WHAT WILL HEALTH CARE LEGISLATION HOLD FOR NONPROFIT HOSPITALS?

NANCY ORTMEYER KUHN

Nonprofit health care institutions should provide extensive explanations of the benefits they provide, lest they be seen as not charitable enough.

The tax-exempt health care community seems to have dodged the prospect of any immediate, statutorily imposed charitable care requirement. There has been much speculation regarding whether nonprofit health care organizations would be subjected to additional regulation and perhaps excise taxes. Several government studies have questioned whether nonprofit hospitals operate any differently than for-profit hospitals. Thus, extensive thought and discussion has been centered around whether nonprofit hospitals need further statutory requirements.

The broad parameters of the policies under consideration have included codification of the "community benefit" standard. This standard dates back to Rev. Rul. 69-545, 1969-2 CB 117, which established a subjective facts-and-circumstances test to determine whether a hospital or other health care entity is operated for a valid charitable purpose. If the IRS determines the entity is not sufficiently benefiting the community, the only recourse under current law is revocation of the entity's exempt status. That draconian step has rarely been taken. However, health care reform could change the available sanctions, either in this round of legislation or in the inevitable follow-up as Congress works to find a solution to the current health care crisis. The end result could be to impose more precise parameters on health care institutions to document that they have met the community benefit standard, with intermediate sanctions imposed in the form of excise taxes if the community benefit standard is not met.

The options broadly proposed last May by the Senate Finance Committee included codifying organizational and operational requirements that Section 501(c)(3) hospitals regularly conduct a community needs analysis, provide a minimum annual level of charitable patient care, not refuse service based on a patient's inability to pay, and not pursue collection actions quickly or aggressively against qualifying patients.[1] For those hospitals unable to meet the standards, intermediate sanctions in the form of excise taxes would be imposed where revocation is deemed inappropriate.

The bill offered by Senate Finance Committee Chairman Max Baucus (D-Mont.) on 9/16/09 did not include a 5% minimum charity care provision, but did require an additional "community health needs assessment," additional transparency reporting with penalties for failure to comply, and imposed limitations on nonprofit hospitals' billing practices. A final bill is not likely to expand on this, although the earlier proposals released by the Finance Committee may reappear in subsequent bills.

There is some suggestion that if the percentage of the population without health insurance was reduced,

NANCY ORTMEYER KUHN is Of Counsel at Caplin & Drysdale, Chartered, in Washington, DC.

there would be less need for nonprofit health care providers. It seems doubtful that Congress would go so far as to deny those organizations their tax exemption, given the broad community benefit that many health care organizations provide in the form of education, free screenings, access to preventive care, and other types of services not covered by insurance. What does seem inevitable, however, is that there will be increased scrutiny by Congress and the IRS to ensure that there are substantive differences between tax-exempt hospitals and for-profit hospitals. Also, there should be scrutiny to ensure that the nonprofit hospitals are filling the needs of all those in the community.

An example of a broken medical system

In 2004 and 2005, a series of cases was filed in district courts across the United States on behalf of numerous uninsured and indigent patients.[2] The litigants in one of the cases, *Kolari v. New York Presbyterian Hospital, et al.*,[3] angered the judge, who began his opinion as follows:

> Plaintiffs here have lost their way; they need to consult a map or a compass or a Constitution because Plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch. This action is one of dozens of similar bootless actions filed in twenty-three district courts across the United States on behalf of uninsured and indigent patients, wherein Plaintiffs argue, without basis in law, that private nonprofit hospitals are required to provide free or reduced-rate services to uninsured persons.

The plaintiffs' complaints in this coordinated attack generally arose out of situations in which the hospitals provided care in emergencies, but the resulting bills that were received were exorbitant (e.g., $20,000 for two days for complications from pregnancy; $58,000 for 11 nights in a hospital following a severe arm burn) in that they reflected rates much higher than would have been charged to insurance companies or Medicare/Medicaid. Since these hospitals were nonprofits and tax exempt under Section 501(3)(c), the uninsured litigants asserted there was some duty for the hospitals to provide care to them in an emergency—or at least not to pursue them very aggressively with bill collectors and, ultimately, lawsuits to recover the seemingly excessive amounts. The judge dismissed the case for lack of subject matter jurisdiction, finding that the district court lacked constitutional and statutory authority to hear it. Although the plaintiffs presumably knew there was little chance of success in their litigation due to the jurisdictional problems, it is an indication of their desperation to attack a broken system.

Even the wealthiest Americans could quickly find their finances depleted with medical bills that can quickly accumulate after a relatively simple injury, health complication, or brief illness. The concept that community benefit results from the difference between the actual cost of care and the Medicare/Medicaid reimbursement rate is testimony to the gap between the services and facilities provided and the government's reimbursement rate. It is not difficult to assume that the hospitals would hope to collect the difference from those who are not within the government's insurance programs. In fact, it has been asserted that there is significant cost-shifting to privately insured patients and uninsured patients who are able to pay their bills to make up for this gap.[4] Regardless of whether this cost-shifting occurs, it cannot be denied that many uninsured patients are not in a position to pay more than the insurance companies or federal government. A group of doctors and lawyers from Harvard Medical and Law Schools and Ohio University recently published a report (the "Medical Bankruptcy Report") on how many U.S. bankruptcies are caused by health care costs.[5] Their review of data from 2007 found that 29% of all bankruptcies in 2007 were directly caused by medical bills, with 62.1% of bankruptcies attributable to a variety of health-related issues. The system is broken, and Congress is attempting to fix it at the time of this writing. The nonprofit community needs to ensure that the "fix" does not negatively impact them.

It is the working poor, and even the working middle class, who tend to be uninsured or underinsured. Those who are impoverished and unemployed are generally covered by Medicaid. The elderly are covered by Medicare. Even those who are not elderly but are retired are covered to some extent by Medicare. Those who have stable, full-time employment are covered by health insurance group policies offered

---

1 "Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options," 5/20/09, available at finance.senate.gov/Roundtable/complete text of financing policy options.pdf.

2 See, e.g., In re Not-For Profit Hospitals/Uninsured Patients Litigation, 341 F. Supp. 2d 1354 (Judicial Panel on Multidistrict Litigation, 10/19/04); Peterson v. Fairview Health Servs., 95 AFTR2d 2005-1005, (DC Minn, 2005); Shriner v. Promedica Health Sys., Inc., 95 AFTR2d 2005-780, (DC Ohio, 2005); Lorens v. Catholic Health Care Partners, 95 AFTR2d 2005- 786, (DC Ohio, 2005). For additional citations *see* Kolari v. New York-Presbyterian Hosp., 382 F Supp 2d 562, 95 AFTR2d 2005-2813 (DC N.Y., 2005).

3 Note 2, *supra*.

4 See, e.g., Fox and Pickering, "Hospital & Physician Cost Shift," available at www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf.

5 Himmelstein, Thorne, and Woolhandler, "Medical Bankruptcy in the United States, 2007: Results of a National Study," 122 American Journal of Medicine 8, page 741 (Aug. 2009), available at www.amjmed.com/article/S0002-9343(09)00404-5/fulltext.

through their employers. Thus, those who are not covered by insurance tend to be hourly or part-time workers whose annual income is perhaps lower than average. The Medical Bankruptcy Report found that for 92% of bankruptcies attributable to health-related issues, high medical bills directly contributed to their bankruptcy. Further findings indicated that it is not uncommon for families to be under-insured, or to lose coverage when wage-earners become too sick to work.[6] These are the people who gathered together and brought the coordinated series of lawsuits against the nonprofit hospitals. The situation is an example of a need that could be addressed by the nonprofit hospitals as an example of community benefit. Other examples were set forth by the IRS in its report on hospitals

Policies under consideration have included codification of the community benefit standard.

The IRS Hospital Report

The IRS began its Hospital Compliance Project in May 2006 by selecting 544 nonprofit hospitals through a review of Forms 990. The IRS mailed those hospitals a nine-page comprehensive questionnaire, Form 13790. After receiving completed questionnaires from 487 hospitals, the IRS compiled the data in a 178-page report, entitled "IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report" (the "IRS Hospital Report"), which was released on 2/12/09.[7]

In the IRS Hospital Report were many graphs and tables reporting data related to "community benefit" as variously defined by the hospitals. Executive compensation was also addressed. As explained by an IRS official involved in the project, the goal of the project was not to come to any conclusions, but to provide data and benchmarks for purposes of the continuing health care debate.[8] In addition, the report furthered the Service's understanding of the health care industry and allowed it to develop a more targeted health care schedule that will be completed by hospitals filing the revised Form 990.[9]

Community benefit standard. The IRS compiled substantial data from all types of hospitals to determine the different categories and levels of community benefits offered by the hospitals. It found four types: uncompensated care, medical education and training, research, and community programs.[10] The community benefits offered varied by the size of the hospital, the population of the surrounding area, and the type of hospital. Unfortunately, without a standard definition of uncompensated care, the reporting hospitals often differed in the items they included in that category.[11] Some hospitals included Medicare and Medicaid shortfalls and bad debt while others did not. The result has been much criticism that the results are not entirely accurate.[12] In any event, the IRS found that the total revenues spent on aggregate community benefit expenditures, as variously reported by the hospitals, averaged 9%, and that the median amount was 6%.[13] The IRS also estimated that the overall average and median percentages of uncompensated care as a percentage of total revenues were 7% and 4%.[14] Within those averages, however, the amount of community benefit expenditures per individual hospital varied widely.

Thus, although the IRS has stated that it did not come to any conclusions as a result of this study, it did conclude that an arbitrary percentage as a measure of the acceptable quantity of community benefit is neither advisable nor recommended. There were too many legitimate variables among the hospitals, which would make such an arbitrary "bright-line" test unworkable.[15] One positive result from this learning process was that Schedule H of the redesigned Form 990 specifically asks for the various types of uncompensated care by category, so that the data for "community benefit" will be more objective. Even so, there is concern that the Schedule H statistics will not be a precise picture of a nonprofit health care organization's community benefit, since there is still room for substantial manipulation of the figures within the parameters of filing an accurate return.

Executive compensation. The IRS Hospital Report also analyzed executive compensation, as variously reported by the hospitals. Not every hospital answered every question, so the results were of mixed accuracy.[16] Overall, according to the responses received, the average compensation for all hospital ex-

6 *Id.*, page 745.

7 Available at www.irs.gov/pub/irs-tege/frepthospproj.pdf.

8 Comments of Ronald Schultz, Senior Technical Advisor to the Commissioner of TE/GE, District of Columbia Bar Association Taxation Section, 2/26/09.

9 Schedule H is phased in beginning in 2008. For tax years beginning in 2008, only Part V, "Facility Information," must be completed (so basic identifying information regarding the hospital's facilities can be collected). The entire Schedule H must be completed for tax years beginning in 2009.

10 IRS Hospital Report, page 4.

11 IRS Hospital Report, pages 100-105, 162.

12 See, e.g., comments of Mindy Hatton, Senior Vice-President and General Counsel of the American Hospital Association, District of Columbia Bar Association Tax Section luncheon, 2/26/09

13 IRS Hospital Report, page 3.

ecutives was $490,000. The IRS conducted 20 examinations as a result of the responses it received, reviewing whether any of the 20 selected hospitals were providing excess compensation to their executives. The 20 examined hospitals reported average total compensation for all listed hospital executives at $801,720, with the average compensation for a CEO at $1.4 million.

The IRS reported that the "organizations met the requirement of the rebuttable presumption process in 85% of the examined hospitals."[17] The examined hospitals used comparability data and independent personnel to review and establish executive compensation amounts, so the rebuttable presumption was satisfied and the IRS determined either that (1) the compensation was reasonable or, (2) apparently, it could not have overcome its burden of proving otherwise. In various public presentations,[18] government panelists indicated that the rebuttable presumption standard is under review and could be revised or abolished through legislation or a withdrawal of the regulations. The initial contract exception to Section 4958 also came under much criticism. The consensus of government speakers seems to be that the rules are too generous to the taxpayer and allow compensation to be treated as reasonable even though it might otherwise be found excessive. However, as long as the current regulations are in effect, hospitals and all Section 501(c)(3) and (c)(4) organizations should protect their interests and take full advantage of the rebuttable presumption in order to protect the hospital's interests and the interests of its executives.

Senator Charles Grassley (R-Iowa), ranking member of the Senate Finance Committee, has stated that he hopes to introduce legislation that would put more pressure on boards of directors of nonprofit hospitals to keep salaries in check. The Senate Finance Committee is also reportedly considering whether to try to change the regulations to shift the responsibility to the hospital board to prove that a salary is reasonable.[19] Such a change would effectively abolish the rebuttable presumption. None of that legislation has appeared in any of the draft proposals extant at the time of this writing.[20]

A better approach may be to recognize that all health care institutions do provide a community benefit, except perhaps those that do only elective procedures, do not accept Medicare or Medicaid patients, and do not have an emergency room. The focus could be better placed on converting all hospitals to nonprofit hospitals, and requiring them to conform to certain standards if they are going to accept government payments from the public assistance programs, including Medicare. Studies have not been completed on the activities of for-profit hospitals, so the lost revenue implications from the conversion of for-profit to nonprofit is unknown, but the benefit to the community would be an offsetting factor. Also, if excise taxes are then imposed on hospitals that do not provide a certain amount of benefit to the community, it is possible that a revenue-neutral bill could be created.

Other federal government studies

On 7/20/09, the Congressional Research Service released a report entitled "Tax Options for Financing Health Care Reform" (the "CRS Report").[21] One option it discussed was modifying the treatment of tax-exempt hospitals.[22] "The Senate Finance Committee proposal [of last May] would codify rules for determining charitable status that include a community needs standard and a minimum annual level of charitable patient care. The provision might have relatively little effect on revenues but could increase the level of charity care."[23] The benefits received by tax-exempt health care entities include exemption from paying tax on health care-related income, the ability to receive tax-deductible charitable contributions, and eligibility for certain tax-exempt bond financing. In exchange, the health care entities are to provide a "community benefit." The CRS Report estimated that the current cost of allowing nonprofit hospitals these tax benefits is approximately $8 billion.[24]

In September 2008, the General Accountability Office issued a report ("GAO Report") to Senator Grassley entitled "Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements."[25]

---

[14] *Id.* at 4. But see *id.* at 98-105.

[15] *Id.* at 169.

[16] *Id.* at 122.

[17] *Id.* at 145.

[18] See, e.g., comments of Lois Lerner (Director, IRS EO Division), American Health Lawyers Association, 7/1/09 (transcript available in 14 EO Tax Jnl. 4, Jul/Aug 2009, page 50); comments of Ronald Schultz, AICPA Not-for-Profit Industry Conference, 6/11/09, 14 EO Tax Jnl. 4, Jul/Aug 2009, page 33; comments of Ronald Schultz, ABA Tax Section Meeting, 14 EO Tax Jnl. 3, May/Jun 2009, page 96.

[19] "Nonprofit Hospitals Targeted On Leader Pay: Boards Must Hold Line, Senator Says," Boston Globe, 3/4/09.

[20] See, e.g., H.R. 3200, the America's Affordable Health Choices Act of 2009.

[21] By Jane G. Gravelle, Senior Specialist in Economic Policy for the Congressional Research Service, Library of Congress. Available at www.wipp.org/resource/resmgr/Healthcare/CRS_Report_on_Tax_Options_fo.pdf.

[22] *Id.* at pages 8-9.

[23] *Id.* at 8.

[24] *Id.* at footnote 21. The estimated benefit to nonprofit hospitals from tax-exempt bonds is approximately $2 billion.

[25] Available at www.gao.gov/new.items/d08880.pdf.

The GAO Report analyzed the community benefit standard and how it is applied in the nonprofit health care community throughout the United States under federal and state law. In 2006, about 59% of the roughly 4,900 nonfederal, acute care general hospitals in the United States were nonprofit.[26] The rest included government hospitals (25%) and for-profit hospitals (17%).[27] Fifteen states have now regulated this area, and the GAO Report provided summaries of the state law definitions and state oversight of the community benefits provided by nonprofit hospitals. The IRS and the Centers for Medicare and Medicaid Services (CMS) are also in the process of collecting data through mandatory reporting on the types and amounts of community benefits that nonprofit hospitals are currently providing.[28] By approximately 2012, enough data should be available to formulate some informed guidance in this area. In the meantime, the GAO Report analyzed data from those states with mandatory community benefit reporting.

There is some suggestion that if the percentage of the population without health insurance was reduced, there would be less need for nonprofit health care providers.

One reason that nonprofit hospitals have come under some criticism for not providing a markedly different amount of community benefit than their for-profit "competitors" is that having an open medical staff, participating in Medicare and Medicaid, and treating all emergency patients without regard to ability to pay are currently common features of both tax-exempt and for-profit hospitals.[29] The nonprofits therefore are under pressure to provide much more benefit to the community than merely the charity care that results from an open emergency room.

According to the GAO Report, 15 states have community benefit reporting requirements for nonprofit hospitals, with 15 different definitions of community benefit plus a wide variety of reporting standards. Five states—Alabama, Mississippi, Pennsylvania, Texas, and West Virginia—specify that a minimum amount of community benefit is required for hospitals to comply with state law. Another four states—Illinois, Indiana, Maryland, and Texas—impose penalties for hospitals that fail to comply with state community benefit standards.[30] However, since "community benefit" is not defined in the same way by the states, an overall standard remains elusive and burdensome to the reporting entities. The most common area of disagreement is whether bad debt should be included as a component of charity care.

For example, nonprofit hospitals in Maryland must annually file a community benefit report[31] and identify community health care needs. The report must include the hospital's mission statement and a list of community benefits initiatives including costs, a description of efforts undertaken to evaluate the effectiveness of each initiative, and a description of gaps in availability of specialists to serve the uninsured. Maryland defines community benefit as including the health services provided to the vulnerable or underserved populations (including participants in Medicaid, Medicare, and the Maryland Children's Health Program), financial or in-kind support of public health programs, donations that contribute to a community priority, health care cost containment activities, health education, screening, and prevention services. If a nonprofit health care facility fails to file the community benefit report, a civil penalty of $100 per day is assessed absent a valid extension. In addition, the Health Services Cost Review Commission may refuse to grant a rate increase to any hospital that does not file the report.[32]

California requires a community needs assessment at least once every three years, with annual updates to include narrative reports of the mechanisms used by the hospital to evaluate the plan's effectiveness, an explanation of the measurable objectives, and examples of community benefit categorized into a specified framework.[33] The definition of community benefit includes a long list of examples. The California test is essentially the same as the federal test under the Internal Revenue Code: all facts and circumstances will determine whether the nonprofit hospital is providing sufficient benefits to the community. Examples in the California definition include prevention services, adult day care, home-delivered meals to the homebound, health care cost containment, enhancement of access to health care, services offered without regard to financial return, charity care, and unreimbursed costs of health care services.[34] The penalty specified if these standards are not met is revocation of exemption from payment of certain state taxes.

Thirty-six states do not have statutory or regulatory community benefit requirements for health care

[26] Federal hospitals include the Veterans Affairs hospital system, the National Institutes of Health, etc.

[27] GAO Report at page 8.

[28] CMS requires hospitals that participate in the Medicare program to file cost reports, including Worksheet S-10, which includes information regarding Medicaid and all state and local uncompensated care programs.

[29] The Emergency Medical Treatment and Active Labor Act applies to hospitals participating in Medicare. See 42 U.S.C. § 1395dd (2000). Under this Act, a hospital (nonprofit or for-profit) that participates in Medicare must treat all patients with emergency medical conditions without regard to ability to pay. The hospital must at least stabilize the individual or arrange for an appropriate transfer to another facility. See 42 C.F.R. § 489.24 (2007).

[30] GAO Report at page 16.

[31] Md. Code Ann., Health-Gen. § 19-303.

[32] Md. Regs. Code tit. 10, § 37.01.03.

[33] Cal. Health & Safety Code § § 127350, 127355; GAO Report at page 57

[34] Cal. Health & Safety Code § 127345.

institutions seeking to qualify for nonprofit status. The GAO Report further grouped these 36 states into three groups: (1) those that address community benefit in some way not tied to nonprofit status, (2) those that require community benefits from all hospitals for licensure purposes, and (3) those that do not mention community benefits at all in a statutory context but may discuss the need in other sources such as property tax exemption standards or attorney general guidelines.[35] As illustrated in the GAO Report, the state laws governing these issues are varied in scope and impact. Thus, federal law is also perceived differently by health care institutions, depending in part on their state reporting requirements.

The Congressional Budget Office issued a paper in December 2006 entitled "Nonprofit Hospitals and the Provision of Community Benefits" ("CBO Report").[36] This report attempted to compare for-profit hospitals with nonprofit hospitals, and was based on the Medicare Hospital Cost Report, 2003, and data from the GAO on uncompensated care. Five states were chosen as representative, and data was analyzed from nonprofit, for profit, and government (non-federal) hospitals in California, Florida, Georgia, Indiana, and Texas. Through use of these sources, the CBO Report found that nonprofit hospitals provided an average of 4.7% of uncompensated care as a share of operating expenses. The figure was 4.2% for the for-profit hospitals, and 13.0% for government (nonfederal) hospitals. The CBO Report used "regression techniques" to adjust for the hospitals' size and location, and for the characteristics of the local populations, in reaching its figures for uncompensated care. After these techniques were applied, nonprofit hospitals were estimated to have an average uncompensated care share that was 0.6 percentage points higher than that for otherwise similar for-profit hospitals. The CBO Report concluded that the "estimated difference corresponds to nonprofit hospitals in the five selected states providing between $100 million and $700 million more in uncompensated care than would have been provided if they had been for-profits."[37]

Officials of the American Hospital Association (AHA), in a PowerPoint presentation given on 4/27/09, discussed the impact of the economic crisis on community hospitals. The AHA conducted a survey via email and fax, collecting responses from 1,078 community hospital CEOs during March 2009. The data collected indicated that the economic crisis has made these hospitals crucial to a community's ability to serve the health care needs of its citizens.[38] Nine in ten hospitals responding to the survey had made cutbacks to address the economic challenges. They cut staff, cut services, divested assets, or took other cost-cutting actions. They found that more uninsured individuals were waiting until an emergency occurs to seek aid at an emergency room, without the benefit of preventive medicine. Of the responding community hospitals, 43% reported a moderate increase in uncompensated care as a percent of total gross revenues, while 27% reported a significant increase. Similarly, 38% reported a moderate increase in patients covered by Medicaid or another program for a low-income population, while 8% reported a significant increase. It would seem imprudent to put further stress on community hospitals and other nonprofit hospitals while they are struggling with an economy in deep recession.

Schedule H of Form 990

The IRS released the revised Form 990 and accompanying schedules on 12/20/07. Schedule H must be completed by all organizations that answered "Yes" to the question in Part IV, line 20 of Form 990.[39] Nonprofit hospitals must provide an extraordinary amount of information, all of which will be available for public review, although the data will not begin to fully accumulate until the organizations file their Forms 990 for tax years starting in 2009.[40] Schedule H requires nonprofit hospitals to report charity care and care provided through "means-tested government programs." In addition, the hospitals must report other benefits provided, including subsidized health services, uncompensated community health improvement services, and community-building activities. There are multiple questions requiring narrative responses, so compiling objective data from which

[35] See Office of Attorney General, Commonwealth of Mass., "The Attorney General's Community Benefits Guidelines for Non-Profit Acute Care Hospitals" (2007).

[36] Available at www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf.

[37] CBO Report , page 2, in which it is noted that the range of $100 million to $700 million represents the 90% confidence interval from the underlying statistical analysis.

[38] American Hospital Association, "The Economic Crisis: Ongoing Monitoring of Impact on Hospitals," available at www.aha.org/aha/content/2009/PowerPoint/090427econcrisisreport.ppt.

[39] Line 20 states: "Did the organization operate one or more hospitals?" The instructions to line 20 define "hospital" as a facility that had to be licensed, registered, or similarly recognized by a state as a hospital, whether owned directly by the reporting exempt organization or through a joint venture or disregarded entity.

[40] The 2008 data collection will be limited to Part V of Schedule H and information about the hospitals' facilities. The other sections of Schedule H are optional for 2008, although many hospitals may choose to provide that information as well.

numerical requirements can be extracted will be difficult and arbitrary. The IRS has presented this new information-gathering device as an objective means of determining whether nonprofit hospitals are providing adequate benefits to the community, although determining the amount of community benefit remains a subjective facts-and-circumstances test due to the differing needs of the communities in which these hospitals are located. It remains to be seen whether any type of objective codification of the community benefits test can be accomplished without putting many nonprofit hospitals under so much stress as to render their continued operation problematic.

Certainly, all nonprofit hospitals will need to spend substantial resources to fully and completely provide the information required by Form 990 and Schedule H, and so justify their tax-exempt status. Long narratives should be the norm, and can be provided in Part VI and Schedule O of the core form, in order to avoid public and IRS criticism that the nonprofit hospital is not providing enough community benefit. Unless the numbers associated with charity care are high, the narratives will provide nonprofit hospitals with the needed opportunity to explain their activities that are providing benefit to the community. It is, essentially, a public relations tool. Without such explanations, the hospital runs the risk of further regulation by the government, ultimately subjecting these nonprofits to excise taxes or a more objective route to revocation.

Conclusion

One option suggested last May by the Senate Finance Committee for financing comprehensive health care reform was to modify the requirements for tax-exempt hospitals.[41] The suggestion was to codify the organizational and operational requirements for determining whether the hospital qualifies as a charity under Section 501(c)(3). In addition, the proposal included an excise tax, similar to the Section 4958 intermediate sanctions excise tax, for those hospitals not meeting these proposed requirements when revocation is not appropriate.[42]

It appears that Congress has taken a step back from codifying the community benefit standard and is not immediately imposing arbitrary revenue percentages with regard to measuring community benefit. The health care reform bill proposed in the House of Representatives does not include any language regarding nonprofit hospitals. Although a Senate draft proposal was not available at the time of this writing, the outline released by Senator Baucus indicates that it, too, will not address hospital tax exemption. The current wisdom is that Congress will not address exemption until information can be gathered from Schedule H, so that further studies can be performed with regard to the impact of objective standards and excise taxes on this extremely important sector of the nation's health care system. Therefore, it is crucial that nonprofit health care institutions take advantage of this opportunity and provide extensive narrative explanations, in addition to the numerical support, for the nonprofit hospital's position that it is providing valuable benefits to its community. Otherwise, the perception may be that the nonprofit hospitals are not charitable enough to justify continued status as Section 501(c)(3) entities. ■

[41] "Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options," *supra* note 1 at 31.

[42] *Id.* at 34.