# N. INTEGRATED DELIVERY SYSTEMS

**by**
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## 1. Background

The Internal Revenue Service has received applications for recognition of exemption under IRC 501(c)(3) from corporations created to manage and administer new alliances of medical facilities and practitioners that comprise what the health industry refers to as "integrated delivery systems" ("IDS"s). This article focuses on the corporation that is formed to manage the medical activities of an IDS and that seeks recognition of tax exemption. Throughout this article, such a corporation is referred to as the "Applicant."

This article analyzes issues affecting exemption and discusses the development to date of Internal Revenue Service requirements for recognition of an IDS Applicant's exemption. This article is structured to educate the reader about the various components, issues, and ramifications of an IDS, and to explain why and when exemption may be appropriate for an Applicant involved in such a system. This article uses a question and answer format to aid the reader in locating issues and answers quickly. One must bear in mind the general principle that each separate entity within an IDS will have its tax status determined separately based on its own individual characteristics and activities.

### A. IDSs Generally

#### (1) What is an IDS?

An IDS is a health care provider (or one component entity of an affiliated network of providers) created to integrate the provision of hospital services with professional medical (e.g., physician) services. Traditionally, hospitals have provided services and facilities such as room, board, emergency care, nursing, and diagnostic services, for which they are paid by patients, their insurers, or government programs. Physicians provided medical and surgical services to patients in their private medical practices, admitting and treating patients, when necessary, in hospital facilities, for which they were paid separately by patients, their insurers, or government programs. In an IDS, one entity may provide and bill for both hospital and all needed physician services, either itself, or through close contractual relationships.

(2) Can a Clinic be an IDS?

A clinic that owns, is controlled by, or is operated in conjunction with a specific hospital may, in fact, be a form of IDS. A clinic is an organization that provides professional medical or other health care services in one or more centralized locations, usually on an outpatient basis. A clinic may be similar to the outpatient department of a hospital, but generally is distinguishable from a hospital in that it lacks facilities for inpatient or emergency care. A clinic also may be similar in many ways to a multi-specialty, private group medical practice.

(3) What Different IDS Models are There?

Health care publications reflect that IDSs take many forms, the most common of which are described below. In all of the basic models, there usually is one central organization (the Applicant if tax exempt status is sought) to integrate provision of hospital services with inpatient and outpatient medical services, and to manage and administer the entire system.

Under the foundation model, a single corporation (the foundation), typically a nonprofit corporation under state law, is created to obtain all assets needed to operate clinics and physician offices, and possibly one or more hospitals. Assets may be acquired by purchases, leases, licenses, stock transfers, gifts, or a combination of these methods. The foundation acquires the services of physicians who will provide professional medical care within the system, either through direct employment or independent contract. The foundation then becomes the provider of health care services, both medical and hospital, inpatient and outpatient. It enters into all payer contracts, provides all nonprofessional personnel for the system, maintains all assets, and collects all revenues for services provided.

A second model is the hospital controlled model. Within this model, a hospital or hospital system may create a subsidiary corporation. Typically, this corporation is organized on a nonprofit basis if tax exempt hospitals are involved. The new corporation obtains physician services, either through direct employment or by independent contract. Alternatively, the hospital may simply begin employing physicians and providing their services itself.

A third model is the clinic controlled model. This model generally has in place an established medical group practice that operates in conjunction with a hospital. These group practices may be taxable, or, in certain circumstances,

exempt. Generally, this model is created by a group practice to allow for fuller market penetration in the service area and, in cases where the practice and hospital are nonprofit, to take advantage of tax-exempt financing for expanding or updating physician and hospital operations.

A fourth model is the horizontally integrated model in which physicians and hospitals establish a new organization that is jointly owned and controlled by the physicians and the hospital. Because of the ownership and control by physicians, IDSs of this model are not exempt under IRC 501(c)(3).

There may also be IDSs that fall short of total integration. For example, in a Medical Service Organization ("MSO"), a hospital or affiliate may, in return for a share of revenues, provide to an independent physician or group of physicians all real and personal property, all support staff, and all management and billing services needed to run an otherwise private medical practice. Here, one entity does not assume responsibility for providing both types of service. The legal and tax issues raised by MSOs are beyond the scope of this article.

B. Formation and Operation of an IDS

(1) An Example of a Foundation Model IDS

The Applicant, a nonprofit corporation, is created under state law. A tax-exempt university medical center or one of its affiliate organizations serves as the sole corporate member of the Applicant, thereby controlling it. The Applicant will acquire the assets of an existing group medical practice ("Medical Group") or clinic. The Applicant also may acquire a small community hospital in the same or a separate transaction.

Under the acquisition arrangement, the Applicant will acquire by donation, fair market value purchase, lease, license, stock transfer or a combination thereof, substantially all the assets of the Medical Group. These assets comprise the land and buildings of the clinics and/or hospital, leasehold interests with improvements, fixtures, furnishings, equipment, inventories, medical records, and intangible assets (including covenants not to compete, third-party payer contracts, other contracts, an assembled work force, warranty rights, prepaid assets and deposits, utility rights, goodwill, and trademarks and trade names).

In the Applicant's state of incorporation, state law prohibits lay corporation employment of physicians. Therefore, instead of employing physicians, the

Applicant contracts with the Medical Group on an exclusive basis to provide all needed medical services for a multi-year period for the entire IDS it manages. The Applicant will compensate the Medical Group for the professional services provided by its physicians by paying it a portion of the capitation it receives from insurers and HMOs. The Applicant will then provide all hospital and medical services, assets, personal property, management services, non-physician support personnel, and billing and collection functions for the IDS.

The remainder of this article will, for ease of discussion, generally will discuss the foundation model and will assume the same facts as in the example above -- acquisition of medical group assets followed by an independent contractor relationship with the group's physicians.

(2) How is the Asset Transfer to the Applicant Accomplished?

a. Purchase and/or Donation

Under this method, the Applicant acquires some or all assets of the Medical Group, either as a charitable donation, or under an asset purchase agreement, possibly containing a bargain-sale element of donation. These assets comprise the real estate and physical facilities of clinics and other facilities, if owned by the Medical Group or any of its physicians; improvements; fixtures; furnishings; equipment; inventories; medical records; and other intangible assets (potentially including covenants not to compete, HMO contracts, other contracts, an assembled work force, warranty rights, prepaid assets and deposits, utility rights, and trademarks and trade names). The Service may review, but will not rule in advance upon, whether the total valuation, cash sales price, or donation amount reflect fair market value ("FMV").

Alternatively, the Applicant, its sole corporate member, or an affiliated corporation in the sole corporate member's system may purchase the stock from the current physician-shareholders of the Medical Group. The value ascribed to the professional medical corporation's stock reflects the appraised FMV of its tangible and intangible assets. If the purchase is funded by the Applicant's parent or an affiliate, the assets are transferred to the Applicant after purchase.

Generally, Applicant issues a promissory note to Medical Group or its individual physicians having ownership interests in the practice, to be paid in installments over a period of years at a commercially reasonable interest rate. The continuing payment mechanism helps ensure that the Medical Group physicians

fulfill their multi-year obligations under the services agreement.

b. Lease, Sublease, and License Agreements

Sometimes the Applicant might represent that it intends to lease from or to assume the Medical Group's leases of space and equipment, instead of purchasing outright Medical Group's assets. The Service will closely scrutinize these transactions. Fair rental value must be supported by an independent appraisal conducted at the time of the transfer of property. The Applicant may also attempt to structure acquisitions of less than all of the Medical Group's rights in certain property. Generally, a complete acquisition of all property rights by the IDS seems preferable in enabling it to use those assets to further a public purpose.

c. Which Method of Transferring Assets is Preferred?

In many situations, the assets to be purchased, leased, or licensed by the Applicant in connection with creating an IDS are owned directly or indirectly by the Medical Group. In these cases, the Service has a legitimate concern about private benefit to the Medical Group.

The Applicant will probably obtain more control if it purchases assets outright instead of leasing or licensing assets from the Medical Group or a related entity. Since the Service is primarily concerned with ensuring community control of charitable and business operations, ownership by the Applicant is a preferred approach. Leases and license agreements negotiated with organizations related by some type of common ownership with the Medical Group offer the Applicant less control over key assets. These agreements require periodic renewal negotiations, which have control implications. Consequently, such agreements require particular scrutiny by the Service since the Medical Group might retain de facto control of a key asset (the location of its clinics and equipment and the ownership of the contracts and patient records, for example). The Service must be assured that leases and licenses will be renewable and that the terms of renewal are fair.

It is essential to establish a unity of interest and purpose in an IDS. The only way to do this is to place the Applicant firmly in control of the assets essential to the system. The Medical Group becomes a subcontractor or employee of the Applicant. If the Medical Group terminates its contract, the Applicant will retain its provider contracts and thus its patient relationships, its income, and its facilities. While it might not easily replace the Medical Group, other medical groups, independent practice associations, and individual physicians in the area

might be recruited as a substitute.

Even with an outright purchase, however, the Medical Group may benefit more than incidentally from the transaction. Consider a situation where the Medical Group sells appreciated assets to a tax-exempt organization at a gain, possibly donating a portion of them, thereby reaping a personal tax advantage from the transaction. The Medical Group might then continue to practice at the same locations, using the same clinic names and possibly even receiving the same net income.

(3) May a Medical Practice's Intangible Assets be Transferred to the Applicant?

Most Applicants will claim that a portion (possibly a large portion) of the sales price represents payment for intangible assets that are being acquired from the selling entity. The Service and Department of Health and Human Services ("HHS"), Office of the Inspector General ("OIG"), both administer bodies of law bearing on this issue. Rev. Rul. 76-91, 1976-1 C.B. 149, allows a charitable organization to purchase intangible assets from a taxable entity as long as those assets contribute directly and substantially to the accomplishment of the purchaser's exempt purposes.

Pursuant to Rev. Rul. 76-91, if there is a close relationship between the buyer and the seller, and both tangible and intangible assets are purchased, the value of the tangible assets must first be established by an independent appraisal. The purchaser must then establish the components of the intangible assets, indicate how these components will be used to further its exempt purposes, and establish the aggregate value of these intangibles. In Rev. Rul. 76-91, a corporation that operated a charitable hospital was allowed to purchase, from a taxable hospital, intangible assets that contributed directly and substantially to the accomplishment of the charitable organization's exempt purposes.

The OIG at HHS administers the Medicare and Medicaid anti-kickback statute, 42 U.S.C. 1320a-7b(b), which provides criminal penalties against anyone who knowingly and willfully solicits, receives, offers, or pays remuneration, in cash or in kind, to induce or in return for the referral of patients whose care will be paid for under the programs. See pages 232-234 of this article for further discussion of this statute. In December 1992, the OIG's counsel wrote to the IRS Office of Associate Chief Counsel (EBEO) to express concern about hospital and IDS acquisitions of physician practices. The OIG stated that the amount paid for

the practice (or as physician compensation) must be evaluated carefully to determine whether it reasonably reflects the FMV of the practice (or services rendered). Furthermore, according to the OIG, payment of any amount in excess of FMV creates an inference of payment for referral of program-related business. In the letter, the OIG also questioned whether consideration paid for intangibles that relate to the continuing treatment of the selling practice's patients might not in certain cases actually represent a disguised payment for referrals. The letter describes as "suspect" amounts paid in excess of the FMV of the hard assets. Included in the "suspect" category are amounts paid for specific intangibles, such as goodwill, value of an ongoing business unit, covenants not to compete, exclusive dealing agreements, patient lists, or patient records.

Both the Service and the OIG are concerned that any acquisition of a physician practice represent no more than a FMV payment for appropriate assets (in the Service's case, assets that will be used in furthering an exempt purpose) to comply with their respective bodies of law. See pages 234-236 of this article for a more detailed discussion of the Service's considerations in the area of establishing fair market value.

Under the Service's current published rulings, the FMV of the assembled assets that comprise an entity as a going concern may include the value of the entity's intangible assets. Intangible assets include medical records, covenants not to compete, HMO contracts, other contracts, trademarks and tradenames, and goodwill. It is unlikely that an Applicant will admit that it intends any portion of its payment for intangibles to compensate the selling physicians for referrals. Nevertheless, whenever exemption is recognized in cases involving practice acquisitions, the determination letter will contain a caveat that the ruling is conditioned upon the Applicant not violating the federal anti-kickback restrictions of 1128(b) of the Social Security Act or 42 U.S.C. 1320a-7b(b). Any Applicant must keep in mind that, even if tax exemption is recognized by the Service, continued exempt status is conditioned upon the practice acquisition and ongoing operation of the IDS complying with the separate body of law administered by the Inspector General at HHS.

(4) How are the Professional Services Provided?

The professional services agreement ("PSA") is a legally enforceable contract that spells out the responsibilities of the Medical Group and the Applicant in their new roles as contracting parties within the IDS. A contract of employment may be used where the physicians are employed directly by the IDS, but for ease

of discussion the term "PSA" will be used here. The PSA contains much of the key information that allows the Service to determine, under all the facts and circumstances, whether the Applicant is entitled to have exemption recognized under IRC 501(c)(3). This document generally contains a significant number of the facts that disclose whether private benefit to the Medical Group is substantial.

a. What Terms are Usually Included in a PSA?

i. Providing Professional Services

The PSA typically establishes that the Medical Group physicians will provide all professional medical services for the Applicant's patients. The PSA should not require physicians to admit patients requiring hospitalization to any specific hospital, because doing so could violate Medicare's anti-kickback statute.

The PSA establishes a period for which physician services will be provided by the Medical Group. Hospital bond financing may limit the maximum length of the PSA to two or five years. See Rev. Proc. 93-19, 1993-11 I.R.B. 52. Where tax exempt bond financing is not anticipated, longer periods are often used.

Under the terms of the PSA, the Applicant is responsible for contracting with third-party payers and billing for the medical, technical, and ancillary services rendered to enrollees. The fees for services provided cover the professional services as well as the expenses involved in providing clinic facilities and services, and should provide a reasonable reserve for future growth.

ii. Setting Fees

The Applicant may set up a fee committee that recommends, by vote of its membership, the initial fee schedule and revisions to the fee schedule for all services provided to the Applicant's patients. The fee committee should have a majority of voting members appointed or elected by the Applicant and, at most, a minority appointed or elected by the Medical Group. The fee schedule must be approved by the Applicant's board of directors.

iii. Setting Physician Compensation

The Medical Group's compensation typically is established in the PSA. The PSA generally establishes compensation for some initial time period and sets guidelines for determining compensation in future years.

Rev. Rul. 69-383, 1969-2 C.B. 113, lists the factors that the Service examines in testing whether a compensation plan results in prohibited inurement. A compensation plan of an exempt organization does not result in prohibited inurement if: (1) the compensation plan is not inconsistent with exempt status, as would be the case with a plan that is merely a device to distribute profits to principals or transform the organization's principal activity into a joint venture; (2) the compensation plan is the result of arm's- length bargaining; and (3) the compensation plan results in reasonable compensation. Whether these criteria are met depends upon the facts and circumstances of each case.

In IDS cases, the Medical Group's compensation must be derived from arm's-length negotiations that reflect competitive rates for medical services that will not exceed reasonable compensation for the services obtained. The compensation should be comparable to payment arrangements adopted by other medical groups of similar size and composition in the same geographic area. The Service will look to compensation for each physician specialty and compare that compensation to compensation paid to those specialists in other medical groups in the geographic area, bearing in mind that the Medical Group no longer provides (or bears the expenses of) its own nonprofessional staff, equipment, or facilities.

Once the IDS is operational, the Applicant will receive all revenues for services provided within the IDS. From that total amount, the Applicant must pay all nonprofessional employees and all capital and administrative costs of the system. The Applicant must also compensate the physicians rendering professional services, whether they are employees or independent contractors. The Applicant will likely want to compensate physicians based on the type of underlying contract and revenue under capitated contracts, or a percentage of gross fee-for-service revenues. In general, the Service will view favorably arrangements establishing compensation as a percentage of the Applicant's capitation or adjusted gross revenues, but not a percentage of net income.

The Applicant may establish a physician compensation committee to determine appropriate compensation. The compensation committee must be independent of the physicians providing services to the IDS. Moreover, physicians on Applicant's board must not violate their fiduciary duty to Applicant. Thus, none of the compensation committee members should be physicians with past or present affiliation with the Medical Group or anyone related to them.

iv. Exclusive Relationships

The PSA typically establishes conditions under which the Applicant and the Medical Group may affiliate with other physician practice groups, and when either party may terminate its contractual relationship with the other. Termination by either party generally will not affect IRC 501(c)(3) exempt status if it is due to either party's bankruptcy, insolvency, expiration of the agreed upon service period, illegal activity, failure to perform contractual duties, or other similar circumstances.

Covenants by the Medical Group not to compete with the Applicant during the term of the agreement sometimes are included in the PSA. Also, noncompetition covenants often are incorporated in separate contracts between individual Medical Group physicians and the Medical Group. If the physicians are directly employed by Applicant, covenants not to compete may be found in separate contracts of employment for the individual physicians.

The Service wants to ensure maximum accessibility to the community of physician services. However, the Service also realizes the contracting physicians or medical groups are important assets to the tax exempt organization, especially after a practice purchase. Therefore, the Applicant has a need to protect the anticipated value created by certain physicians' exclusive practice within its system.

The Service generally recognizes the necessity of noncompetition covenants that run simultaneously with a PSA. Separate covenants for a period after the sale date of the medical practice, and for a specified period upon termination of the physicians' relationship with the Applicant, might also be proposed by the Applicant. Therefore, the Service will generally uphold narrowly drawn covenants for reasonable time periods after the sale transaction and after a physician's departure from the IDS. The covenant must be specific enough to protect the IDS only to the extent that it would be harmed by a departing physician's competition. An acceptable covenant would involve a very limited geographic area and a relatively short time period in relation to the Applicant-physician contract period. The Service has accepted noncompetition provisions that restrict the ability of former physicians to enter into contracts with certain classes of payers with which the Applicant currently contracts or has contracted in the recent past, while leaving the physician free to serve other patients in the community.

v. Community Benefit Provisions

The Applicant's charitable goals are often recited in the PSA so that Medical Group physicians understand that they are obligated to further these goals. It is helpful if physicians of the Medical Group agree in the PSA that they will not discriminate against individual patients based on ability to pay at any of the clinic sites or at any affiliated hospital. Further, the Medical Group physicians should agree to treat patients seeking urgent care at any of Applicant's clinics without regard to ability to pay. PSA provisions may also state that a substantial number of the Medical Group physicians will provide coverage in hospital emergency rooms and will render care in those emergency rooms without regard to the patient's ability to pay.

2. Tax Exemption of an IDS

A. Legal Standard for Exemption

An Applicant applying for recognition of exemption under IRC 501(c)(3) bears the burden of establishing, on the basis of all the facts and circumstances, that it meets the applicable exemption requirements. IRC 501(c)(3) describes, in part, 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.

While IRC 501(c)(3) does not expressly address hospitals or health care providers, Rev. Rul. 69-545, 1969-2 C.B. 117, establishes the "community benefit standard," which focuses on a number of factors indicating that the operation of a hospital benefits the community rather than serving private interests. The facts in Situation 1 of the revenue ruling state that the hospital is controlled by a board composed of independent civic leaders, it has an open medical staff, and an active, open, and accessible emergency room, serving everyone without regard to ability to pay, and it treats all patients able to pay for their care, including Medicare and Medicaid patients. Therefore, the hospital operates to serve public rather than private interests. In Situation 2 of the revenue ruling, five doctors who owned a for-profit hospital sold their interest in the hospital for fair market value to a nonprofit hospital that they controlled and that generally served only patients of those physicians. The new nonprofit hospital was not exempt because of excessive private benefit to the five doctors.

Rev. Rul. 69-545 provides the basis for most of the Service's rulings in the hospital and health care provider area. It focuses on a number of factors indicating that the operation of a hospital benefits the community rather than serving private

interests.

(1) Community Benefit

Rev. Rul. 69-545 states that a properly organized nonprofit hospital will meet the community benefit standard, and thus qualify for exemption, where it has a board composed of prominent citizens drawn from the community (as opposed to physicians, administrators, or others with a private interest in the organization); it has a medical staff open to all qualified physicians in the area, consistent with the size and nature of its facilities; it operates a full-time emergency room open to all persons, without regard to their ability to pay; and it provides hospital care for everyone in the community able to pay the cost thereof, either themselves, through private health insurance, or with the aid of public programs such as Medicare. While the ruling expressly mentions Medicare, the Service has consistently interpreted and applied the phrase "public programs such as medicare" to include Medicaid.

In Rev. Rul. 83-157, 1983-2 C.B. 94, the Service ruled that a nonprofit hospital may, under certain narrow circumstances, be able to demonstrate sufficient community benefit to qualify for exemption without operating an emergency room. Specified instances are where a state agency determines that an emergency room would be unnecessary and duplicative, and in the case of a specialty hospital not generally treating emergency medical conditions.

One issue considered in G.C.M. 39862 (Nov. 21, 1991), was whether a financial benefit (increased market share) to an exempt hospital automatically equated to community benefit. G.C.M. 39862 concluded that benefit to the tax exempt entity itself did not necessarily constitute benefit to the community as a whole. In IDS cases, an exempt hospital or its affiliated system may set up and control an Applicant. There are definite benefits to such an arrangement. Whether or not the community is benefitted is the key question.

a. Favorable Facts and Circumstances

Rev. Rul. 69-545 establishes a facts and circumstances test to weigh community benefit in hospital and health care cases in general. The Service applies this facts and circumstances test to determine if an Applicant organizing an IDS may be recognized as exempt under IRC 501(c)(3). Each fact and circumstance must be weighed carefully. A tax law specialist working an IDS case must view the application in its totality to determine if one fact or grouping of

facts creates significant community benefit. As stated in Geisinger Health Plan v. Commissioner, 985 F.2d 1210, 1215 (3d Cir. 1993), "charitable exemptions from income taxation constitute a quid pro quo: the public is willing to relieve an organization from paying income taxes because the organization is providing a benefit to the public."

i. Integration of Medical Functions

One oft-cited potential benefit to the public is the integration of all medical functions and records for each individual patient. The phrase "medical functions" is used in the broadest sense. When a patient initially visits an outpatient clinic, all records and tests are input into an IDS information system, and these records follow the patient throughout the course of treatment. The integrated recordkeeping system helps eliminate duplication of tests, procedures, and treatments, resulting in greater efficiency and reduced cost to the public.

ii. Increased Accessibility to Medicaid and Charity Care Patients

Under Rev. Rul. 69-545, the affiliated IDS hospital(s) must maintain an open medical staff in order to make its services as readily accessible to the community as possible. The hospital must operate an emergency room that is open to the public and provide emergency care to everyone without regard to ability to pay. It must also serve all patients able to pay the cost of their care, including Medicare and Medicaid patients. In most cases, an IDS will have to go well beyond meeting these hospital thresholds to demonstrate sufficient community benefit, especially in its outpatient or clinic settings.

Two National Office letter rulings have been issued on IDS cases. Both contained favorable determinations. In the first case, all indigent emergency room patients requiring hospitalization will be admitted to the hospital for inpatient care and receive all necessary follow up care free or at discounted rates, depending on the patient's means, including outpatient care through the clinics and use of any diagnostic equipment. Anyone in immediate need of care is treated at any of the clinic locations without regard to ability to pay. Further, the clinics participate in, or have made good faith efforts to participate in, Medicaid in a nondiscriminatory manner. In the second case, the Applicant will treat patients seeking urgent care at its urgent care centers without regard to ability to pay; its contracting physicians will not discriminate against patients based on ability to pay; and it will serve Medicaid patients in a nondiscriminatory manner. In addition, it will devote a

minimum of $400,000 per year to charity care, not including bad debt.

In evaluating Applicant representations about charity care, tax law specialists should distinguish between bad debt and true charity care in accordance with Statement No. 15 of the Principles and Practices Board of the Healthcare Financial Management Association, "Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers," reprinted in Healthcare Financial Management, Feb. 1993, at 54.

iii. Research and Education

Another often cited potential benefit to the public is research and education functions typically associated with a clinic or IDS. The research may add knowledge in primary care and in specialized areas which benefit the public. The Service must evaluate whether these functions will primarily benefit the public or, instead, the particular IDS (or its contracting medical group).

An IDS may also conduct health education programs open to the public, which may be seen as a community benefit.

iv. Community Board of Trustees

The Applicant's articles and bylaws establish the composition of its board of trustees or directors. The board is the body that controls the business and charitable operations of the IDS. All important business and charitable decisions evolve from this body. Because of the unique relationship between the selling Medical Group physicians and the tax exempt Applicant, the Service requires control firmly planted in an independent community board, as it always has in the hospital setting. Because of the Medical Group's past ownership of the Applicant's assets and its present contractual arrangement to provide medical services, there may be a strong presumption of private benefit flowing to the Medical Group. For the Applicant to have charitable status recognized, the public benefit emanating from its activities must demonstrably outweigh any private benefit to such an extent that the private benefit is merely incidental. See Rev. Rul. 69-266, 1969-1 C.B. 151.

The board has responsibility for all business decisions and charitable aspects of the Applicant's health care delivery system. Any committees or subcommittees created to consider the business or charitable aspects of the Applicant's operations must be independent and broadly representative of the

community. However, the Applicant may create committees to consider solely clinical or professional aspects of the health care services to be provided. The Service recognizes that these committees may contain unlimited physician representation, just as the medical staff of a hospital is, solely for these purposes, self-governing.

Because of the obvious control the board has over the operation of the Applicant, the additional private benefit to physicians or the Medical Group through significant board participation is a serious threat to recognition of the Applicant's exemption. Only a minority of board members may represent physicians, the Medical Group, management, or other interested parties. The Service, for ease of administration, generally will allow up to 20% of board members to represent physicians or other interested parties' interests.

For example, an acceptable ten member board of directors would have eight "community members," which may include members selected by the exempt parent, and no more than two members selected by the Medical Group. To meet this "safe harbor" used by the Service in determinations of status, the Applicant's bylaws would have to state that no more than 20% of its board members may be interested or financially related, directly or indirectly, to any owner, partner, shareholder, or employee of the Medical Group or other physicians providing services in conjunction with the IDS. The Applicant must represent that it operates for the benefit of the community, and that its board will be independent and broadly representative of the community.

Exemption is not necessarily precluded if an Applicant fails to meet the safe harbor guidelines. Consideration will be given to all the facts and circumstances of each particular case, but the facts will be closely scrutinized for other than incidental private benefit. See Rev. Rul. 86-98, 1986-2 C.B. 74.

v. Conclusion

The above facts and circumstances, although not always individually critical to exemption, are important Service considerations in evaluating IDS applications for recognition of exemption. Of course, in addition to demonstrating community benefit, the Applicant must meet all the other requirements of exemption.

In summary, an IDS may offer significant benefits in terms of improving access to and delivery of health care in a community. This is balanced against the risk that an IDS will be used as a vehicle of private benefit or inurement for the

physicians who sell their practice to or provide services on behalf of the IDS.

(2) Private Benefit and Inurement

An organization cannot be organized or operated exclusively for charitable purposes unless it serves a public rather than a private interest. Thus, to meet the requirements of IRC 501(c)(3), Applicant must establish that it is not organized or operated for the benefit of private interests such as designated individuals, the creator or his family, shareholders of the organization, or persons controlled, directly or indirectly, by such private interests. See Reg. 1.501(c)(3)-1(d)(1)(ii). The private shareholders or individuals are defined as persons having a personal and private interest in the activities of the Applicant. See Reg. 1.501(a)-1(c).

The private benefit prohibition of IRC 501(c)(3) applies to all kinds of persons and groups, not just to those "insiders" subject to the more strict inurement proscription. In Sonora Community Hosp. v. Commissioner, 46 T.C. 519 (1966), aff'd, 397 F.2d 814 (9th Cir. 1968), two doctors who previously owned the hospital facilities and founded the hospital in question shared in the fees from the privately operated laboratory and x-ray departments within the hospital even through they performed no associated services. The Tax Court found that this demonstrated the hospitals operated to a considerable extent for the private benefit of the two founding doctors, rather than exclusively as a charitable organization.

The private benefit prohibition applies to all the physicians in the Medical Group that sells its assets to the Applicant and has its physicians subsequently performing services for the Applicant. The same physicians may be performing services, but doing so on behalf of a new entity, the Applicant. Benefits to the physicians must be balanced against benefits to the public.

a. Prohibition Against More Than Incidental Private Benefit

Private benefit may include an "advantage; profit; fruit; privilege; gain or interest." Retired Teachers Legal Defense Fund v. Commissioner, 78 T.C. 280, 286 (1982). It is clear that the Medical Group and individual physicians receive an advantage, profit, fruit, privilege, gain, or interest as a natural result of the IDS practice purchase as well as from subsequent provision of professional services to the IDS.

The Applicant may provide benefits to "private individuals," or persons who are not members of a charitable class, provided those benefits are "incidental" both quantitatively and qualitatively. See G.C.M. 37789 (Dec. 18, 1978). To be qualitatively incidental, private benefit must be a necessary concomitant of an activity which benefits the public at large; in other words, the benefit to the public cannot be achieved without necessarily benefitting certain private individuals. Id. at 6. It must be impossible for the organization to accomplish its purposes without providing benefits to private individuals. Id. at 7, quoting Rev. Rul. 70-186, 1970-1 C.B. 128 (organization that preserved a lake as a public recreational facility and to improve water conditions, also benefiting lake front landowners, qualified for IRC 501(c)(3) exemption).

To be "quantitatively incidental," the private benefit must be insubstantial "measured in the context of the overall public benefit conferred by the activity." G.C.M. 37789 at 8. To illustrate the "quantitatively" incidental concept, G.C.M. 37789 compared Rev. Rul. 68-14, 1968-1 C.B. 243, with Rev. Rul. 75-286, 1975-2 C.B. 210. In Rev. Rul. 68-14, an organization that helped beautify a city was exempt when it planted trees in public areas, cooperated with municipal authorities in tree plantings and programs to keep the city clean, and educated the public in advantages of tree planting. In Rev. Rul. 75-286, an organization with similar activities did not qualify under IRC 501(c)(3) where its members consisted of residents and business operators of a city block and its activities were limited to that block. The facts in Rev. Rul. 75-286 indicate the organization was organized and operated for the benefit of private interests by enhancing the value of its members' property. Accordingly, whether private benefit is quantitatively incidental or insubstantial depends on the reason behind the benefit and whether the benefits provided are more than necessary to accomplish the exempt purpose.

b. Possible Benefits to Medical Group or Physicians

Potential private benefit to the physicians involved in the creation of an IDS will be scrutinized in connection with Applicant's IRC 501(c)(3) application. The benefits to a particular Medical Group will vary depending upon the group's unique situation.

The assets of physicians' medical practice generally include both tangible and intangible assets. Any time a for-profit organization is being purchased by an exempt organization, the issue of adequacy of consideration should be raised. Is other than FMV being paid for the real estate, personal property, HMO contracts, goodwill, patient records, etc? In some cases, merely providing a purchaser for a

for-profit's assets can be a significant private benefit. Determination of FMV is discussed elsewhere in the article.

All assets are transferred to Applicant, so Medical Group is excused from real and personal property taxes on all holdings related to medical activities.

Buy-ins and buy-outs of the Medical Group physicians will become easier or be dispensed with. A physician will not have to produce cash, with after-tax dollars, to buy into the group medical practice or to retire debt due to a withdrawing physician because the physicians will no longer own assets.

Valuation and cash payment problems that occur during termination will also be avoided. True limited liability becomes a reality for a physician because the Applicant will own all assets and be liable for all debts. Under this system, the Medical Group is only responsible for employing physicians and providing medical services under contract with Applicant, or as an employee of Applicant (where a direct employment arrangement is utilized).

c. Private Inurement

Private inurement generally involves persons who, because of their particular relationship with an organization, have an opportunity to control or influence its activities. These individuals generally are referred to as "insiders." See, e.g., American Campaign Academy v. Commissioner, 92 T.C. 1053 (1989).

Private benefit is a broader concept than private inurement and has wider application. The Tax Court addressed the distinction in American Campaign Academy, supra, stating that "while the prohibitions against private benefit and private inurement share common and overlapping elements, the two are distinct requirements which must independently be satisfied." Inurement generally will not be found in the absence of an insider, while private benefit can involve anyone. Therefore, an important issue is whether a physician is an insider.

In G.C.M. 39670 (June 17, 1987), the Office of Chief Counsel states that all persons performing services for an organization have a personal and private interest in it and, therefore, possess the requisite relationship necessary to find private benefit or inurement. The Service's position presumes that certain key groups of employees of an exempt organization have a serious potential to exert inside influence. It follows that physicians in a medical group providing services for an IDS under an exclusive contract may enjoy considerable influence over the

Applicant. This insider status would require the Service to examine the potential for inurement as well as other than incidental private benefit.

Private inurement will not be present if the Applicant can demonstrate all of its relationships with a physician in question are truly at arm's length and the physician has no chance to employ inside influence. Even though the Medical Group physicians are subject to the inurement proscription, that does not mean there can be no economic dealings between them and the Applicant. The inurement proscription does not prevent the payment of reasonable compensation for goods and services. It is aimed at preventing dividend-like distributions of charitable assets or expenditures to benefit a private interest. See G.C.M. 39862, supra.

The following list of facts, though not inclusive, may indicate a lack of private inurement: (1) fair market value is paid for all assets conveyed to Applicant; (2) independent negotiations took place between unrelated parties to determine the value of the assets conveyed; (3) certified appraisals were obtained from independent third parties when the Medical Group's assets were being purchased, licensed or leased; (4) the fee schedule and physician compensation are determined by an independent community board and are comparable to what other physicians receive in fees and compensation in the same geographic area taking into consideration the transfer of capital assets; and (5) none of the other arrangements suggest any dividend-like sharing of charitable assets or expenditures for the benefit of private interests.

3. Other Federal Laws

A. Anti-kickback Provisions for Medicare or Medicaid Referrals

The federal anti-kickback restrictions contained in the Social Security Act, which prohibit the payment of remuneration in return for the referral of Medicare patients, provide in pertinent part (42 U.S.C. 1320a-7b(b)(1) and (2)):

> Whoever knowingly and willfully solicits or receives (or offers or pays) any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind --
>
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under

[Medicare or Medicaid], or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under [Medicare or Medicaid],

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

In addition to heavy fines and imprisonment, individuals or entities convicted of a violation of the federal anti-kickback statute face mandatory exclusion from participation in the governmental payment programs. 42 U.S.C. 1320a-7(a). Moreover, the Secretary of HHS may exclude any person from participation in Medicare and Medicaid if the Secretary administratively determines that such person committed an act described in the anti-kickback statute. 42 U.S.C. 1320a-7(b)(7). Exercise of the Secretary's discretionary authority may result in program exclusion regardless of whether a person is convicted of a criminal violation.

G.C.M. 39862, supra, is the definitive statement to date by the Service in the area of physician referrals. Tax Law Specialists are now aware of the implications of hospital-physician financial arrangements. In a recent article, a practitioner experienced in the area noted that having a valid business purpose is essential to avoid fraud and abuse problems in joint ventures. He goes on to say that "... even the cleanest of documentation will not save a business venture which when in operation, amounts to a sham transaction operated in an effort to pass an economic benefit to someone in exchange for referrals . . . Absence of mutual risk is often an indication that the parties have in reality developed a transparent business vehicle to pass money to referral sources." Sanford Teplistzky, Avoiding Fraud and Abuse Problems in Joint Ventures, 4 HealthSpan 17 (Jan. 1987), as quoted in G.C.M. 39862.

B. How Will the Service Address the Anti-kickback Restrictions in Applicant's Ruling Letter?

The Service is not anxious to employ a non-tax statute where the courts and the administrative agency responsible for its administration have not yet enforced the statute with respect to a particular type of transaction. However, it does not

want to appear to approve what may be illegal arrangements. Accordingly, the Service includes the following language in its ruling letters to Applicants in new IDSs:

> This ruling is conditioned upon your not violating the federal anti-kickback restrictions contained in section 1128(b) of the Social Security Act, 42 U.S.C. section 1320a-7b(b)(1) and (2), which prohibit the payment of remuneration in return for the referral of Medicare or Medicaid patients. We express no opinion as to whether your planned purchase of a private group medical practice or your subsequent purchase of services from that group practice for a percentage of your gross revenues complies with these provisions.

4. Reviewing the Application

A. The Sales Transaction

(1) How is FMV Established?

To avert private benefit to the selling parties (generally physicians of an existing Medical Group who own the assets of their practice) in IDS transactions, the Applicant must acquire all assets on an arm's-length, FMV basis. FMV is defined as the price at which a willing buyer and a willing seller agree, neither being under any compulsion to buy or sell, and both having reasonable knowledge of the relevant facts. Rev. Rul. 59-60, 1959-1 C.B. 237.

In general, FMV is determined within the framework of the business enterprise's worth to the most likely hypothetical purchaser, which in this situation, is assumed to be a commercial health care corporation. The business enterprise value or going concern value is defined as the value of a company's capital structure or, alternatively, as the total value of the assembled assets that comprise the entity as a going concern. See Raymond C. Miles, Basic Business Appraisals (1984).

Unlike many enterprise valuations, sales involving medical practices are not merely transfers of a controlling block of stock, but also create a new relationship in that the selling physicians become employees or members of a Medical Group that contracts to provide professional services to the Applicant. It is important that the Applicant have guarantees or assurances with the selling physicians in the form of service contracts.

If the new relationship between the Applicant and the physicians is not clearly detailed, the enterprise valuation approach may not be appropriate. Furthermore, unless the ongoing economic relationship between the Applicant and physicians is clearly defined in a way to assure the Applicants of the selling physicians' services at a determined price, the value of the transferred assets may be speculative.

The valuations in several determination letter cases were reviewed by the Office of Appeals, Office of Appraisal Services, Financial/Engineering Services Branch ("CC:AP:AS"). That Office requested a standard appraisal or valuation package that complied with the standards of Rev. Rul. 59-60, including its later modification and amplifications. A complete valuation under these guidelines contains an executive summary; a discussion of the nature of the business and the history of the enterprise from its inception; the economic outlook in general and the condition and outlook of the specific industry in particular; the book value of the stock, if any, or other hard assets, and the financial condition of the business, including at least two years of balance sheets and enumerated financial ratios; the earning capacity of the company, supported by five years of profit and loss statements; the dividend-paying capacity of the company (if a corporation); the estimated value of goodwill and/or other intangibles; descriptions of the stock or assets to be sold; comparable taxable companies and the market price of their respective stocks.

CC:AP:AS requested that one Applicant whose valuation they scrutinized provide all recognized approaches for estimating the value of a going concern, including income approaches, market approaches, and cost approaches. The income approaches appears to be the most relevant, as they include the "excess earnings method" described in Rev. Rul. 68-609, 1968-2 C.B. 327, and approved for intangibles valuation in Rev. Rul. 76-91.

Another income approach, favored by CC:AP:AS as appropriate in these cases, is the discounted future cash flow method.[1] CC:AP:AS ultimately stated that

[1] The discounted future cash flow method of estimating economic value has its basis in the fact that a sum of money that is expected to be received some time in the future has less present value than the same amount of money in hand today. In applying this method, the amount of projected cash flows from a business is estimated for each of a number of future years. The estimated cash flow for each year is then discounted to determine their present value, and the present values of estimated cash flows for all future years are then added to determine present

they found the method of "discounting forecasted distributable cash flows" to be the most relevant approach to valuing the transfer of operating assets to an Applicant. Therefore, the discounted future cash flows valuation generally should receive the most attention of the valuation procedures submitted. CC:AP:AS cautions, however, that even in those cases where the discounted future cash flow method is appropriate to value the enterprise being transferred, the analysis must be based on reasonable assumptions as to the amount and time of the cash flow, and must use a reasonable discount rate. In any event, the results of the cash flow approach should be tested against other methods such as comparable price-to-earnings and price to book value methods.

In addition to providing a valuation that complies with Rev. Rul. 59-60, the Applicant should obtain and provide to the Service as part of its application financial statements and performance ratios of the selling entity.

(2) How Should the Medical Group be Evaluated Financially?

The Service wants to be assured the Medical Group practice that an Applicant proposes to purchase is financially healthy. Its concern, apart from valuations, is that the community will not benefit if a tax exempt Applicant is created, even in part, to "bail out" a financially weak private medical practice. In addition, the selling physicians in such a situation would receive more than incidental private benefit if Applicant's purchase enabled them to sell a practice that they otherwise would be unable to sell.

The purpose of the financial review is to identify inconsistencies, trends, and comparables. This information is used to project future cash flows, and to estimate relevant risk levels for both the business enterprise and asset valuations. Generally, the financial review consists of analyzing the balance sheet, income statement, and financial performance ratios of the Medical Group. Tax law specialists generally have some experience with balance sheets and income statements but often can use guidance in the basic understanding of financial performance ratios of health care organizations.

CC:AP:AS generally breaks performance ratio analysis into four ratio

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value. Finally, the residual value of the business at the end of the period of years is estimated and this value as discounted to its equivalent present value is then added to the present value of estimated future cash flows to determine the total present value of the business. See Basic Business Appraisals, supra, 262.

sections: liquidity, asset management, debt management, and profitability. Two or three ratios are computed for each section, and at least two comparative industry ratios are given for every section.

### a. Financial Performance Ratios

#### i. Liquidity Ratios

These ratios indicate working capital strength. A current ratio, which is equal to current assets divided by current liabilities, is an indicator of a firm's ability to meet operational cash flows. Working capital divided by revenues ties the balance sheet to the income statement and is a measure of working capital required to support revenues. Therefore, a Medical Group's liquidity ratios that indicate a working capital position significantly below industry averages is of concern. Although liquidity problems can stem from many sources, the Service becomes concerned if liquidity ratios fall significantly below the industry norms.

#### ii. Asset Management Ratios

These ratios indicate asset utilization. The average collection period ratio is equal to accounts receivable divided by average daily revenues; this ratio may identify whether the firms credit policy is too loose or too tight. The net fixed assets ratio quantifies the level of fixed assets required to generate revenues. The total asset turnover ratio is equal to revenues divided by total assets and indicates how effectively the assets are being used to generate revenues.

#### iii. Debt Management Ratios

These ratios indicate a Medical Group's leverage utilization. Dividing liabilities by total assets reflects the creditors' claims against the assets. The debt equity ratio represents the capital structure and the corresponding financial risk. If the percentages are poor compared to industry averages, they could indicate the Medical Group is in a poor position to expand and thrive without introduction of the IDS concept. Again, a purchase of Medical Group's assets under these conditions could create a substantial benefit to the Medical Group physicians.

#### iv. Profitability Ratios

These ratios show the aggregate effect of liquidity, asset management and debt management ratios. The ratios used in this article as examples are a

combination of one numerator (pre-tax income) and two denominators (total assets and equity). Ratios computed from total assets and from equity, respectively, reflect profitability to all sources of capital and to the Medical Group's owners. Again, if "top dollar" is being paid by Applicant to the Medical Group for these assets when these ratios indicate comparatively poor profitability, the Service could conclude that Medical Group is receiving substantial private benefit or inurement.

B. What Questions Should the Tax Law Specialist Ask Applicant in IDS Cases?

The following questions offer guidance for a tax law specialist who is working an IDS case. The list of questions is an attempt to obtain information on issues which could affect exempt status. The topic areas of the questions may also be helpful to revenue agents who later examine an IDS that had exemption recognized in the past and is being audited to confirm that it operates in compliance with prior representations. This list is not all-inclusive and each individual case will have specialized issues which need to be questioned.

1. The Applicant states that its individual clinics will provide charity care.

    a. Have the Applicant submit its written policies on indigent-charity care.

    b. Will the Applicant provide free care to indigent patients (those unable to pay for care who are not covered under any private or government insurance programs)? What limits, if any, apply? How will care for those unable to pay differ from care provided to paying patients?

    c. Does the Applicant adhere to Statement No. 15 of the Principles and Practices Board of the Healthcare Financial Management Association in all of its representations regarding charity care?

2. The Applicant states that it will provide nondiscriminatory treatment of Medicare and Medicaid patients.

    a. Does the Applicant's Medicare and Medicaid policy include

access to all covered inpatient, outpatient, and diagnostic services that are available to non-Medicare and Medicaid patients?

b. If the Applicant's state contracts selectively with providers, will Applicant enter into and pursue in good faith negotiations with its state Medicaid agency in an effort to obtain Medicaid contracts?

c. Will the Applicant participate in Medicaid under fee-for-service arrangements at all of its clinic locations (as opposed to merely serving Medicaid patients enrolled in managed care plans)?

d. Do all hospitals operated as part of or in conjunction with the IDS serve Medicaid inpatients in a nondiscriminatory manner?

3. Confirm that the bylaws provide for control by persons broadly representative of the community. Does Applicant's board meet the 20% physician-representation safe harbor the Service applies in IDS cases? If not, has Applicant provided additional factors to be considered in explaining why it has a higher percentage of physician or Medical Group representation?

4. Does the Applicant have a policy of disclosure of conflicts of interest? Do the Applicant's by-laws include language requiring that, in any exercise of voting rights by board members, no member shall vote on any issue, motion, resolution or other matter which directly or indirectly may inure to his or her benefit?

5. Financial feasibility studies, appraisals, and evaluations normally precede the Applicant's decision to purchase the Medical Group's assets and create an IDS. Those materials should be requested, and should, at a minimum, answer the following questions:

a. What is the amount of the Medical Group's capital reserve account?

b. What is the liquidity ratio (the current assets divided by current liabilities) of the Medical Group?

c. What is the Medical Group's current working capital to revenue ratio (working capital divided by revenues)?

d. What is the Medical Group's debt to assets ratio (total debt divided by total assets)?

e. What is the Medical Group's long term debt to equity ratio (total debt divided by equity)?

f. What is the Medical Group's pre-tax return on asset ratio (pre-tax income divided by total assets)?

g. What is the Medical Group's pre-tax return on equity ratio (pre-tax income divided by equity)?

6. Did the Medical Group receive any other offers to purchase its group medical practice? Indicate how the offers differed and the amount(s) of the proposed purchase price(s).

7. A significant approach to valuing the Medical Group as a business enterprise will be the present value of discounted future cash flows.

   a. In that valuation, are the cash flow projections consistent with the historical financial data? If there are inconsistencies (e.g., cash flows much greater, or practice expanding more quickly than the trend of the historical data), does the valuation explain the assumptions underlying the projections? Are they reasonable?

   b. Is the discount rate used reasonable? Is the rate used supported by an explanation in the valuation?

8. If the Medical Group is going to sublease its interest in any equipment, and some time in the future the organization will sell its interest in the same equipment to the Applicant, have the Applicant submit an appraisal for the equipment indicating that the rental will be at or below fair market value. Have it also indicate that any future purchase of equipment from this organization will be at or below fair market value as determined by an independent appraisal.

9. If the Applicant states that rents for the real estate shall be determined by an appraisal, have it submit an independent appraisal indicating the rent the Applicant pays is at or below fair market value.

10. If the Applicant indicates that it might purchase the real estate at fair market value, have it submit an independent appraisal indicating the proposed sale price will be at or below fair market value.

11. Prior to the IDS, was each new physician required to buy into the medical group practice? What was the cost for a new physician to buy in?

    a. Prior to the IDS, did the Medical Group make specific financial arrangements with new physicians to provide for the buy-in? Please explain. How does this practice differ after the IDS?

    b. Prior to the IDS, how many physicians owed money either to the Medical Group or to third parties for a buy-in? Has the IDS resulted in the reduction or elimination of buy in debt to the Medical Group physicians?

    c. Was the buy-in a hinderance to recruiting for the Medical Group?

12. Prior to the reorganization, what was the financial arrangement if a physician retired? Approximately how much does the Medical Group owe retiring physicians? Briefly break down the financial package. Would the financial package include the following: the value of the medical practice, value of patients, value of assets, value of goodwill, etc.?

13. If a partnership or corporation owns the land, buildings, and equipment the Medical Group plans to lease or sell to the Applicant, are any of the partners or shareholders in any way related to any officers, directors, employees, independent contractors or managers of the Applicant? Will they be after the transaction?

14. Have the Applicant indicate, for all assets to be conveyed to it, which assets are owned by related individuals.

15. Is any officer of the Applicant a present or former partner or employee of the Medical Group?

16. Will members of the Medical Group be given advantaged status (i.e., automatic admission to the staff, preferential admitting and/or surgical scheduling, etc.) at any of the affiliated hospitals of the Applicant?

17. Is the compensation paid to the physicians of the Medical Group subordinate to other obligations of the Applicant, including debt service payments?

18. If the Applicant will be involved in research, what type of research will be carried on? Will the research involve questions and issues that directly affect the Applicant's operations or will the research be medical research involving general questions of medicine (e.g., treatments and cures for cancer, AIDS, etc.) with the results available to the public?

19. If Applicant provides educational programs, will they be available to the general public? This would mean that any fees charged to any participants will not discriminate against non-Applicant patients and the Applicant will effectively advertise these programs to the general public.

20. If the PSA states the Applicant will renovate clinics formerly owned by the Medical Group, have it indicate what percentage of the renovation is repairs and remodeling versus capital improvements.

21. If the fees charged to the Applicant's patients will be determined prospectively by a fee committee, determine that the committee is independent (i.e., its physician or contractor membership constitutes a minority of the committee).

22. If a compensation committee will establish compensation for Medical Group physicians in the future, determine that the committee does not contain any past or present Medical Group physicians, officers, shareholders and/or employees. The board should make the final decision.

23. Will the projected net salaries Applicant's physicians receive from the IDS be similar to their prior net income? If so, how is the fact that the physicians no longer are entitled to payment for the use of capital assets reconciled?

24. Does the Foundation conduct an internship or residency program with an accredited medical school? Please explain.

25. Will the Foundation provide free professional courtesy medical care to any physician or friend, associate, or relative of a physician in the Medical Group?

5. Conclusion

The concept of an IDS, and the Service's understanding of it, is evolving. Therefore, each future case will bring the Service greater sophistication and, with it, a better understanding of the tax and non-tax issues involved.