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INTRODUCTION

The not-for-profit hospital[1] historically has played a central role in the delivery of American health care. In 1991, tax-exempt hospitals made up only one percent of all charitable organizations, but they accounted for over forty percent of all tax-exempt organizations' revenues.[2] In 1990, the value of federal, state, and local tax exemptions to hospitals was estimated at approximately five billion dollars.[3] However, changes in the financing of health care have resulted in the transformation of American health care away from community-focused, stand-alone, nonprofit hospitals toward consolidated, for-profit, multihospital systems.[4] Because the for-profit hospital industry has already largely consolidated, proprietary hospitals are now expanding by purchasing nonprofit organizations.[5]

Anecdotal evidence suggests a possible pattern of abusive behavior in the governance of nonprofit organizations,[6] including

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1. To avoid redundancy, this article uses the terms "charitable," "nonprofit," "not-for-profit," and "tax-exempt" interchangeably throughout to designate corporations that are exempt from taxation under section 503(c)(3) of the Internal Revenue Code ("IRC"). These terms are technically distinct.

2. *See* Richard T. Schulze, *Commentary*, 4 EXEMPT ORG. TAX REV. 263 (1991).

3. *See* John Copeland & Gabriel Rudney, *Federal Tax Subsidies for Not-for-Profit Hospitals*, 46 TAX NOTES 1559, 1560 (1990).

4. Ron Winslow & George Anders, *Not-for-Profit Hospitals Tempt Public Concerns: Many Are Takeover Targets As Nation's Big Chains Seek Ways to Expand*, WALL ST. J., Oct. 11, 1994, at A2.

5. Articles on this subject are numerous. *See, e.g., States Review Oversight Activity As Non-profit Hospital Sales Increase*, 4 BNA's HEALTH L. REP. 861 (June 8, 1995).

6. *See* Charles B. Gilbert, *Health-Care Reform and the Nonprofit Hospital: Is Tax-Exempt Status Still Warranted?*, 26 URB. LAW. 143, 155 (1994) (discussing several recent scandals involving upper management of nonprofit organizations).

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nonprofit hospital sales of questionable propriety.[7] One especially controversial incident involved the sale of fifty percent interest in four hospitals to a major hospital corporation. Two former members of the nonprofit hospital system's board of directors raised serious issues regarding the conduct of the system's chief executive officer and the chairman of its board of directors.[8] They portray a CEO intent upon forcing a sale by refusing possible management changes and other steps to avert a sale. Moreover, the directors allege that they were denied sufficient information upon which to base a decision—even to the point that board members were not told the final sale price.[9] Finally, one director alleged that the board was not informed of a higher offer by another purchaser.[10]

Other recent questionable incidents involve an entire hospital sale that was negotiated and consummated in less than four weeks,[11] a health system that fired twelve trustees of a local hospital after they voiced opposition to an agreement with a major for-profit corporation,[12] and allegations that hospital executives personally benefited from sales to proprietary entities.[13] These accounts raise serious concerns whether these sales are being consummated for private gain rather than for the public good.

One common response to allegations of improper conduct of the parties involved in the sale of nonprofit hospitals has been that the hospitals were independently valued and that the final sale price met or exceeded this valuation. This article examines the valuation process and relates that process to the laws that regulate the sale of a nonprofit hospital to a proprietary entity. Flaws in the oversight of such sales are examined, and a solution

7. *See, e.g.*, Adventist Health Care Sys. v. Nashville Mem'l Hosp., 914 S.W.2d 903 (Tenn. Ct. App. 1995); *see also* Andrea Gerlin, *Hospital in Florida Is Focus of Probes Tied to Scuttled Bid by Columbia/HCA*, WALL ST. J., May 8, 1995, at B10 (detailing allegations that the president of a Florida hospital intentionally devalued the hospital in an attempt to sell it at an attractive price to a proprietary chain).

8. Sandy Lutz, *How Much?: Price Is Becoming a Contentious Issue in Sales of Not-for-Profit Hospitals, As Communities Seek Fair Value and Challenge Secrecy*, MOD. HEALTHCARE, Feb. 12, 1996, at 85.

9. *See id.*

10. *See id.* at 92.

11. *See* Alex Pham, *New Orleans Battle Site of Hospital Takeover War*, COM. APPEAL, Sept. 17, 1995, at C1.

12. Editorial, *Ceding Local Control Is the Price to be Paid for System Advantages*, MOD. HEALTHCARE, June 5, 1995, at 36.

13. *See, e.g.*, Harris Meyer et al., *Selling . . . Or Selling Out*, HOSPS. & HEALTH NETWORKS, June 5, 1996, at 21, 28.

is proposed to solve the problem of attaining an accurate valuation of a nonprofit hospital.[14]

The sale of the assets of a nonprofit corporation is governed largely by state law.[15] In order to understand this body of law, it is important to first understand the various ways a sale may be structured. Typically, the sale of tax-exempt hospitals will fall into one of four categories. Some hospitals will sell their assets and remit the proceeds into an existing tax-exempt charitable trust.[16] Others will transfer funds into a newly created not-for-profit corporation subject to charitable trust principles that will make grants to support health-related projects in the hospital's community.[17] In some situations a multihospital corporation will sell one of several community hospitals and keep the money for its other operations.[18] One other variation consists of the nonprofit corporation transferring its hospital assets to a for-profit joint venture. The nonprofit receives cash equal to the value of its contribution and remains a "passive" investor in the joint venture.[19] Regardless of the sale's structure, the valuation of the hospital's assets is critical to the success of the transaction since the proceeds from the sale of a tax-exempt hospital must continue to serve a charitable purpose.[20]

I. THE VALUATION PROBLEM

In selling the assets of a hospital, as with any business, one crucial step is to obtain an independent valuation report from an

14. Of course, there are many laws that may impact the sale of health care facilities, including but not limited to antitrust laws, Medicare and Medicaid laws, state licensure acts, certificate of need laws, labor and employment laws, and environmental law. This list is by no means exhaustive.

15. Currently, most oversight of the nonprofit corporations is left to the state. *See, e.g., , States Review Oversight, supra* note 5. However, there is proposed legislation by Representative Stark, D-Cal., that would impose significant federal oversight over all conversion of tax-exempt hospitals. *See* Medicare & Nonprofit Protection Act of 1997, H.R. 443, 105th Cong., 1st Sess. (1997) (denying Medicare payment to any hospital that does not demonstrate the fairness of the conversion process to the Secretary of Health and Human Services).

16. INTERNAL REVENUE SERV., EXEMPT ORGANIZATION CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM TEXTBOOK FOR FISCAL YEAR 1996, 393 (1995) [hereinafter 1996 CPE TEXT].

17. *Id.* at 394.

18. *Id.* at 303.

19. Robert A. Boisture & Douglas N. Varley, *State Attorneys General's Legal Authority to Police the Sale of Nonprofit Hospitals and HMOs*, 13 EXEMPT ORG. TAX REV. 227, 227 (1996).

20. *See* Daniel Coyne & Kathleen Kas, *The Not-for-Profit Hospital as a Charitable Trust: To Whom Does Its Value Belong?*, 24 J. HEALTH & HOSP. L. 48, 50 (1991).

outside source.[21] A valuation is the process of appraising the "fair value" of the assets being sold, defined as the price at which a rational seller with knowledge of the relevant facts would sell the assets in an arm's-length transaction.[22] Traditionally, three different methods of corporate valuation are used: cost or asset valuation, market comparison, and income or cash flow determination.[23] The cost method involves determining the replacement cost of an asset. For a hospital, this means determining how much it would cost to build a new hospital, with an allowance for depreciation. The market comparison approach involves comparing the sale price of comparable assets or businesses.[24] Finally, the most widely accepted methodology, the income or cash flow method,[25] involves projecting a hospital's earnings potential.[26] This valuation method is the most accepted because the ability of a hospital to generate cash flow, i.e., the going concern value, typically results in a much higher valuation than simply valuing a hospital's hard assets.[27] However, if there is substantial local competition in a managed care market, cash flow may be at a loss and may cause the fair market value to be less than the book value of the assets. An appraisal report will attempt to reconcile these three different methods to arrive at an overall reasonable valuation.[28]

The concept of value depends entirely upon context, exemplifying the law school adage that "the answer you get depends upon the question you ask." A valuation for purposes of ob-

21. *See* Doyle v. Union Ins. Co., 277 N.W.2d 36, 41 (Neb. 1979) (finding board negligent for approving the sale of assets without obtaining an independent valuation).

22. There is no definition of "fair value" for sales of nonprofit entities. This article borrows the term from Delaware law. DEL. CODE ANN. tit. 8, § 262(h) (1991); *see* Charles Nathan & K. L. Shapiro, *Legal Standard of Fairness of Merger Terms Under Delaware Law*, 2 DEL. J. CORP. L. 44, 48 (1977); Michael Schwenk, Note, *Valuation Problems in the Appraisal Remedy*, 16 CARDOZO L. REV. 649, 653 (1994). There may be other compelling definitions, but this article leaves that issue for discussion at another time. For a discussion regarding different definitions of fairness, see Lucian A. Bebchuk & Marcel Kahan, *Fairness Opinions: How Fair Are They and What Can Be Done About It?*, 1989 DUKE L.J. 27.

23. JAMES J. UNLAND, THE VALUATION OF HOSPITALS AND MEDICAL CENTERS 2-3 (1993).

24. *See, e.g.*, Weinberger v. UOP, Inc., 457 A.2d 701, 712 (Del. 1983); Citron v. E.I. DuPont de Nemours & Co., 584 A.2d 490, 495 (Del. Ch. 1990) (using market comparison methodology to value business).

25. *See Weinberger*, 457 A.2d at 712; *Citron*, 584 A.2d at 495; UNLAND, *supra* note 23, at 50.

26. *See Weinberger*, 457 A.2d at 712.

27. *See* UNLAND, *supra* note 23, at 19.

28. *See id.* at 3.

taining a loan or on behalf of a group of investors interested in a hospital may be very different from one prepared for a hospital considering a merger or sale.[29] Even valuations for purposes of a sale may vary. For example, a hospital's value as an independent entity may differ from its sale price if auctioned off to the highest bidder, or its sale price if sold following bilateral, arm's-length dealings with a single potential purchaser.[30] Ultimately, any market valuation must also take into account the underlying business fundamentals of a hospital, including market share, utilization, quality of facilities, and cash flow.[31] Other relevant factors that may affect a hospital's value include the vitality of the medical staff, trends in managed care contracting, payor mix, and ease of entry of competition in the market.

In making a valuation, any analysis must make a variety of simplifications, assumptions, and estimates. Because appraisers simplify, assume, and estimate in different ways, all of which may be reasonable and justifiable, it may be possible for the same entity to have a range of different estimates of fair price, depending upon who conducts the valuation.[32] For this reason, one can readily appreciate the exasperation that led one court to declare: "Valuation is an art rather than a science."[33] This statement aptly summarizes the opinion of many courts and legal commentators who have pronounced considerable skepticism regarding the valuation process.[34]

Hospital valuations are, arguably, even more complex than valuations of other entities because the nature of the hospital industry presents unique problems. The health care marketplace has undergone, and continues to undergo, tremendous structural changes. This state of constant flux makes any determination of valuation suspect. Hospitals are specialized, single-use institutions, and each hospital is unique in terms of its size, scope of services, condition of facilities, market share, and pa-

29. *See id.* at 30-31.

30. Bebchuk & Kahan, *supra* note 22, at 32.

31. UNLAND, *supra* note 23, at 50-51; *see also* Tri-Continental Corp. v. Battye, 74 A.2d 71, 72 (Del. 1950) (indicating that factors in valuing a corporation for purposes of a "freeze-out" merger should include market value, asset value, dividends, earnings prospects, the nature of the enterprise, and other facts that were known or could be ascertained as of the date of the merger and that throw any light on the future prospects of a merged corporation).

32. Bebchuk & Kahan, *supra* note 22, at 34.

33. *In re* Shell Oil Co., 607 A.2d 1213, 1221 (Del. 1992).

34. *See id.* at 1221; *Weinberger,* 457 A.2d at 712; Bebchuk & Kahan, *supra* note 22, at 27; Schwenk, *supra* note 22, at 650.

tient mix.[35] Oftentimes a little-known factor called Medicare gain/loss recapture may be the single most important factor driving a hospital's purchase price, an issue not present in other facilities or industries.[36] These factors limit the usefulness of traditional valuation methodologies such as the market comparison, cost, and income approaches.

Given the unique characteristics of hospitals, the market comparison approach to valuation is of little use. Sales of hospitals are still relatively rare events, and hospitals that are merging or selling are often financially distressed, meaning that traditional valuation principles may not accurately measure the facility's value.[37] Several factors contribute to the problem of obtaining an accurate value using the market comparison approach: the number of potential buyers for a hospital is often, but not always, quite limited; there are significant regulatory and operational barriers to owning a hospital; and a hospital's assets are of value only when the hospital is operated as a specialized ongoing concern, unless the purchaser's objective is to shut the facility down and be rid of competition.[38] Establishing market comparisons to value a hospital is further hindered because the terms of many sales are kept confidential.[39] Because there is a limited "competitive market" for hospitals, each hospital must be valued in its own context, and the use of comparative valuation analysis is of marginal benefit.[40]

Similarly, the cost or asset valuation method also has severe drawbacks as applied to health care entities. Land associated with an existing health facility, or facility to be constructed, has a special purpose with a value tied to the value of the facility itself. For instance, a piece of real estate may be especially valuable to a hospital because of the patient mix of the surrounding population. This means that it is difficult to value hospital land

35. UNLAND, *supra* note 23, at 4.

36. 42 U.S.C. § 1395x(v)(1)(o) (1994); 42 C.F.R. § 413.134(f) (1996). *See, e.g.*, St. Mark's Hosp. v. Blue Cross & Blue Shield Ass'n/Blue Cross & Blue Shield of Utah, [1993-1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 41,304 (Provider Reimbursement Review Bd. Feb. 19, 1993), *aff'd*, St. Mark's Charities v. Shalala, No. 93-C-565 S, 1996 U.S. Dist. LEXIS 20203 (D. Utah Nov. 4, 1996) (Magistrate's Report and Recommendation), *aff'd*, No. 2:93-CV-0565-S, 1997 U.S. Dist. LEXIS 958 (D. Utah Jan. 27, 1997).

37. *See* UNLAND, *supra* note 23, at 5.

38. *See id.*

39. *See* Lutz, *supra* note 8, at 85; David Segal, *Hospital Venture Leaves Public in Dark; Officials Shroud Arlington-Columbia/HCA Deal in Veil of Silence*, WASH. POST, Mar. 4, 1996, at F5.

40. UNLAND, *supra* note 23, at 4.

and property as improved for "highest and best use" because the hospital facility derives its value primarily from its specialized operations.[41]

Estimates based upon cash flows may also be problematic due to the constantly shifting nature of the health care delivery system in the United States. Because cash flow analysis, by its very nature, depends upon a corporation's ability to generate future earnings, an appropriate valuation must take nonspeculative future events into account.[42] Future estimates related to cash flows include the future investment rate, new product development, market competition, and the general political climate.[43] A valuation must include a discount rate, based upon risk and other factors that are highly subjective.[44] Using a cash flow method to predict hospital revenues may be especially difficult because of fluctuations in payment methodologies by third-party payers.[45] The discounted cash flow methodology does not provide enough information upon which to base a final purchase decision for a complex organization such as a hospital. However, it can be useful in giving administrators and board members an initial rough overview of value that is based upon potential income at various assumed rates of return.[46]

Although valuing any medical facility is difficult, the process of valuing nonprofit hospitals is even more so. Typically, a large proprietary company's value is established through the market system, and a company's minimum value is reflected by the aggregate value of its stock.[47] To the extent that a company's value increases or decreases, that change is reflected in the value of its stock. Moreover, for-profit entities are, by definition, profit seeking, maximizing the shareholder's return. A tax-exempt entity is not valued through the free market, nor is it designed to maximize profits. Indeed, tax-exempt hospitals

41. *Id.* at 14; *see also* Winslow & Anders, *supra* note 4, at A2 (discussing cultural differences between for-profit and nonprofit hospitals, which increases the difficulty associated with nonprofit acquisition).

42. *See, e.g.*, Weinberger v. UOP, Inc., 457 A.2d 701, 713 (Del. 1983).

43. Bebchuk & Kahan, *supra* note 22, at 35.

44. *Id.*

45. UNLAND, *supra* note 23, at 20.

46. *Id.* at 50.

47. It may be possible for a company's value to exceed the aggregate price of its stock in some situations, especially where a controlling block of shares is involved. Hence, in some takeover situations there is a "control premium" offered. *See, e.g.*, Zetlin v. Hanson Holdings, Inc., 397 N.E.2d 387, 388 (N.Y. 1979).

must provide charitable care as a condition of being tax exempt.[48]

It is important to recognize that a charitable hospital's worth may not be reflected in its market value or in the revenues it may generate. The hospital may have value because it exists to fulfill a notion of community mission and purpose, including providing charity care, education, or community service.[49] It may be impossible to attach a true financial measure to a hospital that serves as the sole institutional provider of health care services in a given community.

One final point related to valuation should be noted: some scholars have theorized that the individuals making a valuation may use their discretion in rendering opinions to serve the interests of the managers seeking the valuation.[50] Under this theory, valuations will tend to serve the interests of those officers and directors who selected those individuals making the valuation.[51] This prospect is especially significant in the nonprofit realm, where boards of directors may tend to be less involved in the company's operations than boards of for-profit corporations.

II. LEGAL OVERVIEW

The conversion of *any* tax-exempt entity to for-profit use is limited by three different sources of authority. Of primary importance are state corporate and charitable trust laws. State law imposes fiduciary duties of care, loyalty, and good faith on a hospital's board of directors.[52] Hence, each director must carefully scrutinize all facets of the sale to make an informed decision in the best interests of the community. A breach of these duties may result in individual liability being imposed on the hospital's directors.[53] Additionally, a sale may trigger scrutiny from attorneys general and/or courts because states often impose restrictions upon the change in use of charitable assets

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

49. UNLAND, *supra* note 23, at 6.

50. *See, e.g.*, Bebchuk & Kahan, *supra* note 22, at 37.

51. *Id.*; *see also* Alabama By-Products Corp. v. Neal, 588 A.2d 255, 258 (Del. 1991) (indicating that a valuation could be suspect because it depended entirely upon information provided by defendants who were self-interested).

52. *See* MARILYN PHELAN, NONPROFIT ENTERPRISES: LAW AND TAXATION § 4.04 (1985).

53. There are specific provisions for derivative suits in section 8.30(a) of the REVISED MODEL NONPROFIT CORPORATION ACT (1987) [hereinafter RMNCA].

under state trust laws.[54] Attorneys general in Michigan, Florida, Massachusetts, Ohio, Rhode Island, Tennessee, and California, among others, have recently scrutinized hospital sales, in some cases even obtaining independent appraisals of a hospital's value before allowing a sale to proceed.[55] Finally, the Internal Revenue Service ("IRS") may monitor a sale for compliance with laws governing tax-exempt organizations.

Although these sources of law are intended to protect community assets, they may be insufficient to ensure that charitable resources are used for the good of the community and valued appropriately. Many commentators and public advocates have argued that there is inadequate supervision of nonprofit corporations.[56] Traditional principles of corporate law are of limited applicability in the not-for-profit setting, and attorneys general have multiple responsibilities and limited resources.[57] The nature of the nonprofit form, particularly in nonmembership corporations, leads to self-perpetuating boards accountable to the public, but with little actual public oversight.[58] Finally, the IRS is a relative newcomer to overseeing charitable activities,[59] and its enforcement powers are limited.

It is important to realize that directors of a charitable organization are more familiar than any outsider with that organization, and they are likely to be the parties best able to put a monetary value on that organization.[60] Indeed, even though there are tremendous shortcomings in the operation of charitable boards, the members of these boards have a crucial advan-

54. *See* Yale Univ. v. Blumenthal, 621 A.2d 1304 (Conn. 1993); RESTATEMENT (SECOND) OF TRUSTS §399 (1959).

55. Kelley v. Michigan Affiliate Healthcare Corp., File No. 96-83848-C2 (Mich. Cir. Ct., Ingham County, Sept. 5, 1996); 5 BNA's HEALTH L. REP. 1803 (Dec. 12, 1996); 4 BNA's HEALTH L. REP. 1473 (Sept. 28, 1995) (describing attorneys general's responses to nonprofit conversion activity).

56. Meyer et al., *supra* note 13, at 24.

57. *See* James J. Fishman, *The Development of Nonprofit Corporation Law and an Agenda for Reform*, 34 EMORY L.J. 617, 668 (1985); *see also* NAT'L ASS'N OF ATT'YS GEN., COMMITTEE ON THE OFFICE OF THE ATT'Y GEN., STATE REGULATION OF CHARITABLE TRUSTS AND SOLICITATIONS 9 (1977) (indicating that, in 1977, it was "doubtful" that there were sufficient personnel assigned to monitor charitable activity). More recent analysis of attorney general involvement in policing charities is unavailable, but in light of reduced government resources throughout the 1980s and 1990s, it appears reasonable to speculate that enforcement activities have failed to keep pace with the growing number and worth of charitable entities.

58. Fishman, *supra* note 57, at 677.

59. NAT'L ASS'N OF ATT'YS GEN., *supra* note 57, at 23.

60. *See, e.g.*, Saul Levmore, *Self-Assessed Valuation Systems for Tort and Other Law*, 68 VA. L. REV. 771 (1982).

tage over the IRS and state enforcement authorities in that they theoretically represent their community and should be familiar with the operations of their organizations on an ongoing basis. Valuation by other parties, including judges or appraisers, increases the possibility of inaccuracies and the risk of corruption.[61] Thus, although there is considerable anecdotal evidence that board-level decision making regarding hospital sales has tended to lead to undervalued assets,[62] a hospital's board of directors should play a crucial role in hospital governance; there is no good reason to limit this role in conducting a sale. Instead, until more effective methods of regulating charitable entities are created, it may be best for the states to establish and enforce rigorous procedural protections for hospital sales to ensure that corporate boards properly exercise their duties of corporate governance.

A. State Corporate Law

A tax-exempt hospital's board of directors must exercise fiduciary duties of care and loyalty when selling the hospital.[63] Although at one time the legal standard for directors of nonprofit corporations was uncertain because courts could not decide whether to apply a trustee standard or the lower standard of corporate law,[64] the Revised Model Nonprofit Corporation Act ("RMNCA") established that directors of nonprofit corporations are held to the more lenient corporate duty standard.[65] The result of this shift is significant. The trustee standard historically attempted to ensure absolute loyalty through rigid

61. *Id.*

62. *See, e.g.,* Lutz, *supra* note 8, at 85.

63. *See* Litwin v. Allen, 25 N.Y.S.2d 667, 677-78 (N.Y. Sup. Ct. 1940); RALPH FERRARA ET AL., SHAREHOLDER DERIVATIVE LITIGATION: BESIEGING THE BOARD § 5.01[1] (1996); James Edward Harris, *The Nonprofit Corporation Act of 1993: Considering the Election to Apply the New Law to Old Corporations*, 16 U. ARK. LITTLE ROCK L.J. 1, 16 (1994); Michael Peregrine, *Doing "Big Deals" and the Board's Duty of Care*, 28 J. HEALTH & HOSP. L. 327 (1995).

64. Committee on Charitable Trusts, *Duties of Charitable Trust Trustees and Charitable Corporation Directors*, 2 REAL PROP. PROB. & TR. J. 545 (1967); *see also* PHELAN, *supra* note 52, § 4.04; Fishman, *supra* note 57, at 649 (indicating that the trustee standard of care is more stringent than the business judgment standard now used for directors of corporations).

65. RMNCA, *supra* note 53, § 8.30(e) cmt. 1. For an overview of the RMNCA's impact upon charities, as well as a discussion of the attorney general's enforcement of charitable standards, see Michael C. Hone, *Aristotle and Lyndon Baines Johnson: Thirteen Ways of Looking at Blackbirds and Nonprofit Corporations - The American Bar Association's Revised Model Nonprofit Corporation Act*, 39 CASE W. RES. L. REV. 751 (1989).

prohibitions upon self-dealing and other conflicts,[66] but corporate principles do not prohibit conflict-of-interest transactions altogether, under the theory that some such transactions may at times benefit the corporation.[67]

Section 8.30 of the RMNCA establishes a duty of care that is analogous to the for-profit standard.[68] It provides that a director must discharge his or her duties in good faith, with the care an ordinarily prudent person in a like position would exercise under similar circumstances, and in a manner the director reasonably believes to be in the best interests of the corporation.[69] Moreover, under the "business judgment rule," when determining whether a director of a nonprofit corporation has acted appropriately, courts presume that in making business decisions, the directors of a corporation have acted in good faith and in an honest belief that the action taken was in the best interest of the corporation.[70] Comments in the RMNCA indicate that a board should be subject to scrutiny under the business judgment rule only where compliance with section 8.30 has not been established.[71] Moreover, pursuant to section 8.30, the standard of conduct for a board should take into account the not-for-profit nature of the organization as well as its own objectives and resources.[72] These factors, combined with the historical deference received by nonprofit boards due to recognition of their nonprofit status,[73] effectively leads to a reduced standard of corporate duty.

The protections of the business judgment rule are available only when directors have fulfilled their duty of loyalty.[74] With respect to a proprietary company, a director's loyalty may be questioned if the director stands to receive a substantial personal benefit from, or to be substantially harmed as a result of, a

66. Fishman, *supra* note 57, at 648.
67. PAT CHEW, DIRECTORS' AND OFFICERS' LIABILITY 77 (1996).
68. RMNCA, *supra* note 53, § 8.30; *see also* MODEL BUSINESS CORP. ACT § 8.30 (3d ed. 1979) (analogous section applicable to for-profit corporations).
69. RMNCA, *supra* note 53, § 8.30(a).
70. United Copper Sec. Co. v. Amalgamated Copper Co., 244 U.S. 261, 263-64 (1917).
71. RMNCA, *supra* note 53, at 216.
72. *Id.* at 214.
73. HOWARD L. OLECK & MARTHA E. STEWART, NONPROFIT CORPORATIONS, ORGANIZATIONS AND ASSOCIATIONS 889 (1994); Peregrine, *supra* note 63, at 327.
74. FERRARA ET AL., *supra* note 63, § 5.03[2].

particular business decision.[75] However, section 8.31 of the RMNCA limits the applicability of the business judgment rule to specific categories of conflict-of-interest transactions that may raise questions with respect to a director's loyalty. These include situations where a director (1) has a "direct" interest in the transaction (such as where the director himself is participating on the other side of the transaction); (2) is a general partner in a partnership or a director, officer, or trustee of another entity that has an interest in the transaction; or (3) has a material interest in an entity that has an interest in the transaction.[76] In all other situations, a director must act "in good faith . . . in a manner the director reasonably believes to be in the best interests of the corporation."[77] The relatively narrow conflict-of-interest provisions of section 8.31 remove directors from scrutiny for breach of loyalty in many situations that could arguably affect their judgment. For example, a director may have received an offer of employment with the prospective purchaser, contingent upon consummation of the sale of the hospital to that purchaser, or the purchaser may indicate that it will provide "golden parachutes" to key officers. Here, the RMNCA's conflict-of-interest provisions will not be triggered, and rather than bearing the burden of proving the fairness of the transaction, the directors will be entitled to the deference afforded under section 8.30.[78]

The validity of appraisals conducted at the behest of individuals who stand to benefit from a particular transaction is frequently questioned. Much of the law in this area has been created as a result of squeeze-out mergers, where some of the owners or participants in a business enterprise use strategic position, inside information, or powers of control to eliminate one or more other owners or participants from the enterprise.

75. *See* Cede & Co. v. Technicolor, Inc., 634 A.2d 345 (Del. 1993), *modified in part*, 636 A.2d 956 (Del. 1994); Aronson v. Lewis, 473 A.2d 805, 812 (Del. 1984); FERRARA ET AL., *supra* note 63, § 5.03[2][a].

76. RMNCA, *supra* note 53, § 8.31 cmt. 1.

77. *Id.*

78. The IRS recently issued a Sample Conflicts of Interest Policy that would address some of these concerns. INTERNAL REVENUE SERV., EXEMPT ORGANIZATION CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM TEXTBOOK FOR FISCAL YEAR 1997, at 25 (1996) [hereinafter 1997 CPE TEXT]. However, although the 1997 CPE TEXT provides insights into the IRS's position with respect to these issues, the IRS has yet to take action against any person or entity with respect to actions that would breach this policy, and as a result, it is impossible to ascertain whether this policy will have a significant impact on board behavior.

Often, the context of these cases is a merger between a corporation and its controlling stockholder, which typically appoints one or more directors of the merged corporation. In these situations, courts recognize that there is a potential to understate value because insiders stand on both sides of the transaction.[79]

Courts have stated that the weight to be ascribed to expert valuations necessarily depends upon the assumptions underlying them.[80] A valuation may thus be questionable because the data supporting it may, in some instances, be provided by individuals of dubious loyalty.[81] In addition, two commentators have identified strong incentives, including monetary benefits, for appraisers to render opinions serving those interests of officers and directors who wield the power to select the appraisers and to set their compensation arrangements, in other words, the management of the entity they are valuing.[82]

Courts recognize the vagaries of the valuation process. Thus, in reviewing a squeeze-out merger, a court will examine the "entire fairness" of the merger, including the facts and circumstances behind the merger ("fair dealing") and whether the terms of the merger are fair to the minority shareholders ("fair price").[83] Courts have even gone so far as to examine the actions of "independent" committees in interested merger transactions.[84] As one court stated: "The controlling stockholder relationship has the inherent potential to influence, however subtly, the vote of minority stockholders in a manner that is not likely to occur in a transaction with a noncontrolling stockholder."[85] Accordingly, in squeeze-out mergers, a court does not simply accept a valuation, but it reviews every aspect of the transaction to ensure fairness.

Applying the rigorous standard utilized in reviewing squeeze-out mergers to sales of nonprofit hospitals could significantly decrease the possibility that hospitals will be undervalued. Managers of nonprofit corporations wield enormous power, and often

79. *See, e.g.*, Weinberger v. UOP, Inc., 457 A.2d 701 (Del. 1983); Cede & Co. v. Technicolor, Inc., No. 7129, 1990 Del. Ch. LEXIS 259 (Oct. 19, 1990), *aff'd in part, rev'd in part*, 634 A.2d 345 (Del. 1993), *modified in part*, 636 A.2d 956 (Del. 1994).

80. *See* Cavalier Oil Co. v. Harnett, 564 A.2d 1137, 1143-44 (Del. 1989).

81. Alabama By-Products v. Neal, 588 A.2d 255, 257 (Del. 1991).

82. Bebchuk & Kahan, *supra* note 22, at 37.

83. Kahn v. Lynch Communication Sys., Inc., 638 A.2d 1110, 1115-16 (Del. 1994); *Weinberger*, 457 A.2d at 703.

84. *Kahn*, 638 A.2d at 1117-18; Citron v. E.I. DuPont de Nemours & Co., 584 A.2d 490, 501 (Del. Ch. 1990).

85. *Citron*, 584 A.2d at 502.

they are unchecked by their boards of directors.[86] As a result, hospitals may be sold in transactions that appear to be legitimate, but that are instead initiated at the behest of a few interested individuals. Such a result is made even more likely by the relatively lax conflict-of-interest standards contained in the RMNCA (or similar state laws governing nonprofit corporations), which do not preclude managers who may benefit financially from a sale from participating in sale deliberations.[87] Any valuation or transaction conducted at the behest of individuals who stand to gain from a transaction is questionable and should be viewed from an "entire fairness" perspective.[88] In the context of a sale of assets, the RMNCA and other corporate laws fail to establish sufficient standards of conduct to ensure procedural fairness and reduce the risk of undervaluation. An entire-fairness standard of review would reduce these possibilities.

B. Attorney General Review

While the actions of nonprofit directors are subject to corporate standards of conduct, the assets of a tax-exempt entity itself are governed by state charitable trusts laws.[89] When property is given to a charitable corporation, the corporation is under the same duty as a charitable trust to devote that property to specified charitable purposes.[90] Two commentators contend that court approval and attorney general review are necessary prerequisites for the sale of any nonprofit hospital.[91] Although there is some authority that supports this position, the preponderance of authority vests in the directors of a nonprofit corporation the discretion to sell hospital assets in furtherance of the charitable mission of the corporation.[92]

It is generally settled that a court of equity has the power to authorize a sale of trust property contrary to the intent of the

86. Fishman, *supra* note 57, at 674-75.

87. RMNCA, *supra* note 53, § 8.31.

88. This approach contrasts with the approach taken by the IRS, *see supra* note 78 and accompanying text, which requires disclosure of any interests an officer or director may have related to a hospital sale, but which will allow a sale if it is accompanied by an "appropriate" valuation.

89. *See* WILLIAM F. FRATCHER, SCOTT ON TRUSTS § 348.1 (1989); Fishman, *supra* note 57, at 649-50.

90. Fishman, *supra* note 57, at 651.

91. Boisture & Varley, *supra* note 19, at 227.

92. FRATCHER, *supra* note 89, § 348.1.

trust,[93] and that a state attorney general, as the representative of the public or those specially benefited, has the right to protect or enforce charitable trusts.[94] This power may be derived from either specific statutory authority or common law.[95] Even though many states require nonprofit corporations to provide some notice to the attorney general before selling all or a substantial portion of their assets, these notice provisions do not expand the power of the attorney general to police sales beyond the law of charitable trusts.[96]

As a general rule, the law of charitable trusts empowers directors of a nonprofit hospital to sell property if the sale of that property plausibly furthers the organization's purposes and is not subject to a donor's restrictions.[97] The manner of the sale is within the discretion of the trustee.[98] The standard of review for trustees is highly discretionary. When a trustee acts in good faith, with proper motives, and within the bounds of reasonable judgment, a court will not interfere with the trustee's judgment.[99] Under this standard, a court or an attorney general may be powerless to stop a sale unless the hospital's funds are donor restricted.[100]

In some instances there may be a restriction that requires court involvement, such as a requirement not to sell donated land or a provision that a gift must be used in the operation of a hospital.[101] Even when there are donative restrictions on charitable gifts, a court may find that the hospital's board of directors has an implied power of sale if the sale furthers the hospital's

93. RESTATEMENT (SECOND) OF TRUSTS § 381 (1959); C.T. Foster, Annotation, *Constitutionality, Construction, and Effect of Legislation Authorizing Sale of Charitable Trust Property*, 40 A.L.R.2d 556, 559 (1955).

94. RESTATEMENT (SECOND) OF TRUSTS § 391 (1959); R.E.H., Annotation, *Who May Maintain Suit or Proceedings to Enforce or Administer Benevolent or Charitable Trusts*, 62 A.L.R.2d 881, 882 (1929).

95. GEORGE BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 742 (rev. 2d ed. 1980); FRATCHER, *supra* note 89, § 399 note 2.

96. *See, e.g.*, CAL. CORP. CODE § 5913 (West Supp. 1997); GA. CODE ANN. § 14-3-1202(g) (1994); MO. REV. STAT. § 355.656(7) (Supp. 1997); MONT. CODE ANN. § 35-2-617(7) (1995); N.C. GEN. STAT. § 55A-12-02(g) (1996); OR. REV. STAT. § 65.534(7) (1995); RMNCA, *supra* note 53, § 12.02(g).

97. M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 S. CAL. L. REV. 1035, 1136 (1992).

98. FRATCHER, *supra* note 89, § 190.6.

99. *Id.* §§ 187, 190.6.

100. *Id.* § 187 (indicating that a court will not control a trustee's discretion as long as the trustee does not exceed the bounds of reasonable judgment).

101. *Id.* § 187.

charitable purpose.[102] As a result, an attorney general may be powerless to stop a sale that is deemed necessary by a hospital's board of directors.[103]

Although an attorney general may lack the power to prevent a sale, the law of charitable trusts is clear that any charitable assets should be sold at *maximum price*. In furtherance of this requirement, the selling party should attempt to secure competitive bidding and take other steps to sell the property at the greatest possible advantage.[104] This makes sense, because an independent valuation conducted at the behest of an attorney general may depend upon information provided by the managers of the hospital that is for sale. As discussed above, the resulting appraisal may be of questionable use. Worse yet, an independent appraisal may be conducted without the cooperation of the hospital's management, resulting in increased costs and risk of inaccuracies.[105] Utilizing the competitive bidding process minimizes these concerns. Furthermore, courts tend to give credence to sales utilizing the competitive bidding process.[106]

An appropriately conducted auction of a section 501(c)(3) hospital to the highest bidder eliminates most valuation problems.[107] Because bidders will be competing against each other, their bids should reflect some of the synergies that they expect as a result of the sale. The result should be that the final sale price should exceed the value of the hospital as a stand-alone entity. Moreover, such a sale would also mitigate the incentive of insiders to devalue a hospital in order to align themselves with a particular purchaser.[108] In light of the difficulties in

102. BOGERT, *supra* note 95, § 741.

103. A newly enacted Nebraska law, entitled the Nonprofit Hospital Sale Act, specifically empowers the attorney general to approve the purchase of any nonprofit hospital. NEB. REV. STAT. § 71-20104 (Supp. 1996). Similar legislation has been enacted in California. *See* CAL. CORP. CODE § 5914(a)(1) (West Supp. 1997). Other jurisdictions are also considering enactment of similar legislation. *See, e.g., Conversion Bill Requires Prior Notice for Non-Profit and For Profit Transfers*, 6 BNA's HEALTH L. REP. 507, 507 (Apr. 3, 1997).

104. BOGERT, *supra* note 95, § 745.

105. *See* Levmore, *supra* note 60, at 771.

106. Revlon v. MacAndrews & Forbes Holdings, Inc., 506 A.2d 173, 181 (Del. 1986); Bebchuk & Kahan, *supra* note 22, at 32.

107. The IRS has regarded the bidding process favorably in several private letter rulings. *See* Priv. Ltr. Rul. 82-19-066 (Feb. 12, 1982); Priv. Ltr. Rul. 84-18-127 (May 9, 1984); Priv. Ltr. Rul. 95-38-026 (June 26, 1995).

108. Of course, this solution depends upon the ability of a hospital to solicit a sufficient number of bidders to obtain truly competitive bids and minimize the possibility of collusion. The author recognizes that this may be difficult to do in some circumstances.

the valuation process, an attorney general may credibly make the argument that a hospital has not been sold for maximum price as required under the law of trusts unless there has been a competitive bidding process.

Of course, selling a nonprofit hospital to the highest bidder might undermine the mission of the tax-exempt entity. As discussed earlier, a hospital's sale does not extinguish the mission of the tax-exempt entity where charitable assets remain following a sale. The selling entity must continue to serve its mission by operating other facilities or by establishing a charitable foundation to serve others. Another means for the seller to ensure the continuation of its charitable mission is to base the sale upon factors such as commitment to charitable care and respect for religious or charitable tradition. Such considerations may justify a hospital accepting a lower bid from an entity that agrees to continue some or all of the hospital's charitable mission.

On the other hand, it is also important to recognize that criteria unrelated to price can increase the possibility of an abuse of discretion related to the sale. One means to mitigate this problem somewhat would be to assign a weight to *all* criteria before soliciting bids. These criteria would be distributed along with a request for proposals, contingent upon approval of the attorney general.

C. The IRS's Response

1. Tax Overview

Most nonprofit hospitals obtain federal income tax exemption through section 501(c)(3) of the Internal Review Code. In order to receive an exemption under section 501(c)(3), an entity must be organized and operated exclusively for religious, charitable, educational, scientific, or literary purposes.[109] Under the organizational test, the organizational documents of a section 501(c)(3) entity must limit it exclusively to the performance of exempt purposes and must provide that upon dissolution the entity's assets be distributed for one or more exempt purposes.[110] Hospitals qualify for section 501(c)(3) exemption because they

109. I.R.C. § 501(c)(3) (1994). State tax exemption uses different tests, but largely relies upon federal standards. However, standards for property tax exemption may be tied directly to the charitable contribution a hospital makes to its community. *See, e.g.,* Utah County v. Intermountain Health Care, Inc., 709 P.2d 265 (Utah 1985).

110. Treas. Reg. § 1.501(c)(3)-1(b) (1996).

promote health, a purpose that the IRS has recognized constitutes a charitable purpose in and of itself.[111]

In addition to meeting organizational requirements, a tax-exempt hospital must be careful to ensure that it operates solely for a charitable purpose. That is, it must operate within the parameters of the private inurement and private benefit tests. "Inurement" occurs whenever a person in a position to influence the decisions of an exempt organization (an "insider") uses influence to distribute revenues from the organization in a manner that does not further the exempt purpose of the organization.[112] No part of the net earnings of an exempt organization can inure in whole or in part to the benefit of private shareholders or individuals. Even a minimal amount of inurement may result in disqualification of exempt status.[113]

Hospitals must also comply with the "private benefit" test. The scope of the term "private benefit" is much broader than that of "inurement" in that it applies to a benefit received by any person.[114] Any private benefit a tax-exempt organization confers must be merely "incidental" to its charitable activities. The test requires that the private benefit be incidental in both a *qualitative* and a *quantitative* sense. To be quantitatively incidental, the private benefit must be insubstantial, measured in the context of the overall exempt benefit conferred by the activity.[115] To be qualitatively incidental, the private benefit must be a necessary concomitant of the exempt activity, in that the organization's exempt objectives cannot be achieved without nec-

111. *Id.*; Rev. Rul. 69-545, 1969-2 C.B. 117 (enumerating specific criteria that a hospital must meet in order to qualify as a §501(c)(3) organization). Although the IRS has, in some isolated instances, qualified hospitals that do not meet all the criteria of Rev. Rul. 69-545 for exempt status, the criteria established in that ruling are the basis upon which the vast majority of hospitals rely to secure their tax exempt status.

112. Treas. Reg. § 1.501(c)(3)-1(c)(2) (1996). This definition may be extremely broad. For example, the IRS has taken the position that all physicians on a hospital's medical staff are "insiders." Gen. Couns. Mem. 39,498 (Apr. 24, 1986). Interestingly, the term "insider" does not appear anywhere in the tax code, but it has been borrowed from federal securities law. BRUCE HOPKINS, THE LAW OF TAX-EXEMPT ORGANIZATIONS 266 (6th ed. Cum. Supp. 1996); *see also* Thomas K. Hyatt, *Recent Developments for Tax-Exempt Organizations,* 2 ANNALS HEALTH L. 79 (1993) (describing recent judicial and policy developments impacting nonprofit health care organizations).

113. INTERNAL REVENUE SERV., EXEMPT ORGANIZATIONS EXAMINATION GUIDELINES HANDBOOK § 333.2(2) (1992).

114. Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (1996).

115. Gen. Couns. Mem. 39,762 (Oct. 13, 1988); Gen. Couns. Mem. 37,789 (Dec. 18, 1978); *see* HOPKINS, *supra* note 112, § 13.7.

essarily benefiting certain private individuals.[116] Thus, the fact that a physician uses a hospital's operating room, equipment, and personnel, without any charge, to make a substantial professional income is only an incidental private benefit.

The sale of a tax-exempt hospital may violate proscriptions upon inurement or private benefit in many different ways. For example, an insider, such as the chief executive officer of a hospital, may have a financial interest in the proprietary entity purchasing the hospital. Unless the sale is at "arm's length," the use of the insider's influence to effectuate the sale for his or her own benefit constitutes inurement. Moreover, the sale of a tax-exempt hospital may be problematic if the hospital is undervalued, because a sale under these conditions would create a private benefit that is more than merely "incidental."

Until recently, if the IRS discovered inurement or greater than incidental private benefit, its sole remedy was to revoke the 501(c)(3) status of the hospital.[117] In the sale of a hospital, this loss of exempt status could be retroactive to the date of the sale, resulting in the imposition of a tax on the sale itself as well as subsequent activities of the previously tax-exempt hospital.[118] Also, loss of tax-exempt status could result in the taxation of any previously exempt bonds issued by the hospital under the authority of section 103 of the Internal Revenue Code, meaning that any interest paid on the bonds would be subject to taxation.[119] The penalty of revoking tax-exempt status is severe and may only harm the individuals served by the charity and its bondholders. As a result, the penalty is rarely used and may not be an adequate incentive for directors to properly oversee the conduct of a corporation's affairs. These sanctions are far less prohibitive than those for private foundations, where the IRS has the power to impose penalty taxes on the management and

116. HOPKINS, *supra* note 112, § 13.7.

117. THOMAS HYATT & BRUCE HOPKINS, TAX-EXEMPT HEALTHCARE ORGANIZATIONS 296 (1995) (noting that the IRS does not have a process for "de-recognizing" exempt organizations, but instead that a tax-exempt organization may lose its tax exemption only by violating one or more aspects of the organizational or operational tests).

118. Priv. Ltr. Rul. 91-30-002 (Mar. 19, 1991).

119. I.R.C. § 150 (1994); *see also* Rev. Proc. 93-17, 1993-1 C.B. 507 (providing remedial action that can be taken to prevent a change in the use of proceeds from an issue of government bonds from being treated as violating the Internal Revenue Code tax-exempt interest provisions).

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"disqualified persons" who benefit at the foundation's expense.[120]

The IRS itself recognizes that its ability to adequately police public charities is limited.[121] To remedy this shortcoming, the IRS successfully lobbied for the ability to impose penalty excise taxes, called intermediate sanctions, where a 501(c)(3) organization engages in "excess benefit transactions," with the taxes imposed upon the individual who benefits improperly and upon the organization's management.[122] The IRS has not yet published regulations implementing these intermediate sanctions, and how stringently the IRS will police such transactions is not yet known.

2. Historical Response to Sales

In overseeing sales of tax-exempt hospitals, the IRS has historically maintained a hands-off policy. Early IRS letter rulings relied upon Revenue Ruling 76-91, pertaining to a nonprofit entity purchasing hospital assets from a proprietary corporation.[123] In this ruling, the IRS stated that "[g]enerally, where an organization purchases assets from an independent third party, a presumption exists that the purchase price (arrived at through negotiations) represents fair market value."[124] The ruling did note, however, that this presumption is not valid when a close relationship exists between the purchaser and seller, or where one controls the other. In such a situation, the tangible assets should be valued by an independent appraisal. The purchasing exempt organization then must justify its purchase of the intangible assets in light of its exempt purpose and the value of those intangible assets.[125]

Relying on the presumption of an arm's-length transaction established in Revenue Ruling 76-91, in the early 1980s the IRS approved the sale of several nonprofit hospitals despite the lack of a professional valuation.[126] These rulings were characterized by substantial confidence in the independence and abilities of

120. I.R.C. § 4941 (1996).

121. INTERNAL REVENUE SERV., REPORT ON CIVIL TAX PENALTIES BY EXECUTIVE TAX FORCE, COMMISSIONER'S PENALTY STUDY 32-33 (Feb. 21, 1989).

122. I.R.C. § 4958 (1996).

123. Rev. Rul. 76-91, 1976-1 C.B. 149.

124. *Id.*

125. *Id.*

126. *See* Priv. Ltr. Rul. 84-18-127 (May 9, 1984); Priv. Ltr. Rul. 82-19-066 (Feb. 12, 1982); Priv. Ltr. Rul. 81-52-099 (Sept. 30, 1981). It should be noted that these rulings were all issued prior to amendments to the Anti-Kickback Statute. Since the IRS has

nonprofit boards, and they do not discuss the relationship between the parties except to characterize the transactions as "arm's length."[127] Another characteristic of the early IRS letter rulings is a failure to focus upon the post-transaction interactions between the parties,[128] ignoring both the possibility of the tax-exempt hospital becoming a de facto subsidiary of the acquiring for-profit hospital's operations and the potential inurement problems related to the employment of key officers, administrators, or directors.

In 1983, a particularly troublesome transaction occurred that highlights the difficulties presented by an "independent" valuation conducted at the behest of insiders. Members of the board of directors of a nonprofit Florida hospital purportedly sought to purchase the hospital to obtain capital to expand the facility. The board indicated that the hospital would be sold at its appraised value, and that an independent appraisal would be obtained using a qualified appraiser. The board further represented that it would use arm's-length standards to ensure that in future dealings with the for-profit hospital, any benefits would not be offered on terms more beneficial than could be obtained from unrelated third parties. The IRS relied on these facts, approving the sale in early 1983, and the directors purchased the hospital for $8.3 million.[129] Subsequently, the hospital added thirty-one beds, using a certificate of need that was issued when the hospital was tax exempt, and obtained approval for thirty-six additional beds. In October 1985, the directors sold the hospital for approximately $29.6 million, meaning that each of the twelve directors of the hospital received in excess of $2.3 million after a little more than two years of ownership.

In August 1987, the Florida Attorney General sued the hospital's directors, alleging that the $8.3 million purchase price was not fair and reasonable.[130] The IRS also initiated an investigation, including commissioning an appraisal of the hospital. Us-

recently tied tax exemption to compliance with the Anti-Kickback Statute, boards must now also be cognizant of these prohibitions.

127. Priv. Ltr. Rul. 84-18-127 (May 9, 1984) (relying on a competitive bid process, outside consultants, and the knowledge of the hospital's board of trustees).

128. Priv. Ltr. Rul. 83-12-125 (Dec. 20, 1982) (proceeds of trust funded solely by 90% of a nonprofit hospital's sale could be used to pay for indigent care at the purchased, now for-profit hospital without constituting self-dealing).

129. Priv. Ltr. Rul. 91-30-002 (Mar. 19, 1991).

130. Carol Gentry, *State Suing Anclote Officials over Hospital Sale*, ST. PETERSBURG TIMES, Aug. 6, 1987, at 4B.

ing three different valuation approaches, the appraisal valued the hospital at approximately $24 million at the time of the sale to the directors. The IRS concluded that the directors had not paid fair market value for the hospital and noted that the hospital's accumulated earnings over the years had been used to build up the physical facilities, reputation, and goodwill that were transferred to the directors through the original sale. The IRS ruled that based upon the board's apparent lack of fiduciary responsibility, it was not entitled to rely upon the initial private letter ruling. The IRS then revoked the hospital's section 501(c)(3) status retroactive to the date of the hospital's sale. Apparently, the only reason this transaction received scrutiny was because the directors did not wait longer before selling the hospital. If the initial "independent" appraisal was flawed, as the IRS later believed, was this due to the fact that the appraisers relied upon information supplied by the board of directors, or because of flaws inherent in the valuation process itself? That is, either the appraisal process itself may at times be arbitrary, or it is subject to such influence by insiders that it is essentially meaningless in some situations.

More recent IRS private letter rulings appear to indicate scrutiny of the process behind hospital sales. For example, in 1995, the IRS issued another ruling related to the sale of a tax-exempt hospital.[131] The hospital was suffering financial difficulties arising from its lack of affiliation with one of the two networks in its service area and its inability to obtain managed care contracts. The hospital's board solicited bids from twenty unrelated health care organizations. There were four responses to the solicitation, and two proprietary entities submitted bids.

The hospital board's subsequent actions drew attention primarily because it spurned the highest bid in favor of an entity that the board believed offered a greater geographic diversity, a much larger base of operations, a wider range of services, and greater access to insurance contracts and patients. The board apparently believed that sale to the lower bidder would better ensure the hospital's long-term survival in accordance with its charitable mission. In this case, the hospital represented to the IRS that the final sale price was five times earnings before interest, taxes, depreciation, and amortization ("EBITDA") for the previous fiscal year. In its correspondence to the IRS, the hospital indicated that the current value for comparable transactions

131. Priv. Ltr. Rul. 95-38-026 (June 26, 1995).

involving privately held hospitals was from four to six times EBITDA, although it apparently did not provide information concerning the higher bid. The IRS ruled that the hospital's sale would not jeopardize the 501(c)(3) status of the hospital's holding company.[132]

The IRS's reliance upon an outside valuation, as demonstrated in the 1995 private letter ruling, may fail to adequately protect charitable assets from undervaluation. The use of an EBITDA valuation alone, based upon past earnings of the hospital, contradicts established principles of valuation, which emphasize using projected cash flows. Further, the valuation apparently failed to take into account the individual dynamics of the hospital in question, including market share, utilization, and quality of facilities. For example, an EBITDA valuation may fail to take into account the impact of a significant new managed care contract, the demise of a competitor, the creation of a new service, or other factors that may result in the improvement of the hospital's future competitive position in the market. Although EBITDA multiples may be a valuable tool in appraising a hospital, relying exclusively on EBITDA to establish value is questionable.

3. The IRS Today

Possibly in response to the increasing sales of nonprofit hospitals, the IRS recently issued its *1996 Exempt Organization Continuing Professional Education Technical Instruction Program Textbook* ("*1996 CPE Text*") providing the first published overview of the factors the IRS will consider in monitoring sales of nonprofit hospitals.[133]

The IRS will consider the following factors in assessing the validity of the sale of nonprofit hospitals:

- ***Fair Market Value*** The IRS requires an assertion that the hospital has been sold for fair market value, using information required in the valuation of medical practices for acquisition purposes.
- ***Funding of Projects*** The IRS will attempt to ascertain whether a foundation will be created to support indigent

132. *Id.*

133. The provisions in the 1996 CPE TEXT, supra note 16, are permissive insofar as failure to meet them does not constitute a per se violation of the regulation governing tax-exempt hospitals. However, they do provide insight into the IRS's view on the process that should accompany any sale. A hospital sale that does not meet the standards enumerated in the 1996 CPE TEXT will be more likely to face IRS scrutiny.

and Medicaid services at *all* local health care providers, especially where the foundation's commitment to direct medical care is equivalent to what the section 501(c)(3) hospital provided in the past. Disproportionate payment to the purchaser of the exempt hospital may be a negative factor in ruling on an exemption.

- ***Side Deals*** No "insiders" should receive direct or indirect payments to induce the sale.
- ***Limitation on Providers*** The foundation created with sale proceeds should make grants to all hospitals and health care providers in the community.
- ***Minority of Financially Interested Directors*** Participation in the foundation by representatives of the for-profit purchaser should be limited to a minority of the foundation's board of directors.
- ***Term Limitations*** There should be provisions for the rotation of foundation board members to encourage membership representing various segments of society and to ensure that the for-profit hospital does not enjoy a disproportionate amount of support from the foundation.
- ***Conflict of Interest Policy*** The foundation's bylaws should clearly identify possible conflicts of interest.
- ***Compensation from the Sale*** There must be extensive detailing of all payments, commissions or other arrangements involving any insiders, such as severance packages. The nonprofit's board minutes should reflect any type of compensation flowing from the sale and provide supporting evidence demonstrating that it is reasonable.[134]

The *1996 CPE Text* section on valuation addresses many of the deficiencies of previous private letter rulings discussed above. However, it is important to remember that the *1996 CPE Text* focuses on the process of selling a section 501(c)(3) hospital—it does not purport to examine the specificities of the valuation, the deliberative process underlying a sale, or the choice of to whom a 501(c)(3) hospital should be sold. The underlying assumption of the *1996 CPE Text* is that the hospital's board exercises its fiduciary duty to ensure that the best interests of the community are served when it meets the stated criteria in the process of selling.

In addition, although the *1996 CPE Text* contains a detailed discussion of valuation issues, the validity of its methodology is diminished somewhat because it is entirely reliant upon issues arising with regard to physician practice valuations. By analo-

134. 1996 CPE TEXT, *supra* note 16, at 394-97.

gizing hospital valuations to physician practice acquisition valuations, the *1996 CPE Text* fails to take into account numerous factors that may significantly impact the hospital valuation process.

In valuing a physician practice, the *1996 CPE Text* focuses upon EBITDA, basing projected revenues upon "normalized" financial statements.[135] Factors used in projecting future cash flow include changes in revenue, patient volume, and expenses based upon existing market conditions, growth, and inflationary trends.[136] The emphasis on projected, rather than historical, earnings is significant because use of historical earnings has been highlighted as one way in which hospitals may be undervalued.[137]

Unfortunately, reliance upon EBITDA without taking into account the individual characteristics of a hospital may paint a distorted picture of the hospital's value as a proprietary entity. Physician practices, because they are proprietary entities, have different objectives than nonprofit hospitals. As a charitable entity, a hospital may support some services even though they do not produce sufficient revenues to justify the continued provision of those services. It may support these services through restricted use funds or by subsidizing them with revenue from other operations.[138] Such charitable endeavors can actually reduce a hospital's valuation if based solely upon a cash flow analysis. This raises a crucial issue: when valuing a hospital, should the hospital be appraised based upon the assumption that its operations will continue unchanged, or should it be valued assuming that it is operated to maximize profits? A valuation that fails to account for elimination of services may allow a proprietary entity to reap a windfall gain at the expense of the hospital's community.

Another problem with analogizing hospital sales to physician practice acquisitions is that it fails to encourage valuations to account for synergies or efficiencies that may arise from the sale

135. *Id.* at 418, 420. Normalized statements are financial statements that are adjusted for unusual or nonrecurring items.

136. *Id.* at 418.

137. Lutz, *supra* note 8, at 94.

138. *See* Peter Mitchell, *Florida Journal: Chains Show Hospitals Can Turn a Profit*, WALL ST. J., Sept. 13, 1995, at F1 (noting that not-for-profit hospitals bear the burden of providing high-cost services such as burn, trauma, and neonatal intensive care treatment, as well as providing care to poor and indigent patients, while proprietary hospitals focus upon the most profitable patients).

of a section 501(c)(3) hospital to a larger corporation. Thus, a hospital may be worth more to a larger corporation than its stand-alone value because the corporation may be able to operate the hospital more efficiently, or because the newly acquired hospital may enable the corporation to provide new services.[139]

However, as the Anti-Kickback Statute relates to physician practice acquisitions, it precludes assumptions related to many postacquisition synergies because such assumptions might constitute a payment for illegal referrals of Medicare or Medicaid patients.[140] In valuing physician practice acquisitions, the IRS has focused upon appraisals that assume practices will continue as free-standing entities;[141] such assumptions may be necessary to prevent abuses in physician practice acquisitions. However, these assumptions as applied to hospitals may result in undervaluation and potential windfall gains to proprietary corporations. The result is that the IRS may receive information indicating that a section 501(c)(3) hospital has been sold for "fair market value" when, in fact, the process of valuing the hospital has failed to establish a value reflecting efficiencies and synergies that can be generated.

III. Toward a Process-Oriented Solution to Valuation

The examples mentioned above lend credence to arguments that some nonprofit hospitals have been undervalued when sold to for-profit entities. If such is the case, it may be due to the combination of poor oversight and the difficulties inherent in the valuation of nonprofit hospitals. The simple truth is that it may be impossible to ever arrive at a value reflecting the importance of a nonprofit hospital to its community. However, it

139. In the area of mergers, courts have long recognized that a merger produces synergistic effects that result in the merged corporation being worth more than the sum of the two previous corporations. Mills v. Electric Auto-Lite Co., 552 F.2d 1239, 1248 (7th Cir. 1977). Although the sale of a nonprofit hospital is distinct from a merger, the synergies of such a sale should generate benefits to the purchasing corporation. In the absence of such synergies, the purchaser would have little incentive to buy the hospital.

140. 42 U.S.C. § 1320a-7b(b)(1)-(2) (1994); *see also* Letter from D. McCarty Thornton, Associate General Counsel, Office of the Inspector General, Department of Health and Human Services, to T.J. Sullivan, Technical Assistant, Office of the Associate Chief Counsel, Internal Revenue Service (Dec. 22, 1992), *reprinted in* 2 BNA's Health L. Rep. 245 (Feb. 25, 1993) (noting that payments in excess of fair market value may be construed as payments for referrals).

141. 1996 CPE Text, *supra* note 16, at 394-97.

should also be clear that the value of a hospital is *at least* its stand-alone value under discounted cash-flow methodology, using projected EBITDA. A hospital may be worth much more if its operations can be restructured or because of resulting merger synergies.

Most directors of nonprofit corporations have a strong commitment to their communities, and one can presume that they want to do what is appropriate. The problem is that appropriate board behavior cannot be guaranteed.[142] Part of the solution to maximizing hospital value may be educational. That is, directors should be provided sufficient guidance to assist them in maximizing the hospital's value.[143] The development of appropriate standards of conduct is also necessary to ensure that the sale benefits the community and furthers charitable purposes. In addition, early involvement of the attorney general in the sales process is necessary to ensure that the sale inures to the benefit of the community.

Appropriate standards of conduct related to hospital sales may be derived from *Citron v. E.I. DuPont de Nemours & Company*,[144] another squeeze-out merger case related to the acquisition of Remington Arms Company by E.I. DuPont de Nemours & Company. The merger was approved by an independent, disinterested committee of Remington directors who had never been affiliated with or employed by DuPont. The committee organized itself and chose its own legal counsel and financial advisors. Moreover, the committee did not discuss its activities with Remington management without the prior approval of its counsel. As a result, the decision-making process was untainted, and no Remington director affiliated with DuPont participated in any of the committee's deliberations or attempted to influence its decisions. Similar standards of conduct could ensure the integrity of a sale where officers or directors of a nonprofit hospital may have received employment offers for an entity purchasing the hospital, or where a foundation may be created as a result of the sale. In addition, as discussed above, a hospital's assets should be sold only after the completion of a competitive bidding process, based upon fixed criteria upon which bids

142. Fishman, *supra* note 57, at 648.

143. California recently issued guidelines that will require nonprofits seeking to convert to prepare a health impact statement and to demonstrate that they have considered alternatives to conversion. *Review Guidelines Established for Nonprofit Conversions*, 6 BNA's HEALTH L. REP. 104, 104-05 (Jan. 16, 1997).

144. 584 A.2d 490 (Del. Ch. 1990).

will be evaluated. Bids should be evaluated by independent directors, and by no means should the hospital be sold for less than its appraised value unless the community receives some other value as a result of the sale.

There may be some, if not many, situations where a competitive bidding process is impractical or fails to procure a sufficient number of bids. In such situations, the likelihood of collusive behavior between hospital management and a potential bidder may increase dramatically. Here, it may be necessary to obtain an independent appraisal; while expensive, it may prevent millions of dollars in lost revenue and tens of thousands of dollars in attorneys' fees. This appraisal should not only value the hospital as a stand-alone entity, but it should also reflect structural changes (including management changes) that the hospital could make to increase its value. In addition, the hospital's possible worth to a particular bidder should be analyzed.

Finally, in all situations, the sale price of a hospital should be fully disclosed to the community, with as much detail as is practical. Disclosure will enable other hospitals to make better market comparisons of their value, and it will discourage excessive benefits to insiders. The current standard of nondisclosure does not benefit communities or other nonprofit hospitals. As guardians of community assets, directors and officers of nonprofit hospitals have a duty to take steps that will benefit their communities.