The Future of Property-Tax Exemption for Nonprofit Health Care Organizations

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Just as there has been increased scrutiny by some congressional leaders and the Internal Revenue Service (IRS) of federal tax exemption standards for nonprofit hospitals and the hospitals' compliance with those standards, there also appears to be growing interest by state and local government officials in the property tax exemption of nonprofit hospitals, nursing homes, and other health care organizations. (See Helen Schneider's article, "Paying Their Way? Do Nonprofit Hospitals Justify Their Favorable Tax Treatment?" in *Inquiry's* summer 2007 issue for more on this subject.) Cash-strapped governmental units and growing numbers of uninsured and underinsured individuals and families are two factors that may drive greater focus on this and other types of state and local tax exemptions. Some recent actions are illustrative:

- Denial of the property tax exemptions of a Provena Health hospital and the Carle Foundation hospital by the Illinois Department of Revenue (Provena Health recently won an appeal).
- Denial of the property tax exemption of an outpatient center owned by Wheaton Franciscan Healthcare by the City of Wauwatosa, Wisconsin (under appeal).
- Approval by the California Health Facilities Financing Authority of a $910 million tax-exempt bond issuance for Sutter Health, conditioned on the latter making $8.5 million in contributions over the next six years, including $4 million to rural hospitals to help them improve their electronic health information technology systems and $4.5 million to support community health clinics in the region.

The following discussion is another in an ongoing *Inquiry* series called "Dialogue," a collaboration with the Alliance for Advancing Nonprofit Health Care to provide a variety of voices on current, major issues in the nonprofit health sector.

The panelists for this discussion, held on April 10, 2007, were: **Evelyn Brody,** professor and author on tax and nonprofit law at Chicago-Kent College of Law, Illinois Institute of Technology, in Chicago; **Doug Hammer,** vice president and general counsel of Intermountain Healthcare, headquartered in Salt Lake City, Utah; **Oliver "Pudge" Henkel,** executive director of government relations at the Cleveland Clinic Health System, based in Cleveland, Ohio; **Patsy Matheny,** consultant to nonprofit health care organizations on community benefit practices (and former director of health improvement for VHA, Inc.), based in central Ohio; and **Alan R**. **Morse, Ph.D.,** president and CEO of the Jewish Guild for the Blind, headquartered in New York City. **Bruce McPherson,** president and CEO of the Alliance for Advancing Nonprofit Health Care, moderated the discussion.

Bruce McPherson: *How important is property-tax exemption to the financial status of a nonprofit health care organization? Can any of you give examples?*

Alan Morse: In New York, a typical 30-year-old, medium-sized facility of about 150,000 square feet would have a property valuation of about $20 million, which would translate to about $3.5 million to $5 million in real estate taxes. That same organization might buy goods and services worth $60 million to $80 million, which would mean a significant additional financial hit of more than $7 million if it were also subject to sales taxes. Sales tax can be much more onerous than property tax in some situations. I think the issue is exemption from all types of taxes, and not merely property tax.

Pudge Henkel: The Cleveland Clinic's aggregate real estate tax exemption, for its facilities entitled to exemption, is also a very significant factor for us.

McPherson: *Are you seeing, or do you foresee, more questions and challenges related to the property-tax exemption of nonprofit health care organizations, and if so, why?*

Evelyn Brody: It is very hard to get a systematic read on everything that is happening on property-tax exemption. There might be more challenges occurring or just more reporting by the press, or both. In some cases, the focus is strictly on nonprofit hospitals, while in other situations there appear to be overlapping themes across nonprofits.

There are many different questions and challenges emerging, some at the federal level with the recent Senate Finance Committee and IRS focus on community benefits, as well as the general question on the Hill about tax exemption of college athletics and other commercially oriented activities. The property-tax exemption problem is a local issue, but the solution is at the state level. State legislatures may have very different interests from local tax assessors. There is also the media to deal with, so there are all sorts of players, and some of these issues are legal and others are about politics and perceptions.

When you listen to the arguments and you read the cases, what towns really want to do is tax income. They don't want to tax churches or other charities that are not producing a lot of revenue, but they're aware of significant revenue generation in nonprofits like hospitals and universities. But since the towns are not allowed to tax income, they are trying to shoehorn in what they are allowed to do, which is collect property taxes, and make the finances fit as best they can. For example, back in the 90s Philadelphia had a voluntary PILOT (payment in lieu of taxes) program where the large hospitals and the universities stepped up because they were enjoying good times and could afford to help the city. However, when that five-year period expired and it was time to renew, the municipality still needed the money but these charitable organizations no longer had it.

Information about challenges to property-tax exemption is filtering out. If something works for one revenue-starved municipality, the news will get around to other revenue-starved municipalities and they will give it a try. The more information that is out there, the more people can be expected to act on it.

Henkel: Various governmental entities in northeastern Ohio and other parts of the state exemplify what Evelyn has described. They face budget constraints and view challenges to the property-tax exemption of nonprofit hospitals as a way to generate more revenue. The Cleveland Clinic, now second only to Wal-Mart in total private sector employment in Ohio, and the University Hospitals, the fourth largest employer, are the 800-pound gorillas in the Cleveland area. We are in the gunsights of certain law firms representing school districts, the primary beneficiaries of the real estate tax.

Another point Evelyn made, about income versus property taxes, also rings true in our situation. The Cleveland Clinic recently purchased some valuable property in a suburban community from a for-profit entity. The municipality, which has an income tax, is very enthusiastic about the fact that we will be bringing employees into the buildings with a high average per capita income. On the other hand, because much of the property may go off the real estate tax rolls, the school district stands to lose significant revenue. There was no discussion between the municipality and the school board about revenue sharing, a process that I think may gain acceptance over time in Ohio as these kinds of issues develop.

Morse: I also envision much more scrutiny being paid to all kinds of tax exemptions because no one wants to pay more in taxes, but we all expect more in services from our tax dollars. In New York, the value of property tax in 1997 that was not collected due to tax-exempt status was about $56 billion, rising to $90 billion in 2005. It is important to note, however, that only about 15 percent was related to private, community-based organizations, which include nonprofit health care organizations. The remaining 85 percent was related to state and municipal governments, Indian tribe reservations, public service property that had been granted tax relief, and so on.

So the question of tax exemption should look far beyond health care and community support agencies that provide a public good and a necessary safety net, without which communities could not effectively function.

Patsy Matheny: Another impetus for the focus on nonprofit hospitals has been the Service Employees International Union, which is seeking to organize hospital employees around the whole issue of community benefits, which opens the door for tax exemption challenges.

In some states, like Illinois, the attorney general has taken the lead in challenging whether hospitals or other nonprofit health care organizations are providing sufficient community benefits to justify their various tax exemptions.

The issue of tax exemption is also not going to go away at the federal level, despite a change in Congress. Senator Charles Grassley, ranking member of the Finance Committee, asked the Government Accountability Office to take a closer look at hospitals to see if they are providing sufficient community benefits to justify their tax exemption. In addition, the IRS is considering requiring that community benefit information be attached to Form 990. The good news is that it keeps community benefits in the forefront, stimulating nonprofit hospitals to look at their community benefits more closely and think about how they might improve them. I also expect that the Catholic Health Association/VHA recommendations on what counts and what doesn't count as community benefits will emerge as the accepted national standard from all of this external scrutiny.

McPherson: *It sounds like property tax exemption challenges can get very messy and burdensome to address, with different units of government and even the courts having their own agendas and/or perspectives. Is that the case?*

Brody: Absolutely. Part of what complicates the issue of property-tax exemption is that many states put the exemption in their constitution, resulting in a battle between the courts and the legislature over whether the standards for exemption can be fine-tuned. That has been happening in Pennsylvania and in Illinois, for example.

Henkel: The statute in Ohio under which the exemption from real estate taxes derives is very vague, with the courts and administrative bodies left to determine whether certain activities of nonprofit hospitals should qualify for tax exemption. This results in varying standards depending on the particular venue. We may succeed in obtaining an exemption from real estate tax in one year for one of our properties, yet come under attack about that same exemption the following year and get a different result. There are very inconsistent, seemingly subjective, standards being applied across the state.

Doug Hammer: Ohio is coming a little late to this party in some ways, Pudge, compared to my state. I have been with Intermountain Healthcare for 30 years, and the nonprofit hospital tax exemption issue in Utah dates almost to my childhood. Utah had a statute, in the early 70s, essentially based on Federal Revenue Ruling 69-545, which is still the basic community benefit standard for federal tax exemption of nonprofit hospitals. In the late 70s, that Utah statute was challenged as being unconstitutional because the definition of "exclusively charitable" under the statute was too broad.

The issue went to the Utah Supreme Court in the early 80s, which handed down a controversial decision in the mid-1980s. The court adopted a six-factor test that was also remarkably vague. After two years of hearings, the Utah State Tax Commission developed a more specific set of standards for nonprofit hospitals and nursing homes, the only types of nonprofit health care entities that can qualify for property tax exemption. Our health plan and our clinics—Intermountain has 135 in the state—pay property taxes. Those standards were challenged by two counties, and ended up again before the Utah Supreme Court in 1994, which upheld them. The Tax Commission's standards are reasonably clear and objective. Each year, every nonprofit hospital and nursing home in Utah must still go before a county board of equalization to demonstrate that it meets these standards. We operate in 13 counties in the state, and since the standards were promulgated in 1990, a 17-year period, all of our hospital properties have qualified for tax exemption.

Two of the six standards are basically the federal tax-exemption standard: whether you are organized and operate exclusively for charitable purposes. The remaining four standards are quite objective and we prepare an affidavit for exemption every year to demonstrate how we meet them. The institution claiming the exemption must admit and treat patients with medical needs regardless of ability to pay and have an articulated charity care policy which is made known to the public. The institution must have a governing board that is reasonably representative of the community, and must meet and confer with the county board of equalization regarding the community health care needs. For instance, I just had a phone call this morning from a Salt Lake County Council member wanting us to confer on how to improve the health care clinic in their jail. That is an example of meeting and conferring with the county.

The institution also has to demonstrate that its "gift to the community" exceeds the value of its property-tax exemption. The State Tax Commission standards articulate what should be counted as a "gift," such as charity care, and how to calculate it. It includes shortfalls in Medicaid and Medicare payment, support for research, community health education, and other community health care programs. We prepare an affidavit for exemption every year to demonstrate how we meet the standards.

While government desires for greater revenues to fund public education play some role in the property tax exemption debates in Utah, the most significant force has been for-profit competitors—hospitals or physician-owned ambulatory surgery centers. In fact, about five years ago, the Utah Legislature passed a joint resolution to examine certain nonprofit organizations that compete with private enterprise in the state to determine whether these organizations have an "unfair" competitive advantage because of their tax exemption. We went through 10 hearings before a body called the Utah Tax Review Commission, composed of some legislators, tax experts, and others. At the end of those 10 hearings, the Tax Review Commission published a 16-page opinion which basically concluded that: 1) the Intermountain Healthcare hospitals, which represent the vast majority of the nonprofit hospitals in Utah, do not have an unfair competitive advantage; and 2) all of the hospitals' tax exemptions were justified—federal income, state income, state sales, and state property taxes.

Henkel: Taking a page from your book, Doug, because of the inconsistent application of the real estate tax exemption across the state of Ohio, there is a growing initiative to try to eliminate this inconsistency by developing, through statutory means, a transparent, predictable and rather objective system of defining community benefit, with a threshold amount providing the basis for tax exemption. It would be helpful to have one common federal and state definition of community benefit.

In Cuyahoga County alone, there are 60 separate municipalities and 33 school districts. Each views the portion of our health system located within its boundaries as a Cleveland Clinic entity unto itself, as opposed to looking at the entire health system and the benefits we provide to the community as a whole.

We are spending hundreds of thousands of dollars defending the Clinic against the relentless challenges to our real estate tax exemption in some of these school districts, with unclear discovery rules capable of being abused by resourceful lawyers. So we have a situation where assets which could be devoted to patient care are instead being devoted to defending tax exemptions. That is one of the principal reasons why we think a statewide solution to this would be far more satisfactory.

Matheny: Texas, like Utah and Pennsylvania, has established more objective criteria for tax exemption. Texas has focused only on hospitals, however, and on all of their exemptions, not just property tax. Texas's requirements were catalyzed by a state attorney general in 1990 who sued the Methodist Hospital system in Houston, arguing that it had a major surplus and failed in its duties to provide sufficient charity care to poor people. Methodist won the lawsuit, but in 1993 the state legislature passed a law requiring nonprofit hospitals to assess the health needs of the community, develop and submit a plan to meet those needs to the state, and document in an annual report the needs that were met. In 1995, the state law was revised to make it also applicable to the public hospitals and disproportionate share hospitals, establishing a baseline for comparing community benefits among these three categories.

Besides what has been going on in Utah, Pennsylvania, and Texas, 16 other states have mandated community benefit reporting requirements, and an additional 16 states have voluntary community benefit reporting through the state hospital associations. The state-mandated programs are all over the board on their processes, definitions, and so on.

Morse: Once you move toward a dollar threshold according to some formula, such as having to demonstrate $5 million or $10 million in community benefit in order to qualify for a tax exemption, I think you're on a very slippery slope.

The real value of the nonprofit health care sector is in all the things that we do every day, which include many intangibles. Trying to quantify the value is not possible in many cases. We are there to meet the community's changing needs, whereas the for-profits have a bottom line to account for. If they can't make a service pay for itself, they drop that service. Communities need to have a sense of stability and continuity so that services will be there when and if needed. That's what nonprofit health care does.

When we speak of a town being a good place to live, we need to think about all of the things that make it that way—not just schools, cultural activities, and recreational facilities, but also health care. The majority of our health care provider organizations are nonprofit. If we lost our tax exemptions or were coerced into PILOTs, how would many of us be able to continue our activities? What would happen to the communities and the patients we serve?

Brody: I think, however, that care must be taken to avoid claims that are not unique to nonprofits. The for-profit sector also provides jobs, stability in the community, and other intangibles. Yet they still have to pay property taxes. The nonprofits need to go beyond intangibles to justify their tax exemptions.

Hammer: While we in Utah have become accustomed and comfortable with quantifying community benefit, I also agree that there are important elements that defy quantification. For instance, an important intangible is the difference in governance of nonprofit and for-profit health care organizations. In the nonprofits, where there are no shareholders, the individuals on the board are selected from and represent the community. Intermountain Healthcare has over 300 trustees involved in governance on our parent board, individual hospital boards, and others. They are significant community leaders, including elected officials, whose interest is not in making money for the organization. Their interest is in making health care high quality and available at a reasonable price, while at the same time protecting the assets of the organization so it is there to serve the community in both the short and long run.

Matheny: The Congressional Budget Office (CBO) recently reported on the results of its study showing that public hospitals provided, relatively speaking, the most uncompensated care, with nonprofit hospitals coming in second. As the CBO looked more deeply, it also found that the nonprofits were providing programs needed in the community that the for-profits were not, which fall under the categories of community health and subsidized services, such as burn units or baby care for high-risk infants, that always operate at a loss. Our communities would suffer greatly by not having available the services that nonprofits provide as community benefits.

McPherson: *Examples were given earlier of negotiated agreements between nonprofits and local governments: payments in lieu of taxes (PILOTs) or services in lieu of taxes (SILOTs). Is that a good or bad practice?*

Brody: Let me start by saying that the issue of payments in lieu of taxes is very complicated.To a public finance person who likes transparency and uniformity, with everyone knowing the rules so that the incentives are aligned appropriately, PILOTs are an absolute nightmare. They are ad hoc one-on-one negotiated transactions that get revisited every year. The public may not know how much you are contributing, and may think that you are contributing more or less than you are. And the municipality or the charity may have its own reasons for keeping it unclear. When I was preparing my book containing chapters by authors from charities, municipalities, and academia, those from municipalities called PILOTs "contributions" while those from charities called them "extortion."

What happened in Baltimore versus Pittsburgh on this issue provides an interesting contrast. Big charities often are at greatest risk for PILOTs or other "voluntary" contributions because they are the most visible and easiest to collect all the money from. That was the case in Baltimore, where an energy tax was proposed. The issue went away only when Johns Hopkins and some of the other large charities stepped up to cover the revenue need. In contrast, in Pittsburgh, the nonprofit sector proposed to make a collective payment voluntarily. The city would know the dollar amount but not who had contributed how much to it. I don't know how that is all going to play out, but it is an interesting solution. The nonprofit sector in Pittsburgh was very careful to call this a "gift" rather than a PILOT.

In Providence, a deal was struck whereby the universities would not pay PILOTs on their existing property, but would on future taxable property taken off the rolls. This had a very uneven result, as the Rhode Island School of Design—a much smaller institution but with greater development plans—ended up with a much higher contribution than Brown University.

Morse: All that we do for the community is, in effect, our PILOT or SILOT. To have to pay something on top of that would be an inappropriate tax.

Henkel: I agree. Two years ago, the Cleveland Clinic committed $10 million over five years to public education in those communities where we have facilities, but we did so as a benefit to the community, not as a PILOT. We are also taking a broader view with respect to investment in the community that surrounds the main campus of the Clinic. Regrettably, Cleveland is currently ranked the most impoverished city in the country, with much of that poverty existing around our main campus.

We are partnering with those neighborhoods to help them to revitalize local businesses and the residential housing stock. We think that will have a multiplier effect across the community as others see what an institution like the Clinic is able to do with the neighborhoods that surround it. We have physicians, medical students, and nurse practitioners conducting clinics in the neighborhoods, including health screenings to identify individuals at an early stage of chronic illness. These types of outreach efforts are in essence services in lieu of taxes—SILOTs.

Morse: What you are describing, Pudge, is to me a great example of a nonprofit health organization carrying out its mission, not only providing needed medical care but also trying to help address disparities at their root cause: poverty. And what you are doing is your choice, which is very different than the government telling you what you must do or demanding some financial contribution for the schools, utilities, or whatever.

Matheny: The whole issue of PILOTs is further confused by the question of whether such contributions should be counted as a community benefit. Under Texas law, payments by a nonprofit to a tax entity or government entity (they are not called PILOTs) are not counted as such. In North Carolina, however, nonprofit hospitals are asked to voluntarily report their community benefits and are encouraged to include PILOTs as part of their quantified community benefits. This is also the case in Pennsylvania.

McPherson: *Some of you may have already begun to touch on my final question. What can nonprofit health care organizations do proactively to avoid or successfully address property-tax exemption challenges?*

Matheny: Simply put, the best strategy for any nonprofit health care organization is to demonstrate through its actions that it is truly a charitable organization. Community benefit tends to be thought of as an annual reporting activity, when in fact community benefit should be an organized, systemic, and well-managed program that links the mission of the organization and its operations. The guide that the Catholic Health Association and VHA issued last June on this subject not only provides standard definitions of community benefits and recommendations on accounting principles, "but also describes the steps involved in developing a comprehensive community benefit program as a core function of the organization.

There has to be organizational commitment from the top, as exemplified by a standing committee of the board on community benefit, regular reporting to the board, management job descriptions that include community benefit roles and responsibilities, performance assessments that include community benefits, adequate staffing, and a budget for community benefits. The organization should be identifying the needs of the community and developing a plan to meet those needs that is integrated into the overall strategic and operating plans of the organization. The organization needs to evaluate its community benefit programming on an ongoing basis to make sure that the organization is meeting community needs in the best way and not wasting the resources.

In addition, it is absolutely crucial for the organization to tell its story to multiple audiences continuously, based on credible information and consistent accounting principles. In the mid-1990s, VHA surveyed hospitals that had their tax exemption challenged. The number one answer to the question, "If you had to do it all over again, what would you do differently?" was, "I would have been telling our story." They were doing good things and thought that everybody else knew it, which wasn't the case. You need credible data, both quantitative and qualitative, to be able to tell the story effectively. But if there is any soapbox that I'm on when I go around the country, it is the basic theme that community benefits must be a comprehensive program to which the organization commits resources.

Hammer: I totally agree, Patsy, that identifying and acting on community needs is what it is all about. In almost any community, there are certain populations that are uninsured, medically indigent, or otherwise underserved. We shouldn't wait for them to show up on our doorstep at the hospital emergency room. We should be actively engaged in developing health resources in the community that meet their primary care needs. For instance, Intermountain owns five clinics that serve the uninsured, one of which is located in an elementary school in partnership with the Salt Lake City School District, one of the major underserved areas in the community. We also support 14 other clinics throughout the state of Utah that are located in areas that are medically underserved. In one zip code area within Salt Lake County, we are the only health care provider. This isn't something we have to do for our tax exemption, but it makes sense for the community. It not only reduces costs, but makes the care available to those who need it where they live.

In this same vein, Intermountain has established in each geographic area advisory committees to assist us in shaping our billing and collection practices so that we strike the right balance between obtaining payments from folks who really are able to pay, while helping out those who can't.

Also, as Patsy recommended, you need to identify and address a number of target audiences in telling your organization's story. Certainly one of those important audiences is the decision makers, as it relates to your hospital's tax exemptions. In Utah's case, that audience includes county attorneys, auditors, assessors, council members, commissioners, and so on. It requires a constant educational process with these and other audiences, including legislators and your own trustees. The latter also need to be a real part of overseeing your community benefit program and in telling your story.

What usually hurts most are the anecdotal stories—the one, two, or three cases where you will always find that something went wrong. For instance, someone in the community feels that free or discounted care was warranted but not approved, and it becomes a story. Yet you may have hundreds of thousands of other good stories where things worked the way they should have. If the key community leaders and decision makers understand who you are, what you stand for, and what you do, they will recognize the anecdotal story for what it is.

Henkel: What all of you have said is so true. If we can demonstrate that we are actively involved in the community, providing important benefits, it is less likely that government is going to challenge our exemptions or seek to impose other constraints.

A collateral benefit of the Cleveland Clinic's outreach programs, which I discussed earlier, is that they can break down fears, resentment, or uncertainties that minority or other underserved communities might feel toward a large, seemingly unapproachable and inaccessible organization. Responsive outreach activities tend to break down those inhibitions.

Also, each of the Cleveland Clinic's eight regional hospitals has a community advisory council that meets on a regular basis. We are able to relate to each council what its hospital is doing in the community. In turn, as well-placed citizens in that community, council members can help us to identify any additional unmet needs and can help to communicate by word of mouth to others what we are doing. This has been very beneficial in helping to frame the general attitudes of the people who live in each community we serve.

By the way, as part of our effort in Cleveland to align the community benefits provided by the Clinic with the needs of the community, we are beginning to collaborate with our fellow hospital providers—University Hospitals and the Metropolitan Health System—by combining our analyses of community needs and then strategically planning together to meet those needs. In that way, we can avoid duplication of effort and create important synergies.

Communications to the community are crucial for us. We stress the fact that of the 10 most highly ranked hospitals in the country according to *U.S. News & World Report,* we're the only one whose city is included in our name. We're not going to go anywhere, unlike many for-profit companies which have left the Cleveland area. Residents look on us more and more as a real community asset on which they can rely. A particularly important method of communication is distribution of information about us through the churches that surround our main campus.

Finally, we've learned that we must be very proactive in the way we manage our relationships, particularly with the public sector—at the local, state, and federal levels. We must reach out and make the case much more clearly than we have in the past why what we do is important and unique. And we need to work more closely with every level of government as a team in order to serve the best interests of Ohioans.

Morse: We must all remember who we are and what we are trying to do. We need to be part of the community, not something separate from it. As individuals, we go to the same restaurants, the same movie theaters, and pay the same kinds of taxes as our neighbors. Our organizations are a vital part of the quality of life in the towns in which we live and in the other areas in which we provide service. We can't think in a vacuum and plan what services we want. We need to make those decisions in collaboration with representatives from the community, including legislators and other government officials, talking about the needs of their constituencies. For example, the Jewish Guild has been active in programs with Convent Avenue Baptist Church because that is a big part of the fabric of one of the communities within New York City where we provide our services. When others see us as part of their community and not as some entity taking away resources by virtue of our tax exemptions, all of our organizations will be fine.

We all must find ways to make sure that our constituencies are aware of what we're doing, but without blowing our own horn too much. The main thing is that they know that we're there as a safety net for the community.