

HEALTH LAW FOCUS

MICHIGAN SUPPLEMENT

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MICHIGAN SALES/USE TAX EXEMPTION FOR HOSPITAL CONSTRUCTION

On June 10, 1999, the Michigan legislature passed SB 544 and HB 4744 (Public Acts 116 and 117) to make several sweeping changes to the Michigan sales and use taxes. One issue addressed in this legislation is "clarification" of the longstanding exemption from sales and use tax provided for construction or repair of the real estate of a nonprofit hospital. Prior to 1970, Michigan law provided contractors with an exemption for their purchase of materials used in the construction of real property for all types of nonprofit entities. In 1970, the exemption was amended to exempt only construction for nonprofit housing and nonprofit hospitals. The amended statute defined nonprofit housing by reference to other statutes, but left the term "nonprofit hospital" undefined. For many years interpretive authority focused on the purpose of a particular facility and whether it was licensed as a hospital. In 1996, in a case addressing primarily whether the construction of a skilled nursing facility was exempt as a nonprofit hospital (*Canterbury Healthcare v. Department of Treasury*), the Court of Appeals found that the nursing facility was not exempt and also dramatically changed the exemption standard by considering primarily the purpose of the entity owning the building.

Multiple Entities. Prior to the 1999 legislation but after the *Canterbury* case, hospitals were left with a mixed blessing. The Department of Treasury had been challenging the exemption with respect to medical office buildings ("MOB") (particularly MOBs off-campus from the hospital). The *Canterbury* rule helped with respect to this situation as long as the MOB was owned by the same entity that owned and operated the hospital. However, many hospital systems operate in a multiple entity structure. For example, a diagnostic center, an outpatient surgery center or a critical care clinic might be owned in an affiliated entity. Under the *Canterbury* rule, prior to the 1999 legislation the fact that hospital functions and related buildings were held in a separate entity arguably allowed the Department to deny exemption. Under the same standard, however, a nursing home could be constructed on an exempt basis by the entity that owns and operates the nonprofit hospital.

MOBs. Before *Canterbury*, the Department frequently questioned the exemption of MOB construction (where owned or operated by a separate entity) but did not apply a consistent standard. In some audits, it applied an on-campus standard (with the hospital criteria), in others it even attacked on-campus MOBs or parts of MOBs using varied reasoning.

The Department responded to *Canterbury* by developing a radically new "inurement" position made public in RAB 99-2 only weeks before the 1999 legislation passed. Since the 1970 amendment, the sales/use tax exemption for nonprofit hospital construction referred to "income or property which does not directly or indirectly inure to the benefit of individuals, private stockholders or other private persons." Although this language differs from the language of Internal Revenue Code (the "Code") Section 501(c)(3) by surrounding the word "inure" with additional descriptive phrases, it has not, over the last 29 years, been interpreted differently than the federal concept of private inurement. RAB 92-3, apparently using *Canterbury* as the excuse, suddenly found a dramatic new meaning for inurement.

State Law Inurement. In RAB 92-3, the Department took the position that use of any portion of a nonprofit hospital's real estate project by private physicians, even if arm's length rent is paid for such use, rendered the entire project taxable. The strained nature of this view is apparent if one recalls that this is an exemption provided at the contractor level. Apparently, under RAB, the contractor must police its hospital client's future use of the building. Is the hospital's intent to directly use the building at the time construction begins enough to exempt the building? What if space is first leased to the practice of an on-staff physician two months after the hospital is occupied; two years after; ten years after?

The RAB position is an incredible distortion of the longstanding concept of inurement as applied for federal tax purposes and apparently accepted for the first 29 years of the nonprofit hospital construction exemption. For federal tax purposes, the arm's length rental of space in an MOB to a physician on the hospital staff is not only not inurement (*i.e.*, does not endanger the hospital's federal tax exemption), it is considered substantially related to the hospital's exempt purpose (*i.e.*, it does not generate unrelated business taxable income under Sections 511 - 513 of the Code).

Purpose and Effect of Legislation. The primary basis for most of the 1999 sales/use tax amendments was to statutorily override a case that ruled that property used partially in an exempt manner (under a specific exemption for certain telecommunications equipment) was fully exempt because the Department lacked the statutory authority to apportion the exemption. The 1999 amendments were to clarify that all exemptions under the sales and use taxes could be applied on an apportioned basis. However, the provisions addressing the hospital construction exemption go much further than merely correcting the apportionment issue by making sweeping substantive changes that were drafted in a very

short time frame with very sparse industry input. The legislation was drafted and voted on by the legislature in less than two weeks. No legislative hearings were held at which the concerns of the hospital industry could have been presented to the legislature in an orderly fashion. Moreover, the statutory language was drafted so quickly that many ambiguities have been unnecessarily introduced into this exemption. Moreover, apparently, little consideration was given to the application and implementation of this provision.

Definition of "Hospital". The statutory definition of a nonprofit hospital has several levels, two of which are primarily applicable to the vast majority of hospitals. The first is that portion of a building which is owned or operated by a Section 501(c)(3) entity that is licensed as a hospital under the Michigan Public Health Code. But for a separate, specific exemption for nursing homes, hospices and homes for the aged, this definition appears to adopt the *Canterbury* rule that, as long as the entity owning and operating the nonprofit hospital is the entity constructing and using a facility, the construction is eligible for the exemption irrespective of the nature of the facility. Therefore, it appears that a hospital-owning entity can build and operate a restaurant or other non-health care project on a tax exempt basis, but is taxable if it builds the specifically excluded nursing home, hospice or home for the aged. Moreover, the Department believes that the definition limits the exemption to that portion of the building that is actually used as a "nonprofit hospital," but that interpretation is not in accord with the literal language of the statutes.

The second generally relevant prong of the nonprofit hospital definition is that portion of the building which is "owned or operated by an entity or entities" (an implicit acknowledgment of joint ventures and multiple entity structures) exempt under 501(c)(2) or (3) of the Code in which "medical attention" is provided. Medical attention is defined elsewhere in the statute as, "that level of medical care in which a physician provides acute care or active treatment of medical, surgical, obstetrical, psychiatric, chronic or rehabilitative conditions that require the observation, diagnosis, and daily treatment by a physician."

Under the second prong of the new hospital definition, a facility owned by subsidiaries or brother/sister entities of the entity operating the hospital can achieve exemption in their own right only if medical attention is provided in the facility. However, the medical attention definition is so restrictive that even some hospital inpatients do not receive medical attention because the care must be provided by a physician on a daily basis. Medical attention by nurses, therapists, technicians and others do not count. For example, an outpatient surgery center, a diagnostic center, and even a clinic may not qualify depending on how "daily" is interpreted. In the case of a diagnostic or rehabilitative facility, care is often given by technicians, nurses and other nonphysician healthcare professionals with supervision by a physician. Unless that supervision is considered daily care, many types of medical services provided by a hospital will not be considered medical

attention for this purpose. If medical attention is interpreted strictly, the second prong of the hospital definition will have recognized the multiple entity structure of hospitals and, in the same provision, essentially denied any benefit from such recognition.

More State Law Inurement. The second subsection of both the sales and use tax provisions include inurement language which is very similar to the language included since 1970 in the prior nonprofit hospital exemption. The only difference is the addition of the phrase at the end, "from the independent or nonessential operation of that portion of property." The reference to "any portion of the property" is intended to address the apportionment issue that is the stated purpose for amending the sales/use tax as part of the reform bills. The further impact of the inclusion of "independent or nonessential" as adjectives is unclear. The Department may argue that an MOB owned and operated by a hospital entity is "nonessential." However, this arguably contradicts the longstanding federal exemption position that an MOB can be substantially related to a hospital's exempt purpose.

As discussed above, prior to the 1999 Legislation, the Department had already adopted a radical inurement position which cited the language of the *Canterbury* decision as its basis (RAB 1999-2). However, it has ignored the statutory inurement language that existed for 29 years in the nonprofit hospital construction exemption. It appears reasonable to assume that the Department and taxpayers have, for these 29 years, understood that the inurement referred to in the statute is the same type of inurement that has been thoroughly defined for federal tax exemption purposes under Code Section 501(c)(3). There appears to be a relatively strong argument that the *Canterbury* decision alone does not alter the basic rules of statutory construction or the blatant equal protection problem inherent in the Department's attempt to radically change the way it applies an unchanged statutory provision. The 1999 amendments could have ended any controversy by clearly stating that use of an MOB by a private physician is inurement for purposes of the Michigan sales and use tax exemption. Instead, the language of the 1999 provisions merely restates the longstanding historic inurement language with some minor additions. An argument can certainly be made that the recent amendments provide no more basis than the *Canterbury* case for radically changing the definition of inurement, which remains undefined in the 1999 legislation.

Conclusion. On the pretense of making amendments giving the Department the authority to apportion all sales/use tax exemptions when property is used only partially on an exempt basis, radical substantive changes were made to the hospital construction exemption. The changes greatly restrict the exemption and produce strange results with no basis in tax or health care policy. The health care industry may pursue legislation and/or test-case litigation to correct and/or challenge this overbroad legislation. A test-case challenge may be particularly appropriate with respect to the Department's radical new inurement concept which is inconsistent with the new statutory language and legislative history.