

D. UPDATE ON PARTNERSHIPS AND JOINT VENTURES

by

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1. Background

This topic updates the analysis used in the 1987 and 1988 CPE texts in determining whether an organization described in IRC 501(c)(3) that participates in a limited partnership as a general partner will jeopardize its exempt status. A principal focus will be on the advance sale of the net revenue of particular hospital functions to limited partnerships.

In at least three cases in recent years the Internal Revenue Service has received requests for private letter rulings from hospitals that have proposed to sell the net income from one or more hospital departments to limited partnerships composed of staff physicians, where the hospital (or a subsidiary) serves as the general partner. The sales price was based upon a valuation of the future stream of income during the term of the partnership, reduced to present value. All three of these requests were answered with rulings that the proposed transactions would not jeopardize the IRC 501(c)(3) tax-exempt status of the general partner, and all three of these rulings have now been revoked. G.C.M. 39862 (Nov. 21, 1991) provides the analysis to be used in cases involving the sale of net revenue streams, and clarifies the Service position where partnerships are used as the vehicle.

The sale by tax-exempt hospitals of the net revenue stream of one or more hospital functions has caused the Service to revisit the issue of participation by charities in limited partnerships. The problem, when reduced to first principles, is whether a tax-exempt organization described in section 501(c)(3) can successfully serve both charity and mammon. A general partner has a duty to maximize the profits interest of the limited partners, and typically will be the party liable for the obligations of the partnership. However, an IRC 501(c)(3) organization must be operated exclusively in furtherance of charitable purposes. These duties, obligations, and purposes are not always easy to reconcile.

There may be important reasons for entering into a limited partnership arrangement. It may be a good source of capital for a new activity that furthers exempt purposes, which the tax-exempt entity might be unable or unwilling to undertake otherwise. It may be a way of acquiring a share of significant assets or expertise brought to the partnership by other partners.

As will be discussed later, entering into a partnership may also be a way of influencing the behavior of limited partners in ways that the tax-exempt organization may consider to its advantage. In other cases, the reasons for entering the partnership may be less clear from the charity's perspective, while the benefits distributed to limited partners are quite palpable. These cases require intense scrutiny.

In Plumstead Theater Society, Inc. v. Commissioner, the 9th Circuit approved the Tax Court's holding that an exempt organization would not jeopardize its tax exempt status when it served as a general partner in a limited partnership. 675 F.2d 244 (1982), aff'g 74 T.C. 1324 (1980). Prior to this decision, the Service was reluctant to approve the participation of exempt organizations as general partners on the grounds that such participation would substantially promote the interests of the limited partners and potentially jeopardize charitable assets. Thus, in G.C.M. 36293 (May 30, 1975), an organization was denied exemption where it participated in a government-sponsored housing project through a limited partnership.

While the discussion in this topic is particularly directed toward hospital participation in partnerships, this is chiefly due to the circumstance that hospitals are the exempt entities most likely to utilize them. Similar analysis should be used with respect to any other types of exempt organizations that participate in partnerships. Further, although we use the term "partnership" throughout this topic, this should be understood as including any arrangement that accomplishes a comparable sharing or redistribution of benefits and burdens. Such joint ventures can take the form of a contractual arrangement or a closely held corporation.

2. The Double Hurdle For General Partners

Shortly after the Plumstead decision, the Service began using a two-part test for tax-exempt entities that act as general partners in limited partnerships. In G.C.M. 39005 (June 28, 1983), it was noted that participation by an exempt general partner in a limited partnership would not per se result in denial of section 501(c)(3) status, but the partnership arrangement should be closely scrutinized to assure that the obligations of the general partner do not conflict with the organization's charitable goals. Under this G.C.M., the following questions should be asked with respect to each limited partnership, and both must be answered in the affirmative:

A. Is the organization serving a charitable purpose through the partnership?
(Charitable Purpose Test)

and

- B. If so, does the partnership arrangement permit the exempt organization to act exclusively in furtherance of the purposes for which exemption is granted, and only incidentally for the benefit of the limited partners?
(Private Benefit Test)

Notwithstanding the two-part test of G.C.M. 39005, however, it is clear that any arrangement (whether through a partnership or not) will jeopardize the exempt status of an organization if it causes the net income of the charity to inure to private individuals, or if the charity serves a substantial nonexempt purpose through its participation.

The topic on Health Care in this CPE discusses the standards used in determining whether amounts inure to the benefit of private physicians or whether a substantial private purpose is served. Likewise, that topic notes that an arrangement that is designed to cause physicians to refer Medicare or Medicaid patients to the hospital could run afoul of the Medicare and Medicaid Anti-Fraud and Abuse Law. For our purposes, we will briefly note here that a hospital's staff physicians are considered by the Service to have a personal and private interest in the activities of the hospital, and thus they are subject to the proscription against inurement of IRC 501(c)(3). See G.C.M. 39498 (Jan. 28, 1986). In addition, whether or not particular individuals are considered to have a personal and private interest in the activities of the hospital, a purpose to benefit such individuals, where the purpose is more than incidental to the charitable purpose being served, on either a qualitative or quantitative basis, will jeopardize an organization's tax-exempt status. See G.C.M. 37789 (Dec. 18, 1978); also American Campaign Academy v. Commissioner, 92 T.C. 1053 (1989).

3. The First Hurdle: The Charitable Purpose Test

Determining whether a particular partnership arrangement serves a charitable purpose is relatively straightforward, and involves the same type of analysis as is used in determining whether an organization meets the operational test for exemption as an organization described in IRC 501(c)(3). The mere fact that a partnership is employed to accomplish a purpose that can be accomplished through alternative means, does not change the analysis. A purpose neither gains nor loses charitability by virtue of the fact that a partnership is used to accomplish it. In contrast, the use of a partnership to channel benefits or assets currently enjoyed by the exempt partner to nonexempt partners, to which benefits the latter would not have been entitled had an alternative vehicle been used, may mean that the private benefit test is not met.

The organization that participated in the government-sponsored housing project in G.C.M. 36293 (referred to above) failed the first prong of the test because it could not show that the partnership was serving a charitable purpose. See G.C.M. 39005. Of the 60-units in the housing project, only 15 were designated for low income individuals, and another 20 to 30 were for moderate income tenants. No income restrictions were placed upon the others. Thus, the project could not be said to be relieving the poor or distressed. Further, the project was located in an affluent suburb, which precluded any argument that the partnership was combating community deterioration.

In contrast, participation in a government-sponsored housing project that is restricted to low and moderate income residents, and which is located in a riot-torn inner-city ghetto, tends to show that the project will combat community deterioration, juvenile delinquency, and lessen neighborhood tensions. In such a case, a charitable purpose can be shown that will permit a charity's participation as a general partner.

The organization that was itself at issue in G.C.M. 39005 likewise furthered a charitable purpose. It participated with three other general partners, all for-profit, in a limited partnership that was formed to construct, own, and operate a federally-financed apartment complex for limited income elderly and handicapped persons in a particular city. A qualified tenant was required to be at least 62 years old and within certain income requirements, or handicapped. Rents were to be paid partially by tenants, according to a means-tested formula, with the balance to be provided by the Department of Housing and Urban Development.

The "garden variety" hospital partnership or joint venture. In G.C.M. 39732 (May 19, 1988), three limited partnerships involving IRC 501(c)(3) hospitals (or affiliates) as general partners were considered. Each partnership constituted a joint venture with staff physicians. All three hospital sponsors stated that the reason for entering the partnership was to provide better health care services to the public. Each brought a new health care provider or resource to the community; each entity became the property owner or service provider, and assumed the risks and rewards that flow from its status. In each case a sufficient degree of charitability was found to provide the basis for a favorable determination with respect to the charitable purpose test (but not necessarily with respect to the private benefit test, in the case of the third organization).

A typical case is one where a new and expensive item of equipment is being purchased. Instead of purchasing, owning, and operating the equipment on its own, a

hospital may become a general partner in a limited partnership. Limited partners are often restricted to staff physicians, or to medical practitioners in the community, and each limited partner is required to purchase one or more shares. The partnership will purchase, own, and operate the equipment, and will make distributions of items of income and loss in accordance with partnership interests. In the usual approved case, partnership interests are proportionate to capital contributions, and items of income and loss are distributed in the same proportion as partnership interests. The Service has generally not questioned the charitability of such arrangements.

Charitable purposes and the sale of net revenue streams. The three hospital joint ventures that were the subject of G.C.M. 39862 present an entirely different set of circumstances from the three garden variety joint ventures discussed in G.C.M. 39732. The result of the sale of the right to receive the net income from a hospital function in each case is merely a change in destination of cash flow. There is no new service provider, no new facility, no new equipment, no reduction in cost or improvement in service; nothing in fact whereby a hospital's service to the community can be said to be improved by the existence of the venture. Ultimately, the same services are being performed at the same location as before the creation of the venture. Since the basis of a hospital's exemption relies on the service of the hospital to its community under Rev. Rul. 69-545, 1969-2 C.B. 117, the failure to improve service to the community through the existence of the joint venture means that there is little basis for saying that the venture furthers charitable purposes.

Nevertheless, to justify these joint ventures, the hospitals have cited the goal of maintaining or enhancing utilization of hospital facilities. This in fact appears to be the actual reason for entering into these arrangements. Utilization of a hospital is very much dependent on the referral patterns of private physicians, and an underutilized hospital may have difficulty meeting its expenses. The need for an adequate patient base is paramount to ensure sufficient revenues. The expectation is that once staff physicians have a stake in the revenues of a hospital department, they will have an economic incentive to refer their private patients to the facility in which they have a financial interest. Otherwise, the fear is that physicians will refer their patients to alternative facilities that they may themselves create or that some other provider may establish with comparable incentives. Since a hospital's very survival may depend upon maintaining or increasing its existing patient base, it is easy to understand the pressures upon a hospital to institute programs that will tend to ensure a steady or increased patient flow.

While the economic pressures on a hospital are real, a hospital's efforts to alleviate those pressures are not in themselves charitable. G.C.M. 39862 notes that

the supply of patients is ultimately finite, and efforts to increase or maintain a hospital's patient base may be at the expense of some other health care provider. There is not necessarily a community benefit involved in having one provider perform medical services as opposed to another. If anything, the existence of many competing providers for an inadequate supply of patients indicates that a community is already sated with health care services, and increased competitiveness by one provider may be the death knell for another. Consequently, the mere fact that a hospital may stand to improve or maintain its patient base, and hence its competitive position, should not determine whether it satisfies the charitable purpose test of G.C.M. 39005.

In contrast, a charitable purpose may be served where a community lacks adequate health care facilities or physicians to serve its needs. In such cases, the Service has looked favorably upon incentives provided to physicians to induce them to relocate in medically underserved rural areas. Rev. Rul. 73-313, 1973-2 C.B. 174. Likewise, as in Rev. Rul. 69-463, 1969-2 C.B. 131, and Rev. Rul. 69-464, 1962-2 C.B. 132, there may be facts to indicate that the placement or leasing of a medical office building adjacent to a hospital for the use of staff physicians may serve the community and thus may be related to exempt purposes. These are situations that involve something more than a hospital simply attempting to increase market share. Of course, any analysis of such arrangements must also ensure that any private benefit to the physicians is qualitatively and quantitatively incidental to the charitable purpose being served, and that there is no inurement of the hospital's earnings.

Finally, it should be noted that some Service documents appear to suggest that activities intended to increase utilization of hospital facilities are in themselves in furtherance of a charitable purpose. G.C.M. 39862 modifies G.C.M. 39732 to the extent that it indicates that a hospital's attempts to increase physician referrals to the hospital are in furtherance of an exempt purpose. Also, G.C.M. 39862 distinguishes Rev. Rul. 69-464, which provided that one of the means by which the hospital furthered its exempt purposes was by encouraging fuller utilization of its facilities. In Rev. Rul. 69-464, there were other reasons by which a finding could be made that the hospital was primarily furthering exempt purposes through the leasing of a medical office building to staff physicians, and thus no reliance should be placed on any implication in that revenue ruling that the encouragement of greater utilization of hospital facilities, standing alone, is a positive factor in making a determination whether a particular arrangement furthers charitable purposes.

4. The Second Hurdle: The Private Benefit Test

Once charitability has been established, the partnership arrangement must be examined to ensure that the exempt organization is permitted to act exclusively in furtherance of the purposes for which exemption is granted, and not for the benefit of limited or other taxable partners. This requires a finding that the benefits received by the limited or other taxable partners are incidental to the public purposes of the partnership. If there is inadequate protection against financial loss by the exempt organization, or improper financial gain by the limited or other taxable partners, participation is inconsistent with exemption.

G.C.M. 39005, in fact, lists several factors that may cause the Service to look unfavorably upon exemption. Among these are a failure to insulate the exempt organization, as general partner, from an assumption of all liabilities of the partnership, or a failure to insulate the organization against a basic profit orientation on behalf of the partners. With respect to the profit orientation of the partnership, the fear is that the exempt organization will have an inherent conflict of interest between its pursuit of its exempt activities, and its obligation to further the interests of the private investors.

The organization that was the subject of G.C.M. 39005 was found to have sufficient protection conferred through its partnership agreement to insulate it from these concerns. Significant favorable factors, some of which may be unique to the organization, were the fact that there were other general partners to share the burdens and responsibilities, only the other general partners had an obligation to protect the assets of the limited partners, the exempt organization had no liability on the mortgage attached to the property involved, and the nature of the partnership (operation of low and moderate income elderly housing) appeared to ensure that the profit potential for limited partners was limited.

G.C.M. 39444 (Nov. 13, 1985) noted that where members of a group that controlled an exempt organization were also limited partners in a partnership where the exempt organization was general partner, special safeguards would be necessary to protect against potential conflicts of interest between partnership obligations and tax exempt objectives. In this case, Chief Counsel believed that the organization should form a committee, all members of which were neither officers, board members, or limited partners, to monitor the organization's participation in the partnership and have sufficient powers to guarantee that operations are exclusively for charitable purposes.

Despite the focus of G.C.M. 39005 and G.C.M. 39444 on the protection needed in the partnership agreement to prevent potential conflicts, later G.C.M.'s appear to be more concerned with the clear presence or absence of private benefit, rather than safeguards that may be present in the agreement itself. Thus, in G.C.M. 39732, in two partnerships of hospitals with physician limited partners, the only inquiries were whether profits and losses would be allocated in accordance with the respective partnership interests of the partners on the basis of capital contributions and risks assumed; whether there would be special allocations of items of income, deductions, or credits to any partner; and whether the financing required would be at fair market value and entered into through arm's length negotiations. In other words, as long as there were no facts or agreement terms that would indicate that there might be reason to suspect the dedication of the exempt organization to something other than charitable purposes, no additional safeguards were apparently deemed necessary. The fact that two of the organizations discussed in G.C.M. 39732 were sole general partners in their respective partnerships was not determinative, nor was the fact that the profit potential in each partnership was high.

The third organization discussed in G.C.M. 39732 had more questionable terms in its two partnership agreements. Because of the two-tier structure of these agreements, the ultimate effect of the arrangement may have been to allocate a greater share of the losses attributable to depreciation to the participating physicians than they would have been entitled to had depreciation losses been allocated strictly in accordance with overall capital contributions. The G.C.M. concluded that the propriety of this arrangement should be reviewed by the offices within the Service with greater expertise in partnerships and depreciation deductions. Presumably, an adverse position with respect to IRC 704 or IRC 168 from either office would mean that the Service might find that the benefit to private physicians is not quantitatively or qualitatively incidental to the public benefit being served by the partnership, and that consequently the entry into the partnership by the organization could fail the private benefit test. We believe that the Service should strictly scrutinize cases that involve disproportionate allocations of profits and losses, whether or not disguised. As noted in G.C.M. 39546 (Aug. 14, 1986), we should increase our coordination of such issues with other functions within the Service with an interest in such matters to ensure that the correct technical result is reached.

Garden Variety Hospital Partnerships and Joint Ventures. There is no question that the Service should be alert to private benefit issues even in "garden variety" limited partnerships such as those discussed in G.C.M. 39732. As noted earlier, one reason for encouraging physician participation in such partnerships may be to boost physician referrals to enhance utilization of a facility, or induce physicians to relocate

to or to remain at the hospital. The more tangible the encouragement, the more likely the behavior of physicians will conform to the intended result. A hospital may have every incentive to sweeten the deal for physicians, particularly if the real purpose behind the creation of the partnership is to provide incentives for them rather than to provide new health facilities for the community. Consequently, it is important to review the terms of each partnership agreement to ensure that no disproportionate allocations are present, and that the hospital is not shouldering a greater share of contributions and burdens than its level of participation would warrant.

These are not employee compensation cases. In this regard, physicians are investors rather than hospital employees, and the analysis of the benefits that are conferred upon physicians through these arrangements should not hinge upon whether compensation is reasonable or unreasonable with respect to services performed for the hospital. Physician interests should be analyzed solely in terms of whether the interests conferred through the partnership are qualitatively and quantitatively incidental to the charitable purpose being accomplished by the partnership, and whether the net income of the hospital inures to the benefit of the physicians on its staff. Naturally, any interest that appears designed to provide handsome rewards to a physician for his or her participation could well be considered an amount that benefits private interests more than incidentally, or that results in an inurement of earnings.

We do not mean to imply that the Service will adopt stricter standards of analysis in cases similar to the partnerships discussed in G.C.M. 39732. In two of those partnerships, and perhaps the third, the private benefit to physicians was found to be qualitatively and quantitatively incidental to the charitable benefits resulting from the partnership. The Service, however, will be paying close attention to factors that may suggest that a recited charitable purpose is merely a vehicle to justify rewards to staff physicians, including:

Disproportionate allocations of profit or loss in favor of limited partners.

Nominal or insufficient capital contributions by limited partners.

Where there are no new facilities or equipment, and no other reason why a new method of operation is needed.

Where existing hospital equipment or facilities are to be sold or leased to the partnership, or where services are provided by the hospital, at less than fair market value.

Where limited partners are allowed significant influence or control over partnership operations, or in fact control the exempt organization.

Where the exempt organization bears all risk or liability for partnership losses.

Where commercially unreasonable loans are made to the partnership (low interest rate or inadequate security).

Where any non-exempt partner receives more than reasonable compensation for the sale of property or services to the joint venture.

Announcement 92-83, 1992-22 I.R.B. 59, 63 (June 1, 1992), sets forth the Service's examination guidelines that are applicable to those joint ventures involving hospitals. In any hospital examination where the facts suggest possible inurement or private benefit, these guidelines provide that specialists should request technical advice from the National Office.

Private benefit and the sale of net revenue streams. As we noted earlier, it is unlikely that a partnership between a hospital and physicians that purchases the future net income of a hospital department or function will be considered to further a charitable purpose. Even if it is found to do so, however, it is even more unlikely that the private benefit flowing to the physicians from the arrangement would be considered qualitatively and quantitatively incidental to the charitable purposes being served. A substantial nonexempt purpose is present. Further, in the case of hospital staff physicians, inurement of the hospital's income in their favor could be the result. In either case, the private benefit test prong of G.C.M. 39005 is not satisfied, and the exempt partner could jeopardize its tax-exempt status by entering into the arrangement.

Among the problems we have seen are an inadequate purchase price put forward by the partnership for the rights to the income of the relevant hospital unit. Partnership participation is limited to active physicians able to make referrals. Valuations do not seem to have accounted for an anticipated increase in referral behavior by physicians once they became participants, although changes in referral

patterns are no doubt a significant reason for creating the partnership. Further, in each case the amount of the valuation has been discounted to present value. We understand that at least some of these valuations have been deeply discounted not only to reflect inflation, but also to build into the arrangement a large annual expected return for the limited partners beyond inflation. Even the inflation rate has itself been inflated to accord to the rate of increase in health care costs, rather than to the increase in consumer prices generally. It seems clear in such cases that the exempt hospital has sought to ensure that all financial risk falls upon itself rather than upon the physician partners; it is equally clear that such an arrangement is so rife with private benefit that it could scarcely be called merely incidental to charitable purposes under any circumstances.

5. A Note On Ancillary Services Provided By A Hospital To A Partnership

At least one private letter ruling has been issued to a hospital that states that the hospital's provision of ancillary administrative services, such as purchasing, billing, and collection, to a limited partnership is not subject to unrelated business income taxation. This is being reconsidered. Such administrative services are indistinguishable from ordinary commercial services. Further, when offered to a partnership, they are not being provided to an entity that is an integral part of the hospital. Under ordinary circumstances, the provision of these services will not be considered to contribute importantly to the exempt purposes of a hospital, and consequently should not escape taxation. This issue appears to arise rather frequently, and a hospital may cite one or more such private letter rulings as an indication of Service position. Needless to say, they should not be regarded as authority.

The provision of ancillary medical services to the partnership, such as radiology, anesthesiology, and nursing care, is distinguishable. Since the hospital may be furthering its exempt purposes through the provision of medical care, such services could be directly related to its exempt function.

We should ensure that ancillary services, whether medical or administrative, are furnished at fair market value when provided to a partnership with nonexempt partners. When furnished at cost or in any other manner at less than fair market value, it may be another indication of private benefit in favor of physician partners.

6. Cleaning Up

On May 11, 1992, in Announcement 92-70, 1992-19 I.R.B. 89, the Service stated that exempt organizations that have sold the net revenue stream of one or more

functions can request a closing agreement or other arrangement with the Service with respect to termination of their joint venture prior to September 1, 1992. If there is no further benefit to private physicians, revocation of exempt status will not be an issue.