IN THE CIRCUIT COURT OF SANGAMON COUNTY, ILLINOIS

PROVENA COVENANT MEDICAL CENTER, PROVENA HOSPITALS, *Plaintiffs*, v. THE DEPARTMENT OF REVENUE OF THE STATE OF ILLINOIS, AND BRIAN A. HAMER in his official capacity as DIRECTOR of the Illinois Department of Revenue, *Defendants*.	)	Case No. 2006-MR-000597

BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PLAINTIFFS

STATEMENT OF INTEREST OF *AMICUS CURIAE*

The American Hospital Association (AHA) on behalf of its members submits this brief *amicus curiae* in support of Provena Hospitals' and Provena Covenant Medical Center's (collectively, Plaintiffs') challenge to the final administrative decision made by the Illinois Department of Revenue (Department) through its Director, Brian A. Hamer (Director), denying them a property tax exemption.

Founded more than a century ago, the AHA is a national not-for-profit association that represents the interests of nearly 5,000 hospitals, health care systems, networks and other care providers, as well as 37,000 individual members, all of whom are committed to finding innovative and effective ways of improving the health of the communities they serve. Counted among its broad and diverse membership are all types of not-for-profit hospitals and health care networks that serve individual patients and communities by providing care to those in need

regardless of ability to pay. The AHA educates its members on health care issues and trends and advocates on their behalf in state and federal legislative, regulatory and judicial fora to ensure that its members' perspectives and needs are understood and taken into account in the formulation of healthcare policy.

Because of their abiding commitment to advancing the health of the communities they serve, AHA's members have a great interest in the outcome of this case, for it carries the potential to seriously impair their ability to meet the health care needs of their communities. If it stands, the Department's denial of a property tax exemption to Plaintiffs – and the unsound principle on which it rests – will call into doubt the tax-exempt status of every not-for-profit hospital in Illinois. If these institutions' exemptions are similarly revoked, the resulting financial drain will jeopardize Illinois residents' access to needed care they rely on these hospitals to deliver. Nor is the effect of this decision likely to stop at Illinois' borders: The Department's ruling may influence similar decisions by taxing authorities in other parts of the country.

In view of the far-reaching and ominous implications of the Department's decision for AHA's members nationwide, the AHA offers its views to aid the Court in its review of that decision.

ARGUMENT

Our nation's healthcare system has undergone significant changes during the last century; it has enjoyed great advances in science and technology and witnessed the rise of public and private insurance programs. But for sound public policy reasons one facet of this system has remained constant: Recognizing the benefits not-for-profit hospitals provide to their communities, the states and the federal government have sustained the partnership they forged long ago with these hospitals by continuing to afford them exemption from taxes.

Courts around the country and policymakers have long understood that tax exemption for not-for-profit hospitals is vital to their ability to deliver essential care to the communities they serve. Exemption enables them to dedicate their earnings to advancing their charitable objectives by, among other things, increasing access to care, expanding the range of their services (many of which are themselves unprofitable), conducting research, educating health care professionals, improving the quality of their care, upgrading their facilities and investing in state-of-the-art technology. Tax exemption is thus the foundation on which the long-standing relationship between government and not-for-profit hospitals has been built. This foundation remains firm in Illinois. *See Congressional Sunday Sch. & Publ'g Soc'y v. Board of Review*, 290 Ill. 108, 113 (1919) ("The fundamental ground upon which all exemptions in favor of charitable institutions are based is the benefit conferred upon the public by them, and a consequent relief, to some extent, of the burden upon the state to care for and advance the interests of its citizens.").

By revoking Plaintiffs' tax exemption based on a mistaken notion of charitable purposes, however, the Department's decision discards the policy rationale underlying this historic and crucial relationship. Its rejection of this rationale comes at a time when not-for-profit hospitals face significant challenges in meeting the needs of their communities: The tens of millions of uninsured Americans, mounting underpayments by government healthcare programs, and rising costs of delivering health care have all conspired to increase the burden on the already strained not-for-profit hospitals that provide care to all irrespective of ability to pay. Increasing these hospitals' tax burden threatens to take needed health care resources away from communities. The Court should therefore reverse the Department's ill-considered ruling.

I. NOT-FOR-PROFIT HOSPITALS TODAY MORE THAN EVER LESSEN THE BURDENS OF GOVERNMENT BY ASSURING ACCESS TO HEALTHCARE FOR ALL IN THEIR COMMUNITIES.

The same sound policy reasons that led the Illinois Supreme Court a century ago to recognize that not-for-profit hospitals' property is exempt from taxation remain relevant – indeed *more* relevant – in today's modern healthcare environment. There simply can be no question that, just as they did a century ago, not-for-profit hospitals today significantly "lessen[ ] the burdens of government," by, among other things, serving as an indispensable healthcare safety net to this country's uninsured and underinsured. *Crerar v. Williams*, 145 Ill. 625, 643 (1893). Hospitals indeed "do more to assist the poor, sick, elderly and infirm than any other entity in the health care sector." *Taking the Pulse of Charitable Care & Community Benefits at Nonprofit Hospitals*, Hearing Before the S. Comm. on Finance, 109th Cong. 1 (2006) (statement of Kevin Lofton, Chairman-elect, Board of Trustees, American Hosp. Ass'n) [*AHA Testimony*]. In a very real sense, they represent the healthcare "backbone of the communities they serve," providing care twenty-four hours a day, seven days a week, 365 days a year to all those in need – irrespective of ability to pay. *Id.*

AHA's members understand quite well the critical role that not-for-profit hospitals play in the modern healthcare system. According to a recent study conducted on behalf of the AHA, "[o]ne hundred percent of the general/medical hospitals [surveyed] operate[ ] an emergency room" that provides care to "all members of the community regardless of the patient's ability to pay." *Community Benefit Information from Non-Profit Hospitals: Lessons Learned from the 2006 IRS Compliance Check Questionnaire, A Report Prepared for the American Hosp. Ass'n By Ernst & Young LLP*, Nov. 27, 2006, at i [*Community Benefit Lessons Learned*]; *accord id.* at 3. These hospitals also "provid[ed] uncompensated care to, on average, 12% of their total

patients during the past year," at a cost of approximately "$14 million per hospital." *See id.* at i-ii; *accord id.* at 4. In 2004 alone, "hospitals delivered more than $27 billion (in costs) in uncompensated care," excluding the "uncounted billions more in value to their communities through services, programs and other activities designed to promote and protect health and well-being." *AHA Testimony* at 1.

The critical safety net that not-for-profit hospitals provide to their communities is only becoming more important as the number of uninsured Americans soars. The Census Bureau recently reported that 46.6 million Americans are uninsured, which represents "an increase of 1.3 million people from 2004 to 2005, with 400,000 additional children uninsured." *AHA Testimony* at 5; *see also* Carmen DeNavas-Walt *et al.*, U.S. Census Bureau, Current Population Reports, *Income, Poverty, & Health Insurance Coverage in the United States: 2005*, at 20 (GPO Aug. 2006) ("In 2005, 46.6 million people were without health insurance coverage, up from 45.3 million people in 2004."); *see also id.* at 23 (figure 7).

But the rising tide of uninsured Americans – and the impact of that phenomenon on not-for-profit hospitals – cannot be viewed in isolation. It must be considered alongside the mounting underpayments from government healthcare programs to not-for-profit hospitals for care to program participants. As AHA has reported, for example, 68 percent of hospitals lose money treating Medicare patients, with 33 percent sustaining negative operating margins – meaning "a third of hospitals lose money on operations." AHA, *Protecting & Improving Care for Patients & Communities: Keeping Hospitals Prepared to Care – It's Time for Investment, Not Cutbacks*, at 2. And the lack of health care coverage for so many Americans must also be understood in light of the escalating operating costs to deliver care fueled by an aging population

and healthcare worker shortages as well as the rising costs of medical liability insurance and prescription drugs.

When these realities are viewed together, one ineluctable conclusion emerges: Not-for-profit hospitals now do more to relieve the burdens of government in serving their communities than they did one hundred years ago. In fact, charity care provided by hospitals today is "all that stands between a thorny policy dilemma and an access crisis for millions of Americans." 1/ And in recognition of the increasingly critical role played by these hospitals, AHA has urged its members to "provide free care to those below 100 percent of the federal poverty level and financial assistance to those who are between 100-200 percent of that level." *AHA Testimony* at 5. Without such commitments by private not-for-profit hospitals these governments alone would be required to meet their communities' critical hospital care needs.

Yet, at the same time that the safety net that not-for-profit hospitals – like Plaintiffs – extend to the uninsured is becoming increasingly vital, decisions revoking a not-for-profit hospital's exemption from property taxes – like the Department's – tear the very fiber of that net apart. And without good reason. Only by concentrating narrowly on one component of Plaintiffs' charitable purposes, while excluding important others entirely from view, was the Department able to conclude that Plaintiffs provide merely the "illusion of charity." Final Decision at 11.

1/ PricewaterhouseCoopers, Health Research Institute, *Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape*, at 1 (2005), *available at* http: //www.pwc.com/us/eng/about/ind/healthcare/pubcharitycare.html; *see also AHA Testimony* at 5.

II. THE DEPARTMENT ADOPTED A FAR TOO LIMITED VIEW OF NOT-FOR-PROFIT HOSPITALS' CHARITABLE PURPOSES THAT IGNORES IMPORTANT ASPECTS OF THEIR CHARITABLE CARE.

The Department's decision ultimately turned on one simply stated – but profoundly mistaken – conclusion: Plaintiffs provided "insufficient" free care to merit a tax exemption. Final Decision at 6. But in focusing on only one aspect of a not-for-profit hospital's charitable purposes, and taking an overly narrow view of that contribution, the Department rejected the broad and flexible definition of charity followed in this and other states, brushed aside core principles informing the broad conception of charity and ignored key aspects of the charitable care that not-for-profit hospitals afford their communities.

1. The Director concluded that it would "defy logic" to grant Plaintiffs a property tax exemption given that their primary purpose is the exchange of medical services for fees – not charity. Final Decision at 15. His "primary basis" for this finding was the fact that the medical center's 2002 revenues exceeded $13 million while its "charitable activities cost it only $831,724, or about .7% of total revenue." *Id.* at 2. By focusing narrowly and exclusively on the quantity of free care provided by Plaintiffs, however, the Director adopted a view of charity that breaks faith with the broad standard of charitable undertakings entitled to property tax exemption that this state has employed for a century. 2/ In Illinois, "[c]harity, in the legal sense, is not confined to mere almsgiving or relief of poverty and distress, but has a wider signification, which embraces

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2/ *See Sisters of Third Order of St. Francis v. Board of Review*, 231 Ill. 317, 321 (1907) ("It is an institution of public charity; and where an institution devoted to beneficence of that character is * * * exempt from taxation, it does not lose its immunity by reason of the fact that those patients received by it who are able to pay are required to do so, * * * so long as all the money received by it is devoted to the general purposes of the charity, and no portion of the money received by it is permitted to inure to the benefit of any private individual * * * ."); *see also Lutheran Gen. Health Care Sys. v. Department of Revenue*, 231 Ill. App. 3d 652, 664 (1992) ("The [Illinois Supreme Court] has also held that the fact that an institution charges fees for its services from those who are able to pay does not preclude exemption where no profit is made and the amounts received are applied in furthering the institution's charitable purpose.").

the improvement and promotion of the happiness of man." *Congressional Sunday Sch. & Publ'g Soc'y*, 290 Ill. at 113.

The Department's novel free care test not only marked a departure from Illinois precedent; it blazed an anomalous path seriously out of step with the mainstream view of charity shared by a majority of states. 3/ As AHA has pointed out elsewhere, courts across the country, in decisions stretching back far into the last century, have uniformly rejected the very "free-care" standard the Department used to deny Plaintiffs a property tax exemption. 4/ *See AHA Testimony* at 3. Nearly fifty years ago, for example, the Virginia Supreme Court declared that "[a] tax exemption cannot depend upon any such vague and illusory concept as the percentage of free service actually rendered," but, insofar as not-for-profit hospitals are

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3/ Consideration of other states' views is particularly appropriate here given that the various states' charity laws – including Illinois' – descended from a common English ancestor. *See* Charles A. Borek, *Decoupling Tax Exemption for Charitable Organizations*, 31 Wm. Mitchell L. Rev. 183, 195 (2004) ("As the preeminent English exposition on the law of charity, the Statute of Charitable Uses became the principal source of such law in the United States after the American Revolution. * * * [T]he most important perspective inherited from the English law was its expansive view of what was 'charitable.' "); *Taylor v. Keep*, 2 Ill. App. 368, 1878 WL 10421, at *6 (1878) ("The words *charity* and *charitable uses*, at least in this State, where the statute * * * commonly known as the Statute of Charitable Uses, is held to be in force, must be determined with reference to the provisions of that statute.").

4/ *See, e.g., Harvard Cmty. Health Plan, Inc. v. Board of Assessors*, 427 N.E.2d 1159, 1163 (Mass. 1981) ("[T]he promotion of health, whether through the provision of health care or through medical education and research, is today generally seen as a charitable purpose."); *Evangelical Lutheran Good Samaritan Soc'y v. County of Gage*, 151 N.W.2d 446, 449 (Neb. 1967) (" '[T]he courts have defined 'charity' to be something more than mere alms-giving or the relief of poverty and distress, and have given it a significance broad enough to include practical enterprises for the good of humanity.' ") (quoting *Young Men's Christian Ass'n v. Lancaster County*, 182 N.W. 593, 595 (Neb. 1921)); *Salvation Army v. Hoehn*, 188 S.W.2d 826, 830 (Mo. 1945) (Charity "benefit[s] * * * an indefinite number of persons, * * * by relieving their bodies from disease, suffering, or constraint, * * * or otherwise lessening the burdens of government." (internal quotation marks & citation omitted)); *Nuns of Third Order of St. Dominic v. Younkin*, 235 P. 869, 872 (Kan. 1925) ("[I]t is uniformly held that [a] hospital is conducted exclusively for charitable purposes" when its earnings from "whatever source are used in the maintenance, extension, and improvement of the hospital.").

concerned, depends instead upon "the nature of these institutions and the purpose of their operations." *City of Richmond v. Richmond Memorial Hosp.*, 116 S.E.2d 79, 81-82 (Va. 1960). That court concluded that "[n]on-profit hospitals which are devoted to the care of the sick, which aid in maintaining public health, and contribute to the advancement of medical science are and should be regarded as charities." *Id.* at 84. Time has not taken a toll on this expansive view. 5/

To the contrary, the passage of time has only strengthened states' broad definition of charity: Even today, courts across the country adhere to the expansive view of charity that was initially espoused in cases like *Richmond Memorial*. *See, e.g., ElderTrust of Fla., Inc. v. Town of Epsom*, -- A.2d --, 2007 WL 108936, at *5 (N.H. Jan. 18, 2007) (holding that "charging fees" does not prevent charitable tax exemption "as long as the fees directly fulfill the organization's charitable purpose, or are necessary for the organization to accomplish its purpose"); *Western Mass. Lifecare Corp. v. Board. of Assessors*, 747 N.E.2d 97, 104 (Mass. 2001) ("An organization does not necessarily have to serve the poor or needy in order to qualify for the charitable exemption."); *Carroll Area Child Care Ctr., Inc. v. Carroll County Bd. of Review*, 613 N.W.2d 252, 255, 259 (Iowa 2000) ("[T]his state is committed to the broad definition of charity" as " 'encompass[ing] all humanitarian activities' " and is "not limited to the needy") (citation omitted); *Plainfield Elks Lodge No. 2186 v. State Bd. of Tax Comm'rs*, 733 N.E.2d 32, 34, 36 n.6 (Ind. Tax Ct. 2000) (explaining that definition of "charity" does not "turn[ ] on the percentage of

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5/ Recognizing that not-for-profit hospitals must be flexible and creative in tailoring their services to the communities they serve and that "free care" is only one aspect of their charity, the federal government has also adopted a broad definition of charity for determining whether a hospital may claim a "charitable organization" exemption under 26 U.S.C. § 501(c)(3). The Internal Revenue Service has stated that "the promotion of health * * * is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community." Rev. Ruling 69-545, 1969-2 C.B. 117.

its gross income used for charitable, educational or other benevolent purposes"); *Mingledorff v. Vaughan Reg'l Med. Ctr., Inc.*, 682 So. 2d 415, 422 (Ala. 1996) (holding that "hospitals * * * whose overall objective is to provide health services to the public at large, with no reservation as to those who cannot afford to pay and with no eye toward the attainment of profit or private advantage" qualify for exemption); *Eyota Kid's Korner, Inc. v. County of Olmsted*, 1992 WL 389787, at *3 (Minn. Tax Ct. Dec. 29, 1992) (explaining that " '[p]urely public charity' has been given a broad meaning in many other Minnesota exemption cases" and collecting cases). As the Supreme Court of Alaska recently explained, for instance, "[i]t is quite clear that what is done out of good will and a desire to add to the improvement of the moral, mental, and physical welfare of the public generally comes within the meaning of the word 'charity.' " *Fairbanks North State Borough v. Denά Nenά Henash*, 88 P.3d 124, 132 (Alaska 2004) (internal quotation marks & citation omitted). Reasoning that its "concept of charity – as an activity that improves public welfare – reflects the public policy behind tax exemptions," it went on to hold that "[c]haritable activities provide a public benefit *whether or not* the beneficiaries are indigent." *Id.* at 135 (emphasis added).

The Supreme Court of Michigan, in a case remarkably similar to the one under review, also recently rejected the strict ledger-based analysis employed by the Department. In *Wexford Med. Group v. City of Cadillac*, 713 N.W.2d 734 (Mich. 2006), the tax tribunal denied a property tax exemption to a not-for-profit health care provider "by focusing only on the amount of free medical services [it] provided." *Id.* at 736. The court reversed, explaining that "[a] 'charitable institution' need not meet any monetary threshold of charity to merit the charitable institution exemption; rather, if the overall nature of the institution is charitable, it is a 'charitable

institution' regardless of how much money it devotes to charitable activities in a particular year." *Id.* at 746. The same is true here.

2. The Department's myopic focus on the quantity of free care provided by Plaintiffs led it to misapply core principles informing the broad view of charity recognized by policymakers and courts around the country. First, the Department seems to have mistaken effective management for lack of a charitable purpose insofar as it found the disparity between Plaintiffs' revenues and the amount of "free care" it provided suspect. Not-for-profit hospitals are "not required to use only red ink in keeping [their] books and ledgers," *Milwaukee Protestant Home for the Aged v. City of Milwaukee*, 164 N.W.2d 289, 296 (Wis. 1969), however, and the fact that "a given charity manages, through * * * careful management, to generate a surplus while carrying out its charitable purposes does not necessarily deprive the charity of a property tax exemption," *Fairbanks North State Borough*, 88 P.3d at 131. One commentator has explained:

> 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. [Colombo, *supra*, at 517 (footnote omitted).]

Indeed, "[t]o deny an otherwise qualifying institution charitable status because it is efficiently organized and managed, so as to operate in the black, would be not only illogical but also extremely detrimental to the incentive for sound management in such institutions." *Milwaukee Protestant Home for the Aged*, 164 N.W.2d at 296 n.11 (internal quotation marks & citation omitted). This is in part because a not-for-profit hospital that cannot cover its costs will obviously go out of business, *see* Colombo, *supra*, at 513, but also because "the profit made by

these institutions, if any, is payable to nobody" – it is instead "turned back into improving facilities or extending the benevolence in which the institutions are primarily engaged." 164 N.W.2d at 296. Accordingly, "the profit element [is] immaterial." *Id.* (internal quotation marks & citation omitted).

Second, in finding Plaintiffs' primary purpose was the exchange of medical services for fees, the Director placed undue emphasis on the nominal amount of donations received by Plaintiffs, stressing that they received "virtually no funds from public and private donations." Final Decision at 11-12. But "[t]here are many charities which rely on generating their own income apart from contributions; most hospitals and nursing homes no longer rely on charity, but are self-sustaining." *Dental Home Care, Inc. v. Commissioner of Revenue*, 1978 WL 1009, at *8 (Minn. Tax Ct. May 15, 1978). Consequently, "[m]aking significant donations a central part of the test for property tax exemption * * * would be the equivalent of ending exemption for most hospitals and other health care providers." Colombo, *supra*, at 522.

Third, the Director looked askance at Plaintiffs' reliance on third-party providers to deliver care to patients. *See* Final Decision at 7. That again was error. This is a longstanding practice employed by hospitals around the country. *See* Colombo, *supra*, at 521-522 ("Charities contract with for-profit entities for all sorts of common services in order to perform their charitable function."); *see generally* Barry R. Furrow *et al.*, 1 *Health Law* 109-110 (West 2d ed. 2000) ("For many years, physicians have provided hospital-based medical services * * * under contract with hospitals."). Thus, "if using independent for-profit contractors to help provide services endangers [property tax] exemption, then virtually all charitable organizations are at risk." Colombo, *supra*, at 522.

3. The Director's rigid "free care" test also led him to completely ignore core components of not-for-profit hospitals' charitable purposes. While he recognized that, as a "general proposition," "a hospital and the services it offers may improve the well being of the community in which it operates," he nevertheless concluded that "[p]roperty tax exemptions do not turn on these general propositions." Final Decision at 16-17. But in simply writing off the community benefits provided by Plaintiffs as an irrelevant "general proposition," the Department shut its eyes to a fundamental aspect of the charitable care that not-for-profit hospitals provide – and consequently came to the profoundly mistaken conclusion that Plaintiffs paid only "lip service to their charitable obligations." *Id.* at 14.

Recognizing that community involvement is key to not-for-profit hospitals' charitable objectives, many states – including this one – actually *require* them to file annual reports detailing the community benefits they provide. *See, e.g.*, Idaho Code Ann. § 63-602D(7); 210 Ill. Comp. Stat. 76/20; Tex. Health & Safety Code Ann. § 311.046(a). For its part, the AHA affirmatively encourages its members to tailor their care to their local communities' needs and, toward that end, "passed a resolution calling on hospitals to take steps to foster additional community involvement and to increase transparency in the service of that benefit." *AHA Testimony* at 4; *see also* Letter from Rich Umbdenstock to Chief Executive Officers, AHA Member Institutions, *Reporting Community Benefit – Policy Clarification & Guidance* 1 (Sept. 7, 2006) ("AHA believes it is essential that every hospital voluntarily, publicly and proactively report its community benefit."). Hospitals have responded to this call.

In a recent survey, the AHA found that "[o]ne hundred percent of the [surveyed] hospitals indicated that they provide additional community programs in addition to uncompensated care and charity care programs, including such offerings as community medical

screening programs, immunization programs and health education." *See Community Benefit Lessons Learned* at ii; *accord id.* at 5. More than half of the surveyed hospitals performed studies on the unmet healthcare needs within their communities, while nearly 90 percent had programs to improve access to health care for the uninsured, and over 90 percent "produce[d] or distribute[d] newsletters or other publications that provide information to the community on health care issues." *Id.* at 5.

Not-for-profit hospitals have implemented a variety of creative healthcare solutions responsive to the unique healthcare problems facing their communities. For example, recognizing that "oral health is the number one unmet health care need and a primary concern of Sonoma County residents," St. Joseph Health System in Santa Rosa, California, instituted a "three-pronged approach to oral health care that includes an affordable community dental clinic, school based education and prevention programs and a mobile dental clinic serving underserved members of [the] community." 6/ The St. Joseph dental clinic alone provides more than 5,000 visits to more than 4,200 children each year.

St. Joseph's does not stand alone in offering community-based care programs:

- Appreciating that many children in Nevada (which ranks 49th among the states in number of uninsured children) have foregone non-life-threatening surgeries because of a lack of insurance, Saint Mary's Regional Medical Center instituted "Project New Hope" in 1997. 7/ Project New Hope so far has provided 120 children care they could not otherwise afford.

6/ *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/access/2007/stjoseph.html (last visited Feb. 21, 2007).

7/ *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/access/2007/saintmarys.html (last visited Feb. 21, 2007).

- After discovering that many individuals have foregone prescription drug assistance for which they otherwise qualified simply because of the cumbersome application process involved, Concord Hospital in Concord, New Hampshire, instituted a Prescription Assistance Program in 2000. 8/ The Program has assisted "low-income families in 47 local communities receive more than $25.5 million in needed medications."

- In an effort to "bridge the racial-disparity gap of children with asthma, the most chronic disease among children in the nation," Crozer-Keystone Health System in Philadelphia, Pennsylvania, instituted a community-based program that uses basketball as a platform to teach "participants how to manage asthma through appropriate medication usage, proper nutrition, monitored exercise, and recreational activities." 9/

Many not-for-profit hospitals also provide valuable counseling services to their communities. For example, Massachusetts General Hospital Chelsea Healthcare Center established a "Police Action Counseling Team" in 1998. In order to reduce the long-term effects of trauma on children who witness violence in their families and communities, this program arranges for social workers "to ride along with Chelsea police officers responding to 911 calls where children are present" on a 24 hours a day, seven days a week basis. 10/

8/ *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2007/concord.html (last visited Feb. 21, 2007).

9/ *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/health/2007/crozer.html (last visited Feb. 21, 2007).

10/ *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2007/massgeneral.html (last visited Feb. 21, 2007).

Similarly, responding to the needs of school children suffering emotional, psychological and/or behavior difficulties in Racine, Wisconsin, Wheaton Franciscan Healthcare initiated the "Fresh Start" program. 11/ Fresh Start provides students a highly structured learning environment and counseling with the hope of reducing their "long-term emotional difficulties and successfully transition[ing them] back into the traditional classroom."

As part of serving the unique healthcare needs of their communities, not-for-profit hospitals also provide valuable services to resident homeless and indigent populations. For example:

- The Anne Arundel Medical Center of Annapolis, Maryland, responded to the acute healthcare needs of Annapolis' indigent and homeless by opening a free healthcare clinic – the Annapolis Outreach Center – in 1994. 12/ By 2005, the Center was receiving 300 patients a month.

- Saint Vincent's Hospital in Manhattan, New York, operates the SRO/Homeless Program, which "[p]rovides outreach, direct medical, mental health and substance abuse services, health education and screenings, case finding and case management" to Manhattan's homeless and marginally housed. 13/

11/ *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2007/wheaton.html (last visited Feb. 21, 2007).

12/ *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/access/2007/arundel.html (last visited Feb. 21, 2007).

13/ *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseeexamples/social/2006/saintvincentsny.html (last visited Feb. 21, 2007).

- The Mercy Hospital of Pittsburgh is part of Operation Safety Net, which is "[a]n innovative street outreach program for the unsheltered and transient homeless population." 14/

Not-for-profit hospitals also conduct important medical research and training. Approximately one third of AHA's not-for-profit hospital members conduct medical research, "with those hospitals spending an average of $19 million on the medical research programs." *See Community Benefit Lessons Learned* at 4. Another "[f]orty-two percent * * * conduct[ ] medical trial studies," and yet another "[s]ixty-four percent * * * conduct[ ] professional medical education and training programs" costing these hospitals an average of $7 million annually. *Id.* The Northwestern Memorial Hospital, for example, invested $25.5 million in medical education and training in 2005 alone. *See Northwestern Mem'l Hosp. 2005 Cmty Serv. Report* at 8, *available at* http://www.nmh.org/nmh/pdf/nmh_2005_csr.pdf. This substantial investment allowed the hospital to train 675 medical residents and 740 medical students, as well as launch more than 600 new research studies, with many "aimed at introducing diagnostic or therapeutic techniques that may create new options for patient care." *Id.* at 8-9. Similarly, the Cleveland Clinic has committed substantial sums for medical research inquiries, including studies of vasculitis (a potentially deadly illness caused by the inflammation of blood vessels presently without a cure) and colon cancer. 15/

These community benefits programs are critical to the areas these hospitals serve. They are creatively tailored to meet community needs. They are conceived and implemented with compassion for the plight of the less fortunate members of the surrounding community. And

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14/ *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2006/pittsburghmercy.html (last visited Feb. 21, 2007).

15/ *See* Cleveland Clinic, Catalyst, *2005 Annual Report*, at 4, 8, *available at* http://cms.clevelandclinic.org/giving/workfiles/Catalyst%20Philanthropy%202005%20AR.pdf.

they most certainly are *not* a mere "general proposition"; these and other programs are concrete testaments to creative and compassionate care.

Not-for-profit hospitals also serve and benefit their communities in ways far beyond this representative discussion of diverse community care initiatives. The substantial unreimbursed care all not-for-profit hospitals provide to Medicaid and Medicare patients and the "bad debt" they annually incur in caring for their communities' poorest members also further those hospitals' charitable purposes. *See* Final Decision at 15-16.

Hospitals must provide care to Medicare and Medicaid patients in order to secure a federal tax exemption. They absorb significant costs of providing that care. 16/ The hospitals receive 92 cents for every dollar spent caring for a Medicare patient and only 87 cents for every dollar spent caring for a Medicaid patient, resulting in underpayments that totaled $25 billion in 2005. *See* AHA, *Underpayment by Medicare & Medicaid Fact Sheet*, at 2 (Oct. 1996). As a result of such underpayments, a recent report to Congress warned that hospital margins for caring for Medicare patients will reach *negative* 5.4 percent this year – a 10-year low. *See* Medicare Payment Advisory Comm'n, *Report to Congress: Medicare Payment Policy*, at 47 (Mar. 2006). These negative margins are sustained as a result of caring for our nation's most vulnerable citizens; a large number of the Medicare patients a hospital treats are poor elderly patients with incomes at or below 200 percent of the federal poverty level. In fact, 46 percent of Medicare patients have incomes at or below 200 percent of the federal poverty level and at least 46.5 percent of Medicare spending is for caring for these patients. *See id.* at 11.

16/ That is why many states require not-for-profit hospitals to report underpayments for care to Medicare patients; they recognize the charitable nature of providing such care to the elderly and the impoverished within their communities. *See, e.g.*, Idaho Code Ann. § 63-602D(7); N.H. Rev. Stat. Ann. § 7:32-e(V).

By the same token, the bulk of a hospital's "bad debt" results from providing care to low-income patients who, for any number of reasons, fail to establish their eligibility to receive charity care or other forms of financial assistance. A recent report confirms that "the great majority of [hospitals'] bad debt was attributable to patients with incomes below 200% of the federal poverty level." *See* Congressional Budget Office, *Nonprofit Hospitals & the Provision of Community Benefits*, at 10 n.34 (Dec. 2006). This finding, the report concluded, warrants considering not-for-profit hospitals' bad debt in measuring the extent of their community benefits. *See id.*

The Department paid no heed to any of these substantial charitable commitments, whether they be community care, Medicare underreimbursement, or bad debts borne by not-for-profit hospitals. Instead the Department dismissed hospitals' community-based care programs as nothing more than a "general proposition" immaterial to a not-for-profit hospital's charitable purposes. And it entirely overlooked how government underpayments and bad debt contributes to hospitals' charitable purposes. The Department as a result ignored the full scope and depth of the charity that not-for-profit hospitals provide their communities. Consequently, the Department's reliance on a simple economic test to deny Plaintiffs a property tax exemption can "only be described as a triumph of form over substance." *Lutheran Gen. Health Care Sys.*, 231 Ill. App. 3d at 662.

III. TAXING THE PROPERTY OF NOT-FOR-PROFIT HOSPITALS WILL SERIOUSLY IMPAIR THEIR ABILITY TO PROVIDE THEIR COMMUNITIES NEEDED CARE.

The Department's narrow free-care approach to property tax exemption for not-for-profit hospitals may result in some short-run benefits. It will produce a longer tax roll and, by extension, a larger public fisc. But that circumstance will not last long, as hospitals seek ways to

meet their new tax liability. In the end, the effects of hospitals' increased tax liability will be felt most acutely by the communities those not-for-profit hospitals serve. To be sure, these communities' healthcare needs will not disappear along with not-for-profit hospitals' tax exemptions. And with government support for not-for-profit hospitals removed, government itself may ultimately have to meet these needs – at *its* expense.

Not-for-profit hospitals facing a new property tax burden must fund that additional liability from somewhere. Hospitals may initially attempt to pass their new tax burden along to their patients in the form of higher charges to be borne by insurance companies in the first instance; the insurers will, however, ultimately pass these added costs along as well to their enrollees, including employers who purchase health insurance for their employees.

But, in many areas, hospitals will face difficulties passing these added costs along to commercial health plans that wield significant bargaining power in the health care marketplace. Faced with already significant underpayments from the Medicare and Medicaid programs, these commercial health plans are unlikely to share in the new burden imposed on not-for-profit hospitals. And hospitals that principally serve Medicare and Medicaid patients will have limited ability to pass the costs of their new liability on to commercial insurers in any event.

Ultimately, in order to shoulder their new tax burden, hospitals may be forced to reassess the extent of the services they offer and to whom in their communities services are available. Many hospitals have already stopped providing high-cost services like trauma units that cannot function absent a subsidy. As a result of a new tax liability, some may be required to reconsider community clinics and other outreach efforts that help manage chronic conditions and thereby prevent crisis situations that bring children to emergency departments or elderly into the hospital. Others may have no choice but to sacrifice the very important – but according to the Department,

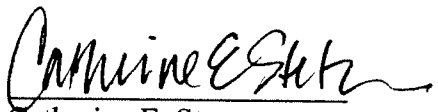
irrelevant – community benefit programs they have implemented to meet the unique care needs of their communities. *See supra* at 13-18. And still others may be forced to delay capital investments in new technology or facility improvements.

Any of these cost-cutting measures would effectively diminish a not-for-profit hospital's ability to provide the community it serves with access to care. That sad result cannot be squared with the guiding purpose of tax exemption for hospitals.

CONCLUSION

For all of the foregoing reasons, as well as those contained in the briefs of Plaintiffs and other *amici* in support of Plaintiffs, this Court should reverse the Department's denial of a property tax exemption to Plaintiffs.

Respectfully submitted,



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