WASHINGTON STATE SOCIETY OF HEALTHCARE ATTORNEYS

SPRING SEMINAR

April 30, 2010

TAX UPDATE

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DWT 14464472v1 0025276-000001

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I. HEALTHCARE AND TAX EXEMPTION TODAY: KEY ISSUES FOR 2010

- The Patient Protection and Affordable Care Act imposes new statutory requirements on hospitals for qualification under Section 501(c)(3)[1] and requires Treasury to review the community benefits provided by all exempt hospitals and make reports to Congress.
- 2009 IRS Form 990: Hospitals for the first time must complete Schedule H for Hospitals and Schedule K for tax-exempt bonds.
- Executive compensation remains a high priority for IRS examinations and hot area for legislative attention.
- The IRS continues to issue determination letters under Section 501(c)(3) for regional health information organizations (RHIOs).
- Concluding a lengthy controversy, the Illinois Supreme Court ruled that Provena Covenant Medical Center did not qualify for state property tax exemption.

II. HEALTHCARE REFORM: NEW REQUIREMENTS FOR TAX-EXEMPT HOSPITALS

A. Background

The Patient Protection and Affordable Care Act ("Act"), as part of its sweeping reform of the U.S. healthcare system, imposes four new requirements on hospitals for qualification under Section 501(c)(3), described in more detail below:

- a mandated community health needs assessment
- written financial assistance and emergency care policies
- limitations on patient charges
- requirements regarding billing and collections practices

The new law is the latest chapter in a long-standing policy debate on the standards that should apply to distinguish hospitals that merit tax exemption as charitable organizations under Section 501(c)(3) from those that do not. Since 1969, hospitals have qualified for federal tax exemption if they were organized and operated as nonprofits and met a "community benefit standard" set out in IRS administrative rulings.

The IRS first articulated the community benefit standard in Revenue Ruling 69-545, 1969-2 C.B. 117, in which the IRS ruled that a hospital could qualify under Section 501(c)(3) if it promotes health for the benefit of the community. The ruling did not require the hospital to provide any level of charity care, as long as the organization benefited the community in other ways. Indicators of community benefits under the ruling include: having a governing board that

[1] All references to Sections, unless otherwise noted, are to the Internal Revenue Code of 1986, as amended ("Code"), or the Treasury Regulations thereunder.

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consists of individuals who represent a broad cross-section of the community; reinvesting net profits in the organization's facilities, training, and patient care; accepting and treating Medicare and Medicaid patients; operating a full-time emergency room that is open to all, regardless of their ability to pay; and an open medical staff policy. The IRS stated in the ruling that it would consider these factors under a facts and circumstances test, and that failure to meet one factor would not preclude exemption.

In 1983, the IRS issued Revenue Ruling 83-157, 1983-2 C.B. 94, which clarifies that a hospital need not operate an emergency room if a state health planning agency has determined that the operation of an emergency room is unnecessary because it would duplicate emergency care facilities that are adequately provided by another medical institution in the community. The ruling in addition concluded that specialty hospitals, such as eye hospitals and cancer hospitals, that offer medical care limited to special conditions unlikely to necessitate emergency care, need not maintain an emergency room in order to qualify for exemption.

B. New Code Section 501(r)

1. Application to "Hospital Organizations"

The Act adds new Section 501(r) to the Code, which for the first time imposes specific statutory requirements that hospitals must satisfy in order to qualify under Section 501(c)(3). The new rules apply to a "hospital organization," defined as any organization that operates a facility that is required to be licensed or registered as a hospital under state law, as well as any organization that the Treasury Secretary determines provides hospital care as the principal basis for its tax exemption. For a "hospital organization" that operates more than one hospital facility, the organization must meet the new requirements separately for each facility, and will not be treated as described in Section 501(c)(3) with respect to any facility that does not separately meet the new requirements.

It is not clear what these provisions mean for a single legal entity that operates multiple hospital facilities, e.g., whether the failure of one facility to meet the requirements will jeopardize the organization's overall Section 501(c)(3) status, or whether the facility that fails to qualify may be treated as an unrelated trade or business of the organization. Nor is it clear how the new rules will affect Schedule H reporting on Form 990 for future years.

2. Community Health Needs Assessment.

Under new Section 501(r), a tax-exempt hospital must conduct a community health needs assessment ("CHNA") at least once during any three-year period. The hospital must then adopt an implementation strategy to meet the needs identified in the CHNA and make the CHNA widely available to the public. In performing the assessment, the hospital is required to obtain input from a broad cross section of the community that the hospital serves, including those with special knowledge or expertise in public health.

3. Financial Assistance and Emergency Medical Care Policies.

Tax-exempt hospitals are required to have written policies that address financial assistance and emergency medical care. The financial assistance policy must address eligibility

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criteria for financial assistance and whether such assistance includes free or discounted care, the application process, the basis for calculating the amount charged to patients, and the measures to publicize the policy widely within the community that the hospital serves. A tax-exempt hospital must also have a separate billing and collection policy, or alternatively include in its financial assistance policy the actions the hospital may take if amounts that it bills are not paid.

The hospital's emergency care policy must require it to provide, without discrimination, care for emergency medical conditions regardless of the patient's eligibility under the financial assistance policy.

4. Limitations on Charges.

For individuals who are eligible to receive financial assistance under the hospital's policy, the hospital cannot charge more than the amounts generally billed to insured individuals for emergency and other medically-necessary care.

The hospital must also prohibit the use of "gross charges." Neither the Act nor the legislative history defines "gross charges," but the term is generally understood to mean the full amount that a hospital charges without taking into account any discounts negotiated with insurance companies.

5. Billing and Collection.

A hospital must make reasonable efforts to determine if a patient is eligible for assistance under its financial assistance policy before taking "extraordinary collection actions" to collect unpaid bills. The new provision does not define extraordinary collection actions, but the term may include lawsuits, arrests, liens on residences, and similar collection methods. The Act requires the Treasury Department to issue regulations defining "reasonable efforts." The legislative history suggests that reasonable efforts include notifying the patient of the hospital's financial assistance policy at the time of admission, submitting invoices, and written and oral communications before taking collection actions or reporting to credit rating agencies.

6. Effective Dates.

The new requirements are generally effective for tax years beginning after the date of enactment (March 23, 2010). For calendar-year organizations this means January 1, 2011, but the requirements could be effective as early as April 1, 2010, for organizations with a March 31 tax year-end.

The CHNA requirement is effective for tax years beginning after the second anniversary of the date of enactment of the Act (January 1, 2013, for calendar-year organizations).

C. Section 4959 Excise Tax for Failure to do Community Needs Health Assessment.

Any hospital that fails to conduct the CNHA will be subject to an excise tax of $50,000 under new Code Section 4959.

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D. Section 6033(b) Reporting Requirements

Hospital organizations subject to Section 501(r) must report on Form 990 how the needs identified in the CHNA are being met, and provide a description of needs that are not being met and an explanation of why such needs are not being addressed. Hospitals must also include audited financial statements with their Form 990 submissions.

E. Treasury Study and Reports

1. Community Benefit Review of All Hospitals.

Beyond the requirements for hospitals, the Act mandates administrative oversight and reporting procedures that may lay the foundation for additional reforms in the future. The Act requires the Treasury Secretary to review the community benefit activities of each tax-exempt hospital at least once every three years. Although the Act does not specify how the review will be conducted, it seems likely that it will be through Schedule H to the Form 990.

2. Annual Report to Congress.

The Treasury Secretary must also submit an annual report to Congress, in consultation with the Health and Human Services ("HHS") Secretary, containing information for tax-exempt, taxable and government-owned hospitals regarding charity care, bad debt expense, unreimbursed costs for services provided under means-tested government programs, and information regarding costs incurred for community benefit activities by tax-exempt hospitals.

3. Five-Year Study and Report to Congress.

Finally, the Treasury Department and HHS must conduct a study and submit a report within five years after the date of enactment of the Act on trends in the information in the annual reports to Congress.

F. What's Not in the Legislation: Minimum Charity Care

A Senate Finance Committee description of healthcare financing options released in the spring of 2009 included a minimum charity care requirement. This option attracted criticism by the American Hospital Association and others, and was dropped from Senate Finance Committee negotiations by the fall.

III. 2009 IRS FORM 990

A. Part VI, Governance, Management and Disclosure

The 2009 Form 990, like the 2008 Form, asks at line 11 whether the organization provided a copy of the Form 990 to all members of the governing body before filing the form. New for 2009, the instructions describe the conditions the organization must meet in order to answer "yes" to the question when it emails board members a link to its Form 990. They provide, at page 19: "The organization can answer "Yes" if it emails all of its governing body

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members a link to a password-protected web site on which the entire Form 990 can be viewed, and notes in the email that the Form 990 is available for review on that site."

B. Schedule H: Hospitals

1. Required for 2009 Tax Year

Implementation of the redesigned Schedule H was delayed until the 2009 tax year (returns filed in 2010) in response to comments received by the IRS. For 2008, organizations were required to complete only Part V, Facility Information, and were not required to complete the other parts of the schedule. For 2009 all parts must be completed.

2. Who Must File.

A key threshold issue for Schedule H was the definition of a "hospital" for purposes of determining what entities would be required to file. For purposes of Schedule H the term "hospital" is limited to facilities that are licensed or certified as hospitals under state law.

Schedule H reporting is done on an entity basis, not on a group or hospital by hospital basis. If an organization operates multiple hospital facilities that meet the state licensure definition, it should complete only one Schedule H for all hospitals, with all information aggregated. Each facility must be listed separately in Part V, Facility Information, however.

3. Schedule H Part I: Charity Care and Other Community Benefits.

Part I requires reporting of charity care policies, including the charity care eligibility criteria that are applied, the availability of community benefit reports, and the cost of certain charity care and other community benefit programs. The IRS designed Part I on the basis of the Catholic Health Association's community benefit reporting model that it developed in cooperation with Volunteer Hospitals of America.

Much of the reporting on Schedule H is based on cost, and the schedule's instructions allow reporting by using cost to charge ratios or a cost accounting system.

The community benefit table in Part I does not include patient bad debt or Medicare shortfalls. Organizations can, however, report that information in Part III.

An IRS official, speaking on March 20, 2008, indicated that the IRS's reason for excluding bad debt and Medicare shortfalls from the community benefit table was that the IRS was not persuaded that all of bad debt or all of Medicare shortfalls should be included. "We were persuaded that some of it should be and we certainly were persuaded that it was important to get the information on bad debt and Medicare. As a result, we added Part III." Remarks of Ronald J. Schultz, Senior Technical Advisor to the Commissioner, IRS Tax Exempt/Government Entities Division, during a teleconference sponsored by the American Bar Association Taxation and Health Law Sections and the ABA Center for Continuing Legal Education, as reported in 2008 Tax Notes Today, 56-4 (March 21, 2008).

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4. Schedule H Part II: Community Building Activities.

Part II provides an opportunity to report on non-charity care community activities, including economic development, environmental improvement, coalition building and community health improvement advocacy.

5. Schedule H Part III: Bad Debt, Medicare and Collection Practices.

Part III requires a hospital to report aggregate bad debt expense, at cost, to provide an estimate of how much bad debt expense, if any, is attributable to persons who qualify under its charity care policy, and to provide a rationale for what portion of bad debt it believes should constitute community benefit. Part III also requires the reporting of Medicare reimbursements and the aggregate allowable costs to deliver care reimbursed by Medicare in order to report aggregate Medicare surpluses or shortfalls. Organizations completing Part III must also explain in narrative form in Part VI why their bad debt expenses and Medicare shortfalls should be considered community benefit.

6. Schedule H Part IV: Management Companies and Joint Ventures.

Part IV requires a hospital to list any joint venture or separate entity (whether taxed as a partnership or a corporation) of which the hospital is a partner or shareholder, any management company in which hospital officers, directors, trustees, key employees and physicians on staff own in the aggregate more than 10%, and that provides management services used by the hospital organization in its provision of medical care or that provides medical care or owns or provides real, tangible personal or intangible property that the hospital organization uses to provide medical care.

7. Schedule H Part V: Facility Information.

This part requires the organization to identify each of its facilities that is a licensed hospital and to identify each as a general medical and surgical hospital, children's hospital, teaching hospital, critical access hospital, research facility, facility that operates a 24 hour emergency room, facility that operates an emergency room for periods other than 24 hours or "other." This was the only part of Schedule H that hospitals were required to complete for the 2008 tax year.

8. Schedule H Part VI: Supplemental Information.

Part VI requires supplemental information regarding community benefit from Parts I and III, including a description of the income-based criteria for determining eligibility for free and discounted care under the organization's charity care policy, the organization's rationale for why any of its bad debt expense and Medicare shortfall should be treated as community benefit, a description of debt collection practices and an explanation of the costing methodology used to calculate the amounts reported as charity care in Part I.

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C. Schedule J: Compensation Information

New for 2009, an organization that answers "yes" to Part I question 8, regarding whether any compensation amounts reported were paid pursuant to a contract that was subject to the initial contract exception to the intermediate sanctions rules under Treas. Reg. Section 53.4958-4(a)(3), must answer a further question, question 9, as to whether the organization nevertheless followed the rebuttable presumption procedure described in Treas. Reg. Section 53.4958-6(c).

D. Schedule K: Supplemental Information on Tax-Exempt Bonds

For the first time for the 2009 tax year, organizations must complete Schedule K, including disclosure of private business use.

IV. EXECUTIVE COMPENSATION

A. Hospital Compliance Project Final Report

The IRS released its Hospital Compliance Project Final Report ("Final Report") on Feb. 12, 2009, available at http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html. In addition to addressing community benefit issues, the Final Report considered executive compensation practices.

The average and median total compensation amounts reported by all hospitals as paid to the top management official were $490,000 and $377,000. The largest amounts were reported by high population hospitals and other urban and suburban hospitals, while the smallest amounts were reported by critical access hospitals. Unsurprisingly, average and median total compensation increased with revenue size.

The Final Report found that nearly all hospitals reported complying with "important elements" of the intermediate sanctions rebuttable presumption procedures (use of comparability data and review and approval by independent personnel) under Treas. Reg. Section 53.4958-6, in order to establish a presumption that executive compensation is reasonable. Final Report at 3. These results did not vary materially by demographic.

The Final Report notes that while "many of the compensation amounts may appear high to some, nearly all of the examined amounts were upheld as established pursuant to the rebuttable presumption process and within the range of reasonable compensation." Final Report at 4.

The IRS states that while amounts paid by tax-exempt hospitals appear high, they also appear to be supported under current law. This seems implicitly to raise the question whether current law, particularly the permitted use of for-profit comparables, is adequate. The Final Report goes on to suggest, somewhat ominously, that there may be a "disconnect" between what members of the public might consider reasonable, and what is permitted under the tax law. Final Report at 4. The IRS will "seek a better understanding of the impact of certain aspects of the existing law," including the use of for-profit comparables and the initial contract exception (sometimes known as the "one free bite rule"), under which a person is not deemed to be a disqualified person under the intermediate sanctions rules of Section 4958 for purposes of the

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initial contract (e.g., with a new CEO) that creates the disqualified person relationship. Final Report at 5.

B. IRS Examinations

The IRS continues to make examinations of executive compensation a high priority, and is looking closely at the "quality" of comparability data used, especially when for-profit comparables are used, and at situations in which the organization relies on the initial transaction exception to the intermediate sanctions rules under Treas. Reg. Section 53.4958-4(a)(3).

Anecdotally, it appears that the IRS in some cases is asserting that excess benefit transactions exist where the organization has satisfied the rebuttable presumption procedures under Treas. Reg. Section 53.4958-6.

C. Reporting

As noted above, in the 2009 Form 990, Schedule J, an organization that answers "yes" to Part I question 8, regarding whether any compensation amounts reported were paid pursuant to a contract that was subject to the initial transaction exception to the intermediate sanctions rules under Treas. Reg. Section 53.4958-4(a)(3), must answer a further question, question 9, as to whether the organization nevertheless followed the rebuttable presumption procedure described in Treas. Reg. Section 53.4958-6(c).

D. Legislative Proposals

Sen. Charles Grassley (R-Iowa), ranking minority member of the Senate Finance Committee, in September 2009 proposed an amendment to the healthcare reform legislation that would have eliminated the initial transaction exception to the intermediate sanctions rules, and would have required organizations to summarize on their annual Form 990 the comparables they used to determine executive compensation. A Senate Finance Committee description of the amendment noted that the IRS in its Final Report had found that exempt hospitals paid very high salaries, but because almost all of the organziations had complied with the rebuttable presumption procedures it was difficult for the IRS to challenge the high amounts. The amendment was not included in the final legislation.

V. REGIONAL HEALTH INFORMATION ORGANIZATIONS (RHIOS)

A. Background

A Regional Health Information Organization, or "RHIO," is dedicated to the use of health information technology, or "HIT" to improve the safety, quality, accessibility, availability, and efficiency of healthcare within a particular community. More specifically, a RHIO generally serves to enable hospitals and health care providers to share and access patients' clinical data, i.e., a patient's electronic health records or "EHR," more effectively and efficiently, and may act as a central health data collection agency. A RHIO's activities may also include education and research projects, as well as creating and operating secure communication systems that support the exchange of health information, data and studies. Each RHIO is different and reflects its unique region and resources, as well as its membership. Members of a RHIO may include such

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diverse stakeholders as hospitals, government health agencies at the national, state or local levels, physicians, and insurers.

B. The 2009 Economic Stimulus Package: RHIOs Lessen the Burdens of Government.

Title XIII of the American Recovery and Reinvestment Act of 2009 (the "Act") made permanent the Office of the National Coordinator of Health Information Technology (ONCHIT), which until then had existed only by Executive Order. One of the ONCHIT's stated goals, which according to ONCHIT is served by RHIOs, is to interconnect clinicians by fostering regional collaborations among health care entities, which allows for a patient's information to be securely stored in the local community and ensures that such data is electronically accessible to those involved with providing the patient's care in that community. See http://www.hhs.gov/healthit/framework.html). The Act also included a number of provisions that provided funding (to states, academic institutions and medical providers) for the electronic use and accurate exchange of electronic health information, and specifically mandated that the Secretary of HHS adopt standards to ensure the utilization of EHRs for every person in the U.S. by 2014.

The Act did not specifically mention RHIOs, nor did it address whether the activities of RHIOs are consistent with the purposes set forth in Section 501(c)(3). The legislative history of the Act did, however, indicate Congress' intent that, so long as a RHIO complies with other provisions of Section 501(c)(3), its purposes to facilitate the use and exchange electronic health information are consistent with the purposes set forth in Section 501(c)(3) and, specifically, that a RHIO's activities lessen the burdens of government. A House of Representatives Conference Report regarding the Act states:

> …if a nonprofit organization otherwise organized and operated exclusively for exempt purposes described in [Section] 501(c)(3) engages in activities to facilitate the electronic use or exchange of health-related information to advance the purposes of the bill, consistent with standards adopted by HHS, *such activities will be considered activities that substantially further an exempt purpose under [Section] 501(c)(3), specifically the purpose of lessening the burdens of government. Private benefit attributable to cost savings realized from the conduct of such activities will be viewed as incidental to the accomplishment of the nonprofit organization's exempt purpose.*

See H.R. Rep. No. 111-16, at 488 (Feb. 12, 2009) (Conf. Rep.) (emphasis added). The Conference Report language does not appear in the Act, and raises legal questions concerning the extent to which the IRS must or should take account of legislative history for non-tax legislation in its decision-making. But this language seems to have assisted the IRS in reaching determinations regarding some RHIO applications for Section 501(c)(3) status.

C. Qualification of RHIOs Under Section 501(c)(3).

RHIOs must navigate difficult legal issues and several sets of complex laws, including antitrust, privacy and fraud and abuse laws, as well as the question of federal tax status. While

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RHIOs may be formed as taxable entities, they may alternatively apply for tax-exempt status under Sections 501(c)(3), (c)(4), or (c)(6) of the Code. Qualification under Section 501(c)(3) may be particularly attractive, to enable the organization to attract funding through foundation grants and charitable contributions.

A RHIO that seeks recognition of exemption under Section 501(c)(3) must satisfy the requirements for that status in the same manner as any other organization. The RHIO must not be organized for the private benefit of any person and its assets must be irrevocably dedicated to its charitable, educational, scientific, or other qualifying exempt purpose. RHIOs may rely on one or more legal bases for qualification under Section 501(c)(3), including operation for the promotion of health, engaging in scientific research and/or engaging in charitable activities by providing services at substantially below cost. In addition, and as a result of recent federal legislation (see above), it may now be possible for a RHIO to argue successfully that its activities lessen the burdens of government, which is an independent basis for qualification under Section 501(c)(3).

D. IRS Posts Frequently Asked Questions Regarding RHIOs On Its Website.

The IRS in 2009 posted a series of FAQs regarding RHIOs on its website. See "Regional Health Information Organization (RHIO) Frequently Asked Questions" available at http://www.irs.gov/charities/charitable/article/0,,id=206129,00.html.

The FAQs note that by passing the Act, Congress "recognized that facilitating health information exchange and technology is important to the delivery of health care and reducing the costs of health care delivery and administration." The IRS also points to the language in the Conference Report in support of a conclusion that RHIOs may qualify as Section 501(c)(3) organizations because they lessen the burdens of government.

The FAQs state that the IRS is in the process of reviewing all pending and new RHIO tax exemption applications in light of Section 501(c)(3) requirements and the Act. The IRS further states that it will issue Section 501(c)(3) determination letters to RHIOs based upon the facts and circumstances set forth in each RHIO's tax exemption application.

E. IRS Determinations of Section 501(c)(3) Status.

After years of inaction on pending RHIO tax exemption applications, the IRS in March 2009 began to issue IRS determination letters of Section 501(c)(3). As of November 2009, according to Steven Grodnitzsky, IRS exempt organizations technical group manager for rulings and agreement, the IRS had resolved the exemption applications of some 30 RHIOs, as a result of the language in the Act. RHIOs that have received determinations under Section 501(c)(3) include CalRHIO in California, East Kern County Integrated Technology Association ("EKCITA") in California, CareSpark in Tennessee, and Vermont Information Technology Leaders ("VITL") in Vermont.

While the facts and circumstances of each organization are unique, there seem to be clear patterns in the facts of these organziations that the IRS has recognized under Section 501(c)(3). Each is regionally-based, is funded primarily with grants, and in particular with government grants, either from DHHS or the state, and government officials play a role in governance. In the

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case of VITL, state legislation required the organization to provide specific services, and the organization had worked with the federal Office of National Coordinator for Health Information Technology.

VI. ILLINOIS PROPERTY TAX EXEMPTION: *PROVENA COVENANT MEDICAL CENTER*

A. Background

Provena Health is a Catholic health system that includes six hospitals, along with long-term care and senior residential facilities, clinics, home health agencies and other health-related activities, operating in both Illinois and Indiana. One of its hospitals, Provena Covenant Medical Center, is located in Urbana, Illinois, on real property owned by Provena Hospitals ("Provena"), a subsidiary of Provena Health. Provena applied to the Champaign County Board of Review (the "Board") for property tax exemption for the 2002 tax year. In January 2003, the Board recommended that Provena's application be denied. The Board based its recommendation on what it viewed as the hospital's lack of charity care, aggressive billing and collection practices, and Provena's joint venture and contractual relationships with for-profit medical groups and other entities, which the Board claimed violated a requirement under Illinois law that property be used exclusively for charitable purposes in order to qualify for exemption.

In February 2004, the Director of the Illinois Department of Revenue (the "Director") endorsed the Board's recommendation. Provena appealed that decision, and a hearing was held before the Department's administrative law judge in December 2004. The judge recommended granting Provena's property tax exemption, but the final decision rested with the Director. In September 2006, the Director rejected the administrative law judge's recommendation, and affirmed the Board's original analysis to deny property tax exemption for Provena.

B. Final Illinois Department of Revenue Decision

In his Final Administrative Decision, the Director considered whether Provena is a charitable organization, and if so, whether Provena uses the real property in question exclusively for charitable purposes. The relevant section of the Illinois property tax code does not exempt property solely based on the type of entity that owns it, and the fact that the property owner is qualified under Section 501(c)(3) is not determinative; rather, the property is exempt only when "actually and exclusively used for charitable or beneficent purposes, and not otherwise used with a view to profit."

1. Provena's Finances.

The Director held that Provena was not a charitable organization, as that term is defined under Illinois law, and that it did not use the property exclusively for charitable purposes. Provena failed the charitable organization test in part because charitable contributions to Provena were negligible, amounting to approximately 0.00067% of collected revenue in 2002, and the bulk of its funding was from fees for services. With respect to the use of the property, the Director put great weight on the fact that Provena admitted in its appeal that its revenues in 2002 exceeded $113 million, while its charity care activities cost it approximately $832,000, or 0.7% of its revenues. The property tax exemption that Provena had requested, on the other hand, was

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worth over $1.1 million. The Director held that the Provena's financial figures for charitable care were "seriously insufficient" and fell far short of meeting the charitable use standard, particularly in light of the fact that the amount of taxes Provena would save under the exemption exceeded the cost of charitable care actually provided.

2. Un-reimbursed Care Deemed Not to be Charity Care.

The Director held that un-reimbursed Medicare and Medicaid bills do not constitute charity care and may not be included in Provena's costs of charitable activities. While Provena claimed that it provided over $10 million in such un-reimbursed care, as determined by the difference in what the services cost the hospital and what the government paid the hospital, the Director stated that Illinois courts have consistently rejected the argument that such un-reimbursed costs constitute charity care.

3. Charity Care Policy.

Although Provena had a charity care policy, the Director stated that the organization did not make a material effort to publicize the availability of charity care to those who were most in need of it. The Director used the fact that Provena adopted publication and dissemination standards for its charitable care policy in subsequent years only to show that Provena tacitly admitted this "serious deficiency." The Director's decision further criticized Provena's billing and collections policies and procedures. Provena's charitable care policy provided that patients whose income was less than the poverty income guidelines as set forth by the Department of Health and Human Resources would be eligible for reduction of the patient portion of billed charges according to a sliding scale. The Director, however, stated that Provena's charity care policy could result in an impoverished patient still facing a large unpaid bill, even after the reduction. A "true" charity care policy, on the other hand, that considers the medical services rendered, the amount of the patient's bill and fairly evaluates a patient's ability to pay would be more meaningful, according to the Director's decision. The Director noted that in some cases, although Provena provided discounts off of its regular charges to impoverished patients, the charges still resulted in a bill that netted Provena a profit above its costs. Moreover, the Director cited Provena's practice of referring patients with unpaid charges to collection agencies, even when a portion of the patient's charges had been reduced pursuant to its own charity care policy, as inconsistent with charitable activities.

4. Emergency Facilities.

In keeping with the "community benefit" standard articulated for federal income tax purposes, Provena asserted that all persons seeking treatment in its emergency facilities receive attention, but the Director was unpersuaded on that point. In his decision, the Director stated that emergency facilities operators are required by federal law to provide appropriate screening, and in many instances treatment, to every person who enters an emergency facility and requests examination or treatment for a medical condition. Thus, the decision stated, this point may simply reflect compliance with federal law, rather than a clear indication of Provena's charity. Further, the Director found the fact that Provena contracts with a for-profit corporation that operates its emergency facilities troubling, as the for-profit entity does its own billing and pursues collection of those bills. While Provena asserted that the for-profit corporation is

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required to follow Provena's procedures, the Director found no evidence that the for-profit entity is complying with Provena's charitable guidelines.

5. Contracts with For-Profit Entities.

Provena also contracted with third-party providers for other major services found on the property, including: pharmacy services, clinical laboratory services, MRI/CT services, neo-natal staff, medical resident program, laundry services, and the management, administration and staffing of rehabilitation and cardiovascular surgery programs. Some of the for-profit entities that provide these services are owned by Provena's parent corporation, Provena Health. The Director found it significant that a person who needs laboratory services or a specialized radiology procedure is apparently presented with a bill for those services that is separate from his or her bill for the hospital bed, and would be expected to pay for those separate bills. The Director's decision reiterated the lack of evidence showing that Provena verifies the for-profit providers comply with its charitable guidelines. The decision also stated that there is no evidence quantifying any charitable care provided to Provena's patients by the for-profit parties with whom Provena contracted, even though those third parties provide substantial quantities of care to Provena's patients.

6. Contributions to Community.

While the Director acknowledged that Provena made many contributions to the well-being of the community through the services it offers, he rejected Provena's broad claim that it provides community benefit, stating that the general proposition holds true for both for-profit and nonprofit hospitals and "property tax exemptions do not turn on these general propositions."

C. Illinois Circuit Court

Provena filed a request for judicial review of the Director's decision in Illinois Circuit Court in October 2006, contending that the decision was unsupported in both law and fact. The Circuit Court, in a one-page order, concluded that the property qualified for both a charitable tax exemption and a religious tax exemption. *Provena Covenant Med. Ctr. v. Dep't. of Revenue*, 2007 WL 4913149 (Ill. Cir., 2007).

D. Illinois Court of Appeals

The Director appealed the case to the Illinois Fourth District Court of Appeals, which as a procedural matter reviewed the Department of Revenue's decision, rather than the Circuit Court decision. The Court of Appeals found no clear error in the Department of Revenue decision. *Provena Covenant Med. Ctr. v. Dep't. of Revenue*, 894 N.E.2d 452 (Ill. App. Ct., 2008). The court noted that the language n the statute conveying exemption from real property tax was derived from Illinois' 1870 constitution, and that it may be "difficult to apply to the modern face of our nation's healthcare delivery systems. . .. It is of obvious public benefit for any community to have available one or more modern hospitals, but until such time as the legislature sees fit" to change the standard, Provena cannot prevail on the record as presented. Id. at 481-2.

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E. Illinois Supreme Court

The Illinois Supreme Court, in a long-awaited decision, upheld the denial of tax exemption for the property. *Provena Covenant Med. Ctr. v. Dep't. of Revenue*, No. 107328, 2010 WL 966858 (Ill. March 18, 2010). The Court ruled that 1) Provena failed to meet Illinois law standards for qualification as a charitable organization because its derives its funds primarily from fees for service, rather than from the receipt of public and private charitable funding, and 2) Provena's use of the property was not charitable, evidenced by the fact that the charity care provided by the Provena hospitals was de minimis in proportion to overall operations, and the property was used primarily to treat patients in exchange for compensation from private insurance, Medicare and Medicaid, and direct payments from patients. The court also pointed to the fact that while Provena did not turn away patients because of their financial circumstances, it did not advertise its charity care policy and automatically referred unpaid bills to collection agencies.

The court rejected Provena's argument that its services to the community, including volunteer initiatives and support of a crisis nursery, should be considered in assessing its charitable activities. While such activities may be relevant under the federal tax law "community benefit" standard for charitable status, the test under state law looks only to whether the property issued exclusively for a charitable purpose.

F. Implications Beyond Illinois

The *Provena* decision has no direct application to hospitals outside Illinois. It is based on specific formulations of charity and charitable use under Illinois law, which are significantly different from the federal tax law community benefit standard and standards in many other states. Its importance outside of Illinois is rather that it encourages tax authorities in other jurisdictions to examine closely the compliance of local hospitals with the particular state or local legal standard for tax exemption, and generally fuels debate on whether a minimum charity care standard should be applied at either the state or federal level.

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