endeavors by hospitals and other healthcare entities. Nevertheless, nonprofit healthcare and other organizations face considerable regulatory requirements at the federal and state levels when they solicit contributions for charitable purposes.[1]

1. In general, *see* Fundraising, Greenfield, Fund-Raising Fundamentals (1994); Greenfield, Fund-Raising: Evaluating and Managing The Fund Development Process (1991).

§ 31.1 STATE LAW REGULATION

The process of raising funds for healthcare and other charitable purposes is heavily regulated by the states. All but three states have some form of statutory structure, termed a *charitable solicitation act*, by which the fundraising process is regulated.[2] These laws may be divided into two categories: (1) those that are massive, full-scale fundraising regulation statutes and (2) those that fall short of that description. There are 48 of these laws. In 35 states,[3] they are comprehensive charitable solicitation acts. In the remaining 13 jurisdictions,[4] the bodies of law in this area have little in common.

(a) State Regulation in General

The various comprehensive state charitable solicitation acts generally contain certain features. These are:

1. A process by which a charitable healthcare (or other charitable) organization registers or otherwise secures a permit to raise funds for charitable purposes in the state
2. Requirements for reporting information (usually annually) about the organization's fundraising program
3. A series of organizations or activities that are exempt from some or all of the statutory requirements
4. A process by which a professional fundraiser, professional solicitor, and/or commercial co-venturer registers with, and reports to, the state
5. Record-keeping requirements, applicable to charitable organizations, professional fundraisers, professional solicitors, and/or commercial co-venturers
6. Rules concerning the contents of contracts between a charitable organization and a professional fundraiser, professional solicitor, and/or a commercial co-venturer
7. Expense disclosure mandates
8. An inventory of *prohibited acts*

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2. The states that have no statutory or other regulatory law in this regard are Delaware, Montana, and Wyoming.
3. Arkansas, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia, and Wisconsin.
4. Alabama, Alaska, Arizona, California, District of Columbia, Indiana, Iowa, Louisiana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, and Vermont.

9. Provision for reciprocal agreements among the states as to coordinated regulation in this field
10. A summary of the powers of the governmental official having regulatory authority (usually the attorney general or secretary of state), including the power to conduct investigations and issue and obtain subpoenas
11. A system of various sanctions that can be imposed for failure to comply with the law (such as injunctions, fines, and imprisonment)

These elements of the law are generally applicable to the fundraising charitable organization. Each of them can apply (absent a stated exemption) when a charitable solicitation is made into or from the state; a charitable organization soliciting funds in every state is generally expected to comply with each law. Yet there are several provisions of law that are directed at the fundraising professional or the professional solicitor, and/or that go beyond traditional fundraising regulation.

(b) Historical Perspective

Until relatively recently, the matter of fundraising practices was not addressed by state law. A few counties had adopted some fundraising regulation ordinances but at that time there was not any state or federal law on the subject.

This began to change in the mid-1950s, as part of the disclosure and consumer protection movements. North Carolina was the first state to enact a fundraising regulation law. Others soon followed, generating a series of laws that came to be known as *charitable solicitation acts*. New York was the second state to enact one of these acts, and this law became the prototype for the many that were to follow. (Over the subsequent years, the states have largely gone their own way; today, no one of these states serves as a standard.)

The New York law and its progeny involved a statutory scheme based on registration and reporting. Charitable organizations were required to register in advance of solicitation and to annually report; bond and other requirements came later. Subsequently, forms of regulation involving professional fundraisers and professional solicitors were developed. Exceptions evolved, disclosure requirements expanded, and a variety of *prohibited acts* [5] developed.

Today's typical charitable solicitation statute is far more extensive than its forebears of decades ago.

When charitable solicitation acts began to develop (as noted, beginning in the mid-1950s), the principal features were registration and annual reporting requirements. These laws were basically licensing statutes. They gave the states essential information about the fundraising program to be conducted, so that they would have a basis for investigation and review should there be suspicion

5. *See* § 31.1(i).

of some abuse. As time passed, some states decided to go beyond the concept of licensing and began to affirmatively regulate charitable solicitations. This was done in part because of citizens' complaints; another factor was grandstanding by state politicians. The regulation worked its way into the realm of attempts to prevent the ''less qualified'' (including out-of-the-mainstream) charities from soliciting in the states.

Structurally, the typical charitable solicitation statute originally did not have much to do with actual regulation of the efforts of either the fundraising institution or the fundraising professional. Rather, the emphasis was on gathering information and disclosing it to desiring donors. As noted, statute requirements were based on the submission of written information (registration statements, reports, and the like) by charitable organizations and their fundraising advisors, on bond requirements, and on enforcement authority granted to the attorneys general, secretaries of state, or other governmental officials charged with administering and enforcing the law.

Later, however, law requirements began to creep in that sounded more like ethical precepts. These requirements were more than just mechanics—they went beyond registration requirements, filing due dates, and accounting principles. They went beyond telling the charity and the professional fundraisers when to do something, and entered the realm of telling them how they must conduct the solicitation and what they cannot do in that regard.

From the regulators' viewpoint, the high point of this form of regulation came when the states could ban charitable organizations with ''high'' fundraising costs from soliciting in their jurisdictions. Ultimately, these forms of regulation were found to be unconstitutional,[6] and this application of constitutional law rights to charitable solicitation acts left the state regulators without their principal weapon. In frustration, they turned to other forms of sanction, based on the principle of *disclosure*.[7]

In this aftermath, more state fundraising law developed. The registration and annual reports became more extensive. The states tried, with limited success, to force charities and solicitors into various forms of point-of-solicitation disclosure of various pieces of information. Some states dictated the contents of contracts entered into by charitable organizations; others decreed the scripts of telephone solicitors. This disclosure approach failed to satisfy the regulatory impulse. More frustration among the regulated and the regulators ensued.

The regulators turned to even more ways to involve themselves in the charitable fundraising process. They started to micromanage charitable fundraising, substituting their judgment for that of donors, charitable organizations, and professional fundraisers. Thus, they engendered laws that expanded the record-keeping requirements, spelled out the contents of written and broadcast charitable solicitation materials, began to regulate commercial co-ventures, and

6. *See* text accompanied by *infra* notes 25–27.
7. *See* § 31.1(k).

injected themselves into matters such as the sale of tickets for charitable events and solicitations by fire and police personnel.

(c) Police Power

Each state (and local unit of government) inherently possesses the *police power*. This power enables a state or other political subdivision of government to regulate—within the bounds of constitutional law principles—the conduct of its citizens and others, so as to protect the safety, health, and welfare of its people.

Generally, it is clear that a state can enact and enforce, in the exercise of its police power, a charitable solicitation act that requires a charity planning on fundraising in the jurisdiction to first register with (or secure a license or permit from) the appropriate regulatory authorities and subsequently to render periodic reports about the results of the solicitation. There is nothing inherently unlawful about this type of law. It may also require professional fundraisers and professional solicitors to register and report, or empower the regulatory authorities to investigate the activities of charitable organizations in the presence of reasonable cause to do so, and impose injunctive remedies, fines, and imprisonment for violation of the statute. It is clear that a state can regulate charitable fundraising notwithstanding the fact that the solicitation utilizes the federal postal system, uses television and radio broadcasts, or otherwise occurs in interstate commerce.

The rationale is that charitable solicitations may be reasonably regulated to shield the public from deceit, fraud, or the unscrupulous obtaining of money under a pretense that the money is being collected and expended for a charitable purpose. For example, the preamble to one of these laws states that, "in order to protect the public from fraud and deceptive practices, it is essential that information concerning charitable fundraising activities of charitable organizations, professional fundraisers, commercial co-venturers and solicitors be readily available to the people" of the state "by whose generosity such funds are raised."[8]

Despite the inherent police power lodged in the states (and local jurisdictions) to regulate the charitable solicitation process, and the general scope of the power, however, principles of law operate to confine its reach. Most of these principles are based on constitutional law precepts, such as freedom of speech, procedural and substantive due process, and equal protection of the laws, as well as the standards usually imposed by statutory law, which bars the exercise of the police power in a manner that is arbitrary.

Indeed, because fundraising for charitable purposes is one of the highest forms of free speech, government cannot regulate it except by the narrowest

8. Preamble to the New Jersey Charitable "Registration and Investigation Act," P.L. 1994, ch. 16 (approved Apr. 11, 1994).

of means. Most of the elements of state charitable solicitation acts have, however, survived constitutional law challenges.[9] Local ordinances also have been upheld[10]—notwithstanding the growing problem of their proliferation.

(d) Definitions

State law regulation of fundraising of this nature pertains to fundraising for charitable purposes. The use of the term *charitable* in this setting, however, refers to a range of activities and organizations that are much broader than those embraced by the term as used in the federal tax context.[11] That is, the term includes organizations that are charitable, educational, scientific, and religious, as those terms are used for federal tax purposes, but it also includes (absent specific exemption) organizations that are civic, social welfare, recreational, and fraternal. Indeed, the general definition is so encompassing as to cause some of these statutes to expressly exclude fundraising by political action committees, labor organizations, and trade organizations.

Some of this regulation is applicable to a *professional fundraiser* (or similar title). The majority of the states define a professional fundraiser as one who, for a fixed fee under a written agreement, plans, conducts, advises, or acts as a consultant, whether directly or indirectly, in connection with soliciting contributions for, or on behalf of, a charitable organization. This definition usually excludes those who actually solicit contributions. Other terms used throughout the states include *professional fundraising counsel*, *professional fundraiser consultant*, and *independent fundraiser*.

Much of this regulation is applicable to those who are *professional solicitors*. Most of the states that use this term define this type of person as one who, for compensation, solicits contributions for or on behalf of a charitable organization, whether directly or through others, or a person involved in the fundraising process who does not qualify as a professional fundraiser. A minority of states define the term as a person who is employed or retained for compensation by a professional fundraiser to solicit contributions for charitable purposes.

There is considerable confusion in the law as to the appropriate line of demarcation between the two terms, *professional fundraiser* and *professional solicitor*. Because the extent of regulation can be far more intense for a professional solicitor, it is often very important for an individual or company to be classified as a professional fundraiser rather than a professional solicitor. (It is fair to surmise that most professionals retained by healthcare institutions are professional fundraisers.)

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9. *American Target Advertising, Inc. v. Giani*, 199 F.3d 1173 (10th Cir. 2000) (upholding the Utah statute).
10. *American Charities for Reasonable Fundraising Regulation v. Pinellas County*, 32 F. Supp. 2d 1308 (M.D. Fla. 1998) (upholding the ordinance of Pinellas County, Florida).
11. *See* §§ 1.4–1.7.

Some states impose disclosure requirements with respect to the process known as *commercial co-venturing*. This type of fundraising occurs when a business announces to the general public that a portion (a specific amount or a specific percentage) of the purchase price of a product or service will, during a stated period, be paid to a charitable organization. This activity results in a payment by the business to a charitable organization, the amount of which is dependent on consumer response to the promotion by, and positive publicity for, the business sponsor.

(e) Registration Requirements

A cornerstone of each state's charitable solicitation law is the requirement that a charitable organization (as defined in that law and not exempt from the obligation (see below)) that intends to solicit—by any means—contributions from persons in that state must first apply for and acquire permission to undertake the solicitation. Forty-two states have this requirement; 37 of them characterize the process as a *registration*; 3 states denominate it as a *license*, 1 as a *permit*, and 1 does not term it at all. The statute usually spells out the information that must be submitted; the states have registration forms. If successful, the result is authorization to conduct the solicitation. These permits usually are valid for one year.

These state laws apply to fundraising within the borders of each state involved. Thus, a charitable or like organization soliciting in more than one state must register under (and otherwise comply with) not only the law of the state in which it is located but the law of each of the states in which it will be fundraising. Moreover, many counties, townships, cities, and similar jurisdictions throughout the United States have ordinances that attempt to regulate charitable fundraising within their borders.

As noted below, most states' charitable solicitation acts require a soliciting charity (unless exempt) to annually file information with the appropriate governmental agency. This is done either by an annual updating of the registration or the like, or by the filing of a separate annual report.

In 29 states, professional fundraisers are required to register with the state (in 3 instances, only where they have control of the contributions). In 38 states, a professional solicitor must register. Professional solicitors must file bonds in 22 states; professional fundraisers must file them in 17 states.

(f) Reporting Requirements

Nearly all of the state charitable solicitation acts mandate annual reporting to the state by registered charitable organizations. This form of reporting can be extensive and entails the provision of information concerning gifts received, funds expended for program and fundraising, payments to service providers, and a battery of other information.

These reports are made on forms provided by the states. These forms, and the rules and instructions that accompany them, vary considerably in content. Underlying definitions and accounting principles differ. There is no uniformity with respect to due dates for these reports.

In many states, professional fundraisers and professional solicitors are required to file annual reports with the state. In others, the same effect is achieved by requiring annual registration. Some states require professional solicitors to file reports as of the close of a specific ''solicitation campaign'' or annually, whichever is the most frequent.

(g) Exemptions from Regulation

Many of the states exempt one or more categories of charitable organizations from the ambit of their charitable solicitation statute. The basic rationale for these exemptions is that the exempted organizations are not part of the objective—the protection of the citizens of the state from fundraising fraud and other abuse—the state is endeavoring to achieve through this type of regulation. (Other rationales are the constitutional law limitations involved in the case of churches and the ability of one or more categories of organizations to persuade the state legislature to exempt them.)

This exemption can be from the entirety of the statute or from its registration and reporting requirements. Some of these exemptions are available as a matter of law. Others must be applied for, sometimes on an annual basis. Some exemptions are not available or are lost if the organization utilizes the services of a professional fundraiser or professional solicitor.

Three states exempt charitable hospitals from the entirety of their laws.[12] Two of these states also similarly exempt foundations that are affiliated with exempted hospitals.[13] Three states exempt charitable hospitals from the registration and reporting requirements.[14] One of these states extends this exemption to auxiliaries of exempted hospitals.[15] Six states exempt charitable hospitals from only the registration requirements.[16] Two of these states extend this exemption to foundations that are affiliated with exempted hospitals.[17]

12. California, New Hampshire, and North Carolina (when the hospital is licensed under the state's law).
13. New Hampshire and North Carolina (when the governing board of the hospital authorized the solicitation and received an accounting of the funds collected and expended).
14. Arkansas (when the hospital is licensed by a state), Connecticut (when the hospital is licensed by a state), and Missouri (when all solicitations for contributions are carried on by employees of the hospital and not by a professional fundraiser acting as an independent contractor).
15. Missouri (when all solicitations for contributions are carried on by members of the auxiliary and not by a professional fundraiser acting as an independent contractor).
16. Arizona, Kansas, Maine, Pennsylvania (when the hospital is subject to regulation by the state's department of health or department of public welfare), Rhode Island, and West Virginia.
17. Arizona and Pennsylvania.

One state exempts from the licensing and financial statement filing requirements licensed charitable hospitals, hospital-based foundations, and auxiliaries that solicit funds solely for one or more exempted hospitals.[18] One state exempts charitable hospitals from the annual report requirement.[19] Another state exempts healthcare institutions and their supporting organizations from the registration and record-keeping requirements.[20]

One state exempts from the registration requirements any licensed medical care facility that is organized as a nonprofit corporation under the state's law, any licensed community mental health center or licensed mental health clinic, or any licensed community mental retardation center and its affiliates.[21] One state exempts from registration nonprofit blood banks and foundations related to them.[22]

A healthcare institution may be exempt, in whole or in part, from a state's charitable solicitation act on other grounds (although this is unlikely). For example, two states exempt all charitable organizations that are tax-exempt under federal law,[23] although in one the organization must annually file proof of tax-exempt status.[24]

(h) Fundraising Cost Limitations

As noted, at one time, the chief weapon for state regulators in this regard was laws that prohibited charitable organizations with ''high'' fundraising costs from soliciting in the states. Allegedly ''high'' fundraising expenses were defined in terms of percentages of gifts received. These laws proliferated, and percentage limitations were extended to the compensation of professional fundraising consultants and professional solicitors. The issue found its way to the U.S. Supreme Court, where—in three separate cases (see below)—all of these percentage limitations were struck down as violating the charities' free speech rights. This application of the First and Fourteenth Amendments to the U.S. Constitution stands as the single most important bar to more stringent government regulation of the process of soliciting charitable contributions.

Also as noted, the states possess the *police power* to regulate the process of soliciting contributions for charitable purposes. The states cannot, however, exercise this power in a manner that unduly intrudes on the rights of free speech of the soliciting charitable organizations and their fundraising consultants and solicitors.

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18. Michigan.
19. Oregon.
20. Virginia (when the institution has been recognized by the IRS as an IRC § 501(c)(3) entity).
21. Kansas.
22. Arizona.
23. Missouri and Utah.
24. Utah.

First, the Supreme Court held that a state cannot use the level of a charitable organization's fundraising costs, such as a percentage of total return, as a basis for determining whether the charity may lawfully solicit funds in a jurisdiction.[25] Four years later, the Court held that the free speech principles apply, even though the state offers a charitable organization an opportunity to show that its fundraising costs are ''reasonable,'' despite the presumption that costs in excess of a specific ceiling are ''excessive.''[26] Another four years later, the Court held that these free speech principles applied when the limitation was not on a charity's fundraising costs but on the amount or extent of fees paid by a charitable organization to professional fundraisers or professional solicitors.[27] Subsequent litigation suggests that the courts are consistently reinforcing the legal principles so articulately promulgated by the Supreme Court during the 1980s.[28]

(i) Prohibited Acts

One of the least-known and yet most common aspects of a state charitable solicitation act is the section listing various *prohibited acts*. This is a list of one or more acts in which a charitable organization (and perhaps a professional fundraiser and/or professional solicitor) may not lawfully engage. These acts may be some or all of the following:

1. A person may not, for the purpose of soliciting contributions, use the name of another person (except that of an officer, director, or trustee of the charitable organization by or for which contributions are solicited) without the consent of the other person. This prohibition usually extends to the use of an individual's name on stationery or in an advertisement or brochure, or as one who has contributed to, sponsored, or endorsed the organization.
2. A person may not, for the purpose of soliciting contributions, use a name, symbol, or statement so closely related or similar to that used by another charitable organization or government agency that it would tend to confuse or mislead the public.

25. *Village of Schaumburg v. Citizens for a Better Environment*, 444 U.S. 620 (1980).
26. *Secretary of State of Maryland v. Joseph H. Munson Co., Inc.*, 467 U.S. 947 (1984).
27. *Riley v. National Federation of the Blind of North Carolina, Inc.*, 487 U.S. 781 (1988).
28. This argument was heard by the U.S. Supreme Court, which, although it held that ''fraudulent charitable solicitation is unprotected speech'' and that here is no ''blanket exemption from fraud liability for a fundraiser who intentionally misleads in calls for donations,'' sidestepped the issue as to whether high fundraising costs, as such, amount to fraud (*Illinois v. Telemarketing Associates, Inc.*, 538 U.S. 600 (2003)). This case, the underlying briefs, and a commentary on the opinion are detailed in FUNDRAISING §§ 4.3(g) and 7.13B, and Appendices G-1–G-3 (2008 Cum. Supp.).

3. A person may not use or exploit the fact of registration with the state so as to lead the public to believe that the registration in any manner constitutes an endorsement or approval by the state.
4. A person may not represent to or mislead anyone, by any manner, means, practice, or device, to believe that the organization on behalf of which the solicitation is being conducted is a charitable organization or that the proceeds of the solicitation will be used for charitable purposes, when that is not the case.
5. A person may not represent that the solicitation for charitable gifts is for or on behalf of a charitable organization or otherwise induce contributions from the public without proper authorization from the charitable organization.

Forty states have some law of this nature. In one state, it is a prohibited act to represent that a charitable organization will receive a fixed or estimated percentage of the gross revenue from a solicitation in an amount greater than that identified to the donor. In another state, it is a prohibited act for an individual to solicit charitable contributions if the individual has been convicted of a crime involving the obtaining of money or property by false pretenses, unless the public is informed of the conviction in advance of the solicitation.

In still another state, the following are prohibited acts for a charitable organization (or, in some instances, a person acting on its behalf): (1) misrepresent the purpose of a solicitation, (2) misrepresent the purpose or nature of a charitable organization, (3) engage in a financial transaction that is not related to the accomplishment of the charitable organization's exempt purpose, (4) jeopardize or interfere with the ability of a charitable organization to accomplish its charitable purpose, (5) expend an ''unreasonable amount of money'' for fundraising or for management.

Some states make violation of a separate law concerning ''unfair or deceptive acts and practices'' or the like a violation of the charitable solicitation act.

(j) Contractual Requirements

Twenty-six of the state charitable solicitation acts require that the relationship between a charitable organization and a professional fundraiser, and/or between a charitable organization and a professional solicitor, be evidenced in a written agreement. This agreement usually is required to be filed with the state soon after the contract is executed.

Some states, however, have enacted requirements that dictate to the charitable organization the contents of the contract. For example, under one state's law, a contract between a charitable organization and a fundraising counsel must contain sufficient information ''as will enable the department to identify

the services the fundraising counsel is to provide and the manner of his compensation.'' Another provision of the same law mandates that the agreement ''clearly state the respective obligations of the parties.''

The law in another state requires a contract between a charitable organization and a fundraising counsel to contain provisions addressing the services to be provided, the number of persons to be involved in providing the services, the time period over which the services are to be provided, and the method and formula for compensation for the services. Under another state's law, whenever a charitable organization contracts with a professional fundraiser or other type of fundraising consultant, the charitable organization has the right to cancel the contract, without cost or penalty, for a period of 15 days.

(k) Disclosure Requirements

Many of the states that were forced to abandon or forgo the use of the percentage mechanism as a basis for preventing fundraising for charity (see above) utilize the percentage approach in a disclosure setting. Several states, for example, require charitable organizations to make an annual reporting, either to update a registration or as part of a separate report, to the authorities as to their fundraising activities in the prior year, including a statement of their fundraising expenses. Some states require a disclosure of a charity's fundraising costs, stated as a percentage, to donors at the time of the solicitation—although this requirement is of dubious constitutionality. In a few states, solicitation literature used by a charitable organization must include a statement that, upon request, financial and other information about the soliciting charity may be obtained directly from the state.

Some states require a statement as to any percentage compensation in the contract between the charitable organization and the professional fundraiser and/or the professional solicitor. A few states require the compensation of a paid solicitor to be stated in the contract as a percentage of gross revenue; another state has a similar provision with respect to a professional fundraiser. One state wants a charitable organization's fundraising cost percentage to be stated in its registration statement.

An example of this type of law is a statute that imposes on the individual who raises funds for a charitable organization the responsibility to ''deal with'' the contributions in an ''appropriate fiduciary manner.'' Thus, an individual in these circumstances owes a fiduciary duty to the public and is subject to a surcharge for any funds wasted or not accounted for. A presumption exists in this law that funds not adequately documented and disclosed by records were not properly spent. By direction of this law, all solicitations must ''fully and accurately'' identify the purposes of the charitable organization to prospective donors. Use of funds, to an extent of more than 50 percent,

for ''public education'' must be disclosed under this law. Every contract with a professional fundraiser must be approved by the charitable organization's governing board.

Another example is one of the provisions of another state's law, which makes an ''unlawful practice'' the failure of a person soliciting funds to ''truthfully'' recite, upon request, the percentage of funds raised to be paid to the solicitor. This state, like many other states, is using the concept of prohibited acts to impose a sort of ''code of ethics'' on all who seek to raise funds for charity.

Under one state's law, any person who solicits contributions for a charitable purpose and who receives compensation for the service must inform each person being solicited, in writing, that the solicitation is a ''paid solicitation.'' In another state, where a solicitation is made by ''direct personal contact,'' certain information must be ''predominantly'' disclosed in writing at the point of solicitation. In another state, the solicitation material and the ''general promotional plan'' for a solicitation may not be false, misleading, or deceptive, and must afford a ''full and fair'' disclosure.

(l) Unified Registration

The National Association of State Charities Officials and the National Association of Attorneys General developed a project to standardize, simplify, and economize the process of registration pursuant to the states' charitable solicitation laws. This project is manifested in the Unified Registration Statement (URS). The URS is part of a larger effort by these organizations to consolidate the information and data requirements of all states requiring registration by charitable organizations engaged in fundraising.

The URS effort consists of three phases: compilation of an inventory of registration information demands from all of the states, production of a format (or form) that incorporates all or most of these demands, and encouragement of the states to accept this standardized format as an alternative to their own forms. This project is ongoing; at present, 36 states are participating in it. A number of states, however, request additional information, entailing supplementary forms.[29]

The URS project addresses only registration. Once registered, even under this uniform approach, a fundraising charitable organization is on its own in connection with annual reporting. Nonetheless, a project is under way to produce a format for annual reporting with the states in the fundraising context.

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29. Details about this project and the forms are available at *www.nonprofits.org/library/gov/urs*. The current version is 2.30 (September 2002).

§ 31.2 FEDERAL LAW REGULATION

Despite the absence of a specific statute on the point, fundraising regulation of healthcare and other charitable organizations at the federal level is immense. Nearly all of this form of regulation is administered by the IRS.

Federal law requires that most charitable gifts, to be deductible, be *substantiated*.[30] Appraisal requirements apply with respect to gifts of property.[31] Special rules apply in the case of *quid pro quo* contributions,[32] contributions of intellectual property,[33] contributions of vehicles,[34] contributions for lobbying purposes,[35] and contributions of money.[36]

The IRS regulates the practice of fundraising for charitable purposes in the following other ways: (1) by engaging in a program of education and examination of charitable organizations that engage in fundraising, to encourage them to disclose the portions of payments that are not considered charitable gifts[37]; (2) by applying the unrelated business income rules[38] in a variety of ways, to cause certain ''fundraising'' practices to be characterized as unrelated businesses; (3) by requiring a charitable organization to summarize its fundraising program at the time it applies for recognition of tax-exempt status[39]; (4) by requiring an organization to report both the receipts of its fundraising activities and its fundraising expenses, on an annual basis[40]; (5) by applying the rules concerning private inurement[41] in such a fashion as to discourage fundraising compensation arrangements that are based on percentages or otherwise involve commissions; (6) by applying the rules embodying limitations on lobbying by, and calculation of the public support of, public charities in a way that defines and encourages certain forms of fundraising[42]; and (7) by ''regulating'' the fundraising process by its interpretations and enforcement of the rules involving deductible charitable contributions.[43]

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30. *See* § 31.2(a).
31. *See* § 31.2(c).
32. *See* § 31.2(b).
33. *See* § 31.2(e).
34. *See* § 31.2(f).
35. *See* § 31.2(d).
36. *See* § 31.2(g). Other charitable contribution deduction rules are less likely to apply in the healthcare setting, such as gifts for conservation purposes (including easements) (*See* CHARITABLE GIVING § 9.7), gifts involving charitable split-dollar insurance plans (*id*. § 17.6), giving involving applicable insurance contracts (*id*. § 17.7), gifts of clothing and household items (*id*. § 9.23B), and gifts of taxidermy (*id*. § 9.23A). Gifts involving planned giving vehicles, often an essential function of a healthcare development foundation (*See* Chapter 14), are the subject of CHARITABLE GIVING, Part Four).
37. *See* text accompanied by *infra* notes 58–61.
38. *See* Chapter 31.2(h).
39. *See* § 33.2(i).
40. *See* § 31.2(j).
41. *See* Chapter 11.
42. *See* § 7.1.
43. *See*, in general, CHARITABLE GIVING.

A brief summary of these forms of federal regulation of fundraising for charitable healthcare purposes follows.

(a) Substantiation Requirements

A healthcare organization or affiliated organization that is a charitable entity and that receives contributions under circumstances where the donor intends to claim a charitable contribution deduction must adhere to the federal tax law substantiation requirements. These requirements are a matter of statutory law, with some accompanying rules in tax regulations.

It has been the perception of the IRS that some charitable organizations are misleading persons, sometimes deliberately, into believing that a payment to a charitable organization is a deductible contribution when in fact the transaction does not involve a gift at all or is only partially a gift. This matter has concerned the IRS at least since 1967, when it issued guidelines directing charitable organizations to advise ''donors'' of circumstances where their ''gifts'' are not deductible at all (where, for their payment, the payors receive from the charity something of approximately equal value) or are only partially deductible (where the donors receive, in return for their gift, something of less value than the amount of the gift).[44] The 1967 guidelines described these rules in some detail and provided examples as to how the rules apply in common situations such as theater parties, sports tournaments, and similar special events. In 1988, a congressional committee expressed dismay over continuation of, if not increase in, these practices, and demanded that the IRS act to resolve the problem. Later in that year, the Commissioner of Internal Revenue sent a special message on the point to the nation's charitable organizations.[45]

This matter concerns a variety of practices. Some are relatively obvious and easy to resolve, such as payments by patients to tax-exempt hospitals. Although these are payments to ''charitable'' organizations, they are purchases of services and are not ''gifts.'' Other payments to charitable organizations that are not gifts are payments for winning bids at auctions and purchases of tickets for games of chance (such as raffles and lotteries).

Other practices that entail partial gifts are special-event programs, where the patron receives something of value (such as a ticket to a theater performance or a dinner, or the opportunity to participate in a sports tournament), yet makes a payment in excess of that value amount. In these circumstances, the amount paid that is in excess of the value received is a deductible charitable gift.

The IRS's lawyers determined that payments by corporate sponsors of college and university bowl games are not charitable gifts to the bowl game associations but must be treated by the association as forms of unrelated

44. Rev. Rul. 67-246, 1967-2 C.B. 104.
45. IRS Pub. 1391 (1988), summarized and analyzed in V *Nonprofit Couns*. 1 (Sept. 1988).

business income because the corporate sponsors received a valuable package of advertising services.[46] This engendered considerable controversy, which in turn led to the issuance by the IRS of general donor recognition guidelines and proposed regulations. Those developments proved insufficient; Congress interceded with legislation in 1997—rules designed to enable charitable organizations to distinguish between instances of ''mere recognition'' and situations where payors are provided a substantial return benefit in the form of services akin to advertising.[47]

This activity by the IRS concerning nondeductible payments to charitable organizations, and the response of the charitable community, was deemed inadequate by Congress. Thus, in 1993, statutory substantiation rules were enacted. Under these rules, a donor who makes a charitable contribution of $250 or more in a year to a charitable organization, for which a charitable contribution deduction is intended, must obtain written substantiation from the donee organization.[48] Noncompliance with these rules precludes the otherwise deductible charitable gift from being deductible. More specifically, the charitable contribution deduction is not allowed for a *separate contribution* of $250 or more unless the donor has written substantiation from the charitable donee of the contribution in the form of a *contemporaneous written acknowledgment*.[49]

An acknowledgment meets this requirement if it includes the following information: (1) the amount of money and a description (but not the value) of any property other than money that was contributed; (2) whether the donee organization provided any goods or services in consideration, in whole or in part, for any money or property contributed; and (3) a description and good-faith estimate of the value of any goods or services involved or, if the goods or services consist solely of *intangible religious benefits*, a statement to that effect.[50] As to the second of these items, if the donee organization did not provide any such goods or services, the acknowledgment must affirmatively state that fact.[51] As to the third of these items, an intangible religious benefit is ''any intangible religious benefit which is provided by an organization

46. Tech. Adv. Mem. 9147007.
47. IRC § 513(i).
48. As to contributions made before 1993 or contributions of less than $250, other substantiation rules contained in the tax regulations applied (Reg. § 1.170A-13(a), (b)). In 2006, however, Congress enacted more stringent rules concerning the substantiation of these smaller gifts (see § 31.2(g)).
49. IRC § 170(f)(8)(A); Reg. § 1.170A-13(f)(1)
50. IRC § 170(f)(8)(B); Reg. § 1.170A-13(f)(2). A court held that this requirement of disclosure of *goods or services* applies also to *expectations*; in the case, donors made cash contributions to a charitable organization with the ''understanding'' that the charity would invest the funds in a life insurance product (*Addis v. Commissioner*, 118 T.C. 528 (2002)), aff'd, 374 F.3d 881 (9th Cir. 2004), *cert. den.*, 125 S. Ct. 1334 (2005). *See* CHARITABLE GIVING § 21.1(b), text accompanied by notes 68–75; PLANNING GUIDE, Chapter 11, text accompanied by notes 78–89.
51. Reg. § 1.170A-13 T(b).

organized exclusively for religious purposes and which generally is not sold in a commercial transaction outside the donative context.''[52] An acknowledgment is *contemporaneous* if the contributor obtains the acknowledgment on or before the earlier of the date on which the donor filed a tax return for the tax year in which the contribution was made or the due date (including extensions) for filing the return.[53]

As noted, this substantiation rule applies with respect to *separate payments*. Separate payments generally are treated as separate contributions and are not aggregated for the purpose of applying the $250 threshold. Where contributions are paid by withholding from wages, the deduction from each paycheck is treated as a separate payment.[54] Goods or services provided in return for a contribution need not be taken into account for this purpose if the goods or services have ''insubstantial value.''[55]

The written acknowledgment of a separate gift is not required to take any particular form. Thus, acknowledgments may be made by letter, post card, or computer-generated form. These acknowledgments may also be provided by e-mail.[56] A donee charitable organization may prepare a separate acknowledgment for each contribution or may provide donors with periodic (such as annual) acknowledgments that set forth the required information for each contribution of $250 or more made by the donor during the period.[57] It is the responsibility of a donor to obtain the substantiation and maintain it in his, her, or its records.

(b) *Quid Pro Quo* Contributions

Rules concerning *quid pro quo contributions* pertain to payments ''made partly as a contribution and partly in consideration for goods or services provided to the payor by the donee organization.''[58]

A charitable organization that receives a *quid pro quo* contribution in excess of $75 must, in connection with the solicitation or receipt of the contribution, provide a written statement to the donor that (1) informs the donor that the amount of the contribution that is deductible for federal income tax purposes is limited to the excess of the amount of any money (and the value of any

52. IRC § 170(f)(8)(B), last sentence.
53. IRC § 170(f)(8)(C); Reg. § 1.170A-13(f)(3).
54. Reg. § 1.170A-13(f)(11).
55. Reg. § 1.170A-13(f)(8). The guidelines for determining insubstantiality are contained in Rev. Proc. 92-49, 1992-1 C.B. 987, and Rev. Proc. 90-12, 1990-1 C.B. 471.
56. IRS Notice 2002-25, 2002-15 I.R.B. 743; *Charitable Contributions—Substantiation and Disclosure Requirements* (IRS Pub. 1771 (rev. Mar. 2002)); in general, *Rio Properties, Inc. v. Rio International Interlink*, 284 F.3d 1007 (9th Cir. 2002).
57. H.R. Rep. No. 103-213, 103d Cong., 1st Sess. 565 note 32 (1993). A charitable organization that knowingly provides a false written substantiation to a donor may be subject to the penalty for aiding and abetting an understatement of tax liability (IRC § 6701). In general, *see* Charitable Giving § 21.1(a).
58. IRC § 6115(b).

property other than money) contributed by the donor over the value of the goods or services provided by the organization, and (2) provides the donor with a good-faith estimate of the value of the goods or services furnished to the donor by the organization.[59] This disclosure must be made in a manner that is reasonably likely to come to the attention of the donor.

For purposes of the $75 threshold, separate payments made at different times of the year with respect to separate fundraising events generally are not aggregated. These rules do not apply where only *de minimis* or token goods or services were provided to the donor.[60] Also, this requirement does not apply with respect to transactions that do not have a donative element, such as the charging of fees by a healthcare provider.

Penalties of $10 per contribution, capped at $5,000 per particular fundraising event or mailing, may be imposed on charitable organizations that fail to make the required disclosure, unless the failure was due to reasonable cause.[61] The penalty applies if an organization either fails to make any disclosure in connection with a *quid pro quo* contribution or makes a disclosure that is incomplete or inaccurate (such as an estimate not determined in good faith of the value of goods or services furnished to the donor).

No part of a payment that a person makes to or for the use of a charitable organization that is in consideration for[62] goods or services[63] is a contribution unless the person intends to make a payment in an amount that exceeds the fair market value of the goods or services and makes a payment in an amount that exceeds that value.[64]

(c) Appraisal Requirements

The law contains requirements relating to the substantiation of deductions claimed by an individual, a closely held corporation, a personal service corporation, a partnership, or an S corporation for charitable contributions of certain property.[65] Property to which these rules apply is termed *charitable deduction property*. These rules must be complied with if the charitable deduction that is otherwise available is to be allowed.[66] These requirements apply to

59. IRC § 6115(a); Reg. § 1.6115-1.
60. *See supra* note 55.
61. IRC § 6714.
62. A charitable organization provides goods or services *in consideration for* a person's payment if, at the time the person makes the payment to the charity, the person receives or expects to receive goods or services in exchange for the payment (Reg. § 1.170A-13(f)(6)). Goods or services a charitable organization provides in consideration for a payment by a person include goods or services provided in a year other than the year in which the person makes the payment to the charity (*id*.).
63. The term *goods or services* means cash, property, services, benefits, and privileges (Reg. § 1.170A-13(f)(5)).
64. Reg. § 1.170A-1(h)(1). In general, *see* CHARITABLE GIVING § 22.2.
65. Reg. § 1.170A-13(c).
66. Reg. § 1.170A-13(c)(2).

contributions of property (other than money and publicly traded securities) if the aggregate claimed or reported value of the property is in excess of $5,000.[67]

For this type of gift, the donor must obtain a *qualified appraisal* and attach an *appraisal summary* to the tax return on which the deduction is claimed.[68] In the case of nonpublicly traded stock, however, the claimed value of which does not exceed $10,000 but is greater than $5,000, the donor does not have to obtain a qualified appraisal but must attach a partially completed appraisal summary form to the return on which the deduction is claimed.[69]

The qualified appraisal must be received by the donor before the due date (including extensions) of the return on which the deduction for the contributed property is first claimed, or, in the case of a deduction first claimed on an amended return, the date on which the return is filed.[70] The appraisal summary must be retained by the donee ''for so long as it may be relevant in the administration of any internal revenue law.''[71] The appraisal summary must be made on a form prescribed by the IRS,[72] signed and dated by the charitable donee and qualified appraiser, and attached to the donor's return on which a deduction with respect to the appraised property is first claimed or reported.[73]

A charitable donee that sells, exchanges, consumes, or otherwise disposes of gift property within two years after the date of the contribution of the property must file an information return[74] with the IRS.[75] This reporting obligation does not apply to a situation where the charitable donee consumes or distributes, without consideration, the property in the course of performing an exempt function.[76]

(d) Contributions for Lobbying Purposes

A donor may not use a charitable organization as a conduit for lobbying activities, the costs of which would be nondeductible as a business expense if conducted directly by the donor.[77] That is, an income tax deduction will not be allowed—either as a charitable contribution deduction or as a business expense deduction—for amounts contributed to a charitable organization that conducts lobbying activities, if the charity's lobbying activities regard matters of direct financial interest to the donor's trade or business, and a principal

67. Reg. § 1.170A-13(c)(1)(i).
68. Reg. § 1.170A-13(c)(2)(i)(A), (B).
69. Reg. § 1.170A-13(c)(2)(ii).
70. Reg. § 1.170A-13(c)(3)(iv)(B).
71. Reg. § 1.170A-13(c)(3)(4)(C).
72. Form 8283, Section B.
73. Reg. § 1.170A-13(c)(4).
74. Form 8282.
75. IRC § 6050L; Reg. § 6050L-1.
76. In general, *see* CHARITABLE GIVING § 21.2.
77. These business expense rules are the subject of § 18.4.

purpose of the contribution is to avoid the general disallowance rule that would apply if the contributor directly had conducted the lobbying activities.[78]

The application of this rule to a contributor would not adversely affect the tax-exempt status of the charitable organization as long as the activity qualified as nonpartisan analysis, study, or research, or was not substantial under either the substantial part test or the expenditure test.[79]

The determination regarding a principal purpose of the contribution must be based on the facts and circumstances surrounding the contribution, including the existence of any formal or informal instructions relating to the charitable organization's use of the contribution for lobbying efforts (including nonpartisan analysis), the ''temporal nexus'' between the making of the contribution and conduct of the lobbying activities, and any historical pattern of contributions by the donor to the charity.[80]

(e) Vehicle Contribution Rules

The federal tax law entails deductibility and substantiation requirements in connection with contributions to charity of motor vehicles, boats, and airplanes—collectively termed *qualified vehicles*.[81] These requirements supplant the general gift substantiation rules[82] where the claimed value of the gifted property contributed exceeds $500.[83]

Pursuant to these rules, a federal income tax charitable contribution deduction is not allowed unless the donor substantiates the contribution by a contemporaneous written acknowledgment of the contribution by the donee organization and includes the acknowledgment with the donor's income tax return reflecting the deduction.[84] This acknowledgment must contain the name and taxpayer identification number of the donor and the vehicle identification number or similar number.[85] If the gift is of a qualified vehicle that was sold by the donee charitable organization without any ''significant intervening use or material improvement,'' the acknowledgment must also contain a certification that the vehicle was sold in an arm's-length transaction between unrelated parties, a statement as to the gross proceeds derived from the sale, and a statement that the deductible amount may not exceed the amount of the gross proceeds.[86] If there is such use or improvement, the acknowledgment

78. IRC § 170(c)(9).
79. *See* § 7.1.
80. H.R. Rep. No. 103-213, 103d Cong., 1st Sess. (1993). In general, Charitable Giving § 10.8.
81. IRC § 170(f)(12)(E), which refers to motor vehicles ''manufactured primarily for use on public streets, roads, and highways.''
82. *See* § 31.2(a).
83. IRC § 170(f)(12)(A).
84. IRC § 170(f)(12)(A)(i).
85. IRC § 170(f)(12)(B)(i), (ii).
86. IRC § 170(f)(12)(B)(iii). Neither the statute nor its legislative history defines the terms *arm's-length* or *unrelated party*. In general, the term *arm's-length* means a distance between

must include a certification as to the intended use or material improvement of the vehicle and the intended duration of the use, and a certification that the vehicle will not be transferred in exchange for money, other property, or services before completion of the use or improvement.[87] An acknowledgment is *contemporaneous* if the donee organization provides it within 30 days of the sale of the qualified vehicle or, in an instance of an acknowledgment including the foregoing certifications, of the contribution of the vehicle.[88]

The amount of the charitable deduction for a gift of a qualified vehicle is dependent on the nature of the use of the vehicle by the donee organization. If the charitable organization sells the vehicle without any significant intervening use or material improvement of the vehicle by the organization, the amount of the charitable deduction may not exceed the gross proceeds received from the sale.[89] Where there is such a use or improvement, the charitable deduction is based on the fair market value of the vehicle.

The legislative history accompanying this law states that these two exceptions are to be strictly construed.[90] To meet this *significant use* test, the organization must actually use the vehicle to substantially further the organization's regularly conducted activities and the use must be significant. The test is not satisfied if the use is incidental or not intended at the time of the contribution. Whether a use is *significant* also depends on the frequency and duration of use.[91]

The history of this legislation provides an example of a charitable organization that, as part of its regularly conducted activities, delivers meals to needy individuals. The use requirement would be satisfied if the organization used a donated vehicle to deliver food to the needy. Use of the vehicle to deliver meals substantially furthers a regularly conducted activity of the organization. The use also must be significant, which depends on the nature, extent, and frequency of the use. If the organization used the vehicle "only once or a few times" to deliver meals, the use would not be considered significant. If the organization used the vehicle to deliver meals every day for one year, the use would be considered significant. If the organization drove the vehicle 10,000 miles while delivering meals, such use likely would be considered significant.

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persons under circumstances where authentic bargaining can take place. Congress obviously wants the sale to occur under these circumstances so that the value of the vehicle can be objectively ascertained. An *unrelated party* essentially is a person who is not related to another person by reason of a family or business relationship. Another way to state this is that an *unrelated party* is a person who is not in a conflict-of-interest position with respect to the other person. The statute is somewhat redundant in using both terms, although it is theoretically possible to have an arm's-length transaction between related parties.

87. IRC § 170(f)(12)(B)(iv).
88. IRC § 170(f)(12)(C).
89. IRC § 170(f)(12)(A)(ii).
90. H. Rep. No. 108-755, 108th Cong., 2d Sess. 737 (2004).
91. *Id*.

Use of a vehicle in such an activity for one week or for several hundreds of miles generally would not be considered a significant use.[92]

This legislative history provides a second example concerning use by a charitable organization of a donated vehicle to transport its volunteers. The use would not be significant merely because a volunteer used the vehicle over a ''brief period of time'' to drive to or from the organization's premises. Conversely, if at the time the organization accepts the contribution of a qualified vehicle, the organization intends to use the vehicle as a ''regular and ongoing'' means of transport for volunteers of the organization, and the vehicle is so used, the significant use test would be met.[93]

The legislative history provides a third example, concerning an individual who makes a charitable contribution of a used automobile in good running condition and that needs no immediate repairs to a charitable organization that operates an elder care facility. The organization provides the donor with a written acknowledgment that includes a certification that the donee intends to retain the vehicle for a year or longer to transport the facility's residents to community and social events, and deliver meals to the needy. A few days after receiving the vehicle, the donee organization commences to use the vehicle three times a week to transport some of its residents to various community events and twice a week to deliver food to needy individuals. The organization continues to regularly use the vehicle for these purposes for approximately one year and then sells the vehicle. The donee's use of this vehicle constitutes a significant intervening use prior to the sale by the organization.[94]

A *material improvement* includes major repairs to a vehicle or other improvements to the vehicle that improve its condition in a manner that significantly increases the vehicle's value. Cleaning the vehicle, minor repairs, and routine maintenance do not constitute a material improvement.[95] This legislative history does not provide any examples pertaining to this exception. Presumably, this exception is available only when the donee charitable organization expresses its intent at the outset (at least in part by means of the certification) that the donee plans to materially improve the vehicle.

A donee organization that is required to provide an acknowledgment under these rules must also provide that information to the IRS.[96] A penalty is imposed for the furnishing of a false or fraudulent acknowledgment, or an untimely or incomplete acknowledgment, by a charitable organization to a donor of a qualified vehicle.[97]

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92. *Id*.
93. *Id*.
94. *Id*. 737–738.
95. *Id*. at 737.
96. IRC § 170(f)(12)(D).
97. *See* Charitable Giving § 10.14, text accompanied by notes 275 and 276.

The IRS issued interim guidance concerning these rules for deductible charitable contributions of qualified vehicles.[98] This guidance added a third exception to these rules, which is for circumstances where the charity gives or sells the vehicle at a significantly below-market price to a needy individual, as long as the transfer furthers the charitable purpose of helping a poor or distressed individual who is in need of a means of transportation.[99] The guidance also explains how the fair market value of a vehicle is determined.[100]

The IRS issued a form (Form 1098-C) to be used by donee charitable organizations to report to the IRS contributions of qualified vehicles and to provide the donor with a contemporaneous written acknowledgment of the contribution.[101]

The items on this form include the following:

- *Box 4a:* This is checked by the charitable donee to certify that the donated vehicle was sold to an unrelated party in an arm's-length transaction.
- *Box 4c:* Here the charity enters the gross proceeds it received from the sale of the donated vehicle. If box 4a is checked, the donor generally may take a deduction in an amount equal to the lesser of the amount in box 4c or the vehicle's fair market value on the date of the contribution.
- *Box 5a:* This is checked by the charity to certify that the donated vehicle will not be sold before completion of a significant intervening use or material improvement by the charity. If this box is checked, the donor generally may take a deduction equal to the vehicle's fair market value.
- *Box 5b:* This box is checked by the charity to certify that the donated vehicle is to be transferred to a needy individual in direct furtherance of the donee's charitable purpose of relieving the poor or distressed or underprivileged who are in need of a means of transportation. If this box is checked, the donor generally may take a deduction equal to the vehicle's fair market value.

A donor of a qualified vehicle must attach Copy B of this form to the donor's income tax return in order to take a deduction for the contribution of the vehicle where the claimed value is in excess of $500. Generally, the donee must furnish Copies B and C of the form to the donor no later than 30 days after the date of sale if box 4a is checked or 30 days after the date of the contribution if box 5a or 5b is checked.

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98. Notice 2005-44, 2005-25 I.R.B. 1287.
99. This example is based on language in the legislative history (H. Rep. No. 108-755, 108th Cong., 2d Sess. 750 (2004)).
100. *See* Charitable Giving § 10.1(c).
101. Ann. 2005-66, 2005-39 I.R.B. 613.

Copy A of this form is to be filed with the IRS, Copy C is for the donor's records, and Copy D is retained by the charitable donee.

(f) Intellectual Property Contribution Rules

Contributions of certain types of intellectual property are included in the list of gifts that give rise to a charitable contribution deduction that is confined to the donor's basis in the property,[102] although, as discussed below, in instances of gifts of intellectual property there may be one or more subsequent charitable deductions. This property consists of patents, copyrights (with exceptions[103]), trademarks, trade names, trade secrets, know-how, software (with exceptions[104]), or similar property, or applications or registrations of such property. Collectively, these properties are termed *qualified intellectual property* (except in instances when contributed to standard private foundations[105]).[106]

A person who makes this type of gift, denominated a *qualified intellectual property contribution*,[107] is provided a charitable contribution deduction (subject to the annual percentage limitations[108]) equal to the donor's basis in the property in the year of the gift and, in that year and/or subsequent years, a charitable deduction equal to a percentage of net income that flows to the charitable donee as the consequence of the gift of the property.[109] For a contribution to be a qualified intellectual property contribution, the donor must notify the donee at the time of the contribution that the donor intends to treat the contribution as a qualified intellectual property contribution for deduction and reporting purposes.[110] The net income involved is termed *qualified donee income*.[111]

Thus, a portion of qualified donee income is allocated to a tax year of the donor,[112] although this income allocation process is inapplicable to income received by or accrued to the donee after 10 years from the date of the gift[113]; the process is also inapplicable to donee income received by or accrued to the donee after the expiration of the legal life of the property.[114]

The amount of qualified donee income that materializes into a charitable deduction, for one or more years, is ascertained by the *applicable percentage*,

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102. IRC § 170(e)(1)(B)(iii).
103. This definition does not encompass a copyright described in IRC § 1221(a)(3) or 1231(b)(1)(C).
104. This definition does not encompass software described in IRC § 197(e)(3)(A)(i).
105. That is, a transaction referred to in IRC § 170(e)(1)(B)(ii) (*see* § 4.5(a)).
106. IRC § 170(m)(9).
107. IRC § 170(m)(8).
108. *See* CHARITABLE GIVING, Chapter 7.
109. IRC § 170(m)(1).
110. IRC § 170(m)(8)(B).
111. IRC § 170(m)(3).
112. IRC § 170(m)(4).
113. IRC § 170(m)(5).
114. IRC § 170(m)(6).

which is a sliding-scale percentage determined by the following table that appears in the Internal Revenue Code:[115]

Donor's Tax Year	Applicable Percentage
1st	100
2nd	100
3rd	90
4th	80
5th	70
6th	60
7th	50
8th	40
9th	30
10th	20
11th	10
12th	10

Thus, if, following a qualified intellectual property contribution, the charitable donee receives qualified donee income in the year of the gift, and/or in the subsequent tax year of the donor, that amount becomes, in full, a charitable contribution deduction for the donor (subject to the general limitations). If such income is received by the charitable donee eight years after the gift, for example, the donor receives a charitable deduction equal to 40 percent of the qualified donee income. As this table indicates, the opportunity for a qualified intellectual property deduction arising out of a qualified intellectual property contribution terminates after the twelfth tax year of the donor ending after the date of the gift.[116]

The reporting requirements rules, concerning certain dispositions of contributed property, were amended in 2004 to encompass qualified intellectual property contributions.[117]

A donor satisfies the notification requirement[118] if the donor delivers or mails to the donee, at the time of the contribution, a statement containing the following:

- The donor's name, address, and taxpayer identification number
- A description of the intellectual property in sufficient detail to identify it
- The date of the contribution
- A statement that the donor intends to treat the contribution as a qualified intellectual property contribution[119]

115. IRC § 170(m)(7).
116. IRC § 170(m)(10)(C).
117. *See* CHARITABLE GIVING § 21.3(b).
118. *See* text accompanied by *supra* note 110.
119. Notice 2005-41, 2005-23 I.R.B. 1203; T.D. 9206; REG-158138-04.

(g) Contributions of Money

With respect to contributions made in tax years beginning after August 17, 2006, in the case of a charitable contribution of money, irrespective of the amount, applicable record-keeping requirements are satisfied only if the donor maintains, as a record of the contribution, a bank record or a written communication from the donee showing the name of the donee organization, and the date and amount of the contribution.[120] For this purpose, a *bank record* includes canceled checks, bank or credit union statements, and credit card statements. Contributions of *money* include those made in cash or by check, electronic funds transfer, credit card, and/or payroll deduction. For payroll deductions, the donor should retain a pay stub, a wage statement (Form W-2), or other document furnished by the employer showing the total amount withheld for charity, along with the pledge card showing the name of the charitable organization.[121]

(h) Unrelated Income Rules

The IRS applies the unrelated income rules[122] as a means of regulating the process of raising funds for charitable purposes. In general, for an activity to be taxed as an *unrelated trade or business*, it must have these characteristics: (1) it must be a *business*, that is, be an activity that is carried on to produce revenue; (2) the business must be *regularly carried on;* and (3) the activity must not be substantially related to the achievement of tax-exempt purposes.

Many fundraising activities are businesses in this sense.[123] This is particularly true with respect to special-event fundraising. Nearly all fundraising activities are not inherently charitable or other tax-exempt undertakings. (An activity is not a related one solely because the net monies from it are applied to exempt purposes.)

Many fundraising activities escape treatment as taxable businesses on the ground that they are not regularly carried on.[124] Thus, an annual charity ball, golf tournament, auction, car wash, bake sale, and the like are not taxable events because they are infrequently carried on and thus are not competitive with for-profit operations.[125]

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120. IRC § 170(f)(17).
121. IR-2006-192. This new law did not change the prior-law requirement that a donor obtain a written substantiation from a charity for each contribution of $250 or more (*see* § 31.2(a)). A statement containing the information required by both of these bodies of law should meet both sets of requirements.
122. *See*, in general, Chapter 24.
123. *See* § 24.2.
124. *See* § 24.3.
125. E.g., Priv. Let. Rul. 200128059.

Some exceptions to unrelated income taxation also help protect various fundraising activities from tax. These include (1) businesses in which substantially all of the work is performed by volunteers[126]; (2) businesses carried on primarily for the convenience of the organization's members, students, patients, officers, or employees[127]; (3) businesses that consist of the sale of merchandise, substantially all of which has been received by the organization as gifts[128]; (4) certain bingo games[129]; (5) certain fairs and expositions[130]; (6) certain practices involving mailing lists rented to and exchanged with charitable organizations[131]; and (7) the offering of certain low-cost premiums as inducements to charitable giving.[132]

Nonetheless, a variety of fundraising techniques and practices have been subject to litigation as to whether they are taxable business. Recent issues include the extent to which a revenue-producing activity can be structured so that the revenue to the tax-exempt organization can be regarded as a nontaxable royalty[133]; whether the distribution of greeting cards is a sale of the cards to the public or a use of premiums to stimulate charitable giving; and the provision of group insurance policy coverage.

Current popular fundraising techniques that are beginning to raise questions about application of the unrelated business rules are forms of *commercial co-venturing* and *cause-related marketing*. The former involves situations in which a charitable organization consents to be a donee under circumstances where a commercial business agrees to make a payment to the organization, with that agreement advertised, of an amount predicated on the extent of products sold or services provided by the business to the public during a particular time period. Cause-related marketing involves the public marketing of products or services by or on behalf of a tax-exempt organization, or some similar use of an organization's resources.

A manifestation of cause-related marketing can be seen in the participation by exempt organizations in affinity card programs, in which an exempt organization is paid a portion of the revenues derived from the use of the cards by consumers who make up the affinity group. The position of the IRS has been that the revenues from affinity card programs are taxable because they arise from the exploitation of mailing lists, and that the special exception for these lists (see above) is not available because the lists are provided to noncharitable organizations. This position has been consistently rebuffed in the courts and the IRS is reformulating its views on the subject.

126. *See* § 24.17(a), text accompanied by note 366.
127. *See* § 24.17(a), text accompanied by notes 360–365.
128. *See* § 24.17(a), text accompanied by notes 368–369.
129. IRC § 513(f).
130. IRC § 513(d).
131. See § 24.17(a), text accompanied by note 374.
132. *Id*., text accompanied by notes 370–373.
133. See § 24.17(b)(iii).

(i) Exemption Recognition Process

A healthcare or like charitable organization generally must secure recognition of its tax-exempt status from the IRS.[134] This application process requires the organization to reveal information about its fundraising program.

In the application, the organization must describe its actual and planned fundraising. The applicant organization must summarize its actual use of, or plans to use (if any), selective mailings, fundraising committees, professional fundraisers, and the like. The organization must identify, in order of size, its sources of financial support.

The application for recognition of tax exemption, if properly completed, amounts to a rather complete portrait of the programs, fundraising plans, and other aspects of the applicant organization. It is a public document and thus, during the course of its existence, the organization probably will be called on to supply copies of the application. Because those who inspect the document are likely to be prospective donors or grantors, it is particularly important that it be properly prepared.

(j) Reporting Requirements

Nearly every tax-exempt healthcare organization must file an annual information return with the IRS.[135] This is usually a Form 990. This return solicits considerable information about an organization's fundraising efforts.

A principal component of Form 990 consists of an extensive reporting of income-producing activities. The information sought is designed to provide Congress with data needed to assess the impact of current or future unrelated business income rules and to enable the IRS to better administer the existing unrelated income laws.

On this form, the tax-exempt organization must identify each income-producing activity. These activities include various forms of program service revenue, membership dues and assessments, investment income, sales of assets, and special fundraising events. The revenue from each reported activity must be categorized as unrelated business income, exempt function (related) income, or income excluded from taxation by a particular provision of the Internal Revenue Code. The IRS has devised a system of codes to use in classifying unrelated (taxable) business income and income excludable from taxation because of a particular Code section. When an exempt organization classifies an item of income as related, it must explain how the associated activity contributed importantly to the accomplishment of exempt purposes.

An organization is required to report all amounts received as contributions or grants. An organization must attach a schedule listing contributors who, during the year, gave the organization, directly or indirectly, money or property

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134. *See* §§ 33.1, 33.2.
135. *See* § 35.3.

worth at least $5,000. Separate reporting is required for program service revenue, membership dues and assessments, investment income, asset sales, revenue from special fundraising events, and other revenue.

Although revenue from special fundraising activities generally is (as noted) separately reported, when the payment is part a purchase for the event or activity and part a contribution, the gift portion is reported separately from the purchase portion. Direct expenses associated with special fundraising events are subtracted on the face of the return. A schedule, attached to the return, must list the three largest (in terms of gross receipts) special events conducted by the organization.

Revenue, for these purposes, does not include the value of services donated to an organization or the free use of materials, equipment, or facilities. These items may, however, be reported elsewhere on the return.

In general, expenses must be both totaled and allocated to the categories of program, management, and fundraising. This is known as the *functional method of accounting*. Proper compliance with the requirements of the functional method of accounting obligates organizations to maintain detailed records as to their fundraising and other expenses, because the fundraising component of each line-item expenditure must be separately identified and reported.

(k) Fundraising Compensation Arrangements

Charitable and like organizations must be operated so that they do not cause any inurement of their net earnings to certain individuals in their private capacity or otherwise cause private benefit.[136] The private inurement and private benefit doctrines can be triggered when a charitable organization pays excessive or otherwise unreasonable compensation for services. Therefore, a charitable organization may not, without endangering its tax-exempt status, pay a fundraising professional an amount that is excessive or unreasonable.

Questions about the propriety of compensation of a fundraising professional may not have as much to do with the amount being paid as the manner in which it is determined. This is particularly true with respect to compensation that is ascertained on the basis of a commission or percentage. Although the IRS is suspicious of fundraising compensation that is based on percentages of contributions received, however, the courts have been tolerant of the practice.

136. *See* Chapter 4.

C H A P T E R   T H I R T Y - T W O

Rural Healthcare Organizations

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Whether or not it's intentional, there are forces at work to break the back of the rural hospital.

—CEO, Rural Hospital
Deloitte & Touche Study (June 1990)

§ 32.1 INTRODUCTION

Rural hospitals differ from their urban counterparts in many ways. Typically, they are smaller and, on average, less profitable. Healthcare Financial Management Association (HFMA) statistics indicate that they are significantly older than urban hospitals. They provide a higher percentage of outpatient services, they often treat an older patient mix, and, surprisingly, they encounter substantial mental health problems in their patients. According to the American Hospital Association, they treat a disproportionate share of uninsured patients. The General Accounting Office (GAO) concluded that rural hospitals' problems could be categorized as: (1) low patient volume (and therefore higher costs per discharge); (2) lesser ability to compete for patients and physicians; (3) limited patient and nonpatient revenues; and (4) regulatory constraints.[1]

Given the nature and extent of these problems, what can rural hospitals do to improve their lot? The Internal Revenue Code, and its interpretation by the Internal Revenue Service, affords rural hospitals significantly greater flexibility in fulfilling their exempt purposes than urban hospitals.

Rural hospitals typically are classified by geography and size. For Medicare reimbursement purposes, a rural hospital is any hospital located outside a metropolitan statistical area. Some rural hospitals, generally facilities located

1. GAO Report, ''Rural Hospitals, Federal Leadership and Targeted Programs Needed,'' GAO/HRD-90-67 (June 1990).

more than 35 road miles from another hospital, are Medicare sole community hospitals. The GAO reported that small hospitals (those with fewer than 100 beds) account for 75 percent of the 2,549 rural hospitals in the United States.[2]

§ 32.2 APPLICATION OF THE SUBSTANTIAL PRIVATE BENEFIT PROHIBITION

As discussed previously, in order to satisfy the operational test of the Code for charitable organizations, an organization must ''serve[ ] a public rather than a private interest.''[3] There will be some serving of a private interest by the exempt organization (e.g., an exempt hospital serves the private interests of its physicians); the IRS is concerned with the *primary* purpose of the organization. If the serving of private interests is incidental to the accomplishment of the organization's charitable purposes and does not represent a substantial nonexempt purpose, the organization's exemption will not be jeopardized.[4]

The IRS has further defined the incidental private benefit rule. For private benefit to be deemed incidental, and thereby not a risk to exemption, it must be incidental both qualitatively and quantitatively.[5]

Thus, in determining whether a rural hospital activity is consistent with exemption, this incidental private benefit test must be applied. However, because of the economic and geographic constraints on rural hospitals, the level of private benefit required before exemption will be threatened is, in practice, frequently higher for these hospitals than it is for urban hospitals.

The principles of private benefit and private inurement are used to assess rural hospital activities just as they are for any other charitable organization. However, the application of these principles is subjective in nature. There are no bright-line tests for determining when private benefit has risen to the level of being more than incidental or when private inurement has occurred. The IRS has historically been more liberal in applying these standards to the activities of rural hospitals, recognizing the greater difficulties they face in recruiting physicians and keeping up with technological advances. It is not inconsistent, under these circumstances, to find that substantial assistance to a physician whose specialty is in ample supply, in an urban setting, would constitute private inurement, while in a rural setting, where such specialists are hard to come by, the same assistance would constitute a necessary benefit to obtain needed physician services in the community.

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2. *Id*. at 11.
3. Reg. § 1.501(c)(3)-1(d)(1)(ii).
4. *See*, e.g., *Better Business Bureau v. United States*, 326 U.S. 279 (1945); *St. Louis Union Trust Co. v. United States*, 374 F.2d 427 (8th Cir. 1967); *Orange County Agricultural Society v. Commissioner*, 893 F.2d 529 (2d Cir. 1990).
5. *See* Chapter 4.

§ 32.3 APPLICATION OF UNRELATED BUSINESS INCOME RULES

A nonprofit organization must be organized and operated exclusively for charitable purposes in order to qualify for exemption from federal income taxation.[6] Notwithstanding this requirement, the Code permits a tax-exempt organization to carry on some level of activity that is not related to its exempt purposes.[7] If, however, the unrelated business activities become the primary purpose of the organization, its exemption will be revoked.[8]

To find that an exempt organization is engaged in an unrelated trade or business, *all* of the following conditions must be satisfied: (a) the activity must be a *trade or business;* (b) the trade or business must be *regularly carried on* by the organization; and (c) the conduct of the trade or business *must not be substantially related to* the organization's performance of its *exempt functions* (other than through the production of income).[9]

The majority of the IRS's rulings on unrelated business income issues focus on whether the activities in question are substantially related to the organization's exempt purposes. This determination requires an examination of the relationship between the business activities that generate the income in question and the accomplishment of the organization's exempt purposes.[10] For purposes of imposing the unrelated business income tax, a trade or business is substantially related to exempt purposes only when the conduct of the business activities has a causal relationship to the achievement of exempt purposes (other than through the production of income) and that causal relationship is a substantial one.[11]

With regard to healthcare activities, certain relatedness tests have developed through the myriad IRS rulings in this area. The use of these tests can help to determine whether the IRS would consider the activities to be substantially related to the organization's exempt purposes. Among these, the IRS has generally followed a *commercial availability* test in reaching determinations of relatedness. Thus, if a business activity undertaken by an exempt provider is also being undertaken by a commercial entity in the same area, and the activity is not strictly related to the provider's exempt purposes, it will likely be determined an unrelated trade or business. If, however, that same service or product is provided in an area in which the service or product is not otherwise commercially available, as is often the case in rural areas, it may escape taxation as an unrelated trade or business. This analysis is based on the unfair competition theory, which is the primary rationale for the tax on

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6. IRC § 501(c)(3); Reg. § 1.501(c)(3)-1. *See* Chapter 4.
7. Reg. § 1.501(c)(3)-1(e)(1).
8. *Id.;* Reg. § 1.501(c)(3)-1(c)(1).
9. Reg. § 1.513-1(a). *See* Chapter 24.
10. Reg. § 1.513-1(d)(1).
11. Reg. § 1.513-1(d)(2).

unrelated business income. No harm, no foul.[12] This test was also adopted in the draft recommendations prepared by the Oversight Subcommittee of the House Committee on Ways and Means, in its unrelated business income tax (UBIT) review in the 1980s.

The commercial availability relatedness test is of great value to rural hospitals. Because there is frequently no commercial alternative, rural hospitals can engage in many activities that would be considered unrelated in an urban setting. Rural hospitals should be wary, however, of an expansion by the courts of the *commerciality doctrine*. Conservatively applied, it may not recognize the *not commercially available* exception if the other commercial factors present are substantial.[13]

The provision of laboratory services by exempt providers frequently raises the question of whether the services are substantially related to the providers' exempt purposes. This question has usually been answered through the application of the patient/nonpatient test. Thus, lab services furnished to a provider's own patients have been considered related and not subject to taxation, while services furnished to nonpatients have been found unrelated.[14]

In addition, unrelated business income does not include income received by a tax-exempt hospital for furnishing data processing, purchasing, warehousing, billing and collection, food, clinical, industrial engineering, laboratory, printing, communications, record center, or personnel services to one or more other tax-exempt hospitals if: (1) the recipient hospitals do not serve over 100 patients; (2) such services, if performed by the recipient hospital, would be consistent with their exempt purposes; and (3) the services are provided at or below actual cost, including straight-line depreciation and a reasonable rate of return on the capital goods used to provide the services.[15]

Even where lab services are provided to the private patients of physicians, however, they can be considered related under certain circumstances. Of relevance to rural hospitals is the recognition by the IRS of a *unique circumstances* exception whereby the provision of diagnostic lab services to nonpatients can be considered related. This would occur, for example, where alternative lab facilities are not available within a reasonable distance or are clearly inadequate, or where the lab services for nonpatients are needed in an emergency and a referral to an alternative facility would endanger the health of the individual. Where services to nonpatients are provided, the provider's

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12. *See*, e.g., Priv. Ltr. Ruls. 8338068, 8305115, and 8004011.
13. *See* Hopkins, "The Most Important Concept in the Law of Tax-Exempt Organizations Today: The Commerciality Doctrine," 5 *Exempt Org. Tax Rev.*, 459–467 (Mar. 1992); *Living Faith, Inc., v. Commissioner*, 950 F.2d 365 (7th Cir. 1991); *United Cancer Council, Inc. v. Commissioner* 109 T.C. 326 (1997); 165 F.3d 1173 (7th Cir. 1999); *United Missionary Aviation, Inc. v. Commissioner*, 60 T.C.M. 1152 (1990); *Public Industries, Inc. v. Commissioner*, 61 T.C.M. 1626 (1991).
14. *See*, e.g., Priv. Ltr. Ruls. 8050105, 8131063, and 8230005.
15. IRC § 513(e); Reg. § 1.513-6; 51 *Fed. Reg*. 5310 (1986).

records must separately account for both patient and nonpatient services in order to properly determine the amount of unrelated business income being generated.[16]

Rural hospitals frequently have 100 or fewer beds and are the most likely type of hospital to benefit from this provision, whether as the provider or the recipient of services.

§ 32.4 PHYSICIAN RECRUITMENT AND RETENTION IN RURAL AREAS

Perhaps no task is more daunting for rural hospital administrators than to successfully recruit and retain a complement of physicians and other health professionals adequate to serve the needs of the rural community. Successful recruitment and retention require creativity in putting together an attractive program that can satisfy physicians' economic and practice needs without running afoul of the private benefit and private inurement principles, or the Office of Inspector General (OIG) conservative interpretation of the Medicare antikickback statute. Fortunately, the IRS has been more liberal in applying these principles to recruitment and retention activities undertaken by rural hospitals, and the OIG has shown an awareness of rural hospitals' plight.[17]

The IRS has approved a physician salary guarantee program where amounts paid to the physician by the hospital are forgiven if the physician maintains a practice in the hospital's service area over a period of years.[18] This is a commonly used and effective technique for retaining a needed physician in the community beyond the original contract term.[19]

The rental of office space by a hospital to the physicians on its medical staff at below-market rents may, in other circumstances, be sufficient to constitute substantial private benefit or private inurement, resulting in a loss of exemption.[20] However, because of the geographical and economic hurdles faced by rural hospitals in recruiting and retaining physicians, below-market rental of office space by rural hospitals may not result in substantial private benefit or private inurement.[21]

16. Rev. Rul. 85-110, 1985-2 C.B. 166. *See also* Priv. Ltr. Ruls. 8305115, 8314002, 8620078, 8941082, and 9023041.
17. *See* Rev. Rul. 97-21, 1997-1 C.B.
18. 3 *Exempt Org. Tax Rev*. (No. 3) 330 (May 1990).
19. *See Healthcare Bottom Line* (July/August 1992), at 4.
20. *See*, e.g., Gen. Couns. Mem. 39598; Rev. Rul. 69-545, 1969-2 C.B. 117 (situation 2); *Harding Hospital, Inc. v. United States*, 505 F.2d 1068, 1078 (6th Cir. 1974).
21. *See*, e.g., Rev. Rul. 73-313, 1973-2 C.B. 174 (below-market rental of office space to induce physician to locate in isolated rural area did not jeopardize exemption); *Olney v. Commissioner*, 17 T.C.M. 982 (1958) (office space provided primarily for benefit and convenience of hospital was justified by duties required by physician, overall compensation not excessive); Priv. Ltr. Rul. 8134021 (*but see* Gen. Couns. Mem. 37789).

Loans from exempt organizations to private individuals, including physicians, have traditionally attracted greater scrutiny on audit. Absent special circumstances, the provision of loans by an exempt organization to an ''insider'' at below-market rates or without adequate security will constitute impermissible private inurement.[22] However, rural hospitals have been given more leeway in using loans to attract physicians. For example, a loan guarantee made by a group of three unrelated hospitals to a radiologist in private practice, to induce the physician to establish a radiation treatment facility in an isolated area, did not adversely affect the hospitals' tax-exempt charitable status.[23]

The IRS has specifically considered the payment of moving expenses as an incentive device.[24] Applying traditional reasonable compensation analysis, the IRS opined that the payment of moving expenses does not result in private benefit or prohibited inurement if the payment is the result of arm's-length bargaining and the compensation package as a whole is reasonable.

The implied approval of a one-time recruitment bonus[25] would also seem to support a payment for moving expenses. Payment of moving expenses is perhaps the easiest benefit to defend, given the difficulties inherent in relocating a physician to a rural community.

22. *See Lowry Hospital Association v. Commissioner*, 66 T.C. 850 (1976); *Orange County Agricultural Society, Inc. v. Commissioner*, 893 F.2d 529 (2d Cir. 1990).
23. Priv. Ltr. Rul. 8419071. *See also* Priv. Ltr. Ruls. 8028011, 8418003, and 8629045.
24. Gen. Couns. Mem. 39670.
25. Gen. Couns. Mem. 39498.

CHAPTER THIRTY-THREE

Governance

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> We remain convinced that an independent, empowered, and engaged board of directors is the key to ensuring that a tax-exempt organization serves public purposes, and does not misuse or squander the resources in its trust.
>
> —Kevin M. Brown, Acting Commissioner, Internal Revenue Service

> People accept the idea that the IRS has a role to play in the area of governance. No one suggests we walk away.
>
> —Steven T. Miller, Commissioner, IRS Tax Exempt and Government Entities

§ 33.1 INTRODUCTION

In the wake of the corporate meltdowns of Enron, Arthur Andersen, MCI Worldcom, and others, there has been increased scrutiny of corporate governance on the part of regulators, legislators, the media, and the public. Nonprofit organizations have not escaped this spotlight, and spectacular governance failures—American University, Smithsonian Institution, American Red Cross, to name a few—have occurred on the nonprofit side as well. The IRS has long extolled the virtues of governance through an independent community board, in particular, to avoid the occurrence of private inurement or impermissible

private benefit.[1] In recent years, the IRS has placed a greater burden on governing boards to be more ''hands on'' in order to ensure their organizations' adherence to charitable purposes. It has stepped up its compliance enforcement activities and added governance to its list of responsibilities. The Congress is also getting into the nonprofit governance picture, most notably through the Senate Finance Committee. Meanwhile, charity-sector groups have sought to regain the leadership position in this area by developing substantial guidance on governance best practices.

§ 33.2 OVERVIEW OF COMMON LAW AND STATUTORY DUTIES OF OFFICERS AND DIRECTORS

(a) Introduction

Under state statutory and common law, officers and directors of business corporations must act in accordance with two complementary duties—the duty of care and the duty of loyalty. The precise meaning and extent of each duty varies from state to state, depending on statutory language and judicial interpretation.

Over the years, courts have held nonprofit officers and directors to a variety of standards of conduct. Some courts have held them to the high level typically reserved for trustees.[2] Other courts and legislatures have adopted a more liberal approach, apparently recognizing that if officers and directors of nonprofits are held to too strict a standard then some will decline to serve for fear of liability.[3] The final approach is the simplest to apply—that is, the duties for nonprofit officers and directors are no different from those required of for-profit corporation officers and directors.[4]

Frequently, one person may be an officer and director of several different but related healthcare organizations. In such cases, it can be difficult to determine to whom fiduciary duties are owed. Accordingly, it is imperative that such persons keep attentive to which ''hat'' is being worn at any given time—whether it be that of corporation A, corporation B, or both. Furthermore,

1. *See*, e.g., Rev. Rul. 69-545, 1969-2 C.B. 117.
2. *See*, e.g., *People v. Larkin et al.*, 413 F. Supp. 978 (1976) (applying charitable trust principles in determining fiduciary duties of controllers of nonprofit corporation).
3. *See*, e.g., N.Y. Not-for-Profit Corp. Law, § 720-a.
4. *See*, e.g., *Stern v. Lucy Webb Hayes Nat'l Training School for Deaconesses & Missionaries*, 381 F. Supp. 1003, 1013 (D.D.C. 1974) (noting ''the modern trend is to apply corporate rather than trust principles in determining the liability of directors of charitable corporations''); *Oberly v. Kirby*, 592 A.2d 445, 467 (stating the choice to establish a charitable corporation rather than a charitable trust results in application of ''the far more flexible and adaptable principles of corporate law''); Eric S. Tower, ''Directors' Duty to Obtain a Fair Price in the Conversion of Nonprofit Hospitals,'' 6 *Ann. Health L.* 157, 164 (1997) (stating §8.30(e) of the Revised Model Nonprofit Corporation Act establishes that directors of nonprofit corporations are held to the same standards as directors of for-profit corporations).

a duty is also owed to the organization's members. However, it must be remembered that the duty to members of a charitable organization is not to maximize profits (as in the case of a for-profit corporation) but instead to advance the organization's charitable purposes.

(b) Duty of Care

The duty of care generally requires officers and directors to carry out their responsibilities in good faith and with that degree of diligence, care, and skill that ordinarily prudent persons would exercise under similar circumstances in like positions.[5]

There can be no single, succinct statement of specific actions or inactions required by the duty of care, since different circumstances will inevitably require different acts. Nevertheless, the duty generally requires informed, good-faith decisions intended to further the organization's charitable purposes. One federal district court has stated that "[a] director who fails to acquire the information necessary to supervise [company] policy or consistently fails even to attend the meetings at which such policies are considered has violated his fiduciary duty to the corporation.[6]"

Officers and directors are frequently faced with myriad issues covering a wide range of topics, and important decisions are sometimes required in a very short period of time. For these reasons, the duty of care does not in all cases require expertise, extensive consideration, or full knowledge of the matter at issue. Instead, the duty generally requires the person to be reasonably well-informed of the relevant issues. What is "reasonable" in a given situation will depend on the facts and circumstances of each case.

In a concession to the reality of modern business, officers and directors may, when appropriate, rely on information and data provided by others and may rely in good faith on such information and data in carrying out their responsibilities. State laws generally recognize the appropriateness of such reliance in many cases.[7]

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5. *See*, e.g., N.Y. Not-for-Profit Corp. Law § 717(a); Revised Model Nonprofit Corporation Act § 8.30(a); *In re Manhattan Eye, Ear & Throat Hospital*, 186 Misc. 2d 126, 152, 715 N.Y.S.2d 575, 593 (Sup. Ct. 1999).
6. *Stern*, 381 F. Supp. at 1014.
7. N.Y. Not-for-Profit Corp. Law, § 717(b), is typical: In discharging their duties, directors and officers, when acting in good faith, may rely on information, opinions, reports, or statements including financial statements and other financial data, in each case prepared or presented by: (1) one or more officers or employees of the corporation, whom the director believes to be reliable and competent in the matters presented, (2) counsel, public accountants, or other persons as to matters that the directors or officers believe to be within such person's professional or expert competence, or (3) a committee of the board upon which they do not serve, duly designated in accordance with a provision of the certificate of incorporation or the bylaws, as to matters within its designated authority, which committee the directors or officers believe to merit confidence, so long as in so relying they shall be acting in good faith and with that degree of care [required

Accordingly, any reliance on information provided by others must be reasonable under the circumstances, considering such factors as from what source the information was obtained, whether the information relied upon is a brief summary or an extensive analysis, whether the matter is routine or exceptional, and the time frame in which a decision must be made. Thus, such information should be a tool and a timesaver for an officer or director in becoming informed, and should not be an excuse for dispensing with or ignoring such information.[8]

The *business judgment rule* assists in determining whether a director, in making corporate decisions, has complied with the duty of care. Courts recognize that directors have broad control over management and must make decisions involving risk. The business judgment rule is designed to protect directors from liability for those decisions made in good faith where the director is disinterested, reasonably informed, and honestly believes the decision to be in the best interest of the corporation.[9] There is a presumption in favor of application of the rule, thus a plaintiff must rebut the presumption in order to impose liability upon a director.[10]

(c) Duty of Loyalty

The duty of loyalty generally requires corporate officers and directors to act in good faith and in a manner that is reasonably believed to be in accordance with the best interests of the corporation.[11]

The requirement that officers and directors discharge their duties in good faith is a subjective one that will vary depending on the facts and circumstances. When at issue, however, courts will generally look to the person's state of mind to determine whether he or she was motivated by honesty and faithfulness to the corporation, or whether self-interest or an interest contrary to the corporation's purposes was a motivating factor in the officer's or director's actions.

The requirement of acting with a reasonable belief that such acts are in the best interests of the corporation is both subjective and objective—that is, the officer or director must actually (subjectively) and honestly maintain the belief, and such belief must be reasonable for a like person in a similar situation.

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by the duty of care]. Persons shall not be considered to be acting in good faith if they have knowledge concerning the matter in question that would cause such reliance to be unwarranted. Persons who so perform their duties shall have no liability by reason of being or having been directors or officers of the corporation.

8. *Stern*, 381 F. Supp. at 1014.
9. *Aronson v. Lewis*, 473 A.2d 805, 812 (Del. 1984).
10. *But see*, *CareFirst* decision (*infra*, at § 33.7); *Banner Health Systems v. Long*, 2003 S.D. 60 (2003); 663 N.W.2d. 242.
11. *See*, e.g., Harvey J. Goldschmid, ''The Fiduciary Duties of Nonprofit Directors and Officers: Paradoxes, Problems, and Proposed Reforms,'' 23 *Iowa J. Corp. L.* 631, 641 (1998) (stating the duty of loyalty requires directors and officers to faithfully pursue the interests of the corporation and its nonprofit purpose rather than their own interests or the interests of another person or organization).

Under this requirement, a person subject to the duty must be loyal to the corporation and not use the position of authority to obtain, whether directly or indirectly, a benefit for himself or herself or for another organization in which the person has an interest.

(d) Duty of Obedience

A subset of the duty of loyalty, evolving into a duty of its own, is the duty of obedience, and it has taken on great significance for nonprofit healthcare organizations, particularly in the context of hospital conversions. The duty of obedience requires that nonprofit governing bodies effectively carry out the purposes of the organization. As one court has said, ''What more formidable cause of action could exist than the assertion that the trustees are failing to carry out the mandates of the indenture under which they operate.'' Even when the organization's assets continue to be used for charitable purposes, if those purposes do not closely follow those set forth in the organization's charter (as may occur when a hospital is sold and the proceeds are used for charitable—but non-hospital—purposes), the duty may be breached.[12]

(e) Internal Revenue Code

The Internal Revenue Code also imposes fiduciary duties upon officers and directors of charitable organizations. In order to satisfy the operational test of Code section 501(c)(3), an organization must ''serve[] a public rather than a private interest.[13] '' Clearly, there will be some serving of a private interest by the exempt organization (e.g., an exempt hospital serves the private interests of its physicians and its patients). The IRS is concerned with the primary purpose of the organization. If the serving of private interests is incidental to the accomplishment of the organization's charitable purposes and does not represent a substantial nonexempt purpose, the organization's exemption will not be jeopardized.[14]

Prominent in the criteria for qualification for tax-exempt status under section 501(c)(3) of the Code is the phrase ''no part of the net earnings of [the organization] inures to the benefit of any private shareholder or individual. . . .'' In addition, this section requires that charitable organizations be organized and operated exclusively for charitable purposes. IRS regulations state that ''[a]n organization is not operated exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the benefit of private shareholders or individuals.[15]'' The regulations go on to define a ''private

12. *Commonwealth of Pennsylvania v. Barnes Foundation*, 398 Pa. 158, 159 A. 2d 500, 505 (1960).
13. Reg. § 1.501(c)(3)-1(d)(1)(ii).
14. *See*, e.g., *Better Business Bureau v. United States*, 326 U.S. 279 (1945); *St. Louis Union Trust Co. v. United States*, 374 F.2d 427 (8th Cir. 1967); *Orange County Agricultural Society v. Comm'r*, 893 F.2d 529 (2d Cir. 1990).
15. Reg. § 1.501(c)(3)-1(c)(2).

shareholder or individual'' as a ''person[] having a personal and private interest in the activities of the organization.[16]'' In 1996, Congress extended the private inurement proscription to social welfare organizations as well.

The IRS has limited the application of the private inurement proscription, for the most part, to ''insiders,'' that is, individuals who have a personal and private interest in the activities of the exempt organization and could thereby cause the organization to provide the benefit. It is often difficult to determine when the line is crossed that causes an individual to be considered an ''insider.'' The IRS regulations, in explaining the substantial private benefit prohibition, focus on private interests such as designated individuals, the creator or his family, shareholders of the organization, or persons controlled, directly or indirectly, by such private interests. The *Exempt Organizations Handbook* refers to an organization's trustees, officers, members, founders, or contributors, stating that they may not acquire any of the organization's funds by reason of their position. The *Exempt Organizations Handbook* consistently looks to *control* as the basis of an insider relationship. However, in the wake of the IRS's final intermediate sanctions regulations and other guidance, it is now clear that an individual must be in a position to substantially influence the affairs of the exempt organization in order to be treated as an insider for private inurement purposes.

Thus, the Code effectively places a fiduciary duty on officers and directors to avoid activities and transactions that would result in private inurement or impermissible private benefit, both for themselves and for the organization.[17]

§ 33.3 GOOD GOVERNANCE PRACTICES

(a) Sarbanes-Oxley Act of 2002: Lessons for Governance of Nonprofits

The Sarbanes-Oxley Act,[18] passed by Congress and signed by the President on July 30, 2002, was enacted in response to major corporate accounting

16. *Id*.
17. In a much heralded case, the Attorney General of Michigan sued to prevent a joint venture between Columbia/HCA and a Michigan nonprofit, tax-exempt health system. *Kelley v. Michigan Affiliated Healthcare System, Inc*., File No. 96-83848-C2 (Cir. Ct. 30th Judicial Circuit, Ingham County, Mich., June 17, 1996). In that case, the Attorney General raised several novel arguments relating to the fiduciary duty of trustees of a charitable organization to protect the assets of the organization. In the transaction at issue, Columbia/HCA and a Michigan tax-exempt hospital proposed to enter into a joint venture to operate the hospital. The board of trustees of the hospital did not seek a private letter ruling from the IRS before proceeding with the transaction. A private letter ruling is a discretionary opportunity for a taxpayer to get an opinion from the IRS, which it is entitled to rely on, as to the tax consequences of a proposed transaction. In his complaint, the Attorney General, a state official, argued that it was a breach of the board of trustees' fiduciary duty to fail to seek this private letter ruling from the IRS, a federal agency, before proceeding.
18. Pub. L. No. 107-204, 116 Stat. 745.

scandals. The Act regulates a broad spectrum of corporate activity and applies to publicly traded companies as well as public accounting firms.

While only two of the Act's provisions have direct application to nonprofit organizations (those pertaining to destruction of documents and protection of whistleblowers[19]), it is nevertheless advisable that they adapt the Act's best practices and procedures to their use and advantage.

The Sarbanes-Oxley Act raises the following questions of application to nonprofits:

- Should the accounting firm retained by a nonprofit organization be a registered public accounting firm? This is particularly a question for the larger nonprofit entities.
- Should a nonprofit organization have an audit committee or similar body?
- Should a nonprofit organization develop a code of ethics for its senior officers? This would go beyond a conflict-of-interest policy.
- Should a nonprofit organization require certification of its financial statements and/or annual information returns by its executive?
- Should a nonprofit organization have a policy of prohibiting loans to its senior executives?
- Suppose there is a need for an accounting restatement by a nonprofit organization due to some form of misconduct. Should any bonuses and/or the like to executive personnel have to be reimbursed?
- Should a nonprofit organization follow the rules regarding audit partner rotation?
- Should a nonprofit organization separate audit and non-audit service providers?
- Should there be a rule requiring real-time disclosures by nonprofit organizations?[20]

Some states are now applying Sarbanes-Oxley-style principles to nonprofits through revisions of the state nonprofit corporation statute.[21]

(b) Nonprofit Sector Group Best Practice Recommendations

The nonprofit sector is actively engaged in the debate on setting corporate responsibility and governance standards for its members. Excellent examples

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19. These provisions apply to nonprofits because the Act implements them through revisions to the federal criminal code, which applies to both for-profit and nonprofit corporations.
20. Hopkins, The Nonprofit Counsel, Vol. XIX, No. 10, October 2002 at p. 4. A useful resource on this topic is a white paper: "The Sarbanes-Oxley Act and Implications for Nonprofit Organizations," BoardSource/Independent Sector (2004) (www.boardsource.org).
21. *See*, e.g., California Nonprofit Integrity Act of 2004 (S.B.1262—Sher, Chapter 919, Stats).

include the standards developed by the Panel on the Nonprofit Sector,[22] the Maryland Association of Nonprofit Organizations,[23] the Better Business Bureau,[24] the Association of Governing Boards of Universities and Colleges,[25] and the American Bar Association.[26]

With an eye toward establishing principles that can be accepted sector-wide to promote self-regulation, the Panel on the Nonprofit Sector compiled 33 principles of sound practice to be considered by charitable organizations as a guide for strengthening their effectiveness and accountability. Six of the principles describe actions that all charitable organizations are required to take because they are required by law. The remaining 27 principles describe actions that the Panel believes charitable organizations should strongly consider following, based on their legal and operational structure and their particular charitable purposes. The 33 principles are organized under four main categories: *legal compliance and public disclosure, effective governance, strong financial oversight*, and *responsible fundraising*.

The Maryland Association of Nonprofit Organizations has developed an Ethics and Accountability Code for the Nonprofit Sector. The Code establishes standards in the following areas: *mission and program, governing board, conflicts of interest, human resources, financial and legal accountability, openness and disclosure, fundraising*, and *public policy and public affairs*. The Association has taken these standards nationwide through its Standards for Excellence Institute.[27] The Standards for Excellence Institute provides a voluntary certification program for organizations that demonstrate good governance in accordance with the program's standards.

The Better Business Bureau Wise Giving Alliance (the ''Alliance'') has established its *Standards for Charity Accountability*. The Standards address public charity accountability concerns including use of funds and fundraising practices, donor privacy, web site disclosures, and the expenditure of funds in accordance with donor intentions. The Standards for Charity Accountability were developed to assist donors in making sound giving decisions as well as to foster public confidence in charitable organizations. The Standards seek to encourage fair and honest solicitation practices, to promote ethical conduct by charitable organizations, and to advance support of philanthropy. The Wise Giving Alliance also offers a voluntary certification program.

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22. *See* www.nonprofitpanel.org/report/principles/Principles_Guide.pdf.
23. *See* www.standardsforexcellenceinstitute.org/index.html.
24. *See* www.give.org/standards/index.asp.
25. *See* www.agb.org/user-assets/Documents/AccountabilityStatementFinalforWeb.pdf.
26. *See* ''Report of The American Bar Association Task Force on Corporate Responsibility'' (Mar. 31, 2003), www.abanet.org/buslaw/corporateresponsibility/. For a report on healthcare-specific governance practices, see ''Governance in Nonprofit Community Health Systems: An Initial Report on CEO Perspectives,'' Grant Thornton, LLP (Feb. 2008).
27. *See* www.standardsforexcellenceinstitute.org.

The Association of Governing Boards' Statement on Accountability describes several areas of organizational operation that merit close examination by boards—fiscal integrity; board performance; educational quality; and presidential search, assessment, and compensation. In AGB's view, a heightened commitment to accountability will enhance the board's performance, the esteem the board earns, and the degree of deference it receives from stakeholders and would-be regulators. It believes that the soundest path to sustaining institutional independence is to achieve a level of confidence and trust in the way the governing board oversees the affairs of the institution and meets its fiduciary responsibilities. The goal of its Statement on Accountability is to motivate boards to commit themselves to model policies and practices that warrant the public trust.

The American Bar Association established a Task Force on Corporate Responsibility in the wake of Sarbanes-Oxley and the scandals that preceded that legislation that prepared a report recommending reforms for internal corporate governance. The Task Force set out to examine public corporation governance and to recommend certain practices for lawyers and directors that enhance corporate responsibility. The recommendations of the Task Force are designed to keep self-interested motivations of senior executive officers and directors in check. The recommendations support an increased role for independent directors within the board of directors of a corporate organization as well as increased oversight by auditors and counsel over corporate activities in an effort to promote effective corporate governance and compliance with the law. The Task Force set forth recommended corporate governance policies and practices that may benefit both public and nonpublic organizations in complying with the law and abiding by ethical standards of conduct.

Reminiscent of the approach of the community benefit standards and self-evaluation programs adopted by the healthcare field in the 1980s, these standards should go a long way in establishing effective governance reforms for nonprofit organizations. They are also the vanguard of a movement to accredit the governance practices of nonprofits. One congressional proposal would require such accreditation in order to receive recognition of tax-exempt status from the IRS.[28]

(c) IRS Good Governance Guidelines

The IRS has issued a discussion draft of good governance practices for tax-exempt organizations.[29] The categories covered by the Good Governance Guidelines are: *mission statement*, *code of ethics*, *due diligence*, *duty of loyalty*, *transparency*, *fundraising policy*, *financial audits*, *compensation practices*, and *document retention policy*.

28. *See* http://finance.senate.gov/sitepages/hearings.htm (hearing date June 2, 2004).
29. *See* Appendix O; www.irs.gov/pub/irs-tege/good_governance_practices.pdf.

These Guidelines are a simplified version of the best practices being recommended by such charity governance groups as BoardSource, Standards for Excellence Institute, AGB, Panel on the Nonprofit Sector, and the Better Business Bureau Wise Giving Alliance. They are not required as a condition of IRS recognition of exempt status and apparently are intended as a discussion piece, although clear connections may be found with the disclosures required in the IRS's redesigned Form 990.

(d) Governance Reporting on the New Form 990

The Form 990 has been reborn. Make no mistake about it; the Form 990 redesigned by the IRS in 2007 is no longer primarily a financial data reporting form. The new 990 has a different key focus: governance. Two of the three guiding principles identified by the IRS in redesigning the Form 990 are governance-driven: enhancing transparency and promoting tax compliance. Part VI of the core form portion of the Form 990 requires statements by the exempt organization regarding governance, management, and disclosure. The form inquires whether the organization has a conflict-of-interest policy, and if so, whether annual disclosures are required and how compliance is monitored and enforced. It also inquires whether the organization has a whistleblower policy and a document retention and destruction policy and whether the organization follows the rebuttable presumption of reasonableness procedures in determining compensation of the chief executive officer, other officers, and key employees.

The form also asks whether (and if so, how) the organization makes its governing documents, conflict-of-interest policy, and financial statements available to the public. Other than disclosure of articles of incorporation, which must be included with Form 1023 and are often available online from the state of incorporation, tax-exempt nonprofits are generally not required by federal law to publicly disclose their bylaws, governance policies, or financial statements. Accordingly, this creates a new standard for transparency for nonprofit boards.

Perhaps the most significant governance question on the new form is this: Was a copy of the Form 990 provided to the organization's governing body before it was filed? The form then states that all organizations must describe in Schedule O the process, if any, the organization uses to review the Form 990. The form of this question is somewhat diluted from its appearance in the original version of the redesigned Form 990. That initial version inquired whether the board of directors had *reviewed* the Form 990 before it was filed. Several public commenters objected to this question due to the logistical burdens imposed by it. It is likely that many organizations will take a shortcut to answering this question by delegating review of the form to a board committee. And indeed, careful review of the form's financial data should be part of the responsibility of the budget and finance committee or the audit

committee. However, notwithstanding the expediency of such a process, the very question points out the need of the board of directors to be conversant with the information presented in the Form 990, particularly as to its governing and operating policies. This role is vital to the organization and arguably a fiduciary duty of the board under its duty of care. To consign review of the governance-related responses to a board committee is to miss an important opportunity for the organization to receive essential, hands-on leadership from all of its directors.

§ 33.4 CONFLICTS OF INTEREST

A key governance issue that has received a great deal of attention post-Sarbanes-Oxley is the resolution of conflicts of interest between the exempt organization and individuals receiving economic benefits from the organization.[30] In 1997, the IRS first established its Community Board and Conflicts of Interest Policy for tax-exempt organizations.[31] The IRS set forth its view of the particular elements that a tax-exempt healthcare organization must demonstrate to make a successful showing that it operates according to this policy. The IRS notes that a community board is one in which independent persons representative of the community constitute the majority. This is significant, in that it creates a 49 percent safe harbor (i.e., 49 percent of the board can be individuals who are not independent of the organization and the policy will still be satisfied). Thus, practicing physicians affiliated with a hospital, officers, department heads, and other employees of the hospital are not independent and may not constitute a majority of the hospital's board. Other persons who may have some business dealings with the healthcare organization are usually included in the majority; however, the entire board of trustees must satisfy the conflict-of-interest policy.

In the IRS's view, the primary benefit of the conflict-of-interest policy is that the governing board can make its decisions in an objective manner without undue influence by persons with a private interest. It believes that the presence and enforcement of a substantial conflict-of-interest policy can also ensure that a tax-exempt healthcare organization will fulfill its charitable purposes, will properly oversee the activities of its governing body and principal officers, and will pay no more than reasonable compensation to physicians or other highly compensated employees.

The IRS will generally apply the Community Board and Conflicts of Interest Policy when it considers applications for recognition of exemption

30. According to a 2007 study, 89 percent of nonprofit respondents had adopted a conflict-of-interest policy, which was the top governance reform instituted by nonprofits. The 2007 Grant Thornton LLP National Board Governance Survey for Not-for-Profit Organizations.
31. FY 1997 IRS CPE Text, Chapter C, "Tax-Exempt Healthcare Organizations Community Board and Conflicts of Interest Policy," Lawrence M. Brauer and Charles F. Kaiser.

from hospitals or from other healthcare organizations that are part of a multi-entity health system. It will also apply this policy to requests for private letter rulings from tax-exempt healthcare organizations that already have received a determination letter or a private letter ruling that expressly applied the 20 percent safe harbor under the IRS's prior policy.

The second section of the IRS's policy refers to the conflict-of-interest policy itself.[32] It notes that a significant fact that will demonstrate that a tax-exempt healthcare organization is promoting the community as a whole is its adoption of a substantial conflict-of-interest policy. The IRS instructs all tax-exempt healthcare organizations in the system to adopt the conflict-of-interest policy. The policy applies to an *interested person*, defined as a trustee, director, or principal officer, or a member of a committee with board-delegated powers who has a direct or indirect financial interest in the organization.

A *financial interest* is defined in the policy as an individual who has (1) directly or indirectly, through business, investment, or family, an ownership or investment interest in any entity with which the tax-exempt healthcare organization has a transaction or arrangement; or (2) a compensation arrangement with the organization or with any entity or individual with which the organization has a transaction or arrangement; or (3) a potential ownership or investment in or compensation arrangement with any entity or individual with which the tax-exempt healthcare organization is negotiating a transaction or arrangement. *Compensation* is defined as direct and indirect remuneration, as well as gifts or favors that are substantial in nature. Thus, the financial interest definition is much broader than is contemplated in most state not-for-profit corporation codes, and is reminiscent of the extremely broad interpretation taken by the U.S. Department of Health and Human Services' Office of Inspector General with regard to the Medicare and Medicaid antikickback statute.

This conflicts policy is now the IRS's standard for all exempt organizations and it is included in the instructions to Form 1023. While the Form 1023 instructions suggest that adoption of this policy is not required, it is unlikely the Service would approve an application for recognition of exemption if such a policy or similar procedures were not in place.

The IRS Form 1023, redesigned in 2006, undertakes a high level of scrutiny of potential conflict-of-interest situations. The questions it raises should be asked of all nonprofits, not just those applying anew for recognition of exempt status, and particularly with regard to compensation arrangements with executives who would be treated as disqualified persons under the IRS intermediate sanctions rules. They include the following:

- Do you have a business relationship with any of your officers, directors, or trustees other than through their position as an officer, director, or trustee?

32. *See* Appendix H.

If ''Yes,'' identify the individuals and describe the business relationship with each of your officers, directors, or trustees.

- Are any of your officers, directors, or trustees related to your highest compensated employees or highest compensated independent contractors listed on lines 1b or 1c through family or business relationships?

  If ''Yes,'' identify the individuals and explain the relationship.

- Are any of your officers, directors, or trustees related to each other through family or business relationships?

  If ''Yes,'' identify the individuals and explain the relationship.

- Do any of your officers, directors, trustees, highest compensated employees, and highest compensated independent contractors listed on lines 1a, 1b, or 1c receive compensation from any other organizations, whether tax exempt or taxable, that are related to you through common control?

  If ''Yes,'' identify the individuals, explain the relationship between you and the other organization, and describe the compensation arrangement.

- Do you or will the individuals that approve compensation arrangements follow a conflict of interest policy?
- Do you or will you approve compensation arrangements in advance of paying compensation?
- Do you or will you document in writing the date and terms of approved compensation arrangements?
- Do you or will you approve compensation arrangements based on information about compensation paid by similarly situated taxable or tax-exempt organizations for similar services, current compensation surveys compiled by independent firms, or actual written offers from similarly situated organizations?
- Do you or will you record in writing both the information on which you relied to base your decision and its source?

Likewise, the redesigned Form 990 asks the following questions: Does the organization have a written conflict-of-interest policy? Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts? Schedule J on Compensation and Schedule R on Related Organizations are also designed to make potential conflict relationships more transparent.

§ 33.5 BOARD OVERSIGHT OF EXECUTIVE COMPENSATION

As with their for-profit counterparts, the boards of directors of nonprofit organizations have been taken to task by regulators, charity watchdog groups, and the public for lax oversight of executive compensation. In 2006, the House Ways and Means Committee requested that the U.S. Government

Accountability Office (GAO) undertake a study of executive compensation in nonprofit healthcare systems.

The GAO issued a 63-page report on its survey of 100 nonprofit hospitals and health systems.[33] The survey focused on three issues related to executive compensation issues in nonprofit organizations:

- What governance is exercised over executive compensation?
- What is the basis for the compensation and benefits paid to CEOs and the four top healthcare executives of each healthcare system?
- What internal controls exist for the review and approval of executive travel and entertainment expenses, gifts, and other perquisites?

These questions are well-stated and cut to the heart of the governance issues in executive compensation. Nonprofit healthcare providers that have good answers to these questions will have largely satisfied their fiduciary duty of care as to their review of compensation, regardless of the type of benefit being provided.

The results of the survey included the following:

- Healthcare systems commonly have policies and practices for establishing executive compensation such as: having an executive compensation committee or the full Board with primary responsibility for approving the CEO and top four executives' base salary, bonuses, and perquisites.
- The 65 healthcare systems (all of the respondents) have conflict-of-interest policies that cover the body that awards executive compensation and 40 of 65 have a policy that requires compensation consultants be free of any conflicts as well.
- The healthcare systems surveyed commonly have policies and practices for travel and entertainment expenses and perquisites such as written policies that address business travel and entertainment expenses, and written policies that provide payment of auto-related expense and/or provide company-paid automobile.

The redesigned IRS Form 990 pays particular attention to the policies and practices of exempt organizations with regard to compensation of officers, directors, key employees, and independent contractors. The core form asks whether the process for determining compensation of the organization's CEO, other officers, or key employees of the organization included a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision. (This process is otherwise known as securing the rebuttable presumption of reasonableness.) Part I of

33. ''Nonprofit Hospital Systems: Survey on Executive Compensation Policies and Practices,'' GAO-06-907 R (June 30, 2006).

Schedule J on Compensation is squarely focused on the board's responsibilities in reviewing executive compensation. It inquires about approval of types of compensation that have been subject to abuse, such as first-class travel, companion travel, housing allowances, and payment of personal expenses. It further inquires whether the board followed a written policy and required substantiation of expenses and about the process and committee review used to oversee payment of compensation.

§ 33.6 FEDERAL LEGISLATIVE INITIATIVES

(a) Congressional Committee Proposals for Governance Reform

In preparation for the Senate Finance Committee hearings on nonprofit organizations held in June 2004, Committee staff developed several proposals.[34] One set of proposals regarding governance would pick up where Sarbanes-Oxley left off, and with renewed vigor. A federal cause of action would be created for the breach of a director's fiduciary duty. Compensation for all senior management must be approved by the Board of Directors in advance. A host of federally created duties would also be imposed: the Board would be required to approve the budget, the entity's programs, a conflict-of-interest policy, the adoption of a compliance plan, and provisions to protect whistleblowers. Although many of these are now undertaken by healthcare providers as a matter of fiduciary duty or as a matter of good governance, these board responsibilities would be federally mandated under the proposal. Entities complying with these ''good-governance'' dictates would be favored in the award of government contracts. Compliance must be documented on the IRS Form 990. Even the board size of the entity would be regulated: at least three but no more than fifteen directors. Finally, like attorneys general in some states, the proposal would give the IRS the power to both remove errant directors and forbid them from serving on other exempt entities for some future period.

In response to the Committee's actions, the independent sector convened the ''Panel on the Nonprofit Sector'' to address the reforms proposed. This blue-ribbon task force prepared a response to the discussion draft's proposals that contains recommendations for Congress, the IRS, and nonprofit organizations.[35] The Pension Protection Act of 2006 contained some of the reforms proposed in the discussion draft; however, the governance reforms were not included in the legislation.

The House Ways and Means Committee also held hearings in June of 2004 and has stated that it intends to continue examining the operation of exempt healthcare providers.

34. *See* http://finance.senate.gov/sitepages/hearings.htm (hearing date 6/22/04).
35. *See* www.nonprofitpanel.org/Report/final/Index.html; www.nonprofitpanel.org/Report/ supplement/Index.html.

§ 33.7 STATE REGULATORY ENFORCEMENT OF CORPORATE RESPONSIBILITY OBLIGATIONS

Typically, the attorney general of a state asserts jurisdiction over nonprofits incorporated in the state by virtue of his or her authority to protect consumers in the state and to protect charitable assets. This may or may not be true in a given state under its statutory and common law. However, it may not be only the state attorney general that seeks to enforce corporate responsibility obligations. In a high-profile healthcare case in Maryland, it was the state insurance commissioner.[36]

CareFirst, Inc. (''CareFirst'') is the nonprofit parent company of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., affiliates that do business as CareFirst BlueCross BlueShield. A third affiliate does business as Blue Cross/Blue Shield of Delaware. The affiliates are health insurance companies. CareFirst is governed by a Board of Directors and special statutes regulating its business in Maryland, the District of Columbia, Delaware, and Northern Virginia.

In reviewing a proposed conversion of CareFirst to a for-profit entity, the Maryland Insurance Administration Commissioner (''Commissioner'') analyzed the duties of the Board of Directors owed to CareFirst in reviewing the proposed conversion. In evaluating the due diligence performed by the Board in considering the merger, the Commissioner determined that the legal standard that governs whether CareFirst's Board acted with due diligence is not the traditional standard applied under Maryland corporation law; rather, it is defined by the Insurance Article governing management of business by a Board of a nonprofit health service plan. The Commissioner cited Maryland insurance law, which sets forth the following standard of duty and loyalty as applicable to the CareFirst Board:

> **(1)** the business and affairs of a nonprofit health service plan shall be managed under the direction of a board of directors.
>
> **(2)** the board and its individual members are fiduciaries and shall act: (i) in good faith; (ii) in a manner that is reasonably believed to be in the best interest of the corporation; and (iii) with the care that an ordinarily prudent person in a like position would use under similar circumstances.[37]

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36. *In Re: The Consolidated Application Conversion of CareFirst, Inc. and CareFirst of Maryland, Inc. to For-Profit Status and the Acquisition of CareFirst, Inc. by WellPoint Health Networks, Inc.*, MIA No. 2003-02-032, Exhibit A, ''Report of the Maryland Insurance Administration, Steven B. Larsen, Commissioner, Regarding the Proposed Conversion of CareFirst, Inc. to For-Profit Status and Acquisition by WellPoint Health Networks, Inc.,'' at 68. *See*, www.mdinsurance.state.md.us.
37. Maryland Insurance Article, Section 14-115.

Therefore, the Commissioner examined whether the CareFirst Board acted in good faith, acted with ordinary care, and acted in what it reasonably believed to be the best interest of the corporation.

The duty of care owed by the Board required each director to act as an ordinarily prudent person under the circumstances; however, due to the nature of CareFirst's business, the Commissioner determined that the board was vested with a public trust and must act with a higher degree of care than the directors of a general corporation.[38] The Commissioner explained that CareFirst is a nonprofit corporation, formed for a public purpose, and its economic ''value'' constitutes a public asset. The CareFirst Board, therefore, was entrusted with an enterprise whose assets belong to the public and was required to act with the highest degree of care in approaching questions regarding conversion, acquisition, and purchase price. The Commissioner further found that the issue is whether ''the Board acted 'in good faith' and 'with the care [with which] an ordinarily prudent person in a like position' would act in order to ensure that the proposed transaction was in the public interest, including whether 'fair value' was obtained.'' With regard to the duty of loyalty owed by the Board, the Commissioner cited a Tennessee case,[39] writing, ''a director's duty of loyalty lies in pursuing or ensuring the pursuit of the charitable purpose or public benefit which is the mission of the corporation.'' Therefore, nonprofit directors have a special duty to advance the charitable goals of the organization and to protect its assets.[40]

The Commissioner also found that the business judgment rule was not a standard of conduct that applied to the CareFirst Board. The Commissioner concluded that the ''business judgment rule was designed to limit judicial interference in corporate affairs and to insulate corporate directors from personal liability that might arise from suits filed by disgruntled shareholders. The 'rule,' as such, has no place in this regulatory proceeding.'' The Commissioner instead determined that the decisions of the Board were not entitled to deference in determining whether the proposed transaction was in the public interest and otherwise complied with all statutes governing the approval of the transaction.

The Commissioner included in his report the following summary of key factual points relating to the Board's decision to abandon its nonprofit status. The list highlights certain issues that the Commissioner found indicative of the Board's lack of diligence:

- Continuation of the ''status quo'' as a regional nonprofit health service plan was not considered a viable option by management, the Board, or

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38. *Id*. at 69.
39. *Summers v. Cherokee Children & Fam. Serv. Inc.*, 2002 WL 31126636 (Tenn. Ct. App.).
40. *Id*. (citing, *Oberly v. Kirby*, 592 A.2d 445, 472-73 (Del. 1991).

its advisors in the process, even though it continued to be presented ostensibly as an option in materials provided to the Board.

- In assessing the advantages and disadvantages of maintaining the status quo, the Board did not consider the nonprofit mission of the company to be an advantage or disadvantage. The Board largely focused on the impact that the nonprofit status had on the company's ability to raise capital.
- The CareFirst Request For Proposal (RFP) does not reflect any consideration by the Board regarding how the Company's mission, as reflected in its Articles of Incorporation, would be impacted by the contemplated conversion, or that it was even considered in the strategic planning process.
- The Board of Directors did not consider in any meaningful way the implications of the strategic plan on the mission of the Company as a nonprofit health service plan as articulated in its Articles of Incorporation: to provide healthcare services at ''minimum cost and expense'' to its insured.
- The Board did not consider that the mission of the company as set out in the Articles of Incorporation constrained their decisions regarding the corporate form of the company or options being considered. CareFirst's nonprofit status played a role in the decision making only to the extent that the Board understood there would be heightened public scrutiny of the decision.
- While the strategic plan was being considered, CareFirst's management conveyed to the Board that CareFirst's business focus would change to become more profit-oriented. The Board did not object to this focus as articulated by management.
- From 1997 to the present, CareFirst management retreated from, and ultimately abandoned, its mission as articulated in the Articles of Incorporation and assumed all the operating characteristics and corporate goals and mission of a for-profit company.
- The Board did not question the action by management to abandon the corporate mission and took no action to prevent it.
- The Board took no action to determine how other nonprofit plans were able to continue as financially strong nonprofits while pursuing a public benefit mission when CareFirst management was abandoning its mission to provide insurance at least cost and expense.
- While there are similarities between the manner in which for-profit and nonprofit companies are operated, their goals and mission are different. Publicly held health plans have a paramount duty to achieve

> long-term profitability for shareholders. The obligation to shareholders means that certain activities associated with nonprofit plans, such as the subsidization of products to serve underserved populations, are inconsistent with the duty to shareholders.[41]

Based on the above factors, the Commissioner found that the Board failed to exercise due diligence in deciding to engage in the acquisition because ''the process used by the Board was based on faulty assumptions which in turn meant that however 'diligent' the board was in following that process the result would not satisfy the applicable legal standards.'' The Commissioner further found:

> The record shows that the Board has misapprehended or simply ignored, its overriding responsibility to the mission of the company and its insureds. The record also shows that the Board failed to seek and consider material information relevant to the decision to convert, information which an ordinarily prudent person would have sought and considered under the same circumstances, and which would likely have caused a prudent Board to reconsider the decision to convert.[42]

Therefore, the conclusions of the Commissioner set forth higher duties for nonprofit directors to preserve and protect the mission for which the corporation was formed and provide guidance for directors in how to exercise such duties for the nonprofit corporation.

41. *Id*. at 110–111.
42. *Id*. at 111.

PART SEVEN

Obtaining and Maintaining Exempt Status For Healthcare Organizations

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CHAPTER THIRTY-FOUR

Exemption Recognition Process

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Under the law of federal income taxation in the United States, every element of gross income received by a person—individual, corporation, trust, estate, or most other entities—is subject to tax[1] unless there is a statutory provision that exempts from tax either that person or that element of income. (The tax law in the states is basically identical on this point.) Thus, the U.S. Supreme Court wrote that the ''starting point in the determination of the scope of 'gross income' is the cardinal principle that Congress in creating the income tax intended 'to use the full measure of its taxing power.' ''[2] That is why tax features such as exemptions and deductions are usually narrowly construed, although there is authority for the proposition that provisions according tax exemption for charitable organizations are to be liberally construed.[3]

For healthcare and other nonprofit organizations desiring federal tax exemption, the requisite statutory exemption provision generally is section 501(a) of the Internal Revenue Code. The Supreme Court characterized

1. IRC § 61(a).
2. *Commissioner v. Kowalski*, 434 U.S. 77, 82 (1977), *quoting from Helvering v. Clifford*, 309 U.S. 331, 334 (1940).
3. *See* § 2.1, text accompanied by note 4.

this section as the ''linchpin of the statutory benefit [exemption] system.''[4] The Court summarized the exemption provided by the section as according ''advantageous treatment to several types of nonprofit corporations [and unincorporated associations and trusts], including exemption of their income from taxation and [for those that are also eligible charitable donees] deductibility by benefactors of the amounts of their donations.''[5] To be qualified for this exemption, an organization usually must be described in at least one of the clauses of Code section 501(c). There are other tax exemption provisions that are of no particular relevance to healthcare organizations.[6] Moreover, in some instances, organizations that are termed *tax-exempt organizations* are in fact subject to tax by application of one or more laws.[7]

An organization is not exempt from federal income tax merely because it is not organized and operated for profit. Organizations are formally tax- exempt where they meet the requirements of a particular statutory provision.[8] In order for an organization to be tax-exempt as a *charitable* entity, the organization asserting the exemption must (with some exceptions) file an application for recognition of exemption with the IRS and receive a favorable determination as to exempt status.[9] Nearly all organizations desiring exempt status pursuant to other provisions of federal tax law may (but are not required to) secure recognition of that exemption from the IRS.[10]

Subject only to the authority in the IRS to revoke a ruling for good cause (such as a change in the law[11]), an organization that has been recognized by the IRS as being tax-exempt can rely on the determination as long as there are no substantial changes in its character, purposes, or methods of operation.[12] On the occurrence of any one of these changes, the organization is required to notify the IRS and potentially obtain a reevaluation of its exempt status.[13]

4. *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26, 29, note 1 (1976).
5. *Id*. at 28.
6. IRC §§ 521 (farmers' cooperatives), 526 (shipowners' protection and indemnity associations), 527 (political organizations), 528 (homeowners' associations), and 529 (qualified state tuition plans).
7. *See* § 2.1, text accompanied by notes 12–16.
8. As noted, for nearly all types of nonprofit organizations in or related to the healthcare field, the particular statutory provision is IRC § 501(c).
9. *See* § 34.1 and 34.3. Also, certain credit counseling organizations and certain employee benefit organizations are required to file for recognition of tax exemption (IRC §§ 501 (q)(3), 505(c)); political organizations are required to file a notice of organization with the IRS (IRC § 527(i)).
10. This is a matter of some misunderstanding and confusion. There is no statute that affirmatively states this point of law; it is inferred from the fact that Congress has required recognition of tax-exempt status only in certain instances (e.g., *see* § 34.1(a), text accompanied by note 24). This aspect of the law, however, has been noted by the IRS in Rev. Rul. 80-108, 1980-1 C.B. 119 (*see* § 34.3(d), text accompanied by note 146).
11. *See*, e.g., § 9.2, which contains a discussion of the enactment of IRC § 501(m) and the resulting loss of certain organizations' tax-exempt status.
12. Reg. §§ 1.501(a)-1(a)(2) and 601.201(n)(3)(ii).
13. *See* § 35.1.

The IRS does not—indeed, it cannot—*grant* tax exemption to an organization. (By an anomaly in the law that has not, by any means, been fully explained, the IRS can *revoke* the tax exemption of an organization, including one that never received recognition of tax-exempt status.) Whether an organization is entitled to tax exemption, on an initial or continuing basis, is a matter of law. Congress, by statute, defines the categories of organizations that are eligible for tax exemption,[14] and Congress, by statute, determines whether a tax exemption should be continued.[15] Similarly, the courts interpret these statutes and, in so doing, accord an organization tax-exempt status or deny or revoke that status. The function of the IRS in this regard is to *recognize* tax exemption where appropriate. Consequently, when an organization applies to the IRS for a determination or ruling[16] as to tax-exempt status, it is requesting the IRS to recognize its tax exemption, not to grant it tax exemption.

Generally, an organization must, if it can, qualify for tax exemption on the basis of its own characteristics.[17] On occasion, however, an organization can achieve exempt status because of its relationship with one or more other tax-exempt organizations; this is known as a *derivative* or *vicarious* tax exemption, as manifested by the *integral part doctrine*.[18]

§ 34.1 EXEMPTION RECOGNITION PROCESS

The IRS promulgated rules by which a determination letter or ruling[19] may be issued to an organization in response to the filing of an application for recognition of its tax-exempt status.[20] These rules are in addition to those concerning requests for determination letters or rulings in the exempt organizations context generally.[21]

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14. E.g., *HCSC-Laundry v. United States*, 450 U.S. 1 (1981) (recognizing that it was the intent of Congress that a cooperative hospital laundry organization not qualify for tax exemption as an IRC § 501(c)(3) organization).
15. E.g., *Maryland Savings-Share Insurance Corp. v. United States*, 400 U.S. 4 (1970) (holding that it was not unconstitutional for Congress to decline to continue a category of tax exemption).
16. *See infra* note 19.
17. E.g., *Mutual Aid Association of the Church of the Brethren v. United States*, 759 F.2d 792, 795, note 3 (10th Cir. 1985).
18. See § 34.6.
19. A *determination letter* is a written statement issued by the IRS's Exempt Organizations (sometimes referenced herein as ''EO'') Determinations office or an Appeals Office in response to the filing of an application for recognition of exemption from federal income tax; a *ruling* is a written statement issued by the IRS's Exempt Organizations Technical office (National Office) in response to the filing of an application for recognition of exemption (Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 1.01(6), (7)). Nearly every instance of recognition of tax-exempt status by the IRS is in the form of a determination letter (*see*, however, text accompanied by *infra* note 61).
20. Rev. Proc. 2008-9, 2008-2 I.R.B. 258.
21. The current version of these rules is published as Rev. Proc. 2008-4, 2008-1 I.R.B. 121. It is the practice of the IRS to revise these rules annually and/or publish them at the beginning of each year.

The procedures for filing applications for recognition of tax exemption discussed in this portion of the book[22] apply to charitable (as well as most other tax-exempt) organizations.[23] As noted, although nonprofit organizations in general can be tax-exempt without having to apply for recognition of exempt status, charitable organizations generally must, to be exempt from federal income tax, file applications with the IRS Exempt Organizations Determinations office which is located in Cincinnati, Ohio.[24] This requirement is applicable to all healthcare organizations that want to be classified as exempt charitable organizations, including hospitals, clinics, homes for the elderly, certain health maintenance organizations, other healthcare providers, and medical research organizations.

(a) General Procedures

A favorable determination letter or ruling recognizing tax-exempt status will be issued by the IRS to an organization, where its application and supporting documents establish that it meets the requirements of the section of the Internal Revenue Code under which tax exemption is claimed.[25] Any oral representation of additional facts, or modification of facts as represented or alleged in the application for a determination letter or ruling, must be reduced to writing and presented over the signature of an authorized individual.[26]

In most instances, an organization seeking recognition of tax exemption by the IRS must file a particular form of application. An organization desiring

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Thus, the IRS will generally issue determination letters and rulings, as well as information letters, on any aspect of the law of tax-exempt organizations, including transactions that may have an impact on an organization's tax-exempt or private foundation/public charity status, or that may involve unrelated trade or business matters. There are certain areas of this law in which the IRS will not issue rulings (these areas are currently the subject of Rev. Proc. 2008-3, 2008-1 I.R.B. 110).

The IRS procedures for the issuance of determination letters, rulings, and information letters in general are contained in Rev. Proc. 2008-1, 2008-1 I.R.B. 1. The IRS procedures for obtaining technical advice from the Office of Chief Counsel and field offices generally are the subject of Rev. Proc. 2008-1, 2008-1 I.R.B. 90; the IRS procedures for furnishing technical advice to area managers, Tax Exempt and Government Entities Division are the subject of Rev. Proc. 2008-5, 2008-1 I.R.B. 164.

22. Rev. Proc. 2008-9, 2008-2 I.R.B. 258.
23. Organizations described in IRC § 501(c)(3). The rules of Rev. Proc. 2008-9, 2008-2 I.R.B. 258, apply with respect to nearly all organizations seeking recognition of tax exemption under IRC § 501 (and § 521), and with respect to modification and revocation of exemption recognition determination letters and rulings. A summary of selected portions of the application for recognition of tax exemption for social welfare organizations (*see* § 1.8) and business leagues (Chapter 18) is provided below (text accompanied by *infra* notes 84–85).
24. IRC § 508(a).
25. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 4.01.
26. *Id*. § 4.02(2)

recognition as a charitable organization must file Form 1023[27]; this is the application to be filed by a nonprofit hospital, medical research organization, home for the elderly, certain health maintenance organizations, and the like. An organization seeking recognition of social welfare, business league, or most other statuses must file Form 1024[28]; this is the form to be filed by certain health maintenance organizations, health advocacy groups, business leagues in the field of healthcare, and the like.

Tax-exempt status for an organization will be recognized by the IRS in advance of operations, where the entity's proposed activities are described in sufficient detail to permit a conclusion that the organization will clearly meet the statutory requirements. A mere restatement of purposes or a statement that proposed functions will be in furtherance of the organization's purposes does not satisfy this requirement. The organization must fully describe the activities in which it expects to engage, including (1) the standards, criteria, procedures, or other means adopted or planned for carrying out the activities, (2) the anticipated sources of receipts, and (3) the nature of contemplated expenditures. Where the organization cannot demonstrate, to the satisfaction of the IRS, that its proposed activities will qualify it for tax exemption, a record of actual operations may be required before a determination letter or ruling is issued. Where an organization is unable to demonstrate to the satisfaction of the IRS that it qualifies for exemption, generally a proposed adverse determination letter or ruling will be issued.[29]

When an application for recognition of tax exemption does not contain the required information, the application usually will be returned to the applicant organization (rather than to anyone on a power of attorney) without being considered on its merits, with a letter of explanation.[30] In the case of a putative charitable organization, where an application is returned, the IRS will inform the organization of the time within which the completed application[31] must be resubmitted in order for the application to be considered a timely notice to the IRS.[32]

The IRS, generally with the support of the courts, will usually refuse to recognize an organization's tax-exempt status unless the entity tenders

27. *Id*. § 3.03. IRC § 508(a); Reg. § 1.501(a)-1(a)(3). The current Form 1023 is dated June 2006. This regulation overstates the filing requirements. It reads: ''An organization claiming exemption under [IRC] section 501(a) and described in *any* paragraph of [IRC] section 501(c) (other than section 501(c)(1)) *shall* file the form of application prescribed by the Commissioner . . . '' (emphasis added). It should state: ''An organization requesting recognition of exemption . . . ''
28. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 3.04. Form 1024 is dated September 1998. *See* text accompanied by *infra* notes 86–87.
29. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 4.03.
30. *Id*. at § 4.05.
31. *See* § 34.1(b).
32. *See* §§ 34.3 and 34.4.

sufficient information to the IRS regarding its operations and finances.[33] It has been held, however, that a refusal by an organization to turn records over to the IRS, in response to a summons, does not give the IRS the authority to summarily revoke the organization's exempt status.[34] An organization will be considered to make the requisite ''threshold showing'' where it describes its activities in ''sufficient detail'' to permit a conclusion that the organization will meet the pertinent requirements,[35] particularly where it answered all the questions propounded by the IRS.[36] One court concluded that an organization failed to meet its burden of proof as to its eligibility for exemption because it did not provide a ''meaningful explanation'' of its activities to the IRS.[37] It is the position of the courts that, when the representatives of a would-be exempt organization fail to submit its books and records to the IRS, an inference arises that the facts involved would denigrate the organization's cause, likely precluding it from exempt status.[38]

A determination letter or ruling recognizing tax exemption ordinarily will not be issued if an issue involving the organization's exempt status is pending in litigation, is under consideration within the IRS or if issuance of a determination letter or ruling is not in the interest of sound tax law administration.[39] An application for recognition of tax exemption may be withdrawn, on the written request of an authorized representative of the organization, at any time prior to the issuance of a determination letter or

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33. E.g., *United Libertarian Fellowship, Inc. v. Commissioner*, 65 T.C.M. 2178 (1993); *Church of Nature in Man v. Commissioner*, 49 T.C.M. 1393 (1985); *La Verdad v. Commissioner*, 82 T.C. 215 (1984); *National Association of American Churches v. Commissioner*, 82 T.C. 18 (1984); *Pius XII Academy, Inc. v. Commissioner*, 43 T.C.M. 634 (1982); *The Basic Unit Ministry of Alma Karl Schurig v. United States*, 511 F. Supp. 166 (D.D.C. 1981).

    A court observed that this standard, known as the *operational* test, ''requires that the organization establish reasonable standards and criteria for its operation as an exempt organization,'' but that the test does not necessitate ''some sort of metaphysical proof of future events'' (*American Science Foundation v. Commissioner*, 52 T.C.M. 1049, 1051 (1986)).
34. *Church of World Peace, Inc. v. Internal Revenue Service*, 715 F.2d 492 (10th Cir. 1983).
35. Rev. Proc. 2008-9, 2008-2 I.R.B. 258.
36. E.g., *The Church of the Visible Intelligence That Governs the Universe v. United States*, 83-2 U.S.T.C. (CCH) ¶ 9726 (Cl. Ct. 1983).
37. *Public Industries, Inc. v. Commissioner*, 61 T.C.M. 1626, 1629 (1991).
38. E.g., *Chief Steward of the Ecumenical Temples and the Worldwide Peace Movement and His Successors v. Commissioner*, 49 T.C.M. 640 (1985); *New Concordia Bible Church v. Commissioner*, 49 T.C.M. 176 (1984) *appeal dismissed* (9th Cir. (1985)); *Basic Bible Church of America, Auxiliary Chapter 11004 v. Commissioner*, 46 T.C.M. 223 (1983); *McElhannon v. Commissioner*, 44 T.C.M. 1392 (1982); *Bubbling Well Church of Universal Love, Inc. v. Commissioner*, 74 T.C. 531 (1980), *aff'd*, 670 F.2d 104 (9th Cir. 1981); *Founding Church of Scientology v. United States*, 412 F.2d 1197 (Ct. Cl. 1969), *cert. denied*, 397 U.S. 1009 (1970); *Parker v. Commissioner*, 365 F.2d 792 (8th Cir. 1966), *cert. denied*, 385 U.S. 1026 (1967).
39. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 4.04.

ruling. The withdrawn application and all supporting documents are retained by the IRS, rather than returned to the organization.[40]

The proper preparation of an application for recognition of tax exemption for a nonprofit healthcare organization (or any nonprofit organization) involves far more than merely responding to questions on a government form. It is (or should be) a process not unlike the preparation of a prospectus for a business in conformance with the securities law requirements. Every statement made in the application should be carefully considered. Some questions will force the applicant organization to focus on matters that good management practices would cause them to consider in any event. The prime objective must be to be accurate and complete; it is essential that all material facts be correctly and fully disclosed. The determination as to which facts are material and the marshaling of these facts require judgment. Also, the manner in which the answers are phrased can be extremely significant; in this regard, the exercise can be more one of art than of science. The preparer or reviewer of the application should be able to anticipate the concerns the contents of the application may cause the IRS and to see that the application is properly prepared, while simultaneously minimizing the likelihood of conflict with the IRS (unless the conflict is intended, as in a test case headed for the courts). Organizations that are entitled to exemption have been denied recognition of exemption, or at least subjected to a more protracted process of gaining recognition, because of unartful phraseology in the application, which motivated the IRS to muster a case that the organization could not qualify for exemption. Therefore, the application for recognition of tax exemption should be regarded as an important legal document and prepared accordingly.[41]

The IRS developed instructions for IRS personnel who process applications for recognition of tax exemption filed by charitable organizations that intend to finance facilities with the proceeds of tax-exempt bond financing. This procedure is designed to enable the EO Determinations office to issue determination letters without referring the cases to the IRS's National Office. The instructions contain the questions to be used to elicit the necessary information from the applicant organization. The processing of this information leads to completion of a ''risk assessment profile worksheet''; the application is scored on the basis of the profile. If the score indicates a low risk of private benefit, the Determinations office can issue the determination letter as to recognition

40. *Id*. at § 6.01(1).

41. If the matter is to be, or may be, reviewed by a court pursuant to the declaratory judgment procedure of IRC § 7428 (*see* § 34.7, text accompanied by note 277, the application for recognition of tax exemption will almost assuredly be a significant element of the administrative record.

of exempt status (assuming the organization otherwise qualifies); in case of higher risk, the application is to be referred to the National Office.[42]

The tax-exempt status of an organization that has been designated as supporting or engaging in terrorist activity or otherwise supporting terrorism can be suspended.[43]

(b) The *Substantially Completed* Application

An application for recognition of tax exemption submitted by a charitable organization will not be processed by the IRS until the application is at least *substantially completed*.[44] Also, for purposes of the declaratory judgment rules,[45] it is the position of the IRS that the 270-day period[46] does not begin until the date a substantially completed application is filed with the IRS.[47]

A substantially completed application for recognition of tax exemption for a charitable organization is one that:

1. Is signed by an authorized individual.
2. Includes an employer identification number.[48]
3. Includes a statement of receipts and expenditures, and a balance sheet for the current year and the three preceding years (or the years the organization was in existence, where that period is less than four years), although if the organization has not yet commenced operations, or has not completed one full accounting period, a proposed budget for two full accounting periods and a current statement of assets and liabilities is acceptable.
4. Includes a narrative statement of proposed activities[49] and a narrative description of anticipated receipts and contemplated expenditures.[50]

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42. *See*, in general, Chapter 30.
43. IRC § 501(p). An organization that is identified as a terrorist organization is ineligible to apply for recognition of exemption (Rev. Proc. 2008-9, 2008-2 C.B. 258 § 3.09).
44. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 3.03.
45. *See* § 34.7, text accompanied by *infra* note 277.
46. Under these declaratory judgment rules, for the first 270 days after a request for a determination is made, an organization is deemed to not have exhausted its administrative remedies, assuming no determination is actually made during that period (IRC § 7428(b)(2)). After that period has elapsed, the organization may initiate an action for a declaratory judgment.
47. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 10.03. The responsibility for processing applications for recognition of tax exemption is centralized in the IRS Exempt Organizations Determinations office in Cincinnati, Ohio (*id.* § 2.01(l)).
48. Application for this number is made on Form SS-4, the current date of which is December 1993.
49. Reg. § 1.501(a)-1(b)(1) and (c)(3)-1(b)(1)(v). *See Draper v. Commissioner*, 32 T.C. 545, 552 (1959) (where the court conceded that there was ''no direct evidence'' as to an organization's operations but found it to be tax-exempt in any event).
50. Reg. § 1.501(a)-1(a)(3).

5. Includes a copy of the organizing or enabling document that is signed by a principal officer or is accompanied by a written declaration signed by an authorized individual certifying that the document is a complete and accurate copy of the original or otherwise meets the requirement that it be a ''conformed copy.''[51]
6. If the organizing or enabling document is in the form of articles of incorporation, includes evidence (such as a copy of the corporation's certificate of incorporation) that it was filed with and approved by an appropriate state official, or includes a copy of the articles of incorporation accompanied by a written declaration, signed by an authorized individual, that the copy is a complete and accurate copy of the original copy that was filed with and approved by the state, and stating the date of filing with the state.
7. If the organization has developed bylaws,[52] includes a current copy of that document.
8. Is accompanied by the correct user fee.[53]

For a charitable organization, the application for recognition of tax exemption also requests information concerning its fundraising program,[54] the composition of its governing body, its relationship with any other organizations, the nature of its services or products, the basis for the imposition of any charges for its services or products, its membership (if any), any relationship with a management firm, and a variety of other matters. A failure to respond to these requests on the application when initially filed does not preclude the application from being *substantially completed*. Nonetheless, it is amply prudent to include a response to these questions on the application that is filed.

When an application for recognition of tax exemption involves an issue as to which contrary authorities (such as court opinions) exist, an applicant's failure to disclose and distinguish contrary authorities may result in requests for additional information, which may delay final action on the application.[55]

The 270-day period that applies in the declaratory judgment context[56] will not be considered by the IRS as starting until the date the application for

51. Rev. Proc. 68-14, 1968-1 C.B. 768, defines a *conformed copy* of a document as ''a copy that agrees with the document it purports to copy,'' that contains ''all the provisions of the document as originally adopted and all amendments to it,'' and is accompanied by a signed declaration that the conformed copy is a ''correct and complete'' copy of the document it purports to copy (*id.*, 768–769).
52. Reg. § 1.501(a)-1(a)(3).
53. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 3.08. As to the user fee, *see* § 34.1(e).
54. *See*, in general, Chapters 14 and 31.
55. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 4.06(1).
56. *See supra* note 46.

recognition of exemption is filed with the IRS with the requested information, or, if remitted and a postmark is not evident, on the date the IRS received a substantially completed application.[57]

The standards for a substantially completed application for recognition of tax exemption for charitable organizations also apply to applications for recognition of other categories of tax exemption. The standards also apply with respect to the notice requirements for charitable organizations.[58] Even though an application for recognition of tax exemption is substantially complete, more information may be required by the IRS before a determination letter or ruling is issued.[59]

(c) Issuance of Determination Letters and Rulings

Generally, a nonprofit organization acquiring recognition of tax-exempt status does so by means of the issuance of a favorable determination letter by the IRS office in Cincinnati, Ohio.[60] Only infrequently are exemption recognition rulings issued by the National Office of the IRS, located in Washington, DC. Nonetheless, the National Office is increasingly articulating tax policy decisions regarding exempt organizations by means of the issuance of these rulings.[61]

The Exempt Organizations Determinations office will refer to the EO Technical office applications that (1) present issues that are not specifically covered by the Internal Revenue Code, the federal tax regulations, an IRS revenue ruling, or a court opinion published in the *Internal Revenue Bulletin*, or (2) have been specifically reserved by an IRS revenue procedure or by other official IRS instructions for handling by EO Technical for purposes of establishing uniformity or centralized control of designated categories of cases. In this instance, EO Technical will notify the applicant organization on receipt of a referred application, consider each application, and issue a ruling directly to the organization.[62] This procedure is used in exempt organization recognition cases where the law is (to the IRS) unclear or where the case entails a matter of some controversy or sensitivity.

If, during the course of consideration of an application for recognition of tax exemption by the EO Determinations office, the applicant organization believes that its case involves an issue on which there is no published precedent

57. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 10.03.
58. *See* § 34.3.
59. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 4.06(1). Reg. §§ 1.501(a)-1(b)(2), 601.201(h)(1)(ii) and (iii).
60. *See supra* note 47.
61. This practice occurs in the healthcare setting. For example, by this process, the IRS began setting the parameters of its position on the qualification for tax exemption of integrated delivery systems (*see* § 23.2).
62. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 5.02.

or no uniformity in the IRS's handling of similar cases, the organization may ask for referral of the application to EO Technical or request technical advice[63] from the EO Technical office.[64] If EO Determinations proposes to recognize the tax exemption of an organization to which EO Technical had previously issued a contrary ruling or technical advice memorandum, EO Determinations must seek technical advice from EO Technical before issuing a determination letter.[65]

Determination letters issued by the EO Determinations office may be reviewed by EO Technical to ensure uniform application of the statutes, regulations, rulings, and court decisions published in the *Internal Revenue Bulletin*.[66] If the IRS National Office takes exception to a determination letter issued by EO Determinations, the manager of EO Determinations must be advised. If the applicant organization disagrees with the exception taken, the file will be returned to EO Technical; the referral will be treated as a request for technical advice.[67]

A determination letter or ruling recognizing tax exemption usually is effective as of the date of formation of the organization, where its purposes and activities during the period prior to the date of the determination letter or ruling were consistent with the requirements for tax exemption.[68] If the organization is required by the IRS to alter its activities or to make substantive amendments to its enabling instrument, the determination letter or ruling recognizing its tax-exempt status will be effective as of the date specified in the determination letter or ruling. If a nonsubstantive amendment is made, tax exemption is ordinarily recognized as of the date of formation.[69]

A determination letter or ruling recognizing tax exemption may not be relied on if there is a material change, inconsistent with exemption, in the character, purpose, or method of operation of the organization.[70] In this instance, the organization is expected to notify the IRS of the material change for the purpose of ascertaining the impact of the change on the organization's ongoing tax exemption.[71]

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63. The revenue procedures governing requests for technical advice are cited in *supra* note 21.
64. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 5.03.
65. *Id*. § 5.04.
66. Id. § 9.01.
67. *Id*. § 9.02.
68. *Id*. § 11.01. There are special requirements for charitable healthcare and other charitable organizations (*see* §§ 34.3 and 34.4).
69. *Id*. § 11.01(l)(2). *Nonsubstantive amendments* include correction of a clerical error in the enabling instrument or the addition of a clause stating the disposition of an organization's assets upon dissolution or liquidation, where the activities of the organization prior to the determination letter or ruling are consistent with the requirements for tax exemption *(id.)*.
70. *Id*. § 11.02.
71. Reg. § 1.501(a)-1(a)(2).

(d) Application Forms in General

A nonprofit organization seeking a determination letter or ruling as to recognition of its tax-exempt status has the burden of proving that it satisfies all the requirements of the particular tax exemption statute.[72] The application forms are designed to enable an applicant organization to present to the IRS the appropriate information necessary to satisfy that burden-of-proof requirement.

Form 1023 consists of the following parts and includes the following schedules:

- Part I, which requests basic information about the applicant organization (such as its name, mailing and web site address, date of formation, and identification number)
- Part II, which inquires as to organizational structure (that is, whether the organization is a corporation, trust, unincorporated association, or limited liability company)
- Part III, which is designed to ensure that the organization has an appropriate statement of purposes and the requisite dissolution clause
- Part IV, which requests a narrative description of the organization's past, present, and planned activities
- Part V, which inquires as to compensation and other financial arrangements with the organization's trustees, directors, officers, employees, and independent contractors[73]
- Part VI, which seeks information about the organization's members and other persons that receive benefits from the organization
- Part VII, pertaining to whether the organization is a successor entity and the timing of the filing of the application
- Part VIII, concerning the organization's activities (such as attempts to influence legislation,[74] participation in political campaigns,[75] fundraising, and involvement in joint ventures[76])
- Part IX, which requests certain financial data (new applicant organizations can submit a budget instead)

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72. E.g., *Harding Hospital, Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1974); *Church of Spiritual Technology v. United States*, 90-1 U.S.T.C. (CCH) ¶ 50,097, 90-2 U.S.T.C. (CCH) ¶ 50,386 (Ct. Cl. 1990).
73. *See* Chapter 5.
74. *See* § 7.1.
75. *See* § 7.4.
76. *See* Chapter 22.

- Part X, concerning the public charity/private foundation status of the organization)[77]
- Part XI, which consists of user fee information
- Schedule C, to be prepared by hospitals[78] and medical research organizations[79]
- Schedule D, to be prepared by supporting organizations[80]
- Schedule G, to be prepared by applicant organizations that are successors to for-profit organizations.[81]

The Form 1023 package contains educational and reference information including an overview of the rules and regulations that may impact an organization's ability to qualify for tax-exempt status as a charitable entity; sample conflict-of-interest policies, including specific provisions for hospitals (Appendix A); and an explanation of the purpose and dissolution clauses required to satisfy the organizational test, including a list of states where state law regarding corporations and testamentary charitable trusts satisfies the requirements for distribution of assets on dissolution. In these states, an organization's organizing documents need not include an express provision for distribution of assets upon dissolution (Appendix B).

This Form 1023 requires careful review when seeking recognition of tax-exempt status for healthcare organizations. For example, adoption of a substantial conflict-of-interest policy, advocated by the IRS since 1997, is used by the IRS as a de facto requirement through its inclusion in the Form 1023 process. Also, healthcare organizations seeking recognition of exemption should be aware of the IRS's definition of *hospital* for Form 1023 purposes, now made more accessible through a glossary section of the instructions, which is considerably broader than the traditional acute care hospital.[82]

This application is used to extend the statute of limitations for the assessment of the private foundation investment income tax[83] during the pendency

77. *See* Chapter 5; § 34.4.
78. See Chapter 8.
79. See § 5.1(b).
80. See § 5.5.
81. *See* § 21.4.
82. ''A hospital includes: a. Hospitals and rehabilitation institutions, outpatient clinics, or community mental health or drug treatment centers if the principal purpose or function is the providing of medical or hospital care or medical education or research. b. Medical research organizations, if the principal purpose or function is the continuous active conduct of medical research in conjunction with a hospital.''
83. IRC § 4940.

of the advance ruling period.[84] The application also is used to pay the appropriate user fee.[85]

Form 1024 also is available, in duplicate, from the IRS in a packet that includes instructions. The form consists of the following parts:

- Part I, which requests basic information about the applicant organization (such as its name, address, date of formation, and the category of tax-exempt status involved)
- Part II, which requests a description of activities and other operational information about the applicant organization
- Part III, which requests certain financial data

The form also includes thirteen schedules. Among them are:

- Schedule B, to be prepared by applicant organizations that are social welfare organizations[86]
- Schedule C, to be prepared by organizations that are business leagues[87]

As noted, the application form packets include general instructions for making application for recognition of tax exemption for a nonprofit organization. Applicant organizations may also refer to IRS Publication No. 557, ''How to Apply for Recognition of Exemption for an Organization.'' The IRS will acknowledge the receipt of the application and assign it a document locator number.[88]

Generally, until recognized as tax-exempt, an ostensibly exempt organization is presumed to be a taxable entity and may be required to file one or more for-profit organization tax returns.[89] As a practical matter, however, applicant organizations may file the annual information return (usually Form 990), expected of exempt organizations, during the period when the application for recognition of exemption is pending, should a return due date fall in that period.[90] Also, generally, a tax-exempt organization must provide a

84. That is, the first five years of the organization's existence.
85. IRC § 7528.
86. *See* § 1.8.
87. *See* Chapter 7.
88. This is done on Form 5548-FP-POA.
89. Reg. § 1.6012-2(a)(1). The tax return usually required in this regard is Form 1120.
90. *See* § 35.3. *See* generally Hopkins, ''A Practical Guide on How to Apply for Section 501(c)(3) Status,'' 4 *J. Tax'n Exempt Orgs*. (No. 4) 8 (Jan./Feb. 1993); Gessay, ''Tracking a Pending Application for Federal Income Tax Exemption,'' 2 *J. Tax. Exempt Orgs*. 4 (Winter 1991); Gardner, ''The Determination Process—Current Changes and Some in the Wind,'' 2 *J. Tax. Exempt Orgs*. 7 (Fall 1990); Temple and Gorbaty, ''How to Properly Obtain and Maintain Tax-Exempt Status for a Charitable Organization,'' 14 *Tax. for Lawyers* (No. 1) 16 (1985); Buratt, ''Procedures for Securing Tax Exemption for Exempt Organizations,'' 34 *N.Y.U. Inst. Fed. Tax*. 181 (1976).

copy without charge, other than a reasonable fee for reproduction and actual postage costs, of all or any part of its application for recognition of exemption to a requestor who makes a request for the copy in person or in writing.[91]

Applications for recognition of tax exemption submitted by tax-exempt organizations must be made available for public inspection at the organization's place of business during normal business hours.[92]

Once the IRS has recognized the tax exemption of an organization, the organization cannot voluntarily relinquish it.[93] There is no provision in the federal tax law for voluntary termination of tax-exempt status. The only way an organization can shed its tax exemption is by violation of the applicable organizational test[94] and/or the applicable operational test,[95] or by dissolution.

(e) User Fees

Requests for determination letters, rulings, and the like must be accompanied by a user fee. The current fee for an initial application for recognition of tax exemption is $500, where the applicant organization (1) had annual gross receipts averaging more than $10,000 during the preceding four (or the first four) years of operation or (2) is a new organization that anticipates gross receipts averaging not more than $10,000 during its first four years; for smaller organizations, the fee is $150. The fee for a group exemption[96] determination letter is $500. A user fee of $100 is charged for a request for a ruling to modify the terms or stipulations stated in an initial ruling, issued by the National Office of the IRS, recognizing the tax-exempt status of an organization.[97]

(f) Interactive Application

The IRS is in the process of development of an application for recognition of exemption, filed by organizations seeking to become tax-exempt charitable entities, on the agency's web site. This Internet-based application will establish an interactive method for preparing this application.

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91. IRC § 6104(d)(1)(B). *See* § 35.5(a).
92. *See* § 35.4(a).
93. Priv. Ltr. Rul. 9141050.
94. That is, the applicable rules that state requirements as to how the organization must be organized if it is to qualify for exemption from the federal income tax. *See* TAX-EXEMPT ORGANIZATIONS § 4.3.
95. That is, the applicable rules that state requirements as to how the organization must be operated if it is to qualify for exemption from the federal income tax. *See* TAX-EXEMPT ORGANIZATIONS § 4.5.
96. *See* § 34.5.
97. Rev. Proc. 93-23, 1993-1 C.B. 538, as modified by Rev. Proc. 2000-5, 2000-1 I.R.B. 280. The user fee program is authorized by IRC § 7528. Congress in 2004 extended the program through September 30, 2014 (American Jobs Creation Act of 2004, Pub. L. No. 108-357 § 891).

This application will not be able to be filed electronically, however. The application is to be prepared with the support of a ''cyber assistant,'' who will guide the applicant organization through the form, explaining the need for and relevance of particular information, referring and linking to relevant IRS publications, defining essential and unfamiliar terms, and relating sections of the form to one another. Nonetheless, the intent of the IRS is that preparation of the application in this setting will enable the agency to provide educational information, making it easier for the document to be prepared and processed.

§ 34.2 APPLICATION DISCLOSURE REQUIREMENTS

Generally, the IRS must disclose the text of any written determination and any background file document relating to such a determination.[98] A *written determination* is a ruling, determination letter, technical advice memorandum, or Chief Counsel advice.[99] The term *background file document* includes the request for the determination, any written material submitted in support of the request, and certain communications between the IRS and other persons.[100] Before the IRS makes a written determination public, the agency is required to delete (redact) certain identifying information, including the ''names, addresses, and other identifying details of the person to whom the written determination pertains.''[101]

This body of law does not, however, apply to all written determinations from the IRS. For example, the general disclosure rule does not apply to ''any matter to which section 6104 . . . applies.''[102] That section of the Internal Revenue Code makes available for public inspection tax information relating to specified entities.

One of the provisions of this law requires the IRS to disclose documents relating to tax-exempt organizations, including applications for recognition of exemption, supporting materials, and IRS determinations granting the exemptions. This body of law does not contain a requirement that identifying information be redacted.[103] The tax regulations accompanying this statutory

98. IRC § 6110(a).
99. IRC § 6110(b)(1)(A).
100. IRC § 6110(b)(2).
101. IRC § 6110(c).
102. IRC § 6110(l)(1).
103. A different disclosure regime is applicable with respect to pension, profit-sharing, and like plans (IRC § 6104(a)(1)(B)). This rule requires disclosure of applications and written determinations regarding tax exemptions for the funds underlying these plans. This provision references ''any applications'' filed with the IRS, which encompasses those that result in a grant or denial of the application (and perhaps revocation of exemption).

regime are based on the premise that the more specific rule[104] applies to all determinations concerning tax-exempt status.[105]

The foregoing statutory and regulatory framework was found to be faulty by a federal court of appeals, with the court voiding the regulations prohibiting disclosure of denials or revocations of exemption, on the ground that these regulations are in conflict with the statutes.[106] The IRS asserted that the general disclosure rule[107] is ''ambiguous'' and that the regulations reflect a reasonable interpretation of the statutory scheme. The appellate court disagreed, ''discern[ing] no ambiguity'' in the statute; the provision was held to be ''straightforward.''[108] The exception provision was held to be applicable only with respect to *tax-exempt* organizations; the court of appeals wrote that the provision ''says nothing about documents relating to non-exempt organizations.''[109] The IRS argued that its interpretation of the law leads to a conclusion by means of ''negative implication'' that Congress did not intend disclosure of documents involving denials or revocations of exemption.[110] To counter this, the court observed that ''Congress knew exactly how to refer to denials and revocations when it so intended,''[111] referring to the rules concerning pension and like plans.[112] The appellate court thus concluded that the IRS must disclose determinations denying or revoking tax exemptions but do so in redacted form.[113] In response, the IRS is in the process of revising the tax regulations to comport with this appellate court decision.[114]

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104. That is, IRC § 6104.
105. Thus, the regulations associated with IRC § 6110 state that matters within the ambit of IRC § 6104 include applications and related documents pertaining to the granting, denying, or revoking of tax-exempt status (Reg. § 301.6110-1(a)).
106. *Tax Analysts v. Internal Revenue Service*, 350 F.3d 100 (D.C. Cir. 2003), *rev'g* 215 F. Supp. 2d 192 (D.D.C. 2002).
107. That is, IRC § 6110.
108. *Tax Analysts v. Internal Revenue Service*, 350 F.3d 100, 103 (D.C. Cir. 2003).
109. *Id*.
110. *Id*.
111. *Id*.
112. *See* text accompanied by *supra* note 103.
113. Despite this appellate court holding, it appears, by application of standard rules of statutory construction, that Congress intended that IRC § 6104(a)(1)(A) be its sole statement as to what exempt organization written determinations are to be made public. Also, in 2000, the staff of the Joint Committee on Taxation made recommendations as to tax law disclosures, including a proposal that the IRS make exempt organization revocation and denial rulings open to the public (*see* XVII *Nonprofit Counsel* (No. 4) 4 (April 2000)); obviously, that recommendation would have been unnecessary had this court of appeals been correct. Moreover, in 2003, the Senate passed legislation to make IRC § 6110 applicable to written determinations and related background file documents relating to tax-exempt organizations, including determinations denying recognition of exempt status (Charity Aid, Recovery, and Empowerment Act of 2003 § 201 (S. 476, 108th Cong., 1st Sess. (2003)); again, if this decision were correct, the Senate legislation would be superfluous.
114. REG-116215-0-7.

§ 34.3 SPECIAL REQUIREMENTS FOR CHARITABLE HEALTHCARE ORGANIZATIONS

(a) Hospitals

A nonprofit hospital that seeks recognition, from the IRS, of tax-exempt status as a charitable organization[115] must provide certain items of information to the IRS, in addition to those required of charitable organizations in general.[116] These items of information are (1) the number of physicians on the hospital's courtesy staff; (2) whether all of the physicians in the community are eligible for staff privileges, and, if not, the reasons why and an explanation as to how the courtesy staff is selected; (3) whether the hospital maintains a full-time emergency room; (4) the hospital's policy on administering emergency services to individuals without the apparent means to pay; (5) whether the hospital has any arrangements with police, fire, and voluntary ambulance services for the delivery or admission of emergency cases; (6) whether the hospital requires or will require, in its admission practices, a deposit from individuals covered by Medicare or Medicaid; (7) whether the same deposit requirement applies to all other patients; (8) whether the hospital provides or will provide a portion of its services and facilities for charity patients; (9) the hospital's policy regarding charity cases, including data on the hospital's past experience in admitting charity patients and on arrangements it may have with municipal or government agencies for absorbing the cost of this type of care; (10) whether the hospital carries on a formal program of medical training and research[117]; and (11) whether the hospital provides office space to physicians carrying on a medical practice.[118] As to this last item, the hospital is requested to attach to the application a list of each physician's name, the amount of space provided, the annual rent, the expiration date of the current lease, and a statement as to whether the terms of the lease represent fair market value.

(b) Medical Research Organizations

A nonprofit medical research organization that seeks recognition of tax-exempt status as a charitable organization[119] must provide certain items of information to the IRS, in addition to those required of charitable organizations in general.[120] These items of information are (1) the name of the hospital with which the organization has a relationship; (2) a description of the relationship; (3) a statement as to the organization's present and proposed medical research activities, showing the nature of the activities and the amount of money that

115. *See*, in general, Chapter 8.
116. Form 1023, Schedule C, Section I.
117. *See* § 24.12.
118. *See* § 24.13.
119. *See*, in general, § 5.1, text accompanied by notes 26–41.
120. Form 1023, Schedule C, Section II.

has been or will be spent in carrying them out; and (4) a statement of the organization's assets, showing the fair market value of the assets and the portion of the assets directly devoted to medical research.

(c) Homes for the Elderly or Handicapped

A nonprofit organization that operates a home for the elderly or the handicapped and seeks recognition of tax-exempt status as a charitable organization[121] must provide certain items of information to the IRS, in addition to those required of charitable organizations in general.[122] These items of information are (1) the requirements for admission to residency (with application forms and promotional literature attached); (2) whether the home charges an entrance fee or a founder's fee (and, if so, the amount and frequency of payment); (3) an explanation of any periodic fees or maintenance charges required of the residents; (4) an explanation of any policy that the home may have concerning residents who become unable to pay their regular charges; (5) an explanation of the arrangements the home may have with local and federal welfare units, sponsoring organizations, or others, to absorb part or all of the costs of maintaining residents who cannot pay their charges; (6) an explanation of the arrangements the home may have to provide for the health needs of its residents (including any continuing arrangement it may have with other organizations, facilities, or health personnel); (7) a statement as to the way in which the home's residential facilities may be designed to meet some combination of the physical, emotional, recreational, social, religious, and similar needs of the elderly or handicapped; (8) a description of the facilities of the home, specifying the residential capacity of the home and the current number of residents; and (9) a sample copy of the agreement the organization makes with or requires of its residents.

(d) General Notification Rules

An organization that desires recognition as a tax-exempt charitable healthcare (or other charitable) organization[123] as of the date of its establishment generally must notify the IRS that it is applying for recognition of tax exemption on that basis within 15 months from the end of the month in which it was organized.[124] (This 15-month rule is, in fact, a 27-month rule.[125]) Otherwise,

121. *See* Chapter 11.
122. Form 1023, Schedule F.
123. An organization described in IRC § 501(c)(3).
124. IRC § 508(a); Reg. § 1.508-1(a)(2)(i). The date of notice is the same as that in the declaratory judgment context (*see* text accompanied by *supra* note 45 (Rev. Rul. 77-114, 1977-1 C.B. 152)). E.g., *Peek v. Commissioner*, 73 T.C. 912 (1980); Rev. Rul. 90-100, 1990-2C.B. 156. This notice is given by the submission of a properly completed and executed Application for Recognition of Exemption (Form 1023) (*see* § 34.1).
125. *See* § 34.4(a).

the recognition of tax exemption as a charitable entity by the IRS generally will not be effective prior to the date on which the application for recognition of exemption was filed.[126]

In general, if any return, claim, statement, or other document is required by federal tax law to be filed before a specified date, and the document is delivered by the United States Postal Service after that date to the government agency, officer, or office with which the document is required to be filed, it is deemed to have been filed on or before the due date if the U.S. postmark stamped on the envelope or other cover in which the document is mailed is dated on or before the date prescribed for filing.[127] On the basis of this standard, the IRS ruled that the date of notice, for purposes of this exemption recognition process, is the date of the U.S. postmark stamped on the cover in which the application for recognition of tax exemption was mailed, or, in the absence of a postmark, the date the application was stamped as received by the IRS.[128]

Where the IRS recognizes the tax exemption of an organization that made a timely filing, the exemption is effective as of the date the organization was created or, if later, the date it qualified as a charitable organization.[129] In determining the date on which a nonprofit corporation was organized, the IRS looks to the date the corporation came into existence under the law of the state in which it was incorporated, which usually is the date its articles of incorporation were filed in the appropriate state office.[130] This date is not the date the organizational meeting was held, bylaws were adopted, or actual operations began.[131]

Once notice is given after the pertinent date, the tax exemption as a charitable organization (if recognized) and the organization's ability to attract deductible charitable contributions generally will only operate prospectively, as of the date the IRS received the application.[132] A timely filed application for recognition of tax exemption satisfies both this notice and the private foundation status requirements.[133]

If an organization makes a nonsubstantive amendment to a governing instrument,[134] that action is not taken into account in determining application

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126. E.g., the IRS so ruled in Priv. Ltr. Rul. 8518067. There are three exceptions to this general rule: (1) where a charitable organization is exempted by statute from the recognition requirement (generally a set of rules of no applicability to charitable healthcare organizations) (*see* text accompanied by *infra* notes 149–153); (2) where the IRS grants an extension of time (*see* text accompanied by *infra* notes 139–143); and (3) the automatic 12-month extension procedure (*see* text accompanied by *infra* notes 144–145).
127. IRC § 7502(a)(1).
128. Rev. Rul. 77-114, 1977-1 C.B. 152.
129. Reg. § 1.508-1(a)(2)(iii). *See* Form 1023, Part I, question 5.
130. Rev. Rul. 75-290, 1975-2 C.B. 215.
131. *Id*.
132. IRC §§ 508(a)(2) and 508(d)(2)(B); Reg. § 1.508-2.
133. As to the latter, *see* § 34.4.
134. *See supra* note 69.

of the 15-month rule.[135] For example, a charitable healthcare organization may submit an application for recognition of tax exemption within the 15-month period and subsequently make a nonsubstantive amendment to its governing instrument; its tax exemption is effective as of the date of its formation. Likewise, a charitable healthcare organization may submit an application for recognition of tax exemption after expiration of the 15-month period and thereafter make a nonsubstantive amendment to its governing instrument; its tax exemption is effective as of the date the application was submitted to the IRS. If an organization makes a nonsubstantive amendment to a governing instrument after expiration of the 15-month period, and then applies for recognition of exemption within 15 months after the date of the amendment, the organization will be recognized as tax-exempt as of the date the application was submitted to the IRS, not the date the amendment was made. Where a substantive amendment is made to a governing instrument, recognition of tax exemption may be effective as of the date of the change, depending on the nature of the change.

If a charitable organization filed a properly completed and executed application for recognition of tax exemption within the 15-month period, then withdrew the application before the IRS could rule on it, and, after expiration of the 15-month period, filed another application showing that the entity had been a charitable one since the date it was organized, the tax exemption would not be retroactive to the date the organization was established because the organization negated the first filed notice.[136] The same result would obtain where a charitable organization filed a properly completed and executed application for recognition of tax exemption within the 15-month period, then withdrew the application before the IRS could rule on it, and substituted an application for recognition as a social welfare organization[137] (which the IRS approved), and after expiration of the 15-month period filed another application showing that the entity had been a charitable one since the date it was organized.[138]

The IRS has general discretionary authority, upon a showing of good cause, to grant a reasonable extension of a time, fixed by the tax regulations, for making an election or application for relief in respect of the federal income tax laws.[139] This discretionary authority may be exercised where the time for making the election or application is not expressly prescribed by statute, the request for the extension is filed with the IRS within a period of time the IRS considers reasonable under the circumstances, and it is shown to the satisfaction of the IRS that granting the extension will not jeopardize the

135. Rev. Proc. 84-47, 1984-1 C.B. 545.
136. Gen. Couns. Mem. 39833.
137. *See* § 1.8.
138. Gen. Couns. Mem. 39833.
139. Reg. § 301.9100-1(a).

interests of the federal government.[140] The IRS's position is that it ''will give consideration'' to application of this discretionary authority so as to extend the time for satisfaction of the 15-month notice requirement (which is prescribed by a regulation,[141] not a statute).[142] The IRS has outlined the information and representations that must be furnished by a person, and some factors that will be taken into consideration in determining whether extensions will be granted.[143]

The foregoing notwithstanding, there are three other pathways to relief from the 15-month rule. One is that the IRS provided for an automatic 12-month extension of time to make certain elections; this extension includes the 15-month notice requirement.[144] Therefore, what was the 15-month rule is, for filings where the due date is on or after October 1, 1992,[145] in effect, the 27-month rule.

Another pathway to relief is temporary use of tax-exempt status as a social welfare organization. An organization that qualifies for tax exemption as a charitable organization but files for recognition of that tax exemption after the 15-month (or 27-month) period can be tax-exempt as a social welfare organization (as to which recognition of exemption is not required) for the period commencing as of the date of its inception and ending on the date the tax exemption as a charitable organization becomes effective.[146] (This statement is based on the assumption that all, or nearly all, tax-exempt charitable organizations can qualify as tax-exempt social welfare organizations.) However, contributions to tax-exempt social welfare organizations generally are not deductible as charitable contributions.[147]

The third exception is the one provided for small charitable organizations.[148]

140. *Id*. at (1)–(3).
141. Reg. § 1.508-1(a)(2)(i).
142. Rev. Proc. 84-47, 1984-1 C.B. 545, § 4; Rev. Rul. 80-259, 1980-2 C.B. 192, 193.
143. Rev. Proc. 79-63, 1979-2 C.B. 578, modified and clarified by Rev. Proc. 80-21, 1980-1 C.B. 646. The application for recognition of tax exemption under IRC § 501(c)(3) (*see* § 34.1) was revised in 1981 to provide a request for this relief as part of the application (*see* Form 1023, Part III, questions 13(c) and (d)) (Ann. 81-245, 1981-39 I.R.B. 14).
144. Rev. Proc. 92-85, 1992-2 C.B. 490 § 4.01.
145. *Id*. § 10.
146. Rev. Rul. 80-108, 1980-1 C.B. 119. In this circumstance, the IRS wishes the charitable organization to file Form 1024, page 1, with its Form 1023 (Form 1023, Part III, instructions accompanying line 6). Technically, however, submission of Form 1024, page 1, is not required because social welfare organizations can be tax-exempt under IRC § 501(c)(4) without applying for recognition of tax exemption (*see* text accompanied by *supra* note 10).
147. This is because IRC § 501(c)(4) social welfare organizations are not enumerated in IRC § 170(c)(2). E.g., *Regan v. Taxation with Representation of Washington*, 461 U.S. 540, 543 (1983); *Alexander v. ''Americans United,'' Inc.*, 416 U.S. 752, 755 (1974); *Smith v. Commissioner*, 51 T.C.M. 1114, 1117 (1986).
148. *See* text accompanied by *infra* note 150.

(e) Exceptions from Notification Rules

The 15-month notice requirement does not apply to any organization that is not a private foundation or a supporting organization[149] and does not normally have, in each tax year, gross receipts of more than $5,000.[150] Also, this notice requirement is inapplicable to subordinate organizations covered by a group exemption letter, as long as the central organization has submitted the requisite notice covering the subordinates.[151] Moreover, the notice requirement does not apply to churches, their integrated auxiliaries, interchurch organizations, local units of a church, and conventions or associations of churches.[152] The IRS is authorized to exempt from the notice requirement any other class of organization as to which full compliance with the requirement is not necessary to the efficient administration of the law relating to private foundations.[153]

The exception in the notification rules for organizations with gross receipts that are normally under $5,000 can operate to relieve an organization from the requirement of filing an application for recognition of tax exemption during the initial years of its operation but expires as the organization begins to receive greater amounts of financial support. An organization in this circumstance, to be ensured of tax status as a charitable entity (assuming it otherwise continues to qualify) throughout its existence, must timely ascertain when to file the application.

The gross receipts of an organization are normally not more than $5,000, for this purpose, if (1) during its first tax year, it received gross receipts of no more than $7,500; (2) during its first two tax years, it received gross receipts of no more than $12,000; and (3) after being in existence for three tax years, it received, during its two immediately preceding tax years plus the current year, gross receipts of no more than $15,000.[154] Once an organization fails to meet the foregoing rules in its formative years, it is required to file the notice (that is, an application for recognition of exemption) within 90 days after the end of the tax year(s) in which its gross receipts exceeded the amounts permitted under the exemption. Thus, this threshold period is used instead of the 15-month (or 27-month) period.[155]

These rules are also inapplicable to a *governmental unit*[156] and an *affiliate of a governmental unit*.[157]

149. *See* Chapter 5.
150. IRC § 508(c)(1).
151. *See* § 34.5.
152. IRC § 508(c)(1) and (2).
153. IRC § 508(c)(2); Reg. § 1.508-1(a)(3)(i)(e).
154. Reg. § 1.508-1(a)(3)(ii).
155. Reg. § 1.508-1(a)(3)(ii). Illustrations of the application of these rules are the subject of Rev. Rul. 81-177, 1981-2 C.B. 132, and Rev. Rul. 80-259, 1980-2 C.B. 192. *See* generally, Holdenried, "Common Threads Link Revocation and Denial of Exemption for Health Care Organizations," 10 *J. Tax'n Exempt Orgs*. (No. 1) 18 (July/Aug. 1998).
156. Rev. Proc. 95-48, 1995-2 C.B. 418.
157. *Id*.

An entity is a governmental unit if (1) it is a state or local governmental unit as defined in the rules proving an exclusion from gross income for interest earned on bonds issued by these units,[158] (2) it is entitled to receive deductible charitable contributions as a unit of government;[159] or (3) it is an Indian tribal government or a political subdivision of this type of government.[160]

An entity is an affiliate of a governmental unit if it is a tax-exempt organization[161] and meets one of two sets of requirements. One is that it has a ruling or determination letter from the IRS that (1) its income, derived from activities constituting the basis for its exemption, is excluded from gross income under the rules for political subdivisions and the like,[162] (2) it is entitled to receive deductible charitable contributions[163] on the basis that contributions to it are for the use of governmental units, or (3) it is a wholly owned instrumentality of a state or political subdivision of a state for employment tax purposes.[164] The other is available for an entity that does not have a ruling or determination letter from the IRS but (1) is either operated, supervised, or controlled by governmental units, or by organizations that are affiliates of governmental units, or the members of the organization's governing body are elected by the public at large, pursuant to local statute or ordinance, (2) it possesses two or more of certain affiliation factors,[165] and (3) its filing of an annual information return is not otherwise necessary to the efficient administration of the internal revenue laws.[166] An organization can (but is not required to) request a ruling or determination letter from the IRS that it is an affiliate of a governmental unit.[167]

§ 34.4 NON-PRIVATE-FOUNDATION STATUS

Every tax-exempt charitable healthcare organization (as well as any other charitable organization) is presumed to be a private foundation.[168] Since almost none of these entities is in fact a private foundation and because the federal tax rules applicable to private foundations[169] are onerous, it is usually critical

158. Reg. § 1.103-1(b). *See* Chapter 30.
159. IRC § 170(c)(1).
160. IRC §§ 7701(a)(40), 7871. This tripartite definition of a governmental unit is in Rev. Proc. 95-48, 1995-2 C.B., § 4.01.
161. That is, is described in IRC § 501(c).
162. IRC § 115.
163. IRC § 170(c)(1).
164. IRC §§ 3121(b)(7), 3306(c)(7). This definition is provided by Rev. Proc. 95-48, 418, § 4.02(a).
165. Rev. Proc. 95-48, 1995-2 C.B. 418, § 4.03.
166. *Id*. § 4.02(b). Relevant facts and circumstances as to whether an annual return is necessary include those provided in *id*. § 4.04.
167. *Id*. § 5. In one instance, several tax-exempt healthcare entities were created out of a governmental district; because these entities maintained a relationship with the district, the IRS ruled that they are affiliated with it and thus excused from the requirement of filing annual information returns (Priv. Ltr. Rul. 9825030).
168. IRC § 509(a). *See*, in general, Chapter 5.
169. IRC §§ 507, 4940–4948. *See*, generally, Private Foundations.

to a tax-exempt charitable healthcare organization to avoid classification as a private foundation.

(a) Notification to IRS

Generally, every charitable healthcare organization, or other charitable entity (would-be or otherwise), must timely notify the IRS that it is not a private foundation (if that is the case) or it will be presumed to be a private foundation.[170] The time for the giving of the notice is the same as for the notice requirement with respect to tax exemption (the 27-month rule), and the same exceptions apply.[171]

Thus, this presumption as to private foundation status is rebuttable. Often, one of the purposes of filing the application for recognition of tax exemption is to rebut this presumption. An organization that in fact is not a private foundation but fails to timely file a notice for that purpose may nonetheless be recognized by the IRS as an entity other than a private foundation. The organization must establish that status by submitting a request for a determination letter to that effect to the IRS.[172]

In one instance, a charitable organization (not exempt from the notice requirements) did not apply for recognition of tax exemption until after expiration of the 15-month deadline. The application of this organization, in which it claimed private foundation status, was subsequently approved by the IRS. Because the organization could not be treated as a charitable entity until the date of filing of its application, however, it could not be classified as a private foundation until that date.[173] The same result obtains as respects applications for public charity status, such as classification as a hospital or medical research organization.[174] When an applicant organization withdraws its application for recognition of exemption prior to the issuance of any adverse determination letter, it also cancels its notification to the IRS that it is applying for recognition of the status, so that the 15-month period continues to run.[175] (Again, the automatic 12-month extension of time[176] applies in these settings.)

Therefore, an organization (not exempt from the notice requirements) that has not had any financial support and that filed its notice after expiration of the 15-month (or 27-month) period can obtain an advance ruling[177] that it is a publicly supported charitable organization as of the date it acquires

170. IRC § 508(a) and (b).
171. *See* § 34.3(d).
172. Rev. Rul. 73-504, 1973-2 C.B. 190.
173. Rev. Rul. 77-207, 1977-1 C.B. 152.
174. Rev. Rul. 77-208, 1977-1 C.B. 153.
175. Rev. Rul. 90-100, 1990-2 C.B. 156.
176. *See* text accompanied by *supra* notes 144–145.
177. *See* text accompanied by *infra* note 186.

recognition of its tax exemption.[178] An organization (not exempt from the notice requirements) that does not have any gross receipts in its first tax year consisting of less than eight months,[179] has no gross receipts in its second tax year, and receives total support of more than $15,000 in contributions from the general public in its third tax year,[180] can be recognized by the IRS as tax-exempt as a charitable organization as of the date of its organization if it files for recognition of exemption within 90 days after the close of its third tax year.[181]

Organizations applying for recognition of exemption as charitable entities claim non-private-foundation status (if they are able) in the application for recognition of tax-exempt status.[182]

The IRS promulgated rules with respect to the issuance of determination letters and rulings as to public charity, private foundation, and private operating foundation status, and reconsiderations, modifications, and revocations of determination letters and rulings.[183] Pursuant to these rules, the IRS is authorized to issue determination letters as to these three statuses, subject to the protest and conference procedures.[184]

(b) Advance and Definitive Rulings

As to non-private-foundation status as a publicly supported organization,[185] the IRS (assuming a favorable determination as to the organization's tax-exempt status as a charitable entity) will issue a *definitive* or *advance* ruling. A definitive ruling is a permanent (or final) determination as to publicly supported charity status; it remains in effect absent a material change in the facts or the law. An advance ruling is a preliminary (or probationary) determination as to publicly supported charity status that is deemed to be in effect for a sufficient period to enable the organization to establish eligibility as a publicly supported organization (if it can).[186] The applicant charitable organization must select either donative publicly supported organization status[187] or service provider publicly supported organization status[188] as part of the application process.

178. Rev. Rul. 80-113, 1980-1 C.B. 58.
179. *See* paragraph containing *infra* notes 190 and 191.
180. *See* text accompanied by *supra* note 154.
181. Rev. Rul. 85-173, 1985-2 C.B. 164.
182. Form 1023, Part III.
183. Rev. Proc. 2008-9, 2008-2 I.R.B. 258.
184. *See* § 34.7.
185. These rules apply with respect to both categories of publicly supported organizations (*see* §§ 5.2, 5.3).
186. An advance ruling is applicable only with respect to an organization's status as a publicly supported organization; the determination letter or ruling is a permanent one as to the organization's tax-exempt status and eligibility to receive deductible charitable contributions.
187. Form 1023, Part III, question 12. *See* § 5.2.
188. Form 1023, Part III, question 13. *See* § 5.3.

If the organization has been publicly supported during this *advance ruling period*, the advance ruling will ripen into a definitive ruling.[189]

A newly created organization recognized as tax-exempt as a charitable entity and seeking non-private-foundation status as a publicly supported organization[190] is entitled to receive (upon making an election[191]) a definitive ruling if it has completed a tax year consisting of at least eight full months (as of the time of filing the application). When this type of organization does not satisfy the eight-month requirement, it must request an advance ruling covering its first five tax years. (Unlike the foregoing eight-month rule, the first year of this five-year period can consist of any number of days, up to a full year.)

An organization that has satisfied this eight-month requirement has two options in this regard: (1) request a definitive ruling, in which case the organization's qualification as a publicly supported charitable organization is initially based on the support the organization has received to that date; or (2) request an advance ruling, in which case the organization's public support computation is based on the support it receives during its first five tax years (measured as described above).[192] As to this choice, the IRS offers this advice: "An organization should consider this [second] option if it has not received significant public support during its first tax year or during its first and second tax years, but it reasonably expects to receive such support by the end of its fifth tax year."[193]

Where (1) an incorporated charitable organization is claiming qualification as a publicly supported entity, (2) the organization is the successor to an unincorporated charitable organization, and (3) incorporation was the only significant change in the organization, the period of time that the predecessor organization operated may be taken into consideration in determining qualification under the time requirements of the rules concerning publicly supported

189. The determination letter or ruling states the date on which the advance ruling period ends; it is always on the last day of the appropriate tax year of the organization (*see* text accompanied by *infra* notes 191 and 192). Within 90 days following expiration of the advance ruling period, the organization is expected to submit a summary of its financial history for that period to the IRS (by means of Form 8734, the current date of which is April 1988). If the data shows that the organization has been publicly supported (under either category) during the period, the IRS will issue a definitive ruling. The concepts of *advance ruling*, *advance ruling period*, and *definitive ruling* are wholly creations of the IRS; they are not statutory.

190. Form 1023, Part III, questions 7 and 9.

191. *See* text accompanied by *infra* notes 192–193.

192. Form 1023, Part III, question 10.

193. Instructions accompanying Form 1023, Part III, line 10. The foregoing description of eligibility for definitive and advance rulings is based on the rules as summarized in the instructions accompanying Form 1023 (*id*.). The rules contained in the tax regulations in this regard (Reg. §§ 1.170A-9(e)(5) and 1.509(a)-3(d)) are quite different and have yet to be updated to conform to the application form and its instructions. TAX-EXEMPT ORGANIZATIONS.

charity classification.[194] At the close of the advance ruling period (during which the organization was presumed to be a publicly supported charity), the IRS will determine whether the organization has met the test for a publicly supported organization on the basis of its financial history during the advance ruling period that began when the unincorporated entity was created; if so, the IRS will issue a definitive ruling.

The publicly supported charity status that is reflected in an advance ruling for a charitable organization does not need to be the same as that reflected in the definitive ruling subsequently issued to the same organization. For example, an organization may be recognized in an advance ruling as a donative publicly supported organization,[195] only to have its financial history during the advance ruling period show its inability to satisfy that public support test while nonetheless satisfying the public support test for a service provider publicly supported organization[196]; the definitive ruling issued by the IRS to this organization would categorize it as this latter type of publicly supported organization.

This matter of advance and subsequent definitive rulings is applicable only with respect to charitable organizations that are attempting to avoid private foundation status as a type of publicly supported charitable entity. Other bases by which a charitable organization can avoid classification as a private foundation—such as by being a hospital,[197] medical research organization,[198] or supporting organization[199]—are manifested in definitive rulings issued as part of the initial determination letter or ruling.

§ 34.5 GROUP EXEMPTION

In general, a nonprofit organization, to be tax-exempt, must qualify for the tax exemption on its own merits.[200] A partial exception to this rule is the *group exemption:* even though each member of the group must be inherently qualified for a tax-exempt status, the recognition of tax exemption is obtained by dint of the relationship between the members of the group and a *central organization*.

A tax-exempt organization can become classified as a central organization or as a *subordinate organization*, for purposes of a group exemption. The concept

194. Rev. Rul. 73-422, 1973-2 C.B. 70. *See* Rev. Rul. 77-116, 1977-1 C.B. 155 (where support received by an organization prior to changes made in its operations to enable it to qualify under IRC § 501(c)(3) were ruled to not be taken into account in determining its publicly supported charitable organization status).
195. *See* § 5.2.
196. *See* § 5.3.
197. *See* Chapter 8.
198. *See* § 24.12.
199. *See* § 5.5.
200. E.g., *Geisinger Health Plan v. Commissioner*, 30 F.3d 494 (3d Cir. 1994); *Mutual Aid Association of the Church of the Brethren v. United States*, 759 F.2d 792, 795 note 3 (10th Cir. 1985).

of the group exemption is to enable the members of the group to have tax-exempt status by reason of their affiliation with the central organization, obviating the need for each of them to seek recognition of tax-exempt status from the IRS. This procedure also saves the IRS from having to process many applications for recognition of tax-exempt status. This approach to tax-exempt status can be very favorable for the clusters of nonprofit organizations that are affiliated. Savings of time, effort, and expenses result, for them and for the IRS.

Nearly every type of tax-exempt organization can be a central organization; these entities—state, regional, or national organizations—usually represent geographical areas. Likewise, nearly every type of exempt organization can be a subordinate organization[201]; usually chapters, locals, posts, or other units within the geographical area represented by the central organization, these entities are affiliated in some manner with and are subject to the general supervision or control of the central organization.[202] A typical central organization is a fraternal organization, veterans' organization, union, or membership organization with many posts, chapters, or like subordinate entities. This model is, however, not required. For example, a tax-exempt hospital could have affiliated with it a variety of separately formed research funds, with the funds tax-exempt because of the affiliation.

A subordinate organization is recognized as being tax-exempt (assuming it otherwise qualifies for the particular exempt status) by reason of its relationship with the central organization. Tax exemption acquired in this manner is referred to as tax exemption on a *group basis*. A *group* can consist of only one subordinate entity; there is no requirement as to how many organizations constitute this type of group. Organizations may be added to or removed from the group by the central organization on an ongoing basis; a subordinate organization can extricate itself from the group.

The procedures by which a group exemption may be recognized by the IRS[203] contemplate a functioning of the central organization as a proxy of the IRS in this regard. The central organization must responsibly and independently evaluate the tax-exempt status of its subordinate organizations from the standpoint of the organizational and operational tests applicable to them.[204] A central organization is required to annually file with the IRS a list of its qualifying tax-exempt subordinate organizations; this listing amounts to an attestation by the central organization that the subordinate

201. *See*, however, *infra* note 213. Also, as discussed below, private foundations may not be included in a group exemption letter, nor may an organization that is organized and operated in a foreign country.
202. *Subordinate organization* is an unfortunate choice of terminology, in that many organizations and those who manage them do not care to be regarded as *subordinates;* this phraseology can lead to some "political" difficulties when a group exemption arrangement is being considered. A preferable term would be *affiliated organization*.
203. Rev. Proc. 80-27, 1980-1 C.B. 677; Reg. § 601.201(n)(7).
204. *See supra* notes 94 and 95.

organizations qualify as tax-exempt organizations so that the IRS need not engage in an independent evaluation as to the exempt status of each of the organizations. It is essential that the central organization, in performing this agency function, exercise responsibility in classifying entities as its subordinate organizations.

A tax-exempt organization becomes recognized by the IRS as a central organization by applying for a group exemption determination. The application must establish that all of the subordinate organizations to be included in the group exemption letter are (1) affiliated with it[205]; (2) subject to its general supervision or control; (3) under the same category of tax exemption (although not necessarily under the same tax-exempt status as the central organization); (4) not private foundations or foreign organizations; (5) on the same accounting period as the central organization if they are not to be included in group returns; and (6) formed within the 15-month period[206] prior to the date of submission of the group exemption application (assuming this is the case and these entities are claiming charitable status and are subject to the general requirements for application for recognition of tax exemption).[207] Each subordinate organization must authorize (in writing) the central organization to include it in the application for the group exemption letter or, subsequently, when being added to the group.

With respect to the third requirement above, a central organization may be tax-exempt as a charitable entity, and all of its subordinate organizations may be exempt as social welfare organizations. Concerning the sixth requirement above, the procedures state that, if one or more of the subordinates have not been organized within the 15-month period, the group exemption letter will be issued only if all of the subordinate organizations agree to be recognized as tax-exempt from the date of the application rather than the date of their creation. Subordinate charitable organizations are exempt from the notice requirements generally applicable to charitable organizations.[208]

A central organization must also submit to the IRS, in addition to certain information about itself, the following information on behalf of the subordinate organizations that are involved in the application[209]: (1) a letter signed by a principal officer of the central organization setting forth or including as attachments (a) information verifying the existence of the foregoing six relationships and requirements, (b) a detailed description of the principal purposes

205. In this setting, *affiliation* is not defined; however, it is usually manifested by a governance and/or financial relationship.
206. Presumably, this can be a 27-month period in appropriate cases (*see* text accompanied by *supra* notes 144–146).
207. *See* § 34.3.
208. *Id*. Reg. § 1.508-1(a)(3)(i)(c).
209. A central organization need have only a few representative subordinate organizations as part of the group exemption application; an unlimited number of subordinate entities can be added on an ongoing basis.

and activities of the subordinate organizations, including financial information, (c) a sample copy of a uniform or representative governing instrument adopted by the subordinate organizations, (d) an affirmation that, to the best of the officer's knowledge, the subordinate organizations are operating in accordance with the stated purposes, (e) a statement that each subordinate organization to be included within the group exemption letter has furnished the requisite written authorization, (f) a list of subordinate organizations to be included in the group exemption letter and to which the IRS issued a determination letter or ruling recognizing tax-exempt status,[210] and (g) an affirmation that no subordinate organization is a private foundation; and (2) a list of the names, addresses, and employer identification numbers of subordinate organizations to be included in the group exemption letter (or, instead, a satisfactory directory of subordinate organizations).[211]

If the general requirements for recognition of tax-exempt status[212] are satisfied, a group exemption letter will be issued to a central organization where: (1) the above requirements as to subordinate organizations are satisfied; (2) the exemption to be recognized is under the general exemption rules[213]; and (3) each of the subordinate organizations has an employer identification number and an organizing document (although these organizations do not have to be incorporated). As to this third requirement, the group exemption contemplates a clustering of separate organizations; nonetheless, some organizations may be able to be considered an integral part of another organization.[214]

Once a group exemption letter is issued, certain information must be submitted annually by the central organization (at least 90 days before the close of its annual accounting period) to the IRS so as to maintain the determination. This information consists of (1) information regarding any changes in the purposes, character, or method of operation of the subordinate organizations; (2) lists of subordinate organizations that have changed their names or

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210. Where a subordinate organization has an outstanding determination letter or ruling from the IRS recognizing tax exemption and becomes included in a group for exemption purposes, the prior exemption recognition determination is superseded by the group exemption (IRM 7600, § 7667, 23 (3)). The central organization, in this circumstance, is obligated to notify the affected subordinate organization(s) of this supersession.
211. The sole court opinion involving the group exemption rules upheld the requirement that detailed information concerning the activities and finances of subordinate organizations be submitted to the IRS (*National Association of American Churches v. Commissioner*, 82 T.C. 18 (1984) (an organization is not eligible for classification as a central organization because the requisite information was not provided)).
212. Rev. Proc. 2008-9, 2008-2 I.R.B. 258.
213. IRC § 501(c). The group exemption procedures are not available to organizations described in IRC §§ 521 (farmers' cooperatives), 526 (shipowners' protection and indemnity associations), 527 (political organizations), and 528 (homeowners' associations).
214. *See* § 34.6. Loss of tax exemption by some members of the group does not adversely affect the group exemption ruling as it pertains to the other members in the group (Tech. Adv. Mem. 9711004).

addresses during the year, are no longer to be included in the group exemption letter (for whatever reason), or are to be added to the group; and (3) the information, required of the subordinate organizations referenced in the group exemption letter,[215] as to any subordinate organizations added to the group.[216]

A central organization must, as a general rule, file an annual information return.[217] Also, as a general rule, this reporting obligation is imposed on a subordinate organization. One or more of the subordinate organizations, however, may file an annual information return with the central organization as part of a group annual information return.[218] (This is an elective practice, and some subordinate organizations (but not all) can use this combined filing option.) Organizations with gross receipts not normally in excess of $25,000 are not required to file an annual information return.[219] Thus, a central organization may exclude from its group return those subordinates that have annual gross receipts below that threshold.[220]

Subordinate organizations may also consolidate[221] their unrelated business income tax returns[222] with the central organization, as long as each of the subordinates (and the central organization) are within the same federal tax-exemption category.[223]

A central organization may be involved in more than one group exemption arrangement, such as a charitable central organization in relation to a group of charitable subordinate organizations and a group of subordinate social welfare organizations. Also, a central organization may be a subordinate organization with respect to another central organization, such as a state organization that has subordinate units in the state and is a subordinate organization affiliated with a national organization.

A group exemption letter may be terminated in several ways. Termination of a group exemption letter will occur where (1) the central organization ceases to exist, (2) one or more of the subordinates fail to satisfy the qualification requirements, or (3) the central organization fails to submit the information to maintain the letter, file an annual information return, or otherwise comply with the requirements. Moreover, if the IRS revokes the tax-exempt status of

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215. That is, the information summarized in the paragraph containing *supra* notes 210 and 211 (items 1(a)-(g)).
216. Group exemption reports are filed with the service center in Ogden, Utah (Rev. Proc. 96-40, 1996-2 C.B. 301).
217. *See* § 35.3.
218. Reg. § 1.6033-2(d). To facilitate this type of group filing, the central organization and the participating subordinate organizations must devise a system by which each subordinate organization involved transmits the required financial information to the central organization on a timely basis. The group exemption rules are silent on this point.
219. *See* § 35.3(b), text accompanied by notes 70 and 71.
220. Priv. Ltr. Rul. 8337094.
221. The consolidated return rules are the subject of IRC § 1504.
222. Form 990-T.
223. Tech. Adv. Mem. 8514001.

a central organization, the group exemption letter involved also is revoked, causing simultaneous revocation of the tax-exempt status of all of the subordinate organizations. When a termination occurs, the tax-exempt status of the subordinate organizations is no longer recognized by the IRS. Where continuing recognition of tax-exempt status is required or desired, each subordinate organization must file an application for recognition of tax exemption, the central organization must obtain a new group exemption letter, or the subordinate organization must affiliate with another qualifying central organization. As of the date an organization is no longer in a group, the 15-month (or 27-month[224]) notice period begins to run. An organization desiring to maintain recognition of tax exemption without interruption must file the application within that period or timely join another group.[225]

Where the central organization and the subordinate organizations are tax-exempt as charitable entities, the matter of their public charity status must be considered, for two reasons: (1) if a charitable entity is not a public charity, it cannot, as noted, be in a group for purposes of tax exemption; (2) if a charitable entity is one of the two types of publicly supported organizations,[226] there needs to be some way to manifest that status.[227] The current posture of the IRS seems to be to require that the subordinate organizations have the same non-private-foundation status as the charitable central organization, and to reflect that shared classification in the group exemption ruling.[228] Where the central organization is not a charitable organization but all members of the group are, the outcome is unclear.

Although there are many advantages to this streamlined approach to the establishment of tax-exempt status for affiliated organizations, there are some disadvantages as well. One is a corollary of the fact that the members of the group do not each possess determination letters or rulings as to their tax exemption. This can pose difficulties for donors and grantors,[229] as well as

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224. *See* text accompanied by *supra* notes 144–146.
225. Rev. Rul. 90-100, 1990-2 C.B. 156.
226. *See* §§ 5.2 and 5.3.
227. The group exemption procedure is just that: an *exemption* recognition process. The rules are silent as to public charity status of charitable subordinate organizations.
228. The policy reason(s) underlying this posture are unknown. It would not seem to make any difference whether the subordinate organizations are publicly supported by reason of the donative rules or the service provider rules. For that matter, it should not be a bar to a group exemption if some members of the group (but not all) are supporting organizations. Because a central organization can be tax-exempt on a basis different from that of the subordinate organizations, it would seem that the public charity statuses as between the central organization and the subordinate organizations can likewise be different, as well as the statuses of the subordinate organizations.
229. A donor of a major gift to a charitable organization in a group may want the security of a determination letter or ruling issued specifically to that organization, to have the optimum basis for relying on the donee organization's status as a charitable entity and/or, if the donee is not a private foundation, for relying on the donee's public charity status (particularly publicly supported organization status, if that is pertinent)

problems for the organization in establishing its tax-exempt status with other federal agencies and in securing state tax exemptions. If a member of a group is found liable for damages, the existence of the group exemption may be used in an effort to show ''ascending'' liability on the part of the central organization.

§ 34.6 INTEGRAL PART DOCTRINE

The integral part doctrine can be of considerable consequence in the setting of tax-exempt healthcare organizations, particularly as to a hospital system that is an array of nonprofit (and sometimes for-profit) entities.

There are two variants of the integral part doctrine. One concerns an organization that acquired tax-exempt status because of its relationship with one or more tax-exempt entities. This type of organization is, in law, a separate entity, and its tax exemption is a function of the affiliation. The other application of the doctrine pertains to tax-exempt organizations that have component entities that, although appearing to be separate organizations, are not, in law, separate but are instead *integral parts* of the larger organization. These component entities are in the nature of *divisions* of a tax-exempt organization.

(a) Affiliated Organizations

As noted, in general, the entitlement of a nonprofit organization to tax-exempt status is derived solely from the entity's own characteristics.[230] There is, however, an exception to this general rule, which is one of two aspects of the *integral part doctrine*. This facet of the doctrine, applied largely with respect to tax exemption as a charitable organization, enables an organization whose sole activity is an integral part of the exempt activities of a related entity to derive tax exemption from the relationship with its affiliate. Tax exemption of this nature is also known, as noted, as a *derivative* or *vicarious* exemption.

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to utilize one or more of the larger percentage limitations in computing the allowable charitable deduction for the year (*see* Charitable Giving, Chapter 7). As to charitable status, however, a donor generally can rely on the group exemption letter and the charitable organization's annual updates of it. A private foundation that is a grantor to a charitable organization in a group may desire similar assurance, to be certain that the grant constitutes a *qualifying distribution* (*see* Private Foundations, Ch. 6), is not an *expenditure responsibility grant* (*id*., Ch. 9), or is not otherwise a *taxable expenditure* (*id*.). To some extent, reliance on these individualized determination letters or rulings is possible (*id*., § 15.10). As discussed (*see* text accompanied by *supra* notes 226–228), ascertaining the public charity status of a charitable organization in a group can be difficult.

230. *See supra* note 200 and text accompanying it.

The genesis of this element of the doctrine is language in the federal tax regulations on the subject of feeder organizations.[231] There it is stated that, as an exception to these rules, a ''subsidiary'' of a tax-exempt organization can be exempt ''on the ground that its activities are an integral part of the activities of the parent organization.''[232] As an illustration, the regulations describe ''a subsidiary organization that is operated for the sole purpose of furnishing electric power used by its parent, a tax-exempt organization, in carrying out its educational activities.''[233] These regulations also state that an entity seeking tax exemption as an integral part of another entity cannot primarily be engaged in an activity that would generate more than insubstantial unrelated business income for the other entity.[234]

Because of recent developments in the healthcare field, the criteria for achieving tax exemption by reason of an affiliation with a charitable entity are in flux. The traditional view is that this aspect of the integral part doctrine applies where the activities of the organization whose tax status is being evaluated are carried on under the supervision or control of an exempt organization and could be carried on by the exempt ''parent'' organization without constituting an unrelated trade or business.[235] Interpretations along this line from the IRS include tax exemption for a trust existing solely as a repository of funds set aside by a nonprofit hospital for the payment of malpractice claims against the hospital and as the payor of those claims,[236] a corporation that published and sold law journals as an adjunct to a tax-exempt law school,[237] and a bookstore used almost exclusively by the faculty and students of a university with which it was associated.[238] This traditional explication of the doctrine is also found in the court cases. For example, one court ruled that a corporation operating a bookstore/restaurant that sold college texts, was wholly owned by a tax-exempt college, used college space without charge, served mostly faculty and students, and devoted its earnings to educational purposes, was tax-exempt because it ''obviously bears a close and intimate relationship to the

231. The feeder organization rule of IRC § 502 generally provides that an organization engaged in a trade or business for profit will be taxed even though it pays all of its profits to an exempt organization. Reg. § 1.502-1(b) states that, ''[i]n the case of an organization operated for the primary purpose of carrying on a trade or business for profit, exemption is not allowed . . . on the ground that all the profits of such organization are payable to one or more [exempt] organizations.'' *See*, in general, TAX-EXEMPT ORGANIZATIONS § 28.6.
232. Reg. § 1.502-1(b). *See also* Gen. Couns. Mem. 39830.
233. Reg. § 1.502-1(b).
234. *Id*.
235. E.g., *Geisinger Health Plan v. Commissioner*, 100 T.C. 394, 402 (1993), *aff'd*, 30 F.3d 494 (3d Cir. 1994).
236. Rev. Rul. 78-41, 1978-1 C.B. 148.
237. Rev. Rul. 63-235, 1963-2 C.B. 210.
238. Rev. Rul. 58-194, 1958-1 C.B. 240.

functioning of the [c]ollege itself.''[239] In general, a principal element leading to a finding that one organization functions as an integral part of another organization is the fact that the function of the integrated organization is ''essential'' to the operation of the larger organization and is an ''ordinary and proper'' function of the larger organization.[240]

The criteria associated with this doctrine may be in transition because, despite this regulation and a wealth of case law and rulings, a court decided that the law is not clear as to ''whether there are any other necessary qualifications'' surrounding the doctrine.[241] Indeed, the court also concluded that there is one additional criterion—and, ''[d]istilling . . . [this body of law] into a general rule,'' wrote that:

> [a] subsidiary that is not entitled to exempt status on its own may only receive such status as an integral part of its . . . [charitable] parent if (i) it is not carrying on a trade or business that would be an unrelated trade or business (that is, unrelated to exempt activities) if regularly carried on by the parent, and (ii) its relationship to its parent somehow enhances the subsidiary's own exempt character to the point that, when the boost provided by the parent is added to the contribution made by the subsidiary itself, the subsidiary would be entitled to . . . [tax - exempt, charitable] status.[242]

Applying this new ''boost'' principle, the court held that a health maintenance organization could not qualify for tax exemption on the ground that it is an integral part of a hospital system, because the plan did not receive any boost from its association with the system.[243] Noting that an entity's ''mere financing of the exempt purposes of a related organization does not constitute

239. *Squire v. Students Book Corp.*, 191 F.2d 1018, 1020 (9th Cir. 1951). *See also University of Maryland Physicians, P.A. v. Commissioner*, 41 T.C.M. 732 (1981); *University of Massachusetts Medical School Group Practice v. Commissioner*, 74 T.C. 1299 (1980); *B.H.W. Anesthesia Foundation, Inc. v. Commissioner*, 72 T.C. 681 (1979); *B.S.W. Group, Inc. v. Commissioner*, 70 T.C. 352 (1978); *Brundage v. Commissioner*, 54 T.C. 1468 (1970) (integral part doctrine applied in context of charitable contribution deduction).

240. E.g., *Schwarz v. United States*, 284 F. Supp. 792, 797 (U.S. Cust. Ct. 1968); *Matczak v. Secretary of Health, Education and Welfare*, 299 F. Supp. 409 (E.D.N.Y. 1969).

241. *Geisinger Health Plan v. Commissioner*, 30 F.3d 494 (3d Cir. 1994).

242. *Id*. at 501.

243. The court concluded that the association of the health maintenance organization with the other entities in the hospital system ''does nothing to increase the portion of the community for which . . . [the plan] promotes health—it serves no more people as a part of the [s]ystem than it would serve otherwise. It may contribute to the [s]ystem by providing more patients than the [s]ystem might otherwise have served, thus arguably allowing the [s]ystem to promote health among a broader segment of the community than could be served without it, but its provision of patients to the [s]ystem does not enhance its own promotion of health; the patients it provides—its subscribers—are the same patients it serves without its association with the [s]ystem. To the extent it promotes health among non- . . . [plan]-subscriber patients of the [s]ystem, it does so only because . . . [plan] subscribers' payments to the [s]ystem help finance the provision of health care to others'' (*id*. at 502).

furtherance of that organization's purpose so as to justify exemption,'' the court observed that ''it is apparent that . . . [the plan] merely seeks to 'piggyback' off of the other entities in the [s]ystem, taking on their charitable characteristics in an effort to gain exemption without demonstrating that it is rendered 'more charitable' by virtue of its association with them.''[244] Revisiting the prior case law, this court wrote that the electric company referenced in the tax regulations received a boost from its association with the educational institution, as did the bookstore and law journal organization. This new articulation of the integral part doctrine prevents ''an organization that is not entitled to an exemption on its own'' from becoming ''tax-exempt *merely* because it happens to be controlled by an organization that is itself exempt.''[245]

Other instances where this variant of the integral part doctrine has been applied have escaped the analysis of the ''boost'' principle court. One instance is the determination by the IRS that a vending machine management organization was an integral part of a tax-exempt university.[246] Another is an IRS ruling that an organization operating, for the convenience of the student body

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This court earlier held that this health maintenance organization could not qualify as a charitable entity on its own merits (*Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3d Cir. 1993) (*see* § 9.1).

244. *Id*. at 503.

245. *Id*. at 502 (emphasis by the court). When this court of appeals remanded the case to the U.S. Tax Court for decision as to application of the integral part doctrine, it said the ''integral part doctrine provides a means by which organizations may qualify for exemption vicariously through related organizations, as long as they are engaged in activities which would be exempt if the related organizations engaged in them, and as long as those activities are furthering the exempt purposes of the related organizations'' (*Geisinger Health Plan v. Commissioner*, 985 F.2d 1210, 1220 (3d Cir. 1993)). No mention was made of the ''boost'' principle. (Likewise, *Texas Learning Technology Group v. Commissioner*, 958 F.2d 122, 126 (5th Cir. 1992)). In its subsequent opinion, the appellate court dismissed its previous summary of the doctrine as simply ''dicta'' and pronounced that it is ''not bound by'' it (*Geisinger Health Plan v. Commissioner*, 30 F.3d 494, 499 (3d Cir. 1994)).

As to the prior law, one IRS ruling (Rev. Rul. 78-41, 1978-1 C.B. 148) did not comport with the boost theory, so the court elected to ''not rely on . . . [it] in our analysis'' (*Geisinger Health Plan v. Commissioner*, 30 F.3d 494, 502, note 8 (3d Cir. 1994)).

When the U.S. Tax Court considered this issue, it looked at whether the organization's overall functions were substantially related to the exempt function of its tax-exempt affiliates in the system; it stated that, if the organization's activities are conducted on a scale larger than is reasonably necessary to accomplish the purposes of the affiliates (see § 24.4(a), text accompanied by notes 126–133), the requisite substantial relationship would not be present (*Geisinger Health Plan v. Commissioner*, 100 T.C. 394, 406 (1993)). The court concluded that, because the health maintenance organization made sales to and provided services for individuals who are not patients of the exempt entities within the healthcare system, the organization's operations were not substantially related to the other components of the system and thus it could not be considered an integral part of the system (*id*. at 406–407). On appeal, this unrelated business argument was not reviewed, because the appellate court held that, inasmuch as the boost principle of the doctrine was not satisfied, there was no need to assess the other prong of this integral part test.

246. Rev. Rul. 81-19, 1981-1 C.B. 353.

and faculty,[247] a book and supply store, and a cafeteria and restaurant, on the campus of a tax-exempt university, qualified as a charitable and/or educational organization.[248] In this latter ruling, the IRS wrote that, because the organization ''is performing functions for their [students' and faculty members'] benefit and convenience and in furtherance of the university's educational program, it is for all intents and purposes an integral part of the university.''[249] In still another instance, when an organization formed and controlled by a tax-exempt conference of churches borrowed funds from individuals and made mortgage loans at less than the commercial rate of interest to affiliated churches to finance the construction of church buildings, it was held to qualify as an integral part of the parent organization.[250]

A court subsequently held, without reference to the ''boost'' principle, that two organizations did not qualify for tax exemption on the basis of the integral part doctrine; indeed, the entities were dismissed as ''appendages rather than integral parts'' and ''superfluous corporate shells that make no cognizable contribution'' to the ostensibly benefited exempt organization's purposes.[251]

(b) Divisions

An organization may be viewed as a composite of integrated parts—being ''composed of constituent parts making a whole.''[252] In comparable instances, the law regards an item of property as an integral part of a larger property or process; for example, bottles and cartons are an integral part of manufactured beer for purposes of state use tax exemptions,[253] and executed contracts are an integral part of a baseball team for purposes of defining the team's ''raw materials.''[254] The *fragmentation rule* utilized in the unrelated business setting is predicated on this view.[255]

A tax-exempt organization may have component entities that are not separate organizations (although they may appear to be) and thus are ''exempt'' from tax because of the tax exemption of the host organization. For example, a tax-exempt hospital may have research funds, a tax-exempt charitable organization may have an endowment fund, and a tax-exempt university may have scholarship funds; these funds may have separate names and be recipients of contributions made in those names. In reality, these component entities may be little more than one of several accounts carried on a tax-exempt

247. *See* § 24.17, text accompanied by notes 360–364.
248. Rev. Rul. 58-194, 1958-1 C.B. 240.
249. *Id*. at 242.
250. Rev. Rul. 75-282, 1975-2 C.B. 201.
251. *University Medical Resident Services, P.C. v. Commissioner*, 71 T.C.M. 3130, 3131–35 (1996).
252. *Application of Larson*, 340 F.2d 965, 967 (U.S. Ct. Cust. Pat. App. 1965).
253. *Zoller Brewing Co. v. State Tax Commission*, 5 N.W.2d 643 (Sup. Ct. Ia. 1942).
254. *Hollywood Baseball Ass'n v. Commissioner*, 423 F.2d 494 (9th Cir. 1970), *cert. denied*, 400 U.S. 848 (1970).
255. *See* § 24.2(a), text accompanied by notes 32–38.

organization's financial records. By analogy to the terminology in the for-profit setting, these component entities are akin to *divisions* (as is the case with the ''departments'' of a hospital or the ''schools'' of a university).[256] The principal distinction from a tax standpoint is that the entity that is an integral part of a tax-exempt organization as a division is itself tax-exempt solely by virtue of the exemption of the home organization, while the tax exemption of a subsidiary must be obtained by reason of the other definition of the integral part doctrine or on the merits of its characteristics.[257]

This application of the integral part doctrine in the tax-exempt organizations context is infrequent. Examples include recognition of a high school as an integral part of a county's school system[258] and of schools that do not have a separate legal existence as an integral part of a church or a convention or association of churches.[259]

§ 34.7 PROCEDURE WHERE DETERMINATION IS ADVERSE

The filing of an application for recognition of tax exemption with the IRS can, of course, lead to the issuance of an initial adverse determination. In this instance, or when a letter proposing revocation or modification of tax-exempt status is issued,[260] the Exempt Organizations Determinations office will advise the organization of its opportunity to appeal the determination by requesting Appeals Office consideration. To initiate an appeal, the organization must submit to the IRS, within 30 days from the date of the letter, a statement of the facts, law, and arguments in support of its position. At this time, the organization must also state whether it wishes a conference with the Appeals Office.[261]

On receipt of an organization's request for Appeals Office consideration, the EO Determinations office will review the appeal and (assuming that office maintains its position) forward the request and case to the Appeals Office.[262] Any determination letter that is issued on the basis of technical advice from EO Technical, however, may not be appealed to an appeals office as regards issues that were the subject of the technical advice.[263] The Appeals Office,

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256. By contrast, the organizations that are tax-exempt by reason of the other application of the integral part doctrine (*see* § 34.6(a)) or the group exemption procedures (*see* § 34.5) are comparable to a for-profit organization's subsidiaries. A somewhat similar body of tax law is that concerning the supporting organization (*see* § 5.4).
257. The *division* aspect of the doctrine assumes that the attributes of this type of component entity do not cause it to be considered a separate organization; for example, one nonprofit corporation cannot be a ''division'' of another nonprofit corporation.
258. *Nellie Callahan Scholarship Fund v. Commissioner*, 73 T.C. 626 (1980).
259. *St. Martin Evangelical Lutheran Church v. South Dakota*, 451 U.S. 772 (1981).
260. Reg. § 1.601.201(n)(6).
261. Rev. Proc. 2008-9, 2008-2 I.R.B. 258 § 7.02.
262. *Id*. at § 7.05.
263. *Id*. at § 7.02.

after considering the organization's appeal and any additional information developed in conference, will advise the organization of its decision and issue the appropriate determination letter to the organization.[264]

If the Appeals Office believes that a tax exemption or private foundation status issue is not covered by published precedent or that there is a lack of uniformity, the Appeals Office must request technical advice from EO Technical.[265] If an organization submits a protest of a proposed adverse exempt status ruling, EO Technical will review the protest statement. If that office becomes convinced that the organization qualifies for exemption, a favorable ruling will be issued. Otherwise, a final adverse ruling will be issued, unless a conference was requested, in which case a final adverse ruling or a favorable exempts status ruling will be issued by EO Technical.[266]

A determination letter or ruling recognizing tax exemption may be modified or revoked by (1) notice to the organization involved, (2) enactment of legislation, (3) ratification of a tax treaty, (4) a decision by the U.S. Supreme Court, (5) issuance of temporary or final regulations, or (6) issuance of a revenue ruling, revenue procedure, or other statement published in the *Internal Revenue Bulletin*. The modification or revocation may be retroactive if the organization omitted or misstated a material fact, or operated in a manner materially different from that underlying the ruling. Where a material change inconsistent with tax exemption occurs in the character, purpose, or method of operation of an organization, modification or revocation of the determination letter or ruling ordinarily will take effect as of the date of the material change.[267]

Once the IRS has acted to revoke the tax exemption of an organization, it will expect the entity to begin paying income taxes (unless the organization can qualify under another category of tax exemption or it changes the facts to enable it to regain recognition of exemption). Should the organization not do so, however, the IRS may be expected to commence proceedings to assess and collect the tax due. This activity is commenced by the mailing to the organization of a *statutory notice of deficiency*. This the IRS is authorized to do following a determination that there is a tax deficiency.[268] Because there cannot be general income tax liability for a tax-exempt organization, however, it is essential to the government's efforts to collect the tax that the statutory notice of deficiency be preceded by a valid letter of revocation of tax-exempt status. To have this letter, the IRS is required to act in conformity with certain procedures[269] and at least generally apprise the organization of the basis for the revocation. The revocation itself, however, must be in conformity with all requirements of law, so that if, for example, the grounds on which

264. *Id*. at § 7.06.
265. *Id*.
266. *Id*. § 7.07.
267. *Id*.
268. IRC § 6212.
269. IRM 7(10)(12).

the revocation was based were erroneous, the revocation is not proper.[270] Likewise, if the letter of revocation was prompted by political or similar considerations that demonstrate lack of objectivity by the IRS, the revocation becomes null and void.[271] Thus, a letter of revocation can be shown to be void *ab initio* because of the considerations governing its issuance. Subsequent actions by the IRS indicating a continuing recognition of tax-exempt status can operate to make a prior revocation of tax exemption nugatory. In either event, because the letter of revocation is not valid, the tax exemption has not been properly revoked, meaning that any notice of deficiency based on the letter of revocation lacks any force and effect.[272]

Other procedures have been promulgated for appeals from the attempted imposition of certain taxes on most tax-exempt organizations and on certain individuals under the private foundation rules. These taxes include the unrelated income tax,[273] the excise taxes pertaining to private foundations,[274] the lobbying activities tax,[275] and the political activities tax.[276]

Once all administrative remedies are exhausted, if a tax-exempt organization desires to continue to contest a denial, modification, or revocation of tax-exempt status, recourse may be had to the courts. There is a special declaratory judgment procedure by which jurisdiction over tax-exempt organization cases involving charitable entities is vested in the U.S. District Court for the District of Columbia, the U.S. Court of Federal Claims, and the U.S. Tax Court.[277] These cases, and other cases concerning other categories of tax-exempt organizations and other exempt organizations law issues (such as those involving the unrelated business income rules), can be addressed in the federal court system by means of the conventional tax litigation procedures.[278]

270. *A. Duda & Sons Cooperative Ass'n v. United States*, 504 F.2d 970, 975 (5th Cir. 1974).
271. E.g., *Center on Corporate Responsibility, Inc. v. Shultz*, 368 F. Supp. 863, 871–873 (D.D.C. 1973).
272. *See Church of Scientology of California v. Commissioner*, 83 T.C. 381 (1984), *aff'd*, 823 F.2d 1310 (9th Cir. 1987).
273. *See* Chapter 24.
274. *See* Chapter 5.
275. *See* § 7.1(g), text accompanied by notes 87–89.
276. *See* § 7.4(f), text accompanied by notes 172–175.
277. IRC § 7428. *See*, in general, TAX-EXEMPT ORGANIZATIONS § 26.2(b).
278. *See* TAX-EXEMPT ORGANIZATIONS § 26.2(c).

CHAPTER THIRTY-FIVE

Maintenance of Tax-Exempt Status and Avoidance of Penalties

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Once a nonprofit healthcare organization achieves tax-exempt status, whether or not as the result of recognition of it by the IRS,[1] that status may be maintained as long as the organization does not materially change its character, purposes, or methods of operation. An organization's tax-exempt status may also be affected by a subsequent change in the law. In addition, a tax-exempt organization most likely has an obligation to report annually to the IRS.

§ 35.1 MATERIAL CHANGES

A healthcare organization's recognition of tax-exempt status remains in effect as long as there are no substantial (material) changes in the organization's character, purposes, or methods of operation.[2] The managers of and advisors to an organization have the burden of determining whether a change of this nature is *material* or merely *immaterial*. A material change should be communicated to the IRS as soon as possible after the change is made or becomes effective.[3] Other changes should be reflected in due course in the organization's annual information return.[4]

A material change in an organization's character, purposes, or methods of operation may result in modification or revocation of the organization's tax-exempt status.[5] A change in the law may also afford the IRS a basis for modifying or revoking an organization's tax-exempt status.[6]

Occasionally, the IRS attempts to make a revocation of tax-exempt status operate retroactively, pursuant to its discretion to do so.[7] A revocation of tax exemption may be retroactive in three instances: where the organization (1) omitted or misstated a material fact in the process of acquiring recognition of tax exemption, (2) operated in a manner materially different from that originally represented to the IRS, and/or (3) engaged in a prohibited transaction.[8] For this purpose, a *prohibited transaction* occurs when an organization enters into the process of pursuing tax exemption in order to divert substantial corpus or

1. *See* Chapter 34, text accompanied by notes 14–16.
2. Reg. §§ 1.501(a)-1(a)(2), 601.201(n)(3)(ii). *See also* Chapter 34, text accompanied by notes 11–12.
3. This requirement is not explicitly stated in, but may be inferred from, Reg. § 1.501(a)-1(a)(2), where it is provided that an organization ''may rely upon'' a determination as to recognition of exempt status as long as there are no substantial changes. Where the matter is of considerable consequence, an organization may be best advised to secure a determination letter on the point before effecting the change (*see* Chapter 34, note 13).
4. E.g., Form 990 (2008), Part III, question 3.
5. Rev. Proc. 2008-9, 2008-2 I.R.B. 258.
6. An example of a law change that is working to preclude tax exemption for organizations that previously would have qualified is the enactment of IRC § 501(m) (*see* § 9.4).
7. IRC § 7805.
8. Reg. § 601.201(n)(6)(i).

income from its exempt purpose.[9] Retroactive revocation of tax exemption is subject to judicial review, where a court may uphold retroactivity[10] or not.[11]

Specifically in the healthcare setting, retroactive revocation occurred with respect to a previously tax-exempt hospital. The institution sold a facility to a group of insiders for an amount that the IRS determined was substantially less than its fair market value, thus contravening the private inurement doctrine.[12] An audit of the hospital occurred after the insiders sold the facility to another charitable organization for a substantial profit. This caused the IRS to revoke the hospital's tax-exempt status retroactively to the date the facility was sold.[13]

The facts and circumstances of a particular case determine whether, in retroactively revoking an organization's tax exemption, the IRS abused its discretion and thus the government is to be estopped from causing a revocation to be retroactive.[14] Retroactive revocation of tax exemption can produce complex and harsh results, particularly where the period embraced by the revocation covers several years.[15] Comparable adverse tax consequences are likely to result under state law. Also, for charitable organizations, retroactive revocation of tax exemption would operate to likewise retroactively revoke the organization's eligibility to receive deductible charitable contributions, although donors may be protected from loss of charitable donee status where they had no knowledge of the circumstances giving rise to the retroactive revocation.[16]

A line of law holds that the IRS has the power to retroactively revoke a determination letter or a ruling it has issued, if the determination becomes

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9. Reg. § 601.201(n)(6)(vii).
10. E.g., *The Incorporated Trustees of the Gospel Worker Society v. United States*, 510 F. Supp. 374 (D.D.C. 1981), *aff'd*, 672 F.2d 894 (D.C. Cir. 1981), *cert. denied*, 456 U.S. 944 (1982); *Prince Edward School Foundation v. United States*, 80-1 U.S.T.C. (CCH) ¶ 9295 (D.D.C. 1979), *aff'd in unpub. opinion* (D.C. Cir. 1980), *cert. denied*, 450 U.S. 944 (1981).

    In one case, the IRS recognized the tax-exempt status of an organization in 1969, revoked the determination letter in 1990, and caused the revocation to be retroactive to 1984 (*United Cancer Council, Inc. v. Commissioner*, 100 T.C. 162 (1993)).
11. E.g., *Freedom Church of Revelation v. United States*, 588 F. Supp. 693 (D.D.C. 1984); *Presbyterian and Reformed Publishing Co. v. Commissioner*, 743 F.2d 148 (3d Cir. 1984), *rev'g* 79 T.C. 1070 (1982).
12. *See* Chapter 4.
13. Priv. Ltr. Rul. 9130002. *See also Anclote Psychiatric Center, Inc. v. Commissioner*, 76 T.C.M. 175 (1998).
14. E.g., *Lesavoy Foundation v. Commissioner*, 238 F.2d 589 (3d Cir. 1957), *rev'g* 25 T.C. 924 (1956) (where the court held that the IRS abused its discretion in this regard where those in charge of the organization "committed no fraud and made no misstatement" (743 F.2d at 594)).
15. The federal tax consequences of retroactive revocation of tax-exempt status of public charities is the subject of TAX-EXEMPT ORGANIZATIONS § 26.4.
16. The subject of donors' and grantors' reliance on an IRS determination letter or ruling as to recognition of an organization's tax-exempt status is the subject of TAX-EXEMPT ORGANIZATIONS, § 17.8.

contrary to law.[17] The cases, however, involve situations where the ''change in the law'' was made by Congress in revising a statute.[18] Also, retroactivity of a tax exemption may occur where the law was clear at the time the ruling was issued and the issuance was an error.[19]

§ 35.2 CHANGES IN FORM

A change in organizational form is a material change in an organization's character;[20] a new legal entity is created. If the successor entity is a charitable organization,[21] an employee benefit organization,[22] or otherwise an entity desiring recognition of tax-exempt status,[23] an application for recognition of the exemption of the successor entity must be filed with the IRS, even though the organization's purposes, methods of operation, sources of support, and method of accounting otherwise remain the same.[24] In each of the following changes in the structures of nonprofit organizations, a new application for recognition of tax exemption (where required or wanted) is warranted: (1) conversion of a trust to a corporation; (2) conversion of an unincorporated association to a corporation; (3) reincorporation of an organization, incorporated under state law, by an act of Congress; or (4) reincorporation of an organization, incorporated under the laws of one state, under the laws of another state.[25] This determination has been endorsed by a court.[26] (This listing assumes, of course, that both entities are nonprofit in nature and otherwise eligible for tax exemption.)

Absent a change in the law[27] or in the rulings policy of the IRS, where a change in form is the only material change, the tax-exempt status of the predecessor entity will, in effect, be transmitted to the successor entity. If the predecessor is a charitable organization but lacks a determination letter or ruling from the IRS to that effect, the organization is treated as a charitable

17. E.g., *Dixon v. United States*, 381 U.S. 68 (1965).
18. E.g., *Bornstein v. United States*, 345 F.2d 558 (Ct. Cl. 1965) (where a ruling was issued one month after a statute was enacted, the matter was reconsidered months later, and the ruling was thereafter retroactively revoked).
19. E.g., *Automobile Club of Michigan v. Commissioner*, 353 U.S. 180 (1957), *aff'g* 230 F.2d 585 (6th Cir. 1956), *aff'g* 20 T.C. 1033 (1955).
20. *See* text accompanied by *supra* note 2.
21. IRC § 501(c)(3).
22. IRC § 505(c)(1).
23. *See* § 34.1, text accompanied by note 25.
24. Rev. Rul. 67-390, 1967-2 C.B. 179.
25. These requirements presumably also apply where a corporation converts to a trust or unincorporated association.
26. *American New Covenant Church v. Commissioner*, 74 T.C. 293 (1980) (where a successor charitable organization failed to file an application for recognition of tax exemption and thus could not avail itself of the declaratory judgment procedure.
27. *See supra* note 6.

entity only as of the date of formation of the successor entity (assuming the determination is timely filed[28]).[29]

It should not be assumed, however, that the tax status of a predecessor entity will automatically be transmitted to a successor entity, particularly where that successor entity is to be a charitable one. The policies and views of the IRS may change, and the IRS may deny recognition of tax exemption to an organization even though it granted recognition of tax exemption to a predecessor organization and the material facts did not differ.[30]

A charitable organization may have its non-private-foundation status predicated on classification as a publicly supported organization, which requires a history of required financial support,[31] and change form. Although the form change would require a new application for recognition of tax exemption, the law allows, where certain requirements are met, the financial history of the predecessor entity to be used in establishing a public support record for the successor entity.[32]

If a tax-exempt organization converts to a taxable entity,[33] the termination of exempt status ordinarily is operative prospectively; retroactive loss of exemption would occur only if there had been a material misrepresentation of fact or material difference in actual operation.[34]

§ 35.3 ANNUAL REPORTING REQUIREMENTS

Nearly every organization that is exempt from federal income taxation must file an annual information return.[35] This filing requirement is thus applicable to almost all healthcare organizations. For these organizations, the annual return form usually is Form 990.[36]

The annual information return must state specifically the items of gross income, receipts and disbursements, and other information, and the filing organization must keep appropriate records, render under-oath statements, make other returns, and comply with other requirements, as the tax regulations may prescribe.[37] Generally, an organization must file an annual information return regardless of whether it is chartered by, or affiliated or associated with, any central, parent, or other organization.[38]

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28. *See* 34.1(c).
29. Rev. Rul. 77-469, 1977-2 C.B. 196; Rev. Rul. 77-208, 1977-1 C.B. 153.
30. E.g., *MIB, Inc. v. Commissioner*, 734 F.2d 71 (1st Cir. 1984); *National Right to Work Legal Defense and Education Foundation, Inc. v. United States*, 487 F. Supp. 801 (E.D.N.C. 1979).
31. *See* §§ 5.2 and 5.3.
32. Rev. Rul. 73-422, 1973-2 C.B. 70, discussed in § 34.4, text accompanied by note 194.
33. *See* § 21.3.
34. Priv. Ltr. Rul. 8446047.
35. IRC § 6033(a)(1); Reg. § 1.6033-2(a)(1).
36. Form 990 is published annually by the IRS. Charitable organizations that are private foundations (*see* § 5.9) file Form 990-PF.
37. IRC § 6033(a)(1); Reg. § 1.6033-2.
38. Reg. § 1.6033-2(a)(1). As to central organizations, *see* § 34.5.

The annual information return filed by tax-exempt healthcare organizations is no longer merely akin to a taxpayer's tax return, where nearly all of the information reported to the IRS is financial. Today, with the addition of substantial factual information that is required to be furnished to the IRS, the complete and accurate preparation and filing of an annual information return by an exempt healthcare organization is in the nature of a ''self-audit'' of the entity, with an opportunity to affirmatively state its program accomplishments.[39]

(a) Annual Information and Other Returns

The annual information returns filed by tax-exempt charitable healthcare organizations are required, by statute, to include:

1. The organization's gross income for the year
2. Expenses attributable to that income and incurred within the year
3. Disbursements within the year for its program (tax-exempt) purposes[40]
4. A balance sheet showing its assets, liabilities, and net worth as of the beginning of the year
5. The total of the contributions received by it during the year, and the names and addresses of all substantial contributors[41]
6. The names and addresses of its managers[42] and highly compensated employees

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39. *See* § 35.4(b)(ii). This aspect of Form 990 becomes even more compelling in light of the public accessibility of the return (*see* § 35.5(a)).

The Office of Legal and Regulatory affairs of the American Hospital Association published a report in 1991 on its review of the annual information returns of a group of nongovernmental nonprofit hospitals. The analysis found (1) that the returns rarely included any information about the hospitals' community benefit programs; (2) a lack of consistency in allocating expenses between program, management and general, and fundraising; (3) minimal disclosure of program service accomplishments; (4) lack of mention of donated services and materials; (5) no consistency in the preparation of the analysis of income-producing activities; (6) minimal and/or incorrect disclosures of the relationship of activities to the accomplishment of exempt purposes; (7) that some of the returns were technically incomplete; and (8) a large number of the returns indicated that the hospitals did not receive any gross unrelated business income.

40. *See* § 35.4(b)(ii).
41. A *substantial contributor* generally is a person who contributed or bequeathed an aggregate amount of more than $5,000 to a charitable organization, where that amount is more than 2 percent of the total contributions and bequests received by the organization before the close of the tax year in which the contribution or bequest was received by the organization from that person (IRC § 507(d)(2)(A)). *See*, in general, Tax-Exempt Organizations, § 12.2(a).
42. The *manager* of a tax-exempt organization is an officer, director, or trustee of the organization, or an individual having powers or responsibilities similar to an officer, director, or trustee (IRC § 4946(b)(1)). *See*, in general, Tax-Exempt Organizations, §§ 12.2(b), 21.3.

7. The compensation and other payments made during the year to each of its managers and highly compensated employees
8. Certain information concerning lobbying activities by those organizations that have elected to come within the expenditure test[43]
9. Information with respect to direct or indirect transfers to, and other direct or indirect transactions and relationships with, other tax-exempt organizations (other than charitable ones), including political organizations[44,45]

(i) Form 990. As noted (and as the nine statutory requirements reflect), the general annual information return for healthcare (and other) tax-exempt organizations (Form 990) originally was a return containing mostly financial information. This return has expanded substantially over the years (at the initiative of the IRS, rather than by statutory mandate), with the most dramatic change occurring in 2007.[46]

Earlier, note was made of the fact that today's annual information return is reflective of an exempt organization's self-audit. No portion of the return gives more evidence of this observation than the element concerning revenue-producing activities. The reporting exempt healthcare organization is expected to inventory each of its sources of revenue (including program service revenues separated by discrete activity, investment income, and special fundraising events). These items of revenue must be differentiated as related income and unrelated income.

In determining whether an activity of a tax-exempt healthcare organization is a *business*, the IRS and the courts look to the presence or absence of a profit motive.[47] An activity that is not conducted with the requisite profit motive cannot be, for these purposes, a *business*. (A consequence of this is that any net losses from this type of unrelated activity cannot be offset against any net gains from an unrelated business undertaking.[48])

(ii) Form 990-EZ. To alleviate the annual reporting burden for smaller tax-exempt organizations, the IRS promulgated a much less extensive annual information return, the two-page Form 990-EZ. This return may be used by tax-exempt healthcare (and other) tax-exempt organizations that have gross receipts that are less than $100,000 and total assets that are less than $250,000 in value at the end of the reporting year.

An organization can use this annual information return in any year in which it meets the two criteria, even though it was and/or is required to file a

43. *See* § 7.1, text accompanied by notes 7–11.
44. *See* Chapter 7.
45. IRC § 6033(b); Reg. § 1.6033-2(a)(2).
46. *See* § 35.4.
47. *See* § 24.2, text accompanied by notes 40–46.
48. *See* text accompanied by *infra* note 96.

Form 990 in other years. A charitable organization filing a Form 990-EZ must also file a Schedule A (see above).

(iii) Form 990-T. Revenue and expenses associated with unrelated business activity by a tax-exempt healthcare organization are reported to the IRS.[49] An exempt organization with unrelated business taxable income must file, in addition to an annual information return, an annual tax return (Form 990-T). On this separate return, the source (or sources) of unrelated business income is reported, the gross revenues and expenses are generally combined (netted), and any tax is computed.[50] As noted, tax-exempt organizations affiliated in a group exemption arrangement may file their unrelated business income tax returns on a consolidated basis.[51]

All forms of unrelated trade or business gross income must be reported, along with associated deductions.[52] Separate schedules pertain to rental income,[53] unrelated debt-financed income,[54] income (other than dividends) from controlled organizations,[55] advertising income,[56] and other exploited exempt activity income.[57]

(iv) Due Dates. The annual information returns, and any unrelated business income tax returns, to be filed by a tax-exempt healthcare (or other) organization are due on or before the fifteenth day of the fifth month following the close of the tax year.[58] Thus, the return(s) for a calendar-year organization should be filed (other than when extensions are obtained) by May 15 of each year.[59] These returns are filed with the IRS service center in Ogden, Utah.[60]

The filing date for an annual information return may fall due while the organization's application for recognition of tax-exempt status is pending with the IRS. In that instance, the organization should file the information return

49. IRC § 6012(a)(2) and (4); Reg. §§ 1.6012-2(e), 1.6012-3(a(5), 1.6033-2(i). *See*, in general, Chapter 24.
50. Reg. § 1.6012-2(e).
51. *See* § 34.5, text accompanied by notes 221–223.
52. Form 990-T, Parts I and II.
53. Form 990-T, Schedule C. *See* § 24.17(b)(ii).
54. Form 990-T, Schedule E. *See* § 24.20.
55. Form 990-T, Schedule G. *See* § 24.19.
56. Form 990-T, Schedule I.
57. Form 990-T, Schedule H. *See* § 24.4(d).
58. IRC § 6072(e); Reg. § 1.6033-2(e).
59. The IRS, on December 6, 2004, issued regulations in final form (T.D. 9163) providing an automatic three-month extension of time to file exempt organization returns, such as the Form 990 series (Reg. § 1.6081-9). An explanation for the extension and a signature are no longer required; the application for the extension is Form 8868. The IRS attended to a minor controversy by making it clear that a corporation required to file an unrelated business income tax return (Form 990-T) is allowed an automatic six-month extension of time to file the return if it timely files the application.
60. Ann. 96-63, 1996-29 I.R.B. 18.

(rather than a tax return) and indicate on it that the application for recognition is pending.[61]

(v) Penalties. Failure to timely file the appropriate annual information return, failure to include any information required to be shown on the return, or failure to show the correction information, absent reasonable cause, can give rise to a $20 penalty, payable by the organization, for each day the failure continues, with a maximum penalty for any one return not to exceed the lesser of $10,000 or 5 percent of the gross receipts of the organization for one year.[62] An additional penalty may be imposed, at the same rate and maximum of $10,000, on the individual(s) responsible for the failure to file, absent reasonable cause, where the return remains unfiled following demand for it by the IRS.[63] There is a much larger penalty on organizations having gross receipts in excess of $1 million for a year; in this circumstance, the per-day penalty is $100 and the maximum penalty is $50,000.[64] An addition to tax for failure to timely file a federal tax return, including an unrelated business income tax return, may also be imposed.[65]

(vi) Assessments. The IRS generally must assess any tax within three years of the due date of the return involved or the date on which the return is actually filed, whichever is later.[66] A six-year statute of limitations applies, however, if an excise tax return ''omits an amount of such tax properly includible thereon which exceeds 25 percent of the amount of such tax reported thereon''; this extended period does not apply in certain cases where there is adequate disclosure in the return to the IRS.[67]

It is the practice of the IRS to omit from its listing of organizations to which deductible gifts may be made[68] those organizations that fail to establish their nonfiling status with the IRS. This practice was upheld by the Chief Counsel of the IRS.[69]

(b) Exceptions to Reporting Requirements

The requirement of filing an annual information return does not apply to several categories of tax-exempt organizations. These exceptions, however, have limited applicability in the healthcare context.

61. Reg. § 1.6033-2(c).
62. IRC § 6652(c)(1)(A).
63. IRC § 6652(c)(1)(B); Reg. § 301.6652-2.
64. IRC § 6652(c)(1)(A), last sentence.
65. IRC § 6651(a)(1).
66. IRC § 6501(a).
67. IRC § 6501(e)(3).
68. ''Cumulative List of Organizations Described in Section 170(c) of the Internal Revenue Code,'' IRS Pub. No. 78.
69. Gen. Couns. Mem. 39389.

The requirement of filing an annual information return is inapplicable to tax-exempt organizations (other than private foundations) the gross receipts of which in each tax year are normally not more than $25,000.[70] For purposes of this threshold, a tax-exempt organization is exempt from filing an annual information return where (1) during its first year, it received (including pledges) gross receipts of $37,500 or less; (2) during a period of more than one year of its existence and less than three years, it received, as an average of gross receipts experienced in the first two tax years, gross receipts of $30,000 or less; and (3) during its existence of more than three years, it received, as an average of gross receipts, $25,000 or less.[71]

Other exceptions from this filing requirement are for churches (including an interchurch organization of local units of a church), their integrated auxiliaries, and conventions or associations of churches,[72] the exclusively religious activities of any religious order,[73] and certain other organizations that the IRS has excepted from the filing requirement.[74]

(c) Disregarded Entities

The IRS advised that certain business organizations, such as single-member limited liability companies, may be treated as disregarded entities for federal tax purposes under the final ''check the box'' regulations.[75] In this regard, the IRS stated that tax-exempt organizations that are owners of disregarded entities must include the financial information pertaining to the disregarded entity in their own annual information returns (e.g., Forms 990, 990-EZ, 990-T, and 990-PF). The announcement also served as notification that the instructions to these forms will be updated to reflect this requirement.

(d) Electronic Filing

The IRS is required to prescribe regulations providing the standards for determining which returns must be filed on magnetic media or in other machine-readable form: the agency is not authorized to require electronic filing of returns by individuals, estates, and trusts.[76] Also, the agency may not require any person to file returns on magnetic media unless the person is

70. Ann. 82-88, 1982-25 I.R.B. 23. This exception was created by the IRS in exercise of its authority to exempt organizations from filing annual information returns where a filing of these returns by them is not necessary to the efficient administration of the internal revenue laws (IRC § 6033(a)(2)(B)). By statute, however, this exception threshold is $5,000 (IRC § 6033(a)(2)(A)(ii)).
71. Ann. 82-88, 1982-25 I.R.B. 23.
72. IRC § 6033(a)(2)(A)(i).
73. IRC § 6033(a)(2)(A)(iii).
74. IRC § 6033(a)(2)(B); Reg. § 1.6033-2(g)(1).
75. *See* Ann. 99-102, 1999-43 I.R.B. 545; *see*, generally, Reg. § 331.7701.
76. IRC § 6011(e)(1).

required to file at least 250 returns during the calendar year.[77] Further, the IRS must, in this regard, take into account the ability of organizations to comply at reasonable cost with the requirements of the regulations.[78]

The IRS announced, in early 2004, in introducing Modernized e-File, that tax-exempt organizations have the option of filing their annual information returns electronically.[79] This new electronic filing system was developed and delivered through the IRS Business Systems Modernization program. The system provides exempt organizations with the option of transmitting return data using an Internet connection in place of a modem. Organizations (and their professional return preparers) can prepare the returns using IRS-approved software. The returns are transmitted to the agency through a secure Internet site accessible only to registered users.

The IRS has worked with organizations and tax practitioners in the design of Modernized e-File to minimize the burdens on filers and tax professionals. The agency has determined that tax-exempt organizations will be able to convert to electronic filing at a reasonable cost, and that the benefits to the IRS and filers substantially outweigh the costs.

The IRS, on January 11, 2005, issued temporary and proposed regulations that require large tax-exempt organizations to electronically file their annual information returns beginning in 2006.[80] The basic rules[81] are as follows:

- Tax-exempt organizations with assets of at least $100 million that are required to file annual information returns must file them electronically beginning with tax years ending on or after December 31, 2005.
- Tax-exempt organizations with assets of at least $10 million that are required to file annual information returns must file them electronically beginning with tax years ending on or after December 31, 2006.
- Private foundations and split-interest charitable trusts (irrespective of asset size) that are required to file annual information returns must file them electronically beginning with tax years ending on or after December 31, 2006.

The determination as to whether an entity is required to file at least 250 returns is made by aggregating all returns that the entity is required to file in the course of the calendar year involved. For exempt organizations, this includes the annual information return, other information returns, excise tax returns, and employment tax returns.

The IRS can waive the electronic filing requirement where a tax-exempt organization is able to demonstrate that ''undue economic hardship'' would

77. IRC § 6011(e)(2)(A).
78. IRC § 6011(e)(2)(B).
79. IR-2004-43.
80. T.D. 9175, REG-130671-04.
81. Reg. §§ 1.6033-4 T, 301.6033-4 T.

result if the entity were required to file its return electronically. Approval or denial of requests for these waivers will be based on each organization's "particular facts and circumstances," with emphasis on the "incremental costs to the filer" and the existence of "technology issues" that prevent the organization from filing its return electronically. An IRS notice inventories the items of information that must be contained in a written request for a waiver.[82]

(e) Small Organizations Notification Requirement

Tax-exempt organizations that are exempt from the requirement of filing an annual information return by reason of having annual gross receipts that are normally less than $25,000[83] must furnish the IRS, annually and in electronic form, a notice containing the legal name of the organization, any name under which the organization operates or does business, the organization's mailing address and any web site address, the organization's taxpayer identification number, the name and address of a principal officer, and evidence of the organization's continuing basis for its exemption from the annual filing requirement.[84] Should the organization terminate its existence, notice of the termination must be provided to the IRS.[85]

(f) Filing Requirements and Tax-Exempt Status

If a tax-exempt organization that is required to file a notice with the IRS in lieu of an annual information return[86] fails to provide the notice for three consecutive years, the organization's exempt status is revoked by operation of law.[87] If an exempt organization that is required to file an annual information return[88] fails to file the return for three consecutive years, the organization's exempt status is revoked by operation of law.[89] If an exempt organization fails to meet its filing obligation to the IRS for three consecutive years in instances where the organization is subject to the annual information return filing requirement in one or more years during a three-year period and also is subject to the notice requirement for one or more years during the same three-year period, the organization's exempt status is revoked by operation of law.[90]

A revocation under these rules is effective from the date the IRS determined was the last day the organization could have timely filed the third required

82. Notice 2005-88, 2005-48 I.R.B. 1060.
83. *See* § 35.3(b), text accompanied by *supra* note 70.
84. IRC § 6033(i)(1).
85. IRC § 6033(i)(2).
86. *See* § 35.3(e).
87. IRC § 6033(j)(1).
88. *See* § 35.3(a).
89. IRC § 6033(j)(1).
90. *Id*.

annual information return or notice. To again be recognized as tax-exempt, the organization must apply to the IRS for recognition of exemption irrespective of whether the organization was required to file an application for recognition of exemption in order to acquire exemption originally.[91] If, on application for recognition of exemption after a revocation under these rules, the organization demonstrates to the satisfaction of the IRS reasonable cause for failing to file the required notices and/or returns, the organization's exempt status may, in the discretion of the IRS, be reinstated retroactively to the date of revocation.[92]

§ 35.4 REDESIGNED ANNUAL INFORMATION RETURN

The IRS, on June 14, 2007, released for public comment a discussion draft of a substantially revamped Form 990 (the annual information return filed with the IRS by most tax-exempt organizations).[93] The agency characterized this as a ''significant redesign'' of the annual return, which has not been substantially revised since 1979.[94] The IRS, on December 20, 2007, released the final version of the annual information return for the 2008 tax year (returns to be filed in 2009).[95]

(a) IRS Guiding Principles

The IRS said that its retooling of this annual information return was based on these guiding principles:

- Enhancing transparency by providing the IRS and the public with a realistic picture of the filing organization and its operations, along with the basis for comparing the organization to similar organizations.

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91. IRC § 6033(j)(2). *See* §§ 34.1.
92. IRC § 6033(j)(3).
93. IR-2007-117.
94. The then-Acting Commissioner of Internal Revenue, on the occasion of the unveiling of the draft Form 990, said: ''The tax-exempt sector has changed markedly since the Form 990 was last overhauled more than a quarter of a century ago. We need a Form 990 that reflects the way this growing sector operates in the 21st century. The new 990 aims to give both the IRS and the public an improved window into the way tax-exempt organizations go about their vital mission.'' The Director of the IRS's Exempt Organizations Division added: ''Most organizations should not experience a change in burden. [Unfortunately, that statement is not accurate.] However, those with complicated compensation arrangements, related entity structures and activities that raise compliance concerns may have to spend more time providing meaningful information to the public.''
95. IR-2007-204. On this occasion, the Commissioner, TE/GE, said: ''When we released the redesigned draft form this past June, we said we needed a Form 990 that reflects the way this growing sector operates in the 21st century. The public comments we received in response to our draft form helped us develop a final form consistent with our guiding principles of transparency, compliance and burden minimization.''

- Promoting compliance, by designing a return that accurately reflects the organization's operations and use of assets, so the IRS may efficiently assess the risk of its noncompliance.
- Minimizing the burden on filing organizations, by asking questions in a manner that makes it relatively easy to prepare the return and not impose unwarranted recordkeeping or information-gathering burdens to obtain and substantiate the reported information.

(b) Summary of Redesigned Annual Information Return

The redesigned Form 990 includes an 11-page ''core form.'' There is a one-page summary of the organization (Part I), followed by ten additional parts (II-XI). Part II is the signature block. This core return is accompanied by 16 schedules.

(i) Part I (Summary). The summary requests a brief description of the organization's mission or most significant activities. It asks for the number of voting members of the organization's governing body, the number of these board members who are independent, the number of employees, and the number of volunteers. Other questions include the amount of contributions and grants, program service revenue, investment income, other revenue, total gross unrelated business income, total revenue and expenses, grants and similar amounts paid, compensation, professional fundraising expenses, other expenses,[96] and total assets and liabilities.

(ii) Part III. Part III of the redesigned Form 990 concerns the filing organization's program service accomplishments. It is required to describe its mission, new significant program services, any significant changes in the way it conducts a program, a cessation of any activity, and the exempt purpose achievements for each of its three largest program services by expenses. Charitable and social welfare organizations are required to report the amount of grants and allocations to others, total expenses, and any revenue for each program service reported.

(iii) Part IV. Part IV of the redesigned Form 990 is a checklist of required schedules. This schedule has 37 lines, with some lines containing up to four subparts.

(iv) Part V. Part V of the Form 990 pertains to a variety of activities and IRS filings. As to the former, there are questions about unrelated business

96. *See* § 24.14.

income,[97] involvement in a prohibited tax shelter transaction,[98] use of supporting organizations,[99] use of donor-advised funds,[100] and payments with respect to personal benefit contracts.[101] As to the latter, there are questions about the filing of Forms 990-T, 1096, 1098-C, 8282, 8886-T, W-2G, and W-3.

(v) Part VI. Part VI of the Form 990 concerns governance, management, policies, and disclosure. As to the governing body and management (Section A), questions include the number of the voting members of the governing body and the number of board members who are ''independent.'' Inquiry is made as to whether the organization has conflict-of-interest, whistleblower, and document retention and destruction policies, as well as policies governing the activities of chapters, affiliates, and ''branches'' (Section B). Additional questions pertain to various disclosures (Section C).[102]

(vi) Part VII. Part VII of the Form 990 focuses on compensation of insiders and independent contractors. These persons currently in their positions must be listed (irrespective of compensation), along with a list of the organization's five highest compensated employees (other than insiders) who received compensation of more than $100,000 from the organization and any related organizations during the year; the organization's former officers, key employees, or highest compensated employees who received more than $100,000 of compensation from the organization and any related organizations during the year; and the organization's former directors or trustees who received (in that capacity) more than $10,000 of compensation from the organization and any related organizations during the year.

(vii) Parts VIII-XI. Part VIII of the Form 990 is a revenue statement, Part IX is a statement of expenses (including functional reporting), Part X is a balance sheet, and Part XI concerns financial statements.

(viii) Schedule A. Schedule A of the Form 990 is used by charitable organizations to report their public charity status.[103] Specific questions about supporting organizations include identification of the organization's type, a certification as to lack of control by disqualified persons, contributions from disqualified persons, and information about supported organizations.

97. *See* Chapter 24.
98. *See* § 27.15.
99. *See* § 12.3(c).
100. *See* § 11.8.
101. *See* § 27.12(c).
102. This Part VI of the Form 990 is an effort on the part of the IRS to substantially modify tax-exempt organizations' behavior in the governing context by encouraging the adoption and implementation of various practices and policies, none of which, for the most part, are required by law.
103. *See* § 12.3.

There are separate public support schedules for the basic types of publicly supported charitable organizations. The public support computation period has been elongated to five years, which makes it consistent with the advance ruling period public support test. An organization can claim public charity status on the basis of the facts-and-circumstances test on this schedule.

(ix) Schedule B. Schedule B is the schedule used to report charitable contributions and grants. It is the same as the preexisting Schedule B.

(x) Schedule C. Schedule C comprises questions concerning political campaign and lobbying activities, principally by charitable organizations. Filing organizations are required to describe their direct and indirect political campaign activities, including the amounts of political expenditures and volunteer hours. There are separate parts for lobbying charitable organizations that are under the substantial part test and the expenditure test. Additional parts must be prepared by certain other types of tax-exempt entities.

(xi) Schedule D. Schedule D is used to report supplemental financial information, such as for investments, liabilities, conservation easements, donor-advised funds, art collections, trust accounts, and endowment funds.

(xii) Schedule E. Schedule E is filed by organizations that constitute tax-exempt private schools.[104] Most of this schedule relates to the requirement that the organization cannot, to be tax-exempt, maintain a racially discriminatory policy. A question inquires as to whether the organization receives any financial aid or other assistance from a governmental agency.

(xiii) Schedule F. The essence of Schedule F is the reporting of activities outside of the United States.[105] These activities, such as program services, grantmaking, and fundraising, are reported on a per region basis. Grantmakers are required to describe their procedures for monitoring the use of grant funds. Information must be supplied if a grantee or other recipient of assistance is related to any person with an interest in the grantmaking organization. Additional details are required in instances of grants or other assistance to organizations or individuals.

(xiv) Schedule G. Schedule G largely concerns fundraising activities. The filing organization indicates the type or types of fundraising in which it is engaged and provides information about any fundraising contracts (including those with insiders). The organization is required to list the jurisdictions in

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104. *See* § 8.3(a).
105. *See* § 27.16.

which it is authorized to solicit funds. A part of this schedule focuses on fundraising events;[106] another part solicits details about gaming activities.[107]

(xv) Schedule H. Schedule H is filed by tax-exempt hospitals.[108] The first part of this schedule (Part I) is a ''community benefit report.'' The filing hospital indicates whether it provides free or discounted care to low-income individuals or to those who are ''medically indigent.'' The hospital reports on its charity care (such care at cost, unreimbursed Medicaid services, and other unreimbursed costs in connection with government programs) and other community benefits (such as health improvement services, health professions education, subsidized health services, and research). The organization is asked whether it prepares an annual community benefit report and to describe its charity care policy.

The second part of this schedule (Part II) inquires as to the hospital's ''community building'' activities. These activities include physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition-building, community health improvement advocacy, and workforce development.

Another part (Part III) pertains to bad debt, Medicare, and collection practices. A fourth part (Part IV) asks questions about the use of management companies and involvement in joint ventures. A fifth part (Part V) seeks information about the hospital's facilities. The schedule (Part VI) requests a description of how the organization assesses the healthcare needs of the communities it serves and how the organization informs patients about their eligibility for assistance under federal, state, or local government programs or under its charity care policy.

Parts I, II, III, IV, and VI of Schedule H are optional for 2008.

(xvi) Schedule I. Schedule I is used to solicit information about the organization's domestic grant and other assistance programs. For example, the organization is asked whether it maintains records to substantiate the amount of its assistance, and about the organization's selection criteria and grantees' eligibility. Information is required for grants of more than $5,000 to organizations and all grants to individuals.

(xvii) Schedule J. Schedule J is used to solicit supplemental information about compensation.[109] The organization must indicate (in Part I) if it provides to its insiders payments or items in forms such as first-class or charter

106. *See* § 24.5(h); FUNDRAISING § 5.25(c).
107. *See* § 24.7(h).
108. *See* § 7.6(a).
109. *See*, e.g., § 20.4.

travel, a discretionary spending account, a housing allowance, or health or social club dues; it is asked whether it follows a written policy in connection with such payments (or reimbursements) or items. The organization is asked how it determines certain executive compensation and, in the case of charitable and social welfare organizations, whether it provided any form of non-fixed payments.[110] The tax-exempt organization reports information concerning compensation paid to trustees, directors, officers, key employees, and highly compensated employees (Part II). There is a breakdown as to base compensation, bonus and incentive compensation, deferred compensation, and nontaxable benefits.

(xviii) Schedule K. Schedule K is used to solicit information about tax-exempt bond issues (Part I) and the use of the proceeds (Part II). There are questions about the private use rules (Part III) and arbitrage (Part IV). Parts II, III, and IV of this schedule are optional for 2008.

(xix) Schedule L. Schedule L concerns excess benefit transactions,[111] and loans to and from interested persons.[112] Information sought includes the name of the debtor/creditor, original principal amount, balance due, the purpose of the loan, and whether there is a written agreement. Questions are also asked about grants or other forms of assistance benefiting, and business transactions involving, interested persons.

(xx) Schedule M. The focus of Schedule M is on noncash contributions. Thus, information is sought about gifts of art (including fractional interests), books, clothing and household goods, automobiles, airplanes, boats, intellectual property, securities, qualified conservation property, real estate, collectibles, food inventory, drugs and medical supplies, taxidermy, historical artifacts, scientific specimens, and archeological artifacts.

This schedule inquires as to the number of Forms 8283 received by the organization for contributions for which the organization completed the donee acknowledgment portion; whether the organization received any property that it must hold for at least three years from the date of its contribution, which is not required to be used for exempt purposes during the entire holding period; whether the organization has a gift acceptance policy that requires the review of non-standard contributions; and whether the organization used third parties or related organizations to solicit, process, or sell non-cash distributions.

110. *See* § 21.4(b).
111. *See* Chapter 21.
112. *See*, e.g., § 20.5(b).

(xxi) Schedule N. Schedule N pertains to liquidations, terminations, dissolutions, and significant dispositions of assets. Questions include a description of the assets involved, their value, the method of determining the value, the date of the distribution, and the name and address of the recipient. Other questions concern the involvement of an insider with the successor or transferee organization, notification of one or more state officials, and other compliance with state laws. Additional information is sought concerning transfers of more than 25 percent of the organization's assets.

(xxii) Schedule O. Schedule O is used by filing organizations to provide additional information for responses to specific questions in the Form 990 and/or its schedules, and to provide additional information.

(xxiii) Schedule R. Schedule R has as one of its purposes the identification of disregarded entities and related tax-exempt organizations. Related organizations taxable as a partnership and as a corporation or trust are also required to be identified. There is a series of questions about transactions with related organizations and unrelated organizations taxable as a partnership.

(xxiv) Transition Rules. The IRS also announced a graduated three-year transition period for annual information return filings. For the 2008 tax year (returns filed in 2009), organizations with gross receipts of more than $1 million or total assets in excess of $2.5 million are required to file the Form 990. For the 2009 tax year (returns filed in 2010), organizations with gross receipts over $500,000 or total assets over $1.25 million will be required to file the Form 990. Exempt organizations below these thresholds are allowed to file the Form 990-EZ (with the option to file the new Form 990). (The Form 990-EZ for 2008 was also released on December 20, 2007.)

The filing threshold will be permanently set, beginning with the 2010 tax year, at $200,000 in gross receipts and $500,000 in total assets. Starting with the 2010 year, the filing threshold for organizations required to file Form 990-N (the e-postcard) will be increased to $50,000 (from $25,000).

§ 35.5 DISCLOSURE REQUIREMENTS

(a) Applications and Annual Information Returns

(i) General Rules. The annual information returns[113] and applications for recognition of tax exemption[114] of tax-exempt healthcare (and other) organizations (other than private foundations) must be made available by the

113. *See* § 35.3.
114. *See* § 34.1.

organizations for public inspection.[115] This requirement does not cause disclosure, in the annual returns, of the names and addresses of donors.[116] Tax-exempt organizations must make a copy of each of the most recent three annual information returns available for inspection during regular business hours by any individual at their principal office.[117] If an exempt organization regularly maintains one or more regional or district offices having at least three employees, this inspection requirement applies with respect to each office.[118]

The penalty for failure to provide access to copies of the annual return is $20 per day, absent reasonable cause, with a maximum penalty per return of $10,000.[119] The penalty for failure to so provide access to a copy of the application for recognition of tax exemption, payable by the person failing to meet the requirements, is $20 per day, absent reasonable cause, without any limitation.[120] Certain information in an application for recognition of exemption can be withheld from public inspection, however, such as trade secrets and patents.[121] Any person who willfully fails to comply with these inspection requirements is subject to a $1,000 penalty with respect to each return or application.[122]

In addition, in general, a tax-exempt organization must provide a copy without charge, other than a reasonable fee for reproduction and actual postage costs, of all or any part of any application for recognition of exemption or return required to be made available for public inspection to any individual who makes a request for the copy in person or in writing.[123]

(ii) Rules as to Inspection. A tax-exempt organization must make its application for recognition of tax exemption available for public inspection without charge at its principal, regional, and district offices during regular business

115. IRC § 6104(e).
116. IRC § 6104(e)(1)(C).
117. IRC § 6104(e)(1)(A). Exact copies of these returns are required, including (for IRC § 501(c)(3) organizations) the disclosure of the compensation of major employees (Schedule A) (IRS Notice 88-120, 1988-2 C.B. 454).
118. IRC § 6104(e)(1)(A). Organizations that are covered by a group exemption and do not file their own annual information returns (*see* § 34.5, text accompanied by notes 217–220), and that receive a request for inspection, must acquire a copy of the group return from the central organization and make the material available to the requestor within a reasonable amount of time (IRS Notice 88-120, 1988-2 C.B. 454). Also, the requestor has the option of requesting, from the central organization, inspection of the group return at the principal office of the central organization (*id.*).
119. IRC § 6652(c)(1)(C).
120. IRC § 6652(c)(1)(D).
121. IRC § 6104(a)(1)(D).
122. IRC § 6685. This disclosure obligation is enforced exclusively by the IRS and cannot be enforced by a private civil action (*Schuloff v. Queens College Foundation, Inc.*, 165 F.3d 183 (2d Cir. 1999), *aff'g* 994 F. Supp. 425 (E.D.N.Y. 1998)).
123. IRC § 6104(d)(1)(B); Reg. § 301.6104(d)-3(d).

hours.[124] Likewise, a tax-exempt organization must make its annual information returns available for public inspection without charge in the same offices during regular business hours.[125] Each annual information return must be made available for a period of three years.

(iii) Rules as to Copies. Generally, a tax-exempt organization must provide copies of the documents, in response to an in-person request, at its principal, regional, and district offices during regular business hours. Also generally, the organization must provide the copies to a requestor on the day the request is made.[126]

In the case of an in-person request, where unusual circumstances exist so that fulfillment of the request on the same business day places an unreasonable burden on the exempt organization, the copies must be provided on the next business day following the day on which the unusual circumstances cease to exist or the fifth business day after the date of the request, whichever occurs first. *Unusual circumstances* include receipt of a volume of requests that exceeds the organization's daily capacity to make copies, requests received shortly before the end of regular business hours that require an extensive amount of copying, and requests received on a day when the organization's managerial staff capable of fulfilling the request is conducting special duties. *Special duties* are activities such as student registration or attendance at an off-site meeting or convention, rather than regular administrative duties.[127]

If a request for a document is made in writing, the tax-exempt organization must honor it if the request (1) is addressed to, and delivered by mail, electronic mail, facsimile, or a private delivery service to a principal, regional, or district office of the organization, and (2) sets forth the address to which the copy of the document should be sent.[128]

A tax-exempt organization receiving a written request for a copy must mail it within 30 days from the date it receives the request. If, however, an exempt organization requires payment in advance, it is only required to provide the copy within 30 days from the date it receives payment. A tax-exempt organization must fulfill a request for a copy of the organization's entire application or annual information return or any specific part or schedule of its application or return.[129]

A tax-exempt organization may charge a reasonable fee for providing copies. A fee is *reasonable* if it is no more than the per-page copying fee charged

124. Reg. § 301.6104(d)-3(a). *See*, in general, TAX-EXEMPT ORGANIZATIONS § 27.9.
125. *Id*.
126. Reg. § 301.6104(d)-3(d)(1)(i).
127. Reg. § 301.6104(d)-3(d)(1)(ii).
128. Reg. § 301.6104(d)-3(d)(2)(i).
129. Reg. § 301.6104(d)-3(d)(2)(ii).

by the IRS for providing copies. It can also include actual postage costs. The requestor may be required to pay the fee in advance.[130]

(iv) Failure to Comply. If a tax-exempt organization denies an individual's request for inspection or a copy of an application or return, and the individual wishes to alert the IRS to the possible need for enforcement action, he or she may send a statement to the appropriate IRS district office, describing the reason why the individual believes the denial was in violation of these requirements.[131]

(v) Widely Available Exception. A tax-exempt organization is not required to comply with requests for copies of its application for recognition of tax exemption or an annual information return if the organization has made the document widely available.[132] The rules as to public inspection of the documents nonetheless continue to apply.

An exempt organization can make its application or a return *widely available* by posting the document on a World Wide Web page that the organization establishes and maintains. It can also satisfy the exception if the document is posted as part of a database of similar documents of other exempt organizations on a web page established and maintained by another entity.[133]

The document is considered widely available only if

1. The web page through which it is available clearly informs readers that the document is available and provides instructions for downloading it.
2. The document is posted in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the application or return as it was originally filed with the IRS, except for any information permitted by statute to be withheld from public disclosure.
3. Any individual with access to the Internet can access, download, view, and print the document without special computer hardware or software required for that format, and can do so without payment of a fee to the exempt organization or to another entity maintaining the web page.[134]

The organization maintaining the web page must have procedures for ensuring the reliability and accuracy of the document that it posts on the page. It must take reasonable precautions to prevent alteration, destruction, or accidental loss of the document when printed on its page. In the event a posted document is altered, destroyed, or lost, the organization must correct or replace the document.[135]

130. Reg. § 301.6104(d)-3(d)(3).
131. Reg. § 301.6104(d)-3(g).
132. IRC § 6104(d)(4); Reg. § 301.6104(d)-4(a).
133. Reg. § 301.6104(d)-4(b)(2)(i).
134. *Id.*
135. Reg. § 301.6104(d)-4(b)(2)(iii).

(vi) Harassment Campaign Exception. If the IRS determines that a tax-exempt organization is the subject of a *harassment campaign* and that compliance with the requests that are part of the campaign would not be in the public interest, the organization is not required to fulfill a request for a copy that it reasonably believes is part of the campaign.[136]

A group of requests for an organization's application or returns is indicative of a harassment campaign if the requests are part of a single coordinated effort to disrupt the operations of the organization rather than to collect information about the organization. This is a facts-and-circumstances test; factors include a sudden increase in the number of requests, an extraordinary number of requests made by means of form letters or similarly worded correspondence, evidence of a purpose to deter significantly the organization's employees or volunteers from pursuing the organization's exempt purpose, requests that contain language hostile to the organization, direct evidence of bad faith by organizers of the purported harassment campaign, evidence that the organization has already provided the requested documents to a member of the purported harassment group, and a demonstration by the tax-exempt organization that it routinely provides copies of its documents upon request.[137]

A tax-exempt organization may disregard any request for copies of all or part of any document beyond the first two received within any 30-day period or the first four received within any one-year period from the same individual or the same address, irrespective of whether the IRS has determined that the organization is subject to a harassment campaign.[138]

There is no procedure to follow for applying to the IRS for a determination that the organization is the subject of a harassment campaign. (There is no form.) The organization may suspend compliance with respect to the request, as long as the application is filed within 10 days after harassment is suspected, until the organization receives a response from the IRS.[139]

(vii) Penalties. An individual failing to allow inspection of an organization's annual information returns is subject to a penalty of $20 per day for each day the failure continues, absent reasonable cause, with a maximum penalty per return of $10,000.[140] An individual failing to allow inspection of an organization's application for recognition of tax exemption must, absent reasonable cause, pay $20 per day for each day the failure continues.[141] A person who willfully fails to comply with these inspection requirements is subject to a penalty of $5,000 with respect to each return or application.[142]

136. IRC § 6104(d)(4); Reg. § 301.6104(d)-5(a).
137. Reg. § 301.6104(d)-5(b).
138. Reg. § 301.6104(d)-5(c).
139. Reg. § 301.6104(d)-5(d), (e).
140. IRC § 6652(c)(1)(C), (3).
141. IRC § 6652(c)(1)(D), (3).
142. IRC § 6685.

(viii) Document Availability at IRS. There are procedures by which annual information returns and applications for recognition of exemption are available from the IRS.[143] Also, a favorable ruling recognizing an organization's tax-exempt status may be issued by the National Office of the IRS in Washington, DC; these rulings and the underlying applications for recognition of tax exemption are available for inspection in the Freedom of Information Reading Room at the National Office.[144] The annual information returns subsequently filed by these organizations are subject to disclosure under the rules summarized above.

(b) Unrelated Business Income Tax Returns

Revenue and expenses associated with unrelated business activity by a tax-exempt organization are reported to the IRS on Form 990-T.[145] This is a *tax return* (which generally is not a public document), rather than an *information return*. Nonetheless, the public inspection and disclosure requirements applicable to annual information returns[146] are applicable to the unrelated business income tax returns filed by charitable organizations,[147] effective for returns filed after August 17, 2006.[148] The 3-year rule[149] is applicable in this context, as is the requirement that the IRS make these returns available to the public.[150]

(c) Disclosure as to Certain Information or Services

A tax-exempt organization[151] must pay a penalty if it fails to disclose that information or services it is offering are available without charge from the federal government. Specifically, if (1) a tax-exempt organization offers to sell (or solicits money for) specific information or a routine service, for any individual, that could be readily obtained by the individual without charge (or for a nominal charge) from an agency of the federal government, and (2) when making the offer or solicitation, fails to make an ''express statement (in a conspicuous and easily recognizable format)'' that the information or service can be so obtained, and (3) the failure is due to intentional disregard of these requirements, then the organization must pay a penalty.[152]

143. IRC § 6104(a) and (b). *See*, in general, TAX-EXEMPT ORGANIZATIONS.
144. IRS Notice 92-28, 1992-1 C.B. 515.
145. IRC §§ 6011, 6012(a)(2), (4).
146. *See* § 35.5(a).
147. That is, organizations described in IRC § 501(c)(3) and thus exempt from federal income tax pursuant to IRC § 501(a).
148. IRC § 6104(d)(1)(A)(ii).
149. *See* § 35.3(e).
150. *See* TAX-EXEMPT ORGANIZATIONS § 27.8.
151. That is, an entity described in IRC § 501(c) or (d) and exempt from federal income tax under IRC § 501(a), or a political organization as defined in and exempt by reason of IRC § 527(e).
152. IRC § 6711(a). If material and/or services are available from the federal government for less than $2.50 (including postage and handling costs), the material and/or services

This requirement applies only if the information to be provided involves the specific individual solicited. Thus, for example, the requirement applies with respect to obtaining the social security earnings record or the social security identification number of an individual solicited, while the requirement is inapplicable with respect to the furnishing of copies of newsletters issued by federal agencies or providing copies of or descriptive material on pending legislation. Also, this requirement is inapplicable to the provision of professional services (such as tax return preparation, grant application preparation, or medical services), as opposed to routine information retrieval services, to an individual even if they may be available from the federal government without charge or for a nominal charge.[153]

The penalty, which is applicable for each day on which the failure occurred, is the greater of $1,000 or 50 percent of the aggregate cost of the offers and solicitations that occurred on any day on which the failure occurred and with respect to which there was this type of failure.[154]

(d) Fundraising Disclosure by Noncharitable Organizations

There are statutory rules that impose certain fundraising disclosure requirements on tax-exempt organizations other than charitable ones.[155] (The federal tax rules that mandate disclosures by charitable organizations engaged in fundraising are discussed elsewhere.[156]) These rules are primarily directed at tax-exempt social welfare organizations[157] that engage in public fundraising activities under circumstances where donors are likely to assume that the contributions are tax-deductible as charitable gifts, when in fact they are not.

Under these rules, the law requires each *fundraising solicitation* by or on behalf of a noncharitable tax-exempt organization to ''contain an express statement (in a conspicuous and easily recognizable format)'' that gifts to it are not deductible as charitable contributions for federal income tax purposes.[158] A fundraising solicitation that is in conformity with rules promulgated by the IRS, which include guidance in the form of ''safe-harbor'' provisions,[159] is deemed to satisfy the statutory requirements. In one instance, a tax-exempt organization that conducted fundraising by means of telemarketing and direct

are considered by the IRS as being available from the federal government at a nominal charge (IRS Notice 88-120, 1988-2 C.B. 454).

153. IRS Notice 88-120, 1988-2 C.B. 454.
154. IRC § 6711(b).
155. That is, these rules are applicable to tax-exempt organizations described in IRC § 501(c) (other than those described in IRC §§ 170(c) (charitable organizations for charitable donee purposes), 501(c)(1) (instrumentalities of the United States), or 501(d) (apostolic organizations)) and political organizations.
156. *See* Chapter 31.
157. *See* § 1.8.
158. IRC § 6113.
159. IRS Notice 88-120, 1988-2 C.B. 454.

mail was found to be in violation of these rules; a notice of nondeductibility of contributions was not included in its telephone solicitations or pledge statements, and the print used in some of its written notices was too small.[160]

Generally, this rule applies to any organization to which contributions are not deductible as charitable gifts and that (1) is tax-exempt,[161] (2) is a political organization,[162] (3) was either type of organization at any time during the five-year period ending on the date of the fundraising solicitation, or (4) is a successor to this type of an organization at any time during this five-year period. This rule is inapplicable, however, to any organization that has annual gross receipts that are normally no more than $100,000. Also, where all of the parties being solicited are tax-exempt organizations, the solicitation need not include the disclosure statement (inasmuch as these grantors do not utilize a charitable contribution deduction).[163] Further exempt from this disclosure rule are a variety of billing practices, such as of those who advertise in an organization's publications, of attendees at a conference, or for payments to a trust for health and/or pension benefits.[164]

The IRS has the authority to treat any group of two or more organizations as one organization for these purposes where ''necessary or appropriate'' to prevent the avoidance of these rules through the use of multiple organizations. The term *fundraising solicitation* means any solicitation of gifts made in written or printed form, by television, radio, or telephone. An exclusion is provided for letters or calls not part of a ''coordinated fundraising campaign soliciting more than 10 persons during the calendar year.''

Failure to satisfy this disclosure requirement can result in the imposition of penalties.[165] The penalty is $1,000 per day (maximum of $10,000 per year), albeit with a reasonable cause exception. In the case of an intentional disregard of these rules, however, the penalty for the day on which the offense occurred is the greater of $1,000 or 50 percent of the aggregate cost of the solicitation that took place on that day, with inapplicability of the $10,000 limitation. For these purposes, the days involved are those on which the solicitation was telecast, broadcast, mailed, otherwise distributed, or telephoned.

§ 35.6 FORM 990 AND COMMUNITY BENEFIT

The annual information return filed by most tax-exempt healthcare (and other) organizations—Form 990—is a record of expenditures and activities that is accessible by the public.[166] Not only is it important that it be accurately

160. Priv. Ltr. Rul. 9315001.
161. That is, tax-exempt under IRC § 501(a) by reason of description in IRC § 501(c) other than IRC § 501(c)(3).
162. An organization described in and tax-exempt by reason of IRC § 527.
163. IRS Notice 88-120, 1988-2 C.B. 454.
164. *Id*.
165. IRC § 6710.
166. *See* § 35.5(a).

and completely prepared,[167] but the accessibility of the return affords the healthcare organization a superb opportunity to convert what might otherwise be a prosaic document into a positive presentation of the organization's programs for the community, the media, and, of course, the IRS.

For example, hospitals and many other healthcare providers have their federal income tax exemption founded on the precept that they are engaged in the promotion of health.[168] The ways in which health is promoted can be featured prominently in the annual information return. This is principally done by means of Schedule H.[169]

The above observations apply to all organizations in the healthcare field, not just providers. For that matter, they apply with respect to all tax-exempt organizations. In short, this is an occasion to turn a government reporting obligation into a trumpeting of all of the organization's accomplishments.

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167. *See* § 35.3, text accompanied by note 39.
168. *See* § 1.7.
169. *See* § 35.4(b)(xv).

CHAPTER THIRTY-SIX

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§ 36.1 IRS AUDITS IN GENERAL

An understanding of the organizational structure of the IRS, which is a component of the Department of the Treasury,[1] enhances an appreciation of the audit policies of the agency with respect to tax-exempt healthcare organizations.[2]

1. Reg. § 601.101(a).
2. These matters are discussed in greater detail in IRS AUDITS, Chapter 2.

(a) Organization of IRS

One of the functions of the Treasury Department is assessment and collection of federal income and other taxes.[3] This department is authorized to conduct examinations,[4] serve summonses,[5] and otherwise undertake what is necessary for ''detecting and bringing to trial and punishment persons guilty of violating the internal revenue laws or conniving at the same.''[6] This tax assessment and collection function has largely been assigned to the IRS.[7]

The principal purpose of the IRS is to enforce the internal (U.S.) revenue laws and collect taxes. The agency states that its mission is to ''provide America's taxpayers with top quality service by helping them understand and meet their tax responsibilities and by applying the tax law with integrity and fairness to all.''[8] A commentator stated the matter this way: ''The specific role of the Internal Revenue Service in the [federal tax] system is to both collect and protect the revenue without incidentally frustrating or terrorizing the taxpayer population.''[9] The IRS noted that Congress creates the tax laws; the taxpayer's role is to understand and meet his, her, or its tax obligations; and the function of the IRS is to ''help the large majority of compliant taxpayers with the tax law, while ensuring that the minority who are unwilling to comply pay their fair share.''[10]

The IRS is headquartered in Washington, D.C.; its operations there are housed principally in its National Office. The executive of the IRS is the Commissioner of Internal Revenue.[11] This commissioner is charged with administering, managing, conducting, directing, and supervising the execution and application of the internal revenue laws.[12] The Commissioner is assisted by two Deputy Commissioners, one for Services and Enforcement, the other for Operations Support. The IRS is organized into four operating divisions, one of which is the Tax Exempt and Government Entities (TE/GE) Division.

The TE/GE Division is headed by a Commissioner (TE/GE), who is ''responsible for the uniform interpretation and application of the Federal tax

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3. IRC § 7601(a).
4. IRC § 7602.
5. IRC § 7603.
6. IRC § 7623.
7. Reg. § 601.101(a).
8. This mission statement is on the IRS web site and is reproduced each week in the Internal Revenue Bulletin. It also appears in the INTERNAL REVENUE MANUAL (''IRM''), Part 1, Chapter 1, Section 1 § 1. Throughout this chapter, citations to the IRM are to the appropriate *part*, then *chapter*, then what the IRS refers to as *section*, then to material *within a section*, referenced in this book as ''§.'' Thus, the foregoing reference to the IRM is reflected in the following format: IRM 1.1.1.1.
9. DAVID, DEALING WITH THE IRS: LAW, FORMS, AND PRACTICE 7 (American Law Institute–American Bar Association 2001).
10. IRM 1.1.1.1 § 2.
11. IRC § 7802(d)(3)(A).
12. IRC § 7803(a)(2)(A).

laws on matters pertaining to the Division's customer base.''[13] Also, the Commissioner (TE/GE) ''provides advice and assistance throughout the Service, to the Department of the Treasury, [and] other government agencies, including state governments and Congressional committees.''[14] This commissioner is assisted by an executive assistant, an executive assistant (technical), a senior technical advisor, a technical advisor, two staff assistants, and a secretary.

Within the TE/GE Division is the Exempt Organizations Division, which develops policy concerning and administers the law of tax-exempt organizations. The Director of the Exempt Organizations Division, who reports to the Commissioner (TE/GE), is responsible for planning, managing, and executing nationwide IRS activities in the realm of exempt organizations. This director also supervises and is responsible for the programs of the offices of Customer Education and Outreach, Rulings and Agreements,[15] Exempt Organizations Electronic Initiatives, and Examinations.

(b) Examinations Office

The Examinations Office within the Exempt Organizations Division[16] focuses on tax-exempt organizations examination programs and review projects. This office:

- Develops and implements measures for the exempt organizations examination program that balance customer satisfaction, employee satisfaction, and business results
- Develops the overall exempt organizations enforcement strategy and goals to enhance compliance consistent with overall TE/GE strategy, and implements and evaluates exempt organizations examination policies and procedures
- Develops and implements the exempt organizations' returns classification and selection process, and the case review and closing processes
- Coordinates with the Directors, TE/GE Research and Analysis, Exempt Organizations Customer Education and Outreach, Exempt Organizations Rulings and Agreements, and TE/GE Customer Accounts Services to identify emerging noncompliance areas, develop proactive education efforts, and identify opportunities for the improvement of exempt organizations processes
- Provides support and resources for Exempt Organizations Customer Education and Communication programs and products

13. IRS web site.
14. *Id*.
15. This component of the Division includes EO Determinations and EO Technical (*see* § 34.1).
16. The EO Examinations function is located in Dallas, Texas.

- Coordinates with the Employee Plans Division with respect to examinations of employee plans maintained by tax-exempt organizations
- Monitors and evaluates the quality and effectiveness of the Exempt Organizations Examination programs, and coordinates the peer review process for large case examinations
- Supervises the activities of Exempt Organizations Examination Programs and Review, and the Exempt Organizations Area offices[17]

Exempt Organizations Examinations is comprised of exempt organizations examination specialists, supervised by Exempt Organizations group managers who are supervised by the Exempt Organizations area manager within various geographical areas.[18]

The support functions of the Examinations Office include Examination Planning and Programs, Classification, Mandatory Review, Special Review, and Examinations Special Support. Two important and relevant units within Examinations were inaugurated in 2004: the Exempt Organizations Compliance Unit (EOCU) and the Data Analysis Unit (DAU).

The EOCU is located in the IRS service center in Ogden, Utah. It is composed of revenue agents and tax examiners who address instances of potential tax-exempt organizations' noncompliance with the tax law, based on reviews of annual information returns,[19] and conduct correspondence examinations.[20] The EOCU model is contact with a particular exempt organization followed by a monitoring of its subsequent annual information returns. The IRS considers this an efficient and effective approach to maintaining a compliance presence.

The DAU is an office composed of economists, statisticians, and research analysts that assemble and review various databases and other techniques to investigate and determine emerging trends in exempt organizations' operations, in an effort to improve identification and selection of exempt organizations for examination. This office develops strategies to improve compliance by means of examinations, compliance checks,[21] educational programs, and other techniques that may not involve the examination of organizations' books and records. A project may measure overall levels of compliance or it may answer specific questions about a market segment.

Also, the Exempt Organizations Financial Investigations Unit (FIU) is staffed with fraud specialists, forensic accountants, and agents with expertise in identifying fraud and tracking foreign grant activities. The FIU conducts examinations of organizations identified as potentially involved with fraudulent transactions. This staff also works with law enforcement agencies, such

17. IRM 1.1.23.5.3 § 1.
18. *Id*. § 2.
19. *See* § 35.3.
20. *See* § 36.2(a)(ii).
21. *See* § 36.5.

as the Joint Terrorism Task Force and the Criminal Investigation Division, by providing support on criminal investigations and expert testimony at trials involving exempt organization–related issues.

Other pertinent aspects of this organization of the IRS include an Exempt Organizations Electronic Initiatives Office (which became operational in June 2003) that is responsible for the coordination, development, and deployment of new technology in the Exempt Organizations Division, including electronic filing of annual information returns, increased disclosure of filings to the public, and data acquisition and display.

§ 36.2 AUDIT PROCEDURES

The IRS is empowered to audit the activities and records of all persons in the United States, including tax-exempt organizations.[22] This examination activity is designed to ensure that exempt organizations and other persons are in compliance with all pertinent requirements of the federal tax law. The IRS audit of this type thus will address matters such as continuation of tax-exempt status, ongoing non-private-foundation status, susceptibility to the tax on unrelated business income, deferred compensation and retirement programs, tax-exempt bond financing, and employment tax issues.[23]

(a) Types of Examinations

There are several types of IRS examinations of tax-exempt organizations; there are formal and informal classifications of them.

(i) Field Examinations. Common (at least historically) among the types of IRS examinations are *field examinations*, in which one or more IRS revenue agents (typically, however, only one) review the books, records, and other documents and information of the exempt organization under examination, on the premises of the organization or at the office of its representative.[24] In general, the primary objective of an exempt organization examination is to determine whether the organization is organized and operated in accordance with its exempt function.[25] The examiner is also expected to determine the organization's liability for the unrelated business income tax, its liability for

22. IRC § 7601(a), which quaintly authorizes the IRS to "cause officers or employees of the Treasury Department to proceed, from time to time, through each internal revenue district and inquire after and concerning all persons therein who may be liable to pay any internal revenue tax, and all persons owning or having the care and management of any objects with respect to which any tax is imposed."
23. The IRS prepared material to guide National Office and field personnel who have responsibilities for the examination of tax-exempt organizations in the form of Exempt Organizations Examination Guidelines (IRM 4.75).
24. Reg. § 601.105(b)(3).
25. IRM 4.75.11.3.

any excise taxes, whether it engaged in political activities that require filing of a return, and whether it has properly filed annual information returns, other returns, and forms.[26] The procedures require the examiner to establish the scope of the examination, outline when the examination will be limited in scope, state the documentation requirements imposed on the examiner, and summarize the examination techniques (such as interviews, tours of facilities, and review of books and records). The IRS, by means of its Tax Exempt Quality Measurement System, established quality standards applicable to exempt organizations examinations.[27]

(ii) Office and Correspondence Examinations. The IRS has an Office/ Correspondence Examination Program (OCEP) pursuant to which examiners of tax-exempt organizations conduct the examination of returns by means of an office interview or correspondence.[28] An *office interview case* is one where the examiner requests an exempt organization's records and reviews them in an IRS office; this may entail a conference with a representative of the organization.[29] This type of examination is likely to be of a smaller exempt organization, where the records are not extensive and the issues not particularly complex. A *correspondence examination* involves an IRS request for information from an exempt organization by letter, fax, or e-mail communication.[30] OCEP examinations generally are limited in scope, usually focusing on no more than three issues, conducted by lower-grade examiners. If warranted, a correspondence examination will be converted to an office or field examination.

(iii) Team Examinations. For years, one of the mainstays of the IRS tax-exempt organizations examination effort was the *coordinated examination program* (CEP), which focused not only on exempt organizations but also on affiliated entities and arrangements (such as subsidiaries, partnerships, and other joint ventures) and collateral areas of the law (such as employment tax compliance and tax-exempt bond financing). The CEP approach, involving relatively sizeable teams of revenue agents, was concentrated on large, complex exempt organizations, such as colleges, universities, and healthcare institutions. This program has been abandoned beginning in fiscal year 2003, however, and replaced by the *team examination program* (TEP). Both the CEP and TEP approaches nonetheless share the same objective, which is to avoid a fragmenting of the exempt organization examination process by using a multi-agent approach. The essential characteristics of the TEP approach that differentiate it from the CEP approach are that the team examinations are being utilized in connection with a wider array of exempt organizations, the number

26. *Id*.
27. *Id*. §§ 11.2, 26.
28. IRM 4.75.27.
29. Reg. § 601.105(b)(2).
30. *Id*.

of revenue agents involved in each examination is smaller, and the revenue agents are less likely to establish audit offices at the exempt organization undergoing an examination.

A TEP case generally is one where the tax-exempt organization's annual information return reflects either total revenue or assets greater than $100 million (or, in the case of a private foundation, $500 million). Nonetheless, the IRS may initiate a team examination where the case would benefit (from the government's perspective) from a TEP approach or where there is no annual information return filing requirement. There is a presumption that a team examination approach will be utilized in all cases meeting the TEP criteria.[31]

In a TEP case, the examination will proceed under the direction of a case manager. There will be one or more tax-exempt organizations revenue agents, possibly coupled with the involvement of employee plans specialists, actuarial examiners, engineers, excise tax agents, international examiners, computer audit specialists, income tax revenue agents, and economists. These examinations are likely to last two to three years; a postexamination critique may lead to a cycling of the examination into subsequent years. The procedures stipulate the planning that case managers, assisted by team coordinators, should engage in when starting a team examination; the procedures also provide for the exempt organization's involvement in the planning process. These procedures, of course, detail the flow of the examination.

(b) Reasons for IRS Audits

The reasons for an IRS examination of a tax-exempt organization are manifold. The agency often focuses on particular categories of major exempt entities, such as healthcare institutions, colleges and universities, political organizations, community foundations, and private foundations. Sometimes the examinations are more targeted, such as those currently involving credit counseling organizations[32] and down-payment assistance organizations.[33] An examination of an exempt organization may be initiated on the basis of the size of the organization or the length of time that elapsed since a prior audit. An examination may be undertaken following the filing of an information return or tax return,[34] inasmuch as one of the functions of the IRS is to ascertain the correctness of returns. An examination (using that term in its loosest sense) may be based on a discrete issue, such as compensation practices.[35] Other reasons for the development of an examination include media reports,[36]

31. IRM 4.75.29.3.
32. See Tax-Exempt Organizations § 7.3.
33. *Id*.
34. Reg. § 601.103(b).
35. *See*, e.g., § 36.5(d).
36. This source of stimuli for IRS audits has been considerably augmented by reason of public access, including by means of the Internet, to annual information returns (*see*

a state attorney general's inquiry, or other third-party reports of alleged wrongdoing.[37]

(c) Documents Likely to Be Requested

Many variables are associated with an IRS examination of tax-exempt organizations. There are, however, some constants and one of these is the range of documents that will be requested. The purpose of a typical IRS audit of an exempt organization is to substantiate the nature of the program and other activities of the organization, verify the accuracy of one or more returns, determine that all required returns have been filed, and ascertain whether any taxes due have been paid. To this end, the IRS will examine the *books and records* of the exempt organization.[38] Thus, when word of an impending IRS audit reaches an exempt organization, its staff should begin assembling copies of the governing instruments, namely, articles of organization (articles of incorporation, constitution, trust agreement, declaration of trust, and the like) and bylaws; application for recognition of exemption (if any); determination letter (if any); minutes of board, and perhaps other, meetings (during the audit period); publications (such as journals, newsletters, brochures, and pamphlets); policies (such as conflict-of-interest, document retention, and whistleblower); operating manuals; leases, employment, and other contracts; audited financial report(s) and CPA management letter(s); annual information returns (if any) and other required federal returns (if any); and rulings from and/or correspondence with the IRS.

The IRS is likely to request other documents pertaining to the audit period(s). The staff of the tax-exempt organization, however, will undoubtedly want to wait to respond to one or more information document requests before making mounds of copies of them. These documents include financial records (chart of accounts, general ledger, financial statements, and other supporting documentation) and correspondence files. Also, the IRS may request hard copies of web site pages.

(d) Audit Techniques

The techniques for coping with IRS personnel on the occasion of an audit are easily summarized, but their deployment and success are likely to depend heavily on the personalities involved. The key staff personnel, accountants, and legal counsel of the audited organization should be involved in the process

§ 35.5(a)). This trend may continue now that the unrelated business income tax returns are public documents (*see* § 35.5(b)).

37. As to this third reason for an IRS examination, the agency refers to these reports as containing *information items*, defined as information from internal or external sources concerning potential noncompliance with the tax law by a tax-exempt organization (IRM 4.75.5).
38. IRM 4.75.11.6.6 § 1.

from the beginning, and it is advisable to select one individual who will serve as liaison with the IRS during the audit. The duration of the audit and the procedures to be followed during the audit should be ascertained at the outset, and records should be carefully maintained as information and documents are examined or copied by the revenue agents. All interviews of those associated with the audited organization should be monitored by the liaison individual, with appropriate records made; at least some of the questioning should occur only in the presence of legal counsel.

Where issues arise, one or both of the parties may decide to pursue the technical advice procedure.[39]

(e) Audit Outcomes

On completion of an audit, the IRS will take one of the following actions:[40]

1. If the IRS determines that there are no inaccuracies with the taxpayer's return, the taxpayer will be issued a ''no change letter,'' which indicates that no change is being made to the taxpayer's tax liability as reported.
2. If the IRS determines that the taxpayer has overpaid tax, the IRS will issue an overadjustment entitling the taxpayer to a tax refund.
3. If the IRS determines that there is a deficiency in the amount of tax paid or reported by the taxpayer, or some other taxpayer error (such as a failure to file a required tax form), the IRS agent will present the taxpayer with findings that assert a deficiency in tax. If the taxpayer agrees with the alleged deficiency, a form can be executed and the taxpayer sent a statement for the additional tax owed. If the taxpayer disagrees with the IRS on the point, the appeals process will commence.

§ 36.3 IRS IMPLEMENTING GUIDELINES

The IRS's audit practices, present and future, should be evaluated from the larger perspective of the agency's plans for allocation of its resources to programs that support the major strategies and operational priorities of the EO Division. These plans are reflected in the agency's *implementing guidelines* published in connection with the government's fiscal year, commencing with fiscal year 2002.

(a) Fiscal Year 2002 Guidelines

The IRS EO Division is in the process of learning more about the tax-exempt organizations sector (what the agency terms the exempt organizations *community*). Its initiatives in this regard are reflected in the IRS EO Implementing

39. Reg. §§ 601.105(b)(5), 601.201(n)(9).
40. Reg. § 601.105(b)(4).

Guidelines for fiscal year 2002.[41] To this end, an EO Compliance Council has been identifying areas that need attention and is recommending the best way to address them, including direct case examinations, compliance checks and other nonexamination compliance activities, and general compliance research activities.

The IRS has decided to view the tax-exempt organizations community as a cluster of *market segments*. This approach is predicated on the ''recognition that the EO community is comprised of widely diverse segments of organizations with widely diverse needs.'' An illustration of this is the fact that small volunteer organizations have ''very different issues and needs'' from large hospital systems.

The Compliance Council has the responsibility of identifying market segments within the exempt organizations community, collating all available information (including compliance data) for each segment, and identifying and analyzing the ''compliance risks'' associated with each segment. Initially, 35 segments were identified. To the extent that the IRS lacks sufficient information on which to assess the characteristics of a segment, *market segment studies* may be necessary. These studies may or may not entail examinations.

These studies will be comprised of research samples designed to profile unique segments of the tax-exempt organizations' universe and are essential to the ''risk assessment process.'' The profile of a market segment will contain information on its characteristics, geographical locations, compliance levels with the ''technical requirements'' of the federal tax law, compliance levels with ''procedural requirements for completeness and accuracy of the return filing,'' and examination coverage.

Each study will measure compliance with all requirements applicable to that segment. Long-range goals call for the ''ratable completion of studies on most or all identified EO market segments.'' Noncompliance identified through the market segment studies will then be ''assessed for the level of associated risk.'' Compliance improvement projects and educational activities will be designed to address areas of noncompliance identified through this risk assessment process. The results of the completed samples and profiling activities will be discussed in formulating the EO Compliance Program Plan. This plan will be reviewed and approved by the director of the EO Division prior to implementation.

Six market segment studies, using statistically valid sampling techniques, began in fiscal year 2002. This involved examination, on a nationwide basis, of 150 annual information returns of social clubs, labor organizations, business

41. The IRS FY 2002 EO Implementing Guidelines (dated Oct. 2001) are summarized in XIX *The Nonprofit Counsel* (No. 2) 2 (Feb. 2002).

leagues,[42] community foundations, social service organizations, and religious organizations other than churches.

Other projects include an analysis of the level of compliance with the tax laws by organizations maintaining donor-advised fund programs, with emphasis on entities associated with commercial investment firms; development of an overall strategy relating to the areas of private inurement[43] and intermediate sanctions[44]; the monitoring of fundraising programs; and a review of the process for applying for recognition of tax-exempt status.[45]

(b) Fiscal Year 2003 Guidelines

In the IRS's Implementing Guidelines for fiscal year 2003,[46] the EO compliance program is portrayed as a "systematic method to understand and improve compliance through its constituent compliance activities: direct case examinations, nonexamination compliance/education activities and general compliance research activities."

This program is building on the market segment approach the IRS announced when it issued the implementing guidelines for the previous fiscal year. The number of these segments was increased to 42. Five market segment studies commenced in fiscal year 2003, involving fraternal organizations, supporting organizations,[47] arts and humanities organizations, private foundations,[48] and elder housing organizations. Two nonstatistical studies are also to begin, concerning colleges, universities, and hospitals. These two studies are to gather compliance information from prior years' examinations programs (largely coordinated examination programs) and other sources.

A variety of other focus areas were identified: antiterrorist efforts, imposition of penalties for the filing of incomplete returns, the reporting of fundraising revenue and expenses, donation (including used vehicle) programs, consumer credit services, group rulings, revision of the annual information return,[49] disaster-relief programs, and grants to foreign entities.

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42. *See* Chapter 18. The issues in this context are the filing requirements, application of the employment tax, unrelated business activities, fundraising, nonexempt activities, lobbying and political campaign activities, the proxy tax, private inurement, the public disclosure rules, and granting of scholarships.
43. *See* Chapter 4.
44. *See* § 4.9.
45. *See* Chapter 34.
46. The IRS FY 2003 EO Implementing Guidelines are summarized in XIX *The Nonprofit Counsel* (No. 12) 5 (Dec. 2002).
47. *See* § 5.5.
48. *See* § 5.9.
49. *See* § 35.3.

(c) Fiscal Year 2004 Guidelines

The IRS's Implementing Guidelines for fiscal year 2004[50] reflected the fact that the agency's market segment study program, by which it uses ''research samples designed to profile unique segments of the EO universe,'' is well under way. Thirteen of these studies are currently in progress. Final reports on social clubs, business leagues, and labor organizations were projected to be submitted during the first quarter of calendar year 2004, but as of the close of the year, that had not occurred. Studies on religious organizations, social service entities, colleges and universities, hospitals, and supporting organizations were projected to conclude by the fourth quarter of fiscal year 2004, but that did not happen by the close of 2004, either.

These reports, in addition to profiling the market segments involved, are likely to yield recommendations for improving any noncompliance identified by the studies. The IRS stated that these recommendations are ''expected to be broad in scope'' and may result in proposals for legislation or regulations, educational initiatives, publications, revision of forms, targeted examinations, and the like. The studies conducted so far have led the IRS to conclude that the period of time needed for development of them is longer than anticipated. Also, the agency's resources are being used to address tax avoidance schemes and tax shelter activity. Thus, there will be only three market segment studies commenced in fiscal year 2004—those pertaining to fundraising organizations, private schools, and nonexempt trusts.

The Exempt Organizations Division Examinations office focuses on exempt organizations examinations programs and review projects. Its support functions include Examination Planning and Programs, Classification, Mandatory Review, Special Review, and Examinations Special Support. The TE/GE strategic plan calls for improvement of the IRS's presence in the exempt organizations community to promote greater overall law compliance and fairness in the sector. The agency has been working to balance its workforce resources between the examination and determination programs, and to develop more effective methods of allocating and utilizing Examinations resources. One of the IRS's initiatives in this area is establishment of an Exempt Organizations Compliance Unit, to address exempt organizations' customer noncompliance using correspondence and telephone contacts. Another new component of this office is the Data Analysis Unit, which will use various databases and other information to investigate emerging compliance trends to improve the identification and selection of source work in the exempt organizations area.

In recent years, IRS audits declined, in part because of lack of resources and in part because Examinations office employees were diverted to determinations

50. The IRS FY 2004 EO Implementing Guidelines are summarized in 21 *Bruce R. Hopkins' Nonprofit Counsel* (No. 2) 1 (Feb. 2004).

work. This workforce allocation dilemma was subsequently stabilized, with the exempt organizations enforcement emphasis expanded. The IRS's examination coverage is improving as more effective methods of allocating and utilizing resources are being pursued.

The coordinated examination program is being phased out; its replacement will be the *team examination program*. The team (TEP) audit will be utilized in connection with a wider array of exempt organizations than was the case with the coordinated examination program. The IRS plans to identify, then examine, TEP entities entailing significant potential noncompliance. Field examinations of large, complex organizations, which require coordination among IRS functions (and perhaps other governmental agencies), will be conducted using team audit procedures.

The IRS's market segment study program has faltered largely because the agency's exempt organization resources have been diverted to higher-priority work that emerged following commencement of the initiative. The Treasury Inspector General for Tax Administration (TIGTA) completed an audit of the IRS's market segment research program as of the close of 2004 and made recommendations to resuscitate and advance this initiative.[51] TIGTA concluded that delays in completing some of the initial studies are due to ''inadequate planning and oversight.'' This higher-priority work consists of examinations of consumer credit counseling organizations, antiterrorism efforts, an excess compensation study, and abusive tax shelters. Also, according to the report, exempt organization management within the IRS is ''evaluating how to develop a more sophisticated workload selection system that will provide better data to identify productive cases for compliance efforts.''

The report states that no new market segment analyses will be undertaken during the government's fiscal year 2005. In a memorandum in reaction to the report, however, the Commissioner, TE/GE, stated that during this fiscal year the IRS will embark on the examination phase of two segment studies already under way, concerning private foundations and community foundations.

The IRS has taken action to improve the market segment approach by changing the methods used to provide oversight of each study. Each study will be assigned a team leader. Also, guidelines have been issued to provide detail on the roles and responsibilities of the IRS personnel involved, procedures for developing and implementing the studies, the process for developing the project proposals, the approval process to be followed, and the requirement for ''action plans detailing the tasks to be conducted and applicable milestone dates.''

51. TIGTA, ''The Exempt Organizations Function's Market Segment Approach Needs Further Development'' (No. 2005-10-020 (Dec. 2004)).

TIGTA, however, recommended the following additional actions to ensure the success of the market segment study program:

1. Additional guidelines are necessary to provide better direction on how market segment studies should be conducted and reported.
2. A process is needed to capture and systemically track useful information to establish compliance baselines, facilitate meaningful compliance levels, and identify education and outreach needs.
3. A statistical sampling methodology is needed to ensure that cases are consistently selected for the market segment studies and the results of the market segment examinations are useful to exempt organization function management.

The IRS agreed to implement these recommendations, although the TE/GE Commissioner noted in his response memorandum that the ''amount of time available for market segment studies has been reduced'' due to the priority workload.

(d) Fiscal Year 2005 Guidelines

The IRS Exempt Organizations Implementing Guidelines for fiscal year 2005[52] addressed the agency's rulings and agreements process, examinations, electronic initiatives, and customer education and outreach.

The IRS continues to place considerable emphasis on abusive tax-avoidance transactions involving exempt organizations. The agency is endeavoring to identify abusive tax shelters early in their formation (including application of its newly developed Touch-and-Go program).

The IRS is, in this connection, reviewing the status of consumer credit counseling organizations, supporting organizations, donor-advised funds, small non-life mutual insurance companies, and producer-owned reinsurance companies.

Another major area of focus is the prevention of charitable organizations from financing terrorism. The agency is providing training in exempt organizations law within the IRS and to other government personnel, and is providing technical assistance regarding exempt organizations law to a variety of interagency task forces.

The IRS is assisting its tax-exempt organizations Examinations component in profiling grantmakers to foreign charities to determine their oversight efforts in ensuring that their assets are devoted to charitable purposes. This function of the agency provides support to a Fraud and Financial Transactions Unit, which is assembling individuals with expertise in tracking foreign grant activities.

52. The IRS FY 2005 EO Implementing Guidelines are summarized in 22 *Bruce R. Hopkins' Nonprofit Counsel* (No. 5) 3 (May 2005).

The IRS is attempting to develop closer relationships with federal, state, and local governmental bodies that share responsibility for monitoring the activities of tax-exempt organizations. This initiative includes a revitalized state information-sharing program.

The IRS plans guidance to the exempt organizations community concerning down-payment assistance organizations, charitable organizations' participation in low-income housing partnerships, private inurement and intermediate sanctions rules, small exempt insurance companies, the unrelated business rules as applied in the Internet context, and qualified tuition programs.

Having issued a substantially revised Form 1023,[53] the agency continues to work on development of an interactive Internet process (the Cyber Assistant) for preparing and filing this application for recognition of exemption. The agency is also working on a complete overhaul of Form 990.[54]

The IRS is developing a comprehensive plan to address the extensive disclosure requirements. The Rulings and Agreements component will continue to provide legal and technical expertise and support to the Examinations function in connection with the market segment research project. The agency continues to provide speakers for conferences, continuing professional education training for IRS exempt organization employees, and educational materials, such as plain-language publications and web site content.

The IRS is exploring opportunities to increase data availability, improve research and analytical systems, and work with other divisions of the agency to identify new data sources—all in advancement of the agency's goal of deterring abuses within tax-exempt organizations and misuse of them for tax-avoidance purposes. The IRS also plans on using this data to support its antiterrorism efforts and advance its education and compliance programs.

Electronic filing of forms by exempt organizations is well under way, by means of the IRS's Modernized e-File program. Form 990 is being made suitable for electronic filing; Forms 990-PF and 990-T are in the process of development for compatibility with electronic filing.

The IRS will be marketing the Modernized e-File program to increase participation of preparers, filers, and the software development community. The agency will conduct a survey of preparers and tax-exempt organizations to gain feedback about electronic filing.

The IRS wants to improve its "presence" in the exempt organizations community to "promote greater overall compliance and fairness." The agency wishes to help EOs "establish the strong internal governance structures required to prevent future abuse." Indeed, the agency wants to "restore public trust in charitable organizations."

The IRS has hired more revenue agents in the EO area and is implementing a new examination organizational structure. The agency is reengineering the

53. *See* § 34.1.
54. *See* § 35.3.

EO examination process (by establishment of its Filing to Closure Project) and is attempting to get annual information returns ''with the most potential'' to examiners as soon as possible; conduct limited scope audits; improve communications among taxpayers, revenue agents, and group managers; and close cases more quickly.

About 30 percent of the IRS's EO examination time and resources is being devoted to the Team Examination Program, which examines the largest and most complex cases. In this fiscal year, the workload priorities for this program are to be aligned and first focused on qualifying cases, beginning with abusive tax-avoidance transactions.

Three teams have been developed to enhance the selection of returns of exempt organizations, the method of contact with EOs, and use of data. The EO Compliance Unit will address entities with issues that do not initially require examinations, by means of inspection of returns and correspondence contacts. The Data Analysis Unit's main objectives will be the support of compliance initiatives through identification of trends, support of the compliance program in achieving operational efficiencies through the use of improved case selection, and identification of potential compliance issues within the EO structure through the use of the Internet and various databases. The Fraud and Financial Transaction Unit will be established to address complex fraud and tax-avoidance cases.

Other cases of IRS examination include political organizations, disaster relief, gaming, fundraising, intermediate sanctions, and incomplete returns and nonfilers.

At the present, the IRS has identified 38 market segments. The guidelines state: ''Although the original plan included initiating studies of a few markets each fiscal year, no new market segment studies will be initiated in the coming year due to EO's focus on [its other] critical compliance initiatives.''

A major priority of the IRS in the EO setting is deterrence of abusive tax-avoidance transactions. The agency is focused on tax schemes ''initiated by organization insiders or by third parties using the cover of charitable purposes.'' One of these projects concerns tax-exempt small non-life mutual insurance companies. Although legislation was enacted to address abuses involving these entities, the IRS is continuing to enforce the rules in place prior to its effective date (2004).

The IRS persists in its review of donor-advised funds, continuing to find funds that appear to be ''established for the purpose of generating questionable charitable deductions, providing impermissible economic benefits to the donors and their families (including tax-sheltered investment income for the donors), and providing management fees for the promoters.'' Examinations in this area are to occur in this fiscal year.

The IRS continues to see abuses in the realm of supporting organizations. These ''schemes'' include tax-exempt support organizations that do not own

or control their assets, have made large loans to the founder or supported organization trustees, do not have independent trustees, and do not provide the support for which they obtained exemption.'' Examinations are to continue in this area during this fiscal year.

The IRS's Tax Exempt Compensation Enforcement Project is under way. This initiative addresses how compensation is determined and reported, loans to employees, deals between employees and organizations, compensation as compared to assets, and whether the excess benefit box was checked on annual information returns. The agency plans about 2,000 contacts, with examination of selected returns. A report on the outcomes of this project was slated for completion in early fiscal year 2006.

The IRS continues to develop the strategic direction of the nationwide education and outreach programs for exempt organizations customers and to deliver programs and products designed to assist exempt organizations ''understand their tax responsibilities.''

The IRS devises communication plans to complement EO compliance initiatives. The agency intends to continue to develop communication plans on critical examination issues in this fiscal year.

A primary focus of the IRS in this fiscal year was education and outreach to the EO community regarding its compliance responsibilities. These activities fall into four categories: publications and forms, presentations, web site–based programs, and other communication activities.

(e) Fiscal Year 2006 Guidelines

The IRS Exempt Organizations Implementing Guidelines for fiscal year 2006[55] were substantially different in tone and length than their predecessors. Essentially they identified four ''new critical initiatives'' of the IRS: abuses in connection with charitable gifts of easements, misuse of charitable trusts, the role of tax-exempt organizations in facilitating abusive tax shelters, and qualification of hospitals for exempt status. Also identified were four ''ongoing critical initiatives'' of the IRS: abusive tax avoidance transactions, antiterrorism efforts, review of compensation practices, and revocation of exemption of nonprofit credit counseling organizations. The agency reported that market segment studies would not be initiated during this fiscal year.

(f) Fiscal Year 2007 Guidelines

The IRS Exempt Organizations Implementing Guidelines for fiscal year 2007[56] stated that a ''major priority'' for the IRS will be providing guidance

55. The IRS FY 2006 EO Implementing Guidelines are summarized in 23 *Bruce R. Hopkins' Nonprofit Counsel* (No. 2) 1 (Feb. 2006).
56. The IRS FY 2007 EO Implementing Guidelines are summarized in 24 *Bruce R. Hopkins' Nonprofit Counsel* (No. 1) 1 (Jan. 2007).

and education about the law changes wrought by enactment of the Pension Protection Act of 2006. Two of the new projects identified by the IRS were income and expense allocations by colleges and universities in the realm of unrelated business, and a review of law compliance by community foundations (presumably including the use of donor-advised funds). Ongoing initiatives include review of compensation practices by tax-exempt (primarily charitable) organizations, eligibility of nonprofit hospitals for exempt status, political campaign activity by public charities, and examinations of down-payment assistance organizations.

(g) Fiscal Year 2008 Guidelines

The IRS Exempt Organizations Implementing Guidelines for fiscal year 2008[57] proclaimed that the Exempt Organizations Division ''has a new way of doing business,'' in that it is ''now bring[ing] a flexible and interdisciplinary array of new tools and talent to bear on the critical issues and opportunities that confront us in working toward our strategic goals: (1) to enhance the enforcement of the tax law, and (2) to improve customer service.''

The principal enforcement initiative slated for this fiscal year is conduct of a research and compliance project involving tax-exempt colleges and universities, similar to the one being undertaken concerning exempt hospitals.[58] The IRS stated that it will ''gather information from a stratified sampling of colleges and universities to gain a better understanding of this important sector,'' by looking at how these institutions report income and expenses on their annual information returns, calculate and report losses on their unrelated business income tax returns, allocate income and expenses in calculating their unrelated business taxable income, determine executive compensations, and invest and use their endowments. Other initiatives include development of a voluntary compliance program in connection with the laws by which small exempt organizations can lose their exempt status for failing to timely file annual information returns and/or notices and review of newly formed supporting organizations.

The IRS is continuing to work on its cyber assistant program, as well as develop an electronic determinations case processing and tracking system. The agency ongoing efforts include the Tax-Exempt Hospitals Compliance project, the Executive Compensation Compliance project,[59] and the Political Activity Compliance Project.[60]

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57. The IRS FY 2008 EO Implementing Guidelines are summarized in 25 *Bruce R. Hopkins' Nonprofit Counsel* (No. 2) 2 (Feb. 2008).
58. See § 36.5(c).
59. See § 36.5(d).
60. See § 36.5(a), text accompanied by *infra* notes 128 and 129.

§ 36.4 HOSPITAL AUDIT GUIDELINES

The IRS, in recent years, has been making the audit of tax-exempt hospitals and other healthcare entities a matter of special priority. In reflection of this, the IRS in 1992 developed audit guidelines specific to these types of tax-exempt organizations (although many of the guidelines are equally applicable to other types of exempt entities).[61] Although these audit guidelines are no longer in general use, they remain useful in identifying issues.

The guidelines emphasize nearly all aspects of qualification for tax-exempt status by hospitals, with emphasis on private inurement and private benefit situations,[62] and also focus on joint venture arrangements[63] and unrelated business income circumstances.[64]

The tax exemption of nonprofit hospitals today rests on the *community benefit standard*.[65] In determining whether a hospital meets this standard, IRS agents are expected to consider the following factors: (1) whether the hospital has a governing board composed of ''prominent civic leaders'' rather than hospital administrators, physicians, and the like (the agents are requested to review the minutes of the board meetings to determine how active the members are), (2) if the organization is part of a multi-entity hospital system, whether the minutes reflect ''corporate separateness'' (and whether the minutes show that the board members understand the purposes and activities of the various entities), (3) whether admission to the medical staff is open to all qualified physicians in the area, consistent with the size and nature of the facilities, (4) whether the hospital operates a full-time emergency room open to everyone, regardless of their ability to pay, and (5) whether the hospital provides nonemergency care to everyone in the community who is able to pay either privately or through third parties (such as Medicare and Medicaid).[66]

The guidelines contain criteria for assessing whether an ''open staff policy'' exists at a hospital.[67] The auditing agent is to (1) identify qualification requirements for admission to staff (by referring to the medical staff bylaws), (2) review application procedures and methods of staff selection, (3) review minutes of medical staff meetings, (4) determine whether staff admission fees are charged on a preferential basis, (5) ascertain whether new physicians in the geographical area are admitted to the staff (inasmuch as the absence of new members could indicate a closed staff), (6) consider the number of physicians in each membership category (such as active, associate, and courtesy),

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61. These guidelines are the subject of the EXAMINATION GUIDELINES HANDBOOK § 333 (''Hospital Audit Guidelines''), reproduced by the IRS for broader dissemination in Ann. 92-83, 1992-22 I.R.B. 59. *See* Appendix F.
62. *See* Chapter 4.
63. *See* Chapter 22.
64. *See* Chapter 24.
65. *See* Chapter 6.
66. Hospital Audit Guidelines at § 333.1(1).
67. *Id*. at § 333.1(2).

(7) interview knowledgeable officials to determine whether physicians have been denied admission to the staff for other than reasonable cause, (8) review the minutes of the credentials committee, and (9) review the hospital's daily consensus report to determine the percentage of use of hospital facilities by various physicians (as the names of the patients and the physicians providing services for these patients are listed in the report).

The guidelines also contain criteria for determining whether use of an emergency room is restricted.[68] The agent is to (1) review the manual of operations, brochures, posted signs, and the like, (2) interview ambulance drivers to determine whether they are instructed to take indigent patients to another hospital, (3) interview emergency room staff to determine admission procedures, (4) interview social workers in the community, who are familiar with delivery of emergency healthcare services, to determine whether the services are known to be available at the hospital, and (5) ascertain when and how determinations of financial responsibility are made and whether a deposit is required of any patient before care is rendered.[69] Examining agents are expected to ascertain whether a hospital engages in the practice known as *patient dumping*.[70]

An examining agent is admonished to determine whether nonemergency services are available to everyone in the community with the ability to pay.[71] To this end, the agent is to (1) review the hospital admission policy, (2) determine whether the hospital admits and treats Medicare and Medicaid patients in a nondiscriminatory manner, (3) review files on denied admissions to ascertain the reasons for denial, (4) determine whether members of the professional staff also serve in administrative capacities and restrict admissions only to patients of staff members, (5) review the accountants' reports for a statement of the hospital's charity care policy and expenditures, and (6) compare the proportion of services provided to Medicaid patients to the proportion of Medicaid beneficiaries living in the area served by the hospital (with the latter data available either from the institution or from the state Medicaid agency).

The examining agent is to obtain copies of any private letter rulings issued to the hospital by the IRS,[72] and to determine (such as by reviewing newsletters, press releases, and calendars of events) whether the hospital is involved in projects and programs that improve the health of the community.[73]

The guidelines contain a discussion of private inurement and private benefit, and the difference between them.[74] The IRS recognizes two key distinctions

68. *Id*. at § 333.1(3).
69. *See* § 26.4 for a discussion of the "emergency room exception." *See also* Hospital Audit Guidelines at § 333.1(4).
70. Hospital Audit Guidelines at § 333.1(5).
71. *Id*. at § 333.1(6).
72. *Id*. at § 333.1(7).
73. *Id*. at § 333.1(8).
74. *Id*. at § 333.2(1). *See*, in general, Chapter 4.

between these concepts: (1) the agency has reiterated its position that even a ''minimal amount'' of private inurement will result in loss of tax-exempt status;[75] private benefit is tested against an *insubstantiality* threshold; (2) private inurement applies only with respect to *insiders;* private benefit can accrue to anyone.[76] Insiders are defined in these guidelines as individuals ''whose relationship with an organization offers them an opportunity to make use of the organization's income or assets for personal gain.''[77] (The IRS considers a physician an insider in relation to a hospital in which he or she practices and/or is a member of the hospital's governing body.)

The following guidelines[78] were followed in determining private inurement or private benefit:

1. Identify the members of the board of directors or trustees and key staff members of the administrative and medical staff. Examine any business relationships or dealings with the hospital. Note transactions where supplies or services are provided at prices exceeding competitive market prices or at preferred terms. Be alert for any loan agreement at less than prevailing interest rates. Scrutinize any business arrangements under which hospitals finance the construction of medical buildings owned by staff physicians on favorable financial terms.
2. Review contracts and leases. Scrutinize any contracts under which the hospital requires physicians to conduct private practices on hospital premises.
3. Review the minutes of the board of directors' executive committee and finance committee for indications of transactions with physicians, administrators, and board members.
4. Review the articles of incorporation, bylaws, minutes, filings with regulatory authorities, correspondence, brochures, newspaper articles, and the like to determine the existence of related parties.
5. Determine whether the hospital is engaged in commercial or industrial research or testing benefiting private individuals or firms rather than scientific or medical research benefiting the general public.[79]
6. Review third-party reports (such as accountants' audit reports, management letters, and annual reports) to determine whether the hospital's activities further an exempt purpose or serve private interests.
7. Review any conflict-of-interest statements, to determine whether medical staff or board members have an economic interest in, or significant dealings with, the hospital.

75. *Id*. at § 333.2(2).
76. *Id*.
77. *Id*.
78. *Id*. at § 333.2(4)–(10).
79. *See* § 24.11.

These guidelines focus on the matter of unreasonable compensation and require examining agents to inquire as to recruiting incentives, incentive compensation arrangements, below-market loans, below-market leases, and hospital purchases of a physician's practice.[80] The agents are provided with this list of recruitment/retention arrangements:[81]

1. Physicians being charged no rent or below-market rent for space in hospital-owned office buildings or being charged less than fair market value for practice management services.
2. Hospitals providing physicians with private practice income guarantees.
3. Hospitals providing financial assistance to physicians for home purchases and/or the purchase of office equipment.
4. Outright cash payments by hospitals to physicians to secure or retain their services.
5. Purchase of the practice of a physician by a hospital that subsequently employs the physician (in many instances, to operate the same practice). These arrangements are to be ''closely scrutinized,'' including the valuation of the practice and the reasonableness of the compensation paid to the physician.[82]

These guidelines contain an extensive list of ''common compensation arrangements'' between hospitals and physicians.[83]

The guidelines also focus on joint ventures, pointing out that a variety of forms may be involved, such as a cooperative agreement or the creation of a separate legal entity. Examples of the items or services involved in these joint ventures are said to include clinical diagnostic laboratory services, medical equipment leasing, durable medical equipment, and other outpatient medical or diagnostic services.[84]

Agents are advised to carefully examine joint ventures between taxable and tax-exempt parties in search of private inurement or private benefit. The facts must be reviewed to determine whether the partnership involved serves a charitable purpose, whether (and how) participation by the exempt entity furthers an exempt purpose, and whether the arrangement permits the exempt entity to act exclusively in furtherance of its exempt purposes.[85] Examples of private inurement issues in this setting include (1) participation in a venture that imposes on the tax-exempt healthcare organization obligations that conflict with its exempt purposes; (2) a disproportionate allocation of profits and losses

80. Hospital Audit Guidelines § 333.3(1). *See*, in general, Chapter 25.
81. *Id*. at § 333.3(3).
82. *Id*. at § 333.3(3)(e).
83. *Id*. at § 333.3(6). These arrangements are discussed in Chapter 4.
84. *Id*. at § 333.4(1). *See*, in general, Chapter 22.
85. *Id*. at § 333.4(2).

to the nonexempt partners (particularly if they are physicians); (3) loans by the exempt partner to the joint venture on terms that are commercially unreasonable (such as a low interest rate or inadequate security); (4) provision of property or services to the joint venture by the exempt partner at less than fair market value; and (5) receipt by a nonexempt partner of more than reasonable compensation for the sale of property or services to the joint venture.[86]

A variety of private inurement issues involving possible violations of the federal antikickback law are explored in these guidelines. They note that the Office of the Inspector General in the Department of Health and Human Services (HHS) has a program to reduce fraud in the Medicare and Medicaid programs.[87] This office administers an antikickback statute that penalizes anyone who solicits, receives, offers, or pays anything of value to induce or in return for:

1. Referring an individual to any person for the furnishing or arranging for the furnishing of any item or service payable under Medicare or Medicaid, or

2. Purchasing, leasing, or ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item payable under Medicare or Medicaid.[88]

HHS has published a list of ''questionable features which, separately or together, could indicate that a joint venture is suspect'' under the antikickback law.[89] These are as follows:

1. Investors are chosen because they are in a position to make referrals.

2. Physicians who are expected to make a large number of referrals are offered a greater investment opportunity in the joint venture than those anticipated to make fewer referrals.

3. Physician-investors are actively encouraged to make referrals to the joint venture, or are encouraged to divest their ownership interest if they fail to sustain an ''acceptable'' level of referrals.

4. The joint venture tracks its sources of referrals and distributes this information to the investors.

5. Investors are required to divest their ownership interest if they cease to practice in the service area (such as by moving or retiring).

6. Investment interests are nontransferable.

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86. *Id*. at § 333.4(3).
87. *Id*. at § 333.4(4). This program is authorized at 42 U.S.C. § 1320a-7b(b).
88. The auditing agent is advised to ''[b]e aware that certain joint ventures and other hospital–physician arrangements could include hidden or disguised payments for referrals'' *(id.)*.
89. *Id*. at § 333.4(5).

7. The amount of capital invested by the physician is disproportionately small and the returns on investment are disproportionately large when compared to a typical investment in a new business enterprise.
8. Physician-investors invest only a nominal amount (such as $500–$1,500).
9. Physician-investors are permitted to ''borrow'' the amount of the ''investment'' from the entity and pay it back through deductions from profit distributions, thus eliminating the need to contribute cash to the partnership.
10. Investors are paid extraordinary returns on the investment in comparison with the risk involved (such as over 50 to 100 percent per year).
11. The structure of some joint ventures is particularly suspect (for example, where one of the parties is an ongoing entity already providing a particular service), such as a joint venture best characterized as a ''shell'' that merely allows referring physicians to share in the income derived from their referrals.

The auditing agent is advised to ''[b]e alert for joint ventures involving the sale by a hospital of the gross or net revenue stream from an existing hospital service for a defined period of time to private interests.''[90] Alertness is also advised with respect to ''arrangements with physician group practices or clinics where the hospital transfers something of value in return for an agreement to refer patients to the hospital for inpatient, surgical, or diagnostic services.''[91]

Sixteen types of ''financial analyses'' by examining agents are requested.[92] These include:

1. Review income and expenditures of affiliated entities, to determine whether nonexempt purposes, private inurement, serving of private interests, or unrelated business income may be present.
2. Look for lobbying or political activities or expenditures; determine whether the hospital has elected the expenditure test as to lobbying expenditures.[93]
3. Reconcile the hospital's books with the figures on its annual information return.[94] Reconcile the working trial balance to the general ledger, accountants' report, and the return.
4. Review the accountants' report and management letter for indications of unrelated business income.[95]

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90. *Id*. at § 333.4(7). This subject is discussed in § 4.5.
91. *Id*. at § 333.4(8).
92. *Id*. at § 333.5.
93. *See* Chapter 7.
94. *See* § 35.2.
95. *See* Chapter 24.

5. Review Medicare cost reports for indications of insider (related-party) transactions or unrelated activities.
6. Review the correspondence files on large gifts and grants; look for unusual transactions that may prohibit the ''donor'' from receiving a charitable deduction.[96]
7. Check the value shown on the books for donated property against any appraisals in the file; if any property was sold, note the difference between the book value and the selling price.
8. Review the travel ledger accounts of the administrative department and the board of directors; be alert for personal items such as spousal travel and ensure that there has been a ''proper accounting.''
9. Where private individuals or outside entities operate the hospital cafeteria, gift shop, pharmacy, parking lot, and the like, determine whether the agreements with these individuals or firms provide for reasonable payments to the hospital.
10. Reconcile expenses on the tax return used to report unrelated business income.[97] If specific cost centers are maintained, review them for possible account analysis. If specific cost centers are not maintained, the agent is to request a copy of the allocation method used and determine whether it is reasonable in accordance with the federal tax requirements.[98]

The guidelines contain the following rules for analyzing a hospital's balance sheet:[99]

1. Review the general ledger control account for receivables from officers, trustees, and members of the medical staff, and analyze for private benefit and additional compensation; review loan or other agreements underlying these transactions.
2. Check notes receivable for interest-free loans to insiders (for example, a mortgage loan to an administrator given as an inducement to accept or continue employment at the hospital); these arrangements are to be scrutinized for inurement, proper reporting, and the like.
3. Review property records to determine whether any assets are being used for personal purposes that should be taxable income to the user (such as vehicles and residential property held for future expansion).
4. Review trust funds to see whether the trusts should be filing separate returns.

96. *See*, in general, CHARITABLE GIVING, particularly §§ 3.1, 7.4, 10.1, 10.3, 23.1, and 23.2.
97. Form 990-T. *See* § 35.3(a)(iii).
98. *See* § 24.22, text accompanied by note 493.
99. *Id*. at § 333.6.

5. Review investment portfolios and check for controlled entities.

6. Review the ledger accounts and check for notes and mortgages payable that could lead to unrelated debt-financed income[100] issues.

7. Analyze any self-insurance trust or fund set up by the hospital to provide liability insurance.[101]

8. Refer to the appropriate IRS guidelines when there is evidence that the hospital has purchased or sold healthcare facilities utilizing tax-exempt bonds.[102]

In the context of discussing audit items,[103] the guidelines also contain rules for determining whether physicians are employees of the hospital (rather than independent contractors).[104] According to these guidelines, if the following factors are present, the physician is ''most likely'' an employee (even if the contract describes the position as an independent contractor): (1) the physician does not have a private practice; (2) the hospital pays wages to the physician; (3) the hospital provides supplies and professional support staff; (4) the hospital bills for physician services; (5) there is a percentage division of physician fees with the hospital (or vice versa); (6) there is hospital regulation of, or right to control, the physician; (7) the physician is on duty at the hospital during specified hours; and/or (8) the physician's uniform bears the hospital name or insignia.[105]

One aspect of the package audit accorded prominence in these audit guidelines is an arrangement where a tax-exempt hospital pays certain personal or business expenses of affiliated physicians and the taxable compensation is not properly reflected as wages or other form of compensation in the annual information returns,[106] employment tax returns, or compensation information returns.[107] The example is provided of college and university medical school faculty physicians who often have employment contracts with medical schools that limit their compensation to low levels compared to compensation obtainable in private practice. These physicians may enter into employment contracts as consultants with several hospitals or clinics unrelated to the medical schools

100. *See* § 24.20.
101. *See* §§ 9.3 and 34.5.
102. *See* Chapter 30.
103. *See* text accompanied by *supra* notes 16–17.
104. Hospital Audit Guidelines § 333.7(5). *See* Chapter 27.
105. *Id*. at § 333.7(5)(a)–(h). The examining agent is referred to the common-law factors that indicate an employment relationship (enumerated in Rev. Rul. 87-41, 1987-1 C.B. 296). In a ''questionable situation,'' the agent is to determine whether the IRS form to determine employee status (Form SS-8) has been filed by the employer or the employee. The agent is advised to ''[b]e aware that, under Revenue Act of 1978 § 530, an employer may have safe harbor protection if he or she fails to raise an employment tax misclassification issue on audit (Rev. Proc. 85-18, 1985-1 C.B. 518).
106. Form 990. *See* § 35.3.
107. Form W-2 or 1099.

where they teach. The written employment contract with these hospitals or clinics may be supplemented by a verbal agreement that provides for the hospital or a third party to pay associated business or personal expenses (such as lease of luxury automobiles, house improvements, and country club memberships) as part of the total annual employment contract amount. Examining agents are cautioned that the compensation information return may reflect the cash amount paid by the hospital or clinic directly to the physician but exclude amounts paid to other parties on the physicians' behalf.[108]

The other package audit issues outlined in these procedures cause the examining agent(s) to undertake the following:

1. Review contracts with hospital-based specialists, such as radiologists, anesthesiologists, and pathologists. These physicians may be employees for federal employment tax purposes, including income tax withholding. The agent is to interview these physicians ''when necessary to clarify and verify contract items.''[109]
2. Review professional service contracts, which usually specify who will carry the malpractice insurance. If the hospital pays for the insurance, that may be an indication of the physician's being an employee (rather than an independent contractor), or of private inurement. Be alert to efforts on the part of physicians to be treated as employees for some purposes (such as deferred compensation benefits) but as independent contractors for compensation purposes.[110]
3. Review fellowships, stipends, or other payments to interns, residents, medical students, and nursing students, to determine whether these arrangements represent taxable income subject to tax and social security withholding if paid in connection with services rendered.[111]
4. Determine how private-duty nurses are compensated and whether the hospital has a responsibility to file a compensation information return.[112]
5. Determine whether the hospital contracts to purchase services that are outside the ambit of those that may be performed by cooperative hospital service organizations, and if so, whether they are purchased from one of these organizations or from unrelated tax-exempt organizations. Determine whether the nature and extent of the services purchased indicate that the exempt organization providing the services should be considered for examination.[113]

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108. Hospital Audit Guidelines § 333.7(2).
109. *Id*. at § 333.7(3).
110. *Id*. at § 333.7(4).
111. *Id*. at § 333.7(6). (Special rules in this regard for student nurses are contained in Rev. Rul. 85-74, 1985-1 C.B. 331.)
112. *Id*. at § 333.7(7).
113. *Id*. at § 333.7(8). These cooperative entities are the subject of § 17.1.

6. Review employment contracts of medical personnel who have tax-deferred annuity contracts, and ensure that only common-law employees are receiving the benefits of these annuities. Test check to determine whether reduction agreements are on file and whether the exclusion allowances are within the federal tax limits.[114]

7. Determine what types of retirement plans, insurance plans, and non-qualified deferred compensation arrangements are in place. Inspect brochures provided to employees, to obtain background information; interview hospital officials in regard to transactions between the hospital and the plan; identify deferred compensation arrangements and determine the correct tax consequences; if the hospital has a profit-sharing plan, determine the effect on the tax-exempt status of the institution and whether an examination of the plan is necessary.[115]

8. Prepare an information report on significant amounts of excess indemnification (patient refunds) received under medical insurance policies that are attributable to an employer's contribution, inasmuch as these refunds are includable in the gross income of the patient.[116]

9. Determine whether the hospital has filed or is liable for eleven specific IRS forms.[117]

Concerning the unrelated income aspects of audits of healthcare institutions, IRS agents are provided a comprehensive listing of issues and authorities, and are advised to be particularly inquisitive with respect to ''[s]pecific examples common in [the] health care field'':[118] laboratory testing; pharmacy sales; cafeterias, coffee shops, and gift shops; parking facilities; medical research; laundry services; leasing of medical buildings; supply departments; and services to other hospitals.[119]

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114. *Id*. at § 333.7(9). These tax-deferred arrangements are discussed in Chapter 28.
115. *Id*. at § 333.7(10). In general, *see* Chapter 28.
116. *Id*. at § 333.7(11).
117. *Id*. at § 333.7(12). These forms are (1) 5578 (annual certification of private school); (2) 5768 (lobbying election (*see* § 7.1, text accompanied by note 7)); (3) 720 (quarterly federal excise tax return); (4) 2290 (highway use tax); (5) 1120 (corporate income tax return, for a taxable subsidiary (see Chapter 16)); (6) 8282 (donee information return (see CHARITABLE GIVING, § 22.3)); (7) 8300 (report of cash payments over $10,000 received in a trade or business); (8) 990 (annual information returns (*see* § 35.3) of related tax-exempt organizations, such as the hospital's development foundation (*see* Chapter 14) or an auxiliary)); (9) 990 (prior and subsequent returns of the hospital under audit); (10) 990-T (prior and subsequent unrelated business income tax returns (*see* § 35.3(a)(iii)) of the hospital under audit); and (11) 1120-POL (income tax return for certain political organizations).
118. Hospital Audit Guidelines § 333.8(1).
119. These and other subjects in the field of unrelated business income taxation for tax-exempt healthcare entities are discussed in Chapter 24. In general, *see* McGovern, ''IRS Audits of Exempt Organizations: News and Tips for the General Practitioner,'' 17 *Exempt Org. Tax Rev*. (No. 1) 125 (1997); Faber, ''How to Handle an IRS Audit of a Tax-Exempt

§ 36.5 IRS COMPLIANCE CHECK PROJECTS

An overlay to the IRS program of examinations of tax-exempt organizations is the agency's *compliance check projects* program.

(a) Compliance Check Projects Program

The IRS's compliance check projects entail forms of examinations of tax-exempt organizations that are driven by specific compliance issues, as contrasted with audits of exempt organizations analyzing the entities' overall compliance with the law of tax-exempt organizations. A definition of an IRS *compliance project* is a project that is ''designed to address an identified issue, which may or may not be associated with a particular market segment.''[120] This summary of these projects added: ''In the past, the EO function has conducted compliance projects to assess and address known areas of noncompliance through examinations, compliance checks, and educational programs. These projects are managed by a project team, which is responsible for developing a strategy to address the issue if a method to address the issue is not readily apparent.''[121] A *compliance check* is a ''review conducted by the IRS to determine whether an organization is adhering to recordkeeping and information reporting requirements and whether an organization's activities are consistent with their [sic] stated tax-exempt purpose.''[122] This process may include the issuance of, in the words of the agency, ''targeted compliance notices to noncompliant organizations, with directions for taking appropriate actions.''[123] These compliance check projects are traceable to the massive effort by the IRS to examine, and largely revoke the tax exemption of, all of the nation's nonprofit credit counseling organizations.[124] (An in-tandem program was and is denial of recognition of exemption to nearly all applicant credit counseling entities.)

Beginning in 2002, after nearly 25 years of quietude on the subject, the IRS renewed its efforts to revoke or deny recognition of tax exemption of

Organization,'' 16 *Exempt Org. Tax Rev.* (No. 5) 753 (May 1997); McGovern, ''The IRS Compliance Program for Nonprofit Hospitals,'' 16 *Exempt Org. Tax Rev.* (No. 2) 201 (Feb. 1997); Theisen and Pelfrey, ''Preparing an Exempt Health Care Organization for an IRS Audit,'' 6 *J. Tax'n Exempt Orgs.* (No. 5) 208 (Mar./Apr. 1995); Flynn, ''Audit Guidelines Send Agents to All Corners of Hospital Operations,'' 4 *J. Tax. Exempt Orgs.* 9 (Nov./Dec. 1992).

120. Treasury Inspector General for Tax Administration, ''Tax-Exempt Hospital Industry Compliance with Community Benefit and Compensation Practices Is Being Studied, but Further Analyses Are Needed to Address Any Noncompliance'' 5, note 10 (no. 2007-10-061) (Mar. 29, 2007).
121. *Id.*
122. *Id.* at 6, note 11.
123. IRS FY2003 Exempt Organizations Implementing Guidelines. *See* § 36.3(b).
124. See TAX-EXEMPT ORGANIZATIONS § 7.3.

nonprofit credit counseling agencies.[125] The agency, in 2003, in conjunction with the Federal Trade Commission and state regulators, launched a program of intense review of these organizations.[126] The IRS made examination of these organizations one of its top enforcement priorities at the time. A similar exercise has been unfolding in connection with down-payment assistance organizations.[127]

Another area of the law of tax-exempt organizations that the IRS generally disregarded over the decades was the rule that exempt charitable organizations may not—if they wish to remain exempt—participate or intervene in political campaigns on behalf of or in opposition to one or more candidates for public office.[128] In 2004, the IRS abruptly changed course in this regard, with the agency plunging into a substantial enforcement (and educational) effort on the subject.[129] The IRS also began to focus on the compensation of exempt organizations' executives.[130] Other past and present IRS initiatives in this regard are the agency's hospital compliance project,[131] an intermediate sanctions reporting project,[132] a fundraising costs reporting project,[133] a tax-exempt bonds record-keeping compliance project,[134] and a successor member interest contributions compliance project.[135] Unlike conventional audits, the IRS usually publicly disseminates information resulting from a compliance check project, thus coupling enforcement with education (and lawmaking).[136]

(b) Concept of Market Segment Study

There can be conceptual overlap between a compliance project and a market segment study. As noted, a compliance project is a project that ''may or may not be associated with a particular market segment.''[137] The concept of the market segment study emerged when, around 2001, the agency became engaged in what was proposed to be a wholesale analysis of the tax-exempt sector. In this connection, the IRS began viewing what it called the *exempt*

125. This intense effort was stimulated and augmented by considerable interest in this matter by Congress, which is atypical of IRS compliance check projects.
126. IR-2003-120; FS-2003-17.
127. See Tax-Exempt Organizations § 7.5.
128. *See* § 7.4.
129. *See* IRS Audits § 4.4.
130. *See* § 36.3(d).
131. *See* § 36.3(c).
132. *See* IRS Audits § 4.6.
133. *Id*. § 4.7.
134. *Id*. § 4.8.
135. *Id*. § 4.9.
136. For example, in conjunction with its examination of down-payment-assistance organizations, the IRS published criteria for tax exemption for these entities (Rev. Rul. 2006-27, 2006-1 C.B. 915); following its inquiries into charitable organizations' involvement in political campaigns, the IRS issued guidance as to what is and is not political campaign involvement (Rev. Rul. 2007-41, 2007-25 I.R.B. 1421).
137. *See* text accompanied by *supra* note 120.

organizations community as a cluster of *market segments*. Thus, the IRS Exempt Organizations Implementing Guidelines for fiscal year 2002 stated that the ''EO community is comprised of widely diverse segments of organizations and widely diverse needs.''[138]

An EO Compliance Council began identifying market segments within the tax-exempt organizations community, and collated information (including compliance data) for each segment and analyzed the ''compliance risks'' associated with each of the segments. (The number of these segments was always fluid, ranging from 35 to 42.) The plan was to research each segment, using statistically valid sampling techniques (including review of about 150 annual information returns for each segment); the profiles were to measure compliance with all federal tax law requirements applicable to the discrete segment. The results of the completed samples and profiling activities were to be used in formulating the IRS's EO Compliance Program Plan.

This ambitious market segment study program was launched with the government's fiscal year 2002, with six studies.[139] Five more studies were added in connection with the fiscal year 2003 plan, plus two nonstatistical studies.[140] The IRS efforts with respect to fiscal year 2004 brought three more studies.[141] Then, this massive project began to collapse, largely because the resources of the EO Division were being diverted in other, more pressing, directions; in the EO Implementing Guidelines for fiscal year 2005,[142] the IRS announced that no new market segment studies would be initiated due to its focus on other ''critical compliance initiatives.'' The EO Implementing Guidelines for fiscal years 2006 and 2007 were essentially silent on new studies.

The IRS had announced that three of the first market segment study reports would be published in the first quarter of calendar year 2004. The agency also said that five other reports would be concluded and made available by the fourth quarter of fiscal year 2004. Not one of these reports has materialized. Along the way (in early 2005), the Treasury Inspector General for Tax Administration audited the IRS's market segment research program, and made recommendations to resuscitate and advance this initiative. According to the resultant TIGTA report, the EO Division was ''evaluating how to develop a more sophisticated workload selection system that will provide better data to identify productive cases for compliance efforts.''[143] The TIGTA effort was of no avail; the formal market segment study program imploded, then disappeared.

But this program did not vanish without any trace. The spirit of it lives on. Many of the compliance check projects have manifestations of a market

138. *See* § 36.3(a).
139. *Id*.
140. *See* § 36.3(b).
141. *See* § 36.3(c).
142. *See* § 36.3(d).
143. TIGTA report 2005-10-020.

segment analysis, such as those involving hospitals, credit counseling organizations, and down-payment assistance providers. Indeed, in the fiscal year 2007 EO Implementing Guidelines,[144] the IRS announced two new projects: examination of income and expense allocations by colleges and universities in the realm of unrelated business, and review of law compliance by community foundations.

(c) Hospital Compliance Project

The IRS, in 2006, initiated its Hospital Compliance Project, the purpose of which is to study tax-exempt hospitals and assess how these institutions believe they are providing a community benefit, as well as to determine how exempt hospitals establish and report executive compensation. Although the IRS published an interim report based on data gathered from questionnaires and annual information returns (Forms 990),[145] the executive compensation component of this project was not addressed in this report inasmuch as examinations in that area are ongoing.

(i) Law Backdrop. Tax-exempt hospitals have attracted the attention of Congress, the Department of the Treasury, and the IRS in recent months. This is not surprising, if only because health-related organizations comprise the largest percentage of exempt charitable organizations and account for about 60 percent of the charitable sector's revenue. Also, there are continuing allegations of a lack of significant difference between exempt and for-profit hospitals, particularly when it comes to charity care and the provision of community benefits.[146]

In addition to meeting the general requirements for tax exemption as charitable institutions, hospitals must satisfy a charity care standard and a community benefit standard. The *charity care standard* requires that an exempt hospital admit and treat patients who are unable to pay either without charge or at rates that are below cost. The *community benefit standard* requires an exempt hospital to operate for the benefit of its community. A hospital that otherwise qualifies for exempt status will meet the community benefit standard when it has a board of directors comprised of prominent citizens drawn from the community, has a medical staff consistent with the size and nature of its facilities that is open to all qualified physicians in the area, operates a full-time emergency room open to all individuals without regard to their ability to pay, and provides hospital care for everyone in the community that is able to pay the costs themselves, by means of private health insurance, or with the aid of public programs (such as Medicare). Nonetheless, a hospital can qualify for

144. *See* § 36.3(f).
145. This interim report is the subject of IR-2007-132.
146. *See* §§ Chapters 3 and 6.

exemption pursuant to the community benefit standard if it does not operate emergency facilities, as long as there are other indications of community benefit.

There is, today, considerable controversy and uncertainty as to the meaning and scope of the concept of *community benefit*. Many of the issues in this context were aired at a hearing before the Senate Committee on Finance, on September 13, 2006, on the subject of community benefit and charity care provided by tax-exempt hospitals. The essence of the testimony presented at this hearing was that the IRS should establish clearer standards for the ascertainment of and reporting by hospitals of community benefit. One approach championed at that hearing involved the guidelines as to community benefit established by the Catholic Health Association, to be used by all exempt hospitals as a template by which community benefit and charity care can be measured and compared to such benefits and care provided by other hospitals.[147] Two of the principal issues in this regard (pitting the Catholic Health Association against the American Health Association) are whether bad debt and unreimbursed amounts paid by hospitals to treat patients should be taken into account in calculating community benefit. It may be presumed that the IRS's compliance check project concerning hospitals will, among other outcomes, bring refinement to identification of the elements that are to be considered in ascertaining community benefit.

(ii) Methodology and Process. The management of the Exempt Organizations Division assembled a multifunctional team to plan and implement the hospital compliance project. This team prepared a detailed action plan and project proposal that outlined the objectives of the project, required action items, dates, resources necessary, and potential actions that may be taken to address the identified issues.

In selecting the hospitals to be contacted in effectuation of this project, the IRS queried its files to identify nonprofit, tax-exempt, charitable hospitals. From an initial identified universe of approximately 6,000 entities, the agency selected 544 organizations that it confirmed were hospitals. The IRS, in May 2006, sent compliance questionnaire letters to each of these hospitals, which were of varying sizes and types, and were located in different regions and communities throughout the United States. The agency exercised "some judgment" in identifying hospitals that were not "uniquely available" in the IRS database. Thus, the resulting sample may or may not reflect the nonprofit hospital sector in general.

Fifty-seven entities were excluded from the original sample of 544 organizations to yield a total net sample of 487 responding hospitals. Forty-six of these hospitals responded that they were not tax-exempt as charitable organizations, generally because they had recently ceased operations and were in

147. *Id*.

the process of winding down or had recently merged with another hospital. Eleven hospitals did not respond to the questionnaire; these hospitals have been ''referred for additional follow-up'' (that is, examination).

The compliance questionnaire consisted of nine pages and 81 questions.[148] Information was requested regarding the type of hospital and patient demographics, governance, medical staff privileges, billing and collection practices, and categories of programs that might constitute community benefit, such as uncompensated care, medical education and training, medical research, and other community programs conducted by hospitals. Not every hospital answered every question, resulting in a variation in the number of responses. The IRS also derived revenue data from annual information returns and other IRS databases.

More specifically, this questionnaire contained the following parts:

- The first part requested entity information, such as the organization's name, employer identification number, and date of the most recently filed annual information return.
- The second part requested information to determine whether and how the tax-exempt hospital demonstrates its qualification for exemption as a charitable entity under the community benefit standard; information gathered in this portion of the project is intended to enable the exempt organizations function of the IRS to determine:
  - Whether nonemergency services are available to everyone with the ability to pay
  - Whether the hospital treats Medicare and Medicaid patients in a nondiscriminatory manner
  - How the hospital deals with the uninsured
  - Whether and how determinations of financial responsibility are made
  - The nature and extent of the hospital's charity care policies and, if such a policy exists, how the hospital distinguishes charity care from bad debt
  - The nature and extent of medical research programs
  - The hospital's participation in partnerships, limited liability companies, other joint ventures, and Subchapter S corporations
  - The hospital's financial relationship with staff members and other closely connected individuals and entities
  - What additional guidance, education, and/or compliance actions are appropriate

148. This questionnaire was published as IRS Form 13790.

- The third part of this questionnaire requested information to identify abuses by tax-exempt hospitals in the form of payment of excessive compensation and benefits to their officers and other insiders; information gathered in this portion of the project is designed to allow the Exempt Organizations function of the IRS to:
    - Address the compensation of specific individuals and instances of questionable compensation practices and procedures.
    - Increase awareness of tax law issues as hospitals establish compensation amounts and types in the future.
    - Learn more about the practices and procedures that hospitals are following as they set compensation.
    - Gauge the existence and effectiveness of the controls employed by hospitals in connection with compensation issues.
    - Learn more about how hospitals report compensation to the IRS and the public on their annual information returns.

There was a high response rate as to most of the questions. For example, all 487 hospitals responded to the questions regarding the type of hospital and frequency of board meetings. Over 480 hospitals responded to questions regarding whether they denied medical services to individuals based on insurance coverage, whether they operated an emergency room, medical staff privileges, medical research, medical education and training, uncompensated care, billing and collection practices, and community programs. Many hospitals provided attachments and other information to supplement their responses to certain questions.

General surgical and medical hospitals comprised 89 percent of the respondents, with the remainder providing specialty care (such as psychiatric or rehabilitation services). Inpatients and emergency room patients accounted for 22 percent of the total patients; outpatients amounted to 78 percent of the total patients reported in connection with this project. Forty-six percent of the patients were covered by private insurance; 46 percent of the patients were covered by public programs (Medicare, Medicaid, or other public insurance). Seven percent of reported total patients lacked insurance coverage.

(iii) TIGTA Review. During the period the IRS was assessing the information it derived from the questionnaires and writing its interim report, the Treasury Inspector General for Tax Administration (TIGTA) reviewed the purpose and scope of this compliance check project, and inquired as to how IRS management intends to use the results to address potential noncompliance with the law of tax-exempt organizations by exempt hospitals. TIGTA issued a report summarizing and describing the status of the Exempt Organizations

Division's tax-exempt hospital compliance project.[149] TIGTA stated that, ''[i]f information gathered in the compliance project shows hospitals are performing only minimum actions to meet the community benefit standard, the function [the Exempt Organizations Division] will consider initiating examinations in this area.'' TIGTA also noted that IRS management may utilize project information to assist in ''differentiating tax-exempt hospitals from for-profit hospitals and in determining whether legislative action would improve'' the ability of the IRS to ''administer [the] tax laws in the tax-exempt hospital industry.''

This TIGTA analysis stated that the Exempt Organizations Division's plan is to issue two reports: an interim report to be made public in mid-2007[150] and a final report, to be issued in September 2008, summarizing the results of this tax-exempt hospitals compliance check project. This final report is expected to provide an update on the community benefit standard since issuance of the interim report, to include a summary of the examination results related to excess compensation, and may include recommendations to improve future compliance by exempt hospitals, recommendations related to educational and outreach efforts needed in these areas, and additional training for Exempt Organization Division personnel in compensation analysis for exempt hospitals.

(iv) IRS Interim Report. The IRS, in 2007, released an interim report summarizing information received from 487 tax-exempt hospitals, in response to questionnaires the agency sent in 2006, as to how they provide and report benefits to the community. The agency concluded, in this report, that ''there is variation in the level of expenditures hospitals report in furtherance of community benefit.'' Also, the respondents ''report[ed] similar information in different ways.'' (The report did not address the point that there is no uniform definition of the concept of *community benefit*.)

The report noted that ''there is considerable variation in how hospitals report uncompensated care.'' (The term *uncompensated care* was deliberately not defined in the questionnaire because the IRS wanted to learn how the exempt hospital community was applying it.) The report stated that hospitals ''use a range of income and asset criteria to establish eligibility for uncompensated care.'' Hospitals ''also vary in how they measure and incorporate bad debt expense and shortfalls between actual costs and Medicare or Medicaid reimbursements into their measures, and whether they use charges or costs in their measures.''

Uncompensated care accounted for 56 percent of the total community benefit expenditures. Although 97 percent of the hospitals reported that they have a written uncompensated care policy, the respondents did not provide a uniform definition of that term. The treatment of bad debt expense as

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149. 2007-10-061 (Mar. 29, 2007).
150. *See* § 36.3(c)(iv).

uncompensated care was mixed, with 56 percent of the hospitals reporting that they did not include bad debt expense as uncompensated care and 44 percent of these institutions reporting that at least some bad debt expense was treated as uncompensated care. Hospitals also varied in reporting uncompensated care on the basis of costs or charges, and the treatment of the difference between gross charges and amounts received for providing care (shortfalls) to Medicare, Medicaid, uninsured, and other patients.

After uncompensated care, the largest categories of expenditures reported by the hospitals as the provision of community benefit were medical education and training (23 percent), research (15 percent), and community programs (6 percent). More than 75 percent of hospitals reported expenditures for producing newsletters and other publications, medical screenings, and public educational programs. Many hospitals reported expenditures to study the unmet health needs of the community (28 percent), immunization programs (40 percent), programs to improve access to health care (54 percent), and other health promotion programs (32 percent).

The report summarized the level of potential reported community benefit expenditures as a percentage of hospitals' total revenue. The mean (average) community benefit expenditures reported by the hospitals, as a percentage of the individual hospital's total revenues, was 9 percent; the median was 5 percent. High percentages of hospitals reported that they did not deny medical services to individuals based on type of insurance or if the patients lacked insurance.

The project team that prepared this interim report recommended that a schedule to the Form 990 be designed to enable exempt hospitals to report their community benefit expenditures. This type of schedule is part of the draft of the revised Form 990 that was released for public comment in June, 2007. Indeed, the project team used data from this compliance check project to assist in the crafting of this proposed schedule (Schedule H), which would require reporting (at cost) the charity care and other community benefits provided by the filing organization, and would require information regarding the organization's charity care policies, revenue profile, bad debt expense, collection practices, and certain other activities.

(v) Future Developments. The project team that developed this interim report is to do the following:

- Analyze the reported data to determine whether differences in reporting, such as the treatment of bad debt and shortfalls as uncompensated care, may be isolated and adjusted to allow more meaningful comparisons among the respondents.
- Engage in additional research and analyze the differences in community benefit expenditure amounts and types to take into account varying demographics, such as rural and urban communities and hospitals.

- Test the reported community benefit amounts and types by conducting data analysis, compliance checks or examinations of individual hospitals, and other means.

(d) Executive Compensation Compliance Project

The IRS announced an Executive Compensation Compliance Initiative in mid-2004. This effort was formally launched on August 10, 2004, when the agency stated that it was going to ''identify and halt'' the practice of some tax-exempt organizations of paying excessive compensation and other benefits to insiders. The purposes of this project were to:

- Address the compensation of specific individuals or instances of questionable compensation practices.
- Increase awareness of the tax law issues involved as organizations establish amounts and types of compensation in the future.
- Enable the IRS to learn more about the practices that exempt organizations are following as they set compensation and report it on their annual information returns.

The IRS, on March 1, 2007, published a report on its findings as a consequence of this executive compensation initiative.[151]

(i) Law Backdrop. Two significant bodies of law, from a federal tax law standpoint, inform the matter of executive compensation paid by tax-exempt organizations. The doctrine of *private inurement* is one of the most important sets of rules constituting the law of exempt organizations; indeed, it is the fundamental defining principle of law that distinguishes *nonprofit organizations* from *for-profit organizations*.[152] The private inurement doctrine is a statutory criterion for federal income tax exemption for 13 categories of exempt organizations, including healthcare organizations.[153] Nearly all of the law concerning the private inurement doctrine has been developed in connection with transactions involving exempt charitable organizations. The sole formal sanction for violation of this doctrine is revocation (or perhaps denial of recognition) of exempt status.

The oddly phrased (and thoroughly antiquated) language of the private inurement doctrine requires that the tax-exempt organization be organized and operated so that ''no part of . . . [its] net earnings . . . inures to the benefit of any private shareholder or individual.''[154] The doctrine today means that none

151. This compliance check project is separate from the inquiry into the compensation practices of tax-exempt hospitals (*see* § 36.3(c)).
152. *See* Tax-Exempt Organizations § 1.1.
153. *See* Chapter 4.
154. E.g., IRC § 501(c)(3).

of the income or assets of an exempt organization subject to the doctrine may be permitted to directly or indirectly inappropriately benefit an individual or other person who has a close relationship with the organization, when he, she, or it is in a position to exercise a significant degree of control over it. This type of person is known as an *insider.*

Many forms of transactions and arrangements can trigger a transgression of the doctrine of private inurement. The underlying standard in this setting is that the transaction or arrangement be *reasonable*. The type of transaction that is relevant is the payment of compensation. Thus, the private inurement doctrine mandates that the compensation amount paid by most tax-exempt organizations to their insiders be reasonable, as opposed to excessive. Whether an amount (or perhaps type) of compensation is reasonable is a question of fact, to be determined in the context of each case.

The process for ascertaining the reasonableness of compensation is an exercise of comparing a mix of variables largely pertaining to the compensation of others in similar circumstances. In general, reasonable compensation is that amount that would ordinarily be paid for like services by like enterprises under like circumstances. This alchemy—what the intermediate sanctions rules[155] refer to as an accumulation and assessment of data as to comparability—yields the conclusion as to whether a particular item of compensation or a compensation package is reasonable or unreasonable (excessive).

Traditionally, the case law has dictated the criteria to be used in ascertaining the reasonableness of compensation. This approach has come to be known as utilization of the *multifactor test*. The elements—factors—to be used in a particular case can vary, depending on the court. Much of the law in this field is based on case law concerning payments by for-profit corporations to their chief executives. This is because a payment of compensation, to be deductible as a business expense, must be an *ordinary and necessary outlay;* the concept of reasonableness and ordinary and necessary are essentially identical. Also, the advent of the intermediate sanctions rules has greatly informed this aspect of the law.

The factors commonly applied in the private inurement setting (and similar settings) to ascertain the reasonableness of compensation are the levels of compensation paid by similar organizations (tax-exempt and taxable) for functionally comparable positions, with emphasis on comparable entities in the same community or region; the need of the exempt organization for the services of the individual whose compensation amount and type is being evaluated; the individual's background, education, training, experience, and responsibilities; whether the compensation resulted from arm's-length bargaining, such as whether it was approved by an independent board of directors; the size and complexity of the organization, in terms of elements such as assets, income, and number of employees; the individual's prior compensation arrangement; the

155. *See* § 4.9.

individual's leadership and other performance; the relationship of the individual's compensation to that paid to other employees of the same organization; whether there has been a sharp increase in the individual's compensation (a spike) from one year to the next; and the amount of time the individual devotes to the position.

The other body of federal tax law directly pertinent to the matter of executive compensation paid by tax-exempt organizations is the regime known as *intermediate sanctions*, with its emphasis on the *excess benefit transaction*. An excess benefit transaction is essentially the same as a private inurement transaction; in the intermediate sanctions setting, an insider is denominated a *disqualified person*. Exempt charitable and social welfare organizations are subject to this body of law. The sanction(s) imposed in this context are excise taxes, payable by the disqualified person(s) involved.

An excess benefit transaction is a transaction in which an economic benefit is provided by a tax-exempt organization subject to this law (known as an *applicable tax-exempt organization*), directly or indirectly, to or for the use of a disqualified person, and the value of the economic benefit provided by the exempt organization exceeds the value of the consideration (including the performance of services) received for providing the benefit. The difference between the value provided by the exempt organization and the consideration it received from the disqualified person is an *excess benefit*.

An excess benefit transaction includes a payment of unreasonable (excessive) compensation by an applicable tax-exempt organization to a disqualified person with respect to it. The general intermediate sanctions law (including the tax regulations) inexplicably fails to enumerate some or all of the factors to consider in determining whether compensation is reasonable (although they are inventoried above). Nonetheless, in conjunction with the rebuttable presumption as to reasonableness, there is reference to *appropriate data as to comparability*. In this context, relevant data includes compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions, the availability of similar services in the geographical area of the exempt organization, current compensation surveys compiled by independent firms, and actual written offers from similar institutions competing for the services of the compensated individual.

A third body of federal tax law has some bearing on tax-exempt organizations' compensation arrangements: the doctrine of *private benefit*.[156] The private benefit doctrine is, in many ways, the same as the private inurement doctrine. The most important distinction is that the prohibition against private benefit is not limited to situations where benefits accrue to an organization's insiders. Thus, the private benefit doctrine encompasses compensation paid to persons who are not insiders (or disqualified persons) with respect to the exempt organization. The principal focus of the IRS, however, is on compensation paid by

156. *See* § 4.6.

exempt organizations to their top executives, who are insiders, so the private benefit doctrine is rarely applied in connection with compensation issues.

(ii) Background. The Exempt Organizations Office of the IRS's TE/GE Division implemented this initiative, managed by an Executive Compensation Compliance Initiative Team. This project used the EOCU and the DAU. This project encompassed review of Forms 990 and 990-PF, and related returns, for tax years beginning in 2002. The IRS contacted 1,826 charitable organizations to seek information about their executive compensation procedures and practices; 1,428 were public charities and 398 were private foundations. The EOCU sent compliance check letters to 1,223 charitable organizations whose annual information returns were missing information; this entailed 1,023 public charities and 200 private foundations. An examination phase of this project involved 603 organizations, including 179 entities that provided unsatisfactory responses to compliance checks; about 10 percent of these examinations remain open.

(iii) Methodology. Organizations (1,223) that received these compliance check letters constituted six categories:

1. The 50 public charities with assets of at least $1 million and revenues of at least $5 million that reported ''significant total compensation'' but failed to provide ''complete detailed information'' about that compensation
2. The 100 public charities of all sizes reporting receivables/loans from trustees, directors, officers, and key employees exceeding $100,000
3. The 378 public charities that either answered ''yes'' or failed to respond to the question on the annual return as to whether they participated in an excess benefit transaction
4. The 497 public charities that either answered ''yes'' or failed to respond to the question about transactions with disqualified persons
5. The 188 private foundations that did not report any officers' compensation on their returns
6. The 12 private foundations were contacted regarding loans to officers

(iv) Examination Phase. The general purpose of the examination phase of this project was a determination of whether the compensation of disqualified persons was reasonable. During this process, revenue agents also considered the private foundation rules concerning loans to disqualified persons, and the purchase and sale of foundation assets by and to disqualified persons.

This phase involved the following 782 organizations:

- The 100 small public charities (assets of less than $1 million and revenues of less than $5 million) that reported significant amounts of compensation for one or more officers

- The 208 larger public charities (at least $1 million in assets and $5 million in revenues) that reported significant amounts of compensation for one or more officers
- The 97 public charities with completed returns chosen pursuant to a sampling procedure
- The 198 private foundations reporting significant officers' compensation
- The 179 organizations that provided unsatisfactory responses to the compliance checks

(v) Findings. This IRS report contained the following findings:

- Over 30 percent of compliance check recipients were required to amend their annual information returns.
- Fifteen percent of compliance check recipients were selected for examination.
- "Examinations to date do not evidence widespread concerns other than reporting."
- Twenty-five examinations resulted in proposed excise tax assessments under IRC Chapter 42, aggregating in excess of $21 million, against 40 disqualified persons or organization managers (over $4 million in connection with public charities and over $16 million in connection with private foundations).
- "Although high compensation amounts were found in many cases, generally they were substantiated based on appropriate comparability data."
- Additional education and guidance, and training for agents, are needed in the areas of reporting requirements and use of the rebuttable presumption procedure (the latter for public charities).
- Changes in annual information returns are needed to reduce errors in reporting and provide sufficient information to enable the IRS to identify compensation issues.
- This effort utilized "new compliance contact techniques," which have been refined in subsequent projects (e.g., those concerning credit counseling and down-payment assistance organizations).

(vi) Conclusions. These compliance checks, while uncovering significant reporting errors and omissions in specific areas, particularly in connection with excess benefit transactions and foundation transactions with disqualified persons, indicated that the organizations selected for review generally were compliant with the federal tax law as to compensation paid by tax-exempt

organizations. Fifty public charities initially failed to file schedules detailing compensation paid; 10 percent of the private foundations reviewed were referred for examination for this reason. Of the 100 public charities involved in loan-making, 37 were referred for examination; seven private foundations provided loans or pledged collateral to or for the benefit of disqualified persons.

Seventy-seven examinations remain open; 705 have been completed (of the latter, 115 were closed with a written advisory suggesting modifications of future behavior and review by the Review of Operations office). The excise taxes assessed were for (1) excessive salary and incentive compensation; (2) payments for vacation homes, personal legal fees, or personal automobiles that were not treated (reported) as compensation; (3) payments for personal meals and gifts to others on behalf of disqualified persons that were not treated as compensation; and (4) payments to an officer's for-profit corporation in excess of the value of the services provided by the corporation. Eleven percent of the disqualified persons involved in private foundation self-dealing transactions reported the transactions; none did so in the public charity excess benefit transactions cases. Thirteen percent of the self-dealing transactions and 11 percent of the excess benefit transactions were corrected before examination.

As to the rebuttable presumption procedure, (1) 51 percent of the organizations attempted to satisfy all of the three prongs; (2) 54 percent of the organizations commissioned comparability studies, with 97 percent of these studies looking to similar types and sizes of organizations; (3) 97 percent of organizations commissioning comparability studies set compensation within the range of the comparability data; and (4) 95 percent of disqualified persons recused themselves from discussion and approval of their compensation.

Of the 27 private foundations that were formally examined, 5 percent paid excessive compensation to officers and directors, 86 percent required recusals of officers and directors from discussion and approval of their compensation, 59 percent had written conflict-of-interest policies, 49 percent commissioned a survey to establish compensation; and 92 percent set compensation within the survey range.

(vii) Lessons Learned and Recommendations. This report included the following lessons learned and recommendations:

- The size of this project and the ''diverse universe'' created logistical difficulties. Future initiatives of this nature should consider breaking the project into components, such as separating public charities and private foundations.
- Using correspondence as the exclusive method of conducting single-issue examinations for ''factually sensitive and complicated issues,'' such as self-dealing and excess benefit transactions, should be reconsidered. Although it is appropriate to use broad contacts to identify cases

to be examined, an upfront field visit or other contact with the examined organization might substantially reduce the volume of records needed to be reviewed and the time spent on the examination.

- Compliance check questions must be ''clear and focused'' so as to produce responses that can be readily analyzed and enable the IRS to select appropriate cases for examination.
- Annual information return compensation reporting needs to be revised to ''facilitate accurate and complete'' reporting. The Form 990 redesign project should focus on reducing the number of places where the same information is required to be reported on the return, providing clearer instructions regarding what needs to be reported, and requesting specific information to identify potential noncompliance areas, such as loans to officers and directors.
- The Exempt Organizations Office (EO) needs to revisit the issue of when penalties should be assessed for filing incomplete annual information returns.
- EO should communicate to the public the most common return preparation errors identified during the compliance checks and examinations.
- EO should further educate the public charity sector about the intermediate sanctions rebuttable presumption and how to satisfy its requirements.
- 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.
- EO should change its process for monitoring excise taxes collected for the payment of excess compensation to better distinguish between the different types of excise taxes collected from public charities and private foundations.
- The relatively small percentage of corrections made by disqualified persons before contact by EO illustrates the need for a continued enforcement presence in this area. EO should continue to review compensation issues in more focused projects and should ''pursue base-lining general compliance with the compensation rules.''

§ 36.6 REVOCATION OF EXEMPTION AND CLOSING AGREEMENTS

Increasingly, the IRS is employing the device of the closing agreement to resolve tax disputes in the tax-exempt organizations context. Although this use of the closing agreement is not new, the approach is receiving a new emphasis

at the IRS and is being used with increasing frequency to resolve a variety of exempt organization matters.[157] With this technique, the organization obtains both certainty that the matter is permanently concluded and guidance as to future conduct, and the IRS resolves a compliance problem that otherwise would consume time and resources (through the revocation or assessment process) and obtains a commitment as to future compliance. Thus, by use of a closing agreement, a tax-exempt organization can avoid revocation of its tax exemption.

One analysis of closing agreements in this setting offers this perspective:

> Although a closing agreement may not be the solution for every disagreement between taxpayers and the Service, it can be a pragmatic method to resolve sensitive matters in which there are mitigating circumstances. In some cases, the infractions are marginal violations of mechanical limits that do not substantially hinder the organization's beneficial operations. In such cases, the standard solutions available to the Service, such as revocation of exemption, may be too harsh. They may seriously impair the organization's ability to function or even put it out of business. A closing agreement gives the Service the leeway to limit the penalty for past transgressions if the taxpayer will commit to future compliance.[158]

The closing agreement procedure is authorized by statute.[159] It is a final agreement between the IRS and a taxpayer on a specific issue or liability. The IRS can negotiate a written closing agreement with any taxpayer to make a final resolution of any of the taxpayer's tax liabilities for any period. After the IRS approves an agreement, it is final and conclusive, and—unless there is a showing of fraud, malfeasance, or misrepresentation of one or more material facts—it cannot be reopened as to the matters agreed on or modified by the IRS, nor may it (or any legal action in accordance with it) be annulled, modified, set aside, or disregarded in any lawsuit, other action, or proceeding. Simple unintentional errors are not treated as fraud, malfeasance, or misrepresentation that would allow reopening of a closing agreement.

The existence of any disqualifying elements is subject to review by a court. This review may entail examination of an organization's books and records. The burden of proof in establishing the disqualifying factor or factors is on the party seeking to set the agreement aside.

The key determinants governing the election of closing agreements are (1) an apparent benefit in having the case permanently and conclusively closed; (2) good and sufficient reasons on the part of the taxpayer for desiring the arrangement; and (3) evidence that the fulfillment of the agreement will

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157. The introductory portions of this section are based in large part on Bloom and Miller, "Closing Agreements," in the FY 1993 Exempt Organizations Continuing Professional Education Technical Instruction Program, at 263. The applicable regulations are at Treas. Reg. §§ 301.7121-1 and 601.202(a)(2). Internal Revenue Manual 8 (13) 10 constitutes the Closing Agreement Handbook.
158. Bloom and Miller, *supra* note 157.
159. IRC § 7121.

not be detrimental to the federal government.[160] (There is no requirement, however, of a showing that the resulting closing agreement will confer any advantage to the federal government.)

A closing agreement can cover the entire tax liability for one or more years, be limited to a specific tax item, and/or cover future periods. This type of agreement can be made a condition to the issuance of a private letter ruling. Agreements for subsequent periods are subject to changes in or modifications of the law enacted subsequent to the date of the agreement.

There is no revenue procedure specifically applicable to closing agreements concerning tax-exempt organizations. The general procedures for the execution of closing agreements,[161] however, can be adapted to exempt organizations cases. These general procedures discuss formulation and drafting of agreements, format, step-by-step instructions, identification of parties and issues, and special circumstances.[162]

Thus, a tax-exempt healthcare organization may negotiate and execute with the IRS a closing agreement with assurance that it will conclusively determine tax liability, tax-exempt status, and/or public charity/private foundation status. At the same time, one set of commentators has observed that ''[b]ecause of its finality, great caution should be exercised in entering into an agreement.''[163]

In general, favorable occasions for the execution of closing agreements between the IRS and tax-exempt organizations would be situations in which revocation of exemption is supported by the facts but is harsh or excessive, such as where revocation of exemption for narrow technical infractions would jeopardize a charitable organization's ability to continue its programs. From the viewpoint of the IRS, if technical flaws such as these can be eliminated definitively by means of agreed-on changes in an exempt organization's operations or procedures, it will be receptive to a closing agreement. By contrast, the IRS is not likely to be interested in the closing agreement procedure where an organization has engaged in flagrant and continuous acts compelling revocation and has not been operating in good faith.

One instance of use of a closing agreement in the healthcare setting was described as follows:

> A hospital has been meeting a legitimate community need, although a few executives have used their positions for personal gain. These transgressions have not discernibly diminished the organization's benefits to the community. It should be

160. Reg. § 301.7121-1(a).
161. Rev. Proc. 68-16, 1968-1 C.B. 770.
162. A sample closing agreement in the tax-exempt organizations context is provided in Bloom and Miller, *supra* note 81, app. B. This sample agreement is based on IRS Form 906 (Closing Agreement as to Final Determination Covering Specific Matters).
163. Bloom and Miller, *supra* note 157, at 269.

> possible to reach an agreement with the institution to curtail the offending behavior or remove the offending individuals without depriving the community of the hospital's valued services.[164]

Another instance is the following:

> Hospitals have been known to ''dump'' patients, that is, to divert emergency patients who are uninsured and unable to pay to other hospitals. This may be identified during examination. News reports or complaints about alleged dumping may even have led to initiation of the examination. This practice is contrary to the requirements that exempt hospitals accept ''charity'' patients to the extent of their financial resources. However, if the hospital's practice is not pervasive and not the result of a generally hostile attitude towards treating indigent or nonreimbursable cases, the hospital might be afforded the opportunity to formally rescind and reverse the policy.[165]

The best-known illustration of the use of closing agreements in the health-care context was summarized as follows:

> A large hospital system that is the sole source of comprehensive health care for the communities it serves entered into a joint venture with related physicians, in which it sold its gross or net revenue stream from some of its activities to the joint venture. This activity resulted in the prospect of revocation of tax exemption due to private inurement and private benefit. Loss of exemption could force the hospital to close or at least to curtail some charitable aspects of its operations. Rather than deprive the community of a vital asset because of what is essentially a one-time violation, it may be more appropriate to allow the offending hospital to rescind the arrangement and institute procedures to prevent similar problems in the future. Such a resolution could be achieved through a closing agreement.[166]

In this case, the hospital voluntarily disclosed to the IRS the practices and arrangements that raised the issues of private inurement and private benefit. Once these matters came to the attention of the hospital's board of trustees, the board on its own initiative undertook substantial corrective and remedial actions, including pursuing restitution where appropriate and establishing safeguards designed to prevent the recurrence of similar transactions. The conditions that the IRS insisted on in the closing agreement were specifically tailored to prevent future physician recruitment arrangements that violated the prohibitions against private inurement and private benefit.

Concessions of this nature regarding a board's functioning or composition (in lieu of an organization's losing its tax-exempt status) are more prevalent than is generally realized because closing agreements are rarely made public.[167]

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164. *Id*. at 277. With the enactment of intermediate sanctions (*see* § 28.2(6)), this use of a closing agreement will be lessened.
165. *Id*. Patient dumping is discussed in § 29.2.
166. *Id*. at 263–264. The federal tax aspect of these revenue stream joint ventures is discussed in §§ 4.5 and 22.7.
167. Outcomes achieved by means of closing agreements are sometimes occasioned by the ruling process. For example, the IRS permitted a public charity to involve itself in a

Typically, the IRS asks that closing agreements with charitable organizations be made public only where offending behavior by organization insiders, such as trustees, is particularly egregious, such as in the case of the closing agreement in the healthcare context.[168]

There are case-closing options other than the closing agreement. One is the *compromise*,[169] which is frequently used in collection cases to settle a tax liability for something less than the assessed amount. Another is the *settlement*, which is sometimes accomplished as part of an administrative appeal process.[170] (Compromises and settlements deal with disputed tax liabilities; if tax exemption is not revoked because of a closing agreement, there is no tax liability to dispute. These alternative procedures are appropriate in unrelated income tax cases.) Also, the IRS sometimes resolves a tax dispute by means of a *collateral agreement*, an income tax examination change,[171] an installment agreement,[172] and a waiver of restriction on assessments and collection of deficiency in tax.[173] Most of these alternatives to a closing agreement are not authorized by statute as being binding on the parties, and do not bar further assessment or prohibit the IRS from determining a tax deficiency.

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partnership without loss of tax exemption (*see* § 22.3). As part of its conclusion that private interests were not being served, the IRS observed that the organization was ''governed by an independent board of directors made up of church and community leaders'' (Priv. Ltr. Rul. 9438030). In another instance, concerning a close operating relationship between a charitable organization and a for-profit fundraising company, the IRS had raised questions as to private inurement and private benefit. The IRS became satisfied that the organization could retain its tax exemption; the IRS noted that the organization enlarged its board of directors to provide for control by individuals other than its founder (who was also the owner of the fundraising company) and her family. The IRS observed that this alteration of board compensation ''should do much to provide assurance'' that the charity will operate ''independently'' of the company (Tech. Adv. Mem. 9417003). In these and comparable cases, it would not be illogical to believe that the IRS may have encouraged or required these changes in the facts as a condition of issuing the ruling.

168. Another well-publicized closing agreement that became public is the one involving the Kamehameha Schools Bernice Pauahi Bishop Estate (Estate), dated February 23, 2000. In that instance, the IRS insisted, as a condition of entering into the agreement, that the trustees whose actions imperiled the tax exemption of the Estate be permanently removed or resign from their positions. This IRS stance was based on evidence that these trustees ignored court orders and stipulations, and the advice of independent experts, relating to activities that impacted the Estate's tax-exempt status, and had a history of pursuing activities that were inconsistent with the advancement of the Estate's exempt purpose. This condition was based on the IRS's policy of not entering into a closing agreement unless it is confident that the agreement will be complied with.
169. IRC § 7122.
170. *See* § 34.7.
171. Form 4549.
172. Form 433-D.
173. Form 870.

PART EIGHT

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APPENDIX A

Internal Revenue Service Integrated Delivery Systems Tax Law Specialist Guidance FY 1994 Exempt Organization CPE Technical Instruction Program Textbook What Questions Should the Tax Law Specialist Ask Applicant in IDS Cases?

B. What Questions Should the Tax Law Specialist Ask Applicant in IDS Cases?

The following questions offer guidance for a tax law specialist who is working an IDS case. The list of questions is an attempt to obtain information on issues which could affect exempt status. The topic areas of the questions may also be helpful to revenue agents who later examine an IDS that had exemption recognized in the past and is being audited to confirm that it operates in compliance with prior representations. This list is not all-inclusive and each individual case will have specialized issues which need to be questioned.

1. The Applicant states that its individual clinics will provide charity care.

   a. Have the Applicant submit its written policies on indigent-charity care.

   b. Will the Applicant provide free care to indigent patients (those unable to pay for care who are not covered under any private or government insurance programs)? What limits, if any, apply? How will care for those unable to pay differ from care provided to paying patients?

   c. Does the Applicant adhere to Statement No. 15 of the Principles and Practices Board of the Healthcare Financial Management Association in all of its representations regarding charity care?

2. The Applicant states that it will provide nondiscriminatory treatment of Medicare and Medicaid patients.

   a. Does the Applicant's Medicare and Medicaid policy include access to all covered inpatient, outpatient, and diagnostic services that are available to non-Medicare and Medicaid patients?

   b. If the Applicant's state contracts selectively with providers, will Applicant enter into and pursue in good faith negotiations with its state Medicaid agency in an effort to obtain Medicaid contracts?

   c. Will the Applicant participate in Medicaid under fee-for-service arrangements at all of its clinic locations (as opposed to merely serving Medicaid patients enrolled in managed care plans)?

   d. Do all hospitals operated as part of or in conjunction with the IDS serve Medicaid inpatients in a nondiscriminatory manner?

3. Confirm that the bylaws provide for control by persons broadly representative of the community. Does Applicant's board meet the 20% physician-representation safe harbor the Service applies in IDS cases? If not, has Applicant provided additional factors to be considered in explaining why it has a higher percentage of physician or Medical Group representation?

4. Does the Applicant have a policy of disclosure of conflicts of interest? Do the Applicant's by-laws include language requiring that, in any exercise of voting rights by board members, no member shall vote on any issue, motion, resolution or other matter which directly or indirectly may inure to his or her benefit?

5. Financial feasibility studies, appraisals, and evaluations normally precede the Applicant's decision to purchase the Medical Group's assets and create an IDS. Those materials should be requested, and should, at a minimum, answer the following questions:

   a. What is the amount of the Medical Group's capital reserve account?

b. What is the liquidity ratio (the current assets divided by current liabilities) of the Medical Group?

c. What is the Medical Group's current working capital to revenue ratio (working capital divided by revenues)?

d. What is the Medical Group's debt to assets ratio (total debt divided by total assets)?

e. What is the Medical Group's long term debt to equity ratio (total debt divided by equity)?

f. What is the Medical Group's pre-tax return on asset ratio (pre-tax income divided by total assets)?

g. What is the Medical Group's pre-tax return on equity ratio (pre-tax income divided by equity)?

6. Did the Medical Group receive any other offers to purchase its group medical practice? Indicate how the offers differed and the amount(s) of the proposed purchase price(s).

7. A significant approach to valuing the Medical Group as a business enterprise will be the present value of discounted future cash flows.

   a. In that valuation, are the cash flow projections consistent with the historical financial data? If there are inconsistencies (e.g., cash flows much greater, or practice expanding more quickly than the trend of the historical data), does the valuation explain the assumptions underlying the projections? Are they reasonable?

   b. Is the discount rate used reasonable? Is the rate used supported by an explanation in the valuation?

8. If the Medical Group is going to sublease its interest in any equipment, and some time in the future the organization will sell its interest in the same equipment to the Applicant, have the Applicant submit an appraisal for the equipment indicating that the rental will be at or below fair market value. Have it also indicate that any future purchase of equipment from this organization will be at or below fair market value as determined by an independent appraisal.

9. If the Applicant states that rents for the real estate shall be determined by an appraisal, have it submit an independent

appraisal indicating the rent the Applicant pays is at or below fair market value.

10. If the Applicant indicates that it might purchase the real estate at fair market value, have it submit an independent appraisal indicating the proposed sale price will be at or below fair market value.

11. Prior to the IDS, was each new physician required to buy into the medical group practice? What was the cost for a new physician to buy in?

    a. Prior to the IDS, did the Medical Group make specific financial arrangements with new physicians to provide for the buy-in? Please explain. How does this practice differ after the IDS?

    b. Prior to the IDS, how many physicians owed money either to the Medical Group or to third parties for a buy-in? Has the IDS resulted in the reduction or elimination of buy in debt to the Medical Group physicians?

    c. Was the buy-in a hinderance to recruiting for the Medical Group?

12. Prior to the reorganization, what was the financial arrangement if a physician retired? Approximately how much does the Medical Group owe retiring physicians? Briefly break down the financial package. Would the financial package include the following: the value of the medical practice, value of patients, value of assets, value of goodwill, etc.?

13. If a partnership or corporation owns the land, buildings, and equipment the Medical Group plans to lease or sell to the Applicant, are any of the partners or shareholders in any way related to any officers, directors, employees, independent contractors or managers of the Applicant? Will they be after the transaction?

14. Have the Applicant indicate, for all assets to be conveyed to it, which assets are owned by related individuals.

15. Is any officer of the Applicant a present or former partner or employee of the Medical Group?

16. Will members of the Medical Group be given advantaged status (i.e., automatic admission to the staff, preferential admitting and/or surgical scheduling, etc.) at any of the affiliated hospitals of the Applicant?

17. Is the compensation paid to the physicians of the Medical Group subordinate to other obligations of the Applicant, including debt service payments?

18. If the Applicant will be involved in research, what type of research will be carried on? Will the research involve questions and issues that directly affect the Applicant's operations or will the research be medical research involving general questions of medicine (e.g., treatments and cures for cancer, AIDS, etc.) with the results available to the public?

19. If Applicant provides educational programs, will they be available to the general public? This would mean that any fees charged to any participants will not discriminate against non-Applicant patients and the Applicant will effectively advertise these programs to the general public.

20. If the PSA states the Applicant will renovate clinics formerly owned by the Medical Group, have it indicate what percentage of the renovation is repairs and remodeling versus capital improvements.

21. If the fees charged to the Applicant's patients will be determined prospectively by a fee committee, determine that the committee is independent (i.e., its physician or contractor membership constitutes a minority of the committee).

22. If a compensation committee will establish compensation for Medical Group physicians in the future, determine that the committee does not contain any past or present Medical Group physicians, officers, shareholders and/or employees. The board should make the final decision.

23. Will the projected net salaries Applicant's physicians receive from the IDS be similar to their prior net income? If so, how is the fact that the physicians no longer are entitled to payment for the use of capital assets reconciled?

24. Does the Foundation conduct an internship or residency program with an accredited medical school? Please explain.

25. Will the Foundation provide free professional courtesy medical care to any physician or friend, associate, or relative of a physician in the Medical Group?

5. Conclusion

The concept of an IDS, and the Service's understanding of it, is evolving. Therefore, each future case will bring the Service greater sophistication and, with it, a better understanding of the tax and non-tax issues involved.

APPENDIX B

Hermann Hospital Closing Agreement

CLOSING AGREEMENT

AS TO FINAL DETERMINATION COVERING SPECIFIC MATTERS

The Hermann Hospital Estate, dba Hermann Hospital ("Hospital"), and the Commissioner of Internal Revenue ("Commissioner") make the following closing agreement under section 7121 of the Internal Revenue Code of 1986, as amended ("Code") and the applicable regulations thereunder:

WHEREAS, Hospital is currently and has for many years been recognized as an organization described in section 501(c)(3) of the Code, and exempt from income tax as provided in section 501(a) or corresponding provisions of prior internal revenue statutes;

WHEREAS, Hospital has investigated and voluntarily disclosed to the Internal Revenue Service ("IRS") certain physician recruitment and retention arrangements and other transactions engaged in by the Hospital or persons associated with the Hospital during fiscal years ending September 30, 1989, September 30, 1990, September 30, 1991, and September 30, 1992, that raise questions as to whether prohibited inurement and private benefit were conferred upon individuals in violation of the proscriptions of section 501(c)(3) of the Code;

WHEREAS, Hospital has acknowledged a lack of legal and Board review and awareness of, and control over, particular actions undertaken during the periods indicated above, allowing for administrative actions during these periods, including:

(a) Incentives offered and provided to newly-recruited physicians that included, among others, income guarantees, office personnel salary support, free office space and subsidized parking, as well as malpractice insurance, phone allowances, equipment loans, and loan guarantees; most of such benefits offered with no required repayment and, in many cases, no performance of specific duties in exchange for benefits received;

(b) Incentives offered and provided to physicians already located in the Houston community that included, among others, income guarantees, free office space, payment of office personnel salaries, malpractice insurance, and subsidized parking;

(c) Incentives offered and provided to full-time faculty members of the University of Texas Medical School in connection with their becoming full-time private practitioners in the Hospital's community. Such incentives included, among others,

income guarantees, free rent, and salary support for office personnel; most of such benefits were not required to be repaid;

(d) The apparent operation of certain Hospital outpatient departments in a manner resembling in certain respects the private practice office of the physicians providing services there (which physicians were acting as independent contractors and not employees of the Hospital); and

(e) Certain purchases and other transactions that may have benefitted certain former Board members and other individuals; and

WHEREAS, once the aforementioned transactions came to the attention of the Board of Trustees, Hospital on its own initiative undertook substantial corrective and remedial actions, including pursuing restitution where appropriate and establishing safeguards designed to prevent the recurrence of similar transactions;

WHEREAS, Hospital provides significant benefits to its community, including a substantial amount of charity care and a number of health care services that are unique and/or important to the community;

WHEREAS, Hospital desires to resolve its federal tax status with the IRS in a manner that would preserve, for the periods indicated above, Hospital's status as an organization described in section 501(c)(3) of the Code; and

WHEREAS, Hospital and Commissioner, through their respective authorized representatives, have each determined that resolution of Hospital's federal tax status according to the terms of the agreement set forth herein is in their respective best interests;

IT IS HEREBY DETERMINED AND AGREED for federal income tax purposes that:

(1) Hospital's exemption from federal income taxes under section 501(a) of the Code as an organization described in section 501(c)(3), and public charity status as an organization described in sections 509(a)(1) and 170(b)(1)(A)(iii), will not be revoked as a result of any act or failure to act that was disclosed to the IRS in connection with this Closing Agreement, and that took place during the fiscal years ending September 30, 1989, September 30, 1990, September 30, 1991, and September 30, 1992;

(2) Hospital will not modify, extend or renew any physician recruiting agreement or physician retention agreement negotiated or executed prior to the date this Closing Agreement is signed that does not conform with the "Hospital Physician Recruitment Guidelines" set forth at Exhibit 1 to this Closing Agreement.

(3) Hospital will require that any physician recruitment agreement executed following the date this Closing Agreement is signed, including those entered into by Hospital as a result of renegotiation of any lapsed or terminated physician service agreement, will comply with all provisions and terms of this

Closing Agreement, including the "Hospital Physician Recruitment Guidelines" set forth in Exhibit 1 to this Closing Agreement.

(4) In the case of physician service agreements other than recruitment agreements, Hospital will require review and approval by Hospital's legal counsel, Vice President, Medical Director, CEO, and, in the case of contracts involving over $250,000 per year, the Executive Committee of the Board of Trustees.

(5) Hospital will, within thirty (30) days of the signing of this Agreement by both parties, adopt a conflict of interest policy, to be set out in writing; such conflict of interest policy shall be signed by all officers, directors (including Medical Directors), and trustees of Hospital.

(6) (A) Hospital hereby agrees to adopt verbatim and in its entirety the "Hospital Physician Recruitment Guidelines" as set forth in Exhibit 1 to this Closing Agreement. The Executive Committee of Hospital's Board of Trustees will, before the signing of this Closing Agreement, adopt the Hospital Physician Recruitment Guidelines, which adoption shall become binding upon Hospital upon the signing of this Closing Agreement by both parties. The adoption of the Hospital Physician Recruiting Guidelines by the Executive Committee will be ratified by the full Board of Trustees of Hospital at the next meeting of the Board of Trustees following the signing of this Closing Agreement by both parties, although the obligation of Hospital to follow such Guidelines after the signing this Closing Agreement, as provided in subparagraph (B), remains and is in no way dependent on ratification of the guidelines by the full Board of Trustees.

(B) Hospital hereby agrees to follow the "Hospital Physician Recruitment Guidelines" as set forth in Exhibit 1 to this Closing Agreement, which Exhibit is an integral part of this Closing Agreement and is hereby incorporated by reference.

(7) Hospital hereby agrees to exercise reasonable and good faith efforts to comply with all employment tax requirements of the Code and the applicable regulations, and Hospital within thirty (30) days of the signing of this agreement by both parties will report to IRS on amended Forms 1099 and W-2 incentives paid to individuals in the manner disclosed to IRS in connection with this Closing Agreement for the years ending December 31, 1990, December 31, 1991, December 31, 1992, and December 31, 1993.

(8) Nothing in this Closing Agreement shall be construed as prohibiting an examination of Hospital by the IRS for any open taxable year with respect to any issue other than revocation of Hospital's tax exempt status as an organization described in section 501(c)(3) of the Code or as a public charity described in sections 509(a)(1) and 170(b)(1)(A)(iii) as a result of matters disclosed to the IRS in connection with this Closing Agreement for the fiscal years ending September 30, 1989, September 30, 1990, September 30, 1991, and September 30, 1992.

(9) As part of this Agreement, Hospital has executed a consent to disclosure pursuant to section 6103(c) of the Code

that will permit the IRS to respond to inquiries regarding this Closing Agreement that the IRS may receive from members of the press and the public, to the extent specified in such consent to disclosure.

(10) Within forty-five (45) days of signing this Agreement by both parties, Hospital shall make a public announcement through one or more Houston-area newspapers of general circulation and through one or more national tax services that it has conducted certain physician recruitment and retention activities that raise questions as to whether Hospital was operated in a manner inconsistent with exemption from federal income taxes as an organization described in section 501(c)(3) of the Code. The announcement shall explain that Hospital voluntarily sought negotiation with the IRS regarding resolution of its federal tax status as an organization described in section 501(c)(3) of the Code. The announcement shall contain all terms and provisions of this Closing Agreement in their entirety, and specifically include the provisions delineated in Exhibit 1 to this Closing Agreement, and shall also include the following statement:

> "A closing agreement is a final agreement between the Internal Revenue Service and a taxpayer on a specific issue or liability. A closing agreement is entered into under the authority of section 7121 of the Internal Revenue Code and is final unless fraud, malfeasance or misrepresentation of a material fact can be shown. Closing agreements may be entered into when it is advantageous to have the matter permanently and conclusively closed. The Hospital has authorized the Internal Revenue Service to disclose certain information concerning this matter in response to inquiries from the press or public."

Time is of the essence with respect to the making of the required announcement and dissemination of the required announcement; the making of the announcement and dissemination of the announcement in the stated manner within the stated time period is a condition precedent to any and all of the determinations and agreements made herein, except that in no circumstance are amounts paid to the IRS under paragraph (11) refundable to Hospital. Bona fide distribution of this Closing Agreement in its entirety to one or more Houston-area newspapers and one or more national tax services described in this paragraph (10) shall constitute compliance with the provisions of this paragraph, except as noted in the following sentence. Within sixty (60) days of the date that this Closing Agreement is signed by both parties, if there has been no publication or descriptive account of this Closing Agreement by at least one national tax service to its subscribers, Hospital shall distribute this Closing Agreement in its entirety to the three largest national tax services.

(11) Within thirty (30) days of signing of this Agreement by both parties, Hospital shall pay to the IRS an amount agreed by the parties to equal 100 percent of the federal income tax

liability of Hospital for fiscal year ending September 30, 1991, were it a taxable entity for that year. This amount is stipulated by parties to be $993,531.00. In addition, and at the same time, Hospital shall pay to the IRS $9,720.00, which is the amount attributable to penalties for nonfiling or late filing of Forms 1099 and W-2 with respect to incentives paid to individuals referenced in paragraph (7) above. Payment of these amounts is to be made by way of certified check payable to the order of the Internal Revenue Service; and such check is to be delivered to the IRS Dallas Key District; Attn: Chief, EP/EO Division; Internal Revenue Service; 4900 DAL; 1100 Commerce Street; Dallas, TX 75242. Time is of the essence with respect to the required payment and the receipt of the stated amount by the stated due date is a condition precedent to any and all of the determinations and agreements made herein.

(12) In computing the amount of stipulated pro forma tax liability for purposes of the preceding paragraph, the parties have not taken into account the Hospital's unrelated business income net operating loss carryovers from prior taxable years. Accordingly, the parties agree that the Hospital's unrelated business income net operating loss carryovers to taxable years subsequent to the taxable year ended September 30, 1991 (to the extent such net operating loss exists), shall not be reduced by reason of such stipulated pro forma tax computation or any assumptions made by the parties (i.e., as to pro forma taxable income) in connection with such computation.

(13) Amounts paid, assessed or collected pursuant to this Agreement are not considered part of, or attributable to, the internal revenue liabilities of Hospital, its consolidated group or any member thereof (if applicable), and are not deductible, refundable or creditable to Hospital or any taxpayer for any purpose. Specifically, the net operating loss described in paragraph (12) above may not be used with respect to any amount paid hereunder. Amounts assessed or collected may be designated as the Commissioner provides so as to avoid characterization as refundable amounts.

(14) With respect to paragraphs (2) through (5), (6)(B), and (7) and Exhibit 1 hereto, the standard to be applied in determining compliance will be whether the Hospital has expended reasonable and good faith efforts in complying with its duties herein and substantially complied with this Agreement. Except with respect to paragraphs (6)(A), (10), and (11) of this Agreement, wherein the duty of Hospital to comply with the precise terms thereof is absolute, the parties expressly agree that isolated inadvertent or unintentional failures to comply shall not constitute noncompliance with this Agreement. The term of Hospital's agreements and duties set forth with respect to all paragraphs herein other than Exhibit 1 is five (5) years. The term of Hospital's agreements and duties with respect to Exhibit 1 of the Closing Agreement is ten (10) years. No inference is intended that Hospital would not be subject to the federal tax laws in effect at those times.

(15) No party shall endeavor by litigation or other means to attack the validity of this Closing Agreement, or of any provision contained herein.

(16) This Closing Agreement, including all provisions contained herein, may not be cited or relied upon by any person or entity whatsoever as precedent or evidence in the disposition of any other case involving persons or entities not a party to this Closing Agreement; however, this shall not be construed as a condition precedent to this Closing Agreement.

THIS AGREEMENT IS FINAL AND CONCLUSIVE EXCEPT:

(a) the matter it relates to may be reopened in the event of fraud, malfeasance, or misrepresentation of material fact;

(b) it is subject to the Code sections that expressly provide that effect be given to their provisions notwithstanding any other law or rule of law except section 7122 of the Code; and

(c) if it relates to any taxable period ending after the date of this agreement, it is subject to any law enacted after the agreement date that applies to that taxable period.

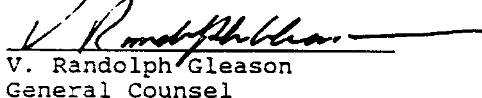
By signing below, the parties certify that they have read and agreed to the terms of this document.

HERMANN HOSPITAL ESTATE

By: Date: Sept. 16, 1994

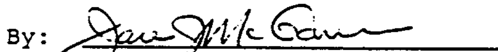
Title: President & CEO

Approved as to Form: 9-16-94



V. Randolph Gleason
General Counsel

COMMISSIONER OF INTERNAL REVENUE

By:  Date: 9 20 94

Title: Assistant Commissioner (EP/EO)

EXHIBIT 1

TO

CLOSING AGREEMENT WITH THE HERMANN HOSPITAL ESTATE

HERMANN HOSPITAL ESTATE HEREBY ADOPTS THE FOLLOWING GUIDELINES EFFECTIVE IMMEDIATELY:

HOSPITAL PHYSICIAN RECRUITMENT GUIDELINES

I. Definitions:

"Existing Physician" - non-employee physician having medical staff privileges at Hospital.

"Newly-Recruited Physician" - non-employee physician not yet having medical staff privileges at Hospital.

"Permissible Recruit" - physician who either (i) is a recent graduate of a residency or fellowship program, whether or not in the Hospital's community, or (ii) has not previously practiced in Hospital's community or been affiliated with another hospital serving all or part of the Hospital's community.

"Permissible Incentive" - a provision of cash, credit, goods, services, or other valuable rights to a physician in exchange for the physician's agreement to relocate into or remain within Hospital's community, if provided in an amount and manner that does not confer prohibited inurement or more than incidental private benefit upon the physician. Incentives shall not be permissible and shall be presumed to confer prohibited inurement or more than incidental private benefit upon physicians unless such incentives are provided in accordance with the specific rules set forth in "II." below.

"Community" - designated geographical area comprising or existing within confines of Hospital's primary and secondary service area as defined by Hospital.

"Recruiting Fees or Costs" - fees or costs paid to recruiting companies, expenses of travel, moving, and relocation, and the dollar cost of any other incentives, provided to or on behalf of, or in connection with, a permissible recruit.

Hospital Physician Recruitment Guidelines

II. Hospital will provide no incentives to physicians that are not permissible incentives.

A. Retention incentives of any kind provided to existing physicians are not permissible incentives.

B. Permissible incentives do not include recruitment or retention incentives provided to other than permissible recruits.

C. Recruitment incentives offered to a permissible recruit will not be considered permissible incentives unless there is a demonstrable community need for the physician, as evidenced by one or more of the following:

a. a population to physician ratio in the community that is deficient in the particular specialty (with reference to the ideal ratio set forth in GMENAC reports) of the physician being recruited;

b. demand for a particular medical service in the community coupled with a documented lack of availability of the service or long waiting periods for the service, if the physician is being recruited to increase availability of that service;

c. designation of the community (or that portion of the community that the physician is serving) at the time the recruitment agreement is executed as a Health Professional Shortage Area (HPSA) as defined in 42 CFR 5.1-5.4;

d. a demonstrated reluctance of physicians to relocate at the Hospital due to the Hospital's physical location (this criterion is intended to refer to a hospital located in a rural or economically-disadvantaged inner-city area);

e. a reasonably expected reduction in the number of physicians of that specialty serving in Hospital's service area due to the anticipated retirement within the next three year period of physicians presently in the community; or

Hospital Physician Recruitment Guidelines

f. a documented lack of physicians serving indigent or Medicaid patients within Hospital's service area, provided that newly-recruited physicians commit to serving a substantial number of Medicaid and charity care patients.

D. In connection with providing permissible incentives to a physician, Hospital may obligate the physician to fulfill any or all of the following stipulations or duties, among others:

a. relocation to service area of Hospital;

b. establishment of a full-time private practice;

c. continued presence in the community for a specified period;

d. maintenance of license to practice;

e. acceptance of Medicaid and charity patients;

f. emergency room duty or other rotations;

g. performance of community or medical teaching;

h. performance of necessary administrative duties;

i. maintenance of staff privileges; and

j. maintenance of a practice in the specialty for which recruited.

E. Incentives may not be conditioned on a requirement or understanding that the physician admit or refer patients to Hospital, or on any prohibition or restriction upon the ability of the physician to obtain or maintain staff privileges at other hospitals or to treat patients at or admit patients to other hospitals.

F. A physician to whom incentives, other than those described in paragraphs G, J, and K, are provided must agree to a periodic accounting to Hospital and to allow Hospital to inspect the physician's financial books and records as a condition to receipt of any such incentive. For incentives described in paragraphs J and K, Hospital shall obtain documentation of expenses from physician prior to providing the allowed reimbursements.

Hospital Physician Recruitment Guidelines

G. Permissible incentives include loans, lines of credit, or loan guarantees offered to physicians, but only if such loans, lines of credit, or loan guarantees, are (a) documented and evidenced by an executed promissory note; (b) adequately secured (such as by accounts receivable and/or office equipment); and (c) bear interest at a reasonable rate reflecting market conditions (e.g., prime plus 1 or 2 percent, or the applicable federal rate). Any loan forgiveness component will be conditioned upon the continued presence of the physician in practice in the community and will be rateable for a period of not less than four years, with the time period specified by contract at the time the loan or loan guarantee is made. A demonstrable need for the particular physician and the amount of the particular incentive shall be evidenced when provision is made for forgiveness of a loan.

H. Permissible incentives include reasonable income guarantees offered to permissible recruits, subject to all the following conditions:

a. such income guarantee is for a period of two years or less;

b. no off-agreement benefits are offered or provided;

c. all terms are agreed to in advance in writing and are not modified over the life of the agreement;

d. in the event periodic income guarantee advances are made to the physician, they will be structured as a loan or loans bearing a reasonable rate of interest with any loan terms or loan forgiveness complying with paragraph "G" above;

e. where the income guarantee is for a net income amount, a reasonable fixed ceiling amount must be placed on allowable expenses and amounts for which advances may be made;

f. the guarantee represents all or part of a compensation package that is reasonable in its entirety.

I. The following shall be permissible incentives only if no comparable and related value through an alternative

Hospital Physician Recruitment Guidelines

incentive mechanism, such as an income guarantee or a forgiven loan, as described in paragraphs G. and H., respectively, is otherwise provided to the permissible recruit receiving such assistance:

a. Reasonable subsidies paid or provided, or other similar financing arrangement, for medical office space rent, overhead expenses (such as utilities), or rental of equipment for a permissible recruit; but no such subsidy may be provided unless the rental amount is (but for the subsidy) at fair rental value, and in no event may such subsidy be provided for more than two years.

b. Reasonable subsidized equipment purchases or other assistance in acquiring equipment on behalf of a permissible recruit, but only if free or reduced cost use by the physician does not exceed two years. If title is transferred to the physician at the end of the period of free or reduced cost use, Hospital will receive payment for such equipment's then fair market value from the physician.

c. No assistance in acquiring equipment or space may be provided if it entails a conveyance or lease of such equipment or office space with a leaseback to Hospital.

J. Permissible incentives include payment of actual moving expenses and relocation costs, subject to reasonable limits and, in any case, a reasonable fixed ceiling amount. Hospital may require return of any such moving expenses or relocation costs in the event the newly-recruited physician does not remain in Hospital's service area for a specified period of time.

K. Reasonable interview travel expenses may be reimbursed to permissible recruits.

L. Permissible incentives shall not include travel and continuing education expenses for any non-employee physician where such expenses are primarily related to the physician's private practice of medicine.[1]

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[1] This paragraph is not intended to prevent payment for or inclusion of these items as allowable expenses subject to the reasonable fixed ceiling amount referred to in paragraph

Hospital Physician Recruitment Guidelines

Educational and related expense reimbursements, however, are permissible in the case of nurses and nurse anesthetists in exchange for future employment commitments, especially if Hospital's service area is experiencing a documented nursing shortage.

M. Permissible incentives shall not include the payment or subsidized provision of private practice start-up or maintenance assistance, such as consulting services to assist in practice management, or other practice management design plans, if an income guarantee has been or will be provided to the same physician.[2]

N. Permissible incentives shall not include Hospital subsidization of salary and benefit costs for the support personnel of a non-employee physician in his or her private practice.[3]

O. Permissible incentives shall not include the payment or provision, directly or indirectly, of malpractice insurance for the current private practice of a non-employee physician. Coverage with respect to a physician's bona fide duties as Medical Director for Hospital, or any other activity undertaken for or on behalf of the Hospital that is distinct from his or her private practice, is permissible. Reasonable payment for tail coverage in the case of a permissible recruit who is relocating is permissible. For purposes of this paragraph and the following paragraph "P", Hospital shall not appoint a Medical Director, full or part-time, unless there is a legitimate and demonstrable business purpose for doing so.[4]

P. Except with respect to a physician's bona fide duties as Medical Director for Hospital, or any other activity undertaken for or on behalf of the Hospital that is distinct from his or her private practice, permissible incentives shall not include: subsidized parking; telephone allowances, including cellular car phones; car

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"II.H.e." above.

[2] See footnote 1.

[3] See footnote 1.

[4] See footnote 1.

Hospital Physician Recruitment Guidelines

allowances; health insurance; or payment of medical society dues or licensing fees.[5]

Q. Signing bonuses or other bonus payments are not permissible incentives and will not be offered or made.

R. Where a permissible recruit is recruited to enter an existing physician's established medical practice, Hospital shall pay no more than 50 percent of the recruiting fees or costs associated with that physician;

S. Permissible incentives shall not include the conveyance or promise of a future conveyance of a Hospital outpatient department (such as Hospital clinics or centers) to a physician. Hospital shall maintain proper records of fees due it for patient utilization of outpatient departments, as well as other overview safeguards, to ensure that such outpatient departments are operated for the benefit of Hospital and its community and are not effectively operated as the private practices of physicians.

T. Recruiting fees or costs shall in no event be paid to existing physicians, but such fees or costs may be paid to outside search consultants.

U. While management may negotiate recruitment agreements within these guidelines, Hospital Board approval and review by Hospital's legal counsel or tax advisor shall be obtained prior to execution for each specific financial package provided to each individual recruited physician.

V. All incentives provided to physicians will be reported on Form W-2 or Form 1099.

W. These physician recruitment guidelines apply to and are binding on each and every current and after-created subsidiary or controlled affiliate of Hospital, or common parent, that recruits physicians.

X. Each incentive arrangement with each physician shall be memorialized in writing and no "off-agreement" incentives or benefits shall be offered or provided. Each such agreement with each physician shall contain a clause allowing Hospital to terminate the agreement and recover from the physician any payment that is determined

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[5] See footnote 1.

Hospital Physician Recruitment Guidelines

by a court or government agency to be illegal or inconsistent with Hospital's tax-exempt status.

Y. In addition to such other records as may be required, Hospital will maintain complete and accurate records documenting amounts paid and other incentives provided to permissible recruits, and community need, to ensure compliance with these guidelines.

Z. Failure to comply with any provision in the above Physician Recruitment Guidelines may be found to constitute prohibited inurement and excessive private benefit that is inconsistent with Hospital's continued status as an organization described in section 501(c)(3) of the Internal Revenue Code; however, it is not intended that any such failure would constitute prohibited inurement or excessive private benefit other than as determined under the federal tax laws in effect at the time of such failure.

AA. The above-described Physician Recruitment Guidelines shall be modified to the extent Congress or the IRS legislatively or administratively, as the case may be, establish different physician recruitment standards for tax-exempt hospitals.

ADOPTED this 16th day of September, 1994.

CONSENT TO DISCLOSURE

THE HERMANN HOSPITAL ESTATE

I certify that I am the President of the Hermann Hospital Estate ("Hospital") and I certify that I have the authority to execute this consent on behalf of Hospital.

Pursuant to section 6103(c) of the Internal Revenue Code, I consent to the disclosure by the Internal Revenue Service, in response to any inquiries it may receive, of the reasons for, and matters discussed in, the Closing Agreement dated September 16, 1994 between Hospital and the Internal Revenue Service, and the terms and provisions detailed therein, pertaining to return information for the tax years listed below. Specifically excluded from this consent to disclose are originals, copies, summaries, or descriptions of any and all background documents and other submissions provided by Hospital in connection with the Closing Agreement; the use of specific names of persons or entities described to or discussed with the IRS not otherwise set forth in the text of the Closing Agreement itself; and any other matter not related to the reasons for, and matters discussed, in the Closing Agreement and the terms and provisions detailed therein.

I understand that the above described information, other than that specifically excluded herein, may be disclosed by the Internal Revenue Service in response to inquiries from members of the press and the public.

Name of Taxpayer:	Hermann Hospital Estate
Address:	6411 Fannin Houston, TX 77030-1501
Taxpayer Identification Number:	74-1282700
Tax Years:	8909, 9009, 9109, 9209

Signature

Sept. 16, 1994
Date

President & CEO
Title

Revenue Ruling 87-41 Employment Status-20 Common Law Factors

Section 2522.

Section 2522 of the Code provides for a gift tax charitable deduction for the value of property transferred to charitable organizations described in section 2522(a).

Section 2522(c)(2) denies the deduction if a donor transfers an interest in property to charity and retains an interest in the same property or transfers an interest in the same property to a noncharitable donee. Section 2522(c)(2), however, provides certain exceptions in allowing a charitable deduction for specific kinds of gifts of partial interests, including an exception for charitable interests described in section 170(f)(3)(B).

Section 170(f) places restrictions on the income tax deduction available for gifts of partial interests to charity. Section 170(f)(3)(B) provides exceptions for certain charitable gifts, among them, the gift of a legal remainder interest in a personal residence or farm.

Rev. Rul. 76-357, 1976-2 C.B. 285, holds that the exception applies only to remainders not in trust. *Ellis First National Bank v. U.S.*, 550 F.2d 9 (Ct. Cl. 1977), and *Estate of Burgess v. Commissioner*, 622 F.2d 700 (4th Cir. 1980), reach the same conclusion.

Estate of Blackford v. Commissioner, 77 T.C. 1246 (1981), *acq. in result*, 1983-2 C.B. 1, held that the section 170(f)(3)(B) exception applied to a legal remainder interest in a residence bequeathed to four different charities, where the executor was instructed to sell the residence and divide the proceeds. Rev. Rul. 83-158, 1983-2 C.B. 159, based the Service's acquiescence in this result on the applicable provisions of local law that would have permitted the four charities to elect to receive the realty as tenants in common in lieu of receiving the cash proceeds.

Rev. Rul. 76-544, 1976-2 C.B. 288, however, holds that the exception for remainder interests in farms or residences does not apply to a remainder interest that vests in a charitable organization and an individual as equal tenants in common, because the entire remainder interest does not pass to charity.

The limitations on the charitable contribution deduction for the gift of split interests to charity were first imposed by section 201 of the Tax Reform Act of 1969, 1969-3 C.B. 10, 51. Extensive discussions in the committee reports show that the intent of these limitations was to deny a charitable deduction in situations where the subsequent administration of a trust or some other contingency might favor a noncharitable beneficiary at the expense of the charitable remainderman. Congress was responding to situations where trusts were administered to the advantage of noncharitable life tenants, where charitable remainders were contingent and never became possessory, or where governing instruments permitted invasions of principal under standards that were too vague to lend themselves to accurate valuation.

Congress concluded, however, that a nontrust gift of a remainder interest in a residence was not subject to such abuses. S. Rep. No. 91-552, 91st Cong., 1st Sess. 88 (1969), 1969-3 C.B. 479, 480. Accordingly, sections 2522(c)(2) and 170(f)(3)(B) of the Code permit a charitable deduction for "a remainder interest in a personal residence." In the present situation, the charity did not receive the entire remainder interest; nevertheless, its interest is a remainder interest in the residence.

The legislative history does not suggest that the charity must receive the entire remainder interest. Indeed, section 170(f)(3)(B)(ii) allows a charitable deduction for a gift of "an undivided portion of the taxpayer's entire interest in property." The fact that a taxpayer may convey a fractional interest in realty to charity and receive a deduction indicates that there is no statutory policy against a charity and an individual holding real property as tenants in common.

More important, the abuses that the split interest rules were designed to prevent would not be possible in this case. *C* is certain to receive its 10 percent interest as a tenant in common; thus, the deduction that *A* receives for the value of the 10 percent remainder interest will correspond to the value of the interest charity ultimately will receive. Should ownership in common involve any disadvantage to *C*, that disadvantage can be resolved by sale of the property.

In this respect, the present case is similar to Rev. Rul. 83-158. That ruling allowed a charitable deduction because the four charities could have chosen to receive the realty as tenants in common rather than receive the proceeds of its sale. There is no reason to conclude that any one of the four charities would have been worse off had one or more of its prospective co-tenants been individuals rather than unrelated charitable organizations.

Accordingly, a charitable deduction is allowable to *A* for the value of *C*'s remainder interest in the residence. In determining the amount of the deduction allowable, however, the value of the charitable interest must be reduced to reflect appropriate valuation discount for the cotenancy arrangement. *See Estate of Fawcett v. Commissioner*, 64 T.C. 889, 900 (1975), *acq.*, 1978-2 C.B. 2.

CONCLUSION

A charitable contribution deduction is allowable for a gift to charity of a legal remainder interest in the donor's personal residence even though the interest conveyed to charity is in the form of a tenancy in common with an individual.

Rev. Rul. 76-544 is revoked.

Subtitle C.—Employment Taxes
Chapter 21.—Federal Insurance Contribution Act
Subchapter C.—General Provisions

Section 3121.—Definitions

26 CFR 31.3121(d)-1: Who are employees.
(Also Sections 3306, 3401; 31.3306(i)-1, 31.3401(c)-1.)

Employment status under section 530(d) of the Revenue Act of 1978. Guidelines are set forth for determining the employment status of a taxpayer (technical service specialist) affected by section 530(d) of the Revenue Act of 1978, as added by section 1706 of the Tax Reform Act of 1986. The specialists are to be classified as employees under generally applicable common law standards.

Rev. Rul. 87-41

ISSUE

In the situations described below, are the individuals employees under the common law rules for purposes of the Federal Insurance Contributions Act (FICA), the Federal Unemployment Tax Act (FUTA), and the Collection of Income Tax at Source on Wages (chapters 21, 23, and 24 respectively, subtitle C, Internal Revenue Code)? These situations illustrate the application of section 530(d) of the Revenue Act of 1978, 1978-3 (Vol. 1) C.B. 119 (the 1978 Act), which was added by section 1706(a) of the Tax Reform Act of 1986, 1986-3 (Vol. 1) C.B. 698 (the 1986 Act) (generally effective for services performed and remuneration paid after December 31, 1986).

FACTS

In each factual situation, an individual worker (Individual), pursuant to an arrangement between one person (Firm) and

another person (Client), provides services for the Client as an engineer, designer, drafter, computer programmer, systems analyst, or other similarly skilled worker engaged in a similar line of work.

Situation 1

The Firm is engaged in the business of providing temporary technical services to its clients. The Firm maintains a roster of workers who are available to provide technical services to prospective clients. The Firm does not train the workers but determines the services that the workers are qualified to perform based on information submitted by the workers.

The Firm has entered into a contract with the Client. The contract states that the Firm is to provide the Client with workers to perform computer programming services meeting specified qualifications for a particular project. The Individual, a computer programmer, enters into a contract with the Firm to perform services as a computer programmer for the Client's project, which is expected to last less than one year. The Individual is one of several programmers provided by the Firm to the Client. The Individual has not been an employee of or performed services for the Client (or any predecessor or affiliated corporation of the Client) at any time preceding the time at which the Individual begins performing services for the Client. Also, the Individual has not been an employee of or performed services for or on behalf of the Firm at any time preceding the time at which the Individual begins performing services for the Client. The Individual's contract with the Firm states that the Individual is an independent contractor with respect to services performed on behalf of the Firm for the Client.

The Individual and the other programmers perform the services under the Firm's contract with the Client. During the time the Individual is performing services for the Client, even though the Individual retains the right to perform services for other persons, substantially all of the Individual's working time is devoted to performing services for the Client. A significant portion of the services are performed on the Client's premises. The Individual reports to the Firm by accounting for time worked and describing the progress of the work. The Firm pays the Individual and regularly charges the Client for the services performed by the Individual. The Firm generally does not pay individuals who perform services for the Client unless the Firm provided such individuals to the Client.

The work of the Individual and other programmers is regularly reviewed by the Firm. The review is based primarily on reports by the Client about the performance of these workers. Under the contract between the Individual and the Firm, the Firm may terminate its relationship with the Individual if the review shows that he or she is failing to perform the services contracted for by the Client. Also, the Firm will replace the Individual with another worker if the Individual's services are unacceptable to the Client. In such a case, however, the Individual will nevertheless receive his or her hourly pay for the work completed.

Finally, under the contract between the Individual and the Firm, the Individual is prohibited from performing services directly for the Client and, under the contract between the Firm and the Client, the Client is prohibited from receiving services from the Individual for a period of three months following the termination of services by the Individual for the Client on behalf of the Firm.

Situation 2

The Firm is a technical services firm that supplies clients with technical personnel. The Client requires the services of a systems analyst to complete a project and contacts the Firm to obtain such an analyst. The Firm maintains a roster of analysts and refers such an analyst, the Individual, to the Client. The Individual is not restricted by the Client or the Firm from providing services to the general public while performing services for the Client and in fact does perform substantial services for other persons during the period the Individual is working for the Client. Neither the Firm nor the Client has priority on the services of the Individual. The Individual does not report, directly or indirectly, to the Firm after the beginning of the assignment to the Client concerning (1) hours worked by the Individual, (2) progress on the job, or (3) expenses incurred by the Individual in performing services for the Client. No reports (including reports of time worked or progress on the job) made by the Individual to the Client are provided by the Client to the Firm.

If the Individual ceases providing services for the Client prior to completion of the project or if the Individual's work product is otherwise unsatisfactory, the Client may seek damages from the Individual. However, in such circumstances, the Client may not seek damages from the Firm, and the Firm is not required to replace the Individual. The Firm may not terminate the services of the Individual while he or she is performing services for the Client and may not otherwise affect the relationship between the Client and the Individual. Neither the Individual nor the Client is prohibited for any period after termination of the Individual's services on this job from contracting directly with the other. For referring the Individual to the Client, the Firm receives a flat fee that is fixed prior to the Individual's commencement of services for the Client and is unrelated to the number of hours and quality of work performed by the Individual. The Individual is not paid by the Firm either directly or indirectly. No payment made by the Client to the Individual reduces the amount of the fee that the Client is otherwise required to pay the Firm. The Individual is performing services that can be accomplished without the Individual's receiving direction or control as to hours, place of work, sequence, or details of work.

Situation 3

The Firm, a company engaged in furnishing client firms with technical personnel, is contacted by the Client, who is in need of the services of a drafter for a particular project, which is expected to last less than one year. The Firm recruits the Individual to perform the drafting services for the Client. The Individual performs substantially all of the services for the Client at the office of the Client, using materials and equipment of the Client. The services are performed under the supervision of employees of the Client. The Individual reports to the Client on a regular basis. The Individual is paid by the Firm based on the number of hours the Individual has worked for the Client, as reported to the Firm by the Client or as reported by the Individual and confirmed by the Client. The Firm has no obligation to pay the Individual if the Firm does not receive payment for the Individual's services from the Client. For recruiting the Individual for the Client, the Firm receives a flat fee that is fixed prior to the

Individual's commencement of services for the Client and is unrelated to the number of hours and quality of work performed by the Individual. However, the Firm does receive a reasonable fee for performing the payroll function. The Firm may not direct the work of the Individual and has no responsibility for the work performed by the Individual. The Firm may not terminate the services of the Individual. The Client may terminate the services of the Individual without liability to either the Individual or the Firm. The Individual is permitted to work for another firm while performing services for the Client, but does in fact work for the Client on a substantially full-time basis.

LAW AND ANALYSIS

This ruling provides guidance concerning the factors that are used to determine whether an employment relationship exists between the Individual and the Firm for federal employment tax purposes and applies those factors to the given factual situations to determine whether the Individual is an employee of the Firm for such purposes. The ruling does not reach any conclusions concerning whether an employment relationship for federal employment tax purposes exists between the Individual and the Client in any of the factual situations.

Analysis of the preceding three fact situations requires an examination of the common law rules for determining whether the Individual is an employee with respect to either the Firm or the Client, a determination of whether the Firm or the Client qualifies for employment tax relief under section 530(a) of the 1978 Act, and a determination of whether any such relief is denied the Firm under section 530(d) of the 1978 Act (added by section 1706 of the 1986 Act).

An individual is an employee for federal employment tax purposes if the individual has the status of an employee under the usual common law rules applicable in determining the employer-employee relationship. Guides for determining that status are found in the following three substantially similar sections of the Employment Tax Regulations: sections 31.3121(d)-1(c); 31.3306(i)-1; and 31.3401(c)-1.

These sections provide that generally the relationship of employer and employee exists when the person or persons for whom the services are performed have the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished. That is, an employee is subject to the will and control of the employer not only as to what shall be done but as to how it shall be done. In this connection, it is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if the employer has the right to do so.

Conversely, these sections provide, in part, that individuals (such as physicians, lawyers, dentists, contractors, and subcontractors) who follow an independent trade, business, or profession, in which they offer their services to the public, generally are not employees.

Finally, if the relationship of employer and employee exists, the designation or description of the relationship by the parties as anything other than that of employer and employee is immaterial. Thus, if such a relationship exists, it is of no consequence that the employee is designated as a partner, coadventurer, agent, independent contractor, or the like.

As an aid to determining whether an individual is an employee under the common law rules, twenty factors or elements have been identified as indicating whether sufficient control is present to establish an employer-employee relationship. The twenty factors have been developed based on an examination of cases and rulings considering whether an individual is an employee. The degree of importance of each factor varies depending on the occupation and the factual context in which the services are performed. The twenty factors are designed only as guides for determining whether an individual is an employee; special scrutiny is required in applying the twenty factors to assure that formalistic aspects of an arrangement designed to achieve a particular status do not obscure the substance of the arrangement (that is, whether the person or persons for whom the services are performed exercise sufficient control over the individual for the individual to be classified as an employee). The twenty factors are described below:

1. *Instructions.* A worker who is required to comply with other persons' instructions about when, where, and how he or she is to work is ordinarily an employee. This control factor is present if the person or persons for whom the services are performed have the *right* to require compliance with instructions. See, for example, Rev. Rul. 68-598, 1968-2 C.B. 464, and Rev. Rul. 66-381, 1966-2 C.B. 449.

2. *Training.* Training a worker by requiring an experienced employee to work with the worker, by corresponding with the worker, by requiring the worker to attend meetings, or by using other methods, indicates that the person or persons for whom the services are performed want the services performed in a particular method or manner. See Rev. Rul. 70-630, 1970-2 C.B. 229.

3. *Integration.* Integration of the worker's services into the business operations generally shows that the worker is subject to direction and control. When the success or continuation of a business depends to an appreciable degree upon the performance of certain services, the workers who perform those services must necessarily be subject to a certain amount of control by the owner of the business. See *United States v. Silk,* 331 U.S. 704 (1947), 1947-2 C.B. 167.

4. *Services Rendered Personally.* If the services must be rendered personally, presumably the person or persons for whom the services are performed are interested in the methods used to accomplish the work as well as in the results. See Rev. Rul. 55-695, 1955-2 C.B. 410.

5. *Hiring, Supervising, and Paying Assistants.* If the person or persons for whom the services are performed hire, supervise, and pay assistants, that factor generally shows control over the workers on the job. However, if one worker hires, supervises, and pays the other assistants pursuant to a contract under which the worker agrees to provide materials and labor and under which the worker is responsible only for the attainment of a result, this factor indicates an independent contractor status. Compare Rev. Rul. 63-115, 1963-1 C.B. 178, with Rev. Rul. 55-593, 1955-2 C.B. 610.

6. *Continuing Relationship.* A continuing relationship between the worker and the person or persons for whom the services are performed indicates that an employer-employee relationship exists. A continuing relationship may exist where work is performed at frequently recurring although irregular intervals. See *United States v. Silk.*

7. *Set Hours of Work.* The establishment of set hours of work by the person or persons for whom the services are performed is a factor indicating control. See Rev. Rul. 73-591, 1973-2 C.B. 337.

8. *Full Time Required.* If the worker must devote substantially full time to the business of the person or persons for whom the services are performed, such person or persons have control over the amount of time the worker spends working and impliedly restrict the worker from doing other gainful work. An independent contractor, on the other hand, is free to work when and for whom he or she chooses. See Rev. Rul. 56–694, 1956–2 C.B. 694.

9. *Doing Work on Employer's Premises.* If the work is performed on the premises of the person or persons for whom the services are performed, that factor suggests control over the worker, especially if the work could be done elsewhere. Rev. Rul. 56–660, 1956–2 C.B. 693. Work done off the premises of the person or persons receiving the services, such as at the office of the worker, indicates some freedom from control. However, this fact by itself does not mean that the worker is not an employee. The importance of this factor depends on the nature of the service involved and the extent to which an employer generally would require that employees perform such services on the employer's premises. Control over the place of work is indicated when the person or persons for whom the services are performed have the right to compel the worker to travel a designated route, to canvass a territory within a certain time, or to work at specific places as required. See Rev. Rul. 56–694.

10. *Order or Sequence Set.* If a worker must perform services in the order or sequence set by the person or persons for whom the services are performed, that factor shows that the worker is not free to follow the worker's own pattern of work but must follow the established routines and schedules of the person or persons for whom the services are performed. Often, because of the nature of an occupation, the person or persons for whom the services are performed do not set the order of the services or set the order infrequently. It is sufficient to show control, however, if such person or persons retain the right to do so. See Rev. Rul. 56–694.

11. *Oral or Written Reports.* A requirement that the worker submit regular or written reports to the person or persons for whom the services are performed indicates a degree of control. See Rev. Rul. 70–309, 1970–1 C.B. 199, and Rev. Rul. 68–248, 1968–1 C.B. 431.

12. *Payment by Hour, Week, Month.* Payment by the hour, week, or month generally points to an employer-employee relationship, provided that this method of payment is not just a convenient way of paying a lump sum agreed upon as the cost of a job. Payment made by the job or on a straight commission generally indicates that the worker is an independent contractor. See Rev. Rul. 74–389, 1974–2 C.B. 330.

13. *Payment of Business and/or Traveling Expenses.* If the person or persons for whom the services are performed ordinarily pay the worker's business and/or traveling expenses, the worker is ordinarily an employee. An employer, to be able to control expenses, generally retains the right to regulate and direct the worker's business activities. See Rev. Rul. 55–144, 1955–1 C.B. 483.

14. *Furnishing of Tools and Materials.* The fact that the person or persons for whom the services are performed furnish significant tools, materials, and other equipment tends to show the existence of an employer-employee relationship. See Rev. Rul. 71–524, 1971–2 C.B. 346.

15. *Significant Investment.* If the worker invests in facilities that are used by the worker in performing services and are not typically maintained by employees (such as the maintenance of an office rented at fair value from an unrelated party), that factor tends to indicate that the worker is an independent contractor. On the other hand, lack of investment in facilities indicates dependence on the person or persons for whom the services are performed for such facilities and, accordingly, the existence of an employer-employee relationship. See Rev. Rul. 71–524. Special scrutiny is required with respect to certain types of facilities, such as home offices.

16. *Realization of Profit or Loss.* A worker who can realize a profit or suffer a loss as a result of the worker's services (in addition to the profit or loss ordinarily realized by employees) is generally an independent contractor, but the worker who cannot is an employee. See Rev. Rul. 70–309. For example, if the worker is subject to a real risk of economic loss due to significant investments or a bona fide liability for expenses, such as salary payments to unrelated employees, that factor indicates that the worker is an independent contractor. The risk that a worker will not receive payment for his or her services, however, is common to both independent contractors and employees and thus does not constitute a sufficient economic risk to support treatment as an independent contractor.

17. *Working for More Than One Firm at a Time.* If a worker performs more than de minimis services for a multiple of unrelated persons or firms at the same time, that factor generally indicates that the worker is an independent contractor. See Rev. Rul. 70–572, 1970–2 C.B. 221. However, a worker who performs services for more than one person may be an employee of each of the persons, especially where such persons are part of the same service arrangement.

18. *Making Service Available to General Public.* The fact that a worker makes his or her services available to the general public on a regular and consistent basis indicates an independent contractor relationship. See Rev. Rul. 56–660.

19. *Right to Discharge.* The right to discharge a worker is a factor indicating that the worker is an employee and the person possessing the right is an employer. An employer exercises control through the threat of dismissal, which causes the worker to obey the employer's instructions. An independent contractor, on the other hand, cannot be fired so long as the independent contractor produces a result that meets the contract specifications. Rev. Rul. 75–41, 1975–1 C.B. 323.

20. *Right to Terminate.* If the worker has the right to end his or her relationship with the person for whom the services are performed at any time he or she wishes without incurring liability, that factor indicates an employer-employee relationship. See Rev. Rul. 70–309.

Rev. Rul. 75–41 considers the employment tax status of individuals performing services for a physician's professional service corporation. The corporation is in the business of providing a variety of services to professional people and firms (subscribers), including the services of secretaries, nurses, dental hygienists, and other similarly trained personnel. The individuals who are to perform the services are recruited by the corporation, paid by the corporation, assigned to jobs, and provided with employee benefits by the corporation. Individuals who enter into contracts with the corporation agree they will not contract directly with any subscriber to which they are assigned for at least three months after cessation of their contracts with the corporation. The corporation assigns the individual to the subscriber to work on the subscriber's premises with the subscriber's equipment. Subscribers have the right to require that an individual furnished by the corporation cease

providing services to them, and they have the further right to have such individual replaced by the corporation within a reasonable period of time, but the subscribers have no right to affect the contract between the individual and the corporation. The corporation retains the right to discharge the individuals at any time. Rev. Rul. 75–41 concludes that the individuals are employees of the corporation for federal employment tax purposes.

Rev. Rul. 70–309 considers the employment tax status of certain individuals who perform services as oil well pumpers for a corporation under contracts that characterize such individuals as independent contractors. Even though the pumpers perform their services away from the headquarters of the corporation and are not given day-to-day directions and instructions, the ruling concludes that the pumpers are employees of the corporation because the pumpers perform their services pursuant to an arrangement that gives the corporation the right to exercise whatever control is necessary to assure proper performance of the services; the pumpers' services are both necessary and incident to the business conducted by the corporation; and the pumpers are not engaged in an independent enterprise in which they assume the usual business risks, but rather work in the course of the corporation's trade or business. See also Rev. Rul. 70–630, 1970–2 C.B. 229, which considers the employment tax status of salesclerks furnished by an employee service company to a retail store to perform temporary services for the store.

Section 530(a) of the 1978 Act, as amended by section 269(c) of the Tax Equity and Fiscal Responsibility Act of 1982, 1982–2 C.B. 462, 536, provides, for purposes of the employment taxes under subtitle C of the Code, that if a taxpayer did not treat an individual as an employee for any period, then the individual shall be deemed not to be an employee, unless the taxpayer had no reasonable basis for not treating the individual as an employee. For any period after December 31, 1978, this relief applies only if both of the following consistency rules are satisfied: (1) all federal tax returns (including information returns) required to be filed by the taxpayer with respect to the individual for the period are filed on a basis consistent with the taxpayer's treatment of the individual as not being an employee ("reporting consistency rule"), and (2) the taxpayer (and any predecessor) has not treated any individual holding a substantially similar position as an employee for purposes of the employment taxes for periods beginning after December 31, 1977 ("substantive consistency rule").

The determination of whether any individual who is treated as an employee holds a position substantially similar to the position held by an individual whom the taxpayer would otherwise be permitted to treat as other than an employee for employment tax purposes under section 530(a) of the 1978 Act requires an examination of all the facts and circumstances, including particularly the activities and functions performed by the individuals. Differences in the positions held by the respective individuals that result from the taxpayer's treatment of one individual as an employee and the other individual as other than an employee (for example, that the former individual is a participant in the taxpayer's qualified pension plan or health plan and the latter individual is not a participant in either) are to be disregarded in determining whether the individuals hold substantially similar positions.

Section 1706(a) of the 1986 Act added to section 530 of the 1978 Act a new subsection (d), which provides an exception with respect to the treatment of certain workers. Section 530(d) provides that section 530 shall not apply in the case of an individual who, pursuant to an arrangement between the taxpayer and another person, provides services for such other person as an engineer, designer, drafter, computer programmer, systems analyst, or other similarly skilled worker engaged in a similar line of work. Section 530(d) of the 1978 Act does not affect the determination of whether such workers are employees under the common law rules. Rather, it merely eliminates the employment tax relief under section 530(a) of the 1978 Act that would otherwise be available to a taxpayer with respect to those workers who are determined to be employees of the taxpayer under the usual common law rules. Section 530(d) applies to remuneration paid and services rendered after December 31, 1986.

The Conference Report on the 1986 Act discusses the effect of section 530(d) as follows:

> The Senate amendment applies whether the services of [technical service workers] are provided by the firm to only one client during the year or to more than one client, and whether or not such individuals have been designated or treated by the technical services firm as independent contractors, sole proprietors, partners, or employees of a personal service corporation controlled by such individual. The effect of the provision cannot be avoided by claims that such technical service personnel are employees of personal service corporations controlled by such personnel. For example, an engineer retained by a technical services firm to provide services to a manufacturer cannot avoid the effect of this provision by organizing a corporation that he or she controls and then claiming to provide services as an employee of that corporation.
>
> . . . [T]he provision does not apply with respect to individuals who are classified, under the generally applicable common law standards, as employees of a business that is a client of the technical services firm.

2 H.R. Rep. No. 99–841 (Conf. Rep.), 99th Cong., 2d Sess. II–834 to 835 (1986).

Under the facts of Situation 1, the legal relationship is between the Firm and the Individual, and the Firm retains the right of control to insure that the services are performed in a satisfactory fashion. The fact that the Client may also exercise some degree of control over the Individual does not indicate that the individual is not an employee. Therefore, in Situation 1, the Individual is an employee of the Firm under the common law rules. The facts in Situation 1 involve an arrangement among the Individual, Firm, and Client, and the services provided by the Individual are technical services. Accordingly, the Firm is denied section 530 relief under section 530(d) of the 1978 Act (as added by section 1706 of the 1986 Act), and no relief is available with respect to any employment tax liability incurred in Situation 1. The analysis would not differ if the facts of Situation 1 were changed to state that the Individual provided the technical services through a personal service corporation owned by the Individual.

In Situation 2, the Firm does not retain any right to control the performance of the services by the Individual and, thus, no employment relationship exists between the Individual and the Firm.

In Situation 3, the Firm does not control the performance of the services of the Individual, and the Firm has no right to affect the relationship between the Client and the Individual. Consequently, no employment relationship exists between the Firm and the Individual.

HOLDINGS

Situation 1. The Individual is an employee of the Firm under the common law rules. Relief under section 530 of the 1978 Act is not available to the Firm because of the provisions of section 530(d).

Situation 2. The Individual is not an employee of the Firm under the common law rules.

Situation 3. The Individual is not an employee of the Firm under the common law rules.

Because of the application of section 530(b) of the 1978 Act, no inference should be drawn with respect to whether the Individual in Situations 2 and 3 is an employee of the Client for federal employment tax purposes.

Chapter 23.—Federal Unemployment Tax Act

Section 3306.—Definitions

26 CFR 31.3306(i)-1: Who are employees.

Guidelines for determining the employment status of taxpayers (technical service specialists) affected by section 530(d) of the Revenue Act of 1978, as added by section 1706 of the Tax Reform Act of 1986. The specialist are to be classified as employees under generally applicable common law standards. See Rev. Rul. 87–41, page 296.

Chapter 24.—Collection of Income Tax at Source on Wages
Subchapter A.—Withholding from Wages

Section 3401.—Definitions

26 CFR 31.3401(c)-1: Employee.

Guidelines for determining the employment status of taxpayers (technical service specialists) affected by section 530(d) of the Revenue Act of 1978, as added by section 1706 of the Tax Reform Act of 1986. The specialist are to be classified as employees under generally applicable common law standards. See Rev. Rul. 87–41, page 296

Section 3402.—Income Tax Collected at Source

Information which must be obtained by a withholding agent in order to rely on a nonresident alien student's claim for exemption from federal income tax on compensation for services under an income tax treaty to which the United States is a party. See Rev. Proc. 87–8, page 366.

Information which must be obtained by a withholding agent in order to rely on a nonresident alien's claim for exemption from federal income tax on income received as a teacher or researcher under an income tax treaty to which the United States is a party. See Rev. Proc. 87–9, page 368.

26 CFR 31.3402(f)(1)-1T: Additional withholding exemption to which an employee is entitled in respect of the standard deduction. (temporary)

T.D. 8112

TITLE 26.—INTERNAL REVENUE.—CHAPTER 1, SUBCHAPTER C, PART 31—EMPLOYMENT TAXES AND COLLECTION OF INCOME TAX AT SOURCE

Employment Taxes and Collection of Income Tax at Source; Submission of Certain Withholding Exemption Certificates and Entitlement to Additional Withholding Exemption

AGENCY: Internal Revenue Service, Treasury.

ACTION: Temporary regulations.

SUMMARY: This document contains temporary regulations that relate to the submission of withholding exemption certificates when the total number of withholding exemptions claimed on the certificate exceeds 10, and to the requirements that an employee must meet to be entitled to the additional withholding exemption in respect of the standard deduction. The temporary rules modify the withholding rules as made by the Tax Reform Act of 1986. In addition, the temporary regulations set forth in this document serve as the text of the proposed regulations***[page 805, this Bulletin].

EFFECTIVE DATE: These regulations are effective with respect to Forms W–4 received after November 30, 1986.

FOR FURTHER INFORMATION CONTACT: Laura Ann M. Lauritzen of the Legislation and Regulations Division, Office of Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue N.W., Washington, DC 20224 (Attention: CC:LR:T) (202–566–3459, not a toll-free call).

SUPPLEMENTARY INFORMATION:
BACKGROUND

This document contains temporary regulations under section 3402 of the Internal Revenue Code of 1986 that detail the circumstances under which an employer must submit an Employee's Withholding Allowance Certificate and those under which an employee may claim an additional withholding exemption. The Tax Reform Act of 1986 increased the amount of each withholding exemption. It also modified or eliminated a number of deductions and credits which an employee previously could take into account in determining the number of withholding allowances the employee was entitled to claim on the withholding exemption certificate. The temporary regulations provided by this document will remain in effect until superseded by final regulations on this project.

EXPLANATION OF PROVISIONS

Section 3402(f)(2) of the Code provides that an employee must furnish his or her employer with a withholding exemption certificate claiming a number of withholding exemptions, which may in no event exceed the number to which the employee is entitled. In an attempt to ensure that employees do not claim an excessive number of withholding exemptions, current §31.3402(f)(2)–1(g) provides that an employer must submit to the Internal Revenue Service a copy of any withholding exemption certificate if the total number of withholding exemptions claimed on the certificate exceeds 14. Since the Tax Reform Act of 1986 increased the amount of each withholding exemption and eliminated or limited a number of the deductions and credits previously used in determining the number of withholding allowances to which an employee was entitled, in some cases the number of withholding exemptions that an employee is entitled to claim has been reduced. To reflect these changes, these temporary regulations amend the regulations relating to withholding exemption certificates to require employers to submit to the Service a copy of any Form W–4 (Employee's Withholding Allowance Certificate) on which an employee claims more than 10 exemptions.

Section 31.3402(f)(1)–1(e) provides that an employee may claim an additional withholding exemption if certain requirements are met. Since the Tax Reform Act of 1986 replaced the zero bracket allowance with the standard deduction and to ensure that withholding more closely matches tax liabilities, these temporary regulations amend the regulation relating to this additional withholding exemption to reflect the new law.

NON-APPLICABILITY OF EXECUTIVE ORDER 12291

The Commissioner of Internal Revenue has determined that this temporary rule is not a major rule as defined in Executive Order 12291 and that a regulatory impact analysis therefore is not required.

REGULATORY FLEXIBILITY ANALYSIS

A general notice of proposed rulemaking is not required by 5 U.S.C. 553 for temporary regulations.

APPENDIX D

Revenue Procedure 97-13: Private Business Use of Bond Proceeds—Management and Service Contracts

26 CFR 601.601: Rules and regulations.
(Also Part I, §§ 103, 141, 145; 1.141–3, 1.145–2.)

Rev. Proc. 97–13

SECTION 1. PURPOSE

The purpose of this revenue procedure is to set forth conditions under which a management contract does not result in private business use under § 141(b) of the Internal Revenue Code of 1986. This revenue procedure also applies to determinations of whether a management contract causes the test in § 145(a)(2)(B) of the 1986 Code to be met for qualified 501(c)(3) bonds.

SECTION 2. BACKGROUND

.01 *Private Business Use.*

(1) Under § 103(a) of the 1986 Code, gross income does not include interest on any state or local bond. Under § 103(b)(1) of the 1986 Code, however, § 103(a) of the 1986 Code does not apply to a private activity bond, unless it is a qualified bond under § 141(e) of the 1986 Code. Section 141(a)(1) of the 1986 Code defines "private activity bond" as any bond issued as part of an issue that meets both the private business use and the private security or payment tests. Under § 141(b)(1) of the 1986 Code, an issue generally meets the private business use test if more than 10 percent of the proceeds of the issue are to be used for any private business use. Under § 141(b)(6)(A) of the 1986 Code, private business use means direct or indirect use in a trade or business carried on by any person other than a governmental unit. Section 145(a) of the 1986 Code also applies the private business use test of § 141(b)(1) of the 1986 Code, with certain modifications.

(2) Corresponding provisions of the Internal Revenue Code of 1954 set forth the requirements for the exclusion from gross income of the interest on state or local bonds. For purposes of this revenue procedure, any reference to a 1986 Code provision includes a reference to the corresponding provision, if any, under the 1954 Code.

(3) Private business use can arise by ownership, actual or beneficial use of property pursuant to a lease, a management or incentive payment contract, or certain other arrangements. The Conference Report for the Tax Reform Act of 1986, provides as follows:

> The conference agreement generally retains the present-law rules under which use by persons other than governmental units is determined for purposes of the trade or business use test. Thus, as under present law, the use of bond-financed property is treated as a use of bond proceeds. As under present law, a person may be a user of bond proceeds and bond-financed property as a result of (1) ownership or (2) actual or beneficial use of property pursuant to a lease, a management or incentive payment contract, or (3) any other arrangement such as a take-or-pay or other output-type contract.

2 H.R. Conf. Rep. No. 841, 99th Cong., 2d Sess. II–687–688, (1986) 1986–3 (Vol. 4) C.B. 687–688 (footnote omitted).

(4) A management contract that gives a nongovernmental service provider an ownership or leasehold interest in financed property is not the only situation in which a contract may result in private business use.

(5) Section 1.141 3(b)(4)(i) of the Income Tax Regulations provides, in general, that a management contract (within the meaning of § 1.141–3(b)(4)(ii)) with respect to financed property may result in private business use of that property, based on all the facts and circumstances.

(6) Section 1.141–3(b)(4)(i) provides that a management contract with respect to financed property generally results in private business use of that property if the contract provides for compensation for services rendered with compensation based, in whole or in part, on a share of net profits from the operation of the facility.

(7) Section 1.141–3(b)(4)(iii), in general, provides that certain arrangements generally are not treated as management contracts that may give rise to private business use. These are—

(a) Contracts for services that are solely incidental to the primary governmental function or functions of a financed facility (for example, contracts for janitorial, office equipment repair, hospital billing or similar services);

(b) The mere granting of admitting privileges by a hospital to a doctor, even if those privileges are conditioned on the provision of de minimis services, if those privileges are available to all qualified physicians in the area, consistent with the size and nature of its facilities;

(c) A contract to provide for the operation of a facility or system of facilities that consists predominantly of public utility property (as defined in § 168(i)(10) of the 1986 Code), if the only compensation is the reimbursement of actual and direct expenses of the service provider and reasonable administrative overhead expenses of the service provider; and

(d) A contract to provide for services, if the only compensation is the reimbursement of the service provider for actual and direct expenses paid by the service provider to unrelated parties.

(8) Section 1.145-2(a) provides generally that §§ 1.141–0 through 1.141–15 apply to § 145(a) of the 1986 Code.

(9) Section 1.145–2(b)(1) provides that in applying §§ 1.141–0 through 1.141–15 to § 145(a) of the 1986 Code, references to governmental persons include section 501(c)(3) organizations with respect to their activities that do not constitute unrelated trades or businesses under § 513(a) of the 1986 Code.

.02 *Existing Advance Ruling Guidelines.* Rev. Proc. 93–19, 1993–1 C.B. 526, contains advance ruling guidelines for determining whether a management contract results in private business use under § 141(b) of the 1986 Code.

SECTION 3. DEFINITIONS

.01 *Adjusted gross revenues* means gross revenues of all or a portion of a facility, less allowances for bad debts and contractual and similar allowances.

.02 *Capitation fee* means a fixed periodic amount for each person for whom the service provider or the qualified user assumes the responsibility to provide all needed services for a specified period so long as the quantity and type of services actually provided to covered persons varies substantially. For example, a capitation fee includes a fixed dollar amount payable per month to a medical service provider for each member of a health maintenance organization plan for whom the provider agrees to provide all needed medical services for a specified period. A capitation fee may include a variable component of up to 20 percent of the total capitation fee designed to

protect the service provider against risks such as catastrophic loss.

.03 *Management contract* means a management, service, or incentive payment contract between a qualified user and a service provider under which the service provider provides services involving all, a portion of, or any function of, a facility. For example, a contract for the provision of management services for an entire hospital, a contract for management services for a specific department of a hospital, and an incentive payment contract for physician services to patients of a hospital are each treated as a management contract. See §§ 1.141-3(b)(4)(ii) and 1.145-2. .

04 *Penalties* for terminating a contract include a limitation on the qualified user's right to compete with the service provider; a requirement that the qualified user purchase equipment, goods, or services from the service provider; and a requirement that the qualified user pay liquidated damages for cancellation of the contract. In contrast, a requirement effective on cancellation that the qualified user reimburse the service provider for ordinary and necessary expenses or a restriction on the qualified user against hiring key personnel of the service provider is generally not a contract termination penalty. Another contract between the service provider and the qualified user, such as a loan or guarantee by the service provider, is treated as creating a contract termination penalty if that contract contains terms that are not customary or arm's- length that could operate to prevent the qualified user from terminating the contract (for example, provisions under which the contract terminates if the management contract is terminated or that place substantial restrictions on the selection of a substitute service provider).

.05 *Periodic fixed fee* means a stated dollar amount for services rendered for a specified period of time. For example, a stated dollar amount per month is a periodic fixed fee. The stated dollar amount may automatically increase according to a specified, objective, external standard that is not linked to the output or efficiency of a facility. For example, the Consumer Price Index and similar external indices that track increases in prices in an area or increases in revenues or costs in an industry are objective external standards. Capitation fees and per-unit fees are not periodic fixed fees.

.06 *Per-unit fee* means a fee based on a unit of service provided specified in the contract or otherwise specifically determined by an independent third party, such as the administrator of the Medicare program, or the qualified user. For example, a stated dollar amount for each specified medical procedure performed, car parked, or passenger mile is a per-unit fee. Separate billing arrangements between physicians and hospitals generally are treated as per-unit fee arrangements.

.07 *Qualified user* means any state or local governmental unit as defined in § 1.103-1 or any instrumentality thereof. The term also includes a section 501(c)(3) organization if the financed property is not used in an unrelated trade or business under § 513(a) of the 1986 Code. The term does not include the United States or any agency or instrumentality thereof.

.08 *Renewal option* means a provision under which the service provider has a legally enforceable right to renew the contract. Thus, for example, a provision under which a contract is automatically renewed for one-year periods absent cancellation by either party is not a renewal option (even if it is expected to be renewed).

.09 *Service provider* means any person other than a qualified user that provides services under a contract to, or for the benefit of, a qualified user.

SECTION 4. SCOPE

This revenue procedure applies when, under a management contract, a service provider provides management or other services involving property financed with proceeds of an issue of state or local bonds subject to § 141 or § 145(a)(2)(B) of the 1986 Code.

SECTION 5. OPERATING GUIDELINES FOR MANAGEMENT CONTRACTS

.01 *In general.* If the requirements of section 5 of this revenue procedure are satisfied, the management contract does not itself result in private business use. In addition, the use of financed property, pursuant to a management contract meeting the requirements of section 5 of this revenue procedure, is not private business use if that use is functionally related and subordinate to that management contract and that use is not, in substance, a separate contractual agreement (for example, a separate lease of a portion of the financed property). Thus, for example, exclusive use of storage areas by the manager for equipment that is necessary for it to perform activities required under a management contract that meets the requirements of section 5 of this revenue procedure, is not private business use.

.02 *General compensation requirements.*

(1) *In general.* The contract must provide for reasonable compensation for services rendered with no compensation based, in whole or in part, on a share of net profits from the operation of the facility. Reimbursement of the service provider for actual and direct expenses paid by the service provider to unrelated parties is not by itself treated as compensation.

(2) *Arrangements that generally are not treated as net profits arrangements.* For purposes of § 1.141-3(b)(4)(i) and this revenue procedure, compensation based on

(a) A percentage of gross revenues (or adjusted gross revenues) of a facility or a percentage of expenses from a facility, but not both;

(b) A capitation fee; or

(c) A per-unit fee is generally not considered to be based on a share of net profits.

(3) *Productivity reward.* For purposes of § 1.141-3(b)(4)(i) and this revenue procedure, a productivity reward equal to a stated dollar amount based on increases or decreases in gross revenues (or adjusted gross revenues), or reductions in total expenses (but not both increases in gross revenues (or adjusted gross revenues) and reductions in total expenses) in any annual period during the term of the contract, generally does not cause the compensation to be based on a share of net profits.

(4) *Revision of compensation arrangements.* In general, if the compensation arrangements of a management contract are materially revised, the requirements for compensation arrangements under section 5 of this revenue procedure are retested as of the date of the material revision, and the management contract is treated as one that was newly entered into as of the date of the material revision.

.03 *Permissible Arrangements.* The management contract must be described in section 5.03(1), (2), (3), (4), (5), or (6) of this revenue procedure.

(1) *95 percent periodic fixed fee arrangements.* At least 95 percent of the compensation for services for each annual period during the term of the

contract is based on a periodic fixed fee. The term of the contract, including all renewal options, must not exceed the lesser of 80 percent of the reasonably expected useful life of the financed property and 15 years. For purposes of this section 5.03(1), a fee does not fail to qualify as a periodic fixed fee as a result of a one-time incentive award during the term of the contract under which compensation automatically increases when a gross revenue or expense target (but not both) is reached if that award is equal to a single, stated dollar amount.

(2) *80 percent periodic fixed fee arrangements.* At least 80 percent of the compensation for services for each annual period during the term of the contract is based on a periodic fixed fee. The term of the contract, including all renewal options, must not exceed the lesser of 80 percent of the reasonably expected useful life of the financed property and 10 years. For purposes of this section 5.03(2), a fee does not fail to qualify as a periodic fixed fee as a result of a one-time incentive award during the term of the contract under which compensation automatically increases when a gross revenue or expense target (but not both) is reached if that award is equal to a single, stated dollar amount.

(3) *Special rule for public utility property.* If all of the financed property subject to the contract is a facility or system of facilities consisting of predominantly public utility property (as defined in § 168(i)(10) of the 1986 Code), then "20 years" is substituted—

(a) For "15 years" in applying section 5.03(1) of this revenue procedure; and

(b) For "10 years" in applying section 5.03(2) of this revenue procedure.

(4) *50 percent periodic fixed fee arrangements.* Either at least 50 percent of the compensation for services for each annual period during the term of the contract is based on a periodic fixed fee or all of the compensation for services is based on a capitation fee or a combination of a capitation fee and a periodic fixed fee. The term of the contract, including all renewal options, must not exceed 5 years. The contract must be terminable by the qualified user on reasonable notice, without penalty or cause, at the end of the third year of the contract term.

(5) *Per-unit fee arrangements in certain 3-year contracts.* All of the compensation for services is based on a per-unit fee or a combination of a per-unit fee and a periodic fixed fee. The term of the contract, including all renewal options, must not exceed 3 years. The contract must be terminable by the qualified user on reasonable notice, without penalty or cause, at the end of the second year of the contract term.

(6) *Percentage of revenue or expense fee arrangements in certain 2-year contracts.* All the compensation for services is based on a percentage of fees charged or a combination of a per-unit fee and a percentage of revenue or expense fee. During the start-up period, however, compensation may be based on a percentage of either gross revenues, adjusted gross revenues, or expenses of a facility. The term of the contract, including renewal options, must not exceed 2 years. The contract must be terminable by the qualified user on reasonable notice, without penalty or cause, at the end of the first year of the contract term. This section 5.03(6) applies only to—

(a) Contracts under which the service provider primarily provides services to third parties (for example, radiology services to patients); and

(b) Management contracts involving a facility during an initial start-up period for which there have been insufficient operations to establish a reasonable estimate of the amount of the annual gross revenues and expenses (for example, a contract for general management services for the first year of operations).

.04 No Circumstances Substantially Limiting Exercise of Rights.

(1) *In general.* The service provider must not have any role or relationship with the qualified user that, in effect, substantially limits the qualified user's ability to exercise its rights, including cancellation rights, under the contract, based on all the facts and circumstances.

(2) *Safe harbor.* This requirement is satisfied if—

(a) Not more than 20 percent of the voting power of the governing body of the qualified user in the aggregate is vested in the service provider and its directors, officers, shareholders, and employees;

(b) Overlapping board members do not include the chief executive officers of the service provider or its governing body or the qualified user or its governing body; and

(c) The qualified user and the service provider under the contract are not related parties, as defined in § 1.150–1(b).

SECTION 6. EFFECT ON OTHER DOCUMENTS

Rev. Proc. 93–19, 1993–1 C.B. 526, is made obsolete on the effective date of this revenue procedure.

SECTION 7. EFFECTIVE DATE

This revenue procedure is effective for any management contract entered into, materially modified, or extended (other than pursuant to a renewal option) on or after May 16, 1997. In addition, an issuer may apply this revenue procedure to any management contract entered into prior to May 16, 1997.

DRAFTING INFORMATION

The principal author of this revenue procedure is Loretta J. Finger of the Office of Assistant Chief Counsel (Financial Institutions and Products). For further information regarding this revenue procedure contact Loretta J. Finger on (202) 622–3980 (not a toll-free call).

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26 CFR 601.601: Rules and regulations.
(Also Part I, §§ 103, 141, 145; 1.141–3, 1.145–2.)

APPENDIX E

IRS Hospital Audit Guidelines

(6) Analyze and review corporate minutes, correspondence and contracts to determine whether any arrangements exist that would provide directly or indirectly a deduction for the cost of litigation that is for the private benefit of the donor.

(7) Review carefully any litigation in which litigants made payments (contributions) to public interest law firms (PILF). Consider submission of Form 5666, EP/EO Information Report, to ensure contributions for legal services provided are not being deducted under IRC 170.

(8) Review financial records for evidence of fee-splitting with local law firms (Rev. Rul. 76–5, 1976–1 C.B. 146).

(9) Review litigation or legal work performed for a fee in light of IRC 511. This is possible even when work is done for another exempt organization. Legal work performed for a fee for another exempt organization that does not further the purposes for which the exemption of the public interest law firm was recognized, e.g., drafting legal documents on matters not related to litigation on behalf of the public at large or on matters of public interest would not be a related activity.

333 *(3–27–92)* 7(10)69 Hospitals

333.1 *(3–27–92)* 7(10)69 The Community Benefit Standard

(1) A hospital must meet the community benefit standard to be exempt as an organization described in section 501(c)(3). To determine whether a hospital meets the standard, the following factors found in Rev. Rul. 69–545, 1969–2 C.B, 117, should be considered.

(a) Does the hospital have a governing board composed of prominent civic leaders rather than hospital administrators, physicians, etc.? This information should be evident from the Form 990 and the minutes should indicate how active the individual members are.

(b) If the organization is part of a multi-entity hospital system, do the minutes reflect corporate separateness? Do they show that the board members understand the purposes and activities of the various entities?

(c) Is admission to the medical staff open to all qualified physicians in the area, consistent with the size and nature of the facilities?

(d) Does it operate a full-time emergency room open to everyone, regardless of their ability to pay?

(e) Does it provide non-emergency care to everyone in the community who is able to pay either privately or through third parties including Medicare and Medicaid?

(2) Most hospitals today are seeking to attract qualified doctors. However, if you suspect that an "open staff policy" with privileges available to all qualified doctors consistent with the size and nature of the facilities may not be in effect:

(a) Identify qualification requirements for admission to staff by referring to the medical staff bylaws.

(b) Review application procedures and methods of staff selection.

(c) Review minutes of medical staff meetings.

(d) Determine whether staff admission fees are charged on a preferential basis.

(e) Ascertain if new doctors in the geographic area are admitted to the staff. Absence of new members could indicate a closed staff.

(f) Consider the number of doctors in each membership category (i.e. active, associate, courtesy).

(g) Interview knowledgeable officials to determine if doctors have been denied admission to the staff for other than reasonable cause.

(h) Reveiw the minutes of the credentials committee.

(i) Review the hospital's Daily Census Report to determine the percentage of use of hospital facilities by various doctors. Names of patients and doctors providing services for these patients are listed in the report.

(3) To determine if use of the emergency room is restricted:

(a) Review manual of operations, brochures, posted signs, etc.

(b) Interview ambulance drivers to determine whether they are instructed to take indigent patients to another hospital.

(c) Interview emergency room staff to determine admission procedures.

(d) Interview social workers in the community familiar with delivery of emergency health care services to determine whether such services are known to be available at the hospital.

(e) Ascertain when and how determinations of financial responsibility are made and whether a deposit is required of any patient before care is rendered.

(4) Although operation of an emergency room is generally one of the primary determining factors for exemption, Rev. Rul. 83–157, 1983–2 C.B. 94, states that exemption would not be precluded if a hospital did not operate an emergency room where the state health planning agency independently determined that an emergency room would be unnecessary and duplicative. In addition, specialized facilities such as eye or cancer hospitals treat conditions unlikely to need emergency care and do not, as a practical matter, operate emergency rooms. In these cases, where there is no full-time emergency room providing services to everyone re-

gardless of ability to pay, careful consideration must be given to other services and activities, such as provision of charity care and the other factors listed in Rev. Rul. 83-157, to determine whether the hospital operates exclusively to benefit the community.

(5) The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires hospitals that participate in Medicare and have emergency departments to treat any patient in an emergency condition, regardless of their ability to pay. This applies to *all* patients whether or not the patient is covered by Medicare or Medicaid. Almost all hospitals participate in Medicare. Hospitals that knowingly "dump" indigent emergency patients on other hospitals are subject to fines and possible loss of exemption. The Department of Health & Human Services, Office of Inspector General (HHS/OIG) monitors this requirement. Review the hospital's records on transfers (they are required to keep them for 5 years). Check with HHS to see if the hospital has any violations. Determine if the hospital has a sign conspicuously posted in its emergency department which specifies the rights of individuals to emergency treatment and indicating whether it participates in Medicaid.

(6) To determine whether non-emergency services are available to everyone in the community with the ability to pay:

(a) Review the hospital admission policy.

(b) Determine if the hospital admits and treats Medicare and Medicaid patients in a nondiscriminatory manner.

(c) Review files on denied admissions to ascertain the reasons for denial.

(d) Determine whether members of the professional staff also serve in administrative capacities and restrict admissions to only patients of staff members.

(e) Review the CPA report for years ending after 6/30/90 for a statement of the hospital's charity care policy and expenditures.

(f) Compare the proportion of services provided to Medicaid patients to the proportion of Medicaid beneficiaries living in the hospital's service area. The organization may be able to provide the statistics on beneficiaries. Or, if it is suspected that Medicaid patients are not being served in a nondiscriminatory manner, contact the State Medicaid agency personally to secure the statistics.

(7) Ask for copies of any private letter rulings the hospital has received from IRS.

(8) Determine whether the hospital is involved in projects and programs which improve the health of the community. Review newsletters, press releases and calendars of events.

333.2 *(3-27-92)* 7(10)69
Private Inurement and Private Benefit (In General)

(1) Inurement and private benefit may occur in many different forms, including, for example, excessive compensation (discussed below); payment of excessive rent (*Texas Trade School v. Commissioner*, 30 T.C. 642 (1958), *aff'd.* 272 F.2d 168 (5th Cir. 1959)); receipt of less than fair market value in sales or exchanges of property (*Sonora Community Hospital v. Commissioner*, 46 T.C. 519 (1966)); inadequately secured loans (*Lowery Hospital Association v. Commissioner*, 66 T.C. 850 (1976)); or other questionable loans, etc. (*Founding Church of Scientology v. United States*, 412 F.2d 1197 (Ct. Cl. 1969), *cert. den.*, 397 U.S. 1009 (1970)). Note that the payment of personal expenses of an insider that the organization did not characterize as compensation at the time of payment may constitute inurement even when, if added to compensation, the total amount of compensation would be reasonable. (Id.; *John Marshall Law School and John Marshall University v. United States*, 81-2 USTC 9514 (Ct. Cl. 1981)).

(2) Although the requirements for finding inurement or private benefit are similar, inurement and private benefit differ in two key respects. The first is that even a minimal amount of inurement results in disqualification for exempt status, whereas private benefit must be more than quantitatively or qualitatively incidental in order to jeopardize tax exempt status. The second is that inurement only applies to "insiders" (individuals whose relationship with an organization offers them an opportunity to make use of the organization's income or assets for personal gain), whereas private benefit may accrue to anyone. Physicians are considered insiders and in their dealings with the hospital are subject to the inurement prohibition. All contracts with insiders should be reviewed to determine if they were negotiated at arm's-length. If a doctor is also a department head or board member, the contracts will require closer scrutiny.

(3) Some private benefit is always present in hospital-physician relationships since physicians use hospital facilities to treat paying patients. All private benefit must be incidental to accomplishment of the public benefits involved. This prohibition on excessive private benefit is not restricted to insiders.

(4) Identify the board of trustees or directors, and key staff members of the administrative and medical staff. Examine any business relationships or dealings with the hospital. Note any pertinent transactions where supplies or services are provided at prices exceeding competitive market or at preferred terms. Be alert for any loan agreement at less than prevailing interest rates. Scrutinize any business arrangements under which hospitals finance the construction of medical buildings owned by staff doctors on favorable financial terms that may result in inurement or more than incidental private benefit.

(5) Review contracts and leases to determine whether there is any inurement. Scrutinize any contracts under which the hospital requires doctors to conduct private practices on hospital premises.

(6) Review the minutes of the board of directors executive committee and the finance committee for indications of transactions with physicians, administrators, or board members.

(7) Review the articles of incorporation, bylaws, minutes, shareholder lists, filings with regulatory authorities, correspondence, brochures, newspaper articles, etc. to determine the existence of related parties.

(8) Determine whether the hospital is engaged in commercial or industrial research or testing benefiting private individuals or firms rather than scientific or medical research benefiting the general public.

(9) Review third party reports (such as C.P.A. Audit Reports, management letters, and annual reports) to determine whether the hospital's activities further an exempt purpose or serve private interests.

(10) To determine if medical staff or board members have an economic interest in, or significant dealings with the hospital, ask to see any conflict of interest statements that have been filed.

333.3 *(3-27-92)* 7(10)69

Unreasonable Compensation and Other Inurement Issues

(1) Unreasonable compensation issues are often found in a hospital's dealings with its doctors or senior executives. Areas of concern include recruiting incentives, incentive compensation, below market loans, below market leases, and hospital purchase of a physician's practice.

(2) Specialists should be alert for compensation arrangements such as open-ended employment contracts or compensation based on a percentage of a hospital's profits.

(3) Look for recruitment/retention arrangements similar to the following:

(a) physicians being charged no rent or below market rent for space in hospital-owned office buildings or being charged less than fair market value for practice management services;

(b) hospitals providing physicians with private practice income guarantees;

(c) hospitals providing financial assistance to physicians for home purchases and/or the purchase of office equipment;

(d) outright cash payments by hospitals to physicians to secure or retain their services; or

(e) the hospital purchases the practice of a physician and subsequently employs the physician (in many instances to operate the same practice). All of these arrangements must be closely scrutinized including the valuation of the practice and the reasonableness of the compensation paid to the physician.

(4) In order to establish that any loans, income guarantees or other subsidies used as recruiting incentives further charitable purposes and are reasonable, the specialist must be able to determine that there is a need for the physician in the community served by the hospital. Absent evidence of a compelling community need or a significant other benefit to the community, the recruitment contract should require full repayment (at prevailing interest rates). Evidence of need may include the previous absence of practitioners in a given specialty, governmental studies of health manpower, patient travel patterns, etc.

(5) In order to determine that a recruiting incentive is reasonable, it should be linked to the physician's value to the hospital (e.g., a new service or enhanced productivity) or community (e.g., a needed specialty) and all incentives considered must not exceed a reasonable amount. In addition, the type of practice, the physician's experience, and comparative incomes must be considered. For further information, see GCM 39498.

(6) The following is a list of common compensation arrangements between physicians and hospitals.

(a) Fixed Compensation—This arrangement may be associated with either employee or independent contractor status for the physician. A salary arrangement tends to be associated with employee status and gives the hospital maximum control over the physician's compensation. Fixed compensation is the most predictable and least complicated arrangement and it allows the hospital the greatest control over patient charges and physician compensation. In contrast, an income guarantee arrangement associated with independent contractor status that guarantees private practice income in the form of loans or subsidies for a specified period must be closely scrutinized for inurement because it typically is not related to services provided to or on behalf of the hospital.

(b) Fee-for-Service—Under this arrangement, the physician is compensated based upon his or her charges or on a fee schedule establishing the fee per unit of professional service rendered. The arrangement may provide for either separate billing by the physician, in which case he or she may not receive any compensation at all from the hospital, or billing by the hospital with separately identified physician charges to be collected and remitted to the physician. When the physician is an employee, the fees billed to patients are generally considered income of the hospital. When the physician is an independent contractor, the fees are generally considered income of the physician. A fee-for-service arrangement generally gives the hospital little control over the physician's compensation. In certain circumstances, an independent contractor may also receive fixed compensation (e.g., for part-time administrative duties) along with the fee-for-service income.

(c) Percentage of Gross or Adjusted Gross Departmental Revenue—Physician compensation is based upon a predetermined percentage of gross departmental revenue derived from combined charges for facility use and professional services. (Adjusted gross revenue is defined as total charges less bad debt, contractual allowances, and other charge adjustments. Or, it is the collections or money actually received by the billing office as payment for services rendered.) This used to be common for determining compensation for hospital-based specialists such as radiologists, but is less common today due to third party payer restrictions. This type of arrangement must be closely scrutinized for potential inurement. See Rev. Rul. 69-383, 1969-2 C.B. 113.

(d) Be alert for arrangements, other than permissible incentive compensation plans, that involve physicians sharing net revenues of the hospital or any portion thereof.

(7) The following additional items are sometimes found in employee or contractor compensation packages.

(a) Guarantee of Private Practice Income—Under certain circumstances this may be acceptable for a one or two-year period as part of a physician recruiting arrangement where the physician is relocating his or her practice to the hospital's service area; there is sufficient evidence of need for the physician in the community; the level of income guaranteed is reasonable; there is a reasonable and explicit ceiling on total outlays by the hospital; and there is an unconditional obligation to repay any amounts advanced by the hospital. Any forgiveness arrangement must be demonstrably related to community benefit and treated as compensation.

(b) Rent Subsidies—The hospital may provide office space in the hospital for use in providing services to the hospital. Office space in the hospital/medical office building for use in the physician's private practice generally must be provided at a reasonable rental rate gauged by market data and by actual rental charges to other tenants in the same facility. If the physician splits activities between duties for the hospital and private practice, it is acceptable to use the same office for both activities. However, time/use of office must be apportioned between hospital activities and private practice activities and a reasonable rent must be charged for the private practice activities.

(c) Support Staff—The hospital may provide support staff for use in providing services to the facility. Support staff for use in the physician's private practice generally must be provided at a reasonable rate for the services of support staff guaged by market data and by actual staffing costs for similar physician offices. If the physician splits activities between duties for the hospital and private practice, it is acceptable to use the same support staff for both activities. However, time/use of support staff must be apportioned between hospital activities and private practice activities and there must be a reasonable charge for use attributable to private practice activities.

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(8) Unfunded deferred compensation arrangements. For 1987 and subsequent years, tax exempt organizations may use unfunded deferred compensation arrangements subject to section 457. Arrangements that meet the requirements of section 457 are proper for tax exempt organizations and need not be questioned. However, many tax exempt organizations use unfunded deferred arrangements subject to the general rules of section 83. If those arrangements are properly structured they create a deferral of income for the employee that may far exceed the rather low limits of section 457 (usually a maximum of $7500 per year). Thus, such arrangements should be examined to determine if they might contribute to a determination of unreasonable compensation. Further, you should be alert for such arrangements because they are normally provided only to the more highly compensated employees, and do not necessarily show up in financial statements. Since they are unfunded and must be subject to a substantial risk of forfeiture, the only evidence of their existence may be a contract between the parties or a board resolution authorizing them. While exempt organizations have used plans subject to the general rules of section 83, creation of such a plan by an exempt organization after 1/1/87 may be improper and should be brought to the attention of the National Office. You should also be alert to the possible use of these arrangements by a controlled subsidiary.

(9) Because of the different and complex compensation arrangements that may be involved in hospital cases, the determination of what constitutes unreasonable compensation is a facts and circumstances test. Specialists who encounter unusual compensation arrangements and/or are uncertain whether an excess compensation issue exists should request technical advice.

(10) The following factors should be considered to determine whether any loans made to a physician, employee, or other insider are reasonable.

(a) Generally, the agreement should specify a reasonable rate of interest (prime plus 1 or 2 percent) and include adequate security.

(b) The decision should be reviewed by the board and should include consideration of the history of payment on prior loans by the physician or employee.

(c) Even if determined reasonable, any variance in the terms of the loan from what the borrower could obtain from a typical lending institution must be treated as compensation, and reported at the appropriate time on Form W-2 or 1099.

(11) Determine whether any part of the hospital's property (facilities, space, equipment) or services are used by or rented to doctors or others. Examples of services, facilities, etc. are x-ray and laboratory services or facilities (including lab work for non patients), pharmacy departments, outpatient treatment facilities, office space, land and buildings. If so, obtain copies of pertinent leases and contracts to determine whether exempt purposes or private interests are being served or whether liability for unrelated business income tax exists. In determining whether private interests are being served in lease transactions, ascertain whether the lease payment represents fair rental value.

(12) Hospitals or medical practices originally owned by private interests may require additional scrutiny.

(a) In these cases, review the transfer agreement with the hospital to determine whether the transfer served private interests more than incidentally.

(b) Determine whether the agreement involved an employment contract between the hospital and the transferor.

(13) Review the actual copy of the Form 990 the hospital makes available to the public. Determine whether accurate and complete compensation information is disclosed and whether the hospital has fully complied with its disclosure obligations under IRC 6104(e)(1). Consider applicability of penalties under IRC 6652(c)(1).

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Joint Ventures

(1) A joint venture may take a variety of forms: it may be a contractual agreement between two or more parties to cooperate in providing services, or it may involve the creation of a new legal entity by the parties, such as a limited partnership or closely held corporation, to undertake an activity or provide services. Some examples of the items or services provided in these arrangements are clinical diagnostic laboratory services, medical equipment leasing, durable medical equipment, and other outpatient medical or diagnostic services.

(2) Joint ventures between taxable and exampt parties must be carefully examined for inurement and private benefit. The facts must be reviewed to determine whether the partnership serves a charitable purpose, whether and how participation by the exempt entity furthers its exempt purpose, and whether the arrange-

ment permits the exempt entity to act exclusively in furtherance of its exempt purposes. Where the facts suggest possible inurement or private benefit, specialists should request technical advice.

(3) Examples of private inurement issues are participation imposes obligations on the exempt organization that conflict with its exempt purposes; there is a disproportionate allocation of profits and losses to the non-exempt partners, e.g., physicians; the exempt partner makes loans to the joint venture that are commercially unreasonable (inadequate security or low interest rate); the exempt partner provides property or services to the joint venture at less than fair market value; or a non-exempt partner receives more than reasonable compensation for the sale of property or services to the joint venture.

(4) The HHS Office of Inspector General has a program to reduce fraud in the Medicare and Medicaid programs. They administer an anti-kickback statute that penalizes anyone who solicits, receives, offers or pays anything of value to induce or in return for

(a) referring an individual to any person for the furnishing or arranging for the furnishing of any item or service payable under Medicare or Medicaid, or

(b) purchasing, leasing or ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item payable under Medicare or Medicaid. Be aware that certain joint ventures and other hospital-physician arrangements could include hidden or disguised payments for referrals. See 42 USC 1320a–7b(b).

(5) The Department of HHS has published a Special Fraud Alert containing the following list of questionable features which, separately or together, could indicate that a joint venture is suspect under the anti-kickback Statute.

(a) Investors are chosen because they are in a position to make referrals.

(b) Physicians who are expected to make a large number of referrals are offered a greater investment opportunity in the joint venture than those anticipated to make fewer referrals.

(c) Physician-investors are actively encouraged to make referrals to the joint venture, or are encouraged to divest their ownership interest if they fail to sustain an "acceptable" level of referrals.

(d) The joint venture tracks its sources of referrals, and distributes this information to the investors.

(e) Investors are required to divest their ownership interest if they cease to practice in the service area, for example, if they move, become disabled, or retire.

(f) Investment interests are nontransferable.

(g) The amount of capital invested by the physician is disproportionately small and the returns on investment are disproportionately large when compared to a typical investment in a new business enterprise.

(h) Physician-investors invest only a nominal amount, such as $500 to $1500.

(i) Physician-investors are permitted to "borrow" the amount of the "investment" from the entity, and pay it back through deductions from profit distributions, thus eliminating even the need to contribute cash to the partnership.

(j) Investors are paid extraordinary returns on the investment in comparison with the risk involved, often well over 50 to 100 percent per year.

(k) The structure of some joint ventures is particularly suspect. For example, one of the parties may be an ongoing entity already providing a particular service. That party may act as, e.g., the reference laboratory or durable medical equipment supplier for the joint venture. In some of these cases, the joint venture can be best characterized as a "shell" that merely allows referring physicians to share in the income derived from their referrals.

(6) For a discussion of the proper analysis of a joint venture with physicians, including the potential for inurement and private benefit and the possible effect of a violation of the anit-kickback law, see GCM 39862.

(7) Be alert for joint ventures involving the sale by a hospital of the gross or net revenue stream from an existing hospital service for a defined period of time to private interests. For further information, see GCM 39862.

(8) Even absent a true joint venture, hospitals may be pressured to pay other providers for a stream of referrals. Be alert for arrangements with physician group practices or clinics where the hospital transfers something of value in return for an agreement to refer patients to the hospital for inpatient, surgical, or diagnostic services. Such arrangements may involve inurement or serve private purposes more than incidentally. If in doubt, seek technical advice.

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Financial Analysis

(1) Review income and expenditures of all affiliated entities to determine if nonexempt purposes, inurement, serving of private interests, or unrelated business income may be present. Also look for lobbying or political activities or expenditures and determine whether an IRC 501(h) election has been made.

(2) Reconcile the books to the Form 990. Reconcile the working trial balance to the general ledger, CPA report, and the return.

(3) Determine if the hospital has complied with IRC 6033(b) in regard to netting of income and expense. Note any unusual accounts that should be analyzed.

(4) Review the CPA report and management letter for indications of UBI. The management letter also provides information in regard to internal control problems that could result in expansion of the audit.

(5) Review Medicare cost reports for indications of insider (related party) transactions. Such transactions could result in UBI and/or private benefit. The Medicare cost report also identifies non-patient revenue which could indicate UBI. Be alert for misuse of Medicare costs in calculating net UBI. For further information, see GCM 39843.

(6) If other reports, such as the Blue Cross audit report are available, review for indications of UBI and private benefit.

(7) Determine whether the hospital reports grants of $5000 or more on the Form 990. This should be reported on a cash basis as required by IRC 6033(b)(5). The accounting practice of hospitals is usually to charge the gift to a balance sheet account and transfer it into income as the grant or gift is consumed or used for its intended purpose.

(8) Review the correspondence files on the large gifts and grants. Look for unusual transactions that may prohibit the donor from receiving a charitable deduction and prepare a referral if appropriate.

(9) Check the value shown on the books for donated property against any appraisals in the file. If any property was sold, note the difference between the book value and the selling price. Prepare an information report, Form 5346, as needed.

(10) Review noncash contributions received (other than publicly traded securities). Determine what use the hospital is making of the donated assets, whether any have been disposed of by sale or otherwise (a subsequent arm's-length sale might indicate donor's estimate of fair market value was substantially overstated), whether donors still have use of the property, or other factors affecting the amount or deductibility of the contribution.

(11) If the hospital has an adjacent medical office building (MOB), check the financing arrangement to determine if the hospital made low interest laons to private developers. Determine whether any partnerships or joint ventures are involved. Determine whether the lease agreements were negotiated at arm's-length. If the MOB is not located near the hospital, determine the justification for such a facility.

(12) To verify bad debt expense, review contracts with collection agencies and note the compensation arrangement. If the agency retains its fee from the collected bad debt, consider whether Form 1099 is still required. Be alert for arrangements whereby the comptroller releases delinquent patient accounts prematurely to a collection agency and then receives a kickback.

(13) Review the travel ledger accounts of the administrative department and the board of directors. Be alert for personal items such as spouse's travel and ensure that there has been proper accounting.

(14) Review the legal fees ledger account and secure source documents that identify what the fees relate to. Check for Forms 1099 to individuals and partnerships. Check for possible political activity and political contributions being funneled through the law firm or any other professional service provider.

(15) Where private individuals or outside entities operate the hospital cafeteria, gift shop, pharmacy, parking lot, etc., determine whether the agreement with these individuals or firms provide for reasonable payments to the hospital.

(16) Reconcile expenses on Form 990-T to the CPA's workpapers. If specific cost centers are maintained, review cost centers for possible account analysis. If specific cost centers are not maintained, request a copy of the allocation method used and determine if it is reasonable in accordance with IRC 512.

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Balance Sheet Analysis

(1) Review the general ledger control account for receivables from officers, trustees, and members of the medical staff, and analyze for private benefit and additional compensation. Review the loan or other agreements underlying these transactions.

(2) Check notes receivable for interest-free loans to insiders (e.g., a mortgage loan to an administrator given as an inducement to accept or continue employment at the hospital). These arrangements must be scrutinized for inurement, proper reporting, etc.

(3) Review property records to determine whether any assets are being used for personal purposes that should be taxable income to the user. (e.g., vehicles, residential property held for future expansion, etc.)

(4) Review trust funds to see if the trusts should be filing separate returns.

(5) Review investment portfolios and check for any controlled entities. See IRC 512(b)(13).

(6) Review the ledger accounts and check for notes and mortgages payable that could lead to IRC 514 issues.

(7) Analyze any self-insurance trust or fund set up by the hospital to provide liability insurance.

(8) Refer to IRM 7(10)7(11) guidelines when there is evidence that the hospital has purchased or sold health care facilities utilizing tax exempt bonds.

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Package Audit

(1) The package audit procedures in IRM 7(10)44.5 should be followed and, as appropriate, the employment tax procedures in IRM 7(10)(16)0. The following items that are uniquely related to hospitals should also be considered.

(2) Specialists should be alert to any arrangements under which the hospital pays certain personal or business expenses of affiliated doctors and the taxable compensation is not properly reflected as wages in Forms 990, employment tax returns, or Forms W–2 or 1099. For example, college and university medical school faculty physicians often have employment contracts with medical schools that limit their compensation to low levels compared to compensation obtainable in private practice. Such physicians may enter into employment contracts as consultant/practitioners with several hospitals or clinics unrelated to the medical schools for which they teach. The written employment contract with such hospitals or clinics may be supplemented by a verbal agreement that provides for the hospital or a third party to pay associated business or personal expenses (e.g., lease of luxury cars, house improvements, country club memberships, etc.) as part of the total annual employment contract amount. The Forms W–2 issued may reflect the cash amount paid by the hospital or clinic directly to the physician but exclude amounts paid to other parties on the physicians's behalf. In such cases, appropriate referrals should be made.

(3) Review agreements with specialists. Certain hospital-based specialists such as anesthesiologists, radiologists, and pathologists may be employees for federal employment tax purposes, including income tax withholding. Interview the anesthesiologist, pathologist, radiologist, and other physicians with unusual contracts or arrangements when necessary to clarify and verify contract items.

(4) Professional service contracts usually specify who will carry the malpractice insurance. If the hospital pays for it, the doctor may be an employee, not an independent contractor or there may be private inurement. Be alert to efforts to be treated as an employee for some benefits, such as the 403(b) tax sheltered annuity, but as an independent contractor for compensation.

(5) If the following factors are present, the physician is most likely an employee even if the contract describes the position as an independent contractor.

(a) The physician does not have a private practice.

(b) Hospital pays straight wage to physician.

(c) Hospital provides supplies and professional support staff.

(d) Hospital bills for physician services.

(e) Percentage division of physician fees with the hospital or vice versa.

(f) Hospital regulation of, or right to control physician.

(g) Physician on-duty at hospital during specified hours.

(h) Physician's uniform bearing hospital name or insignia.

(i) There are, of course, other factors that may indicate an employment relationship. For a list of the 20 common law factors, see Rev. Rul. 87–41, 1987–1 C.B. 296. In any questionable situation, determine whether a Form SS–8 has been filed by the hospital or the employee. Be aware that under section 530 of the Revenue Act of 1978, an employer may have safe harbor protection if you fail to raise an employment tax misclassification issue on audit. See Rev. Proc. 85–18, 1985–1 C.B. 518.

(6) Review fellowships, stipends, or other payments to interns, residents, medical students, and nursing students. These may represent taxable income subject to withholding and FICA if paid in connection with services rendered. With regard to student nurses, see Rev. Rul. 85–74, 1985–1 C.B. 331.

(7) Determine how private duty nurses are compensated and determine if the hospital has a Form 1099 filing responsibility.

(8) Determine if the hospital contracts to purchase services not described in IRC 501(e)(1)(A) from cooperative hospital service organizations recognized under IRC 501(e) or unrelated exempt organizations recognized under IRC 501(c)(3). Determine whether the nature and extent of the services purchased indicate the exempt organization providing the services should be considered for examination.

(9) Review employment contracts of medical personnel that have annuities under IRC 403(b) to insure that only common law employees are receiving the benefits of such annuities. If other than common law employees are invovled, make appropriate referrals. Test check to determine if reduction agreements are on file and whether exclusion allowances are within the limits of IRC 403(b) and 415. (See Publication 571)

(10) Determine what types of retirement plans, insurance plans and non-qualified deferred compensation arrangements are in place. Inspect brochures given to employees to get background information. Interview hospital officials in regard to transactions between the hospital and the plan. Identify deferred compensation arrangements and determine the correct tax consequences. If the hospital has a profit sharing plan, determine the effect on exempt status. Determine whether an examination of the plan is necessary.

(11) Excess indemnification (patient refunds) received under medical insurance policies that is attributable to an employer's contribution is includable in the gross income of the patient. An information report should be prepared on significant amounts.

(12) Determine if the hospital has filed or is liable for the following:

(a) Form 5578, Annual Certification of Private School

(b) Form 5768, Lobbying Election

(c) Form 720, Quarterly Federal Excise Tax Return

(d) Form 2290, Highway Use Tax

(e) Form 1120, Corporation Income Tax Return (subsidiary)

(f) Form 8282, Donee Information Return

(g) Form 8300, Report of Cash Payments Over $10,000 Received in a Trade or Business

(h) Forms 990 of related entities such as the hospital foundation or auxiliary

(i) Prior and subsequent years Forms 990 and 990–T.

(j) Form 1120 POL, U.S. Income Tax Return for Certain Political Organizations.

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Unrelated Business Income Tax

(1) During interviews, while touring facilities, and while reviewing books and records, the specialist should be indentifying activities that are unrelated to exempt purposes and sources of revenue that may be subject to UBIT. The UBIT examination guidelines in text 160 of this handbook should be followed. Specific examples common in health care field are provided below.

(2) Laboratory Testing

(a) Laboratory services provided to hospital patients are related to a hospital's exempt purpose.

(b) To determine whether there is lab income from non-hospital patients, such as lab specimens from patients of private doctors, nursing homes, other hospitals, and commercial labs, you may need to interview the lab director. Ask if the lab maintains a secondary record showing patient vs non-patient revenue. Determine if blood from the hospital blood bank is being sold to commercial labs.

(c) Agents should determine whether salesmen are calling on physicians to solicit business, whether a pick-up service is provided to carry specimens, whether the hospital advertises its lab services on television or in the telephone yellow pages, etc.

(d) Determine whether any of the exceptions shown below apply.

1 The casual sales exception under Regs. 1.513-(1)(2)(ii).

2 The tests are available only at the hospital.

3 The hospital lab is the only lab within a reasonable distance for outsiders to send specimens.

4 The specimens are necessary for the teaching of lab students.

5 The hospital sends its own pesonnel to an outside facility to secure the specimens for lab testing.

6 The tests are performed at cost for a hospital that has 100 or less beds.

(e) The following rulings apply to laboratory testing:

1 Rev. Rul. 68–376 1968–2 C.B. 246;

2 Rev. Rul. 85–109, 1985–2 C.B. 165;

3 Rev. Rul. 85–110, 1985–2, C.B. 166.

(3) Pharmacy Sales

(a) Determine the locations of the pharmacies. Are there satellite locations in the medical office building? Pharmacies that are located away from the hospital are more likely to engage in non-patient sales.

(b) Be alert for newspaper and telephone yellow page ads for the pharmacy.

(c) Determine hospital policies regarding sales to non-patients, other hospitals, nursing homes, non-employee doctors, etc. If they allow sales to outsiders, determine the amount. Consider the casual sales exception under Regs. 1.513–(1)(c)(2)(ii).

(d) Check pharmacy department records including sales registers and prescription logs and compare to patient records. Interview pharmacy personnel.

(e) Determine if the pharmacy sells items other than drugs.

(f) The following references involve hospital pharmacies:

1 Rev. Rul. 68–374, 1968–1 C.B. 242

2 Rev. Rul. 68–375, 1968–2 C.B. 245

3 Rev. Rul. 68–376, 1968–2 C.B. 246

4 Rev. Rul. 85–110, 1985–2 C.B. 166

5 Carle Foundation, 611 F2d 1192 (7th Cir. 1979)

6 Hi-Plains Hospital, 670 F2d 528 (5th Cir. 1982).

(4) Cafeterias, Coffee Shops and Gift Shops—Generally, cafeterias, coffee shops and gift shops are deemed to be for the convenience of employees, patients and visitors. See Rev. Ruls. 69–268 and 69–267, 1969–1 C.B. 160. However, the specialist should check for facilities in adjacent medical office buildings that primarily serve the private patients of doctors in the building.

(5) Parking Facility—The provision of parking facilities is generally considered to be for the convenience of employees and patients. However, if the parking facility is primarily serving private patients of doctors in an adjacent office building, there may be UBI. See Rev. Rul. 69–269, 1969–1 C.B. 160.

(6) Medical Research

(a) Review contracts to determine whether the hospital is engaged in testing drugs for drug companies.

(b) Review grants awarded to physicians/ professors to determine the nature of sponsored research and the arrangement between the parties.

(c) Determine if clinical testing of drugs principally serves the private interest of the manufacturer rather than the public interest.

(d) Determine whether the hospital is doing any other type of research and review any agreements.

(e) Determine if the research activities are of a type ordinarily carried on as an incident to commercial or industrial operations. See Regs. 1.512(b)–(f).

(f) Determine if results of research are freely available to the public.

(g) The following references apply to hospital research activity:

1 Rev. Rul. 54–73, 1954–1 C.B. 160

2 Rev. Rul. 68–373, 1968–2 C.B. 206

3 Rev. Rul. 76–296, 1976–2 C.B. 141.

(7) Laundry Services—Determine if the hospital performs services for outsiders such as nursing homes and other unrelated hospitals with more than 100 beds. See Rev. Rul. 69–633, 1969–2 C.B. 121 and IRC 513(e).

(8) Leasing of Medical Buildings

(a) Review leases to determine whether commercial businesses are renting space. Consider the debt financing rules under IRC 514.

(b) The following references apply to construction and leasing of medical office buildings:

1 Rev. Rul. 69–463, 1969–2 C.B. 131

2 Rev. Rul. 69–464, 1969–2 C.B. 132

3 Rev. Rul. 65–269, 1965–2 C.B. 159.

(9) Supply Department—Determine if the hospital sells medical supplies to outsiders such as nursing homes, private doctors, other hospitals, and commercial labs.

(10) Robinson-Patman Act "Own Use" Rule—Non-profit institutions often are able to obtain supplies and medicines at substantial discounts and are statutorily exempt from the Robinson-Patman Price Discrimination Act for purchases of supplies for their own use. The Supreme Court set the limits of the term "own use" for consumable supplies in *Abbott Laboratories v. Portland Retail Druggists*, 425 U.S. 1 (1976) when it distinguished several categories of sales and dispensations of pharmaceutical products by hospitals.

(a) Resale of items can be made, but only to six classes of resale customers:

1 hospital inpatients;

2 hospital emergency room patients;

3 hospital outpatients for use on hospital premises;

4 patients being discharged from the hospital for immediate take home use;

5 hospital employees and medical staff for their personal use; and

6 members of non-profit HMO's.

(b) Exemption is expressly refused for:

1 prescription refills;

2 hospital medical staff members for use in private practice;

3 resale to walk-in customers who are not being treated at the hospital; and

4 resale to walk-in customers who are not members of the non-profit HMO.

(11) 501(e) Services—If the hospital is providing any of the services specified in IRC 501(e)(1)(a) to another hospital, determine whether the recipient hospital has 100 or less inpatient beds; whether the service constitutes an activity substantially related to furthering the recipient hospital's exempt purpose; and whether the service is provided at cost. If all questions are answered in the affirmative, the activity is not an unrelated trade or business. See IRC 513(e).

(12) Be alert for income and expense allocations set up for Medicare purposes that may not be directly connected with an unrelated trade or business or may not clearly reflect income for federal income tax purposes. For further information see GCM 39843.

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Clinics

(1) The examination guidelines for clinics are similar in many respects to those for a hospital. The examiner must be alert for inurement to private individuals or operating for a business rather than a charitable purpose.

(a) Review the records and administrative policy showing to whom the services are offered, i.e., the public at large or a specific group. A clinic operated to serve the employees of a particular industrial firm may not be exempt.

1 Examine patient cards or interview knowledgeable officials.

2 Determine source of payment for medical care.

(b) Review the organizational structure to ascertain who administers and controls the clinic. Techniques are similar to those used for hospitals.

(c) Ascertain whether any of the professional staff (that is, those who perform the clinical services) also serve in an administrative capacity.

(d) Determine the criteria used to fix compensation paid to the professional staff.

(2) Be alert to possibility that a group of doctors may be using an exemption as a tax shelter for their medical practice.

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Homes For The Aged

(1) To be exempt under IRC 501(c)(3), the home must:

(a) provide health care and housing specially designed for the elderly by rendering services at the lowest feasible cost and maintaining residents who become unable to pay; and

(b) provide services to relieve the distress of aged persons. (See Rev. Rul. 72-124, 1972-1 C.B. 145.)

(2) Ascertain the criteria for admission and residency requirements.

(a) Analyze occupant's admission application and other reports to determine age of occupants.

(b) Review life care and entrance agreements to determine the responsibility of the home. Note any special clauses which might cause operations to conflict with exempt purposes.

APPENDIX F

Valuation of Medical Practices

The Importance of Valuation Principles in Exemption Determinations

In deciding if an IDS organization providing healthcare services qualifies for exemption under IRC 501(c)(3), the Service applies a "facts and circumstances" approach based on Rev. Rul. 69-545, *supra.* An important factor in determining if an organization operates exclusively for the benefit of the community, as opposed to private interests, is whether the organization's acquisition of assets from physicians confers private benefit on, or causes its earnings to inure to, the sellers. If the organization pays more than fair market value, private benefit, and possibly inurement, is present, and the organization does not qualify for exemption.

Fair market value is the price on which a willing buyer and a willing seller would agree, neither being under any compulsion to buy or sell, and both having reasonable knowledge of the relevant facts. *See, e.g.,* Rev. Rul. 59-60, 1959-1 C.B. 237. As discussed in the 1995 CPE text, at pp. 163–69, whether the price paid for assets exceeds fair market value may be determined in various ways. It is the putative exempt organization's burden to establish this fact. In ruling on initial applications for recognition of exemption under IRC 501(c)(3), the Service does not determine that the price paid is fair market value; it does, however, require applicants to establish that the methodology used to arrive at the price is reasonably likely to result in a final sales price consistent with the requirements for exemption.

Generally, where the sales transaction involves unrelated parties bargaining at arm's length, the actual sales price may be assumed to be fair market value. However, when hospitals acquire practices owned by physicians who are on their medical staffs and who continue to provide services through a new

affiliated organization, the existence of arm's-length bargaining may be questionable.

In the absence of an arm's-length transaction, the best determinant of fair market value is a properly performed, unbiased valuation appraisal of the medical practice. This appendix describes general valuation methodology principles and notes particular issues/concerns in the valuation of medical practices.

3. *Business Enterprise Value*

A. *Business Enterprise Value Defined*

Fair market value is determined within the framework of the business enterprise's value ("BEV") to a hypothetical purchaser; it is not appropriate to assume a particular purchaser, such as an exempt hospital or a commercial healthcare corporation. Thus, for example, as discussed in the 1995 CPE Text, at pp. 167–68, it is inappropriate to assume that the acquired practice will not be subject to federal income taxation because it will be tax exempt; or that the purchase will bring certain "synergies" or management improvements to the business being valued.

BEV is generally defined as the total value of the assembled assets that comprise the entity as a going concern, or the value of a company's capital structure. BEV can be defined in other ways. A technical definition states that BEV is the capital structure of the business, the components of which are common (partner's) equity, preferred (stockholder's) equity, and long-term debt. If long-term debt is removed, what is left is equity, or the net worth of the firm.

B. *How Is BEV Determined?*

A valuation appraisal should include all recognized approaches for estimating BEV, including the market approach, cost approach, and income approach. The income approach is generally employed in IDS cases, because it includes the "excess earnings method" described in Rev. Rul. 68-609, 1968-2 C.B. 327, and approved for the valuation of intangible assets acquired by exempt organizations in Rev. Rul. 76-91, 1976-1 C.B. 149. Valuation analysts generally favor the income approach in appraising physician practices.

While BEV may appropriately be measured using the income approach, it is important to note that the approach (which includes a number of different methodologies) frequently depends on assumptions made about future events;

information on which the assumptions are based is under the control of the parties—who may not be dealing at arm's length—and is often difficult to verify. Different assumptions can result in different values. Thus, the factual assumptions on which such a valuation is based should be reviewed carefully to ensure that they are realistic, and if the valuation uses the income approach, it should be confirmed, if possible, by the cost and market approaches. Requiring that multiple approaches be used is consistent with the statement in Rev. Rul. 68-609, *supra,* that "[t]he formula [income] approach may be used for determining the fair market value of intangible assets of a business only if there is no better basis therefore available."

The value of intangible assets is particularly difficult to measure, and it is with respect to valuation of intangibles that inflation of value is most likely to occur. Valuation of intangibles is made even more complicated by the fact that valuation analysts are constrained from assigning value to the anticipated indirect revenues from referrals. Often, the same value is assigned to other intangible assets.

C. *"Allocation" Valuation*

Once arrived at, BEV is allocated among the assets comprising the business enterprise. The individual assets are valued, using appropriate methodologies; the aggregate value of the individual assets thus arrived at should equal the BEV.

This process is sometimes referred to as the "allocation" technique. The cornerstone of this technique is its combination of the cost and market approaches with judicious use of the income approach.

When this technique is used in valuation appraisals to allocate asset value, the result is a report containing predominantly verifiable information which facilitates review. In addition, tensions relating to payment for intangible assets are reduced where the elements of value are clearly delineated and verifiable.

Under this technique, assets capable of valuation under a nonincome (i.e., cost or market) approach are valued under that approach. An income approach is then used to value only those assets not susceptible to valuation by another approach. The values obtained are aggregated to reach BEV for the overall enterprise.

The following suggests approaches for valuing assets commonly found in medical practices:

Tangible Assets	Approach
Medical and office equipment, furniture, and fixtures	Cost
Buildings and real estate (including leases)	Market

Intangible Assets	Approach
Medical records	Cost
Assembled work force	Cost
Computer software	Cost
Covenants not to compete	Income
Contracts	Income
Trade name	Income
Below-market leases	Income

Application of the allocation technique is further explained [later in this Appendix]. Exhibit B [to this Appendix] provides an example of the allocation technique for the hypothetical medical practice valued under the income approach in Exhibit A. Notice that the cost and market values of the tangible assets, combined with the value of the intangible assets, equals the BEV determined under the income approach.

4. *Cost Approach*

A. *In General*

The cost approach to asset valuation measures value by determining the cost to replace or reproduce an asset, less an allowance for physical deterioration or obsolescence. Similarly, when used to value an entire business enterprise, the cost approach uses the fair market value of the enterprise's individual assets as a starting point. After the fair market value of the individual assets is estimated, the book value of liabilities is subtracted to arrive at an indication of the cost value of the business.

B. *Different Methods for Valuing Assets under the Cost Approach*

In valuing tangible assets, it is generally agreed that assets remaining in place are worth more than assets that are moved. The idea behind this principle is that the purchaser has the "turnkey" value of the assets—the immediate use

of an accumulation of assets that allows the purchaser the ability to walk into a business and operate it immediately.

The cost approach embraces a number of methods for determining fair market value. Use of the various methods creates a scale of value ranging from high to low.

Cost of reproduction. At the top of the value scale is the cost of reproduction. It is often very expensive to reproduce an asset. For example, consider the cost of an office building. Modern buildings are normally constructed with poured concrete, not marble which was once a more common building material; a marble building constructed today is far more expensive than the same building constructed with poured concrete. Applying the reproduction cost method to a marble office building would result in a relatively high valuation.

Cost of replacement. Next on the scale is the cost of replacement. Replacement cost forms the basis of the fair market value in use ("FMVIU") method of valuation. Under FMVIU, assets are valued by subtracting the seller's portion of "estimated use" of the property from current replacement cost (versus original cost/price paid by the seller). Estimated use is the "working life" of an asset; this is not the same as depreciated life, which is based on artificial time limits established to depreciate or amortize assets for tax purposes. Thus, an amount representing the seller's use of the asset is subtracted from current replacement cost to arrive at FMVIU. While this method results in values at the higher end of the scale, its logic may be seen from the following example:

> ***Example:*** In 1995, Purchaser is buying an examination table acquired by Seller in 1989 for $1,000. In 1995, the same (or comparable) table costs $1,500. The replacement cost in 1995 is $1,500. The value of the estimated use by Seller for 6 years is $800. Thus, the "replacement" value or FMVIU is $700.

Under the FMVIU method, the appraiser begins with the replacement cost of 1989 technology in 1995 which can be readily ascertained through equipment or furniture suppliers or price guides. An allowance is made for previous estimated use, preventing private benefit/inurement concerns that results if the purchaser paid a price which did not reflect usage. The logic justifying paying based on current (versus original) cost relates to the fact that the asset will remain in place; no money is spent on the purchase, assembly, or training costs needed to operate the asset. The FMVIU method thus allows the purchaser the turnkey value of the accumulation of assets.

The FMVIU method has two recognized pitfalls. First, the appraiser must consider the possibility of functional obsolescence (e.g., is the 1989 examination table functionally equivalent to the 1995 table?) and make appropriate reductions for obsolescence. For many assets in a medical practice (tables and some office and medical equipment, for example), obsolescence is not a significant factor. For other assets (office computers and high technology medical equipment, for example), functional obsolescence may be significant and the valuation should recognize this. Second, the appraiser must consider the actual physical use the asset has sustained. Physical use is an important consideration with older furniture, office and medical equipment, and fixtures. The appraiser must examine each article, note its condition, and add or subtract for physical use. If functional obsolescence and physical use are taken into account, however, the FMVIU method is a reasonable approach to evaluating a medical practice's tangible assets. *See* American Society of Appraisers, *Appraising Machinery and Equipment,* p. 86 (1989).

Actual cost. Third down on the "value scale" is actual cost. This method uses the actual cost/original price of the asset (1989 price in the example above), and makes a reduction based on estimated life of the asset. The actual cost method closely resembles FMVIU; the only difference is the starting point (original price versus replacement cost). It results in a lower value than FMVIU for the same asset because original cost is generally less than replacement cost.

Unlike FMVIU, this method does not account for functional obsolescence. Physical use is taken into account, however. This is the method often used to value assets of small medical practices with older equipment and furniture. (Logically, the purchaser in such a situation is less likely to leave the assets in place and therefore turnkey value is lower.)

Depreciated cost. At the bottom of the "value scale" is depreciated cost. This approach values assets at their actual cost/original price, and makes a reduction for scheduled tax depreciation. This approach generally results in the lowest price because tax depreciation schedules are frequently more generous than reductions based on estimated useful life.

5. *Market Approach*

A. *In General*

The second valuation approach, the market approach, measures value based on prices paid in the marketplace for similar assets. The market approach

is familiar to home buyers who compare the value of homes they are interested in purchasing to recent prices paid for similar homes.

The market approach tracks actual sales of comparable assets or businesses. Projections and estimates, a necessary part of the income approach, are not used. The only subjective component of this approach involves determining appropriate adjustments for comparability.

B. *Buildings, Real Estate, and Leases*

The market approach is an excellent technique to value buildings and real estate (including leases). Generally, a market valuation analysis starts by describing the community. The description provides important information about its economic, social, transportation, and environmental strengths and weaknesses.

Next, the building and land being appraised are compared to actual sales of comparable buildings and land in the community. The appraiser lists recent sales transactions for office buildings and land. The list of recent transactions compares the property being appraised to that sold in recent transactions, in terms of such factors as building square footage, lot square footage, location, age, condition, quality of construction and design, and access to transportation. The appraiser visually inspects comparable properties to better evaluate their comparability to the subject property. After all important information is gathered, the appraiser estimates the value of the property being appraised by making appropriate comparability adjustments to the sales prices of the comparable properties. A final fair market value is determined using the impartial data based on the actual sales of comparable buildings and real estate in the community. Because this method relies on data derived from actual transactions, it is less subjective than the income approach.

C. *Is the Market Approach Useful in Determining BEV?*

The market approach is also used to determine the value of a whole business, not just its buildings and real estate. In a market approach to BEV, a meaningful (though approximate) comparison must be made of the seller's business to similar businesses.

In selecting comparable companies for the medical practice being appraised, the appraiser first looks to the public marketplace, because more information is available on public companies than private businesses. The universe of possible comparable companies starts with all companies that

provide healthcare services; it thus would exclude HMOs and other managed-care entities, since managed care involves assuming healthcare provider risk whereas physician practices are primarily oriented to providing healthcare services and generally assume little provider risk. (In heavily "capitated" markets, where physicians are compensated primarily through capitated (managed care) arrangements, managed-care companies might be appropriate "comparables," however.) Hospitals and home healthcare services would also be excluded because they provide specialty in-patient medical services or in-home secondary healthcare services, respectively.

Publicly traded physician practices do not exist. Thus, there is no truly comparable business enterprise that can be used in applying the market approach. Companies that operate physician practices under long-term service arrangements may provide the closest available comparison. (For additional discussion of this issue, *see* Zukin, *Financial Valuation: Businesses and Business Interests,* ¶ 18B.10[2] (1995 Update).) Public information on the sales of medical practices is generally not available, since physicians normally like to keep this information confidential. Thus, sales information on medical practices is difficult to obtain.

D. *Is There a Market for Physician Practices?*

An additional potential source of market information on medical practices are private "local" or "contractual" markets.

The sale of medical practices is a relatively new phenomenon. Unlike real estate, for which actual sales information is readily available, little accurate data exists on prices paid for medical practices. Because medical practices are not public companies and physicians generally view sales information as confidential, sales information is difficult to obtain. And even where such information is accessible, information demonstrating the "comparability" of the practices sold may not be available.

Where information about private sales of physician practices is used in the market approach, it should be substantiated by appropriate documentation.

E. *Establishing Comparability*

(1) *Market Established by Actual Sales*

Actual sales of physician practices in the same community as the subject practice may be used in the market approach. Where market information is

included in a valuation, actual purchase prices paid for comparable physician practices should be evaluated, adjusted, and applied to the operating data of the seller's business to arrive at FMV. The factors affecting comparability between the market and the seller's business should be discussed.

Factors affecting comparability include markets served; practice and specialty type; competitive position; profitability; growth prospects; risk perceptions; financial composition (capital structure); physician compensation; physician age, health, and reputation; physician productivity; average revenue per physician; cost structure; and average revenue per visit or covered life to revenue mix (capitated versus fee for service). *See Financial Valuation: Businesses and Business Interests* at ¶ 18B.10[3].

(2) *Market Established by Offers*

Market information involving letters of intent or memoranda of understanding to purchase medical practices could be used in a market approach. Because offers are not actual sales transactions, however, this information is inferior to actual sales transactions. Also, "comparable" information based on offers is only relevant when the offers are legally binding and contain detailed information about the terms and conditions of sale (e.g., price, financing, assets purchased, compensation to be paid for sellers' services as employees or independent contractors after the sale). Factors affecting comparability must be discussed in the appraisal report.

6. *Income Approach*

A. *Introduction*

The income approach focuses on incorporating the specific operating characteristics of the seller's business into a cash flow analysis. Discounted cash flow ("DCF") and excess earnings are two methodologies often used.

DCF is by far the most common methodology seen in appraisals of physician practices. For this reason, the following discussion focuses on that method. Exhibit A [to this Appendix] summarizes a hypothetical DCF analysis, and is referred to throughout this discussion.

In a DCF analysis, cash flow that could be taken out of the company being valued without impairing operations and profitability is estimated. The cash flow available for distribution is reduced to a present value by applying

a discount rate. Exhibit A, lines 15 and 16, demonstrates how the discount rate reduces future years' cash flow.

B. *Estimation Period*

The income approach to BEV is based on the fact that money received in the future has a lower present value than the same amount of money received today. The future time period over which cash flows are projected—generally five years in a medical practice valuation—is referred to as the *estimation* or *projection period.* Thus, a valuation will project the cash flow of a business to determine its present value as of the date of the appraisal. The sum of the present value of annual cash flows is added to the present value of the *terminal year* or *reversion* (the value of the cash flows at the end of the estimation period) to arrive at BEV. The mechanics of this calculation can be seen in Exhibit A, lines 16 through 19.

C. *Normalized Financial Statements*

The first step in a DCF analysis involves developing financial statements for the estimation period. This data is derived from historical financial information. Historical information should be adjusted ("normalized") for any unusual or nonrecurring items that were included in the medical practice's financial results. The resulting financial information is called *normalized financial information.* This is reported in the left-most column of Exhibit A. Expected unusual occurrences or known changes in revenues or expenses for years included in the estimation period should be reflected only in the results of the year or years affected.

D. *Assumptions*

After developing normalized financial statements, reasonable *assumptions* are made about events affecting future cash flow: rates of revenue increase/decrease, patient volume, and rates of expense increase/decrease based on current market conditions, growth, and inflation trends, for example.

Overvaluation problems often emerge at this stage. For example, projections of revenue growth may appear to be at odds with known market conditions in a particular area. Thus, revenue projections require close scrutiny to test their assumptions and make appropriate adjustments to normalized financial information. The following factors, derived from Cimasi, *Valuation*

of Healthcare Professional Practice, ASA International Appraisal Conference, Seattle, Washington (June 29, 1993), may be used in verifying assumptions underlying revenue projections:

(1) **Who owns the patient base—payor or physician?** In a managed care arrangement, the patient goes where the payor directs, affecting the base on which revenues are projected.

(2) **What is the mix of managed care and fee for service?** The larger the percentage of income generated by managed care, the greater the guarantee of revenues. Thus, the mix of managed care and fee-for-service arrangements is an important factor in revenue projections, as are the length of managed care contracts and the probability of their renewal.

(3) **A description of the physician practice.** This description should include a description of the medical community environment (primary service area of the practice and local medical competition, including number of practitioners in the specialty of the subject practice and other specialties). It should also thoroughly analyze the patient base. This may include a discussion of the volume and quality of patient charts, patient age mix and demographics, and payor source. The age of physicians and number of years in practice should be stated.

(4) **Are necessary adjustments made to the income stream?** Future cash flows/income may need to be adjusted for—

(a) Diagnostic Related Groups ("DRGs") which are now being applied to certain physician services under Medicare.

(b) The incorporation of pre- and postsurgical care into global surgical fees that incorporate pre- and postsurgical care along with surgery. In a surgical specialty, only the portion of payments reflecting the surgical component should be included in revenue projections.

(c) Increases or decreases in fees or capitation because of competition and government regulations. These might include, for example, expected decreases in physician referrals resulting from changes in federal antikickback laws. . . .

(d) Effects of "tightening" of federal antireferral restrictions. (Stark I and II). *See* 1995 CPE Text, at p. 176.

(e) Does the cash flow analysis include under expenses or salary the higher salaries for the additional nonphysician staff with the requisite training needs (i.e., gate keepers).

Assumptions are also made about expenses. While not as many problems appear here, expense projections and assumptions should also be carefully reviewed to ensure they are reasonable and appropriate.

E. *Earnings before Depreciation, Interest, and Taxes ("EBDIT")*

After projecting reasonable levels of revenue and expense, the resulting figure is *EBDIT*—earnings before depreciation, interest, and taxes. (In Exhibit A, EBDIT appears on line 4). Sometimes valuations include amortization (depreciation of intangible assets) into the formula. Thus, the formula appears as *EBDITA*—earnings before depreciation, interest, taxes, and amortization.

EBDITA is often used as a measurement to compare one business investment with another. Valuation analysts will divide EBDITA by revenues to obtain an EBDITA/revenue ratio. This ratio is then compared to industry averages to determine how the proposed investment compares with the industry at large.

F. *Earnings before Taxes ("EBT")*

EBDIT is then adjusted by subtracting depreciation/amortization (Exhibit A, line 5). The result is *EBT*—earnings before taxes (Exhibit A, line 6). Then, a tax rate is applied to determine net income after taxes (Exhibit A, line 7). Topic L in the 1995 CPE Text, at p. 167, discusses the importance of using after-tax cash flows in a DCF analysis.

G. *Cash Flow Available for Distribution*

Net income after taxes (Exhibit A, line 8) is then adjusted for depreciation/amortization, changes in working capital, and capital expenditures (Exhibit A, lines 9-11). The result is debt-free cash flow available for distribution (Exhibit A, line 12).

H. *Discount Rate*

The next key step in a DCF analysis is discounting the cash flows for the estimation period and the terminal year. In each succeeding year, cash flows are discounted (reduced) by a higher percentage. This effect is seen by comparing lines 12 and 16 on Exhibit A; notice how the discount rate reduces the value of the cash flows in the various columns in line 12.

The discount rate is a key component of a valuation based on a DCF analysis. The rate should reflect the risk of the investment in the business. Investment risk represents the probability of failure; prudent investors examining two investments, each having a similar rate of return, prefer the investment with less risk. However, an investor may be induced to participate in the riskier investment if the price is lower.

Choosing a correct discount rate is an important component of a valuation. The discount rate determines the value of the cash flows during the estimation period and the terminal year. The important concept to understand is the lower the discount rate, the higher the current value of the cash flows—the basis for the sales price of the physician's practice. Sellers generally want low discount rates while purchasers want high discount rates. *See* Gordon V. Smith & Russell L. Parr, *Valuation of Intellectual Property and Intangible Assets* 259 (1989).

The methodology most commonly used to determine the discount rate in a DCF analysis is the *weighted average cost of capital (WACC).* The theory behind cost of capital discounting techniques is that they allow alternative potential investments to be compared by using an identical set of yield performance standards.

(1) *Cost of Capital*

The cost of capital is the minimum rate an investment must yield to provide a required return to all sources of capital. Sources of capital include common and preferred stock, long-term debt, and retained earnings. Debt has a lower cost of capital than equity because it has a priority claim on earnings and assets in liquidation. The overall cost of capital is a function of the relative proportions of debt and equity. As more debt is added, the cost of capital declines.

(2) *Cost of Equity*

The Capital Asset Pricing Model ("CAPM") is the traditional approach to determine the cost of equity capital in a BEV. It was judicially accepted in *Northern Trust Co. v. Commissioner,* 87 T.C. 349 (1986). CAPM is based on the principle that a business enterprise's required rate of return (cost of equity capital) is related to the current interest rate environment, the expected volatility of investment returns, and the market equity risk premium in excess of the current risk free rate of return. *See* Brigham, *Financial Management: Theory and Practice*, p. 551 (1982).

CAPM evaluates the relative risk of a particular investment compared to the average return on all common stocks. It does so through use of a formula:

$$Ke = Rf + B1\ (Rp) + Rs$$

or

Required Equity Rate of Return (Ke) = The Risk Free Rate (Rf) + Investment's Beta (B1) x Market Equity Risk Premium (Rp) + Small Stock Risk Premium (Rs)

Risk free rate ("Rf"). The risk free rate is the yield on the U.S. Treasury obligation that matches the tenor of the investment being considered. With investments in publicly held companies, for example, the risk free rate is often based on short-term Treasuries, mirroring the liquidity of such investments. For purposes of medical practice valuations, however, the 30-year Treasury yield is more appropriate and is generally used as the risk free rate; it reflects the long-term nature of the investment and the anticipated long-term partnership between the hospital and the physician practice.

The 30-year Treasury yield as of 5/11/95, was 6.98 percent; on 5/11/94, it was 7.61 percent. Generally, the higher the risk free rate percentage, the higher the discount rate. If the other numbers in the cost of equity formula are constant, the discount rate in May 1994 would be higher than in May 1995. Thus, in volatile markets, the timing of a valuation can significantly change the value of the physician practice.

Beta ("B1"). Beta is a pragmatic measurement of the historical correlation of the return on an investment in relation to overall market performance. An investment's Beta factor reflects the extent to which returns on it are affected by changes in returns on all assets in the economy. The most common method of estimating Beta uses the Standard & Poor's Index of 500 Stocks.

The Beta of an investment with an average volatility of return equals 1.0. The Beta of an investment with below-average volatility of return is less than 1.0, whereas the Beta of a stock with above-average volatility is greater than 1.0. Value Line, Inc., and Standard and Poor's Corp. publish Beta values for stocks of publicly traded corporations.

Valuations of medical practices reviewed in the National Office in 1994-1995 have typically employed Beta factors between 1.1 to 1.4.

Market equity risk premium ("Rp"). The market equity risk premium component of the cost of equity formula is an empirical measurement of the amount by which historical average return on common stocks exceeds the historical average return on risk free securities of a given type. Presently, the market equity risk premium is 6.90 percent for average common stocks over the long term, as stated in Ibbotson & Associates, Inc., *Stocks, Bonds, Bills, and Inflation 1994 Yearbook.* (Ibbotson & Associates compiles and analyzes market results for stocks, bonds, and U.S. Treasury bills. Its indexes described in this article are widely used in DCF analyses.)

Small stock risk premium ("Rs"). Since medical practices are less marketable than many investments, the cost of equity formula should generally include an adjustment—referred to in the CAPM formula as a small stock risk premium—for lack of marketability. This adjustment reflects the fact that investments that lack marketability sell at a discount from the prices of comparable publicly traded shares. *See* Emory, *The Value of Marketability As Illustrated in Initial Public Offerings of Common Stock—August 1990 through January 1992,* Business Valuation Review, pp. 208–12. It should be noted that since the marketability discount is factored into the discount rate through the small stock risk premium, it should not be applied also at the end to the final value developed for the medical practice through use of the income approach since that would be "double counting."

The current small stock risk premium is 5.3 percent. *See* Ibbotson & Associates, *supra.* It is not unusual for valuations to add a "premium for specific risks" of between 4 percent and 8 percent to the cost of equity calculation. The premium for specific risks is added because Ibbotson small stocks consist of publicly traded equities with a market capitalization less than that of the lower one-fifth of the New York Stock Exchange. Thus, the small stock premium is based on securities issues that are still quite large and for which public information is readily available.

The following is an example of a cost of equity (Ke) calculation using the data discussed above.

$$Ke = Rf + B1\ (Rp) + Rs$$
$$1.3\% \times 6.9\%$$

$$21.25\% = 6.98\% + 8.97\% + 5.3\%$$

(3) *Weighted Average Cost of Capital ("WACC")*

Once the valuation analyst calculates the cost of equity, the discount rate can be determined. As noted above, the weighted average cost of capital ("WACC") methodology is commonly used for this purpose. WACC is derived from the cost of equity, the after-tax cost of debt, and the relative proportions of debt and equity financing, using the following formula:

$$WACC = Kd \times (1\text{-}t) \times D\% + Ke \times E\%$$

Cost of debt ("Kd"): Selecting an appropriate cost of debt ("Kd") generally begins with the prime rate plus basis points, if applicable. This information is included in the business sections of major newspapers and also appears in the Federal Reserve Statistical Release. On May 12, 1995, the prime rate was 9% with no points. The cost of debt that should be used should match that of the medical practice being valued or that of the publicly traded comparables, which is typically higher than the prime rate.

Cost of equity ("Ke"): Cost of equity ("Ke") is the percentage (21.25%) calculated using the CAPM formula, discussed above.

Debt ("D"): Debt ("D") is generally stated as a percentage of total capital in capital structures similar to seller's business. In this example, 14% is used which is the average amount of debt in the closest comparable companies.

Equity ("E"): Equity ("E") is stated as a percentage of total capital in capital structures similar to seller's business. In this example, 86 percent is used which is the average amount of equity in the closest comparable companies.

Tax rate ("t"): Tax rate ("t") is the appropriate combined federal, state, and local income tax rate for the medical practice. With a rate of 40 percent, in the above formula (1-t) equals .60.

Once the variables are derived using the appropriate methodology, WACC may be calculated:

WACC =	Kd x (1-t) x D%	+	Ke x E %
	9.00% x .60%		21.25% x 86%
	5.4% x 14%	+	
	.76%	+	18.28%
WACC =	19.04%		

Discount rates (WACC) used in valuations of medical practices reviewed at the National Office during 1994–1995 have generally ranged between 16 percent and 21 percent depending on variations in the cost of equity, cost of debt, and the debt/equity ratio at the time of appraisal.

I. *Terminal Value Exit Multiples*

The terminal value is a very important calculation in a DCF analysis. It is an estimate of the worth of a business' cash flows beyond the estimation period. The terminal value can represent between 50 percent and 150 percent of the total value determined by a DCF analysis. This inflating effect is demonstrated in Exhibit A, lines 12–14 (far right column). Notice how line 12—the debt-free cash flow available for distribution in the fifth (final) year—is multiplied by the exit multiple—5—in line 13, to reach the terminal value in line 14. In this example, the terminal value is based on the capitalization of the business' debt free cash flow at a rate equal to the discount rate less its expected long-term growth rate.

Exit multiples ranging from 3 to 8 are generally seen in valuations of medical providers. Lower multiples within that range might be seen in a medical practice consisting of older physicians in a specialty affected by managed care, for example, whereas a valuation of a practice consisting of younger, primary care practitioners who will benefit from managed care might use a somewhat higher multiple. An exit multiple at the high end of the range might be seen in an appraisal of an established outpatient specialty center—an ambulatory surgery center, for example—which is positively affected by favorable reimbursement policies and managed care.

Given the exit multiple's influence on the "bottom line" in a DCF analysis, it is important to examine critically the criteria used in selecting it. Factors reasonably relevant in selecting an exit multiple include the following:

- The growth and stability of the local market environment as suggested in the financial forecast
- Long-term growth expectations for the industry
- The perceived quality and composition of the valuation target
- Exit multiples used in similar transactions
- The interest rate environment at the time of valuation
- The financial and business risk of the valuation target
- The weighted average cost of capital used in the valuation

J. *Validating the Bottom Line Using the Allocation Technique— Valuation Methodologies for Intangible Assets*

(1) *Introduction*

The last step in a DCF analysis is totaling the present value of the cash flows during the estimation period and the present value of the terminal year, to arrive at BEV (Exhibit A, lines 17–19).

BEV determined under an income approach is often greater than the combined fair market value of equipment, furniture, and fixtures (determined under the cost approach) and buildings and real estate (determined under the market approach), because it includes the intangible value of the business as a going concern—i.e., the goodwill of the business.

Goodwill represents the intrinsic value in a viable, competitive, and well-run business that exceeds the value of its tangible assets. "Goodwill is comprised of patronage, excess earnings and residual. This is a permutation of the excess earnings concept because the value of the enterprise will only exceed the value of the identifiable assets (and create room for the residual) if there are excess earnings." *Valuation of Intellectual Property and Intangible Assets, supra,* at 88.

(2) *Goodwill in the Allocation Technique*

The value of goodwill can be allocated to specific intangible assets; the value of the latter is limited to the value of the former, as calculated under the income approach. For example, if the total value of the individual intangible assets exceeds the total value of the medical practice net of the aggregate fair market value of the tangible assets, the amount of value that can be allocated among the intangible assets is more limited. Also, it is important to note that intangible value may not always be present in a medical practice.

Thus, ascribing value to intangible assets is a matter of allocating value derived using the income approach to specific intangible assets. The following example illustrates this process:

> ***Example:*** The BEV of a medical practice under the income approach is $ 12,200,000. Medical equipment, furniture, and fixtures have a value of $2,200,000 determined under the cost approach. Buildings and real estate have a value of $6,400,000 determined under the market approach. The maximum value attributable to all intangible assets is $3,600,000.

Applying the allocation technique introduced in Part 3-C, this value should be assigned to specific intangible assets using appropriate valuation methodologies for each asset. As discussed above, this method helps validate the inherently subjective nature of the income approach, and ensure that the valuation process does not result in payments for patient referrals.

Methods for valuing specific intangible assets commonly present in a medical practice are discussed below.

(3) *Medical Records*

Accurate and readily accessible medical records are an important asset of an operating medical practice. In addition, a growing market exists for the information in these records. Depending on such factors as how long the practice has operated and how many physicians it has, medical records can number in the hundreds of thousands and extend back a lifetime.

How long records are retained in a medical practice may depend on professional standards, state law, and practice in a particular community. Professional standards indicate that it is ordinarily sufficient to retain patient records for 10 years; after that, records can be destroyed unless destruction is prohibited by law. This is based on a 1974 study by the American Hospital Association's Committee on Medical Records and the American Medical

Record Association's Planning and Bylaws Committee. State laws (and federal regulations applicable to provider participation in healthcare benefit programs) vary in their requirements. California, for example, generally requires that medical records be retained for 7 years; pediatric records must be kept for 18 years, while obstetric-gynecology and workers' compensation records must be retained for 30 years and records that have been subjected to legal subpoena must be maintained for the patient's lifetime. *See* Cal. Health & Safety Code § 1457. In some communities, general practice is to retain medical records indefinitely.

The cost method is commonly used to value medical records based on the concept that the value of each medical record incorporates the cost of creating and maintaining it. For a large practice, cost is calculated based on annual medical records department expenditures for creating/maintaining records, minus the portion of those departmental expenditures for withdrawal of records, divided by the number of records created/maintained in that year. (For smaller practices, a similar methodology, using the salary of records retention personnel or a portion thereof, is used.) Applying this approach typically results in a new per record value ranging from $12-20. Rough validation of the per record value can, where appropriate, be secured by comparing the amount determined under the cost method to what it would cost to secure copies of the records at rates imposed by state and federal social service agencies, insurance companies, and law firms.

Medical records diminish in value once a patient is no longer a regular patron of the practice. Thus, a reasonable allowance for depreciation is made when valuing medical records under the cost approach. Two bases sometimes used to establish a depreciation period (useful life) are the average term of residence in the community where the practice is located and the legally required retention period for medical records. Thus, if a seven-year depreciation period is used, one-year-old records lose 14 percent of their cost value while six-year-old records lose 86 percent of their cost value.

(4) *Assembled Work Force*

A well-trained, organized, and efficient work force is a valuable asset in any business. The value of the assembled nonphysician work force in a medical practice may be appraised using the cost approach, and depends on the number of full- and part-time employees, their positions, and the annual employee turnover rate (typically 15 to 35 percent). Use of the cost approach is based on the premise that for a potential buyer to recreate the particular practice, it has to hire and train a similar work force; that hiring/training process has identifiable costs—for recruitment, orientation, training, and lost salary—that form the basis of the valuation process. In general, the cost approach uses historical expenditures for these items to derive cost amounts which are multiplied by the number of employees in various job categories to derive the value of the assembled work force. Historical expenditures for the work force should be adjusted to levels in existence as of the valuation date.

(5) *Going Concern Value*

Going concern value has been defined as "the additional element of value which attaches to property by reason of its existence as part of a going concern." *VGS Corp. v. Commissioner*, 68 T.C. 563, 569 (1977), *appeal dismissed* (5th Cir.). For example, compare a building that will house a retail business with an operating business in an identical building. For the former to become functional, it will have to incur costs to recruit and train employees, furnish the building, and market the product. The value inherent in the latter, over and above the value of the building, is its going concern value. The elements of going concern value are turnkey value and immediate use value. *Miami Valley Broadcasting Corp. v. United States*, 204 Ct. Cl. 582, 499 F.2d 677 (1974).

Medical practices have going concern value. The buyer of an existing practice purchases a turnkey operation and receives immediate valuc from the assembled work force and other assets needed to operate the business.

The cost approach can be used to determine going concern value, based on the concept that specific costs are associated with finding a location, purchasing or leasing furniture and equipment, marketing the business, and hiring and training the work force. Application of the cost approach to appraising going concern value thus involves a process similar to that explained above for valuing assembled work force. (Indeed, assembled work force may be viewed as a component or element of going concern value.

Accordingly, it is inappropriate to value *both* assembled work force and going concern value.) Identifiable costs associated with creating going concern value are estimated and totaled to arrive at fair market value.

(6) *Covenants Not to Compete*

Sales of medical practices often involve the selling physicians' promises (covenants) not to compete with the new owners. An agreement by a seller not to compete with a buyer for a definite period of time after the sale may be a valuable intangible asset to the buyer. Thus, if the economic effect of the covenant can be reasonably estimated, and the duration of the covenant is finite, the covenant's value may be quantified in monetary terms through a valuation appraisal. *See Better Beverages Inc. v. United States,* 619 F.2d 424 (5th Cir. 1980), *aff'g* 44 A.F.T.R.2d 79-5101 (S.D. Tex. 1978); and *Ansan Tool & Manufacturing Co. v. Commissioner,* T.C. Memo. 1992-121.

The sale of a physician practice can entail several different covenants not to compete. Three types of covenants are typically present.

Between the individual employee physician and the selling medical practice (employer): This first type of covenant prevents the physician employee from competing with the employer during the term of employment and, depending on the terms of the covenant, may run for an additional finite period of time after termination of employment. This is the basic covenant that runs between an employee and an employer and sometimes is purchased by the IDS organization. This covenant benefits the employer because it protects against physicians leaving the practice with "their" patients.

Between the individual selling physician and the buyer: The second type of covenant, between the individual selling physician and the purchasing organization, similarly prevents the individual physician from competing with the purchaser for a stated period of time. The protection provided by this covenant is the same as with the first.

Between the selling medical practice and the buyer: The third type of covenant provides that the selling medical practice as a whole will not compete with the buyer for a fixed period. For example, the selling practice covenants that for two years after the sale and/or during the term of its professional services agreement, it will not compete against the buyer. This covenant protects against the seller's removing the patient base, for which substantial value may have been paid.

Covenants not to compete may extend only to specific categories of patients—managed care or fee-for-service patients, for example. They may

contain different terms and conditions for different covenanting parties. For example, the duration of the covenant and the "protected" service area may differ for covenants with individual physicians and those with the practice as a whole.

If there is more than one type of covenant not to compete, each should be separately valued.

> ***Example:*** A practice receives 100 percent of its revenue from fee-for-service patients. Both the practice and all individual physicians covenant not to compete with respect to the entire geographic area for two years. In this example, it could be appropriate, with proper factual substantiation (i.e., patient retention rates) to assume that as much as a 100 percent of the cash flow from patients is protected for two years. In succeeding years, the covenant must be analyzed to determine if, and the extent to which, cash flows are protected for the remainder of the estimation period. In the third through fifth years, the covenant prevents the terminating physician from competing with respect to existing patients of the practice, but allows the physician to compete with respect to other patients in the community. If the practice's existing patients account for 60 percent of the revenues, as much as 60 percent of the practice's cash flow could be protected, with proper substantiation of patient retention rates.

In valuing covenants not to compete, it is important to analyze not only their terms and conditions, but their real economic effect. In some communities, such covenants may not be legally enforceable or for other reasons may be widely disregarded. Thus, before any value may be assigned to covenants not to compete, it must be determined if it is unrealistic for the seller to have given a covenant—the "economic reality" test. This test was first enunciated in *Schulz v. Commissioner,* 294 F.2d 52 (9th Cir. 1961), *aff'g* 34 T.C. 235 (1960). In this case, the court stated that a covenant "must have some independent basis in fact or some arguable relationship with business reality such that reasonable men, genuinely concerned with their economic future, might bargain for such an agreement." Generally, where the seller is, objectively, likely to pose a real threat of competition, courts will probably sustain some allocation of value to the covenants. In making such a determination, a variety of factors must be considered, such as whether the seller has the ability to compete with the buyer. The courts have stated that the following are important considerations in determining if the seller has the ability to compete:

- Did the seller have a customer network and experience that makes competition real?
- Did the seller have the financial ability to compete?
- Did the seller's physical ability allow for him/her to compete (i.e., age and state of health)?
- Did noncontractual restrictions, such as limited market entry, prohibit the seller from competing in the absence of the covenant not to compete? (This factor may be important where a certificate of need requirement exists, for example.)
- Did the seller intend to retire or leave the geographic area covered by the covenant?
- Did negotiations to sell the business make it clear to the seller that a covenant was essential to the transaction?

Another important factor in the value of a covenant not to compete is the portion of protected cash flow attributable to fee-for-service and capitated contracts. Individual physicians' covenants not to compete may be more valuable if more revenues are attributable to fee-for-service arrangements than managed care contracts, because patients are freer to choose to see the competing physician. In other words, the covenant protects the cash flow generated by the ability of the individual physician and/or practice to attract and retain patients in the community. Where more patients are "locked in" a practice by managed care arrangements, the physician's covenant not to compete may be less valuable. Also, where covenants not to compete extend to managed care patients, care should be taken to ensure that the valuation appraisal does not assign value to the same revenues as part of the valuation of the covenants not to compete and the contracts themselves. (Valuation of managed care contracts is discussed in the following section.)

In addition, whether the covenant not to compete is executed in conjunction with an employment contract is also significant. If it is, both agreements need to be evaluated carefully because their provisions, and their values, may overlap. An employment agreement may convey similar benefits and cover the same time period as a covenant not to compete, and thus its value is not separate and distinct from the value of the covenant.

In summary, covenants not to compete have value if the terms are reasonable and if the seller is truly being compensated for giving up the right to forego opportunities that would place him/her in competition with the purchaser. Often, a large portion of total BEV is assigned to covenants; the assignment may appear to be arbitrary, with little discussion of the basis for establishing value. Such appraisals do not provide an adequate basis for establishing fair market value.

(7) *Managed Care Contracts*

Fixed revenue contracts are often an important source of value for a business entity. Managed care contracts are such an asset for a healthcare provider.

Managed care contracts are typically valued under an income approach. In this approach, revenues associated with contracts are determined, minus a pro rata portion of expenses (including capital charges). The resulting cash flow is discounted to arrive at the contracts' present value.

The valuation analysis should list all contracts and their term. Value should be allocated using this methodology only to contracts providing for payment on a capitated basis, because generally only that revenue is certain.

A significant issue in valuing managed care contracts is whether the contracts have value after their term. The assignment of value after the contract expires, like the assignment of value to a covenant not to compete after its expiration/termination, seems questionable and should be carefully scrutinized. Any such assignment should be well-documented and supported by information such as the following:

- The percentage of contracts renewed annually
- The number of years the practice serviced the contracts

- The contract retention rate prevailing in the community
- The portion of the community that receives healthcare under managed care contracts
- Whether contracts have recently been renewed at lower rates than in previous years

(8) *Trade Name*

Generally, an individual physician practice retains the benefits of a trade name—"Dr. Jane Doe, MD, Family Practice," for example—only so long as the practitioner remains in practice. The trade name of a large group practice—"Women's Health Clinic of Gotham," for example—may be an important and enduring asset, however, particularly where the practice has operated under the same name for a long time. A number of other factors influence the value of a trade name.

The premise according to which the name of a physician group practice has value is that patients can choose where to receive medical treatment. Thus, any appraisal in which value is assigned to a trade name should discuss factors bearing on the name's influence on patient choice, such as organizational reputation; individual physician reputation, location, longevity/history, innovation; and historical advertising of the name.

The income method is generally used to value trade names. Typically, fee-for-service and managed care revenues are addressed separately, reflecting the different degree or level of patient choice reflected in such revenues. Managed care contracts should result in little (if any value) assigned to trade name; as noted above, those contracts are generally separately valued. As with the application of the income approach to other intangible assets, discounted cash flows reasonably attributed to the target asset for the estimation period are totalled to arrive at fair market value.

EXHIBIT A

DISCOUNTED CASH FLOW ANALYSIS

ESTIMATION OF VALUE

	Normalized Financial Statement	Twelve Months ending May 31,					
	1994	1995	1996	1997	1998	1999	Terminal Year
Adjusted Gross Revenue	$43,217,775	$44,788,094	$47,845,072	$50,986,721	$54,197,490	$57,619,964	
Total Labor Costs	32,861,436	33,838,497	34,667,117	36,643,572	38,674,523	40,827,325	
Total Operating Expenses	8,469,539	9,416,755	9,228,706	9,694,300	10,170,348	10,670,718	
Earnings Before Depreciation, Interest and Taxes (EBDIT)	1,886,800	1,532,842	3,949,249	4,648,849	5,352,619	6,121,921	
Depreciation	958,211	1,110,457	1,360,457	1,574,743	1,753,314	1,896,171	
Earnings Before Taxes (EBT)	928,589	422,385	2,588,792	3,074,106	3,599,305	4,225,750	

Effective Income Taxes (40% of Earnings)	371,436	168,954	1,035,517	1,229,643	1,439,722	1,690,300	
Debt Free Net Income	557,153	253,431	1,553,275	1,844,464	2,159,583	2,535,450	
Add: Depreciation		1,110,457	1,360,457	1,574,743	1,753,314	1,896,171	
Less: Changes in Debt Free Net Working Capital		45,703	30,570	31,416	32,108	34,225	
Less: Capital Expenditures		1,000,000	1,500,000	1,500,000	1,000,000	1,000,000	
Debt Free Cash Flow Available for Distribution		318,185	1,383,162	1,887,791	2,880,789	3,397,396	3,397,396
Terminal Year Exit Multiple							5
Terminal Value							16,986,980
Present Value Factor @ 19% Discount Rate		0.9129	0.7703	0.6473	0.5440	0.4571	0.3841
Present Value — Debt Free Cash Flow/Terminal Value		$290,471	$1,065,450	$1,221,967	$1,567,149	$1,552,950	$6,524,699

Sum of Present Values — 5 Years	5,697,987
Add: Present Value of Terminal Year	6,524,699
Business Enterprise Value	12,222,686
Indicated Business Enterprise Value (rounded)	$12,200,000

EXHIBIT B

ALLOCATION TECHNIQUE

Cost Approach:

Medical Equipment	$2,000,000
Furniture & Fixtures	200,000
Total	$2,200,000

Market Approach:

Building	$5,800,000
Land	600,000
Total	$6,400,000

Market and Cost Total	$8,600,000

Intangible Assets:

Medical Records	$ 600,000
Assembled Workforce	600,000
Covenants	1,200,000
Contracts	800,000
Trade name	400,000
Total Value of Intangibles	$3,600,000

Total BEV	$12,200,000

= Cost + Market + Intangibles

APPENDIX G

IRS Checklist for Hospital Joint Operating Agreement Applicants

Date: July 9, 1996
Refer Reply to: CP:E:EO:T:1
Employer Identification Number: * * *
Key District Office: * * *

Dear Sir/Madam:

This is in regard to your application for recognition of exemption and/or ruling request. Please answer the following questions over the signature of one of your principal officers or directors.

Overview

The Service is looking for explicit manifestations of control under all the facts and circumstances of a joint operating agreement (JOA) between otherwise unrelated hospitals or hospital systems such that dealings between the hospitals (and the parts of the hospital systems that are completely financially integrated) under the agreement are merely matters of accounting between related organizations rather than rising to a level of unrelated trade or business activity contemplated by § 513 of the Code. (*See* Rev. Rul. 77-72.) Where there is a (super) parent organization established by the hospitals or hospital systems to implement the joint operating agreement, it may be considered to be carrying out an integral part of the activities of the hospitals (and the parts of the hospital systems that are completely financially integrated) under all the facts and circumstances. (*See* Rev. Rul. 75-282.) This is a flexible control analysis that does not rely on structural control or on any one factor (although some factors are more significant than others) but, rather, a preponderance of all the facts and circumstances that demonstrate that significant control over management and financial decisions have been ceded by participating entities to a mutual governing body under a joint operating agreement.

The following is a list of the facts and circumstances that we would appreciate your addressing by stating whether each is satisfied and noting the reference to an underlying document. If there are specific facts and circum-

stances we have not included which you believe should be important to our consideration, please reference those as well. In addition, if there is a factor or an aspect that you do not currently satisfy but which you would agree to satisfy, please note this point.

1. Delegation of Significant Management Responsibility

This factor looks to aspects of long-range and day-to-day management decisions by the JOA governing body. It looks to frequency of meetings by the JOA governing body and its responsibility for operational decisions. Where the JOA governing body meets infrequently merely to ratify a participating entity's decision, this factor is not satisfied.

(1) Responsibility to establish budgets. This is a significant aspect that involves responsibility to establish overall budgets, including authority to approve major expenditures, debt, contracts, managed care agreements, and capital expenditures. This aspect also looks at whether the JOA governing body meets on a regular basis to establish long-term and short-term budget planning and to implement its decisions.

(2) Authority by the JOA governing body to monitor and audit each participating entity's compliance with its directives. This is a significant aspect.

(3) Responsibility to direct services. This is a significant aspect that looks to whether the JOA governing body can direct that healthcare services be undertaken or not be undertaken by the participating entities. For example, whether the governing body of the JOA can direct a participating hospital to refrain from bringing [in] a provider of pediatric services.

(4) Responsibility to enter into contracts binding the participating entities, particularly with managed care providers.

(5) Responsibility to hire and fire personnel.

(6) Responsibility to grant hospital staff privileges.

(7) Responsibility to set or approve fees and prices.

(8) Power to buy assets for and sell assets of participating entities.

(9) Responsibility to re allocate income among the participating entities to balance income and expenses so that financial integration and mutual objectives are assured.

2. Binding Agreements

This factor looks to whether there are significant hindrances to terminating the joint operating agreement, including penalties or other provisions that serve as a disincentive to undo the agreement.

3. Dispute Resolution

This factor looks to whether there are mechanisms in place to resolve disputes among the participating entities, including direct negotiation and binding arbitration. This is a significant aspect.

4. Veto and Reserved Powers

Veto powers are not the same as initiating powers and are not equivalent to the ceding of authority to the JOA governing body. Reserved powers relates to the degree of authority ceded to the JOA governing body where there are reservations or limits placed on powers otherwise granted to the governing body. If nearly all the powers ceded to the governing body of a joint operating agreement are subject to veto and reserved powers so that authority over a sufficient number of managerial and financial decisions is retained by the participating entities, then the requirements for exemption on the integral part basis would not be satisfied. Nevertheless, the fact that some powers are reserved by the participating entities is not, in and of itself, necessarily determinative. For example, powers over ethical or moral issues based on religious principles may be reserved to the participating entities without resulting in a finding that sufficient control has not been ceded to the governing body of the joint operating agreement.

We will defer action on your application/ruling request to enable you to submit the requested information. If we do not hear from you within 30 days from the date of this letter, we will assume that you do not want us to consider the matter any further and will close your case. If you want the matter reopened at a later time, you must pay a new user fee. When you reply to this letter, please include the following information on the envelope: Internal Revenue Service, 1111 Constitution Avenue, N.W., Washington, D.C. 20224, Attn: CP:E:EO:T:1, Room 6514.

If you do not provide the requested information in a timely manner, it will be considered by the Service as a failure to take all reasonable steps to secure the ruling you requested. Under Code § 7428(b)(2), your failure to take all reasonable steps to secure the ruling requested in a timely manner may be considered as a failure to exhaust the administrative remedies available to you within the Service, and thus may preclude the issuance of a declaratory judgment in this matter under the judicial proceedings of Code § 7428.

Thank you for your cooperation.

Sincerely Yours,

Steve Jankowitz
Tax Law Specialist
Exempt Organization
Technical Branch 1

APPENDIX H

Sample Conflicts of Interest Policy

Note: Items marked ***Hospital insert – for hospitals that complete Schedule C*** are intended to be adopted by hospitals.

Article I
Purpose

The purpose of the conflict of interest policy is to protect this tax-exempt organization's (Organization) interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of an officer or director of the Organization or might result in a possible excess benefit transaction. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

Article II
Definitions

1. **Interested Person**
Any director, principal officer, or member of a committee with governing board delegated powers, who has a direct or indirect financial interest, as defined below, is an interested person.

[Hospital Insert – for hospitals that complete Schedule C
If a person is an interested person with respect to any entity in the health care system of which the organization is a part, he or she is an interested person with respect to all entities in the health care system.]

2. **Financial Interest**
A person has a financial interest if the person has, directly or indirectly, through business, investment, or family:

a. An ownership or investment interest in any entity with which the Organization has a transaction or arrangement,

b. A compensation arrangement with the Organization or with any entity or individual with which the Organization has a transaction or arrangement, or

c. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the Organization is negotiating a transaction or arrangement.

Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial.

A financial interest is not necessarily a conflict of interest. Under Article III, Section 2, a person who has a financial interest may have a conflict of interest only if the appropriate governing board or committee decides that a conflict of interest exists.

Article III
Procedures

1. **Duty to Disclose**
In connection with any actual or possible conflict of interest, an interested person must disclose the existence of the financial interest and be given the opportunity to disclose all material facts to the directors and members of committees with governing board delegated powers considering the proposed transaction or arrangement.

2. **Determining Whether a Conflict of Interest Exists**
After disclosure of the financial interest and all material facts, and after any discussion with the interested person, he/she shall leave the governing board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

3. **Procedures for Addressing the Conflict of Interest**

a. An interested person may make a presentation at the governing board or committee meeting, but after the presentation, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement involving the possible conflict of interest.

b. The chairperson of the governing board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

c. After exercising due diligence, the governing board or committee shall determine whether the Organization can obtain with reasonable efforts a more advantageous transaction or arrangement from a person or entity that would not give rise to a conflict of interest.

d. If a more advantageous transaction or arrangement is not reasonably possible under circumstances not producing a conflict of interest, the governing board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in the Organization's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination it shall make its decision as to whether to enter into the transaction or arrangement.

4. **Violations of the Conflicts of Interest Policy**

a. If the governing board or committee has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member of the basis for such belief and afford the member an opportunity to explain the alleged failure to disclose.

b. If, after hearing the member's response and after making further investigation as warranted by the circumstances, the governing board or committee determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

Article IV
Records of Proceedings

The minutes of the governing board and all committees with board delegated powers shall contain:

a. The names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or possible conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the governing board's or committee's decision as to whether a conflict of interest in fact existed.

b. The names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Article V
Compensation

a. A voting member of the governing board who receives compensation, directly or indirectly, from the Organization for services is precluded from voting on matters pertaining to that member's compensation.

b. A voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Organization for services is precluded from voting on matters pertaining to that member's compensation.

c. No voting member of the governing board or any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Organization, either individually or collectively, is prohibited from providing information to any committee regarding compensation.

[***Hospital Insert – for hospitals that complete Schedule C***
d. Physicians who receive compensation from the Organization, whether directly or indirectly or as employees or independent contractors, are precluded from membership on any committee whose jurisdiction includes compensation matters. No physician, either individually or collectively, is prohibited from providing information to any committee regarding physician compensation.]

Article VI
Annual Statements

Each director, principal officer and member of a committee with governing board delegated powers shall annually sign a statement which affirms such person:

a. Has received a copy of the conflicts of interest policy,

b. Has read and understands the policy,

c. Has agreed to comply with the policy, and

d. Understands the Organization is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempt purposes.

Article VII
Periodic Reviews

To ensure the Organization operates in a manner consistent with charitable purposes and does not engage in activities that could jeopardize its tax-exempt status, periodic reviews shall be conducted. The periodic reviews shall, at a minimum, include the following subjects:

a. Whether compensation arrangements and benefits are reasonable, based on competent survey information, and the result of arm's length bargaining.

b. Whether partnerships, joint ventures, and arrangements with management organizations conform to the Organization's written policies, are properly recorded, reflect reasonable investment or payments for goods and services, further charitable purposes and do not result in inurement, impermissible private benefit or in an excess benefit transaction.

Article VIII
Use of Outside Experts

When conducting the periodic reviews as provided for in Article VII, the Organization may, but need not, use outside advisors. If outside experts are used, their use shall not relieve the governing board of its responsibility for ensuring periodic reviews are conducted.

APPENDIX I

Revenue Ruling 97-21 on Physician Recruitment

Issue

Whether, under the facts described below, a hospital violates the requirements for exemption from federal income tax as an organization described in section 501(c)(3) of the Internal Revenue Code when it provides incentives to recruit private practice physicians to join its medical staff or to provide medical services in the community.

Facts

All of the hospitals in the situations described below have been recognized as exempt from federal income tax under section 501(a) as organizations described in section 501(c)(3) and operate in accordance with the standards for exemption set forth in Revenue Ruling 69-545, 1969-2 C.B. 117. The physicians described in the following recruiting transactions do not have substantial influence over the affairs of the hospitals that are recruiting them. Therefore, they are not disqualified persons as defined in section 4958, nor do they have any personal or private interest in the activities of the organizations that would subject them to the inurement proscription of section 501(c)(3). Furthermore, in Situations 1, 2, and 4, the physicians have no pre-existing relationship with the hospital or the members of its board. For purposes of this revenue ruling, the physician-recruiting activities described in Situations 1, 2, 3, and 4 are assumed to be lawful. However, because the Internal Revenue Service does not have jurisdiction regarding whether the activities described in Situations 1, 2, 3, and 4 are lawful under the Medicare and Medicaid anti-kickback statute, 42 U.S.C. section 1320a-7b(b), taxpayers may not rely upon the facts or assumptions described in this ruling for purposes relating to that statute.

Situation 1

Hospital A is located in County V, a rural area, and is the only hospital within a 100 mile radius. County V has been designated by the U.S. Public Health Service as a Health Professional Shortage Area for primary medical care professionals (a category that includes obstetricians and gynecologists). Physician M recently completed an ob/gyn residency and is not on Hospital A's

medical staff. Hospital A recruits Physician M to establish and maintain a full-time private ob/gyn practice in its service area and become a member of its medical staff. Hospital A provides Physician M a recruitment incentive package pursuant to a written agreement negotiated at arm's-length. The agreement is in accordance with guidelines for physician recruitment that Hospital A's Board of Directors establishes, monitors, and reviews regularly to ensure that recruiting practices are consistent with Hospital A's exempt purposes. The agreement was approved by the committee appointed by Hospital A's Board of Directors to approve contracts with hospital medical staff. Hospital A does not provide any recruiting incentives to Physician M other than those set forth in the written agreement. In accordance with the agreement, Hospital A pays Physician M a signing bonus, Physician M's professional liability insurance premium for a limited period, provides office space in a building owned by Hospital A for a limited number of years at a below market rent (after which the rental will be at fair market value), and guarantees Physician M's mortgage on a residence in County V. Hospital A also lends Physician M practice start-up financial assistance pursuant to an agreement that is properly documented and bears reasonable terms.

Situation 2

Hospital B is located in an economically depressed inner-city area of City W. Hospital B has conducted a community needs assessment that indicates both a shortage of pediatricians in Hospital B's service area and difficulties Medicaid patients are having obtaining pediatric services. Physician N is a pediatrician currently practicing outside of Hospital B's service area and is not on Hospital B's medical staff. Hospital B recruits Physician N to relocate to City W, establish and maintain a full-time pediatric practice in Hospital B's service area, become a member of Hospital B's medical staff, and treat a reasonable number of Medicaid patients. Hospital B offers Physician N a recruitment incentive package pursuant to a written agreement negotiated at arm's-length and approved by Hospital B's Board of Directors. Hospital B does not provide any recruiting incentives to Physician N other than those set forth in the written agreement.

Under the agreement, Hospital B reimburses Physician N for moving expenses as defined in section 217(b), reimburses Physician N for professional liability "tail" coverage for Physician N's former practice, and guarantees Physician N's private practice income for a limited number of years. The private practice income guarantee, which is properly documented, provides that Hospital B will make up the difference to the extent Physician N practices full-time in its service area and the private practice does not generate a certain level of net income (after reasonable expenses of the practice). The amount guaranteed falls within the range reflected in regional or national surveys regarding income earned by physicians in the same specialty.

Situation 3

Hospital C is located in an economically depressed inner-city area of City X. Hospital C has conducted a community needs assessment that indicates indigent patients are having difficulty getting access to care because of a shortage of obstetricians in Hospital C's service area willing to treat Medicaid and charity-care patients. Hospital C recruits Physician O, an obstetrician who is currently a member of Hospital C's medical staff, to provide these services and enters into a written agreement with Physician O. The agreement is in accordance with guidelines for physician recruitment that Hospital C's Board of Directors establishes, monitors, and reviews regularly to ensure that recruiting practices are consistent with Hospital C's exempt purpose. The agreement was approved by the officer designated by Hospital C's Board of Directors to enter into contracts with hospital medical staff. Hospital C does not provide any recruiting incentives to Physician O other than those set forth in the written agreement. Pursuant to the agreement, Hospital C agrees to reimburse Physician O for the cost of one year's professional liability insurance in return for an agreement by Physician O to treat a reasonable number of Medicaid and charity-care patients for that year.

Situation 4

Hospital D is located in City Y, a medium- to-large sized metropolitan area. Hospital D requires a minimum of four diagnostic radiologists to ensure adequate coverage and a high quality of care for its radiology department. Two of the four diagnostic radiologists currently providing coverage for Hospital D are relocating to other areas. Hospital D initiates a search for diagnostic radiologists and determines that one of the two most qualified candidates is Physician P.

Physician P currently is practicing in City Y as a member of the medical staff of Hospital E (which is also located in City Y). As a diagnostic radiologist, Physician P provides services for patients receiving care at Hospital E, but does not refer patients to Hospital E or any other hospital in City Y. Physician P is not on Hospital D's medical staff. Hospital D recruits Physician P to join its medical staff and to provide coverage for its radiology department. Hospital D offers Physician P a recruitment incentive package pursuant to a written agreement, negotiated at arm's-length and approved by Hospital D's Board of Directors. Hospital D does not provide any recruiting incentives to Physician P other than those set forth in the written agreement.

Pursuant to the agreement, Hospital D guarantees Physician P's private practice income for the first few years that Physician P is a member of its medical staff and provides coverage for its radiology department. The private practice income guarantee, which is properly documented, provides that Hospital D will make up the difference to Physician P to the extent the private practice does not generate a certain level of net income (after reasonable expenses of the practice). The net income amount guaranteed falls within the range reflected in regional or national surveys regarding income earned by physicians in the same specialty.

Situation 5

Hospital F is located in City Z, a medium- to-large sized metropolitan area. Because of its physician recruitment practices, Hospital F has been found guilty in a court of law of knowingly and willfully violating the Medicare and Medicaid anti-kickback statute, 42 U.S.C. section 1320a-7b(b), for providing recruitment incentives that constituted payments for referrals. The activities resulting in the violations were substantial.

Law

Section 501(c)(3) provides, in part, for the exemption from federal income tax of corporations organized and operated exclusively for charitable, scientific, or educational purposes, provided no part of the organization's net earnings inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations provides that the term "charitable" is used in section 501(c)(3) in its generally accepted legal sense. The promotion of health has long been recognized as a charitable purpose. *See* Restatement (Second) of Trusts, sections 368, 372 (1959); 4A Austin W. Scott and William F. Fratcher, The Law of Trusts sections 368, 372 (4th ed. 1989); and Rev. Rul. 69-545, 1969-2 C.B. 117. Under the common law of charitable trusts, all such organizations are subject to the requirement that their purposes may not be illegal. *See* Restatement (Second) of Trusts section 377 (1959); 4A Austin W. Scott and William F. Fratcher, The Law of Trusts section 377 (4th ed. 1989); *Bob Jones University v. U.S.,* 461 U.S. 574, 591 (1983); Rev. Rul. 80-278, 1980-2 C.B. 175; Rev. Rul. 80-279, 1980-2 C.B. 176.

Section 1.501(c)(3)-1(c)(2) states that an organization is not operated exclusively for charitable purposes if its net earnings inure in whole or in part to the benefit of private shareholders or individuals.

Section 1.501(a)-1(c) defines "private shareholder or individual" as referring to persons having a personal and private interest in the activities of the organization.

Section 1.501(c)(3)-1(d)(1)(ii) states that an organization is not organized exclusively for any of the purposes specified in section 501(c)(3) unless it serves public, rather than private interests. Thus, an organization applying for tax exemption under section 501(c)(3) must establish that it is not organized or operated for the benefit of private interests.

Rev. Rul. 69-545, 1969-2 C.B. 117, holds that a non-profit hospital that benefits a broad cross section of its community by having an open medical staff and a board of trustees broadly representative of the community, operating a full-time emergency room open to all regardless of ability to pay, and otherwise admitting all patients able to pay (either themselves, or through third party payers such as private health insurance or government programs such as Medicare) may qualify as an organization described in section 501(c)(3). The same standard has been used by the courts as the basis for evaluating

whether health maintenance organizations qualify for exemption as organizations described in section 501(c)(3). *Sound Health Association v. Commissioner,* 71 T.C. 158 (1978), acq. 1981-2 C.B. 2; *Geisinger Health Plan v. Commissioner,* 985 F.2d 1210 (3rd Cir. 1993), rev'g 62 T.C.M. (CCH) 1656 (1991).

Rev. Rul. 72-559, 1972-2 C.B. 247, holds that an organization that provides subsidies to recent law school graduates during the first three years of their practice to enable them to establish legal practices in economically depressed communities that have a shortage of available legal services and to provide free legal service to needy members of the community may qualify as an organization described in section 501(c)(3).

Rev. Rul. 73-313, 1973-2 C.B. 174, holds that attracting a physician to a community that had no available medical services furthered the charitable purpose of promoting the health of the community. In Rev. Rul. 73-313, residents of an isolated rural community had to travel a considerable distance to obtain care. Faced with the total lack of local services, the community formed an organization to raise funds and build a medical office building to attract a doctor to the locality. (No hospitals or existing medical practices were involved.) The ruling states that certain facts are particularly relevant: (1) the demonstrated need for a physician to avert a real and substantial threat to the community; (2) evidence that the lack of a suitable office had impeded efforts to attract a physician; (3) the arrangements were completely at arm's-length; and (4) there was no relationship between any person connected with the organization and the recruited physician. The ruling states that, under all the circumstances, the arrangement used to induce the doctor to locate a practice in the area "bear[s] a reasonable relationship to promotion and protection of the health of the community" and any private benefit to the physician is incidental to the public purpose achieved. It concludes that the activity furthers a charitable purpose and the organization qualifies for exemption as an organization described in section 501(c)(3).

Rev. Rul. 75-384, 1975-2 C.B. 204, holds that an organization whose primary activity is sponsoring antiwar protest demonstrations in which demonstrators are urged to commit violations of local ordinances and breaches of the public order does not qualify as an organization described in section 501(c)(3) because its activities demonstrate an illegal purpose that is inconsistent with charitable purposes.

Rev. Rul. 80-278, 1980-2 C.B. 175, and Rev. Rul. 80-279, 1980-2 C.B. 176, discuss the qualification as organizations described in section 501(c)(3) of organizations that conduct environmental litigation and environmental dispute mediation. In holding that these organizations may qualify, the rulings state that, in determining whether an organization meets the operational test, the issue is whether the particular activity undertaken by the organization appropriately furthers the organization's exempt purpose. The rulings state that an organization's activities will be considered permissible under section 501(c)(3) if the following conditions are met: (1) the purpose of the organization is charitable; (2) the activities are not illegal, contrary to a clearly defined and

established public policy, or in conflict with express statutory restrictions; and (3) the activities are in furtherance of the organization's exempt purpose and are reasonably related to the accomplishment of that purpose.

Analysis

In order to meet the requirements of section 501(c)(3), a hospital that provides recruitment incentives to physicians must provide those incentives in a manner that does not cause the organization to violate the operational test of section 1.501(c)(3)-1. Whether the recruitment incentives cause the organization to violate the operational test is determined based on all relevant facts and circumstances. When a section 501(c)(3) hospital recruits a physician for its medical staff who is to perform services for or on behalf of the organization, the organization meets the operational test by showing that, taking into account all of the benefits provided the physician by the organization, the organization is paying reasonable compensation for the services the physician is providing in return. A somewhat different analysis must be applied when a section 501(c)(3) hospital recruits a physician for its medical staff to provide services to members of the surrounding community but not necessarily for or on behalf of the organization. In these cases, a violation will result from a failure to comply with any of the following four requirements:

First, the organization may not engage in substantial activities that do not further the hospital's exempt purposes or that do not bear a reasonable relationship to the accomplishment of those purposes. As discussed in Rev. Rul. 80-278 and Rev. Rul. 80-279, in determining whether an organization meets the operational test, the issue is whether the particular activity undertaken by the organization is appropriately in furtherance of the organization's exempt purpose.

Second, the organization must not engage in activities that result in inurement of the hospital's net earnings to a private shareholder or individual. An activity may result in inurement if it is structured as a device to distribute the net earnings of the hospital. *See Lorain Avenue Clinic v. Commissioner,* 31 T.C. 141 (1958); *Birmingham Business College, Inc. v. Commissioner,* 276 F.2d 476 (5th Cir. 1960).

Third, the organization may not engage in substantial activities that cause the hospital to be operated for the benefit of a private interest rather than public interest so that it has a substantial non-exempt purpose. Section 1.501(c)(3)-1(d)(1)(ii).

Finally, the organization may not engage in substantial unlawful activities. As discussed in Rev. Rul. 75-384, Rev. Rul. 80-278, and Rev. Rul. 80-279, the conduct of an unlawful activity is inconsistent with charitable purposes. An organization conducts an activity that is unlawful, and therefore not in furtherance of a charitable purpose, if the organization's property is to be used for an objective that is in violation of the criminal law. Activities can accomplish an unlawful purpose through either direct or indirect means.

Situation 1

Like the organization described in Rev. Rul. 73-313, Hospital A has objective evidence demonstrating a need for obstetricians and gynecologists in its service area and has engaged in physician-recruitment activity bearing a reasonable relationship to promoting and protecting the health of the community in accordance with Rev. Rul. 69-545. As with the subsidies provided to the recent law school graduates in Rev. Rul. 72-559, the payment of a bonus, the guarantee of a mortgage, the reimbursement of professional liability insurance and provision of subsidized office space for a limited time, and the lending of start-up financial assistance as recruitment incentives are reasonably related to causing Physician M to become a member of Hospital A's medical staff and to establish and maintain a full-time private ob/gyn practice in Hospital A's service area. The provision of the incentives under the circumstances described furthers the charitable purposes served by the hospital and is consistent with the requirements for exemption as an organization described in section 501(c)(3).

Situation 2

Like Hospital A in Situation 1, Hospital B has objective evidence demonstrating a need for pediatricians in its service area and has engaged in physician-recruitment activity bearing a reasonable relationship to promoting and protecting the health of the community in much the same manner as the organization described in Rev. Rul. 73-313. As with the recruitment incentive package provided by Hospital A, the payment of moving expenses, the reimbursement of professional liability "tail" coverage, and the provision of a reasonable private practice income guarantee as recruitment incentives are reasonably related to causing Physician N to become a member of Hospital B's medical staff and to establish and maintain a full-time private pediatric practice in Hospital B's service area. Thus, the recruitment activity described furthers the charitable purposes served by the hospital and is consistent with the requirements for exemption as an organization described in section 501(c)(3).

Situation 3

In accordance with the standards for exemption set forth in Rev. Rul. 69-545, Hospital C admits and treats Medicaid patients on a non-discriminatory basis. Hospital C has identified a shortage of obstetricians willing to treat Medicaid patients. The payment of Physician O's professional liability insurance premiums in return for Physician O's agreement to treat a reasonable number of Medicaid and charity-care patients is reasonably related to the accomplishment of Hospital C's exempt purposes. Because the amount paid by Hospital C is reasonable and any private benefit to Physician O is outweighed by the public purpose served by the agreement, the recruitment activity described is consistent with the requirements for exemption as an organization described in section 501(c)(3).

Situation 4

Hospital D has objective evidence demonstrating a need for diagnostic radiologists to provide coverage for its radiology department so that it can promote the health of the community. The provision of a reasonable private practice income guarantee as a recruitment incentive that is conditioned upon Physician P obtaining medical staff privileges and providing coverage for the radiology department is reasonably related to the accomplishment of the charitable purposes served by the hospital. A significant fact in determining that the community benefit provided by the activity outweighs the private benefit provided to Physician P is the determination by the Board of Directors of Hospital D that it needs additional diagnostic radiologists to provide adequate coverage and to ensure a high quality of medical care. The recruitment activity described is consistent with the requirements for exemption as an organization described in section 501(c)(3).

Situation 5

Hospital F has engaged in physician-recruiting practices resulting in a criminal conviction. As in Rev. Rul. 75-384, the recruiting activities were intentional and criminal, not isolated or inadvertent violations of a regulatory statute. An organization that engages in substantial unlawful activities, including activities involving the use of the organization's property for an objective that is in violation of criminal law, does not qualify as an organization described in section 501(c)(3). Because Hospital F has knowingly and willfully conducted substantial activities that are inconsistent with charitable purposes, it does not comply with the requirements of section 501(c)(3) and section 1.501(c)(3)-1.

Holding

The hospitals in Situations 1, 2, 3, and 4 have not violated the requirements for exemption from federal income tax as organizations described in section 501(c)(3) as a result of the physician-recruitment incentive agreements they have made because the transactions further charitable purposes, do not result in inurement, do not result in the hospitals serving a private rather than a public purpose, and are assumed to be lawful for purposes of this revenue ruling.

Hospital F in Situation 5 does not qualify as an organization described in section 501(c)(3) because its unlawful physician-recruitment activities are inconsistent with charitable purposes.

Scope

This ruling addresses only issues under section 501(c)(3) in the described situations. No inference is intended as to any other issue under any other provision of law, including any issue involving worker classification, income tax consequences to the physicians, and application of the Medicare and Medicaid anti-kickback statute, 42 U.S.C. section 1320a-7b(b).

Drafting Information

The principal author of this revenue ruling is Judith E. Kindell of the Exempt Organizations Division. For further information regarding this revenue ruling, contact Judith E. Kindell on (202) 622-6494 (not a toll-free call).

APPENDIX J

Revenue Ruling 98-15 on Whole Hospital Joint Ventures

Part 1

Section 501.—Exemption From Tax on Corporations, Certain Trusts, Etc.

26 CFR 1.501(c)(3)-1: Organizations organized and operated for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals. (Also §§ 170 and 509.)

Rev. Rul. 98-15, 1998-12 I.R.B.

ISSUE

Whether, under the facts described below, an organization that operates an acute care hospital continues to qualify for exemption from federal income tax as an organization described in § 501(c)(3) of the Internal Revenue Code when it forms a limited liability company (LLC) with a for-profit corporation and then contributes its hospital and all of its other operating assets to the LLC, which then operates the hospital.

Facts

Situation 1

A is a nonprofit corporation that owns and operates an acute care hospital. *A* has been recognized as exempt from federal income tax under § 501(a) as an organization described in § 501(c)(3) and as other than a private foundation as defined in § 509(a) because it is described in § 170(b)(1)(A)(iii). *B* is a for-profit corporation that owns and operates a number of hospitals.

A concludes that it could better serve its community if it obtained additional funding. *B* is interested in providing financing for *A's* hospital, provided it earns a reasonable rate of return. *A* and *B* form a limited liability company, *C*. *A* contributes all of its operating assets, including its hospital to *C*. *B* also contributes assets to *C*. In return, *A* and *B* receive ownership interests in *C* proportional and equal in value to their respective contributions.

C's Articles of Organization and Operating Agreement ("governing documents") provide that *C* is to be managed by a governing board consisting of three individuals chosen by *A* and two individuals chosen by *B*. *A* intends to appoint community leaders who have experience with hospital matters, but who are not on the hospital staff and do not otherwise engage in business transactions with the hospital.

The governing documents further provide that they may only be amended with the approval of both owners and that a majority of three board members must approve certain major decisions relating to *C's* operation, including decisions relating to any of the following topics:

A. *C's* annual capital and operating budgets
B. Distributions of *C's* earnings
C. Selection of key executives
D. Acquisition or disposition of healthcare facilities
E. Contracts in excess of $x per year
F. Changes to the types of services offered by the hospital
G. Renewal or termination of management agreements

The governing documents require that *C* operate any hospital it owns in a manner that furthers charitable purposes by promoting health for a broad cross section of its community. The governing documents explicitly provide that the duty of the members of the governing board to operate *C* in a manner that furthers charitable purposes by promoting health for a broad cross section of the community overrides any duty they may have to operate *C* for the financial benefit of its owners. Accordingly, in the event of a conflict between operation in accordance with the community benefit standard and any duty to maximize profits, the members of the governing board are to satisfy the community benefit standard without regard to the consequences for maximizing profitability.

The governing documents further provide that all returns of capital and distributions of earnings made to owners of *C* shall be proportional to their ownership interests in *C*. The terms of the governing documents are legal, binding, and enforceable under applicable state law.

C enters into a management agreement with a management company that is unrelated to *A* or *B* to provide day-to-day management services to *C*. The management agreement is for a five-year period, and the agreement is renewable for additional five-year periods by mutual consent. The management company will be paid a management fee for its services based on *C*'s gross revenues. The terms and conditions of the management agreement, including the fee structure and the contract term, are reasonable and comparable to what other management firms receive for similar services at similarly situated hospitals. *C* may terminate the agreement for cause.

None of the officers, directors, or key employees of *A* who were involved in making the decision to form *C* were promised employment or any other inducement by *C* or *B* and their related entities if the transaction were approved. None of *A*'s officers, directors, or key employees have any interest, including any interest through attribution determined in accordance with the principles of § 318, in *B* or any of its related entities.

Pursuant to § 301.7701-3(b) or the Procedure and Administrative Regulations, *C* will be treated as a partnership for federal income tax purposes.

A intends to use any distributions it receives from *C* to fund grants to support activities that promote the health of *A*'s community and to help the indigent obtain health care. Substantially all of *A*'s grantmaking will be funded by distributions from *C*. *A*'s projected grant-making program and its participation as an owner of *C* will constitute *A*'s only activities.

Situation 2

D is a nonprofit corporation that owns and operates an acute care hospital. *D* has been recognized as exempt from federal income tax under § 501(a) as an organization described in § 501(c)(3) and as other than a private foundation as defined in § 509(a) because it is described in § 170(b)(1)(A)(iii). *E* is a for-profit hospital corporation that owns and operates a number of hospitals and provides management services to several hospitals that it does not own.

D concludes that it could better serve its community if it obtained additional funding. *E* is interested in providing financing for *D*'s hospital, provided it earns a reasonable rate of return. *D* and *E* form a limited liability company, *F*. *D* contributes all of its operating assets, including its hospital to *F*. *E* also contributes assets to *F*. In return, *D* and *E* receive ownership interests proportional and equal in value to their respective contributions.

F's Articles of Organization and Operating Agreement ("governing documents") provide that *F* is to be managed by a governing board consisting of three individuals chosen by *D* and three individuals chosen by *E*. *D* intends to appoint community leaders who have experience with hospital matters, but who are not on the hospital staff and do not otherwise engage in business transactions with the hospital.

The governing documents further provide that they may only be amended with the approval of both owners and that a majority of board members must approve certain major decisions relating to *F*'s operation, including decisions relating to any of the following topics:

A. *F*'s annual capital and operating budgets
B. Distributions of *F*'s earning over a required minimum level of distributions set forth in the Operating Agreement
C. Unusually large contracts
D. Selection of key executives

F's governing documents provide that *F*'s purpose is to construct, develop, own, manage, operate, and take other action in connection with operating the healthcare facilities it owns and engage in other healthcare-related activities. The governing documents further provide that all returns of capital and distributions of earnings made to owners of *F* shall be proportional to their ownership interests in *F*.

F enters into a management agreement with a wholly owned subsidiary of *E* to porvide day-to-day management services to *F*. The management agreement is for a five-year period, and the agreement is renewable for additional five-year periods at the discretion of *E*'s subsidiary. *F* may terminate the agreement only for cause. *E*'s subsidiary will be paid a management fee for its services based on gross revenues. The terms and conditions of the management agreement, including the fee structure and the contract term other than the renewal terms; are reasonable and comparable to what other management firms receive for similar services at similarly situated hospitals.

Pursuant to § 301.7701-3(b), F will be treated as a partnership for federal income tax purposes.

D intends to use any distributions it receives from *F* to fund grants to support activities that promote the health of *D*'s community and to help the indigent obtain healthcare. Substantially all of *D*'s grantmaking will be funded by distributions from *F*. *D*'s projected grant-making program and its participation as an owner of *F* will constitute *D*'s only activities.

LAW

Section 501(c)(3) provides, in part, for the exemption from federal income tax of corporations organized and operated exclusively for charitable, scientific, or educational purposes, provided no part of the organization's net earnings inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(c)(1) of the Income Tax Regulations provides that an organization will be regarded as operated exclusively for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in § 501(c)(3). An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose. In *Better Business Bureau of Washington, D.C. v. United States,* 326 U.S. 279, 283 (1945), the Court stated that "the presence of a single . . . [non-exempt] purpose, if substantial in nature, will destroy the exemption regardless of the number or importance of truly . . . [exempt] purposes."

Section 1.501(c)(3)-1(d)(2) provides that an organization is not organized or operated exclusively for exempt purposes unless it serves a public rather than a private interest. It further states that "to meet the requirement of this subdivision, it is necessary for an organization to establish that it is not organized and operated for the benefit of private interests. . . . "

Section 1.501(c)(3)-1(d)(2) provides that the term "charitable" is used in § 501(c)(3) in its generally accepted legal sense. The promotion of health has long been recognized as a charitable purpose. *See Restatement (Second) of Trusts,* §§ 368, 372 (1959); 4A Austin W. Scott and William F. Fratcher, *The Law of Trusts*, §§ 368, 372 (4th ed. 1989). However, not every activity that promotes health supports tax exemption under § 501(c)(3). For example, selling prescription pharmaceuticals certainly promotes health, but pharmacies cannot qualify for recognition of exemption under § 501(c)(3) on that basis alone. *Federation Pharmacy Services, Inc. v. Commissioner*, 72 T.C. 687 (1979), *aff'd*, 625 F.2d 804 (8th Cir. 1980) ("*Federation Pharmacy*"). Further-

more, "an institution for the promotion of health is not a charitable institution if it is privately owned and is run for the profit of the owners." 4A Austin W. Scott and William F. Fratcher, *The Law of Trusts* § 372.1 (4th ed. 1989). *See also Restatement (Second) of Trusts* § 376 (1959). This principle applies to hospitals and other healthcare organizations. As the Tax Court stated, "[W]hile the diagnosis and cure of disease are indeed purposes that may furnish the foundation for characterizing the activity as 'charitable,' something more is required." *Sonora Community Hospital v. Commissioner*, 46 T.C. 519. 525-526 (1966); *aff'd* 397 F.2d 814 (9th Cir. 1968) ("*Sonora*"). *See also* Sound Health Association v. Commissioner, 71 T.C. 158 (1978), acq. 1981-2 C.B. 2 ("*Sound Health*"); *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3rd Cir. 1993), *rev'g* 62 T.C.M. 1656 (1991) (*"Geisinger"*).

In evaluating whether a non-profit hospital qualifies as an organization described in § 501(c)(3), Rev. Rul. 69-545, 1969-2 C.B. 117, compares two hospitals. The first hospital discussed is controlled by a board of trustees composed of independent civic leaders. In addition, the hospital maintains an open medical staff, with privileges available to all qualified physicians; it operates a full-time emergency room open to all regardless of ability to pay; and it otherwise admits all patients able to pay (either themselves, or through third-party payors such as private health insurance or government programs such as Medicare). In contrast, the second hospital is controlled by physicians who have a substantial economic interest in the hospital. This hospital restricts the number of physicians admitted to the medical staff, enters into favorable rental agreements with the individuals who control the hospital, and limits emergency room and hospital admission substantially to the patients of the physicians who control the hospital. Rev. Rul. 69-545 notes that in considering whether a nonprofit hospital is operated to serve a private benefit, the Service will weigh all the relevant facts and circumstances in each case, including the use and control of the hospital. The revenue ruling concludes that the first hospital continues to qualify an organization described in § 501(c)(3) and the second hospital does not because it is operated for the private benefit of the physicians who control the hospital.

Section 509(a) provides that the term "private foundation" means a domestic or foreign organization described in § 501(c)(3) other than an organization described in § 509(a)(1), (2), (3), and (4). The organizations described in § 509(a)(1) include those described in § 170(b)(1)(A)(iii). An organization is described in § 170(b)(1)(A)(iii) if its principal purpose is to provide medical or hospital care.

Section 512(c) provides that an exempt organization that is a member of a partnership conducting an unrelated teade or business with respect to the exempt organization must include its share of the partnership income and deductions attributable to that business (subject to the exceptions, additions, and limitations in § 512(b)) in computing its unrelated business income. *See also* H.R. No. 2319, 81st Cong., 2d sess. 36, 111-112 (1950): S. Rep. No. 2375, 81st Cong., 2d Sess. 26, 109-110 (1950): § 1.512(c)-1.

In *Butler v. Commissioner*, 36 T.C. 1097 (1961), *acq.* 1962-2 C.B. 4 ("*Butler*"), the court examined the relationship between a partner and a partnership for purposes of determining whether the partner was entitled to a business bad debt deduction for a loan he had made to the partnership that it could not repay. In holding that the partner was entitled to the bad debt deduction, the court noted that "[B]y reason of being a partner in a business, petitioner was individually engaged in business." *Butler*, 36 T.C. at 1106 *citing Dwight A. Ward v. Commissioner*, 20 T.C. 332 (1953), *aff'd* 224 F.2d 547 (9th Cir. 1955).

In *Plumstead Theatre Society, Inc. v. Commissioner*, 74 T.C. 1324 (1980), *aff'd* 675 F.2d 244 (9th Cir. 1982) ("*Plumstead*"), the Tax Court held that a charitable organization's participation as a general partner in a limited partnership did not jeopardize its exempt status. The organization co-produced a play as one of its charitable activities. Prior to the opening of the play, the organization encountered financial difficulties in raising its share of costs. In order to meet its funding obligations, the organization formed a limited partnership in which it served as general partner, and two individuals and a for-profit corporation were the limited partners. One of the significant factors supporting the Tax Court's holding was its finding tat the limited partners had no control over the organization's operations.

In *Broadway Theatre League of Lynchburg, Virginia, Inc. v. U.S.*, 293 F.Supp. 346 (W.D.Va. 1968) ("*Broadway Theatre League*"), the court held that an organization that promoted an interest in theatrical arts did not jeopardize its exempt status when it hired a booking organization to arrange for a series of theatrical performances, promote the series and sell season tickets to the series because the contract was for a reasonable term and provided for reasonable compensation and the organization retained ultimate authority over the activities being managed.

In *Housing Pioneers v. Commissioner*, 65 T.C.M (CCH) 2191 (1993), *aff'd*, 49 F.3d 1395 (9th Cir. 1995), amended 58 F.3d 401 (9th Cir. 1995) ("*Housing Pioneers*"), the Tax Court concluded that an organization did not qualify as a § 501(c)(3) organization because its activities performed as

co-general partner in for-profit limited partnerships substantially furthered an nonexempt purpose, and serving that purpose caused the organization to serve private interests. The organization entered into partnerships as a one percent co-general partner of existing limited partnerships for the purpose of splitting the tax benefits with the for-profit partners. Under the management agreement, the organization's authority as co-general partner was narrowly circumscribed. It had no management responsibilities and could describe only a vague charitable function of surveying tenant needs.

In *est of Hawaii v. Commissioner*, 71 T.C. 1067 (1979), *aff'd in unpublished opinion* 647 F.2d 170 (9th Cir. 1981) ("*est of Hawaii*"), several for-profit est organizations exerted significant indirect control over est of Hawaii, a nonprofit entity, through contractual arrangements. The Tax Court concluded that the for-profits were able to use the non-profit as an "instrument" to further their for-profit purposes. Neither the fact that the for-profits lacked structural control over the orgainization nor the fact that amounts paid to the for-profit organizations under the contracts were reasonable affected the court's conclusion. Consequently, est of hawaii did not qualify as an organization described in § 501(c)(3).

In *Harding Hospital, Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1974) ("Harding"), a nonprofit hospital with an independent board of directors executed a contract with a medical partnership composed of seven physicians. The contract gave the physicians control over care of the hospital's patients and the stream of income generated by the patients while also guaranteeing the physicians thousands of dollars in payment for various supervisory activities. The court held that the benefits derived from the contract constituted sufficient private benefit to preclude exemption.

ANALYSIS

For federal income tax purposes, the activities of a partnership are often considered to be the activitities of the partners. *See, e.g., Butler.* Aggregate treatment is also consistent with the treatment of partnerships for purpose of the unrelated business income tax under § 512(c). *See* H.R. No. 2319, 81st Cong., 2d Sess. 36, 110-112 (1950); § 1.512(c)-1. In light of the aggregate principal discusses in *Butler* and reflected in § 512(c), the aggregate approach also applies for purposes of the operational test set forth in § 1.501(c)(3)-1(c). Thus, the activities of an LLC treated as a partnership for federal income tax purposes are considered to be the activities of a nonprofit organization that is

an owner of the LLC when evaluating whether the non-profit organization is operated exclusively for exempt purposes within the meaning of § 501(c)(3).

A § 501(c) (3) organization may form and participate in a partnership, including an LLC treated as a partnership, including an LLC treated as a partnership for federal income tax purposes, and meet the operational test if participation in the partnership arrangement permits the exempt organization to act exclusively in furtherance of its exempt purpose and only incidentally for the benefit of the for-profit partners. *See Plumstead* and *Housing Pioneers*. Similarly, a § 501(c)(3) organization may enter into a management contract with a private party giving that party authority to conduct activities on behalf of the organization and direct the use of the organization's assets provided that the organization retains ultimate authority over the assets and activities being managed and the terms and conditions of the contract are reasonable, including reasonable compensation and a reasonable term. *See Broadway Theatre League*. However, if a private party is allowed to control or use the nonprofit organization's activities or assets for the benefit of the private party, and the benefit is not incidental to the accomplishment of exempt purposes, the organization will fail to be organized and operated exclusively for exempt purposes. *See est of Hawaii; Harding;* § 1.501(c)(3)-1(c)(1); and § 1.501(c)(3)-1(d)(I)(ii).

Situation 1

After *A* and *B* form *C*, and *A* contributes all of its operating assets to *C*, *A's* activities will consist of the healthcare services it provides through *C* and any grant-making activities it can conduct using income distributed by *C*. *A* will receive an interest in *C* equal in value to the assets it contributes to *C*, and *A's* and *B's* returns from *C* will be proportional to their respective investments in *C*. The governing documents of *C* commit *C* to providing healthcare services for the benefit of the community as a whole and to give charitable purposes priority over maximizing profits for *C's* owners. Furthermore, through *A's* appointment of members of the community familiar with the hospital to *C's* board, the board's structure, which gives *A's* appointees voting control, and the specifically enumerated powers of the board over changes in activities, disposition of assets, and renewal of the management agreement *A* can ensure that the assets it owns through *C* and the activities it conducts through *C* are used primarily to further exempt purposes. Thus, *A* can ensure that the benefit to *B* and other private parties, like the management company, will be incidental to the accomplishment of charitable purposes. Additionally, their terms and

conditions of the management contract, including their terms for renewal and termination, are reasonable. Finally, *A's* grants are intended to support education and research and give resources to help provide healthcare to the indigent. All of these facts and circumstances establish that, when *A* participates in forming *C* and contributes all of its operating assets to *C*, and *C* operates in accordance with its governing documents, *A* will be furthering charitable purposes and continue to be operated exclusively for exempt purposes.

Because *A's* grant-making activity will be contingent upon receiving distributions from *C*, *A's* principal activity will continue to be the provision of hospital care. As long as *A's* principal activity remains the provision of hospital care, *A* will not be classified as a private foundation in accordance with § 170(b)(1)(A)(iii).

Situation 2

When *D* and *E* form *F*, and *D* contributes its assets to *F*, *D* will be engaged in activities that consist of the healthcare services it provides through *F* and any grant-making activities it can conduct using income distributed by *F*. However, unlike *A*, *D* will not be engaging primarily in activities that further an exempt purpose. "While the diagnosis and cure of disease are indeed purposes that may furnish the foundation for characterizing the activity as 'charitable,' something more is required." *Sonora*, 46 T.C. at 525-526. *See also Federation Pharmacy*; *Sound Health*; and *Geisinger*. In the absence of a binding obligation in *F's* governing documents for *F* to serve charitable purposes or otherwise provide its services to the community as a whole, *F* will be able to deny care to segments of the community, such as the indigent. Because *D* will share control of *F* with *E*, *D* will not be able to initiate programs within *F* to serve new health needs within the community without the agreement of at least one governing board member appointed by *E*. As a business enterprise, *E* will not necessarily give priority to the health needs of the community over the consequences for *F's* profits. The primary source of information for board members appointed by *D* will with the chief executives, who have a prior relationship with *E* and the management company, which is a subsidiary of *E*. The management company itself will have broad discretion over *F's* activities and assets that may not always be under the board's supervision. For example, the management company is permitted to enter into all but "unusually large" contracts without board approval. The management company may also unilaterally renew the management agreement. Based on all these facts and circumstances, *D* cannot establish that the activities it

conducts through *F* further exempt purposes. "[I]n order for an organization to qualify for exemption under § 501(c)(3) the organization must 'establish' that it is neither organized nor operated for the 'benefit of private interests.'" *Federation Pharmacy*, 625 F.2d at 809. Consequently, the benefit to *E* resulting from the activities *D* conducts through *F* will not be incidental to the furtherance of an exempt purpose. Thus, *D* will fail the operational test when it forms *F*, contributes its operating assets to *F*, and then serves as an owner of *F*.

HOLDING

A will continue to qualify as an organization described in § 501(c)(3) when it forms *C* and contributes all of its operating assets to *C* because *A* has established that *A* will be operating exclusively for a charitable purpose and only incidentally for the purpose of benefiting the private interests of *B*. Furthermore, *A's* principal activity will continue to be the provision of hospital care when *C* begins operations. Thus, *A* will be an organization described in § 170(b)(1)(A)(iii) and thus, will not be classified as a private foundation in accordance with § 509(a)(1), as long as hospital care remains its principal activity.

D will violate the requirements to be an organization described in § 501(c)(3) when it forms *F* and contributes all of its operating assets to *F* because *D* has failed to establish that it will be operated exclusively for exempt purposes.

DRAFTING INFORMATION

The principal author of this revenue ruling is Judith E. Kindell of the Exempt Organizations Division. For further information regarding this revenue ruling contact Judith E. Kindell on (202) 622-6464 (not a toll-free call).

APPENDIX K

FY 1999 IRS CPE Text on Bond Financed Facilities

Identifying Abusive Transactions Involving Section 501(c)(3) Organizations and Tax-Exempt Bonds
[Excerpt]

B. *Facts to Consider*

The impact of IRC § 501(c)(3) exempt status of financing with tax-exempt bonds cannot be accurately determined unless all of the salient facts related to the matter are uncovered, weighed, and properly characterized. This most likely will require that the specialists and agents consider, at the minimum, the following general items: (1) the composition of the board of directors; (2) the relationships of the parties to the arrangement; (3) the organization's relationship with other exempt organizations, governmental entities, and banks or guarantors; and (4) the facts surrounding the management of the facility.

Factors indicating that an organization's bond financed project does not adversely affect the organization's status under IRC § 501(c)(3) may include, among other items, the following:

a. The governing board of the organization is comprised of local, independent, civic leaders that broadly represents [sic] the community in which the bond financed facility is located.

b. The organization is controlled by an established IRC § 501(c)(3) organization whose exempt purposes are also furthered by the bond financed project. For example, a charity plans to bond finance the

construction of an elderly home on the campus of a university. The fact that the university acts as the charity's parent would be a significant fact weighing in the organization's favor.

c. The organization was created by a local governmental entity to be the lessor in a lease back transaction in which the lessor issues bonds or certificates of participation.

d. None of the for-profit parties involved in the bond financed project (sellers, developers, contractors, managers, etc.) or individuals connected with them were instrumental in the creation of the organization or exercise substantial influence over the affairs of the organization.

e. Prior to selecting the bond financed project, the organization had made a good-faith effort to find a suitable project.

f. A feasibility study reflects a projected rate of occupancy that is similar to the actual occupancy rate of the facility being acquired and indicates that the organization will be able to operate the facility in a charitable manner.

g. An appraisal of the bond financed facility uses the income method, market method, and cost method of valuation to estimate the facility's current business enterprise value.

h. The organization plans to manage the bond financed facility itself, hire a related exempt organization that has experience managing similar facilities to manage the facility, or selects a manager through competitive bidding.

Factors indicating that an organization's bond financed project may adversely affect the organization's status under IRC § 501(c)(3) may include, among other items, the following:

a. Members of the governing board of the organization are located throughout the country and have no discernable connection with each other or the community in which the bond financed facility is located.

b. A for-profit developer, manager, or other party engaged in bond financed projects throughout the country created and controls the organization.

c. A for-profit activity involved in the bond financed project loaned the organization funds or paid various costs incurred in the process of

organizing the organization and pursuing tax-exempt financing. Such costs might include incorporation fees, application fees, and fees for feasibility studies, appraisals, and engineering and environmental studies.

d. The for-profit entity selling the bond financed facility to the organization recently purchased the facility and is making a substantial profit on the sale.

e. The for-profit seller has provided a portion of the financing for the project by purchasing a series of subordinate bonds.

f. A bank lender or third-party guarantor, such as a bond insurer or a letter of credit bank, has final authority over the organization's budget and fees and has required the organization to maintain an unreasonable amount of cash on hand.

g. The organization has entered into a management contract with a for-profit manger to operate the bond financed facility which provides for the sharing of net profits or provides for penalties if the applicant terminates the contract.

APPENDIX L

FY 2000 IRS CPE Text on Physician Compensation Incentive Compensation Factors (Excerpt)

4. *Incentive Compensation Factors*

In analyzing any physician incentive compensation arrangement the Service has generally considered various factors to determine whether the arrangement violates the proscriptions against private inurement and impermissible private benefits.

A. *Independent Board of Directors and Conflicts of Interest Policy*

Was the compensation arrangement established by an independent board of directors or by an independent compensation committee?

In determining whether a health care organization complies with the community benefit standard established in Rev. Rul. 69-545, 1969-2 C.B. 117, one significant fact the Service considers is whether the organization has a community board of directors. The Service considers a community board as one in which independent persons who are representative of the community comprise a majority. Another significant fact the Service considers is whether the board of directors has adopted a substantial conflicts of interest policy. This policy should include restrictions barring a physician, who is a voting member of the board of directors and who receives compensation from the organization, from discussing and voting on matters pertaining to that member's compensation. This policy should also restrict physicians from membership on the organizations compensation committee and should preclude a voting member of a compensation committee from voting on matters pertaining to that member's compensation. However, physicians are not prohibited

from providing information to the board of directors or to any committee regarding physician compensation. *See* the article in this CPE text "Tax-Exempt Health Care Organizations, Revised Conflicts of Interest Policy."

B. *Reasonable Compensation*

Does the compensation arrangement with the physician result in total compensation that is reasonable?

The Service will not rule on whether compensation to be paid to any particular employee is reasonable since this involves a factual matter that cannot be determined in advance. *See* section 8.01, Rev. Proc. 99-4, 1999-1 I.R.B. 115, 129. However, in considering applications for recognition of exemption and requests for private letter rulings, the Service considers whether the compensation information indicates a potential problem with inurement or impermissible private benefit.

Therefore, the Service may request from health care organizations more information on compensation plans, such as representative physicians' employment contracts, especially those that apply different methods in determining incentive compensation. In addition, reliable physician compensation survey data for the physician specialty and geographic locale are helpful in establishing reasonableness.

C. *Arm's-Length Relationship*

Is there an arm's-length relationship between the health care organization and the physician, or does the physician participate impermissibly in the management or control of the organization in a manner that affects the compensation arrangement?

D. *Ceiling*

Does the compensation arrangement include a ceiling or reasonable maximum on the amount a physician may earn to protect against projection errors or substantial windfall benefits?

E. *Reduction in Charitable Programs*

Does the compensation arrangement have the potential for reducing the charitable services or benefits that the organization would otherwise provide?

F. *Quality of Care and Patient Satisfaction*

Does the compensation arrangement take into account data that measures quality of care and patient satisfaction?

G. *Net Revenue Based*

If the amount a physician earns under the compensation arrangement depends on net revenues, does the arrangement accomplish the organization's charitable purposes, such as keeping actual expenses within budgeted amounts, where expenses determine the amounts the organization charges for charitable services?

H. *Joint Venture*

Does the compensation arrangement transform the principal activity of the organization into a joint venture between it and a group of physicians?

I. *Distribution of Profits*

Is the compensation arrangement merely a device to distribute all or a portion of the health care organization's profits to persons who are in control of the organization?

J. *Business Purpose*

Does the compensation arrangement serve a real and discernable business purpose of the exempt organization, such as to achieve maximum efficiency and economy in operations that is independent of any purpose to operate the organization for the impermissible direct or indirect benefit of the physicians?

K. *Abuse or Unwarranted Benefits*

Does the compensation arrangement result in no abuse or unwarranted benefits because, for example, prices and operating costs compare favorably with those of other similar organizations?

This includes effective controls to avoid increases in compensation predicated on increases in fees charged to patients. Effective controls to guard against unnecessary utilization are also important.

L. *Services Personally Performed*

Does the compensation arrangement reward the physician based on services the physician actually performs, or based on performance in an area where the physician performs no significant functions?

APPENDIX M

FY 1999 IRS CPE Text on Whole Hospital Joint Ventures Charitable Purposes Questionnaire (Excerpt)

The following inquiries may be useful in discerning whether the partnership furthers charitable purposes and whether private benefit to the for-profit partners and/or manager is greater than incidental:

1. Does participation in the joint venture by the exempt organization further its exempt purposes?

   For example, is it necessary for the nonprofit to participate in the joint venture because of its needs for capital, expertise, or assets? Merely increasing a competitive edge through, for example, potential referrals from participating physicians does not further exempt purposes; nor does selling the net revenue stream. *See* GCM 39862.
2. Is the partnership required by its governing documents to promote the health of a broad section of the community?
3. Do the joint venture agreements explicitly state that the governing board members have a duty to promote the health of a broad cross section of the community which takes precedence over any fiduciary duty, such as maximizing profits?
4. Is there actual evidence that partnership activities are undertaken chiefly to promote the health of a broad cross section of the community rather than to produce profits?

   For example, what is the Medicare and Medicaid payer mix and the indigent care mix; what is the extent of community service programs, teaching, or research conducted; is there an open emergency room; open medical staff; admission of patients able to pay directly or through third party payers; what do minutes of board meetings reflect in terms of how decisions are reached affecting the level of community care; does the exempt organization have the authority to compel compliance with community benefit standards, and if so, how has it exercised this authority.
5. How is the governing board of the joint venture selected?

6. Who is on the governing board of the partnership?
7. What is the governing structure for the joint venture board?

   For example, are major decisions approved by a majority vote of the governing board; are they approved through block voting; how are deadlocks decided; what are the quorum requirements.
8. What decisions are approved by the board?

   In other words, who has the right to change the partnership's governing documents; approve the partnership's annual capital and/or operating budgets; approve partnership distribution of earnings and of available cash; approve additional capital contribution calls; approve partnership assumption of additional indebtedness; approve partnership acquisition or disposition of health care facilities; approve unusually large contracts, including managed care, provider, equipment, pharmaceuticals, and other goods and service contracts; approve changes in the types of services offered at the health care facilities; select key executives of the partnership and of the health care facilities; ensure adequate reserves; credentialize professional staff; hire and fire employees; and, compel an audit.
9. If there is a management firm, how is it selected?

   For example, is it a firm that is affiliated to the for-profit partner? Do the terms of the joint venture agreement require the use of a firm related to the for-profit partner?
10. How is the management firm paid?

    For example, is the fee reasonable in terms of comparables for similarly situated management firms? Does the fee represent an improper sharing of net revenues?
11. What are the other terms of the management agreement, including length of contract, renewals, and termination rights?
12. What are the duties of the management firm?

    This should be viewed in terms of whether there are any duties that may conflict with the partnership's ability to promote the health of a broad section of its community. Another concern would be if the management firm's powers restrict the authority of the exempt organization's representatives to the board of directors to initiate or react to decisions that would ensure community benefit.

13. How are fees and prices for the delivery of health care determined?
14. How are key executives selected and approved?
15. Who establishes compensation for physicians and for executives?
16. How are accountants and attorneys for the partnership selected? How are accountants and attorneys for the exempt hospital selected? Do such accountants and attorneys also represent the for-profit partner?
17. Are returns of capital and distributions of earnings of the partnership required to be proportional to capital contributions?
18. How are issues brought to the governing board?
19. Were any of the exempt organization's executives or governing board members promised positions within the LLC or with the for-profit partner or affiliates of it, or offered other personal financial inducements to approve the affiliation?
20. Do any of the representatives of the exempt partner who serve on the governing board of the partnership have a conflict of interest with their ability to represent community interests?

    For example, are they financially interested through employment arrangements or otherwise dependent on the hospital or partnership for their livelihood?
21. Who is responsible for establishing and setting medical and ethical standards?
22. Who has oversight of quality health care?

    Ensure that if oversight is within the control of the exempt organization, it is meaningful.
23. What specific activities does the exempt organization conduct?
24. What are the specific responsibilities of the exempt organization with respect to the partnership?

These factors are not exhaustive. Depending on the situation, additional or different factors may need to be developed and considered in determining whether the partnership arrangement allows the nonprofit organization to operate exclusively for charitable purposes.

APPENDIX N

IRS HMO Audit Guidelines

[7.8.1] 27.1 (05-25-1999)
Overview

1. This chapter provides descriptions and guidelines for examiners of health maintenance organizations (HMOs).
2. The examination of HMOs has the following objectives:
   A. to determine whether the organization qualifies for exemption under either IRC 501(c)(3) or IRC 501(c)(4);
   B. to determine whether the organization is precluded from qualifying for exemption by IRC 501(m)(1); and
   C. to determine whether any part of the organization's activities is subject to tax under IRC 501(m)(2).

[7.8.1] 27.2 (05-25-1999)
Examination Guidelines -- In General

1. Due to the varied character of HMOs and the rapidly changing nature of the health care industry, examiners should be flexible in applying these guidelines.

[7.8.1] 27.3 (05-25-1999)
Activities

1. HMOs directly provide, or arrange for the provision of, health care services to members on a prepaid basis typically through a managed care arrangement.
   A. Direct Provider. A direct provider HMO provides health care services to its members principally by its employed health care providers at facilities that the HMO either owns or leases. (This arrangement is sometimes referred to as a "staff model" HMO.) An HMO's services may consist of only primary care or may also include specialist care, inpatient and outpatient hospital care, mental health care, vision care and dental care.
   B. Arranger. An arranger HMO arranges for the provision of health care services to its members principally through a network of contracted health care providers at the providers' own facilities. An arranger HMO's services may consist of arranging for only primary care or may also include arranging for specialist care, inpatient and outpatient hospital care, mental health care, vision care and dental care.
   C. Managed Care Arrangement. A managed care arrangement describes an HMO that uses its employed and/or contracted primary care providers as "gatekeepers." Members

choose or are assigned a primary care provider and must obtain a referral from the primary care provider to utilize inpatient or outpatient hospital services, specialist physician services, and ancillary health care services.

2. Point-of-service. An HMO may permit members to obtain health care services from providers who are not employed or contracted by the HMO. These benefits, referred to as "point-of-service benefits," may be available to members within the HMO's service area or may be limited to emergency situations where the member is out of the HMO's service area.
3. An HMO may also engage in other activities, such as:
   A. Providing whole or partial subsidies of premiums for persons who cannot afford to pay the established premiums;
   B. Health care education programs; or
   C. Health research programs.
4. Stop-loss insurance. To reduce its risk of loss associated with providing, or arranging for the provision of, health care services to its members, an HMO may purchase insurance from an insurance company, a state or local government agency or from another organization in the HMO's health care system.

[7.8.1] 27.4 (05-25-1999)
Providers

1. An HMO employs or contracts with physicians and other health care professionals. An HMO may also contract with hospitals or clinics. Under these contracts, the providers agree to provide health care services to the HMO's members.

[7.8.1] 27.4.1 (05-25-1999)
Physicians

1. An HMO's physicians may be employed by the HMO, or may be independent physicians in private practice who contract with the HMO, or both.
   A. Contracts with physicians in private practice are typically on a non-exclusive basis.
   B. Contracted physicians may practice individually, in a group of several physicians, or as an individual practice association (IPA).
   C. An HMO may employ or contract with primary care physicians, specialists, or both.
   D. An HMO may employ or contract with other health care professionals, such as osteopaths, registered nurses, nurse practitioners, physician assistants, psychologists or social workers.

[7.8.1] 27.4.1.1 (05-25-1999)
Physician Compensation Methods

1. An HMO usually compensates its employed physicians on a salaried basis. Some HMOs may also pay bonuses.
2. An HMO compensates its contracted physicians using various compensation methods:
   A. Capitated Fee. An HMO pays the physician a fixed monthly fee for each HMO member for whom the physician serves as the member's primary care provider. This compensation method usually applies only to primary care physicians.
   B. Fee-For-Service. An HMO pays the physician a predetermined fee for services the physician actually provides to a member. The fee schedule may reflect a discount below the usual and customary fees charged by similarly situated providers for comparable services. The fee schedule may be based on the Medicare fee schedule (Resource Based Relative Value Scale or RBRVS) or the state Medicaid fee schedule. This method may be used to compensate primary care providers, specialists, or both.
   C. Withholding. An HMO may withhold a percentage of the fees paid to its contracted physicians and place the amount withheld in a reserve. Withholding arrangements generally are found only in fee-for-service arrangements with primary care physicians.

(Withholding rates generally range from 10 percent to 20 percent). The physician may be eligible to recover all or a portion of the amount withheld based on a variety of factors, for example, if the physician achieves certain predetermined budget goals and certain patient satisfaction standards, quality care standards or efficiency standards.

D. Bonuses. An HMO may agree to pay its contracted physicians a bonus. If the HMO withholds from the physicians' fees, the bonus may be limited to the amount withheld or it may also include additional amounts.

E. Point-of-service. If an HMO offers point-of-service benefits, the HMO either directly compensates the provider or reimburses the member based on a predetermined fee schedule.

[7.8.1] 27.4.2 (05-25-1999)
Hospitals

1. An HMO may contract with hospitals and clinics to provide members with inpatient and/or outpatient health care services. The contracted hospitals and clinics may be related to the HMO or may be independent organizations.

[7.8.1] 27.4.2.1 (05-25-1999)
Hospital Compensation Methods

1. For inpatient hospital services, an HMO usually pays hospitals on a per diem basis. For outpatient hospital services, an HMO usually pays hospitals based on a predetermined fee schedule.
2. For clinic services, an HMO usually pays clinics based on a predetermined fee schedule.

[7.8.1] 27.5 (05-25-1999)
Enrollment

1. An HMO may offer enrollment to certain groups, such as commercial employer groups, state or local government employer groups, insurance companies, other HMOs, Medicaid beneficiaries, Medicare beneficiaries, or individuals unaffiliated with any group.
2. Generally, individuals are not rejected for enrollment based on pre-existing conditions or excessive utilization of the HMO's services. HMOs commonly impose a reasonable waiting period, such as six months to one year, before a member is eligible to receive treatment of pre-existing condition.

[7.8.1] 27.6 (05-25-1999)
Premiums

1. An HMO determines its premiums using various methods, such as a community rating method or an experience rating method. In the case of HMOs that enroll Medicaid and Medicare beneficiaries, the government program generally sets the premiums.
   - A. Community Rating. Premiums are determined without regard to the member's utilization of services. All members pay the same premium regardless of the extent of health care services they require. An HMO may use an adjusted community rating method under which the premiums are the same for all members in a particular class.
   - B. Experience Rating. Premiums vary based on utilization of services. Members who require more health care services pay higher premiums.
   - C. Medicaid and Medicare. State Medicaid agencies generally establish the premiums for enrolled Medicaid beneficiaries. The Health Care Financing Administration (HCFA) determines the premiums it pays for enrolled Medicare beneficiaries.

[7.8.1] 27.7 (05-25-1999)

Control

1. An HMO's governing body, such as its board of directors, may consist of independent members of the community. In addition, an HMO may be controlled by:
   A. One or more IRC 501(c)(3) organizations, such as hospitals, which may be related to each other or may be unrelated;
   B. One or more HMOs, which may be exempt under IRC 501(c)(3) or IRC 501(c)(4), or may be non-exempt;
   C. Physicians, either individually or as part of a group or IPA; or
   D. Enrollees in the HMO.

[7.8.1] 27.8 (05-25-1999) IRC 501(c)(3)

1. To qualify for exemption as an organization described in IRC 501(c)(3), an HMO must be organized and operated exclusively for one or more exempt purposes.
2. An HMO is organized exclusively for one or more exempt purposes if it satisfies the organizational test in Reg. 1.501(c)(3)-1(b).
3. An HMO is operated exclusively for one or more exempt purposes if it satisfies the operational test in Reg. 1.501(c)(3)-1(c).
4. The promotion of health is considered an exempt purpose. See IRM 3.11.1 (Exempt Organizations Handbook). However, not every activity that promotes health supports tax exemption. See, for example, Federation Pharmacy Services, Inc. v. Commissioner , 72 T.C. 687 (1979), aff'd , 625 F.2d 804 (8th Cir. 1980).
5. No part of net earnings may inure to the benefit of private shareholders or individuals. Reg. 1.501(c)(3)-1(c)(2). See IRM 3.11.1 (Exempt Organizations Handbook.)

[7.8.1] 27.8.1 (05-25-1999) Direct Provider

1. The promotion of health in a charitable manner may be accomplished by the direct provision of health care services.
2. An HMO that operates exclusively as a direct provider of health care services accomplishes the charitable promotion of health if it operates in a manner comparable to the hospital described in Situation 1 in Rev. Rul. 69-545, 1969-2 C.B. 117, or to the HMO described in Sound Health Association v. Commissioner , 71 T.C. 158 (1978), acq . 1981-2 C.B. 2.

[7.8.1] 27.8.2 (05-25-1999) Arranger

1. Under certain circumstances, the promotion of health in a charitable manner may be accomplished by arranging for the provision of health care services.
2. In determining whether an arranger HMO qualifies for tax-exempt status under IRC 501(c)(3), the totality of the circumstances must be examined, with an eye toward discerning whether the HMO benefits the community as a whole in addition to its subscribers. Geisinger Health Plan v. Commissioner , 985 F.2d 1210 (3rd Cir. 1993), rev'g 62 T.C.M. (CCH) 1656 (1991).
3. Under this community benefit standard, the HMO's activities must be directed toward achieving a charitable purpose, such as benefiting the community as a whole in addition to its members, rather than merely arranging for the provision of health care services to its members for a fee.

[7.8.1] 27.8.2.1 (05-25-1999) Medicaid HMO

1. An HMO that arranges for the provision of health care services to its members, consisting exclusively of persons eligible under Medicaid, a comparable state program, or persons having special health care needs, promotes the health of the community if it also actively engages in the following programs that provide related health care services to its members:
   A. Educational programs regarding the benefits available.
   B. Counseling and assistance in making the transition to managed care.
   C. Preventive health care programs.
   D. Coordinating health care services among providers.
   E. Facilitates access to the plan's providers.

[7.8.1] 27.8.2.2 (05-25-1999)
Integral Part

1. An HMO that arranges for the provision of health care services and is part of an IRC 501(c)(3) health care system may qualify for exemption under IRC 501(c)(3) as an integral part of the health care system. See Reg. 1.502-1(b); Rev. Rul. 78-41, 1978-1 C.B. 148.
2. To be considered as an integral part, an HMO must be financially and structurally controlled by either:
   A. One organization in the health care system that is exempt under IRC 501(c)(3), or
   B. Two or more organizations in the health care system that are exempt under IRC 501(c)(3) and related to each other through common control.
3. An HMO must perform an essential function of one or more related IRC 501(c)(3) organizations in the health care system of which it is a part. For related organizations that are hospitals, the HMO must serve only the patients of these hospitals. Thus, the HMO's members must also be patients of the related exempt hospitals. Geisinger Health Plan v. Commissioner 100 T.C. 394 (1993), aff'd on other grounds , 30 F.3d 494 (3rd Cir. 1994); Rev. Rul. 68-374, 1968-2 C.B. 242; Rev. Rul. 68-375, 1968-2 C.B. 245; Rev. Rul. 68-376, 1968-2 C.B. 246.

[7.8.1] 27.8.3 (05-25-1999)
Examination Guidelines for IRC 501(c)(3)

1. The following guidelines should be used for examining an HMO that otherwise satisfies the organizational and operational tests to determine whether it qualifies for exemption under IRC 501(c)(3) on the basis that it promotes health or relieves the poor and distressed.

[7.8.1] 27.8.3.1 (05-25-1999)
Open Enrollment

1. Determine whether the HMO enrolls more than an insubstantial number of persons who generally are unable to obtain affordable health care services or health care insurance, or who have special health care needs, such as:
   A. Individuals;
   B. Employer groups consisting of employers having 50 or fewer employees;
      NOTE:
      The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, § 102; 42 USC § 300gg- 91(e)(4), defines the term "small employer" as an employer who employed an average of at least 2 but not more than 50 employees.
   C. Elderly persons, such as persons qualifying for benefits under Medicare;
   D. Low income persons, such as persons qualifying for benefits under Medicaid, a comparable state program, or who cannot obtain affordable health insurance; and
   E. Other individuals having special health care needs, such as persons who are disabled or who suffer from substance abuse.

[7.8.1] 27.8.3.2 (05-25-1999)
Premium Methodology

1. Determine whether the method the HMO uses to determine the premiums it charges to the members described in IRM 27.8.3.1(1) results in premiums that are generally affordable. A community rating methodology is one method that generally results in premiums that are generally affordable.
2. This guideline does not apply to enrollees who are beneficiaries under Medicaid, a comparable state program, beneficiaries under Medicare, or other persons having special health care needs, where a government agency determines the premiums.

[7.8.1] 27.8.3.3 (05-25-1999)
Community Control

1. Determine whether the HMO is controlled by community interests rather than by health care providers or others who can benefit personally from the HMO's operations. See Sound Health Association v. Commissioner, 71 T.C. 158 (1978); Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3rd Cir. 1993).
   A. An HMO that satisfies the "community benefit standard" discussed above and in Rev. Rul. 69-545 is controlled by community interests.
   B. One factor demonstrating control of an HMO by community interests is an HMO that is controlled by one or more organizations exempt under IRC 501(c)(3), all of which satisfy the "community benefit standard" discussed above.
   C. One factor demonstrating that the HMO has taken sufficient steps to prevent any private inurement or impermissible private benefit is that the HMO has adopted a substantial conflicts of interest policy or is controlled by an IRC 501(c)(3) organization that has adopted a substantial conflicts of interest policy that applies to the HMO.
   D. An HMO that is controlled by one or more organizations exempt under IRC 501(c)(4) is not alone sufficient to demonstrate that the HMO is controlled by community interests.

[7.8.1] 27.8.3.4 (05-25-1999)
Promotion of Health

1. Determine whether as its primary purpose, the HMO operates programs that accomplish the charitable promotion of health as:
   A. A direct provider, consistent with IRM 27.8.1;
   B. An arranger, consistent with IRM 27.8.2; or
   C. As an integral part, consistent with IRM 27.8.2.2.

[7.8.1] 27.8.3.5 (05-25-1999)
Relief of the Poor and Distressed

1. If the HMO does not primarily operate programs that accomplish the charitable promotion of health, determine whether the HMO operates, as its primary purpose, programs that otherwise accomplish charitable purposes, such as the relief of the poor and distressed or of the underprivileged. Reg. 1.501(c)(3)-1(d)(2).

[7.8.1] 27.8.3.5.1 (05-25-1999)
Medicaid HMO

1. An HMO that enrolls only Medicaid beneficiaries, or beneficiaries of a comparable state program, and arranges for the provision of health care services to these individuals by a group

of health care providers, should be considered as providing relief of the poor and distressed because it facilitates the provision of health care services to low-income individuals (a group having special health care needs) if it also actively engages in programs that provide related health care services to its members.

2. Determine whether the Medicaid HMO:
   A. Provides educational programs relating to the benefits available.
   B. Provides counseling and assistance in making the transition to managed care.
   C. Provides preventive health care programs.
   D. Coordinates health care services among providers.
   E. Facilitates access to the plan's providers.

[7.8.1] 27.9 (05-25-1999)
IRC 501(c)(4)

1. To qualify for exemption as an organization described in IRC 501(c)(4), an HMO must be not organized for profit and must be operated exclusively for the promotion of social welfare.
2. An HMO is operated exclusively for the promotion of social welfare if it is primarily engaged in promoting in some way the common good and general welfare of the people of the community. Reg. 1.501(c)(4)-1(a)(2).
3. If an HMO does not qualify for exemption under IRC 501(c)(3), it may qualify for exemption under IRC 501(c)(4). For examination guidelines for IRC 501(c)(4), see IRM 27.9.3.

[7.8.1] 27.9.1 (05-25-1999)
Medicaid HMO

1. An HMO that arranges for the provision of health care services to its members, consisting exclusively of persons eligible under Medicaid, a comparable state program, or persons having special health care needs, and provides its members with related health care education, counseling and preventive health care services, qualifies for exemption under IRC 501(c)(4) if it satisfies the examination guidelines in IRM 27.9.3.

[7.8.1] 27.9.2 (05-25-1999)
Integral Part

1. An HMO that arranges for the provision of health care services to its members and is part of a health care system may qualify for exemption under IRC 501(c)(4) as an integral part of the health care system. See Reg. 1.502-1(b); Rev. Rul. 78-41, 1978-1 C.B. 148.
2. To be considered an integral part, an HMO must be financially and structurally controlled by either:
   A. One organization in the health care system that is exempt under IRC 501(c)(3) or IRC 501(c)(4), or
   B. Two or more organizations in the health care system that are exempt under IRC 501(c)(3) or IRC 501(c)(4) and are related to each other through common control.
3. An HMO must perform an essential function of one or more related IRC 501(c)(3) or IRC 501(c)(4) organizations in the health care system of which it is a part. For related organizations that are hospitals, the HMO must serve only the patients of these hospitals. Thus, the HMO's members must also be patients of the related exempt hospitals. Geisinger Health Plan v. Commissioner , 100 T.C. 394 (1993), aff'd on other grounds , 30 F.3d 494 (3rd Cir. 1994); Rev. Rul. 68-374, 1968-2 C.B. 242; Rev. Rul. 68-375, 1968-2 C.B. 245; Rev. Rul. 68-376, 1968-2 C.B. 246.

[7.8.1] 27.9.3 (05-25-1999)
Examination Guidelines for IRC 501(c)(4)

1. The following guidelines should be used for examining an HMO to determine whether it qualifies for exemption under IRC 501(c)(4).

[7.8.1] 27.9.3.1 (05-25-1999) Organization and Operations

1. Determine whether the HMO is:
   A. Not organized for profit;
   B. Operated exclusively for the promotion of social welfare by primarily engaging in activities that promote the common good and general welfare of the people of the community (Reg. 1.501(c)(4)-1(a)(2)); and
   C. No part of its net earnings inures to the benefit of any private shareholder or individual.

[7.8.1] 27.9.3.2 (05-25-1999) Open Enrollment

1. Determine whether the HMO enrolls more than an insubstantial number of persons who generally are unable to obtain affordable health care services or health care insurance, or who have special health care needs, for example:
   A. Individuals;
   B. Employer groups consisting of employers having 50 or fewer employees;
      NOTE:
      The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, § 102; 42 USC § 300gg-91(c)(4), defines the term "small employer" as an employer who employed an average of at least 2 but not more than 50 employees.
   C. Elderly persons, such as persons who qualify for benefits under Medicare;
   D. Low income persons, such as persons who qualify for benefits under Medicaid or a comparable state program; or
   E. Other individuals who have special health care needs, such as persons who are disabled or who suffer from substance abuse.

[7.8.1] 27.9.3.3 (05-25-1999) Premium Methodology

1. Determine whether the method the HMO uses to determine the premiums it charges to the members described in IRM 27.9.3.2(1) results in premiums that are generally affordable. A community rating methodology is one method that generally results in premiums that are generally affordable.
2. This guideline does not apply to enrollees who are beneficiaries under Medicaid, a comparable state program, beneficiaries under Medicare, or other persons having special health care needs, where a government agency determines the premiums.

[7.8.1] 27.9.3.4 (05-25-1999) Community Control

1. Determine whether the HMO is controlled by community interests rather than by health care providers or others who can benefit personally from the HMO's operations. See Sound Health Association v. Commissioner , 71 T.C. 158 (1978); Geisinger Health Plan , 985 F.2d 1210 (3rd Cir. 1993).
   A. An HMO that satisfies the "community benefit standard" discussed above and in Rev. Rul. 69-545 is controlled by community interests.
   B. One factor demonstrating control of an HMO by community interests is an HMO that is controlled by one or more organizations exempt under IRC 501(c)(3), all of which

satisfy the "community benefit standard" discussed above.

C. One factor demonstrating that the HMO has taken sufficient steps to prevent any private inurement or impermissible private benefit is that the HMO has adopted a substantial conflicts of interest policy or is controlled by an IRC 501(c)(3) organization that has adopted a substantial conflicts of interest policy that applies to the HMO.

D. An HMO that is controlled by one or more organizations exempt under IRC 501(c)(4) is not alone sufficient to demonstrate that the HMO is controlled by community interests.

[7.8.1] 27.10 (05-25-1999) Exemption Precluded by IRC 501(m)

1. An HMO that satisfies the requirements for exemption under IRC 501(c)(3) or IRC 501(c)(4) is precluded from qualifying for exemption if a substantial part of its activities consists of providing commercial-type insurance. IRC 501(m)(1).

[7.8.1] 27.10.1 (05-25-1999) Examination Guidelines for IRC 501(m)

1. In determining whether a substantial part of an HMO's activities consists of providing commercial-type insurance, all the surrounding facts and circumstances should be taken into account.
   A. The law does not define the concept of "substantial," which is dependent on all the facts and circumstances. However, as a safe harbor guideline, if less than 15% of an HMO's activities consists of providing commercial-type insurance, it should be considered that no substantial part of the HMO's activities consists of providing commercial-type insurance.
   B. See, for example, Haswell v. U.S. , 500 F.2d 1133 (Ct. Cl. 1974), cert. den. , 419 U.S. 1107 (1975) (16.6% to 20.5% was "substantial"); Seasongood v. Commissioner , 227 F.2d 907 (6th Cir. 1955) (5% was not "substantial"); Rev. Rul. 71-529, 1971-2 C.B. 234 (less than 15% was not "substantial").
   C. However, if more than 15% of an HMO's activities consists of providing commercial-type insurance, whether a substantial part of the HMO's activities consists of providing commercial-type insurance depends on all the facts and circumstances.
2. In measuring an HMO's activities for a particular year, the following factors should be considered:
   A. That year's activities; or
   B. An average of the activities of that year plus the immediately preceding three years.
3. One factor demonstrating that an HMO's activities do not consist of providing commercial-type insurance is an HMO that has shifted a significant portion of its risk of loss to its primary care providers. See Rev. Rul. 68-27, 1968-1 C.B. 315.
4. An example of an HMO that has shifted a significant portion of its risk of loss to its primary care providers is an HMO that uses one or more of the following methods for compensating its primary care providers:
   A. Salary (and bonus);
   B. Capitated fees; or
   C. Fees-for-service.

   NOTE:

   The fee schedule consists of fees that are substantially discounted; and the fees paid are subject to a substantial withhold.
5. Substantially Discounted Fee Schedule. An example of a substantially discounted fee schedule is a fee schedule that is at least 15% less than the usual and customary fees charged by similarly situated primary care providers for comparable services.
   A. An example of a fee schedule that is not a substantially discounted fee schedule is one that permits the provider to recover the discount. See IRM 27.10.1 for a discussion of the term "substantial."

6. Substantial Withhold. An example of a substantial withhold is a withholding arrangement where the HMO withholds from the primary care provider at least 15% of the discounted fees paid. The provider may recover all or a portion of the amounts withheld based on a variety of factors, for example, if the physician achieves certain predetermined budget goals and certain patient satisfaction standards, quality care standards or efficiency standards.
   A. An example of a withholding arrangement that does not involve a substantial withhold is a compensation system that permits the provider to recover automatically the amount withheld. See IRM 27.10.1 for a discussion of the term "substantial."
7. Whether a fee schedule that is equal to the Medicare fee schedule (Resource Based Relative Value Scale or RBRVS) or the state Medicaid fee schedule shifts a significant portion of the HMO's risk of loss depends on all the facts and circumstances.

[7.8.1] 27.10.2 (05-25-1999)
Risks Assumed by HMO

1. Stop-Loss Insurance. An HMO that compensates providers using a fee-for-service arrangement may obtain stop-loss insurance from an unrelated party to protect itself from a portion of the financial risk associated with operating the HMO. Whether a stop-loss insurance arrangement obtained by an HMO shifts a significant portion of the HMO's risk of loss depends on all the facts and circumstances.
2. Deficit Sharing. An HMO that compensates providers using a fee-for-service arrangement may enter into an arrangement with the providers for the providers to share a portion of the HMO's operating losses. Whether a deficit sharing arrangement that an HMO has with its providers shifts a significant portion of the HMO's risk of loss depends on all the facts and circumstances.
   A. An HMO that has a deficit sharing arrangement with a related organization does not shift a significant portion of its risk of loss because the related organization is part of the HMO's "economic family." See Rev. Rul. 77-316, 1977-2 C.B. 53; Rev. Rul. 78-338, 1978-2 C.B. 107.

[7.8.1] 27.10.3 (05-25-1999)
Statutory Exceptions to Commercial-Type Insurance

1. Certain activities of an HMO should not be considered as providing commercial-type insurance:
   A. An HMO that provides insurance at substantially below cost to a class of charitable recipients. IRC 501(m)(3)(A).
   B. An HMO that provides incidental health insurance of a kind that is customarily provided by HMOs. IRC 501(m)(3)(B).

[7.8.1] 27.10.3.1 (05-25-1999)
Examination Guidelines for IRC 501(m)(3)(A)

1. The following guidelines should be used for examining an HMO to determine whether insurance that it provides is substantially below cost to a class of charitable recipients.
2. An HMO that contracts with a government agency to directly provide or arrange for the provision of health care services to persons who have special health care needs, such as persons who are Medicaid beneficiaries, indigent, disabled or substance abusers, should not be considered as providing commercial-type insurance at substantially below cost.
   A. See Rev. Rul. 71-529, 1971-2 C.B. 234; H.R. Rept. No. 99-426, 99th Cong., 2d Sess. 662 (1986), 1986-3 C.B. Vol. 2 664; Nonprofits' Insurance Alliance of California v. U.S. , 94-2 USTC (CCH) ¶ 50,593 (Fed. Cl. 1994); and Paratransit Insurance Corporation , 102 T.C. 745 (1994).

[7.8.1] 27.10.3.2 (05-25-1999)
Examples Under IRC 501(m)(3)(B)

1. Examples of incidental health insurance of a kind that is customarily provided by HMOs are:
   A. Dental care, vision care and mental health care services. See H.R. Conf. Rep. No. 100-1104, 100th Cong. 2d Sess II-9 (1988).
   B. Inpatient and outpatient hospital services, specialist physician services and ancillary health care services that are provided by an HMO as a result of referral by a member's primary care provider under a managed care arrangement.
   C. Point-of-service benefits relating to emergency health care services provided to the HMO's members out of the HMO's service area.

[7.8.1] 27.11 (05-25-1999)
Unrelated Trade or Business

1. If an HMO that satisfies the requirements for exemption under IRC 501(c)(3) or IRC 501(c)(4) is not precluded by IRC 501(m) from qualifying for exemption, any commercial-type insurance activities of the HMO should be considered as an unrelated trade or business and the HMO should be considered as an insurance company for applying Subchapter L to such activity. IRC 501(m)(2).

[7.8.1] 27.11.1 (05-25-1999)
Examination Guidelines for IRC 501(m)(2)

1. For guidelines to determine whether any activities of an HMO constitute the provision of commercial-type insurance, see IRM 27.10.1 and IRM 27.10.2.
2. Premiums that are not directly related to commercial-type insurance activities should be allocated. Allocations should be based on all the facts and circumstances. In making allocations, direct expenses paid to providers for commercial-type insurance activities and total numbers of patient encounters should be taken into account.
3. Expenses that are not directly related to commercial-type insurance activities should be allocated. Allocations should be based on all the facts and circumstances. In making allocations, premiums paid directly for commercial-type insurance should be taken into account.

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(05-25-1999)

APPENDIX O

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Good Governance Practices for 501(c)(3) Organizations

The Internal Revenue Service believes that governing boards should be composed of persons who are informed and active in overseeing a charity's operations and finances. If a governing board tolerates a climate of secrecy or neglect, charitable assets are more likely to be used to advance an impermissible private interest. Successful governing boards include individuals not only knowledgeable and passionate about the organization's programs, but also those with expertise in critical areas involving accounting, finance, compensation, and ethics.

Organizations with very small or very large governing boards may be problematic: Small boards generally do not represent a public interest and large boards may be less attentive to oversight duties. If an organization's governing board is very large, it may want to establish an executive committee with delegated responsibilities or establish advisory committees.

The Internal Revenue Service strongly recommends that organizations review and consider adopting the following nine recommendations to help ensure that directors understand their roles and responsibilities and actively promote good governance practices. While adopting a particular practice is not a requirement for exemption, an organization that adopts some or all of these practices is more likely to be successful in pursuing its exempt purposes and earning public support. Moreover, any decision by the Service to conduct a review of operations[1] subsequent to exemption is required will be influenced by whether an organization has voluntarily adopted good governance practices.

1. Mission Statement
2. Code of Ethics
3. Due Diligence
4. Duty of Loyalty
5. Transparency
6. Fundraising Policy
7. Financial Audits
8. Compensation Practices
9. Document Retention Policy

1. The Review of Operations (ROO) unit within Exempt Organizations Examinations follows up on certain organizations within the first three years of their obtaining exempt status.

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1. Mission Statement

A clearly articulated mission statement that is adopted by an organization's board of directors will explain and popularize the charity's purpose and serve as a guide to the organization's work. A well-written mission statement shows why the charity exists, what it hopes to accomplish, and what activities it will undertake, where, and for whom.

2. Code of Ethics

The public expects a charity to abide by ethical standards that promote the public good. The board of directors bears the ultimate responsibility for setting ethical standards and ensuring they permeate the organization and inform its practices. To that end, the board should consider adopting and regularly evaluating a code of ethics that describes behavior it wants to encourage and behavior it wants to discourage. The code of ethics should be a principal means of communicating to all personnel a strong culture of legal compliance and ethical integrity.

The board of directors should adopt an effective policy for handling employee complaints and establish procedures for employees to report in confidence suspected financial impropriety or misuse of the charity's resources. Such policies are sometimes referred to as whistleblower policies.

3. Due Diligence

The directors of a charity must exercise due diligence consistent with a duty of care that requires a director to act:

- In good faith;
- With the care an ordinarily prudent person in a like position would exercise under similar circumstances;
- In a manner the director reasonably believes to be in the charity's best interests.

Directors should see to it that policies and procedures are in place to help them meet their duty of care. Such policies and procedures should ensure that each director:

- Is familiar with the charity's activities and knows whether those activities promote the charity's mission and achieve its goals;
- Is fully informed about the charity's financial status; and
- Has full and accurate information to make informed decisions.

4. Duty of Loyalty

The directors of a charity owe it a duty of loyalty. The duty of loyalty requires a director to act in the interest of the charity rather than in the personal interest of the director or some other person or organization. In particular, the duty of loyalty requires a director to avoid conflicts of interest that are detrimental to the charity. To that end, the board

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of directors should adopt and regularly evaluate an effective conflict of interest policy[2] that:

- Requires directors and staff to act solely in the interests of the charity without regard for personal interests;
- Includes written procedures for determining whether a relationship, financial interest, or business affiliation results in a conflict of interest; and
- Prescribes a certain course of action in the event a conflict of interest is identified.

Directors and staff should be required to disclose annually in writing any known financial interest that the individual, or a member of the individual's family, has in any business entity that transacts business with the charity.

5. Transparency

By making full and accurate information about its mission, activities, and finances publicly available, a charity demonstrates transparency. The board of directors should adopt and monitor procedures to ensure that the charity's Form 990, annual reports, and financial statements are complete and accurate, are posted on the organization's public website, and are made available to the public upon request.

6. Fundraising Policy

Charitable fundraising is an important source of financial support for many charities. Success at fundraising requires care and honesty. The board of directors should adopt and monitor policies to ensure that fundraising solicitations meet federal and state law requirements and solicitation materials are accurate, truthful, and candid. Charities should keep their fundraising costs reasonable. In selecting paid fundraisers, a charity should use those that are registered with the state and that can provide good references. Performance of professional fundraisers should be continuously monitored.

7. Financial Audits

Directors must be good stewards of a charity's financial resources. A charity should operate in accordance with an annual budget approved by the board of directors. The board should ensure that financial resources are used to further charitable purpose by regularly receiving and reading up-to-date financial statements including Form 990, auditor's letters, and finance and audit committee reports.

If the charity has substantial assets or annual revenue, its board of directors should ensure that an independent auditor conduct an annual audit. The board can establish an independent audit committee to select and oversee the independent auditor. The auditing firm should be changed periodically (e.g., every five years) to ensure a fresh look at the financial statements.

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2 Appendix A to the Form 1023 instructions contains a sample conflict of interest policy.

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For a charity with lesser assets or annual revenue, the board should ensure that an independent certified public accountant conduct an annual audit.

Substitute practices for very small organizations would include volunteers who would review financial information and practices. Trading volunteers between similarly situated organizations who would perform these tasks would also help maintain financial integrity without being too costly.

8. Compensation Practices

A successful charity pays no more than reasonable compensation for services rendered. Charities should generally not compensate persons for service on the board of directors except to reimburse direct expenses of such service. Director compensation should be allowed only when determined appropriate by a committee composed of persons who are not compensated by the charity and have no financial interest in the determination.

Charities may pay reasonable compensation for services provided by officers and staff. In determining reasonable compensation, a charity may wish to rely on the rebuttable presumption test of section 4958 of the Internal Revenue Code and Treasury Regulation section 53.4958-6.

9. Document Retention Policy

An effective charity will adopt a written policy establishing standards for document integrity, retention, and destruction. The document retention policy should include guidelines for handling electronic files. The policy should cover backup procedures, archiving of documents, and regular check-ups of the reliability of the system. For more information see IRS Publication 4221, Compliance Guide for 501(c)(3) Tax-Exempt Organizations, available on the IRS website.

APPENDIX P

Internal Revenue Service

memorandum

date: ***05/11/07***

to: Director, Exempt Organizations, Examinations SE:T:EO:E
Director, Exempt Organizations, Rulings & Agreements SE:T:EO:RA

From: Director, Exempt Organizations SE:T:EO
/s/ *Lois G. Lerner*

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subject: Hospitals Providing Financial Assistance to Staff Physicians Involving Electronic Health Records

The purpose of this memorandum is to provide a directive for handling examination and exemption application cases involving hospitals that provide physicians who have staff privileges at those hospitals ("medical staff physicians") with financial assistance to acquire and implement software that is used predominantly for creating, maintaining, transmitting, or receiving electronic health records ("EHRs") for their patients.

Many hospitals described in section 501(c)(3) of the Internal Revenue Code ("Code") plan to establish interoperable EHR systems to improve the effectiveness and efficiency of their medical care and to reduce medical errors. Some hospitals believe that their medical staff physicians need a financial incentive to acquire and implement EHR software that would allow the physicians to connect to the hospitals' EHR systems. On August 8, 2006, the U.S. Department of Health and Human Services ("HHS") issued final regulations (see 42 C.F.R. Section 411.357 and 42 C.F.R. Section 1001.952) ("HHS EHR Regulations") that allow hospitals to provide, within specific parameters, EHR software and technical support services ("Health IT Items and Services") to their medical staff physicians without violating the federal anti-kickback law, 42 USC §1320a-7b and physician self-referral law, 42 USC §1395nn.

We will not treat the benefits a hospital provides to its medical staff physicians as impermissible private benefit or inurement in violation of section 501(c)(3) of the Code if the benefits fall within the range of Health IT Items and Services that are permissible under the HHS EHR Regulations and the hospital operates in the manner described below.

A hospital that is otherwise described in section 501(c)(3) of the Code enters into Health IT Subsidy agreements with its medical staff physicians for the provision of Health IT Items and Services at a discount ("Health IT Subsidy Arrangements"). These Health IT Subsidy Arrangements require both the hospital and the participating physicians to comply with the HHS EHR Regulations on a continuing basis. The Health IT Subsidy Arrangements provide that, to the extent permitted by law, the hospital may access all of

the electronic medical records created by a physician using the Health IT Items and Services subsidized by the hospital. The hospital ensures that the Health IT Items and Services are available to all of its medical staff physicians. The hospital provides the same level of subsidy to all of its medical staff physicians or varies the level of subsidy by applying criteria related to meeting the healthcare needs of the community.

This memorandum does not apply to a hospital that allows its earnings to inure to the benefit of one or more medical staff physicians through arrangements that are other than Health IT Subsidy Arrangements, because the hospital would not be considered to be described in section 501(c)(3) of the Code.

If you have any questions regarding this memorandum, please contact Stephen Clarke at 202-283-9474, or Steven Grodnitzky at 202-283-8941.

Q&A on Hospitals' Health IT Subsidy Arrangements with Medical Staff Physicians (as described in May 11, 2007 Field Memorandum)

Q1 — What if a hospital's Health IT Subsidy Arrangements with its medical staff physicians aren't entirely consistent with the conditions in the Memorandum? Would those arrangements result in impermissible private benefit or inurement?

A1 — Such arrangements will not be covered by the "safe harbor" described in the Memorandum. However, they will not necessarily generate impermissible private benefit or inurement, because the Memorandum is not meant to set forth the only permissible Health IT Subsidy Arrangement between hospitals and physicians. Rather, the facts and circumstances of any arrangement that does not meet the conditions described in the Memorandum will need to be reviewed to determine if it results in any impermissible private benefit or inurement.

Q2 -- What is meant in the Memorandum by "financial assistance" and "subsidies" to medical staff physicians to acquire and implement electronic health records ("EHR")-related software and services that would enable the physicians to connect to the hospitals' EHR systems?

A2 – Consistent with the HHS regulations referenced in the Memorandum, "financial assistance" and "subsidy" do not include cash payments from the Hospital to the physicians. Rather, they refer to arrangements in which the hospital provides the physician with EHR-related software or information technology and training services, and the physician contributes a portion of the cost.

Q3 – What if the hospital provides a Health IT Subsidy to a "disqualified person" as defined in section 4958?

A3 – Assuming that the hospital meets all the conditions described in the Memorandum, the agent will not treat such Health IT Subsidy Arrangement as an excess benefit transaction.

Q4 -- What if the agent finds inurement to a medical staff physician outside the context of the Health IT Subsidy Arrangement?

A4 -- If the agent finds that the hospital's net earnings have inured to the benefit of one or more medical staff physicians outside the context of such arrangement, then the hospital would not be covered by the safe harbor set forth in the memorandum. Although the safe harbor would not apply in this situation, a determination of whether the Health IT Subsidy Arrangement results in impermissible private benefit or inurement will depend on all the facts and circumstances.

Q5 -- What type of restrictions, if any, may a medical staff physician impose on the hospital's access to electronic medical records created by the physician using the Health IT Items and Services subsidized by the hospital?

A5 – A physician may deny a hospital access to such records if that access would violate federal and state privacy laws or the physician's contractual obligations to patients. Also, the hospital and physician may agree on reasonable conditions to the hospital's access. For example, their agreement could allow the hospital to access a patient's medical records only when that patient becomes a patient of the hospital, and could deny the hospital access to non-medical information such as billing, insurance eligibility, and referral information.

Q6 -- Does the hospital have to ensure that the Health IT Items and Services are available to all of its medical staff physicians at the same time?

A6 --The hospital may provide access to various groups of physicians at different times according to criteria related to meeting the health care needs of the community. The hospital should establish a plan for providing such access.

APPENDIX Q

IRC 509(a)(3) Supporting Organizations Guide Sheet

INSTRUCTIONS: This guide sheet is designed to assist in determining public charity status under IRC 509(a)(3). Items on this guide sheet are written in the present tense; however, answers should be based on present and planned activities.

NOTE: *The guide sheet asks for more information than is currently requested by Schedule D of Form 1023 because of changes made by the Pension Protection Act of 2006 (PPA of 2006) and the need for heightened scrutiny because some supporting organizations are being used to inappropriately benefit private interests.* ***In addition, asterisks (*) are placed next to questions that cross reference information contained in Form 1023.*** *When using this guide sheet, please reference the Guide Sheet Explanation for information that will help explain these questions.*

PART 1: Relationship Requirement under IRC 509(a)(3)(B)

An organization must answer "Yes" to IA(1), IIA(1), or III(A) of this PART 1 to qualify as a supporting organization.

I. Type I – "Operated, Supervised or Controlled By"

A(1). Is the supporting organization seeking to meet the "operated, supervised or controlled by" relationship test with respect to one or more IRC 509(a)(1) or (2) organizations? If "Yes," continue. If "No," skip to II below.
***A(2).** Are a majority of the supporting organization's officers, directors, or trustees appointed or elected by a supported organization's officers, directors, trustees or membership? F. 1023, Schedule D, Sec. II .1
A(3). Does the supporting organization accept gifts or contributions from any person (other than a public charity described in IRC 509(a)(1), (2) or (4)) who directly or indirectly controls the governing body of a supported organization (alone, or together with family members or a 35% controlled organization)? If "No," proceed to the next question. If "Yes," the organization does not meet this requirement.
***A(4).** Does the organization support organizations that are not organized in the United States? If "No," proceed to Part 2. If "Yes," proceed to the next questions since there must be a yes answer to one of these questions for the organization to qualify under IRC 509(a)(3). F. 1023, Part VIII, 14a.
A(4)(a). Is the foreign supported organization recognized by the IRS as exempt under IRC 501(c)(3) and a public charity under IRC 509(a)(1) or (2)? OR
A(4)(b). Is the foreign supported organization described in IRC 501(c)(3) and a public charity described under IRC 509(a)(1) or (2)?

II. Type II – "Supervised or Controlled in Connection With"

A(1). Is the organization seeking to meet the "supervised or controlled in connection with" relationship test with respect to one or more IRC 509(a)(1) or (2) organizations? If "Yes," continue. If "No," skip to III below.
***A(2).** Is control or management of the supporting organization placed with the same persons that control or manage the supported organization? F. 1023, Schedule D, Sec. II.2
***A(3).** Does the organization support organizations that are not organized in the United States? If "No," proceed to Part 2. If "Yes," proceed to the next questions since there must be a yes answer to one of these questions for the organization to qualify under IRC 509(a)(3). F. 1023, Part VIII, 14a.
A(3)(a). Is the foreign supported organization recognized by the IRS as exempt under IRC 501(c)(3) and a public charity under IRC 509(a)(1) or (2)? OR
A(3)(b). Is the foreign supported organization described in IRC 501(c)(3) and a public charity described under IRC 509(a)(1) or (2)?

III. Type III – "Operated in Connection With"

A(1) Is the organization seeking to meet the "operated in connection with" relationship test with respect to one or more IRC 509(a)(1) or (2) organizations? If "No," stop and see the Guide Sheet Explanation. If "Yes," continue. To qualify, an organization must meet the requirements under A(2), A(3), B(1) and B(2).
A(2) Does the supporting organization accept gifts or contributions from any person (other than a public charity described in IRC 509(a)(1), (2) or (4)) who directly or indirectly controls the governing body of a supported organization (alone, or together with family members or a 35% controlled organization)? If "No," proceed to the next question. If "Yes," the organization does not meet this requirement.
***A(3)** Does the organization support organizations that are not organized in the United States? If "No," proceed to Part 2. If "Yes," the organization does not meet this requirement unless it meets a transition rule. See the Guide Sheet Explanation for the transition rule. F. 1023, Part VIII.14a.

Responsiveness Test
***B(1).** Does the organization meet the *responsiveness test*? To qualify there must be a "Yes" answer to questions (a), (b) or (c) plus a "Yes" answer to question (d). For trusts in existence prior to August 17, 2006, see the Guide Sheet Explanation for a description of the alternative responsiveness test. F. 1023, Schedule D, Section II.4. a-d.

* (a). Do the officers, directors, trustees, or membership of the supported organization(s) elect or appoint one or more of the supporting organization's officers, directors, or trustees? F. 1023, Schedule D, Section II.4.a
*(b). Are one or more members of the governing bodies of the supporting organization also officers, directors, or trustees or hold other important offices in the supported organization(s)? F. 1023, Schedule D, Section II.4.b
*(c). Do the officers, directors, or trustees of the supporting organization maintain a close and continuous working relationship with the officers, directors, or trustees of the supported organization(s)? F. 1023, Schedule D, Section II.4.c
*(d). By reason of the relationship described above in (a), (b) or (c), does the supported organization(s) have a significant voice in the supporting organization's investment policies, the timing of grants, the manner of making grants, or the selection of recipients of grants? F. 1023, Schedule D, Section II.4.d

Integral Part Test
B(2). Does the organization meet the *integral part test*? A Type III supporting organization must meet the integral part test requirements by meeting either question B(2)(a) or question B(2)(b). Question B(2)(a) asks about the "payout/attentiveness" part of the integral part test, which requires that a supporting organization distributes payments to support at least one supported organization sufficient to ensure its attentiveness. Question B(2)(b) asks about the "but for" part of the integral part test, which requires that a supporting organization provides services or programs to support at least one supported organization that it would otherwise undertake for itself.

NOTE
The existing integral part test regulations at Reg. 1.509(a)-4(i)(3)(i) will be modified to implement certain provisions of the PPA of 2006. Since the existing integral part test regulations are still in effect, questions (B)(2)(a) and B(2)(b) are designed to demonstrate whether an organization meets the existing integral part test. The PPA of 2006 also established two new categories for Type III supporting organizations: (1) functionally integrated Type III supporting organizations described in IRC 509(d) and 4943(f)(5)(B), and (2) Type III supporting organizations that are not functionally integrated. Until final regulations are issued that provide the criteria for Type III supporting organization that are functionally integrated, determination letters will generally be issued without categorizing a Type III supporting organization as functionally integrated or not functionally integrated. However, an advance notice of proposed rulemaking was issued in which criteria is provided for determining whether a Type III supporting organization is functionally integrated. [Advance Notice of Proposed Rulemaking (ANPRM), 72 Fed. Reg. 42335 (Aug. 2, 2007) (to be codified at 26 C.F.R. pt. 1). This ANPRM is available from the IRS website at "Charities and Nonprofits" under the

heading "Payout Requirements for Certain Supporting Organizations – Advance Notice of Proposed Rulemaking."] If a Type III supporting organization chooses to meet the ANPRM criteria applicable to a functionally integrated Type III supporting organization before regulations are finalized, the IRS may issue it a determination letter that classifies it as a functionally integrated Type III supporting organization. In this situation, the organization would have to meet the responsiveness test referenced in question B(1); the existing "but for" test referenced in question B(2)(b); and the advance notice of proposed rulemaking criteria referenced in question B(2)(c). See the Guide Sheet Explanation for further information about the type of determination letter that will be issued to Type III supporting organizations.

"Payout/Attentiveness" Part

B(2)(a). Is the organization seeking to be a Type III supporting organization that meets the "payout/attentiveness" part of the integral part test of Reg. 1.509(a)-4(i)(3)(iii)? If "Yes," there must be "Yes" answers to B(2)(a)(i) and B(2)(a)(ii). If "No," skip to question B(2)(b).
***B(2)(a)(i).** *The Payout Requirement* Does the supporting organization pay substantially all (85%) of its adjusted net income to or for the use of the supported organization(s)? If "Yes," go to B(2)(a)(ii). If "No," the organization does not meet the payout requirement. F. 1023, Schedule D, Section II.6.a.
B(2)(a)(ii). *The Attentiveness Requirement* The answer must be "Yes" to Cluster 1, Cluster 2, Cluster 3, or Cluster 4.

Cluster 1

To meet Cluster 1, the answers must be "Yes" to (a) and (b).

(a). Is the payout to one or more of the supported organizations large enough to ensure the attentiveness of the organization(s) to the operations of the supporting organization (equals 10% or more of the supported organization's (1) total support for the year, or (2) support for the year received by a department where the supported organization is a school, hospital, or church)?
(b). Does a substantial amount of the supporting organization's total support (one-third of the supporting organization's income for the year) go to those publicly supported organizations that meet the attentiveness requirement described in (a) above?

Cluster 2

To meet Cluster 2, the answers must be "Yes" to (a) through (e).

(a). Are the payments sufficiently significant to ensure the attentiveness of the supported organization(s) because they are earmarked for a particular substantial program or activity of the supported organization(s) that would not exist or would be interrupted without the payment?
(b). Does the supporting organization provide 50% or more of the funding of the earmarked program or activity?
(c). Is the supporting organization funding the same earmarked program continuously year after year?
(d). Is the earmarked program a substantial program?
(e). Does a substantial amount of the supporting organization's total support (one-third of the supporting organization's income for the year) go to those publicly supported organizations that meet this earmarked attentiveness requirement?

Cluster 3

To meet Cluster 3, the answer must be "Yes" to (a).

(a). Is/are the supported organization(s)' attentive to the supporting organization based on all the pertinent facts and circumstances, including the length and nature of the relationship; the number of other supported organizations the supporting organization supports; the percentage of support contributed by the supporting organization to the supported organization's total support; evidence of actual attentiveness; and a substantial identity of interests between the supporting organizations and its supported organizations?

Cluster 4

To meet Cluster 4, the answers must be "Yes" to (a) or (b) and to (c), (e) and (h). The answers must be "No" to (d), (f) and (g).

(a). Was the supporting organization a trust whether or not exempt from taxation under IRC 501(a) on November 20, 1970?
(b). Was the supporting organization an irrevocable split-interest trust described in IRC 4947(a)(2) before November 20, 1970, and that subsequently became a charitable trust described in IRC 4947(a)(1)?
(c). Are all of the unexpired interests in the trust devoted to one or more charitable purposes for which a deduction was allowed with respect to such interest under IRC 170, 545(b)(2), 556, 642(c), 2055, 2106(a)(2), 2522 or corresponding provisions of prior law?
(d). Did the trust receive any grant, contribution, bequest or other transfer on or after November 20, 1970?
(e). Is all of the supporting organization's net income distributed to benefit the supported organization(s)?
(f). Do the supporting organization's trustees have a right to vary beneficiaries or amounts?

(g) Do disqualified persons described in IRC 4946 (other than foundation managers) serve as trustees?
(h) Do the trustees of the supporting organization provide annual written reports to the supported organization(s) describing the supporting organization's assets and income?

"But For" Part

B(2)(b). Is the organization seeking to be a Type III supporting organization that meets the "but for" part of the integral part test of Reg. 1.509(a)-4(i)(3)(ii)? If "Yes," there must be "Yes" answers to B(2)(b)(i) and (ii). If "No," skip to B(2)(c).
B(2)(b)(i). Does the supporting organization engage in activities, not including grant making, for or on behalf of supported organization(s) that perform the functions of or carry on the purposes or programs of the supported organization(s)? If Yes, proceed to question B(2)(b)(ii).
B(2)(b)(ii). Would the supported organization(s) normally undertake such activity but for the involvement of the supporting organization?

Functionally Integrated

B(2)(c). Functionally Integrated Type III Supporting Organization Is the organization seeking to be classified as a functionally integrated Type III supporting organization? If "Yes," proceed to question B(2)(c)(i) and B(2)(c)(ii).

B(2)(c)(i). Is there a "Yes" to B(2)(b)(i) and B(2)(b)(ii)? If "No," the organization does not qualify to obtain a functionally integrated Type III supporting organization determination at this time. If "Yes," continue to B(2)(c)(ii).

B(2)(c)(ii). Does the organization represent that it will satisfy the ANPRM criteria applicable to functionally integrated Type III supporting organizations? If "No," the organization does not qualify to obtain a functionally integrated Type III supporting organization determination at this time. If "Yes," the organization may qualify to receive a determination letter that classifies it as a functionally integrated Type III supporting organization. See the Guide Sheet Explanation.

PART 2: Organizational Test under IRC 509(a)(3)(A)

An organization must meet the organizational test to qualify under IRC 509(a)(3). If a supporting organization does not meet either I or II, it is not qualified under IRC 509(a)(3). Special organizational test rules pertain to supporting organizations that support IRC 501(c)(4), (5) or (6) organizations. Therefore, complete PART 5 rather than

this PART 2 to demonstrate that an organization meets the organizational test where it seeks to qualify under IRC 509(a)(3) because it is supporting an IRC 501(c)(4), (5) or (6) organization.

I. Organizational Test for a Type I or II Supporting Organization

A. Is the supporting organization requesting classification as a Type I or II supporting organization? If "Yes," to satisfy the organizational test there must be a yes answer to one of the questions B, C or D below. In addition, all three components of question E must be met.
***B.** Does the supporting organization's organizing document specify by name the IRC 509(a)(1) or (2) organization(s) it supports? If "Yes," skip to E below. F. 1023, Schedule D, Section III.1.a OR,
***C.** Does the supporting organization's organizing document identify the IRC 509(a)(1) or (2) organization(s) it supports by class or purpose? If "Yes," skip to E below. F. 1023, Schedule D, Section III.1.a
D. Do the supporting organization and the supported organization(s) have a historic and continuing relationship such that there is a substantial identity of interests between the two organizations?
E. To meet the organizational test, there must be a "Yes" answer to E(1) and "No" answers to E(2) and E(3).

E(1). Does the organization's organizing document limit its purposes to provide that it is organized, and at all times thereafter is operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more specified 509(a)(1) or (a)(2) organizations?
E(2). Does the organization's organizing document expressly empower it to engage in activities which are not in furtherance of the purposes stated in (E)(1) above?
E(3). Does the organization's organizing document expressly empower it to operate to support or benefit any organization not specified by name, purpose, or class in its organizing document?

II. Organizational Test for a Type III Supporting Organization

A. Is the supporting organization requesting classification as a Type III supporting organization? If "Yes," there must be a yes answer to either question B or C below. In addition, all three components of question D must be met.
***B.** Does the supporting organization's organizing document specify by name the IRC 509(a)(1) or (a)(2) organization(s) it supports? F. 1023, Schedule D, Section III.1.b

C. Do the supporting organization and the supported organization(s) have a historic and continuing relationship such that there is a substantial identity of interests between the two organizations?
D. To meet the organizational test, there must be a "Yes" answer to D(1) and "No" answers to D(2) and D(3).

D(1). Does the organization's organizing document limit its purposes to provide that it is formed for the benefit of, to perform the functions of, or to carry out the purposes of one or more specified publicly supported organizations or provide some other statement committing the supporting organization to support or benefit publicly supported organizations?
D(2). Does the organization's organizing document expressly empower it to engage in activities which are not in furtherance of the purposes stated in D(1)?
D(3). Does the organization's organizing document expressly empower it to operate to support or benefit any organization not specified by name in its organizing document?

PART 3: Operational Test under IRC 509(a)(3)(A)

An organization must meet the operational test to qualify under IRC 509(a)(3). If an organization does not meet the requirements of either A or B (or a combination of A and B) below, it does not met the operational test.

A. Does the organization make payments to or for the use of the specified IRC 509(a)(1) or (2) organizations? If "No," skip to B. If "Yes," to meet the operational test there must be a "Yes" to 1, 2, 3 or 4.

***1.** Does the organization make payments only to or for the use of one or more specified IRC 509(a)(1) or (2) organization(s)? F. 1023, Part VI.1.b.
***2.** Does the organization make payments to or for the use of individual members of the charitable class benefited by the specified IRC 509(a)(1) or (2) organization(s)? F. 1023, Part VI. 1.a and 2.
3. Does the organization make payments indirectly through another unrelated organization to or for the use of a member of a charitable class benefited by the specified IRC 509(a)(1) or (2) organization(s), but only if the payment constitutes a grant to an individual rather than a grant to an organization?
4. Does the organization make payments to or for the use of another supporting organization that also supports or benefits the specified IRC 509(a)(1) or (2) organization(s)?.

B. Does the organization provide services or facilities to or for the use of the specified IRC 509(a)(1) or (2) organization(s)? If "No," the organization must meet A to meet the operational test. If "Yes," to meet the operatonal test there must be a "Yes" to 1, 2 or 3 below.

***1.** Does the organization provide services or facilities only to or for the use of one or more specified IRC 509(a)(1) or (2) organization(s)? F. 1023, Part VI.1.b.
***2.** Does the organization provide services or facilities to or for the use of individual members of the charitable class benefited by the specified IRC 509(a)(1) or (2) organization(s)? F. 1023, Part VI. 1.a and 2.
3. Does the organization provide services or facilities to or for the use of another supporting organization that also supports or benefits the specified IRC 509(a)(1) or (2) organization(s)?

PART 4: Control Test – IRC 509(a)(3)(C)

I. An IRC 509(a)(3) organization cannot be controlled by disqualified persons (other than foundation managers).

***A.** Is the organization controlled directly or indirectly by disqualified persons because disqualified persons on the governing board can potentially aggregate their votes together to control the operations of the supporting organization? ["No" required] F. 1023, Schedule D, Section IV.1.c
***B.** Is the organization controlled directly or indirectly by disqualified persons because disqualified persons on the governing board can potentially aggregate their votes together with other board members who provide personal services to the disqualified persons, such as legal, accounting, or investment advice, to control the operations of the supporting organization? ["No" required] F. 1023, Schedule D, Section IV.1.b
***C.** Do disqualified persons have the right to appoint the nominating committee or successor governing board members? ["No" required] F. 1023, Schedule D, Section IV.1.a
D. Is the organization controlled directly by disqualified persons because the disqualified persons either have 50% of the voting power on the governing board or a veto power over the supporting organization's activities? ["No" required]
E. Is the organization controlled directly or indirectly by disqualified persons because disqualified persons have veto power over the supporting organization's activities? ["No" required]

F. Is the organization controlled directly because the disqualified persons control the primary assets of the supporting organization? ["No" required]
G. Does a disqualified person own a general partnership interest in a limited partnership in which the supporting organization owns an interest?
H. Does a disqualified person own an interest of 51% or more of the voting stock of a corporation in which the supporting organization is a stockholder?
I. Does a disqualified person hold 51% or more control of a corporation through a voting trust or other voting arrangement in which the supporting organization is a stockholder?
J. Does a disqualified person have a controlling interest in a limited liability corporation (LLC) in which the supporting organization has an interest?
K. Does a disqualified person have an ownership interest in assets such as real estate, insurance, art work, collectibles, intellectual property, promissory notes, or other assets in which the supporting organization also has an interest?
L. Do donors or their family members have the right to provide advice to the supporting organization regarding investments or grant making? See the Guide Sheet Explanation.
M. Taking into account all of the facts and circumstances, including information described in questions G through L, are disqualified persons in a position to directly or indirectly control the decisions made by the supporting organization?

PART 5: Special Rules Pertaining to Supporting Organizations that Support IRC 501(c)(4),(5) or (6) Organizations – Reg. 1.509(a)-4(c)(1)

A. Does the supporting organization claim to support an IRC 501(c)(4), (5) or (6) organization? If "Yes," proceed to questions B through E; if "No," go to PART 6.
B. Does the IRC 501(c)(4), (5) or (6) organization meet the public support tests of IRC 509(a)(2)?
C. Does the supporting organization meet the organizational test? See the Guide Sheet Explanation.
D. Does the supporting organization meet the Type I or II relationship requirement?
E. Does the supporting organization have sufficient safeguards to ensure its support is used exclusively for charitable purposes?

PART 6: Organizations Requiring Heightened Scrutiny

Most supporting organizations further legitimate charitable purposes. However, some taxpayers may seek to shield assets inappropriately through supporting organizations. This has resulted in the need for heightened scrutiny of supporting organizations generally to screen for those where there is a significant potential for abuse. The typical

Type I or II supporting organization that supports a hospital, university, or other large charitable institution generally does not raise the private benefit concerns that require heightened scrutiny. The questions below are aimed at identifying situations that raise potential for impermissible private benefit. Additional questions needed to develop an issue should be tailored to the organization's specific situation.

I. Promoters - For purposes of completing this guide sheet, a promoter is a person who organizes or assists in the organization of a partnership, trust, investment plan, or any other entity or arrangement that is to be sold to a third party and is designed to be used or is actually used by that third party to obtain tax benefits not allowable by the Internal Revenue Code.

A. Are any promoters identified with the establishment or operation of the supporting organization?
B. Does the supporting organization benefit a list of more than five supported organizations?

II. Unreasonable Compensation/Loans

***A.** Are goods, services, or cash provided to donors or their family members or persons with whom they have business relationships? F. 1023, Part V.7.a-b
***B.** Are the goods, services, or cash provided to donors or their family members or persons with whom they have business relationships part of reasonable compensation arrangements? F. 1023, Part V.7.a-b
***C.** Are goods, services, or cash provided to officers, directors, or trustees? F. 1023, Part V.7.a-b
***D.** Are the goods, services, or cash provided to officers, directors, or trustees part of reasonable compensation arrangements? F. 1023, Part V.7.a-b
***E.** Are the goods, services, or cash provided to the five highest compensated employees or independent contractors part of reasonable compensation arrangements? F. 1023, Part V.7.a-b
***F.** Is there evidence of any loan activity? F.1023, Part V.8.a-f and Part IX. Balance Sheet
***G.** Are loans made to donors or their family members or persons with whom they have a business relationship, to officers, directors, or trustees, or to the five highest compensated employees or independent contractors? F. 1023, Part V.8.a-f and 9a
***H.** Are the loans made to donors or their family members or persons with whom they have a business relationship, to officers, directors, or trustees, or to the five highest compensated employees or independent contractors part of reasonable compensation arrangements? F. 1023, Part V.8 a-f and 9a

III. Closely Held Stock/Non-Liquid Investments/Assets That Do Not Produce Current Income

A. Does the supporting organization hold closely held stock? F. 1023, Part VIII.11 and Part IX, Balance Sheet
***B.** Does the supporting organization hold an interest in a partnership or limited liability company in which the donor retains an interest as a general partner or member? F. 1023, Part VIII.8 and Part IX, Balance Sheet
C. Does the supporting organization own significant other investments ($100,000 or more) that are not explained in detail? F.1023, Part IX, Balance Sheet
D. Does the supporting organization own significant land ($100,000 or more)? F. 1023, Part VIII.11 and Part IX, Balance Sheet
***E.** Does the supporting organization own significant other property ($100,000 or more) that does not produce current income? F. 1023, Part VIII. 10-11 and Part IX, Balance Sheet
F. Does the supporting organization own life insurance on the donor's life or the life of the donor's family member? F. 1023, Part IX, Balance Sheet
***G** Does the supporting organization own more than 20% of the stock of a corporation, partnership interest, or beneficial interest of an estate? F. 1023, Part VIII.8 and Part IX, Balance Sheet

APPENDIX R

Annotated IRS Health Care Provider Legal Guide

The IRS published a *Health Care Provider Reference Guide* for the benefit of the agency's reviewers of applications for recognition of exemption submitted by healthcare providers. Accompanying this publication is a guide sheet containing questions to aid the reviewer in processing these applications. This document is dated September 1, 2003.

The guide skims over the basics: promotion of health as a charitable activity, qualification of a healthcare provider as a tax-exempt organization, the organizational and operational tests, private inurement and the identification of insiders, intermediate sanctions, the private benefit doctrine, the community benefit doctrine, community boards, conflicts-of-interest policies, research, and public charity status.

The publication dwells, however, on the matter of physician compensation arrangements, focusing on recruitment incentives, reasonableness of compensation, revenue-based compensation, and overall compensation plans. Attention also is accorded partnerships and other joint ventures with for-profit entities, raising for the reviewer a number of factors to consider in determining whether exemption is appropriate.

Certain healthcare providers—other than hospitals, clinics, and the like—are referenced: health maintenance organizations; faculty group practices; fire, rescue, and emergency services; membership organizations; and volunteer firefighters' relief organizations.

The text of this guide is reproduced in this appendix, annotated to the section or sections of the book where the various topics are more fully discussed.

HEALTH CARE PROVIDER REFERENCE GUIDE

By Janet E. Gitterman and Marvin Friedlander

Overview

Purpose. The purpose of this article, with the accompanying guide sheet, is to provide an introduction to and aid in the processing of IRC 501(c)(3) exemption applications submitted by health care providers, including issues

to keep in mind in evaluating whether activities that ''promote health'' are also charitable. Exhibit 1, *Guide Sheet for Hospitals, Clinics and Similar Health Care Providers*, is for the agent's use in identifying issues specific to health care in processing applications. A ''Q'' followed by a number, (Q#) in block labels (left side of page), refers to questions in the guide. The information provided in this article is subject to change by published guidance, court decisions, or tax law changes.

In This Article. This article contains the following topics:

Topic

Overview
Qualifying as a Tax-Exempt Health Care Provider
Insiders, Disqualified Persons, and Private Benefit
Promotion of Health as a Charitable Purpose
Meeting the Community Benefit Standard
Community Board
Open Hospital Staff
Corporate Practice of Medicine
Emergency Room and Non-Emergency Care
Charity Care and Research
Private Benefit Issues: Fair Market Value
Private Benefit Issues: Compensation
Joint Ventures or Partnerships with For-Profit Entities
Other Health Care Providers
Foundation Status: Hospital
Exhibit 1—Guide Sheet for Hospitals, Clinics, and Similar Health Care Providers

Promotion of Health Charitable or Non-Charitable Activity?[1]

The promotion of health for the benefit of the community is a charitable purpose. Engaging in health care activities alone does not necessarily further charitable purposes.

For example, in *Federation Pharmacy Services, Inc. v. Commissioner*, 72 T.C. 67 (1979), *aff'd* 625 F.2d 804 (8th Cir. 1980), the Tax Court held that an organization operating a pharmacy to sell drugs at cost to elderly and handicapped persons did not qualify for tax exemption under IRC 501(c)(3). The court stated:

> We do not believe that the law requires that any organization, whose purpose is to benefit health, however remotely, is automatically entitled, without more, to the desired exemption.

1. *See* § 1.7.

> The proliferation of different types of health care providers and the growing complexity of health care entities require a careful review of exemption applications to ensure that health care providers primarily operate for the benefit of the community.

Qualifying as a Tax-Exempt Health Care Provider[2]

A hospital, clinic, or other similar health care provider (collectively ''health care provider'') may qualify for tax-exempt status under IRC 501(c)(3) provided it is organized and operated exclusively for charitable purposes. To qualify as a health care provider that promotes health as its charitable purpose, the organization must meet the community benefit standard described in Rev. Rul. 69-545, 1969-2 C.B. 117, as well as the other requirements of IRC 501(c)(3) and its regulations.

Organizational Test Q1

The organizational test is the same for health care organizations as it is for any other IRC 501(c)(3) organization.

The organizational test described in Treas. Reg. 1.501(c)(3)-1(b) requires, in part, that an organization's organizing document provide that it is organized and will be operated for exclusively charitable purposes, and that upon dissolution its assets will be distributed for exclusively charitable purposes, either by an express statement in its governing document or by operation of state law.

The operational test is also the same for health care organizations as it is for any other IRC 501(c)(3) organization.

The operational test described in Treas. Reg. 1.501(c)(3)-1(c) provides, in part, that:

> . . . an organization will be regarded as ''operated exclusively'' for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in section 501(c)(3). An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose.

Insiders, Disqualified Persons, and Private Benefit[3]

Inurement. IRC 501(c)(3) expressly provides that to qualify for exemption, no part of an organization's net earnings shall inure in whole or in part to the benefit of private shareholders or individuals. Private shareholders or individuals are defined as persons having a personal and private interest in the activities of the organization.

In Context of Exemption Application. Inurement is statutorily prohibited for IRC 501(c)(3) organizations. In the context of an application for exemption

2. *See* §§ 1.3, 1.4.
3. *See* Chapter 4.

from federal income tax, where the operations of an organization would result in inurement that cannot be resolved during the application process, exempt status would be denied

In Context of Examination. However, in the context of the examination of an existing exempt organization, the presence of inurement issues would likely be addressed through IRC 4958 sanctions (excise tax and correction) before any move to revoke exemption.

Insiders. In practice, the inurement prohibition applies to insiders, rather than members of the general public or the intended class of beneficiaries. As one court noted, ''The test is functional. It looks to the reality of control rather than to the insider's place in a formal table of organization.'' *United Cancer Council v. Commissioner*, 165 F.3d 1173. However, conferring excessive private benefits on non-insiders may cause an organization to be operated for private interests rather than public purposes.

In the health care setting physicians may be insiders depending upon whether they exercise control.

Example. An organization has applied for exemption under IRC 501(c)(3). The organization was created by a physician to operate a medical clinic. Under Rev. Proc. 90-27, 1990-1 C.B. 514, Section 5, *Standards for Issuing Rulings or Determination Letters with Respect to Exempt Status*, we would need detailed information as part of the application to provide assurances concerning the absence of private benefit and inurement. Questions to elicit this information would include:

- Is there a community board of directors? If not, how will the organization make decisions to ensure the clinic is operating for a public rather than a private purpose? For example, are patient services available to the community or only to the physician's private practice patients?
- What is the physician's compensation package? How was it determined? Were comparable data applicable to similarly situated physicians utilized?
- If the organization leases, purchases, or shares facilities, employees, equipment, or its name with the physician's own medical practice, what are the terms of any such arrangement? How does the organization ensure that theses arrangements do not result in excessive private benefit?

Nevertheless, if on examination the physician is determined to be a disqualified person receiving excess benefits, it could be handled as an excess benefit transaction and/or a revocation issue as explained below.

Intermediate Sanctions.[4] IRC 4958, which was added to the Code by the Taxpayer Bill of Rights 2, Pub. L. No. 104-168, §1311, 110 Stat. 1452 (1996), popularly known as ''intermediate sanctions,'' provides a sanction, short of revocation, for situations in which a disqualified person receives an excess benefit from an IRC 501(c)(3) or 501(c)(4) organization.

IRC 4958 imposes an initial excise tax of 25 percent of the value of excess benefits the organization provides to a disqualified person, and imposes a second-tier tax of 200 percent of the excess benefits if the act is not corrected within the specified time.

Disqualified Persons. IRC 4958 imposes intermediate sanctions on the disqualified persons in a charity (IRC 501(c)(3)) or social welfare organization (IRC 501(c)(4)) who receive excessive economic benefits from the exempt organization. Disqualified persons are persons who are in a position to exercise substantial influence over the organization, including officers, directors, and trustees. In the health care setting, physicians may be disqualified persons, depending upon their extent of influence or control due to positions such as chief of staff, department head, or other medical staff appointment.

Intermediate sanctions include both excise taxes on the excess value and correction of the excess benefit transaction by those disqualified persons who engage in an excess benefit transaction with a tax-exempt organization. Disqualified persons are subject to intermediate sanctions on excess business transactions that are reported by the organization after it becomes operational or that may be uncovered during an examination of the organization. Still, it is important to explore the provision of services or goods between the applicant and its officers, directors, trustees, and other individuals who are in a substantial position of authority with respect to the applicant during the application process. Intermediate sanctions may be imposed by the IRS in lieu of (or in addition to) revocation of an organization's tax-exempt status. An excess benefit can occur in an exchange of compensation and other compensatory benefits in return for the services of a disqualified person, or in an exchange of property between a disqualified person and the exempt organization. Excess benefit occurs when the value of the economic benefit provided by the organization exceeds the value of the consideration (including the performance of services) received for providing the benefit. Fair market value is the benchmark used to determine value.

Private Benefit. Unlike the express prohibition of inurement of earnings to private shareholders or individuals, IRC 501(c)(3) does not specifically mention the broader concept of ''private benefit.'' However, the statute requires that an organization be ''organized and operated exclusively'' for specified purposes. Treas. Reg. 1.501(c)(3)-1(c)(1) provides that an organization will be regarded

4. *See* § 4.9.

as operated exclusively for exempt purposes only if it engages primarily in activities which accomplish one or more exempt purposes.

Further, Treas. Reg. 1.501(c)(3)-1(d)(1)(ii) states that an organization exempt under IRC 501(c)(3) must serve

> . . . a public rather than a private interest. Thus, to meet the requirement of this subdivision, it is necessary for an organization to establish it is not organized or operated for the benefit of private interests such as designated individuals . . .

Inurement versus Private Benefit.[5] Inurement and private benefit are often confused. Inurement is a subset of private benefit that involves unjust benefit from the income or assets of an exempt organization going to insiders. Unlike inurement, private benefit does not necessarily involve the flow of benefits to insiders. Private benefit can involve benefits to anyone.

Incidental Private Benefit. Private benefit is not fatal to an application for exempt status unless it is more than incidental. In the context of processing a Form 1023 application, the issue of whether an organization's activities will serve private interests excessively is a factual determination. GCM 37789 explains that private benefit must be both qualitatively and quantitatively incidental. *Qualitatively* incidental means the private benefit is a mere byproduct of the public benefit. *Quantitatively* incidental means the private benefit granted as a result of the specific activity must be insubstantial in amount when compared to the public benefit of the same specific activity.

Private Benefit. Two tax court cases that illustrate these aspects of ''private benefit'' are *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989) and *Aid to Artisans, Inc. v. Commissioner*, 71 T.C. 202, 215-216 (1978).

The court in American Campaign Academy provided a useful definition of ''private benefit'' outside of the context of inurement as ''non-incidental benefits conferred on disinterested persons that serve private interests.'' In that case, the organization's disqualifying private benefit resulted from its operating seminars that had as a significant purpose the advancement of one particular political party.

In Aid to Artisans, the exempt organization's purpose was to support struggling artists in developing countries, with any private benefit to the artists being a necessary byproduct of a greater public benefit.

In *United Cancer Council, Inc. v. Commissioner*, 109 T.C. 326 (1997), reversed and remanded by the U.S. Court of Appeals for the Seventh Circuit by *United Cancer Council, Inc. v. Commissioner*, 165 F.3d 1173 (7th Cir. 1999), the Appeals Court stated on the private benefit issue that:

> . . . the board of a charity has a duty of care, just like the board of an ordinary business corporation . . . and a violation of that duty which involved the dissipation

5. *See* § 4.7.

of the charity's assets might . . . support a finding that the charity was conferring a private benefit, even if the contracting party did not control, or exercise undue influence over, the charity. Id. at 1180.

Thus, if a charity confers a private benefit on non-insiders, the charity is not operating exclusively in the public interest and its exemption may be jeopardized if the private benefit is substantial. Whether private benefit is deemed to be substantial or insubstantial depends upon all the facts and circumstances.

Promotion of Health as a Charitable Purpose

Rev. Ruling 69-545: Community Benefit Standard.[6] The test used for determining if a health care provider satisfies the IRC 501(c)(3) operational test is the ''community benefit standard'' enunciated in Revenue Ruling 69-545, 1969-2 C.B. 117, and court cases that apply Rev. Rul. 69-545.

The community benefit standard is the test used to determine whether a hospital, clinic, or other health care provider is operated to promote health in a way that accomplishes a charitable purpose.

Rev. Rul. 69-545 defined the community benefit standard in the context of a hospital. The Service and the courts have applied this standard to hospital and non-hospital health care providers. See *IHC Health Plans, Inc. v. Commissioner*, 325 F.3d 1188 (10th Cir. 2003); *Sound Health Association v. Commissioner*, 71 T.C. 158 (1978); and *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210 (3rd Cir. 1993).

Rev. Ruling 56-185: Financial Ability Standard.[7] Prior to Rev. Rul. 69-545, tax-exempt hospitals were required by Rev. Rul. 56-185, 1956-1 C.B. 202 to admit and treat patients who were unable to pay, either without charge or at rates below cost. This requirement was referred to as the ''financial ability standard'' because this uncompensated care had to be provided to the extent of the hospital's financial ability.

Rev. Rul. 69-545 modified the financial ability standard by introducing additional considerations known as the community benefit standard. Although a formal policy to provide charity care is still relevant, the new standard also takes into account a number of additional factors indicating that the operation of the hospital benefits the community as a whole.

Other Health Care Providers. Similarly, a rehabilitation institution, outpatient clinic, community mental health center, dental clinic, drug treatment center, or community chiropractor may qualify as an exempt health care provider if it meets the community benefit standard and otherwise qualifies under IRC 501(c)(3).

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6. *See* Chapter 6.
7. *See* § 6.2.

Meeting the Community Benefit Standard

Does a Hospital Meet the Community Benefit Standard? As used with regard to a hospital, the ''community benefit standard'' in Rev. Rul. 69-545 includes the following factors:

- Does the hospital have a governing board, community board, board of trustees, or board of directors composed of prominent civic leaders rather than exclusively members who are hospital administrators, physicians, or others professionally connected to the hospital?
- Is admission to the hospital's medical staff open to all qualified physicians in the area, consistent with the size and nature of the facilities?
- Does the hospital operate a full-time emergency room open to everyone, regardless of his or her ability to pay? (However, Rev. Rul. 83-157, 1983-2 C.B. 94, in some situations, allows hospitals not to operate an emergency room.)
- Does the hospital provide non-emergency care to everyone in the community who is able to pay either privately or through third parties, including Medicare and Medicaid?
- Does the hospital serve a broad cross section of the community through research or charity care (as defined in Rev. Rul. 56-185)?

Each of these factors will be discussed separately in the following sections.

Community Board[8]

Independent Persons Q2. As discussed in Article C, *Tax-Exempt Health Care Organizations Community Board and Conflicts of Interest Policy*, in the CPE volume for FY 1997 at p. 18, a ''community board'' is one in which independent persons representative of the community comprise a majority. Practicing physicians affiliated with the hospital, officers, department heads, and other employees of the hospital are not independent due to their close and continuing connection with the hospital. They may serve on the hospital's board of trustees, but cannot comprise a majority. Other persons who may have some business dealings with the hospital are usually included in the majority. Rev. Rul. 69-545, *supra*, states that control of a charitable hospital in a board of directors composed of ''independent civic leaders'' is a significant factor in determining community benefit.

In a multi-entity hospital system, a subsidiary tax-exempt organization (an applicant) that does not have a community board is considered to have a community board if it is controlled by an IRC 501(c)(3) organization whose board is comprised of a majority of voting members who are independent community members.

8. *See* § 6.4.

Definition of "Control." Control means authority over structural and financial aspects. For example, structural control may include the right to appoint, elect, or remove the directors of the applicant. Financial control may include the right to approve annual operating and capital budgets, strategic planning initiatives, and significant sales, leases, mortgages or other transfers or encumbrances of real or personal property.

Conflict of Interest Policy Q3. The presence and enforcement of a conflict of interest policy applicable to a health care provider's directors, trustees, principal officers, highly compensated employees, and members of committees with board-delegated powers, can help assure fulfillment of charitable purposes.

While not mandatory, adoption of a conflict of interest policy is almost universal because it represents an important opportunity for health care providers to avoid potential private benefit, inurement, and intermediate sanction violations. A sample conflict of interest policy recommended by the Service is reproduced in Article E, *Tax-Exempt Health Care Organizations Revised Conflicts of Interest Policy*, in the CPE volume for FY 2000.[9]

Open Hospital Staff

Open Hospital Staff Privileges Q4. A hospital's medical staff privilege refers to permission a hospital provides to physicians, who are not employees of the hospital, to practice at the hospital. A policy of having an open medical staff demonstrates that a hospital furthers the interests of the community rather than the private interests of a select group of physicians. Contrast *Situation 2* in Revenue Ruling 69-545, 1969-2 C.B. 117, where there was not an open medical staff.

Open hospital staff privileges do not mean that any or all physicians may practice there. A hospital may place limitations on its medical staff based on physicians meeting professional standards of care, education, licensure, and accreditation, and on practice and capacity limitations of the facility. The requirement for open staff privileges is not necessarily applicable to clinics, specialty hospitals, or similar health care providers.

- Note: Where a hospital's medical staff is restricted solely to physicians from a particular medical practice, this would raise the question of possible private benefit that should be explored through further development.

Corporate Practice of Medicine

Corporate Practice of Medicine Q5. Some states prohibit non-profit corporations from employing physicians to provide outpatient medical services. These states require physicians to incorporate under the state's for-profit

9. *See* Appendix H.

professional corporation laws. This is commonly known as the corporate practice of medicine doctrine. These laws require a physician licensed in the state to hold all the stock in the corporation providing medical services and all board members are required to be physicians licensed by the state. Generally, one physician holds all the stock.

For-profit medical practices in states that adhere to the corporate practice of medicine doctrine may qualify for exemption, but only if the health care provider implements a considerable number of safeguards to ensure charitable organization and operation. Although Article F, *Corporate Practice of Medicine*, in the FY 2000 CPE Text at page 55 provides a discussion, this type of case is currently handled by EO Technical.

Emergency Room and Non-Emergency Care[10]

Emergency Rooms Open to All Q6. Usually, a hospital must have an emergency room open to all persons regardless of their ability to pay to meet the community benefit standard.

However, an emergency room is not required if a governmental planning agency has determined it would unnecessarily duplicate an existing service or if the health care provided by the hospital is not the type of care requiring an emergency room (e.g., specialized eye care). Therefore, an emergency room is not required for a clinic or specialty hospital. See Rev. Rul. 83-157, 1983-2 C.B. 94.

Key factors in determining if the emergency room is open to all regardless of ability to pay are:

- No one is denied treatment in the emergency room based on ability to pay. (Note: Admission to the hospital may be based on ability to pay directly or through third-party providers.)
- The hospital's emergency room generally has patient transportation arrangements with police, fire, and ambulance services.

Medicare or Medicaid Q7. Participation in Medicare (government program that pays health care for the elderly or disabled) or Medicaid (government program that pays health care for the poor) is a factor that helps establish that a health care provider meets the community benefit standard.

Charity Care and Research

Charity Care Q8. The provision of charity care is relevant in determining whether a hospital meets the community benefit standard of Rev. Rul. 69-545. Many hospitals adopt a charity care policy to help them meet the health care

10. *See* § 26.4.

needs of low-income and uninsured members of their communities. A charity care policy is reflected by the formal adoption of a written policy providing objective standards that are used in determining who qualifies for such care. Hospital bad debt is not considered to be charity care.

Further, because clinics and other health care providers are not required to have an emergency room, many demonstrate community benefit by implementing a charity care policy and by providing a significant amount of charity care. Treating patients covered through Medicare and Medicaid may also demonstrate community benefit. Charity care policies must be available to the public.

A charity care policy provides that certain patients will be offered free or reduced-cost care, often using a sliding scale, based on the patient's ability to pay. Health care providers should be in a position to describe the amounts expended or anticipated to be expended on charity care.

Medical Training, Research and Other Health-Related Activities Q9. Other activities that serve the community, when combined with factors enumerated in Rev. Rul. 69-545, help to demonstrate the required benefit to the community.

Medical training or research are ways that a health care provider can serve the health needs of the community. Additional activities demonstrating community benefit include free health education programs (e.g., cardiac information, pregnancy counseling), seminars (e.g., stop-smoking seminars), or community health fairs (e.g., blood pressure or cholesterol testing).

Private Benefit Issues: Fair Market Value[11]

Private Benefit and Valuation Issues. Whenever a transaction takes place between an exempt organization and other individuals or groups, care must be taken to ensure there is not excessive private benefit conferred on members or officers. Values related to transactions must be documented in order to establish any private benefit is merely incidental.

Physician Office Space Q10. The terms of any lease must be at fair market value to prevent excessive private benefit. Rev. Ruls. 69-463, 1969-2 C.B. 131 and 69-464, 1969-2 C.B.132, state a hospital may lease space to physicians and to medical groups at locations adjacent to the hospital campus. This is considered to further the hospital's exempt purposes by facilitating patient access to the hospital.

The lease must be at fair market value and the hospital should explain how it arrived at a commercially reasonable lease.

Lease of Assets Q11. When an exempt health care provider leases equipment, office space or other assets from individuals and entities with whom it has an

11. *See* § 4.4.

ongoing financial relationship, such as a member of its board of directors, an employee, officer, or a physician with staff privileges, the possibility that the lease is not at fair market value is greater than if the lease is at arm's length. In these situations, it is important to review the lease and any documentation about how the lease was negotiated to ensure that it is commercially reasonable and represents fair market value.

If the dollar amounts are significant, the health care provider should obtain independent verification that the transaction is commercially reasonable and is at fair market value.

Hospital Purchase of Physician Practices Q12. Hospitals may purchase medical practices, ambulatory surgery centers, magnetic imaging centers, and other for-profit health care operations and often employ or contract back with the selling physicians to operate these entities as wholly owned, IRC 501(c)(3) health care providers.

When the purchase involves significant amounts of money, the organization should be in a position to justify the terms of the purchase through, for example, timely valuation of the assets purchased. Such valuations help ensure the hospital has not overpaid. See Article Q, *Valuation of Medical Practices*, in the FY 1996 CPE text for a discussion of acceptable valuation methods.

Retained Rights

A review of the underlying documents is necessary to determine if there is retained authority over the use of the assets by the seller. For example, the right to direct future affiliations with other medical practices, the right to hire additional physicians, or the right to repurchase a medical practice (other than a right of first refusal) may effectively limit the ability of a hospital to utilize its assets to further exclusively charitable purposes and also reduces the value of the assets.

Retained rights can usually be found in the asset purchase agreement, but they can also be in a professional service agreement or employment contract.

Private Benefit Issues: Compensation

Recruitment Incentives Q13.[12] Recruitment incentives are used by a hospital to recruit physicians to its staff or its community. Where the hospital or community is experiencing a shortage of physicians, incentives such as bonuses, housing or moving allowances, guaranteed income allowances, or below-market rental of office space can be used to further the hospital's exempt purposes. See Rev. Rul. 97-21, 1997-1 C.B. 121.

Incentives should be provided at arm's length, be consistent with written policies, should not result in excessive compensation paid to employees or unreasonable payments (including unreasonable income guarantees) paid to non-employees, and should be legal.

12. *See* Chapter 25.

Reasonable Compensation Q14.[13] In determining whether compensation is excessive, total compensation must be determined first. Compensation includes not only salary, but also any fringe benefits and pension plans or other deferred compensation provided. The exempt organization should provide assurance that the total compensation package provided to a physician (base salary, bonuses, and benefits) is reasonable for the physician's specialty and area.

Generally, compensation is more likely to be reasonable if it is established at arm's length by an independent board of directors or committee subject to a conflict-of-interest policy and is based on current compensation studies of similarly situated employees in similar geographic locales.

Revenue-Based Compensation.[14] If compensation is based on revenues, the potential for unreasonable compensation warrants a close review of the compensation arrangement.

A fixed salary with a bonus based on a percentage of a physician's gross or net collections or billings is revenue-based. Employment contracts should be examined to determine if the amounts paid are excessive and to ensure that the exempt organization is not using the revenue-based compensation as a vehicle for distributing the organization's profits. It may be appropriate to accept employment contracts with names and other identifying information redacted when the health care provider is concerned with confidentiality.

Compensation Plan. The compensation plan, first and foremost, must be a legitimate vehicle to compensate physicians fairly. If the health care provider cannot explain how it determines compensation is reasonable, then it needs to develop a process to ensure that its significant employment contracts will result in the payment of reasonable compensation. A process that undertakes to review compensations studies of similarly situated employees would provide an appropriate process.

Compensation for a For-Profit Medical Group Q15. A health care provider may contract with a for-profit medical group to provide professional health care services. This is not an exempt organization issue as long as the total payment by the exempt organization is reasonable in relation to the total services it receives.

Joint Ventures or Partnerships with For-Profit Entities[15]

Exemption Issues Q16. A joint venture between an exempt organization and a for-profit entity can take the form of a partnership or a limited liability company (LLC).

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13. *See* § 4.4(b).
14. *See* § 4.5.
15. *See* Chapter 22.

EO Technical will handle all applications for exemption submitted by health care providers that will engage in whole-hospital joint ventures with for-profit entities or in joint ventures with for-profit entities when the joint venture is the applicant organization's primary activity.

Rev. Rul. 98-15, 1998-1 C.B. 718, provides two examples demonstrating when a whole-hospital joint venture with a for-profit entity will or will not adversely affect exemption. In Situation 1, which does not jeopardize exemption, the organization and operation of the joint venture allows the exempt health care provider to continue to further a charitable purpose and to act exclusively in furtherance of its exempt purpose and only incidentally for the benefit of the for-profit partners. This is the case because, among other requirements, the governing documents of the joint venture provide for the exempt organization to appoint three of the five directors and require that the joint venture operate any hospital it owns in a manner that furthers charitable purposes by promoting health for a broad cross section of the community.

In contrast, Situation 2 involves a joint venture in which the partners each name three members to the six-member board. A majority of the board members must approve certain major decisions regarding operation of the joint venture. The governing documents provide that the joint venture operate the health care facilities it owns and engage in other health care-related activities. However, there is no binding obligation for the joint venture to serve charitable purposes or otherwise provide its services to the community as a whole. For this and other reasons the tax-exempt partner can no longer establish that it is neither organized nor operated for the benefit of private interests nor is the benefit to the for-profit partner incidental to the furtherance of an exempt purpose. Thus, the tax-exempt partner will fail the operational test when it enters into the joint venture, adversely affecting exemption.

Other joint ventures where the hospital is the controlling partner and has an operational role generally do not raise exemption issues if participation in the partnership is necessary for the hospital's exempt purpose and the benefit to the for-profit partners is not excessive. However, the details of the partnership arrangement need to be carefully developed to ensure the joint venture falls within the confines of Situation 1 of Rev. Rul. 98-15.

A certificate of need may help to establish that an activity is necessary to accomplish exempt purposes. Return of capital (initial investment) is generally beyond the scope of an exempt partner's obligation to the for-profit partners and indicates the for-profit partners' investment is not at risk.

Factors to Consider. Some factors to consider in developing a joint venture case are whether:

- The exempt organization has an operational role
- The investment is limited to the specific amount invested

- The partners receive distributions consistent with their economic interests
- Ownership interests are proportionate to the partners' investment
- The exempt organization obtains access to capital or expertise that is not otherwise available

When a health care provider that engages in other charitable activities also participates in a joint venture with for-profit entities where this activity does not further its charitable purposes, the tax-exempt entity may be subject to unrelated business income taxation under IRC 512(c).

Other Health Care Providers

HMOs Q17.[16] Where the health care provider is a health maintenance organization (HMO), the case is currently handled by EO Technical. An HMO is generally an organization that arranges for its members or subscribers to obtain medical care by contracting with health care providers.

Faculty Group Practices Q18.[17] A faculty group practice is a health care provider established to employ physicians who are faculty members of a medical school. The group practice offers faculty physicians an opportunity to sharpen their skill by providing medical treatment of patients. It may be organized under corporate practice of medicine state laws. Generally, the courts have determined that faculty group practices qualify under IRC 501(c)(3). See *University of Maryland Physicians, P.A. v. Commissioner*, 41 T.C.M. 732 (1981); *University of Massachusetts Medical School Group Practice v. Commissioner*, 74 T.C. 1299 (1980); and *B. H. W. Anesthesia Foundation v. Commissioner*, 72 T.C. 681 (1979).

Currently, these types of cases are handled by EO Technical.

Fire, Rescue, and Emergency Services Q19. Providing fire, rescue, or emergency services for the general community may accomplish charitable purposes under IRC 501(c)(3) because such services provide relief to the poor and distressed, or lessen the burdens of government.

- Rescue service—A nonprofit organization that conducts emergency rescue services for stranded, injured, or lost persons provides relief of distressed persons and is exempt as an organization described in IRC 501(c)(3). See Rev. Rul. 69-174, 1969-1 C.B. 149.
- Volunteer fire company—A nonprofit organization that provides fire protection and ambulance and rescue services to a community qualifies for exemption as a charitable organization under IRC 501(c)(3). See Rev. Rul. 74-361, 1974-2 C.B. 159.

16. *See* § 9.2.
17. *See* § 12.2.

Membership Organization

However, when a nonprofit organization operating fire, rescue, or emergency services is a membership organization, it must clearly demonstrate that it benefits the community as a whole in addition to its members.

Where an organization, otherwise qualified for exemption under IRC 501(c)(3), provides emergency, fire, rescue, and ambulance services for its members on a fee basis, the following types of factors should be considered to ensure that it does not operate for the private benefit of its members:

- Does the organization operate on a policy of furnishing services to all individuals in need regardless of membership or the ability to pay?
- Is membership available to everyone in the community at nominal cost so that nearly all segments of the interested public could obtain services at the preferential member rate?
- Are charges to non-members reasonably related to the cost of services rendered and not of a punitive nature?

By meeting the above factors, the organization can demonstrate that it is not impermissibly serving its members' private interests.

Volunteer Firefighters' Relief Organizations

Typical volunteer firefighters' relief organizations are created to provide ancillary benefits such as disability and accident insurance, life insurance, and pensions to unpaid, volunteer firefighters. Using a ''lessening the burdens of government'' rationale, some of these organizations may qualify for exemption under IRC 501(c)(3). Other volunteer firefighters' relief organizations may qualify under IRC 501(c)(4) using a ''community benefit'' rationale. For more information relating to the treatment of this type of organization, see Article N, *Volunteer Firefighters' Relief Organizations*, in the FY 1996 CPE Text at page 349 and Article G, *Volunteer Firefighters' Relief Organizations*, in the FY 2000 CPE Text at page 105.

Foundation Status: Hospital[18]

General Discussion. Applications may be submitted by organizations where it is difficult to determine if they are a hospital under IRC 509(a)(1) and 170(b)(1)(A)(iii), or a publicly supported organization under IRC 509(a)(1) and 170(b)(1)(A)(vi) or IRC 509(a)(2). They may ask for one particular foundation classification, when they may be better described under another foundation status.

This commonly occurs with small clinics, generally in rural or inner city settings. They are organized to treat patients suffering from a wide range of maladies or suffering from a particular condition. Such an organization may not have the need for operating an emergency room or for a wide variety

18. *See* Chapter 5.

of staff practicing different specialties. Examples could include, but are not limited to, a rural medical clinic serving the poor or a women's health clinic serving those in need of maternity care.

On occasion, an applicant receiving exemption under one foundation classification, but not the requested classification, has challenged the Service's determination despite being found not to be a private foundation. In *Friends of the Society of Servants of God v. Commissioner*, 75 T.C. 209 (1980), petitioner had requested a definitive ruling that it was not a private foundation under IRC 509(a)(1) on the basis that it was a church described in IRC 170(b)(1)(A)(i). The Service granted an advance ruling as a public charity under IRC 509(a)(1) and 170(b)(1)(A)(vi). Under the advance ruling, the applicant would need to meet the public support requirements during the advance period or be reclassified as a private foundation. The tax court agreed that the advance ruling on petitioner's status as a private foundation under IRC 509(a) was adverse in many important respects and that the court had jurisdiction under IRC 7428(a) to review the advance ruling.

Note also that classification of foundation status under IRC 509(a)(1) and 170(b)(1)(A)(vi) or IRC 509(a)(2) does not allow the applicant to avoid the community benefit test or allow insiders, rather than a community board, to control the organization. The community benefit standard arises out of the IRC 501(c)(3) requirements, not out of IRC 509(a).

Eligible for Hospital Exclusion IRC 170(b)(1)(A)(iii) Q20, Q21

An organization whose principal purpose is the provision of medical or hospital care will qualify as a hospital under IRC 509(a)(1) and 170(b)(1)(A)(iii). The term *hospital* includes a federal, state, county or municipal hospital; a rehabilitation institution; an outpatient clinic; a community mental health center; or a drug treatment center. A health care provider whose accommodations qualify as being part of a skilled nursing facility within the meaning of 42 U.S.C. 1395x(j) may qualify as a hospital.

Medical care means the treatment of any physical or mental disability or condition, whether on an inpatient or outpatient basis, provided the cost of such treatment is deductible under IRC 213 by the person being treated. See Treas. Reg. 1.170A-9(c)(1).

An *outpatient clinic* includes a medical center equipped to provide health care services to persons in the community through a staff of health specialists who provide medical care to persons in the community even though it does not have facilities to maintain patients overnight or provide any non-ambulatory care. See Rev. Rul. 73-313, 1973-2 C.B. 174.

Not Eligible for IRC 170(b)(1)(A)(iii) Exclusion

However, an organization that primarily provides health care services to patients in their own homes under the direction of their private physicians and

only incidentally provides patient treatment at the organization's offices is not described in IRC 170(b)(1)(A)(iii). See Rev. Rul. 76-452, 1976-2 C.B. 60.

Hospitals do not include convalescent homes or homes for children or the aged, nor do they include institutions whose principal purpose is to train handicapped individuals to pursue a vocation.

EXHIBIT 1

GUIDE SHEET FOR HOSPITALS, CLINICS, AND SIMILAR HEALTH CARE PROVIDERS

INSTRUCTIONS—This guide sheet is designed to assist in the processing of certain health care provider IRC 501(c)(3) exemption applications. Generally, a ''Yes'' response indicates a favorable factor, whereas a ''No'' response indicates a potential concern. See the accompanying health care provider reference guide for assistance in completing this guide sheet. Contact EO Technical for additional help.

		Yes	No
1.	Does the health care provider's organizing document meet the ''organizational test?''		
2.	Does the health care provider have a community board of directors?		
	a. If the health care provider does not have a community board and is part of a multi-entity health care system, are there any other IRC 501 (c)(3) entities in the system with a community board that has structural control over the health care provider?		
3.	Does the health care provider have a conflict-of-interest policy covering its directors, principal officers, highly paid employees, and members of committees with board delegated authority that is similar to the policy recommended by the Service?		
4.	If the organization is a hospital, does it maintain an open medical staff whereby medical staff privileges are available to all qualified physicians in the area consistent with the size and nature of its facilities?		
5.	Is the health care provider a professional corporation organized under a corporate practice of medicine state law? If Yes, send the application EO Technical.		
6.	If the organization is a hospital, does it maintain a full-time emergency room?		
	a. Is the emergency room open to all persons regardless of their ability to pay?		
	b. Does the hospital have arrangements with police, fire, and ambulance services to deliver patients to its emergency room?		

		Yes	No
7.	Does the health care provider accept persons covered under Medicare or Medicaid?		
	a. If the health care provider has not obtained a Medicaid contract, has it pursued good-faith negotiations to obtain a Medicaid contract?		
	b. If the health care provider does not accept Medicare, contact EO Technical.		
8.	Does the health care provider have a charity care policy and is it communicated to the public?		
	a. Was a copy of the charity care policy submitted with the application?		
	b. Does the charity care policy provide for free or reduced-rate medical care consistent with the patient's financial resources?		
9.	Does the health care provider conduct a formal program of medical training, medical research, or community educational programs?		
10.	Does the health care provider lease office space to physicians with whom it has a financial relationship?		
	a. Was a copy of the lease submitted?		
	b. Has the health care provider explained how it established a lease at fair market value?		
11.	Does the health care provider lease any equipment, assets, or office space from physicians or other individuals, corporations, or partnerships (aside from structurally controlled organizations) with an ongoing financial relationship with the provider?		
	a. Was a copy of the lease submitted?		
	b. Has the health care provider explained how it established a lease at fair market value?		
12.	Has the health care provider purchased medical practices, ambulatory surgery centers, or other business assets from physicians or other persons (1) who have substantial influence over the health care provider; (2) who are employed by the health care provider; or (3) who contract back with the health care provider to operate the business?		
	a. Was a copy of the asset purchase agreement (purchase and sale contract) submitted?		
	b. Is there an appraisal supporting the purchase price?		
	c. Does the appraisal utilize the cost, market, and/or income methods or some combination thereof to arrive at fair market value?		

		Yes	No
	d. Does the asset purchase agreement include any retained rights by the seller to (1) affect future affiliations with others; (2) determine if additional physicians can be hired; or (3) repurchase the assets within a certain time period (other than a right of first refusal)?		
13.	Does the hospital offer recruitment incentives to physicians?		
	a. Are recruitment incentives consistent with Rev. Rul. 97-21, 1997-1 C.B. 121?		
14.	Has the health care provider explained the amounts and bases by which it compensates its officers, highly compensated employees, and physicians?		
	a. Were representative employment contracts submitted?		
	b. Are compensation arrangements approved by an independent board of directors or compensation committee subject to a conflict-of-interest policy?		
	c. If a physician's compensation is based on revenues, is there an incentive for providing charity care and/or meeting quality of care or patient satisfaction benchmarks?		
	d. If a physician's compensation is based on revenues, is there a cap on total compensation based on reasonable compensation for physicians in similar specialties in similar geographic locales?		
	e. If a physician's compensation is based on revenues, are the revenues limited to the work product of the physician and/or nurse practitioner(s) under the direct supervision of the physician?		
15.	Does the medical provider employ a for-profit medical group to serve its patients?		
	a. Was the professional services agreement or employment contract submitted with the application?		
	b. Is total compensation reasonable based on the factors in Q14?		
16.	Does the health care provider participate in a joint venture, partnership, or limited liability company (LLC) arrangement with a for-profit entity?		
	a. Were copies of all such agreement(s) provided?		
	b. Did the health care provider receive ownership interest in the joint venture, partnership, or LLC proportionate to its contribution?		
	c. Are all returns of capital and distributions of earnings made to the members proportional to their ownership interests?		
	d. Is a majority of the governing board chosen by the tax-exempt health care provider?		

		Yes	No
	e. Does a majority of the governing body approve major decisions that include: the annual capital and operating budgets; distribution of earnings; selection of key executives; acquisition or disposition of health care facilities; contracts in excess of a specific dollar amount threshold; changes to the types of services offered by the hospital; and renewal or termination of any management agreements?		
	f. Do the governing documents require it to operate all of its health care entities (including any health care entities contributed by the for-profit) in a manner furthering charitable purposes?		
	g. Do the governing documents explicitly provide directors have a duty to operate in a manner furthering charitable purposes and this may override their duty to operate for the financial benefit of the for-profit members?		
	h. Are the governing documents legal, binding, and enforceable under applicable state law?		
	i. Are any management contracts for a definite term of years and terminable for cause? Were copies of management contracts provided?		
	j. Has the Applicant provided information to establish that the terms, fees, and conditions of any management agreements are reasonable and comparable to management contracts of other organizations providing similar services at similarly situated health care entities?		
	k. Have you determined that no officers, directors, or other employees of the health care provider who were involved in the decision making or the negotiations involving the formation of the joint venture, partnership, or LLC were promised employment or any other inducements by the for-profit and any of its related entities, or the joint venture, partnership, or the LLC itself?		
	l. Have you determined that none of these individuals has any interest, directly or indirectly, in the for-profit or any of its related entities?		
17.	Is the health care provider an HMO? If Yes, send application to EO Technical.		
18.	Is the health care provider a faculty group practice? If Yes, send application to EO Technical.		
19.	If the organization is a fire, rescue, or emergency service provider, does it offer comparable services to the entire community?		
20.	Does the hospital or clinic qualify as a hospital described in IRC 509(a)(1) and 170(b)(1)(A)(iii)?		
21.	Is the health care provider a drug treatment center, a community mental health center, or skilled nursing facility?		

APPENDIX S

IRS Revenue Ruling on Ancillary Service Provider Joint Ventures

Rev. Rul. 2004-51, 2004-1 C.B. 974 (June 1, 2004)

ISSUES

1. Whether, under the facts described below, an organization continues to qualify for exemption from federal income tax as an organization described in § 501(c)(3) of the Internal Revenue Code when it contributes a portion of its assets to and conducts a portion of its activities through a limited liability company (LLC) formed with a for-profit corporation.
2. Whether, under the same facts, the organization is subject to unrelated business income tax under § 511 on its distributive share of the LLC's income.

FACTS

M is a university that has been recognized as exempt from federal income tax under § 501(a) as an organization described in § 501(c)(3). As a part of its educational programs, *M* offers summer seminars to enhance the skill level of elementary and secondary school teachers.

To expand the reach of its teacher training seminars, *M* forms a domestic LLC, *L*, with *O*, a company that specializes in conducting interactive video training programs. *L*'s Articles of Organization and Operating Agreement (''governing documents'') provide that the sole purpose of *L* is to offer teacher training seminars at off-campus locations using interactive video technology. *M* and *O* each hold a 50 percent ownership interest in *L*, which is proportionate to the value of their respective capital contributions to *L*. The governing documents provide that all returns of capital, allocations and distributions shall be made in proportion to the members' respective ownership interests.

The governing documents provide that *L* will be managed by a governing board comprised of three directors chosen by *M* and three directors chosen by *O*. Under the governing documents, *L* will arrange and conduct all

aspects of the video teacher training seminars, including advertising, enrolling participants, arranging for the necessary facilities, distributing the course materials and broadcasting the seminars to various locations. *L*'s teacher training seminars will cover the same content covered in the seminars *M* conducts on *M*'s campus. However, school teachers will participate through an interactive video link at various locations rather than in person. The governing documents grant *M* the exclusive right to approve the curriculum, training materials, and instructors, and to determine the standards for successful completion of the seminars. The governing documents grant *O* the exclusive right to select the locations where participants can receive a video link to the seminars and to approve other personnel (such as camera operators) necessary to conduct the video teacher training seminars. All other actions require the mutual consent of *M* and *O*.

The governing documents require that the terms of all contracts and transactions entered into by *L* with *M*, *O* and any other parties be at arm's length and that all contract and transaction prices be at fair market value determined by reference to the prices for comparable goods or services. The governing documents limit *L*'s activities to conducting the teacher training seminars and also require that *L* not engage in any activities that would jeopardize *M*'s exemption under § 501(c)(3). *L* does in fact operate in accordance with the governing documents in all respects.

M's participation in *L* will be an insubstantial part of *M*'s activities within the meaning of § 501(c)(3) and § 1.501(c)(3)-1(c)(1) of the Income Tax Regulations.

Because *L* does not elect under § 301.7701-3(c) of the Procedure and Administration Regulations to be classified as an association, *L* is classified as a partnership for federal tax purposes pursuant to § 301.7701-3(b).

LAW

Exemption Under § 501(c)(3)

Section 501(c)(3) provides, in part, for the exemption from federal income tax of corporations organized and operated exclusively for charitable, scientific, or educational purposes, provided no part of the organization's net earnings inures to the benefit of any private shareholder or individual.

Section 1.501(c)(3)-1(c)(1) provides that an organization will be regarded as operated exclusively for one or more exempt purposes only if it engages primarily in activities that accomplish one or more of the exempt purposes specified in § 501(c)(3). Activities that do not further exempt purposes must be an insubstantial part of the organization's activities. In *Better Business Bureau of Washington, D.C. v. United States*, 326 U.S. 279, 283 (1945), the Supreme Court held that "the presence of a single . . . [non-exempt] purpose, if substantial in

nature, will destroy the exemption regardless of the number or importance of truly . . . [exempt] purposes.''

Section 1.501(c)(3)-1(d)(1)(ii) provides that an organization is not organized or operated exclusively for exempt purposes unless it serves a public rather than a private interest. To meet this requirement, an organization must ''establish that it is not organized or operated for the benefit of private interests . . . .''

Section 1.501(c)(3)-1(d)(2) defines the term ''charitable'' as used in § 501(c)(3) as including the advancement of education.

Section 1.501(c)(3)-1(d)(3)(i) provides, in part, that the term ''educational'' as used in § 501(c)(3) relates to the instruction or training of the individual for the purpose of improving or developing his capabilities.

Section 1.501(c)(3)-1(d)(3)(ii) provides examples of educational organizations including a college that has a regularly scheduled curriculum, a regular faculty, and a regularly enrolled body of students in attendance at a place where the educational activities are regularly carried on and an organization that presents a course of instruction by means of correspondence or through the utilization of television or radio.

Joint Ventures

Rev. Rul. 98-15, 1998-1 C.B. 718, provides that for purposes of determining exemption under § 501(c)(3), the activities of a partnership, including an LLC treated as a partnership for federal tax purposes, are considered to be the activities of the partners. A § 501(c)(3) organization may form and participate in a partnership and meet the operational test if 1) participation in the partnership furthers a charitable purpose, and 2) the partnership arrangement permits the exempt organization to act exclusively in furtherance of its exempt purpose and only incidentally for the benefit of the for-profit partners.

Redlands Surgical Services, 113 T.C. 47, 92-93 (1999), *aff'd* 242 F.3 d 904 (9th Cir. 2001), provides that a nonprofit organization may form partnerships, or enter into contracts, with private parties to further its charitable purposes on mutually beneficial terms, ''so long as the nonprofit organization does not thereby impermissibly serve private interests.'' The Tax Court held that the operational standard is not satisfied merely by establishing ''whatever charitable benefits [the partnership] may produce,'' finding that the nonprofit partner lacked ''formal or informal control sufficient to ensure furtherance of charitable purposes.'' Affirming the Tax Court, the Ninth Circuit held that ceding ''effective control'' of partnership activities impermissibly serves private interests. 242 F.3 d at 904.

St. David's Health Care System v. United States, 349 F.3 d 232, 236-237 (5th Cir. 2003), held that the determination of whether a nonprofit organization that enters into a partnership operates exclusively for exempt purposes is not limited to ''whether the partnership provides some (or even an extensive amount

of) charitable services.'' The nonprofit partner also must have the ''capacity to ensure that the partnership's operations further charitable purposes.'' *Id*. at 243. ''[T]he non-profit should lose its tax-exempt status if it cedes control to the for-profit entity.'' *Id*. at 239.

Tax on Unrelated Business Income

Section 511(a), in part, provides for the imposition of tax on the unrelated business taxable income (as defined in § 512) of organizations described in § 501(c)(3).

Section 512(a)(1) defines ''unrelated business taxable income'' as the gross income derived by any organization from any unrelated trade or business (as defined in § 513) regularly carried on by it less the deductions allowed, both computed with the modifications provided in § 512(b).

Section 512(c) provides that, if a trade or business regularly carried on by a partnership of which an organization is a member is an unrelated trade or business with respect to the organization, in computing its unrelated business taxable income, the organization shall, subject to the exceptions, additions, and limitations contained in § 512(b), include its share (whether or not distributed) of the gross income of the partnership from the unrelated trade or business and its share of the partnership deductions directly connected with the gross income.

Section 513(a) defines the term ''unrelated trade or business'' as any trade or business the conduct of which is not substantially related (aside from the need of the organization for income or funds or the use it makes of the profits derived) to the exercise or performance by the organization of its charitable, educational, or other purpose or function constituting the basis for its exemption under § 501.

Section 1.513-1(d)(2) provides that a trade or business is ''related'' to an organization's exempt purposes only if the conduct of the business activities has a causal relationship to the achievement of exempt purposes (other than through the production of income). A trade or business is ''substantially related'' for purposes of § 513 only if the causal relationship is a substantial one. Thus, to be substantially related, the activity ''must contribute importantly to the accomplishment of [exempt] purposes.'' Section 1.513-1(d)(2). Section 513, therefore, focuses on ''the manner in which the exempt organization operates its business'' to determine whether it contributes importantly to the organization's charitable or educational function. *United States v. American College of Physicians*, 475 U.S. 834, 849 (1986).

ANALYSIS

L is a partnership for federal tax purposes. Therefore, *L*'s activities are attributed to *M* for purposes of determining both whether *M* operates

exclusively for educational purposes and therefore continues to qualify for exemption under § 501(c)(3) and whether *M* has engaged in an unrelated trade or business and therefore may be subject to the unrelated business income tax on its distributive share of *L*'s income.

The activities *M* is treated as conducting through *L* are not a substantial part of *M*'s activities within the meaning of § 501(c)(3) and § 1.501(c)(3)-1(c)(1). Therefore, based on all the facts and circumstances, *M*'s participation in *L*, taken alone, will not affect *M*'s continued qualification for exemption as an organization described in § 501(c)(3).

Although *M* continues to qualify as an exempt organization described in § 501(c)(3), *M* may be subject to unrelated business income tax under § 511 if *L* conducts a trade or business that is not substantially related to the exercise or performance of *M*'s exempt purposes or functions.

The facts establish that *M*'s activities conducted through *L* constitute a trade or business that is substantially related to the exercise and performance of *M*'s exempt purposes and functions. Even though *L* arranges and conducts all aspects of the teacher training seminars, *M* alone approves the curriculum, training materials and instructors, and determines the standards for successfully completing the seminars. All contracts and transactions entered into by *L* are at arm's length and for fair market value, *M*'s and *O*'s ownership interests in *L* are proportional to their respective capital contributions, and all returns of capital, allocations and distributions by *L* are proportional to *M*'s and *O*'s ownership interests. The fact that *O* selects the locations and approves the other personnel necessary to conduct the seminars does not affect whether the seminars are substantially related to *M*'s educational purposes. Moreover, the teacher training seminars *L* conducts using interactive video technology cover the same content as the seminars *M* conducts on *M*'s campus. Finally, *L*'s activities have expanded the reach of *M*'s teacher training seminars, for example, to individuals who otherwise could not be accommodated at, or conveniently travel to, *M*'s campus. Therefore, the manner in which *L* conducts the teacher training seminars contributes importantly to the accomplishment of *M*'s educational purposes, and the activities of *L* are substantially related to *M*'s educational purposes. Section 1.513-1(d)(2). Accordingly, based on all the facts and circumstances, *M* is not subject to unrelated business income tax under § 511 on its distributive share of *L*'s income.

HOLDINGS

1. *M* continues to qualify for exemption under § 501(c)(3) when it contributes a portion of its assets to and conducts a portion of its activities through *L*.
2. *M* is not subject to unrelated business income tax under § 511 on its distributive share of *L*'s income.

DRAFTING INFORMATION

The principal author of this revenue ruling is Virginia G. Richardson of Exempt Organizations, Tax Exempt and Government Entities Division. For further information regarding this revenue ruling, contact Virginia G. Richardson on (202) 283-8938 (not a toll-free call).

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