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The Charitable Hospital

Robert S. Bromberg*

After thirteen years the Internal Revenue Service (IRS) has promulgated a major revision in its criteria for the tax exemption of "charitable" hospitals. In 1956, Revenue Ruling 56-185¹ set forth the Service's long standing requirement that a tax exempt, charitable hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expect to pay." Furnishing free care or "services at reduced rates which are below cost" were the prescribed methods for doing charity in compliance with this ruling. However, in Revenue Ruling 69-545² published in 1969, the IRS recognized that this form of doing charity should not be a prerequisite to the tax-exemption of a nonprofit hospital and specifically modified Revenue Ruling 56-185 "to remove therefrom the requirements relating to caring for patients without charge or at rates below cost."

If that ruling had finally settled the legal definition of the charitable hospital for purposes of tax exemption, this article would be superfluous. Dispute over the tax-exempt status of certain hospitals, however, still continues. In a recent staff report to the Senate Finance Committee, for example, the recommendation has been made that Revenue Ruling 69-545 be revoked.³ Of even greater significance perhaps is the fact that state and local taxing authorities, under pressure to expand their tax rolls, have been questioning the tax exempt status of nonprofit hospitals with respect to the amount of free care being provided by these institutions. It would seem appropriate, therefore, to take a new look at the legal concept of the charitable hospital and, in doing so, to review its development in English and American common law.

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1. 1956-1 CUM. BULL. 202.

2. 1969 INT. REV. BULL. No. 44 at 10.

3. STAFF OF SENATE FINANCE COMM., 91ST CONG., 1ST SESS., MEDICARE AND MEDICAID: PROBLEMS, ISSUES AND ALTERNATIVES, Ch. 4 (Comm. Print 1970).

While this article will consider carefully the terms of Revenue Ruling 69-545, it will examine at greater length state court decisions in *ad valorem* or real property tax exemption cases. Time and again state courts have wrestled with the question of whether a charitable hospital must serve the poor or merely the sick. By contrast, one finds sparse discussion of this problem in federal decisions. The issue in the federal cases more often has been whether private rather than public interests are being served by the hospital, and there has been little discussion of the more fundamental question: What constitutes a "charitable" hospital?⁴

The Hospital in History

It should come as no surprise that the development of the charitable hospital as a legal concept is in many ways dependent upon the historical evolution of the voluntary hospital as an institution. Therefore, before attempting to understand the legal development, we must first have some understanding of the historical development. At their inception, hospitals were primarily custodial institutions for the unwanted members of society—the sick poor, the wanderers and the displaced, the incurables and the infectious. The oldest hospital in western Europe was the Hotel Dieu, founded at Lyons in 542 A.D. It was a charitable institution which embraced every form of aid for the poor and needy—inn, workhouse, asylum, and infirmary.⁵ Early English hospitals were also designed to serve the needs of the indigent, with care of the sick being an incidental activity. The following passage gives some indication of the function of the early hospitals:

During the Renaissance, hospitals were frequented only by the poor and dying who had no other place to go. Anyone who had a bed with a roof over it chose to suffer his illness at home, treated by his physician, bled by his surgeon-barber, and nursed by his servants or his family. The hospital was known as a pest house⁶

These conditions persisted well into the 19th century. For example, in 1788 at the Hotel Dieu of Paris one bed was frequently shared by two to

4. As a result of a two year study conducted by the IRS, a substantial number of revenue rulings involving different aspects of the activities of tax exempt hospitals were published in 1968 and 1969. However, I have covered them in detail in three earlier articles and will therefore limit this one to the most basic question of all, the exemption issue. For a discussion of other areas involving exempt hospitals, see Bromberg, *When are drug sales by hospitals taxed as unrelated business income?* J. OF TAX., April 1969 at 248; *Tax Problems of Nonprofit Hospitals*, TAXES, September 1969 at 524; *Income Tax*, HOSPITALS, November 16, 1969, at 45.

5. C. LETOURNEAU, *HOSPITAL TRUSTEESHIP* (1959); COMMISSION ON HOSPITAL CARE, *HOSPITAL CARE IN THE UNITED STATES* (1947); KNOWLES, *HOSPITALS, DOCTORS, AND THE PUBLIC INTEREST* 65 (1965).

6. E. HOYT, *CONDITION CRITICAL; OUR HOSPITAL CRISIS* 14 (1966).

eight persons, suffering a variety of diseases, and 25 percent of those who entered the hospital died. Nineteenth century hospitals sustained their reputation for uncleanness, mismanagement, and slovenly, incompetent nursing care.

American hospitals followed a parallel line of development. They grew out of a variety of institutions whose function was overseeing the poor. For example, the Philadelphia General Hospital, America's first hospital, grew out of the Philadelphia Almshouse founded in 1713. Most early hospitals were essentially almshouses, providing havens for indigents, criminals, foundlings, the physically handicapped, and the mentally unbalanced.

The hospital, as we know it today, was the result of two major developments in the 19th century. The first, occurring in the early part of the century, was the use of the voluntary hospital which served not only the indigent but the entire community. The voluntary hospital grew out of a basic community need for a place to house the sick, both rich and poor. These institutions were financed by philanthropic contributions, and they were able to underwrite free care for the poor out of the charges to those who could afford to pay. Because of their generally unsanitary conditions, widespread use of the hospitals did not occur until after the introduction of asepsis and anesthesia at the end of the 19th century. With the development of diagnostic procedures, specialization, expert nursing services, clinical laboratory services, the x-ray, and antibiotics in the 20th century, the voluntary hospital evolved into an institution which could be described as "the community's centralized facility for medical care."⁷ Thus "the modern hospital can scarcely be recognized as the offspring of the almshouse and pesthouse of the 18th Century."⁸

Accompanying this shift in the nature of the institution has been a number of important changes in the financing of hospital care. These include: (1) a steady increase in patients' income, with a corresponding increase in the percentage of expenses covered by revenues from paying patients, as compared with revenues from charitable contributions; (2) a dramatic rise in the cost of hospital care in response to higher, more equitable, wages and expanded technology; (3) the growth of prepayment to meet increasing costs; (4) the public acceptance of the concept of health care as a right, not a privilege, for the poor; and (5) the implementation of this principle by federal action under Medicare and Medicaid, with its correlative decline in the amount of free or uncompensated care being rendered.

7. R. BROWN, A CURRENT EVALUATION OF HOSPITAL PLANNING: PRINCIPLES FOR PLANNING THE FUTURE HOSPITAL SYSTEM (PHS 1959).

8. G. ROSENTHAL, THE DEMAND FOR GENERAL HOSPITAL FACILITIES 3 (1964).

Despite the evolution of the hospital from almshouse to provider of the community's health care, the image of the charitable hospital as an institution primarily dedicated to the service of the poor and funded by philanthropic contributions from benevolent citizens, continues to exercise a certain vitality in the common law and among certain taxing authorities. The persistence of this image helps to explain the conflicting legal theories of what constitutes a "charitable" hospital for purposes of tax exemption, charitable bequests, and immunity from tort liability. In the ensuing sections, the state of the common law definition of a "charitable" hospital in terms of these opposing theories will be considered.⁹

English Law: The Disjunctive Versus The Conjunctive

In order to appreciate the developments in American common law, it is instructive to look briefly at the continued debate in English common law about the nature of the charitable hospital or old age home. In its catalogue of charitable purposes, the preamble to that venerable cornerstone of the English law of charity, the Statute of Charitable Uses, begins with "Relief of aged, impotent, and poor persons."¹⁰ The question is whether one is required to read these words conjunctively or disjunctively. As one commentator has observed, the "main question in regard to trusts for the relief of the aged or the impotent has not been so much the necessity for public benefit, but whether age per se or impotence per se without any element of poverty can be regarded as good charitable objects."¹¹

In English law, trusts for the relief of the aged or the impotent now ordinarily come under the separate heading of trusts for the relief of distress, rather than under the heading of relief of poverty. It was only after years of debate that trusts for the relief of the distress of the aged were held charitable *per se*.¹² The cases dealing with trusts for the relief of impotence appear to reach the same result.¹³ In *In re Lewis*,¹⁴ Chancery held gifts to blind boys and girls to be charitable because the words, "aged, impotent, and poor" in

9. For a complete discussion of the impact of social and technological change upon the basic tenets of the law of charity, see Bromberg, *Charity and Change: Current Problems of Tax Exempt Health & Welfare Organizations in Perspective*, in PROCEEDINGS OF THE SIXTH ANNUAL CONFERENCE OF FEDERAL TAX PROBLEMS OF NON-PROFIT ORGANIZATIONS (1970).

10. 43 Eliz. 1, c.4 (1601). It is to be noted that the term "impotent" is used to mean sick persons. See *Charitable Purposes*, 106 SOL. J. 969 (1962).

11. Atiyah, *Public Benefit in Charities*, 21 MODERN L. REV. 138 (1958).

12. See *In re Wall* [1889] 42 Ch. D. 510; *In re Lucas* [1922] 2 Ch. D.; *In re Geslyn* [1950] 2 All E.R. 1150; *In re Bradbury* [1951] 1 T.L.R. 130 [Ch. D.]; *In re Robinson* [1951] Ch. 198.

13. *In re Roadley* [1930], Ch. D. 524; *In re Estlin*, 72 L.J. [Ch.] 687; *In re Chaplin* [1932] 1 Ch. D. 115; *In re James* [1932] 2 Ch. 25.

14. [1954] 3 All E.R. 257.

the Statute of Elizabeth were to be read disjunctively so far as the word "impotent" was concerned.¹⁵ Halsbury makes this comment:

The relief of 'aged, impotent and poor people' is charitable; and these words are to be read disjunctively, so that relief of aged people who are not poor comes within, and the relief of impotence without any element of poverty is a charitable purpose.¹⁶

American Law: Three Approaches

Upon careful study, one can discern three general approaches to defining a "charitable" hospital in the American law of charity. None of these approaches should be taken as a categorical statement of the law; each is rather intended to describe a different image of the charitable hospital. One may call the first of these the *conservative* approach. This approach is essentially similar to the conjunctive reading of the phrase "relief of aged, impotent, and poor persons" under English law. According to this view of the charitable hospital, relief of distress must always include relief of poverty. The conservative approach appears to be predicated upon an image of the charitable hospital of yesterday.

The second approach may be described as *liberal*. Its equivalent in English law is the prevailing disjunctive reading of the preamble to the Statute of Elizabeth. It accepts relief of distress or promotion of health as *per se* a charitable purpose and does not require any element of relief of poverty. In so doing, its image of the hospital as a charitable institution appears to conform more closely to the realities of the modern hospital.

The third approach emphasizes *community benefit*. In the ensuing discussion of the components of each heading, it will be shown that this approach adopts all of the elements of the liberal approach, but adds an additional requirement in order to make sure that a charitable hospital does, in fact, benefit the community. It is the most existential image of the charitable hospital and the one which seems most representative of the mainstream of American law. With this brief introduction to the three approaches to defining the charitable hospital, it is appropriate now to examine each of them in detail.

The Conservative Approach

There are four general elements or principles that comprise the conservative approach: (1) the care of indigent patients must be the primary concern of a charitable hospital; (2) the correlative of this is that a charitable hospital cannot be primarily concerned with the care of pay patients; (3) some unde-

15. *Id.* at 259. See also 18 MODERN L. REV. 76 (1955).

16. 4 LAWS OF ENGLAND § 492 (3d Ed. 1953).

financed amount of free care is required; (4) the hospital cannot be self-supporting, but must sustain its operations to some extent by philanthropic contributions from the public. These principles are derived from the historical roots of the charitable hospital as an almshouse. This almshouse image has tenaciously held its place in the law, and as late as 1926 we find a court quoting this language: "A public hospital is a charitable institution, and under some statutes, an *almshouse*, so as to be exempt from taxation; but not so if it is entirely self-supporting"¹⁷

Unquestionably the leading exponents of the conservative approach are the Ohio courts. In the 1917 case of *O'Brien v. Physicians' Hospital Association*, the Supreme Court of Ohio stated: "The *first concern* of a public charitable hospital must be for those who are unable to pay."¹⁸ Thirty-three years later the same court had only slightly modified its position when it stated: ". . . a hospital to qualify as a charitable institution . . . should have as an *important objective* the care of the poor, needy and distressed who are unable to pay. . . ."¹⁹

A similar attitude reflecting the first two elements of the conservative approach, as enunciated by two southern state courts, can be found in *Mayor of Vicksburg v. Vicksburg Sanitarium*,²⁰ where the court cited the following definition of charity from *Webster's New International Dictionary* (1910 ed.): "An institution or place in which sick or injured are given medical or surgical care, commonly in whole or in part at public expense. . . ."²¹

One of the best statements of the third component (the requirement of free care) comes from a respected legal treatise:

[Charity] has been defined as an organization or institution engaged in the free assistance of the poor, incapacitated, distressed, etc., and under this definition the characteristics of an organized charity are that whatever it does for others *it does free of charge*.²²

Another example of this requirement is the following statement from a recent article discussing the IRS's requirements under Revenue Ruling 56-185:

Minimum charitable services must, at least be more than is 'customary for reputable physicians'. Where less than five percent of the total patients were given free service, private hospitals

17. *Southwestern Osteopathic Sanitarium v. Davis*, 115 Okla. 296, 297, 242 P. 1033, 1034 (1926) (emphasis added).

18. 96 Ohio St. 1, 9, 116 N.E. 975, 977 (1917) (emphasis added).

19. *Cleveland Osteopathic Hosp. v. Zangerle*, 153 Ohio St. 222, 228, 91 N.E.2d 261, 264 (1950) (emphasis added). See also *Lincoln Memorial Hosp., Inc. v. Warren*, 13 Ohio St. 2d 109, 235 N.E.2d 129 (1968).

20. 117 Miss. 709, 78 So. 702 (1918).

21. *Id.*, 169 S.E. at 703; see also *Richardson v. Executive Comm.*, 176 Ga. 705, 169 S.E. 18 (1933).

22. 84 C.J.S. *Taxation* § 282 (1954) (emphasis added).

have been found nonexempt, and the converse has been found where six to eight percent were treated without charge.²³

The last element of the conservative approach is the requirement that a charitable hospital not support itself through receipts for services rendered, but through public benevolence in the form of charitable contributions. Since the charitable hospital cannot be self-supporting, it naturally follows that it cannot operate at a profit.²⁴ An early expression of these sentiments comes from the Supreme Court of Minnesota, which held that "an institution established, maintained, and operated for the purpose of taking care of the sick, without any profit, or view to profit, but at a loss which has to be made up by benevolent contribution, is a charity."²⁵ A 1932 Wisconsin decision takes much the same position: "A hospital which pays no dividends and is largely supported by donations is a charitable institution."²⁶ The most recent expression of this requirement of deficit spending comes from the Oregon Supreme Court. One of the six factors it looks to in deciding whether a hospital is charitable for real property tax exemption purposes is "[w]hether there is a charitable trust fund created by benevolent and charitably-minded persons for the needy or donations made for the use of such persons. . . ."²⁷

When we compare the foregoing elements of the conservative approach with the recent trends in hospital care, it becomes obvious that this approach is an anachronism. It insists that the charitable hospital primarily concern itself with the poor, although the hospital as an almshouse disappeared over a century ago. It insists that the charitable hospital not concentrate its efforts upon caring for pay patients, although this is precisely the modus operandi of nearly all of our hospitals today. It insists that free services be provided, although private health insurance, Medicare, Medicaid, and other government assistance now provide funds which diminish the amount of free care needed. It insists upon a hospital's operating below costs and receiving charitable contributions to make up the deficit, although hospital costs are rising and the percentage of operating costs able to be met by contributions is diminishing. For these reasons, the conservative approach has not been widely accepted by

23. Note, *Federal Income Tax Exemption for Private Hospitals*, 36 *FORDHAM L. REV.*, 747, 758 (1968).

24. For cases where profits are treated as incompatible with charity, see *Cleveland Osteopathic Hosp. v. Zangerle*, 153 Ohio St. 222, 91 N.E.2d 261 (1950); *St. Francis Memorial Hosp. v. San Francisco*, 137 Cal. App. 2d 321, 290 P.2d 275 (Dist. Ct. App. 1955); *Sutter Hosp. v. Sacramento*, 39 Cal. 2d 33, 244 P.2d 390 (1952).

25. *In re Lots 8&9*, 27 Minn. 460, 461, 8 N.W. 595, 596 (1881), cited in *Smith v. Reynolds*, 43 F. Supp. 510 (D. Minn. 1942).

26. *In re Prange's Will*, 208 Wisc. 404, 410, 243 N.W. 488, 491 (1932).

27. *Oregon Methodist Homes, Inc. v. Horn*, 226 Ore. 298, 304, 360 P.2d 293, 298 (1961); *Hamilton v. Corvallis General Hosp. Ass'n*, 146 Ore. 168, 30 P.2d 9 (1934); *Waller v. Lane County*, 155 Ore. 63 P.2d 214 (1936).

the courts in recent years. Its current vitality rests largely in state and local taxing authorities which attempt to use this approach to bring in added revenues.

The Liberal Approach

The liberal approach is based upon a broad view of charity; one which looks beyond one form of human distress (poverty) and sees a wide spectrum of human suffering.²⁸ It may be summed up in this language from two California cases:

Any person, the rich as well as the poor, may fall sick or be injured or wounded and become a fit subject for charity. St. Luke, chapter 10, verses 30-37. A trust may be and often is charitable in its nature, uses and purposes without giving alms to the poor.²⁹

Relief of poverty is not a condition of charitable assistance. If the benefit conferred has a sufficiently widespread social value, a charitable purpose exists.³⁰

Thus the central thesis of the liberal approach is that a valid legal charity can exist without any element of relief of poverty.³¹ The proposition that (1) charity is not limited to relief of poverty is, in fact, the first element of this approach. The remaining components can be classified as follows: (2) promotion of health is a charitable purpose; (3) an absence of private profit or advantage is required; (4) free care is not a prerequisite for a charitable hospital; (5) a charitable hospital may serve paying patients and be self-supporting; and (6) the presence of profits does not conflict with charitable status, provided they are applied to the hospital's purposes.

The authorities supporting the proposition that promotion of health is a charitable purpose are so numerous that, as Professor Scott has stated, "it is well settled that the promotion of health is a charitable purpose."³² One of the best statements of this proposition, as applied to the charitable hospitals, is the following:

Hospitals which are devoted to the care of the sick and injured, which aid in maintaining public health and which make valuable contributions to the advancement of medical science are rightly

28. For an excellent discussion of the relief of burden theory versus the humanitarian theory of tax exemption, see Note, *Exemption of Educational, Philanthropic and Religious Institutions from State Real Property Taxes*, 64 HARV. L. REV. 288 (1950).

29. *Dingwell v. Seymour*, 91 Cal. App. 483, 487, 267 P. 327, 333 (1928).

30. *In re Henderson's Estate*, 17 Cal. App. 2d 853, 855, 112 P.2d 605, 607 (1941).

31. RESTATEMENT (SECOND) OF TRUSTS, §§ 368, 374; A. SCOTT, THE LAW OF TRUSTS § 372 (3d ed. 1967); [hereinafter cited as SCOTT]; H. BLACK, A TREATISE ON THE LAW OF INCOME TAXATION 404 (2d ed. 1915).

32. SCOTT §§ 368, 372; accord, G. BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 374 (2d ed. 1964); RESTATEMENT (SECOND) OF TRUSTS § 372 (1959); Sacks, *The Role of Philanthropy*, 46 VA. L. REV. 516 (1960); 15 AM. JUR. 2D *Charities* § 148 (1964).

regarded as benevolent and charitable. A hospital association not conducted for profit which devotes all of its funds exclusively to the maintenance of the institution is a public charity and this is so irrespective of whether patients are required to pay for the services rendered.³³

Correlative to the liberal position that the promotion of health is a charitable purpose, is the principle that this activity must be conducted without private profit. "The test is not whether the patients of the hospital pay more or less for their services, but whether those charged with its operation were conducting it for their private profit or advantage."³⁴ As one treatise notes, the "test of a charitable institution in many jurisdictions is not the extent of the free services rendered, not whether the patients pay more or less than cost for services, but whether those who operate it are doing so for private profit, directly or indirectly."³⁵ This prohibition against private profit cannot be emphasized too strongly and will be discussed at greater length in a subsequent section.

One of the most critical factors and the one which has caused voluntary hospitals the greatest concern in tax exemption cases is the requirement of free care. The recognition that free care is not an indispensable requirement for charitable exemption is one of the liberal approach's most important contributions to the law. Most treatise writers in fact have rejected free care as a standard of exemption.

To say that the test of a charitable hospital is the amount of free service rendered is to apply a standard which is impractical and unsound Free service is not a prerequisite to tax exemption and the legal meaning of charitable purpose is not limited to the care of the indigent.³⁶

The *Hospital Law Manual*, unquestionably the most comprehensive source book in the area of hospital law, states that "it is logical that the amount of charity work done by the institution should not, in itself, be determinative of whether it qualifies for an exemption."³⁷

33. *People ex rel. Doctors Hosp. v. Sexton*, 267 App. Div. 736, 741, 48 N.Y.S.2d 201, 205 (1944). See also *In re Mendelsohn*, 262 App. Div. 605, 31 N.Y.S.2d 435 (1941); *Richmond v. Richmond Memorial Hosp.*, 202 Va. 86, 116 S.E.2d 79 (1960); *Weiss v. Swedish Hosp.*, 16 Wash. 2d 709, 133 P.2d 978 (1943); *St. Elizabeth Hosp. v. Lancaster County*, 109 Neb. 104, 189 N.W. 981 (1922).

34. *Southern Methodist Hosp. & Sanitorium v. Wilson*, 51 Ariz. 424, 427, 77 P.2d 458, 462-63 (1938).

35. E. HAYT, L. HAYT & A. GROESCHEL, *LAW OF HOSPITAL, PHYSICIAN & PATIENT*, 65-8 (2d ed. 1952) [hereinafter cited as HAYT]. See also *In re Mendelsohn*, 262 App. Div. 605, 31 N.Y.S.2d 435 (1941); *McDonald v. Massachusetts Gen. Hosp.*, 120 Mass. 432 (1876); *State v. Browning*, 192 Minn. 25, 255 N.W. 254 (1934); C. ZOLLMAN, *AMERICAN LAW OF CHARITIES* 188 (1963) [hereinafter cited as ZOLLMAN].

36. HAYT at 68.

37. *HOSPITAL LAW MANUAL* 25 (1968). See also Harty, *How Does Surplus Affect Tax Status*, 107 *MODERN HOSPITAL*, July 1966, at 1.

State courts have likewise shown an awareness of the dangers of imposing a test based on the amount of free care provided:

We think the position that the test of a charitable institution is the extent of the free services rendered, is difficult of application and unsound in theory.³⁸

A tax exemption cannot depend upon any such vague and illusory concept as the percentage of free service actually rendered. This would produce chaotic uncertainty and infinite confusion, permitting a hodgepodge of views on the subject.³⁹

One of the reasons for rejecting the free care standard is indicated in a recent and excellent decision of the Supreme Court of Nebraska, which pointed out that "[w]ith the advent of present day social security and welfare programs, this type of charity is not often found because assistance is available to the poor under these programs."⁴⁰

Another basic precept of the liberal approach is that a charitable hospital may accept pay patients and operate in a self-supporting manner. "The fact that a hospital charges the full cost, or more, to patients who are able to pay, does not show that it is not operated exclusively for charitable purposes."⁴¹ Professor Scott has added his weight to the authorities who recognize that charitable institutions may have means of self-support:

A trust to establish or maintain an institution may be charitable, however, although it is provided that some or all of the persons to receive benefits from the institution are to pay fees or otherwise contribute to the expense of maintaining the institution.⁴²

Fortunately, American courts have moved away from the implication in the conservative position that it is a logical contradiction for patients to pay in a charitable hospital. In an early Texas case, for example, we find the statement:

[T]he mere fact that pay patients largely predominated over the charity patients, or that the institution did not go out into the highways and byways seeking out those to whom its charitable offices

38. *Southern Methodist Hosp. & Sanitorium v. Wilson*, 51 Ariz. 424, 429, 77 P.2d 458, 462 (1938).

39. *Richmond v. Richmond Memorial Hosp.*, 202 Va. 86, 88, 116 S.E.2d 79, 81-82 (1960).

40. *Evangelical Lutheran Good Samaritan Soc'y v. County of Gage*, 181 Neb. 831, 834, 151 N.W.2d 446, 449 (1967). See also *Miami Retreat Foundation v. Ervin*, 62 So. 2d 748 (Fla. 1952).

41. *Internal Revenue-Exempt Organizations*, Annot. 69 A.L.R.2d 871 (1960), citing *Comm'r v. Battle Creek, Inc.*, 126 F.2d 405 (5th Cir. 1942); *Intercity Hosp. Ass'n v. Squire*, 56 F. Supp. 472 (S.D. Wash. 1944); *Goldsby King Memorial Hosp. v. Commissioner*, 14 CCH Tax Ct. Mem. ¶ 14,042 (1944); *Davis Hosp. v. Commissioner*, P-H Tax Ct. Mem. ¶ 45,097 (1945).

42. SCOTT at § 376. See also RESTATEMENT (SECOND) OF TRUSTS § 376, comment (c) (1959); ZOLLMAN at §§ 714-15.

might be extended, could not, under the great weight of authority, be said to so detract from its charities as to disqualify it as an institution of purely public charity.⁴³

If one accepts the thesis that promotion of health is a charitable purpose and that all receipts must be applied to that charitable purpose of the hospital, there would seem to be no logical reason why a hospital could not accept only paying patients, charge each the full cost of care, remain entirely self-supporting, and still qualify as a charitable institution. That is the conclusion which one could draw from the liberal position, and one could look to the Supreme Court of California for support:

But even if each inmate were required to pay in full for his care, a bequest to the institution may still be charitable. A gift or trust to support an institution beneficial to the community is charitable even though the inmates must pay fees or contribute to the expense of maintaining the institution so long as the income thus derived is used only to maintain the institution or for some other charitable purpose.⁴⁴

The final component of the liberal approach is its approval of operating at a net profit. The authorities which sanction institutions such as schools or hospitals finishing the year with a surplus are numerous.⁴⁵ The basic rule was incisively stated some years ago by Judge Cardozo in the noted case of *Butterworth v. Keeler*:

What controls is not the receipt of income, but its purpose. Income added to the endowment helps to make it possible for the work to go on. It is only when income may be applied to the profit of the founders that business has a beginning and charity an end.⁴⁶

We may summarize our discussion of profits with this pertinent excerpt from the *Hospital Law Manual*:

An excess of income over expenses does not preclude a hospital from being a charity which qualifies for tax exemption, so long as the profit does not inure, directly or indirectly, to the benefit of any person.

Some cases have held that the hospital does not jeopardize its tax-free status so long as charges for services are not intended to result in general profit to the institution. This is unnecessarily harsh. The intent of the exemption statute is not to require that the hospital show a net loss each year in order to qualify for a tax exemption, though such might be the case if effective cost ac-

43. *Santa Rosa Infirmary v. San Antonio*, 259 S.W. 926, 932 (Tex. Comm'n App., 1924).

44. *In re Henderson's Estate*, 17 Cal. 2d 853, 855, 112 P.2d 605, 608 (1941).

45. See, e.g., RESTATEMENT (SECOND) OF TRUSTS § 376, comment (d) (1959); ZOLLMAN at § 717; 84 C.J.S. *Taxation* § 282(b) (1954); SCOTT at § 376.

46. 219 N.Y. 446, 447, 114 N.E. 803, 804 (1916).

counting procedures were always applied to the hospital's operation. Prudent management would seem to dictate that the hospital attempt to accumulate a surplus against lean periods and to finance expansion and modernization of its facilities.⁴⁷

The Community Benefit Approach

The cases and authorities cited above in support of the liberal approach appear to betoken the somewhat extreme position that, in order to gain charitable exemption, a hospital need only provide services for patients who are able and willing to pay, and see to it that no part of its net earnings inure to the benefit of any private party. Undoubtedly, the cases and treatises cited above offer some support for this proposition. It is submitted, however, that a more accurate understanding of the language used in many of these sources may be gained from reading it as a reaction to the elements of the conservative approach. Both the courts and the commentators are trying to counter the superannuated elements of the conservative definition.

One cannot ignore, however, an obligation imposed upon the charitable hospital under American law which is more specific than that imposed by the unqualified liberal position that the promotion of health is per se a charitable purpose. Such an approach may be valid in dealing with trusts to promote health, where the purpose may be solely to discover a cure for cancer or to alleviate the suffering of victims of a particular disease.⁴⁸ In the case of a charitable hospital however, something more is needed.

It is not suggested here that the elements of the liberal approach are inaccurate or inapposite. By contrast to the conservative approach, they represent sound and rational legal principles. It is clear, however, that American law adds one additional requirement to the six components of the liberal approach. This seventh element may be viewed as an existential requirement designed to make certain that the charitable hospital does, in fact, benefit the community. The legal principle underlying this requirement is that the charitable class served (the sick) must not be so small that its relief is not of benefit to the community.⁴⁹ As Professor Scott has stated: "A trust is not charitable if the persons who are to benefit are not of a sufficiently large or indefinite class so that the community is interested in the enforcement of the trust. This is true even though the purpose of the trust is to promote

47. HOSPITAL LAW MANUAL 27 (1968).

48. For this line of cases, see *Anna Jacques Hosp. v. Att'y Gen.*, 341 Mass. 179, 167 N.E.2d 875 (1960); *Barrett v. Brooks Hosp.*, 338 Mass. 754, 157 N.E.2d 638 (1959); *In re Judd's Estate*, 242 App. Div. 389, 274 N.Y.S. 902 (1935); *Estate of McKenzie*, 38 Cal. 496, 227 Cal. App. 2d 167 (1930).

49. RESTATEMENT (SECOND) OF TRUSTS, § 372, comment (c) (1959).

health.”⁵⁰ In the case of a community hospital, this fundamental principle is translated into a rule or requirement which has been phrased in various ways—it must admit “patients without regard to race, creed, or wealth,”⁵¹ or “[t]he rich should not be turned away because of their wealth nor the poor because of their poverty.”⁵²

This language, when applied to the modern American hospital system can easily be misunderstood. It is therefore important to appreciate that its underlying rationale is that: (1) a charitable hospital must in fact benefit the community, and (2) the community may not be benefited if its needs are not met, *i.e.*, if a substantial portion of its residents are turned away. This does not mean that we must return to demanding that a charitable hospital must render some minimum percentage of its services free of charge or that it may not recover the cost of its services from each patient. The community benefit approach is an existential one; in order to be meaningful, therefore, this approach *must* take account of the realities of each hospital's situation. Individual hospitals in different locales often have particular responsibilities. In urban areas for example, one might be deluded that every voluntary hospital shoulders equally the burden of indigent care, but the truth of the matter is that certain patterns of patient flow develop and become stratified. Certain hospitals, particularly the municipal, county, and state institutions, together with the larger teaching hospitals, traditionally bear the greater part of this burden. Other hospitals are responsive to the needs of the middle and more affluent classes.⁵³ All of these hospitals, nevertheless, play an important part in the overall health care plan for the community. Each is providing hospital services to a substantial portion of the populace and could thus be deemed beneficial to the community.

If this is so, does the community benefit approach, with its “rich and poor alike” language have any real meaning? Unquestionably, it has, for one can read into this approach two general rules to insure that the charitable hospital is responsive to the needs of the community, rich and poor alike. Before stating them, it must be recognized that as in the case of any general rules, they admit of exceptions. Former Secretary of Health, Education, and Welfare, Wilbur Cohen, recently expressed the opinion that in order to hold exemption

50. SCOTT at § 372.2; Estate of Gray, 2 T.C. 97 (1943); New England Sanitarium v. Inhabitants of Stoneham, 205 Mass. 335, 91 N.E. 385 (1910).

51. Nuns v. Younkin, 118 Kans. 554, 556, 235 P. 869, 872 (1925). See also Sisters v. Bd. of Review, 83 N.E. 272; Seaside Memorial Hosp. v. California Employment Comm'n, 24 Cal. 2d 681, 151 P.2d 116 (1944); Bishop v. Denver, 37 Col. 378, 86 P. 1021 (1906).

52. Hart v. Taylor, 301 Ill. 344, 345, 133 N.E. 857, 858 (1921).

53. It is well to remember that with health insurance so widespread, most people now have access to our hospitals as paying patients and may be considered members of the middle class for purposes of hospital care.

as a charitable institution, a charitable hospital should be held to two tests. First, does it have an emergency room open to all persons? Second, does it refuse admission to Medicaid patients? These two tests suggested by former Secretary Cohen provide a valid measure of whether a hospital is entitled to charitable exemption.

Some courts and treatises have already commented on the importance of the emergency room. As one leading authority has stated:

The hospitals probably need treat no set number of indigent patients; they can bill all patients and may attempt to collect from all patients. However, the institution's tax exemption is in jeopardy if it refuses emergency hospitalization or treatment to anyone solely because of an inability to pay.⁵⁴

The maintenance of an open emergency room is vital to the community's well being. "Under modern conditions, especially as respects serious personal injuries, now happening with more and more frequency than in the past, it is important in the public interest that persons so injured or taken suddenly and seriously ill shall be immediately treated and cared for at the nearest hospital which may be reached"⁵⁵ An open emergency room is one feature of a charitable hospital which insures that the organization will serve the sufficiently large and indefinite class of persons required to be served by the law of charity. Since the emergency room is normally the principal means of entry into the hospital for indigent inpatients, some hospitals may not be overly enthusiastic about maintaining one. Some instruct the ambulance services to take economically questionable cases elsewhere. Such a practice may seriously jeopardize a hospital's exempt status.

Having said this, however, one must quickly take note of certain valid exceptions. It could very well be inefficient and wasteful, particularly in urban areas where hospitals are located near each other, for every hospital to duplicate facilities available nearby, and this would be true whether those facilities were emergency rooms or expensive radiological equipment. Thus if a hospital can establish that maintenance of an emergency room is a duplication of the same facilities in other adjacent hospitals, and that those facilities are sufficient to fill the needs of the community, that hospital should not be penalized for practicing sound management. Another exception to the general rule would apply in the case of certain types of specialty hospitals. It would not be sound administration to require a children's hospital to treat an adult

54. Harty, *How Does Surplus Affect Tax Status?* *supra* note 37, at 42; HOSPITAL LAW MANUAL 26 (1968).

55. *Natchez v. Natchez Sanitorium Benev. Ass'n*, 191 Miss. 91, 92, 2 So. 2d 798, 799 (1941); *Palestine v. Missouri-Pac. Lines Hosp. Ass'n*, 99 S.W.2d 311 (Tex. Civ. App. 1936).

emergency nor a psychiatric hospital to render other types of medical services. A hospital not equipped with an obstetrics unit is not necessarily doing an expectant mother a disservice by referring her to a hospital that is better equipped to deliver her child.

The second general rule in testing benefit to the community is that a charitable hospital should not follow a policy of regularly refusing admission to Medicaid patients. A hospital may adopt a policy of not providing care for Medicaid patients for various reasons. A principal one is that while Medicaid may be based on a cost reimbursement formula, many states rapidly use up the funds designated for health care, and then expect the hospitals to take whatever token payment is available for Medicaid patients for the balance of the year. Officials in those states rarely inquire where the hospital will obtain the funds necessary to meet the increasing costs of caring for these patients. Since they are dealing with "charitable" institutions, they expect the difference to be made up by contributions (which can no longer be expected to provide sufficient excess income to cover large numbers of charity patients).

As a general rule, however, community hospitals should not follow a program of continually turning away Medicaid patients. To permit them to do so would be to frustrate public policy. This rule must, however, be realistically administered, with recognition being given to particular circumstances. A hospital heavily saddled with debt and struggling to pay off its mortgage, or one which is desperately trying to put aside funds for expansion to meet the increased needs of the community, may not be expected to admit as large a number of nonpaying patients as a hospital that is in sound fiscal condition. Each hospital must strike a balance of its own priorities—patient care, research, education, training. All of these, as well as the care of Medicaid patients, benefit the community. The overriding concern should be whether the charitable hospital is, in fact, benefiting the community at large. If it is deliberately and without just cause restricting its facilities to one segment of that community, to the exclusion of other segments needing its services, then a serious question arises as to whether that hospital is entitled to exemption.⁵⁶

Private Benefit

Charitable exemption has two elements; both are indispensable for qualification as a legal charity. The first, is the requirement that the organization be

56. One factor to be considered is the availability of other hospitals to care for these segments of the populace. The Hill-Burton regulations follow this principle by stating: "In determining what constitutes a reasonable volume of services to persons unable to pay therefor, there shall be considered conditions in the area to be served by the applicant including the amount of such services that may be available otherwise than through the applicant." 42 C.F.R. § 53.111 (1970).

organized and operated in furtherance of a purpose which is recognized as charitable in the general law of charity. The foregoing discussion has been directed toward this requirement. The second part of charitable exemption is the prohibition against private benefit. This latter requirement is of equal importance and has been particularly crucial in the long line of federal decisions involving hospitals. One treatise has stated the benefit problem in these terms: "where a dominant and substantial use is for pecuniary advantage to individuals who have the hospital under their management and control, it is not a use for benevolent purposes, or without profit"⁵⁷ The professional relationship between a doctor and a hospital is such that some professional advantage always will accrue to the doctor by reason of such association. It is, however, only where this relationship is abused by the physician's use and control over the hospital facilities, that the nature of the benefit derived becomes antithetical to the law of charity. The problem is to determine when there is a dominant and substantial use for pecuniary advantage. Since physicians and surgeons make up the life-blood of the hospital, and in a sense, the hospital is their workshop, it is not always a simple matter to make this determination. A reading of the case law, both state and federal, indicates that there are no hard and fast rules, but only a series of factors that one can apply in individual situations. Furthermore, these factors indicating private benefit cannot be applied in a vacuum, but must be balanced against the evidence of public benefit stemming from the hospital's activities.

The following could be designated as factors which indicate a use of the hospital for private benefit: (1) *Control*—While the mere fact that a group of physicians or former owners control a nonprofit hospital will rarely disqualify the hospital per se, the fact that such groups exercise control over the organization is one of the salient factors pointing to the possibility of private benefit. The potential for abuse stemming from control usually arises where it is exercised by a relatively small group. Where control rests in representatives of a group practice of, for example, fifty doctors, there is little danger of the hospital being operated for private benefit. On the other hand, where four or five doctors have set up a proprietary hospital and eventually transferred it to a nonprofit organization in which they retain control, the possibility of abuse clearly exists. (2) *Division of Profits*—When control is exercised in such a way as to siphon profits from the institution, there is substantial evidence of private benefit. (3) *Private use of Funds*—This is a form of inurement and indicates that someone is using his control over the organization for his private benefit. (4) *Exclusive Admission Privileges*—Here again

57. HAYT at 67.

the small hospital with a limited medical staff of a few doctors who bar other qualified physicians from staff privileges is the usual offender. A hospital with a large staff which cannot expand further because of limitations imposed by the available facilities would not fall into this category. Criteria three of Revenue Ruling 56-185 sets forth this rule in its requirement that an exempt hospital maintain an open staff. (5) *Exclusive Right to Treat Patients*—This is similar to the abuse inherent in limiting the right of admission. In some cases, hospitals will admit patients of nonstaff members, but restrict their treatment exclusively to members of the staff. Here again it is only the clear cases of abuse that cause concern, since it is reasonable for a hospital to restrict surgical privileges to those whom it deems properly qualified. (6) *Free Office Space*—Provision of free office space to doctors controlling the hospital can be another indication of private benefit. But once again one must approach this factor with an open mind. It is usually highly advantageous to a hospital to have its staff members locate their offices for private practice on the hospital grounds.⁵⁸ However, the usual means of attracting staff members to hospital offices is to offer them leases at reasonable rentals, rather than without charge. If there is a rental, the rent charged should approximate the fair market value of the premises, unless the hospital can show a benefit to it derived from the reduced rates. (7) *Low Charity Record*—In this context, the amount of free or below-cost care does not by itself settle the question of whether the organization has a charitable purpose, but rather is considered in its relation to the question of private benefit. To put the matter simply, an analysis of cases involving private benefit shows that where some of the other factors are present, the organization will also have a low charity record. Those in control are trying to make the most of a good thing; so they are not interested in giving anything away.

Turning now to the cases from which these indicia of private benefit are derived, one finds in the federal decisions that the two most serious offenses are the existence of control over the organization and the use of that control to divert some of the profits or to realize some special professional advantage. One of the best illustrations of this in recent years is *Sonora Community Hospital v. Commissioner*.⁵⁹ Most of the factors evidencing private benefit were present here. The founders of the proprietary organization continued in control of the nonprofit one. Through private arrangements with the x-ray and laboratory facilities, they were able to divert to themselves a part of the hospital's income. The fact that five members of the founders' medical group accounted for ninety percent of the hospital's patients indicates a virtually ex-

58. See Rev. Rul. 69-463, 1969 INT. REV. BULL. No. 35 at 16; Rev. Rul. 69-464, *Id.* at 18.

59. 46 T.C. 519 (1966), *aff'd*, 397 F.2d 814 (9th Cir. 1968).

clusive right in the hands of a closed group to treat and admit patients. The hospital, furthermore, showed a negligible charity record. Because of this latter fact, this case has been widely misinterpreted to stand for the proposition that a charitable hospital must provide a substantial amount of free care. The court's holding in *Sonora* was based instead on the overall finding that the hospital was operated to a considerable extent for the benefit of the founding doctors. The poor charity record thus evidenced private benefit, but not the lack of a charitable purpose (except in the sense that the hospital was not operated "exclusively" for such purpose because of the presence of private benefit).⁶⁰

In *Lorain Avenue Clinic v. Commissioner*,⁶¹ the Tax Court found that the clinic "was operated for profit by a small family group; that operations for profit were petitioner's predominant activity. . . ." Control of the clinic rested in the family group, compensation was fixed by a method which divided the profits among this group, and the organization had a negligible record of charity. Exclusive control plus a financial arrangement designed to divide profits through the payment of salaries were also the causes of denial of exemption in *Medical Diagnostic Association v. Commissioner*.⁶² In *Kenner v. Commissioner*,⁶³ the court denied exemption because of extensive commingling of Kenner's personal funds and those of the exempt hospital. This use of the hospital's funds for the founder's personal living expenses was sufficient evidence of private benefit to sustain denial. Finally, mention must be made of the case of *Fort Scott Clinic & Hospital Corp. v. Brodrick*.⁶⁴ While the factors of exclusive control, use of that control to enable the doctors to fix their own salaries, and an inadequate record of charity appear to be present, the case is a poor one and devoid of any illuminating rationale.

The federal cases discussed above have their counterparts in state decisions. *Malone-Hogan Hospital Clinic Foundation v. Big Spring*⁶⁵ presents a fact pattern and rationale for denial of exemption similar to that of *Lorain Avenue Clinic*. There the amount of salary paid to doctors depended on the income of the hospital, and this method of payment constituted a division of

60. See also, *Maynard Hosp. Inc.*, 52 T.C. 107 (1969).

61. 31 T.C. 141 (1958). On the use of percentage arrangements and other devices to distribute profits, see *Klamath Medical Serv. Bureau*, 29 T.C. 339 (1957); *Northern Illinois College*, 12 P-H Tax Ct. Mem. ¶ 43,396 (1943); *Gemalogical Institute of America*, 17 T.C. 1604 (1952); *Birmingham Business College Inc. v. Comm'r*, 276 F.2d 476 (5th Cir. 1960).

62. 42 B.T.A. 610 (1941). See also, *John J. Cranley, Jr.*, 20 CCH Tax Ct. Mem. ¶ 24,609 (1961).

63. 20 CCH Tax Ct. Mem. ¶ 24,664 (1961), *aff'd*, 318 F.2d 632 (7th Cir. 1963).

64. 99 F. Supp. 515 (D. Kan. 1951).

65. 288 S.W.2d 550 (Tex. Civ. App. 1956). See also *Corpus Christi v. Roberts Memorial Hosp.*, 195 S.W.2d 429 (Tex. Civ. App. 1946).

the profits. *Bistline v. Bassett*⁶⁶ involved the same type of commingling found in the Kenner case, as well as control by a few, exclusive right to treat patients, and free office space furnished to the founders.

In state court decisions, the presence of a closed staff utilizing the hospital exclusively for their private practice assumes a greater importance as a factor in denial of exemption. In *Raymondville Memorial Hospital v. State*, the court found that the "medical staff [of five doctors] actually controls the operations of the hospital to such an extent that patients of nonstaff doctors cannot use the hospital." The trial court held that these five doctors received "indirect benefits in the way of decreased expenses and increased revenue by reason of their exclusion of patients other than their own and by indirection there [was] private gain in the hospital operation."⁶⁷ Other cases following a similar pattern of abuse are *Fleming Hospital Inc. v. Williams*,⁶⁸ in which all patients admitted were those of the former owner; *Georgia Osteopathic Hospital v. Alford*,⁶⁹ and *Prairie Du Chien Sanitarium Co., Inc. v. Prairie Du Chien*.⁷⁰

Having catalogued the evils, one must now make the observation that no single one of the above factors is determinative of the question of private benefit. Furthermore, because of the necessary interrelationship between doctor and hospital, a certain amount of professional advantage will always accrue to the doctor. The nature of the hospital as a place where a doctor practices his profession makes this inescapable. Thus one must balance the benefits resulting from the hospital's activities against any patent and egregious abuses by the medical staff or founders. As one author has observed:

[P]ractical employment of the test requires a balancing between actual charitable use and inurement of net earnings. Only the more flagrant, and not petty or aberrant instances of inurement have been considered so to contradict actual charitable purposes of a hospital as to be the primary cause for denial of exemption.⁷¹

Thus, in *Goldsby King Memorial Hospital v. Commissioner*⁷² and *Olney v. Commissioner*,⁷³ the courts sanctioned leases of office space to founding doctors in situations where there was overbalancing evidence of public service in the operations of the hospital. In these cases, the courts found that the hospitals had open staffs, good charity records, had never turned patients away,

66. 47 Idaho 66, 272 P. 696 (1928).

67. 253 S.W.2d 1012 (Tex. Civ. App. 1952).

68. 169 S.W.2d 241 (Tex. Civ. App. 1943).

69. 217 Ga. 663, 124 S.E.2d 402 (1962).

70. 242 Wis. 262, 7 N.W.2d 832 (1943); see also, *Riverview Hosp. v. Tomahawk*, 243 Wis. 581, 11 N.W.2d 188 (1943).

71. *Federal Income Tax Exemption for Private Hospitals*, supra note 23 at 761.

72. 3 CCH Tax Ct. Mem. ¶ 14,042 (1944).

73. 27 P-H Tax Ct. Mem. ¶ 58,200 (1958).

and had received fair rental value for leased space (or a reasonable return in the form of services by the tenant).⁷⁴ In *Intercity Hospital Association v. Squire*,⁷⁵ the fact that the hospital was controlled by its former owners was insufficient to deny it exemption in view of the fact that it had an open staff, made its facilities available to all who needed them, and had a six percent to eight percent charity record. Cases such as this one illustrate that control can sometimes be utilized for the good of the public, rather than for personal ends.⁷⁶

A number of interesting state court decisions deal with permissible arrangements between doctors and hospitals. In *Virginia Mason Hospital Association v. Larson*,⁷⁷ the court sanctioned an arrangement involving a hospital-based medical group and a voluntary hospital. It stated:

We are unable to see how an arrangement by which essential services are supplied to the hospital at a reasonable cost, and under which a reasonable rental value is paid to the hospital for the use of its property, can be said to be an allocation of the net earnings of the hospital to the benefit of private individuals.⁷⁸

The relationships between hospitals and physicians, either in group practice or as individual specialists, become even more difficult to evaluate where the latter provide essential services to the hospital, but are compensated on a percentage basis. In *Board of Supervisors of Wythe County v. Medical Group Foundation*,⁷⁹ the Virginia Supreme Court of Appeals approved such relationship with a group practice. In *Vick v. Cleveland Memorial Medical Foundation*⁸⁰ and *Barrett v. Brooks Hospital*,⁸¹ similar arrangements with individual radiologists were held not to jeopardize exemption.

The Internal Revenue Service dealt with one aspect of this problem in Revenue Ruling 69-383⁸² which sanctions percentage compensation arrangements (consisting of a fixed percentage of a radiology department's gross billings) between hospitals and radiologists and pathologists, provided that: (1) the specialists do not control the hospital; (2) the agreement is negotiated at

74. See also *W.A. Henke*, 1 P-H Tax Ct. Mem. ¶ 32,335 (1932); *Estate of Smith*, 30 P-H Tax Ct. Mem. ¶ 61,242 (1961).

75. 56 F. Supp. 472 (S.D. Wash. 1944).

76. For other cases of this type, see *Commissioner v. Battle Creek Inc.*, 126 F.2d 405 (5th Cir. 1942); *Davis Hosp. Inc.*, 14 CCH Tax Ct. Mem. ¶ 45,097 (1945); *Clark D. Brooks*, 10 CCH Tax Ct. Mem. ¶ 51,335 (1951).

77. 9 Wash. 2d 284, 114 P.2d 976 (1941). See also *Board of Supervisors v. Vicksburg Hosp., Inc.*, 173 Miss. 805, 163 So. 382 (1935); *Rush Hosp. Benev. Ass'n v. Board of Supervisors*, 187 Miss. 204, 192, So. 829 (1940).

78. 9 Wash. 2d 284, 291, 114 P.2d 976, 984 (1941).

79. 204 Va. 807, 134 S.E.2d 258 (1964).

80. 2 Ohio St. 2d 30, 206 N.E.2d 2 (1965).

81. 338 Mass. 754, 157 N.E.2d 638 (1959).

82. 1969 INT. REV. BULL. No. 28.

arm's length; and (3) the amounts received are reasonable in terms of responsibilities and activities assumed under the contract. The IRS has thus made it clear that except in the circumstances carefully delineated in that ruling, "the use of a method of compensation based upon a percentage of the income of an exempt organization can constitute inurement of net earnings to private individuals."⁸³

Revenue Ruling 69-545

With the foregoing analysis as background, the meaning of Revenue Ruling 69-545 becomes clear. From its style and language, it is evident that it attempts to accomplish two purposes. First it sets forth the IRS's view of the charitable purpose of the nonprofit hospital. Second, by using contrasting situations, it places the exemption question in the private versus public interest context developed in federal and state court decisions.

Revenue Ruling 56-185, with its emphasis on free or below-cost care of those persons unable to pay for the services rendered, took a position consonant with the conservative (or "relief of poverty") approach described above. Revenue Ruling 69-545 modifies this earlier ruling with respect to its relief of poverty requirements and places the IRS on the side of the community benefit approach. The rationale of Revenue Ruling 69-545 begins with the statement that "the promotion of health is a charitable purpose." It goes on to recognize that a nonprofit organization whose purpose and activity are to provide hospital care and whose form of organization satisfies the requirements of a legal charity, may qualify as a charitable organization under Section 501(c)(3).⁸⁴ Another element of this approach in the ruling is contained in the statement that operation at an annual surplus of receipts over disbursements does not preclude [the hospital's] exemption, provided that all surplus funds are used for hospital purposes. So far, these are the basic elements of the liberal approach.

However the ruling goes one step beyond these requirements and thereby aligns itself with community benefit approach. It holds that promotion of health "is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, provided that the class is not so small that its relief is not of benefit of the community."⁸⁵ The fact that the hospital in the example (Hospital A) operates an emergency room open to all persons and that it provides hospital care "for *all* those persons in the community able to pay the cost thereof either directly *or through third party re-*

83. *Id.*

84. 26 U.S.C. § 501(c)(3) (1964).

85. 1969 INT. REV. BULL. No. 44.

*imbursement*⁸⁶ give evidence that it is promoting the health of a class of persons broad enough to benefit the community. In light of the analysis of the community benefit approach above, little comment is required upon these facts. The open emergency room and the willingness to take all paying patients (which would include Medicaid patients since hospitals are reimbursed for them) are the existential requirements imposed to insure that the charitable hospital is responsive to the community's needs. Although these two criteria will be subject to exceptions, they should still be easier to administer than the former unrealistic requirement that a charitable hospital must provide some undefined amount of free or below-cost service. The elimination of this anachronism is the great virtue of the recent ruling.

The ruling also offers contrasting fact patterns, involving Hospital A, which is exempt, and Hospital B, which is not. Although it is essentially a black and white distinction that is drawn, this approach has the advantage of offering guidelines as to what factors the IRS will consider in measuring private benefit and what facts it considers as evidencing public benefit. Among the former are: (1) retention of control by the founders of the proprietary institution; (2) restrictions on admission to the medical staff, to the exclusion of qualified doctors; (3) favorable rental arrangements with those controlling the organization; and (4) limiting emergency room and hospital admissions substantially to the patients of the controlling physicians. On the other hand, the following are indications of a strong commitment to serving the public: (1) control by independent civic leaders; (2) an open medical staff; (3) renting privileges available to all staff members; (4) an active and accessible emergency room; and (5) involvement in medical training, education, and research.

The ruling states that in determining private benefit, "the Service will weigh all of the relevant facts and circumstances in each case. The absence of particular factors set forth above or the presence of other factors will not necessarily be determinative."⁸⁷ With the publication of this ruling, however, the basic guideposts, long visible in the common law, have now been recognized by the Internal Revenue Service.

86. *Id.* (emphasis added).

87. *Id.*