



A Special Report From Health Business And Policy

Champaign County, Illinois Gets the Hospital Industry's Attention by Revoking the Property Tax-exemption of a Local Catholic Hospital

*Now The Chairman of the Local Tax Review Board Answers Questions Put to Him
By Health Business And Policy's Executive Editor, James Unland¹*

“...Hospitals that enjoy the benefits of exempt status—*benefits which in no manner derive from a right in any sense but are, rather, a gift from public treasuries*—need to unmistakably recognize that the term ‘charitable purpose’ as applied to a community hospital does not connote a passive, detached state of being as some corporate entity separate and apart from real people. “Charitable purpose” connotes *an involved, proactive presence both in their communities in general and with respect to their patients in particular*. A tax-exempt ‘charitable hospital’ has a ‘charitable purpose’ that is not evidenced simply by virtue of a beautifully crafted set of corporate mission statements. Instead, “charitable purpose” *must be an ongoing state of action, in particular action pursuant to the fundamental purpose of any ‘charitable hospital’ in regards to proactively assisting human beings each day in respect to meeting their medical needs and, to the extent necessary and possible given hospital resources, assisting them in paying for services thus rendered...*”

Stan Jenkins, Chairman, Champaign County, Illinois Board of Review

Background and Editor's Note: In February 2004 the Illinois Department of Revenue (IDOR) agreed with a recommendation sent to the IDOR by the Champaign County (Illinois) Board of Review to revoke the property tax-exemption of Provena Covenant Medical Center in Urbana, Illinois. Although the hospital is expected to appeal this decision by the IDOR, as matters stand now the IDOR has ruled that:

- “The property is not in exempt ownership.”
- “The property is not in exempt use.”

Because the ramifications of this decision are already being felt throughout the healthcare industry and because such ramifications may be more far-reaching than just the property tax issue, I approached the Chairman of the local Champaign County Board of Review, Mr. Stan Jenkins, who was kind enough to agree to elaborate through a question and answer format on the original local governmental body's rationale in hopes that, from his point of view, not-for-profit ‘charitable’ community hospitals will better understand how at least one county taxing authority views the full responsibilities conferred along with ‘tax-exempt’ status. J.U. April, 2004

¹ Health Business and Policy is at HealthBusinessAndPolicy.Com and the special series of feature interviews, articles, teleconferences and other information is at HealthBusinessandPolicy.Com/TaxChallenge.htm. A link to the full written Champaign County Board of Review brief can be found toward the top of this web page.

What status, if any, is conferred by the fact that a hospital or other 'charitable organization' may have a federal 501(c)(3) designation? Does such a designation carry weight or the presumption of tax-exemption(s) at the state or local level, and if so, what weight does the (c)(3) designation carry and under what circumstances?

For many years a 501(c)(3) designation was recognized at state and local levels, but that is changing. The IRS has its standards; various states have their own standards. There is no "presumption" of tax-exempt status based on a 501(c)(3) designation (at least, not in Illinois).

Does Illinois have distinct constitutional and/or statutory provisions governing the requisite circumstances under which an organization is granted property and/or sales tax-exemptions, and in this regard does Illinois have provisions regarding the characteristics or behavior that such organizations need to possess in order to qualify for tax-exemptions?

I am unfamiliar with the requirements to qualify for a sales tax-exemption. The requirements to qualify as exempt from property tax differ depending on the type of organization applying for exemption. The requirements for park district property or cemetery property to be exempt differ from the requirements for a charitable organization to be exempt. The statutes state that certain properties may be exempt if they are 'used for charitable or beneficent purposes, and not leased or otherwise used with a view to profit.' These requirements are further defined in Illinois case law.

How is it that county boards or committees thereof have or acquire authority over making determinations with respect to applications for exempt status?

State law dictates that county Boards of Review make 'recommendations' to the Illinois Department of Revenue as to whether tax-exempt status should be granted or denied to the applicant.

Is there a routine process for applying for a tax-exemption? Does this require that an organization re-apply or otherwise update its application annually?

When an organization (owner/taxpayer) is applying for tax-exempt status for the first time an application must be completed. The property in question must be in 'exempt ownership' and in 'exempt use.' If exempt status is granted, then each subsequent year, the owner/taxpayer must complete a very short 'status form' indicating that the ownership and use have not changed.

Is the burden of proof on the applicant with respect to the initial application and updates thereof?

There are over thirty categories of exempt property ranging from schools, to cemeteries, to park districts, water districts, housing authorities, etc. Property owned by charitable organizations and used for charitable purposes is a category unto itself. *The burden of proof is always on the applicant to demonstrate exempt ownership and exempt use.*

Is there a difference between a 'charitable' organization in terms of its 'charitable purpose,' 'charitable use of facilities,' 'charitable state of organization' or other finer distinguishing points in these regards?

Neither statute nor case law fine-tunes the definitions to such a degree as to differentiate between 'charitable purpose,' 'charitable use of facilities,' and 'charitable state of organization'. The Board of Review looked at the statutes and case law. *Methodist Old Peoples Home v. Korzen*, 39 Ill. 2d 149, 233 N.E.2d 537 (1968) sets out five specific criteria that have to be satisfied to qualify for the charitable exemption:

1. The use was for the benefit of an indefinite number of persons, persuading them to educational or religious conviction, for their general welfare or in some way reducing the burdens of government;
2. The charitable institution must have no capital, capital stock or shareholders, earns no profits or dividends.
3. The institution must dispense charity to all who need and apply for it, does not provide gain or profit in a private sense to any person connected with it, and does not appear to place obstacles of any character in the way of those who need and would avail themselves of the charitable benefits it dispenses.
4. The institution had the burden of proving that its property actually and factually is so used, and
5. The term "exclusively used" means the primary purpose for which property is used and not by any secondary or incidental purpose.

What kinds of proof are important to establish that the facilities are used for 'charitable purposes'?

Areas inside the hospital that are used by outside service providers and physician groups must be accurately accounted for AND promptly reported. Pursuant to state law, Provena had an "obligation" to report and account for the areas inside their facility that were used by for-profit business entities in furtherance of their respective profit-making activities.

Under section 15-15 of the Illinois Property Tax Code heading "Obligation to file copies of leases or agreements" it states: *"If any property listed as exempt by the chief county assessing officer is leased, loaned or made available for profit, the title-holder or the owner of the beneficial interest **SHALL file with the assessment officer a copy of all such leases or agreements and a complete description of the premises, so the chief county assessment officer can ascertain the exact size and location of the premises, in order to create a tax parcel. Failure to file such leases, agreements or descriptions shall, in the discretion of the chief county assessment officer, constitute cause to terminate the exemption, not withstanding any other provision of this Code.**"*

In the case of a hospital what kinds of proof are important to establish that 'charity care' is being rendered? Is a Charity Care Policy important and if so, what kinds of information should it contain?

A Charity Care Policy and a Community Benefits Report that are 'bulletproof' are necessary. A Charity Care Policy must be thorough, meaningful and made available to patients in a timely manner. A Community Benefits report must be complete, accurate and conform to recognized industry standards in reporting. Hard facts, statistical data and accurate reporting are of the utmost importance.

A Charity Care Audit conducted by outside experts is an excellent way to demonstrate an institution's commitment to real, meaningful charity care. Implementing recommendations made in such an audit is the next step.

Is there a threshold that is considered proper with respect to the relative amount of charity care that a hospital renders? Meaning, should a hospital designate a certain portion of its fund-raising assets, net cash flow or other financial resources for charity care and if so, how is this determined?

Let me open by saying that 'bad debts' or 'bad debt write-offs' are NOT to be counted or otherwise attributable to the provision of charity care, per case law and, honestly, common sense.

In general, a hospital should render charity care within its financial resources such that it can be as generous as possible to the medically indigent population while, at the same time, not jeopardizing the hospital's own fundamental financial viability. That said, the provision of charity care within reasonable guidelines should take precedent over: (a) the promulgation or funding of for-profit subsidiaries, (b) the subsidization of medical practices (except for recruiting physicians and subsequently 'seeding' medical practices in medically underserved areas) and (c) the transference of funds to a corporate headquarters. Fund-raising assets (gifts, bequests, etc.) should be allocated first, to the extent necessary, to maintaining physical buildings and equipment in reasonably up-to-date condition and second, to the perpetuation of the 'charitable purpose' and the provision of charity care (inclusive of the full range of 'charity care' meaning all the way from free care to discounts, payment plans, debt counseling, consumer education, etc.).

There is no predetermined 'threshold' to qualify an institution as 'charitable.' However, in *Morton Temple Association, Inc. v. Department of Revenue*, the Illinois Third District Appellate Court wrote: "Incidental acts of charity by an organization will not be enough to establish that organization as charitable."

Are 'bad debts' able to be counted as charity care and if not, why not?

In *Alivio Medical Center v. Illinois Department of Revenue*, the Illinois First District Appellate Court wrote: "...writing off a bad debt is not tantamount to providing charity". These amounts were not considered to be 'charity,' just bills that could not be collected.

In respect to patients who might be uninsured, underinsured or otherwise 'medically indigent' is there a manner of dealing with such patients that is considered appropriate within the context of: (a) notifying patients about 'charity care' at the hospital, including at what point in the encounter notification should be given, (b) assisting them for qualifying for charity care, (c) determining what proportion of their total hospital bill the charity will cover and (d) if the charity care does not cover 100% of a qualified person's hospital bill, assisting the individual with discounts, the formulation of a realistic payment plan or other helpful measures?

Since appropriate ways of dealing with the uninsured or 'medically indigent' are still evolving in an ever-changing healthcare environment, I do not believe there is just one, singularly correct way of dealing with this issue and, furthermore, the industry needs to encourage creativity in this regard. However, I do believe that the principle of a hospital or other charitable tax-exempt entity (for example, a tax-exempt physicians' group) being proactive in informing people about charity care and related matters *is a crucial underpinning of, and responsibility pursuant to, the entire concept of a 'charitable organization.'*

Moreover, it is clear that certain methods of approaching charity care and related matters are clearly inappropriate: for example, making charity care available to a patient only *after* repeated collection attempts either by the hospital or a collection agency. By that point in time damage has already occurred to a patient's credit rating and caused stress to the patient and the patient's family resulting from being hounded by bill collectors.

Hospitals that enjoy the benefits of exempt status—*benefits which in no manner derive from a right in any sense but are, rather, a gift from public treasuries*—need to unmistakably recognize that the term 'charitable purpose' as applied to a community hospital does not connote a passive, detached state of being as some corporate entity separate and apart from real people. "Charitable purpose" connotes *an involved, proactive presence both in their communities in general and with respect to their patients in particular*. A tax-exempt 'charitable hospital' has a 'charitable purpose' that is not evidenced simply by virtue of a beautifully crafted set of corporate mission statements. Instead, "charitable purpose" *must be an ongoing state of action*, in particular action pursuant to the fundamental purpose of any 'charitable hospital' in regards to proactively assisting human beings each day in respect to meeting their medical needs and, to the extent necessary and possible given hospital resources, assisting them in paying for services thus rendered.

Hence, a hospital's charity care policy should be explained to a patient as close to the moment of first 'patient encounter' with hospital personnel as possible given that, in life-threatening emergencies, serious accidents, etc. medical care obviously needs to come first. Hospitals need to determine as close to first contact as practicable whether a patient is insured, uninsured, underinsured, etc. If it is determined that a patient qualifies for charity care or other assistance (partial charity care, deep discounts, payment plans, etc.), then a trained professional should be available to walk them through the process. It is crystal clear from many sources that patients who qualify for such assistance most often don't even know what questions to ask or whom to go to for help. This is an example of the principle that 'charitable purpose' is a state of action, not just a state of being.

In this regard, I do not consider the posting of a sign in a hospital emergency room describing a particular hospital's charity care policy as being the slightest bit proactive. 'Proactive' is not about posting signs. It's about actively intervening with and counseling patients. Just as it is the hospital's burden of proof to demonstrate to local tax review bodies such as the Champaign County Board of Review that the organization deserves the privilege of tax exemptions, so it is the hospital's burden to assertively abide by the true meaning of 'charitable purpose.'

To what extent did the Board of Review become concerned about the pricing practices of the hospitals in Champaign-Urbana? Was the level of pricing to the uninsured, underinsured and otherwise medically indigent a concern, and why? And if so, what kind of pricing policy would be more commensurate with what the Board would expect from a 'charitable' hospital?

It greatly concerned us that multi-million dollar insurance companies are charged a fraction of what poverty level patients are charged for the same service, the same procedure or the same medication. This is a common sense concept of inherent unfairness that the general public can "get their hands around" and the general public does not like it. For hospitals, it is a public relations disaster when this kind of pricing practice is disclosed, bringing into serious question the commitment that a hospital has to its own charity care policy to say nothing of the broader ramifications relating to the hospitals' supposed 'charitable purpose.'

The general public's revulsion surrounding hospitals overcharging medically indigent patients, not telling them about charity care, then pursuing aggressive collection efforts and even suing those patients is now well known. Class action lawsuits are taking place over just the consumer fraud implications of this although, as yet, there is not such a lawsuit in Champaign County.

As far as a pricing policy that I would expect from a 'charitable hospital' once again common sense can be a guide to hospitals. At the least, it would seem logical that the extent to which the uninsured, underinsured or medically indigent need to pay a portion of their hospital bill, that portion should equate to prices given to insurance companies, HMOs and large employers. My understanding is that the Secretary of HHS himself is stating that hospitals have always been and should now be encouraged to discount their 'off-the-shelf' fees.

Beyond the issue of patients presented to a hospital, does a hospital 'organized for a charitable purpose' have an additional responsibility for proactive 'outreach' to the uninsured, underinsured or otherwise medically indigent? If so, what would be some examples of this kind of outreach?

It's not that an institution has any 'additional responsibility' for proactive outreach to be considered charitable since *outreach should fundamentally be part of the intrinsic set of actions pursuant to an ongoing state of 'charitable purpose' in the first place.* Much like contracting for an independent Charity Care Audit, outreach programs demonstrate the level of commitment an institution has to charity care in the local community. There are many ways of partnering with existing community programs to enhance services and provide alternatives to those most in need. Relatively speaking many of these outreach efforts can be low cost and at the same time create a very positive image for the institution.

In the filing to the State of Illinois by the Champaign County Board of Review, much discussion revolved around arrangements on the hospital's 'charitable property' with respect to contracts with physician groups and financial arrangements with other vendors or health care providers/contractors/managers. Of what significance are such arrangements from the point of view of the local board, and why? Was the local board aware that many of the arrangements mentioned in the board's filing to the IDOR are commonplace in the hospital industry and are considered acceptable by federal regulatory agencies?

We knew this was commonplace in the hospital industry, but if it is commonplace to drive 70 miles an hour in a 55 zone does that make the practice legal and proper?

Our position is that although some of these arrangements are intrinsic to the business purposes and activities of charitable hospitals, our own criteria for facilities use review dictate that, with respect to the actual portions of hospitals (meaning the actual physical property space/square footage) that are routinely utilized by profit-making physicians or other organizations in furtherance of their profit-making goals, those actual activities in those physical spaces do not comport with a hospital's 'charitable status.'

In the Provena Covenant filing mention was made of the fact that positive net cash flow was moved out of the community of Champaign-Urbana and 'up to Provena's headquarters' so to speak. In addition, the transferring of positive net cash flow, or 'hospital profits' from a not-for-profit holding company to one or more for-profit subsidiaries was mentioned. What is the significance of these items from the Board of Review's point of view?

When a 'non-profit' hospital that is supposed to have a 'charitable purpose' *in respect to the patients within its respective community* produces a positive cash flow and then that positive cash flow is subsequently transferred directly or indirectly (a) out of the local community and its particular patient service area or (b) to 'for-profit' entities of a parent company, serious questions arise regarding the true 'non-profit' nature of the purported 'non-profit' entities.

In this case, data revealed that \$159.7 million was transferred in such a manner from Provena Covenant Medical Center in Champaign-Urbana, Illinois to Provena's corporate headquarters in Mokena, Illinois, much of which was then, in turn, transferred to 'Provena corporate' for-profit subsidiaries.

Of grave concern was that all of this took place during a time when: (a) uninsured, poverty-level patients were being charged much higher rates than insurance companies for the same hospital services, (b) poverty-level and other medically indigent patients were being subjected to aggressive collection efforts and being sued, and (c) 'bad debts' were being classified by the hospital as 'charity care'—all of which raised serious questions as to whether the real commitment was to the hospital's local 'charitable purpose' or whether the hospital was actually just making a profit for the parent company.

To what extent does the Board of Review expect full disclosure from a hospital?

The Board of Review expected disclosure according to statutory requirements. Certain documents and data are required to be filed with county officials.

In the recent matter of Provena Covenant Medical Center, Provena refused to provide leases and/or agreements with the for-profit physician groups and service providers that were operating within the hospital. Provena refused to provide a statistical breakdown (square footage) of how much of the hospital was being used by these for-profit entities. Provena provided no detail, verification or categorization of the "bad debt" figure that was provided. All of this information was deemed to be crucial to the Board of Review in accurately arriving at a recommendation regarding Provena's tax-exempt status.

CONCLUDING THOUGHTS FROM MR. JENKINS

Hospital boards and administrators need to recognize that the tax-exempt status they have enjoyed for many, many years can no longer be taken for granted. Scrutiny is increasing and public awareness is at an all time high. Unfortunately, many taxing bodies are 'salivating' at the prospect of increased tax revenues from formerly exempt healthcare institutions.

Marketing campaigns, positive media 'spin' and 'feel good' stories on local news channels serve their purpose, but do little to address property tax issues and the requirements that need to be met to remain tax-exempt.

Administrators must think 'outside of the box.' Doing it the way that it has always been done is no longer going to suffice. Counterparts and peers within the medical community may not be the best source of advice in such matter. It is not counterparts and peers who will be determining that tax-exempt status.

Hospitals must have policies, procedures and documentation in place that can withstand scrutiny. If a hospital's charitable status comes under government scrutiny and it is determined that it is NOT charitable, the property tax bill that the hospital will be receiving is just a drop in the proverbial bucket. The broader ramifications may include loss of a sales tax-exemption and payment of state and federal corporate income tax.

More resources need to be devoted to educating hospital administrators in this area. More resources need to be devoted to true charity care. The alternative is that many more of those same valuable resources will be devoted to taxes. The choice should be clear; the decision should be easy.