

**PRESENT LAW AND BACKGROUND
RELATING TO THE TAX-EXEMPT STATUS
OF CHARITABLE HOSPITALS**

Scheduled for a Hearing
Before the
SENATE COMMITTEE ON FINANCE
on September 13, 2006

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION



September 12, 2006
JCX-40-06

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INTRODUCTION

The Senate Committee on Finance has scheduled a public hearing on September 13, 2006, titled “Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals.” This document,¹ prepared by the staff of the Joint Committee on Taxation, provides a description of, and selected issues arising with respect to, the standard for tax-exempt status of charitable hospitals (the community benefit standard), the rules against private inurement and private benefit, and the disclosure rules generally applicable to charitable hospitals. The document also describes the present-law rules relating to tax-exempt financing for charitable hospitals.

¹ This document may be cited as follows: Joint Committee on Taxation, *Present Law and Background Relating to the Tax-Exempt Status of Charitable Hospitals* (JCX-40-06), September 12, 2006.

I. PRESENT LAW AND ISSUES RELATING TO THE COMMUNITY BENEFIT STANDARD APPLICABLE TO CHARITABLE HOSPITALS

A. Overview

Charitable organizations, i.e., organizations described in section 501(c)(3),² generally are exempt from Federal income tax,³ are eligible to receive tax deductible contributions,⁴ have access to tax-exempt financing through State and local governments (described in more detail below),⁵ and generally are exempt from State and local taxes.

A charitable organization must operate primarily in pursuance of one or more tax-exempt purposes constituting the basis of its tax exemption.⁶ The Code specifies such purposes as religious, charitable, scientific, educational, literary, testing for public safety, or to foster international amateur sports competition, or for the prevention of cruelty to children or animals. In general, an organization is organized and operated for charitable purposes if it provides relief for the poor and distressed or the underprivileged.⁷

In order to qualify as an organization described in section 501(c)(3), an organization must satisfy the following: (1) the net earnings of the organization may not inure to the benefit of any person in a position to influence the activities of the organization; (2) the organization must operate to provide a public benefit, not a private benefit;⁸ (3) the organization may not be operated primarily to conduct an unrelated trade or business;⁹ (4) the organization may not engage in substantial legislative lobbying; and (5) the organization may not participate or

² Certain organizations described elsewhere within section 501, namely cooperative hospital service organizations (sec. 501(e)), cooperative service organizations of operating educational organizations (sec. 501(f)), child care organizations (sec. 501(k)), and charitable risk pools (sec. 501(n)), are treated as charitable organizations described within section 501(c)(3). Such organizations generally are subject to distinct organizational and operational requirements as specified in the relevant Code provision. Although tax-exempt, government owned organizations, such as hospitals, generally are not described in section 501(c)(3) and are not subject to its requirements.

³ Section 501(c)(3) organizations are subject to the unrelated business income tax on income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization's tax-exempt functions. Secs. 511-514.

⁴ Sec. 170.

⁵ Sec. 145.

⁶ Treas. Reg. sec. 1.501(c)(3)-1(c)(1).

⁷ Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

⁸ Treas. Reg. sec. 1.501(c)(3)-1(d)(1)(ii).

⁹ Treas. Reg. sec. 1.501(c)(3)-1(e)(1). Conducting an insubstantial level of unrelated trade or business activity generally will not jeopardize tax-exempt status.

intervene in any political campaign. An organization that fails to satisfy any of these requirements is not described in section 501(c)(3).

The Code does not provide a per se exemption for hospitals. Rather, a hospital qualifies for exemption if it is organized and operated for a charitable purpose and meets additional requirements of section 501(c)(3).¹⁰ The promotion of health has been recognized by the IRS as a charitable purpose that is beneficial to the community as a whole.¹¹ It includes not only the establishment or maintenance of charitable hospitals, but clinics, homes for the aged, and other providers of health care. However, not every activity that promotes health qualifies for tax exemption under section 501(c)(3).¹² For example, selling prescription pharmaceuticals promotes health, but pharmacies cannot qualify as charitable on that basis alone.¹³ Furthermore, an organization providing health care, such as a hospital, is not a charitable organization if it is privately owned and is run for the profit of the owners.¹⁴

Medical care generally is provided by government-owned, for-profit, and tax-exempt organizations. A majority of the nation's hospitals operate as charitable tax-exempt organizations.¹⁵ The character of the charitable hospital sector has changed significantly over the past several decades due to (1) employer-provided health insurance, (2) governmental programs such as Medicare (for the elderly and disabled) and Medicaid (for the poor),¹⁶ and (3) the

¹⁰ Although nonprofit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some may qualify for exemption as educational or scientific organizations because they are organized and operated primarily for medical education and research purposes.

¹¹ Rev. Rul. 69-545, 1969-2 C.B. 117; see also Restatement (Second) of Trusts secs. 368, 372 (1959); see Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 6.3 (8th ed. 2003) (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

¹² See *Sonora Community Hospital v. Commissioner*, 46 T.C. 519, 525-526 (1966), *aff'd*, 397 F.2d 814 (9th Cir. 1968) (while the diagnosis and cure of disease are purposes that may furnish the foundation for characterizing the activity as "charitable," something more is required).

¹³ *Federation Pharmacy Services, Inc. v. Commissioner*, 72 T.C. 687 (1979) (finding that organization relied financially on the sale of prescription drugs to the public with no accommodation made for those unable to pay and, thus, did not have a charitable purpose), *aff'd*, 625 F.2d 804 (8th Cir. 1980).

¹⁴ Rev. Rul. 98-15, 1998-1 C.B. 718.

¹⁵ Gary J. Young, *Federal Tax-Exemption Requirements for Joint Ventures Between Nonprofit Hospital and For-Profit Entities: Form over Substance*, 13 *Annals of Health L.* 327 (Summer 2004); see also GAO Report to the Chairman, Select Committee on Aging, House of Representatives, *Nonprofit Hospitals: Better Standards Needed for Tax Exemption Tax Compliance of Nonwage Earners*, GAO/HRD-90-84, May 1990.

¹⁶ Mark A. Hall and John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 *Wash. L. Rev.* 307 (April 1991).

availability of other third-party payment programs. Demands for managed care and other efforts by employers, insurers, and Federal and State governments to contain the rapid growth of health care costs have led to an increasingly cost-conscious hospital sector.¹⁷ Today's charitable hospitals generate most of their revenues by serving paying patients rather than from charitable contributions.¹⁸

¹⁷ GAO Report to the Chairman, Select Committee on Aging, House of Representatives, *Nonprofit Hospitals: Better Standards Needed for Tax Exemption Tax Compliance of Nonwage Earners*, GAO/HRD-90-84, May 1990, at 13-14. The GAO reported that cost-containment initiatives may make it more difficult for nonprofit hospitals to provide uncompensated care.

¹⁸ Joint Committee on Taxation, *Historical Development and Present Law of the Federal Tax Exemption for Charities and Other Tax-Exempt Organizations* (JCX-29-05), April 19, 2005, at p. 151, Table 8 (summarizing data from IRS Statistics of Income Division showing that, for each of the years 1995 through 2001, contributions, gifts, and grants comprised less than three percent of the total revenue of section 501(c)(3) hospitals); see also Helena G. Rubinstein, *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, 7 Health Matrix 381 (Summer 1997); *Sound Health Assoc. v. Commissioner*, 71 T.C. 158, 180-81 (1978), *acq.*, 1981-2 C.B. 2.

B. Present Law

Financial ability standard

Much like the nature of the health-care industry itself, the definition of the term charitable as applied to hospitals has not been static. In 1956, the IRS issued Revenue Ruling 56-185, which addressed the tax-exempt status of charitable hospitals.¹⁹ The ruling adopted the “financial ability standard,” requiring that a charitable hospital be “operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.”²⁰ This standard effectively meant that a charitable hospital could not refuse to accept patients in need of hospital care who could not pay for such services. However, the IRS acknowledged that hospitals normally charge patients who are able to pay for services in order to meet the hospital’s operating expenses and stated that the “fact that the hospital’s charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability.”²¹ Although the ruling allowed hospitals to satisfy the charity requirement by furnishing services at reduced rates which are below cost, if a hospital operated with the expectation of full payment from all patients, the hospital would not be deemed to “dispense charity merely because some of its patients fail to pay for the services rendered.”²² The ruling’s requirement that charitable hospitals provide some amount of free or reduced-rate care reflected the view that hospitals and other health care institutions were charitable only if they both provided relief to the poor and promoted health.²³

Community benefit standard

The financial ability standard governed charitable hospitals until 1969. Congress had criticized the financial ability standard as imprecise concerning the extent to which a hospital must accept patients who are unable to pay.²⁴ In addition, the creation of Medicare and Medicaid in 1965 had a fundamental effect on hospitals; a substantial portion of the free care previously

¹⁹ Rev. Rul. 56-185, 1956-1 C.B. 202, *modified by* Rev. Rul. 69-545, 1969-2 C.B. 117.

²⁰ *Id.* The ruling also required an open staff provision, mandating that charitable hospitals not restrict use of their facilities to particular groups of physicians or surgeons, to the exclusion of other qualified physicians. Finally, the ruling provided that a charitable hospital’s net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual; a requirement that repeated the statutory prohibition on private inurement and private benefit.

²¹ *Id.*; see also *Commissioner v. Battle Creek, Inc.*, 126 F.2d 405 (5th Cir. 1942) (noting that it is usual for charitable hospitals and sanitariums to charge those able to pay for services rendered, in order to pay the expenses of the institution, while not denying treatment to others unable to pay anything).

²² Rev. Rul. 56-185, 1956-1 C.B. 202.

²³ *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210, 1216 (3d Cir. 1993).

²⁴ See H.R. Rep. No. 91-413, 91st Cong., 1st Sess., pt.1, at 43 (1969) (“Such obligations to serve those who cannot pay are indefinite under existing law and existing interpretations of the law.”).

subsidized by charitable hospitals now was reimbursed through these governmental programs.²⁵ In response to these developments, the IRS issued Revenue Ruling 69-545, modifying its position in Revenue Ruling 56-186 and adopting the “community benefit standard,”²⁶ which remains the principal test applied by the IRS for determining whether a hospital is charitable.

In Revenue Ruling 69-545, the IRS stated that the promotion of health is “one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members, provided that the class is not so small that its relief is not of benefit to the community.”²⁷ Applying this community benefit standard, the IRS found that a hospital’s operation of a generally accessible emergency room open to all persons, regardless of ability to pay, provided a benefit to a sufficiently broad class of persons in the community. The ruling did not, however, require that the hospital accept indigent patients on an inpatient basis for any purpose other than its emergency room. Revenue Ruling 69-545 also expressly removed the requirement that charitable hospitals provide care to patients without charge or at rates below cost.²⁸

In addition to the open emergency room requirement, Revenue Ruling 69-545 set forth additional factors for determining whether a hospital qualifies as charitable, specifically whether the hospital: (1) is run by an independent board of trustees composed of representatives of the community (as opposed to financially interested individuals); (2) operates with an open medical staff policy, with privileges available to all qualified physicians; (3) provides care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement; and (4) utilizes surplus funds to improve the quality of patient care, expand its facilities, and advance medical training, education, and research.²⁹

The validity of the community benefit standard enunciated in Revenue Ruling 69-545 was challenged in a class action lawsuit by various health and welfare organizations and private citizens who argued that the IRS should continue to require charitable hospitals to provide free care to those unable to pay. In *Eastern Kentucky Welfare Rights Organization v. Simon*,³⁰ the district court sustained the challenge and concluded that Congress intended to restrict the term charitable to its narrow sense, that is, relief of the poor. The appeals court reversed, however,

²⁵ See Helena G. Rubinstein, *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, 7 Health Matrix 381 (Summer 1997).

²⁶ Rev. Rul. 69-545, 1969-2 C.B. 117.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ 370 F. Supp. 325, 338 (D.D.C. 1973), *rev'd*, 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds*, 426 U.S. 26 (1976).

and upheld the broader interpretation of charitable applied in Revenue Ruling 69-545.³¹ The court explained that the term charitable is capable of a definition far broader than merely the relief of the poor.³² The court also concluded that Revenue Ruling 69-545 did not overrule the financial ability requirement of Revenue Ruling 56-185, but that it simply provided an alternative method whereby a hospital can qualify as a tax-exempt charitable organization.³³

In a 1983 ruling, the IRS applied the community benefit standard in the context of a hospital that did not operate an emergency room but that otherwise was similar to the hospital described in Revenue Ruling 69-545.³⁴ The IRS stated that a charitable hospital need not maintain an emergency room when State health planning authorities determine that doing so would produce unnecessary duplication of services otherwise provided in the community.³⁵ The IRS ruled that the operation of an emergency room and community access to it is merely one factor evidencing a hospital's benefit to the community. Other significant factors may enter into the community benefit determination, such as "a board of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like Medicare and Medicaid, and application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research."³⁶ Finally, the IRS noted that certain specialized hospitals, such as eye hospitals and cancer hospitals, offer medical care limited to special conditions unlikely to necessitate emergency care and do not, as a practical matter, maintain emergency rooms.³⁷ The IRS found that these organizations also may qualify as charitable if there are present similar, significant factors that demonstrate that the hospitals operate exclusively to benefit the community.³⁸

In 1992, the IRS issued examination guidelines for use by IRS agents in the examination of charitable hospitals. Although the guidelines are not binding, they discuss factors the IRS considers in determining whether a hospital meets the community benefit standard. Some of the factors are: whether the hospital has a governing board that includes prominent civic leaders rather than primarily hospital administrators and doctors; whether the hospital provides nonemergency care to everyone in the community who is able to pay either privately or through third parties including Medicare and Medicaid; whether admission to the hospital's medical staff

³¹ 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds*, 426 U.S. 26 (1976).

³² *Id.* at 1287-88.

³³ *Id.* at 1289.

³⁴ Rev. Rul. 83-157, 1983-2 C.B. 94.

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

is open to all qualified physicians in the area, consistent with the size and nature of the facilities; and whether the hospital has a full-time emergency room open to everyone, regardless of their ability to pay.³⁹

Community benefit standard applied to other health care organizations

The community benefit standard applies not only to traditional hospitals, but also other health care provider organizations, such as clinics or health maintenance organizations (HMOs). An HMO provides medical care to its subscribers through selected physicians, hospitals and other providers who are connected by contract or other arrangement with the HMO. Although HMOs provide health care, one of their major purposes is to serve their subscribers. HMO operations could be described as similar to the provision of traditional health insurance.⁴⁰ Thus, it was not clear whether such entities were organized and operated exclusively for charitable purposes.⁴¹

In *Sound Health Association v. Commissioner*,⁴² the Tax Court held that a staff model HMO⁴³ qualified as a charitable organization. The court, applying the community benefit analysis derived for hospitals, concluded that the HMO satisfied the community benefit standard as its membership was open to almost all members of the community. Although membership was limited to persons who had the money to pay the fixed premiums, the court held that this was not disqualifying as the HMO had a subsidized premium program for persons of lesser means to be funded through donations and Medicare and Medicaid payments. The HMO also operated an emergency room open to all persons regardless of income. The court rejected the government's contention that the HMO conferred primarily a private benefit to its subscribers, stating that when the potential membership is such a broad segment of the community, benefit to the membership is benefit to the community.

In *Geisinger Health Plan v. Commissioner*,⁴⁴ the court applied the community benefit standard to an individual practice association (IPA) model HMO.⁴⁵ Reversing a Tax Court

³⁹ Announcement 92-83, 1992-22 I.R.B. 59 (IRS Audit Guidelines for Hospitals).

⁴⁰ Section 501(m) prohibits exemption for an organization that provides commercial-type insurance as a substantial part of its activities. An exception in section 501(m)(3)(B) states that this exclusion does not apply to an HMO providing health insurance that is merely incidental to the HMO's principal activity of providing medical services.

⁴¹ HMOs and other organizations that fail to qualify as charitable under section 501(c)(3) may nevertheless qualify for the more limited exemption under section 501(c)(4), which provides exemption for social welfare organizations.

⁴² 71 T.C. 158 (1978), *acq.*, 1981-2 C.B. 2.

⁴³ A staff model HMO employs its own physicians and staff and serves its subscribers at its own facilities.

⁴⁴ 985 F.2d 1210 (3d Cir. 1993), *rev'g* T.C. Memo. 1991-649.

decision, the court held that the HMO did not qualify as charitable because the community benefit standard requires that an HMO be an actual provider of health care rather than merely an arranger or deliverer of health care, which is how the court viewed the IPA model in that case.

More recently, in *IHC Health Plans, Inc. v. Commissioner*,⁴⁶ the court ruled that three affiliated HMOs did not operate primarily for the benefit of the community they served. The organizations in that case did not provide health care directly, but provided group insurance that could be used at both affiliated and non-affiliated providers. The court found that the organizations primarily performed a risk-bearing function and provided virtually no free or below-cost health care services. In denying charitable status, the court held that a health-care provider must make its services available to all in the community plus provide additional community or public benefits.⁴⁷ The benefit must either further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the provision of tax-exempt status. Further, the additional public benefit conferred must be sufficient to give rise to a strong inference that the public benefit is the primary purpose for which the organization operates.⁴⁸

⁴⁵ In the IPA model, health care is provided by physicians practicing independently in their own offices, with the IPA usually contracting on behalf of the physicians with the HMO.

⁴⁶ 325 F.3d 1188 (10th Cir. 2003).

⁴⁷ *Id.* at 1198.

⁴⁸ *Id.*

C. Issues

From 1956 to the present, there have been two different standards of charity for hospitals. Between 1956 and 1969, a charitable hospital was required to provide some care for the poor according to its financial ability. Since 1969, the IRS has applied the community benefit standard, under which health-care providers must meet a flexible test based upon a variety of indicia. Providing free care to indigents is not required, though it is an indication of community benefit.⁴⁹ Under the community benefit standard, it is not required that “the care of indigent patients be the primary concern of the charitable hospital, as distinguished from the care of paying patients.”⁵⁰ Instead, the community benefit standard reflects “a policy of insuring that adequate health care services are actually delivered to those in the community who need them.”⁵¹ In general, the community benefit standard has been expansive, and under court decisions, applies not just to hospitals. Thus, a medical care organization like an HMO generally meets the community benefit standard if it demonstrates that its activities are targeted to a charitable class. However, the “precise nature of that charitable class has been and continues to be a source of controversy.”⁵²

Today, charitable hospitals and their for-profit counterparts operate under the same healthcare regulations, compete for the same patients and doctors, and derive funding from many of the same sources as other types of hospitals.⁵³ Some charitable hospitals have entered into business arrangements similar to those employed by the for-profit sector in an effort to contain costs, improve efficiency, and generate surplus revenues. For example, mergers and consolidations, the formation of joint ventures with for-profit entities, and the creation of integrated delivery systems⁵⁴ have become more common in the charitable hospital sector. Although Federal tax exemption does not prevent charitable hospitals from generating surplus revenues, unlike for-profit hospitals, the assets of a charitable hospital must remain irrevocably dedicated to the benefit of the community, whereas the assets of a for-profit hospital are owned by private investors.

⁴⁹ See *Redlands Surgical Services, Inc. v. Commissioner*, 113 T.C. 47, 73 (1999), *aff'd*, 242 F.3d 904 (9th Cir. 2001).

⁵⁰ *Sound Health Association v. Commissioner*, 71 T.C. 158, 180 (1978).

⁵¹ *Id.* at 180-81.

⁵² Joint Committee on Taxation, *Description and Analysis of Title VII of HR 3600, S.1757 and S. 1775 (“Health Security Act”)* (JCS-20-93), December 20, 1993.

⁵³ Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. Rev. 1345 (August 2003).

⁵⁴ Integrated delivery systems are combinations of nonprofit hospitals and private physician groups. These systems were originally created to enable nonprofits to enter the managed care business, a sector dominated by taxable insurance companies and by tax-exempt and taxable health-maintenance organizations.

In light of these market developments, the IRS finds it difficult to apply the community benefit standard. At a recent hearing before the House Committee on Ways and Means, IRS Commissioner Mark Everson testified that “it is increasingly difficult to differentiate for-profit from non-profit health care providers,” highlighting in particular the “complex web of service and other contractual relationships” between tax-exempt hospitals and other entities.⁵⁵ Commissioner Everson welcomed a discussion of reforms that would address gaps that have arisen between the statutory and regulatory frameworks since the IRS first adopted the community benefit standard. More specifically, Commissioner Everson identified a need for: (1) “bright-line tests . . . to aid the public in complying with the law, and the IRS in administering it”; (2) additional enforcement tools for the IRS, including intermediate sanctions short of revocation of exempt status; (3) more transparency; and (4) additional IRS resources.

Comptroller General David Walker testified about differences between tax-exempt hospitals and for-profit hospitals and described a Government Accountability Office (“GAO”) report regarding uncompensated care and other community benefits provided by for-profit, nonprofit, and government-owned hospitals in five U.S. States. The report concludes that, while nonprofit hospitals provided more uncompensated care than for-profit hospitals, government-owned hospitals provide significantly more uncompensated care than either of the other two hospital groups. The report noted that within each group of hospitals, “the burden of uncompensated care costs was not evenly distributed among hospitals but instead was concentrated in a small number of hospitals” meaning that “a small number of nonprofit hospitals accounted for substantially more of the uncompensated care burden than did others receiving the same tax preference.” The report also found that “current tax policy lacks specific criteria with respect to tax exemptions for charitable entities and detail on how that tax exemption is conferred.”⁵⁶ Jill R. Horwitz, Assistant Professor, University of Michigan Law School, did not specifically address the community benefit standard, but testified about differences in behavior between nonprofit and for-profit hospitals, finding that nonprofit hospitals are more likely than for-profit hospitals to offer less profitable services (such as mental health services) that may nevertheless be beneficial or even essential to the community.⁵⁷

Some argue that the community benefit standard should be revisited. John D. Colombo, Professor of Law, University of Illinois College of Law, testified that the community benefit standard “simply does not require any measurable difference in behavior from a for-profit entity.”⁵⁸ He offered three alternatives to the present-law standard: (1) a strict, measurable

⁵⁵ Written statement of Mark W. Everson, Commissioner of the Internal Revenue Service, before the House Committee on Ways and Means, May 26, 2005.

⁵⁶ Government Accountability Office, *Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits* (GAO-05-743T), May 26, 2005.

⁵⁷ Written statement of Jill R. Horwitz, Assistant Professor, University of Michigan Law School, before the House Committee on Ways and Means, May 26, 2005.

⁵⁸ Written statement of John D. Colombo, Professor of Law, University of Illinois College of Law, Urbana-Champaign, before the House Committee on Ways and Means, May 26, 2005.

charity care standard;⁵⁹ (2) a standard that is more flexible than a strict charity care standard, but which includes specific behavioral guidelines, such as guidelines that would limit the forms of community benefit that would be deemed to satisfy the standard to behaviors unlikely to occur in the for-profit sector; or (3) repeal of the community benefit standard. In connection with the third option, Professor Colombo notes that only those health care organizations that also would be described as educational or scientific organizations under section 501(c)(3), or clinics whose primary purpose is to serve the poor, would continue to qualify for exemption.

A significant issue is what should qualify as “charity care” under the present-law community benefit test (or under any proposal to adopt a charity care requirement as a condition of tax-exemption). Some argue, for example, that tax-exempt hospitals should not be permitted to count as charity care bad debts written off by a hospital or the treatment of Medicare or Medicaid patients at the discounted rate the government reimburses under those programs.⁶⁰ Others argue that the total amount of uncompensated care is a more appropriate measure of a hospital’s charity care. Some also argue that hospitals that aggressively seek to obtain payment from indigent patients through the use of private debt collectors or other means should not be viewed as charitable within the meaning of section 501(c)(3).⁶¹ Another significant issue in determining the amount of charitable care is how much of the hospital’s fixed cost may be counted as charitable.

Others argue that the community benefit standard provides an important alternative to charity care as a standard for exemption. Sister Carol Keehan, Board Chairperson of Sacred

⁵⁹ Professor Colombo cited the Texas State-law charity care requirement as an example. Texas law requires that nonprofit hospitals, as a condition of tax exemption, satisfy a community benefit standard and that such hospitals maintain and report on community benefit plans with measurable objectives for meeting community health care needs. Although Texas law requires that nonprofit hospitals confer at least a threshold level of community benefit, the law provides three alternative means of satisfying the community benefit requirement: (1) provide charity and government-sponsored indigent care at a level that is reasonable in relation to community needs, the available resources to the hospital, and the tax-exemption benefits received by the hospital; (2) provide charity and government-sponsored indigent health care equal to 100 percent of the State tax-exemption benefits provided to the hospital; or (3) provide charity care and other community benefits (e.g., donations, education, research, etc.) equal to at least five percent of the net patient revenue of the hospital, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of the net patient revenue.⁵⁹ Texas Health and Safety Code Ann. secs. 311.043 - 311.047 (2004).

⁶⁰ See, e.g., Written Statement of Mike Hatch, Attorney General, State of Minnesota, before the Senate Committee on Finance, April 5, 2005.

⁶¹ *Id.* In May of 2004, several class-action lawsuits were filed in Federal court against tax-exempt hospitals on behalf of uninsured patients, asserting, among other things, that the hospitals failed to satisfy their obligations with the Federal government and State and local governments to provide charitable medical care to uninsured patients in return for tax-exempt status, for example by overcharging the uninsured. Many of the lawsuits have been dismissed for the failure to state a claim and for lack of standing. See, e.g., *Shriner v. Promedica Health System, Inc.*, 95 A.F.T.R. 2d 2005-780 (N.D. Ohio 2005).

Heart Health System, Pensacola, Florida, testified that, although the provision of charity care is important, a community benefit standard should consider more than the provision of uncompensated care, including activities such as: outreach to low-income and other vulnerable persons; health education and illness prevention; special health care initiatives for at-risk school children; free or low-cost clinics; training for physicians and nurses; and efforts to improve and revitalize communities.⁶²

In addition to Federal income tax exemption, charitable hospitals in most States are afforded State-level benefits, sometimes in the form of exemption from State income, sales, or property taxes. States adopt divergent approaches to the standards for exemption, with some States basing exemption on a hospital's satisfaction of Federal requirements, and other States requiring adherence to State law standards of providing community benefit. Many States require hospitals to report certain community benefit information to State regulatory authorities.

In its 2005 report, the GAO discussed the levels of uncompensated care provided by, and the varying community benefit requirements applicable to, hospitals located in five U.S. States (California, Florida, Georgia, Indiana, and Texas).⁶³ In describing the difficulty in analyzing community benefit patterns nationwide, GAO highlighted the "wide variation in hospitals' reporting of community benefits," both as a result of hospitals choosing to report different types of community benefits and "variations in the applicability, specificity, and breadth of state requirements."⁶⁴ Specifically, the report provides:

[T]he five states reviewed require all hospitals to report financial data, including data on the cost of charity care they provide. However, . . . California, Indiana, and Texas also have statutory requirements for nonprofit hospitals to develop plans for meeting their communities' health needs and to report annually on the types and value of the community benefits they provide. Of these three states, only Texas and Indiana require nonprofit hospitals to report using standardized forms and have the explicit statutory authority to impose fines for noncompliance as part of the requirements.

The State laws described in the GAO report also incorporated varying statutory definitions of "community benefit." The following chart, reproduced from the GAO report, provides a summary of these divergent standards:⁶⁵

⁶² Written statement of Sister Carol Keehan, Board Chair, Sacred Heart Health System, Pensacola, Florida, before the House Committee on Ways and Means, May 26, 2005.

⁶³ Government Accountability Office, *Nonprofit, For-Profit, and government Hospitals: Uncompensated Care and Other Community Benefits* (GAO-05-743T), May 26, 2005. The report provides that hospitals located in the five States included in the study represent more than a quarter of the nation's hospitals in each hospital ownership group – government-owned hospitals, nonprofit hospitals, and for-profit hospitals. *Id.* at 2.

⁶⁴ *Id.* at 17.

⁶⁵ *Id.* at 24.

| State | Statutory Definition of Community Benefit | Cross-Reference to Tax Exemption in Community Benefit Provisions |
|-------------------------|--|--|
| California ¹ | <p>Hospital activities to address community needs and priorities through disease prevention and improvement of health status, including, but not limited to:</p> <ul style="list-style-type: none"> • health care services, rendered to vulnerable populations (e.g., charity care and unreimbursed costs of providing services to uninsured and underinsured); • health promotion, prevention services, adult day care, child care, medical research and education, nursing and other professional training, home delivered meals, aid to the homeless, and outreach clinics; • financial or in-kind support of public health programs; • donation of funds, property, or other resources for a community priority; • health care cost containment; • enhancement of access to health care; • services offered without regard to profitability to meet a community need; and • goods and services to help maintain a person’s health. | No provisions explicitly cross-referencing definitions and related requirements to tax exemption. |
| Florida | Not defined. | Not applicable. |
| Georgia ² | Not defined, but community benefit reporting requirement refers to charity and indigent care. | No provisions explicitly cross-referencing definitions and related requirements to tax exemption. |
| Indiana ³ | Unreimbursed cost to hospitals of providing charity care, government-sponsored indigent care, donations, education, government-sponsored program services, research, and subsidized health services. Does not include hospital taxes or other government assessments. | No provisions explicitly cross-referencing definitions and related requirements to tax exemption. ⁴ |
| Texas ⁵ | Unreimbursed cost to hospitals of providing charity care, government-sponsored indigent health care, donations, education, government-sponsored program services, research, and subsidized health services, but not hospital taxes or other government assessments. | Numerous provisions cross-referencing definition of community benefit and related requirements to tax exemption. |

¹ California Health and Safety Code secs. 127340 and 127345(c) (2004).

² Georgia Code Ann. sec. 31-7-90.1 (2004).

³ Indiana Code Ann. secs. 16-18-2-64.5 and 16-21-9-1 (2004).

⁴ There are no provisions explicitly cross-referencing community benefits to nonprofit hospitals’ tax exemption, but hospital-owned physician offices or practices, or other property not substantially related to inpatient facilities, must provide or support charity care or community benefits, as it is defined above to qualify for property tax exemption. Indiana Code Ann. sec. 6-1.1-10-18.5 (2004).

⁵ Texas Health and Safety Code Ann. secs. 311.042 and 311.045 (2004).

II. PROHIBITION AGAINST PRIVATE INUREMENT AND PRIVATE BENEFIT

A. Present Law

Organizations described in section 501(c)(3) may not permit private benefit or private inurement. Private benefit occurs if the assets or revenues of the exempt organization are used to benefit an individual or entity more than incidentally. Inurement, a narrower concept, arises whenever a person in a position to influence the decisions of an exempt organization (i.e., an “insider” of the organization) receives benefits from the organization disproportionate to the person’s contribution to the organization.⁶⁶ In situations in which an individual does not rise to the level of insider within an organization, the IRS still would apply a private benefit analysis to the individual’s relationship with the organization.

The inurement prohibition, although stated in terms of the net earnings of an organization, applies to any of an organization’s charitable assets and is not limited to the net profits shown on the books of the organization or the surplus of gross receipts over disbursements.⁶⁷ Similarly, net earnings may inure to the benefit of an individual in ways other than through the distribution of dividends.⁶⁸ Inurement may be found even though the amounts involved are small or de minimis.⁶⁹ Although insiders are subject to the inurement proscription, economic dealings between such individuals and the related organization are permitted. Historically, the only sanction for a private inurement violation was the revocation of the organization’s tax exemption. The intermediate sanctions rules enacted in 1996 (section 4958 of the Code), however, provide a sanction short of revocation of tax exemption for cases of private inurement. In general, these rules allow the IRS to impose an excise tax on insiders who improperly benefit from transactions with charitable organizations (and social welfare organizations) and on organization managers.⁷⁰

Unlike the absolute prohibition against private inurement, de minimis private benefit is permitted. If private benefit exists, it must be incidental in both a qualitative and quantitative

⁶⁶ Treas. Reg. sec. 1.501(c)(3)-1(c)(2). For purposes of section 501, Treas. Reg. sec. 1.501(a)-1(c) defines a “private shareholder or individual” as persons having a personal and private interest in the activities of the organization. The relationship between inurement and private benefit was clarified by the Tax Court in *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989). There, the court explained that “while the prohibitions against private inurement and private benefit[] share common and overlapping elements, the two are distinct requirements which must independently be satisfied.” *Id.* at 1068-69 (internal citations omitted). The court stated that the presence of private inurement violates both prohibitions, but the absence of inurement does not mean the absence of private benefit. Inurement, then, may be viewed as a subset of private benefit.

⁶⁷ *Harding Hospital, Inc. v. United States*, 505 F.2d 1068, 1072 (6th Cir. 1974).

⁶⁸ *Id.*

⁶⁹ *Spokane Motorcycle Club v. United States*, 222 F. Supp. 151, 153 (E.D. Wash. 1963).

⁷⁰ Sec. 4958.

sense to the public benefit. To be qualitatively incidental, a private benefit must occur as a necessary concomitant of the activity that benefits the public at large; in other words, the benefit to the public cannot be achieved without necessarily benefiting private individuals.⁷¹ Such benefits also might be characterized as indirect or unintentional. To be quantitatively incidental, a benefit must be insubstantial when viewed in relation to the public benefit conferred by the activity.⁷² However, if an activity provides a direct benefit to private interests, it does not matter if the benefit is quantitatively insubstantial – “the direct private benefit is ‘deemed repugnant to the idea of an exclusively public purpose’ and the organization cannot be exempt under section 501(c)(3).”⁷³

Both private inurement and private benefit may occur in many different forms, including, for example, excessive compensation;⁷⁴ payment of excessive rent;⁷⁵ receipt of less than fair market value in sales or exchanges of property;⁷⁶ inadequately secured loans;⁷⁷ other questionable loans;⁷⁸ or, as described below, certain joint venture activities or conversion transactions.

Prior to enactment of the intermediate sanctions rules in 1996 the IRS generally viewed members of a hospital’s medical staff as insiders for purposes of the private inurement rules.⁷⁹ In addition, the IRS stated that private benefit is present in all typical hospital-physician

⁷¹ See *American Campaign Academy v. Commissioner*, 92 T.C. at 1076.

⁷² Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 19.10 (8th ed. 2003).

⁷³ Gen. Couns. Mem. 37789 (Dec. 18, 1978).

⁷⁴ *Harding Hospital, Inc. v. United States*, 505 F.2d 1068, 1072 (6th Cir. 1974); *World Family Corp. v. Commissioner*, 81 T.C. 958, 969 (1983) (stating that the law “places no duty on individuals operating charitable organizations to donate their services; they are entitled to reasonable compensation for their efforts”). Whether compensation is reasonable is a question of fact. *Founding Church of Scientology v. United States*, 412 F.2d 1197, 1200 (Ct. Cl. 1969), *cert. denied*, 397 U.S. 1009 (1970).

⁷⁵ *Texas Trade School v. Commissioner*, 30 T.C. 642 (1958), *aff’d*, 272 F.2d 168 (5th Cir. 1959).

⁷⁶ *Sonora Community Hospital v. Commissioner*, 46 T.C. 519, 526 (1966), *aff’d*, 397 F.2d 814 (9th Cir. 1968) (finding that a hospital was operated for the private benefit of the two founding doctors, who previously had owned hospital facilities, and who shared in the fees from a privately operated laboratory and X-ray departments within the hospital even though they performed no associated services).

⁷⁷ *Lowery Hospital Association v. Commissioner*, 66 T.C. 850, 858-59 (1976).

⁷⁸ *Founding Church of Scientology v. United States*, 412 F.2d 1197, 1202 (Ct. Cl. 1969), *cert. denied*, 397 U.S. 1009 (1970).

⁷⁹ Gen. Couns. Mem. 39862 (Nov. 22, 1991); see also Gen. Couns. Mem. 39498 (Jan. 28, 1986) (stating that all physicians on the medical staff of a hospital, as employees or persons with a close professional working association with the hospital, are persons who have a personal and private interest in the activities of the hospital, and are subject to the inurement proscription).

relationships because physicians generally use hospital facilities at no cost to themselves to provide services to private patients for which they earn a fee.⁸⁰ Thus, in situations in which a physician did not rise to the level of an insider, the IRS applied a private benefit analysis to the physician's relationship with the hospital.

However, the introduction of the intermediate sanctions rules in 1996 had implications for the law of private inurement by introducing the imposition of excise taxes in cases of inurement – specifically when an “excess benefit” was conveyed as part of a transaction between the organization and a “disqualified person” of the organization. Although the statutory definition of “disqualified person” is not necessarily synonymous with the notion of an “insider” of the organization under the private inurement doctrine, in general, it may be a rare case where a person who satisfies the definition of a disqualified person is not also considered an insider, and vice-versa. If the IRS's pre-1996 position that physicians generally were insiders of a hospital applied under the intermediate sanctions rules, physicians also likely would have qualified as per se disqualified persons for purposes of such rules. However, in enacting intermediate sanctions, Congress intended “that physicians will be disqualified persons only if they are in a position to exercise substantial influence over the affairs of an organization.”⁸¹ The IRS now follows this legislative history, that physicians are not per se insiders, and also has found, in the context of physician recruitment, that physicians do not “have any personal or private interest in the activities of the [hospital]” for purposes of the inurement proscription.⁸²

⁸⁰ Gen. Couns. Mem. 39862 (Nov. 22, 1991).

⁸¹ H.R. Rep. No. 104-506, 104th Cong., 2d Sess. 58, n. 12 (1996).

⁸² Rev. Rul. 97-21, 1997-1 C.B. 121.

B. Issues

Joint ventures

Traditionally, section 501(c)(3) health care organizations managed their charitable operations independently. With the advent of the for-profit hospital companies, however, nonprofit hospitals began to participate in business transactions, such as joint ventures or partnerships that previously had not been utilized to the same degree.⁸³ By 1980, exempt hospitals increasingly turned to joint ventures and other partnership transactions with for-profit interests to raise capital or establish contractual relationships with physicians, business consultants, medical staffers, or institutional managers.⁸⁴ Joint venture arrangements are one variety of an increasingly common type of competitive behavior engaged in by nonprofit hospitals in response to significant changes in their operating environment.⁸⁵

Although exempt hospitals are not prohibited from entering into joint ventures, the presence of a for-profit partner raises private inurement and private benefit issues.⁸⁶ In general, joint ventures must be examined to determine whether (1) the organization's income derived from the venture is taxed as unrelated business taxable income; (2) the organization receives fair market value in connection with all aspects of the venture; (3) the joint venture furthers a charitable purpose; and (4) the arrangement does not provide an impermissible private benefit to any private persons, including others who participate in the joint venture. The IRS and the courts have emphasized the extent to which the exempt organization may and does control the activities of the joint venture, particularly with respect to the charitable aspects and day-to-day operations of the venture, when examining whether the joint venture jeopardizes the exempt status of the participating organization, or causes the exempt organization's share of the income from the venture to be taxed as unrelated business taxable income.

In Revenue Ruling 98-15,⁸⁷ the IRS held that a section 501(c)(3) organization may form and participate in a partnership and meet the operational test if (1) participation in the partnership furthers a charitable purpose, and (2) the partnership arrangement permits the exempt organization to act exclusively in furtherance of its exempt purpose and only incidentally for the benefit of the for-profit partners. The Tax Court, in *Redlands Surgical Services v.*

⁸³ Jack E. Karns, *Justifying the Nonprofit Hospital Tax Exemption in a Competitive Market Environment*, 13 Widener L.J. 383, 498-99 (2004).

⁸⁴ *Id.*

⁸⁵ Gen. Couns. Mem. 39862 (Nov. 22, 1991).

⁸⁶ *Redlands Surgical Services, Inc. v. Commissioner*, 113 T.C. 47, 74-5 (1999), *aff'd*, 242 F.3d 904 (9th Cir. 2001).

⁸⁷ 1998-1 C.B. 718; see also Rev. Rul. 2004-51, 2004-22 I.R.B. 974 (providing guidance regarding ancillary joint ventures (i.e., joint ventures in which the participating exempt organization does contribute all or substantially all of its assets)).

Commissioner,⁸⁸ held that an organization may form partnerships, or enter into contracts, with private parties to further its charitable purposes on mutually beneficial terms, “so long as the nonprofit organization does not thereby impermissibly serve private interests.” In that case, the Tax Court held that the nonprofit partner must have “formal or informal control sufficient to ensure furtherance of charitable purposes.” Affirming the Tax Court, the Ninth Circuit held that ceding “effective control” of partnership activities impermissibly serves private interests.⁸⁹

In *St. David’s Health Care System v. United States*, the Fifth Circuit held that the determination of whether a nonprofit organization that enters into a partnership operates exclusively for exempt purposes is not limited to “whether the partnership provides some (or even an extensive amount of) charitable services.”⁹⁰ In that case, an exempt organization contributed all of its health care facilities to a partnership joint venture with a for-profit health care system. The Court held that in such situations the nonprofit partner must have the “capacity to ensure that the partnership’s operations further charitable purposes.”⁹¹ “[T]he non-profit should lose its tax-exempt status if it cedes control to the for-profit entity.”⁹²

Conversions

In recent years, the conversion of public charities to for-profit entities, especially of hospitals and other health care providers, has resulted in significant amounts of charitable assets being converted to for-profit uses. Conversion transactions are sometimes used to provide organizations access to equity markets, and advocates of conversion transactions claim additional advantages of: (1) cost reduction due to efficiency and enhanced bargaining power with respect to providers of services or goods to the organization; (2) greater accountability to consumers and enhancement of consumer choices; (3) providing a means to offer stock options, restricted stock, and other long-term incentives to management; and (4) avoiding the limiting effects of certain tax rules (such as the treatment of commercial-type insurance under section 501(m)) and fear of regulatory changes.⁹³ Provided that the converting charity receives fair market value for its assets, pays no more than reasonable compensation for services rendered in connection with the transaction, and takes appropriate steps to assure that its assets (including conversion transaction proceeds) remain dedicated to charitable purposes, conversion transactions may be completed in

⁸⁸ 113 T.C. 47, 92-93 (1999), *aff’d* 242 F.3d 904 (9th Cir. 2001).

⁸⁹ *Redlands Surgical Services v. Commissioner*, 242 F.3d 904 (9th Cir. 2001).

⁹⁰ 349 F.3d 232, 236-37 (5th Cir. 2003).

⁹¹ *Id.* at 243.

⁹² *Id.* at 239. On remand, a jury determined that the exempt organization did retain sufficient effective control of the venture to ensure that the joint venture’s operations would substantially further charitable purposes.

⁹³ Frances R. Hill and Douglas M. Mancino, *Taxation of Exempt Organizations*, sec. 30.01 (2002).

a manner that is consistent with the organization's charitable mission and the tax subsidies provided by the Federal government.

Private benefit and private inurement can occur during the conversion process if charitable assets are transferred for below fair market value to an entity whose owners include the hospital's management. Conversion transactions also raise concerns that excessive compensation and severance amounts are paid to officers, directors, and employees of the charity or the acquiring for-profit entity and the charity's assets will not be used for their intended charitable purposes following the completion of the transaction.⁹⁴ Opportunities for such abuses are greatest in situations where officers, directors, and employees of the charity enter into relationships with the acquiring entity that put them in a position of influence over the affairs of the acquirer. Such conflicts of interest may make it difficult to ensure that the best interests of the charitable beneficiaries are protected and that the charity's assets remain dedicated for charitable purposes.

A recent decision by the Court of Appeals for the Fifth Circuit dismissed the IRS's attempt to impose excise taxes on a conversion transaction of a nursing home from nonprofit to for-profit status. The decision, *Caracci v. Commissioner*,⁹⁵ primarily concerned the valuation of the nursing home acquired by the for-profit entity. In general, under current-law section 4958, if an "excess benefit" is provided to an insider of a charitable organization as part of a transaction between the charity and the insider, excise taxes apply to the insider and, in some cases, to the manager of the charity. The IRS asserted that the nursing home assets were greatly undervalued and that an excess benefit of \$18.5 million was provided to the S corporation acquirer of the nursing home, the shareholders of which were the original founders of the nursing home. The IRS issued deficiency notices requiring payment of over \$250 million in excise taxes. The Tax Court held that there was an excess benefit provided to the acquirer, but substantially reduced the amount of the excess benefit to \$5 million and the taxes owed to about \$70 million. The Fifth Circuit reversed, however, and dismissed the case in favor of the taxpayer, holding that the Commissioner failed to meet the burden of proof on the valuation issue.

⁹⁴ Evelyn Brody, *Whose Public? Parochialism and Paternalism in State Charity Law Enforcement*, 79 *Indiana Law Journal* 937, 962-63 (Fall 2004) ("[c]ommunities have been worrying about behind-closed-doors sales of nonprofit hospital assets: the community might be short-changed either in the amount paid for the assets (and hence the funds available for future charity) or in the quality and price of future for-profit hospital services. Some also suspect conflicts of interest on the part of the nonprofit's trustees and officers, who might receive positions either in the new hospital management or the resulting foundations."); Terry Roth Reicher, *Assuring Competent Oversight to Hospital Conversion Transactions*, 52 *Baylor Law Review* 83, 91-92 (Winter 2000) (major objections to conversion transactions stemmed from undervaluation of the nonprofit with the resultant underfunding of the charity, the channeling of sales proceeds back to the for-profit purchaser, restrictions on the surviving charity's ability to function as a charity after the transaction, and improper inducements to board members).

⁹⁵ 98 A.F.T.R. 2d 2006-5264.

III. DISCLOSURE AND RETURN REQUIREMENTS FOR CHARITABLE HOSPITALS

A. Present Law

Application for tax-exemption

Section 501(c)(3) organizations (with certain exceptions) are required to seek formal recognition of tax-exempt status by filing an application with the IRS (Form 1023).⁹⁶ In response to the application, the IRS issues a determination letter or ruling either recognizing the applicant as tax-exempt or not.

Charitable hospitals are required, as part of the Form 1023, to complete a separate schedule (Schedule C – Hospitals and Research Organizations), on which the hospital must answer a series of questions regarding its medical, charitable, and other activities, as well as its relationships with other organizations.⁹⁷ Many of the questions on Schedule C generally are directed toward establishing whether the organization will satisfy the community benefit standard. For example, the hospital is asked whether:

- all the doctors in the community are eligible for staff privileges,
- it will provide medical services to all individuals in the community who can pay for themselves or have private health insurance,
- it will provide medical services to all individuals in the community who participate in Medicare,
- it will provide medical services to all individuals in the community who participate in Medicaid,
- it will maintain a full-time emergency room,
- it has a policy on providing emergency services to persons without apparent means to pay,
- it provides for a portion of its services and facilities to be used for charity patients,
- it distinguishes between charity care and bad debts,
- it will carry on a formal program of community education, and
- the board of directors is comprised of a majority of individuals who are representative of the community served.

⁹⁶ Sec. 508(a).

⁹⁷ For purposes of the Schedule C filing requirement, an organization generally is considered a hospital “if its principal purpose or function is providing medical or hospital care or medical education or research.” Internal Revenue Service, Instructions for Form 1023 (Rev. June 2006), at 18.

Other questions are directed more toward ensuring that the hospital's assets are used for charitable purposes and not for the personal or private benefit of individuals. For example, the hospital is asked whether:

- it will provide office space to physicians carrying on their own medical practices,
- it participates in any joint ventures,
- it will manage its activities or facilities through its own employees or volunteers,
- it will offer recruitment incentives to physicians,
- it will lease equipment, assets, or office space from physicians with whom it has a financial or professional relationship,
- it will purchase medical practices, ambulatory surgery centers, or other business assets from physicians or other persons with whom it has a business relationship, and
- it has adopted a conflict of interest policy.

Annual information return

Present law requires that, in general, tax-exempt organizations, including charitable hospitals, file an annual information return (Form 990 series) with the IRS.⁹⁸ The annual information return is intended to provide the IRS with information sufficient to make a determination whether the organization is operating consistent with the requirements of the Code section under which it is organized – and so, whether the organization should continue to be exempt from Federal income tax.

In general, the annual information return is a generic document that is filed by the many types of tax-exempt organizations, not just section 501(c)(3) organizations.⁹⁹ The Form 990 requires organizations to report their gross income, information regarding their finances, functional expenses, compensation, activities, and other information regarding the organization's activities and operations during the previous taxable year. Examples of the information required by Form 990 include: (1) a statement of program accomplishments; (2) a description of the relationship of the organization's activities to the accomplishment of the organization's exempt purposes; (3) a description of payments to individuals, including compensation to officers and directors, highly paid employees and contractors, grants, and certain insider transactions and loans; and (4) disclosure of certain activities, such as expenses of conferences and conventions, political expenditures, compliance with public inspection requirements, and lobbying activities.

⁹⁸ Sec. 6033(a). The requirement that a exempt organization file an annual information return does not apply to churches, certain other organizations, and organizations (other than private foundations and supporting organizations) the gross receipts of which in each taxable year normally are not more than \$25,000. However, pursuant to the Pension Protection Act of 2006, for returns with respect to annual periods beginning after 2006, such small organizations generally are required annually to file with the IRS a brief statement containing basic information about the organization. See sec. 6033(i).

⁹⁹ Private foundations file a distinct information return, the Form 990-PF.

Other requirements

A charitable hospital that is subject to the unrelated business income tax (e.g., if the hospital has more than \$1,000 of gross income from a trade or business that is regularly carried on and that is not substantially related to exempt purposes) must report that income on Form 990-T (Exempt Organization Business Income Tax Return).

In general, tax-exempt organizations, including charitable hospitals, are required to make available for public inspection a copy of the organization's annual information return (Form 990) and exemption application materials.¹⁰⁰ Effective for returns filed after August 17, 2006, an organization described in section 501(c)(3) also is required to make available for public inspection a copy of its unrelated business income tax return (Form 990-T).¹⁰¹ Penalties may be imposed on any person who does not make an organization's annual information return, unrelated business income tax return, or exemption application materials available for public inspection.

In addition to the Federal tax-related reporting and disclosure requirements described above, several States impose reporting requirements on tax-exempt hospitals. For example, as discussed more fully above, a number of States require charitable hospitals to report financial and other data regarding levels of charity care provided, and other community benefit activities undertaken, by such hospitals.

¹⁰⁰ Sec. 6104(d).

¹⁰¹ Sec. 6104(d)(1)(A)(ii).

B. Issues

The questions on Schedule C of the Form 1023 are in the “yes” or “no” format, with explanatory information required depending on which box is checked. The IRS uses this information in order to determine whether a hospital should be recognized as a charitable hospital on a going-forward basis. However, often this information is provided at the time an organization is formed and is not necessarily helpful in determining whether, in fact, an organization operates on an ongoing basis consistent with legal requirements.

There are no special requirements on the Form 990 for charitable hospitals. For purposes of the annual information return, hospitals are treated, as a general matter, identically to any other charitable organization. Specifically, the Form 990 does not require that hospitals show whether any charity care was provided during the taxable year or whether or how a benefit was provided to the community during the taxable year. However, IRS Commissioner Mark Everson has testified that the IRS presently is revising Form 990 to include a new hospital-specific schedule that will require the provision of information similar to the information sought through Schedule C to Form 1023.¹⁰² More detailed annual reporting by hospitals regarding satisfaction of exemption standards would better inform the IRS and the public regarding whether a hospital provides a community benefit. On the other hand, it also would impose an additional compliance burden for hospitals, which some may argue would detract a hospital from performing its core mission.

¹⁰² Written statement of Mark W. Everson, Commissioner of the Internal Revenue Service, before the House Committee on Ways and Means, May 26, 2005.

IV. DESCRIPTION OF PRESENT LAW RELATING TO TAX-EXEMPT FINANCING FOR CHARITABLE HOSPITALS

In general

In addition to issuing tax-exempt bonds for government operations and services, State and local governments may issue tax-exempt bonds to finance the activities of charitable organizations described in section 501(c)(3). Because interest income on tax-exempt bonds is excluded from gross income, investors generally are willing to accept a lower rate on such bonds than they might otherwise accept on a taxable investment. This, in turn, lowers the cost of capital for the users of such financing. Both capital expenditures and limited working capital expenditures of charitable organizations described in section 501(c)(3) of the Code generally may be financed with tax-exempt bonds. Private, nonprofit hospitals frequently are the beneficiaries of this type of financing.

Qualified section 501(c)(3) bonds

Interest on bonds issued by State and local governments generally is excluded from gross income for Federal income tax purposes. Bonds issued by State and local governments may be classified as either governmental bonds or private activity bonds. Governmental bonds are bonds the proceeds of which are primarily used to finance governmental functions or which are repaid with governmental funds. Private activity bonds are bonds in which the State or local government serves as a conduit providing financing to nongovernmental persons¹⁰³ (e.g., private businesses or individuals). For these purposes, section 501(c)(3) organizations are treated as nongovernmental persons. The exclusion from income for interest on State and local bonds does not apply to private activity bonds, unless the bonds are issued for certain permitted purposes (“qualified private activity bonds”) and other Code requirements are met.

The definition of a qualified private activity bond includes bonds issued to finance the activities of charitable organizations described in section 501(c)(3) (“qualified 501(c)(3) bonds”).¹⁰⁴ Facilities financed with qualified 501(c)(3) bonds are required to be owned by a section 501(c)(3) organization or by a governmental unit. Moreover, a bond issue is not treated as a qualified 501(c)(3) bond (i.e., is not tax-exempt) if such bond issue meets the private business test. A bond issue meets the private business test if more than five percent of the net

¹⁰³ For these purposes, the term “nongovernmental person” generally includes the Federal Government and all other individuals and entities other than States or local governments.

¹⁰⁴ Sec. 141(e). Qualified activity bonds also include exempt facility bonds, qualified mortgage or veterans’ mortgage bonds, small issue and redevelopment bonds, and student loan bonds. Present law also provides special rules for qualified private activity bonds issued within certain geographic areas (e.g., enterprise or empowerment zones, the New York Liberty Zone, and the Gulf Opportunity Zone) to provide incentives for businesses to locate in those areas.

proceeds¹⁰⁵ of the issue are used or to be used in the trade or business of any nongovernmental person, other than a section 501(c)(3) organization, (the “private business use test”) and more than five percent of the payment of principal or interest on the issue is secured (directly or indirectly) by payments or property used or to be used for a private business use (the “private payment test”).¹⁰⁶ The use of bond proceeds or bond-financed property in unrelated trades or businesses (determined by applying section 513(a)) is treated as private business use. Thus, the use of bond proceeds by a section 501(c)(3) organization in an unrelated trade or business is limited to five-percent of the net proceeds of the bond issue.

Qualified 501(c)(3) bonds are not subject to a number of restrictions that apply to other qualified private activity bonds. For example, the aggregate volume of most qualified private activity bonds is restricted by the annual volume cap imposed on issuers within each State (the “State volume cap”).¹⁰⁷ For calendar year 2006, these annual volume limits, which are indexed for inflation, equal \$80 per resident of the State, or \$246.61 million, if greater. The volume cap rules reflect Congress’ intent to control the total volume of tax-exempt bonds issued for private activities. Qualified 501(c)(3) bonds, however, are not subject to the State volume cap. In addition, unlike most qualified private activity bonds issued after August 7, 1986,¹⁰⁸ the interest income from qualified 501(c)(3) bonds is not a preference item for purposes of calculating the alternative minimum tax.

Advance refunding of qualified section 501(c)(3) bonds

The Code also provides more favorable refunding rules for qualified 501(c)(3) bonds than for other types of qualified private activity bonds. A refunding bond is defined as any bond used to pay principal, interest, or redemption price on a prior bond issue (the refunded bond). The Code contains different rules for “current” as opposed to “advance” refunding bonds. A current refunding occurs when the refunded bond is redeemed within 90 days of issuance of the refunding bonds. Conversely, a bond is classified as an advance refunding bond if it is issued more than 90 days before the redemption of the refunded bond.¹⁰⁹ Proceeds of advance refunding bonds generally are invested in an escrow account and held until a future date when

¹⁰⁵ The term “net proceeds” means the proceeds of a bond issue reduced by amounts in a reasonably required reserve or replacement fund (which is generally limited to 10 percent of the proceeds). Sec. 150(a)(3).

¹⁰⁶ Sec. 145(a)(2). A similar test applies for purposes of determining whether bonds issued as governmental bonds are taxable private activity bonds, except there is a 10 percent of proceeds limit for purposes of the business use and private payment tests.

¹⁰⁷ Sec. 146.

¹⁰⁸ Sec. 57(a)(5). Special rules apply to exclude refundings of bonds issued before August 8, 1986, and certain bonds issued before September 1, 1986.

¹⁰⁹ Sec. 149(d)(5).

the refunded bond may be redeemed. Thus, after issuance of an advance refunding bond, there is a period of time when both the refunding bonds and the refunded bonds remain outstanding.

There is no statutory limitation on the number of times that tax-exempt bonds may be currently refunded. However, the Code limits the number of advance refundings with tax-exempt bonds. Generally, qualified 501(c)(3) bonds and governmental bonds may be advance refunded one time.¹¹⁰ Private activity bonds, other than qualified 501(c)(3) bonds, may not be advance refunded.

The \$150 million limit for nonhospital bonds

Prior to the Taxpayer Relief Act of 1997 (the “1997 Act”), the Code limited the amount of qualified 501(c)(3) outstanding bonds from which a section 501(c)(3) organization could benefit to \$150 million. In applying this “\$150 million limit,” all section 501(c)(3) organizations under common management or control were treated as a single organization. The limit did not apply to bonds for hospital facilities, defined to include acute care, primarily inpatient, organizations. The 1997 Act repealed the \$150 million limit for bonds issued after the date of enactment (August 5, 1997), to finance capital expenditures incurred after such date.

Because the 1997 Act provision applies only to bonds issued with respect to capital expenditures incurred after August 5, 1997, the \$150 million limit continues to govern the issuance of other non-hospital qualified 501(c)(3) bonds (e.g., advance refunding bonds with respect to capital expenditures incurred on or before such date, new-money bonds for capital expenditures incurred on or before such date, or new-money bonds for working capital expenditures). Thus, there are two rules governing qualified 501(c)(3) bonds for capital expenditures. The application of a particular rule depends on whether the capital expenditures were incurred on or before or after the date the 1997 Act was enacted.

¹¹⁰ Sec. 149(d)(3). Bonds issued before 1986 and pursuant to certain transition rules contained in the Tax Reform Act of 1986 may be advance refunded more than one time in certain cases.