1992

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THE SERVICE'S LATEST ATTEMPT TO REGULATE HOSPITAL-PHYSICIAN RELATIONSHIPS: A CRITICAL ANALYSIS

by

PATRICK H. LUCAS*

INTRODUCTION

In November of 1991, Chief of Counsel (the "Chief Counsel") of the exempt organization division of the Internal Revenue Service (the "Service" or "IRS") issued its latest in a series of rulings intended to restrict tax-exempt hospitals' practices in recruiting or retaining physicians. 1 The most recent ruling, General Counsel Memorandum ("GCM") 39,862 expands upon prior rulings issued by the Chief Counsel. These "GCMs" represent the legal advice given by the Chief Counsel to the IRS. Although such GCMs are not binding upon the IRS or any taxpayer, a lack of published rulings and court decisions dealing with increasingly more complex hospital-physician relationships has made these GCMs uniquely important to tax-exempt hospitals in structuring their affairs.

Despite this importance, the failure of these legal interpretations to undergo the rigors of the administrative process applicable to published rulings or the critical examination of the courts must be considered. The most recent GCM and all its predecessors have sound policy bases for their legal conclusions but each lacks certain analytical support. Recent articles have discussed in detail this GCM, the Chief Counsel's most recent interpretation. 2 However, these articles do not attempt a detailed critical examination of the authority for the Service's positions set forth in this GCM. This article is a search for the GCM's foundation and a discussion of what that search reveals. Only after such critical examination can an exempt hospital completely evaluate whether its current and future practices endanger its exemption.

The principal purpose of GCM 39,862 was to review and reconsider three private letter rulings issued in the 1980s. 3 The rulings approved the sales by hospitals of revenue streams from the operation of departments of those hospitals


2 See e.g., Peregrine and Broccoli, Health Care Joint Ventures After GCM 39862: The Chief Counsel's Boarding House Reach, 4 EXEMPT ORGANIZATION TAX REV. 1309 (1991); Robert S. Bromberg, IRS Announces New Position on Hospital-Physician Joint Ventures, 5 EXEMPT ORGANIZATION TAX REV. 31 (1992); Richard Lipton, IRS Attacks Hospital Joint Ventures, 70 TAXES 59 (1992).


Published by IdeaExchange@UAkron, 1992
to limited partnerships between the particular hospital as general partner and its staff physicians as limited partners. The revenue streams generally had five-year initial terms with five-year renewal periods. The price for the stream was determined by discounting an appraised value of the future revenue streams to present value using an appropriate discount rate. In each case the hospitals picked facilities such as outpatient surgery departments which were experiencing underutilization or other financial difficulty. By giving the physicians part of the financial benefit of increased referrals the hospitals believed the transaction would bring up utilization of those departments.

The Chief Counsel concluded in the GCM that each of these rulings should be revoked for three reasons: (1) The transactions violated the proscription against inurement of an exempt organization's earnings to any private individual; (2) the transactions infringed upon the doctrine that an organization must operate for public rather than private benefit in order to be exempt from the income tax; and (3) the transactions may violate federal law and that such violations are inconsistent with exemption from the income tax. Each of these theories is examined separately in detail below. The examination is then accompanied by a critical analysis of the Chief Counsel's interpretation of such doctrines in reaching his conclusions.

PRIVATE INUREMENT

In General

Section 501(c)(3) of the Internal Revenue Code (the "Code") proscribes the inurement of any part of the net earnings of an exempt organization to the benefit of any private shareholder or individual. Any inurement within the meaning contemplated by the statute, however small, results in the loss of exemption.

There are two critical elements to the proscription: (1) the "inurement" of earnings for (2) the benefit of a "private shareholder or individual." Both must be present to apply the proscription. Neither of these elements has been easy to define. With regard to the concept of "private individual," the regulations provide that the term refers to persons who have a "personal and private interest" in the organization. This generally means the founders or controlling members of the organization (i.e., officers or directors) who have a personal stake in the organization's receipts. The proscription does not apply to unrelated third parties.

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Frequently, persons subject to the proscription are referred to as "insiders." Officers, directors, founders, trustees, shareholders and the like are easy to identify as "insiders" or "private shareholders or individuals" but the Service apparently asserts that the term may also include anyone able to exert influence on the organization with respect to the transaction allegedly giving rise to the inurement. This concept is reasonable but the Service's application of it has produced some questionable results. For example, the Service takes the position that all employees "possess the requisite relationships necessary to find private inurement." It has been suggested that this position is not an absolute rule, but a presumption "that employees as a class relate to an exempt organization in such a manner that significant potential exists for inside influence." The IRS has also taken the position that newly recruited physicians of a tax-exempt hospital are subject to the inurement proscription.

The issue of inurement has directly arisen in several court decisions involving putatively tax-exempt hospitals. In all of those decisions involving physicians who were either trustees/directors or officers of the hospital the courts directly found that the net earnings of the organizations inured to the benefit of such physicians.

In only one decision, however, has the inurement question been addressed in the context of physicians having no or little governing authority over the hospital. In Harding Hospital v. United States, the Sixth Circuit stated that the subject hospital's exemption should be revoked because the court could not conclude that a nationally recognized psychiatric hospital was organized and operated exclusively for exempt purposes or that no part of its net earnings inured to the benefit of private individuals. The hospital had contracted with a physician group to provide medical supervision in the hospital, teaching and supervising in the hospital's residency and other training programs, and medical services to indigent...
patients without a charge or at a reduced rate. The group performed all psychiatric treatment on ninety to ninety-five percent of the patients admitted to the hospital. A majority of the board of directors of the hospital, however, was not connected to the physician group.

Although the decision does not establish a test for determining when physicians are deemed "insiders," it does give some indication of when staff physicians at an independently governed hospital will acquire such status. The factors important to the decision were the day to day supervision of the hospital's activities by a small group of physicians and attribution of substantially all of the hospital's revenue to such group. These factors fall far short of the Service's bold assertion that all staff physicians, no matter what amount of hospital revenue they control and no matter what degree of management supervision they possess, constitute "insiders."

Because of the Service's all-consuming view of what constitutes a "physician insider" and because no court decisions have specifically rejected this view, the second element — the inurement of earnings — must also be examined in the context of hospital-physician transactions. As is often stated, "Earnings may inure to an individual in ways other than through the distribution of dividends." Basically, the inurement proscription "means that a[n insider] cannot pocket the organization's funds except as reasonable payment for goods or services." Thus, the bottom line for determining whether inurement has occurred is whether the exempt organization is receiving fair value for the economic benefits it provides to an insider. Thus, inurement can occur as a result of unreasonable compensation to an insider, a below market interest rate loan to an insider, below market rent

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17 Id. at 1070.
18 Id.
19 Id. at 1071.
20 See also Lowry Hosp. Assoc. v. Commissioner, 66 T.C. 850, 859 (1976) (stating that where a doctor or group of doctors dominate the affairs of a hospital close scrutiny of its exempt status is required).
21 Harding Hosp., Inc., 505 F.2d at 1072.
22 IRS, EXEMPT ORGANIZATIONS HANDBOOK § 381.1.
24 See, e.g., Birmingham Business College, Inc. v. Commissioner, 276 F.2d 476 (5th Cir. 1960); Mabee Petroleum Corp. v. United States, 203 F.2d 872 (5th Cir. 1953); World Family Corp., 81 T.C. 958; People of God Community v. Commissioner, 75 T.C. 127 (1980); Saint Germain Found. v. Commissioner, 26 T.C. 648 (1956); Alive Fellowship of Harmonious Living v. Commissioner, 47 T.C.M. (CCH) 1134 (1984).
Contingent Compensation

A most difficult situation for determining whether an exempt organization is receiving fair value for the economic benefits it provides is the payment of contingent compensation. There have been three seminal court decisions addressing the role of contingent compensation in exempt organizations and the examination of each bears merit. The first decision, *People of God Community v. Commissioner*,28 involved a newly formed church which compensated its minister-founder and two other ministers on the basis of a percentage of gross tithes and offerings. The base percentage for the founder was adjusted upward annually to reflect increased personal expenses or downward to the extent that larger receipts permitted an increase in compensation for the other ministers. No upper limit or cap was placed on the total amount any minister could receive.29 The Tax Court concluded that the method by which the ministers' compensation was determined clearly showed that part of the church's earnings was paid to private shareholders or individuals:

> Whatever [the founder's] services were worth, they are not directly related to the [church's] gross receipts; the value of solace and spiritual leadership cannot be measured by the collection box. By basing [the founder's] compensation upon a percentage of [the church's] gross receipts, apparently subject to no upper limit, a portion of [the church's] earnings is being passed on to [the founder].30

The court, however, was careful to point out that all contingent arrangements were not *per se* inurement, stating that "such arrangements are a part of business life and must occasionally be paid by a charity to salesmen, publishers, support groups, and even fundraisers."31

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28 75 T.C. 127 (1980).

29 *Id.* at 129. The percentage of tithes being paid to the founder ranged between 53% and 64% and to all ministers between 69% and 86%.

30 *Id.* at 132.

31 *Id.* at 133.
In *World Family Corp.*, the Tax Court began to indicate the distinction between permissible and impermissible contingent compensation arrangements. World Family Corporation was organized and operated to provide grants and interest free loans to missionaries sent out by the Church of Jesus Christ of Latter Day Saints. The organization's fund-raising program involved commissions payable to fund-raisers of up to twenty percent of the amount raised by each fund-raiser. The organization's balance sheet showed an account payable to its president for an accrued commission. The Service contended that the organization's net earnings inured to the benefit of its president. The Tax Court disagreed holding that a contingent fee arrangement made by a tax-exempt entity is not *per se* unreasonable as the Service appeared to contend. The Tax Court distinguished *People of God Community*:

[The] commissions are directly contingent on success in procuring funds and as such are tied to services rendered. These elements distinguish [the organization's] commission arrangement from other arrangements found by the courts to constitute private inurement . . . In [those] cases, some percentage of receipts or salary was routinely designated for one dominant individual, and he was entitled to receive this income whether or not he rendered services to the payor organization.

*World Family Corp.* and its successor, *National Foundation, Inc.*, demonstrate the primary problem caused by contingent fee arrangements. Frequently, such arrangements may by their very nature provide compensation to the service provider in excess of the value of the services he provides. In such case, the Service and the courts look for protections against the possibility such excess will be paid. In *World Family Corp.* the Tax Court focused on the fact that the amount of compensation was dependent upon the accomplishment of the objectives of the contract and was not based solely upon the incoming revenue of the organization. This fact tends to establish that the service provider is unlikely to receive compensation in excess of the value of his services.

An added protection which insures against the likelihood of such excess is a ceiling on the contingent compensation. The ceiling avoids the possibility of a windfall benefit to the service provider, particularly in those instances where the base for the contingent compensation cannot bear any relationship to the level of

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33 *Id.* at 962.
34 *Id.*
35 *Id.* at 968.
36 *Id.* at 970 (footnote omitted).
37 *National Found., Inc. v. Commissioner*, 87-2 U.S.T.C. 89,827 (CCH) ¶ 9602 (Ct. Cl. 1987).
In *National Foundation, Inc. v. United States*, the Court of Claims pointed to the existence of a ceiling on the contingent compensation received by its fund-raisers as evidence that the earnings of the subject organization ("NFI") did not inure to the benefit of private individuals. As compensation for soliciting donors, the fund-raisers were paid a percentage, ranging from three to six percent, of the donations they generated. The percentage paid varied with the value of the donation. The Service argued that the fund-raisers were co-venturers with NFI and that the compensation resulted in inurement. The Court of Claims disagreed with the Service distinguishing NFI from the church in *People of God Community* on the basis that the church had no upper limit on the percentage paid to the minister whereas NFI's fund-raisers were subject to a six-percent upper limit.

The Service has issued one revenue ruling addressing the contingent compensation arrangements of hospitals. In Revenue Ruling 69-383, advice was requested as to whether payment of contingent compensation to a radiologist jeopardized a hospital's tax-exempt status. Under the hospital's contract with the radiologist it was required to provide space, equipment, and supplies and to make nonmedical personnel available to the department of radiology. The radiologist agreed to manage the department, participate in the hospital's educational program, and perform all radiological services required by hospital patients, employees, and students. While the radiologist served as the professional and administrative head of the department, he had no control over or management authority with respect to the hospital. The hospital, with the approval of the radiologist, established the amounts charged to patients for services rendered. The hospital billed and collected the charges.

The hospital paid the radiologist a fixed percentage of the department's gross billings, adjusted by an allowance for bad debts. "The amount received by the subject radiologist [was] not excessive when compared to the amounts received by other radiologists having similar responsibilities and handling a comparable patient volume at other similar hospitals." The Service's ruling noted that under certain circumstances, the use of contingent compensation can constitute inurement of net earnings to private individuals. The Service ruled that no such inurement was present based on the following factors: (1) The radiologist did not control the organization; (2) the agreement was negotiated at arm's length; and (3) the amount

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39 *Id.*
40 87-2 U.S.T.C. 89,827 (CCH) ¶ 9602 (Ct. Cl. 1987).
41 *Id.* In addition, CDOs received $50 of a $100 application fee paid by donors.
42 *Id.* at 89,832.
44 *Id.* at 114.
45 *Id.*
the radiologist received was reasonable in terms of the responsibilities and activities he assumed under the contract. 46

The ruling does not indicate which of these factors was the primary basis for the holding. However, shortly after the ruling, the Service contested a hospital’s tax-exempt status based on inurement to a group of physicians, even though the physicians were not members of the hospital’s governing board. 47 So it would seem that the Service was not relying primarily on the radiologist’s lack of control. In addition, in the ruling the Service indicated its belief that contingent compensation, which at the time of entering a contract may be reasonable, can later cause inurement. It would seem, therefore, that the major basis for the Service’s ruling is that the contract was negotiated at arm’s length. By arm’s length the ruling does not mean the contract was negotiated fairly or aggressively among the parties, but rather that the terms of the transaction are similar to those terms reached by other persons 48 or that the nature of the contract is such that payment in excess of reasonable compensation is unlikely to occur.

The arrangement described in the ruling was typical for pathology and radiology departments prior to 1982. 49 Accordingly, one interpretation of the ruling may be that contingent-based compensation is proper if, at the time the contract is entered into, its terms are consistent with others in the trade or industry. This rationale is consistent with some of the Tax Court’s comments in World Family Corp. 50 and People of God Community. 51

The arrangement described in Revenue Ruling 69-383 occurred as a result of the fact that prior to 1982 hospitals usually billed on a global charge basis for both the radiologist’s professional charges as well as its own facility charge. Thus, the percentage compensation arrangement represented an allocation of a portion of the global charge (referred to as the "professional component") to the physician to compensate him for his services. The hospital retained the remainder (the "technical" or "facility component") as compensation for use of its facilities and equipment. Because the hospital could reasonably determine the portion of each dollar collected attributable to the efforts of the physician and correspondingly attributable to the facilities of the hospital, the risk of unreasonable compensation being paid was minimized. In effect, the radiologist’s situation was similar to the fund-raiser in World Family Corp. in that the radiologist’s pay was dependent

46 Id.
47 See Harding Hosp., Inc. v. United States, 505 F.2d 1068 (6th Cir. 1974).
50 See also Douglas M. Mancino, Nonexempt Uses of Tax-Exempt Hospital Bonds, 24 J. HEALTH & HOSP. LAW 73, 79-80 (1991).
upon seeing more patients and not upon the revenue of the hospital including departments other than radiology.

Although the previous discussion has focused on compensation for services, it would appear that the same analysis applies to any arrangement under which an insider receives contingent compensation directly from any exempt organization. Thus, the analysis should apply to payments for the use of property or money. In fact, in one recent private letter ruling involving the rental of equipment, the Service has indicated that the protections described above will be required for such payments.

In conclusion, when an individual is entitled to receive, in return for services or the use of property, payments from an exempt organization which are contingent, the payments may constitute inurement because of the possibility that the organization may pay more than fair value for the services rendered or the property used. In order to protect against such possibility, the courts and the Service require the presence of one or more of the following: (1) The amounts paid are dependent upon objectives of the contract and are not solely based on the incoming revenue of the organization, including revenue from activities unrelated to the contract's subject matter; (2) there is a ceiling on the amounts to be paid so as to avoid the possibility of a windfall to the service provider; and (3) the terms of the contract are consistent with others in the trade or industry.

**Disguised Distributions**

Another area of contention between the Service and exempt organizations involves what may be called "disguised" or "hidden distributions." Frequently exempt organizations attempt to argue that they should not be penalized for distributing proceeds in the form of fringe benefits to insiders rather than in the form of salaries, since the fringe benefits, when added to the salary payments,

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2. See infra text accompanying notes 131-42 for a discussion of compensation received by an insider from a partnership in which the exempt organization and insiders are partners.

3. Priv. Ltr. Rul. 90-24-805 (Mar. 22, 1990). In Priv. Ltr. Rul. 90-24-085, a hospital planned to install and operate an MRI system. To secure financing for the system, a limited partnership was created with individuals unaffiliated with the hospital acting as general partners. The limited partners were to be physicians with staff privileges at the hospital. The partnership was to purchase the MRI equipment and lease it to the hospital. During the term of the proposed lease, the hospital was obligated to pay monthly rent denominated as "basic rent." In addition to basic rent, the hospital was obligated to pay amounts designated as "contingent rent." Contingent rent was equal to the lesser of a fixed dollar amount or "adjusted net income" as defined in the lease. Greater use of the MRI system generally would result in a higher adjusted income and therefore a higher contingent rent subject to the annual cap. But, critically, the hospital was not obligated to pay contingent rent out of cash flow from its other operations. Finally, the hospital received the opinion of an independent appraiser that the rental arrangement was fair and reasonable. The letter ruling held that there was no private benefit or private inurement involved in the arrangement due to the fact that the lease was the result of arm's length negotiations, contingent rent was payable only out of cash flow from the system, the amount of contingent rent in any one year was capped, and an expert had reviewed the arrangement and concluded that it was fair and reasonable.
would have been considered reasonable compensation. If, however, such payment is a "disguised dividend or benefit from net earnings, the character of the payment is not changed by the fact that the recipient's salary, if increased by the amount of the distribution or benefit, would still have been reasonable." This should not mean that an organization cannot pay benefits other than fixed salary which, when added to such fixed salary, constitutes reasonable compensation. It also should not mean that there are payments made by an exempt organization in a fair exchange for services or the use of property which by their nature alone constitute inurement so long as such payments have the protections described above. Instead, what the courts mean and what the Service has accepted is that even if a benefit to an insider would constitute reasonable compensation, it is inurement per se if the benefit was not reported as income to the insider before challenge of the subject organization's exemption by the IRS. In fact, the Service has specifically recognized this failure to report as the basis for the "disguised distribution" language: "Note that payment of personal expenses of an insider that the organization does not characterize as compensation at the time of payment may constitute inurement even when, if added to compensation, the total amount of compensation would be reasonable."

GCM 39,862

The Chief Counsel's analysis of the sales of net revenue streams by hospitals demonstrates the Service's continued use of overly restrictive tests and its confusion of issues and doctrines. These malapropisms of tax doctrine are apparent throughout the Chief Counsel's analyses of private inurement, private benefit, and public policy.

Although it is difficult to sort out, the Chief Counsel's analysis of the private inurement aspect of revenue stream sales falls into four parts. First, the Chief Counsel continues to take the outrageous position that all staff physicians of a hospital are subject to the inurement proscription. Physicians generally do not have inside control over hospital policy, but are able to influence the hospital only through their market power. Except where a single small physician group controls substantially all of a hospital's patient revenue, as in Harding Hospital, members of the group should not be viewed as insiders. Even if a physician group might by itself be viewed as "insiders," it is difficult to view a number of

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57 IRM MT 7(10) 69-38 (Mar. 27, 1992).
such groups as limited partners having a single mind-set of collective self-interest sufficient enough to constitute them as insiders. Hospital administrators will readily admit that there is a competitive mind-set, both economically and politically, among practice groups of a large hospital which is sufficient to prevent any one group from exercising "control" and that rarely, if ever, do such groups act in concert. Finally, treating all physicians as insiders is problematic, for if every physician is an "insider," transactions with one hundred or more persons become subject to the inurement proscription where one misstep causes revocation of exemption.

But even if some or all physicians are insiders, the Chief Counsel's conclusions are largely unsupportable. The second part of the Chief Counsel's analysis is the assertion that a transfer of assets to an insider must have a charitable purpose or the transfer constitutes inurement. Since the Chief Counsel did not view the transfer of the revenue streams as having a charitable purpose, he states the transfer gives rise to inurement. 59 Although People of God Community indicated that the contingency upon which contingent compensation is based should be related to the performance of an exempt function, subsequent decisions expressly ruled otherwise. 60 The proper analysis in any contingent payment situation is whether the payment to be made by the exempt organization is dependent upon the amount of consideration provided by the insider rather than merely upon the incoming revenue of the organization. 61

This brings one to the third part of the Chief Counsel's analogy which is that the structure of the transaction itself gives rise to inurement. Apparently, the Service reads People of God Community as requiring that all contingent-based compensation be treated as inurement per se. In postulating this theory, the Chief Counsel first argues that there is no parallel between the radiologist's compensation in Revenue Ruling 69-383 and the sale of the net revenue streams. The reason for this conclusion is that the Chief Counsel's analysis is superficial in that there is no in-depth search for the parallel. Part of the rationale for the acceptance of the contingent-based compensation in Revenue Ruling 69-383 was that the hospital was able to insulate the hospital's earnings in excess of the value of the services received from being paid out to the radiologist. It did this by limiting the percentage arrangement to the hospital's radiology department and by developing a rational basis for determining the value of the radiologist's services relative to that

59 The Chief Counsel states: "This Office has stated 'inurement is likely to arise where the financial benefit represents a transfer of the organization's financial resources to an individual solely by virtue of the individual's relationship with the organization, and without regard to the accomplishment of exempt purposes'... The proper starting point for our analysis of the new revenue stream arrangements is to ask what the hospital gets in return for the benefit conferred on the physician-investors. Put another way, we ask whether and how engaging in the transaction furthers the hospital's exempt purposes. Gen. Couns. Mem. 39,862 at 20-25.
60 See World Family Corp. v. Commissioner, 81 T.C. 958 (1983).
61 See supra text accompanying notes 28-53.
of the hospital's radiology facilities. In effect, the hospital was effectively able to isolate the hospital's other income from the radiology department and pay the radiologist's and the hospital's share of the department's income proportionate to their relative contributions.

It can be argued that the sale of the revenue stream does a more effective job of isolating the physician contributions. This argument can be demonstrated by a rough analogy. Assume that instead of selling the net revenue stream to the hospital-physician partnership, the hospital contributes the outpatient surgery center to the partnership in exchange for a capital interest in the partnership equal to the value of the center's tangible assets and a profits interest consisting of a preferred return and participation in the partnership's profits in excess of the preferred return. The preferred return is a fixed dollar amount payable annually equal to the annual average earnings of the surgery center. In effect the hospital is granted the preferred return in lieu of crediting to its capital account the surgery center's goodwill. Profits remaining after the payment of the preferred return are distributed to the hospital-general partner and the physician-limited partners in accordance with their opening capital accounts. The limited partners make cash contributions to the partnership which are reinvested in refurbishing the center.

At the end of five years, because all profits have been distributed, the partners' capital accounts are the same as their beginning accounts. The hospital and the physicians decide to terminate the partnership. The hospital contributes an amount of cash equal to the limited partners' capital accounts. The limited partners receive such cash in liquidation of their interests. The hospital receives the refurbished center in liquidation of its interest. In this situation the hospital has isolated its current earnings from physician participation through the use of the preferred return. The physicians' contribution (through their investment or increased referrals) is related solely to the generation of earnings in excess of the preferred return. The partnership has developed a rational basis for apportioning such earnings according to the hospital's and the physicians' relative contributions. In effect, the hospital has prevented the diversion of earnings to the physicians without regard to the value of their participation. Thus, the hospital has avoided the problem with contingent payment arrangements specifically described in People of God Community and World Family Corp.

In the revenue stream situations, the hospital has merely sold the goodwill up front rather than take it as a preferred return. In addition, rather than drop the center into the partnership and receive it upon liquidation, the hospital has decided to retain title to the center. Further, the physicians' cash contribution is paid directly to the hospital for use in other health care facilities rather than invested in the surgery center. These are the only differences in the two scenarios. Assuming the valuation of the earnings stream is fair, the hospital has again limited the basis of
the physicians' shares of revenue to amounts having a relationship to their efforts in increasing the utilization of the center. In effect, the physicians have become like the insider fund-raiser in *World Family Corp.* in that the compensation of each is based on the success in raising the revenue of the exempt organization. So long as the physicians' percentages are limited to the relative values of their efforts in increasing utilization of the center, no inurement exists.\(^6\) In brief, the Service should attack the transaction either by challenging the valuation of the goodwill or the relative percentages of the revenue stream accorded the hospital and the physicians; but it cannot attack the transaction on the basis of the structure alone. The transaction does not constitute inurement *per se.*\(^7\)

The Chief Counsel discards the applicability of Revenue Ruling 69-383 on three different grounds. First, the Chief Counsel argues that Revenue Ruling 69-383 has no relevance because the ruling was published prior to a 1980s change in practice in the manner in which radiologists' compensation was determined. Second, the Chief Counsel states that the ruling dealt with compensating the physician with revenues derived from the professional component of the facility's or department's revenue. Since the net revenue stream situation involved solely the facility's component, the Chief Counsel asserts that Revenue Ruling 69-383 has no relevance. Finally, the Chief Counsel asserts that the revenue ruling is inapplicable because it dealt with a compensation agreement rather than a joint venture. Each of these assertions avoids the critical issue of whether the hospital has incurred a significant risk of paying amounts which have no or little relationship to the consideration provided to it, i.e., the referrals. Neither history, nor the source of the revenue, nor the subject matter or structure of the transaction is relevant.

After presenting his reasons for discarding Revenue Ruling 69-383, the Chief Counsel presents his substantive arguments for finding inurement *per se.* These reasons are equally superficial and even more fallacious. First, the Chief Counsel quotes the disguised dividend language of those cases discussed in the immediately preceding section. Those cases held that failure to report a benefit as compensation constitutes a disguised distribution requiring revocation under the inurement doctrine even if such amount would constitute reasonable compensation if properly reported. The Chief Counsel merely quotes the language and asserts that this language supports inurement solely on the basis of structure and without regard to the reasonableness of amount. The Chief Counsel does not, however, explain the factual context of the quote, namely, the failure to report the benefits as

\(^{\text{6}}\) In this regard it should be noted that the physicians are not receiving a percentage based on their capital invested in the Center. Instead their percentage is solely based on their efforts in raising revenue. As such their relative percentage should be less than the physicians of the earlier example. The fund-raiser in *World Family Corp.* received 20% of the revenue he raised.

\(^{\text{7}}\) Admittedly, this view of the transaction involves the recognition that the hospital is paying for physician services in increasing revenue, i.e., it is paying for referrals. As such the transaction may violate federal law but as is indicated herein such recognition means that transaction will be subject to a much more lenient prohibition than the inurement proscription.
compensation. In this respect, the Chief Counsel is being just as deceptive as the organizations in those cases. As is indicated above, the disguised dividend decisions were not based on structure but on failure to report.

Second, without the substantive analysis of the contingent payment arrangement presented here, the Chief Counsel merely asserts that the arrangement is the equivalent of paying dividends on stock. Although this is a compelling proposition, it misses the point. The purpose of the inurement proscription is to prevent the payment of earnings to insiders in amounts exceeding the value of the consideration they provide. As is described herein, exempt organizations may, as general partner, form limited partnerships with insider-limited partners. Certainly, the net profits distributions out of the partnership could be viewed as dividends violating the inurement proscription. But the Service has lost that argument because the limited partners are being compensated for their capital. Assuming the basis for such compensation is rational, no inurement violation has occurred because there has been no diversion of excess earnings to the insiders.

As is pointed out above, it can be persuasively argued that the hospital has limited the ability for such excess earnings to be paid by tying physician compensation to increased revenue. So long as there is a reasonable basis for apportioning the hospital's share of such excess and the share attributable to physicians' efforts, no inurement should occur.

PRIVATE BENEFIT AND EXEMPT PURPOSES

Under Code Section 501(c)(3), an organization must be "operated exclusively" for tax-exempt purposes if its exemption is to be maintained. The regulations provide that (1) an organization will be regarded as "operated exclusively" if it is operated exclusively for a charitable, scientific, religious, educational, or other exempt purpose and that (2) the organization's governing instrument provides that it is operated exclusively for such purposes. See infra text accompanying note 136. There may be a violation of the private benefit or exclusivity doctrines if the hospitals form too many joint ventures with physicians.

The partnership should probably pay to the physicians a percentage of the amount equal to the preferred return equivalent based on their and the hospital's relative capital contributions. However, the remainder should be paid according to a much lower percentage allocable to the physicians than in the subject private rulings. See supra note 62. In addition, if the Service disagreed with the apportionment percentages applied, a cap on the physicians' earnings might be appropriate. See also supra text accompanying note 42.

exclusively" for one or more exempt purposes if it engages in activities which accomplish one or more exempt purposes and (2) an organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of exempt purposes.\(^9\) As a corollary to this substantiality test, the regulations provide that an organization is not operated exclusively for exempt purposes unless it serves a public, rather than private, purpose. To meet this requirement, the regulations require that the organization establish that it is not operated for the benefit of private interests.\(^70\)

The private benefit prohibition can apply in situations under which the private inurement proscription would not apply. Therefore, if there is inurement, there will also be private benefit, but there can be private benefit without there being inurement.\(^71\) The first of the situations in which there can be private benefit but no inurement arises from the fact that the private benefit prohibition applies to everyone, not just insiders.\(^72\) In addition, the private benefit prohibition may apply to benefits provided by an exempt organization even if the organization is fully compensated for such benefit.\(^73\)

The private benefit prohibition is intertwined with and is actually a part of the provisions of the Code and the regulations that an organization must operate "exclusively for exempt purposes,"\(^74\) and that an organization will not be regarded as operating exclusively for exempt purposes if more than an insubstantial part of its activities is not in furtherance of exempt purposes.\(^75\)

The court decisions with regard to this prohibition are confusing as to how the private benefit doctrine is to be applied because the courts have not established a definitive test. The Tax Court itself has frequently admitted the confusion.\(^76\) If any analytical framework can be derived from such cases, it begins with a determination of whether an activity conducted by an organization has no more than an insubstantial nonexempt purpose. In determining whether an activity has a nonexempt purpose, the courts have given several guideposts. First, occasional or incidental private benefits flowing from an activity will not prevent the activity from being deemed in pursuit of exempt purposes.\(^77\) Second, if the persons

\(^71\) American Campaign Academy v. Commissioner, 92 T.C. 1053 (1989).
\(^72\) Id. at 1069.
\(^77\) American Campaign Academy v. Commissioner, 92 T.C. 1053 (1989); Kentucky Bar Found., Inc. v. Commissioner, 78 T.C. 921 (1982).
receiving the private benefit are not part of a "charitable class" and the private benefit is not incidental to the public benefit provided, the activity will be in furtherance of a nonexempt purpose. 78 Third, the determination of whether an activity serves a nonexempt purpose apparently does not necessarily completely hinge upon the activity's serving of private interests more than incidentally. If the activity has a predominately commercial or business hue, it can be deemed to serve a nonexempt purpose even though there is no identifiable non-charitable class of private individuals benefited. 79

Once it has been determined that an activity is in furtherance of a nonexempt purpose because the private benefits provided by such activity are not incidental to its public benefits, one must determine whether the presence of such nonexempt purpose will cause revocation. If an organization has some activities serving exempt purposes and some serving nonexempt purposes, the organization does not necessarily fail the exclusivity test because the regulations recognize and the courts have specifically held that "exclusively" does not mean "solely." 80

However, when faced with situations involving multiple exempt and nonexempt activities, the courts have not set forth a consistent approach for determining when the nonexempt activities will cause the loss of exemption. The regulations apparently require a determination of whether a more than insubstantial part of the total activities are nonexempt. 81 This activity-by-activity approach has at times been adopted by the Tax Court. 82 Under the facts of a 1983 case, ten percent of the organization's expenditures went to nonexempt activities. The Tax Court found such activities to be insubstantial in relation to the organization's exempt activities. 83 In a prior decision, the Tax Court had held that an activity which was nonexempt and which received twenty percent of the organization's expenditures was held to be "more than insubstantial." 84 In both cases, the Tax Court stated that it was not establishing a percentage test and that all relevant facts and circumstances must be examined. 85

78 American Campaign Academy, 92 T.C. 1053; Estate of Hawaii, 71 T.C. 1067; Christian Stewardship Assistance, Inc. v. Commissioner, 70 T.C. 1037 (1978).
83 World Family Corp., 81 T.C. at 967.
84 Church in Boston, 71 T.C. at 108.
85 World Family Corp., 81 T.C. at 967 n.10; Church in Boston, 71 T.C. at 108.
The Tax Court has also applied an overall approach in which the court will not conduct a tally of all activities to see if more than an insubstantial part of them have nonexempt purposes. Instead, the court will consider whether the nonexempt objective component of activities having dual purposes is substantial, and combine such component with other purely nonexempt objectives, to determine whether the nonexempt objectives in the aggregate are substantial.  

The Service appears to believe that the private benefit standard is absolute; that is, if any activity of an organization serves a private benefit more than incidentally, that activity in and of itself will cause revocation. According to the Service, private benefit resulting from a particular activity must be incidental in both a qualitative and a quantitative sense. It will be qualitatively incidental if the benefit to the public cannot be achieved without necessarily benefiting certain private individuals. It will be quantitatively incidental if the private benefit is insubstantial after considering the overall public benefit resulting from the activity. The absolute prohibition of these rulings is inappropriate. While it may be appropriate to determine whether an activity serves a private purpose by applying a test of incidentalness, a finding that the private benefit of an activity is not incidental does not mean that exemption is lost. Instead, the exemption should be lost only if the activity is substantial in relation to the organization's exempt activities, or if the nonexempt component of such activity and the nonexempt components of other activities are in the aggregate substantial.

Charitable Purposes of Exempt Hospitals

As set forth above, an organization's exempt status depends upon whether no more than an insubstantial part of its activities is in furtherance of nonexempt purposes. In the case of a hospital, this rule begs the question of what is as exempt purpose. There are several generic classes of exempt purposes set forth in Internal Revenue Code § 501(c)(3) and the one applicable to hospitals is the broadest: "charitable." The regulations state that the term "charitable" is used in "its generally accepted legal sense," and includes "[r]elief of the poor and distressed or of the underprivileged; . . . lessening of the burdens of Government; and promotion of social welfare . . . ." Although providing health care is not specifically described in either the Code or the regulations as a charitable purpose, the Service has long recognized that organizations providing health care may be

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86 Manning Assoc. v. Commissioner, 93 T.C. 596 (1989); see also Aid to Artisans, Inc. v. Commissioner, 71 T.C. 202 (1978).
89 Manning Assoc., 93 T.C. 596.
exempt if they meet certain other requirements. However, the Service did not set forth specific standards for determining whether hospitals as health care providers qualified for exempt status until 1956. In Revenue Ruling 56-185, the Service set forth a number of requirements the most significant of which was that the hospital "be operated to the extent of its financial ability for those not able to pay for the services rendered . . .". Thus, the Service required that a hospital not only operate on a nonprofit basis but that it also provide more than an insubstantial amount of uncompensated care to be recognized as tax-exempt. The standard of substantial uncompensated care proved vague and difficult to apply.

Developments in the 1960s began to militate against continuing an absolute requirement that hospitals provide a particular amount of uncompensated care. Growing availability of third-party payments for hospital care, including employer provided insurance and government programs such as Medicaid and Medicare, led to a decline in free or subsidized care for the poor as a significant mission of many nonprofit hospitals. Recognizing these developments, in 1969 the Service set forth new standards for exemption. Revenue Ruling 69-545 recognized the general legal principle that promotion of health is itself a charitable purpose and removed the express requirement that hospitals relieve poverty by providing as much uncompensated care as they could afford. In order to qualify as an exempt purpose, the promotion of health purpose was required to satisfy a new standard, the so-called community benefit standard. This standard focuses on a number of factors indicating that the operation of the organization benefits the community. The community benefit standard requires that all relevant facts and circumstances be weighed in each case. Rather than setting forth a list of requirements, the revenue ruling illustrated the application of the standard by way of two hypotheticals.

Hospital A was a private nonprofit community hospital with an open staff policy and a board of trustees composed of prominent citizens of the community. The hospital operated a full-time emergency room with no one needing emergency care being denied treatment. The hospital provided inpatient care to all in the community who were able to pay, either themselves or through third-party reimbursement, including Medicare and Medicaid. However, indigent persons

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96 Id. at 119.
97 See Sound Health Assoc., 71 T.C. at 180; Bromberg, supra note 94, at 248; Mancino, supra note 94, at 1025-26; Sullivan and Moore, supra note 11, at 67.
needing admission as inpatients ordinarily were referred to a public hospital in the area. The hospital usually ended each year with an excess in receipts over disbursements, applying the surplus to expansion and replacement of facilities and equipment, amortization of indebtedness, improvement of patient care and medical training, education, and research. 98

Hospital B was a small facility originally owned by five physicians who sold their interests in the hospital to a nonprofit corporation for fair market value. The new hospital's trustees continued to be predominantly the same physicians. Only four other physicians were granted staff privileges in the new hospital's first five years of existence, although a number of qualified physicians applied. Admission to the hospital was restricted to patients of the staff physicians and ordinarily was limited to those able to pay. Although the hospital operated an emergency room (primarily for patients of its staff physicians), local ambulance services were instructed to take emergency cases to other hospitals in the area. In addition, the founding five doctors were permitted to lease office space in the building at below market rates. 99

The Service began its analysis of the two hypotheticals by accepting the proposition that the promotion of health is, in and of itself, a charitable purpose. According to the Service, the charitable purpose is served even though certain members of the community, such as indigent patients, are excluded from the class served by the exempt entity, so long as the class served is "not so small that its relief is not of benefit to the community." 100 Hospital A's operation of an emergency room open to all and its provision of hospital care for all those able to pay either themselves or through third parties allowed the Service to conclude that it promoted the health of a class or persons broad enough to benefit the community as a whole. 101 Thus, the Service held that Hospital A was exempt under I.R.C. § 501(c)(3). 102

In analyzing Hospital B's situation, the Service shifted its focus to private benefit. In contrast to Hospital A, which had a board of directors composed of independent civic leaders, an open medical staff, and an active, open emergency room, Hospital B had a board of trustees dominated by five physicians, a closed medical staff, rental agreements with and favorable to its physician board members, and emergency room care and hospital admissions substantially limited to the physicians' paying patients. Accordingly, the Service held that Hospital B did not qualify for exemption under I.R.C. § 501(c)(3).

99 Id.
100 Id. at 118.
101 Id.
102 Id.
In 1969, the Service issued two other rulings which recognized the changed economic atmosphere in which nonprofit hospitals operated. In Revenue Ruling 69-464, a hospital built an adjacent office building for doctors in order to encourage members of its medical staff to maintain their practices near the hospital. According to the ruling, the hospital established that (1) as a result of having members of its medical staff in offices adjacent to the hospital, there was a **greater use and fuller utilization of the hospital's diagnostic facilities** and easier patient admissions, and (2) the physical presence of the members of the medical staff on the hospital's grounds made the services of these doctors more readily available for outpatient and inpatient emergencies, facilitated carrying out their every day medical duties in the hospital, made their attendance at staff meetings easier, and served to increase their participation in the hospital's medical education and research programs. The ruling noted that while these leasing arrangements were also a convenience to the lessees, many of the benefits were passed on to the hospital and its patients in the form of **greater efficiency and better overall medical care**. The Service stated that these benefits derived by the hospital and its patients indicated that such leases were entered into primarily for purposes that were substantially related to the performance of hospital functions.

In Revenue Ruling 69-463, a hospital, through arm's length bargaining, leased nearby office space to a physician group. Because of its physical proximity to the hospital, the group was able to serve the outpatient needs of the hospital's patients and essentially functioned as the outpatient department of the hospital. The Service in its ruling stated:

The hospital has established that the presence of the group practice at the hospital has the effect of (1) reducing hospital admissions, days of stay and surgical rates; (2) permitting **more efficient use of existing facilities;** (3) **making more effective use of scarce health manpower;** (4) fulfilling the hospital's role as the health center of the community; (5) fixing administrative responsibility in a single group; and (6) making more effective use of the hospital facilities for training purposes.

The Service held that the lease and the relationship with the physician group were substantially related to the carrying on of the hospital's exempt function.

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104 Id. (emphasis added).
105 Id. (emphasis added).
106 Id.
108 Id. (emphasis added).
109 Id.
These 1969 revenue rulings indicated that the Service had come to accept that the primary distinction between for profit and exempt nonprofit hospitals was not in the nature of their operations but in the use of their proceeds. This was reflected in the fact that the 1969 rulings recognized that an exempt hospital could make a profit so long as it was invested in the replacement or expansion of facilities rather than distributed to private parties\(^\text{110}\) and that a hospital could be operating in furtherance of its exempt purposes by attempting to maximize profits through fuller utilization of its facilities.\(^\text{111}\) Thus, the rulings indicated a theoretical abandonment of any argument that an activity of a health care provider serves a nonexempt purpose because of a predominantly commercial hue\(^\text{112}\) and focused instead on private benefit or inurement as the central issue in determining qualification of a health care provider for exemption.\(^\text{113}\)

With this acceptance of competitive health care as a charitable purpose, the Service's litigation positions and rulings, both published and unpublished, with respect to the application of the private benefit/inurement doctrines to health care entities have not been consistent with their historical development.\(^\text{114}\) As stated earlier, the Chief Counsel has issued GCMs espousing principles contrary to established precedent such as treating all physicians as insiders and in effect treating any nonexempt activity characterized by private benefit as grounds for revocation.\(^\text{115}\) The Service's attempt to reach commercial practices of health care entities by expanding private benefit/inurement rather than attacking the commercial purposes of the entities' operation had, with one exception prior to the issuance of GCM 39,862, primarily focused on non-hospital entities.\(^\text{116}\) The concepts of inurement and, for the most part, private benefit traditionally have involved a diversion of an exempt organization's assets to or for the benefit of private individuals. However, beginning with the *Harding Hospital* case,\(^\text{117}\) the Service litigated several cases in an attempt to expand the private inurement and private benefit doctrines.\(^\text{118}\)

\(^\text{112}\) *See supra* note 74.  
\(^\text{113}\) *See Colombo, supra* note 94, at 480. *See also* Rev. Rul. 83-157, 1983-2 C.B. 94 (The Service declared exempt a hospital which did not have an open emergency room because state health authorities had declared that the operation of an emergency room would unnecessarily duplicate existing facilities provided elsewhere in the community. The Service noted that an entity, such as a specialized hospital, does not need an open emergency room and instead can rely on other indicia of public service such as a board of directors drawn from the community, an open staff policy, treatment of medicare/medicaid patients and the application of surplus funds for such things as improved facilities and equipment). *Cf* County Bd. of Equalization v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985) (State court noted that hospitals exempt from federal income tax have no relevant distinctions from for-profit hospitals).  
\(^\text{114}\) *Colombo, supra* note 94 at 482.  
\(^\text{115}\) *See supra* text accompanying notes 11 and 12.  
\(^\text{116}\) *Colombo, supra* note 94, at 482.  
\(^\text{117}\) *Harding Hosp., Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1974).  
\(^\text{118}\) *Colombo, supra* note 94, at 485.
In *Harding*, the Sixth Circuit ruled in favor of revocation of exemption because the court could not conclude that the hospital was organized and operated exclusively for exempt purposes or that no part of its net earnings inured to the benefit of private individuals. In reaching its conclusion, the court relied on a number of factors, none of which was viewed by the court as conclusive. The case is notable not so much for the factors relied upon by the court but for the factors asserted by the Service that were rejected. The Service argued that the hospital's exemption should be revoked because had the hospital's facilities not been available to the physician group, the group would not have been able to practice its special type of psychiatric therapy. Second, the Service contended that the hospital's special type of treatment acted as a de facto limitation on the staff of the hospital.

These arguments' implication that private benefit or private inurement exists simply because the doctors needed a hospital in which to practice indicates the lengths to which the Service will go to extend these concepts. In the Service's mind, the commercial needs of a specialized hospital to have specialized physicians became a reason for applying the private benefit doctrine.

The Service's attempt to classify the newfound commercialism allowed by the 1969 rulings as private benefit inurement was even more obvious in three non-hospital cases litigated in the 1970s and early 1980s. In each case, the Service denied a § 501(c)(3) exemption for a practice group of physicians associated with a medical school hospital. The last of these decisions, *University of Maryland Physicians, P.A.*, accurately reflects the Tax Court's rejection of the Service's arguments in each case. In *Maryland Physicians*, the subject organization was the incorporation of the University of Maryland Medical School's cardiology, nephrology, pulmonary diseases, and nuclear medicine departments. All physicians who were part of these departments were employees of the subject organization. Substantially all of the organization's financial support came from fees for medical care performed by the physicians at the University hospital. The fees collected were paid out first for the overhead costs of the practice, second to supplement each faculty member's Medical School salary, and the remainder was apportioned between the Medical School and bonuses set aside for faculty members.

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119 *Harding Hosp., Inc.*, 505 F. 2d at 1077.
120 *Id.* at 1076. The therapy was a nontraditional psychiatric therapy called "Milieu therapy."
121 *Id.*
123 *University of Md. Physicians, 41 T.C.M. (CCH) 732 (1981).*
124 *Id.*
125 *Id.* Approximately 25% of the billable value of the services performed by the physicians was rendered to patients who were unable to pay and were not required to pay for such services.
The Service argued that the organization was merely a billing entity serving the private interests of the physician employees. The Tax Court, as in the previous two cases, rejected this conversion of a commercialism argument, now bankrupt in precedent, into a private benefit one:

[R]espondent's argument that petitioner is primarily a billing entity really proves nothing at all. It is true one of the petitioner's functions is to collect fees from patients and their insurers. However, there is nothing inherently commercial about billing as such. The Hospital, the Medical School and the University each bill for the services they provide, but this has little bearing on whether or not they are operated for profit . . . The relevant inquiry concerns how the money is raised and how it is spent.\footnote{126}

The Court held that the money raised was spent for the provision of health care in that there was no inappropriate diversion of earnings or assets to the private benefit of the physicians. Since the money was raised through the provision of health care and since excess earnings were reinvested in the provision of health care, the fact that the organization performed a commercial activity (i.e., billing and collection) necessary to both is irrelevant. Despite these losses, the Service continued to allege that billing and collection activities incidental to the provision of health care by non-hospital organizations lead to improper private benefit.\footnote{127} In GCM 39,862 the Service has extended this bankrupt commercialism argument in the guise of private benefit to attempts by hospitals to increase health services revenue.\footnote{128}

\textit{Participation In Joint Ventures}

Prior to 1980, the Service took the position that the mere entering into a partnership as general partner was sufficient cause to revoke an organization's exemption.\footnote{129} It was unclear, however, whether the Service viewed such transactions inurement \textit{per se} or whether it took the position that the private benefit inherent in the transaction was always sufficient to require revocation.\footnote{130}
The Service contended in *Plumstead Theatre Society, Inc.*\(^{131}\) that entering into a joint venture constituted inurement per se. This contention as well as others advanced by the Service were disregarded by the Tax Court and the Ninth Circuit Court of Appeals.\(^{132}\)

In *Plumstead*, the subject organization was a nonprofit corporation formed to promote and foster the performing arts, particularly by presenting professional productions of the classical theatre, both ancient and contemporary, performing workshops for playwrights, and establishing a fund to assist new and established playwrights in writing new plays for the organization to produce. In October of 1977, the Service issued a tentative adverse ruling letter to the organization holding it had a substantial commercial purpose evidenced by the fact that locales for its plays were only in cities where there could be guarantees of subscriptions and that only paid professionals (actors, directors, etc.) were to be used.\(^{133}\) After the protest was filed, the organization had difficulty raising capital for its first production. Working under time constraints imposed by the Kennedy Center, the organization, as general partner, entered into a limited partnership arrangement with a corporation and two individuals, none of which were insiders or related to insiders. The organization contributed its rights to the play and the other partners contributed cash in exchange for their respective share of profits and losses arising from the production.

On the basis of the continuing commerciality and the newly formed partnership, the Service issued a final adverse ruling to the organization on July 31, 1978. The ruling alleged three grounds: (1) The organization was a commercial theatre organization and accordingly was not operated for substantially charitable purposes; (2) the arrangement providing for the partnership served to promote the interests of the limited partners, contrary to the regulations; and (3) the earnings of the organization inured to the benefit of private individuals as shareholders.\(^{134}\) The Tax Court and the Ninth Circuit rejected all of these arguments.\(^{135}\)

The Tax Court and Ninth Circuit opinions provided the following guiding principles:

\(^{131}\) *Plumstead Theatre Soc'y*, Inc. v. Commissioner, 74 T.C. 1324 (1980), *aff'd*, 675 F.2d 244 (9th Cir. 1982).

\(^{132}\) Id.


\(^{134}\) Opening Br. of Commissioner, *supra* note 133, at 20. *See Plumstead Theatre Soc'y*, 74 T.C. at 1328 n. 3.

\(^{135}\) *Plumstead Theatre Soc'y*, 74 T.C. 1324 (1980), *aff'd*, 675 F.2d 244 (9th Cir. 1982) .
(1) The charity must control its own operations without regard to the contractual or other opportunities provided the other partners by the partnership;

(2) The other partners' role may only be with respect to the specific project in the partnership and no profit may accrue to the other partners outside the project from other money-making programs of the charity;

(3) The other partners should not be officers or directors of the exempt organization so as to be on both sides of the same transaction, creating a conflict of interest and requiring further evaluation of the bona fides of the arrangement;

(4) The value of the ownership interests in the partnership of partners (including a share in profits or losses) must not be disproportionate to the value of their contributions in exchange therefor;

(5) The partnership agreement has specific protections and reservations with respect to the degree of involvement in the general operations of the charity of other partners;\(^\text{136}\)

(6) The entering into a single joint venture one or more of whose purposes are nonexempt does not require revocation of the organization's exemption, but instead one must examine all of the organization's activities and purposes to determine whether the organization violates the exclusivity test;\(^\text{137}\)

(7) The purpose of the joint venture may be an exempt one even though it possesses a commercial hue.\(^\text{138}\)

Soon after *Plumstead*, the Service recognized that, with its ever expanding view of who constituted an insider, it could not prohibit insiders from becoming partners in joint ventures with exempt organizations. In GCM 39,444, the Chief Counsel addressed the noneconomic role of insiders in partnerships.\(^\text{139}\) The Chief Counsel found that there was no absolute prohibition on insiders' of the exempt general partner being limited partners as long as there are constraints in the arrangement which assures that the partnership acts for exempt purposes.

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\(^{137}\) *Plumstead Theatre Soc'y*, 74 T.C. at 1333-34.

\(^{138}\) *Id*.

With the elimination of any absolute prohibition on the participation in partnerships by insiders, the Service has synthesized the Plumstead guidelines set forth above into a three-prong test. The Service holds that

the initial focus should be on [(1)] whether the partnership is serving a charitable purpose. Once a charitable purpose is established, the partnership . . . should be examined [not only (2)] to assure that the arrangement permits the exempt organization to act primarily in furtherance of exempt purposes . . . [but also to determine (3) whether] the benefits received by the private investors are incidental to the public purposes served by the partnership and whether the return which the investors may earn is reasonable considering the amount of their investment, its duration and the degree of risk. 140

As to what constitutes a charitable purpose for a partnership with physicians, the author has found several rulings, other than those discussed in GCM 39,862 which have specifically recognized the newfound commercialism of the 1969 rulings as an appropriate charitable purpose. In each of these rulings the hospital transferred an existing outpatient surgery center, and in one case an entire hospital facility, to a limited partnership between the hospital or its affiliate as general partner and its staff physicians as limited partners. In each ruling, the Service has recognized one or more of the following rationales as sufficient bases to hold that the transfer and partnership involvement by the hospital were in furtherance of its exempt purposes: (1) retention of existing staff physicians who might otherwise be recruited by other hospitals; (2) the attraction of new physicians; (3) increase of the hospital's efficiency through fuller utilization of existing facilities; (4) increased usage of the facility by providing physicians an opportunity to acquire an equity interest in the facility; (5) increased hospital cash flow because of greater utilization of the transferred facility; (6) retention of the hospital's current market share of services in order to support expanded services; (7) discouraging the construction of physician-owned facilities which could reduce utilization of hospital facilities; and (8) encouragement of physicians to maintain their current level of admissions of patients requiring inpatient care at the hospital. 141

These rulings illustrate the commercial reality of hospitals. In order for hospitals to provide improved health care in an increasingly more technical medical world, they must increase and retain their revenue shares. In order to do so they

must maintain relationships with physicians so that those physicians' patients will continue to provide revenue for the hospital. This so-called physician bonding is the flip side of billing and collection which has been specifically recognized as an activity substantially related to the promotion of health.\textsuperscript{142} In order to reinvest patient revenues into improve health care, health care providers must collect these revenues. Correspondingly, in order to provide improved health care, hospitals must create patient revenue. Both the collection and the creation may have commercial hues but their purpose is substantially related to the promotion of health.

With regard to the second part of the test, the protections regarding control of the exempt organization's participation by insiders described in GCM 39,444 assure that the first part of the text (i.e., charitable purpose) will continue to be satisfied.

The third part of the test is the Service's qualitative-quantitative analysis for determining private benefit. The third part is significant in that it does not reflect an inurement analysis once the partnership venture is operational. This absence aligns with the fact that two of the Plumstead guidelines were that (1) no profits accrue to the private partners outside the partnership's activities from other money-making programs of the charity and (2) the value of all partners' ownership interests in the partnership must not be disproportionate to the value of their contributions in exchange therefor.

Apparently, the Tax Court and the Sixth Circuit believed and the IRS has accepted the view that only the private benefit doctrine should apply to the allocation of profits in partnerships between exempt organizations and insiders. The rationale for this view is probably that such partnerships, unlike contingent compensation or contingent rent do not involve the direct diversion of the exempt organization's earnings to the insider but instead involve merely the indirect use of such assets through the partnership. A direct division of earnings would occur only if the value of the private parties' contribution upon admission to the partnership are obviously less than the value of the partnership interests they have received.

\textit{GCM 39,862}

As the discussion above reveals, there are two possible reasons for concluding that the inurement doctrine is inapplicable to the net revenue stream sales. First, the physicians might not be insiders. Second, the transaction does not involve the direct transfer of the hospital's earnings but instead constitutes merely

\textsuperscript{142} See \textit{supra} note 122.
the usage of the hospital's assets by the hospital-physician partnerships. As has been indicated by the Service and the courts, such usage may only be subject to the private benefit prohibition. 143

Recall the two examples provided in the inurement discussion. In the first example, the hospital transferred its existing outpatient surgery center into the partnership in exchange for a capital interest equal to the value of the center's tangible assets and a profits interest consisting of a preferred return and participation in the excess earnings. The hospital shares in such excess with the physicians on the basis of their relative capital contributions. The distribution of such excess earnings can be viewed as constituting merely the equitable usage of the capital by the parties. If the hospital received a lesser share of such excess, it could be argued that there is no direct diversion of earnings since the preferred return compensates the hospital for present earnings. Instead, there is only an inequitable usage of capital. Similarly, the up-front payment of fair value for the revenue stream may avoid direct diversion of earnings. In such case, the excess earnings allocation becomes a question of whether the usage of the capital contributed by the hospital and the usage of physician referral services are apportioned equitably. If they are apportioned equitably, it is unlikely that the application of the private benefit doctrine would cause revocation of exemption. If they are not apportioned equitably, the application of the doctrine may cause revocation.

As to the application of the doctrine, the Chief Counsel's analysis continues two gross misapplications even though the conclusion he reaches is likely correct. First, the Chief Counsel now states absolutely rather than by implication that "even though exemption of the entire organization may be at stake, the private benefit conferred by an activity is balanced only against the public benefit conferred by that activity or arrangement, not the overall good accomplished by the organization." 144 As stated earlier, the private benefit doctrine is part of the exclusivity test, whose application was described by the Tax Court in American Campaign Academy, 145 as follows:

[S]hould [the organization] be shown to benefit private interests, it will be deemed to further a non-exempt purpose . . . This non-exempt purpose will prevent [the organization] from operating primarily for exempt purposes absent a showing that no more than

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143 See supra text accompanying notes 140 to 142. See also Sonora Community Hosp. v. Commissioner, 46 T.C. 519 (1966) (An independent laboratory used hospital space rent free and directed one third of the profits from the lab to the hospital's controlling physicians. The Tax Court held the hospital was not operated exclusively for exempt purposes presumably on the basis of the private benefit to the physicians).
an insubstantial part of its activities further the private interests or any other non-exempt purposes.146

Even though the court may conduct an examination of the exempt organization's purposes rather than its activities, in applying the exclusivity test, the court will still examine the activities of the organization as a whole to determine whether the nonexempt objectives of the organization are substantial.147

The Chief Counsel also continues the Service's attempts to restrict the commercial aspects of exempt hospitals' operations. As noted earlier, frequently when the Service sees a method of operation of an exempt health care entity which resembles that of for profit counterparts it asserts that the organization is not operated for exempt purposes. Since 1969, the Service has substantially recognized that the major distinction between exempt hospitals and their for profit counterparts is that an exempt hospital's net revenue is reinvested in expanding health care services. In GCM 39,862, the Chief Counsel recognizes this fact but does not carry it to its logical conclusion. The GCM implies that only the reinvestment is a charitable purpose by emphasizing only the following as charitable purposes: (1) creation of a new provider; (2) expansion of health care resources; (3) improvement in treatment modalities; (4) reduction in health care costs; and (5) improved patient convenience and access to physicians.

However, in order to raise the revenue for reinvestment the hospital must maintain its financial health and increase its market share. The Chief Counsel concludes that increasing market share or maintaining financial health by bonding with physicians does not constitute a charitable purpose. This conclusion makes no rational sense. Although such a purpose may not carry as much weight to be balanced against the benefit to private physicians as the creation of a new provider, it should constitute a charitable purpose. In essence, the Chief Counsel is questioning the transfer of any activity of an exempt hospital to a partnership in order to create the increased revenue necessary to maintain the activity. This questioning goes against many of the Service's previous rulings and the holding of Plumstead, which held that the theater society therein could transfer an existing play in order to maintain the play's financial health. In addition to his denying of the Plumstead rationale and all of the other cases recognizing that in the health care arena the raising and collecting of revenue cannot be separated from its reinvestment, the Chief Counsel specifically disavows attracting business as an important basis for Revenue Ruling 69-464. In doing so, the Service continues its denial of the relationship between the commercial side of health care and the exempt purpose of investing in health care facilities.

146 *Id.* at 1066.
The GCM 39,862 concludes that the limited partners received a substantial benefit from the transactions and implies that such benefit exceeded the value of their contributions. Although the Chief Counsel's feelings as to the countervailing weight to be afforded the hospitals' financial health purposes are probably misguided, his belief that the financial benefits afforded the physicians were substantial has merit. In two of the rulings the limited partners acquired fifty percent of the partnership's profits and in the third ruling ninety percent. The hospital or an affiliate acquired the remaining interest in profits or losses. It is assumed that the partners made cash capital contributions in proportion to their percentage interests and that such cash was used to pay for the revenue stream. The revenue stream purchase was based on the assumption that the previous level of earnings produced by the ambulatory surgery center could continue. To apportion this amount of earnings produced according to relative contributions toward the purchase price is appropriate assuming the discount rate and other actuarial assumptions used were appropriate.

However, as was pointed out earlier, earnings beyond the previous or assumed level are attributable to two factors: (1) increased usage of the hospital's facility and (2) increased physician efforts at increasing revenues, for example, by referrals. In apportioning these increased earnings, it would be difficult for the hospital to argue that the relative value of referrals to the increases was ninety or even fifty percent. The insider fund-raiser in World Family Corp. was limited to a twenty percent commission. A similar or lesser percentage for the physicians in the earnings in excess of the assumed stream would seem more in line with analogous contingent compensation situations. Because the percentages were alternatively fifty or ninety percent, the physicians most likely received an impermissible private benefit in their usage of hospital facilities. Given the magnitude of the excess percentage afforded them, it appears reasonable for the Service to have found that the private benefit did not outweigh the exempt purposes served. The Chief Counsel would not recognize specifically such an analogy but implied its use when he emphasized that the earnings streams' values were computed on the assumption that increased physician referrals would not occur.

Of course, because of Medicare-Medicaid fraud, hospitals are not willing to classify an apportionment of earnings as payment for referrals. Thus, the hospitals in the net revenue stream rulings urged that the revenue stream sales were analogous to loans. It is true that the net revenue stream payments up to the amount of the assumed earnings are roughly analogous to the payment of principal

149 The fund-raisers in National Found., Inc. v. United States, 87-2 U.S.T.C. 89,827 (CCH) ¶ 9602 (Ct. Cl. 1987), received commissions ranging between three and six percent of funds raised.
plus interest at the rate used in discounting the value of the stream. However, the payment of the excess earnings could only be viewed as an "equity kicker." Such equity kickers are not totally unusual in commercial financing. However, to grant an equity kicker equal to ninety or even fifty percent of profits would go far beyond reasonable. Accordingly, the Chief Counsel's rejection of the hospital's arm's length financing technique analogy is proper. This, plus the discussion set forth above as to the disproportionate compensation for referrals, probably allowed the Chief Counsel to conclude that the transaction risked revocation. However, this does not mean that appropriate transfers of existing capabilities to or the creation of new capabilities in a partnership with physicians cannot have as a basis for the transfer or creation the maintenance of the hospital's financial health or an increase in its market share.

VIOLATION OF PUBLIC POLICY

Since the early 1970's, the Service has taken the position that an organization whose activities violate public policy cannot be tax exempt. In two published rulings, the Service held that independent private schools and churches which operated schools that did not have a racially nondiscriminatory policy as to students could not qualify as exempt under I.R.C. § 501(c)(3). The Service based its rulings on the common law principle that all charitable trusts, educational or otherwise, are subject to the requirement that the purpose of the trust may not be illegal or contrary to public policy. In these rulings, the Service did not determine whether a single non-substantial purpose of the organization which was illegal would disqualify the organization for the exemption. In one subsequently published ruling, the Service had the opportunity to make such a determination but failed to do so.

In contrast to the published rulings, an early GCM stated that if illegal acts were a substantial part of an organization's activities, it would not qualify for exemption. The Service in this ruling stated:

To determine when disqualifying activities . . . become "substantial" . . . more must be considered than the ratio they bear to activities in furtherance of exempt purposes. The quality of such acts are as important as their quantity. A great many violations of local pollution regulations relating to a sizable percentage of an organization's operations would be required to disqualify it from

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501(c)(3) exemption. Yet, if only .01% of its activities were directed to robbing banks, it would not be exempt. This is an example of an act having a substantial non-exempt quality, while lacking substantiality of amount. A very little planned violence or terrorism would constitute "substantial" activities not in furtherance of exempt purposes.\textsuperscript{156}

This GCM indicates that the Service, with regard to this public policy doctrine and its relationship to the exclusivity test, will employ an overall approach rather than an activity-by-activity tally.\textsuperscript{157}

The courts have not indicated what type of approach they will take. The single most important case in this area was \textit{Bob Jones University v. United States}.\textsuperscript{158} The issue in \textit{Bob Jones} was whether the IRS could refuse exemption to a private school either having racially discriminatory admission policies or maintaining a racially discriminatory code of conduct for students. The Supreme Court concluded that the service had such authority.

Although the Court's opinion seemed to imply that one illegal activity no matter how substantial or insubstantial violates an organization's exemption, the Court's opinion stated in a footnote:

\begin{quote}
In view of our conclusion that racially discriminatory private schools violate fundamental public policy and cannot be deemed to confer a benefit on the public, we need not decide whether an organization providing a public benefit and otherwise meeting the requirements of § 501(c)(3) could nevertheless be denied tax-exempt status if certain of its activities violated a law or public policy.\textsuperscript{159}
\end{quote}

Therefore, as with the general exclusivity test, there is no real indication from the Service or the courts as to whether revocation of exemption requires that a substantial portion of the organization's activities violate public policy or whether one isolated activity with substantial nonexempt purposes due to its violation of public policy constitutes sufficient reason for denial of exempt status.

\textit{GCM 39,862}

Although the Chief Counsel believed that the subject transactions violated public policy, he was unwilling to assert the violation as an absolute basis for his
ruling. There are two alternative reasons for such action. First, the application of
the public policy doctrine as to the number or magnitude of violations causing
revocation is ill defined. In this regard, the Service covered at length the law
discussed above and the Chief Counsel essentially reaches this conclusion.
Second, and the more likely basis, is that what constitutes a violation has not been
defined.

The Medicare and Medicaid Anti-Fraud and Abuse Law

The public policy at issue is contained in a portion of the Social Security Act
called the Medicare and Medicaid Anti-Fraud and Abuse Law and is commonly
referred to as the "anti-kickback" statute. This law prohibits the knowing and
willful offer, solicitation, payment, or receipt of any remuneration, in cash or in
kind, in return for or to induce the referral of a patient for any service that may be
paid for by Medicare or Medicaid. 160 Nearly every exempt hospital participates in
the Medicare and Medicaid programs and is therefore subject to the prohibition.

The Department of Justice and the Office of Inspector General ("OIG") of
the U.S. Department of Health and Human Services ("HHS") share responsibility
for enforcing the anti-kickback statute. Both agencies have agreed that neither has
authority to issue advisory opinions regarding the statute and the OIG has stated
that the requirement of scienter in the statute would make meaningful advisory
opinions almost impossible. 161 In addition, there have been few court or
administrative decisions interpreting the statute. 162 Finally, unlike the situation of a
school which adopts a discriminatory admission policy, a hospital is highly
unlikely to state expressly that referrals are a basis for its entering into a
partnership. Thus, the public policy doctrine is difficult, if not impossible, to apply
without an expression of a violation by the agencies responsible for the policy's
application. Accordingly, the Chief Counsel refused to issue an opinion as to
whether the statute had been violated and thus, although he believed that a violation
had occurred, refused to recommend revocation on that basis. Nevertheless, his
discussion of the anti-kickback statute provides an illustrative backdrop to his
inurement and private benefit decisions.

As is pointed out in the GCM, the ownership of almost any interest in a joint
venture gives the owner an incentive to refer business to that entity. The question
is at what point does the distribution of profits to a physician-owner constitute a
payment to induce such referral. In order to help identify these situations where

162 See, e.g., United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Bay State
Ambulance and Hosp. Rental Serv., Inc., 874 F.2d 20 (lst Cir. 1989); United States v. Greber, 760 F.2d 68
the intent may be present, the OIG released a "Special Fraud Alert--Joint Venture Arrangements" in 1989. There are three factors indicating a joint venture may be suspect: (1) Investors are admitted or terminated as partners based on their ability to make referrals; (2) the venture is merely a shell, that is, one party is already involved in the activity that is the subject of the venture and continues to undertake most or all of the activity; and (3) the amount of capital invested by the physicians may be disproportionately small and the returns on investment disproportionately large. In addition, the HHS Departmental Appeals Board (the "DAB") has stated in one famous decision that "in the ownership setting, an illegal inducement may consist of an opportunity to earn money on an investment, if a non-incident purpose of providing that opportunity is to induce referrals" and that remuneration offered or paid which exceeds the reasonable value of any investment made is likely intended as an inducement for referrals. 163

CONCLUSION

These pronouncements by the OIG and HHS have had a very strong influence on the Chief Counsel's inurement and private benefit assertions. First, the Chief Counsel is determined to make the payment for referrals, whether directly or indirectly through a joint venture, a violation of the inurement proscription. He does this by holding that the apportionment of any venture's earnings, not only as explicit but also as implicit compensation for referrals, is inurement per se. Thus, the Chief Counsel has apparently concluded that remuneration to a physician which may exceed the value of his investment is inurement per se and causes revocation. As was discussed herein, this conclusion is wrong. Furthermore, it is much bolder than the DAB's conclusion that remuneration to a physician which actually exceeds the value of his investment is likely intended as an inducement for referrals. In effect, the Chief Counsel's inurement analysis is an effort by him to be the strong arm for HHS and the OIG, a role which he himself admits is inappropriate. Yet if the Chief Counsel were to rely on the public policy doctrine for support, he realizes that his argument would be subject to a balancing of activities and purposes to determine whether the particular violation is substantial enough to require revocation. This is a task he is apparently unwilling to take on as is pointed out in the GCM:

The harmful effects of selling the net revenue stream from just one department may appear limited, but once the first such transactions gain approval, they might be difficult to contain. It could prove difficult to establish a distinction between syndicating the revenue stream from 4 percent of a hospital's activities and 49 percent. 164

163 Hanlester Network, HHS departmental Appeals Board Dec. No. 1275 at 37, 55.
Like it or not, the application of an uncertain substantiality test is what is required of the Service and a hospital's tax advisors. If this uncertainty makes tax planning and tax administration cumbersome, the proper solution is for Congress to create a more definitive test as it has in the tax-exempt lobbying area or to create lesser sanctions as it has with respect to private foundations.

The OIG and HHS pronouncements also significantly influence the Chief Counsel's private benefit analysis. Here again, the Chief Counsel attempts to align the anti-kickback statute with tax doctrine by avoiding any required balancing of exempt and nonexempt purposes. The Chief Counsel attempts to remove the required balancing of the private benefit standard by stating that a hospital's encouraging of fuller utilization of its facilities cannot be an exempt purpose. If the Chief Counsel is successful in this assertion, then the transfer of an existing facility to a hospital-physician joint venture will likely never satisfy the requirement that the private benefit be incidental to the public benefit conferred by the activity because there will be no exempt purpose to balance against the private benefit to the physician-investors. The Chief Counsel's longstanding but incorrect second position that any activity having a substantial private benefit causes revocation of tax-exempt status will then mean that any such transfer will cause revocation. This absolutism is much bolder than the HHS and the OIG's position that the existing involvement of one party in the activity that is the subject of the venture, coupled with that person's continued undertaking of most or all of the activity, may violate the anti-kickback statute. Again, by stretching a tax doctrine unrelated to the anti-kickback statute, the Chief Counsel is attempting to be the strong arm for HHS and the OIG. It is also bolder than the DAB's pronouncement that an illegal inducement may consist of an opportunity to earn money on an investment if a non-incidental purpose of providing the opportunity is to induce referrals.

Using the private benefit doctrine as a mechanism to enforce the anti-kickback statute is just as inappropriate as so using private inurement. The Chief Counsel's attempt to align exempt purposes and purposes permissible under the anti-kickback statute is clearly overkill. Hospitals clearly may engage in conduct which is primarily intended to maintain their financial health. Such conduct in and of itself has an exempt purpose. If this conduct violates public policy, the proper analysis is under the public policy doctrine. The private benefit doctrine's application solely relates to whether such exempt purpose is counterbalanced by a private purpose. The Chief Counsel's fear that a majority of a hospital's activities would be conducted in joint ventures is misplaced. If this were to occur, it is likely that the exclusivity test and the holding of Plumstead would require revocation.

In the cases which were the subject of the ruling, the private benefit was clearly overwhelming. If tax advisors desire to attack some of the less defensible positions of the GCM, they should keep in mind the pitfalls of being too greedy. Inevitably, some hospitals will feel compelled to transfer an existing facility into joint ventures with physicians in order to increase that facility's utilization. In doing so, tax advisors should keep several things in mind.

First, the entire facility should be transferred, not just the revenue stream. Although the author believes such a transfer could be structured to avoid inurement and private benefit, similar benefits to the hospital can be received by transferring the entire physical facility since transfer of the entire facility may avoid a confrontation with the Service.

Second, the physician's capital should be invested in the facility, either in new additions or the refurbishing of the existing facility. This will allow the hospital to present as an exempt purpose for the transfer a new or better equipped provider. This gives the Service the opportunity to rule on this ground rather than face the disfavored purpose of increased utilization.

Third, a less obvious lesson can be learned from the discussion herein. It may be advisable for the hospital to be given some credit for the value of its existing revenue stream, i.e., its goodwill in the facility. As is demonstrated herein, a major functional problem with the transactions described in the GCM was that the physicians received benefits from both the current level of earnings and future increases in earnings. This was true even though their investment was based solely on current earnings. Accordingly, practitioners may want to credit goodwill to the hospital's capital account. In such case, all profits could be allocated in accordance with contributed capital. Alternatively, the hospital could be granted a preferred return roughly equal to the current average earnings. In such case, earnings in excess of the preferred return would be apportioned in accordance with tangible property contributed. In the latter situation, the preferred return may provide justification for granting the physician-investors a percentage of the excess earnings greater than their relative capital contributions. In effect, this would grant them an increased benefit from increased usage. Again, the key here is not to be too greedy so as to possibly subject the venture to violation of the anti-kickback statute or the private benefit doctrine.

If such avarice can be avoided and if the amount of hospital activity in joint ventures is limited, it is the author's view that transfers of existing hospital facilities to hospital-physician joint ventures with the express purpose of increasing such facilities' utilization is permissible under the private inurement and private benefit doctrines and the anti-kickback statute.