Douglas County Hospital
September 11, 2015

Difference Between Public and Nonprofit 501(c)(3) Hospitals; Increasing Trend to Public Hospital Conversion to Nonprofit 501(c)(3) Platform

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JANUARY 22, 2014
A. Trend to Conversion of Governmental Hospitals to 501(c)(3)

- In the 19\textsuperscript{th} and 20\textsuperscript{th} centuries, what we now view as hospitals began to be established in the United States. There were essentially 4 types
  - Religiously/ethnically affiliated nonprofits, primarily in the northeast and in large urban centers in the rest of the country
  - Non-sectarian nonprofits in larger communities
  - Doctors’ hospitals, predominantly in the South
  - Governmental hospitals, largely in the rural Midwest, West and South

  - Original reasons for governmental hospitals – inadequate market to support hospital, inadequate philanthropy, securing the ability to operate a hospital and recruit physicians with local property taxes
  - Beginning with the advent of Medicare and Medicaid, these rationales began to diminish
A. Trend to Conversion of Governmental Hospitals to 501(c)(3), continued

• By the mid-twentieth century, Minnesota had only religious/ethnic nonprofits and governmental hospitals (city, county or hospital district-owned). There were also a couple of for-profit operations.

• Today, the vast majority (over 80%) of acute care hospitals in Minnesota are nonprofit. Technically religious nonprofits no longer differentiate between members of the general public and members of their denominations in furnishing services to the community, because of mission shift and anti-discrimination provisions attached to receipt of governmental financial assistance or payment (Hill-Burton, Medicare, Medicaid, etc.).

• Governmental hospitals – a minority – are dwindling – e.g.,
  ▫ Only approximately 26 of Minnesota’s total of approximately 136 acute care general hospitals remain governmentally owned.
A. Trend to Conversion of Governmental Hospitals to 501(c)(3), continued

- The trend has been to conversion of governmental hospitals to 501(c)(3) nonprofits, e.g.:
  - Early 90’s – Chisago District; Sandstone District
  - Late 90’s – Waconia City
  - Early 2000 – Staples District
  - Recent examples
    - Hutchinson
    - Virginia
    - Monticello
    - Paynesville
    - Arlington
B. Significant Similarities/Differences Between Minnesota Governmental Hospitals and Minnesota Nonprofit 501(c)(3) Hospitals

<table>
<thead>
<tr>
<th>Factor</th>
<th>Governmental Hospital</th>
<th>Nonprofit 501(c)(3) Hospital</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Life</td>
<td>Virtually Perpetual</td>
<td>Same</td>
<td>---</td>
</tr>
<tr>
<td>Can contract, sue, be sued</td>
<td>Yes</td>
<td>Same</td>
<td>---</td>
</tr>
<tr>
<td>Levy for healthcare</td>
<td>Within statutory limits</td>
<td>No</td>
<td>Can be significant</td>
</tr>
<tr>
<td>Issue G.O. debt and revenue bonds</td>
<td>Yes</td>
<td>No; can borrow via governmental conduit qualified 501(c)(3) debt</td>
<td>Advantage with G.O. if used</td>
</tr>
<tr>
<td>Sovereign immunity</td>
<td>Yes</td>
<td>No</td>
<td>Insurance may render immunity moot</td>
</tr>
<tr>
<td>Permitted Investment</td>
<td>Limited to government paper under Chapter 118A</td>
<td>Only due care/prudence</td>
<td>Said to be significant difference</td>
</tr>
<tr>
<td>Confidentiality of Operations, Strategic Plan</td>
<td>Open Meeting Law, Data Pricing Act, Uniform Municipal Contracting Act</td>
<td>Generally all operations and strategic plans are confidential</td>
<td>Very significant difference</td>
</tr>
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C. Generally – Stated Reasons for Conversion

• **Exclusive Focus on Healthcare**: For multipurpose local governments (cities, counties) provides exclusive focus on health care at a governance level and frees local government to focus on a myriad of other important issues

• **Board Participation**: Use of lay boards by municipal governments is ultimately advisory because of reserved rights and option to eliminate lay boards; can affect willingness of people to serve on hospital boards of this type

• **Addressing Mismatch Between Patient Residents and Political Boundaries**: As health care becomes increasingly more complex, a greater percentage of hospital patients now come from outside the boundaries of the public hospital; a community board may provide broader representation more consistent with hospital patient population residence.

• **Physician Voice in Governance**: Enables participation of physicians in governance, within certain IRS and bond law restrictions

• **Philanthropy**: Perceived to be better platform for philanthropy

• **Reduction of Need for Tax Support**: Relieves taxpayers of property tax burden and displacing effect of general obligation municipal borrowing
C. Generally – Stated Reasons for Conversion, continued

• **Enhances Competitive Position**: Enables a level playing field with privately-owned competitors that is not present because of significant difficulty with maintaining confidence around strategic business plans (open meeting law, data practices act and uniform municipal contracting law)

• **Physician Recruitment and Employment**: Given an increasing recognition of the need for clinics and hospitals to integrate their operations to be more efficient in the context of health care reform, the reluctance of physicians to integrate their practices into governmental hospitals because of the potentially greater public nature of compensation
D. Options/Techniques of Conversion

• The option of sale to a for-profit entity has not been used in Minnesota because of community expectations and the Minnesota environment.

• The option of affiliation with a multi-hospital system (MHS) (e.g., Allina, CentraCare or Sanford)
  ▫ Involves transfer of hospital to a new, nonprofit entity
  ▫ Controlled by an MHS
  ▫ An MHS almost never pays cash for public hospitals; rather, an MHS will make commitments of capital and continued services to community; it also will sometimes agree to PILOT (payment in lieu of property tax)

• Transfer of the hospital operation to a locally-governed new nonprofit (“NEWCO”) is a practical option for those public hospitals wishing to convert but remain independent of an MHS.
D. Options/Techniques of Conversion, continued

• NEWCO would be a tax-exempt 501(c)(3) organization as well as a Minnesota non-profit
  ▫ Delays often occur in IRS processing of requests for 501(c)(3) determinations
  ▫ Such a determination must be received prior to any transfer of the hospital to NEWCO for bond compliance and other reasons
  ▫ If an IRS delay might be problematic for a local government, “repurposing” of an existing 501(c)(3) hospital foundation is an option. “Repurposing” involves changing the existing 501(c)(3)’s articles and bylaws to hospital type organizational documents. IRS is notified at next 990 filing. New foundation may be created, if appropriate, later on.

• A NEWCO will be unlikely to be able to afford to purchase the hospital; it is also unlikely to be able to arrange to pay off or defease material existing debt and governmental debt not generally assumable

• A specific type of lease authorized by the statutes would be the only practical variant of this NEWCO option
D. Options/Techniques of Conversion, continued

• The statutes (Minn. Stat. § 447.47) do permit a governmental unit (city, county, hospital district) that owns a hospital to lease it to a nonprofit corporation* if:
  ▫ Facilities are open to all residents of the community on equal terms
  ▫ The term of the lease does not exceed 30 years, with one renewal option, presumably for no more than 30 years
  ▫ A minimum rent is paid that covers principal and interest on any bonds issued by the municipality to improve the hospital and any amount necessary to maintain the agreed-upon bond reserve
  ▫ A purchase option can be included in the lease, but the terms must be specified and minimum price cannot be less than the amount necessary to pay off or defease the bonds
  ▫ The governmental unit may, but need not, elect to subsidize the operations of the facility out of a property tax levy via transfer of a fixed amount to the nonprofit; this is almost never done. Cities also have the ability to make gifts to such nonprofits under Minn. Stat. § 465.037

*Minn. Stat. § 376.06, subd.1. permits a county to lease its hospital to a nonprofit on terms the county deems advisable. This statute must be read together with Section 447.47, which provides greater particularity as to the requirements for a lease.
E. The Conversion Process

• Governmental unit determination of wisdom of conversion

• PERA Study: If governmental employees are covered by PERA, Chapter 353F provides such employees with enhanced actuarial benefits (certain immediate vesting and an enhanced PERA benefit if the employee continues to work for the hospital after its privatization). Chapter 353F requires an actuarial study to be performed in order to determine whether the privatization will produce a “net gain” or “net loss” to PERA. Simplified, if there will be a net loss to PERA, the hospital proposing privatization would need to make up the loss.

• Development of lease term sheet, employee salary/benefits crosswalk, etc.
E. The Conversion Process, continued

• Typical lease term sheet topics:
  ▫ Lease of space and equipment
  ▫ Transfer of balance sheet assets/liabilities
  ▫ Transfer of non-balance sheet liabilities
  ▫ Rent (and security of payment therefor) and purchase option
  ▫ Covenants to hire workforce
  ▫ Transfer of key contracts to lessee (e.g., payor agreements, professional service agreements, etc.)
  ▫ Service and capital commitments
  ▫ No sale to for-profit; no change of ownership
  ▫ Provision for unwind at end of lease term if no purchase option or purchase option not exercised
  ▫ Etc.

• Due diligence, particularly regarding necessary 3rd party consents (e.g., bondholders, voters under some city charters, key contract partners)
E. The Conversion Process, continued

- Formation of a NEWCO by governmental unit and appointment of initial board or repurposing of existing 501(c)(3)
- Filing IRS 1023 application for income tax exemption as 501(c)(3) (if repurposing track not followed)
- Drafting and execution of lease and related documents with following conditions to closing:
  - 1023 approval
  - Consent of bondholders, trustee, approval by bond counsel
  - Bond law change in use/remediation hearing re use of facilities by nonprofit
  - Regulatory approvals
  - Approvals of other parties to contracts to be assigned (payors, vendors, etc.)

- Closing/Effective Date
  - There is usually a gap between executing the document and the closing/effective date of 30-120 days
F. Transaction Depiction

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<tr>
<th>Elected Governance</th>
<th>Self-Perpetuating Board</th>
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<tr>
<td>City/County/Hospital District</td>
<td>NEWCO Minnesota Nonprofit Corporation 501(c)(3) Tax-Exempt</td>
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- Space/Equipment Lease
- Rent
- Remaining Balance Sheet Assets/Liabilities
G. Hennepin County Medical Center Conversion

• Even though the statutes provide general authority for public hospital conversion via a lease arrangement, some public hospitals are subject to additional requirements in order to effect a conversion.

• For example, hospitals established via a city charter may be subject to a citizen vote on a charter amendment.

• Some public hospitals are subject to special, uncodified, legislation.

• Others, like the Hennepin County Medical Center, are subject to codified legislation, such that the state legislature is required to act to enable the privatization.

• In Hennepin County’s case, legislation was enacted in 2005 permitting the County to establish as a county subsidiary, a public hospital called Hennepin Health System.

• Several years later, the hospital “privatized”.

• However, it is fair to say that this was a partial privatization, enabling partial relaxation of the applicability of the Open Meeting Law and the Data Practices Act and an exemption from the public procurement laws.
H. Questions and Discussion