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John D. Colombo
University of Illinois College of Law

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Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps

John D. Colombo*

I. INTRODUCTION

Illinois recently made the national press in the tax exemption world.¹ As a result of a recommendation from the Champaign County Board of Review (Board of Review)² in 2004, the Illinois Department of Revenue (Department of Revenue) revoked the property tax exemption for Provena Covenant Medical Center in Urbana, Illinois.³ In April 2005, the Board of Review made a similar recommendation for Carle Hospital in Urbana, which at the time of the writing of this Article was still pending before the Department of Revenue.⁴ In each case, the Board of Review found that the hospitals failed their charity-care obligations to the population by billing all patients, including the uninsured poor, for services and then pursuing aggressive debt collection techniques against them.⁵ In addition, the Board of Review complained that each hospital had entered into complex joint venture and contractual arrangements with for-profit doctor groups and other entities, violating the "exclusive use" requirement of Illinois law.⁶

The story about the tax exemption woes of these two hospitals has been the subject of two articles in the Wall Street Journal,⁷ two in USA

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¹ See infra notes 7-9 (listing the newspaper and magazine articles that have been written about the property tax exemption issues concerning Provena Covenant Medical Center and Carle Hospital).

² The Board of Review is a citizens' board that reviews local property tax issues including property tax exemptions.

³ CHAMPAIGN COUNTY BOARD OF REVIEW, NOTES ON EXEMPT APPLICATIONS 6–7 (2004), http://www.co.champaign.il.us/SOAOFF/PROVENA.pdf [hereinafter PROVENA FILING].

⁴ CHAMPAIGN COUNTY BOARD OF REVIEW, NOTES ON EXEMPT APPLICATIONS 8–9 (2005), http://www.co.champaign.il.us/BOR/CARLE2004.pdf [hereinafter CARLE FILING].

⁵ CARLE FILING, supra note 4, at 9–10; PROVENA FILING, supra note 3, at 5.

⁶ CARLE FILING, supra note 4, at 4–6; PROVENA FILING, supra note 3, at 2–4.

⁷ Lucette Lagnado, A Nonprofit Hospital Fights to Win Back Charitable Halo, WALL ST. J.
Today, and one in Modern Healthcare magazine. Stan Jenkins, the chairman of the Board of Review, was invited to Washington, D.C. to testify before the House Ways and Means Committee regarding the Board’s findings in the two cases. Unfortunately, the sound bites captured by the press failed to unravel the complex issues raised by the current tax exemption controversies. Accordingly, this Article attempts to do so. Part II reviews the federal rules for the exemption of hospitals and health care providers under Internal Revenue Code (I.R.C. or Code) § 501(c)(3). Parts III and IV then turn to an analysis of the recent Illinois cases dealing with the property tax exemption for health care providers, the open issues presented by those cases, and the open policy issues raised by those decisions. This Article suggests that the courts have failed to analyze serious health and tax policy issues surrounding the tax exemption for hospitals and offers parameters of debate or solutions to these policy questions.

II. TAX EXEMPTION BACKGROUND: FEDERAL INCOME TAXATION

Tax exemption is a complicated world because in most cases “exemption” involves at least three, sometimes four, separate taxes imposed by at least two separate taxing jurisdictions. At the federal level, hospitals usually try to qualify for federal income tax exemption under § 501(c)(3) of the I.R.C. as “charitable” organizations. But
hospitals must also contend with up to three separate state taxes. In Illinois, these taxes are the income tax, property tax, and sales tax. Because the federal and state governments are each sovereign entities in imposing their taxes, the exemption standards for these various taxes often differ. While state income tax exemptions typically track federal standards under § 501(c)(3), property and sales tax exemptions generally follow different rules.

Because the Illinois property tax exemption is at the heart of the recent Provena Covenant and Carle tax controversies, this Article focuses primarily on the recent interpretations of the Illinois property tax exemption with respect to hospitals. Nevertheless, some understanding of the federal income tax exemption standard is necessary to fully appreciate the unanswered policy questions presented by recent Illinois property tax exemption precedents.

Hospitals are not specifically enumerated as exempt entities anywhere in the I.R.C. Historically, however, nonprofit hospitals have been recognized as exempt as “charitable organizations” under § 501(c)(3). While there are a number of requirements for exempt status under this section, the most important issues with respect to hospitals have been showing (1) that the hospital pursues a charitable purpose; (2) an absence of “private inurement”; and (3) an absence of “private benefit.”

15. See infra Part III (discussing the Illinois property tax exemption).
16. In Illinois, for example, 35 ILL. COMP. STAT. 5/205 bases state income tax exemption on federal exempt status under § 501 of the I.R.C.
17. In Illinois, the standards for property tax exemption are set forth in 35 ILL. COMP. STAT. 200/15-65. Sales tax exemptions are outlined in 35 ILL. COMP. STAT. 120/1. Neither of these sections in any way cross-references federal law.
18. See infra Part III (discussing the Illinois property tax exemption).
19. Administrative rulings on tax exemption for hospitals date back at least to 1928. E.g., I.T. 2421, VII-28-3796 C.B. 150 (1928) (holding that the private hospital, the “M Company,” is not exempt from federal income taxation).
21. Id. § 1.501(c)(3)-1(c)(2).
22. Id. § 1.501(c)(3)-1(d)(1)(ii). In addition to these three requirements, federal law mandates certain “organizational” requirements for an exempt charity—requiring that the organizing documents of the charity contain special language to ensure that if the organization dissolves, its assets will go to another charity. Id. § 1.501(c)(3)-1(b)(1). Code § 501(c)(3) also limits political lobbying activity and prohibits political campaign activity. Court interpretations of charitable status under the Code also prohibit a charitable organization from engaging in illegal activity or activities contrary to established public policy, Bob Jones University v. United States, 461 U.S. 574 (1983) (finding a racially discriminatory school not exempt because racial discrimination violates fundamental public policy), and limit the amount of commercial activity an organization can pursue, see John D. Colombo, Commercial Activity and Charitable Tax Exemption, 44 WM.
A. Charitable Purpose: The Community Benefit Test

Prior to 1969, the official position of the Internal Revenue Service (IRS or Service) regarding the charitable purpose requirement as it applied to hospitals was set forth in Revenue Ruling 56-185. This ruling required a hospital seeking exemption under § 501(c)(3) to be "operated to the extent of its financial ability for those not able to pay for the services rendered." While the Service never took an official position regarding how much charity care was "enough," or even how to define charity care for these purposes, if a hospital lacked a substantial charity care program, auditing agents almost always recommended denial or revocation of exempt status. This charity care standard reflected the long-held stance of the IRS (and centuries of legal precedent in the charitable trust arena) that the "relief of the poor" constituted a charitable purpose.

& MARY L. REV. 487 (2002) (discussing commercial activity conducted by charities and its relation to tax exemptions). Thus, one might organize the legal tests for exemption as follows. In order to be exempt, an organization must first show that it is properly organized as a nonprofit and then must show that it pursues a recognized charitable purpose under Code § 501(c)(3), such as relief of the poor or educating the public. If the organization passes that hurdle, it must also show that it does not run afoul of several separate limitations on exemption, which are: (1) the "public policy/ illegality" doctrine; (2) private inurement/intermediate sanctions; (3) private benefit; (4) the "commerciality" limitation; (5) no "substantial" lobbying; and (6) no participation in a political campaign. For more general discussions of the requirements for exemption under Code § 501(c)(3) and these limitations, see FRANCES R. HILL & DOUGLAS M. MANCINO, TAXATION OF EXEMPT ORGANIZATIONS (2002); BRUCE R. HOPKINS, THE LAW OF TAX-EXEMPT ORGANIZATIONS (7th ed. 1998). With respect to tax exemption for hospitals in particular, see THOMAS K. HYATT & BRUCE R. HOPKINS, THE LAW OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS (2d ed. 2001); DOUGLAS M. MANCINO, TAXATION OF HOSPITALS AND HEALTH CARE ORGANIZATIONS (2001). As the text notes, most of the disputes regarding federal tax exemption for health care providers center on the definition of health care as a charitable purpose, the private inurement limitation, and the private benefit limitation.


24. While the ruling recognized that this test would be applied on all the facts and circumstances (and that a low charity care record would not necessarily bar exemption), IRS auditing agents often denied or revoked exempt status if a hospital's charity care was less than 5% of gross revenues. Hospital Charity Care and Tax Exempt Status: Restoring the Commitment and Fairness: Hearing Before the H. Select Comm. on Aging, 102d Cong. 58 (1990) (statement of James J. McGovern, IRS Assistant Chief Counsel); Robert S. Bromberg, Charity and Change: Current Problems of Tax Exempt Health and Welfare Organizations in Perspective, in TAX PROBLEMS OF NONPROFIT ORGANIZATIONS 249, 256 (1970).

25. E.g., Treas. Reg. § 1.501(c)(3)-1(d)(2) (listing "relief of the poor and distressed" as a charitable purpose). Historically, relief of the poor has been viewed as a charitable purpose at least since the Elizabethan Statute of Charitable Uses enacted by the English Parliament in 1601. The preamble to that statute, which is generally viewed as the "headwaters" of charitable trust law, listed "relief of aged, impotent and poor people" as an appropriate charitable purpose. See JOHN D. COLOMBO & MARK A. HALL, THE CHARITABLE TAX EXEMPTION 34 (1995) (discussing the impact of the Statute of Charitable Uses on charitable trust law). The official citation for the Elizabethan Statute of Charitable Uses is An Act to Redress the Mis-Employment of Lands, Goods
Concurrent with Congressional consideration of the Medicare and Medicaid legislation in the mid-1960s, however, exempt hospitals began pushing the IRS for reconsideration of exemption standards on the grounds that between private medical insurance and the "new" Medicare and Medicaid programs, there simply would not be enough of a demand for charity care to satisfy the IRS, and hence exemption standards should become more flexible in order to maintain exempt status for hospitals.26 A staff attorney with the IRS apparently took the complaints of the hospital industry seriously and began work on a new exemption standard.27

The new standard appeared in Revenue Ruling 69-545, which quickly became known as the "community benefit" standard.28 This ruling abandoned charity care as the touchstone of exemption at the federal level. Instead, citing the law of charitable trusts, the IRS held that the "promotion of health" for the general benefit of the community was itself a charitable purpose, even though some portion of the community, such as the uninsured, was excluded.29 Factors that indicated that a hospital met the community benefit test included a community board, an open medical staff, treatment of Medicare and Medicaid patients, and operation of an emergency room that provided emergency treatment to charity patients.30 Charity care other than emergency treatment, however, was not required; and in a 1983 ruling, the IRS held that hospitals without emergency facilities could qualify for exemption under the community benefit approach.31

Despite the 1969 and 1983 rulings, recent cases dealing with tax exemption for health maintenance organizations (HMOs) have made

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27. Fox & Schaffer, supra note 26, at 269–70.


30. Id. An "open medical staff" for these purposes refers to permitting all doctors with proper credentials to admit and treat patients at the hospital. HYATT & HOPKINS, supra note 22, at 171.

31. Rev. Rul. 83-157, 1983-2 C.B. 94. This ruling held that if emergency services were deemed unnecessary by state regulatory agencies or by the nature of the hospital’s services (e.g., cancer treatment hospitals), a hospital still could qualify for exemption under the community benefit approach, even though it did not operate emergency facilities.
clear that the federal test for exemption requires more than simply treating all patients who can pay for their care either directly or via private or government insurance.\textsuperscript{32} In the most recent of these cases, dealing with subsidiary corporations of the Intermountain Health Care group, the United States Court of Appeals for the Tenth Circuit stated plainly that “an organization cannot satisfy the community-benefit requirement based solely on the fact that it offers health-care services to all in the community in exchange for a fee. . . . Rather, the organization must provide some additional ‘plus.’”\textsuperscript{33} First on the list of these “pluses” was “free or below-cost services,” though the court acknowledged that “devoting surpluses to research, education and medical training” might also suffice, and that treatment of Medicare and Medicaid patients was a virtual requirement.\textsuperscript{34}

Thus, the federal test for exempting health care providers requires an exempt provider to have a community board, treat Medicare and Medicaid patients along with all privately insured patients (an “open door” policy), and engage in some other significant community “plus” such as community outreach programs, health education, health research, and/or charity care (of which free emergency room care may be a part). Moreover, despite recent emphasis in the case law on charity care as the biggest “plus” factor in the “health care plus” formulation of the community benefit test, there is still no absolute requirement in federal law that a hospital engage in free care for the poor (beyond providing free care in the emergency room, if the entity in question provides emergency services) in order to be exempt under federal law.

\textbf{B. Private Inurement}

Pursuing a charitable purpose is not sufficient to insure exempt status under federal law. Rather, an organization seeking exemption must comply with various limitations on the conduct of tax-exempt entities. The two requirements most often at issue with respect to hospitals and other health care providers are the “private inurement” limitation contained in the statutory language in § 501(c)(3) and the “private benefit” limitation that has arisen from various cases and IRS interpretations.

The private inurement prohibition is the federal statutory method of

\textsuperscript{32} For a complete discussion of the cases and rulings relating to federal income tax exemption for health care providers after Rev. Rul. 69-545, see John D. Colombo, The Failure of Community Benefit, 15 HEALTH MATRIX 29, 32-37 (2005).

\textsuperscript{33} IHC Health Plans, Inc. v. Comm’r, 325 F.3d 1188, 1197 (10th Cir. 2003).

\textsuperscript{34} Id. at 1197-98 (“[T]he primary way in which health-care providers advance government-funded endeavors is the servicing of the Medicaid and Medicare populations.”).
requiring that an exempt organization be "nonprofit" in the sense of not distributing earnings to private individuals.\textsuperscript{35} IRS rulings and cases agree that the substance of this limitation is that the economic benefits of exemption cannot be "siphoned off" to managers, board members, or other "insiders."\textsuperscript{36} Or, put another way, private inurement occurs when an exempt organization fails to get fair value in return for an economic transfer to a private individual who is an "insider."\textsuperscript{37} Until the enactment of § 4958 in 1996, the IRS's enforcement tools for violations of the private inurement limitation were limited to revocation of exempt status and/or closing agreements with an exempt entity.\textsuperscript{38}

Most cases of private inurement are not subtle. They involve situations in which insiders are provided with property or services at below-market rates (e.g., a below-market loan, use of property at below-market rent, a sale of property by the exempt entity to the insider at less than full fair-market-value) or where an insider overcharges the entity for services or property provided to the entity (e.g., unreasonable compensation, a sale of property by the insider to the entity at greater than fair-market-value, use of property provided by the insider at greater than market rental rates). Thus, in \textit{Lorain Avenue Clinic v. Commissioner}, the Tax Court found prohibited private inurement in a compensation arrangement that divided profits from the operation of a medical clinic among the controlling doctors.\textsuperscript{39} Similarly, in \textit{Sonora Community Hospital v. Commissioner}, the Tax Court prohibited a private inurement arrangement that permitted the founding and

\textsuperscript{35} As Henry Hansmann noted many years ago, the essence of nonprofit status is the "nondistribution constraint." That is, a nonprofit organization can indeed make a profit in the sense of having net earnings for the year. What it cannot do is distribute that profit to equity owners or other private individuals. Henry Hansmann, \textit{The Role of Nonprofit Enterprise}, 89 \textit{Yale L.J.} 835, 840 (1980). State nonprofit organization law usually incorporates the nondistribution constraint as a result of nonprofit corporation statutes or the common law of charitable trusts; the private inurement prohibition is the Code's method of expressing this same concept in § 501(c)(3).

\textsuperscript{36} For a list of common inurement transactions and the IRS rulings and cases on these transactions, see \textit{Hill & Mancino}, supra note 22, at 4.03[7] and John D. Colombo, \textit{Private Benefit, Joint Ventures, and the Death of Healthcare as an Exempt Purpose}, 34 \textit{J. Health L.} 505, 507 (2001).

\textsuperscript{37} See \textit{United Cancer Council v. Comm'r}, 165 F.3d 1173, 1176 (7th Cir. 1999) (holding that a charity may not siphon its earnings to anyone described as an insider, including its founder and members of its board).

\textsuperscript{38} Today, the intermediate sanctions statute has all but displaced private inurement as a limitation on exempt status. While the IRS still can revoke exempt status for inurement transactions, I.R.C. § 4958 has displaced revoking exemption in all but the most egregious cases. See \textit{infra} note 43 and accompanying text (explaining the replacement of the private inurement doctrine by the intermediate sanctions regime).

controlling doctors to receive one-third of the gross receipts from privately-operated x-ray and laboratory departments for which the doctors performed no services. 40 A more recent example is the 1994 revocation of exemption for LAC Facilities, Inc. (LACF), a health care provider in Florida. There, the IRS cited payment of excessive compensation to LACF’s executives by an insurance company affiliated with LACF, payment of lump sum retirement benefits to LACF executives during a time when they were ineligible for such benefits, payment of personal food and liquor expenses of LACF executives, and other excessive payments. 41 On the other hand, where an economic arrangement between an exempt entity and unrelated parties is negotiated at arm’s length, private inurement will not exist even if the arrangement might be considered a “bad deal” for the exempt charity. 42 Today, the private inurement doctrine largely has been displaced by the intermediate sanctions regime enacted as § 4958 of the I.R.C. 43 Nevertheless, as noted below in Part III, state property tax exemption standards set forth by Illinois courts include a concept very similar to the federal private inurement doctrine, and thus the doctrine remains relevant today.

C. Private Benefit

By far, the more important of the two conduct limitations is the private benefit doctrine. This is unfortunate because “private benefit” is a much harder doctrine to define precisely. Unlike private inurement, which is part of the statutory language in § 501(c)(3), the phrase “private benefit” does not appear anywhere in the statute. The regulations, moreover, contain only a vague reference to the doctrine.

42. United Cancer Council, 165 F.3d at 1174–75 (stating that an arrangement between a charity and private fundraiser giving fundraiser 90% of gross proceeds did not constitute private inurement because contract was negotiated at arm’s length and the fundraiser was not an insider of the exempt charity).
43. Section 4958 provides for excise taxes on an “excess benefits transaction,” defined as a transaction in which “the value of the economic benefit provided exceeds the value of the consideration (including the performance of services) received.” 26 U.S.C § 4958 (2000). This is the § 4958 analog to the “siphoning off” concept in private inurement. Excess benefit transactions can occur only between an exempt organization and a “disqualified person,” defined as a person who, during the preceding five years, was “in a position to exercise substantial influence over the affairs of the organization.” This is the § 4958 analog to the “insider” concept. While the IRS retains authority to revoke exempt status for inurement transactions, most observers agree that revocation will be a “last resort” sanction for inurement-type transactions.
Treasury Regulations § 1.501(c)(3)-1(d)(1)(ii) state that an organization will not meet exemption requirements "unless it serves a public rather than a private interest," and that the organization seeking exemption 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."44

The concept of private benefit appears to have originated in the common law of charitable trusts, which required a charitable trust to serve a broad charitable class rather than specific individuals.45 In the early 1980s, however, the IRS began to use the private benefit concept in a far more expansive way, asserting that it was an independent limitation on exemption.46 Under this broader interpretation, private benefit prohibits exempt organizations from engaging in certain economic transactions with individuals outside the charitable class when such individuals receive economic benefits that are more than incidentally necessary to the performance of the exempt organization's charitable mission. For example, in General Counsel's Memorandum 39,598, the IRS found that a proposed rental of office building space by a subsidiary of an exempt hospital to a group of doctors was inconsistent with exempt status. Basing its decision explicitly on the private benefit doctrine, the IRS stated,

An organization is not described in section 501(c)(3) if it serves a private interest more than incidentally. . . . If, however, the private benefit is only incidental to the exempt purposes served, and not substantial, it will not result in a loss of exempt status . . . . A private benefit is considered incidental only if it is incidental in both a qualitative and a quantitative sense. In order to be incidental in a qualitative sense, the benefit must be a necessary concomitant of the activity that benefits the public at large, i.e., the activity can be accomplished only by benefiting certain private individuals. . . . To be

44. Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (as amended in 1990). One could make a fairly strong textual argument that this language in the regulations is intended to do nothing more than explain the "private inurement" prohibition contained in the statute. As the text notes, however, the Service has viewed "private benefit" as a separate limitation on exempt status since at least the 1970s, and the Tax Court officially accepted this concept in the American Campaign Academy case decided in 1989. See infra notes 48–52 and accompanying text for a discussion of the American Campaign Academy case.


46. See infra text at notes 48–52 (discussing a case wherein such an independent limitation on exemption was asserted).
incidental in a quantitative sense, the private benefit must not be substantial after considering the overall public benefit conferred by the activity.\textsuperscript{47}

In \textit{American Campaign Academy v. Commissioner},\textsuperscript{48} decided in 1989, the Tax Court accepted the view that private benefit was an independent limitation on economic benefits that could flow to individuals outside the charitable class. In that case, the court analyzed whether a school that trained individuals to be political campaign professionals qualified as a tax-exempt educational institution. Although the school clearly served a large charitable class (e.g., it did not limit admissions to particular individuals)\textsuperscript{49} and also clearly met the tests for an educational organization under § 501(c)(3),\textsuperscript{50} the Tax Court used the private benefit doctrine to hold that the organization was not exempt. Noting that most of the school’s graduates worked for the Republican Party or its related entities, the court found that the school benefited the private interests of the Republican Party to an impermissible degree and hence was not exempt, even though no evidence of traditional private inurement existed.\textsuperscript{51} In the course of the opinion, the Tax Court accepted the IRS argument that the “secondary” benefits flowing to the Republican Party as a result of the school’s operation were not incidental to the primary educational benefits flowing to students.\textsuperscript{52}

\textit{American Campaign Academy} firmly established private benefit as a key limitation on exempt status under federal law, and the IRS took full advantage. In 1990, the Service used the private benefit analysis to reject revenue stream joint venture arrangements between hospitals and doctors.\textsuperscript{53} These arrangements, in which hospitals would “spin off” certain outpatient services to a joint venture between the hospital and doctors, were used by hospitals as a means of increasing utilization of hospital facilities by giving doctors a direct economic stake in the “spun off” facility.\textsuperscript{54} The hope was that the participating doctors would refer

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\bibitem{48} 92 T.C. 1053, 1069 (1989).
\bibitem{49} \textit{Id.} at 1058. The court’s opinion indicated some skepticism regarding whether the school took students who did not have Republican Party affiliations, but the record did not indicate such a limitation, and the IRS conceded that the Academy did not discriminate on the basis of race, ethnicity, or national origin. \textit{Id.}
\bibitem{50} The IRS conceded this point. \textit{Id.} at 1063.
\bibitem{51} \textit{Id.} at 1074–79.
\bibitem{52} \textit{Id.}
\bibitem{53} \textit{See infra} text at notes 54–58 (discussing I.R.S. General Counsel Memorandum 39,862).
\bibitem{54} I.R.S. Gen. Couns. Mem. 39,862 (Nov. 22, 1991); \textit{see} MANCINO, supra note 22, § 19.04 (noting that net revenue stream joint ventures were used by hospitals as a means of “solidifying a
more patients to the facility, thus increasing revenues to the hospital.\textsuperscript{55} In General Counsel's Memorandum 39,862 (GCM 39,862) the IRS ruled that these arrangements violated the private benefit doctrine because the direct and substantial financial benefit to the participating doctors could not be justified as "incidental" to the hospital's mission of providing health services to the community.\textsuperscript{56} According to the Service, "[o]btaining referrals or avoiding new competition may improve the competitive position of an individual hospital, but that is not necessarily the same as benefiting its community."\textsuperscript{57} The Service, however, indicated in an earlier part of the GCM 39,862 that if a joint venture was needed to expand health care resources in the area, create a new provider, reduce treatment costs, or provide new treatment modalities, then the arrangement might pass muster.\textsuperscript{58}

The private benefit analysis also played a key role in two major healthcare exemption rulings released by the IRS in the late 1990's. Revenue Ruling 97-21, dealing with physician recruitment, involved two separate situations.\textsuperscript{59} The first concerned financial incentives to recruit a physician to be an employee of a hospital or other provider, and the second related to financial incentives to recruit doctors to the community to be on staff but not as employees of the hospital.\textsuperscript{60} While private inurement analysis controlled the first situation, the IRS relied on private benefit analysis in the second, holding that reasonable incentives would be permitted when the recruitment was justified by community need, expanding services provided by the hospital, or providing new services to the community.\textsuperscript{61}

In the second major ruling, Revenue Ruling 98-15, the IRS examined the "whole hospital joint venture" transaction in which an existing exempt hospital corporation would contribute all its assets (the hospital building, equipment, contracts with staff and providers, etc.) to a joint

\textsuperscript{57} Id.
\textsuperscript{58} Id. The IRS stated:
We recognize that there may well be legitimate purposes for joint ventures, whether analyzed under the anti-kickback statute or the tax Code. These may include raising needed capital; bringing new services or a new provider to a hospital's community; sharing the risk inherent in a new activity, or pooling diverse areas of expertise.
\textsuperscript{59} Rev. Rul. 97-21, 1997-1 C.B. 121.
\textsuperscript{60} Id.
\textsuperscript{61} Id.; see MANCINO, supra note 22, § 20.02[4][f] (discussing Revenue Ruling 97-12).
venture with a for-profit hospital chain. Typically, these transactions were structured as fifty-fifty partnerships, with the for-profit provider contributing cash to the deal equal to the value of the assets contributed by the exempt partner, and a for-profit management company (usually affiliated in some way with the for-profit partner) would manage the business via a contract with the partnership. Using private benefit analysis as its main analytical tool, the IRS concluded that these whole-hospital joint venture arrangements were consistent with exempt status only if the exempt partner retained control over the management of the joint venture, a position later upheld by the courts.

The Service noted that in cases where the exempt organization did not retain management control, it could not initiate programs to meet the health needs of its community, and other community-benefit programs such as free care for the poor could be terminated. As in GCM 39,862, the IRS refused to view the economic advantages of the joint venture arrangement as a sufficient counterbalance to the private benefits flowing to the for-profit partner and the for-profit management company.

At present, therefore, the private benefit analysis seems to boil down to the following: when an exempt organization enters into a transaction that results in a substantial economic benefit flowing to a private individual or entity not a part of the charitable class, the exempt organization must justify why that transaction is needed to perform the exempt organization's charitable function. In the health care world, where this doctrine has been used the most, the appropriate justifications will involve enhancing health services to the community—providing new services, new treatment modalities, and enhanced access to previously-restricted services. The economic convenience of the exempt entity will not be a sufficient justification; and therefore, enhancing profitability alone will not satisfy this test.

63. For extended discussions of this ruling, see MANCINO, supra note 22, § 19.04[5][a] and HYATT & HOPKINS, supra note 22, at 373–78.
64. E.g., St. David's Health Care Sys., Inc. v. United States, 349 F.3d 232, 237 (5th Cir. 2003) (stating that the court presumes that an organization furthers the private individuals' for-profit motivation when a nonprofit organization forms a partnership with a for-profit entity); Redlands Surgical Servs., Inc. v. Comm'r, 113 T.C. 47 (1999), aff'd 242 F.3d 904 (9th Cir. 2001) (applying a three prong test: (1) whether the organization organized and operated exclusively for a charitable purpose; (2) whether promotion of health for the benefit of the community is a charitable purpose; and (3) whether the organization operates exclusively for exempt purposes or if it operates for the benefit of private interests).
66. Id.
67. On the other hand, there is some suggestion, by inference, in GCM 39,862 that if the exempt organization could make a credible case that medical services would be irreparably
D. Summary

To summarize, for a hospital to maintain exempt status under federal law, it must meet the community benefit test of charitable purpose, which in its current incarnation appears to be a “health care plus” standard.68 This means that the hospital must have a community board and treat all patients able to pay, including Medicare and Medicaid patients, and then provide some significant community plus, such as charity care for the poor, an open emergency room, medical research, education programs, or medical outreach programs. Charity care, however, is not an absolute requirement for exemption under federal law; it is simply one of several items that can constitute the appropriate “plus” factor. In addition, an exempt entity must avoid transactions that involve private inurement or private benefit.69

III. ILLINOIS PROPERTY TAX EXEMPTION

As the discussion below will illustrate, Illinois property tax exemption law has some requirements that are similar to federal exemption provisions, but also some that are different. In certain situations, though, Illinois law might do well to adopt aspects of federal exemption rules.

A. Illinois Constitutional and Statutory Law

As in many states, Illinois property tax exemption law begins with the Illinois Constitution. Article IX, Section 6 of the 1970 Constitution states “[t]he General Assembly by law may exempt from taxation only the property of the State, units of local government and school districts and property used exclusively for agricultural and horticultural societies, and for school, religious, cemetery and charitable purposes.”70 The statutory execution of this grant provides a property tax exemption for property “actually and exclusively used for charitable or beneficent purposes” by institutions of public charity.71

68. See supra Part II.A (discussing the charitable purpose that requires an organization to provide healthcare services to all in the community as well as some additional plus factors to qualify for exempt status).

69. See supra Part II.B–C (discussing the private inurement and private benefits doctrines).

70. ILL. CONST. art. IX, § 6.

B. Hospital Exemption Case Law

As with federal income tax exemption, hospitals are not specifically listed as exempt organizations, but Illinois courts have recognized the exempt status of nonprofit hospitals as "charities" since the early 1900s. In these early cases, the Department of Revenue contended that a hospital that charged for its services was not an "institution of public charity." The Illinois Supreme Court, however, concluded that hospitals would be exempt even if they charged those patients who were able to pay, so long as the hospital provided charity care to all patients who needed it and treated all patients on a nondiscriminatory basis.

After these cases, property tax exemption for hospitals went virtually unquestioned under Illinois law for almost eighty years. Then a funny thing happened on the way to the operating room. In 1987, the Second District Court of Appeals considered a case in which Highland Park Hospital sought exemption for certain portions of a building it owned in Long Grove, Illinois. Part of the building was used as an "Immediate Care Center," a walk-in clinic operated by the hospital and its staff doctors to treat minor emergencies and illnesses, which the hospital argued was exempt. In analyzing the Immediate Care Center's eligibility for exemption, the court turned to criteria to identify "charitable organizations" laid out by the Illinois Supreme Court in the 1968 case Methodist Old Peoples Home v. Korzen. In that case, the

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72. *E.g.*, Bd. of Review v. Provident Hosp. & Training Sch. Ass'n, 84 N.E. 216 (Ill. 1908) (holding that Provident Hospital was tax exempt); German Hosp. v. Bd. of Review, 84 N.E. 215 (Ill. 1908) (holding that the German Hospital was tax exempt); Sisters of the Third Order v. Bd. of Review, 83 N.E. 272 (Ill. 1907) (holding that St. Francis hospital was tax exempt). Certain health maintenance organizations are specifically listed as exempt in 35 ILL. COMP. STAT. 200/15-65(d) (2004).

73. *E.g.*, Sisters of the Third Order, 83 N.E. at 273-74 ("It is then argued that this hospital should not be held to be an institution of public charity by reason of the great disparity between the number of charity patients and those who pay for the care and attention they receive at this institution.").

74. "Those who are without money or property are cared for without charge. . . . In this hospital, charity is extended to all the members of the community and is not confined to any particular class of individuals." *Id.* at 273. "[T]he hospital makes the usual and reasonable charge for its accommodations to patients coming to it who are financially able to pay, but . . . it receives all patients who apply, without reference to their financial circumstances or ability to pay its charges, and without distinction as to race, color or religion, or any other distinction[.]" German Hosp., 84 N.E. at 216. "[A]ll persons . . . who are in need of medical or surgical attention, who apply, are received into the hospital and treated and cared for without regard to whether they have means to pay for such care and treatment or not[.]" Provident Hosp. & Training Sch. Ass'n, 84 N.E. at 216. In each of these cases, moreover, the record showed that the hospital in question treated a significant number of charity patients.


76. *Id.* at 1333.

77. 233 N.E.2d 537 (Ill. 1968).
court identified six factors relevant to charitable status:

The property in question must be used "for the benefit of an indefinite number of persons... for their general welfare—or in some way reducing the burdens of government";

the charitable institution must have no capital, capital stock or shareholders, and earns no profits or dividends;

it "derives its funds mainly from public and private charity";

the institution "dispenses charity to all who need and apply for it, does not provide gain or profit in a private sense to any person connected with it, and does not appear to place obstacles of any character in the way of those who need [charitable services]";

the institution has the burden of proving that its property actually and factually is so used; and

the term "exclusively used" means the primary purpose for which property is used and not any secondary or incidental purpose. 78

The Second District found fault with Highland Park Hospital's exemption request under the fourth factor. Noting that "[a]ll patients who utilize the Immediate Care Center are billed" and that "[f]ree or charitable care is not mentioned," the court held that the Immediate Care Center did not "dispense charity to all those who need or apply for it." 79 The court also rejected Highland Park Hospital's claim that its uncollectible bad debts constituted charity care: "On these facts, we conclude that the small amount of uncollectible bills... which are only classified as free care when ultimately determined to be uncollectible, does not entitle plaintiffs to a charitable exemption...." 80

The Second District's analysis went relatively unnoticed until 1993, when the Department of Revenue denied a property tax exemption to Alivio Medical Center (Alivio), which operated an ambulatory medical center in Cook County. 81 Although targeted specifically at the Hispanic community, Alivio's services were available on a nondiscriminatory basis to anyone. 82 Its billing practices, however, were the source of the exemption dispute. Alivio never waived fees up-front and did not

78. Id. at 541-42. In Highland Park, the Second District characterized the Methodist Old Peoples Home test as having five factors, combining factors (2) and (3) into one. Highland Park Hosp., 507 N.E.2d at 1336. More recent cases, however, have separated these factors. See Eden Ret. Ctr. v. Dep't of Revenue, 821 N.E.2d 240, 248 (Ill. 2004) (citing Methodist Old Peoples Home and using all six factors); Riverside Med. Ctr. v. Dep't of Revenue, 795 N.E.2d 361, 365-67 (Ill. App. Ct. 3d Dist. 2003) (listing all six factors).


80. Id. at 1336.


82. Id.
advertise or inform patients that it had any charity care program. Instead, it billed all patients for services rendered and expected payment on the day of the patient's visit. Those patients who could not pay immediately were billed on thirty-day cycles. If the bill was not collected after 180 days (six billing notices), the unpaid portion of the account could be written off as a bad debt by approval of Alivio's Director of Finance and Executive Director. The Department of Revenue concluded that Alivio was not a charity because of these billing practices and the fact that Alivio had a net profit of $138,256 for the year in question. After a failed administrative appeal, the case went to the Illinois Appellate Court.

The First District agreed with the Department of Revenue that the profit reported by Alivio was inconsistent with the second item in the Methodist Old Peoples Home test, and that Alivio's billing practices were inconsistent with the requirement of dispensing charity to all who need it. Echoing the Second District's opinion in Highland Park, the court stated that "writing off a bad debt is not tantamount to providing charity. These were amounts which Alivio was unable to collect, not charity." As a result, the court upheld the denial of an exemption to Alivio.

Five years later, the Illinois Appellate Court for the Third District faced a similar case. Riverside Medical Center (Riverside) owned a hospital and eight medical clinics in and around Kankakee. After the Illinois Department of Revenue approved property tax exemptions for all but certain property rented to private physicians, the Kankakee County Board of Review requested an administrative review of the exemptions. The administrative law judge (ALJ) recommended that the exemptions for Riverside be denied, and after a lower court upheld the exemptions for Riverside, the Board of Review appealed.

Like the First and Second Districts, the Third District applied the six-

83. Id. at 192–93.
84. Id. at 191.
85. Id.
86. Id.
87. Id. at 191–92.
88. Id. at 191.
89. Id. at 192.
90. Id. at 193.
92. Id. at 363.
93. Id.
94. Id. at 364.
factor test from *Methodist Old Peoples Home* to Riverside. Once again, the issue of charity care and billing practices proved to be the taxpayer's undoing. In a more detailed analysis than the First District's in *Alivio*, the Third District found that Riverside did not discriminate in its services and was properly formed as a nonprofit organization, meeting parts one and two of the *Methodist Old Peoples Home* test. Its billing practices, however, were inconsistent with the "dispense charity" criterion. The court noted that, like *Alivio*, Riverside billed all its patients for services, did not advertise a charity care program, and did not provide any pre-care screening program to determine whether a patient should be a charity patient. Citing *Alivio* and *Highland Park Hospital*, the court determined that writing off bad debts is not the same thing as providing charity care and that Riverside thus failed to meet this criterion. The court also noted that another factor in *Methodist Old Peoples Home* was whether the organization in question "derived its funds from public or private charity." Finding that only .05% of Riverside's income came from donations, the court ruled that Riverside failed on this point as well.

Finally, the court appeared to agree with the ALJ's finding that Riverside's reservation of 3% of its annual budget for charity was too small an amount in comparison to paid revenues. The court characterized this as a "small percentage" and rejected Riverside's argument that the discounted rates it gave to Medicare and Medicaid patients should be considered part of its overall charity program.

The large insurers have negotiated preferential rates with Riverside, but there is no indication that Riverside agreed to the arrangement in pursuit of its charitable mission. It may be that Riverside agreed to the rate discounts as a way of attracting a reliable stream of business from patients insured by the large insurers.

Accordingly, the court held against Riverside.

95. *Id.* at 365.
96. *Id.*
97. *Id.*
98. *Id.* at 365–66.
99. *Id.* at 366.
100. *Id.* at 365.
101. *Id.*
102. *Id.* at 367.
103. *Id.* at 366–67.
104. *Id.* at 367.
IV. ANALYSIS: EXPLORING THE POLICY GAPS

Two parts of the Methodist Old Peoples Home test are uncontroversial. The first factor simply restates a form of the "community benefit" approach used in federal exemption law, requiring providers to have an "open door" policy in treating all patients able to pay for services. Similarly, the second and part of the fourth factors mirror the federal exemption requirements by prohibiting "private inurement" through distributions of profit to private individuals and requiring that exempt organizations adopt the nonprofit ownership form.

Beyond these issues, however, the courts' analyses in Highland Park, Alivio, and Riverside raise some very troubling public policy issues that the judges deciding these cases did not appear to think through thoroughly. Below, this Article examines several of these areas, offering suggestions for possible policy solutions or the parameters for future policy debate.

A. "Dispensing Charity": The Charity Care Element

As noted above, recent Illinois cases make clear that under the "dispensing charity" element of the Methodist Old Peoples Home test, some substantial charity care program is a necessary part of the exemption analysis for hospitals. The cases also make clear that bad debt write-offs will not qualify as charity care for this purpose. This court-crafted definition of the charity care requirement is what underlies the Champaign County Board of Review's primary complaints against Provena Covenant and Carle; in both cases, the Board of Review found that the hospitals were providing too little "real" charity care and were inappropriately counting bad-debt write-offs and contractual discounts in their charity care reporting. But a host of issues remain unresolved, and even the positions that are clear raise some difficult policy questions.

105. See supra Part II.A (describing the community benefit standard established by the IRS and its application to nonprofit hospitals).
106. See supra Part II.B (defining private inurement prohibition as a ban on distributing earnings to private individuals).
107. See supra Part III.B (describing Illinois cases that establish the requirement that nonprofit hospitals dispense charity).
108. See supra Part III.B (noting that Illinois courts do not count bad debt write-offs to be consistent with dispensing charity).
109. CARLE FILING, supra note 4, at 8–9; PROVENA FILING, supra note 3, at 6–7. See Jenkins Statement, supra note 10 (describing the actions taken against Provena Covenant Medical Center and Carle Hospital).
The unresolved issues center around two broad categories: (1) how to measure charity care, and (2) how much of it is enough to justify exemption. Neither of these issues is analyzed by the court decisions. Because of the importance of these outstanding issues, this Article considers them next.

1. Measuring Charity Care

The issue regarding how to measure charity care is an old one. Academics writing in the late 1980s and early 1990s identified the measurement problems: the dollar amount of charity care can be measured by either the hospital's costs of care or its charges.\(^\text{110}\) If costs are used, they can either be average costs (including overhead) or marginal costs.\(^\text{111}\)

The methodology used for measuring charity care makes a huge difference in the dollar amounts. Measuring charity care by charges results in a higher dollar figure than measuring by costs, and measuring by average costs results in a higher dollar figure than measuring by marginal costs.

Although the American Institute of Certified Public Accountants' (AICPA) standards for charity care reporting use charges as the measure of charity care,\(^\text{112}\) as a matter of theory, using charges to measure charity care is patently ridiculous. In this regard, hospitals operate akin to hotels, which have a "rack rate" for their rooms. Like the rack rate on hotel rooms, virtually no one actually pays the hospital's "rack rate" for services; instead, hospitals negotiate discounted reimbursement rates with insurance companies, or such rates are set by the government as part of the Medicare and Medicaid program.\(^\text{113}\) Using charges as the measure of charity care, therefore, would simply let hospitals inflate

\(^{110}\) See, e.g., COLOMBO & HALL, supra note 25, at 55–56 (concluding that total average costs present a fair measurement); Gary Claxton et al., Public Policy Issues in Nonprofit Conversions: An Overview, HEALTH AFFAIRS, Mar.–Apr. 1997, at 9, 16 (noting that charity care is "more accurately measured on a cost than a charge basis"); David A. Hyman, The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals, 16 AM. J.L. & MED. 327, 359 & n. 214 (1990) (describing the difficulty in measuring the provision of charity care).

\(^{111}\) COLOMBO & HALL, supra note 25, at 55–56; Hyman, supra note 110, at 361. Marginal cost refers to the excess cost of producing an additional unit. If, for example, producing ten units of a product costs $10, but producing eleven units costs $10.50, the marginal cost of the eleventh unit is $0.50. The average cost of all eleven units is $10.50 divided by 11, or about $0.95.

\(^{112}\) AICPA, HEALTH CARE ORGANIZATIONS—AICPA AUDIT AND ACCOUNTING GUIDE ¶10.21 (2003).

their charity care "numbers" by setting higher prices for services that they know will never be collected, or if collected at all, are charged only to uninsured patients.\textsuperscript{114} In fact, the Illinois court in River\-side seemed to recognize this point by holding that a negotiated discount off the "rack rate" between a hospital and an insurer or the government should not count toward charity care.\textsuperscript{115} On the other hand, unreimbursed costs (for example, Medicaid reimbursements that fail to fully cover average costs) probably should count as charity care because this represents a net cash outflow, although some academics disagree even on this.\textsuperscript{116}

As between average and marginal cost measures, a good case can be made for either. The argument for marginal costs is that in the short run, filling empty beds with charity patients or taking a few extra x-rays with a machine already paid for costs very little, and hospitals should not be "credited" in the charity care ledger with part of their overhead and capital investment in providing these services, since those investments would have to be made anyway for paying patients. Over time, however, nonpaying patients represent a more or less permanent burden on a hospital and will eventually require replacement of assets sooner than would have been the case if the charity patients had not been served. Thus, average costs (e.g., including overhead and depreciation in the cost number) represent a better "true" measure of charity care in the long run. Average costs, in fact, are the measure that most academics use in measuring the value of charity care.\textsuperscript{117} Also, average costs are the measure used by a number of states in legislation relating to charity care reporting,\textsuperscript{118} including the recently enacted Community Benefits Act in Illinois\textsuperscript{119} (although states have also used

\begin{footnotesize}
\begin{enumerate}
\item This problem of having a "rack rate" charge applicable only to uninsured patients has itself created serious controversy and is one of the practices underlying the suits brought by Richard Scruggs against exempt hospitals. See, e.g., Paul Barr, Changing Venues, MODERN HEALTHCARE, Feb. 14, 2005, at 14 (alleging that hospitals are "essentially hiding [their] charity care from patients").
\item See supra text accompanying note 104 (noting that Riverside may have agreed to the discounts in order to attract business).
\item Compare Claxton, supra note 110, at 16 (arguing that such amounts should be included), with Hyman, supra note 110, at 360 n.219 (arguing that such amounts should not be included).
\item See Nancy M. Kane & William H. Wubbenhorst, Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption, 78 MILBANK Q. 185, 190 (2000) (stating that the majority of the literature on this topic uses average cost).
\item Id. (noting that Texas, New Hampshire, and Massachusetts use average cost measures in their legislation).
\item 210 ILL. COMP. STAT. 76/1-76/99 (2004). The Act states that hospitals must report charity care on the "actual cost of services provided based on the total cost to charge ratio derived from the hospital's Medicare cost report[.]") 210 ILL. COMP. STAT. 76/20.
\end{enumerate}
\end{footnotesize}
the marginal cost measure in some circumstances).120

The position of the courts in *Highland Park, Alivio* and *Riverside* that bad debt should not count as charity care for purposes of justifying exemption under the *Methodist Old Peoples Home* test, presents a different kind of problem. One can certainly sympathize with the view that from the standpoint of the patient, being accepted for treatment with an up-front guarantee that the hospital will not seek payment is better than being billed for treatment and hounded by collection efforts, even if the ultimate result (no payment) is the same. But from the standpoint of the hospital, both scenarios result in a lack of payment that the hospital must make up for elsewhere to stay financially viable, and there is little doubt that a significant portion of bad debt is in fact related to the patient’s financial inability to pay (and not to hospital inefficiency or poor management of accounts receivable).121 At the end of the day, even a nonprofit organization has to make enough money to cover its costs and set aside reserves for asset replacement and other capital projects. If it cannot do so, it is not a financially viable enterprise and it will go out of business.122 There is no magic money tree that nonprofit hospital managers can go to and pick off $100 bills to pay their costs. At some point, if government keeps piling on uncompensated care obligations without some kind of offsetting revenue enhancement, the hospital will simply no longer be able to operate. Thus, an absolute rule that bad debts do not “count” as part of the justification for exemption also seems wrong despite the courts’ conclusions.

One possible compromise on this front would be to require hospitals to have procedures in place to identify charity patients up-front, and then to permit hospitals that in fact follow these procedures to include a portion of bad debt in their charity care totals. Some academic studies have shown that roughly 50% of hospital bad debt is likely due to inability to pay, rather than simply debt avoidance or poor management.123 As a result, this system would allow that 50% amount to count toward charity care obligations in the same manner as any other free care (that is, the cost of such care, whether measured on

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120. Kane & Wubbenhorst, supra note 117, at 190 (noting that in the 1980s, New York, Massachusetts and Maryland used marginal cost measures to reimburse hospitals for charity care increases beyond a base year).
121. Claxton, supra note 110, at 16 & n.23.
122. Residents of Champaign-Urbana, for example, might recall that Burnham City Hospital did just that—it went out of business because it could not generate revenues sufficient to cover its costs.
123. See Kane & Wubbenhorst, supra note 117, at 191 (citing academic studies that suggest that approximately 50% of bad debt reported by nonprofit hospitals is due to inability to pay, rather than simply avoidance of payment).
average or marginal basis, not the actual charge).

2. Justifying the Exemption

The second issue related to charity care is that Illinois law does not provide any standard establishing how much charity care, however measured, will be enough to justify exemption. The ALJ in Riverside found that 3% of gross revenues dedicated to charity care was insufficient to justify exemption, characterizing this amount as "de minimis," even though national studies have shown that uncompensated care rates across nonprofit institutions are not that much higher, at roughly 4.5% of revenues, and at least one state law uses 4% of revenues as a target number for exemption. The Third District appeared to sympathize with the ALJ's de minimis view, but did not opine on what percentage it thought would be significant. So how much is enough? Once again, there are several possible approaches that raise different policy concerns.

First, I have argued, as have others, that as a minimum, we should expect an exempt hospital to offer substantially more in charity care than a for-profit hospital. This is not a joke; as the discussion on bad debt indicated, for-profit hospitals also have large amounts of uncompensated care annually, although they generally refer to this free care as bad debt, rather than charity care. Some significant portion of this bad debt is related to the inability of patients to pay, so if one is going to use uncompensated care as the touchstone for exemption, then a nonprofit hospital at minimum should provide substantially more of such care than similarly situated for-profit providers, who do not enjoy the benefits of exemption. Otherwise, society is getting nothing for the tax exemption over what it would get by simply repealing the

124. See Frank A. Sloan, Commercialism in Nonprofit Hospitals, in TO PROFIT OR NOT TO PROFIT: THE COMMERCIAL TRANSFORMATION OF THE NONPROFIT SECTOR 151, 161 (Burton A. Weisbrod ed., 1998) (noting that "[u]ncompensated-care data for 1994 showed nonprofits at 4.5 percent of revenues and for-profits at 4.0 percent").
127. See COLOMBO & HALL, supra note 25, at 32 (noting that the value of the uncompensated care should equal or exceed the exemption value).
128. See Sloan, supra note 124, at 161 (noting that for-profit and nonprofit hospitals serve uninsured patients equally when they are in the same location). Obviously, in making this comparison one should use the same methodology as for evaluating charity care (e.g., average costs, not charges). See supra notes 114-121 and accompanying text (describing the difficulty in measuring the provision of charity care).
129. See supra notes 123-124 and accompanying text (stating that the inability of patients to pay is sometimes the cause of bad debt rather than poor management).
exemption and turning health care over to for-profit entities. Using such a baseline, however, did not appear to be part of the court’s thinking in Riverside when it belittled Riverside’s charity care percentages.

Beyond requiring this minimum baseline, the question remains whether the law should require a nonprofit to have its charity care dollar amount “match” the amount of foregone tax revenues. Put another way, should the law force a nonprofit to prove that it is “paying” for its exemption by giving away care in an amount at least equal to the value of exemption? Once again, neither the Highland Park, Alivio nor Riverside courts contemplated this issue, and the answer is not as simple as one might think.

Though many tax and health policy experts support the “matching” approach, others note that nonprofit hospitals may provide intangible benefits that cannot be reduced to a dollar amount. Nonprofit hospitals, for example, may provide a community-centered orientation, community outreach, or education programs that similar for-profit organizations may not provide. Nonprofits might provide a better environment to foster “trust” in health care, since patients presumably will not have to worry that the hospital is cutting corners in order to increase profits for shareholders. Or the nonprofit might provide a different mix of services and enhanced access to those services for its community. One recent empirical study, for example, showed that nonprofit hospitals are more likely to provide unprofitable services than similarly situated for-profit hospitals. Ultimately, one’s view about whether nonprofit hospitals should have to justify exemption by

130. E.g., Charles B. Gilbert, Health-Care Reform and the Nonprofit Hospital: Is Tax-Exempt Status Still Warranted?, 26 URBAN LAW. 143 (1994) (proposing to eliminate tax-exempt status for nongovernmental nonprofit hospitals that fail to provide sufficient charity care to justify the exemption); Kane & Wubbenhorst, supra note 117 (concluding that the efficient way to redistribute resources, to match excess tax benefits to areas with the most need, is at the state level); Alice A. Noble, A. L. Hyams & Nancy M. Kane, Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives, 26 J.L. MED. & ETHICS 116 (1998) (proposing that the standard of charity care be linked to the value of the tax exemptions).


132. The seminal work on trust in health care is Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. 941 (1963).

showing that they give away care equal in value to the exemption probably boils down to whether one believes that there are these intangible, immeasurable benefits to the nonprofit form that ought to be given weight in tax exemption analysis. Sound policymaking would require that we at least consider if and how these intangibles work before adopting a “matching” approach.

Finally, one can also make the argument that tying exemption to charity care at all is simply bad health policy. A number of health policy experts have opined that our health care system would be better served by using entity-neutral direct subsidies for specific behaviors. 134 For example, if health care for the uninsured is a primary policy concern, one could contemplate a system in which tax exemption for health care providers is repealed, coupled with a state law mandate that local communities must invest some substantial portion of the tax dollars received as a result of repeal in local free-care pools for the poor, or in which the tax dollars are used to increase the coverage for Medicaid statewide. If properly administered, such a system might well produce better health care results than a system of using tax exemption to force charity care by hospitals, since a free-care pool or expanded Medicaid could concentrate to some extent on preventive care, avoiding the situation in which the uninsured wait until they are sick and then run to the local emergency room for free care. 135 Virtually all health policy experts agree that a focus on preventive care is far more efficient and less costly to the health care system than waiting to treat people when they are seriously ill, yet the focus of using tax exemption to provide free care for the poor produces exactly that latter result. 136 Moreover,
because doctors are not tax-exempt entities, there is no leverage in the tax exemption system (unless they are employees of exempt hospitals) to get them to treat patients for free; we hope that some do so as part of their ethical obligations to their profession (just as we hope that some lawyers do pro bono work), but hope and spotty realization of that hope do not equal a functioning health care system.

B. Can Nonprofits Make Profits?

As noted above, the First District in Alivio also found that Alivio’s net profits violated the second factor in Methodist Old Peoples Home, an argument repeated by the Champaign County Board of Review in its challenges to Provena Covenant and Carle’s exemptions. This conclusion, however, is simply absurd. All sorts of legitimate reasons exist for nonprofits to earn a profit from their operations. In capital-intensive organizations such as hospitals, profits are necessary to set aside money in excess of depreciation for future replacement of plant and equipment, to provide contingency funds for unforeseen liabilities, and to invest in improved services. Even if a nonprofit targeted a “break-even” operation, prudent budgeting would often produce a profit: no managing board would properly execute its duty of care if it approved a budget without some cushion for unexpected expenses or lower than expected revenues. In a “good” year, the hospital would not use these contingency funds, resulting in an accounting profit for the year.

The proper question associated with nonprofits making a profit is not whether the organization earns a profit, but why—that is, what is the organization’s expected use of the profits? One certainly should be

http://www.americanheart.org/presenter.jhtml?identifier=4734 (finding that an emphasis on prevention is necessary because “[i]f all heart attack-prone people were treated surgically, the cost would be prohibitive”); Sharon A. Falkenheimer, The Adequacy of Preventive Health Care: Does the Health Care Provider Matter?, CENTER FOR BIOETHICS & HUMAN DIGNITY, Sept. 24, 2004, http://www.cbhd.org/resources/healthcare/falkenheimer_2004-09-24.htm (“Preventing chronic and/or often-incurable diseases such as breast cancer and emphysema certainly is preferable to long-term clinical treatment, with its associated suffering, limitations, and costs.”).

137. CARLE FILING, supra note 4, at 7; PROVENA FILING, supra note 3, at 5.

138. Depreciation is an accounting expense, but simply setting aside the amount of cash equal to annual depreciation would be insufficient to replace capital equipment because the costs of replacement virtually always exceed the original cost due to inflation, equipment improvements, etc. Thus a nonprofit would have to build in an accounting profit in its operations and set aside some of that profit (along with the cash equal to depreciation) to insure it has sufficient future funds to actually replace worn-out equipment or renovate worn-out buildings.

139. The Champaign Board of Review seemed to recognize this point in the Carle review, where the Board stated that it “understands that the issue is not whether there was a profit, but rather how that profit was treated.” CARLE FILING, supra note 4, at 7. The Board then seems to assert that the profit must be devoted to charity care in order to be consistent with the second
concerned if nonprofit organizations hoard profits for no apparent reason instead of using those profits to reinvest in their charitable purpose. But having profits per se simply cannot be an exemption problem no matter what the language in Methodist Old Peoples Home.

The state policy issues raised by exempt organizations making substantial profits have vexed federal exemption policy as well. One aspect of federal exemption law, however, might help resolve concerns at the state level. In the federal tax world, the IRS has sometimes used a "commensurate in scope" doctrine to assess whether the revenues earned by an exempt organization are appropriately applied to charitable purposes. The doctrine comes from a 1964 Revenue Ruling in which the IRS approved exemption for an organization that derived its revenues largely from commercial office building rent. These profits, however, were then used by the organization to make grants to other charitable entities. The IRS opined that using the profits in this manner was consistent with exempt status under I.R.C. § 501(c)(3), because the organization was carrying on a charitable program of grant-making "commensurate in scope with its financial resources." The background to this ruling indicates that the IRS's view at the time was that an exempt organization could make substantial profits as long as those profits were dedicated to charitable purposes—that is, used to subsidize charitable services.

States could apply a similar kind of doctrine to property tax exemptions, so that exempt organizations would have to provide an explanation for why accumulations of profit are consistent with their charitable purpose. Under such a provision, simply hoarding cash for the sake of doing so (the equivalent of Scrooge McDuck taking a daily dive into his money bin) would not be permitted. But if the exempt entity could demonstrate that the profits were appropriately dedicated to charitable purposes (e.g., placed in a reserve for future improvements or capital replacements, or to expand services), then simply having profits should not lead to an exemption problem.

criterion of Methodist Old Peoples Home. Id. As the text notes, however, there are many reasons why a nonprofit organization might legitimately run financial surpluses.


142. Id.

143. Id.

144. Colombo, supra note 140, at 347.
C. The Role of Donations

The language of the third factor of the Methodist Old Peoples Home test and the analysis of the Riverside court suggests that the receipt (or lack thereof) of private donations should weigh heavily in exemption analysis. The Champaign County Board of Review likewise focused on a lack of donative support in its filing against Carle.\(^\text{145}\) While I agree with this stance as a policy matter,\(^\text{146}\) again this analysis raises policy questions that the courts have simply failed to explore.

The theoretical case for using donations as an exemption criterion is as follows.\(^\text{147}\) One can think of charitable organizations as performing functions that neither the private market nor government fulfill. Charitable organizations often produce quasi-public goods that for reasons of economic theory cannot be produced efficiently by for-profit businesses,\(^\text{148}\) and government may not fill this gap because of the constraints of majoritarian politics.\(^\text{149}\) In these circumstances, nonprofit organizations step in to fill the service gap, and individuals donate to these organizations in order to provide the economic resources necessary to provide those services. Thus, donations are an excellent "signal" that the public views a particular entity as undertaking charitable activities. Accordingly, an excellent conceptual reason exists to use donations as a measure of an entity's "charitable-ness."

Despite my enthusiasm for using donations as an integral part of tax exemption policy, the empirical fact is that very few nonprofit hospitals

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145. CARLE FILING, supra note 4, at 7. The Board did not raise this point in the Provena filing.

146. E.g., COLOMBO & HALL, supra note 25, at 197–98 (noting the relevance of private donations, but also the difficulty in setting the donative threshold in order to qualify the organization as a charity); Mark A. Hall & John D. Colombo, The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption, 66 WASH. L. REV. 307 (1991) (critiquing the conventional and academic theories of the charitable tax exemption); Mark A. Hall & John D. Colombo, The Donative Theory of the Charitable Tax Exemption, 52 OHIO ST. L.J. 1379 (1992) (finding that a donative theory of the charitable exemption is a stronger theory than previously expounded theories).

147. See supra note 146 (citing sources explaining the donative theory).

148. For example, think about public television. Once a public TV station goes on the air, everyone can watch it. Unless the station were to use a pay-per-view system, therefore, there is no way for the station to charge viewers for the consumption of its product the way Starbucks can charge individuals for coffee. Economists often refer to these characteristics as "durability" and "indivisibility"—that is, when a public good is produced, it costs no more to supply it to many people than to one person (durability) and there is no way to exclude "free riders" from enjoying the benefit once the good is available (indivisibility). As a result, the private market cannot produce public goods efficiently.

149. For example, high demanders of symphonic music probably do not constitute a majority of the electorate; it is not possible, therefore, for this group to exercise majoritarian power to get the government to fully fund symphonic orchestras.
receive significant donations. Recent data shows that, overall, nonprofit hospitals receive less than 2% of their revenues from private philanthropy, although individual hospitals, such as the Shriners children’s hospitals, may rely far more heavily on donations. Making significant donations a central part of the test for property tax exemption, therefore, would be the equivalent of ending exemption for most hospitals and other health care providers. If Illinois (or some other state) wants to be the first jurisdiction to adopt my “donative theory” of exemption, I certainly am not opposed to such an approach, but as with the other doctrinal points noted above, I would prefer that happen with some public debate and knowledge of the consequences rather than by accident of judicial language.

D. “Exclusive Use” and Independent Contractors

Although the issue was not raised in Highland Park, Alivio, or Riverside, the fifth and sixth elements of the Methodist Old Peoples Home test both involve the exclusive use requirement of property tax exemption. The exclusive use provision figured heavily in the Champaign County Board of Review’s filings against Provena and Carle. In the Provena case, the Board cited several instances in which Provena had contracted with for-profit service providers in order to provide medical services to hospital patients. In the Carle case, the Board focused on the hospital’s relationship with the for-profit Carle Clinic (a group of doctors), which provided the bulk of health services in the hospital. According to the Board of Review, these arrangements in both cases potentially violated the “exclusive use” test for exemption in Illinois law because they allowed private parties to use property for profit-making purposes. Because the hospitals refused to provide details of the use of facilities by these for-profit entities, the Board concluded that the taxpayers had failed to carry their burden of proof to establish exempt use.

In the context of the actual cases, the Board of Review certainly was

152. The donative theory that Mark Hall and I proposed would tie eligibility for tax exemption to a nonprofit’s ability to show that donations were a substantial part of the organization’s operating revenues each year. We suggested that “substantial part” be defined as one-third of operating revenues, tested on a three-year rolling-average basis, though we also acknowledge that the percentage could be set lower for certain traditional charities. COLOMBO & HALL, supra note 25, at 198–201.
153. PROVENA FILING, supra note 3, at 2–5.
154. CARLE FILING, supra note 4, at 10.
entitled to ask for documentation from the hospitals regarding their relationships with these various entities, and without such documentation (which the Board alleged the hospitals failed to provide), to suspect the worst. As with the federal system, the taxpayer has the practical burden of proof in state property tax matters. But the relationships between the hospitals and both third-party for-profit organizations and sibling entities raise some broader legal issues that are unresolved. For purposes of further analysis, I am going to assume that whatever arrangements Provena and Carle had with third-party providers using their facilities were negotiated at arm’s length and that in fact neither organization simply transferred wads of cash to either unrelated or related for-profit entities for no reason. If the latter were true, it clearly violates the private inurement proscription under both federal and state law, rendering these easy exemption revocation cases.

Rather, the more interesting question is whether arm’s-length arrangements with third-party for-profit service providers might imperil exempt status. The Board of Review’s filing hints that this might be so under the theory that employing private, for-profit firms to provide patient services separately billed by the for-profit companies results in a for-profit use of hospital facilities, contrary to the exclusive use requirement. Moreover, the “private benefit” prohibition of federal law described above also suggests that arm’s-length arrangements with third parties can create exemption problems.

A variety of Illinois cases hold that when property owned by a charity is used primarily to produce a profit, as opposed to primarily for charitable purposes, the property is not exempt. Thus, Illinois courts once held that a thrift shop operated by the Salvation Army was taxable because its primary purpose was to generate income for the Salvation Army’s charitable works. But as with the issue of an exempt

155. 35 ILL. COMP. STAT. 5/904 establishes a presumption that a tax assessment made by the Department of Revenue is correct. Challenging the statutory presumption, therefore, requires the taxpayer to assume the burden of going forward to rebut the statutory presumption. See generally Richard L. Ryan, Department of Revenue Procedure, in ILLINOIS STATE AND LOCAL TAXATION §§ 8.81, 8.84 (Illinois Institute for Continuing Legal Education 2004) (outlining the Department of Revenue’s case and the taxpayer’s burdens at a tax deficiency hearing).

156. See United Cancer Council v. Comm’r, 165 F.3d 1173, 1179–80 (7th Cir. 1999) (holding that a contract between charity and fundraiser might raise private benefit concerns even if negotiated at arm’s length).

157. For a general discussion of the exclusive use provision in Illinois law and extensive case citations, see Mark R. Davis and Hon. Randye A. Kogan, Taxable and Exempt Property, in REAL ESTATE TAXATION §1.53 (Illinois Institute for Continuing Legal Education 2001).

organization making a profit, the proposition that arrangements between a charity and independent contractors to provide services to or on behalf of the charity create exclusive use problems is simply incorrect. Charities contract with for-profit entities for all sorts of common services in order to perform their charitable function. Charities enter into contracts with third parties for electrical service, phone service, maintenance and janitorial services, insurance, etc. All these third-party providers presumably make a profit on the services they provide to the charity; if using independent for-profit contractors to help provide services endangers exemption, then virtually all charitable organizations are at risk.

Even if it were limited to the relatively unique circumstances of the health care sector, such a rule makes no sense. For example, doctors routinely bill separately for the services they provide to patients in a hospital context. When a person has surgery in a hospital, that person typically gets two bills: one from the doctor for her professional services in performing the surgery and the other from the hospital for the use of the facilities. If one accepted the Board of Review’s theory of exclusive use, a doctor's use of hospital facilities to provide services to patients for which the doctor separately bills and makes a profit on would violate exemption standards. Accordingly, the proposition, as a broad statement, is wrong.

The case precedents also do not support such a broad reading of the exclusive use requirement. The question for Illinois property tax purposes is whether the property is used for the charitable purpose, not whether third parties are making profits by supplying services for that use. Thus the Salvation Army Thrift Store was a problem because operating a retail store for profit was not a charitable use.\(^{159}\) Similarly, a portion of a building owned by an exempt hospital and used by a for-profit pharmacy would not be exempt, but the portion of that same building used for management services for the hospital would be.\(^{160}\)

In the Provena Covenant case, however, there is no doubt that the hospital used its building and grounds to provide health services to patients. The correct question is whether the hospital provided these health services on an overall charitable basis, not how the services were provided (e.g., whether the services were provided via contract with for-
profit third parties) or whether bills came from for-profit entities. If Provena provided services that met the other four factors in *Methodist Old Peoples Home*, it clearly met the exclusive use requirement since its building and grounds were used to provide those services literally twenty-four hours per day. Specifically, one cannot imagine that if Provena Covenant devoted all its surplus funds to providing free care for the uninsured, the fact it employed for-profit third parties to help it do so would have negative exemption consequences.

Nevertheless, the Champaign County Board of Review may have stumbled on a somewhat different legitimate concern. Suppose that an ostensibly charitable organization has so many arrangements with external service providers that it really is nothing more than a shell acting as a sort of “broker” between service recipients and for-profit service providers. In such a case, even if the arrangements with the for-profit service providers are negotiated at arm’s length (so that there is no private inurement argument), one might legitimately question whether the revenues funneled through the charitable “broker” could be expended more judiciously by providing such services directly and thus avoiding the profit-margin and overhead of the external for-profit providers.

A better way to address this core concern than the exclusive use argument, however, would be to adopt something akin to a limited version of the private benefit rule of federal exemption law described above. That is, either the state legislature or the courts might state as a requirement for exemption that when a charitable organization employs for-profit outside independent contractors to provide *core services* to the organization’s charitable class, the charity must justify why that arrangement is appropriate to further its charitable mission. As with GCM 39,862, that justification cannot be simply administrative or economic convenience, but one could imagine situations in which “contracting out” services would be necessary to providing such services at all, or would be cheaper than providing them in-house, thus saving the charity money to expend on other charitable services. In other cases, contracting with for-profit service providers or entering into

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161. See supra Part II.C (summarizing the private benefit rule that requires an exempt organization to justify why it entered into a transaction that results in economic benefits for a private individual or organization).

162. For example, one accountant I talked to who did auditing for several nonprofit hospitals noted that one of his clients contracted with an independent group of doctors to provide emergency room services because no other staff doctors in the area wanted to do emergency room work. In this case, the external contract is easily justified: absent the contract arrangement, the hospital in question would have been unable to staff its emergency room and provide emergency services to its service area.
joint-venture arrangements might be necessary to expand services. For example, one could imagine an exempt hospital entering into a joint venture arrangement to provide psychiatric care or drug rehabilitation services that were not otherwise provided by the hospital. By limiting this requirement to core services, we would relieve charities of the obligation to explain the rationale for hiring a private janitorial service and avoid the reductio ad absurdem that an expanded view of the exclusive use argument presents.

E. Complex Corporate Structures

The final issue raised by the Champaign County Board of Review, particularly in the Provena case, also is not directly addressed in the Illinois court decisions. That issue involves whether internal funds transfers between Provena and its parent corporation and other sibling entities raise potential exemption problems.165

Health care providers in particular often use complex parent and subsidiary structures to isolate liability for particular operations in a single corporate container in order to protect other assets or to satisfy regulatory concerns.164 As with the existence of profits or use of independent contractors, the array of legitimate business reasons for

163. PROVENA FILING, supra note 3, at 8.
164. See, e.g., Highland Park Hosp. v. Dep't of Revenue, 507 N.E.2d 1331, 1340 (Ill. App. Ct. 2d Dist. 1987) (Dunn, J. dissenting) ("[T]he hospital formed five corporations to provide flexibility and protection of assets for the total organization."). For another example of a complex corporate structure used by a health care provider, see Geisinger Health Plan v. Comm'r, 100 T.C. 394, 395–96 (1993). As explained by the Tax Court:

Petitioner [GHP] owned and operated a health maintenance organization (HMO) under the Pennsylvania Health Maintenance Organization Act, Pa. Stat. Ann. tit. 40, secs. 1551-1567 (Supp. 1991). Petitioner was one of nine related organizations. The eight other organizations, referred to collectively as the Geisinger system and described below, were the Geisinger Foundation (the Foundation), Geisinger Medical Center (GMC), Geisinger Clinic (the Clinic), Geisinger Wyoming Valley Medical Center (GWV), Marworth, Geisinger System Services (GSS), and two professional liability trusts. Each of these eight entities was recognized by the Internal Revenue Service as an exempt organization described in sections 170(b)(1)(A)(iii), 501(c)(3), and 509(a)(1).

The Foundation controlled petitioner and the other entities in the Geisinger system, as well as three for-profit corporations.

Id.

In many states, HMOs must be separately incorporated to meet state regulatory requirements, and in any event it would be good management for the board of a health care provider to isolate the potential tort liability for the operation of an HMO from core hospital assets (or vice versa). See, e.g., MANCINO, supra note 22, at § 6.02[2][a][iv] (noting that the subsidiary HMOs at issue in the Geisinger exemption case were formed for "several regulatory, governance and system-wide organizational and management reasons").
using complex structures means that these structures should not be inherently suspect from an exemption standpoint. Nevertheless, such structures do raise two potential issues.

The first is the standard private inurement concern that any payments by an exempt organization to a for-profit sibling be only for the fair market value of goods or services provided to the exempt organization. Any violation of this fair-market-value rule is a violation of the private inurement prohibition (because charitable revenues are being diverted to a for-profit entity and ultimately to the benefit of that entity’s equity owners) and should result in immediate revocation of exempt status.

The second is the question of what to do about “dividend” distributions from an exempt subsidiary to an exempt parent that are not fair-market-value payments for services rendered. In Provena’s case, for example, one of the things that troubled the Board of Review was the distributions made by Provena Covenant to its parent Provena Health. From a corporate standpoint, of course, such distributions are perfectly legal within normal corporate law constraints. But the difficulty with such transfers is that property tax exemption uniquely burdens local government. If exempt entity B earns a profit (e.g., has revenues in excess of expenses) and transfers that profit to a parent A as a distribution (as opposed to payment for equal-value goods or services received), the amount of the distributed profit up to the value of the property tax exemption for B essentially is money transferred from the local community granting exemption (the foregone taxes) to the parent corporation for possible use elsewhere. Provena Health, for example, owns hospitals in a number of Illinois cities other than Urbana. If Provena Covenant makes a distribution to Provena Health (the parent), which is then used by the parent corporation to subsidize operations in Joliet, Urbana taxpayers have a right to ask why they subsidized health care in Joliet.

165. Obviously, distributions to a for-profit enterprise would violate the private inurement prohibition, since those profits could then be distributed to individual owners.


167. Two courts have faced a similar issue and reached opposite conclusions. In Banner Health Sys. v. Long, 663 N.W.2d 242 (S.D. 2003), the South Dakota Supreme Court held that the proceeds of the sale of a local nonprofit hospital by a nonprofit parent corporation could be subject to a charitable trust, requiring the proceeds to be set aside for the benefit of the local community served by the hospital. Under the same facts, however, a North Dakota trial court dismissed a complaint by the North Dakota Attorney General to impose a charitable trust on the proceeds of the sale of assets by a charitable parent corporation. North Dakota ex rel Stenehjem v. Banner Health Sys., Civ. No. 09-02-C4093 2003 WL 501821 (D.N.D. 2002). Both cases
This concern obviously would be alleviated by a requirement that an exempt hospital provide charity care in the local community in an amount at least equal to the value of the tax exemption. Absent such a requirement (which, as noted above, has its own set of problems), the question of profit distribution raises larger concerns about whether private organizations in effect should be permitted to redistribute tax dollars from one community to another. As a legal matter, such distributions would not appear to violate Illinois law, at least as long as the distributed revenues are used elsewhere for charitable purposes, even if such use was in another state. As a policy matter, however, the legislature certainly might consider a requirement that an exempt organization may not distribute dividends to a parent charitable organization except to the extent profits exceed the value of the local property tax exemption. Such a prohibition would at least insure that the value of the local property tax exemption is not transferred from the local community (although it does not guarantee that those funds would be used wisely by the hospital to benefit the local community).

V. CONCLUSION

The analysis presented in Part IV of this Article illustrates that the question of what doctrinal tests the court should employ to govern property tax exemption for hospitals and other health care providers is far more complex than popular press accounts might lead one to believe or than the Illinois courts may have realized. One can hardly blame the courts, however, for lacking the expertise in health care or tax policy to appropriately recognize the pitfalls inherent in interpreting property tax exemption rules. Even the Internal Revenue Service, whose job it is to think more comprehensively about tax policy and its far-reaching

168 The Illinois Not For Profit Corporation Act does limit the ability of a nonprofit corporation to make distributions of assets, but it also states that “[a]ny payment or transfer of money, property or other assets in furtherance of any of the purposes of the corporation shall not be deemed a distribution for the purposes of this Article...” 805 ILL. COMP. STAT. 105/109.10 (2004). Therefore, as long as the distributed money is used for “the purposes of the corporation” (e.g., charitable purposes, in the case of an exempt charity), a distribution should not run afoul of Illinois statutory law. Id.
effects, has fallen into a similar trap.  

But the policy problems identified above are real, and they demand the serious attention of the legislature, rather than piecemeal attention by courts followed by a spasm of legislative action when newspaper headlines roar. Without such consideration, the process of individual adjudication by litigation almost certainly will result in ill-conceived tax and health policy as a by-product of defining charitable property tax exemption. The people of Illinois (and other states where these issues may arise) and the uninsured who are directly affected by these policy decisions deserve better.

169. Fox & Schaffer, supra note 26, at 277-78 (noting that the IRS in effect was making health policy when it issued Rev. Rul. 69-545 and was neither well-equipped to do so nor accountable for the effects of its decision on health policy).
ADDENDUM

As this Article was going to press, the Illinois Attorney General’s office released a draft of proposed new legislation called the Tax-Exempt Hospital Responsibility Act. The Act would impose new charity-care requirements (as well as reporting requirements) on hospitals exempt from Illinois Property Tax. The Act was introduced in the Illinois House on January 23, 2006.\footnote{170}

The primary requirement of the proposed legislation is to impose a specific legal obligation on tax-exempt hospitals to treat charity patients. In this regard, the Act would clear up some of the confusion regarding an exempt hospitals’ charity care obligations that the Article notes in Part IV.A.1, above. As drafted, the Act seems to impose two separate obligations on exempt hospitals. One obligation is to provide free care to any uninsured Illinois resident with family income equal to or less than 150% of the federal poverty level. In addition, the Act requires exempt hospitals to provide sliding-scale discounts to patients with family income between 150% and 250% of the federal poverty level.\footnote{171}

The second obligation is that a hospital would be required to furnish an amount of charity care at least equal to eight percent of the hospital’s total operating costs as reported on its Medicare cost reports.\footnote{172} The interaction of this eight percent requirement with the obligation to treat poverty-level patients is somewhat unclear. As drafted, the poverty-level care requirements and eight percent requirement appear to be independent. That is, a hospital must meet all its poverty-level charity care obligations even if that results in charity care above the eight percent requirement, and conversely, if that happens to be less than eight percent, then a hospital must “expand” its charity care to meet the eight percent floor.

With respect to the eight percent requirement, the Act appears to


171. Act Section 15. Under this sliding scale, no bill can exceed between 20% and 35% of the actual cost of services. In addition, to the extent that services exceed $10,000 in any twelve-month period, the excess must be provided free of charge to this group of residents. According to the Chicago Sun Times, in 2005, the federal poverty limit was $9,570 for a single person and $19,350 for a family of four. Rackl, supra note 1.

172. Act Section 25.}
define charity care with reference to a hospital’s marginal costs, although this also is somewhat unclear. In Section 10 of the Act, the definition of “charity care” is “medically necessary services provided without charge or at a reduced charge to patients who meet eligibility criteria no more restrictive than those set forth in Sections 15 and 20 of this Act.” That language seems to define charity care as any care provided at less than the hospital’s standard charge. But then in Section 25, the Act states that a hospital can demonstrate that it meets its eight percent obligation “by documenting the costs” of charity care provided under the Act. That language seems to imply that the eight percent obligation will be judged with reference to a hospital’s “costs” rather than charges, and the Act defines costs as “the actual expense a hospital incurs to provide each service or supply.” This definition of costs as “actual expense a hospital incurs” seems to adopt a marginal cost approach to valuing charity care, which is the most strict of the three approaches (charges, average costs or marginal costs) discussed in the Article. The Act also makes clear that bad debt write-offs do not qualify as “charity care”; only free or discounted care for which the hospital expects no payment and is never recorded as revenue, an account receivable, or bad debt qualifies. Medicaid reimbursement shortfalls (that is, the amount by which reimbursements fail to cover “costs” as defined), however, are included in the charity care number, and hospitals would also be able to count contributions to community health centers. A companion bill, the Fair Hospital Billing and Collection Practices Act, would regulate the way hospitals collect bills from patients.

Although Attorney General Madigan has agreed with legislative leaders not to pursue passage of the legislation in the current session, at least the bill has put the issue of tax-exemption for nonprofit hospitals in the legislative domain, where it belongs, and has provided an opening for a thorough discussion of the issues raised. If my interpretation of the main provisions of the bill are correct, then it at least answers the question posed in the Article about “how much charity care is enough”

173. The Act defines “charge” as “the price set by a hospital for a specific service or supply provided by the hospital.” Act Section 10.
174. Act Section 10.
175. Id.
176. Act Section 25(b)(5).
177. Act Section 25(b)(2).
and also seems to have adopted one of the two sensible approaches to measurement of charity care (marginal cost).

Unfortunately, the bill fails to address any of the other issues raised by the Article concerning the judicial definition of exemption for nonprofit hospitals. The bill itself states in Section 45 that it does not displace other requirements for tax exemption.\textsuperscript{179} Hence the issues identified in the Article regarding profits, exclusive use, donations, and complex entities remain unresolved. Moreover, the bill itself does not answer what is perhaps the most important policy question identified in the Article, which is whether tying tax exemption to specific charity care levels is in fact good health policy. For example, would the State be better off by simply collecting the eight percent minimum amount from each hospital and investing that in preventive care for the poor or using it to buy coverage for the poor in an HMO? These overarching policy issues are now on the table; let us hope that the legislature debates them with the seriousness and careful attention they deserve.

\textsuperscript{179} "Nothing in this Act shall be construed as relieving any hospital of any other legal obligation under the Illinois Constitution, or under any other statute or the common law, including, without limitation, obligations of tax-exempt hospitals to furnish charity care or community benefits, or as reducing any such obligation on the part of any hospital." Act Section 45.
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