Nonprofit Joint Ventures and Community Benefit: A New Approach

By Gail Rebecca Floyd

Over the past few decades, reduced reimbursement from government payers and a quickly expanding uninsured population have put pressure on nonprofit hospitals to find new ways to finance their operations.[1] Increasingly, nonprofit hospitals are forming joint ventures with for-profit entities.[2] These arrangements allow nonprofit hospitals to provide needed services in the community and to benefit from the management expertise of their for-profit partners.[3] Since the late 1990s, these ventures have faced increasing scrutiny from the Internal Revenue Service because of claims that benefits to the for-profit partners are more than insubstantial. Some of these ventures have caused the IRS to revoke the nonprofit partner's tax-exempt status.[4]

In addition to facing increased scrutiny over their partnerships with for-profit entities, nonprofit hospitals have recently been asked to show that they provide enough benefits to the community to justify these hospitals' tax-exempt status.[5] Over the past few years, critics have accused nonprofit hospitals of taking advantage of steep tax breaks while providing little care to indigent patients and aggressively pursuing patients who cannot pay their bills.[6] In 2006, the IRS initiated an investigation into the level of benefits nonprofit hospitals actually provide to the community. The IRS's findings led to changes in the requirements for how nonprofit hospitals are to report their activities that benefit the community. [7]

This article argues that the analysis of whether joint ventures between nonprofit and for-profit hospitals cause the nonprofit partner to lose its tax-exempt status should be tied to the new standards for community benefit that are established in the Affordable Care Act (ACA).[8] The current framework for determining whether the nonprofit partner may retain its tax-exempt status focuses on whether the organization seeking exempt status serves a charitable purpose and whether the arrangement allows the nonprofit entity to act exclusively in furtherance of the charitable purpose.[9] This standard requires the nonprofit partner to have control of the joint-venture organization's assets and day-to-day operations to ensure that it is able to initiate projects that further its mission and do not provide excessive benefit to the for-profit partner.[10]

The discussion also argues that the current framework is too complex and does not ensure that nonprofit joint ventures provide adequate benefits to their communities. A better approach would be to allow compliance with the new community benefit standard that is set forth in the Affordable Care Act to create a presumption that the benefits provided to for-profit partners are insubstantial. This alternative approach would provide more clarity to entities that want to initiate joint ventures between nonprofit and for-profit organizations and to the practitioners who help to structure these transactions.

This article discusses the rationale and requirements for allowing hospitals to be tax-exempt and explores the evolving community benefit standards for nonprofit hospitals and also describes the economics behind joint ventures between nonprofit hospitals and for-profit entities and explains the legal framework for analyzing the impact on the nonprofit partner's tax-exempt status. Last, the article explains how the changing community benefit standards should affect the analysis of joint ventures between nonprofit and for-profit hospitals.

Nonprofit Status for Hospitals and Evolving Community Benefit Standards

Overview of Federal Tax Exemption for Hospitals

Hospitals may be exempt from federal taxation under

I.R.C. § 501(c)(3) if they are "organized and operated exclusively for religious, charitable, scientific … or educational purposes."[11] In order to meet the requirements of § 501(c)(3), an entity must meet an organizational test and an operational test.[12] The organizational test considers whether the entity's governing document (1) limits the organization's activities to one or more charitable purposes and (2) does not allow the entity to engage in more than an insubstantial amount of noncharitable activity.[13] The operational test examines whether or not the organization actually operates in a manner that furthers its charitable purpose.[14] The operational test requires the organization to operate exclusively for one or more exempt purposes and prohibits the organization's earnings from inuring to the benefit of one or more private individuals or shareholders.[15]

In Revenue Ruling 56-185, the IRS articulated the standards a hospital must meet to qualify for federal tax exemption under § 501(c)(3)[16]—including the requirement that the hospitals must operate in a way that serves those unable to pay, to the extent that the hospitals are financially able to do so, and that the hospital's earnings do not inure directly or indirectly to any private individual or shareholder. In 1969, the IRS broadened the scope of its charity care standard in response to fears that the new Medicare and Medicaid programs would dramatically reduce the number of patients needing charity care and therefore would make it difficult for hospitals to meet the exemption requirements.[17] In Revenue Ruling 69-545, the IRS stated that hospitals may be eligible for tax-exempt status if they operate an emergency room that is open to everyone in the community regardless of ability to pay, participate in the Medicare and Medicaid programs, have a governing board composed of members of the community, and maintain an open medical staff.[18] Ruling 69-545 also stated that a hospital would not qualify for tax-exempt status if it provided care only to those who were able to pay for it.[19] In 1983, the IRS further broadened the scope of the § 501(c)(3) exemption for hospitals when it ruled that operating an emergency room was not necessary to maintain tax-exempt status if local planning officials determined that doing so would unnecessarily duplicate existing services in the area.[20]

As the requirements imposed on hospitals that seek to obtain tax-exempt status under § 501(c)(3) have been relaxed, critics have pointed out that the distinction between for-profit and nonprofit hospitals has nearly disappeared.[21] Some have argued that there is little empirical evidence that nonprofit and for-profit hospitals differ in the range and price structure of the services they offer.[22] However, other research has demonstrated that nonprofit hospitals are more likely to offer unprofitable services that are needed in the community than their for-profit competitors are, and these nonprofit hospitals are unable to offer more lucrative services solely because of the profit-making potential of these services.[23]

Changing Community Benefit Requirements for Nonprofit Hospitals

The Hospital Compliance Project and Schedule H of the New IRS Form 990

In response to questions about what role nonprofit hospitals should play in the health care debate, in May 2006, the IRS initiated the Hospital Compliance Project, whose aim was to study the community benefits that nonprofit hospitals provide and to examine how nonprofit hospitals establish executive compensation.[24] The major findings of the study, as explained in final report of the project, were the following:

- Hospitals had different definitions of uncompensated care.
- Hospitals' expenditures associated with community benefits averaged about 9 percent of total revenue.
- Uncompensated care was the largest component of the reported benefits provided to the community.
- Hospitals' spending on medical research and community health programs combined made up an average of less than 3 percent of total revenue.[25]

One of the most important ways in which the results of the Hospital Compliance Project were used was in the development of Schedule H of the revised IRS Form 990,[26] which the IRS issued the 2008 tax year with the goal of enhancing transparency and forcing hospitals to go to greater lengths to justify their tax-exempt status.[27] Schedule H requires nonprofit hospitals to provide detailed information about their charity care policies and the amount of charity care they actually provide as well as an explanation of their billing and collection practices and how they report expenses involving bad debts. The information requested on Schedule H is to be presented in narrative form, which allows hospitals to explain their activities and how they provide benefits to the community.[28]

The New Community Benefit Standard Under § 501(r)

When the ACA was enacted in March 2010, Congress modified the Internal Revenue Code to include § 501(r), which imposes the following new requirements for charitable hospitals seeking tax-exempt status:

- Nonprofit hospitals must conduct a community health needs assessment every three years by soliciting input from people in the community, developing a strategy for meeting the identified community needs, and making the needs assessment widely available to the public.[29] In addition, the hospital must adopt a policy that requires it to provide emergency medical care to all who need it regardless of their ability to pay for the service.[30]
- Hospitals must adopt a written financial assistance policy and widely publicize the policy throughout the community.[31]
- Hospitals may not charge patients who need financial assistance more than the lowest amount charged to

people who have insurance coverage and are prohibited from using gross charges.[32]
- Hospitals may not engage in extraordinary collection practices before determining patients' eligibility for financial assistance.[33]

In addition to the above changes to I.R.C. § 501, the ACA requires nonprofit hospitals to explain how they are addressing community needs on their Form 990, to describe any identified community needs they are not addressing, and to explain why those needs are not being met.[34] The ACA also imposes a $50,000 fine on hospitals that fail to comply with the new requirements.[35] Notably, the ACA requires hospitals to adopt policies related to charity care policies and to provide more detail in reporting their community benefit activities, the act did not set a quantitative standard for the amount of community benefits nonprofit hospitals must provide in order to maintain their tax-exempt status under § 501(c)(3).[36]

Joint Ventures Between Nonprofit and For-Profit Hospitals

Economics of Joint Ventures

Nonprofit hospitals may enter into joint ventures with for-profit entities for a variety of reasons.[37] In general, joint ventures between for-profit and nonprofit organizations involve an infusion of capital from the for-profit partner and allow the nonprofit organization to expand the amount of charitable services it provides as its infrastructure and staff expands.[38] For struggling hospitals, joint ventures with for-profit entities can provide needed capital and can help the hospital recruit management talent, pool risk in an emerging service line, and offer new services to communities in need.[39]

There are two main types of joint ventures between nonprofit and for-profit hospitals.[40] In an ancillary joint venture, a nonprofit hospital enters into an agreement with a for-profit entity to engage in a specific activity, such as the operation of an imaging center or ambulatory surgery center.[41] The nonprofit hospital typically contributes assets and/or cash to the venture, usually a limited liability corporation, and the for-profit partner contributes cash.[42] The nonprofit and for-profit entities negotiate ownership interests in the venture; the new corporation operates and manages the facility; and the nonprofit partner continues to own and operate the hospital.[43]

A whole-hospital joint venture is a transaction in which a nonprofit hospital contributes the entire hospital, and the for-profit partner contributes cash.[44] An operating agreement between the parties establishes ownership interests as well as issues related to governance and control.[45] When the transaction is complete, the joint venture owns and operates the hospital, and the nonprofit entity's sole activity is participation in the joint venture.[46]

The Legal Framework for Analyzing Joint Ventures

Early Standards

Before the early 1980s, any organization having tax-exempt status under I.R.C. § 501(c)(3 that formed a joint venture with a for-profit entity became ineligible for tax-exempt status because the Internal Revenue Service viewed the arrangement as a vehicle for the nonprofit organization to share in the net profits of a for-profit partner.[47] The IRS later revised its position on these arrangements and developed a two-prong test for determining when an organization's tax-exempt status can be questioned: (1) the "charitable purpose" test, which examines whether or not participation in the joint venture furthers the nonprofit entity's tax-exempt purpose,[48] and (2) the "private benefit" test, asks if the organization is able to operate exclusively for its charitable purpose and results in more than incidental benefit to the for-profit partner.[49]

The IRS's Revenue Ruling 98-15

As joint ventures between nonprofit hospitals and for-profit entities became more popular during the 1990s, practitioners requested further guidance from the IRS about the tax implications of these arrangements.[50] In 1998, the IRS issued Revenue Ruling 98-15, which shifted the focus of the analysis to the determination of which partner controls the assets and the operation of the joint venture.[51] The IRS held that a nonprofit hospital involved in a joint venture with a for-profit entity would continue to qualify for tax-exempt status under the following conditions:

- The governing documents committed the joint venture to pursue the nonprofit hospital's charitable mission over maximizing profits of the for-profit partner.
- The nonprofit entity had voting control over the governing board, which ensured that it could initiate activities that furthered its charitable mission.
- Management contracts with any third parties were reasonable and did not provide more than incidental private benefit.[52]

A joint venture that did not meet these requirements would be ineligible for tax-exempt status.

Application of Revenue Ruling 98-15

The first case in which the IRS applied the standard set in its Revenue Ruling 98-15 was *Redlands Surgical Services v. Commissioner*.[53] In this case, a nonprofit hospital formed a wholly owned subsidiary whose sole activity was participating in a joint venture with a for-profit partner that owned and operated an ambulatory surgical center.[54] The Tax Court found the newly formed nonprofit organization ineligible for tax-exempt status for the following reasons:

- The for-profit partner was not obligated to put charitable interests ahead of profits.
- The nonprofit organization did not have voting control over the partnership.
- The long-term contract between the parties allowed the for-profit partner to control the day-to-day operations of the joint venture.
- The for-profit partner gained market advantages as a result of the arrangement.[55]

The decision in *Redlands* was controversial because the surgical center actually increased the nonprofit partner's ability to pursue charitable activities and because the analysis made it difficult to determine how the Tax Court would apply the control test to ancillary joint ventures.[56]

Another case related to the standard set in the IRS's Revenue Ruling 98-15, *St. David's Health Care System v. United States*, involved a nonprofit hospital that had entered into a whole-hospital joint venture with a for-profit hospital chain because of financial difficulties facing the health care market.[57] The IRS revoked the hospital's tax-exempt status because of its participation in the joint venture, and the hospital sued to recover the taxes it had already paid.[58] In overturning the district court's grant of summary judgment in favor of the nonprofit hospital, the Fifth Circuit found that there were genuine issues of material fact as to whether the nonprofit hospital had ceded effective control to its for-profit partner in the joint venture.[59] Even though the nonprofit hospital had half of the votes on the governing board and could block objectionable programs, the hospital did not have enough control to initiate programs that might benefit the community.[60] On remand, a jury found that the hospital was entitled to a federal tax exemption and awarded back taxes the hospital had paid.[61] After this decision, practitioners in the field viewed control of the governing board as the per se standard for whether a joint venture with a for-profit entity will threaten a nonprofit hospital's tax-exempt status.[62]

How the Changing Community Benefit Standards Should Affect the Joint Venture Analysis

Criticisms of the Current Standard

In its Revenue Ruling 98-15, the IRS states that a nonprofit hospital's partnership with a for-profit entity will not threaten the hospital's tax-exempt status if the partnership furthers the nonprofit entity's charitable purpose and allows the nonprofit partner to act exclusively in furtherance of the purpose that resulted in gaining tax-exempt status.[63] According to the IRS, if the for-profit partner has control over the organization's assets and activities, the benefit to the for-profit partner will be more than incidental and the organization will therefore fail to be organized and operated exclusively for purposes that allow it to be exempt from federal taxes.[64] However, the IRS arrives at this conclusion without explaining why the for-profit partner's control or even shared control of the organization's activities ensures that the benefit to the for-profit will be more than incidental and negates the possibility that the partnership will further the organization's charitable purpose.

In *Redlands* the Tax Court found that the absence of any obligation to put the nonprofit hospital's charitable mission ahead of profit and the absence of formal or informal voting control by the nonprofit partner meant that the surgery center was not operating exclusively for purposes for which it would receive tax-exempt status.[65] In addition to analyzing the factors included in Revenue Ruling 98-15, the Tax Court reviewed the actual operations of the joint venture[66] and found that the surgery center failed to provide free care to indigent patients, did not operate an emergency room, and treated a negligible number of Medicaid patients.[67] Some commentators have argued that, even though the Tax Court claims to have based its decision on Revenue Ruling 98-15, the court was significantly influenced by the nonprofit hospital's failure to provide charity care.[68]

In *St. David's Health Care System v. United States*, a nonprofit hospital formed a joint venture with a for-profit hospital chain because reduced reimbursements from managed care organizations and government payers were making it difficult for the nonprofit partner to carry out its charitable mission.[69] Even though the joint venture's partnership agreement gave each party 50 percent control of the governing board, the agreement also stated that the joint venture was to operate in compliance with the community benefit standard set forth in Revenue Ruling 69-545.[70] Within four years of executing the agreement, the partnership had provided $64 million worth of uncompensated care, including $17 million in subsidized care to Medicare and Medicaid patients and $24 million in care to indigent patients.[71] Overall, the hospital provided an increase in uncompensated care amounting to $26 million in the four-year period following formation of the partnership.[72] The district court analyzed the joint venture under the standard set forth in Revenue Ruling 69-545 and found that the nonprofit organization was entitled to summary judgment on the issue of whether it was operating exclusively for a charitable purpose.[73] On appeal, the Fifth Circuit found Revenue Ruling 98-15 to be the starting point for analysis and reversed the district court's summary judgment because the nonprofit hospital lacked sufficient control over the governing board and could not initiate charitable programs without support from its for-profit partner.[74]

The *Redlands* and *St. David's* cases demonstrate the tension between the IRS's emphasis on which party has operational control in a joint venture between a nonprofit and a for-profit organization and the actual benefit such a venture provides to the community. The court in *Redlands* applied the standard set out in Revenue Ruling 98-15 but seemed ready to uphold denial of the venture's tax-exempt status because of its poor record of charity care.[75] The district court in *St. David's* found that, because the hospital provided enough charity care to meet the requirements set by Revenue Ruling 69-545, the hospital was operating exclusively for a charitable purpose, despite the 50/50 split in voting rights on the board.[76] When the Fifth Circuit put Ruling 98-15 at the starting point of the analysis, the court effectively placed the governance and control issues ahead of the community benefit standards set out in prior IRS rulings, making it unclear whether a nonprofit hospital's charitable activities would weigh into the analysis at all.

Courts that need to review the tax status of nonprofit joint ventures may have trouble applying the IRS standards because the IRS has not been clear in its explanation of what is expected of tax-exempt hospitals. In Revenue Ruling 56-185, the IRS includes operation "to the extent of its financial ability for those not able to pay for services" among the four factors required for a hospital to be tax-

exempt under § 501(c)(3),[77] indicating that the IRS views some level of uncompensated care to be a requirement for federal tax exemption. In Ruling 69-545, the IRS overruled the community benefit requirement found in Ruling 56-185 when it broadened the standard for eligibility under § 501(c)(3) by including "promotion of health" under the definition of "charity" and removing the requirement of delivering uncompensated care.[78] When the IRS issued Revenue Ruling 98-15 to explain how a joint venture with a for-profit partner would affect a nonprofit hospital's tax-exempt status, the IRS's focus was mainly on preventing more than incidental benefit to private third parties. Moreover, Ruling 98-15 did not make it clear whether the standard under Ruling 69-545 was still intact, or whether the IRS was reinstating the requirement to provide some level of uncompensated care.

Another problem with the current framework is that it ignores the potential for community benefit when nonprofit hospitals form joint ventures with for-profit entities. In *St. David's*, the nonprofit hospital was able to provide more uncompensated care after the hospital formed its partnership with a for-profit hospital chain.[79] In *Redlands*, the nonprofit entity argued that the joint venture arrangement helped further its charitable purpose by expanding access to its services in the community based on the medical needs of its members.[80] Forming a partnership with a for-profit entity that has experience and management expertise enables a joint venture to provide a benefit to the community even if the nonprofit hospital does not provide uncompensated care by bringing new and more efficient services to the area.[81]

Another reason for the confusion found in the current framework is that the case law and Revenue Rulings describe the need for nonprofit hospitals to be able to initiate charitable activity but fail to define "charitable activity" fully. Even though the IRS did not have the data gathered by the Hospital Compliance Project when it issued its most recent rulings on joint ventures between nonprofit and for-profit entities, the project's final report shows that the vast amount of community benefit provided by nonprofit hospitals is through uncompensated care to uninsured and underinsured patients.[82] The project found that, on average, less than 20 percent of total expenditures on community benefits were for community health programs.[83] The data seem to indicate that the charitable programs that nonprofit hospitals are supposed to be able to initiate on their own, without approval from their for-profit partners under the Ruling 98-15 standard, are programs that provide medical services to the needy. Communities could benefit a great deal from partnerships between nonprofit and for-profit organizations if the for-profit partner were able to provide an infusion of capital to the hospital and help it operate more efficiently, allowing the hospital to provide more care to indigent patients.

Neither the cases nor the Revenue Rulings discuss whether nonprofit and for-profit hospitals differ in the types of services they offer. Research has shown that some services—such as psychiatric and emergency care, AIDS/HIV services, burn treatment, and treatment for alcohol and substance abuse—are less profitable and more likely to be offered by nonprofit hospitals.[84] Some commentators have even suggested that provision of these services should be considered per se community benefits.[85] If joint ventures with for-profit entities allow nonprofit hospitals to continue to offer such services, communities stand to benefit substantially.

The control standard included in Revenue Ruling 98-15 may even threaten benefits provided to communities by making joint ventures between nonprofit and for-profit organizations unattractive to for-profit entities.[86] Requiring joint ventures to put the nonprofit hospital's charitable objectives ahead of profits increases the risk for the for-profit partner,[87] which may be unwilling to contribute large amounts of capital if they will not be able to have the control necessary to ensure that they can profit from the undertaking.[88] This chilling effect on joint ventures will have a negative impact on accessibility if the rules make it too difficult for nonprofit hospitals to find for-profit partners that can help finance the hospital's operations.[89]

Applying the New Community Benefit Standards

The current framework for analyzing joint ventures between nonprofit hospitals and for-profit entities is designed to ensure that the nonprofit hospital does not violate the private benefit prohibition under the operational test of the § 501(c)(3) requirements by providing more than incidental benefits to the for-profit partner.[90] The IRS presumes that, if the nonprofit hospital has control over the joint-venture organization's assets and operations, the nonprofit hospital will be able to ensure that its activities further the organization's charitable mission and that the benefits to for-profit partners are only incidental.[91]

Over the last decade, much of the health care debate has shifted to ensuring that nonprofit hospitals provide enough community benefits to justify their tax-exempt status.[92] The revised IRS Form 990 increases transparency for nonprofit hospitals and provides clear standards for how they are to report the benefits they provide to their communities.[93] With I.R.C. § 501(r), Congress set new requirements for nonprofit hospitals making it easier to distinguish them from their for-profit counterparts.[94] This article argues that the new community benefit standard will ensure that joint ventures between nonprofit and for-profit organizations will operate in accordance with the nonprofit partner's charitable mission better than the current control standard does. Joint ventures between nonprofit hospitals and for-profit entities that comply with the § 501(r) standard should be presumed to comply with the operational test under § 501(c)(3). If a joint venture is in compliance with § 501(r), it will be operating in a manner that satisfies expectations for how nonprofit hospitals should behave and should therefore be able to maintain its tax-exempt status.

Under the new standard, nonprofit hospitals engaging in joint ventures with for-profit entities will be required to comply with the § 501(r) standard if the hospitals wish to remain tax-exempt under § 501(c)(3). For-profit partners may gain some benefit under the arrangement because the

current control standard allows them to benefit to a certain degree, but the venture will be subject to the § 501(r) community benefit standards. Because an influx of cash and assets will be what allows the organization to conduct community benefit activities, the for-profit partner should be able to have enough operational control to ensure that the organization functions as efficiently as possible.

To comply with I.R.C. § 501(r), the organization formed by the joint venture will be required to conduct an assessment of the community's health care needs at least once every three years.[95] In conducting the needs assessment, the joint venture will have to seek input from community leaders and people with specialized knowledge and expertise in public health and to develop an implementation plan and make it widely available to the public.[96] The Affordable Care Act also requires nonprofit hospitals to describe any identified health need that is not being met and to explain why such needs are not being addressed.[97] Under the control standard, the nonprofit partner in the venture must have control over organizational operations, but the organization is not required to function in a way that actually responds to the community's health needs. In complying with the requirement to conduct an assessment of the community's health care needs, the nonprofit and for-profit partners will be forced to respond to community needs and will be held accountable when they are not being met.

Compliance with § 501(r) will require the joint-venture organization to develop a financial assistance program, to establish eligibility requirements, and to make the program widely available to the public.[98] The joint venture will also be required to adopt a policy for treating all patients who need emergency medical care regardless of their ability to pay.[99] This new standard makes it more likely that nonprofit hospitals will provide some level of charity care to the community—and perhaps even a higher level because of the requirement to publicize their financial assistance programs widely. A joint venture that complies with the § 501(r) standard should be able to maintain tax-exempt status regardless of whether the for-profit partner has operational control, because the financial assistance policy requirement makes it more certain that community needs are actually being met.

I.R.C. § 501(r) prohibits nonprofit hospitals from charging patients who are eligible for financial assistance more than the lowest amount charged to patients who have insurance coverage and also prohibits the use of gross charges.[100] This provision has the potential to reduce the level of revenue a nonprofit hospital receives from uninsured patients. Thus, a for-profit partner should be able to have more control over hospital operations so that it can provide needed medical services at a reduced cost.

The new § 501(r) also prohibits nonprofit hospitals from engaging in extraordinary collection actions before determining whether a patient is eligible for financial assistance.[101] This provision is a response to complaints that nonprofit hospitals have used aggressive debt collection practices against indigent patients in the past.[102] This rule can also have a potential impact on hospital revenue, because it makes it more difficult to collect payment from certain patients. Because the requirement prohibits certain collection practices and potentially reduces reimbursement, the for-profit partner's control over the organization's operations should not threaten tax-exempt status, because the for-profit partner may be better able to ensure that the hospital is operating efficiently.

Compliance with § 501(r) should not be too difficult to assess, because Schedule H of the revised IRS Form 990 already requires reporting much of this information.[103] By enacting § 501(r), Congress has clarified its expectations for how nonprofit hospitals are to differentiate themselves from their for-profit counterparts. Under this new standard, organizations wishing to enter into a tax-exempt joint venture between a nonprofit and for-profit entity will be aware of the kind of community benefit activities the venture will be expected to initiate. For-profit entities that comply with the requirements of § 501(r) in a joint venture with a nonprofit hospital will be likely to contribute much to the community by increasing the availability of needed health care services in the area and by allowing the organization to offer more uncompensated care. A nonprofit/for-profit joint venture that complies with the standards set in § 501(r) should be presumed to be offering only incidental benefit to the for-profit partner because the benefit gained by the community is so large by comparison.

Potential Problems with the New Standard

The first potential problem with the new standard is that nonprofit organizations that operate more than one hospital facility must meet the requirements of § 501(r) for each individual facility.[104] It is unclear whether failure to meet the § 501(r) requirements will cause just one facility to lose its tax-exempt status under § 501(c)(3) or cause the entire hospital system to lose tax-exempt status.[105] In addition, there is a question as to whether or not a system that operates a hospital and other ancillary facilities, such as a nursing home and imaging center, would lose tax-exempt status for all facilities if only the hospital failed to comply with § 501(r).

The second major concern is what types of organizations will be subject to the new § 501(r) standards. The rule defines "hospital" as "an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital," and also "any other organization which the Secretary determines has the provision of hospital care as its principal function."[106] The definition that the rule provides presents a problem because some states define "hospital" more broadly than others do[107]—for example, Florida defines hospital as any facility that offers medical care beyond a 24-hour period, whereas New York's definition includes any facility that provides services for treatment and prevention of disease that are performed under the supervision of a physician.[108] If an ancillary health care facility is operated in a state that defines "hospital" broadly, the facility could be subject to the requirements set forth in § 501(r), even though it provides a very limited range of services and does not provide 24-hour care.[109] Moreover, giving the U.S. treasury secretary authority to determine that other facilities fall

under the definition of "hospital" increases uncertainty as to which organizations will be subject to the statute.[110]

The third potential problem with the law concerns how the community health care needs assessment, which is required under I.R.C. § 501(r), will apply to ancillary joint ventures. Many ancillary facilities are operated to provide a specific service.[111] The law is unclear as to whether organizations that are operated for a limited purpose will be expected to conduct a community needs assessment and address identified needs that the facility is not prepared to accommodate.[112] This will probably be less of a problem for facilities in states where the definition of "hospital" is narrow and does not include ancillary health care facilities.

Another major concern relates to the provision that requires nonprofit hospitals to provide emergency medical care. This provision conflicts with Revenue Ruling 83-157, in which the IRS found that operating an emergency room is not necessary to maintaining tax-exempt status under § 501(c)(3).[113] The provision is problematic because many ancillary health care facilities provide outpatient services and are not equipped to handle emergency cases.[114] In addition, in Revenue Ruling 83-157, the IRS found that a hospital may have perfectly good reasons for not operating an emergency room—for example, when the facility is located in a region that already has adequate emergency medical services or the facility provides specialized services, such as an eye or cancer hospital, which do not require involve emergency treatment.[115]

The fifth potential problem relates to the penalty imposed for noncompliance. I.C.S. § 501(r)(7) imposes an excise tax of $50,000 for any hospital that fails to meet the requirements of § 501(r)—a fine that could be quite substantial for some small facilities.[116] On the other hand, large facilities may find it much more cost-effective to pay the fine than to actually comply with § 501(r).[117]

Finally, another potential problem with the new rule is that it does not set a quantitative standard for community benefit. Some commentators in the field predicted that, if Congress ever passed a community benefit requirement for nonprofit hospitals, it would include a minimum percentage of annual revenue that had to be spent on uncompensated care and community benefit activities.[118] However, in the final report of its Hospital Compliance Project, the IRS noted that community benefit expenditures were concentrated in a relatively small number of hospitals and that setting a specific percent-of-revenue threshold would have a disproportionate impact on some hospitals and would effectively end tax-exempt status for others.[119] Still, it is possible that, without a quantitative community benefit requirement, many nonprofit hospitals will attempt to offer as few community benefits as they can get away with and still be compliant with § 501(r).

Conclusion

Joint ventures between nonprofit hospitals and for-profit entities have the potential to enhance community benefit because of the possibility of expanding the range of available services in the area and allowing organizations to provide more uncompensated care to indigent patients. The current standard for analyzing the effect of these arrangements on nonprofit hospitals' tax-exempt status under § 501(c)(3) is too restrictive, because it places too much emphasis on the for-profit partner's ability to control the organization's day-to-day operations. The focus of the analysis should be on whether the arrangement provides substantial benefit to the community—not impermissible gain to the for-profit partner.

Now that Congress has clarified how nonprofit hospitals are expected to behave, this framework should apply in the joint venture context as well. A joint venture between a nonprofit hospital and a for-profit entity—a venture that complies with the requirements of § 501(r)—should be presumed to be providing only insubstantial benefits to the for-profit partner. Such a rule would allow for-profit entities to have the operational control necessary to ensure that the organization functions in the most efficient manner and would make joint ventures with nonprofit hospitals more attractive to for-profit entities. Communities will benefit from a more flexible standard that allows nonprofit hospitals to form the partnerships that allow them to continue to offer needed services. **TFL**

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Endnotes

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[9]Young, *supra* note 2, at 334.

[10]*Id.* at 354.

[11]I.R.C. § 501(c)(3).

[12]Treas. Reg. § 1.501(c)(3)-1(a).

[13]*Id.* § 1.501(c)(3)-1(b).
[14]*Id.* § 1.501(c)(3)-1(c).
[15]*Id.*
[16]Internal Revenue Service, Revised Ruling 56-185, 1956-1 C.B. 202.
[17]Young, *supra* note 2, at 329.
[18]IRS, Revised Ruling 69-545, 1969-2 C.B. 117.
[19]*Id.*
[20]IRS, Revised Ruling 83-157, 1983-2 C.B. 94.
[21]Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. Rev. 1345, 1376 (2003).
[22]John D. Colombo, *Commercial Activity and Charitable Tax Exemption*, 44 Wm & Mary L. Rev. 487, 563 (2002).
[23]Horwitz, *supra* note 20, at 1373.
[24]*IRS Exempt Organizations (TE/GE), Hospital Compliance Project Final Report* (Feb. 22, 2009), available at www.irs.gov/pub/irs-tege/frepthospproj.pdf.
[25]John D. Colombo et al., *Hospital Compliance Project Establishes a Framework for Nonprofit Hospitals*, 21 Tax'n Exempt 3, 4–5 (2009).
[26]*Id.* at 6
[27]James R. King et al., *Form 990 Disclosure Requirements Challenge Hospitals, Provide Opportunities*, 21 No. 3 Health Law 1, 2 (2009).
[28]Nancy Ortmeyer Kuhn, *What Will Health Care Legislation Hold for Nonprofit Hospitals?* 21 Tax'n Exempt 20, 22 (2009).
[29]ACA, § 9007, § 501(r)(3).
[30]*Id.*
[31]*Id.* § 501(r)(4).
[32]*Id.* § 501(r)(5).
[33]*Id.* § 501(r)(6).
[34]*Id.* § 4959.
[35]*Id.* § 501(r)(7).
[36]Fine and Jedry, *supra* note 5, at 6.
[37]Young, *supra* note 2, at 327.
[38]Michael I. Sanders, *Can the Commercial Model of "Unorthodox" Joint Ventures Meet the Service's Control Objectives?* 17 Tax'n Exempt 99 (2005).
[39]Mirkay, *supra* note 1, at 22.
[40]Young, *supra* note 2, at 336.
[41]*Id.*
[42]*Id.*
[43]*Id.* at 337.
[44]*Id.*
[45]*Id.*
[46]*Id.*
[47]Mirkay, *supra* note 1, at 36.
[48]I.R.S., Gen. Couns. Mem. 39,005 (June 28, 1983).
[49]*Id.*
[50]Young, *supra* note 2, at 342.
[51]IRS, Revised Ruling, 98-15, 1998-1 C.B. 718.
[52]*Id.*
[53]*Redlands Surgical Services v. Comm'r*, 113 T.C. 47 (1999).
[54]I*d.*
[55]*Id.* at 92–93.
[56]Young, *supra* note 2, at 348, 353.
[57]*St. David's Health Care System v. United States*, 349 F.3d 232, 233 (5th Cir. 2003).
[58]*Id.*
[59]*Id.* at 243.
[60]*Id.* at 241.
[61]*St. David's Health Care System v. United States*, 2004 WL 555095 at *1 (W.D. Tex. Mar. 18, 2004).
[62]Mirkay, *supra* note 1, at 48.
[63]IRS, Rev. Rul., *supra* note 51.
[64]*Id.*
[65]*Id.* at 92.
[66]David M. Flynn, *St. David's Health Care System, Inc. v. United States: District Court in Texas Rejects IRS "Whole Hospital" Joint Venture Positions*, 15 No. 1 Health L. 45, 47 (2002).
[67]*Redlands*, *supra* note 53, at 67–68.
[68]Flynn, *supra* note 66, at 47.
[69]*Id.*
[70]*Id.* at 48–49.
[71]*Id.* at 49.
[72]*Id.*
[73]*St. David's Health Care System v. United States*, 2002 WL 1335230 at *8 (W.D. Tex. June.7, 2002).
[74]*St. David's Health Care System*, 349 F.3d at 241–242.
[75]Flynn, *supra* note 66, at 47.
[76]*St. David's Health Care System*, *supra* note 73, at *8.
[77]IRS, Rev. Rul., *supra* note 16.
[78]IRS, Rev. Rul., *supra* note 18.
[79]Flynn, *supra* note 66, at 49.
[80]*Redlands*, *supra* note 53, at 70.
[81]Michael I. Sanders, *Hospital Joint Ventures and the Provision of Charity Care*, 20 Tax'n Exempt 14, 18 (2008).
[82]Colombo et al., *supra* note 25, at 4.
[83]*IRS Exempt Organizations (TE/GE), Hospital Compliance Project Final Report*, *supra* note 24, at 40.
[84]Horwitz, *supra* note 21, at 1365.
[85]Sanders, *Hospital Joint Ventures*, *supra* note 81, at 16.
[86]Young, *supra* note 2, at 362.
[87]Sanders, *Can the Commercial Model of "Unorthodox" Joint Ventures Meet the Service's Control Objectives? supra* note 38, at 100.
[88]*Id.* at 103.
[89]Young, *supra* note 2, at 363.
[90]*Id.* at 354.
[91]Aitsebaomo, *supra* note 4, at 448.
[92]Lorraine McClenny Wright et al., *Unraveling the New Form 990: Implications for Hospitals*, 35 No. 4 J. Health Care Fin. 83, 83–84 (2009).
[93]Colombo et al., *supra* note 25, at 9.
[94]Matie Stewart and Darren Azman, *Section 501(r) and Nonprofit Hospital Joint Ventures*, 22 Tax'n Exempt 9, 11 (2010).
[95]ACA, *supra* note 29, § 501(r)(3).
[96]*Id.* § 501(r)(3)(B).
[97]*Id.* § 4959.
[98]*Id.* § 501(r)(4)(A).
[99]*Id.* § 501(r)(4)(B).

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sion. Tapia now appeals to the U.S. Supreme Court, contending that the plain meaning and legislative history of the Sentencing Reform Act confirm that rehabilitation is an inappropriate consideration in prison sentencing. The United States agrees with Tapia and urges vacating the lower court decision. Writing as amicus curiae by invitation of the Supreme Court, Professor Stephanos Bibas asserts that district courts may properly consider the rehabilitative potential of in-prison targeted treatment programs when determining a prison sentence. Full text is available at topics.law.cornell.edu/supct/cert/10-5400. **TFL**

Prepared by Jacqueline Bendert and Rachel Sparks Bradley. Edited by Kate Hajjar.

United States v. Jicarilla Apache Nation (10-382)

Appealed from the U.S. Court of Appeals for the Federal Circuit (Feb. 1, 2010)
Oral argument: April 20, 2011

In 2002, the Jicarilla Apache Nation filed a breach of trust action against the United States, alleging mismanagement of funds held in trust for the tribe. In 2008, the Jicarilla Apache Nation moved to compel the production of a few hundred documents exchanged between the government and its attorneys, but the government refused to disclose nearly 160 documents on the grounds of attorney-client privilege. The Court of Federal Claims subsequently granted Jicarilla's motion to compel production of the documents, and the Federal Circuit affirmed. Now, the United States argues that disclosure of the documents was unwarranted, because no statute or regulation specifically requires the disclosure. The Jicarilla Apache Nation, however, contends that the government must be treated like an ordinary private trustee and forced to disclose information exchanged with its attorneys. Full text is available at topics.law.cornell.edu/supct/cert/10-382. **TFL**

Prepared by Colin O'Regan and Edan Shertzer. Edited by Joanna Chen.

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[100]*Id.* § 501(r)(5).
[101]*Id.* § 501(r)(6).
[102]Fine and Jedry, *supra* note 5, at 6.
[103]King et al., *supra* note 27, at 11–13.
[104]ACA, *supra* note 29, § 501(r)(2)(B).
[105]Fine and Jedry, *supra* note 5, at 7.
[106]ACA, *supra* note 29, § 501(r)(2)(A).
[107]Stewart and Azman, *supra* note 94, at 12.
[108]*Id.*
[109]*Id.*
[110]Fine and Jedry, *supra* note 5, at 7.
[111]Stewart and Azman, *supra* note 94, at 15.
[112]*Id.*
[113]IRS, Rev. Rul., *supra* note 20.
[114]Stewart and Azman, *supra* note 94, at 15.
[115]*Id.* at 16.
[116]*Id.* at 17.
[117]*Id.*
[118]*Id.* at 16.
[119]*IRS Exempt Organizations (TE/GE), Hospital Compliance Project Final Report*, *supra* note 24, at 169, 171.

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[23]*Breard*, *supra* note 16, at 194.
[24]*Medellín*, *supra* note 17, at 494.
[25]Vienna Convention of the Law on Treaties, 1155 U.N.T.S. 331 (May 23, 1969).
[26]*See Convention Between the Government of the United States and the Government of Ireland for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion With Respect to Taxes on Income and Capital Gains*, *U.S.-Ireland*, Jul. 28, 1997. A list of links to all U.S. tax treaties is provided by the IRS and is available at www.irs.gov/businesses/international/article/0,,id=96739,00.html. The OECD's list of member countries is available at www.oecd.org/countrieslist/0,3025,en_33873108_33844430_1_1_1_1_1,00.html.
[27]*See* Congress of the United States, Congressional Budget Office, *Corporate Tax Rates: International Comparisons*, Nov. 2005 (Ireland has one of the world's lowest corporate tax rates at 12.5 percent on nontrading income.).
[28]Vienna Convention on the Law of Treaties, *supra* note 24.
[29]Organisation for Economic Co-Operation and Development, Centre for Tax Policy and Administration, *Proposed Revision of Chapters I-III of the Transfer Pricing Guidelines* (Jan. 9, 2010), available at www.oecd.org/dataoecd/1/57/43655703/pdf.
[30]*See* OECD, *supra*, note 12; *See* Wittendorff, *supra* note 7, at 650.
[31]*Veritas*, *supra* note 1, at 327.
[32]*Veritas*, *supra* note 1.
[33]Wittendorff, *supra*, note 7 at 655–656; Dept. of Treas., Reg. § 1.482-5(b)(2)(i).
[34]*Id.,* § 1.482-4(f)(2)(i).