C. HEALTH CARE ORGANIZATIONS

1. Hospital Reorganizations

During the last year the Service has received many applications and ruling requests from hospitals that are proposing to reorganize. Most of these reorganizations involve the creation of new entities that will serve as affiliates of an existing hospital. Usually the new entities apply for tax-exempt status. Meanwhile, the hospital and the new affiliates each seek rulings from the National Office that the corporate restructuring and any asset transfers between the affiliated entities will not result in the loss of exemption or of foundation status, and will not result in unrelated business income taxation to the organizations. Generally, where no problems have been found concerning exempt status, foundation status, or UBIT, the Service has approved the exemption applications and the ruling requests.

A. Typical Reorganizations

Reorganizations take a variety of forms and each is to some extent unique. However, there are some recurring themes that virtually all share such as the creation of a parent organization over the hospital and over any other entities within the system.

In the typical case, a reorganizing hospital will remove certain of its services into other related organizations that are often newly created for the purpose. For example, radiology and fund-raising services previously performed by the hospital may be transferred outside the hospital. Structurally, a typical reorganized hospital may take this configuration:

[Chart not shown here]

P, F, S, and R represent newly created organizations that will apply for recognition of tax exemption soon after creation. After exemption is received, the structural reorganization and transfers of assets will take place. The endowment fund in this example is transferred from H to F along with fundraising functions. Radiology and laboratory services are transferred to S. T is created as a for-profit entity to perform services that would result in unrelated business taxable income if performed by H. P's function is to formulate policy and to provide overall management for the affiliated group, and P will allocate funds raised by F among

its various subsidiaries. H, in addition, may purchase services from S and T and lease property from R.

Another type of reorganization involves a merger of hospitals. Two or more hospitals may decide to reorganize under a common parent and then remove all endowment funds and certain services into newly created organizations. A typical such reorganization may look like this:

[Chart not shown here]

As in the previous example, the endowment fund and fund-raising activities of each hospital are transferred to F, and various other health-related services are transferred to S; R, in turn, will hold real property of the hospitals, while P will provide planning, overall management, and policy services to the group. P will also allocate funds raised by F among the three hospitals, which will in turn purchase services from S and make lease payments to R.

B. Reasons for Reorganization

Usually a number of reasons are cited by the hospitals for reorganizing, including increased management specialization and efficiency, facilitating compliance with state regulations and reporting requirements, and the insulation of hospital assets from malpractice claims.

In an attempt to protect the hospital's assets from possible malpractice claims arising from the medical and surgical activities of the hospital, a substantial part of these assets may be transferred outside of the hospital corporation and into other entities. Specifically, the endowment fund may be removed to a foundation or fund-raising organization that is exempt under IRC 501(c)(3). Likewise, the real property and buildings may go to an IRC 501(c)(2) title holding company.

In the case of merging hospitals, the reorganization may serve the purpose of saving funds by allowing the hospitals to engage in shared services without incurring unrelated business income taxation.

While these may be legitimate reasons for reorganization, we believe that there are also significant unstated reasons.

First, the reorganization may provide the hospital a means of opting out of existing FICA coverage of its employees, thereby allowing the hospital to retain

funds that would otherwise be used for employer contributions to FICA. While IRC 501(c)(3) organizations are exempt from FICA taxes, this exemption can be waived under IRC 3121(k) by filing Form SS-15. Once covered by FICA, an exempt organization cannot leave the system without first providing a two year notice. This two year notice cannot be given until the organization has been in the system for at least eight years. Thus, a minimum of ten years of coverage is required before a covered exempt organization can terminate FICA participation.

Many hospitals have waived their FICA exemption. Now, however, some hospitals are seeking to cut employment costs by transferring employees into newly created IRC 501(c)(3) organizations that have not waived their FICA exemption. This procedure allows the hospital to circumvent the ten year waiting period with respect to the transferred employees.

The acceptability of the use of a reorganization to accomplish removal of employees from FICA coverage is implied in Revenue Ruling 77-159, 1977-1 C.B. 302. In that ruling, a newly created IRC 501(c)(3) entity taking over operations from another IRC 501(c)(3) entity that had waived its FICA exemption was determined to be a new organization for purposes of filing a waiver certificate. Consequently, employees transferred to the new entity were no longer subject to FICA.

Revenue Ruling 77-159 reflects the current Service position with respect to employee transfers to avoid FICA coverage; i.e., they will not be challenged. However, legislative initiatives dealing with the situation may be forthcoming.

Another unstated reason for reorganizing may be to enhance medicare and medicaid reimbursements to the hospital. The potential medicare reimbursement advantages to an exempt hospital through reorganization are twofold. First, the Health Care Financing Administration (HCFA), the agency that administers medicare reimbursement, has established rules requiring that federal reimbursement to a hospital be offset by certain grants or other endowment fund income to the hospital. A hospital may seek to remove its endowment fund and grantmaking function into another entity in an attempt to avoid the offset.

The hospital may also be seeking to take maximum advantage of HCFA cost reimbursement formulas that are geared to reimbursing hospital costs on the basis of its degree of medicare utilization. Under these formulas, the higher the ratio of medicare utilization to total services a hospital has, the higher the percentage of hospital costs that will be federally reimbursed. By spinning off services that have

low medicare utilization as well as low costs into separate entities, a hospital will increase its ratio of medicare utilization to total services on its own books, thereby increasing the percentage of costs reimbursed.

To illustrate this point, we will set forth the reimbursement formula used by HCFA:

[Not shown here]

In a simplified example, before reorganization Hospital Z provides total services of $ 100,000 of which $ 50,000 is attributable to the medicare program. The allowable cost for a reimbursement determination includes the portion of the hospital's overhead allocated to patient care. We will assume for purposes of this example that Hospital Z's allowable cost is $ 200,000. Using the above formula, the pre-reorganization reimbursement of Hospital Z is:

[Not shown here]

By removing services with low medicare utilization and with low allowable costs attributable to them, Hospital Z may increase its federal reimbursement. For example, by removing a radiology program (total services $ 10,000, program services $ 1,000, and allowable cost $ 10,000) from Hospital Z into Corporation D, Hospital Z will be left with $ 49,000 in program services, $ 90,000 in total services, and $ 190,000 in allowable cost. Post-reorganization medicare reimbursement to Hospital Z will now be:

[Not shown here]

an increase of $ 3,444 over the pre-reorganization figure. In addition, Corporation D may also receive medicare reimbursement:

[Not shown here]

Consequently, the net reimbursement increase for the two entities is $4,444 from this reorganization.

HCFA will often view the reorganized entities as in fact a single entity for reimbursement purposes, and has the authority to make adjustments on that basis. Consequently, attempts by hospitals to increase their medicare reimbursement through reorganization may be unsuccessful. We have discussed these issues with HCFA and are sharing information with them to the extent we can. However,

HCFA's ability to make adjustments is limited by a lack of staff and by an organizational structure that allows intermediary organizations, in many cases, to be responsible for determining reimbursement amounts. Further, HCFA often is unaware of a reorganization until an audit is made. Consequently, potential for claims abuse by reorganizing hospitals exists. The reorganizations themselves, however, violate no HCFA regulations and are strictly legal.

C. Technical Issues

Initial exemption applications for the newly created parent and for the subordinate entities should be considered with several factors in mind.

1. Revenue Ruling 78-41, 1978-1 C.B. 148 allowed exemption to a trust fund against medical malpractice claims on the ground that the fund was an integral part of a tax-exempt hospital. It was noted that the fund was controlled by the hospital and was a function that the hospital could perform directly consistently with its exempt purpose.

The "integral part" basis for exemption is derived from Reg. 1.502-1(b). We have generally accepted the argument that the various newly created entities are integral parts of, or are adjuncts to, the reorganizing hospitals. This is particularly easy to visualize in the case of a reorganization because the new entities are taking over functions that were spun off from the hospital.

Where, however, a new entity has as its primary purpose a trade or business with unrelated organizations, it is not exempt. See IRC 501 and Reg. 1.502-1(b). Organizations are related for these purposes only if they have a parent-subsidiary relationship or if they are subsidiaries of a common parent.

2. In the case of merging hospitals, care should be taken that the parent organization actually has the power to direct and to control its subsidiaries. If the several hospitals are in fact controlling the parent, the reorganization could be a means of circumventing IRC 501(e). In such a case, the parent and any new service subsidiaries would be functioning, in effect, as cooperative service organizations. In HCSC - Laundry v. United States, 450 U.S. 1 (1981), the Supreme Court held that IRC 501(e) was the exclusive provision through which a

cooperative service organization could obtain exemption. Thus, in cases where several hospitals control the parent organization, the provisions of IRC 501(e) must be met by the parent and by the new subsidiaries. Further, any of these organizations providing services not listed in IRC 501(e)(1)(A) -- such as laundry services -- would not be exempt. Reg. 1.502-1(b) also could be used to deny exemption in these cases on the grounds that the parent is actually a subsidiary of several unrelated organizations.

In the ruling requests received in the National Office, the preceding issues will be considered in determining the effect of the reorganization upon the exempt status of the organizations. Another issue considered will be whether the reorganization will give rise to problems of foundation status. This could occur where an IRC 509(a)(3) organization is the specified supporting organization of another IRC 509(a)(3) entity, a relationship that may not be permitted under IRC 509(a)(3)(A).

The National Office has also ruled on questions involving the provision of services between subordinates. Services provided by the newly created exempt subordinate entities for other exempt entities within the system will not result in unrelated business income taxation if these are services that would be related to the hospital's exempt function if the hospital performed the services on its own behalf. See Reg. 1.502-1(b). However, services that are not provided for exempt entities subordinate to a common parent could result in unrelated business income taxation. For a discussion of the unrelated business income effects of hospital operations, see Part 2 of this topic.

2. Unrelated Business Income of Exempt Hospitals

A. Hospital Pharmacy Sales

Hospital pharmacy sales to the public directly compete with those of commercial pharmacies and are squarely within the policy of the tax on unrelated business income.

1. Sales to Hospital Patients and Employees

IRC 513(a)(2) excepts from the term "unrelated trade or business" activities that are primarily for the convenience of patients and employees of the hospital. Revenue Ruling 68-376, 1968-2 C.B. 246 sets forth six

categories of persons who will be considered "patients" of a hospital for purposes of IRC 513(a)(2). Sales to these persons will not be considered to generate UBI:

(1) a person admitted to the hospital as an inpatient;

(2) a person receiving general or emergency diagnostic, therapeutic, or preventive health services from outpatient facilities of a hospital;

(3) a person directly referred to the hospital's outpatient facilities by his private physician for specific diagnostic or treatment procedures;

(4) a person refilling a prescription written during the course of his treatment as a patient of the hospital;

(5) a person receiving medical services as part of a hospital administered home care program; and

(6) a person receiving medical care and services in a hospital-affiliated extended care facility.

2. Sales to the General Public

Hospital pharmacy sales to the general public do not fall within the exception of IRC 513(a)(2) of the Code and are not considered to be substantially related to a hospital's exempt purposes. Situation 1 of Revenue Ruling 68-374, 1968-2 C.B. 242.

3. Sales to Private Patients of Hospital Staff Physicians

Often a medical group practice is located adjacent to a hospital or within a hospital building. The physicians within that practice may also serve on the hospital's staff. Private patients of these physicians, who do not otherwise avail themselves of the hospital's diagnostic or treatment facilities, are not considered to be "patients" of the hospital for purposes of IRC 513(a)(2). Pharmacy sales to these private patients are considered to be unrelated to the hospital's exempt function. Situation 2 of Revenue Ruling 68-374; Revenue Ruling 68-375, 1968-2 C.B. 245; Carle Foundation v.

United States, 611 F. 2d 1192 (7th Cir., 1979). Likewise, the physicians are not "employees, officers, or members" of the hospital in their roles as private practitioners of medicine for purposes of IRC 513(a)(2), as will be discussed in the consideration of St. Luke's Hospital of Kansas City v. United States below.

The recent case Hi-Plains Hospital v. United States 670 F. 2d 528 (5th Cir., 1982), found sales to private patients of staff physicians, under particular circumstances, to be directly related to the hospital's exempt function. The hospital in that case was located in a rural community of 2200 persons that had lacked medical services before the hospital was established. The court found that the pharmacy sales to private patients were part of a package of benefits provided by the hospital to staff physicians to attract and maintain these physicians in the community. The hospital's activity of making medical services available to the community was cited by the court in holding these sales to contribute importantly to the hospital's exempt function.

We believe that any future application of the holding of Hi-Plains should be narrowly limited to the facts of that case, and that the holding would not in any case be applicable other than in isolated rural areas.

B. Laboratory Testing

As with pharmacy sales, laboratory testing of specimens from individuals by a hospital is potentially in competition with commercial enterprises performing the same function and within the policy of the statute.

1. Testing of Patient and Employee Specimens

Under IRC 513(a)(2), testing of laboratory specimens primarily for the benefit of hospital patients and employees will not be considered an unrelated trade or business. For purposes of determining those persons who are "patients" of a hospital, the categories of Revenue Ruling 68-376, previously cited, should be used.

2. Testing of Nonpatient Specimens: General Rule

The Service position is that the testing of referred specimens by an exempt hospital is unrelated to the hospital's exempt function. In most cases

there are commercial facilities or other entities that are capable of performing such testing, which is often of a routine nature. Failing to tax these operations would result in an unfair advantage to these hospitals against commercial enterprises with which they compete.

The general rule holding referred specimen testing to be unrelated to a hospital's exempt function includes the testing of specimens of private patients of hospital staff physicians.

In St. Luke's Hospital of Kansas City v. United States, 494 F. Supp. 85 (W.D. Mo., 1980), an exempt hospital operated a pathology laboratory in which tests were made on specimens obtained from patients of St. Luke's staff physicians in the course of their private practices. The court held that these tests were substantially related to St. Luke's educational function. The court also held that the performance of the tests was primarily for the convenience of physicians on St. Luke's medical staff, who the court concluded were "members" of the hospital for purposes of the convenience exception.

We believe that the latter holding is wrong for several reasons. For purposes of the convenience exception, the physicians on the hospital's medical staff should not be considered members of the hospital while treating patients who are not patients of the hospital. Further, even if it is conceded for the sake of argument that staff physicians are "members" of the hospital, we do not accept the court's conclusions that these tests were performed "primarily for the convenience" of these individuals, as required by IRC 513. In order to satisfy this requirement, St. Luke's must establish that its primary objective in conducting these outside pathology tests was for the convenience of its staff physicians. Given the large amount of revenue produced by these tests and the court's previous conclusion that the tests contributed importantly to the hospital's education function, we believe the court erred in concluding that these tests were performed by the hospital primarily for the convenience of these physicians. Thus we do not believe the facts otherwise demonstrated that performance of the tests provided a convenience for the medical staff. However, since the government offered no evidence to dispute the plaintiff's claim as to the educational importance of the outside testing, and since this ground was sufficient in itself to carry the case for the plaintiff, the Chief Counsel's office did not recommend appeal of this decision.

3. Testing of Nonpatient Specimens: Exceptions

There may be special circumstances where an exempt hospital's testing of referred specimens may fulfill an important community medical need and thus serve the hospital's exempt purposes. For example, if testing facilities are otherwise unavailable in the community for a particular type of test, and the diagnosis or treatment of the nonpatient would be hindered or jeopardized by referral of the specimen to another location, the hospital's testing serves an important community need. Likewise, if the hospital possesses sophisticated equipment for specific types of tests not available elsewhere in the community, and it would be impractical to transport nonpatient specimens to distant facilities, an important community need may be served. The facts and circumstances of each case should be examined to determine if special circumstances exist; in virtually no case, however, will laboratory testing of referred nonpatient specimens be considered related to a hospital's exempt purpose if commercial testing facilities exist within the community that are capable of performing the same testing.

An exception also exists for hospitals performing testing services for other small hospitals under certain circumstances. See below.

C. Shared Services Among Hospitals

Hospitals often perform services for other hospitals. Under certain circumstances these services may not result in unrelated trade or business income for the hospital providing the services.

First, IRC 513(e) provides that the term "unrelated trade or business" does not include a hospital's furnishing of one or more of the services listed in IRC 501(e)(1)(A) to other hospitals if: (1) the services are furnished solely to hospitals with facilities for not more than 100 inpatients; (2) the services would be related if performed by the recipient hospital on its own behalf; and (3) the services are performed at no more than actual cost as defined in that section.

The listed services in IRC 501(e)(1)(A) are:

(1) Data Processing

(2) Purchasing

(3) Warehousing

(4) Billing and Collection

(5) Food

(6) Clinical (added by the Tax Reform Act of 1976)

(7) Industrial Engineering

(8) Laboratory

(9) Printing

(10) Communications

(11) Record Center, and

(12) Personal Services (including selection, testing, training, and educational or personnel)

The services listed in IRC 501(e)(1)(A), other than laboratory services (discussed earlier) and clinical services, are of an administrative nature and their provision would under most circumstances be considered an unrelated trade or business when provided by an exempt hospital to another unrelated hospital. IRC 513(e) provides a limited exception to this rule. This exception, however, does not apply to services not listed in IRC 501(e)(1)(A), including laundry services.

Revenue Ruling 69-633, 1969-2 C.B. 121, Situation 2, provides that an exempt hospital performing laundry services for another hospital is engaging in an unrelated trade or business. The same rationale underlying this ruling is also applicable to the administrative services in IRC 501(e)(1)(A) in cases where IRC 513(e) is not applicable.

In Chart, Inc. v. United States, 491 F. Supp. 10 (D.D.C., 1979), the District Court allowed IRC 501(c)(3) status to a cooperative services organization providing data processing services to exempt hospitals. While this decision related to exempt status, rather than to unrelated business income taxation, the decision

can be interpreted to mean that the provision of data processing services is directly related to a health organization's exempt function, at least in the case of a cooperative service organization. The Chart decision was one of a string of decisions allowing cooperative service organizations to be exempt under IRC 501(c)(3). However, the Supreme Court, in HCSC-Laundry v. United States, 450 U.S. 1 (1981), held that IRC 501(e) of the Code, and not IRC 501(c)(3), was the exclusive provision through which cooperative service organizations can qualify for exemption. The U.S. Court of Appeals for the District of Columbia Circuit, finding the HCSC case to be controlling, reversed the lower court in an unpublished decision and denied IRC 501(c)(3) exemption to Chart, Inc. Chart, Inc. v. United States (No. 801138, 3-6-81).

The provision of services, including laundry services, by a hospital to related entities will not result in unrelated business income taxation. For these purposes an organization is related only if the relationship is described in Reg. 1.502-1(b); i.e., a parent and its subsidiaries or subsidiaries of a common parent.

There may be certain clinical services performed by exempt hospitals for other hospitals. To the extent that these services involve direct patient care, the services would be considered to be central to the exempt function of the hospital and directly related, or within the exception of IRC 513(a)(2). The analysis of other cases, often the most difficult in this area, should be undertaken on a case-by-case basis using an approach similar to that used in laboratory testing cases.

D. Miscellaneous Services

Certain activities of hospitals peripheral to patient care have been ruled not to result in unrelated business income taxation. Hospital gift shops (Revenue Ruling 69-267, 1969-1 C.B. 160); cafeterias and coffee shops (Revenue Ruling 69-269, 1969-1 C.B. 160); and parking lots (Revenue Ruling 69-269, 1969-1 C.B. 160), are considered to be directly related to the exempt function of a hospital. In these cases use of the facilities by the general public was very limited. If such services were extensively used by the general public (other than by patients, visitors, and employees), the case for taxation would be strong. See Revenue Ruling 68-374, cited earlier, dealing with pharmaceutical sales to the general public.

Other activities that are an integral part of a hospital's direct care program will also be considered to be directly related to the hospital's exempt purposes. For example, the sale and fitting of hearing aids (Revenue Ruling 78-435, 1978-2 C.B.

181) and the design, sale, and fitting of orthotic devices for the handicapped may contribute importantly to a hospital's exempt function. However, cases in which advertising and other promotions indicate that the activity may be similar to a commercial venture should be referred to the National Office.

3. Individual Practice Associations (IPAs)

IPAs are nonprofit organizations composed of health professionals. The organizations contract with prepaid health care plans to provide health services to members of the plans on a fee-for-service basis. In many cases, the prepaid health care plan contracting with the IPA is a Health Maintenance Organization (HMO).

In a typical case, the IPA membership is limited to participating physicians in a particular geographic area. Participating physicians agree to accept patients covered under the contract between the IPA and an HMO. The physicians bill the IPA for services performed for these patients on a fee-for-service basis according to a fee schedule established by the IPA. The HMO will reimburse these IPA expenditures in accordance with its contract with the IPA. Alternatively, some contracts with HMOs allow for direct physician billing to the HMO. The typical IPA will not solicit nonphysician member input and will not assume the costs of services to indigent patients that are not covered in its agreement with the HMO.

The function of the IPA is to represent physician's interests in dealing with HMOs or other prepaid health care plans.

We have received applications for exemption under IRC 501(c)(4) from IPAs. The Service's tentative position is that IPAs of the type described above will not qualify for exemption. In serving as a representative of individual practitioners to ensure that they obtain sufficient fees to cover costs plus profits, the IPA is serving the interests of its physician-members rather than those of the community. The effect of the IPA is to ensure that the fees charged to patients are reasonable to the physician rather than to the patients. The formation of the IPA generally has no effect upon the amount of medical services available to the community, and no bona-fide community problem is alleviated by virtue of the IPA.

However, exemption applications from IPAs should continue to be suspended in the field until paragraph 7664.62(1) of IRM 7600 no longer requires it.

4. Home Health Agencies (HHAs)

An update on these organizations is included within the topic "Inurement" in the 1983 CPE.