No. 4-07-0763

IN THE
APPELLATE COURT OF ILLINOIS
FOURTH JUDICIAL DISTRICT

PROVENA COVENANT MEDICAL CENTER and PROVENA HOSPITALS, *Plaintiffs-Appellees,* 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-Appellants.*	Appeal from the Circuit Court of the Seventh Judicial Circuit, Sangamon County, Illinois Case No. 2006-MR-000597 The Honorable PATRICK J. LONDRIGAN Judge Presiding

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

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STATEMENT OF INTEREST OF *AMICUS CURIAE*

The American Hospital Association (AHA) on behalf of its members submits this brief *amicus curiae* in support of the Plaintiffs-Appellees Provena Hospitals and Provena Covenant Medical Center (collectively, the Hospitals) in this appeal of the Seventh Judicial District Circuit Court's decision reversing the decision made by the Illinois Department of Revenue, through its Director, Brian A. Hamer, to deny the Hospitals a charitable property tax exemption. *See* A1-2; *see also* A3-7.

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. Among the AHA's broad 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 health care policy.

Because of their abiding commitment to advancing the health of the communities they serve, the AHA's members have a great interest in the ultimate outcome of this case; indeed, the AHA participated as an *amicus curiae* both before the Department and the Circuit Court. The Department's final administrative decision – which the Circuit Court correctly reversed and which is now under review by this Court – would have seriously

impaired AHA members' ability to meet the essential health care needs of their communities. And if the Department's denial of a property tax exemption to the Hospitals – and the unsound principle on which its decision rests – is reinstated, the continued tax-exempt status of every not-for-profit hospital in Illinois would be thrown into grave doubt. If these other institutions' exemptions were revoked on the same faulty rationale the Department invoked against the Hospitals (and to which it continues to adhere before this Court), the resulting financial drain on Illinois not-for-profit hospitals will jeopardize Illinois residents' access to care they rely on these hospitals to deliver. Nor is the effect of the Department's misguided decision likely to stop at Illinois' borders: If this Court reinstates it, the Department's administrative decision may well 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

Courts and policymakers around the country have long understood that tax exemption is vital to not-for-profit hospitals' ability to deliver essential care to the communities they serve. Tax 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 – and this foundation has remained firm in Illinois for nearly a century. *See Congregational Sunday Sch. & Publ'g Soc'y* v. *Board of Review*, 290 Ill. 108, 113, 125 N.E. 7, 10 (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 the Hospitals' property tax exemption based on the narrow view that their property was not devoted principally to a charitable purpose because (in the Department's opinion) they provided an insufficient level of free care to patients, however, the Department's final administrative decision ignored the policy rationale underlying this historic and crucial relationship. The Circuit Court quite properly reversed the Department's decision; yet on appeal, the Department continues to hew to its novel, narrow – and mistaken – concept of charitable purposes.

The Department's capricious rejection of the settled rationale girding the charitable property tax exemption, and its continued attempts to obtain tax money from these not-for-profit Hospitals, also comes at a time when not-for-profit hospitals (including the Hospitals here) face significant challenges in meeting the growing needs of their communities: The tens of millions of uninsured Americans, mounting underpayments by government health care programs, and rising costs of delivering health care have all combined to increase the burden on the already-strained not-for-profit hospitals that provide care to all irrespective of ability to pay. Increasing not-for-profit hospitals' tax burdens threatens to deprive communities of vital health care resources.

The Court should affirm the Circuit Court's reversal of the Department's ill-considered final administrative ruling denying the Hospitals a charitable property tax exemption.

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

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 health care safety net for this country's uninsured and underinsured. *Crerar* v. *Williams*, 145 Ill. 625, 643, 34 N.E. 467, 470 (1893). That "safety net" is more important now than ever: Hospitals now "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, AHA) [*AHA Testimony*]. In a very real sense, they represent the health care "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 and embrace the critical role not-for-profit hospitals play in our modern health care system. According to a recent national study on community benefit, "*[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 AHA By Ernst & Young LLP, Nov. 27, 2006, at i [*Community Benefit Lessons Learned*] (emphasis added); *accord id.* at 3. The study similarly showed that *one hundred percent* of surveyed hospitals also offered preventative care and wellness programs designed to address unmet medical needs before they require treatment in an emergency room. *See id.* at ii & 5; *see also infra* 14-24.

The same study demonstrated that not-for-profit hospitals' efforts do not end there. It showed that, in addition to emergency care facilities and preventative care programs, not-for-profit hospitals "provid[ed] uncompensated care to, on average, 12% of their total patients during" 2006, at a cost of approximately "$14 million per hospital." *See id.* at i-ii; *accord id.* at 4. In 2006 alone, hospitals absorbed more than $31 *billion* in uncompensated care costs, excluding the many billions more they spent on valuable community service programs and other activities designed to promote and protect health and well-being. *See* AHA, *Uncompensated Hospital Care Cost Fact Sheet*, at 4 (Oct. 2007); *see also AHA Testimony* at 1.

The critical safety net that not-for-profit hospitals provide to their communities is increasingly important as the number of uninsured Americans continues to soar. The Census Bureau recently reported that 47 million Americans currently are uninsured, an increase of 2.2 million people from 2005 to 2006. *See* Carmen DeNavas-Walt *et al.*, U.S. Census Bureau, Current Population Reports, *Income, Poverty, & Health Insurance Coverage in the United States: 2006*, at 18 (GPO Aug. 2007); *see also id.* at 19 (figure 6). Among these new uninsured are approximately 700,000 children. *See id.* at 19 ("The percentage and the number of children under 18 years old without health insurance

increased to 11.7 percent and 8.7 million in 2006 (from 10.9 and 8.0 million, respectively, in 2005)."); *see also id.* at 21 (table 6).

The rising tide of uninsured Americans – and the impact of their number on not-for-profit hospitals – also cannot be viewed in isolation. Hospitals are facing ever-escalating operating costs: they are delivering care to an aging population, contending with health care worker shortages, and confronting the rising costs of medical liability insurance and prescription drugs. And while the Department wholly discounts the mounting underpayments from government health care programs to not-for-profit hospitals providing care to the indigent, elderly, and others served by the programs, the true relevance of these hospitals cannot be appreciated absent consideration of the underpayments issue. *See* Dep't Br. 26. As AHA has reported, for example, 64 percent of hospitals actually lost money treating Medicare patients in 2006; 76 percent lost money treating Medicaid patients that same year. *See* AHA, *Underpayment By Medicare & Medicaid Fact Sheet*, at 2 (Oct. 2007). This translates into a total shortfall of $18.6 billion for Medicare patients and $11.3 billion for Medicaid patients. *See id.* at 3. The upshot of these profound shortfalls is not surprising: Thirty-two percent of these hospitals sustained negative operating margins in 2006 – meaning fully a third of them lost money on their hospital operations. *See* AHA, *Analysis of AHA Annual Survey Data 2006*. Without not-for-profit hospitals' abiding commitment to their communities, governments alone would be required to meet their communities' health care needs, at staggering cost.

When these realities are viewed together, one ineluctable conclusion emerges: The Department's assertion that the Hospitals actually "increase" – rather than relieve –

the burdens of government stems from a woefully inadequate understanding of the role not-for-profit hospitals play in their communities today. *See* Dep't Br. 10. It was only by myopically concentrating on one component of the Hospitals' charitable purposes, while improperly excluding several important others entirely from consideration, was the Director initially able to conclude that the Hospitals offer insufficient "charity" to qualify for an exemption. A23; Dep't Br. 10, 19. On a realistic appraisal of the modern health care environment, it is clear that not-for-profit hospitals now do more to relieve the burdens of government in serving their communities than they did one hundred years ago when Illinois first exempted their property from taxation. In fact, experts on the topic recognize that charity care provided by hospitals today is "all that stands between a thorny policy dilemma and an access crisis for millions of Americans." 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/extweb/pwcpublications.nsf/docid/1766F3BFD7D4C80A852572F-007E46F6 (last visited Jan. 10, 2008); *see also AHA Testimony* at 5.

II. THE DEPARTMENT CONTINUES TO ADVANCE A FAR TOO LIMITED VIEW OF NOT-FOR-PROFIT HOSPITALS' CHARITABLE PURPOSES.

The Department now *concedes*, as it must, that the Hospitals in no way profit from delivering medical care to patients. *See* Dep't Br. 8-9. But it continues to insist that the Hospitals provided a mathematically "insufficient" level of free care to merit a tax exemption. *See* A18-19; Dep't Br. 10-11, 24 & 29. Using this simplistic – and profoundly mistaken – assumption as its starting point, the Department marches through the guidelines the Illinois Supreme Court adopted in *Methodist Old Peoples Home* v.

Korzen, 39 Ill. 2d 149, 156-157, 233 N.E. 2d 537, 541-542 (1968), and concludes that these Hospitals fail the test. *See* Dep't Br. 9. 1/ But when it reduced the analysis to a consideration of a single aspect of a not-for-profit hospital's charitable purposes – the amount of free care provided – the Department improperly disregarded the broad and flexible definition of charity followed in this and other states.

A. The Department's Narrow And Mathematical "Free Care" Test Is Inconsistent With The More Expansive View Of Charity Embraced By Illinois And Other States.

In his final administrative decision, the Director concluded that it would "defy logic" to grant the Hospitals a property tax exemption given that their primary purpose is the exchange of medical services for fees – not charity. A27. His "primary basis" for this finding was the fact that the medical center's 2002 revenues exceeded $113 million while its charitable activities purportedly "cost it only $831,724." A14. In its brief to this Court, the Department reiterates this view. Dep't Br. 24.

The Department has it quite wrong. The Hospitals' charitable activities extend well beyond the one metric used by the Director, and the "cost" to the hospitals of providing charitable benefit to their communities was higher by several orders of magnitude than the (still substantial) sum attributed to the Hospitals by the Department. By focusing narrowly and exclusively on the quantity of free care provided by the

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1/ That the Department continues to adhere to its arithmetic test for charitable exemption is clear from its analysis of the *Methodist Old Peoples Home* factors. *See* Dep't Br. 10, 19, 22 & 24 (asserting the Hospitals failed to provide a sufficient amount of "free care" in applying *Methodist* factors).

Hospitals, the Department adopted a view of charity that breaks faith with the broad range of charitable undertakings entitled to property tax exemption that this state has employed for a century. *See Sisters of Third Order of St. Francis* v. *Board of Review*, 231 Ill. 317, 321, 83 N.E. 272, 273 (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, 595 N.E.2d 1214, 1222 (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.") 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 the improvement and promotion of the happiness of man." *Congregational Sunday Sch. & Publ'g Soc'y*, 290 Ill. at 113, 125 N.E. at 10.

The Department's narrow and novel "free care" test not only marks a departure from Illinois precedent; it sets Illinois on a path seriously out of step with the mainstream view of charity shared by a majority of states. 2/ As AHA has pointed out elsewhere,

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2/ Consideration of other states' views is particularly appropriate here given that the various states' charity laws – including Illinois' – descended from a common English

courts across the country, in decisions stretching back far into the last century, have uniformly rejected the "free-care" standard the Department invoked here to deny the Hospitals a property tax exemption. 3/ *See AHA Testimony* at 3. Nearly fifty years ago,

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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.").

3/ *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 *In re 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

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, where not-for-profit hospitals are concerned, depends instead upon "the nature of the[se] 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 view. 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 espoused in cases like *Richmond Memorial. See, e.g., ElderTrust of Fla., Inc.* v. *Town of Epsom*, 919 A.2d 776, 783 (N.H. 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' ") (citation omitted); *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

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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.").

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 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); *Surtees* v. *Carlton Cove, Inc.*, -- So. 2d --, *available at* 2007 WL 80473, at *8 (Ala. Civ. App. Jan. 12, 2007) (explaining that "a charitable facility, to be considered as such, is not limited in its enterprise to the provision of free or reduced-cost services"); *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). 4/ As the

4/ In *Under the Rainbow Child Care Center, Inc.* v. *County of Goodhue*, 741 N.W.2d 880 (Minn. 2007), the Minnesota Supreme Court recently reaffirmed that state's expansive view of charity, explaining that "[t]he legal meaning of the word 'charity' has a broader significance than in common speech and has been expanded in numerous decisions." *Id.* at 886 (quoting & citing *Junior Achievement of Greater Minneapolis, Inc.* v. *State*, 135 N.W.2d 881, 885 (Minn. 1965)). In its view, "the expanded legal definition

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 Star Borough v. Dená Nená 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).

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of charity that has evolved in the context of tax exemptions *does not require that the charitable benefit be provided to all recipients entirely free of charge*." *Id.* at 890 (emphasis added). After having reaffirmed Minnesota's broad conception of charity, however, the court went on to hold that even a broad definition has a limit: a not-for-profit child care center – Rainbow – failed to qualify for a charitable property tax exemption because it did not "provide *any* services on a charitable basis." *Id.* at 895 (emphasis added). As the court explained, the child care center "sets its rates at or above market levels and charges all the recipients of its services at those rates," and "makes *no* accommodations for those who are unable to pay the full rates." *Id.* (emphasis added). In this case, by contrast, the Department does not – and could not – claim that the Hospitals charge all patients market (or above-market) rates; it only complains instead that the Hospitals, in its view, failed to provide enough free and discounted care (again without regard to the many other charitable services in which the Hospitals engage).

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 Michigan Supreme 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. By reducing the entire charitable exemption analysis to a consideration of how much money is devoted to one particular charitable activity, the Department has endorsed a test seriously out of step with the well-considered policy of this and many other states.

B. The Department's Free-Care Test Ignores Core Components Of Not-For-Profit Hospitals' Charitable Purposes.

The rigid "free care" test the Department presses here completely disregards important aspects 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," the Director nevertheless concluded that "[p]roperty tax exemptions do not turn on these general propositions." A28-29. The Department similarly dismisses these contributions now as nothing more than an "amorphous idea." Dep't Br. 26. But in simply writing off the community benefits provided by the Hospitals as an irrelevant "general proposition" and "amorphous idea,"

A28-29; Dep't Br. 26, the Director and the Department shut their eyes to a fundamental aspect of the charitable care that not-for-profit hospitals provide to their communities.

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 of 132 not-for-profit hospitals, 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. Many of these efforts are directed at wellness and preventative care – that is, they aim to address members of their communities' unmet basic care needs and chronic conditions before they require emergency treatment at a hospital. *See, e.g.*, AHA, TrendWatch, *Coverage Counts: Supporting Health & Opportunity for Children*, at 6 (Feb. 2007) (discussing importance of programs aimed at

improving access for uninsured children to preventative care). Toward this end, more than half of the surveyed hospitals performed studies on the unmet health care 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." *Community Benefits Lessons Learned* at 5.

The Hospitals in this case have also responded to their communities' critical health care needs through specially tailored programs. For just one example, as the Director found, the Hospitals sponsor the Crisis Nursery of Campaign/Urbana, which "is an emergency shelter and a child abuse and neglect prevention center." A40. This unique program operates 24 hours a day and "provides food, clothing, and safe and confidential care for children from birth to 5 years old at no cost to individuals in need of help." A40.

Other not-for-profit hospitals have similarly implemented a variety of creative health care solutions directly responsive to the unique health care problems facing their communities, including preventative care programs. 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." *Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunitie

s/hospitalsaction/caseexamples/access/2007/stjoseph.html (last visited Jan. 10, 2008). The St. Joseph mobile dental clinic alone makes more than 5,000 visits to over 4,200 children each year. *See id.*

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

- Recognizing that many children in Nevada (which ranks 49th among the states in number of uninsured children) have forgone non-life-threatening surgeries because of a lack of insurance, Saint Mary's Regional Medical Center in Reno instituted "Project New Hope" in 1997. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/access/2007/saintmarys.html (last visited Jan. 10, 2008). Project New Hope so far has provided 120 children care they could not otherwise afford. *See id.*

- After discovering that many individuals have forgone 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. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2007/concord.html (last visited Jan. 10, 2008). The Program has obtained 90,000 medications for 4,100 patients, thus assisting "low-income families in 47 local communities receive more than $25.5 million in needed medications." *Id.*

- 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." *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/health/2007/crozer.html (last visited Jan. 10, 2008).

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, the Hospital's 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. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2007/massgeneral.html (last visited Jan. 10, 2008).

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. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2007/wheaton.html (last visited Jan. 10, 2008). Fresh Start provides students a highly structured learning environment and counseling to reduce their "long-term emotional difficulties and successfully transition[ing them] back into the traditional classroom." *Id.*

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

- The Anne Arundel Medical Center of Annapolis, Maryland, responded to the acute health care needs of Annapolis' indigent and homeless by opening a free health care clinic – the Annapolis Outreach Center – in 1994. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/access/2007/arundel.html (last visited Jan. 10, 2008). The Center currently treats 300 patients a *month*. *See id.*

- Saint Vincent's Hospital in Manhattan 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. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2006/saintvincentsny.html (last visited Jan. 10, 2008).

- The Mercy Hospital of Pittsburgh is part of Operation Safety Net, "[a]n innovative street outreach program for the unsheltered and transient homeless population." *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2006/pittsburghmercy.html (last visited Jan. 10, 2008).

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," with these hospitals spending 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 (last visited Jan. 10, 2008). 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. *See* Cleveland Clinic, Catalyst, *2005 Annual Report*, at 4, 8, *available at* http://cms.clevelandclinic.org/giving/workfiles/Catalyst%20Philanthropy%202005%20AR.pdf (last visited Jan. 10, 2008).

These community benefits programs are critical to the areas these hospitals serve. They are creatively tailored to meet identified community needs. They are conceived and implemented with compassion for the plight of the less fortunate members of the surrounding community. And they most certainly are *not* the mere "general proposition" (A28-29) or "amorphous idea" (Dep't Br. 26) the Department claims; these and other

programs are concrete testaments to creative and compassionate care for those most in need.

Not-for-profit hospitals also serve and benefit their communities in ways far beyond this representative discussion of diverse community care initiatives. Notwithstanding the Department's discounting of 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 (A27-28; Dep't Br. 26), these contributions also significantly further not-for-profits hospitals' charitable purposes. 5/ *See Wexford Medical Group*, 713 N.W.2d at 747 (because "the

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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 charitable activities, the federal government has also adopted a broad definition of "charity" for determining whether a hospital may claim an exemption under 26 U.S.C. § 501(c)(3). The Internal Revenue Service has stated that "[t]he 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. In accordance with this expansive view of charitable purposes, the IRS recently released an updated version of IRS Form 990, the annual information return submitted by exempt organizations and a new Schedule H for tax-exempt hospitals. *See* IRS, *Tax Information for Charities & Other Nonprofits*, *at* http://www.irs.gov/charities/index.html (last visited

reimbursements petitioner receives from government funding fall well short of defraying the costs petitioner incurs to render medical care," "not only are Medicare and Medicaid patients receiving a gift from petitioner, but petitioner is not fully recouping its costs from the government"); *accord McLaren Reg'l Med. Ctr.* v. *City of Owosso*, 738 N.W.2d 777, 786 (Mich. App. Ct. 2007).

Hospitals must provide care to Medicare and Medicaid patients in order to secure a federal tax exemption. *See* AHA, *Underpayment By Medicare & Medicaid Fact Sheet*, at 2 (Oct. 2007). They absorb significant costs of providing that care. 6/ The hospitals receive 91 cents for every dollar spent caring for a Medicare patient and only 86 cents for every dollar spent caring for a Medicaid patient, resulting in underpayments that totaled $30 billion in 2006. *See Underpayment By Medicare & Medicaid Fact Sheet*, at 2. As a result of such underpayments, a recent report to Congress warned that hospital margins

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Jan. 11, 2008). In addition to free care, the IRS's Schedule H requires not-for-profit hospitals to report, among other things, the community benefit provided through health improvement, education, research, patient bad debt, and Medicare underpayments as constituent parts of their charitable purposes. *See*, IRS, *Form 990 Redesign for Tax Year 2008*, *at* http://www.irs.gov/charities/article/0,,id=176637,00.html (last visited Jan. 11, 2008).

6/ Like the IRS, many states affirmatively 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).

for caring for Medicare patients will reach *negative* 5.4 percent in 2007 – a 10-year low. *See* Medicare Payment Advisory Comm'n, *Report to Congress: Medicare Payment Policy*, at xii, 48 (Mar. 2007). 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 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.

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.*

* * *

In this Court, just as it did in the Circuit Court and in its original decision, the Department (Dep't Br. 26-27) pays no heed to any of these substantial charitable commitments – whether they be community care, Medicare and Medicaid underreimbursement, or bad debts – borne by not-for-profit hospitals. A27-29. Just as did the Director (A27-28) in his decision, the Department continues to overlook how government underpayments and bad debt contribute to hospitals' charitable purposes.

See Dep't Br. 26. Thus, the Department now, no less than the Director before, ignores the full scope and depth of the charity that not-for-profit hospitals such as those involved in this case provide to their communities. *See* Dep't Br. 26-29. The upshot of this is obvious: The Department's invocation of a free-care test to deny the Hospitals 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, 595 N.E.2d at 1222.

C. The Department's Narrow "Free Care" Formulation Ignores Basic Principles of Not-For-Profit Hospital Administration.

Beyond inappropriately discounting not-for-profit hospitals' community benefits programs, the Department's crabbed view of the Hospitals charitable purposes also led it to misapply core principles undergirding the broad view of charity recognized by policymakers and courts around the country.

First, the Department mistook effective management for lack of a charitable purpose when it took issue with the disparity between the Hospitals' revenues and the amount of "free care" it provided. *See, e.g.*, A14, A18, A24, A27; Dep't Br. 10-16 & 23. 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, 294 (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 Star Borough*, 88 P.3d at 131. As one commentator has explained:

> 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. [John D. Colombo, *Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps*, 37 Loy. U. Chi. L. Rev. 493, 517 (2006) (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 294 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 295. Accordingly, "the profit element [is] immaterial." *Id.* (internal quotation marks & citation omitted). The Department is thus quite wrong to penalize the Hospitals for attempting to maintain a healthy operating margin. *See* Dep't Br. 15-16.

Second, in finding the Hospitals' primary purpose was the exchange of medical services for fees, the Director placed undue emphasis on the nominal amount of donations received by the Hospitals, stressing that they received "virtually no funds from

public and private donations." A23-24. The Department similarly faults the Hospitals in its brief to this Court. *See* Dep't Br. at 15-16. 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 520. This Court should reject the Department's use of such an anachronistic standard in denying the Hospitals a charitable tax exemption.

Third, as did the Director in its final administrative decision (A19), the Department continues to look askance at the Hospitals' reliance on third-party providers to deliver care to patients. *See* Dep't Br. 25-26. Once again, this is error. Reliance on third-party providers is a longstanding and accepted 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. Thus, the Hospitals' use of third-party health care providers to provide care to patients cannot reasonably "undermine[ ]

[their] claim that [they] use[ ] [their] property primarily for charitable purposes." Dep't Br. 25.

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

The Department's inflexible free-care approach to property tax exemption for not-for-profit hospitals may result in some short-run benefits. It will produce a slightly longer tax roll and, by extension, a slightly 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 not-for-profit hospitals' increased tax liability will be felt most acutely by the communities those hospitals serve. These communities' health care 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 own 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 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. These commercial health plans, faced with already significant underpayments from the Medicare and Medicaid programs, 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.

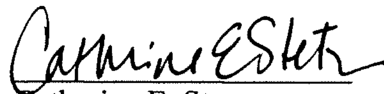
Ultimately, in order to shoulder their new tax burden, hospitals may be forced to reassess the extent of the services they offer to their communities. Some hospitals have already stopped providing high-cost services – like trauma units – that cannot function absent a subsidy. If they are forced to shoulder a new tax liability, not-for-profit hospitals may be required to reconsider community clinics and other outreach and preventative efforts that help manage chronic conditions and thereby prevent crisis situations that bring children to emergency departments or elderly into the hospital. Other hospitals may have no choice but to sacrifice the very important – but according to the Department, insubstantial – community benefit programs they have implemented to meet the unique care needs of their communities that reduce the severe strain already placed on not-for-profit hospitals' emergency room facilities. *See supra* at 14-24. Still others may be forced to delay capital investments in new technology or facility improvements.

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

CONCLUSION

For all of the foregoing reasons, as well as those contained in the briefs of the Hospitals and other *amici* in support of the Hospitals, this Court should affirm the decision of the Circuit Court reversing the Department's final administrative decision denying the Hospitals a charitable property tax exemption.

Respectfully submitted,



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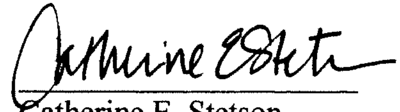
January 28, 2008

SUPREME COURT RULE 341(C) COMPLIANCE

I certify that this brief conforms to the requirements of Supreme Court Rules 341(a) and (b). The length of this brief is 29 pages.



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PROOF OF SERVICE

The undersigned, being first duly sworn upon oath, deposes and states that on this 28th day of January 2008, three copies of the foregoing **BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PLAINTIFFS-APPELLEES** were served by overnight delivery on:

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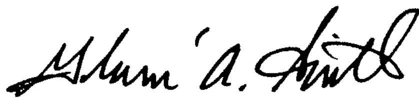

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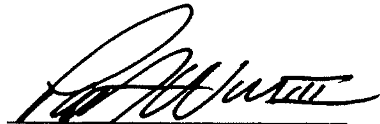

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