How Good a Samaritan? Federal Income Tax Exemption for Charitable Hospitals Reconsidered

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I. INTRODUCTION

For many years charitable, nonprofit hospitals have received income, property, and other tax exemptions.¹ These tax subsidies were enacted at a time when hospitals were primarily operated to provide recuperative care without charge to the indigent and the destitute.²

In the latter half of the twentieth century charitable hospitals have changed dramatically.³ Today's charitable hospitals make available a technologically sophisticated setting in which physicians and other health personnel perform complex diagnostic and therapeutic procedures. Charitable hospitals have become wealthy institutions, with power and presence in the community far beyond their almshouse forebears. The indigent are seldom encouraged, and are sometimes shunned, from seeking treatment in many of these institutions. Instead, charitable hospitals compete with profit-making hospitals for a share of the privately and publicly insured patient market. Despite these changes, charitable hospitals have enjoyed an essentially unquestioned exemption from income, property, and other taxes; access to tax-exempt financing; and other tax subsidies.

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2. See infra notes 42-43 and accompanying text.
Do contemporary charitable hospitals provide a sufficient community benefit to justify the loss of government revenue caused by their tax exemption? Focusing particularly on federal income tax exemption and on the community benefit derived from the provision of services to persons unable to pay, this Article argues that not all hospitals do. Accordingly, the authors recommend that the Internal Revenue Service issue a Revenue Ruling revising the current standards for federal income tax exemption to encourage charitable hospitals to clearly and explicitly identify and respond to health care needs, including the needs of persons unable to pay, in their local communities. The proposed text of such a ruling is set forth in an appendix to this Article.

II. CHANGING HOSPITAL MARKET

The provision of charity care is discouraged by the contemporary hospital market. This is largely the result of actions taken in the past ten years by payors of hospital care: state and federal governments and private insurance companies. Seeking to stem the inexorable inflation of medical care costs in recent decades, public and private payors have established hospital payment mechanisms that implicitly or explicitly encourage nonprofit hospitals to reduce internal subsidies for unpaid services and to compete on the basis of price. If the basis for hospital tax exemption continues to be the provision of uncompensated services as a quid pro quo for the tax subsidy, current hospital payment strategies and tax exemption may be operating at cross purposes.

A. Expansion of Proprietary Hospital Sector

The increased share of the hospital market held by proprietary institutions has prompted concern that the tax laws unfairly discriminate between nonprofit and proprietary hospitals. Nonprofit and proprietary hospitals increasingly look more alike than different, both when measured in terms of efficiency and provision of uncompensated services.4 A tax subsidy for one otherwise indistinguishable sector of the hospital industry may dilute the economic incentives built into new payment systems by supporting inefficient nonprofit institutions or discouraging the expansion of their more efficient

4. See generally INSTITUTE OF MEDICINE, FOR-PROFIT ENTERPRISE IN HEALTH CARE (Bradford Gray, ed. 1986).
competitors.\textsuperscript{5}

\textbf{B. Access to Hospital Care}

There is a growing recognition among health policymakers and legislators that medical indigency is a serious and widespread problem in the United States. Statistics and anecdotal evidence support this view. It is estimated that 30 to 38 percent of Americans, from 58.8 to 63.0 million people, are uninsured or underinsured.\textsuperscript{6}

\textbf{C. Changing Public Perception of the Hospital}

In addition, the public has become uneasy with the increasingly commercial behavior of hospitals. A recent national public opinion survey reported that 67 percent of respondents believe nonprofit hospitals are essentially "commercial" entities, not social service organizations.\textsuperscript{7} State and local property tax officials have made numerous well-publicized efforts to forfeit the property tax exemption of nonprofit hospitals.\textsuperscript{8} The popular press has recounted numerous horror stories of denial of care to persons unable to pay.\textsuperscript{9} Legislation has been proposed that would curtail access to tax-exempt bond financing for hospitals not providing a minimal volume of care to the poor and link the federal income tax exemption to the provision of specified levels of charity care.\textsuperscript{10} Forty-five


\textsuperscript{6} P. BUTLER, TOO POOR TO BE SICK: ACCESS TO MEDICAL CARE FOR THE UNINSURED 25 (1988).


\textsuperscript{10} H.R. 2207, 101st Cong., 2nd Sess. (1990) would have restricted the use of tax-exempt bonds by charitable hospitals that failed to achieve a certain level of charity care. See Barker, \textit{Re-examining the 501(c)(3) Exemption of Hospitals as Charitable Organizations}, 3 EXEMPT ORG. TAX REV. 539, 546-47 (1990). H.R. 5688, 101st Cong., 2nd Sess. would have required charitable hospitals to provide a minimum volume of charity care, tied to the value of their tax exemption, to avoid an excise tax which would be provided to their state to fund charity care in public and other charitable hospitals.
percent of the public believe that nonprofit hospitals should forfeit their tax exemption.\textsuperscript{11}

\textbf{D. Nonprofits Under Fire}

The tax status of the entire nonprofit sector has been questioned in recent years. The impetus for this scrutiny has come from several fronts. There has been increasing competition between nonprofit and proprietary businesses. Travel agencies, private educational institutions, sports clubs, and a variety of health care providers have objected to the incursion of nonprofits into their entrepreneurial domains and to the subsidy they enjoy. The Small Business Administration has devoted considerable attention to the issue, and the House Ways and Means Committee on Tax Oversight has conducted hearings on the "unrelated business income" of exempt organizations.\textsuperscript{12} In the wake of the taxpayer's revolt, local governments have sought to identify new sources of tax revenue. It has been suggested that exempt organizations, particularly those such as hospitals that provide essentially commercial services, are as heavy of a user of tax-supported public services such as police, fire safety, and public roads as their taxable counterparts. Tax exemption allows them to free-ride, increasing the tax burden of non-exempt organizations.\textsuperscript{13}

\textbf{E. New Techniques for Tax Expenditure Analysis}

In addition to direct expenditures, the federal budget contains indirect expenditures accomplished through the tax sys-

\textsuperscript{11} \textit{Opinion Survey, supra note 7, at 101. This figure may reflect concern about hospitals' diminishing indigent care levels among the 85 percent of the American public who, according to another recent survey, believe hospitals should provide care to everyone regardless of ability to pay. \textit{HMO Survey: A Mandate for High Quality Health Care, 4 Health Mgmt. Q. 5 (1986).}

\textsuperscript{12} The Small Business Administration has aggressively pursued the issue of competition between tax-exempt nonprofits and small businesses. \textit{See SMALL BUSINESS ADMINISTRATION, UNFAIR COMPETITION BY NONPROFIT ORGANIZATIONS WITH SMALL BUSINESS: AN ISSUE FOR THE 1980'S (3rd ed. 1984). Concern about the scope of income-producing activities by nonprofits prompted hearings by the House Ways and Means Subcommittee on Oversight in 1987, and increased I.R.S. reporting requirements.}

\textsuperscript{13} \textit{See generally J. BENNET, UNFAIR COMPETITION; THE PROFITS OF NONPROFITS (1989). For a scholarly critique of tax exemption for nonprofit organizations, including charitable hospitals, that act essentially as commercial enterprises, see Hansmann, \textit{The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation, 91 Yale L.J. 54 (1981).}
tem.14 When the tax code grants preferential treatment to particular kinds of income through deductions, credits, or exclusions, the government spends money on the underlying object of that income as surely as if it had appropriated and spent the funds.

Congress and the public have not traditionally subjected the cost and relative value of this type of tax expenditure to the scrutiny given direct expenditures.15 However, in recent years the federal government has paid increasing attention to the cost and utility of tax expenditures.16 Tax exemption for nonprofit charitable organizations has been recognized as a tax expenditure.17 Recently, the U.S. General Accounting Office evaluated the cost and utility of the federal income tax exemption for nonprofit hospitals by calculating the revenue loss associated with the federal and state charitable hospital income tax subsidies and comparing this amount with the estimated value of charity care provided by the hospitals.18 Evidence from the GAO Report suggests that there are many charitable hospitals that cost society more than they provide in return.19

F. Hospital Exemption

At the present time charitable hospitals unquestionably qualify for federal income tax exemption.20 The most recent

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16. The Tax Reform Act of 1986 was in part an effort to excise hidden tax subsidies from the Internal Revenue Code.

17. In Regan v. Taxation With Representation of Washington, 461 U.S. 540 (1983), the Supreme Court acknowledged as much, stating: "Both tax exemptions and tax deductibility are a form of subsidy that is administered through the tax system. A tax exemption has much the same effect as a cash grant to the organization of the amount of tax it would otherwise have to pay on its income. Deductible contributions are similar to cash grants of the amount of a portion of the individual's contributions." Id. at 544. See also S. Surrey & G. McDaniel, TAX EXPENDITURES 219 (1985) (nonprofit hospital tax exemption is a tax expenditure).


19. See infra text accompanying notes 93-100.

20. The Internal Revenue Code provides exemption from federal income taxation for: "Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports
IRS revenue ruling on this issue states that the provision of hospital services is an exempt charitable purpose as long as a hospital promotes the health of a class of persons broad enough to benefit the community and operates to serve public rather than private interests. A hospital may meet these standards if it offers services to those who can pay, including Medicare and Medicaid patients; has a governing board of prominent citizens and an open medical staff policy; and applies surplus funds to improving operations, capital plant, medical education, and research. It need not provide what is known as "charity care": services to indigent patients without expectation of payment.

Of course, the majority of charitable hospitals provide at least some charity care. Some deliver substantial amounts. The impetus to do so, however, likely comes more from an internally-generated sense of mission or an accident of proximity to a poor neighborhood than from concern with Internal Revenue Code compliance.

This state of affairs would certainly surprise those who administered the federal income tax laws for the first forty-plus years of their existence. It would probably startle those who founded America's first hospitals, for the very notion of a charitable hospital that did not serve the poor would seem utterly foreign to them. It seems particularly surprising in light of the multi-billion dollar tax subsidy granted to charita-

competition . . . , or for the prevention of cruelty to children or animals . . . " I.R.C. § 501(c)(3) (West Supp. 1986). The Supreme Court has ruled that as a general proposition hospitals are eligible for exemption as charitable organizations under § 501(c)(3). Simon v. Eastern Kentucky Welfare Rights Org., 426 U.S. 26, 29 (1976). Under the Code, an exempt charitable entity must be both "organized" and "operated" for exempt purposes. Treas. Reg. § 1.501(c)(3)-1(a). The organizational requirement is met if the entity's articles of incorporation limit it to exempt purposes and do not expressly empower it to engage, except to an insubstantial degree, in activities not in furtherance of its exemption. Treas. Reg. § 1.501(c)(3)-1(b)(1)(i). The operational component requires the organization to engage primarily in activities that accomplish its exempt purposes. It also prohibits inurement of the organization's net earnings to the benefit of private individuals, and certain political activities. Treas. Reg. § 1.501(c)(3)-1(c). The requisites of "charitability", including the provision of services to those unable to pay, are operational issues.

24. See infra text accompanying notes 96-100.
25. See infra text accompanying notes 28-40.
ble hospitals by the federal government. 27

G. Origins of Federal Income Tax Exemption for Charitable Hospitals

Exemption provisions for charitable organizations have always been present in federal income tax laws. The first broad corporate income tax, the Tariff Act of 1894, exempted "corporations, companies, or associations organized and conducted solely for charitable, religious, or educational purposes." 28 Similarly, exemption provisions were included in all the subsequent pre-Code Revenue Acts. 29 Additional exempt categories and restrictions were added from time to time. The 1939 Code incorporated the accumulated language of the revenue acts and, in turn, was included (with additional prohibitions on political activity and the inclusion of a public safety testing purpose) in the 1954 and 1986 Codes. 30

H. Definition of "Charitability"

Courts and commentators sometimes speak as if there existed two partially exclusive competing definitions of charity. 31 One, the so-called "popular and ordinary" or "soup kitchen" definition, says that charity consists exclusively of the

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27. Estimates of the amount of the tax subsidy for charitable hospitals vary. There are difficult methodological problems in estimating taxes that would have been paid by an exempt organization had it been taxable. The estimates are least for ad valorem taxes and greatest for income-related taxation. A recent estimate that includes all the major subsidies (federal and state income tax exemption, state and local property and sales tax, issuance of tax-exempt bonds and deductibility of charitable contributions) but unfortunately does not specify estimation methods is contained in Copeland & Rudney, Federal Tax Subsidies of Not-for-Profit Hospitals, 3 EXEMPT ORG. TAX REV. 161, 167 (1990). The annual subsidy in the mid-1980's is estimated to have been $8.5 billion.


relief of poverty, or almsgiving. A hospital seeking to come within this definition would be dedicated exclusively to caring for indigent clients. The second definition, commonly referred to as the "legal" definition and said to underlie the common law standards for qualification of charitable trusts, deems as charitable any activities beneficial to a broad class of the public, which may, but need not, include the poor. A hospital could come within this definition simply by making its facilities available to all paying members of the public.

In fact, charity has a range of possible meanings, including numerous intermediate meanings in which charity implies some combination of almsgiving and broad public benefit. For example, charity can be interpreted to refer primarily to the relief of poverty, but to include some service to the nonpoor. Conversely, charity can refer to any activity of broad social benefit that includes some service to the poor. Under the first of these approaches, a hospital would qualify as a charity if it primarily treated an indigent clientele but also made its facilities available to occasional paying patients. Under the second approach, a hospital would qualify as a charity if it primarily served the paying public but also delivered some care to indigents.

"Charitable" is not defined in the Internal Revenue Code, nor is it self-defining. It is not possible to discern with any degree of confidence a congressional intent to select either the "relief of poverty" or "broad social benefit" definition of charity from the wording of the law or its legislative history. Probably neither was consciously intended. It seems more

32. RESTATEMENT (SECOND) OF TRUSTS § 369, comment a (1959).
33. Commentators deduce that any socially beneficial activity qualifies as charity from (a) the variety of charitable purposes listed in the Preamble to the Statute of Charitable Uses of 1601 (Stat. 43 Eliz. I, c.4.); and (b) the multitude of aims courts have upheld over the years as charitable trust purposes. See SCOTT, THE LAW OF TRUSTS, § 370 (3rd ed. 1967 and 1988 Supp.); BOGERT, THE LAW OF TRUSTS AND TRUSTEES, § 370 (rev. 2d ed. 1977 and 1988 Cum. Pocket Part).
35. Section 501(c)(3) and its predecessors are sufficiently cryptic that either interpretation can survive but not flourish. Thus, applying the principle that all words in statutes have meaning, in 1923 the Internal Revenue Service concluded that since all the statutorily-listed organizations qualified as common law charitable trusts, Congress must have meant "charitable organizations" to be confined to those devoted to almsgiving. Otherwise, listing the others would have been pointless. I.T. 1800, 11-2 C.B. 152 (1923). In 1959 the Service reversed field. Treas. Reg. § § § 1.501(c)(3)-1(d)(2)(1959) announced that the Code used "charitable" in its "generally accepted legal sense", and accordingly downgraded relief of poverty from the primary charitable purpose to one of several. Although the IRS has never explained the grounds for this
likely that, by choosing a word without a fixed meaning, Congress intended to assign tax officials the task of defining "charity" by applying contemporary standards and notions of public benefit to its accumulated common law meaning. This is the Supreme Court's interpretation, announced in the Court's most thorough analysis of charitable exemption in recent years, *Bob Jones University v. United States.*

In *Bob Jones University*, the Court held that racially exclusionary private school admission standards violated an established national policy embedded in the charitable exemption against racial discrimination in education. The Court concluded that in adopting the charitable exemption, Congress was "guided by the common law of charitable trusts." Long-recognized fundamental principles of charitable trust law were incorporated into the income tax exemption, to be defined and interpreted in accordance with contemporary standards. In particular, the Court indicated that Congress intended that Section 501(c)(3) incorporate two principles: (1) that charities advance purposes consistent with fundamental public policy; and (2) that charities provide a public benefit to compensate for the public revenue loss caused by their exemption.

The legislative history of the charitable exemption is sparse. In *Bob Jones Univ. v. United States*, 461 U.S. 574, 588, n.12 (1983), the Supreme Court suggests that in drafting § 501(c)(3), Congress was guided by the common law of charitable trusts. However, the Court's evidence—similar wording in pre-Code Revenue Act charitable exemption provision and descriptions of charitable purposes in the English law of charity and the Revenue Act draftsmen's presumed familiarity with English tax law—is weak. The Court's assertion actually amounts to little more than a restatement of the principle that words in statutes retain their common law meaning. More recent legislative actions tell little. A 1924 tax amendment proposed to extend the definition of "charitable" for purposes of the contribution deduction to entities organized and operated for "preventive and constructive service for relief, rehabilitation, health, character building, and citizenship." 26 CONG. TREAS. REG. 8171 (1924). The stated goal was to override I.T. 1800, *supra*, and allow charitable contributions to social service organizations not serving the poor. The amendment was opposed, not out of support for the Rule, but because it would have excessively widened the scope of purposes to which contributions were deductible. The amendment was later withdrawn. 26 CONG. REC. 8173. In 1969 legislation was proposed to expressly exempt hospitals, in order to free them from IRS challenges based on insufficiency of charity care. See H.R. REP. NO. 413, 92st Cong., 1st Sess., reprinted in 1969 U.S. CODE CONG. & ADMIN. NEWS 1688. The proposal was not enacted.

37. *Id.* at 595-96.
38. *Id.* at 588 n.12.
39. *Id.* at 593 n.20.
40. *Id.* at 586.
I. "Charity" in the Courts

Historically, IRS criteria for measuring the adequacy of charitable hospitals' contributions to charity have generally reflected the standards contained in contemporaneous judicial decisions. These decisions were reached in the context of reviewing the validity of charitable trusts for hospital purposes, or the entitlement of charitable hospitals to exemption from various state and local taxes. The decisions rejected the idea that charity demanded exclusive attention to the indigent, but made the accessibility of the hospital to all without regard to ability to pay as an important consideration.

In the 19th century, a number of courts addressed the charitable status of hospitals, nursing homes, and other health-related institutions, and their duty to serve the poor. These cases clearly indicate that a trust for the promotion of health through the establishment of a hospital or other health service institution was a valid charitable use. For practical rather than legal reasons, requisite levels of indigent care were not an issue in these decisions. The small number of hospitals in existence before the turn of the century primarily treated a "deserving poor" clientele. Because no charitable hospital was established for a primary purpose other than indigent care, the existence of a legally-required minimum level of indigent care would have been a purely hypothetical question.

Surgical intervention became more feasible because of

41. See infra text accompanying notes 42-58.

42. See, e.g., Jones v. Habersham, 107 U.S. 174, 190-91 (1882) (bequest to establish hospital for sick and indigent females sufficiently definite to be valid); cf. Inglis v. Sailors' Snug Harbor, 28 U.S. 99 (1830) (marine hospital for aged, decrepit, and worn-out sailors); Ould v. Washington Hosp. for Foundlings, 95 U.S. 303 (1877) (trust for establishment of hospital foundlings upheld; "[e]ndowment of hospitals for the afflicted and destitute . . . is one of the commonest [sic] forms of [charitable] uses."); Hayden v. Connecticut Hospital for Insane, 64 Conn. 320, 30 A. 50 (1894) (devise in trust to establish free beds at mental hospital creates a valid trust); State v. Board of Assessors, 52 La. Ann. 223, 26 So. 872 (1898) (hospitals or infirmaries exempt from taxation as charitable institutions); State v. Powers, 10 Mo. App. 263, aff'd, 74 Mo. 476, (1881) (hospital building whose object is charity and whose profit from pay patients is applied exclusively charity exempt from taxation as purely public charity); People v. Purdy, 58 Hun. 386, 12 N.Y.S. 307 (1890); City of Philadelphia v. Pennsylvania Hosp. for the Insane, 154 Pa. 9, 25 A. 1076 (1893).

43. Early hospitals were essentially almshouses specializing in the chronically ill and decrepit. Contemporary medical science emphasized restoration of health through rest and diet rather than active intervention in disease processes, and the role of hospitals was accordingly limited. See generally C. ROSENBERG, THE CARE OF STRANGERS: THE RISE OF THE AMERICAN HOSPITAL SYSTEM (1987).
advances in theories of disease and medical technology. Hospitalization became more desirable, and more expensive. Hospitals began to attract paying patients for the services they could provide. They charged fees to cover rising costs and to subsidize continued treatment of the poor. When confronted with this trend, courts across the country ruled that hospitals could admit paying patients and still qualify as charitable institutions. However, the same courts repeatedly affirmed that the touchstone of charitable hospital status was a willingness to treat patients without regard to their ability to pay. Excessive attention to paying patients and zealous billing and collection efforts were evidence of unwillingness to treat the poor. So too were low percentages of indigent patients. Courts often emphasized that revenues derived from paying patients would enable hospitals to extend their capacity to provide free care. It was acknowledged that revenues from paying patients enabled the hospital to maintain its physical plant and

44. See id. at 122-166 (1987).


equipment. However, the hospital that provided little or no charity care stood to lose its exemption.

In terms of doctrine, the courts seem to have accepted neither the "popular and ordinary" definition of hospitals' charitable obligations nor the so-called "legal" definition. Hospitals were not required to devote themselves exclusively to treatment of those unable to pay but neither were they permitted to turn away the indigent. The courts opted for an intermediate standard that looked to the absence of admission criteria based on ability to pay and the presence of something more than minimal numbers of indigent patients as the basic criteria of charitable. Treating paying patients was allowed, but it was the delivery of care to those unable to pay that constituted the "charity" that entitled a hospital to preferred trust or tax exempt status.

J. Early IRS Interpretation

The IRS' interpretation of the obligations of charitable hospitals during the first half of the 20th century was, if anything, stricter than the prevailing standard. The IRS did, however, acknowledge that relief of poverty need not be the sole purpose of an exempt charity. Consistent with the Commissioner's narrow reading of the meaning of "charity" at the


51. Regulations implementing the Revenue Act of 1918 provided that exempt charities would include associations for relief of families of clergymen (even though they donate to the association), for furnishing the services of trained nurses to persons unable to pay, or for aiding the general body of litigants by improving the efficient administration of justice. Treas. Reg. § 45 (1919), compiled in 10 FOX, INTERNAL REVENUE REGULATIONS (1951) [hereinafter FOX]. These provisions imply a concept of charity extending, at least at some instances, beyond the relief of poverty. Although family relief funds and free nursing services might both constitute almsgiving, some beneficiaries of improved administration of justice could be non-indigent.
time, the IRS placed relief of poverty at the core of the charitable exemption. Treasury Regulation 65, adopted to accompany the Revenue Act of 1924, provided that “[c]orporations organized and operated exclusively for charitable purposes comprise, in general, organizations for the relief of the poor.” In an obvious effort to assure that indigent patients were being cared for, treasury regulations expressly required charitable hospitals to notify the IRS whether nonpaying patients were accepted. Furthermore, the IRS apparently did not willingly embrace the proposition, widely-accepted at the time, that charitable hospitals could serve paying patients.

A 1956 revenue ruling set forth in detail the IRS' view of the charitable obligations of exempt hospitals. Revenue Ruling 56-185 announced that an exempt hospital “must be operated to the extent of its financial ability for those not able to pay” and not exclusively for those who are able and expected to pay. The Revenue Ruling continued as follows:

It is normal for hospitals to charge those able to pay for services rendered in order to meet the operating expenses of the institution, without denying medical care or treatment to others unable to pay. The fact that its charity record is relatively low is not conclusive that a hospital is not operated for charitable purposes to the full extent of its financial ability. It may furnish services at reduced rates which are below cost, and thereby render charity in that manner. It may also set aside earnings which it uses for improvements and addi-

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52. See supra note 35 and accompanying text.
55. See, e.g., Davis Hosp., Inc. v. Commissioner, 4 T.C.M. 372 (1945), in which the IRS argued without success that a Hospital should be denied exemption for charging fees to those able to pay. The proposition was, however, accepted by the Tax Court and federal appellate courts. See, e.g., Commissioner of Internal Revenue v. City of Battle Creek, 126 F.2d 405 (5th Cir. 1942) (sanatorium charging people able to pay for services but not denying treatment to those unable to pay entitled to federal income tax exemption). The IRS eventually moderated its views on private pay patients in Rev. Rul. 56-181, infra notes 56-58 and accompanying text.
tions to hospital facilities. It must not, however, refuse to accept patients in need of hospital care who cannot pay for such services. Furthermore, if it operates with the expectation of full payment from all those to whom it renders services, it does not dispense charity merely because some of its patients fail to pay for the services rendered.\textsuperscript{57}

Revenue Ruling 56-185 indicated that the IRS agreed with the prevailing view of courts across the country that charitable hospitals were obliged to provide services without charge to persons unable to pay.\textsuperscript{58}

\section*{K. Contemporary Court Rulings}

It is unlikely that any private hospital today is operated primarily to serve charity patients. In the latter half of the twentieth century, hospitals greatly accelerated the transition from their almshouse origins to modern businesses.\textsuperscript{59} Costs of hospital care soared, increasing the burden of charity care on hospital finances and making the hospital financially inaccessible to people with moderate incomes as well as the destitute. Today many charitable hospitals consciously attempt to minimize the levels of charity care they provide.\textsuperscript{60} The actual

\textsuperscript{57} Id. at 203.

\textsuperscript{58} Commissioner of Internal Revenue v. City of Battle Creek, 126 F.2d 405 (5th Cir. 1942); Goldsby King Memorial Hosp. v. Commissioner, 3 T.C.M. (CCH) 693 (1944); Davis Hosp., Inc. v. Commr, 4 T.C.M. (CCH) 312 (1945) (hospital receiving no compensation from 30-40 percent of its patients entitled to federal income exemption); Intercity Hosp. Ass'n v. Squire, 56 F.Supp. 472 (W.D. Wash. 1944) (hospital with extremely liberal rule concerning admittance of unfunded patients entitled to social security tax exemption); Lorain Avenue Clinic v. Commissioner, 31 T.C. 141 (1958) (hospital providing free services to only a small percent of patients not entitled to federal income tax exemption; charging moderate, compared to high, fees insufficient grounds for exemption); Sonora Community Hosp. v. Commissioner, 46 T.C. 519 (1966), aff'd per curiam, 397 F.2d 814 (9th Cir. 1968) (hospital providing \textit{de minimis} free care not entitled to federal income tax exemption; some record of charity care beyond diagnosis and cure of disease is required).

\textsuperscript{59} See generally R. STEVENS, supra note 3.

\textsuperscript{60} "[M]any private hospitals have for years been transferring poor or uninsured patients to public hospitals, admitting only those persons who are well insured or are affluent enough to pay the high cost of hospital care." 3 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE 284 (1983). "[F]inancial pressures under which private nonprofit hospitals operate have already led many of them to turn away patients who cannot pay or to severely limit the number of indigents they will admit." Memorial Hosp. v. Maricopa County, 415 U.S. 250, 265 (1974). For an empirical study of patient dumping, see Schiff, Transfers to a Public Hosp.; A Prospective Study of 467 Patients, 314 NEW ENG. J. MED. 552 (1986). The GAO Report found that many charitable hospitals in the study communities limited a majority of charity care to that initiated in the emergency room.
levels of indigent care provided by charitable hospitals are low in comparison with the levels reported in the court decisions from the first half of the century. Horror stories of hospitals turning away acutely sick or injured persons unable to pay have become commonplace.

In the last fifty years, state courts, and occasionally legislatures, have continued to examine the free care obligations of charitable organizations, generally in the context of challenges to their property tax exemptions. In the majority of jurisdictions where the question of free care has been raised in the hospital context, the provision of charity care and the accessibility of the hospital to indigent patients continue to be determinative, or at least important, criteria for entitlement to tax exemption.

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61. See infra text accompanying note 65. Perhaps to downplay their dramatic shift in charitable service, hospital advocates have argued that the industry continues to provide "charity" in the form of discounts between a hospital's stated charges and the rates it negotiates with large payors such as Medicare, Medicaid, Blue Cross, and other insurers, and bad debt losses. See Lewin, Eckels, & Roenigk, Setting the Record Straight: The Provision of Uncompensated Care by Not-For-Profit Hospitals (1988). As political arguments for more generous Medicare and Medicaid payment, these arguments may carry some weight. But the claim that price discounts and bad debt losses constitute charity in any legal sense is hard to accept. It is analogous to the claim that taxpayers are entitled to charitable deductions for the difference between the price they pay for goods or services provided by a charitable organization and the market value of goods and services received. These claims are evaluated by whether the excess payment is motivated by donative intent or is a quid pro quo. United States v. American Bar Endowment, 477 U.S. 105, 117-18 (1986). Medicare, Medicaid, and other large payor price discounts are clearly granted by charitable hospitals as a quid pro quo for such business, not as a gift. See Mancino, supra note 1, at 1047 (Medicare contractual allowances irrelevant to hospital charity record after enactment of prospective payment system). Similarly, bad debt losses are costs of conducting business as a hospital, incurred by charitable and proprietary hospitals alike without donative intent. Highland Park Hosp. v. Department of Revenue, 155 Ill. App. 3d 272, 280, 507 N.E.2d 1331, 1336 (1987) (hospital not entitled to claim amounts determined to be uncollectible bad debts as free care to justify property tax exemption); Haines v. St. Petersburg Methodist Home, 173 So. 2d 176, 185 (Fla. Dist. Ct. App. 1965), cert. denied, 183 So.2d 211 (1965) (one nursing home resident's inability to meet contractual obligation to pay insufficient to justify property tax exemption; possibility of non-payment is foreseeable business risk).

62. See Dallek & Waxman, supra note 9.

The cases do suggest an increasing recognition that hospitals operate like businesses. The proposition that paying patients may be admitted and fees charged continues to be accepted. In addition, there is greater acceptance of the practice of billing all patients and attempting to collect on all bills.\textsuperscript{64} A reduced emphasis on target levels or percentages of free care is evident. Nevertheless, the prevailing view is that tax exempt charitable hospitals must not refuse to serve patients on account of an inability to pay.

\textsuperscript{64} E.g., Calloway Community Hosp. v. Craighead, 759 S.W.2d 253 (Mo. App. 1988).
A minority of jurisdictions have apparently concluded that charitable hospitals providing little or no free care are still entitled to the tax exemption.\textsuperscript{65} In these states, the courts have extrapolated from the earlier rule that a charitable hospital might be allowed to serve paying patients as well as its charity clientele to a new rule that the provision of services to paying patients constitutes charity in and of itself. They appear to have done so by a process of reverse logic, concluding that changes in hospital operations and administration, including the increased attention on paying patients, necessitate broadened standards for exemption.\textsuperscript{66}

The question of charity care also comes up in the case of non-hospital institutions in the health and social service fields. In many jurisdictions, the question has been litigated with respect to nursing homes, retirement communities, and low-cost housing facilities.\textsuperscript{67} The great majority of cases find that

\begin{enumerate}
\item \textit{California}: Cedars of Lebanon Hosp. v. Los Angeles County, 35 Cal. 2d 729, 221 P.2d 31 (1950) (hospital providing services to rich and poor entitled to property tax exemption); cf. Fredericka Home v. San Diego County, 35 Cal. 2d 789, 221 P.2d 68 (1950) (life care community not required to extend free services to the poor to be entitled to property tax exemption); \textit{Georgia}: Douglas County v. Annewaukee, Inc., 179 Ga. App. 270, 346 S.E.2d 368 (1986) (hospital that was not a public charity and did not devote its income to caring for the indigent was nevertheless entitled to property tax exemption); \textit{New York}: People ex rel. Doctors Hosp., Inc. v. Sexton, 267 A.D. 736, 48 N.Y.S.2d 201 (1944), aff’d, 295 N.Y.S.2d 553, 64 N.E.2d 273 (Ct. App. 1945) (hospital providing limited charity care entitled to property tax exemption); \textit{Vermont}: Medical Center Hosp. v. City of Burlington, 152 Vt. 611, 566 A.2d 1352 (1989) (hospital with “open door” policy not required to dispense free care in excess of revenues received from paying patients to be entitled to property tax exemption); \textit{Virginia}: City of Richmond v. Richmond Memorial Hosp., 202 Va. 86, 116, S.E.2d 79 (1960) (hospital providing some free care entitled to property tax exemption; argument that exemption requires “considerable” or “substantial” free care rejected); \textit{Wisconsin}: Milwaukee Protestant Home v. City of Milwaukee, 41 Wisc. 2d 284, 164 N.W.2d 289 (1969) (dicta: hospital not required to extend free services to some community residents to qualify for property tax exemption).
\item \textit{Alaska}: City of Nome v. Catholic Bishop of No. Alaska, 707 P.2d 870, 891 (Alaska 1985) (youth hostel open to all regardless of ability to pay entitled to property tax exemption); \textit{Arizona}: Tucson Junior League of Tucson v. Emerine, 122 Ariz. 234, 594 P.2d 1020 (Ariz. Ct. App. 1979) (community organization not providing relief to indigent not entitled to property tax exemption); \textit{Colorado}: Stabro v. Baptist Home Ass’n, 172 Colo. 572, 475 P.2d 23 (1970) (nursing home providing discounts to patients unable to pay entitled to property tax exemption); United Presbyterian Ass’n v. Bd. of County Comm’rs, 167 Colo. 485, 448 P.2d 967 (1969) (nursing home providing negligible free care not entitled to property tax exemption); \textit{Connecticut}: United Church of Christ v. Town of West Hartford, 206 Conn. 711, 539 A.2d 573 (1988) (retirement housing inaccessible to elderly without $73,000 down payment and income to pay $350 per month not entitled to property tax exemption); \textit{Florida}: Haines v. St. Petersburg
although these charitable institutions need not confine them-

Methodist Home, Inc., 173 So. 2d 176 (Fla. App.), cert. denied, 183 So. 2d 211 (1965) (nursing home providing minimal free care not entitled to property tax exemption; charitable exemption requires relief to those unable to help themselves); Idaho: In Re Sunny Ridge Manor, Inc., 106 Idaho 98, 675 P.2d 813 (1984) (retirement community charging fees to all residents sufficient to recover expenses and providing no services to the needy not entitled to property tax exemption); Iowa: Atrium Village v. Board of Review, 417 N.W.2d 70 (Iowa 1987) (nursing home providing services only to those able to pay not entitled to property tax exemption); Kansas: Lutheran Home, Inc. v. Board of County Comm'rs, 211 Kan. 270, 505 P.2d 1118 (1973) (nursing home providing no charity care and charging charity patients a discounted rate not entitled to property tax exemption); Louisiana: Ruston Hosp. v. Riser, 191 So. 2d 665 (La. App. 1966) (nursing home not admitting charity patients and charging fees to all patients not entitled to property tax exemption); Maine: Maine AFL-CIO Housing Dev. v. Town of Madaworks, 523 A.2d 581 (Me. 1987) (low cost housing charging rent but restricting tenants to those with very low incomes entitled to tax exemption); Maryland: Supervisor v. Group Health Ass'n, 308 Md. 151, 517 A.2d 1076 (1986) (HMO providing no charity care not entitled to property tax exemption); Michigan: Retirement Homes of Detroit v. Sylvan Township, 416 Mich. 340, 330 N.W.2d 682 (1982) (nursing home charging fee designed to cover all costs and conditioning admission on ability to pay not entitled to property tax exemption); Nebraska: Bethesda Found. v. County of Saunders, 200 Neb. 574, 264 N.W.2d 664 (1978) (nursing home open to all without regard to ability to pay and not discharging patients for inability to pay entitled to property tax exemption); OEA Senior Citizens, Inc. v. County of Douglas, 186 Neb. 593, 185 N.W.2d 464 (1971) (nursing home not knowingly accepting patients unable to pay not entitled to property tax exemption; fact that some residents may have been unable to pay did not make home charitable); New Jersey: Presbyterian Homes v. Division of Tax Appeals, 55 N.J. 275, 261 A.2d 143 (1970) (retirement community providing services only to those able to pay not entitled to property tax exemption); New Mexico: Mountain View Homes, Inc. v. State Tax Comm'n, 77 N.M. 649, 427 P.2d 13 (1967) (low-cost housing facility charging tenants at cost not entitled to property tax exemption; no evidence that public is relieved of any expense in comparison with the loss of tax revenue); North Carolina: In Re Chapel Hill Residential Retirement Center, 60 N.C. App. 294, 299 S.E.2d 782, review denied, 308 N.C. 386, 302 S.E.2d 249 (1983) (retirement community not providing free services to needy not entitled to property tax exemption); Oklahoma: Baptist Health Center v. Board of Equalization, 750 P.2d 127 (Okla. 1988); Glass v. Oklahoma Methodist Home for the Aged, 502 P.2d 1268 (Okla. 1972) (nursing homes open to all regardless of ability to pay and operating at a loss entitled to property tax exemption); Oregon: Oregon Methodist Homes, Inc. v. Horn, 226 Or. 298, 360 P.2d 293 (1961) (nursing home not providing discounts or free services to poor not entitled to property tax exemption); Dove Lewis Memorial Emergency Veterinary Clinic v. Department of Revenue, 301 Or. 423, 723 P.2d 320 (1986) (veterinary hospital providing free or below cost services only by happenstance not entitled to property tax exemption); Washington: Adult Student Housing v. Department of Revenue, 41 Wash. App. 583, 705 P.2d 793 (1985) (low cost student housing facilities not providing housing to students unable to pay not entitled to property tax exemption).

A minority of states find levels of charity care not relevant to tax exemption for non-hospital charities: Hawaii: In re Tax Appeal of Central Union Church, 63 Haw. 199, 624 P.2d 1346 (1981) (retirement community not providing free services and charging fees to all residents entitled to excise tax exemption); Kentucky: Banahan v. Presbyterian Housing Corp., 553 S.W.2d 48 (Ky. 1977) (low-income housing project apparently not providing free services entitled to property tax exemption); Massachusetts: Harvard Community Health Plan v. Board of Assessors, 384 Mass. 536,
selves to caring for the indigent, some of their resources must be devoted to the poor.68

If one assumes that courts will apply a similar rule to hospitals, then it can be said that of the forty-odd states whose law in the general area can be discerned, three-fourths expect hospitals to provide at least a minimal volume of services to the poor.

In summary, it appears that the most accurate definition of the obligations generally required of charitable hospitals under current law would be neither the above-noted "popular and ordinary" definition nor the "legal" definition but instead a mixture of the two. Under this intermediate definition charity encompasses activities of broad social benefit like the provision of services to persons able to pay, but only if an element of almsgiving through care of the poor is preserved. Such a definition conforms with public opinion69 and reflects long-standing judicial interpretation.70

L. Current IRS Interpretation: The "Community Benefit" Standard

Revenue Rulings 69-545 and 83-157 provide the current IRS view of the charitable obligations of hospitals. The current IRS position is founded upon a genuine concern that hospitals not forget the indigent members of their communities. However, in application, the IRS position leads to results similar to those obtained when the "legal" definition of charity is applied.

Revenue Ruling 69-545 describes a hypothetical charitable hospital. By indicating that a hospital exhibiting the described characteristics would be exempt, the IRS effectively announces its minimum criteria for exemption. The hypothetical exempt hospital has the following characteristics: (1) a board of trustees composed of prominent citizens; (2) medical staff privileges open to all qualified physicians; (3) a full-time emergency room in which no one requiring emergency care is denied treatment;

427 N.E.2d 1159 (1987) (HMO providing lower than average cost services to enrollees but no charity care entitled to property tax exemption); North Dakota: Evangelical Lutheran Good Samaritan Soc'y v. Board of County Comm'rs, 219 N.W.2d 900, 908-09 (N.D. 1974) (nursing home which has policy of providing care without regard to ability to pay but which has never provided free care entitled to property tax exemption).

68. See cases cited supra note 67.

69. See supra text and accompanying notes 7-11.

70. See supra text accompanying notes 31-50.
admissions limited to paying patients (including public-pay patients), with those unable to pay referred to hospitals that serve the indigent; and (5) operating surpluses applied to capital replacement and expansion, debt amortization, improvement in patient care, and medical training, education, and research.\textsuperscript{71}

In Revenue Ruling 69-545, the IRS professed its adherence to the view that charitability, for purposes of Section 501(c)(3), would be defined in the generally accepted "legal" sense.\textsuperscript{72} The IRS opined that the promotion of health through provision of hospital services to non-indigent members of the community was a distinct category of charitable activity in the general law of charity. By this pronouncement, the IRS abandoned the requirement of Revenue Ruling 56-185 that charitable hospitals be operated "to the extent of their financial ability for those not able to pay . . . and not exclusively for those who are able and expected to pay."\textsuperscript{73}

However, Revenue Ruling 69-545 contains a limitation on its relaxed standards. At common law, a trust for charitable purposes must not benefit such a narrow class that it may not be said to benefit the community as a whole.\textsuperscript{74} The inclusion of this limitation on the ability of hospitals to exclude persons unable to pay for care is significant. In effect, the exclusion of the indigent from the hospital's benefits could, at some point, narrow the class of charitable beneficiaries to the point where the hospital would no longer benefit the community as a whole. However, Revenue Ruling 69-545 indicated that the threshold for excessive exclusion of indigent members of the community would not be crossed by a hospital that operated a full-time emergency room open to all persons without regard to ability to pay.

This limitation was also addressed by Revenue Ruling 83-157.\textsuperscript{75} In that ruling, the Service considered a hospital, otherwise identical to the one described in Revenue Ruling 69-545, that did not operate an emergency room because a state health planning agency had made an independent determination that the operation of an emergency room would be unnecessarily duplicative of emergency facilities adequately provided by

\textsuperscript{72} Id. at 118.
\textsuperscript{73} Rev. Rul. 56-185.
\textsuperscript{74} G. BOGERT, TRUSTS, 201-207 (6th ed. 1987).
another medical institution in the community. The ruling indicated that the remaining characteristics of the hospital were sufficient to indicate that the hospital continued to promote the health of a sufficiently broad class of persons to benefit the community as a whole.\textsuperscript{76}

These revenue rulings do not give any obvious reasons for abandoning the free care requirement and the open emergency room limitation except for the conclusionary statements that promoting health is a valid exempt purpose and that treating paying clientele benefits the entire community. However, one can deduce that the decisions were based in large measure on factual assumptions about the hospital market and the accessibility of hospital services to the indigent.

Revenue Ruling 69-545 was issued shortly after the passage of landmark legislation establishing Medicare, Medicaid, and other "Great Society" programs intended to eliminate pov-

\textsuperscript{77} ery. It came shortly before the enormous inflation in medical care costs occasioned by those programs became apparent.\textsuperscript{78} Many in the health policy community and in government believed at the time that these programs would do away with medical indigency.\textsuperscript{79} It seems likely that the IRS assumed in 1969 that the problem of access to hospital care for persons unable to pay had been, if not solved, converted from a tax policy matter to a health and social services budgetary question. As a result, the IRS appears to have concluded that to require hospitals to continue to provide free care would be meaningless and redundant. Thus, when the IRS indicated that the hypothetical qualifying hospital need not offer services without charge to poor patients, it did so on the stated assumption that the hospital would service the same formerly-indigent patients through Medicare and Medicaid. In addition, there appears to have been an assumed presence of another hospital in the community serving indigent patients to whom the minimally qualifying exempt hospital could refer the poor.

Revenue Ruling 83-157 is even more clearly the product of contemporary beliefs about the hospital environment. The factual situation described in the ruling has surely never been a

\textsuperscript{76} \textit{Id.} at 94-95.

\textsuperscript{77} Medicare and Medicaid were adopted in the Social Security Amendments of 1965. \textit{See generally} 3 \textsc{Medicare & Medicaid Guide} (CCH), \textsuperscript{\textdagger}16031.

\textsuperscript{78} \textit{See generally} P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 363-388 (1982).

\textsuperscript{79} Cf. Mancino, \textit{supra} note 1, at 1043 n.109.
common one. Health planning agencies have struggled to find ways to encourage health facilities to serve the medically indigent.\textsuperscript{80} Thus, the idea that a planning agency might even discourage the operation of an emergency room to prevent a hospital from being overly solicitous of the needs of the poor is hard to imagine.\textsuperscript{81} Nonetheless, the IRS must have concluded that situations could reasonably be expected to arise in which the community as a whole simply did not contain indigent patients.\textsuperscript{82}

The IRS' optimistic view of medical indigency would command few followers today. In 1986, 39 million Americans reported difficulty in obtaining medical care and 1 million


\textsuperscript{81} Id.

\textsuperscript{82} The interpretation of Revenue Ruling 69-545 and 83-157 suggested in the text is similar to that reached by the United States Court of Appeals in Eastern Kentucky Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974). In \textit{Simon}, welfare rights advocates sought equitable relief from the IRS, claiming that Revenue Ruling 69-545 was improperly promulgated and inconsistent with the Code. Upholding the Ruling, the Court of Appeals stated:

In the field of health care, the changes have been dramatic. Hospitals in the early part of this nation's history were almshouses supported by philanthropy and serving almost exclusively the sick poor. Today, hospitals are the primary community health facility for both rich and poor. Philanthropy accounts for only a minute percentage of the hospital's total operating costs. Those costs have soared in recent years as constant modernization of equipment and facilities is necessitated by the advances in medical science and technology. The institution of Medicare and Medicaid in the last decade combined with the rapid growth of medical and hospital insurance has greatly reduced the number of poor people requiring fee or below cost hospital services. Much of that decrease has been realized since the promulgation of Revenue Ruling 56-185. Moreover, increasingly counties and other political subdivisions are providing nonemergency hospitalization and medical care for those unable to pay. Thus, it appears that the rationale upon which the limited definition of "charitable" was predicated has largely disappeared. To continue to base the "charitable" status of a hospital strictly on the relief it provides for the poor fails to account for these major changes in the area of health care.

\textit{Id.} at 1288-89.

\textit{See also} Sound Health Ass'n v. Commissioner, 71 T.C. 158, 187-88 (1978) (steady rise in product income and growth of health insurance, Medicare and Medicaid makes free care requirement for Hospitals an anachronism). Similar conclusions about the outdated nature of free care requirements may be found in the court decisions of those jurisdictions that do not require the provision of services to patients unable to pay as a condition of state and local charitable hospital tax exemption. \textit{See, e.g.}, Evangelical Lutheran Good Samaritan Soc'y v. Gage, 181 Neb. 831, 151 N.W.2d 446 (1967) (advent of present day social security and welfare programs has obviated need for hospitals and nursing homes to provide free services to the poor).
were unable to obtain it at all because of cost.  Gaps in Medicare and Medicaid coverage and inadequate health insurance or no insurance, even for working persons, belie the vision of universal access implicit in Revenue Ruling 69-545.  Today, the neighboring hospital that would accept indigent patients turned away from the IRS’ hypothetical qualifying hospital no longer does so, and emergency rooms are closed not because state health planning agencies find them unneeded, but to discourage indigent patients from presenting themselves for treatment.

However, the IRS’s approach of measuring the charitable obligations of exempt hospitals by contemporary needs and circumstances should not be condemned. It is consistent with the Supreme Court’s pronouncement of the underlying intent of the charitable exemption. What is wrong about Revenue Rulings 69-545 and 83-157 is not their analytical approach, but their overly optimistic assumptions about the capacity of the health care delivery system to subsidize services to the poor.

III. TAX EXPENDITURE ANALYSIS OF THE CHARITABLE HOSPITAL EXEMPTION

Congress expects charitable organizations that attain exemption from federal income tax to provide a public benefit commensurate with the revenue loss caused by their exemption. Exemption is a quid pro quo for the provision of services government would otherwise be obliged to deliver, or for services that augment existing governmental programs.

The concept of tax exemption as an exchange originated in the common law of charitable trusts and is frequently restated in contemporary court decisions considering charitable hospi-
tals' exemption from various taxes. The cases do not indicate that charitable exemptions turn on an exact accounting of the costs of public services provided in comparison with tax revenues foregone. Exemption has not, at least historically, been conceived as a negotiated transaction between the tax authorities and the exempt organization. The task of such an accounting would be beyond the institutional capacities of the courts. Instead, the exchange concept appears to function as one of the underlying assumptions that lead a legislature to grant exempt status to a class of organizations. However, it is clearly appropriate to evaluate the continued utility of an exemption with reference to its costs and benefits. As indicated above, such an evaluation is a form of tax expenditure analysis.

A tax expenditure analysis is essential to attaining a sufficient understanding of the income tax exemption for charitable hospitals. Charitable hospitals first acquired their tax exemptions when they were almsgiving organizations with modest assets and regular deficits. The tax revenue loss was probably insignificant. Today, charitable hospitals have accumulated substantial capital assets. Although many individual hospitals are in difficult financial condition, the annual net revenue of charitable hospitals, as a class, is considerable. As a result, the tax revenue loss side of the exchange equation may have increased significantly. If, as the preceding discussion suggests, some tax authorities have relaxed their requirements on the public benefit side, there may be a significant imbalance in the exchange between society and hospitals.

IV. GAO'S TAX EXPENDITURE ANALYSIS

In response to congressional concerns that charitable hospitals might be devoting fewer resources to the indigent, the U.S. General Accounting Office (GAO) recently undertook a broad study of charitable hospitals' activities. One aspect of this study was a comparison of the federal and state income tax revenue lost as a result of the charitable hospital tax

89. See generally id.
90. See supra text accompanying notes 25-27.
92. See AMERICAN HOSPITAL ASS'N, HOSPITAL STATISTICS (1989).
93. GAO REPORT, supra note 18, at 17-18.
exemption with the amount of charity care provided by charitable hospitals in five states.

According to the GAO Report, 57 percent of the study hospitals provided charity care with a value less than the estimated value of the tax revenues foregone as a result of their federal and state income tax exemptions. For example, the federal and state tax revenues foregone exceeded the amount of charity care provided by 43 and 71 percent of charitable activities in New York and California respectively. The following chart indicates the estimated number of hospitals that failed to meet this theoretical standard in the states studied by the GAO.

### Chart 1

*Hospitals for Which Tax Exemption Value Exceeds Charity Care Costs*

<table>
<thead>
<tr>
<th>No. of Hospitals</th>
<th>Percent of Charitable Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>30</td>
</tr>
<tr>
<td>Michigan</td>
<td>N/A</td>
</tr>
<tr>
<td>New York</td>
<td>85</td>
</tr>
<tr>
<td>California</td>
<td>151</td>
</tr>
<tr>
<td>Florida</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Note:* GAO was unable to break down charity care from uncompensated care in its analysis of Michigan and Florida. From unpublished GAO data.

When the GAO altered the equation and gave charitable hospitals credit for care categorized as bad debt expense as well as care categorized as charity expense, the five states' charitable hospitals as a group provided more uncompensated

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94. The GAO Report defined charity care as "services provided to patients who do not have the means to pay all or a portion of their bills." *Id.* at 18 n.13.

95. Data were analyzed for all short-term acute care hospitals in California, Florida, Iowa, Michigan and New York. *Id.* at 18.

96. To estimate the value of a hospital's income tax exemption, GAO applied the average effective rate of a sample of for-profit hospital corporations to the charitable hospitals' net incomes. The estimate significantly understates the total value of tax exempt status because it does not include the value of the other significant tax advantages in addition to income tax exemption, such as exemption from property or other local taxes, tax exempt bond financing, and tax-deductible donations. The GAO estimate is not very sensitive to changes in profitability or tax rate assumptions. Even if the profit margin or the tax rates of the hospitals had been 50 percent less than the one GAO used, 48 percent of the charitable hospitals studied would still have been estimated to provide less charity care than the value of their tax exemptions.
care than the estimated value of the tax revenues forgone.\textsuperscript{97} However, the uncompensated care expenses were not distributed evenly among hospitals.\textsuperscript{98} The GAO found that about 15 percent of the hospitals studied provided less uncompensated care than the estimated value of their tax exemption.\textsuperscript{99} These hospitals had profit margins significantly higher than those of other hospitals and uncompensated care expenses significantly less than the average hospital in the state in which they are located.\textsuperscript{100} The following table shows the number of hospitals failing the hypothetical test, and the amount of tax revenues at stake.

\begin{center}
\textbf{CHART 2}
\textit{Hospitals for Which Tax Exemption Value Exceeds Uncompensated Care Costs}
(Dollars in millions)
\begin{tabular}{|l|c|c|c|c|}
\hline
 & No. of Hospitals & Percent of Hospitals & Uncompensated Care Costs & Value of Tax Exemption \\
\hline
Iowa & 14 & 24 & $8 & $11 \\
Michigan & 7 & 5 & 1 & 4 \\
New York & 23 & 12 & 5 & 11 \\
California & 50 & 24 & 55 & 92 \\
Florida & 8 & 9 & 10 & 13 \\
\hline
\end{tabular}
\textit{GAO's Study of Other Indigent Care Services and Policies}
\end{center}

In summary, a significant number of charitable hospitals in the states that the GAO studied failed to provide charity care in an amount at least equal to the amount of taxes forgiven for the charitable exemption. Their higher profit margins

\textsuperscript{97} Uncompensated care can be emergency, inpatient, or outpatient hospital care given to those who cannot or do not pay their bills. It includes bad debt and charity care. Using uncompensated care significantly overstates the magnitude of charity care provided by hospitals. Available data indicate that only one third of uncompensated care is defined as charity, the remainder is defined as bad debt.

\textsuperscript{98} For GAO's analysis, the most recent data available were from 1985 to 1987. Inpatient hospital margins have declined since then and uncompensated care levels for some hospitals have increased. However, GAO's analysis focus on the distribution of uncompensated care among charitable hospitals. Though the absolute levels of uncompensated care and profitability may change if different periods were analyzed, the distribution itself is not likely to change significantly from year to year. Thus, the GAO finding of an uneven distribution would likely remain unchanged.

\textsuperscript{99} GAO REPORT, supra note 18, at 27.

\textsuperscript{100} Id.
indicate strongly that these hospitals are able to provide more charity care if required to do so.

A. The GAO's Study of Other Indigent Care Services and Policies

In addition to the tax expenditure analysis, the GAO Report encompassed other aspects of hospitals' activities for the indigent. The other aspects include: 1) the distribution of uncompensated care among different types of hospitals statewide; 2) factors causing imbalances in the distribution of uncompensated care among hospitals within single communities; and 3) the other community services provided in addition to charity care. Comparisons between charitable and investor-owned hospitals were made when possible.

First, the GAO analyzed the distribution of uncompensated care among hospitals in the five states mentioned above. Not unexpectedly, the GAO found that the burden of uncompensated care was not distributed equally among the charitable hospitals studied. Large, urban teaching hospitals had a higher share of uncompensated care expense than did other charitable hospitals. The hospitals that had lower than average uncompensated care rates also had lower Medicaid patient volume, a finding which tends to negate the argument that Medicaid participation is an alternate form of public service by charitable hospitals which do not provide uncompensated care.

Second, the GAO conducted case studies in five communities to study factors affecting an uneven distribution of indigent care. Factors that can influence the distribution of indigent care among hospitals include the hospitals' admission and staffing policies and practices, their strategic goals, their services, and their locations. In each community, some charitable hospitals' policies—such as those governing patient admissions and transfers, physician staffing, and the setting of strategic goals—discouraged the provision of nonemergency care to those unable to pay for it. The GAO found that a majority of hospital goals concerned maintaining the hospitals' goals.

101. Id. at 21-29.
102. Id. at 22-23.
103. Id. at 25.
104. Id. at 30-36.
105. Id. at 30.
106. Id. at 33-35.
financial viability, improving their competitive positions, expanding services and facilities, or developing employee skills and personnel practices.\textsuperscript{107} Although the charitable hospital set numerous goals related to expanding medical services on account of increased patient demand or for the purpose of increasing their market share, the GAO found that, in general, goals were not directed at serving low-income community residents.

Third, the GAO surveyed a nationwide sample of hospitals regarding other types of community services provided in addition to acute medical care.\textsuperscript{108} A high percentage of hospitals, whether their tax status was charitable or investor-owned, reported providing community services such as health screening or health education activities.\textsuperscript{109} These services were most often offered to the community as a whole, however, and were usually not targeted to the poor.\textsuperscript{110} Thus, it is difficult to conclude that the provision of these services by charitable hospitals derives from charitable motivations distinct from the marketing and public relations purposes that such services provide for investor-owned hospitals.

The GAO Report concluded that an insufficient link existed between charitable tax status and service to the poor for the nation's charitable hospitals.\textsuperscript{111} This conclusion was based on the uneven distribution of uncompensated care among study hospitals, the lack of proactive policies for indigent care, and the lack of factors to differentiate community services other than charity care provided by charitable hospitals from those provided by investor-owned facilities. The GAO Report concluded that if Congress wished to encourage charitable activities for the poor, the current criteria for income tax exemption should be changed.\textsuperscript{112} If Congress wished to articulate an operational test for charitable hospitals focusing their activities on the poor, the GAO Report suggests three alternative standards directly linked to a minimum level of (1) care provided to Medicaid patients; (2) free care provided to the poor; or (3) efforts to improve the health status of

\begin{itemize}
\item \textsuperscript{107} Id. at 34-35.
\item \textsuperscript{108} Id. at 37-43.
\item \textsuperscript{109} Id. at 38-39.
\item \textsuperscript{110} Id. at 40-41.
\item \textsuperscript{111} Id. at 44.
\item \textsuperscript{112} Id. at 44-45.
\end{itemize}
underserved portions of the community.\textsuperscript{113}

As indicated above, the GAO Report found that in the aggregate charitable hospitals provide more uncompensated care than their \textit{estimated tax savings} from federal and state income tax exemption.\textsuperscript{114} In addition, an indeterminate, but clearly quite large, proportion of charitable hospitals individually provides charity care and other services to the community whose value equals or exceeds that of the tax revenues lost as a result of their exemption.\textsuperscript{115} These results could be read to indicate that the current standards for tax exemption are effective to some extent in encouraging charitable hospitals to provide charity care. The uneven distribution of uncompensated care among charitable hospitals reported by the GAO, with uncompensated care concentrated in major urban teaching institutions, suggests that other factors are at least partially responsible. However, these results do confirm that the charitable hospital exemption provides a major tax subsidy to a large number of deserving hospitals. As long as no alternative mechanism for directly subsidizing hospitals with high levels of charity care is in place, the results of the GAO Report do not support removal of the charitable hospital exemption.

However, the GAO Report's results do suggest that the test for entitlement to federal income tax exemption for charitable hospitals should be modified.\textsuperscript{116} In addition to the uneven distribution of uncompensated care, the GAO Report found that over half of the charitable hospitals studied provided charity care with a value less than the federal and state income tax revenues foregone as a result of their exemptions.\textsuperscript{117} There are over 180 such hospitals in New York and California alone. It is highly unlikely that all these facilities are located in communities with no charity care patients. Thus, under the current exemption standards it appears to be possible for some, perhaps a large number, of charitable hospitals to enjoy a tax subsidy while ignoring the needs of the poor or passing responsibility to public, inner-city, and teaching hospitals.

\begin{itemize}
\item \textsuperscript{113} Id.
\item \textsuperscript{114} Id. at 26-27.
\item \textsuperscript{115} Id. at 27.
\item \textsuperscript{116} Modifying the standard for exemption could be accomplished by issuance of a new revenue ruling, or general counsel memorandum. Appendix "A" contains a draft revenue ruling reflecting our suggestions for revised exemption criteria.
\item \textsuperscript{117} See supra text accompanying notes 96-98.
\end{itemize}
V. RECOMMENDATIONS FOR CHANGE

We believe that a central feature of a modified standard should be a requirement that charitable hospitals analyze the health status of their communities, assess their own performance in meeting community health needs, and take appropriate actions based on identified needs and their financial abilities to respond. Whether, to what extent, and in what combination charity care and community services are required would thus come to depend more closely on the local community need for such services.

This addition to the standards for charitable hospital exemption would not change the exemption’s doctrinal underpinnings. The “community benefit” standard elucidated by Revenue Ruling 69-545 would still apply, and promoting health by hospitalizing a paid clientele would continue to be a legally sufficient basis for exemption. As now, a charitable hospital would be required to serve a public, rather than private, interest and would be prohibited from promoting the health of so limited a class of beneficiaries as to be deemed to serve private interests, rather than public interests. The difference would be in the evidentiary test of excessive limitation of the class of beneficiaries. In short, the current “open emergency room/Medicare and Medicaid participation” test would be subsumed within a “community need” test.

Changing the standard for charitable hospitals is unlikely to cause the conversion of charitable hospitals to investor-owned status or shifting of substantial volumes of indigent care into already over-burdened public hospitals for several reasons. First, leaders of the charitable hospital community have already recognized the need to reaffirm their commitment to target underserved parts of their communities without official prompting from the IRS. For example, a Catholic hospital association task force recommended that member hospitals take steps to reaffirm their mission to the poor in a time of increasing fiscal pressures. Suggested steps included improving methods for collecting information on the health needs of the poor and integrating specific objectives and operational guidelines for care to the poor into an annual planning and budgeting process. Second, conversion of exempt status would cause hospitals to forfeit sizable tax advantages, such as

exemption from local property taxes and the ability to obtain financing through tax exempt bonds. Compliance with the standards we recommend appears unlikely to outweigh the sum of the financial advantages of charitable status. Of the hospitals scrutinized in recent years by state or local tax authorities, we are aware of none that have elected to convert to investor-owned status to escape further inspection. Finally, the GAO report indicates that the hospitals that have provided the least in charity care tend to be those having higher-than-average financial margins.119 Thus, hospitals that would be most affected by the change in policy tend to be those that are the most able to afford to provide more charitable services to their communities without going out of business.

Our focus on community needs assessment and goal-setting is a response to the GAO Report's discovery of a widespread absence among study hospitals of proactive policies for addressing issues of access to care. Although charitable hospitals in the study communities set numerous goals relating to maintaining financial viability and improving competitive position, generally few goals were directed at serving low-income community residents.120 Because these goals are reflective of charitable hospitals' aspirations, not merely their financial performance, these findings are the GAO Report's most telling commentary on the charitable hospitals' loss of their traditional community service orientation.

Our attention to community need assessment is also designed to respond to the GAO Report's finding that the admissions policies of hospitals tend to limit a majority of charity care to that initiated in the emergency room.121 This finding suggests that an effect of the current criteria for income tax exemption may be to encourage hospitals to treat indigent patients only when their problems are serious enough to constitute medical emergencies. It is inefficient for the tax subsidy to elicit charity care only as a last resort, and not to subsidize primary or preventive services. Our expectation is that a community need assessment would encourage hospitals to treat charity patients before their needs reached the crisis point.

A positive feature of our recommended approach is that it

119. GAO REPORT, supra note 18, at 25-27.
120. Id. at 34-35.
121. Id. at 32.
tracks efforts already underway by charitable hospital industry groups to encourage voluntary self-policing. The American Hospital Association and Catholic Health Association have developed self-assessment guides for nonprofit hospitals. With funding from the W.K. Kellogg Foundation, New York University's Wagner School of Public Service has developed a voluntary accreditation program, known as the "Hospital Community Benefit Standards Program," for hospitals serving their local communities.

Current IRS standards for hospital exemption call for a board of directors comprised of prominent citizens in the community. This rule is presumably intended to institutionalize representation of the interests of the required beneficiaries of charitable hospitals. Consistent with our call for strengthened assurance that charitable hospitals not let their attention stray from the needs of the indigent persons in its community, we believe that a second feature of revised standards should be a strong encouragement to charitable hospitals to include representatives of the entire community, including low-income and minority persons, on their boards. The IRS Exempt Organizations Division has recently indicated that a board of directors broadly representative of the community is a key factor for 501(c)(3) HMO exemption, and a similar standard is presently applied to public interest law firms. The presence of representatives of the entire community on the Board will help to assure that the charitable hospital's self-assessment and goal-setting programs are responsive to the entire community's interests.

Under current IRS standards, Medicaid participation appears to be mandatory, and there are indications that the Service views the presence of an open emergency room as a virtual requirement. The reason, we think, is the Service's presumption that there are Medicaid beneficiaries needing hos-

123. KOUNER & HATTIS, BENEFITTING COMMUNITIES HEALTH MANAGEMENT QUARTERLY 6-10 (Fourth Quarter 1990).
127. See Remarks of Jim McGovern, IRS Assistant Chief Counsel, Employee
pital care and persons needing emergency care but lacking the ability to pay in essentially all U.S. communities. Revenue Ruling 83-157 indicates that the presumption can be rebutted by independent evidence that no community need for emergency services exists.\footnote{128} Our proposed standards would not directly affect this presumption. However, the proposed standards would permit a charitable hospital to rebut the presumption if a bona fide, but non independent, evaluation of community health status and access to care. An obvious risk of reliance upon self-evaluation and self-policing is that charitable hospitals may underestimate the extent of community need for charity care or other free or low-cost services in an effort to reduce their obligations. By providing for representation of low-income persons on charitable hospital boards, community participation in the self-assessment process, and circulation of self-assessment reports throughout the community, we hope to make such self-deception difficult. In addition, such participation would enlist the local community as the front line of enforcement. In the current environment of strong local concern over the levels of charity care provided by hospitals, we think it is likely that sham assessments would be rare. Additionally, the needs assessment of each hospital in the community would be shared with the other hospitals, as well as being available to the community at large and to the IRS in an audit. If, however, experience showed that more than a small fraction of hospitals were unable to responsibly conduct self-assessment and goal-setting, we would support either a return to mandatory charity care quotas, or a repeal of the exemption for hospitals.

It would certainly not be a precipitous step for the IRS to issue a new revenue ruling or other guidance to charitable hospitals. Revenue Ruling 69-545 was issued 13 years after Revenue Ruling 56-185, its predecessor. The hospital industry has undergone dramatic changes in the twenty years since the issuance of Revenue Ruling 69-545. The IRS has the authority to

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Benefits and Exempt Organizations Division, ALI-ABA Program on Health Care in the 90's, (September, 1990), \textit{reprinted in 3 EXEMPT ORG. TAX REV.} 893, 894-5 (1990).

128. Rev. Rul. 83-157, 1983-2 C.B. 94 provides that a hospital that does not operate an open emergency room because a state health planning agency has made an independent determination that the operation would be unnecessary and duplicative can rely on other factors, such as Medicare and Medicaid participation, to indicate that it promotes the health of a sufficiently broad class of persons to benefit the community.
reconsider the nature of charitable hospitals' obligations in light of contemporary circumstances, and to adjust the standards accordingly. A suggested revenue ruling considering those adjusted standards is contained in Appendix "A".

Taken together, our suggested revised standards for federal income tax exemption would prompt charitable hospitals to reaffirm their historical commitment to serving the poor. They would underscore the requirements for income and property tax exemptions for hospitals in most states. They would require relatively minor administrative costs on the part of federal tax authorities and, for many hospitals, would require minimal changes in behavior.

It is important to recognize that the question of a charitable hospital's tax exemption appears against a backdrop of larger health policy concerns, such as gaps in the nation's health insurance mechanisms and weaknesses in federal and state health programs. Adjusting the tax exemption standards for charitable hospitals is no panacea for the problems of access to medical care for the uninsured and indigent in our society. However, redistributing the tax subsidy more equitably among charitable hospitals, leveling the playing field for investor-owned hospitals, and improving the linkage between tax dollars foregone and service to the medically needy are justification enough for the changes we recommend. Furthermore, these considerations would be sufficient grounds for changing the tax exemption rules even if Congress were to mandate expanded health insurance coverage and/or extend the coverage of Medicaid or other need-based programs of healthcare for the poor.

However, if the suggested revisions were adopted, it would be important to subject them, after the passage of several years, to an examination of their efficacy similar to the analysis recently conducted by the GAO. If such an analysis indicated a continuing discrepancy between tax revenues foregone and the value of services provided by charitable hospitals, it would then be appropriate to consider more drastic measures, including imposing minimum percentages of free or below-cost care, or repealing the charitable hospital federal income tax exemption.

* * *
APPENDIX “A”

Suggested Revenue Ruling:

A. ISSUE

Do the nonprofit hospitals described below qualify for exemption from federal income tax as organizations described in Section 501 (c)(3) of the Internal Revenue Code?

B. FACTS

Situation No. 1: Hospital A is a 250-bed community hospital located in a city with one other community hospital and a public city hospital. Twenty-one years ago Hospital A was identical in all respects to Hospital A described in Situation 1 of Revenue Ruling 69-545. Today a substantial proportion of the population is Medicaid-eligible, medically uninsured or underserved, and Hospital A’s financial condition has eroded over the years. Inpatient care expenses exceeded inpatient care revenues in the most recent fiscal year, but Hospital A realized an overall net gain as a result of outpatient service revenue. Hospital A participates in Medicare. Hospital A has a contract with the State to provide inpatient services to Medicaid beneficiaries. Hospital A continues to provide emergency room services to all members of the community without regard to ability to pay.

Hospital A’s Board is broadly representative of the entire community including the medically underserved. The Board recently conducted a self-assessment to (1) determine community health status, including that of low-income and minority groups; (2) measure accessibility of hospital services in the community, including physical and financial barriers to access; and (3) evaluate the hospital’s performance in meeting community health needs, including treatment of indigent patients and compliance with legal requirements concerning emergency care. The entire community was invited to participate and the assessment report was circulated widely. Copies were provided to other community hospitals. The assessment documented needed improvements to the physical plant and confirmed the existence of an indigent population in the community whose needs for hospital care may exceed the ability of Hospital A and the public hospital to satisfy. It also documented high cancer incidence in minority neighborhoods, and community-wide

ignorance of diet and cancer issues. In response to the assessment Hospital A’s Board announced to the community that a percentage of its net revenues from exempt function activities, determined annually on the basis of the hospital’s overall financial position and the need to apply excess revenues to improving facilities, equipment, patient care, medical training, education, and research, would be set aside for charity care. In addition, the hospital would assist a city-operated cancer screening program for minorities and run a series of public service announcements on nutrition in the local media.

Situation No. 2: Hospital B is the other community hospital in Hospital A’s city. Twenty-one years ago Hospital B was identical in all respects to the Hospital A described in Situation 1 of Revenue Ruling 69-545. Since then Hospital B has increased its share of private-pay patients through aggressive marketing, satellite services in the city's expanding suburbs, and recruitment of physicians who practice in profitable specialties. Hospital B participates in Medicare. Hospital B did not submit a bid to the State for a Medicaid contract. Hospital B's Board recently accepted a local consulting firm’s recommendation that the level of service offered in its emergency room be downgraded since so few patients are admitted through that route. Hospital B has no patient transfer policy, but its practice is to transfer any medically stable patient who is unable to pay to either Hospital A or the city hospital.

C. LAW AND ANALYSIS:

Section 501(c)(3) of the Internal Revenue Code provides for exemption from federal income tax of organizations organized and operated exclusively for charitable purposes, no part of the net earnings of which inures to the benefit of any private shareholder or individual. Section 1.501(c)(3)-1(d)(2) provides that the term “charitable” is used in Section 501(c)(3) in its generally accepted legal sense. Charitable trust law makes clear that the definition of charity depends upon contemporary standards, and that qualification for charitable exempt status is not perpetual or immutable.131

The IRS has recognized that in the general law of charity the promotion of health is considered to be a charitable purpose. A nonprofit organization whose purpose and activity are

130. Id.
providing hospital care is promoting health and may therefore qualify as organized and operated in furtherance of a charitable purpose. Such an organization is not absolutely required to admit and treat patients who are unable to pay.\textsuperscript{132}

However, section 1.501(c)(3)-1(d)(1)(ii) provides the collateral rule that an organization will not be considered organized or operated exclusively for charitable purposes unless it serves a public, rather than private, interest. An organization that promotes the health of a limited class of beneficiaries serves the private interests of those individuals rather than a public interest. A hospital that is exempt as a Section 501(c)(3) entity must not exclude members of the community such that it ceases to benefit the community as a whole. The totality of the hospital's operations must be examined to determine whether private or community interests are being served. A nonprofit hospital that wishes to obtain exemption under Section 501(c)(3) should be able to present meaningful evidence that its entire community benefits from the totality of its operations.

There is sufficient evidence to conclude that Hospital A's operations serve the entire community. A key factor is Hospital A's assessment of community need for hospital and health-related services and the evidence of meaningful actions taken in response to identified community needs. These include care for those covered by Medicare and Medicaid, health promotion and education programs open to the community, emergency services open to the entire community without regard to ability to pay, and the set-aside of a portion of surplus for charity care. Other important factors include the broadly representative composition of its Board, public participation in the assessment process, and public notice of the hospital's community service programs.

There is insufficient evidence to conclude that Hospital B operates to serve the community as a whole. A key factor is its absence of a meaningful effort to identify and respond to the interests of the entire community. Hospital B's policy of limiting admission to paying patients, failure to bid on a Medicaid contract, emergency room downgrading, and transfer policy cannot be justified in light of the available evidence of underserved indigent and Medicaid-eligible patients in its community. Another important factor is Hospital B's lack of a

transfer policy, which violates the anti-dumping provisions of COBRA.\textsuperscript{133} Repeated violations of federal or state law whose purpose is to protect the health of the entire community may be grounds for denial of exemption.

D. EFFECT ON OTHER REVENUE RULINGS

Rev. Rulings 69-545 and 83-157 are amplified.