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I. INTRODUCTION

Over the past twenty years, many tax-exempt hospital providers have formed joint ventures with for-profit entities.[1] Some of these joint ventures were formed in order to market and provide specialized outpatient medical services,[2] such as diagnostic imaging centers, ambulatory surgical centers, and physician office buildings, while others were formed to allow struggling local hospitals to benefit from the management expertise of successful healthcare services companies.[3] Other joint ventures, however, involve the entire hospital whereby a for-profit entity has an ownership position in the hospital itself.[4] Tax-exempt hospital providers have undertaken these ventures in response to powerful industry-wide competitive and reimbursement pressures.[5]

Such arrangements between exempt hospital providers and for-profit entities, particularly those involving for-profit involvement in the

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1. *See infra* Section III.B. A joint venture is:

> [A]n association of two or more persons or entities that undertake a project with a community of interests in the performance of common purposes, a proprietary interest in the subject matter, a right to govern and direct the policy in connection therewith, and a duty . . . to share in both profits and losses.

Rochelle Korman & Dahlia Balsam, *Joint Ventures with For-Profits After Revenue Ruling 98-15*, 27 EXEMPT ORG. TAX REV. 441, 441 (2000). *See generally* ROSS E. STROMBERG & CAROL R. BOMAN, JOINT VENTURES FOR HOSPITALS AND PHYSICIANS: LEGAL CONSIDERATIONS 1-33 (Sandra L. Weiss ed., 1986).

2. *See infra* Section III.A.
3. *Id.*
4. *Id.*
5. *See infra* Section III.B.

management and ownership of tax-exempt hospitals, have raised issues regarding the tax-exempt status of the participating providers.[6] The IRS has adopted a controversial rule addressing tax exemption for hospital providers that form joint ventures with for-profit entities.[7] The adoption of this rule, which focuses on the hospital provider's degree of operational control over the venture,[8] has been followed by two related cases that resulted in controversial decisions by the Tax Court[9] and, very recently, the Fifth Circuit Court of Appeals.[10]

This article discusses the IRS rule on hospital joint ventures and related legal developments. The central thesis is that the IRS's emphasis on operational control is misplaced from both a legal and a policy perspective, and reflects the Service's focus on the form of a joint venture's governance rather than the substance of its charitable activities. Section II of this article provides an overview of the federal tax-exemption requirements for hospitals. Section III discusses the prevalence of joint ventures between tax-exempt hospital providers and for-profit entities and the factors motivating the formation of these arrangements. Section IV reviews the IRS rule on joint ventures between tax-exempt hospital providers and for-profit entities and two major cases that applied its underlying principles. Section V examines critically the legal and policy underpinnings of the IRS rule. Section VI offers concluding remarks.

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6. *See, e.g.*, Kevin F. Donohue, *Crossroads in Hospital Conversions: A Survey of Nonprofit Hospital Conversion Legislation*, 8 ANNALS HEALTH L. 39, 58 (1999); David A. Hyman, *Hospital Conversions: Fact, Fantasy and Regulatory Follies*, 23 J. CORP. L. 741, 741-48 (1998); Gary J. Young & Kamal R. Desai, *Nonprofit Hospital Conversions and Community Benefits: New Evidence from Three States*, HEALTH AFF., Sept.-Oct. 1999, at 146-55. *See also* Kara Marschke, *Protecting the Public Interest: The Role of the State Attorney General in Regulating Hospital Conversions*, 42 HOSP. & HEALTH SERV. ADMIN. 546, 547-48 (1997) (discussing a variety of legal and public policy concerns related to the conversion of hospitals from nonprofit to for-profit). *See generally* John D. Colombo, *Private Benefit, Joint Ventures, and the Death of Healthcare as an Exempt Purpose*, 34 J. HEALTH L. 505 (2001) (tracing the use of the private benefit doctrine as a criterion for tax exemption in healthcare, and particularly as to joint ventures). In addition to tax issues, joint ventures between tax-exempt hospitals and for-profit companies have raised concerns about the impact of for-profit ownership on the delivery of healthcare services. *See generally* various authors, HEALTH AFF., Mar.-Apr. 1997 (Special Issue: Hospital & Health Care Conversions).

7. Rev. Rul. 98-15, 1998-1 C.B. 718. *See also infra* Section IV.A.

8. Rev. Rul. 98-15, 1998-1 C.B. 718. *See also infra* Section IV.A.

9. *See infra* Section IV.B.

10. *See infra* Section IV.C.

II. OVERVIEW OF FEDERAL TAX EXEMPTION REQUIREMENT FOR HOSPITALS

The federal tax exemption for hospitals represents a significant public investment in the healthcare services industry. Most nonprofit hospitals are exempt from federal corporate income tax,[11] which, by one estimate, translates to well over four billion dollars in forgone federal tax revenue.[12] Another four-plus billion dollars is lost to states and local jurisdictions that likewise exempt hospitals from taxes.[13] Because the United States invests such sums in nonprofit healthcare, there are necessarily legal safeguards in place to insure that the public investment in nonprofit hospitals serves its intended goals. This section of the article discusses the legal requirements for federal tax exemption for nonprofit hospitals.

A. Charitable Exemption Requirements

Hospitals qualify for federal income tax exemption under section 501(c)(3) of the Internal Revenue Code (I.R.C.), which applies to "[c]orporations . . . organized and operated exclusively for religious, charitable, scientific . . . or educational purposes."[14] To assess generally whether an organization qualifies for exemption under section 501(c)(3),

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11. *See* Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 309-24 (1991). Approximately sixty percent of U.S. hospitals are voluntary nonprofits institutions. *See* AM. HOSP. ASS'N, FAST FACTS ON U.S. HOSPITALS, *available at* http://www.hospitalconnect.com/aha/resource_center/fastfacts/fast_facts_US_hospitals.html (last visited Apr. 6, 2003). For-profit hospitals are not eligible for federal tax exemption. *See infra* Section II.A.

12. John Copeland & Gabriel Rudney, *Federal Tax Subsidies for Not-For-Profit Hospitals*, 26 TAX NOTES 1559, 1565 (1990). Copeland's and Rudney's estimate of 4.5 billion dollars in forgone federal tax revenue is based on data from the late 1980s. The figure might well be significantly higher if it were calculated today.

13. Hall & Colombo, *supra* note 11, at 324-26. Many states and localities confer, as a matter of course, corporate income tax and property tax exemptions on 501(c)(3) entities, in accordance with the federal approach that is discussed *infra* Section II.A. *See also* Copeland & Rudney, *supra* note 12, at 1565 (estimating that state and local tax exemptions amounted to as much as four billion dollars in forgone annual tax revenues in the late 1980s).

14. I.R.C. § 501(c)(3) (West 2000). The American concept of the charitable organization as a legal entity originates from the charitable trusts of English statutory and common law. Andras Kosaras, *Federal Income and State Property Tax Exemption of Commercialized Nonprofits: Should Profit-Seeking Art Museums Be Tax Exempt*, 35 NEW ENG. L. REV. 115, 126-27 (2000). The English Statute of Charitable Uses was first enacted in 1601 to prevent the misappropriation of charity monies. *Id.* Historically, charity, as legally defined, included "trusts for the relief of poverty, trusts for the advancement of education, trusts for the advancement of religion, and trusts for other purposes beneficial to community not falling under any of the preceding heads." *Id.*

the IRS applies two tests, one organizational and the other operational.[15] The organizational test requires that the organization's formative documents (i.e. articles of incorporation, partnership agreement, etc.) limit the organization solely to exempt activities and forbid it from engaging in activities not in furtherance of its stated exempt purposes.[16] The operational test focuses in principle on an organization's activities.[17] The IRS has interpreted section 501(c)(3) to require organizations to engage primarily in activities that accomplish one or more of the exempt purposes set forth in the statute.[18] The operational test will not be satisfied if more than an insubstantial part of the organization's activities is not in furtherance of an exempt purpose.[19]

Although section 501(c)(3) does not mention healthcare specifically as an exempt purpose, the IRS has long recognized that hospital care may qualify as a charitable purpose under certain conditions.[20] Although early

15. Section 501(c)(3) states that an organization must be organized and operated solely for the organization's enumerated exempt purposes. John D. Colombo, *Charitable Tax Exemption, in* HEALTH CARE CORPORATE LAW 5-3 (Mark A. Hall ed., Supp. 1999); BRUCE R. HOPKINS, THE LAW OF TAX EXEMPT ORGANIZATIONS 109-22 (6th ed. 1992).

16. Treas. Reg. § 1.501(c)(3)-1(b)(1)(i) (2003). The organizational test requires also that the assets of the organization be dedicated to a charitable purpose and that, should the organization be dissolved, its assets be distributed for exempt purposes, or, alternatively, transferred to a governmental unit. Treas. Reg. § 1.501(c)(3)-1(b)(4).

17. Colombo, *supra* note 15, at 5-4, 5-5. Although the operational test is intended to focus on an organization's activities, I argue in this article that the IRS legal position on hospital joint ventures largely ignores the joint venture's actual activities or substantive performance.

18. Treas. Reg. § 1.501(c)(3)-1(c)(1).

19. *Id.* Whether an organization has a substantial nonexempt purpose is a question of fact to be resolved on the basis of the evidence in the administrative record. Living Faith v. Comm'r, 950 F.2d 365, 371 (7th Cir. 1991), *aff'g* T.C. M. (CCH) 1990-484; B.S.W. Group Inc. v. Comm'r, 70 T.C. 352, 357 (1978). The applicant seeking exemption has the burden of proof to demonstrate that it is operated exclusively for exempt purposes. *Id.*

20. While the promotion of health has long been recognized to be a charitable purpose, *see* RESTATEMENT (SECOND) OF TRUSTS §§ 368, 372 (1959), courts have held that the *mere* promotion of health may not be enough to support a tax exemption under section 501(c)(3). *See, e.g.*, Sonora County Hosp. v. Comm'r, 46 T.C. 519, 525-26, *aff'd*, 397 F.2d 814, 814 (9th Cir. 1968) ("While the diagnosis and cure of disease are indeed purposes that may furnish the foundation for characterizing the activity as 'charitable' something more is required."). Still, there has been a longstanding debate among tax experts as to whether Congress, in enacting section 501(c)(3), contemplated the term "charitable" in its narrow sense, meaning relief to the poor, or in a broader sense that is more consonant with the common-law understanding that charity extends to promoting the well-being of people in general, regardless of socioeconomic status. Nina J. Crimm, *Evolutionary Forces; Changes in For-Profit and Not-for-Profit Health Care Delivery Structures: A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 41 (1995); Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. HEALTH POL., POL'Y & L., 251, 256 (1991). Current IRS regulations provide that the term "charitable" is used in section 501(c)(3) in its broader sense encompassing not

IRS rulings stated that hospital care was a charitable purpose only if provided to the poor,[21] the IRS broadened its view in response to the advent of the Medicare and Medicaid programs that dramatically expanded health insurance coverage in the U.S. and substantially reduced the number of Americans unable to obtain reimbursed healthcare services. In 1969, the IRS issued a revenue ruling announcing a promotion-of-health rationale for granting tax-exempt status to hospitals, reasoning that the delivery of healthcare services for the general benefit of the community is inherently a charitable purpose.[22] The ruling set out several factors the Service would consider in evaluating a hospital's qualification for tax-exempt status under the promotion-of-health rationale. These factors, which constitute the so-called community benefit standard, are: operate a 24-hour emergency room; provide charity care to the extent of the hospital's financial ability; extend medical staff privileges to all qualified physicians in the area, consistent with the size and nature of the facility; accept payment from the Medicare and Medicaid programs on a nondiscriminatory basis, and maintain a community-controlled board, i.e. a governing board with membership primarily from the local community.[23] A hospital that meets this standard

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only relief to the poor, but also "advancement of religion; advancement of education or science; erection or maintenance of public buildings, monuments, or works; lessening of the burdens of Government; and promotion of social welfare by organizations designed to accomplish any of the above purposes." Treas. Reg. § 1.501(c)(3)-1(d)(2). *See generally* Douglas M. Mancino, *A Contemporary Reexamination of Revenue Ruling 69-545 and the Promotion of Health Rationale for Exemption*, 34 J. HEALTH L. 615 (2001); Hall & Colombo, *supra* note 11, at 319-23.

21. *See, e.g.*, Rev. Rul. 56-185, 1956-1 C.B. 202 (stating that tax exemption was available only to those hospitals that " operated to the extent of [their] financial ability for those not able to pay for services rendered"). Rev. Rul. 56-185 did not set out any objective criteria for assessing whether a hospital is operating to the extent of its financial ability in serving indigent patients, but rather allowed for such assessments to be conducted on the basis of the applicable facts and circumstances. Colombo, *supra* note 15, at 5-5.

22. Rev. Rul. 69-545, 1969-2 C.B. 117. There has been much debate about whether this ruling created a new exemption policy for healthcare organizations or merely expanded the existing policy articulated in Rev. Rul. 56-185. Although the IRS's official position was that the ruling did not announce new policy, the issue became the subject of litigation in *Eastern Kentucky Welfare Rights Organization v. Schultz*, 370 F. Supp 325, 336-38 (D.D.C. 1973), *rev'd sub nom.* Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278, 1286 (D.C. Cir. 1974), *vacated on other grounds* 426 U.S. 26, 46 (1976). In *Eastern Kentucky*, a court of appeals reversed a district court's decision that Congress, in enacting section 501(c)(3), intended to restrict the term "charitable" to its narrow sense meaning relief of the poor. *Id.* The court of appeals concluded that Congress contemplated a broader and more flexible definition. *Id. See generally* Fox & Schaffer, *supra* note 20, at 259-73 (tracing the evolution of IRS statutory interpretation and policy promulgation as to healthcare exemptions).

23. Rev. Rul. 69-545, 1969-2 C.B. 117. Commentators have noted that, among the factors set out in this ruling, the IRS attaches particular weight to an open emergency room and unrestricted provision of care to Medicare/Medicaid patients. Colombo, *supra* note 15, at 5-7. Still, in Rev. Rul. 83-157, 1983-2 C.B. 94, proposed in Gen. Couns. Mem. 38,669

qualifies as a public charity and stands to enjoy the significant benefits of public charity status, including an exemption from the federal corporate income tax and the substantial fund-raising advantage of a fifty percent personal income tax deduction to financial benefactors.[24]

In addition, in order to qualify for federal tax exemption, an organization must limit private benefit.[25] IRS regulations state that exempt organizations must serve public, rather than private, interests.[26] That is, the organization's activities should benefit the community as a whole. While an exempt organization's activities may result in some private benefit,[27] the private benefit must be merely incidental to the broader community benefit.[28] Related to private benefit is the prohibition on private inurement, namely that "no part of the net earnings of [the organization] inures to the benefit of any private shareholder or individual."[29] The IRS has defined private shareholders, or "insiders," as "individuals whose relationship with an organization offers them an opportunity to make use of the organization's income or assets for personal gain."[30] While insiders are typically persons highly placed in an organization, like corporate directors or officers, insiders in the healthcare setting may also include members of a hospital's

(Mar. 30, 1981), the IRS indicated that a hospital need not have an emergency room to qualify for exemption if it could show that: (1) adequate emergency room services already existed in its community and (2) the hospital satisfied other factors of the community benefit standard.

24. The I.R.C. creates two categories of exempt organization—public charities and private foundations—but explicitly limits hospitals to public charity status. Hospitals (like other organizations) that qualify for both tax exemption and status as public charities enjoy substantial advantages over foundations, namely larger tax deductions to donors, fewer reporting requirements, and fewer restrictions overall. *See* I.R.C. §§ 170(b)(1)(a)(iii), 509(a). *See also* Colombo, *supra* note 15, at 5-34-43.

25. One other major restriction on section 501(c)(3) eligibility, not directly apposite to the present discussion, involves political activities, namely that no substantial part of a 501(c)(3) organization's activities may be used to influence legislation nor may a 501(c)(3) organization participate in any political campaign for or against any candidate for public office. I.R.C. § 501(c)(3). *See generally* Colombo, *supra* note 6.

26. Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii).

27. And, as the IRS has pointed out, it is inevitable in some cases that private parties will benefit from the charitable activities of an exempt organization. Gen. Couns. Mem. 37,789 (Dec. 18, 1978). For example, when an organization is formed to preserve and protect a lake, the organization's goals and activities are charitable even if the preservation of the lake happens to benefit property owners near the lake as well as the general public. *Id.*

28. *Id. See also* Rochelle Korman & William F. Gaske, *Joint Ventures Between Tax-Exempt and Commercial Healthcare Providers*, 16 EXEMPT ORG. TAX REV. 773, 775 (1997). The private benefit doctrine has provoked much debate over its meaning and scope. *See generally* Colombo, *supra* note 6.

29. I.R.C. § 501(c)(3).

30. I.R.S. Announcement 92-83, 1992-22 I.R.B. 59, *7-*10.

medical staff,[31] and thus joint ventures between a hospital and members of its medical staff may raise private inurement issues.[32]

There are also circumstances in which an organization that cannot itself qualify for tax-exempt status may qualify by virtue of being an integral part of an exempt organization.[33] The integral-part doctrine allows an organization to derive exempt status through its relationship with a 501(c)(3) entity, namely by conducting activities that are essential to the exempt purposes of the 501(c)(3) entity, and that would not comprise an "unrelated trade or business" if the 501(c)(3) entity conducted the activities itself.[34] In the healthcare industry, the integral part doctrine may be used to claim exempt status for entities that are part of integrated delivery systems organized around exempt hospitals.[35] However, the entity claiming derivative exemption must be structurally and financially integrated with the exempt hospital and must not just serve similar functions or purposes.[36]

B. Conduct of Non-Exempt Activities

While a 501(c)(3) organization must operate primarily to further its exempt purpose, the organization may also conduct non-exempt activities as long as the activities are in furtherance of its exempt purpose and

31. Gen. Couns. Mem. 39,862 (Nov. 22, 1991). Indeed, unlike most insiders, medical staff members are not highly placed corporate leaders. Moreover, they are typically not even employees of the hospitals for which they work; rather, they are almost always independent contractors. The IRS has classified medical staff as insiders because their close working relationship with the hospital puts them in a position to influence decision-making for their own personal gain. Still, the classification of medical staff members as insiders is a controversial issue. When Congress had the task of defining hospital insiders for the purposes of the Taxpayer Bill of Rights 2 ("TBOR2"), it took a narrower approach. TBOR2 authorized the IRS to impose a tax on excess benefit transactions (a form of inurement) that occur between an exempt organization and a "disqualified person" (i.e. an insider). H.R. REP. NO. 104-506, at 58 (1996), *reprinted in* 1996 U.S.S.C.A.N. at 1181. Congress limited the definition of "disqualified persons" to those medical staff members who have been in a position to "exercise substantial influence" over the affairs of an organization within the past five years. H.R. REP. NO. 104-506, at 58 n.12. *See generally* Gerald M. Griffith, *TBOR2 Compliance Plans: From Rebuttable Presumption to Enforcement*, 34 J. HEALTH L. 567 (1997).

32. Gen. Couns. Mem. 39,862.

33. Colombo, *supra* note 15, at 5-43. *See also* Rev. Rul. 81-19, 1981-1 C.B. 353; Rev. Rul. 78-41, 1978-1 C.B. 148; Priv. Ltr. Rul. 2000-44-040 (Aug. 3, 2000); Gen. Couns. Mem. 39,830 (Aug. 24, 1990).

34. Colombo, *supra* note 15, at 5-43. *See infra* note 38 for further discussion of "unrelated trade or business."

35. *See, e.g.*, Geisinger Health Plan v. Comm'r, 30 F. 3d 494, 502 (3d Cir. 1994) (upholding determination that an HMO did not qualify for exemption under the integral part doctrine, but suggesting circumstances under which it would qualify).

36. *See supra* note 34.

insubstantial relative to its exempt activities.[37] Non-exempt activities may subject a 501(c)(3) organization to the unrelated business income tax (UBIT)—a levy on income from those activities that are not substantially related to the organization's exempt purpose[38]—but otherwise, a 501(c)(3) charity may generally conduct non-charitable activities without jeopardizing its exempt status.

However, the IRS casts a wary eye on business partnerships between charitable organizations and for-profit entities, particularly where the charitable organization is a general partner and for-profit entities are limited partners.[39] The IRS has long been concerned that where a charitable organization serves as a general partner in a limited partnership it will have fiduciary obligations to the limited partners that take precedence over, and may conflict with, its own charitable obligations.[40] Although the IRS once

37. Treas. Reg. § 1.501(c)(3)-1(c)(1). *See also* Colombo, *supra* note 15, at 5-32-33. Whether an organization has a substantial nonexempt purpose is a question of fact to be resolved on the basis of all the evidence presented in the administrative record. *See supra* note 8.

38. Colombo, *supra* note 15, at 5-23-29. The I.R.C. imposes a tax, at corporate tax rates, on the unrelated business taxable income of organizations exempt under section 501(c). IRS regulations provide that income is subject to UBIT if (1) it is income from a trade or business; (2) such trade or business is regularly carried on by the organization; and (3) the conduct of such trade or business is not substantially related to the organization's performance of its exempt function. I.R.C. §§ 511(a)(1), 512(a)(2), 513(a) (West 2000); Treas. Reg. §§ 1.513-1(a), (b), (c)(1), (d)(2) (2003). Congress excluded from UBIT treatment certain types of passive income such as interest, dividends, rents, royalties, capital gains, and other traditional methods for earning income from a charitable endowment (although when passive income is collected from the taxable subsidiary of an exempt parent, or when income of an exempt corporation is debt-financed, it will be taxed as UBIT). I.R.C. § 512(b). This exclusion reflects the basic rationale underlying the UBIT, namely to limit the otherwise unfair competitive advantage that exempt organizations would have over for-profit entities if they were permitted to operate businesses without having to paying tax on the income earned from those businesses. Colombo, *supra* note 15, at 5-29-39.

39. Colombo, *supra* note 6, at 509-12; Korman & Balsam, *supra* note 1, at 442-44. The IRS generally adheres to an aggregate theory of partnership taxation that attributes to the partners the activities of a partnership. Thus, for an exempt organization involved in a partnership, the activities of the partnership have a direct bearing on its tax-exempt status. In the case of an organization whose sole purpose or primary activity is participation in a partnership (as in the case of a whole hospital joint venture, *see infra* Section III.A.), the IRS will view that organization's activities as the same as those of the partnership. *Id.*

40. *See* Korman & Balsam, *supra* note 1, at 442-44; Colombo, *supra* note 6, at 511. The IRS's central concern is that such conflicts may expose charitable assets to unlimited liability for the benefit of the limited partners. Korman & Balsam, *supra* note 1, at 442-43. Accordingly, some practitioners suggest that exempt organizations are on safer ground, from a tax standpoint, if they participate solely as limited partners, in which case their role is that of passive investor. MICHAEL I. SANDERS, JOINT VENTURES INVOLVING TAX-EXEMPT ORGANIZATIONS 11 (2d ed. 2000). As such, their exposure is limited to their investment and they do not have a duty, statutory or otherwise, to maximize profits for the investors. *Id.* However, this guidance would appear to hold only where the exempt organization contributes something less than a substantial portion of its assets to the limited partnership.

treated these partnerships as prohibited per se under section 501(c)(3),[41] such arrangements are now permissible if they satisfy a two-prong test that the IRS adopted in 1983.[42] The first prong requires that the entity seeking exemption serve a charitable purpose,[43] and the second requires that the arrangement be structured so that it "permits the exempt entity to act exclusively in furtherance of the purposes for which exemption may be granted and not for the benefit of the limited partners."[44]

III. HOSPITAL JOINT VENTURES

A. Types of Hospital Joint Ventures

Joint ventures between tax-exempt hospital providers and for-profit companies are of two primary types: ancillary joint ventures and whole hospital joint ventures.[45] Ancillary joint ventures (AJVs) are common arrangements that have existed for many years in the hospital industry.[46]

Id. at 11-12. *See also* Korman & Balsam, *supra* note 1, at 443.

41. Gen. Couns. Mem. 36,293 (May 30, 1975).

42. Gen. Couns. Mem. 39,005 (June 28, 1983). Even before this memorandum, the IRS had begun to reconsider its position on partnerships between a tax-exempt organization as general partner and a for-profit entity as limited partner. *See, e.g.*, Gen. Couns. Mem. 37,852 (Feb. 15, 1979) (determining that an entity's non-profit status was not jeopardized by an arrangement with a for-profit pharmaceutical company). Then came *Plumstead Theatre Soc'y, Inc. v. Comm'r*, 74 T.C. 1324, 1334 (1980), *aff'd*, 675 F.2d 244, 245 (9th Cir. 1982), a key case in which the Tax Court ruled in favor of a tax-exempt organization's participation in a partnership where it was a general partner and for-profit entities served as limited partners. The Tax Court concluded that the partnership obligations of the exempt organization did not conflict with its tax-exempt status because (1) the exempt organization did not have an obligation to return limited partners' capital contributions from its own funds, (2) the limited partners did not have control over the exempt organization's activities, and (3) none of the limited partners had any involvement with the exempt organization. *Id.* Even before *Plumstead*, at least one court had already sanctioned an arrangement in which an exempt entity contracted with a for-profit company to manage certain of the exempt entity's business activities. *See* Broadway Theatre League of Lynchburg, Va., Inc. v. United States, 293 F. Supp. 346, 355-56 (W.D. Va. 1968). The court upheld the arrangement because the exempt organization retained ultimate authority over the assets and activities being managed and the terms of the contract were reasonable. *Id.*

43. Gen. Couns. Mem. 39,005.

44. *Id.* This often requires determining whether the financial exposure of the exempt organization is sufficiently limited, as through insurance or a limit on capital calls. Gerald M. Griffith, *Revenue Ruling 98-15: Dimming the Future of All Nonprofit Joint Ventures?*, 20 EXEMPT ORG. TAX REV. 405, 408 (1998).

45. Mary Jo Salins et al., *Whole Hospital Joint Ventures*, *in* IRS TAX EXEMPT & GOVERNMENT ENTITIES PROFESSIONAL EDUCATION GUIDE: TECHNOLOGY INSTRUCTION PROGRAM, pt.I.A. at 1 (1999), *available at* http://www.irs.gov/pub/irs-tege/topica.pdf ; Colombo, *supra* note 6, at 513-15, 518-27.

46. STROMBERG & BOMAN, *supra* note 1, at 21-24 & Apps. (illustrating examples of joint venture projects).

They entail an agreement between an exempt hospital provider and a for-profit entity to conduct a specific business activity, such as a diagnostic imaging center or ambulatory surgical center.[47] Many of these ventures are so-called hospital-physician joint ventures, formed between an exempt hospital provider and a local for-profit entity owned by members of the hospital's medical staff.[48] Ancillary joint ventures are also formed between exempt hospital providers and much larger for-profit entities, often regional or national companies that specialize in outpatient diagnostic or surgical services.[49]

Ancillary joint ventures are typically structured as partnerships or limited liability companies (LLC).[50] The exempt hospital provider typically transfers assets or contributes cash to the joint venture, while the for-profit entity contributes cash.[51] The exempt provider and for-profit partner negotiate ownership interests in the venture, which may or may not be proportional to their respective capital contributions.[52] The joint venture owns and operates the facility or service it provides and the exempt hospital

47. *Id.* at 30-32. *See also* Salins et al., *supra* note 45, pt. I.A. at 9-10.

48. Korman & Gaske, *supra* note 28, at 781-82. *See also* William Grete, *IRS Issues Whole Hospital Joint Venture Ruling*, NAT'L L.J., July 6, 1998, at B11; Mary Chris Jaklevic, *A Deal That's Hard to Refuse*, MOD. HEALTHCARE , Dec. 3, 2001, at 4-5. Some hospital-physician joint ventures are formed to pursue managed care contracts, an arrangement known as a physician-hospital organization, or PHO. Peter R. Kongstvedt et al., *Integrated Health Care Delivery Systems*, *in* ESSENTIALS OF MANAGED HEALTH CARE 31 (Peter R. Kongstvedt ed., 4th ed. 2001).

49. Korman & Gaske, *supra* note 28, at 781-82; Deanna Bellandi & Mary Chris Jaklevic, *What Gain Sharing?*, MOD. HEALTHCARE 8, July 26, 1999, at 8.

50. The exempt hospital provider may serve as a partner in a general partnership or as either a general partner or limited partner in a limited partnership. Salins et al., *supra* note 45, at 4, 5; Korman & Gaske, *supra* note 28, at 782. An exempt provider may also serve as a member in a LLC. Salins et al., *supra* note 45, at 4. An LLC is an attractive legal structure for exempt hospital providers involved in joint ventures because, in contrast to a general partner in a partnership, an LLC member does not have personal liability for entity-level debts. *Id.* Thus, some practitioners see the LLC structure as a means to address IRS concerns about exempt organizations participating in partnership arrangements as a general partner. *See* Korman & Gaske, *supra* note 28, at 782. An LLC structure eliminates personal liability for entity-level debt but still provides all members with an opportunity to participate in management (which is not allowed to limited partners) and can obtain the pass-through tax treatment of a partnership. *Id.* LLCs can be formed under state law in all fifty states and the District of Columbia. Salins et al., *supra* note 45, at 4. For an LLC, the articles of organization and the operating agreement are the primary governing instruments. *Id.* The operating agreement typically defines the operating rules of the organization and the relationship of the members to one another and, as such, is similar to a partnership agreement. *Id.* In most states an LLC must have two or more members. *Id. See generally* Michael I. Sanders, *Exempt Organizations Investing Through Limited Liability Companies*, 14 EXEMPT ORG. TAX REV. 91, 92-99 (1996).

51. Salins et al., *supra* note 45, at 9-10.

52. *Id.*

provider retains ownership and management of the hospital.[53]

By contrast, a whole hospital joint venture (WHJV) is an arrangement that involves not just one specialized facility, but an entire hospital.[54] Specifically, a WHJV is a transaction between an exempt hospital provider and a for-profit entity where one of the two parties, more often the exempt organization,[55] contributes a hospital, and the other contributes funds and other assets.[56] An operating agreement formalizes such matters as ownership interests, governance and control of the venture, and income distributions.[57] The joint venture owns and operates the hospital and, as such, the exempt provider's sole purpose may then be its participation in the venture.[58] Like AJVs, WHJVs may be formed as either partnerships or LLCs.[59]

One other joint venture structure worth noting is the so-called hospital subsidiary joint venture, a hybrid of a WHJV and an AJV.[60] In the hospital subsidiary arrangement, the exempt provider creates a wholly-owned subsidiary for the sole purpose of participating in a joint venture with a for-profit entity. Unlike the WHJV, the exempt provider does not directly participate in the venture but does control the participating subsidiary.[61] The subsidiary contributes cash to the joint venture equal to the value of the assets transferred by the for-profit entity, or is assigned the joint venture interest of its exempt parent. The for-profit entity contributes a healthcare

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53. *Id.*

54. *Id. See also* JAMES R. SCHWARTZ & H. CHESTER HORN, HEALTH CARE ALLIANCES AND CONVERSIONS 83-89 (1999).

55. SCHWARTZ & HORN, *supra* note 54, at 83. Though in some cases, it is the for-profit entity that owns and contributes the hospital. *See, e.g.*, Priv. Ltr. Rul. 93-08-034 (Nov. 30, 1992); Korman & Gaske, *supra* note 28, at 785.

56. *See supra* note 50. Typically, in a WHJV, where the non-profit entity contributes a hospital—an asset of substantial value—the for-profit partner will contribute an amount of cash sufficient to equalize, or nearly equalize, the parties' investments in the joint venture.

57. *Id.*

58. *Id.*

59. Another possible arrangement is a joint operating agreement (JOA). In a JOA, two or more organizations agree contractually to operate a hospital, allocating among themselves discrete areas of operational responsibility as well as participation in the hospital's financial gains and losses. Unlike WHJVs, JOAs involve no change in asset ownership for the purpose of forming a third entity. Joint operating agreements have been the focus of a number of IRS private letter rulings addressing, *inter alia*, whether the entity formed to implement the JOA qualifies for tax exemption under the integral part doctrine. *See, e.g.*, Priv. Ltr. Rul. 97-38-039 (June 26, 1997); Priv. Ltr. Rul. 2001-08-045 (Nov. 29, 2000). *See also* Korman & Gaske, *supra* note 28, at 783; Roderick Darling & Marvin Friedlander, *Virtual Mergers: Hospital Joint Operating Agreement Affiliations*, *in* IRS TAX EXEMPT & GOVERNMENT ENTITIES PROFESSIONAL EDUCATION GUIDE: TECHNOLOGY INSTRUCTION PROGRAM pt.J (1999), *available at* http://www.irs.gov/pub/irs-tege/topic-j.pdf.

60. Salins et al., *supra* note 45, at 7-8. *See also infra* Section IV.B.

61. Salins et al., *supra* note 45, at 7-8.

facility or service program, such as an ambulatory surgery center or physical therapy center.[62] The subsidiary generally seeks to be recognized as exempt under section 501(c)(3).[63]

B. Prevalence of and Motivation for Hospital Joint Ventures

The number of tax-exempt hospital providers forming joint ventures with for-profit entities appears to have increased substantially during the last twenty years, although precisely by how much is not known.[64] Whole hospital joint ventures were rarely seen before the 1990s and are today still much less common than AJVs. However, one recent estimate is that more than fifty WHJVs were in existence as of 2001,[65] some involving prominent players in the U.S. healthcare industry, including the country's largest for-profit hospital company, HCA,[66] and several high-profile academic medical centers, including Tulane University Hospital[67] and The George Washington University Medical Center.[68]

Ancillary joint ventures have likewise become more numerous in recent years, although the AJV concept has been in existence longer than the WHJV, and thus has had more time to gain acceptance. The U.S. General Accounting Office (GAO) conducted a study of hospital-physician joint ventures and reported that the number of AJVs had more than doubled during the 1980s, from approximately 200 to over 450.[69] The GAO

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62. *Id.*

63. *Id.*

64. Neither of the two major hospital associations (the American Hospital Association and the Federation of American Hospitals) tracks the numbers of ventures, Mark Taylor, *Joint Ventures Win the Draw*, MOD. HEALTHCARE, June 17, 2002, at 8, and the small amount of commercially available data on hospital joint ventures is of unknown reliability.

65. *Id.*

66. Scott Hall, *Largest For-profit Hospital Chains Set Poor Example*, DAILY JOURNAL, Nov. 29-30, 2003, *available at* http://www.thejournalnet.com. HCA was formerly known as Columbia/ HCA Healthcare Corp.

67. Gina Rollins, *Post-Mortem on the Tulane-Columbia Partnership*, EXECUTIVE SOLUTIONS FOR HEALTHCARE MGMT., June 1999, at 1. *See also* David Blumenthal & Joel S. Weissman, *Selling Teaching Hospitals to Investor-Owned Hospital Chains: Three Case Studies*, HEALTH AFF., Mar.-Apr. 2000, at 159.

68. Jonathan Gardner, *Change on Horizon for D.C. Hospitals: Entrance of For-Profit Universal and Coming of Managed Care Set Stage for Merger-and-Acquisition Frenzy in Washington*, MOD. HEALTHCARE, Sept. 22, 1997, at 56. *See also* Blumenthal & Weissman, *supra* note 67, at 159.

69. U.S. GEN. ACCOUNTING OFFICE (GAO), PUB. NO. GAO/HRD-93-124, NONPROFIT HOSPITALS: FOR-PROFIT VENTURES POSE ACCESS AND CAPACITY PROBLEMS 4 (July 1993), *available at* http://www.gao.gov. Hospital-physician joint ventures also raise concerns about physicians referring patients to entities in which they or their family members have a financial interest. This concern led Congress to enact the Stark amendment as part of the Omnibus Reconciliation Act of 1989, which took effect January 1, 1992. The so-called

estimated that as of 1991 about eighteen percent of nonprofit hospitals were participating in for-profit joint ventures with physicians.[70] When one adds to this the number of AJVs between exempt hospital providers and other (non-physician-owned) for-profit entities, the total number of AJVs may well be in the thousands.[71]

Underlying the increasing popularity of hospital joint ventures is the reimbursement and competitive pressures in the hospital industry. During the 1990s, hospitals experienced substantial declines in reimbursement rates for inpatient care services. This dramatic shift in the economics of healthcare was driven primarily by the increasing prevalence and dominance of managed care organizations, namely health maintenance organizations (HMOs)[72] and preferred provider organizations (PPOs),[73] which substantially increased their share of the health insurance market.[74] These insurance entities provide health services to their enrollees by negotiating with healthcare providers for price discounts—discounts that cut into hospitals' profit margins.[75] Another factor driving down reimbursement rates was political; in 1997 Congress enacted legislation that

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Stark law prohibited physicians from referring Medicare beneficiaries for clinical laboratory services to entities in which they or members of their immediate family had a financial interest. *See* Omnibus Reconciliation Act of 1989, Pub. L. No. 101-239, § 6204, 103 Stat. 2106 (1989). In 1993, in "Stark II" (which took effect in 1995) Congress expanded this self-referral prohibition to other healthcare services, as well as to Medicaid beneficiaries. *See* Omnibus Reconciliation Act of 1993, § 13,562, 42 U.S.C. § 1395nn (Supp. V 1993). *See also* Amy L. Woodhall, *Integrated Delivery Systems: Reforming the Conflicts Among Federal Referral, Tax Exemption, and Antitrust Laws*, 5 HEALTH MATRIX 181, 187-95 (1995).

70. GAO, *supra* note 69, at 4.

71. Taylor, *supra* note 64, at 8.

72. It has become increasingly difficult to define the term "HMO" because of the wide variety of arrangements that HMOs have come to encompass. According to Kongstvedt, "HMO" can be used to describe either of two distinct types of managed healthcare plan: "a licensed health plan that places at least some its providers at risk for medical expenses" (the conventional HMO), or "a health plan that uses designated (usually primary care) physicians as gatekeepers" to moderate the use of specialized medical care, like cardiology and surgery. Peter R. Kongstvedt, *Glossary of Terms and Acronyms*, *in* ESSENTIALS OF MANAGED HEALTH CARE 842 (Peter R. Kongstvedt ed., 4th ed. 2001).

73. A PPO is a health plan that contracts with independent providers for discounted services. The number of providers is typically limited and the plan usually has a utilization review system. *Id.* at 848.

74. Peter D. Fox, *An Overview of Managed Care*, *in* ESSENTIALS OF MANAGED HEALTH CARE 10 (Peter R. Kongstvedt ed., 4th ed. 2001). Between 1988 and 1998 HMO market share nationwide grew from eighteen percent (of insured individuals under age sixty-five) to thirty percent, while PPO market share grew from eleven to thirty-four percent. During the same period market share for indemnity (i.e., non-managed care) plans declined from seventy-one percent to fourteen percent. *Id.*

75. David Dranove et al., *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 36 J.L. & ECON. 179, 180 (1993).

reduced Medicare payments to hospitals for inpatient care.[76] At the same time, hospitals were, and have been, facing increasing competition from for-profit medical providers that capitalize on new technologies to specialize in certain, particularly marketable, outpatient diagnostic and surgical procedures.[77] In many cases these companies, such as diagnostic imaging centers and ambulatory surgical centers, are formed by members of a hospital's own medical staff.[78] Physicians form these companies independently of the hospital and thus set themselves up to compete with the hospital for patient care revenues.[79]

In light of these reimbursement and competitive pressures, tax-exempt hospital providers have been pursuing both WHJVs and AJVs. Whole hospitals joint ventures are attractive because they offer exempt providers some of the advantages of being a part of a large national hospital company, specifically greater bargaining leverage with suppliers, better access to financial capital, and stronger expertise in operational and financial management.[80] As well, because a WHJV is not a full-asset acquisition, it allows a nonprofit, tax-exempt provider to reduce its investment in healthcare operations while retaining a financial stake and some governance role in the hospital.[81] For-profit companies have a similarly strong incentive to participate in WHJVs, namely to gain a foothold in provider networks with a smaller financial investment than would be required if they

76. Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 4401-54, 111 Stat. 251 (1997). In subsequent legislation, Congress slowed or reversed some of these some of these cuts. *See, e.g.*, Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, §§ 101, 112, 113 Stat. 1501 (1999); Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, 106 Pub. L. No. 554, §§ 301-15, 114 Stat. 2763 (2000). *See generally* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY (2001), *available at* http://www.medpac.gov/publications/congressional_reports/Mar01%20Entire%20report.pdf.

77. Jaklevic, *supra* note 48, at 4; William J. Lynk & Carina S. Longley, *The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery*, HEALTH AFF., July-Aug. 2002, at 215.

78. *See supra* note 77.

79. *Id.*

80. *See* Chris Serb, *Money for Mission*, HOSP. & HEALTH NETWORKS, Apr. 20, 1998, at 57; Salins et al., *supra* note 45, at 3-4. Some of the literature on multi-hospital systems challenges the idea that hospitals can benefit by joining a national hospital system through a WHJV. Indeed, two recent studies yielded ambiguous results as to whether and to what degree hospitals can gain efficiencies through system affiliation. David Dranove et al., *Are Multihospital Systems More Efficient?*, HEALTH AFF., Spring 1996, at 100; Kathleen Carey, *Hospital Cost Efficiency and System Membership*, INQUIRY, Spring 2003, at 25. *But see* Terri J. Menke, *The Effect of Chain Membership on Hospital Costs*, 32 HEALTH SERV. RESEARCH 177, 191-93 (1997) (finding that multi-hospital chains are more efficient than independents, but that for-profit hospitals are no more efficient than not-for-profits).

81. SCHWARTZ & HORN, *supra* note 54, at 53.

had to engage in a full-asset acquisition.[82] Indeed, by making a relatively modest financial contribution to a WHJV—an amount equal to as little as half the value of the hospital—the for-profit partner can sometimes acquire effective control of the hospital, particularly of its governance.[83]

Ancillary joint ventures are a good alternative because they offer tax-exempt hospital providers the prospect of an important additional source of revenue outside the maturing market of inpatient care.[84] Because tax-exempt hospitals often form AJVs with members of their own medical staff, the venture provides the hospital with a means for collaborating, rather than competing, with its own physicians.[85] This helps the hospital forge a bond with its physicians that can translate into greater loyalty and thus more admissions from those physicians.[86] In addition, entering into a physician-hospital organization (PHO), a particular type of AJV that was noted previously,[87] typically helps a hospital strengthen its negotiating position with insurance plans.[88] Furthermore, by forming an AJV with a for-profit entity that already specializes in providing the type of diagnostic or surgical services the AJV is formed to provide, a tax-exempt provider gains access to expertise in managing the delivery of a lucrative service in an efficient and effective manner.[89] If the for-profit entity contributes financial capital to the AJV, the tax-exempt provider also gets the benefit of spreading its own financial risk.[90]

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82. *Id.*

83. *Id.* Analysts have suggested that for-profit entities have been able to use such ventures to enhance their attractiveness to investors, since, under existing financial reporting standards, even if the for-profit entity owns only half of the venture's equity, it can list all of its assets on its balance sheet. Gregory A. Petroff, *Whole Hospital Joint Ventures: The IRS Position on Control*, 21 EXEMPT ORG. TAX REV. 19, 27 (1998).

84. *See* Jaklevic, *supra* note 48, at 4; Claudia Kocher et al., *Physician-Hospital Integration Strategies: Impact of Physician Involvement in Hospital Governance*, HEALTH CARE MGMT. REV., Summer 1998, at 38-39.

85. *See supra* note 84.

86. *See id. See also* James B. Goes & ChunLiu Zhan, *The Effects of Hospital-Physician Integration Strategies on Hospital Financial Performance*, 30 HEALTH SERV. RES. 507, 511 (1995) (providing an empirical assessment of hospital-physician integration strategies on hospital performance).

87. *See supra* note 48.

88. Kongstvedt et al., *supra* note 48, at 41-44. The authors correctly note that while the PHO offers few demonstrable advantages as a business entity it is an effective mechanism by which hospitals can develop stronger relations with their medical staff members. *Id.*

89. *See* Jaklevic, *supra* note 48, at 4.

90. *See id.*

IV. REGULATORY AND LEGAL DEVELOPMENTS PERTAINING TO HOSPITAL-BASED JOINT VENTURES

As the number of joint ventures between tax-exempt hospital providers and for-profit organizations increased during the 1990s, the IRS began to confront complex questions about the tax implications of such arrangements for the exempt entity (or for an entity petitioning for exempt status).[91] Although the IRS issued a number of private letter rulings favoring these arrangements,[92] the rulings were inconsistent in defining the circumstances under which a tax-exempt hospital provider may participate in a WHJV without jeopardizing its exempt status.[93] As a result, practitioners requested further guidance from the IRS as to the tax implications of these arrangements.[94]

A. IRS Revenue Ruling 98-15

In 1998 the IRS issued a revenue ruling addressing the question of whether a tax-exempt hospital provider may retain its exempt status when participating in a WHJV.[95] The IRS adopted the position that the tax-exempt provider, to maintain its exemption, must have overall operational control of the venture.[96] The IRS illustrated its position with two distinct scenarios, the first in which the tax-exempt provider maintains its exemption, the second in which it does not.[97]

The premise of both scenarios is a tax-exempt hospital provider that decides it needs additional funding to serve its community and, together with a for-profit company, forms a WHJV that is a limited liability company (LLC). The exempt provider and the for-profit entity each receive an ownership interest in the venture proportional to its capital contribution. Pursuant to the operating agreement, all returns of capital and distributions of earnings are to be proportional to the respective ownership interests.[98]

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91. *See* Griffith, *supra* note 44, at 405.

92. *See, e.g.*, Priv. Ltr. Rul. 95-17-029 (Jan. 27, 1995); Priv. Ltr. Rul. 93-18-033 (Feb. 8, 1993); Priv. Ltr. Rul. 93-08-034 (Nov. 30, 1992). None of these rulings focuses on the degree of control that the exempt provider must have to preserve its exempt status in a situation where it has committed a substantial portion of its assets to a joint venture with a for-profit entity.

93. *See supra* note 91. *See also* Ernst & Young LLP, *Ernst & Young Comments on Whole-Hospital Joint Venture Issues*, 16 EXEMPT ORG. TAX REV. 297, 299-300 (1997).

94. Ernst & Young, *supra* note 93, at 300. By contrast to a private letter ruling, a revenue ruling has the binding authority of a regulation.

95. Rev. Rul. 98-15, *supra* note 7.

96. *Id.*

97. *Id.*

98. *Id.*

The key elements that distinguish the two scenarios, and which illustrate the IRS's concern that the control and direction of the joint venture properly reflect the participation of a tax-exempt entity, are mission, governance, and management. As to mission, in the first scenario, the venture is required by its governing instruments to operate its hospital "in a manner that furthers charitable purposes by promoting health for a broad cross-section of its community."[99] The governing instruments further impose a duty on board members to operate the venture for such charitable purposes instead of for the financial benefit of the for-profit owners.[100] In the second scenario, by contrast, the governing instruments do not give priority to the exempt provider's charitable purposes.[101]

As to governance, in the first scenario, the exempt provider controls three of five seats on the governing board, while in the second, the exempt provider controls the same number of seats as the for-profit participant.[102] In both scenarios, the governing board has authority over major decisions, including approval of operating and capital budgets. However, only in the first, "exempt," scenario is the for-profit owner's receipt of distributions effectively controlled by the tax-exempt provider, and hence made subordinate to the exempt provider's charitable mandate.[103]

Finally, as to management, in the first scenario, the joint venture contracts with an unrelated third party to manage the hospital.[104] In the second, the venture contracts with a wholly-owned subsidiary of the for-profit partner.[105]

In setting forth its position requiring operational control, the IRS relied on much the same case law underlying the two-pronged test for partnerships between exempt and for-profit entities announced in General Counsel Memorandum 39,005.[106] At the same time, the Service introduced a new approach to analyzing whether the exempt provider meets the test by focusing on facts and circumstances regarding the exempt provider's control over the venture.[107] Under this approach, if the exempt provider

99. *Id.*

100. *Id.*

101. Rev. Rul. 98-15, *supra* note 7.

102. *Id.*

103. *Id.*

104. *Id.* In scenario one, the term of contract is for five years and is renewable for additional five-year periods by mutual consent between the parties involved in the venture. In scenario two, the contract is also for five years and is renewable for five-year periods but renewal is subject to the discretion of the management company.

105. *Id.*

106. *Id. See also* Gen. Couns. Mem. 39,005, *supra* note 42.

107. Rev. Rul. 98-15, *supra* note 7. *See* discussion *infra* Section IV.A. for a critical appraisal of the Service's approach in this Ruling. *See generally* Griffith, *supra* note 44

maintains operational control of the venture, it can ensure that benefit to the for-profit partner will remain incidental to the venture's charitable objectives, and thus satisfy the stringent requirements of the private benefit doctrine.

Thus, the IRS held that the tax-exempt provider in scenario one meets the two-prong test because its governing instruments require charitable activity to be a priority and give the exempt provider a voting majority on the governing board and hence control over operational decisions.[108] By contrast, the exempt provider in the second scenario does not meet the test and, accordingly, is no longer organized and operated exclusively for a charitable purpose.[109] The critical factors in this regard were the absence of a binding obligation to give priority to charitable activity, the sharing of control by the exempt provider and the for-profit entity, and the management of the venture by a subsidiary of the for-profit entity.[110] Further disqualifying the venture in the second scenario is the fact that the exempt provider will not be able to initiate community health programs, in keeping with its mission, without the agreement of at least one board member representing the for-profit entity.[111]

Revenue Ruling 98-15 was very controversial. Although practitioners and commentators appreciated the guidance offered by the ruling, some practitioners representing exempt hospital providers raised concerns about the IRS position on control.[112] Commentators questioned the legal basis for the IRS position, particularly the Service's apparent focus on the exempt provider's voting position on the venture's governing board.[113]

(discussing the legal considerations underlying the nexus between the two-prong test and IRS Revenue Ruling 98-15).

108. Rev. Rul. 98-15, *supra* note 7.

109. *Id.*

110. *Id.* The IRS concluded, unsurprisingly, that a conflict of interest existed because the management company is a subsidiary of the for-profit partner and the executives responsible for overseeing the joint venture have a pre-existing relationship with the for-profit partner.

111. *Id.* This initiation requirement appears to be at the heart of the control requirement, and thus appears to be the basis for the Service's decision to reject shared-control arrangements between exempt providers and for-profit entities. *See* discussion *infra* Section IV.A.

112. *See* Carolyn D. Wright & Fred Stokeld, *Joint Venture Revenue Ruling Gets High Marks with Some Reservation*, 78 TAX NOTES 1220, 1220 (1998); Korman & Balsam, *supra* note 1, at 448; Griffith *supra* note 44, at 409-11.

113. Wright & Stokeld, *supra* note 112, at 1222; Korman & Balsam, *supra* note 1, at 448; Griffith *supra* note 44, at 409-11. While the IRS did not require explicitly that the exempt entity have numerical control of the board, several commentators noted that the tone of the ruling suggests that the issue of board control would be very important to the IRS in assessing the exempt status of the hospital provider. *See* Douglas M. Mancino, *New Ruling Provides Guidance, Raises Questions for Joint Ventures Involving Exempt Organizations*, 88

Commentators also complained that the two scenarios presented ventures at extreme ends of the spectrum in terms of their stated commitment to charitable activity, thus leaving open important questions about the many arrangements that fall somewhere in the middle.[114] Further, commentators suggested that while the focus of the revenue ruling was clearly on WHJVs, the IRS's analytic framework has implications for AJVs, as well, raising concerns about whether an exempt provider's participation with a for-profit entity in an AJV in which it lacks operational control could threaten the provider's exempt status.[115]

B. Redlands Surgical Services v. Commissioner

The first judicial test of the IRS position on WHJVs came a year after Revenue Ruling 98-15, in *Redlands Surgical Services v. Commissioner*, in which the Tax Court essentially affirmed the IRS's position.[116] The petitioner, Redlands Surgical Services ("Redlands Surgical"), was a nonprofit subsidiary of a tax-exempt corporation called Redlands Health Systems ("Redlands Health").[117] Redlands Health's primary endeavor was its ownership of Redlands Hospital, a well-established, nonprofit hospital that had served its community since 1929. In 1990, in light of the hospital's need for greater outpatient surgical capacity and the effects of competition from a nearby freestanding surgical center (owned in limited partnership by several Redlands Hospital physicians), Redlands Health entered into an arrangement with a for-profit healthcare services company (SCA) to acquire the surgical center. Redlands Health formed Redlands Surgical as a nonprofit subsidiary which became a general partner with the for-profit

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J. TAX'N 294, 294-95 (1998). A related point raised by some commentators concerned the legal structure of the WHJVs presented in the ruling. Prior to the ruling, some tax attorneys believed that the IRS would look more favorably on the use of a limited liability company than a partnership, since an LLC would provide participants the protection of limited liability and would give the exempt entity an opportunity to participate in the management of the venture without assuming fiduciary duties to other participants. *Id.* Indeed, the IRS had previously expressed concerns precisely about exempt entities' fiduciary obligations in limited partnerships with for-profit entities. However, in Revenue Ruling 98-15, the IRS made no issue of the partnership/LLC dichotomy, presenting both joint ventures as LLCs (and thus making no point of identifying one business form as preferable to another). *Id.* *See also supra* Section II.B. for a parallel analysis of limited versus general partnerships.

114. *See, e.g.*, Wright & Stokeld, *supra* note 112, at 1222.

115. Michael W. Peregrine & T.J. Sullivan, *Rev. Rul. 98-15 Confirms Traditional Tax Planning Approach for 'Typical' Joint Ventures*, 20 EXEMPT ORG. TAX REV. 220, 220-21 (1998) (noting that the analytic framework presented in the ruling is generally consistent with the controlling case law governing the exemption aspects of all joint ventures between exempt and for-profit entities); Kristen Hallam, *IRS May Broaden Ruling*, MOD. HEALTHCARE, Mar. 30, 1998, at 28; Griffith, *supra* note 44, at 405.

116. 113 T.C. 47, 92 (1999), *aff'd*, 242 F.3d 904, 904-05 (9th Cir. 2001).

117. *Id.* at 48-49.

SCA, which partnership acquired control and became the general (operating) partner of the surgical center, sharing ownership with the limited partner physicians.[118] Thus, the arrangement fit the definition of a hospital subsidiary joint venture.[119] Redlands Surgical shared control of the general partnership with the for-profit entity, SCA,[120] and it effectively held a twenty-seven percent interest in the profits of the operating partnership.[121]

The case came before the Tax Court following the IRS's denial of exempt status to Redlands Surgical.[122] The Tax Court ruled in favor of the IRS, adopting substantially the control analysis of Revenue Ruling 98-15.[123] The court concluded that Redlands Surgical was not operated exclusively for charitable purposes because it had ceded operational control of the partnership to the for-profit partner and a management company affiliated with the for-profit partner.[124] In its analysis, the court focused on whether Redlands Surgical exercised either formal or informal control over the venture. The court found that Redlands lacked formal control, given that it (1) did not have a majority position on the venture's governing board, (2) was subject to an arbitration agreement with the for-profit entity that did not require community or charitable objectives to be taken into account in an arbitration proceeding, and (3) was also subject to a long-term contract with a management company that was owned by the for-profit partner and the contract gave the management company broad authority over the operational decisions of the venture.[125] The court likewise found that

118. *Id.*

119. *See supra* Section II.A.

120. *Id.* at 79. Redlands Surgical and the for-profit participant each received fifty percent of the board vote.

121. Redlands Surgical had rights to forty-six percent of the profits of its general partnership with SCA (although it contributed thirty-seven percent of the equity), *id.* at 50, and the general partnership had a fifty-nine percent interest in the surgical center, *id.* at 54; thus, forty-six percent of fifty-nine percent equals twenty-seven percent.

122. *Redlands Surgical Servs.*, 113 T.C. at 47. *See also Redlands Surgical Services Revised Denial Letter*, 97 TAX NOTES TODAY 213-27 (Apr. 1, 1996). The IRS denied exemption to Redlands Surgical because it lacked the requisite control over the joint venture to qualify as an exempt organization. *Id.* Following the analytic framework of Revenue Ruling 98-15, the IRS determined that Redlands Surgical did not have the control necessary to assure that its income and assets would be used to carry out its charitable purposes. *Id.* As such, the IRS concluded that the arrangement violated the prohibition on private benefit since the surgical center would be operated for the financial benefit of its investors, including the for-profit management company. *Id.*

123. *Compare Redlands Surgical Servs.*, 113 T.C. 47, 76-86 *with* Rev. Rul. 98-15, 1998-1 C.B. 718.

124. *Redlands Surgical Servs.*, 113 T.C. at 92-93.

125. *Id.* at 79-84. The management contract was for a fifteen-year term, renewable at will by the management company, terminable only for cause, and providing for fees based on a percentage of gross revenues.

Redlands Surgical lacked informal control of the venture. The court found, based on a review of the administrative record, that Redlands Surgical lacked the necessary "allegiance or loyalty of the [for-profit entity] or of the limited partners to cause them to put charitable objectives ahead of their own economic objectives."[126] Furthermore, the court found that, even with Redlands Surgical as a co-general partner, the surgical center venture neither sufficiently espoused a charitable purpose nor sufficiently undertook charitable responsibility in the community.[127]

Concluding that Redlands Surgical lacked either formal or informal control, the Tax Court held that the arrangement conferred upon the for-profit partner private benefit that was more than incidental; thus, Redlands Surgical did not qualify for tax-exempt status.[128] The court rejected Redlands Surgical's contention that, under the operational test of section 501(c)(3), the question of partnership control should be disregarded in favor of a conduct-in-fact analysis.[129] Redlands argued that, under such an analysis, the venture satisfied the goals of section 501(c)(3), since, on one hand, the surgical center was actively engaged in charitable activities, and on the other, none of Redlands Surgical's partnership income benefited "private interests."[130] However, the court sided with the IRS, finding that Redlands Surgical had ceded sufficient control to its for-profit partner to indicate a substantial nonexempt purpose, thereby disqualifying it from 501(c)(3) status.[131] Furthermore, the court noted, consistent with Revenue Ruling 98-15,[132] that the arrangement was inconsistent with tax-exempt status because it did not permit Redlands Surgical to unilaterally respond to changing community needs (as by having the surgical center offer different, or more affordable, services); rather, Redlands was limited to the passive role of merely vetoing proposed partnership actions that it deemed contrary to its exempt status.[133] Finally, the court rejected Redlands Surgical's argument that it qualified for exemption by virtue of being an integral part of its exempt parent corporation (Redlands Health) and/or its exempt sister hospital (Redlands Hospital). The court concluded that, however close its relationship with its related entities might be, the surgical center venture

126. *Id.* at 85.

127. *Id.* at 87. The court noted, for example, the surgical center's negligible provision of care to low-income, state-subsidized patients.

128. *Id.* at 92-93.

129. *Id.* at 77.

130. *Redlands Surgical Servs.*, 113 T.C. at 77-78. The court noted that the logical extension of Redland's position would be that mere passive investment in a for-profit healthcare enterprise would be a charitable activity, contrary to established precedent.

131. *Id.* at 78.

132. *See infra* Section IV.A.

133. *Redlands Surgical Servs.*, 113 T.C. at 79-80.

was not furthering their charitable purposes.[134] The Tax Court's decision denying exemption to Redlands Surgical was affirmed by the Ninth Circuit Court of Appeals in a *per curiam* opinion issued March 15, 2001.[135]

The *Redlands* decision provoked renewed debate over Revenue Ruling 98-15. Some commentators believed the Tax Court reached the right decision for the wrong reasons, agreeing that Redlands Surgical did not deserve exemption because it had a poor record of charity care and community service, but arguing that the court's focus on operational control was misplaced in light of the broader policies and principles underlying the concept of tax-exempt status in healthcare.[136] Others argued that the court erred in disregarding the fact that the surgical center venture actually made it possible for Redlands Hospital to provide *more* charity care and community service.[137] In addition, commentators expressed concern that the decision would raise additional questions about the scope of Revenue Ruling 98-15 and its potential application to AJVs.[138]

C. St. David's Health Care System, Inc. v. United States

The IRS position on WHJVs was tested a second time in *St. David's Health Care System, Inc. v. United States*.[139] In *St. David's*, the Fifth Circuit Court of Appeals vacated a grant of summary judgment in favor of a hospital provider challenging the IRS's revocation of its tax-exempt status for participating in a WHJV with a for-profit entity.[140] In 1996, St. David's Health Care System, a tax-exempt hospital provider, entered into a joint venture relationship with a subsidiary of the for-profit hospital company HCA.[141] St. David's and the HCA subsidiary were each ten percent general partners in the venture.[142] Like the arrangement in *Redlands*, the partnership agreement called for the tax-exempt provider and for-profit

134. *Id.* at 96-97.

135. Redlands Surgical Servs. v. Comm'r, 242 F. 3d 904, 904-05 (9th Cir. 2001).

136. *See, e.g.*, Darryl K. Jones, *Private Benefit and the Unanswered Questions from* Redlands, 89 TAX NOTES, Oct. 2, 2000, at 121, 131-38 (arguing that the decision should have rested on the ground that the venture resulted in charitable assets benefiting a select and small group of private individuals).

137. *See, e.g.*, Carolyn D. Wright, *IRS Wins First Round in* Redlands*: Exemption Properly Denied*, 25 EXEMPT ORG. TAX REV. 189, 190 (1999).

138. *Id.*

139. Civ. No. A-01-CA-046 JN, 2002 U.S. Dist. LEXIS 10453 (W.D. Tex. June 7, 2002), *vacated by* 349 F.3d 232 (5th Cir. 2003).

140. 349 F.3d at 244.

141. *Id.* at 233. As noted in note 66, *supra*, HCA was formerly known as Columbia/HCA Healthcare Corp.

142. *St. David's*, 2002 U.S. Dist. LEXIS 10453, at *4. The limited partners were St. David's and another HCA subsidiary. Additional classes of limited partnerships were reserved for acquisition by staff physicians and management investors at a later date.

entity to have equal voting rights on the governing board.[143] However, unlike *Redlands*, the partnership agreement in *St. David's* included several provisions focusing on charitable conduct. These included a provision stating that the partnership's operations would be conducted so as to satisfy the community benefit standard of section 501(c)(3).[144] In addition, St. David's had the right to unilaterally dissolve the joint venture if the venture failed to meet its commitments to the community.[145]

Following a tax audit, in October 2000 the IRS revoked the tax-exempt status of St. David's retroactive to the date of the formation of the WHJV in 1996.[146] According to the IRS's Technical Advice Memorandum (TAM)[147] that was prepared after the audit, the revocation was based on a finding that St. David's, in the context of the WHJV arrangement, was no longer operating exclusively to further a charitable purpose. The IRS's analytical framework for the audit, as presented in the TAM, focused on the exempt provider's ability to control the partnership.[148] The IRS concluded that St. David's lacked any direct control over the partnership because it did not have a voting majority on the board.[149] The fact that St. David's had equal voting rights enabled it to block proposals from HCA representatives but did not allow it to "initiate changes to enhance charitable care in the community."[150] The lack of a voting majority for St. David's precluded the board of the partnership from qualifying as a community board, which meant that the venture failed to meet the community benefit standard set out in Revenue Ruling 69-545.[151]

The IRS also concluded that St. David's lacked any indirect control over the venture in light of two provisions in the partnership agreement. One was a management services agreement, which, like the arrangement in *Redlands*, provided for the management of the day-to-day operations of the joint venture by a company that was affiliated with the for-profit

143. *Id.* at *19-20. Each party contributed various assets to the venture. St. David's ownership interest in the venture was approximately forty-six percent and HCA's ownership interest was approximately fifty-four percent. *Id.* at *4.

144. *Id.* at *20.

145. *Id.*

146. *Id.* at *4.

147. Tech. Adv. Mem., 2002 PRL LEXIS 2090 (Aug. 20, 2002).

148. *St. David's*, 2002 U.S. Dist. LEXIS 10453, at *57-64.

149. *Id.* at *59.

150. *Id.* at *57. The partnership agreement did provide for St. David's to appoint the chairperson of the board, though the IRS did not consider this significant because the board chairperson lacked the authority to break a tie between St. David's and HCA voting blocks. *Id.* at *60.

151. *Id.* at *78. *See infra* Section II.A. for discussion of Rev. Rul. 69-545 and the community benefit standard.

participant.[152] The other was an employment agreement that provided that all individuals working on behalf of the partnership, including former St. David's executives, were to be employees of the HCA subsidiary serving as general partner in the arrangement.[153] Finally, the IRS noted that the partnership agreement did not explicitly give priority to charitable objectives.[154]

St. David's challenged the IRS decision to revoke its tax-exempt status in a suit to recover the back taxes it had paid pursuant to the revocation, and prevailed in the district court, winning a grant of summary judgment.[155] The court applied the analytical framework favored by the IRS and adopted by the Tax Court in *Redlands*,[156] and framed the key issues as: (1) "is St. David's operated exclusively for charity, meaning that only insubstantial portions of its activities benefit private, non-exempt purposes?" and (2) "is it operated for the community interest and not for a private interest, specifically, HCA?"[157]

In addressing the first issue, the court applied the community benefit standard, focusing particularly on whether the venture was under the control of a community board.[158] The court held that the St. David's board qualified as a community board, notwithstanding that the for-profit partner controlled the same number of votes as St. David's, because the partnership agreement offered exceptional protections for St. David's exempt purposes, including a provision that all hospital activities had to be conducted in accord with the community benefit standard.[159] The District Court explained that:

> Voting strength is more than a numbers game, and the [partnership

152. *Id.* at *62-64. The IRS criticized the management services agreement as unreasonable in duration (fifty-five years) and financial structure (the management company would receive approximately six percent of the partnership's net revenues).

153. *Id.* at *64.

154. *St. David's*, 2002 U.S. Dist. LEXIS 10453, at *74-75. The IRS discounted the provisions in the partnership agreement focusing on charitable conduct. One such provision required the CEO of the hospital to calculate the amount of charity care the hospital provided for each fiscal year and report the amount provided to the board. *Id.* at *75. However, the IRS appeared to view these provisions as insubstantial juxtaposed to the absence of any "express statement in the Agreement that establishes any obligation that charitable purposes will take precedence over profit motives." *Id.* at *58.

155. *Id.* at *3.

156. *Id.* at *23.

157. *Id.* at *13.

158. *Id.* at *19-20. The court initially considered whether a community board was a requirement under the community benefit test as articulated in Revenue Ruling 69-145. The court concluded that "the presence of a community board is a point in favor of exemption but not an absolute requirement for exemption." *Id.* at *16. *See also infra* Section IV.C.

159. *St. David's*, 2002 U.S. Dist. LEXIS 10453, at *20-21.

> agreement] provisions clearly protect the non-profit, charitable pursuits as well as any community board could. The government seems focused on majority control, but the law is more concerned with control, regardless of whether its control springs from a majority or from a corporate structure.[160]

In approving the control arrangement, the court found salutary several provisions in the partnership agreement, including St. David's right to appoint the board chairperson, which the court said would give St. David's much control over the board's agenda; St. David's authority to unilaterally remove the CEO of the partnership; and St. David's right to unilaterally dissolve the partnership.[161]

As to the question of private benefit, the court found that the structure of the venture was protective of charitable purpose and thus concluded that St. David's operated exclusively for exempt purposes.[162] The court distinguished *Redlands* on its facts, noting that St. David's was clearly pursuing charitable objectives, while the surgery center in *Redlands* "operated no emergency room and provided no free care to indigents."[163]

On review, the Fifth Circuit reversed the grant of summary judgment, finding that the joint venture between St. David's and HCA presented genuine issues of material fact with regard to whether St. David's met the operational test for tax exemption.[164] The court focused its analysis on the question of control, identifying the key inquiry as being whether St. David's had ceded formal or effective control of the venture to its for-profit partner such that more than an insubstantial amount of its activities were serving non-charitable purposes.[165] The court examined several provisions in the partnership agreement that St. David's contended assured it of control of the joint venture, but the court was clearly unconvinced.[166] For example, one provision purported to give St. David's authority to dissolve the joint venture, but the court observed that the provision could only be rightfully invoked if St. David's exempt status were determined by legal counsel to be clearly jeopardized.[167] The court found such a qualified right to be inconsistent with substantial control over the venture. The court further

160. *Id.*

161. *Id.* at *20. However, as discussed *infra*, the court of appeals found that the right to dissolve the partnership, although unilateral, was impermissibly qualified, an important factor in the court's decision to reverse the district court. *See infra* Section IV.C.

162. *Id.* at *24.

163. *Id.* at *19.

164. *St. David's*, 349 F.3d at 244.

165. *Id.* at 237.

166. *Id.*

167. *Id.* at 243-44.

noted that, even if St. David's could rightfully exercise its right of dissolution, it was unlikely ever to do so, given a non-compete clause that prohibited either partner from operating after dissolution in Austin, Texas, the primary service area for St. David's.[168] Thus, the court found the purported control provision to be hollow as well as qualified, and thus not a persuasive indicium of St. David's effective control of the joint venture.

The court also addressed the community benefit standard, agreeing with the district court that a community board was not a *sine qua non* pre-condition for tax-exemption,[169] but also noting that St. David's lack of majority control of the partnership board limited significantly its ability to initiate charitable activities.[170]

The court concluded that St. David's had not met its burden in moving for summary judgment and that there remained uncertainty whether St. David's had ceded control to HCA.[171] Thus, the court vacated the grant of summary judgment and remanded the case to the district court.[172]

D. Future Outlook for IRS Position on Hospital Joint Ventures

Tax-exempt hospitals must now look to *Redlands* and *St. David's* for insight as to what will satisfy the IRS's control requirement relative to joint venture arrangements with for-profit entities. The two cases indicate that, in WHJVs, the exempt provider must be in a position to control decision-making about the operation of the venture. It is unclear whether the provider's control must be formalized. The IRS has advised that it is not necessary for the exempt provider to have a voting majority on the board,[173] but the tone of Revenue Ruling 98-15 and the IRS's posture in *Redlands*

168. *Id.* at 244.

169. *Id.* at 236. But unlike the district court, the court of appeals did not rule on whether the joint venture's board, in fact, qualified as a community board.

170. *St. David's*, 349 F.3d at 241-42.

171. *Id.*

172. *Id.* On remand, a district court jury found for St. David's, finding that the hospital satisfied the control test mandated by the Fifth Circuit. Don Kramer, *Jury Finds St. David's Hospital Has Enough Control to Retain Exemption*, NONPROFIT LEADER, Apr. 2004, *available at* http://www.nonprofitleader.org/04_04/article6.html.

173. Bernadette Broccolo et al., *IRS FY 2002 CPE Text Provides Valuable New Healthcare Tax Guidance*, HEALTH L. DIG., Nov. 2001, at 6. Also, within the last year, the IRS recognized the tax-exemption of a health system subsidiary whose sole activity is participating in ancillary joint ventures (as was the case in *Redlands*) and which shares board control of some of the joint ventures (50/50) with for-profit entities. This was apparently a hard fought victory for the health system involved in the case and is likely to represent an exception to the Service's position on these types of joint ventures. *See* Client Memorandum, Gardner Carton & Douglas, IRS Recognizes Exemption for 50/50 Joint Venture Partner (July 2003), *available at* www.gcd.com.

and *St. David's* suggest otherwise.[174] What is clear, particularly in light of the Fifth Circuit's recent decision in *St. David's*, is the vitality of the IRS's approach to operational control. Indeed, not even the district court in *St. David's*, ruling for the taxpayer, challenged the IRS's approach; its decision focused more narrowly on how the IRS assessed evidence related to the control requirement.

As to AJVs the situation is less clear. The IRS has sent conflicting signals as to whether and how Revenue Ruling 98-15 would apply to AJVs.[175] The concern for tax-exempt providers is two-fold: does the operational control requirement apply to AJVs, and, if so, what are the consequences for failing to meet the control requirement? Some commentators have argued that, even if the operational control requirement does apply to AJVs, it should apply narrowly, only for the purposes of determining whether the venture triggers UBIT.[176] Under such an approach, the fact that an exempt provider lacks control of an AJV would not endanger its exempt status, but would merely subject it to UBIT on its income from the venture.

Of course, even under a more lenient approach, the IRS might still see fit to challenge the exempt status of providers participating in AJVs.[177] Unfortunately, existing case law provides a meager basis for forecasting the outcome of such challenges, since cases thus far have dealt primarily with WHJVs. While *Redlands* may be at least somewhat instructive, since it involved a venture that was not a whole-hospital, the *Redlands* venture was also not a prototypical AJV in that the exempt provider was not engaged in activities outside of the joint venture that supported its tax-exempt status.[178] Thus, neither current case law, IRS private letter rulings, nor general counsel memoranda offer tax-providers particularly helpful guidance on AJVs involving for-profit entities.

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174. *Id.* at 5-6.

175. *See, e.g.,* Hallam, *supra* note 115, at 28; Carolyn Wright, *Owens: Whole Hospital JV Ruling Has 'Value' for Other Charities*, 79 TAX NOTES 1102, 1102 (1998).

176. Commentators argue that a narrow approach is appropriate because a provider's participation in an AJV is, by definition, ancillary to its other (exempt) activities, and typically a relatively small part of its overall operations—precisely the factual situation contemplated by Congress when it enacted the UBIT. *See, e.g.*, Colombo, *supra* note 6, at 526.

177. *See* discussion *infra* Section V.A.1.

178. Some commentators, by contrast, argue that *Redlands* is precisely applicable to AJVs because the joint venture in *Redlands* was, in fact, an AJV masquerading as a whole hospital joint venture, given that it involved a hospital subsidiary rather than an entire hospital. *See* Wright, *supra* note 137, at 190.

V. ANALYSIS OF IRS POSITION ON HOSPITAL JOINT VENTURES

A. Legal Considerations

When the IRS issued its long-awaited Revenue Ruling 98-15, it gave little indication that it was doing anything revolutionary, or even evolutionary. Rather, it presented 98-15 as little more than a restatement of well-settled tax law principles,[179] namely the two-prong charitable purpose test and the community benefit standard first announced in Revenue Ruling 69-545.[180] Whatever the intended descriptive or prescriptive reach may have been for Revenue Ruling 98-15, it provides an apt occasion for re-assessing its key underlying principles.

1. Revenue Ruling 98-15 and the Two-Prong Test

In its articulation of the two-prong test, Revenue Ruling 98-15 focused primarily on the second prong, which requires that a joint venture between an exempt provider and a for-profit entity be structured so that it does not preclude the exempt hospital provider from acting exclusively in furtherance of its exempt purpose.[181] The IRS requires the exempt provider to have operational control of the joint venture to assure that the joint venture will pursue solely the provider's charitable activities, and to assure that the venture will not confer private benefit on the for-profit entity. The exempt provider is said to have operational control if it is in a position to initiate activities that promote the health of the community in a manner that supports its charitable mission. As salutary as the concept and goals of the operational control requirement may be, there is little legal justification for it, with respect to either WHJVs or AJVs, and the IRS's insistence upon it reveals a preference for form over substance in its treatment of joint ventures between exempt hospitals and for-profit entities.

Consider, first, the WHJV. If, as is typical, the joint venture is to be the only activity of the exempt provider (or petitioner for exemption), the IRS must premise its grant or denial of exemption solely on the joint venture's activities.[182] While this is consistent with the aggregate theory of

179. In keeping with its position that the ruling was merely a clarification of existing law, the IRS chose to issue the ruling without a notice and comment period. Wright & Stokeld, *supra* note 112, at 1222.

180. *See* discussion *supra* Section II.A.

181. *See supra* note 41.

182. Exempt providers in WHJVs usually are engaged in only one activity—participating in the joint venture—but it is possible for the exempt provider to be engaged in charitable activities other than hospital care. Under such circumstances, the exempt provider may be able to retain its exemption regardless of the way in which the WHJV is structured.

partnership taxation—whereby the activities of a partnership are attributed to its partners[183]—it does not follow that a tax-exempt provider must have operational control over joint ventures with for-profit entities. Indeed, the IRS's emphasis on operational control is of recent vintage. Neither General Counsel Memorandum 39,005, in which the IRS presented the two-prong test, nor the case law cited by the IRS in Revenue Ruling 98-15, focuses on operational control as an absolute requirement for joint venture arrangements between tax-exempt and for-profit entities. While operational control has been used by the Tax Court as a factor in determining an organizations' eligibility for 501(c)(3) status,[184] it was only one of several factors the court considered in determining whether a putatively charitable entity would, in fact, serve charitable objectives.[185] Thus, the two-prong test need not be interpreted so narrowly as to require the exempt provider to possess operational control of a WHJV. Indeed, the test should be applied more flexibly to allow for the multitude of possible arrangements in which the tax-exempt provider could act exclusively in furtherance of its charitable purpose, which, in the context of healthcare, means that its resources are being used primarily to promote the health of the community in satisfaction of the community benefit standard.

For example, in the WHJV context, there are several alternatives to operational control that would satisfy the policy concerns underlying the two-prong test. The IRS could require that joint venture participants formalize in the partnership's governing instruments commitments to activities that promote the health of the community in accordance with the community benefit standard. While participants are required under current rules to commit generally to the principle of giving charitable goals priority over financial goals,[186] new rules could require participants to set forth specific measurable goals consistent with the community benefit standard, and hold the participants accountable for meeting those goals. In this vein, the participants might commit to providing emergency room services or a specified amount of free medical care each year. The IRS could monitor the joint venture's progress in accomplishing the goals and make the

183. *See supra* Section II.B.

184. Est of Hawaii v. Comm'r, 71 T.C. 1067, 1079-80 (1979), *aff'd in unpublished opinion*, 647 F.2d 170, 170 (9th Cir. 1981); Housing Pioneers, Inc. v. Comm'r, T.C. Memo 1993-120 (1993), *aff'd*, 49 F. 3d 1395, 1395 (9th Cir. 1995).

185. *Est of Hawaii*, 71 T.C. at 1079-80; *Housing Pioneers*, T.C. Memo 1993-120. In both cases, the Tax Court appeared more concerned with the arrangements' vague description of charitable objectives and poorly developed plans for charitable activities. For example, in *Housing Pioneers* the Tax Court questioned the credibility of the petitioner's claim that it would perform charitable activities by noting that it had made no attempt to adopt any actual plan by which petitioner expected to implement its stated objectives.

186. Rev. Rul. 98-15, *supra* note 7.

provider's tax exemption contingent on satisfactory progress toward those goals. If the venture were to fail to meet its charitable obligations, the tax-exempt provider would be required to withdraw from the arrangement by exercising an escape clause in the governing instruments. Furthermore, the exempt provider would risk losing its own exemption if it were unable to document charitable activities outside of the joint venture. Such a focus on measurable charitable goals is consistent with the district court's decision in *St. David's*, which noted with such favor the charitable provisions in the partnership agreement.[187]

Of course, a rule requiring participants to commit contractually to compliance with the community benefit standard is not the same as mandating (as the IRS does currently) that the exempt provider have initiation (i.e. unilateral) rights to pursue community needs. However, while the IRS may believe that its current requirement of initiation rights is an effective way to ensure that community needs are met, there exists no basis in current tax law or regulation for such rights to be the *sine qua non* for tax exemption for exempt hospital providers participating in WHJVs. As noted by one commentator in his analysis of 98-15, "section 501(c)(3) does not in any way prescribe exactly how an organization must conduct its activities. Indeed, the absence of a power to initiate new activities through the [joint venture] is simply a speculative issue that should have no bearing on this particular matter." [188]

Still, even if initiation rights are considered central to the tax-exempt status of a provider participating in a WHJV, it does not follow as a matter of law that the exempt provider must have operational control over all joint venture activities. Indeed, this requirement has the perverse effect of eviscerating one of the key advantages of the healthcare joint venture. A primary reason for which tax- exempt hospitals form joint ventures with for-profit entities is to gain access to the managerial expertise of the for-profit company.[189] However, the current rule prevents the for-profit partner from having any control whatsoever over the venture, even where some control may be desirable and result in the more efficient management of the venture.

A more flexible rule would permit participants to negotiate an arrangement that conferred on the tax-exempt provider initiation rights for certain decisions, those directly related to charitable activities, while allowing the for-profit partner more leverage in the general management of the healthcare organization.

187. *See* discussion *supra* Section IV.C.
188. Mancino, *supra* note 113, at 298.
189. *See supra* Section III.B.

Nor can a requirement for operational control be justified as a measure to protect the assets of the tax-exempt provider. Certainly, the exempt provider does place charitable assets at risk by participating in the venture. But, as noted by Professor Colombo,[190] this is the case whenever a tax-exempt entity engages in commercial activities. Moreover, an important distinction exists between control over the joint venture and control over the tax-exempt provider. As long as the for-profit entity does not exercise control over the exempt provider, the exempt provider can take steps to minimize its financial exposure from the venture. The IRS appeared to adopt this view in General Counsel Memorandum 39,005, which concurred with a proposed private letter ruling favorable to an exempt entity participating as one of two managing partners in a limited partnership that planned to develop a housing project for low-income elderly and handicapped individuals.[191] The Service did not consider whether the exempt entity had more control over the venture than the other general partner, a for-profit entity, but rather focused on the financial protections afforded the exempt entity by the partnership instruments.[192]

As to the AJV, the operational control requirement has no clear legal foundation whatsoever in either previous IRS rulings or case law. As long as a substantial portion of the exempt provider's activities are fulfilling a charitable purpose apart from the AJV, its tax-exempt status should not be placed in jeopardy simply because it lacks control over the venture. Of course, if the venture is controlled by members of the hospital's medical staff, private inurement concerns may arise, since the IRS may chose to view medical staff members as insiders.[193] Even so, the exempt provider's lack of operational control over the venture is not itself tantamount to private inurement. Furthermore, while the exempt provider's degree of control over the venture may be relevant to the question of whether the venture is substantially related to the charitable mission of the hospital provider, and thus whether its income is subject to UBIT,[194] it is only one of several factors for consideration, since it does not by itself prove the nexus between the venture and the exempt provider's charitable mission.[195]

190. Colombo, *supra* note 6, at 526.

191. Gen. Couns. Mem. 39,005.

192. *Id.*

193. *See supra* Section II.A.

194. See *supra* Section II.B.

195. *See* Colombo, *supra* note 6, at 526 (arguing that any joint venture activity designed to provide healthcare services would ostensibly be substantially related to the charitable purpose of an exempt hospital provider).

2. Revenue Ruling 98-15 and Community Benefit Standard

In *St. David's*, the IRS argued that the community benefit standard requires a WHJV to have a community board and, by extension, that voting rights on the board are an important indicator of control over the venture.[196] While Revenue Ruling 69-545, which set out the community benefit standard, did refer to a community board, the ruling did not refer explicitly to such a board as a requirement for exemption.[197] Even the Fifth Circuit Court of Appeals in *St. David's*, reversing in favor of the IRS, concluded that hospitals do not need to demonstrate every factor set out in Revenue Ruling 69-545, including a community board.[198] This view appears to have been tacitly adopted by the IRS in the years since Revenue Ruling 69-145, as evidenced by the Service's inaction as many hospitals have moved away from a community board model.[199] Two trends in particular underlie the movement among hospitals away from a community board, both of which are responses to industry-wide reimbursement and competitive pressures.[200]

First, many hospitals appear to have reconstituted their boards with insiders—typically members of the hospital's medical staff and senior

196. *St. David's*, Civ. No. A-01-CA-046 JN, 2002 U.S. Dist. LEXIS 10453, at *16 (W.D. Tex. June 7, 2002), *vacated by* 349 F.3d 232 (5th Cir. 2003).

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

198. *St. David's*, 349 F.3d at 236. The IRS has stated that "a board of directors drawn from the community" is a "significant factor" related to the community benefit test, however, it did not refer to it as a necessary or determinative factor. Rev. Rul. 83-157, 1983-2 C.B. 94. Moreover, the IRS has never issued any guidance to hospitals as to a requisite number or proportion of community representatives comprising the board. Mancino, *supra* note 20, at 629; Gary J. Young, *Insider Representation on the Governing Boards of Nonprofit Hospitals: Trends and Implications for Charitable Care*, 33 INQUIRY 352, 354 (1997).

199. The IRS has done little to resist this trend, either by clarifying the definition or required composition of a community board or by revoking the exempt status of hospitals whose boards no longer satisfy the community benefit standard. *See* Mancino, *supra* note 20, at 628-32. Where the IRS has moved to clarify board composition requirements, particularly as to other types of tax-exempt healthcare organizations, it has taken a liberal approach. In 1996 the IRS relaxed restrictions on physician participation on governing boards of tax-exempt integrated delivery systems (IDS). Fred Stokeld, *Exempt Health Care Organizations Face Many Challenges, Sullivan Says*, 16 EXEMPT ORG. TAX REV. 186, 186 (1997). The IRS had previously required no more than twenty percent of the board to consist of physicians. *Id.* The revised policy permits physicians to constitute a majority of the board of an IDS as long as it is a controlled subsidiary of a community-controlled organization and a conflict of interest policy is adopted by both the IDS and its parent. *Id. See also* Bernadette Broccolo et al., *The 97 Percent Solution: New Flexibility for Physician Board Membership*, 15 EXEMPT ORG. TAX REV. 247, 253 (1996).

200. These are the same pressures that have resulted in the increased prevalence of joint ventures between tax-exempt hospitals and for-profit entities. *See supra* Section III.B. *See also* Gary J. Young et al., *Community Control and Pricing Patterns of Nonprofit Hospitals: An Antitrust Analysis*, 25 J. HEALTH POL., POL'Y & L. 1051, 1051-52 (2000).

management—rather than representatives of the community.[201] This trend has occurred as some healthcare lawyers and consultants have advised hospitals to increase insider representation in order to strengthen their boards' capabilities in financial and operational planning.[202] Hospitals have also been advised to reduce the size of their boards, which many appear to have done as well.[203] As a result, hospitals have fewer board seats available for community representatives.[204]

Second, a trend toward consolidation of hospitals into systems or chains appears to have diminished the decision-making authority of hospital boards. This has occurred because hospital systems, which developed in order to gain negotiating leverage with insurance plans and to achieve economies of scale,[205] typically have corporate boards that make, or at least have ultimate control over, operational decisions of member hospitals. These corporate boards often have a regional or national orientation, rather than a local one, and likely have few representatives from the communities that member hospitals serve.[206] As such, the formation and growth of hospital systems has in many cases shifted the locus of hospital-level policy making away from communities and toward corporate offices.

Notwithstanding this apparent shift among hospitals away from a community board structure, the IRS now insists that in WHJV arrangements, the exempt hospital provider either have a majority position on the joint venture's board, or be in some comparably dominant position

201. Young, *supra* note 198, at 354. This trend was documented in one study that examined insider representation among nonprofit hospitals in California from 1981 through 1991. *Id.* According to the study, in 1981 only twenty percent of hospitals had governing boards on which more than one-third of the members had insider status as either senior managers or medical staff (i.e. physicians). *Id.* By 1991, more than a third of hospitals had boards with substantial insider representation. *Id.* This study is supported by a variety of anecdotal reports suggesting the trend towards greater insider influence on hospital boards. *See, e.g.*, Stephen M. Shortell, *New Directions in Hospital Governance*, 34 HOSP.& HEALTH SERV. ADMIN. 7, 17 (1989); Carol Molinari et al., *Hospital Board Effectiveness: Relationships Between Governing Board Composition and Hospital Financial Viability*, 28 HEALTH SERV. RES., 269, 359-62 (1993); Carol Molinari et al., *Does the Hospital Board Need a Doctor?*, 33 MEDICAL CARE 170, 171-75 (1995).

202. Young, *supra* note 198, at 354.

203. *But see* Jeffrey A. Alexander et al., *Changes in the Structure, Composition, and Activity of Hospital Governing Boards, 1989-1997: Evidence from Two National Surveys*, 79 MILBANK Q. 253, 257-59 (2001) (noting that, while some argue that smaller boards result in more efficient decision-making, this is not a consensus view, and if there has been a movement to reduce board size, it has had very little noticeable impact to date).

204. Young, *supra* note 198, at 354.

205. As of the late 1990s, over thirty-five percent of tax-exempt hospitals were members of systems. AM. HOSP. ASS'N & ERNST & YOUNG LLP, 1997 HOSPITAL AND HEALTH SYSTEM GOVERNANCE SURVEY: SHINING LIGHT ON YOUR BOARD'S PASSAGE TO THE FUTURE 28 (1997).

206. *Id.* at 1058-59.

over the venture's operations. As a result, such tax-exempt providers need to be more concerned about their degree of control over the venture than how they themselves are controlled and governed. But therein lies the irony of the rule; the exempt provider must have control over the venture but the exempt provider's own governance arrangement may be devoid of the necessary control to ensure that charitable activities are given highest priority. In any event, the IRS's own actions (or inactions) are directly contrary to the conclusion that Revenue Ruling 98-15 is nothing more than a corollary of the community benefit standard.

B. Policy Considerations

In the foregoing section, it is argued that there is little or no legal justification for Revenue Ruling 98-15's focus on operational control. It would be far more consistent with the statutory and regulatory policies that Revenue Ruling 98-15 was intended to further for the IRS to evaluate WHJVs, and some AJVs, under the community benefit standard, using operational control as one, non-dispositive factor in the analysis. Furthermore, in shifting its focus back to the community benefit standard, the IRS would have the opportunity to re-affirm the importance of the community board and attach greater weight to it in assessing a joint venture's compliance with the standard. In this sense, the IRS might consider operational control as but one policy-relevant factor for promoting U.S. health policy objectives, namely expanding the delivery of charity care and other community-oriented services. By contrast, the Service's continued emphasis on operational control as a determinative factor is not likely to serve U.S. health policy objectives.

1. Operational Control and Charitable Activity

The IRS's current focus on operational control assumes that the form of a joint venture's control arrangement is related to the substance of its conduct; it is premised on the assumption that only those ventures that are "controlled" by exempt entities effectively fulfill charitable goals, and those ventures not so controlled are unlikely to do the same.[207] However, much evidence from the social science literature challenges this assumption. This evidence comes from empirical studies examining whether a hospital's behavior is related to its type of ownership, nonprofit or for-profit, since type of ownership is the most obvious indicator of control. Three sets of studies are worth noting.

207. The Tax Court apparently endorsed this assumption in *Redlands* by noting that "there is something in common between the structure of petitioner's sole activity and the nature of petitioner's purposes in engaging in it." *Redlands,* 113 T.C. at 78.

One set compares nonprofit and for-profit hospitals in terms of the amount of charity care they provide, a widely used indicator of community benefit.[208] While these studies generally indicate that nonprofits provide somewhat more charity care than do their for-profit counterparts, the differential is not large.[209] In addition, at least one such study suggests that the differential is due in large part to differences in where nonprofit and for-profits locate—for-profits are less likely to be located in poor communities.[210] A second set of studies examines changes in the behavior of hospitals that convert from nonprofit to for-profit status.[211] These studies point to few changes in levels of charity care, prices, or service offerings. A third set of studies compares the pricing patterns of nonprofit and for-profit hospitals. While some older studies point to more aggressive pricing practices by for-profit hospitals,[212] more recent studies suggest that nonprofit hospitals are as inclined as for-profits to capitalize on market power to raise prices.[213]

In addition to these empirical studies, there is persuasive anecdotal evidence that suggests that the control status of hospitals is a poor proxy for charitable activity. In particular, local communities across the country are becoming increasingly critical of hospitals that are exempted from property and other local taxes, but then fail to provide an adequate level of community services. Indeed, some communities are now requiring these

208. *See, e.g.*, Lawrence S. Lewin et al., *Setting the Record Straight: The Provision of Uncompensated Care by Not-for-Profit Hospitals*, 5 NEW ENG. J. MED. 1212, 1215 (1988); GAO, PUB. NO. GAO/HRD-90-84, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION (May 1990), *available at* http://www.gao.gov.

209. *See supra* note 208.

210. *See* Edward C. Norton & Douglas O. Staiger, *How Hospital Ownership Affects Access to Care for the Uninsured*, 25 RAND J. ECON. 171, 184 (1994).

211. Young & Desai, *supra* note 6, at 149; Jack Needleman et al., *Uncompensated Care and Hospital Conversions in Florida*, HEALTH AFF., July-Aug. 1999, at 125; Kenneth E. Thorpe et al., *Hospital Conversions, Margins, and the Provision of Uncompensated Care*, HEALTH AFF., Nov.-Dec. 2000, at 87; Blumenthal & Weissman, *supra* note 67, at 159.

212. J. Michael Watt et al., *The Effects of Ownership and Multihospital System Membership on Hospital Functional Strategies and Economic Performance*, *in* FOR-PROFIT ENTERPRISE IN HEALTH CARE 287 (Bradford H. Gray ed., 1986); Lawrence S. Lewin et al., *Investor-Owneds and Nonprofits Differ in Economic Performance*, HOSPS., July 1, 1981, at 57.

213. Emmett B. Keeler et al., *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior*, 18 J. HEALTH ECON. 69, 83 (1999). *But see* Robert A. Connor et al., *The Effects of Market Concentration and Horizontal Mergers on Hospitals Costs and Prices*, 5 INT'L J. ECON. BUS. 159, 159-175 (1998) (finding little difference between non-profits and for-profits, but also concluding that consolidation in hospital services had actually resulted in *lower* prices in some markets); William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437, 441 (1995) (finding that nonprofit hospitals are somewhat less aggressive in using market power to extract higher prices from insurance plans and other payers of hospitals care services).

hospitals to make payments in lieu of taxes.[214] For similar reasons, some states and local communities have taken steps to exact greater accountability from their tax-exempt hospitals by requiring them to submit annual reports detailing the community services they provide.[215]

In light of this evidence, the IRS's insistence that operational control of WHJVs be in the hands of the tax-exempt, nonprofit provider, and the implicit assumption that such a requirement will ensure better community medical care, appears naive. It need hardly be said that simply because a tax-exempt provider has initiation rights in a joint venture it will necessarily exercise those rights in a manner that promotes charitable activity.[216] The available evidence suggests that neither board control nor any other criterion that focuses purely on the form or structure of a joint venture is a particularly reliable indicator of a healthcare organization's commitment to charitable activity.

2. Operational Control and Future Joint Venture Activity

In addition to the foregoing evidence suggesting that Revenue Ruling 98-15 will not promote health policy objectives, there is also reason to believe it will actually undermine such objectives. The ruling has likely had a chilling effect on the formation of joint ventures between tax-exempt hospital providers and for-profit entities, particularly WHJVs, at a time when such ventures are likely to be important to the future viability of tax-

214. Andrew L. Hyams et al., Nonprofit Hospital Tax Exemption: A Review of Legal and Policy Developments in Defining Hospital Responsibilities to Providing Charity Care (1998) (unpublished report submitted to the Robert Wood Johnson Foundation) (on file with author).

215. *Id.* For example, both California and Texas require hospitals to submit such reports. *Id.*

216. The seminal question raised by this statistical and anecdotal research (showing little positive correlation between nonprofit status and the effective provision of community services) is why nonprofit ownership of hospitals does not appear to result consistently in the better provision of community services. One answer may be found in agency theory, which has long been used by economists and management scholars to explore the conflicting incentives that principals and agents often face in both nonprofit and for-profit organizations. Agency theorists have observed that, in larger, more complex organizations, the principals—i.e. company owners—typically have little meaningful oversight over their agents—managers employed to maximize shareholder (or other ownership) value for the principals. Eugene F. Fama & Michael C. Jensen, *Separation of Ownership and Control*, 26 J.L. & ECON. 301, 308-09 (1983). Such a disconnect is especially likely in the nonprofit hospital context, in which the principals are not shareholders with a concrete financial investment at risk, but rather community stakeholders whose ownership interests are more abstract and thus perhaps not safeguarded with the same degree of vigilance. *See id.* at 318-19 (hypothesizing, however, that an effective community board may serve to bridge the gap between nonprofit "ownership" and management). In this context, it is inevitable that managers of nonprofit hospitals will often act in their own best interests rather than those of community stakeholders. *But see id. See also* Young, *supra* note 198, at 355.

exempt hospital providers. Although a precise census of these joint ventures on a year-by-year basis is not publicly available, healthcare attorneys and other industry observers have noted that that the number of new WHJVs has been on the decline in recent years.[217] Certainly, some of this decline can be attributed to the enactment of state laws regulating such transactions, as well as other business-related factors.[218] But numerous anecdotal reports point also to the chilling effect of the IRS's rule. In several publicly-reported accounts, tax-exempt and for-profit entities acknowledged that the ruling prompted them to either unwind existing WHJVs or discontinue plans to form such ventures.[219] For-profit organizations are likely to be reluctant to participate in ventures where they lack authority to limit the amount of money the venture devotes to unprofitable activities. At the same time, tax-exempt hospital providers are likely to concerned about the risks that WHJVs carry for their exempt status in any arrangement where they do not posses operational control through majority control of the board.

Given this possible chilling effect, Revenue Ruling 98-15 may very well undermine United States health policy objectives in two ways. First, it may have a negative effect on the future accessibility of hospital services. Many tax-exempt providers now operate in a highly challenging business environment in which their long-term viability is threatened.[220] Indeed, during the 1990s, a substantial number of hospitals (both for-profit and non-profit) closed, often due to the pressures of competition and tighter Medicare/Medicaid reimbursement policies.[221] Policy makers and analysts are concerned that such closings are leaving certain (particularly rural and inner-city) areas of the country with severely reduced, and likely inadequate

217. *See, e.g.*, Leigh Walton et al., *For-Profit and Non-Profit Joint Ventures: Recent Guidance for Hospital and Ancillary Services Collaborations*, HEALTH L. UPDATE (Bass, Berry & Sims, PLC, Nashville, Tenn.), July 2002, *available at* http://www.bassberry.com/resources/health (last visited April 7, 2004).

218. *See* Donahue, *supra* note 6, at 63-74 (evaluating a variety of approaches taken by states in regulating the sale of nonprofit hospitals to for-profit entities).

219. *See, e.g.*, Jon Aspund, *IRS Joint-Venture Rules Make One Potential Partner Back Out*, AHA NEWS, April 13, 1998, at 4; Cynthia F. Reaves & Jay E. Gerzog, *Unwind of Columbia/HCA Whole Hospital Joint Venture in Northern Virginia May Just Be the Writing On the Wall*, 23 EXEMPT ORG. TAX REV. 455, 455 (1999); Kristen Hallam, *IRS Rule Might Slow Joint Ventures*, MOD. HEALTHCARE, Mar. 9, 1998, at 3.

220. *See supra* text and accompanying notes at Section II.B.

221. OFFICE OF INSPECTOR GEN. (OIG), U.S. DEP'T OF HEALTH & HUMAN SERVS. (HHS), PUB. NO. OEI 04-02-00611, TRENDS IN URBAN HOSPITAL CLOSURE: 1990-2000 (May 2003), *available at* http://oig.hhs.gov/oei/reports/oei-04-02-00611.pdf; OIG, HHS, PUB. NO. OEI 04-02-00610, TRENDS IN RURAL HOSPITAL CLOSURE: 1990-2000 (May 2003), *available at* http://oig.hhs.gov/oei/reports/oei-04-02-00610.pdf.

hospital capacity.[222] Although the extent to which a more flexible IRS rule would reduce the number of closings is not clear, WHJVs offer tax-exempt hospital providers an alternative to closure by affording them an opportunity to secure managerial expertise and financial resources while retaining some role in the governance of the hospital. AJVs likewise represent a potentially important source of revenue that financially strapped hospitals could draw upon if they did not fear that such arrangements might cause them to lose their exempt status.

Second, and somewhat paradoxically, Revenue Ruling 98-15 may contribute to the incidence of tax-exempt hospital providers that convert their hospitals entirely to for-profit ownership.[223] A conversion represents another alternative to closure for hospitals whose viability is threatened by financial pressures. In contrast to a WHJV, which preserves some role for the tax-exempt provider in the governance of the hospitals, a conversion results in the total loss to the community of the tax-exempt provider. Whether a greater share of for-profit ownership in the U.S. hospital industry is beneficial to consumers is a longstanding debate,[224] but it appears that most communities prefer to keep their nonprofit hospitals nonprofit.[225]

VI. CONCLUSION

At the time the IRS issued Revenue Ruling 98-15, tax-exempt hospital providers were looking for guidance from the IRS regarding joint venture arrangements with for-profit entities, particularly those that involved the entire hospital. Although this ruling offers guidance, it does so in the form of a requirement as to the joint venture's form of governance rather than the substance of its actual conduct. This approach is not a corollary of existing tax law principles. Nor is it beneficial for achieving U.S health policy objectives.

Accordingly, the IRS should reconsider Revenue Ruling 98-15. The agency should provide exempt hospital providers with guidance relating to the actual commitments a joint venture makes to the provision of charitable care and other community services. The guidance should be consistent with the community benefit standard. Further, the IRS should hold tax-exempt providers accountable for these commitments.

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222. Karen Pallarito, *Good, Bad Results Come from Urban Hospital Closures*, MOD. HEALTHCARE, Nov. 25, 1996, at 3; Susan Reif et al., *Community Perceptions of the Effects of Rural Hospital Closure on Access to Care*, 15 J. RURAL HEALTH 168, 168-69 (1999); Ron Todt, *Hospital Overloads Becoming a Worry*, CHARLESTON GAZETTE, Jan. 13, 2001, at 11A.

223. Hallam, *supra* note 219, at 3.

224. *See generally* FOR-PROFIT ENTERPRISE IN HEALTH CARE (Bradford H. Gray ed., 1986).

225. *See supra* note 6.