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Are We Getting Our Money's Worth? - Charity Care, Community Benefits, and Tax Exemption at Nonprofit Hospitals

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I. Introduction: Nonprofit Hospitals and Access for the Uninsured

Nearly 45 million people in this country—15.6% of the total population—have no health insurance.[1] As many as 70 million more Americans are underinsured.[2] That's 115 million people—roughly 40% of Americans—who lack adequate health coverage.[3] In Illinois, 1.8 million people have no health insurance, including some 495,000 Chicagoans—almost one-fifth of the city's population.[4]

Ready access to quality, affordable health care is not available to most of the uninsured and underinsured. A trip to the hospital can be financially devastating for someone without adequate health insurance. In fact, a recent study by researchers from the Harvard School of Public Health revealed that medical bills are a leading cause in about half of all personal bankruptcies in the United States.[5] There is, in short, a powerful economic incentive for a huge number

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[1] Lee Scheier, *Busted*, CHI. TRIB. MAG., Jan. 2, 2005, at 15-16.

[2] *Id.*

[3] Based on figures from the U.S. Census Bureau August 2004 Current Population Survey.

[4] GILEAD OUTREACH AND REFERRAL CENTER, *Numbers and Neighbors–A Detailed Description of Illinois' Uninsured*, at 3 (Apr. 2005).

[5] David Himmelstein *et al.*, *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS web exclusive, at W5-63 (Feb. 2, 2005).

of people to seek medical care only in emergencies, if even then. Nonprofit hospitals have a special obligation to help alleviate this problem by providing "charity care"—free and reduced-price health care services for those who cannot afford to pay.

However, several recent developments have raised questions about whether nonprofit hospitals are fulfilling that special obligation.[6] Part II of this article outlines the policy considerations that underlie the special obligation of nonprofit hospitals to provide charity care. Part III examines, against the backdrop of those policy considerations, recent national criticism of nonprofit hospital behavior and, on a local level, the poor performance of Chicago's two largest nonprofit hospital systems. Finally, Part IV of this article sketches some avenues for action to rectify that situation.

II. Social Contract / Public Expectations: Tax Exemption and Community Benefits

Nonprofit hospitals were originally organized around a mission to serve the health needs of the poor.[7] At the start of the twentieth century, private charities and beneficent groups around the country—many of which were affiliated with religious organizations—began to establish community hospitals to provide medical care to families unable to pay for doctor visits at home, where most primary health care was provided.[8] In recognition of their charitable missions and of the important public benefits to be gained, these hospitals were granted special status as nonprofit organizations.[9] Today, the majority of private hospitals in the United States—roughly eighty-five percent—are nonprofits owned and operated by private organizations, many of which maintain their affiliation with religious groups.[10] Although they no longer provide care exclusively to the poor, nonprofit hospitals are still expected to serve a charitable mission.[11]

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[6] *See* discussion *infra* Part III.

[7] William Gentry & John Penrod, *The Tax Benefits of Not-For-Profit Hospitals*, NATIONAL BUREAU OF ECONOMIC RESEARCH (Feb. 1998), at 3.

[8] *Id.*

[9] *Id.*

[10] Sean Nicholson *et al.*, *Measuring Community Benefits Provided by For-Profit and Nonprofit Hospitals*, 19 HEALTH AFFAIRS, at 168 (Nov./Dec. 2000).

[11] *Id.*

Nonprofit hospitals differ from government-run public hospitals and from private for-profit hospitals in several ways. Only public hospitals are directly funded by taxpayer dollars, while both for-profit hospitals and private nonprofit hospitals rely heavily on income from their day-to-day operations—though, typically, a significant proportion of operating income is federal and state money collected from Medicare and Medicaid.[12] For-profit hospitals are also able to raise capital through the issuance of stock, but nonprofits are not. However, unlike for-profits, nonprofit hospitals have access to tax-exempt bond debt and tax-deductible contributions.[13]

Another significant difference between for-profit and nonprofit hospitals is that nonprofits typically enjoy exemption from a wide range of taxes and fees, from federal and state income taxes to state and local property and sales taxes to municipal sewer and water fees.[14] In order to pay for public schools, police and fire protection, and other municipal services, communities must levy higher taxes on individuals and for-profit businesses to recoup the revenue lost by exempting nonprofit hospitals from taxes. The basic idea behind exempting these institutions from the taxes levied on for-profits is that nonprofit hospitals provide public health benefits that would otherwise have to be provided by some level of government.[15] Charity care is the most important among the *community health benefits* that nonprofit hospitals are expected to provide, but other free or reduced-price goods and services that promote public health

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[12] *See* Alice Noble, Andrew Hyams, & Nancy Kane, *Charitable Hospital Accountability: A Review of Legal and Policy Initiatives*, 26 JOURNAL OF LAW, MEDICINE & ETHICS 116, 117-118 (1998) (outlining the changes in hospital financing that have occurred over the last 60 years); and Nancy Kane & William Wubbenhorst, *Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption*, 78 MILBANK QUARTERLY 185, 196 (2000) (suggesting that levels of participation in the Medicaid program are similar for for-profit and nonprofit hospitals).

[13] Michael Morrisey, Gerald Wedig, & Mahmud Hassan, *Do Nonprofit Hospitals Pay Their Way?*, 15 HEALTH AFFAIRS 132 (1996).

[14] *See infra* App. I (discussing the legal conditions on qualifying for exemption from federal, state, and local taxes in Illinois).

[15] Gabriel Aitsebaomo, *The Nonprofit Hospital: A Call for New National Guidance Requiring Minimum Annual Charity Care to Qualify for Federal Tax Exemption*, 26 CAMPBELL L. REV. 75, 84-85 (2004). *See also* Jack Burns, *Are Nonprofit Hospitals Really Charitable?: Taking the Question to the State and Local Level*, 29 IOWA J. CORP. L. 665, 676-677 (2004) (discussing the prominence of the "quid pro quo" theory as an explanation of the policy considerations behind the tax exemptions of nonprofit hospitals).

and welfare—such as health education and wellness programs, disease screenings, and public health outreach initiatives—may also qualify as community health benefits.

Providing real community health benefits is not simply a matter of donating goods and services to people in the community, though. The Access Project, a respected national initiative to improve health care access, explains that community health benefits, properly understood, are "the unreimbursed goods, services, and resources provided by healthcare institutions that address *community-identified* health needs and concerns, *particularly those of people who are traditionally uninsured and underserved.*"[16] This point is accepted by the nonprofit hospital industry as well. Both the Catholic Health Association and VHA Inc., two leading national associations of nonprofit hospitals, recognize that a genuine community benefits program "*implies collaboration with a 'community'* to 'benefit' its residents—particularly the poor, minorities, and other underserved groups . . . ."[17]

In short, the preferential tax treatment afforded nonprofit hospitals amounts to an investment of public resources in support of their charitable missions. In return, nonprofit hospitals are expected to provide benefits to the community that are equal to or greater in value than what the community gives up by exempting them from taxes. And they are expected to actively involve members of affected communities in the planning, development, and implementation of community benefit programs.

III. Recent National and Local Controversies Concerning Nonprofit Hospital Behavior

In exempting nonprofit hospitals from taxation, government is, in effect, contracting to purchase from the private sector goods and services that are supposed to address important community-identified health needs. As with any other purchase that we make, collectively or individually, it makes sense to ask whether we are getting our money's worth. The relevant questions with respect to any particular

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[16] Natalie Seto & Bess Karger Wesikopf, THE ACCESS PROJECT, *Community Benefits: The Need for Action, an Opportunity for Healthcare Change*, at 2 (2000) (emphasis added), *available at* www.accessproject.org/publications.htm.

[17] CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES AND VHA INC., *Community Benefit Reporting Guidelines and Standard Definitions*, at 7 (Dec. 2004) (emphasis added), *available at* www.vha.com/publicpolicy/public/communitybenefit.asp.

nonprofit hospital are:

> Does the value of the hospital's community benefit programs equal or exceed the value of its preferential tax treatment?
>
> Does the hospital involve community members in the community benefits planning process?
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> If the answer to either of these questions is "no," then the community is not getting what it is paying for—and it thus has a right to demand more from that hospital.

Concern over whether nonprofit hospitals do in fact provide social benefits sufficient to justify their preferential tax treatment has grown over the past two decades. One study, now 10 years old, suggests that anywhere from 20% to 80% of nonprofit hospitals fail to provide community benefits commensurate with their tax savings, depending on how the value of community benefits is calculated.[18] This growing concern has led local officials and communities across the nation to review the tax exemptions enjoyed by nonprofit hospitals. At least eleven states have enacted legislation requiring nonprofit hospitals to conduct community health needs assessments and to develop community health benefit plans in return for state and local tax exemptions.[19] Texas has gone even further, enacting legislation in 1993 that requires each nonprofit hospital in the state to provide charity care at least equal in value either to the hospital's state and local tax subsidies or to four percent of the hospital's net revenue.[20] Similarly, the Utah Supreme Court has interpreted that state's constitution as requiring nonprofit hospitals to provide charity

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[18] J.P Clement, D.G. Smith, & J.R.C. Wheeler, *What Do We Want and What Do We Get from Not-for-profit Hospitals?*, 39 HOSPITAL AND HEALTH SERVICES ADMINISTRATION 159 (1994).

[19] *See* COMMUNITY CATALYST, *Free Care: A Compendium of State Laws*, *available at* www.communitycatalyst.org (Sept. 2003) (providing an overview of state laws governing nonprofit hospital free care and community benefits). *See also* COALITION FOR NONPROFIT HEALTH CARE, *Redefining the Community Benefit Standard: State Law Approaches to Ensuring the Social Accountability of Nonprofit Health Care Organizations* (July 1999) (discussing in greater depth the laws in eight states).

[20] Charity Care and Community Benefits Requirements for Charitable Hospitals, TEX. TAX CODE ANN. § 11.1801 (WEST 2005).

care equal to the value of their property tax exemptions.[21]

Recently, the business practices of nonprofit hospitals have also come under scrutiny from national policymakers and health care advocacy groups. In June 2004, for instance, the U.S. House Ways and Means Committee launched a broad, ongoing examination of the federal tax-exempt status that nonprofit hospitals and other nonprofit organizations enjoy.[22] The Committee began looking into whether the behavior of nonprofit hospitals—including their behavior toward those patients who are unable to pay for care—differs in any significant way from that of for-profit hospitals.[23] When he announced the Committee's interest in these matters, Chairman Bill Thomas (R-Calif.) noted that, in the face of mounting budget deficits, revoking the nonprofit status of organizations that behave like for-profits represents "an enormous area of potential revenue" for the federal government.[24]

Meanwhile, in the courts, several groups have filed class action lawsuits against nonprofit hospitals across the country alleging not only that these hospitals fail to provide adequate levels of charity care, but also that they charge uninsured patients inflated prices for care and use overly aggressive collections practices against those who cannot afford to pay. In November 2003, attorneys in Chicago, acting on research conducted by the Hospital Accountability Project, a research and advocacy initiative of the Service Employees International Union ("SEIU"), pioneered the tactic of filing class action suits on behalf of former patients against nonprofit hospitals that shirk their duties to the communities in which they operate and, specifically, to the uninsured.[25] Another SEIU advocacy initiative in New England filed a similar suit against two Connecticut nonprofit

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[21] Noble, Hyams, & Kane, *supra* note 12, at 120-121.

[22] U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON WAYS AND MEANS, *Pricing Practices of Hospitals: Hearing before the Subcommittee on Oversight* (June 22, 2004) (opening statements of Rep. Bill Thomas, chairman), *available at* http://waysandmeans.house.gov/hearings.asp.

[23] *Id.*

[24] Jeff Tieman, *Examining Exemptions: House to re-evaluate tax status of not-for-profits*, MODERN HEALTHCARE, Mar. 8, 2004, at 8.

[25] Kelly Quigley, *Uninsured patients sue Advocate*, CRAIN'S CHI. BUS., at www.crainschicagobusiness.com (Nov. 19, 2003); Francine Knowles, *Madigan backs suit against Advocate*, CHI. SUN-TIMES, July 5, 2004, at 49, 53; Kari Lydersen, *Weird Charity*, CHI. READER, July 9, 2004, at 8, 10.

hospitals shortly thereafter.[26] Eventually, Richard Scruggs, the Mississippi attorney famous for spearheading the legal attack on U.S. tobacco companies in the 1990s, took up the cause.[27] Between June and December 2004, Scruggs coordinated the filing of at least 49 federal class action lawsuits charging approximately 370 nonprofit hospitals in 25 states with mistreating uninsured patients by, among other things, failing to provide adequate charity care.[28] Though federal judges have since dismissed a number of these lawsuits as a matter of law, Scruggs and his team have vowed to re-file them in state courts.[29]

In Illinois, the state Department of Revenue, at the request of the Champaign County Board of Review, revoked the property tax exemption of nonprofit Provena Covenant Medical Center in Champaign-Urbana in February 2004.[30] The Board documented that the hospital, instead of providing charity care to eligible low-income uninsured patients, routinely used aggressive debt collection tactics against those who could not pay their bills.[31] The comments of Chairman Stan Jenkins explaining the Board's action against Provena Covenant are worth quoting at length:

> Hospitals that enjoy the benefits of exempt status—*benefits which in no manner derive from a right in any sense but are, rather, a gift from public treasuries*—need to unmistakably recognize that the term "charitable purpose" as applied to a community hospital . . . connotes *an involved, proactive presence both in their communities in general and with respect to their patients in particular.* A tax-exempt "charitable hospital" has a "charitable purpose" that is not evidenced simply by virtue of a beautifully

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[26] Diane Lewis, *Union Sues 2 Conn. Hospitals Over Use of Free-Care Funds*, BOSTON GLOBE, Dec. 17, 2003, at C3.

[27] NOT-FOR-PROFIT HOSPITAL CLASS ACTION LITIGATION SITE, *at* www.nfplawsuit.com (providing comprehensive information regarding the Scruggs lawsuits).

[28] *Id.*

[29] *See Mississippi Nonprofit Hospital System Shuns Proposed Charity Care Settlement*, 14 BNA HEALTH LAW REPORTER 513 (Apr. 14, 2005) (mentioning the Scruggs firm's plans to move its litigation to state courts).

[30] Lucette Lagnado, *Hospital Found 'Not Charitable', Loses Its Status as Tax Exempt*, WALL ST. J., Feb. 19, 2004, at B1.

[31] *Id.*

> crafted set of corporate mission statements. Instead, "charitable purpose" *must be an ongoing state of action*, in particular action pursuant to the fundamental purpose of any "charitable hospital" in regards to proactively assisting human beings each day in respect to meeting their medical needs and, to the extent necessary and possible given hospital resources, assisting them in paying for services thus rendered . . . .[32]

As the decision currently stands, Provena is liable for over $1 million in annual property taxes on multiple parcels of land. Provena is appealing the decision.[33] And, with the Provena appeal still pending, the Champaign County Board of Review recently recommended revocation of the property tax exemption of Champaign-Urbana's other major nonprofit health care provider, the Carle Foundation Hospital.[34] That recommendation is now being considered by the Illinois Department of Revenue.

Chicago communities, too, have begun to call for greater accountability and, specifically, for increased charity care and community benefit spending from their nonprofit hospitals. Chicago's two largest private health care providers—Advocate Health Care and Resurrection Health Care—have come under scrutiny and received harsh criticism for failing to fulfill their charitable missions.[35] What makes the criticism of Resurrection and Advocate especially interesting is that, in these two cases, unlike most other recent cases, solid information has been compiled that shows just how far short of their charitable obligations these nonprofit hospital systems fall.

Resurrection Health Care, Chicago's second-largest private nonprofit hospital system, operates nine hospitals in the Chicago metro area and is sponsored jointly by two Catholic religious

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[32] James Unland, *Champaign County, Illinois, Gets the Hospital Industry's Attention by Revoking the Property Tax Exemption of a Local Catholic Hospital*, HEALTH BUSINESS AND POLICY, at 5 (Apr. 2004), *available at* www.healthbusinessandpolicy.com.

[33] Lucette Lagnado, *A Nonprofit Hospital Fights to Win Back Charitable Halo*, WALL ST. J., June 29, 2004, at B1.

[34] *See* the Champaign County Board of Review's April 2005 recommendation to the Illinois Department of Revenue, *available at* www.co.champaign.il.us/BOR.htm.

[35] Jonathan Cohn, *Uncharitable?*, NEW YORK TIMES MAG., Dec. 19, 2004, at 51.

orders.[36] According to research conducted by the American Federation of State, County, and Municipal Employees, Resurrection enjoyed an estimated $72 million in savings from tax exemptions and fee waivers in 2002, but provided charity care to patients worth only $6.5 million during the same period.[37] Resurrection also reports that it provided a variety of free and reduced-price community services in fiscal year 2002 at a total cost of $30.4 million.[38] But, even when all of these expenditures are factored in—and, in fact, some of them probably should not be counted as genuine community benefits expenditures[39]—Resurrection's total spending on charity care and community benefit programs in 2002 comes to $36.9 million. Simply put, Resurrection Health Care gives back to Chicago communities, at best, just *a little over half* of what it receives in tax breaks and other subsidies.

The situation is even worse with respect to Chicago's largest private nonprofit hospital system and the Illinois health care market leader, Advocate Health Care, which operates eight hospitals in the Chicago metro area and is affiliated with the United Church of Christ and the Evangelical Lutheran Church in America.[40] According to extensive research conducted by the SEIU Hospital Accountability Project, the average annual value of Advocate's preferential tax treatment during the four years from 1999 through 2002 was between $73.9 million and $85 million.[41] Yet, Advocate's own reported

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[36] *See* RESURRECTION HEALTH CARE, *About Us* and *Locations*, *available at* www.reshealth.org (providing basic information about the corporation's hospitals and faith sponsors) (last visited May 8, 2005).

[37] *Resurrection Health Care: Hearings before the Finance Committee of the Chicago City Council* (Nov. 29, 2004) (statement of Henry Bayer, executive director, AFSCME Council 31) (discussing estimates of the value of tax exemption for 2002).

[38] 2002 I.R.S FORM 990 for the Resurrection Health Care System.

[39] *See infra* App. II (discussing why certain expenditures that are often reported by nonprofit hospitals as community benefit expenditures should *not* be counted as such).

[40] *See* ADVOCATE HEALTH CARE, *About Us* and *Advocate Locations*, *available at* www.advocatehealth.com (providing basic information about the corporation's hospitals and faith sponsors) (last visited May 8, 2005).

[41] SEIU HOSPITAL ACCOUNTABILITY PROJECT, *Neglecting Taxpayer Health—How Advocate Health Care's $40 Million Community Benefits Shortfall Hurts Chicago* (Oct. 2004), *available at* www.hospitalmonitor.org. *See also infra* App. III (discussing approaches to calculating the value of nonprofit hospital preferential tax treatment).

spending on charity care and community benefit programs during the same period averaged just $35.9 million per year.[42] The disturbing fact is that, at best, Advocate returns to Chicago communities *less than half* of the tax savings, charitable contributions, and other subsidies that it enjoys as a nonprofit, putatively charitable institution.

There is a growing sense among legislators, public interest groups, health care access advocates, government officials, and ordinary citizens across the country that the public is not getting what it is paying for from nonprofit hospitals. This sense is borne out by the available evidence in those communities where hard data have been compiled. Indeed, it seems that Chicago taxpayers are the victims of a particularly grand swindle perpetrated by their two largest private nonprofit hospital systems. And all of this is taking place at a time when the ranks of uninsured Americans, already staggeringly large, are swelling. Access to health care for low-income and uninsured people is shrinking in this country. But what can and should be done about it?

IV. Holding Nonprofit Hospitals Accountable

The best solution to America's current health care woes—not only to the problems of access to care for the poor and uninsured, but also to the broader problems of skyrocketing health care costs and disappointing outcomes—is the implementation of a rationally-structured, national single-payer health plan. A growing number of policy experts and advocacy groups have, over the past decade, made an increasingly compelling case for the desirability and viability of some sort of single-payer national health system.[43] However, such a plan is probably not feasible in the current national political climate.

Short of comprehensive reform of the entire American health care delivery system, communities and governments can—and should—demand greater accountability and greater fidelity to charitable mission from the nation's thousands of nonprofit hospitals.

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[42] SEIU HOSPITAL ACCOUNTABILITY PROJECT, *supra* note 41.

[43] *See* PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, *Proposal of the Physicians' Working Group for Single-Payer National Health Insurance* (Aug. 2003), *available at* www.pnhp.org (arguing that, because incremental changes in the current U.S. health care system cannot solve its many and serious shortcomings and continued reliance on market-based reform strategies will only exacerbate those shortcomings, a move to a national health system is the only way to protect the interests of all patients).

Grassroots organizing at the community level and legislative action at the local and state levels offer the most direct and effective means for ensuring that we get what we are already paying for.[44]

A. Grassroots Community Organizing

It is important to remember that, in return for their valuable tax exemptions and related perks, nonprofit hospitals are expected to provide health benefits to the *local communities* in which they operate. So communities already have the right—perhaps even the responsibility—to actively participate in the planning and implementation of their local nonprofit hospitals' community health benefit programs. Unfortunately, too many communities have done little or nothing to exercise this right, and too many nonprofit hospitals are quite happy to leave community members out of the process. But nonprofit hospitals are sensitive to public criticism and keenly aware of the value of maintaining a positive public image, especially in the current climate of widespread dissatisfaction with the health care system. Community advocacy groups, particularly in areas with large uninsured populations, need to add nonprofit hospital accountability to their issue agendas. These groups can and should insist that their local hospitals disclose information about the provision of charity care and other community health benefits; request seats at the community benefits planning table; and, where it is discovered that a hospital is not fulfilling its obligations, demand more from that hospital.

This approach has been surprisingly effective in the Illinois communities where it has been tried. In Champaign-Urbana, for example, it was a local health care justice advocacy group—Champaign County Health Care Consumers ("CCHCC")—that moved the local tax review board to investigate Provena Covenant Medical Center's uncharitable behavior and, ultimately, to recommend revocation of the hospital's property tax exemptions.[45] This, in turn, led to significant changes in the management team at Provena Covenant and to a partnership between the hospital and CCHCC, along with other community groups, that is working to reform the hospital's charity care, pricing, and collections practices.[46]

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[44] *See* THE ACCESS PROJECT, *at* www.accessproject.org (compiling some excellent informational resources and a variety of guides on how to hold nonprofit hospitals accountable to their charitable missions) (last visited May 8, 2005).

[45] Lagnado, *supra* note 30, at B1.

[46] James Unland, *Scrutiny of Not-for-Profit Community Hospitals' Exempt*

Similarly, when a coalition of community groups on Chicago's north and northwest sides discovered that one of their neighborhood nonprofit hospitals, Advocate Illinois Masonic Medical Center, was failing to live up to its charitable mission, they organized a community health benefits task force and took their concerns public, enlisting the help of public officials.[47] The task force demanded and won inclusion in the Illinois Masonic community benefits planning process, though the hospital continues to resist implementing substantive reforms of its charity care practices.[48]

B. Legislative Action

As noted above in Part III of this article, several states have enacted legislation aimed at eliciting better information and securing greater and more appropriate public health benefits from nonprofit hospitals. Illinois recently joined these ranks with the passage, in August 2003, of the Illinois Community Benefits Act.[49]

But the Illinois law illustrates—all too plainly—how a poorly crafted community benefits law does little to further the cause of greater hospital accountability. Though the Illinois law does require nonprofit hospitals to file community benefit plans and reports of expenditures with the state attorney general—and this is a step in the right direction—the law, according to the Illinois Attorney General's interpretation of it, does not require hospitals to actively involve members of affected communities in the development and implementation of benefit plans, nor does it require hospitals to conduct focused community health needs assessments.[50] Even worse, the law sets back the cause of full and meaningful disclosure because it allows hospitals to report as community benefit expenditures a variety of expenses that should not be counted as such, including bad

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Status Targets Their Pricing/Collection Practices, Charitable Purposes and Finances Resulting in Significant Local, State and National Events that Now Challenge Hospital Management and Boards, HEALTH BUSINESS AND POLICY, at 2 (July 2004), *available at* www.healthbusinessandpolicy.com.

[47] SEIU HOSPITAL ACCOUNTABILITY PROJECT, *supra* note 41, at 10-11.

[48] *Id.*

[49] Community Benefits Act, 210 ILL. COMP. STAT. 76/1 (WEST 2005).

[50] Community Benefits Act, 210 ILL. COMP. STAT. 76/20(a)(3) and 76/15 (WEST 2005). *See also* STATE OF ILLINOIS OFFICE OF THE ATTORNEY GENERAL, *Community Benefits Act Compliance Information* (Feb. 4, 2004), at 2, *available at* www.ihatoday.org/issues/payment/charity/defin.html (discussing the requirements for compliance with the Community Benefits Act).

debt, Medicare and Medicaid shortfalls, and, remarkably, the value of the hours spent by hospital employees who volunteer in the community *on their own time*—which is not even an expense incurred by the hospital.[51] In addition, the law, as interpreted by the attorney general, allows multi-hospital systems to avoid disclosure of community benefit expenditures at individual hospitals, which makes it difficult for community groups to determine exactly how much community support their particular local hospital provides.[52]

Most importantly, though, the Illinois law does not actually require a nonprofit hospital to devote any resources at all—let alone some specific proportion of its resources every year—to charity care or other community benefit programs.[53] In fact, a hospital can be in full compliance with the Illinois law, yet provide no charity care or any other free or reduced-price goods or services. In stark contrast, the Texas community benefits law mentioned above in Part III of this article explicitly requires nonprofit hospitals to devote significant resources to providing free care for uninsured and indigent populations.[54] The Texas law thus provides a much better model of effective community benefits legislation. In order to secure greater nonprofit hospital accountability, a legislative solution, whether implemented at the state level or at the municipal level, must establish specific community benefit spending requirements; empower an appropriate government agency or regulatory body to monitor compliance; and set out real penalties—such as revocation of tax exemptions—for noncompliance.[55]

V. Conclusion

Private nonprofit hospitals are an essential component of the health care delivery system in the United States. And they are the very webbing of the health care safety net, such as it is, for the huge

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[51] Community Benefits Act, 210 ILL. COMP. STAT. 76/10 (WEST 2005) and STATE OF ILLINOIS OFFICE OF THE ATTORNEY GENERAL, *supra* note 50, at 3, 4.

[52] STATE OF ILLINOIS OFFICE OF THE ATTORNEY GENERAL, *supra* note 50, at 1.

[53] Community Benefits Act, 210 ILL. COMP. STAT. 76 (WEST 2005) (failing to mandate expenditures on community benefit programs).

[54] Charity Care and Community Benefits Requirements for Charitable Hospitals, TEX. TAX CODE ANN. § 11.1801 (WEST 2005).

[55] *See* Noble, Hyams, & Kane, *supra* note 12, at 131 (recommending a model "Community Benefit Accountability Act" that includes these features, among others).

number of Americans who lack adequate health insurance. In support of the charitable mission that they are supposed to serve, nonprofit hospitals enjoy exemption from a wide range of taxes, access to tax-exempt financing, and access to charitable donations—all of which amounts to a considerable investment of outside resources in these private institutions. However, as nonprofit hospitals have come under increased scrutiny, there is a growing sense, at both the national and local levels, that the public is not getting from nonprofit hospitals all that it is paying for. Until such time as comprehensive reform of the American health care system becomes a real political prospect, communities, governments, and ordinary citizens must demand greater accountability and greater fidelity to charitable mission from nonprofit hospitals. Grassroots community mobilization at the local level and carefully crafted accountability legislation at the state or local levels offer the most promising opportunities for securing those ends.

Appendix I—Federal and State Tax Exemption Regulations

A. Federal Guidelines

Nonprofit hospitals qualify for exemption from federal taxes under Section 501 of the Internal Revenue Code.[56] Part (c)(3) of that section exempts the following sorts of organizations from income tax:

> Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific . . . purposes . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation . . . and which does not participate in, or intervene in . . . any political campaign on behalf of (or in opposition to) any candidate for public office.[57]

According to a 1956 IRS revenue ruling intended to clarify the application of this regulation to hospitals, "[t]he only ground upon which a hospital may be held to be exempt under section 501(c)(3) of the Code is that it is organized and operated primarily for educational, scientific or public charitable purposes. Usually the ground for exemption is that it is organized and operated for public charitable purposes."[58] This ruling goes on to state that, in order to qualify for exemption, a hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."[59] Simply put, the 1956 IRS ruling required any nonprofit hospital to provide charity care as a condition on maintaining its tax-exempt status.[60]

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[56] Noble, Hyams, & Kane, *supra* note 12, at 118.

[57] I.R.C. § 501 (West 2005).

[58] Rev. Rul. 56-185, 1956-1 C.B. 202.

[59] *Id.*

[60] Aitsebaomo, *supra* note 15, at 87-88.

After the creation of Medicare and Medicaid programs in 1965, nonprofit hospitals began to receive compensation from federal and state government for many services that formerly would have counted as charity care.[61] In recognition of this change, the IRS in 1969 issued a new ruling that set out a less restrictive "community benefits standard" for hospital tax exemption.[62] The 1969 ruling suggests that, in order to maintain its tax-exempt status, a hospital need only demonstrate that its "use and control . . . are for the benefit of the public and that no part of the income of the organization is inuring to the benefit of any private individual nor is any private interest being served."[63] So the 1969 ruling—which remains the controlling federal guideline today—says that a nonprofit hospital qualifies as an institution of public charity and is thus exempt from federal tax provided that it returns significant benefits to the community in which it operates. Charity care is no longer considered the only such benefit, though, and the provision of charity care is no longer specifically mandated. Medical research, health education programs, community outreach initiatives, and the maintenance of an emergency room open to all are now recognized as qualifying community benefits, among others.[64]

B. Illinois State Guidelines

In Illinois, as in many other states, a nonprofit corporation that qualifies for exemption from federal income tax as a charitable organization under Section 501(c)(3) of the Internal Revenue Code also thereby qualifies for exemption from state income tax.[65] This holds for nonprofit hospitals as well as for other nonprofit organizations.

However, under Illinois law, the fact that a nonprofit hospital is recognized as an exempt organization by the federal government is not sufficient to qualify it for exemption from state sales tax and local property taxes. Exemption from sales tax is granted to a non-governmental organization only if it is "a corporation, society, association, foundation, or institution organized and operated

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[61] Noble, Hyams, & Kane, *supra* note 12, at 118. Burns, *supra* note 15, at 669.

[62] Aitsebaomo, *supra* note 15, at 88-89

[63] Rev. Rul. 69-545, 1969-2 C.B. 117.

[64] Noble, Hyams, & Kane, *supra* note 12, at 118.

[65] Illinois Income Tax Act, 35 ILL. COMP. STAT. 5/205 (WEST 2005).

exclusively for charitable, religious, or educational purposes."[66] Similarly, a nonprofit hospital is exempt from property tax only if it qualifies as an "institution of public charity" and the property in question is "actually and exclusively used for charitable or beneficent purposes, and not leased or otherwise used with a view to profit."[67]

These requirements for sales and property tax exemption are, it turns out, quite demanding. The point is brought home by the guidelines, set out in a 1968 decision by the Illinois Supreme Court, for assessing whether an organization is genuinely an "institution of public charity":

> (1) the benefits derived [from the operations of the organization] are for an indefinite number of persons;
>
> (2) the organization has no capital, capital stock or shareholders;
>
> (3) funds are derived mainly from private and public charity, and the funds are held in trust for the objects and purposes expressed in the charter;
>
> (4) the charity is dispensed to all who need and apply for it, and does not provide gain or profit in a private sense to any person connected with it;
>
> (5) the organization does not appear to place obstacles of any character in the way of those who need and would avail themselves of the charitable benefits it dispenses.[68]

These guidelines remain the core of the standard for property and sales tax exemption in Illinois, and have been reaffirmed by other state court decisions in the intervening thirty-seven years.[69]

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[66] Illinois Use Tax Act, 35 ILL. COMP. STAT. 105/3-5(4) (WEST 2005); Illinois Retailers' Occupation Tax Act, 35 ILL. COMP. STAT. 120/2-5(11) (WEST 2005).

[67] Illinois Property Tax Code, 35 ILL. COMP. STAT. 200/15-65 (WEST 2005).

[68] Methodist Old People's Home v. Korzen, 39 Ill. 2d 149 (1968).

[69] Alivio Med. Cen. v. Ill. Dept. of Rev., 299 Ill. 3d 647 (1998); Riverside Med. Ctr. v. Ill. Dept. of Rev., 342 Ill. App. 3d 603 (2003); Eden Retirement Ctr. v. Ill. Dept. of Rev., 213 Ill. 2d 273 (2004).

Appendix II—What Does and Does Not Count As A Community Benefit Expenditure

Not every donated or under-reimbursed good or service that a nonprofit hospital may want to claim as a community health benefit should be counted as such. Indeed, some health care industry experts suggest that charity care is the only legitimate community benefit.[70] But, even if it is allowed that spending on goods and services other than charity care can count as genuine community benefit expenditures, there are some commonly claimed expenditures that clearly do *not* count. Foremost among these is bad debt. Hospital bad debt is "uncollectible charges, excluding contractual adjustments, arising from the failure to pay *by patients whose health care has not been classified as charity care*."[71] According to the industry standard community benefits reporting handbook put out by the Catholic Health Association and VHA Inc., bad debt is not a genuine community benefit and should not be counted as such.[72] Bad debt is simply the cost of doing business in any industry. In the health care industry, it is a cost borne by for-profit providers as well as nonprofit providers.[73] And bad debt is certainly *not* a measure of the free or discounted care that a nonprofit hospital *intentionally* and *voluntarily* provides to those in need.[74] Nonetheless, some nonprofit hospitals and hospital systems attempt to get away with including bad debt in

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[70] *See* Susan Sanders, *The 'Common Sense' of the Nonprofit Hospital Tax Exemption: A Policy Analysis*, 14 JOURNAL OF POLICY ANALYSIS AND MANAGEMENT 446 (1995) (arguing for linking tax exemptions to nonprofit hospitals' provision of direct charity care).

[71] CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES AND VHA INC., *supra* note 17, at 12 (emphasis added).

[72] *Id.* at 37.

[73] Mark Hall & John Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, at 347 (1991). *See also* Frank Sloan, *Commercialism in Nonprofit Hospitals*, 17 JOURNAL OF POLICY ANALYSIS AND MANAGEMENT 234 (1998) (arguing that nonprofit hospitals do not differ significantly from for-profit hospitals with respect to quality of care provided, amount of uncompensated care provided, and adoption of new medical technologies).

[74] *See* Burns, *supra* note 15, at 681 (arguing that "[w]riting off bad debt after the fact should not be considered charitable because it is not altruistic and it mitigates the benefit conferred on society. Charity care, when in the form of bad debt, can financially cripple indigent patients.").

their reporting of community benefit expenditures, typically by lumping charity care together with bad debt and reporting the whole sum as "uncompensated care."[75]

On a related note, when claimed as a community benefit expenditure, charity care should be valued *at cost*, rather than at charge.[76] This point, too, has been recognized and accepted by the nonprofit hospital industry for some time,[77] even though certain hospitals continue to inflate their reports of spending in this area by reporting charity care as "charges foregone," which values the care at the inflated prices listed on the hospital's chargemaster.[78]

Many nonprofit hospitals also conflate spending on community benefit programs with spending on marketing programs. It is often difficult to distinguish a free service that provides a genuine community health benefit from a marketing program that generates revenue, and hospitals routinely take advantage of this difficulty to inflate their reports of community benefit spending.[79] For example, providing free blood pressure testing may be, in part, a community benefit, but it also serves as advertising for a hospital and potentially generates new paying business. Likewise, a free informational session on new weight loss surgery techniques may provide useful health information to certain members of the community, but it is also an opportunity for the hospital to market the new surgery to paying customers. Many for-profit hospitals also

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[75] *Id.* at 673. *See also, e.g.*, the "Financials" section of the "System Report" in ADVOCATE HEALTH CARE, *2003 Annual Report*, *available at* www.advocatehealth.com/system/about/reports/ar2003/index.html (claiming that "Advocate provided more than $218 million in uncompensated care and community benefit programs and services" in 2003); and RESURRECTION HEALTH CARE, *Resurrection Health Care: Fulfilling Our Charitable Commitment* (June 14, 2004), *available at* www.reshealth.org/aboutus/newsmedia/press_info.cfm (claiming that, in 2003, Resurrection fulfilled its charitable commitment by providing "approximately $124.5 million in uncompensated care to patients").

[76] *See* Clement, Smith, & Wheeler, *supra* note 18, at 164.

[77] CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES AND VHA INC., *supra* note 17, at 12.

[78] *See, e.g.*, ADVOCATE HEALTH CARE, *Advocate Health Care Network and Subsidiaries Consolidated Financial Statements—Years Ended December 31, 2003, 2002, and 2001*, at 12 (reporting "*charges foregone* for services and supplies provided to the community . . . " as part of the corporation's benefit provided to the community [emphasis added]).

[79] Thomas Buchmueller, *Hospital Community Benefits Other Than Charity Care: Implications for Tax Exemption and Public Policy*, 41 HOSPITAL AND HEALTH SERVICES ADMINISTRATION 461, 464 (1996).

engage in such activities, presumably for good business reasons.[80] So, unless a nonprofit hospital provides a line-item breakdown of its spending on specific programs and activities—which, unfortunately, most nonprofit hospitals still do not do—it is impossible to tell how much of that hospital's spending on free and reduced-price public programs goes toward genuine community benefit activities, and how much goes toward programs that mix community benefits with marketing.

Finally, many nonprofit hospitals report unreimbursed Medicaid and Medicare costs—the difference between cost of care and government reimbursement for services provided to Medicaid and Medicare patients—as community benefit expenditures. But the rationale for doing so is dubious at best. In those states where there is a Medicaid or Medicare shortfall, *every* Medicaid and Medicare provider, whether for-profit or nonprofit, bears the burden of low reimbursements.[81] What's more, both the federal and state governments typically disburse additional payments to hospitals in order to offset the costs of providing care to Medicaid and Medicare patients.[82] Tax exemptions were never intended to serve that purpose. And, in Illinois, a recent court decision addressing the requirements for charitable exemption from property tax suggests that unreimbursed Medicaid and Medicare costs do not count as charitable expenditures.[83] All of this indicates that a nonprofit hospital's unreimbursed Medicaid and Medicare costs should not be counted as spending on community benefits.

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[80] Buchmueller, *supra* note 79, at 464-65.

[81] *See* Kane & Wubbenhorst, *supra* note 12, at 196 (arguing that evidence suggests that there is no significant difference between for-profit and nonprofit hospitals in their levels of participation in the Medicaid program).

[82] *Id.* at 186.

[83] Riverside Med. Ctr. v. Ill. Dept. of Rev., 342 Ill. App. 3d 603 (2003).

Appendix III – Estimating the Value of Preferential Tax Treatment

A full accounting of the value of tax-exempt status to a nonprofit hospital requires capturing five different categories or sources of value.

A. Federal and State Income Tax Savings

While for-profit hospitals pay federal and state income taxes on their yearly earnings, nonprofits do not pay taxes on their "surplus revenues"—and many nonprofit hospitals do post annual revenue surpluses. To calculate a hospital's total state and federal income tax savings, apply the federal and state tax rates paid by for-profit hospitals (available from the IRS and from the state department of revenue) to the total surplus revenue or "income" reported by the hospital on its annual audited financial statement. Though this approach does not take into account the changes in business behavior and accounting practices that might occur should a nonprofit hospital be subject to income tax, it is a standard approach used by experts researching the value of hospitals' nonprofit status.[84]

B. State and Local Sales Tax Savings

In many states, including Illinois, nonprofit hospitals enjoy exemption from state and municipal sales and use taxes on the purchase of supplies that they use in the course of normal business operations.[85] To calculate the value of a hospital's sales and use tax savings, multiply the system's annual expenses on supplies, as reported in the IRS form 990 filing, by the sales tax rate in the municipality where the hospital is located, which is available from the state department of revenue or from local government.

Because some hospital systems have hospitals in different municipalities and different municipalities often have different sales tax rates, it may be necessary to calculate separately the savings at each of a system's individual hospitals and then sum those figures to arrive at the overall savings for the system. In addition, some states,

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[84] *See, e.g.*, Morrisey, Wedig, & Hassan, *supra* note 13, at 134-135 (defending this approach to estimating the value of nonprofit hospital income tax savings).

[85] 86 ILL. ADM. CODE 130 § 2005(m) (2003).

including Illinois, have lower sales tax rates for medical supplies.[86] In such a case, because it is typically not possible to tell from a hospital's IRS form 990 disclosures what proportion of its supply expenditures would have been subject to the medical tax rate and what proportion would have been subject to the general sales tax rate, it may be necessary to express that hospital's annual sales tax savings as falling somewhere within a range.

C. Local Property Tax Savings

Illinois tax law, like the law in many states, provides that property owned and used by nonprofit hospitals is exempt from property taxes.[87] In places where some government assessing body maintains official assessment records on such property, calculating the value of a hospital's property tax exemptions is an easy matter: simply take the assessed values of the hospital's property, as recorded by the assessing body, and apply the formula for calculating property taxes in that locality to determine what the tax bills would have been if that property had been taxed.

In places such as Cook County, Illinois, where assessment records for exempt property are not available, there are a couple of other ways in which one can estimate property tax bills.[88] One way is to obtain, from a consultant or private assessor, an independent assessment of the value of the hospital property in question, and then apply to that assessment the formula for calculating property taxes. But private assessors and consulting services can be expensive. Alternatively, if there are some for-profit hospitals operating in the community in question, then one can determine from public tax records what the for-profit hospitals in that area pay in property taxes per hospital bed and multiply that figure by the total number of beds at the nonprofit hospital in question to get an estimate of the nonprofit's property tax liability.

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[86] *See* ILLINOIS DEPARTMENT OF REVENUE, *Frequently Asked Questions—Sales Tax*, *available at* www.iltax.com/Businesses/Faq/rotfaq.html (discussing the different sales tax rates for different goods and services in Illinois).

[87] Illinois Property Tax Code, 35 ILL. COMP. STAT. 200/15-65 (WEST 2005).

[88] In addition to the two approaches mentioned here, still other approaches to estimating the value of property tax exemptions are discussed in Gentry & Penrod, *supra* note 7, at 27-30, and in Kane & Wubbenhorst, *supra* note 12, at 192-194.

D. Savings from Access to Tax-Exempt Debt

Investors are willing to lend to tax-exempt bond issuers—such as nonprofit hospitals—at lower interest rates than those at which they lend to issuers of taxable debt—such as for-profit hospitals—because investors do not pay income tax on the interest they earn from tax-exempt bonds.[89] To estimate the value of this savings to a nonprofit hospital, calculate the difference between the interest rates on taxable and tax-exempt bonds at a given point in time (available from financial publications or bond rating agencies) and multiply that differential by the total amount of bond debt that the hospital has outstanding at that time (as disclosed in the hospital's annual audited financial statement).[90]

E. Charitable Contributions

As nonprofit organizations, donations to nonprofit hospitals are tax-deductible for the donors. Most such hospitals thus receive contributions and gifts that they would, presumably, not receive if they were for-profit operations. To determine the annual value of contributions to a nonprofit hospital, simply take the amount of charitable contributions as reported in the hospital's IRS form 990 filing. Some nonprofit hospitals set up nominally independent charitable foundations to solicit contributions, in which case it will be necessary to identify those foundations and to obtain their IRS form 990 filings.[91]

Two notes of caution here: First, some hospitals with nominally independent foundations may report (some of) the same charitable contributions on both the hospital's and the foundation's IRS form 990 filings. If it cannot be determined in a particular case whether this is happening, it is best to avoid double counting by including only those contributions made to one source. Second, include only the reported amount of "direct public support"—that is, contributions and gifts made directly to the hospital or foundation by private individuals, corporations, and other foundations. Do not include grants that the hospital or foundation received from government agencies, because for-profit hospitals also receive government grant money and, therefore, this is arguably not an

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[89] *See* Morrisey, Wedig, & Hassan, *supra* note 13, at 132.

[90] *Id.* at 135.

[91] *See* Kane and Wubbenhorst, *supra* note 13, at 195 (raising the difficulties posed by donations to nominally independent foundations).

advantage enjoyed uniquely by nonprofits in virtue of their special status.

F. Other Savings

Many nonprofit hospitals also receive additional subsidies at the local level such as free or reduced-price water and sewage service. Whether it is possible to accurately determine the monetary value of such savings will depend on what information is available to the public at the local level.