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Hospital =

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Dear :

This letter is in response to the request for a ruling submitted on behalf of the Authority that the professional services agreements (described below) to be entered into by the Hospital or the System and the physicians performing professional services on property owned by the Hospital and financed with the Bonds (the “Facility”) do not cause the Bonds to meet the private business use test under § 1.141-3(b)(4) of the Income Tax Regulations.

FACTS AND REPRESENTATIONS

The Authority is a public municipal corporation and a public body corporate established by the County for the purpose of developing, constructing, acquiring, and leasing hospital facilities. Under State law, the Authority may issue revenue bonds to finance the project costs of hospital facilities or refinance outstanding indebtedness of hospitals. The Authority has issued the Bonds, the proceeds of which were used to finance the Facility.

The Hospital is a nonprofit corporation organized under the laws of the State, is described in § 501(c)(3) of the Internal Revenue Code (the "Code"), and owns an acute care hospital facility located in County. The sole member, shareholder, and parent of the Hospital is the System. The System is also a State nonprofit corporation described in § 501(c)(3) of the Code. The function of the System includes oversight and coordination of system-wide long range strategic and financial planning, budgeting and quality improvement. The Hospital and the System are governed by their respective boards of directors (the "Boards"). The membership of the Boards of the Hospital and the System are substantially identical.

The Hospital uses services of physicians practicing medicine in various specialties such as family practice, general surgery, and other specialties. The Hospital and the System propose to enter into professional service agreements with physicians (the "Contracting Physician(s)") for medical services ("the Agreement(s)"), chiefly for specialty care such as surgery. Under the Agreements, the Contracting Physicians would devote a significant portion of their time to patient care services within the Facility. The Hospital will pay for all of the expenses incurred as a result of the Contracting Physicians performing professional services on patients at the Hospital and will submit invoices for those services to the patients or their payors (such as insurance companies). In addition, the Hospital will reimburse the Contracting Physicians' expenses incurred for continuing medical education, professional reference materials, text books, licensing fees, and professional membership dues up to a maximum of $l.

Under the Agreements, the Contracting Physician will receive a percentage of Net Professional Patient Billings ("NPPB") equal to:

- a% of the first $w NPPB;
- b% of the NPPB between $w+1 and $x;
- c% of the NPPB between $x+1 and $y;
- d% of the NPPB between $y+1 and $z; and
- e% of the NPPB in excess of $z.

NPPB is defined as gross patient billings for the professional component of direct physician care services that are personally provided by the Contracting Physician (but not for the technical component of any ancillary services) and specifically excludes the provision of any services which are defined as "designated health services" under the Federal Ethics in Patient Referrals Act, 42 U.S.C. § 1395nn. Gross patient billings also

include capitation fees, and will be reduced by Medicare and Medicaid contractual write-offs, usual and customary reductions by private insurers, physician discretionary discounts and managed care discounts. Charitable expenses (uninsured, indigent patients) and bad debt, unless caused by the Contracting Physician's lack of medical record and proper coding, which causes the bad debt to be incurred, will not reduce the gross billings.

If a Contracting Physician's actual compensation pursuant to the above formula exceeds f percent of the most current Medical Group Management Association (MGMA) Physician Compensation Survey for physicians practicing the same medical specialty within the same or comparable location within the United States, then the Hospital will undertake a review of the Contracting Physician's practice and billing to determine if the compensation being paid to the Contracting Physician is equitable for both parties, and consistent with fair market value for the services being provided by the Contracting Physician.

As part of the Agreements, in addition to the compensation based upon the applicable percentage of Contracting Physicians' NPPB according to the tiered formula above, the Contracting Physicians will also be compensated for supervising physician extenders (nurse practitioners and physician assistants). The supervising physician will receive g percent of the NPPB generated by the physician extenders.

During the course of the year, the Contracting Physician will be paid a mutually agreed upon amount that is established at the beginning of the year. A reconciliation of compensation will be performed within 60 days after the end of each year. Any excess compensation will be repaid by Contracting Physicians through a decrease in the next three months' compensation. Any shortfall in compensation paid to the physician will be paid in the next biweekly payment to the Contracting Physicians.

In addition, the Agreements provide that the Contracting Physicians will be eligible to receive supplemental compensation paid into a non-qualified deferred compensation plan (the "Plan") described more fully below. The sum of the compensation based upon the applicable percentage of the Contracting Physician's NPPB and the g percent of the physician extenders' NPPB supervised by the Contracting Physician (the "Base Compensation") constitutes the basis for the Contracting Physician's supplemental compensation. The supplemental compensation consists of an incentive portion (the "Incentive Compensation") and a portion based upon the Contracting Physician's duration of service at the Hospital (the "Deferred Compensation"). The Contracting Physicians are eligible for the payment of up to h percent of the Base Compensation as Incentive Compensation. The actual amount of Incentive Compensation is subject to the Contracting Physician's satisfaction of certain pre-established goals designed for that particular Contracting Physician. Each goal is assigned a certain percentage of the Incentive Compensation, and the total Incentive Compensation payable to a particular Contracting Physician is determined by the Contracting Physician's cumulative

attainment of these goals. There are three goals named “Quality,” “Learning,” and “Customer”, respectively. The Quality goal targets the directives relating to national quality initiatives and evidence-based clinical best practices established by national health services organizations and bodies. The Learning goal is designed to build a high performance culture through education and effective communication among medical staff and the promotion of use of technology to support quality and patient satisfaction. The Customer goal is intended to promote a customer service culture and patient satisfaction.

The Contracting Physician will receive as a contribution to the Plan, the Deferred Compensation as a specified percentage of the Base Compensation within 60 days after the end of each fiscal year quarter. The applicable percentage ranges between i and j percent depending on the years of service with the Hospital. The amounts of Deferred Compensation paid into the Plan are subject to a substantial risk of forfeiture under § 457(f) of the Code relating to a specifically required term of service.

The Agreements will have an initial term of k years and will be automatically renewed for additional consecutive k-year terms unless either party gives 90 days notice prior to the end of the term. In addition, the Agreements will terminate if the Contracting Physician is unable to substantially perform the material requirements of the practice of medicine, if there is an uncured breach lasting over 30 days, if Contracting Physician’s privileges at the Hospital are restricted, if the Contracting Physician does not participate in any Federal health care program from which the Contracting Physician derives i percent or more of revenue, for certain acts by the Contracting Physician, in case of the Contracting Physician’s death, or by mutual agreement of the parties.

The Issuer, the Hospital, and the System represent that the above described business model in the form of the Agreements is necessary because of poor economic climate and sub-par provider payment history, causing difficulties in the recruitment and retention of qualified physicians in the State, particularly outside of the largest metropolitan areas. The traditional salary plus bonus business model has shown inadequate to address these difficulties. The business model contained in the Agreements is an expression of the Hospital’s effort to recruit and retain qualified physicians who are committed to staying in the community, and maintaining a highly productive and efficient practice.

The Contracting Physicians will not have a role with the Hospital or the System that substantially limits the Hospital’s or the System’s ability to exercise their rights under the Agreements, including the right to terminate the Agreements. Less than 20% of the voting power of the Hospital’s or System’s Board of Directors will be vested in any one or more of the Contracting Physicians. The Contracting Physicians are not related to the Hospital or the System within the meaning of § 1.150-1(b).

LAW

Under § 103(a), gross income does not include interest on any state or local bond. Section 103(b) provides, however, that § 103(a) shall not apply to any private activity bond which is not a qualified bond (within the meaning of § 141).

Section 141(a) provides that the term "private activity bond" means any bond issued as part of an issue which: (1) meets the private business use test of § 141(b)(1) and the private security or payment test of § 141(b)(2); or (2) meets the private loan financing test of § 141(c). Section 141(b)(1) provides, in general, that an issue meets the private business use test if more than 10 percent of the proceeds of the issue are to be used for any private business use.

Section 141(b)(6) provides that the term "private business use" for purposes of § 141(b), means use (directly or indirectly) in a trade or business carried on by any person other than a governmental unit. For this purpose, any activity carried on by a person other than a natural person is treated as a trade or business.

Section 141(e)(1)(G) provides that the term "qualified bond" includes any private activity bond if such bond is a qualified 501(c)(3) bond and meets other specified requirements.

Section 145(a) provides that a "qualified 501(c)(3) bond" means any private activity bond issued as part of an issue if (1) all property which is to be provided by the net proceeds of the issue is to be owned by a 501(c)(3) organization or a governmental unit, and (2) such bonds would not be a private activity bond if -- (A) 501(c)(3) organizations were treated as governmental units with respect to their activities which do not constitute unrelated trades or businesses, determined by applying § 513(a), and (B) §§ 141(b)(1) and (2) were applied by substituting "5 percent" for "10 percent" each place it appears and by substituting "net proceeds" for "proceeds" each place it appears.

Section 1.145-2(a) provides generally that §§ 1.141-0 through 1.141-15 apply to § 145(a). Section 1.145-2(b) provides, in part, that in applying §§ 1.141-0 through 1.141-15 to § 145(a), (1) references to governmental persons include 501(c)(3) organizations with respect to their activities that do not constitute unrelated trades or businesses under § 513(a); and (2) references to "10 percent" and "proceeds" in the context of the private business use test and the private security or payment test mean "5 percent" and "net proceeds".

Section 1.141-3(a)(1) provides that the private business use test relates to the use of the proceeds of an issue. The 10 percent private business use test of § 141(b)(1) is met if more than 10 percent of the proceeds of an issue is used in a trade or business of a nongovernmental person. For this purpose, the use of financed property is treated as the direct use of proceeds. Any activity carried on by a person other than a natural person is treated as a trade or business.

Section 1.141-3(b)(1) provides that both actual and beneficial use by a nongovernmental person may be treated as private business use. In most cases, the private business use test is met only if a nongovernmental person has special legal entitlements to use the financed property under an arrangement with the issuer. In general, a nongovernmental person is treated as a private business user of proceeds and financed property as a result of ownership; actual or beneficial use of property pursuant to a lease, or a management or incentive payment contract; or certain other arrangements such as a take or pay or other output-type contract.

Section 1.141-3(b)(4)(i) provides that, except as provided in § 141-3(d), a management contract with respect to financed property may result in private business use of that property, based on all of the facts and circumstances. A management contract generally results in private business use of that property if the contract provides for compensation for services rendered with compensation based, in whole or in part, on a share of net profits from the operation of the facility.

Section 1.141-3(b)(4)(ii) defines a management contract as a management, service, or incentive payment contract between a governmental person and a service provider under which the service provider provides services involving all, a portion of, or any function of, a facility. For example, a contract for the provision of management services for an entire hospital, a contract for management services for a specific department of a hospital, and an incentive payment contract for physician services to patients of a hospital are each treated as a management contract.

Revenue Procedure 97-13, 1997-1 C.B. 632, as modified by Revenue Procedure 2001-39, 2001-2 C.B. 38 ("Rev. Proc. 97-13"), sets forth conditions under which a management contract does not result in private business use under § 141(b). Under § 5.01 of Rev. Proc. 97-13, if the requirements of § 5 are satisfied, the management contract does not itself result in private business use. Under § 5.02(1), the management contract must provide for reasonable compensation for services rendered with no compensation based, in whole or in part, on a share of net profits from the operation of the facility. Reimbursement of the service provider for actual and direct expenses paid by the service provider to unrelated parties is not by itself treated as compensation. Under § 5.02(2), for purposes of § 1.141-3(b)(4)(i) and Rev. Proc. 97-13, compensation that is based on (a) a percentage of gross revenues (or adjusted gross revenues) of a facility or a percentage of expenses from a facility, but not both, (b) a capitation fee, or (c) a per-unit fee, is generally not considered to be based on a share of net profits.

Section 3.01 defines adjusted gross revenue to mean gross revenues of all or a portion of a facility, less allowances for bad debts and contractual and similar allowances.

Section 3.02 defines capitation fee to mean a fixed periodic amount for each person for whom the service provider or the qualified user assumes the responsibility to provide all

needed services for a specified period so long as the quantity and type of services actually provided to covered persons varies substantially. For example, a capitation fee includes a fixed dollar amount payable per month to a medical service provider for each member of a health maintenance organization plan for whom the provider agrees to provide all needed medical services for a specified period.

Section 3.06 of Rev. Proc. 97-13 defines a "per-unit fee" as a fee based on a unit of service provided specified in the contract or otherwise specifically determined by an independent third party, such as the administrator of the Medicare program, or the qualified user. For example, a stated dollar amount for each specified medical procedure performed, car parked, or passenger mile is a per-unit fee. Separate billing arrangements between physicians and hospitals generally are treated as per-unit fee arrangements.

Section 3.08 of Rev. Proc. 97-13 provides that a renewal option means a provision under which the service provider has a legally enforceable right to renew the contract. Thus, for example, a provision under which a contract is automatically renewed for one year periods absent cancellation by either party is not a renewal option (even if it is expected to be renewed).

Section 5.03 of Rev. Proc. 97-13 sets forth six permissible arrangements that satisfy the requirements of § 5. Under § 5.03(6), a permissible arrangement is an arrangement providing for compensation for service based on a percentage of fees charged or a combination of a per-unit fee and a percentage of revenue or expense fee. The term of the contract, including renewal options, must not exceed 2 years. The contract must be terminable by the qualified user on reasonable notice, without penalty or cause, at the end of the first year of the contract term. This permissible arrangement only applies to contracts under which the service provider primarily provides services to third parties (for example, radiology services to patients) and in one other circumstance not applicable in the instant case.

Section 5.04(1) of Rev. Proc. 97-13 provides in general that a service provider must not have any role or relationship with the qualified user that substantially limits the qualified user's ability to exercise its rights, including cancellation rights, based on all the facts and circumstances. Under § 5.04(2), the qualified user's rights are not substantially limited if the following requirements are satisfied: (1) not more than 20 percent of the voting power of the governing body of the qualified user in the aggregate is vested in the service provider and its directors, officers, shareholders, and employees; (2) overlapping board members do not include the chief executive officers of the service provider or its governing body or the qualified user or its governing body; and (3) the qualified user and the service provider under the contract are not related parties, as defined in § 1.150-1(b).

ANALYSIS

Initially, we find that the Agreements meet the definition of a management contract under § 1.141-3(b)(4)(ii) because they constitute incentive payment contracts for physician services to patients of a hospital. However, the Agreements do not meet the requirements of § 5.03 of Rev. Proc. 97-13. Therefore, whether the Agreements result in private business use of the Facility under § 1.141-3(b)(4) depends on all of the facts and circumstances. In determining whether the facts and circumstances relating to a management contract indicate private business use, the factors set forth in Rev. Proc. 97-13 are useful reference points. For the reasons described below, we conclude that the Agreements do not result in private business use of the Facility.

We note that all of the compensation under the Agreements consists of a percentage of fees generated by the physicians adjusted for items such as insurance discounts and certain bad debts. As such, the compensation structure most closely resembles the permissible arrangement under § 5.03(6) of Rev. Proc. 93-17 applicable to the provision of services to third parties such as physician services to patients at the Hospital. However, the k-year term of the Agreements exceeds the permissible term under § 5.03(6).[1]

In reviewing all the facts and circumstances relating to the Agreements, we note that the Agreements provide for reasonable compensation, in part because the Agreements provide for a right by the Hospital to review a Contracting Physician's portion of the Base Compensation allocable to the direct provision of medical services by the Contracting Physician if that portion reaches f percent of an objective industry standard. Because the Incentive Compensation and the Deferred Compensation are determined as a percentage of the Base Compensation, although indirectly, they are also subject to the Hospital's review of the direct services portion of the Base Compensation.

Further, a Contracting Physician's Base Compensation is based on the sum of a percentage of the Contracting Physician's NPPB and the g percent of the physician extenders' NPPB, *i.e.*, adjusted gross revenues allocable to that Contracting Physician and not, in whole or in part, on a share of net profits from the operation of the Facility. None of the expenses of the Facility, or of the Contracting Physicians, incurred in performing medical services at the Facility are taken into account in determining the amount of the Base Compensation.[2]

The maximum amount of the Incentive Compensation is based on a percentage of the Base Compensation, which, as indicated above, is a percentage of fees or adjusted gross revenues allocable to the Contracting Physician. The actual amount of the

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[1] The Agreements do not contain a legally enforceable right to renew on the part of the Contracting Physicians as service providers under Rev. Proc. 97-13.

[2] Under § 5.02(1), reimbursement of the Contracting Physicians' expenses incurred for continuing medical education, professional reference materials, text books, licensing fees, and professional membership dues up to a maximum of $l, as provided in the Agreements, is not treated as compensation.

Incentive Compensation that a Contracting Physician will receive depends on how the Contracting Physician meets that Contracting Physician's specific Quality, Learning, and Customer goals, none of which are based upon the number of patients treated by the Contracting Physician at the Facility, the productivity of the Facility, or the net profits of the Hospital.

The amount of the Deferred Compensation also depends on the percentage of fees or adjusted gross revenue with the additional factor of the Contacting Physician's years in service at the Hospital. As such, it is also not based upon the productivity of the Contracting Physician or of the Facility, or upon the net profits of the Hospital.

The term of the Agreements, although greater than the permissible term under § 5.03(6), is specifically tailored to address the difficulties encountered by the health industry in the Hospital's health coverage area in attracting and retaining qualified physicians that would become members of, and improve the provision of health care services in, the local community.

Finally, the Contracting Physicians do not have a role in, or relationship with, the Hospital or the System that substantially limits the Hospital's or the System's ability to exercise its rights under the Agreements, including cancellation rights, because no more than 20% of the voting power of the governing body of the Hospital or the System is vested in one or more of the Contracting Physicians. Also, none of the Contracting Physicians, on the one side, and the Hospital and the System, on the other, are related parties within the meaning of § 1.150-1(b).

CONCLUSION

Accordingly, although the Agreements do not satisfy the requirements of § 5.03, given all the facts and circumstances of this case as described above, the Agreements do not result in private business use of the Facility under § 1.141-3(b)(4) as applied to § 145.

This ruling is specifically made contingent upon the above described provisions of the Agreements being effective and binding between the Hospital or the System and the Contracting physicians. Except as expressly provided herein, no opinion is expressed or implied concerning the tax consequences of any aspect of any transaction or item discussed or referenced in this letter, including whether any agreements other than the Agreements fail to meet the private business use test under §§ 1.141-3(b)(4) as applied to 145, or whether the Bonds are tax-exempt for purposes of § 103 of the Code.

This ruling is directed only to the taxpayer requesting it. Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent.

In accordance with the Power of Attorney on file with this office, a copy of this letter is being sent to your authorized representative.

The rulings contained in this letter are based upon information and representations submitted by the taxpayer and accompanied by a penalty of perjury statement executed by an appropriate party. While this office has not verified any of the material submitted in support of the request for rulings, it is subject to verification on examination.

Sincerely,

Timothy L. Jones
Senior Counsel, Branch 5
(Financial Institutions & Products)