

January 1995

Overview of the Tax Treatment of Nonprofit Hospitals and Their For-Profit Subsidiaries: A Short-Sighted View Could Be Very Bad Medicine Comment

Andrea I. Castro

Follow this and additional works at: <https://digitalcommons.pace.edu/plr>

Recommended Citation

Andrea I. Castro, *Overview of the Tax Treatment of Nonprofit Hospitals and Their For-Profit Subsidiaries: A Short-Sighted View Could Be Very Bad Medicine Comment*, 15 Pace L. Rev. 501 (1995)

DOI: <https://doi.org/10.58948/2331-3528.1366>

Available at: <https://digitalcommons.pace.edu/plr/vol15/iss2/4>

This Article is brought to you for free and open access by the School of Law at DigitalCommons@Pace. It has been accepted for inclusion in Pace Law Review by an authorized administrator of DigitalCommons@Pace. For more information, please contact dheller2@law.pace.edu.

Comment

Overview of the Tax Treatment of Nonprofit Hospitals and Their For-Profit Subsidiaries: A Short-Sighted View Could Be Very Bad Medicine

I. Introduction

Nonprofit hospitals have recently found themselves between the proverbial rock and hard place. These tax-exempt health care entities are subject to the vagaries of the federal and state governmental agencies which, through legislative grace, bestow favorable tax treatment on them.¹ Until recently, the nonprofit hospital sector existed in a tolerant environment where only the most egregious conduct would cause the loss of tax-exempt status.²

Lately, however, that tolerance has shifted to stricter scrutiny at both the federal and state levels, often resulting in revocation of exempt status under circumstances that would not have occurred in the past.³ Much of the changed attitude has

1. 26 U.S.C. § 501(c)(3) (1988 & Supp. V 1993). This section of the Internal Revenue Code grants federal tax exemption to nonprofit hospitals based upon a determination that nonprofit hospitals serve a charitable purpose. *See infra* note 21 and text accompanying note 35. Although the Internal Revenue Code ("the Code" or "I.R.C.") is codified at 26 U.S.C., it will hereinafter be referred to by its I.R.C. designation alone (for example I.R.C. § 501(c)(3)), as this is the common way that the Code is referenced in tax materials and by practitioners.

See also Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 310-13 (1991) (examining the origin of the charitable exemption).

2. *See* John D. Colombo & Mark A. Hall, *The Future of Tax-Exemption for Nonprofit Hospitals and Other Health Care Providers*, 6 EXEMPT ORG. TAX REV. 395, 396-99 (Mar. 1993).

3. *Id.*

been attributed to the increased commercial activity⁴ that hospitals have undertaken.⁵ These hospitals have been criticized for allegedly redirecting their focus away from their exempt purpose of health care, to that of a commercial entity. In so doing, it is argued that they have come to differ little from their for-profit counterparts,⁶ and accordingly, deserve no favorable tax treatment.⁷

The nonprofit hospitals, on the other hand, contend that they must engage in joint ventures with physicians, and other revenue raising activities, in addition to their primary focus on health care, merely to survive.⁸ They counter that economic conditions have strained their traditional revenue sources to the point that these sources no longer cover the litany of costs to which they are subject.⁹ Thus, they must find other avenues in order to raise income.¹⁰ They stress, however, that their primary mission is still unquestionably charitable and, thus, deserving of exempt recognition, irrespective of the commercial ventures in which they are engaged.¹¹

The responses on the federal and state levels to this nonprofit commercial activity have been to examine exempt hospitals more closely.¹² For example, the Internal Revenue

4. See discussion *infra* part II.C.

5. See Edward Skloot, *Enterprise and Commerce in Nonprofit Organizations*, in *THE NONPROFIT SECTOR: A RESEARCH HANDBOOK* 380, 380 (Walter W. Powell ed., 1987).

6. For-profit hospitals, like all for-profit enterprises, have an ultimate purpose of earning profits for their shareholders. Walter W. Powell & Rebecca Friedkin, *Organizational Change in Nonprofit Organizations*, in *THE NONPROFIT SECTOR: A RESEARCH HANDBOOK* 180, 180 (Walter W. Powell ed., 1987). See also *infra* text accompanying notes 225-28 for a further discussion on the differences between the services delivered by nonprofit and for-profit hospitals.

7. See generally G.J. Simon, Jr., Comment, *Non-Profit Hospital Tax Exemptions: Where Did They Come From and Where Are They Going?*, 31 DUQ. L. REV. 343, 343 (1993) (questioning the continued validity of exempt status).

8. See *infra* notes 86-88 and accompanying text.

9. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 160 (1982) (discussing the change in hospital financing from the 19th to the 20th century).

10. *Id.* at 161-63.

11. J. David Seay, *Tax-Exemption for Hospitals: Towards an Understanding of Community Benefit*, 7 EXEMPT ORG. TAX REV. 413, 414 (Mar. 1993).

12. See discussion *infra* parts III.A and III.B.

Service¹³ ("the Service") has raised the level of scrutiny in audits of taxable subsidiaries, replacing the former practice of using one auditor to review all aspects of a nonprofit hospital organization, with a team of agents.¹⁴ The purpose of this action being that as involvement with for-profit enterprises increases, the nonprofit hospitals lose their traditional charitable mission. Hence, the Service has reasoned, this arguable change in focus makes nonprofit hospital organizations with many for-profit subsidiaries virtually indistinguishable from their for-profit hospital counterparts. Consequently, it calls into question their traditional justification for receiving favorable tax status.¹⁵

Additionally, the state and federal governments have developed two distinct, and seemingly incompatible criteria for maintaining or receiving exemption, sending the nonprofit hospital industry into turmoil.¹⁶ Thus, the nonprofit hospitals must choose whether to continue the activity that will raise commercial revenue and lose the exemption at one governmental level, but maintain it at the other; or meet both standards by virtually ceasing commercial activity, thereby risking their ability to survive.

This Comment presents an examination of the state and federal taxation consequences faced by nonprofit hospitals, which own for-profit subsidiaries. Part II reviews the history of the nonprofit hospital sector from its inception as a purely charitable, health-care entity, through events that led to diversification of the market, including the acquisition and formation of taxable subsidiary enterprises. Part III explores the taxation treatment that nonprofit hospitals have received at the federal, state and local levels, emphasizing how the changing hospital landscape has caused governments to alter their taxation proce-

13. The Internal Revenue Service is a federal tax agency which has been given broad authority by Congress to issue Revenue Regulations and Revenue Rulings. Regulations and Rulings are authoritative interpretations of tax code sections which can be overturned only by a judicial decision or congressional action.

14. Gen. Couns. Mem. 39,862 (Nov. 22, 1991). See also discussion *infra* part III.A for a full discussion of the impact of General Counsel Memorandum 39,862.

15. Paul Streckfus & Harriett Hanlon, *Tax Reports from the American Academy of Hospital Attorneys' 26th Annual Meeting on June 28, 1993: Officials, Hospital Attorneys Look at Current Exempt Organization Concerns*, 8 EXEMPT ORG. TAX REV. 254, 254 (Aug. 1993).

16. See discussion *infra* part IV.A.

dures. Part IV analyzes whether the present and projected taxation treatment of for-profit subsidiaries corresponds with the prevailing health-care realities. Here, the impact of the increasingly aggressive actions taken by state governments and the Service to scrutinize hospital revenue-generating activities will be examined. This increased scrutiny will be weighed against the need for nonprofit hospitals to generate additional revenue as traditional funding sources diminish, while costs increase due to the rise in hospital operation expenses. Finally, Part IV suggests the course of action that taxing entities should take in light of the negative consequences their current positions may bring to hospitals. Lastly, Part V concludes that appropriate government taxing authorities should ensure that the nonprofit hospital's mission remains primarily charitable. Unless appropriate commercial activity is allowed to continue in the nonprofit sector, the revenue shortfalls these ventures were created to address could conceivably eliminate an industry which provides the nation with vital health services that their for-profit counterparts will not.

II. Background

A. *History and Development of the Nonprofit Hospital Tax-Exempt Status*

The Sixteenth Amendment to the United States Constitution grants Congress the power to levy taxes on income.¹⁷ The general philosophy of our federal income taxation system is that "every element of gross income¹⁸ of a person, corporate or individual, is subject to tax unless there is a statute or some rule of law that exempts that person or [organization]."¹⁹ In 1959, Congress consolidated the statutes that had previously provided tax exemption to organizations that performed exclu-

17. U.S. CONST. amend. XVI. This amendment provides that "[t]he Congress shall have power to lay and collect taxes on incomes, from whatever source derived" *Id.*

18. I.R.C. § 61(a) (1988 & Supp. V 1993). Specifically, gross income includes "all income from whatever source derived" *Id.* (a very limited number of income categories are specifically excluded from gross income, and are enumerated in I.R.C. §§ 101-135 (1988)).

19. *HCSC-Laundry v. United States*, 450 U.S. 1, 5 (1981).

sively charitable functions²⁰ into section 501(c)(3) of the Internal Revenue Code.²¹

Section 501(c)(3) does not enumerate health-care organizations as one of the enterprises comprising "charitable organizations."²² In addition, the Code does not expressly define the meaning of "charitable."²³ The policies that initially conferred tax-exempt status on hospitals can trace their roots to the Elizabethan Statute of Charitable Uses of 1601.²⁴ This British statute commonly bestowed exemptions upon hospitals and other "charitable" organizations which promoted the common general welfare.²⁵ The United States initially adopted this interpretation through its early common law.²⁶ The federal government subsequently recognized income tax exemption with the enactment of the Revenue Act of 1894,²⁷ and afterward with the ratification of the Sixteenth Amendment.²⁸

20. BRUCE R. HOPKINS, *THE LAW OF TAX EXEMPT ORGANIZATIONS* 92 (5th ed. 1987).

21. I.R.C. § 501(c)(3) (1988 & Supp. V 1993). Specifically, this section of the Code describes organizations that shall be exempt from taxation under I.R.C. § 501(a) (1988 & Supp. V 1993) as: "Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition . . . or for the prevention of cruelty to children or animals . . ." *Id.* § 501(c)(3).

22. *Id.*

23. *Simon v. Eastern Ky. Welfare Rights Org.*, 426 U.S. 26, 29 (1976) (holding that 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").

24. Hall & Colombo, *supra* note 1, at 332-33. See also Peter D. Hall, *A Historical Overview of the Private Nonprofit Sector*, in *THE NONPROFIT SECTOR: A RESEARCH HANDBOOK* 3, 4 (Walter W. Powell ed., 1987) (citing Statute of Charitable Uses of 1601 (43 Eliz. I, ch. 4 (1601))); Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L. REV. 299, 301 (1976) (examining the origin of the charitable exemption).

25. *Simon*, *supra* note 7, at 343.

26. See, e.g., *Trustees of Protestant Episcopal Academy v. Taylor*, 25 A. 55 (Pa. 1892). See also James Douglas, *Political Theories of Nonprofit Organization*, in *THE NONPROFIT SECTOR: A RESEARCH HANDBOOK* 43, 43 (Walter W. Powell ed., 1987) (discussing the historical development of the charitable exemption).

27. Bittker & Rahdert, *supra* note 24, at 301. See Act of Aug. 27, 1894, ch. 349, § 32, 28 Stat. 556 (granting recognition of exemption for "literary, scientific, or other charitable institutions"). Bittker and Rahdert note that the Revenue Act of 1894 was the first time that charitable organizations were exempt from federal income tax. Bittker & Rahdert, *supra* note 24, at 330.

28. See *supra* note 17 and accompanying text.

Notwithstanding a broad common-law interpretation, the initial tax treatment given to hospitals in this country was based upon the fact that they typically provided shelter and treatment for the poor.²⁹ This change in focus was mainly due to popular sentiments which arose in the period following the American Revolution that had the result of distancing early American jurisprudence from British legal doctrine.³⁰ Accordingly, when the Service first formally addressed this issue, it interpreted the term "charitable" narrowly to include only organizations providing relief for the poor.³¹ However, over time, a combination of Revenue Rulings³² and judicial opinions³³ interpreted the term "charitable" to encompass a variety of standards that have permitted hospitals to occupy a place among the various organizations that receive tax exemption on the federal level. Federal exemption, in return, is a *de facto* prerequisite for receipt of tax exemption on the state and local levels.³⁴

Under I.R.C. section 501(c)(3), nonprofit entities receive tax exemption which extends to the organization's gross income and net earnings, including interest on endowments or funded depreciation.³⁵ Section 501(c)(3) states that an organization must be "*organized and operated exclusively for . . . charitable . . . purposes.*"³⁶ Accordingly, in order to qualify for tax-exempt status, the entity must meet two threshold qualifications,³⁷ commonly referred to as the organizational and operational tests.³⁸

29. STARR, *supra* note 9, at 145-69.

30. *Id.* The period immediately following the American Revolution saw the creation of "radical" state governments, many of which passed decisions that questioned whether they could continue to follow legal precedent set by England. In this climate one result was that hospitals initially developed not as medical centers, but rather sheltering places for the sick or poor. *Id.* at 30-40. See also Hall, *supra* note 24, at 6-7.

31. HOPKINS, *supra* note 20, at 48, 62-63.

32. See *infra* notes 71-72, 76-86 and accompanying text.

33. See discussion *infra* part III.B.2.

34. Hall & Colombo, *supra* note 1, at 323 n.5. See also ALA. CODE § 40-18-32(11) (1993); COLO. REV. STAT. § 39-22-112(1) (Supp. 1992); CONN. GEN. STAT. ANN. § 12-214(a)(2) (West 1993); GA. CODE ANN. § 48-7-25 (Supp. 1994).

35. HOPKINS, *supra* note 20, at 92-93.

36. I.R.C. § 501(c)(3) (emphasis added).

37. HOPKINS, *supra* note 20, at 239.

38. BARRY R. FURROW ET AL., HEALTH LAW CASES, MATERIALS AND PROBLEMS 458 (2d ed. 1991). Under the "organizational test," the hospital's charter must limit its operation to exempt purposes. The "operational test" compels a hospital to "be operated primarily for exempt purposes." *Id.*

To satisfy the organizational test, the entity's articles of organization³⁹ must limit its purpose to one or more of the exempt purposes described in I.R.C. section 501(c)(3),⁴⁰ and may not expressly empower the organization to engage in activities, other than unsubstantially, that are not in furtherance of those purposes.⁴¹ Similarly, "[t]o satisfy the 'operational test,' the organization's resources must be devoted to purposes that qualify as exclusively charitable within the meaning of section 501(c)(3) of the Code"⁴² An organization will not pass this test if a substantial part of its activities do not further its exempt purposes.⁴³

After the operational and organizational tests have been satisfied, an organization that wishes to obtain tax-exempt status must meet two additional requirements. First, there must not be any private inurement⁴⁴ of individuals associated with the entity.⁴⁵ Second, any private benefit must be incidental to the public benefit.⁴⁶ The Tax Court has distinguished private inurement from private benefit by classifying inurement as a subset of private benefit.⁴⁷

The private inurement requirement states that no part of the exempt entity's net earnings or other assets may benefit pri-

39. Examples of articles of organization include corporate charters, articles of association, or other written instruments by which an exempt organization is created. HOPKINS, *supra* note 20, at 68.

40. See *supra* note 21.

41. Treas. Reg. § 1.501(c)(3)-1(b)(1)(i) (as amended in 1990).

42. Rev. Rul. 72-369, 1972-2 C.B. 245, 245.

43. Treas. Reg. §§ 1.501(c)(3)-1(b)(1)(i), 1.501(c)(3)-1(c)(1) (as amended in 1990).

44. In this context, private inurement "arises whenever a financial benefit represents a transfer of resources to an individual solely by virtue of the individual's relationship with the organization, without regard to accomplishing its exempt purposes." *Prepared Statements for June 15 Oversight Subcommittee Hearing*, 8 EXEMPT ORG. TAX REV. 44, 45 (July 1993) [hereinafter *Prepared Statements*]. See also *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989) (discussing private inurement).

45. I.R.C. § 501(c)(3). Specifically, I.R.C. § 501(c)(3) states that a tax-exempt organization must be organized and operated so that "no part of the net earnings . . . inures to the benefit of any private . . . individual." *Id.*

46. *Id.*

47. *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989). The court explained that the presence of private inurement violates both prohibitions, but the absence of inurement does not mean the absence of private benefit. *Id.* at 1068-69.

vate individuals.⁴⁸ The prohibition begins at the inception of the organization and, in the event of dissolution, applies to the liquidated assets.⁴⁹ This doctrine has come to be known as the "nondistribution constraint"⁵⁰ and is the major factor which distinguishes taxable enterprises from tax-exempt organizations.⁵¹

The prohibition against inurement applies to "insiders" of the organization, namely officers, directors or others who created or control the organization, their families, or any person who has a personal interest in the entity's activities,⁵² rather than members of the general public or the entity's intended beneficiaries.⁵³ In General Counsel Memorandum ("G.C.M.") 38,459,⁵⁴ the Office of the Chief Counsel of the Internal Revenue Service affirmed that "[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."⁵⁵ This prohibition, therefore, is not limited to insiders and is meant to ensure that the exempt charitable organization fulfills its commitment to serve the public rather than private interest.⁵⁶

Transactions that the Service is likely to classify as private inurement include:⁵⁷ excessive or unreasonable compensation

48. See generally PAUL E. TREUSCH, *TAX-EXEMPT CHARITABLE ORGANIZATIONS* 122 (3d ed. 1988).

49. *Prepared Statements*, *supra* note 44, at 44.

50. Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 *YALE L.J.* 835, 838 (1980).

51. *Id.* See also HOPKINS, *supra* note 20, at 240.

52. HOPKINS, *supra* note 20, at 239.

53. *Prepared Statements*, *supra* note 44, at 45.

54. Gen. Couns. Mem. 38,459 (July 31, 1980).

55. *Id.*

56. *Id.*

57. An example of how courts have dealt with the issue of private inurement is presented by *Harding Hosp., Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1974), where the court upheld the Service's revocation of a hospital's tax-exempt status. The court explained that an agreement between staff physicians and the hospital, which paid the doctors to supervise the hospital, constituted private inurement. *Id.* at 1078. Similarly, in *Kenner v. Commissioner*, 33 T.C.M. 1239 (1974), the Tax Court upheld the revocation of exemption to a hospital owned and operated by one of its doctors. *Id.* at 1259-66. The court concluded that since the hospital had distributed its earnings to the doctor in the form of direct payments, free use of facilities and improvements to the hospital corporation's property, it had violated the prohibition against private inurement. *Id.* at 1258-59.

(including perquisites);⁵⁸ unreasonable rental charges to or by an insider;⁵⁹ or interests which are received or retained by the insider in the assets of the organization.⁶⁰ This is not to say that compensation, for example, cannot be generous. The threshold inquiry of whether inurement has occurred involves an analysis of whether providing the benefit is reasonable in light of all the circumstances, and not adverse to the organization's interests.⁶¹

The nondistribution constraint is an absolute requirement to the granting and retention of exempt status.⁶² In contrast, a private benefit may occur "so long as it is qualitatively and quantitatively incidental to the public benefits involved."⁶³ In this situation, the Service will utilize a balancing approach to determine whether the private benefit is greater than or only incidental to the public benefit derived from the activity.⁶⁴ Consequently, an incidental or unintended benefit will not be regarded as a violation of this doctrine.⁶⁵

B. *Reinterpreting the Federal Charitable Requirement*

The first Revenue Ruling issuing explicit criteria for hospital tax exemption⁶⁶ was issued in 1956 and required: 1) care for the sick; 2) to an extent commensurate with its financial ability to provide *free or below-cost* care to those both sick and *poor*; (3) to permit all qualified physicians to use its facilities; and (4) not to benefit monetarily any private shareholder or individual.⁶⁷ Placing a burden for the care of the sick-poor on nonprofit hospitals in return for receipt of tax-exempt status was seen as an appropriate trade-off to compensate for the loss of tax revenues.

58. *Prepared Statements*, *supra* note 44, at 45 (citing *Harding Hosp.*, 505 F.2d at 1078). Payment of a reasonable salary does not constitute inurement and will not cause revocation of exemption. However, if compensation is deemed excessive or unreasonable, it can result in a finding of private inurement, followed by revocation. *Id.*

59. *Id.*

60. *Id.* See also I.R.C. §§ 4941(d)(1)(A)-(E) (1988 & Supp. V 1993).

61. *Prepared Statements*, *supra* note 44, at 46.

62. *Id.* at 45.

63. *Id.* See also *HOPKINS*, *supra* note 20, at 248.

64. *Prepared Statements*, *supra* note 44, at 45.

65. *HOPKINS*, *supra* note 20, at 248.

66. Rev. Rul. 56-185, 1956-1 C.B. 202.

67. *Id.* at 203-04 (emphasis added).

The Service's decision to grant tax exemption to hospitals in this fashion was consistent with the philosophical development of the private nonprofit sector in the United States.⁶⁸ The development of nonprofit philanthropy was seen as the private alternative to socialism.⁶⁹ The concept behind this approach was that social justice goals, such as providing uncompensated medical care to the indigent, should be assisted, but not directed, by the government.⁷⁰

Dramatic changes in the health-care industry caused the Service to reinterpret what constituted "charitable purposes," from a focus on charity care⁷¹ to a definition more in line with the traditional common-law concept of providing for the general welfare.⁷² Medical technical advances and the resulting demand for high-quality care by the public led to a highly competitive health-care market.⁷³ This newly competitive thrust was compounded by constraints on hospital reimbursement by third-party insurance providers, especially Medicare and Medicaid.⁷⁴ The demand for traditional as well as specialty services increased causing a simultaneous rise in health care costs.⁷⁵ As the hospital sector evolved, so did the Service's guidelines on conferring tax exemption.

In response to the evolving realities, in 1969 the Service issued Revenue Ruling 69-545,⁷⁶ creating what has become known as the "Community Benefit Standard."⁷⁷ In a sharp de-

68. Hall, *supra* note 24, at 9.

69. *Id.*

70. *Id.*

71. See Rev. Rul. 56-185, 1956-1 C.B. 202 (criteria for tax exemption required giving free or below cost care commensurate with a hospital's financial ability).

72. See *supra* text accompanying note 25.

73. STARR, *supra* note 9, at 154-62, 428.

74. *Id.* at 428. Medicaid was established by the Medicare Act. 42 U.S.C. §§ 1395b-1395bbb (1988 & Supp. II 1990). Medicaid is a federally funded, state administered program which underwrites medical services to various categories of health care recipients, including poor and indigent patients. Reimbursement rates are generally lower than those paid by private insurers. Uncompensated care must be subsidized by the hospital and is generally listed as charity care or written off as bad debts. GAO Reports on Nonprofit Hospitals' For-profit Ventures, 8 EX-EMPT ORG. TAX. REV. 623, 627 n.2. (Sept. 1993) [hereinafter GAO Report].

75. STARR, *supra* note 9, at 381-88.

76. Rev. Rul. 69-545, 1969-2 C.B. 117.

77. The community benefit standard developed by Revenue Ruling 69-545 is that a "hospital [to be exempt] must promote the health of a class of persons broad

parture from Revenue Ruling 56-185, this new ruling swept away the earlier, narrower emphasis on relief for the poor⁷⁸ and substituted it with a mandate that nonprofit hospitals need only serve the general needs of the common welfare.⁷⁹ In formulating this new standard, the Service returned to the historical interpretation of "charitable benefit" drawn from English law.⁸⁰

The new criteria for obtaining charitable status became: 1) "whether the hospital has a governing board composed of civic leaders;" 2) "whether the organization is part of a multi-entity hospital system;" 3) "whether admission to the hospital staff is open to all qualified physicians in the area;" 4) "whether it operates a full-time emergency room open to everyone;" and 5) "whether it provides nonemergency care to *everyone in the community able to pay* privately or through third parties."⁸¹ This ruling for the first time deemed the promotion of health alone a *per se* community benefit.⁸² Since the introduction of Revenue Ruling 69-545, challenges have been made to the Service's determination that to serve a charitable purpose under section 501(c)(3), nonprofit hospitals no longer are compelled to provide relief solely to the poor as a major part of their mission. However, the courts have successfully and repeatedly defeated the challenges on procedural grounds.⁸³ The net effect has been a

enough to benefit the community and must be operated to serve a public rather than a private interest." HOPKINS, *supra* note 20, at 105.

78. Rev. Rul. 69-545 provided that "Revenue Ruling 56-185 is hereby modified to remove therefrom the requirements relating to caring for patients without charge or at rates below cost." Rev. Rul. 69-545, 1969-2 C.B. 117, 119.

79. Rev. Rul. 69-545 held that "[a] nonprofit organization whose purpose and activity are providing hospital care *is* promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose." *Id.* at 118 (emphasis added). See also Treas. Reg. § 1.501(c)(3)-1(a)(1) (as amended in 1990).

80. See *supra* text accompanying notes 24, 25.

81. Barbara Kirchheimer et al., *Attorneys Updated on IRS Concerns About Hospitals, Fund-Raising*, 57 TAX NOTES 453, 454 (Oct. 1992) (emphasis added).

82. Rev. Rul. 69-545, 1969-2 C.B. 117. This ruling also declared that "[i]n the general law of charity, the promotion of health is considered to be a charitable purpose." *Id.* at 118.

83. See *Simon v. Eastern Ky. Welfare Rights Org.*, 426 U.S. 26, 41-43, 46 (1975). The Court held that the plaintiff class seeking to enjoin the Internal Revenue Service from granting exemptions without obligating hospitals to treat the medically indigent lacked standing because the class had not shown that a direct causal relationship existed between lack of access to health care and the Revenue Ruling, or in the alternative, that a favorable ruling would redress their injury. *Id.* at 26, 37-46. See also *Lugo v. Miller*, 640 F.2d 823, 823-24 (6th Cir. 1981) (denying

lack of judicial relief to plaintiffs challenging the Service's position.

In fact, in 1983, Revenue Ruling 83-157 went so far as to remove the requirement that a nonprofit hospital operate a full-time emergency room, if that service would be "unnecessary and duplicative" of nearby facilities.⁸⁴ Since the emergency room criterion is the only component of Revenue Ruling 69-545, which compelled hospitals to provide medical service regardless of the patients ability to pay, Revenue Ruling 83-157 has made it possible for some nonprofit hospitals to operate within the regulations without rendering *any* services to patients unable to pay the full cost of the medical service.⁸⁵ While this result seems to go far beyond the original philosophy for granting tax-exempt status, the Commissioner has explained the Service's position by stating that in the limited circumstances where a hospital meets Revenue Ruling 83-157's standard, it will be found to operate exclusively for the benefit of the community, and thus receive charitable tax-exempt status.⁸⁶

The enhanced competition within the hospital field, accompanied by a scarcity of capital, problems accessing financial markets,⁸⁷ and medical cost reimbursement problems, combined to cause nonprofit hospitals to restructure in an attempt to generate the resources necessary to survive and compete with their for-profit counterparts.⁸⁸ The resulting entities have

standing to a class of low income plaintiffs who sought to meet the causal relationship requirement in *Simon*, by suing specific nonprofit hospitals to accept a precise number of indigent patients, on the grounds that a direct causal relationship was still not present).

84. Rev. Rul. 83-157, 1983-2 C.B. 94, 94.

85. *Id.*

86. *Id.* at 95. There is an almost absurd quality to the notion that the Service has extended its blessing to hospitals that fairly exclude indigent patients. This is especially true in light of the Service's "hard line" approach to revenue generation by hospitals which have high indigent patient populations and are using their for-profit commercial enterprises to generate enough revenue to cover operational costs that go, in large part, to support their relief to the poor and under-insured. *Id.*

87. Most nonprofit hospitals face constraints in the commercial capital marketplace because they do not have access to equity markets, have inadequate access to debt financing or are undercapitalized. Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 72-74 (1981).

88. Douglas M. Mancino, *Income Tax Exemption of the Contemporary Non-profit Hospital*, 32 ST. LOUIS U. L.J. 1015, 1026-28 (1988).

often been criticized for not being substantially different from for-profit hospitals to justify their tax advantages.⁸⁹

C. *The Emergence of For-Profit Subsidiaries in the Nonprofit Hospital Sector*

The existence of commercial enterprises has been a long-standing tradition in the nonprofit sector, and hospitals have been no exception.⁹⁰ This trend became particularly pronounced in the early 1980s, as nonprofit hospitals and other nonprofit organizations strove to increase and diversify their sources of revenue.⁹¹ Several factors contributed to the growth of this activity in the health-care market.

First, the rise in competition with for-profits came about as the result of improved medical technology and the concurrent increase in patient demand for the improved treatments.⁹² Since for-profit hospitals had the capital to make medical improvements, they captured much of the patient demand for these advances, resulting in market loss by nonprofits.⁹³ As a result, nonprofit hospitals, which had come to rely almost exclusively on patient revenues for their operating needs, were forced to come up with creative solutions to increase their competitive position, and recapture or increase their patient flow to restore their revenues.⁹⁴

A second catalyst in the diversification of nonprofit hospitals were the Reagan and Bush administrations' budget cuts in federal domestic spending.⁹⁵ These cuts impacted Medicare/Medicaid payments—a traditional and major source of revenue for many nonprofits. A complementary event that drastically lowered the funding received from Medicare was the new reimbursement system of payments instituted in 1983.⁹⁶ This new

89. Hansmann, *supra* note 87, at 54.

90. Skloot, *supra* note 5, at 380. Examples of traditional involvement in for-profit enterprises include the ownership of college bookstores, museum gift shops and university presses. *Id.*

91. *Id.*

92. STARR, *supra* note 9, at 154-62, 428.

93. *Id.* at 436-39.

94. Skloot, *supra* note 5, at 380.

95. *Id.*

96. David W. Ball, *Charitable Hospitals' Tax Exempt Status at Risk*, 4 S.C. LAW. 25 (July-Aug. 1992). Prior to 1983, "hospitals were reimbursed [under Medicaid] using a retrospective cost-based system [which repaid the hospital for all

approach created Diagnostic Related Groups ("DRGs"), which set up categories of illnesses and paid set rates according to the category, regardless of the cost of the service to the hospital or patient.⁹⁷ Prior to DRGs, payments were made according to the treatments received, and charges submitted were almost always fully reimbursed so long as they were "reasonable and necessary."⁹⁸ Under the DRG system, full reimbursement for the cost of a medical service is not given, thus the amount received by the hospital does not fully meet the charges incurred. As a result of the decreased revenue, nonprofit hospitals gained a "strong financial incentive to admit more patients and release them more quickly" in order to enhance their revenue flow.⁹⁹

Nonprofit hospitals have also engaged in collaborative activities with their physicians and both for-profit and nonprofit health care entities as another way to remain financially viable.¹⁰⁰ One such activity is physician recruitment programs. Physicians have traditionally controlled patient admissions and referrals to hospitals, and consequently the payments that logically flow from those transactions.¹⁰¹ Therefore, the present goal of these incentive programs is to create strong ties to the hospital, ensuring doctor loyalty, which in turn leads to stable or increased admissions and referrals. In addition, these ties ideally prevent patients from being directed to competing hospitals. The most common risks caused by this particular remedy are, ironically, the potential of running afoul of the federal Medicare "anti-kickback" statute,¹⁰² and recently, the loss of

costs which were 'reasonable and necessary']. Under the new prospective system, hospital reimbursements are based on payment categories called Diagnostic Related Groups (DRGs) with payment fixed prospectively." *Id.* at 25.

97. *Id.*

98. See *Presbyterian Hosp. of Dallas v. Harris*, 638 F.2d 1381, 1383 (5th Cir. 1981). The court noted that a hospital which is a qualified provider of medical services is entitled to reimbursement for "reasonable costs" incurred in necessary health care. *Id.* at 1387.

99. Ball, *supra* note 96, at 25.

100. Michael W. Peregrine, *Creative Health Care Collaborations Showcased in New Letter Rulings*, 8 EXEMPT ORG. TAX REV. 113, 113 (July 1993).

101. *Presbyterian Hosp.*, 638 F.2d at 1387. See also GAO Reports, *supra* note 74, at 624 (discussing joint ventures between nonprofit hospitals and physicians).

102. 56 Fed. Reg. 35,952 (1991). This statute imposes criminal, as well as civil penalties for the offer, solicitation, payment or receipt of remuneration received in return for the referral (or to induce the referral) of a patient for any service reimbursed under the Medicare program. *Id.* The penalties for violation

federal tax exemption for the hospital as the result of new Service requirements.¹⁰³

Many hospitals achieved their revenue enhancement goals through corporate reorganization. "Polycorporate enterprise models,"¹⁰⁴ came into existence in this climate. They have allowed hospitals primarily controlled by administrators to create enterprise systems consisting of nonprofit and for-profit entities.¹⁰⁵ The revenues generated by the for-profit subsidiaries have been used to offset operating costs of the nonprofit enterprises. The benefit is that profits which are directly siphoned back to the parent receive tax-exempt status.¹⁰⁶ Nonprofits have formed a wide range of entrepreneurial ventures,¹⁰⁷ the most common, as described by Edward Skloot, are examined below.

1) *Program-related products*: These are ventures which promote the exempt mission of the enterprise, while turning a significant profit. They include fully updated maternity and surgery wards.¹⁰⁸ These projects are allowed to maintain exempt status because they fully support the health care mission. In addition, it was never the intent of the Service to prohibit nonprofits from generating a profit. Rather, they are prohibited from distributing revenue to insiders, and must instead return the funds to support their exempt operation.

2) *Program-related services*: These for-profit activities are ancillary commercial services, such as parking lots, cafeteria food sales used for convenience of those visiting a patient, and

include felony prosecution with up to five years in jail and exclusion from future participation in Medicare programs. *Id.*

103. See discussion *supra* part II.B.

104. The most common form of reorganization undertaken by nonprofit hospitals is the "polycorporate enterprise model," which generally includes a tax-exempt parent holding company with both for-profit and nonprofit entities, at least one of which is a hospital. Tax-exempt status of the enterprise is not affected as long as the after-tax profits of the for-profit subsidiaries support the nonprofit corporations. STARR, *supra* note 9, at 437; Mary P. Squires, *Corporate Restructuring of Tax-Exempt Hospitals: The Bastardization of the Tax-Exempt Concept*, 14 LAW, MED. & HEALTH CARE 66, 71-73 (1986).

105. Melvin Horowitz, *Corporate Reorganization: The Last Gasp or Last Clear Chance for the Tax Exempt, Nonprofit Hospital?*, 13 AM. J.L. & MED. 527, 528 (1988).

106. *Id.* at 536-37.

107. Skloot, *supra* note 5, at 381.

108. *Id.*

laundry cooperatives.¹⁰⁹ As long as the amount of these services provided remains incidental in proportion to the amount of exempt functions provided, they will not be subject to taxation.

3) *Staff and client resources*: This area encompasses the variety of ways that a nonprofit utilizes its available human resources to generate additional profits, and includes providing computer department support or financial and management consulting services to other nonprofit or for-profit enterprises, and joint ventures with doctors.¹¹⁰ The former category will generally receive favorable treatment from the Service so long as the organization observes the non-distribution requirement.¹¹¹ The more problematic situation arises in the area of joint ventures because the Service has generally held that all joint ventures with doctors create significant private inurement to the doctors.¹¹²

4) *Real property*: These ventures include the sale, lease or rental of land and buildings owned by the hospital.¹¹³ Generally, these ventures will not subject the hospital to unfavorable tax consequences unless the Service determines that the transaction did not occur at arms length and improperly benefitted an insider.

Since nonprofits are forbidden by law to distribute the profits from these ventures to "insiders," most of this income is used for the general operating fund to promote ongoing or new projects related to the hospital's exempt mission.¹¹⁴

109. *Id.*

110. *Id.* at 381-82.

111. *See supra* text accompanying notes 62-65.

112. *Joint Venture With Doctors May Jeopardize Hospitals' Exempt Status*, 53 TAX NOTES 1129, 1130 (Dec. 1991). *But see* Internal Revenue Service, *Exempt Hospitals' Joint Venture with For-Profit Firm Has No Adverse Tax Effects*, 59 TAX NOTES 1618 (June 1993) (determining transaction to fall within Section 501(c)(3) requirements on a finding that the joint venture to maintain a rehabilitation services hospital would serve an exclusively charitable public purpose).

113. Skloot, *supra* note 5, at 382-83.

114. *Id.* at 387.

III. Current Climate

A. Federal Trends

General Counsel Memorandum 39,862 became effective on December 31, 1991.¹¹⁵ It confirmed the Service's position on substantive tax issues and reflected the Service's commitment to intensified scrutiny of the structure, activities and operations of large exempt hospitals.¹¹⁶ The G.C.M. directly reflected the Service's concerns that its audit system did not have examination procedures in place to deal with the growing phenomenon of large exempt organizations which resemble for-profit enterprises.¹¹⁷ The Service's initial step to address this situation was in the form of hospital system audits begun in 1990 under the Coordinated Examination Program ("CEP").¹¹⁸ Under CEP, a team of agents replaced the former system of using just one auditor.¹¹⁹ This increased coverage was meant to raise the level of scrutiny and ensure compliance with all aspects of exemption requirements.¹²⁰ Although G.C.M. 39,862 was intended for use in all hospital audits, it was released largely as a tool to assist CEP examiners, and reflected the Service's new "hard-line" approach to nonprofit hospital activities that might generate unrelated business income.¹²¹

Specific focus was placed on ensuring that hospitals meet the community benefit standard and do not violate exemption

115. Gen. Couns. Mem. 39,862 (Nov. 22, 1991).

116. Milton Cerny & Eileen M. Mallon, *Extensive New IRS Audit Guidelines Intensify Scrutiny of Colleges and Universities*, 78 J. TAX'N 298, 298 & n.5 (May 1993).

117. *Id.* at 298.

118. *Id.*

119. *Id.*

120. *Id.*

121. *Id.*

The guidelines incorporated or expanded aggressive IRS legal interpretations of, among other things, the community benefit standard; the definition of "insiders" for purposes of the inurement provisions; the reasonableness of physician recruitment incentives; the effect of joint ventures on exemption; and the allocation of Medicare costs for purposes of calculating UBIT (unrelated business income tax). Indeed, Service officials predicted that the hospital CEP audits would raise revocation-of-exemption issues.

Id. (citing Rita L. Zeidner, *IRS Writes Tough Prescription for Some Tax-Exempt Hospitals*, 5 EXEMPT ORG. TAX REV. 640 (Apr. 1992)).

requirements.¹²² The mandate of the G.C.M. was that a tax exempt hospital's financial arrangements with physicians and other hospital "insiders" must provide a benefit to the community at large, not just the hospital.¹²³ Applying the "community benefit standard" to all of a hospital's for-profit financial arrangements, the Service called for objective evidence that there was a tangible benefit to the community, rather than to private interest.¹²⁴

In March 1992, the Service came out with audit guidelines to reflect the policies of G.C.M. 39,862, which set forth factors to consider in determining whether a nonprofit hospital met the community benefit standard.¹²⁵ Specifically targeted for close scrutiny under the guidelines are: joint ventures; practice acquisition activities; private foundation status of the parent entity in a hospital system; the flow of funds through a system; and the private use provision of the tax law affecting exempt bonds.¹²⁶ While highlighting areas that the Service is likely to challenge, the guidelines do not, and cannot, definitively reflect the current state of the law on this point because courts remain the ultimate arbiter of the congressional intent behind the relevant tax law, and may still disagree with this interpretation.

The Service still supports tax exemption for income earned by hospitals which will be used to support their exempt mission.¹²⁷ Interestingly, while the Service has become increasingly hostile toward some commercial enterprises,¹²⁸ most notably joint ventures with physicians,¹²⁹ it favors tax exemption for passive income earned by hospitals' commercial ven-

122. *Id.*

123. Gen. Couns. Mem. 39,862 (Nov. 22, 1991).

124. *Id.* The joint ventures addressed by this G.C.M. involved the reconfiguration of existing hospital departments. The Service concluded that since the ventures did not result in expansion of health care resources, improvement of quality, or reduction of cost, no charitable purpose had been served. Instead the Service found the ventures to have been created primarily for the inurement of the physicians. Therefore, the Service concluded, exemption should be revoked. Marlis L. Carson, *Brier and Mancino Address Health Care Tax Issues*, 7 EXEMPT ORG. TAX REV. 717, 719 (May 1993).

125. See *supra* notes 76-81 and accompanying text.

126. Kirchheimer et al., *supra* note 81, at 453.

127. John Copeland, *Some Suggestions for Revision of Tax-Exempt Organization Rules*, 51 TAX NOTES 911 (May 1991).

128. See, e.g., *supra* text accompanying notes 108-13.

129. See *supra* note 112 and accompanying text.

tures that are used to support the exempt mission.¹³⁰ “[W]e believe the exemption for passive income may appropriately encourage exempt organizations to avoid deeper commercial involvements and the potential distractions and conflicts they present.”¹³¹

It is interesting that the standards promulgated by the guidelines appear aimed at urban and suburban hospitals. A lower level of scrutiny has been set in the case of rural hospitals in the areas of private inurement and private benefit.¹³² The contrast was made between urban settings where physicians are in “ample supply” and, thus, a finding of private inurement is easily justified, versus a rural setting where the community benefit in obtaining a needed specialist is seen to outweigh any private benefit to the physician.¹³³ Historically, the Service has applied these principles more liberally in order to combat the obstacles faced due to their demographics.¹³⁴ Similarly, commercial activity principles are more liberally enforced because of the likelihood that no commercial alternative exists to raise needed funds,¹³⁵ and thus the community benefit is the choice between a financially sound hospital, or none at all.

B. State Trends

1. Activity Regarding Nonprofit Hospital Property Tax Exemptions¹³⁶

Many states have begun to scrutinize their grants of property tax exemptions to hospitals.¹³⁷ In doing so, some have concluded that it was necessary to refine or even redefine their

130. Copeland, *supra* note 127, at 914.

131. *Id.*

132. Kirchheimer et al., *supra* note 81, at 455.

133. *Id.*

134. *Id.*

135. *Id.* Hyatt cited UBITs and physician recruitment programs (e.g., loan programs, salary guarantees, scholarship programs) as examples of the liberal application received by rural hospitals. In contrast, similar ventures often violate the aforementioned principles if they occur in an urban setting. *Id.*

136. State income tax treatment of for-profit hospitals is beyond the scope of this Comment since this Comment deals with changes in federal and state taxation treatment of nonprofit hospitals.

137. Catherine Hubbard, *State, Local Governments Eliminating Exemptions for, Increasing Audits of Nonprofits*, 7 EXEMPT ORG. TAX REV. 695, 695 (Apr. 1993).

basis for granting these exemptions.¹³⁸ Traditionally, once federal tax exemption had been granted to a hospital, it also received relief from state property tax levies.¹³⁹ However, many states have recently considered allowing cities and towns to levy taxes on exempt institutions, including hospitals.

Examples of states which have initiated activities aimed at raising revenue from nonprofit hospitals include Texas and New York. Texas, which responded aggressively to the issue of linking charity status with providing relief to the poor, mandated a minimum level of charity care for nonprofit hospitals that want to retain their tax-exempt status.¹⁴⁰ The law Texas enacted requires hospitals to develop a community benefits plan, which must include a "community-wide assessment of local health care needs, and a method to evaluate achievement of the goals."¹⁴¹

In New York, a detailed study has been commissioned by the Governor's Panel on Real Property Tax Exemption and Classification Issues ("the Panel") to explore "real property tax exemptions, their impact on local governments and their effectiveness in achieving statewide policy objectives."¹⁴² The Panel Report candidly declares that the primary motivation for re-examining the state's property tax exemption policy is the critical fiscal situation facing many of the State's local governments due to needs that have grown, while resources have shrunk.¹⁴³ The

138. *Id.*

139. *Id.*

140. Marlis L. Carson, *Texas Statute Mandates Minimum Level of Charitable Care for Tax-Exempt Hospitals*, 8 EXEMPT ORG. TAX REV. 498, 498 (Sept. 1993). The law allows a hospital to elect among one of five standards to meet their "charity care requirements." *Id.* All mandate, on a sliding scale, that the hospital provide indigent care based on a percentage of either net patient revenues or state provided exemptions. *Id.* The purpose of these standards is to have all hospitals provide some degree of indigent patient care. *Id.* Exemptions from this law are provided to hospitals in very rural areas, and those deemed to have provided a "disproportionate share" of charity care in either of the two previous fiscal years. *Id.* The legislation appears to have been prompted by a suit brought by the State Attorney General against Methodist Hospital of Houston, which spent less than one percent of gross revenues for charity care, even though it had a cash reserve fund of more than \$330 million. *Id.*

141. *Id.* See TEX. TAX CODE ANN. §§ 311.043-.047 (West Supp. 1995).

142. GOVERNOR'S PANEL ON REAL PROPERTY TAX EXEMPTION AND CLASSIFICATION ISSUES, INTERIM REPORT 1 (Dec. 1993) [hereinafter PANEL REPORT] (on file with *Pace Law Review*).

143. *Id.* at 4.

Panel Report acknowledges that revenue raised from repealing exempt status would substantially increase local government revenue.¹⁴⁴ The draft recommendations focus on requiring municipalities to grant future, and to continue existing, exemptions on an "opt in" basis.¹⁴⁵

Recommendations affecting nonprofit hospitals include authorizing municipalities to replace fixed dollar value exemptions for exemptions based on a percentage of property value ("ad valorem"), or other relevant measures.¹⁴⁶ The Panel Report has suggested that municipalities be permitted to impose charges for services provided for fire and police protection, capital infrastructure, and snow removal.¹⁴⁷ A tax base sharing plan has also been suggested as a way to alleviate pressure on the municipality which provides the exemption to the hospital and spread the exemption burden over the entire area benefited by the hospital's services.¹⁴⁸ Concurrent with the Panel's activity, both houses of the New York legislature introduced bills in 1991 that mirror the Panel's recommendations.¹⁴⁹

Not surprisingly, the nonprofit sector has raised a number of objections to the Panel's initial recommendations.¹⁵⁰ The main argument addressed the perceived inequity of a proposed ad valorem measure to compensate for service costs incurred by the nonprofit sector. Namely, the Panel contended that it might be acceptable to impose a service charge to cover the cost of

144. *Id.*

145. *Id.* at 9. Under the current practice of "opting out," only the revocation or denial of an exemption is made on a case by case basis, while grants of exemption are not scrutinized. In contrast, "opting in" would require a municipality to affirmatively grant exemptions. *Id.*

146. *Id.* at 12. Local governments currently have authority to impose charges for certain services that can be provided on a method other than ad valorem or special assessment. *Id.*

147. *Id.* at 27. The Panel suggested it would be appropriate for municipalities to impose a fixed charge for making the service available and then a variable charge based on actual usage of the service. *Id.* at 28.

148. *Id.* at 14.

149. *Id.* at 29-30. These bills, which were introduced in 1991 and which passed during the 1994 session, limit available property tax exemptions to that portion of land which is used *exclusively and actively* for exempt purposes. *Id.* at 30. See N.Y.S. 5261, N.Y.A. 3384, 215th Sess. (1994)

150. MINORITY REPORT BY PETER SWORDS, NONPROFIT COORDINATING COUNCIL OF NEW YORK (Sept. 7, 1993), in PANEL REPORT, *supra* note 142, app. 1 [hereinafter MINORITY REPORT] (on file with *Pace Law Review*). Mr. Swords is a member of the Governor's Panel.

services, which directly benefit the exempt property. Notwithstanding, an ad valorem tax would be an unacceptable solution since it would bear no real relationship to the services rendered, and an ad valorem tax creates a tendency to increase the rate charged in order to help finance general government services and debt reduction.¹⁵¹ The nonprofits suggested that problems related to exempt organizations in the State of New York arise from lax enforcement of existing tax laws, rather than over-involvement in commercial activities.¹⁵²

2. *State Judiciary Response to the Property Tax Issue*

In addition to legislative initiative, several state courts, led by Utah and Pennsylvania, have created more stringent standards by which to measure whether a hospital is engaging in activity that justifies the bestowal of favorable tax treatment.¹⁵³ In *Utah County v. Intermountain Health Care Inc.*,¹⁵⁴ the Utah Supreme Court held that a nonprofit hospital organization which owned for-profit subsidiaries had to pay property taxes.¹⁵⁵ The court determined that the hospital had failed to meet the charity standard of a "gift to the community," identified as either a substantial imbalance in the exchange between the charity and the recipient of services, or the lessening of the government burden through charity operations.¹⁵⁶ The factors the court analyzed to reach this conclusion included: 1) that both the hospital and parent holding company received a very small percentage of revenue from charitable donations; 2) that while the "corporate purposes" of the hospital prevented inurement to any private individual there were various forms of commercial activity conducted as a relevant part of the hospital's operations; and 3) that the hospital made concerted efforts to receive payment for its services as opposed to "being in the busi-

151. *Id.* at 2 n.**, 5.

152. PANEL REPORT, *supra* note 142, at 10.

153. See *Hospital Utilization Project v. Commonwealth*, 487 A.2d 1306 (Pa. 1985); *Utah County v. Intermountain Health Care Inc.*, 709 P.2d 265 (Utah 1985).

154. 709 P.2d 265 (Utah 1985).

155. *Id.*

156. *Id.* at 269.

ness of providing hospital care for the poor.”¹⁵⁷ Thus the tax relief unfairly advantaged the nonprofits.¹⁵⁸

Analyzing its findings, the court noted that “[t]he emergence of hospital organizations with both for-profit and non-profit components has increasingly destroyed the charitable pretensions of nonprofit organizations”¹⁵⁹ Consequently, the “gradual disappearance of the traditional charitable hospital for the poor” resulted.¹⁶⁰ Once it reached the conclusion that there was no true distinction between for-profits and nonprofits, the court had no choice but to revoke state property tax exemption.¹⁶¹ The court justified its decision by declaring that taxes levied would have no likelihood of jeopardizing current or future levels of care.¹⁶²

Similarly, in *Hospital Utilization Project v. Commonwealth*,¹⁶³ the Pennsylvania Supreme Court addressed the property tax exemption issue by creating a standard to determine whether a hospital system is a “purely public charity” and, accordingly, deserving of state property tax relief.¹⁶⁴ The five element test states that a hospital must: “a) [a]dvance[] a charitable purpose; b) [d]onate[] or render gratuitously a substantial portion of its services; c) [b]enefit[] a substantial and indefinite class of persons who are legitimate subjects of charity; d) [r]elieve[] the government of some of its [health care] burden; and e) [o]perate[] entirely free from private motive.”¹⁶⁵ The court then applied the criteria to the HUP, and held that it did not meet the prescribed standard.¹⁶⁶ Thus, the standard developed by the court puts a heavy emphasis on relief for the

157. *Id.* at 272-76.

158. *Id.* at 278.

159. *Id.* at 272 (citing STARR, *supra* note 9, at 438).

160. *Id.* at 271.

161. *Id.* at 278.

162. *Id.* at 275-76.

163. 487 A.2d 1306 (Pa. 1985).

164. *Id.* at 1317.

165. *Id.* See also PA. CONST. art. VIII § 2(a) which states: “The General Assembly may by law exempt from taxation: . . . (v) Institutions of purely public charity, but in the case of any real property tax exemptions, only that portion of real property of such institutions which is actually and regularly used for the purposes of the institution.” *Id.*

166. *Hospital Utilization Project*, 487 A.2d at 1317.

poor as a prerequisite for the receipt or continuation of exempt status.

IV. Analysis

A. *Federal Versus State Taxation Approaches*

The fundamental difference in the federal and state level tax treatment toward nonprofit hospitals can be directly traced to the ways these two levels of government define what constitutes a "charitable activity." While federal standards require that some element of indigent care be provided, usually in the form of acceptance of patients on Medicare,¹⁶⁷ a nonprofit hospital may still meet the federal criteria without providing any medical care for the poor or uninsured, so long as there is evidence that it provides a benefit to the community.¹⁶⁸ Consequently, the Internal Revenue Service definition set a community benefit standard, which permits a hospital to operate as a nonprofit entity even though it may have commercial subsidiaries, so long as the profit motive is incidental to the primary health care objective.¹⁶⁹

In contrast, the trend at the state level is to subject nonprofit hospitals to property tax on the theory that they have become "too commercial" and are no longer deserving of special protection.¹⁷⁰ The "charitable care" standard,¹⁷¹ adopted by states which have increased their scrutiny of property tax exemptions,¹⁷² will be met only if a hospital provides a substantial level of indigent health services. In addition, almost any level of commercial venture, even without private inurement, will be seen as evidence that the hospital no longer fulfills a charitable mission.¹⁷³ This generates fundamental policy dilemmas for

167. See *supra* note 102 and accompanying text (Medicare anti-kickback statute).

168. See *supra* notes 78-79 and accompanying text.

169. Rev. Rul. 83-157, 1983-2 C.B. 94.

170. Hubbard, *supra* note 137, at 695.

171. See *supra* notes 76-78 and accompanying text.

172. See discussion *supra* part III.B.1.

173. Hubbard, *supra* note 137, at 695. It has been recommended that hospitals review their mission statements to ensure that they do not focus only on increasing market share or revenue. *Id.* This contrasts with the I.R.S. which has a de facto requirement that there be private inurement before tax exemption is challenged. See *supra* text accompanying notes 44, 48-61 and accompanying text.

hospitals located in revenue-hungry states. The choice has been removed: if nonprofit hospitals must engage in commercial activities just to survive, they almost automatically forfeit their property tax exemption.

Since state-level criteria also vary from state to state, there is no one "local" test on which a multi-state hospital system can rely.¹⁷⁴ The obvious conclusion is that caught between an unpredictably changing state system and contrasting federal criteria, nonprofit hospitals may choose to meet the federal standard, and risk forgoing their state exemption, or meet the state standard and risk forgoing their federal exemption.¹⁷⁵

B. *Where is the Federal Government Headed?*

The current activity by the federal government regarding taxation issues surrounding nonprofit hospitals is occurring in three areas: regulations and guidelines adopted by the Internal Revenue Service; congressional tax legislation; and health care reform. The Service has shown a willingness to adapt to the evolving nature of nonprofit health care systems.¹⁷⁶ Undoubtedly, the Service should monitor and prohibit instances of private inurement which occur as a result of commercial activity. It must, however, remain sensitive to the necessity for a viable health care industry while achieving its underlying goals of collecting revenue and enforcing exemption requirements.

Nonprofits, for their part, can avoid common inurement problems that jeopardize federal exemption when engaging in physician recruitment techniques¹⁷⁷ by seeking to secure relationships only with doctors that possess skills needed by the patient population.¹⁷⁸ Comparable precautions in the area of physician retention schemes will ensure that a nonprofit's tax-

174. See *supra* parts III.B.1, B.2 for a discussion of the tests used by Texas and New York, and by the judiciaries of Utah and Pennsylvania.

175. The most common result is for a hospital to be well within the federal guidelines, but fail to keep its property tax exemption in a state that is determined to raise revenues at the expense of redefining, almost overnight, its historical reasons for granting exemption, namely that the nonprofit was providing needed health care services to the community as a whole.

176. See discussion *supra* part III.A.

177. Examples include practice guarantees and payment of malpractice insurance premiums, which the Service will tolerate if the hospital is receiving a *quid pro quo* from its physicians. Carson, *supra* note 124, at 720.

178. *Id.*

exempt status is not threatened. As long as the hospital can show that the programs it wishes to establish with doctors will improve efficiency, lead to better patient care, and perhaps even lower costs to patients, the issue of inurement or private benefit is essentially mooted.¹⁷⁹ Inurement is likely to be found, however, if the only reason for the recruitment or retention of an individual doctor is to improve the hospital's market share.¹⁸⁰

In 1991, Representative Edward Roybal, Democrat from California, introduced a bill that would require nonprofit hospitals to provide specific standards of charity care in order to receive federal exemption.¹⁸¹ These standards are met if a hospital spends at least 50 percent of the value of the exemption on unreimbursed charity care and quantifiable community benefits.¹⁸² Representative Brian Donnelly, Democrat from Massachusetts, also proposed legislation which would grant exemption only if a hospital meets a combination of charity care and community service standards.¹⁸³ Both of the bills seek to set clear standards by which hospitals are granted, or allowed to maintain, federal exemption status, through the adoption of a "relief of government burden" approach.¹⁸⁴ However, by tying a grant of exemption to expenditures for charity care, the bills redefine "charitable purpose," returning to the "relief of the poor" standard formerly used, and discarded, by the Service.¹⁸⁵ The Donnelly bill relies on revocation of exemption, in contrast to the Roybal bill which imposes a new excise tax on a hospital that fails to meet its standards.¹⁸⁶

One criticism of these bills is that they create "quagmires of complexity" for hospitals and the Service because each proposal has a variety of possible options for hospitals.¹⁸⁷ A significant shortfall of the Donnelly bill is that specialty hospitals would

179. *Id.*

180. *See id.*

181. Colombo & Hall, *supra* note 2, at 400. *See* H.R. 790, 102d Cong., 1st Sess. (1991).

182. *Id.* at 401.

183. *Id.* at 403. These include operating an "open emergency room," treating Medicaid patients and meeting one of five community benefit tests. *Id.* *See* H.R. 1374, 102d Cong., 1st Sess. (1991).

184. Seay, *supra* note 11, at 413.

185. *Id.* *See also supra* text accompanying notes 66-67.

186. Colombo & Hall, *supra* note 2, at 405-06.

187. Seay, *supra* note 11, at 414.

automatically lose exemption because, by their nature, they are unlikely to have enough indigent patients to meet the bill's requirements.¹⁸⁸ In view of the serious criticisms of both bills, it seems unlikely that they will reach a point where they can solve the pressing issues this sector faces.

Congressional action taken to date has been in the form of proposed tax legislation and is for the moment overshadowed by health care reform measures being advanced by President Clinton. The newest wrinkle on the federal level is the proposed Health Security Act.¹⁸⁹ In addition to the traditional community benefit requirement, this Act also contains a "community needs assessment and plan development" report that hospitals must prepare in order to be tax-exempt.¹⁹⁰ The proponents of this hybrid plan assert that it enhances the traditional community benefits standard by adding a component of flexibility.¹⁹¹ Flexibility was built into the plan in order to accommodate the "wide variety of . . . organizations, the diverse needs of the communities in which they operate, and the changes in the marketplace expected to result from the adoption of the President's health care reform plan."¹⁹²

The most important factor determining that a hospital meets the proposed requirements is whether it has given the community a meaningful opportunity to be involved in developing the programs.¹⁹³ Consequently, the emphasis of the new plan is to ensure that health care providers are responsive to the unique demands of their communities.¹⁹⁴ By tailoring the health care services being delivered to the needs of the communities, nonprofits eliminate the temptation of delivering duplicative services that unnecessarily compete with for-profits, and this inherently produces a concrete community benefit. This

188. *Id.*

189. UNOFFICIAL TRANSCRIPT OF THE HOUSE WAYS & MEANS PANEL HEARING ON HEALTH CARE REFORM 6-16 (Doc. 93-12990) (Dec. 14, 1993) [hereinafter UNOFFICIAL TRANSCRIPT] (on file with *Pace Law Review*). The Act is part of the Clinton Health Plan. Neither the President's health care reform measures nor the Act had been adopted at the time of publication.

190. *Id.* at 6-9.

191. *Id.* at 11.

192. *Id.* at 8.

193. *Id.* at 7-8, 9-10.

194. *Id.* at 7.

component also becomes a tangible gauge for assessing which hospitals should receive, or be denied, tax exemption.

The reform plan introduces "universal coverage,"¹⁹⁵ and eliminates any requirement for charity care.¹⁹⁶ Nevertheless, this does not mean that nonprofits will become indistinguishable from for-profit providers. Since nonprofits do not face the same bottom line pressures (i.e., making the most money they can for their owners), they often provide more services to the community than simply treating fee-paying patients.¹⁹⁷ Other services offered by nonprofits include, but are not limited to: medical research; education programs; health screening; immunization; preventive care; and outreach programs.¹⁹⁸ These preventive programs provide a "return" on the health care exemption by helping control health care costs. Thus, they are legitimate bases for receiving a government subsidy, even in the absence of providing indigent health services. Since providers will not meet the new requirements if the community is not meaningfully involved in determining provider programs, the concern that the plan will create a proliferation of "undeserving" nonprofits is eliminated.

Current opposition to the plan is based on the arguments that hospitals in poorer communities will have a difficult time fulfilling the assessment and planning requirements, and that the act's requirements allow almost any hospital to obtain exemption.¹⁹⁹ However, the reply to the latter concern is that the administration does not intend to interfere with the traditional nonprofit health care providers and believes the enhanced community benefit requirement will avoid feared abuses.²⁰⁰

The remaining issue on the federal level is that currently the only sanction available to the Service for any violation of exemption standards is revocation of exemption.²⁰¹ This is very

195. *Id.* at 11. The plan only covers employees of companies; self-employed and unemployed citizens are not protected. However, Medicare/Medicaid is expected to remain in place to cover the latter categories of the population. *Id.*

196. *Id.* Since the Clinton reform plan "provides coverage to all Americans, [the] Health Security Act does not include any specific rules on charity care." *Id.*

197. *Intermountain Health Care*, 709 P.2d at 290 (Stewart, J., dissenting).

198. UNOFFICIAL TRANSCRIPT, *supra* note 189, at 12.

199. *Id.* at 21-22.

200. *Id.* at 23-24.

201. *See Prepared Statements*, *supra* note 44, at 46.

serious punishment, and certainly too severe for minor violations in view of the profound impact revocation can have on a nonprofit hospital. Accordingly, the Service frequently chooses to do nothing at all when faced with violations. Intermediate sanctions are a good way to discipline clear misuses of hospital resources by insiders without penalizing the community that the hospital serves. Narrowly targeted sanctions are also an effective way of addressing the problem of private inurement, which underlies today's diversified nonprofit entities.

The consequences of a federal policy that has the effect of creating a predominately for-profit hospital sector can only be the subject of speculation. A common concern is that the for-profits' natural bottom-line focus and mandate to distribute profits to stockholders will cause declines in basic research, compromise critical care, lower training for professional staff, and increase health care rationing.²⁰² Another possible consequence is that health care services, especially tertiary care, will become scarce in rural areas where, because of population demographics, there is rarely enough profit to be made.²⁰³

Lawmakers who issued the tax laws did not envision the significant changes that are occurring in the nonprofit area nor the types of networks which would have to emerge to meet the ensuing challenges.²⁰⁴ The solution for not hampering the changes which must be made is for the Service, and states, to be flexible enough to allow the progress that must take place.

C. *Are All States Advocating Revocation?*

States which link charitable activity to providing relief for the poor appear to be doing so because they need revenue. Shrinking municipal tax bases, and cuts in federal funding of entitlement programs place increasing pressures on state economies. These constraints, in turn, generate a need for increased income. The lucrative tax revenues to be received by revoking tax exemption status have motivated several states, through their political subdivisions, to take aggressive action to narrow their criteria which allow for exemption qualification. For ex-

202. See *Intermountain Health Care*, 709 P.2d at 290 (Stewart, J., dissenting).

203. *Id.* at 288. See *infra* notes 218, 228 for an explanation of tertiary health care services.

204. Carson, *supra* note 124, at 717.

ample, the City of Boston estimates that imposing property taxes on its exempt institutions would generate \$10 million annually from hospitals alone.²⁰⁵ Accordingly, in 1993, the Massachusetts legislature debated a bill that would allow many of its municipalities to levy a variable rate property tax against non-profit hospitals ranging from \$5 to \$40 per \$1000 of assessed value.²⁰⁶

In addition to internal economic pressures, a coalition of trade organizations has formed in order to persuade states to adopt a model bill²⁰⁷ which would remove state tax exemption to any nonprofit which engaged in any commercial activity that competes with a for-profit enterprise.²⁰⁸ The impetus behind this attempt is apparently to capitalize upon the sentiment among many state authorities that once a nonprofit begins to engage in commercial activities, a favorable tax treatment grants it an unfair competitive advantage against for-profits. Since the model bill defines "commercial activity" as the provision of any services or goods that could be obtained from a private enterprise, this bill would adversely affect most nonprofit hospitals to some degree.²⁰⁹ It is easy to see the short term benefits that such a bill would bring to for-profits, including hospitals, in the form of removal of a competitive force. However, while competition does exist to some extent when for-profit and nonprofit hospitals serve the same constituency, the entire point of having a nonprofit hospital system is that it delivers a type of service that for-profit hospitals have been reluctant to

205. Tom Moccia, *Massachusetts: Legislature Considers Tax on Nonprofit Hospitals*, 8 EXEMPT ORG. TAX REV. 455, 456 (Aug. 1993). When revealed that hospitals would generate close to half of the anticipated revenue imposed on exempt institutions in Boston, it is easy to see why nonprofit hospitals are such an attractive target to any revenue-starved municipality. Churches, government property and property owned by veteran's groups would remain exempt under the Boston plan. *Id.* at 455.

206. *Id.* at 456. See Mass. H.B. 4042, 178th Sess. (1993). At the time of publication, this bill had not been enacted.

207. Hubbard, *supra* note 137, at 695. The "Model State Unfair Competition Bill" was developed by the Business Coalition for Fair Competition. *Id.*

208. *Id.*

209. *Id.* The model bill is opposed by the ABA committee task force on state and local tax issues because it only authorizes a very narrow category of nonprofits: those with statutory authorization; those that engage in activities not regularly carried on by for-profits; and those that have no competing private enterprise. *Id.*

provide.²¹⁰ Thus, the net result of such an initiative would serve only to limit health care facilities and options available to a community.

The major problem with the aggressive stance taken by states is that some of the legislative and judicial decisions ignore federal tax law precedent, state judicial precedent and legislative history.²¹¹ Enacting measures which completely redefine a "charitable objective," merely in a quest for revenue, places an inequitable burden on existing entities which have in good faith complied with previous standards, and have served the community. Also a search for income is not a compelling reason to destroy years of common law, and threaten the survival of an industry vital to many communities.

The adoption of less dramatic measures, such as annual payments for services would achieve revenue objectives while not completely destroying the tax-privileges previously earned by the affected hospitals. The benefits of adopting an "annual payment" are that it is easy to budget, charges the entity for costs actually incurred by the state or municipality, and avoids levying based solely on the value of the property, which is often not in relation to the amount of services consumed. On the other hand, charging an exempt entity for "services," even if proportional to the amount of services utilized is still a form of property tax, if only by a more "equitable" means.

The transformation to a for-profit hospital system has been a viable alternative in some states.²¹² However, while for-profit hospitals do exist, a large scale transformation to a system where for-profits predominate would generate conditions leading to greatly diminished scope of care and service alternatives.²¹³ Higher costs for services is also a very real and proven scenario²¹⁴ since, by their very nature, for-profits must charge at a higher margin in order to satisfy investors.

210. See *infra* notes 197-98, 218 and accompanying text.

211. MINORITY REPORT, *supra* note 150, at 4. See also *Intermountain Health Care*, 709 P.2d at 279 (Stewart, J., dissenting) (arguing that "[t]he Court's holding is without precedent either in Utah or elsewhere in the United States. The majority seeks to dismiss the solid array of law from other jurisdictions . . .").

212. Simon, *supra* note 7, at 359.

213. See *Intermountain Health Care*, 709 P.2d at 290 (Stewart, J., dissenting).

214. *Id.* See also STARR, *supra* note 9, at 433.

Especially on a state level, nonprofit hospitals provide a tangible benefit directly to the community where they exist. In the case of private nonprofit hospitals, the government is relieved of the burden of having to operate its own hospitals. In addition, nonprofits provide community health care services at levels superior to those of their for-profit counterparts, if the for-profits provide them at all.²¹⁵ Since nonprofits use excess revenue directly for their primary health care purpose, any funds which are diverted either by removal of property tax exemption, or imposition of an "annual payment" or "payment for services," reduce funds that would be placed directly back into the operation.²¹⁶ Affected therefore, are not perks to insiders,²¹⁷ but the general operating capability of the affected hospital. Since nonprofits often deliver levels of care not provided by for-profits,²¹⁸ the reduction in operating capital caused by payment of property taxes would directly impact health care service delivery. In addition, it would remove funds previously used for capital improvements.²¹⁹

Fortunately, not all states have chosen to improve their fiscal health at the expense of constituencies served by nonprofit hospitals. The legislation passed by Texas has taken the lead in addressing the exemption issue in a manner consistent with the Service's focus on community benefit, rather than creating an entirely novel standard.²²⁰ This statute grants exemption only upon a showing of availability of care to indigent, uninsured patients, but does not penalize an institution merely because it has subsidiary commercial ventures.

215. See *infra* notes 218, 228 for examples of "community benefit" services unique to nonprofit providers.

216. See *Intermountain Health Care*, 709 P.2d at 290 (Stewart, J., dissenting).

217. If a nonprofit does engage in this activity, it is subject to loss of federal and state exemption for failure to abide by the prohibition against private inurement. See *supra* text accompanying notes 48, 52-53.

218. For example, tertiary care (cardiac operations, dialysis etc.) is almost never provided by for-profits because it is very expensive, and adequate compensation is not forthcoming from insurers. *Intermountain Health Care*, 709 P.2d at 290 (Stewart, J., dissenting). For-profit hospitals also do not want to own hospitals in economically depressed neighborhoods. With the profit motive removed, for-profit hospitals have no incentive to provide care in these areas. See also STARR, *supra* note 9, at 435. If nonprofits, which currently do serve these areas are reduced, government operated services would need to fill the gaps.

219. STARR, *supra* note 9, at 435.

220. See *supra* notes 140-41 and accompanying text.

Tennessee has consented to the early expiration of a law which placed a services tax on hospitals.²²¹ This action partially resulted from vigorous lobbying by the health care industry, which was able to convince lawmakers that the revenue benefits derived from the tax were gained at the expense of negative impact from the huge tax burden it placed on the hospitals.²²² The hospitals, however, had to agree to support a proposal to replace Medicaid with a state medical insurance program.²²³ Since the program is anticipated to bring 1.5 million additional citizens into the states' health care systems, the hospitals, in effect, voluntarily assumed a higher charitable burden in return for a release from taxation.²²⁴

Courts are aggressively backing state moves to extract property tax payments from nonprofit hospitals. Here again, less draconian measures could have been adopted instead of the ultimate penalty of loss of exemption. Factors which the Utah court should have considered, and were referred to in the dissent, include, but are not limited to: examination of the value of the benefits provided by the exempt hospital to determine if they furnish services not provided by their for-profit counterparts;²²⁵ physical assets donated to the hospital corporation, providing a "gift" to the community and allowing the hospital to use revenues for furthering its health care mission;²²⁶ whether the prices charged to patients are significantly lower than those charged by for-profits for services of the same complexity;²²⁷ and whether for-profits and nonprofits provide comparable services.²²⁸ Consideration of these factors would have led to a balanced conclusion that the mere existence of commercial activity does not destroy the distinction between for-profit and nonprofit

221. Andree Blumstein, *Tennessee: Lawmakers Reach Hospital Services Tax Compromise*, 8 EXEMPT ORG. TAX REV. 458, 458 (Aug. 1993). See Tenn. H.B. 2816, 97th Sess. (1992).

222. Blumstein, *supra* note 221, at 458.

223. *Id.*

224. *Id.*

225. See *Intermountain Health Care*, 709 P.2d at 284 (Stewart, J., dissenting).

226. *Id.*

227. *Id.* The dissent noted that on the average, for-profits charge 17% more per admission to patients with insurance. *Id.* (citing STARR, *supra* note 9, at 434).

228. *Id.* at 285. The dissent noted that in Utah only nonprofit hospitals provide tertiary care, consisting of complex procedures (heart transplants, dialysis, etc.) which generate little or negative revenue to the hospital. *Id.* at 290.

hospitals. Consequently, the court's justification for revoking exemption on those grounds would not have existed.

D. Where Are the Nonprofit Hospitals Currently Headed?

A recent trend by nonprofit hospitals has been the development of Integrated Delivery Systems ("IDSs").²²⁹ These are networks created with doctors and other health care providers which provide a range of services.²³⁰ IDSs developed as rising costs and increasing numbers of uninsured patients caused hospitals to develop novel ways to deal with competitive, capital resource pressures, in a manner that would avoid the threats of revocation which traditional joint ventures face.²³¹

The IDS concept has received an initially favorable response from the Service, which has acknowledged that IDSs are part of "the restructuring of health care and medical practice at the grassroots level."²³² Currently the only guidance on IDS is an exemption ruling which granted exemption on the grounds that the IDS met the "community benefits standard."²³³ The ruling suggests factors an IDS must comply with to receive exemption include, but are not limited to: affiliation with a research hospital; nontraditional compensation for physicians; Medicare participation, including obligation to continue care beyond the emergency room; and physician control of the network kept well below 50 percent.²³⁴

E. What Will It Take to Help Nonprofit Hospitals Survive the Current Assault on Their Commercial Activities?

There is a need for nonprofit hospitals to acknowledge that since they are directly competing with for-profit hospitals in certain areas, they must be held to a higher standard than simply avoiding private inurement of individuals when they decide to engage in a permissible level of commercial activity. This

229. Michael W. Peregrine & Bernadette M. Broccolo, *IRS Issues Guidance on Integrated Delivery Systems*, 7 EXEMPT ORG. TAX REV. 391, 391 (Mar. 1993).

230. *Id.*

231. *Id.*

232. *Summaries of Today's Important Tax Items*, TAX ANALYST DAILY MAG., June 30, 1993, at 4557.

233. Peregrine & Broccolo, *supra* note 229, at 392. See also Rev. Rul. 69-545, 1969-2 C.B. 117, 117.

234. Carson, *supra* note 124, at 720.

higher standard is necessary to clearly distinguish nonprofits and thereby justify the preferential tax relief that they receive. In addition, income-generating ventures can compromise the organization's charitable mission, hence nonprofits must be vigilant to ensure that commercial pursuits do not grow to the point that they distract from the health care mission.

Federal and state authorities need to redefine the criteria for exemption as new needs arise, and new health care vehicles are developed to meet those needs. The Internal Revenue Service has struggled to do so, as is evident by the evolving guidelines it promulgates.²³⁵ The Service does need to go further, however, and adopt intermediate sanctions, not just the all-or-nothing sanction of revocation which currently exists.²³⁶ Since revocation is perceived as such an extreme penalty, it has never been a viable option in most cases.²³⁷ Some states, on the other hand, motivated by an insatiable appetite for tax revenue appear to be mired in a historical time warp, penalizing hospitals by the imposition of exemption defeating property taxes.²³⁸

Presented below are some thoughts on where the governmental bodies which control taxing policy should be heading to ensure that nonprofit hospitals survive, and how nonprofit hospitals should also refocus some of their activities. The Health Security Act certainly seems headed in the right direction by mandating that hospitals work hand-in-hand with the communities they serve when determining what services will be provided. The issue of charity care, however, is not one which should be lightly set aside. Even if health care reform is adopted, the cost of health care treatments for the Medicare patients will continue to exceed the level of reimbursement.

In 1969, Congress compelled private foundations to donate a percentage of either their assets or income to grant-making in

235. Recent Private Letter Rulings have acknowledged the need for ventures between for-profit and nonprofit health care entities by bestowing favorable tax treatment upon them. Michael W. Peregrine, *Creating Health Care Collaborations Showcased in New Letter Rulings*, 8 EXEMPT ORG. TAX REV. 113 (July 1993).

236. It has been commented that "[r]evocation of an exemption is a severe sanction that may be greatly disproportional to the violation in issue." *Prepared Statements*, *supra* note 44, at 47.

237. *Id.*

238. See Moccia, *supra* note 205, at 455.

order to maintain their tax-exempt status.²³⁹ Similarly, Congress could establish a standard by which nonprofit hospitals must contribute a percentage of their resources (medical staff, facilities, etc.) towards the care of indigent, in addition to meeting the more general community benefit criteria. Recognizing that certain regional areas may have different health care needs, and that certain specialty hospitals would never reach a mandated percentage, a "vital services exception" would provide deserving nonprofits a degree of flexibility. Such an exception would keep state and local governments from comprehensively mandating the percentage of resources that must be devoted to indigent care. Thus, some hospitals could provide less indigent care than others, if they demonstrate that they provide a "heightened" community benefit pre-determined to be "vital" (e.g., ground breaking research, clinical program, affiliation to a university, etc.), which would be imperiled by granting a higher amount of indigent care.

In light of the large amount of property tax revenue that states forgo as a result of the grant exemptions, it is proper for them to impose requirements that hospitals provide, or attempt to provide, a benefit to the community comparable to the tax exemption provided. In Vermont, for example, the state supreme court created an effective compromise which compels charity care, but does not hold the hospital to a rigid standard.²⁴⁰ The court held that hospitals provide adequate charitable care if they are able and willing to accept patients on an ability to pay basis.²⁴¹ This standard is a fair response since it does not penalize a hospital in the event that a fixed amount of care is not provided because a predetermined level of indigent patient demand never materialized.²⁴²

V. Conclusion

As nonprofit hospitals diversified, federal and state tax treatment of these enterprises set a variety of standards aimed at addressing the concern that nonprofit hospitals stay true to

239. Hall, *supra* note 24, at 20.

240. Carson, *supra* note 124, at 719 (discussing *Medical Center Hosp. v. Burlington*, 556 A.2d 1352 (Vt. 1982)).

241. *Medical Center Hosp.*, 556 A.2d at 1355.

242. Carson, *supra* note 124, at 719.

their mission of providing charitable care. As exemption standards changed, different concepts emerged as to what constituted charitable activity for an exempt hospital system. As these hospitals increased their commercial activities, the judicial and governmental authorities responsible for promulgating taxation guidelines scrutinized these ventures more closely. This has been done to ensure that the commercialization of hospital enterprises does not overwhelm the hospital's exempt mission to the point that commercial activity becomes substantial, which in turn, subjects the hospital to revocation of favorable tax status.

The appropriate government authorities should continue to monitor nonprofit hospitals to ensure their mission remains charitable. Notwithstanding this point, it is incumbent upon them not to become insensitive to the financial pressures facing nonprofits, and to ensure their oversight does not precipitate actions which spell the death-knell for this sector. The authorities promulgating tax policies must not forget that the nonprofit hospital industry has become financially dependent on commercial ventures precisely because short falls in income can no longer be covered by revenue from third party providers or donations. It must not be overlooked that nonprofits deliver essential health services which for-profit hospitals appear unwilling to provide.

Nonprofit hospitals should learn an important lesson: as long as for-profit hospitals exist, commercial ventures must be conducted with the health care mission as the utmost priority. They must be vigilant to ensure that the activities must be carried on in ways that do not smack of inurement, regardless of their need to raise capital and attract physicians. One easy way to ensure that those who define exempt standards remain mollified with most commercial ventures is to ensure that nonprofits dedicate a percentage of their services to the delivery of indigent care. After all, they should not disregard that receipt of exemption is an entitlement which comes with strings attached. It has become increasingly apparent that those who have power are now more than ever willing to yank those strings wherever possible.

Nonprofit hospitals are a vital part of this country's health care network. Their unique character serves to fulfill a public

policy demand for quality health care, at lower prices than for-profits, with a broad range of services, and high quality health care for the indigent and underinsured. With the large number of exempt hospitals in operation, a persuasive argument exists that this network relieves the federal government of a burden because even though federal tax dollars pay for the nation's health care to a large extent, it is still relieved of the burden of actually operating hospital systems.

*Andréa I. Castro**

* This Comment is dedicated to my son, Charles Alexander, and to Maria and Carlos Castro for their constant encouragement and support.