CENTER FOR TAX AND BUDGET ACCOUNTABILITY
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An Analysis of the Tax Exemptions Granted to Cook County Non-Profit Hospitals and the Charity Care Provided in Return

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Executive Summary

The nation's health care safety-net is a patchwork of federal, state and local government programs that are either funded directly through appropriation of tax revenue, or indirectly through tax incentives provided to non-profit hospitals. This safety-net is intended to provide vulnerable members of society who cannot afford private insurance, access to basic health care. Medicaid and the State Children's Health Insurance Program ("**SCHIP**") are the primary health care programs directly financed through appropriations of tax revenue. These programs provide coverage for 57 million poor and low-income individuals nationwide. In Illinois, the Medicaid and SCHIP programs provide health care access to over two million individuals, one million of which are children; pay for 40 percent of the state's births; and pay for two of every three nursing home days. Despite the significant roles Medicaid and SCHIP play, these two programs do not catch all individuals without health insurance. Fully 45.8 million additional Americans, 1.8 million of which are Illinoisans, do not have public or private health insurance.[1]

In addition to direct spending on programs such as Medicaid, the health care safety-net includes indirect spending in the form of tax expenditures granted by federal, state and local governments. These tax expenditures provide non-profit hospitals special tax status. The preferential tax treatment accorded to non-profit hospitals includes an exemption from paying federal, state and local taxes; eligibility to receive charitable contributions, which are deductible for federal income tax purposes by the donor; and eligibility to receive tax-exempt bond financing, which allows borrowing at lower rates than taxable debt and allows lenders to exclude from their federal taxable income, the interest earned on the loans made to non-profit hospitals. In exchange for preferential tax treatment, non-profit hospitals are required to provide public benefits which vary in type depending on the tax break received (*e.g.*, the standard for eligibility for exemption from federal income taxes differs significantly from the standard for exemption for Illinois-based property taxes), but which all further the historic purpose of providing health care access to individuals who lack the financial ability to pay.[2]

The underlying rationale for the various tax exemptions is that non-profit hospitals are relieving government of an obligation that the public sector would otherwise assume.[3] That is why tax breaks are technically referred to as tax "expenditures." Effectively, the public sector is spending tax dollars to generate a public good. In the instance of direct expenditures, government appropriates tax dollars collected to expend on a public service, such as education or health care. With a tax break, government forgoes collecting taxes otherwise payable by specific taxpayers, in exchange for those taxpayers using the revenue they otherwise would have paid in taxes to provide a public service. In essence, the value of the tax exemptions conferred are an appropriation of public funds (in the form of forgone tax revenue) to serve a specific public need (the provision of health care to individuals who cannot afford private insurance and do not qualify for or have failed to obtain public coverage through a program such as Medicaid). Currently, there is considerable debate at both the national and state levels over which hospital services constitute the type of public benefits that justify the tax breaks received, and how much, in terms of hospital costs, non-profit hospitals should devote to providing such services to warrant the forgone tax revenue.

Three very different and distinct concepts play a role in this debate. The first is "charity care." Charity care is commonly defined as free or discounted care provided to low-income uninsured individuals who cannot afford to pay for health services. It is called "charity" care because at the time a hospital delivers the care it either has no expectation of payment, or intends to charge a significantly discounted rate for the services rendered. Charity care is at the heart of what is expected of non-profit hospitals in return for tax exemption. The second concept is "bad debt." Bad debt expense is incurred by a hospital when a patient is charged for services provided but fails to pay, for whatever reason. In the case of bad debt, a hospital pursues collection, but is unsuccessful. Illinois law is clear – bad debt is not the equivalent of charity.[4] The third concept, "uncompensated care," is an umbrella term that encompasses both bad debt and charity care, and includes any health care a hospital provides for which it does not receive payment.

The current debate over non-profit hospital tax exemptions is further complicated by two factors. First, the standards for what qualifies a non-profit hospital to be eligible for tax exemption vary significantly depending on which tax is involved. There are different tests for exemption from: (i) federal and state income taxes; (ii) state sales taxes; and (iii) local property taxes.

Second, to date no independent review of the value of tax expenditures provided non-profit hospitals in Illinois versus the value of charity care they provide in return has been completed. Without knowing how the dollar value of these tax expenditures compares to the public benefits hospitals provide, it is difficult for state and local decision-makers to evaluate the current tax exemption structure or design policy on the subject.

This report attempts to bring some clarity to the debate by: (i) reviewing the rationale for providing non-profit hospitals with preferential tax treatment; (ii) identifying the different standards for exemption from federal and Illinois state income taxes, Illinois state sales taxes and local property taxes; (iii) analyzing the role of bad debt in the debate; and (iv) creating a model to estimate the dollar value of the tax benefits provided to non-profit hospitals in Cook County, Illinois, versus the dollar value of charity care such hospitals report in their statutorily required Community Benefit Reports. This report also reviews some other issues which surface in this debate, such as Medicaid and Medicare reimbursement rate shortfalls.

Key Findings

This study analyzes 21 Cook County non-profit hospitals and hospital networks (collectively referred to as "**Hospitals Studied**"), comparing the value of the tax exemptions granted to such Hospitals and the charity care they reported providing in return. Following are the key findings of the study:

- The most recent annual value of all tax exemptions provided to the Cook County non-profit Hospitals Studied is estimated to be $325.6 million, based on this report's methodology. This estimated annual tax benefit is more than three times greater than the dollar value of charity care the same hospitals reported providing – $105.2 million.

- Illinois state and local tax exemptions accounted for 96 percent of the tax benefits received by the Hospitals Studied, with property tax exemption being the most valuable, representing $209.1 million, or nearly two-thirds, of the total value of exemptions.

- The value of the federal, state and local tax benefits received by the Hospitals Studied was on average 3.7 percent of total hospital expenses, ranging from a high of 9.2 percent of total hospital expenses to a low of 1.1 percent.

- The Hospitals Studied reported a total bad debt cost of $181.8 million. It is estimated that currently 50 percent of hospital bad debt is owed by individuals who qualify for charity care and hence should not have been subjected to billing in the first place, but should have received free or discounted services. If this estimate is accurate, then by simply doing a better job of identifying

individuals who qualify for charity care prior to initiation of the billing process, the Hospitals Studied could have increased the amount of charity care provided by $90.9 million, for a potential charity care total of $196.1 million. This would effectively eliminate 41 percent of the gap that currently exists between the value of tax breaks received and charity care provided, *at no additional cost to the Hospitals Studied*.

- Charity care as a percentage of total hospital expenses for the Hospitals Studied ranged from a high of 6.2 percent of total hospital expenses to a low of 0.1 percent. Again, if 50 percent of bad debt currently reported by the Hospitals Studied is captured as charity care prior to billing and collection, the range improves to 10.2 percent of total expenses to 0.6 percent.

1. Rationales for Reviewing Non-Profit Hospital Tax-Exempt Status

A. Increasing Health Care Costs Contribute to Federal and State Fiscal Problems

Government-financed health care for working-poor Americans continues to rise at difficult-to-sustain levels. Federal Medicaid expenditures, which totaled $176 billion for fiscal year 2004, are expected to double in the next ten years, growing between 8 percent and 9 percent annually.[5] This not only outpaces inflation, it also exceeds projected revenue growth for federal, state and local governments. As all levels of government experience significant deficits, policymakers have been more closely scrutinizing how tax revenues – including tax expenditures – are being spent, what public benefits are being provided in return and who is receiving the benefits.

Because of the high cost of health care, one area currently receiving considerable attention is the tax-exempt status granted to non-profit hospitals. As the federal government and states like Illinois confront substantial revenue shortfalls and severe fiscal constraints, policymakers are trying to evaluate every aspect of the health care safety-net to ensure public benefits are maximized. This is an especially crucial exercise in Illinois because of the state's fiscal problems. Under its current fiscal structure, Illinois does not generate enough revenue annually to maintain the prior year's level of public services, adjusting solely for inflation.[6] As a result, each year the state has a gap between revenues and expenditures. The technical term for this is a "structural deficit." It means the state is insolvent. Because Illinois is constitutionally required to balance its budget, revenue shortfalls often lead to the twin problems of cuts in essential services and increasing reliance on debt to fund services.

Both of these negative consequences have manifested in Illinois over the last decade. After adjusting for inflation, Illinois has reduced spending on all public services other than education and health care.[7] Meanwhile, the state is proposing financing over 12 percent of its proposed fiscal year 2007 General Revenue Fund budget with debt – primarily by borrowing over $1.1 billion from its pension contribution obligation and $1.8 billion from private providers of health care services to Medicaid populations.[8] That fiscal reality has compelled policymakers to review whether local communities are receiving a level of public benefits provided by non-profit hospitals in an amount roughly equal to the value of their state and local tax exemptions.

B. Cook County is Particularly Affected by Health Care Costs

Cook County government has particularly strong reasons to evaluate the value of charitable health services it receives because the County bears a tremendous burden in providing indigent and uncompensated care. Through its network of publicly-financed hospitals, clinics, and community health centers, Cook County is the largest provider of Medicaid services and indigent care for the uninsured in Illinois, and is the third largest provider of uncompensated care in the nation.[9] The Cook County Bureau

of Health Services, the agency that runs the three County public hospitals, spends approximately 39 percent of its expenditures on uncompensated care.[10]

However, the dollar value of uncompensated care provided by the County does not paint the entire picture. The volume of uncompensated care cases at the County hospitals also far exceeds the number of such cases in private non-profit hospitals. More than 70 percent of ambulatory visits at the County hospitals are uncompensated.[11] While the County's public hospitals play a far greater role in the health care safety-net than private, non-profit hospitals, the behavior of non-profit hospitals significantly impacts the County hospitals, both in terms of case load and financially. That is because after Cook County, the largest providers of free or reduced cost health services to poor and low-income Illinois families are non-profit hospitals.

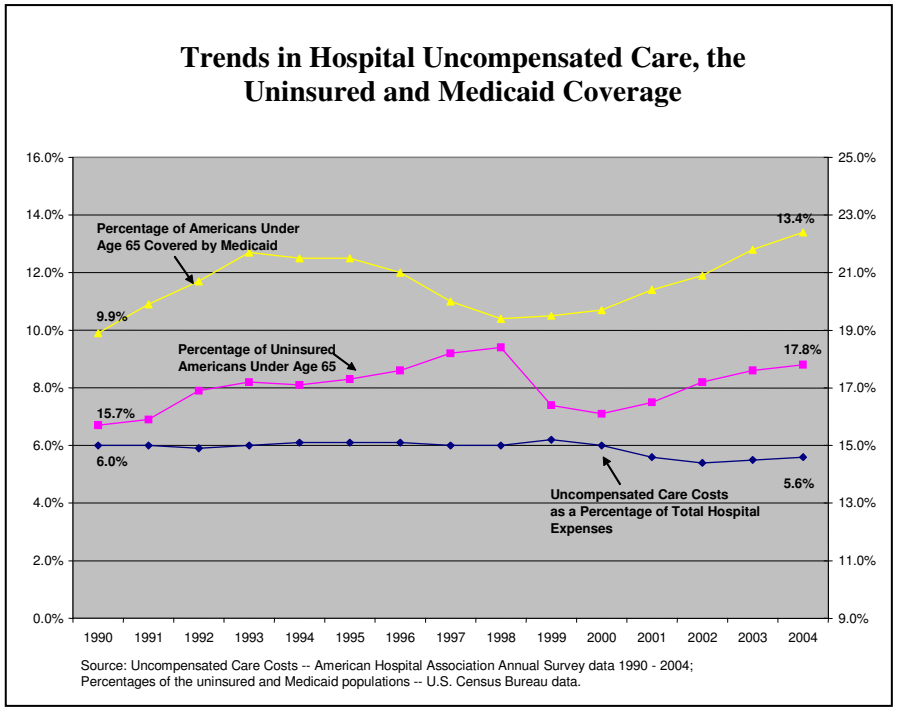
Cook County has another significant reason to monitor closely the value of charity care it receives from non-profit hospitals. Simply put, from a dollar-value standpoint, the local property tax exemption given to non-profit hospitals is the most significant tax benefit they receive.[12] Because Cook County has experienced continued budget deficits in recent years, the County has a responsibility to ensure all its expenditures – both direct and through forgone revenue in the form of tax expenditures – are generating the anticipated public benefit.

Non-profit hospitals have evolved from alms houses for the poor in the nineteenth century, to the large health care conglomerates they are today. According to the American Hospital Association, 60 percent of the community hospitals across the country are non-profit, tax-exempt hospitals.[13] In Illinois, fully 78 percent of all community hospitals are tax-exempt, significantly more than the national average.[14] Accordingly, it is important to know whether the significant forgone property tax revenue Cook County loses in the form of non-profit hospital tax expenditures is relieving the County of a commensurate burden in providing health care to low-income uninsured County residents. If the non-profit hospitals are not fulfilling their charity care responsibilities, they are in effect shifting more of the burden onto the County.

C. National Trends Indicate Charity Care has Not Increased with Need

Chart 1 below illustrates three different trends since 1990: (1) the declining amount of all hospital (non-profit, for-profit and public) uncompensated care over the last several years when measured as percentage of total hospital expenses;[15] (2) the increasing percentage of uninsured Americans under age 65 (Medicare generally covers the vast majority of individuals when they reach age 65);[16] and (3) the increasing percentage of Americans covered by Medicaid.[17] Chart 1 illustrates that as the number of uninsured Americans continues to climb, the government burden in providing a health care safety-net continues to expand. Yet the role played by non-profit hospitals during the same time period contracted slightly.

Chart 1



The middle trend line demonstrates that from 1990 through 2004, the percentage of uninsured Americans not covered by Medicare (*i.e.*, under age 65) increased, growing from a low of 15.7 percent of the population in 1990, to 17.8 percent in 2004. More than 11 million individuals became uninsured during this period. Because of this increase in the number of uninsured over this period, logic would dictate that both Medicaid and uncompensated care costs would increase accordingly. The top trend line highlights that indeed, during this period, the percentage of individuals covered by Medicaid increased from 9.9 percent of the population in 1990, to 13.4 percent in 2004. Surprisingly, non-profit hospitals' cost of providing uncompensated care actually *declined* slightly during this period, falling from 6 percent of total hospital expenses in 1990, to 5.6 percent in 2004, as shown in the bottom trend line in Chart 1.

Moreover, the trend to expand Medicaid coverage to deal with ever-increasing numbers of uninsured may soon reverse, due to a retrenchment in funding from the federal government. Congress recently passed the Deficit Reduction Act, which allows states to charge higher co-payments for medication and doctor and hospital visits in an effort to rein in Medicaid costs. The cost-sharing measures are estimated to save the federal and state governments $28.3 billion between 2006 and 2015.[18]

Moreover, in a recent report, the Congressional Budget Office estimates that approximately 80 percent of the anticipated savings will result from decreased use of Medicaid services, because many low-income families unable to absorb these additional costs will forgo care or drop out of the Medicaid program altogether.[19] It will also create more uninsured low-income Americans. In all likelihood, federal Medicaid cuts will also shift the cost of caring for these newly uninsured individuals to hospitals – non-profit hospitals in particular – as former Medicaid beneficiaries are forced to seek basic health care in emergency rooms.

Current trends strongly indicate that the number of uninsured low- and, increasingly, middle-income individuals will increase in the coming years. These trends include skyrocketing health insurance costs, which are growing at more than five times the rate of inflation;[20] the scaling back of employer-provided health care benefits, particularly in low-wages jobs (in Illinois alone, employer-sponsored health care coverage declined from 75.4 percent of the workforce in 1979 to just 60.8 percent in 2003, nearly a 15

percent decline);[21] and the slow pace of economic recovery throughout the Midwest generally, and Illinois specifically.[22] Given these trends, more individuals can be expected to turn to the public sector to provide access to affordable health services. Moreover, as the cost of health insurance continues to increase at rates that outpace inflation, inflation-adjusted median household income in Illinois has declined 12.2 percent since 1999, dropping to 1989 levels.[23] Increasingly, many Illinois families are confronted with the difficult task of spreading fewer household dollars over higher expenses, especially with respect to health care.

2. Qualifications for Federal Corporate Income Tax Exemption

While the rationales for granting preferred tax status to non-profit hospitals are similar for all levels of government, the requirements for exemption are different for each tax. Hospital tax exemption generally begins, but does not end, with federal income tax status. Tax-exempt status at the federal level is based on whether a hospital qualifies as a "charitable organization" under the Internal Revenue Code ("**Code**"). The Code provides non-profit hospitals must pay corporate income tax unless operated exclusively for "charitable" purposes as defined in § 501(c)(3).[24] For non-profit hospitals, what constitutes a "charitable purpose" has evolved over time to reflect changes in the hospital industry and public health programs. In 1956, prior to the existence of Medicare and Medicaid, and in the absence of a more explicit statutory definition of "charitable purpose," the Internal Revenue Service (the "**IRS**") ruled that to qualify for tax-exempt status, a non-profit hospital "must be operated to the extent of its financial ability for those not able to pay for services rendered and not exclusively for those able and expected to pay."[25]

Under this standard, non-profit hospitals were not permitted to refuse patients who could not pay for care. This requirement became the foundation of the initial charity care standard used for federal income tax exemption. In essence, it required non-profit hospitals to provide free or discounted care for those unable to pay for needed hospital services. Subsequent cases began to quantify the standard, suggesting that as long as there was sufficient local need, a non-profit hospital must provide free care for at least five percent of its patients, or lose its federal income tax exemption.[26] This became known as the "financial ability" standard because it required a quantifiable minimum amount of charity care a hospital must provide, so long as it had the revenue to absorb the cost and the need existed in the community.

Following the advent of Medicare and Medicaid in 1965, the provision of non-profit hospital charity care declined, while the burden of providing health care to low-income people shifted away from charitable organizations to the federal and state governments.[27] At the time, some experts even predicted that Medicare and Medicaid would entirely replace non-profit hospital charity care.[28]

A mere four years later, in 1969, believing that the charity care standard was obviated by Medicare and Medicaid, the IRS felt compelled to create a new standard for tax exemption. Otherwise, it was feared that hundreds of non-profit hospitals nationwide would lose tax-exempt status and go out of business because there would be none left who needed charity care. To avoid that problem, the IRS replaced the charity care and financial ability standard with a nebulous "community benefit" standard.[29] Ruling that the "promotion of health" in and of itself qualifies as a charitable purpose, the IRS stated that if a non-profit hospital provides care for all people within a community "*able to pay the cost*" it is providing a community benefit.[30] (Emphasis added) This new standard effectively turned qualification for federal income tax exemption on its head. Initially, a hospital was required to provide free or reduced cost care to those who could not afford to pay. Now, all a hospital had to do was service those who *could* pay. The IRS' novel approach to federal income tax exemption was affirmed in a Circuit Court ruling that found the need for traditional charity care had largely been eliminated by Medicaid, Medicare and the growth of health insurance.[31]

Adding ambiguity to a nebulous standard, the IRS failed to articulate what activities would qualify as benefits to the community. This left the door open for widely varying interpretations of which activities

satisfied the new test for federal tax exemption. Thus, for federal income tax purposes, while traditional charity care still remains one type of recognized community benefit, non-profit hospitals are not required to provide any defined amount of free or reduced-cost care to poor or low-income uninsured individuals. What is required is that a non-profit hospital's emergency room is open to all community residents in need of care, and that the hospital provide a yet undefined "benefit to the community."[32]

The community benefit standard is controversial not only because it is unclear what hospital activities qualify, but also because the justification for this relaxed and ambiguous test – that Medicare and Medicaid would eliminate the ongoing societal need for charity care – was wrong. As the economy evolved over time, it became clear that, while publicly-funded programs help address the problem of health care access confronted by poor and low-income individuals, these programs have by no means eliminated it. Even with Medicare and Medicaid, the high cost of health care frequently acts as a de facto bar, or at least a significant obstacle, that prevents low-income uninsured individuals from receiving needed care. Currently, it is not uncommon for low-income, uninsured individuals to forgo or prolong needed health care due to cost.[33] As low-income individuals refrain from seeking early treatment, becoming sicker and more expensive to treat, when they finally seek help, it is frequently by going to the emergency room.[34] Increasingly, problems with health care affordability are becoming middle class concerns. Moreover, medical debt is one of the leading causes of bankruptcy in the nation.[35] As such, many low- and middle-income workers who cannot afford health insurance are only one medical emergency away from bankruptcy.

The amorphous federal community benefit standard continues to be debated today. In 2004, the House Ways and Means Subcommittee on Oversight began hearings to review non-profit hospital tax exemption from federal income taxes. The Subcommittee is concerned that non-profit hospitals receive a federal tax break, but are not required by current federal law to assume responsibilities that differ substantively from for-profit hospitals. A Subcommittee press release announcing the hearings stated that one reason that would justify continuing the federal hospital tax exemption is the value of exemption is a subsidy for the cost of providing charity care that the federal government would otherwise incur in the absence of exemption.[36] Until Congress or the IRS change the rule, however, federal income tax exemption for hospitals remains based on the ambiguous community benefit standard, with no specific requirement of charity care.

3. Qualification for State and Local Tax Exemptions

In Illinois, the general rule is corporations are required pay state income tax and a personal property replacement tax on their annual net income.[37] However, if a corporation is exempt from federal income taxation under § 501(a) of the Internal Revenue Code, it is also exempt from the Illinois corporate income and replacement taxes.[38]

However, exemption from paying state and federal income taxes does not automatically exempt a non-profit corporation from paying the state sales tax, which is called the Retailers' Occupation Tax. Even non-profits are subject to the Illinois sales tax on purchases of tangible personal property, unless organized and operated "exclusively for charitable purposes."[39] Only in that case will a non-profit also be relieved of its state sales tax obligation.

Local governments in Illinois use a similar test for exempting non-profits from the obligation to pay property taxes. That is, exemption from federal and state income taxes is not enough to qualify for a property tax exemption. Instead, the real property (*i.e.*, land and buildings) owned by a non-profit organization will be exempt from property taxation only if such property is actually and exclusively used for charitable purposes.[40] Because property taxes are based on the value of the underlying property and can therefore result in a significant amount of local tax revenue, or, as the case may be for an exempt

organization, a valuable tax benefit, the issue of whether a non-profit hospital's property has been used exclusively for charitable purposes has been the subject of much litigation in Illinois over the years.[41]

Satisfying the standard of using property "actually and exclusively" for charitable purposes is difficult indeed, since hospitals must generate enough revenue to keep their doors open. This would be difficult to accomplish if a hospital were prohibited from charging for services provided, as the standard seems to imply. As far back as 1907, the Illinois Supreme Court recognized the inherent tension between a non-profit hospital satisfying its obligation to be operated *exclusively* for charitable purposes and generating sufficient revenue for survival. The Court determined that a hospital satisfied its charitable mission as long as it served those who needed charity without charge, and no "obstacle, of any character" was placed in the way of those who might need charity.[42] Accordingly, charity care became the early standard for exempting non-profit hospitals from paying local property taxes in Illinois.

In *Methodist Old People's Home v. Korzen*, a later case again addressing non-profit hospital property tax exemption, the Illinois Supreme Court clarified the charity care standard by holding "charity is a gift to be applied … for the benefit of an indefinite number of persons … for their general welfare, or in some way *reducing the burdens of government*."[43] (Emphasis added). The *Methodist* Court developed the test for meeting this standard that is still applied today, ruling, among other things, that property constitutes "charitable use property" if a hospital does not appear to place obstacles of any character in the way of those who need and would avail themselves of the benefits provided by the organization, and the property is used exclusively – interpreted as primarily – for charitable purposes.[44] Accordingly, Illinois law is clear – to qualify for property tax exemption, non-profit hospitals must provide low-income and poor individuals unhindered access to charity care. This is a much stricter standard than the community benefits standard that determines eligibility for federal income tax exemption.

There is one aspect of charity care which remains at issue in Illinois – who actually qualifies to receive it. Current state law does not define the income levels that qualify an individual to receive free or discounted care. Rather, this determination is left to hospital policy, and is generally tied to a patient's gross income compared to the federal poverty level.[45] Hence, who qualifies to receive charity care varies from hospital to hospital.

Not satisfying Illinois' charity care requisite can result in a non-profit hospital losing its property tax exemption. This is precisely what happened to Provena Covenant Medical Center. The Champaign County Board of Review revoked Provena's property tax exemption, after ruling that Provena was not using its property for charitable purposes.[46] This ruling was based in part on the finding that the hospital was not providing charity to all who needed it. Provena has appealed to the Illinois Department of Revenue, but the Department has yet to rule in the case.

4. The Illinois Community Benefits Act

As a result of recent studies highlighting aggressive hospital billing practices, many states now require non-profit hospitals to report the amount of charity care provided to low-income uninsured patients unable to pay.[47] Some states even mandate a defined amount of charity care to be provided.[48] Illinois, following the lead of other states, addressed the issues of non-profit hospital charity care, how it is measured and what other community benefits are provided by non-profit hospitals, by enacting the Community Benefits Act (the "**Act**").[49] The Act does not require non-profit hospitals to provide a certain amount of charity care. Rather, it operates as a report card on charity care and other community benefits provided.[50] Charity care, which the Act defines as care provided for which a hospital does not expect to receive payment from the patient or a third party payer, must be reported at cost as a separate line-item in a hospital's Community Benefit Report.[51]

The requirement that charity care be reported at "cost" is an important one. Prior to the Act, non-profit hospitals usually reported the value of charity care provided at the "charge" for the services, rather than cost. Charges vary, sometimes substantially, from hospital to hospital, and even from patient to patient. Frequently, the charges for the service are significantly more for uninsured patients than for those covered by insurance.[52] This led to confusion about the actual value of the charity care being delivered, and made it difficult to compare effort. Moving to a cost basis in reporting under the Act reduces or eliminates much of this confusion.

The Act defines other community benefits that may be reported, such as the unreimbursed cost of government sponsored indigent health care, including Medicare, Medicaid and other public health care programs; language services; donations; volunteer services; education; research; hospital-subsidized health services provided in response to community needs; and collecting bad debts.[53]

While the Act permits reporting on a wide range of community benefits, it does not change the legal requirement that charity care be delivered to qualify for local property tax exemption. Despite the reporting of other community benefits under the Act, providing charity care to anyone unable to pay for such care is still the sole legal metric used to determine whether a non-profit hospital qualifies for property tax exemption under Illinois law.

5. The Role of Bad Debt

Despite the unequivocal charity care requirement for property tax exemption in Illinois, many non-profit hospitals find it difficult to identify patients that qualify for charity care prior to collection efforts, even though hospitals set their own charity care standards. This has resulted for a number of reasons, not the least of which is the reluctance of individuals to provide complete, accurate or in some cases any, income data during the admissions process. In other cases, administrative policies of the hospitals themselves are inadequate to capture income data appropriately on admission or before sending a patient a bill. The net result is that many non-profit hospitals use the billing and collections process to distinguish individuals who are eligible for and in need of free or discounted care from patients who can pay. The American Hospital Association ("**AHA**") acknowledges that rather than having any procedures in place to identify patients eligible for charity care prior to billing, some hospitals use the billing and collections process to identify charity care cases.[54]

Hospitals account for both charity care and bad debt under the more inclusive term "uncompensated care." Uncompensated care is defined as care provided by a hospital, but for which it does not receive payment. However, the two components of uncompensated care – charity and bad debt expense – are very different. "Charity," or free or discounted care, occurs when a hospital, prior to billing a patient for health care services received, determines the individual does not have the ability to pay based on his or her income and insurance status. In the case of charity care, the hospital never expects to receive payment, either from the patient or a third-party payer, and does not pursue payment. "Bad debt," on the other hand, occurs when a hospital expects to receive payment for services provided, but the patient fails to pay for whatever reason. In the case of bad debt, the hospital bills the patient and attempts collection but is unsuccessful. The distinguishing characteristics are obvious. Charity care, as its name implies, constitutes a charitable act of providing free or discounted health care to an individual a hospital knows cannot afford to pay. Bad debt, on the other hand, is owed by patients from whom a hospital expects payment, and if payment is not received, the hospital pursues collection.

The AHA argues that because some patients whose unpaid hospital bills have been classified as bad debt have limited resources, the distinction between bad debt and charity care is "virtually meaningless."[55] This has led to the contention that uncompensated care related to low-income patients should be considered when evaluating whether a non-profit hospital is satisfying the requisites for tax exemption. However, few would agree that sending a low-income patient's bill through a collections process

constitutes a charitable act.[56] It may be true that from a hospital's perspective, total uncompensated care cost remains the same, whether the cost is categorized as charity care or bad debt. However, from a patient's perspective, the classification of bad debt can be devastating – leading to the destruction of an individual's credit rating and even resulting in bankruptcy.

An Illinois court has specifically ruled, however, that hospitals should not get credit for charity when low-income individuals are put through collections procedures.[57] Again, the law is clear in Illinois, for purposes of local property tax exemption – bad debt is not tantamount to charity care.[58]

This is not to say uncompensated care does not impose costs – it does. According to the Illinois Hospital Association ("**IHA**"), all Illinois hospitals, including for-profit, non-profit and public hospitals such as Cook County, collectively incurred $1.2 billion in uncompensated care costs in 2003.[59] This amount reflects all uncompensated care, including all bad debt, whether or not it is related to low-income individuals. The IHA does not publish charity care and bad debt separately. Moreover, 2003 is the first year for which the IHA reported uncompensated care at cost – prior years were reported at charges – making it impossible to compare 2003 uncompensated care costs to prior years and identify any trends in such care over the last decade. Although total uncompensated care is a significant financial burden on non-profit hospitals and must be balanced with hospital survival, it is only the charity care component that should be considered when examining tax-exempt status from local property taxes in Illinois.

6. Estimating the Value of Non-Profit Hospital Tax Exemptions and Charity Care

Lack of available, relevant data is the principal difficulty lawmakers confront when evaluating charity care provided by non-profit hospitals against tax-expenditure cost. Until this year, lack of information hindered determining both: (i) the value of the annual tax expenditures given non-profit hospitals; and (ii) charity care provided by such hospitals in return. The Illinois Community Benefits Act, which requires most Illinois non-profit hospitals to report the value of charity care they provide at the cost of service, fills in one unknown. However, the key question of how much is given in tax breaks remains unanswered.

This study attempts to inform the public debate on this missing, but critical piece of information, by valuing the tax benefits received by non-profit hospitals located in Cook County, Illinois, and comparing this value to the cost of charity care provided in exchange. This study focuses on charity care because of the well-settled law on the issue of property tax exemption in Illinois. Further, the underlying purpose of the study is to inject into the charity care debate, sound data that will allow for an honest evaluation of whether the forgone tax revenue in the form of tax expenditures is generating the amount of charity care lawmakers anticipated.

The first step of the study entailed developing a methodology to estimate the value of each of the following tax exemptions granted to non-profit hospitals in Cook County: (i) the federal corporate income tax exemption; (ii) the Illinois corporate income and personal property replacement tax exemptions; (iii) the Illinois sales tax exemption; and (iv) the Illinois local property tax exemption. The study then compared the aggregate value of these tax exemptions to the cost of charity care publicly reported by each Hospital Studied under the Community Benefits Act. Recognizing that a significant portion of hospital bad debt might have qualified as charity care if low-income, uninsured patients were identified prior to initiation of the billing and collection process, this study also estimates how much additional charity care the Hospitals Studied could have generated, for no additional cost, if 50 percent of the cost of bad debt had instead been identified as charity care upon patient admission.

A more complete evaluation of what non-profit hospitals do differently than their for-profit counterparts (of which there are only five in Cook County) to warrant tax exemption was not possible. For-profit hospitals are not required to file Community Benefit Reports with the state and, as private businesses,

their audited financial statements are not public information. The necessary data simply was not available to allow such an analysis.

A. Cook County Non-Profit Hospitals Analyzed in the Study

Initially, the study attempted to analyze each of the 47 non-profit, general hospitals in Cook County. However, because many hospitals are part of a system or a consolidated health care network and therefore file tax returns, financial statements and Community Benefit Reports on a combined basis, a hospital-by-hospital analysis was not possible. This study estimated the value of tax exemptions and the cost of charity care reported on a stand-alone hospital basis whenever separate hospital data was available. However, when this was not possible due to consolidated reports, the variables were measured on a hospital network basis. In some instances, non-profit hospitals are part of larger consolidated groups which include entities outside Illinois. If such non-profit hospitals did not publish reports or data that isolated their individual activities, this study could not estimate the value of their tax exemptions, and therefore, such hospitals were not included in this report.[60]

Following is the complete list of the hospitals or hospital networks (referred to collectively throughout this study as "**Hospitals Studied**") for which data was available that allowed evaluation of federal, state and local tax exemptions they received as well as the cost of charity care they provided. See Appendix F for a detailed explanation of data sources and assumptions made for each Hospital Studied.

1. Advocate Health Care Network
2. Alexian Brothers Hospital Network
3. Evanston Northwestern Healthcare Corporation
4. Gottlieb Memorial Hospital
5. Holy Cross Hospital
6. Jackson Park Hospital
7. Little Company of Mary Hospital & Health Care Centers
8. Loyola University Medical Center
9. Mercy Hospital & Medical Center
10. Mount Sinai Hospital
11. Palos Community Hospital
12. Resurrection Health Care
13. Roseland Community Hospital
14. Rush North Shore Medical Center
15. Rush University Medical Center & Rush Oak Park Hospital
16. Saint Anthony Hospital
17. St. Bernard Hospital
18. St. James Hospitals – Olympia Fields and Chicago Heights
19. South Shore Hospital
20. Thorek Hospital
21. University of Chicago Hospitals

Cook County non-profit hospitals which were not included in this study due to a lack of sufficient data were Ingalls Memorial Hospital, Methodist Hospital of Chicago, LaGrange Memorial Hospital, Northwest Community Hospital, Northwestern Memorial Hospital, Norwegian-American Hospital, St. Francis – Blue Island, and Swedish Covenant Hospital. Appendix G lists the non-profit hospitals for which the necessary data was unavailable and why.

B. Data Sources and Variables Measured

The primary source of financial data for this report was collected from the tax returns of the Hospitals Studied. Federal Form 990 is the tax return filed by organizations exempt from federal income taxes. Tax returns were selected instead of audited financial statements, because the financial statements were often filed on a consolidated basis which did not provide data on hospital-by-hospital basis. Tax returns on the other hand, generally appeared to be filed on a separate hospital basis, allowing differentiation among the data for non-profit hospitals that were part of larger networks. The following information was gathered from the tax returns of the Hospitals Studied:

- Annual hospital income or loss. For purposes of estimating the property tax exemption, and federal and state income tax exemptions, annual income or loss was obtained from the three most recently-filed tax returns for the Hospitals Studied.

- Earnings before interest, taxes, depreciation and amortization ("**EBITDA**"). EBITDA is a widely-accepted metric for measuring profitability. A three-year average EBITDA was calculated for purposes of valuing the property tax exemption for each of the Hospitals Studied. However, when a Hospital Studied had an extraordinary loss in one year, resulting in a three-year average EBITDA loss, the loss year was omitted from the calculation, and a two-year average EBITDA was computed for purposes of estimating the property tax exemption.

- Operating revenue. When a Hospital Studied had a three-year average EBITDA loss due to more than one loss year, operating revenue was used as an alternative measurement for valuing the property tax exemption. The average ratio of EBITDA to operating revenue of the Hospitals Studied with a positive average EBITDA was applied to the three-year average operating revenues of the Hospitals Studied with EBITDA losses to determine the Hospital's pro forma EBITDA.

- Supply expense. A three-year average supply expense was determined for each of the Hospitals Studied to estimate the value of their sales tax exemption.

- Total contributions. Direct, indirect and government contributions were used in the calculation of estimated federal and state income tax.

- Total hospital expenses. The amount claimed for total expenses for each Hospital Studied was used for purposes of measuring charity care and the value of tax exemptions as a percentage of overall expenses. Evaluating what percentage of total hospital expenses are consumed by charity care and covered by tax exemptions, places those items into a context that allows measuring their relative importance. Total expenses reported on each of the Hospitals' most recent tax return was used, rather than a three-year average. Using a three-year average most likely would have lowered overall expenses. Therefore, total expenses as reported in this study may be overstated relative to the three-year average EBITDA and supply expense. *As a result, the value of tax exemption for the Hospitals Studied, measured as a percentage of total expenses, may be understated.*

The annual amount of charity care provided for each Hospital Studied was obtained from the Community Benefit Reports. Beginning last year, most Illinois non-profit hospitals are required to file such reports annually with the state. The Community Benefits Act requires that charity care be reported at cost, based on the cost-to-charge ratio on each hospital's Medicare Cost Report, which is another public report that is filed annually with the Center for Medicare and Medicaid Services.

These data sources provide a sound basis for calculating charity care and tax exemption values because they were prepared by the non-profit hospitals being studied, are public records and are updated annually. That said, admittedly, there remain some problems which highlight the difficulties encountered in comparing the value of tax benefits to charity care, and the lack of transparency in charity care and

community benefits reporting. For instance, because the Community Benefit Reports were filed for the first time in 2005, covering 2004 year-end results, the data source for the cost of charity care (the Community Benefit Reports) and the data source used to compile annual financial information (hospital tax returns for the three most recently filed tax years, which generally were 2003, 2002 and 2001), cover different hospital year-ends. This was unavoidable because the community benefit reporting requirement is new and the Community Benefit Report is the only data source for charity care provided by non-profit hospitals that is computed at cost rather than hospital charges. This problem is somewhat mitigated by use of a three-year average for financial information, which should level out peaks and valleys in financial results, allowing for a fairly accurate comparison. This is a problem that will not exist in the future, as tax returns become available that cover the same period as Community Benefit Reports.

It is also important to reemphasize that Illinois has no legally mandated, uniform standard of who qualifies for charity care. Rather, the provision of free or discounted care is based on individual hospital policy and varies from hospital to hospital. Charity care policies for the Hospitals Studied varied from offering free care to individuals earning an income equal to or below the federal poverty level, to 200 percent of the federal poverty level. The Hospitals Studied generally provided for sliding discounts depending on income for individuals earning between 200 percent and 400 percent of poverty. The discounts offered differed depending on the hospital. Hence, comparing the amounts of charity care provided across Hospitals Studied does not provide much information about the exact populations being served, nor how extensive hospital efforts are given local demographics.

Bad debt expense data was culled from the Community Benefit Reports. The Community Benefits Act requires bad debt to be reported at cost. However, the amount of bad debt reported by many of the Hospitals Studied in their Community Benefit Reports matched the amount of bad debt reported in their financial statements. That is problematic because bad debt expense is generally reported at charges – not cost – in financial statements.[61] Therefore, this study adjusted the bad debt to cost for the Hospitals Studied that stated bad debt at charges, by multiplying the cost-to-charge ratio reported in each hospital's Medicare Cost Report.

Recognizing that non-profit hospitals have difficulty identifying patients eligible for charity care, and that a portion of bad debt may qualify as charity if it were captured before patients are sent through the billing and collection process, this study estimates what hospital charity care would be if 50 percent of the reported bad debt, computed at cost, were considered potential charity care.

The value of other community benefits, such as the unreimbursed cost of providing Medicare, Medicaid and other government health care program services; language services; donations; volunteer services; education; research; and hospital-subsidized health care services was obtained from the Community Benefit Reports.

C. Methodology Used in Estimating the Value of Tax Exemptions

In estimating the value of the tax exemptions for the Hospitals Studied, this study uses the model developed by Drs. Nancy Kane and William Wubbenhorst of the Harvard School of Public Health.[62] This methodology was selected for two reasons. First, it is both recognized and well-respected nationally. Second, it closely approximates the actual value of property tax exemptions computed for non-profit hospitals in other states that currently make such valuations.[63]

(i) Estimating the Property Tax Exemption

The Cook County Assessor's Office is the governmental agency that places a value on real estate for property tax purposes in Cook County. However, the Assessor's Office does not currently assess property owned by non-profit, tax-exempt organizations, including hospitals. Hence, there is no data set

available from the Assessor's Office for use in determining the value of property held by non-profit hospitals, which is needed to determine the value of the exemption from paying property taxes.

There are three basic methods of property valuation: the comparison method, the income method and the replacement cost method. The Assessor's Office currently uses the income approach, or a combination of the income and the replacement cost approaches, for assessing for-profit hospital property.[64] Accordingly, this study applied the income method of valuation to estimate the value of property owned by the Hospitals Studied. Because of limited access to financial data, it was not possible to estimate hospital value using the replacement cost method.

In nearly all cases, this study's valuation methodology for hospital property yielded reasonable results. However, it posed two problems. First, when a Hospital Studied had a three-year average EBITDA loss, the income method placed a negative value on its property. This meant that, for purposes of this study, the local property tax exemption for such hospitals was determined to have no value. This would not occur if the Assessor's Office was determining such property tax value, because the Assessor would have applied the replacement cost approach in these circumstances. As noted above, insufficient information made it impossible to use the replacement cost method in this study. As such, an alternative methodology was used for Hospitals Studied with a three-year average EBITDA loss. For purposes of estimating the annual property tax exemption in this instance, if a Hospital Studied had an average EBITDA loss due to one loss year, the loss year was eliminated from the calculation, and a two-year average EBITDA was calculated. When a Hospital had more than one loss year, the average ratio of EBITDA to operating revenues was calculated for all Hospitals Studied with a positive average EBITDA. This average ratio was then applied to the three-year average of the loss Hospital's operating revenue to determine the pro forma EBITDA for such Hospitals to estimate the value of their property tax exemptions.

The Assessor's Office also has historically undervalued the fair market value of property for assessment purposes. The income method of valuation on the other hand, is designed to determine actual fair market value. This initially resulted in an estimated property tax exemption for the Hospitals Studied much greater than what the Assessor would find. The formula, therefore, had to include a "discount factor" that would yield a close approximation of the amount of property tax the Assessor would calculate. The state equalization multiplier, which the Illinois Department of Revenue computes annually to account for the undervaluation of Cook County property, was used as the basis for determining the discount factor for this study's methodology. In Illinois, the total assessed valuation of real estate in each county must be 33.3 percent of the total fair market value of all property in such county. The state equalization multiplier is applied in the property tax assessment formula to achieve this requirement. Because the Assessor's valuation of property is typically lower than fair market value, the equalization multiplier usually increases property value for estimating property taxes owed. This study therefore used the reciprocal of the state equalization multiplier as a reasonable proxy for the discount factor in the current Cook County assessment process.

The first step in estimating the value of property tax exemption of the Hospitals Studied was determining the value of the real property they own. This required determining each hospital's three-year average EBITDA (or pro forma EBITDA in the case of the Hospitals Studied with a three-year average EBITDA loss), and then capitalizing that amount to project cash flow of the hospital into future years. When the Assessor's Office applies this methodology, it is attempting to estimate the market "rent" of the property being valued. A capitalization rate of 14.5 percent was used because this is the rate applied to for-profit hospitals by the Cook County Assessor's Office.[65] The formula for this calculation is:

$$\text{Average EBITDA} \div \text{the capitalization rate} = \text{estimated value of hospital property}$$

The discount factor discussed above was then applied to the estimated fair market value of hospital property, resulting in the discounted value of the property. Next, the complex Cook County assessment

formula was applied to the discounted property value. Commercial property in Cook County is assessed at 38 percent of the value of the property. Accordingly, the discounted value was multiplied by 38 percent, to determine what is called the "assessed valuation." Next, an equalization multiple of 2.4598, determined by the Illinois Department of Revenue for 2003, the most recent year available, was multiplied by the "assessed valuation." This resulted in the "equalized assessed value." Lastly, the "equalized assessed value" was multiplied by an average property tax rate for all of Cook County. While local property tax rates vary substantially depending on the taxing districts in which the property is located, the study applied an average tax rate of 9.029 percent.[66] This was the average Cook County property tax rate for 2003, the most recent year for which an average tax rate was available. The study recognizes that if these properties were assessed by the County Assessor's Office, actual tax rates in effect would apply rather than an average rate.

(ii) Estimating the Sales Tax Exemption

To estimate the value of the aggregate sales tax exemption for the Hospitals Studied, this study used a three-year average of supply expenses as reported by each hospital on its Federal Form 990, multiplied by the Chicago sales tax rate of nine percent. This is the current sales tax rate for the city of Chicago. The study acknowledges that for non-profit hospitals located in suburban Cook County, a different tax rate would apply.

(iii) Estimating the Federal and State Corporate Income Tax Exemptions

To estimate the value of the aggregate federal corporate income tax exemption for the Hospitals Studied, the study used a three-year average of net earnings, less total contributions for such hospitals, reduced by their estimated property and state income tax expenses. This resulted in estimated taxable income for each of the hospitals. Next, this estimated taxable income figure was multiplied by the federal corporate income tax rate of 34 percent, to compute the estimated value of federal income tax exemption.

The Illinois corporate income and personal property replacement taxes were calculated by beginning with estimated federal taxable income determined under the preceding paragraph, and then adding back any estimated state corporate income and replacement tax deducted in calculating federal income tax liability. A tax rate of 7.3 percent was then applied to this sum, which includes both the 4.8 percent corporate income tax and the 2.5 percent personal property replacement tax rates.

(iv) Tax Benefits Not Estimated

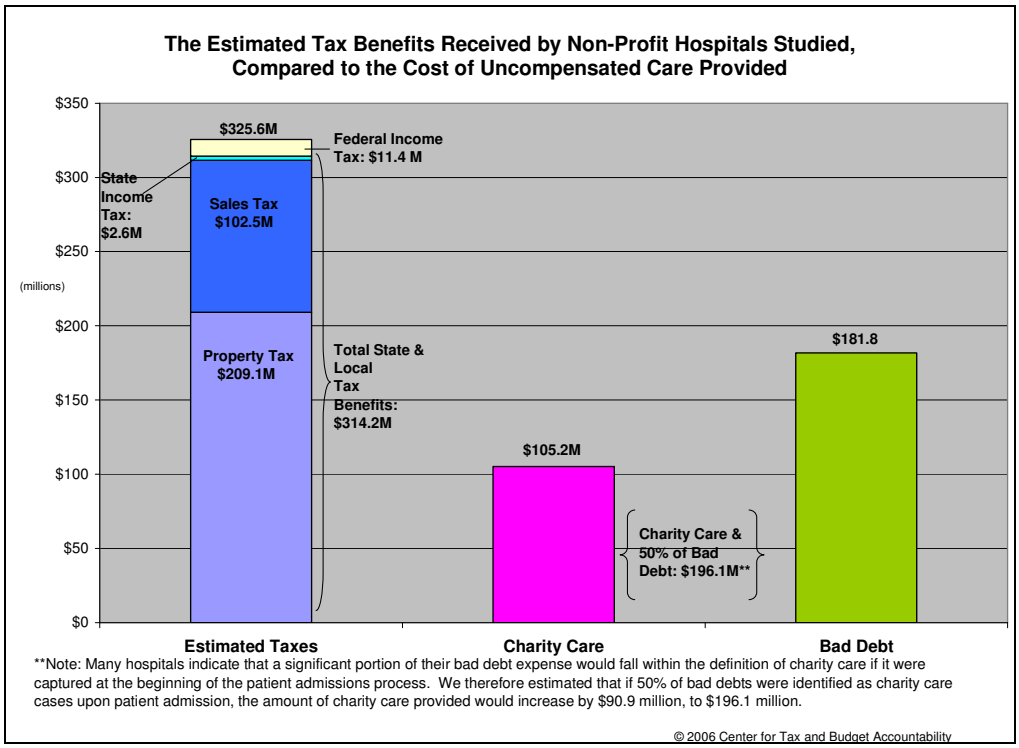
This study does not estimate the value of tax-exempt bond financing, which allows non-profit hospitals to borrow at lower rates than for-profit corporations, while permitting lenders to exclude income earned on bonds issued to finance non-profit hospitals, for federal income tax purposes. There is much debate over whether tax-exempt debt is a significant tax benefit.[67] Nonetheless, assuming tax-exempt bonds have some value over and above taxable debt, the estimated tax benefits for the Hospitals Studied in this report are understated.

In addition, this study does not value charitable donations received by the Hospitals Studied, because these donations frequently are given to multiple entities within a hospital network or affiliated group of organizations. This made tracking the amount of donations to specific non-profit hospitals impossible. Again, assuming charitable donations are of some value to non-profit hospitals, the estimated tax benefits for the Hospitals Studied in this report are understated.

7. Findings

Chart 2 below identifies the key findings of this study. The first column shows that the estimated value of the tax exemptions which all levels of government (federal, state and local) have granted to the Hospitals Studied is $325.6 million annually. It is important to emphasize that this estimated tax benefit is understated, for the reasons identified in the preceding section of this study. On average, the estimated tax benefits received by the Hospitals Studied represent 3.7 percent of total expenses for such Hospitals. It is also more than three times greater than the $105.2 million of charity care the Hospitals Studied report providing, as shown in the second column of Chart 2. On average, the charity care reported represented 1.8 percent of total expenses for the Hospitals Studied.

Chart 2



Frequently, experts in the field note that a significant amount of bad debt reported by non-profit hospitals – upwards of 50 percent – is owed by individuals who would have qualified for charity care (and not have been subject to debt collection) if such cases were identified prior to billing.[68] The third column of Chart 2 shows that bad debt reported at cost by the Hospitals Studied for the year 2004 was $181.8 million. If it is truly the case that half of this debt is owed by individuals who should have qualified for charity care, this creates an opportunity for the Hospitals Studied to eliminate almost half of the $220.4 million shortfall between tax benefits they receive and the charity care they provide, for no addition cost. All that is required is designing a better system for identifying charity care candidates upon admission, or at the very least, before pursuing debt collection. This also would result in the corollary benefit of saving low-income individuals from having their credit records harmed, and from being subjected to the aggressive practices used by many agencies to collect debts.

The annual property tax exemption was easily the most valuable annual tax benefit given to the Hospitals Studied, totaling $209.1 million, or 64 percent, of all tax benefits received. Next in importance is the sales tax exemption, with a value of $102.5 million, representing 31 percent of the overall tax benefits. The exemptions from federal and state corporate income taxes were much less significant, with the value

of the Illinois income and replacement tax exemptions being the least valuable at $2.6 million, while the federal income tax exemption was worth $11.4 million.

One of the most important findings of this report is that fully 96 percent of the value of all tax exemptions received by the Hospitals Studied are granted by state and local taxing authorities. Recall that most state and local tax benefits – in particular the state sales and local property tax exemptions – are tied to the stricter charity care standard, not the nebulous community benefits standard. Accordingly, it is incumbent on decision-makers to at least know how the value of state and local tax exemptions given compares to charity care provided.

A. Estimated State and Local Tax Exemptions Compared to Charity Care

Chart 3 below identifies the dollar value of the total estimated state and local tax benefits received by each Hospital Studied and the total dollar value of the charity care those Hospitals reported providing, valued at cost rather than charges.

Chart 3: State and Local Tax Exemptions Compared to Charity Care Provided

Hospital/Hospital Network	Estimated Value of State & Local Tax Exemptions	Charity Care
Advocate Health Care Network	$79,032,570	$20,267,000
Alexian Brothers Hospital Network	$22,837,112	$5,198,375
Evanston Northwestern Healthcare	$22,980,617	$9,905,463
Gottlieb Memorial Hospital	$4,289,045	$986,957
Holy Cross Hospital	$4,018,838	$1,661,892
Jackson Park Hospital	$1,188,516	$1,667,904
Little Company of Mary Hospital	$8,736,578	$2,288,368
Loyola University Medical Center	$20,297,147	$8,999,172
Mercy Hospital & Medical Center	$3,781,966	$3,388,818
Mount Sinai Hospital	$2,852,605	$4,477,500
Palos Community Hospital	$7,792,176	$3,570,000
Resurrection Health Care	$44,858,697	$13,871,149
Roseland Community Hospital	$528,846	$3,050,000
Rush North Shore Medical Center	$5,533,584	$388,000
Rush University Medical Center & Rush Oak Park**	$22,425,246	$2,520,552
Saint Anthony Hospital	$4,468,575	$1,460,349
St. Bernard Hospital	$1,740,025	$2,286,647
St. James Hospitals	$14,496,194	$6,615,164
South Shore Hospital	$721,170	$1,606,436
Thorek Hospital	$3,277,231	$1,208,000
University of Chicago Hospitals	$38,395,267	$9,751,414
TOTAL	**$314,252,006**	**$105,169,160**

**Note: The estimated value of the state and local tax exemptions for Rush University Medical Center and Rush Oak Park may be overstated due to the inclusion of significant University facilities in the non-profit corporation.

The values of each of the property, sales, and combined state corporate income and personal property replacement tax exemptions for each Hospital Studied are set forth in Appendix A.

Five out of the 21 Hospitals Studied – Jackson Park, Mount Sinai, Roseland, St. Bernard and South Shore – provided more charity care than they received in state and local tax breaks.

Charts 4a and 4b below show the estimated value of state and local tax benefits received by the Hospitals Studied ranged from a high of 6.7 percent (Thorek Hospital) to a low of 1.1 percent (Roseland Community Hospital). The average value of the state and local tax exemptions of all the Hospitals Studied was 3.4 percent of total expenses. Appendix B identifies estimated state and local tax exemptions as a percentage of total expenses for each of the Hospitals Studied.

Chart 4a

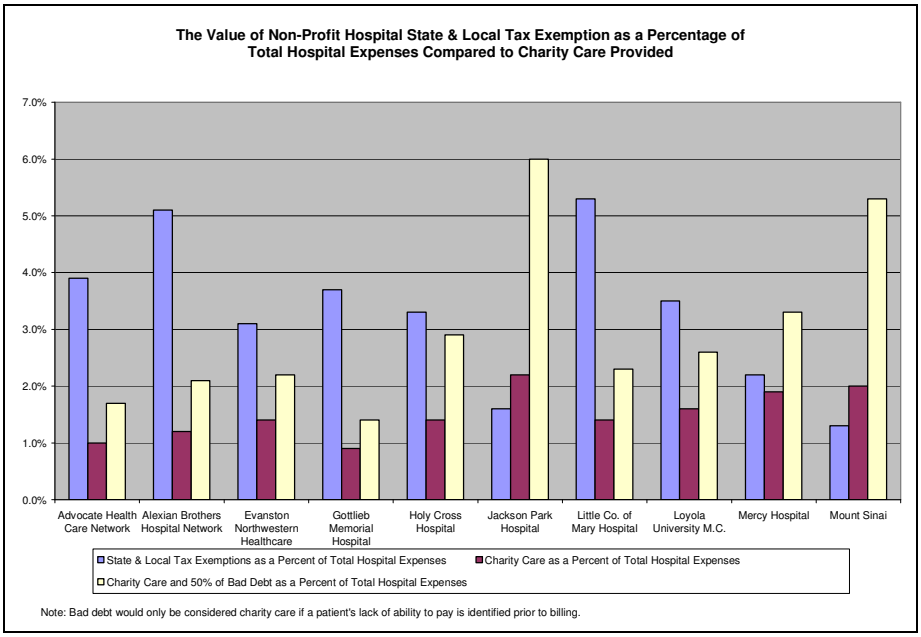
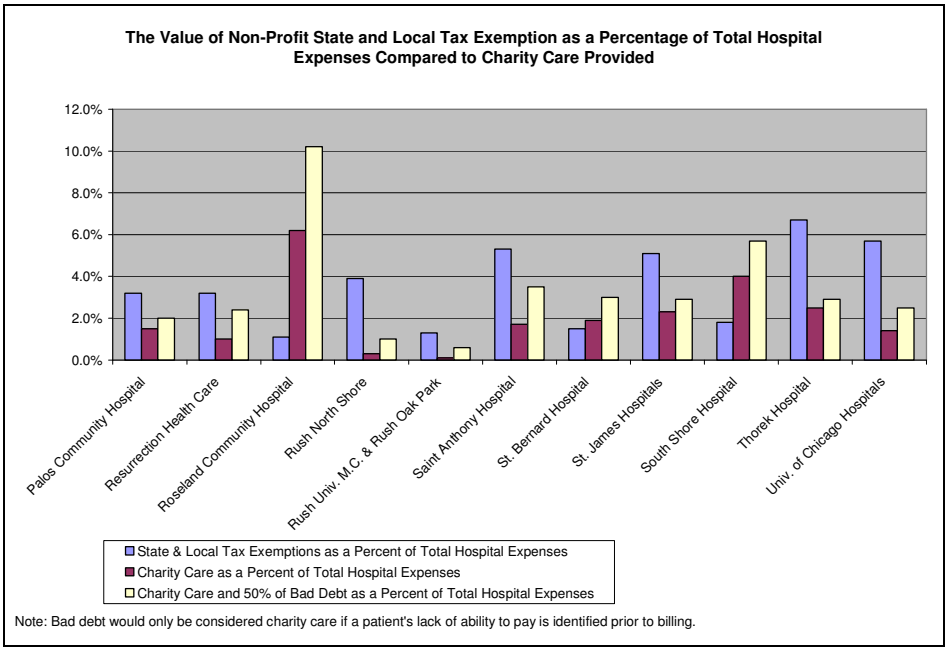


Chart 4b



Charts 4a and 4b also show charity care provided as a percentage of total hospital expenses for each of the Hospitals Studied. As the graphs illustrate, this ratio ranges from charity care representing a high of 6.2 percent of all expenses, incurred by Roseland Community Hospital, to a low of 0.1 percent for Rush University Medical Center/Rush Oak Park Hospital. However, it is important to note that Rush University Medical Center includes significant University facilities in addition to the hospital. Therefore, the charity care as a percentage of total hospital expenses for Rush University Medical Center/Rush Oak Park is likely understated.

Charts 4a and 4b help demonstrate the potential implications of better identifying individuals who would qualify for charity care upon admission, rather than subjecting them to debt collection practices. It estimates the impact of identifying, prior to billing, 50 percent of what is now bad debt as charity care. In that case, potential charity care as a percentage of total hospital expenses increased significantly, ranging from a high of 10.2 percent, provided by Roseland Community Hospital, to a low of 0.6 percent, provided by Rush University Medical Center/Rush Oak Park Hospital. Again, Rush University Medical Center's charity care and bad debt as a percentage of hospital expenses is likely understated due to the inclusion of significant University operations in the corporation.

Fifteen Hospitals Studied – 71 percent of the hospitals in the study – received tax benefits greater than charity care provided, even after including 50 percent of bad debt as potential charity care. Those hospitals included Advocate Health Care Network, Alexian Brothers Hospital Network, Evanston Northwestern, Gottlieb Memorial Hospital, Holy Cross Hospital, Little Company of Mary Hospital, Loyola University Medical Center, Palos Community Hospital, Resurrection Health Care, Rush North Shore Medical Center, Rush University Medical Center/Rush Oak Park, Saint Anthony Hospital, St. James Hospitals, Thorek Hospital and University of Chicago Hospitals. Advocate Health Care Network showed the greatest disparity in terms of charity care and 50 percent of bad debt compared to the value of its state and local tax benefits – totaling more than $45 million in excess tax benefits, while Holy Cross Hospital showed the smallest gap – $428,025.

B. Estimated Federal Income Tax Exemption

The federal corporate income tax exemption was a relatively small tax benefit for most of the Hospitals Studied. As Chart 5 below shows, only six out of the 21 Hospitals Studied, or 29 percent, benefited at all from the federal income tax exemption. The federal exemption in terms of a percentage of total hospital expenses ranged from a high of 2.6 percent (Thorek Hospital), to a low of 0.3 percent of total expenses (South Shore Hospital) for hospitals that had a potential federal income tax liability.

As Chart 5 below illustrates, the estimated value of all the federal, state and local tax exemptions combined ranged from a high of 9.2 percent of total hospital expenses (Thorek Hospital), to a low of 1.1 percent of total expenses (Roseland Community Hospital).

Chart 5: The Value of All Tax Exemptions

Hospital or Hospital Network	Value of Federal Income Tax Exemption	Federal Tax as a Percentage of Total Hospital Expenses	Value of State & Local Tax Exemptions	Value of All Tax Exemptions	All Taxes as a Percentage of Total Hospital Expenses
Advocate Health Care Network	$0	0.0%	$79,032,570	$79,032,570	3.9%
Alexian Brothers Hospital Network	$2,349,699	0.5%	$22,837,112	$25,186,811	5.6%
Evanston Northwestern Healthcare	$0	0.0%	$22,980,617	$22,980,617	3.1%
Gottlieb Memorial Hospital	$0	0.0%	$4,289,045	$4,289,045	3.7%
Holy Cross Hospital	$0	0.0%	$4,018,838	$4,018,838	3.3%
Jackson Park Hospital	$0	0.0%	$1,188,516	$1,188,516	1.6%
Little Company of Mary Hospital	$2,297,989	1.4%	$8,736,578	$11,034,567	6.7%
Loyola University Medical Center	$0	0.0%	$20,297,147	$20,297,147	3.5%
Mercy Hospital & Medical Center	$0	0.0%	$3,781,966	$3,781,966	2.2%
Mount Sinai	$0	0.0%	$2,852,605	$2,852,605	1.3%
Palos Community Hospital	$0	0.0%	$7,792,176	$7,792,176	3.2%
Resurrection Health Care	$0	0.0%	$44,858,697	$44,858,697	3.2%
Roseland Community Hospital	$0	0.0%	$528,846	$528,846	1.1%
Rush North Shore Medical Center	$0	0.0%	$5,533,584	$5,533,584	3.9%
Rush University Medical Center & Rush Oak Park**	$0	0.0%	$22,425,246	$22,425,246	1.3%
Saint Anthony Hospital	$976,223	1.2%	$4,468,575	$5,444,798	6.4%
St. Bernard Hospital	$0	0.0%	$1,740,025	$1,740,025	1.5%
St. James Hospitals	$0	0.0%	$14,496,194	$14,496,194	5.1%
South Shore Hospital	$136,754	0.3%	$721,170	$857,923	2.1%
Thorek Hospital	$1,261,156	2.6%	$3,277,231	$4,538,387	9.2%
University of Chicago Hospitals	$4,386,844	0.7%	$38,395,267	$42,782,111	6.3%
TOTAL/AVERAGE	**$11,408,664**	**0.3%**	**$314,252,006**	**$325,660,669**	**3.7%**

**Note: The estimated value of all tax exemptions for Rush University Medical Center and Rush Oak Park may be overstated due to the inclusion of significant University facilities in the non-profit corporation. For the same reason, estimated taxes as a percentage of total hospital expenses may be understated.

C. Other Charitable Services Provided by Non-Profit Hospitals

Non-profit hospitals provide charitable services in addition to charity care that are not considered when determining state sales and local property tax exemptions. One such service is providing hospital care to Medicaid beneficiaries. Caring for Medicaid recipients is similar to charity care because both services are intended to increase health care access to poor and low-income uninsured individuals. Because government Medicaid reimbursement rates to hospitals for Medicaid services do not cover the full cost of providing such care, hospitals subsidize a portion of the cost of such care. According to the Illinois Hospital Association, hospitals are reimbursed by government for only 81.5 percent of the cost of caring for Medicaid patients.[69] The remaining unreimbursed cost, 18.5 percent, is therefore borne by hospitals. In Illinois, the unreimbursed cost of providing Medicaid services, often called the "Medicaid shortfall," is not considered charity for purposes of the local property tax exemption.[70]

Nonetheless, in an effort to quantify Medicaid shortfalls for non-profit hospitals, this study attempted to analyze the cost to the Hospitals Studied of providing this service. However, such costs were not reported separately on the hospital Community Benefit Reports and therefore, could not be analyzed. The Community Benefit Report does contain a line-item for "government sponsored indigent health care," which includes the unreimbursed cost not only of Medicaid, but Medicare and other government indigent health care programs.[71] Medicare does not fall within the same rationale as Medicaid since Medicare eligibility is based on age rather than financial need. In addition, the financial statements of most Hospitals Studied did not identify the Medicaid shortfall. For this reason, it was not possible to illustrate the unreimbursed cost of Medicaid borne by the Hospitals Studied.

Interestingly, some Hospitals Studied that provide an extraordinary amount of Medicaid services did not place a dollar value on their unreimbursed cost of "government sponsored indigent health care" in their Community Benefit Report. For instance, Mount Sinai, a hospital that received more disproportionate share hospital ("**DSH**") payments than any other private hospital in Illinois in 2000[72] – DSH payments are federal dollars paid to hospitals that provide significant amounts of Medicaid and indigent care – did not report any unreimbursed cost of government sponsored indigent health care on its Community Benefit Report.

Other activities provided by non-profit hospitals that might be considered charitable in nature are unprofitable services provided in response to community need. Some of these services include trauma units, neonatal intensive care units, community health clinics, immunization programs and wellness programs. An analysis of whether these services should be considered when evaluating non-profit hospital tax exemption is beyond the scope of this report.

D. Community Benefits Not Considered Unique to Charitable Hospitals

The Illinois Community Benefits Act defines a number of other non-profit hospital activities as community benefits. These include items such as language services, hospital donations, volunteer services provided by hospital employees and non-employees, and medical education and research. While these services certainly add value to the community, they are not services which are unique to non-profit hospitals. Nor do they increase health care access to low-income uninsured individuals. Rather, many such services are provided by non-profit and for-profit hospitals alike as competitive business practices and marketing tools. Chart 6 below illustrates the services non-profit hospitals report in the Community Benefit Reports and compares it to services typically provided by for-profit hospitals. Additionally, Appendix E itemizes all the community benefits reported by the Hospitals Studied.

Chart 6: Charity Versus Competitive Business Practices

Hospital Service	Non-Profit Hospitals	For-Profit Hospitals
Charity care	Required	Provided at the election of the hospital
Bi-lingual language services	Competitive practice	Competitive practice
Medicare	Competitive practice	Competitive practice
Medicaid	Competitive practice	Typically provided in limited amounts
Hospital donations	Competitive practice	Competitive practice
Volunteer services	Competitive practice	Competitive practice
Medical education	Competitive practice	Competitive practice
Medical research	Competitive practice	Competitive practice
Hospital-subsidized services	Competitive practice	Competitive practice
Bad debt	Expense incurred by all hospitals	Expense incurred by all hospitals

Finally, some note the contributions non-profit hospitals make in brining jobs and economic development to local communities. However, this is hardly a charitable activity that either Congress or Illinois lawmakers had in mind when granting charitable hospitals privileged tax status. Any employer, whether for-profit or not, provides this benefit. Certainly, Illinois hospitals play a vital role in the state's economy, employing more than 233,000 individuals statewide.[73] However, providing access to health care to vulnerable members of society is the "charitable" act required by the charity care standard – not economic development.

8. Conclusion

Federal, state and local governments grant non-profit hospitals tax-exempt status with the expectation that these hospitals will provide a public benefit in return. This historically has meant providing low-income individuals who cannot afford to pay for hospital services, access to necessary health care. Legal precedent at all levels of government suggests an expectation – and for Illinois local property tax exemption, a requirement – that non-profit hospitals fulfill both their missions and satisfy their public benefit obligations by providing free or discounted care to low-income, uninsured individuals who cannot afford health care – in other words – charity care.

Since tax exemption is, in essence, the use of public funds for a specific public purpose, it follows that government should understand and evaluate whether the forgone tax revenue is being used to provide the desired public benefit. To help decision-makers attain that goal, this report compares the value of the aggregate tax exemptions of non-profit hospitals in Cook County, Illinois for which data was available, against the cost of charity care those hospitals provide in return. Recognizing the valuable role non-profit hospitals play in the health care safety-net, ever-increasing health care costs, private sector retrenchment from providing employees with health care coverage, and on-going fiscal problems confronted by all levels of government, it is hoped that the data produced in this report will inform this crucial debate in a manner that leads to constructive policy solutions.

Appendix A: Estimated Value of State and Local Tax Exemptions for the Hospitals Studied

Hospital/Hospital Network	Property Tax	Sales Tax	Illinois Income Tax	Total State & Local Taxes
Advocate Health Care Network	$57,272,665	$21,759,905	$0	$79,032,570
Alexian Brothers Hospital Network	$16,482,315	$5,810,574	$544,223	$22,837,112
Evanston Northwestern Healthcare	$16,449,419	$6,531,199	$0	$22,980,617
Gottlieb Memorial Hospital	$2,706,659	$1,582,385	$0	$4,289,045
Holy Cross Hospital	$2,860,782	$1,158,056	$0	$4,018,838
Jackson Park Hospital	$781,640	$406,876	$0	$1,188,516
Little Company of Mary Hospital	$6,368,400	$1,835,933	$532,246	$8,736,578
Loyola University Medical Center	$11,126,557	$9,170,590	$0	$20,297,147
Mercy Hospital & Medical Center	$1,756,175	$2,025,791	$0	$3,781,966
Mount Sinai	$1,712,315	$1,140,290	$0	$2,852,605
Palos Community Hospital	$4,119,778	$3,672,398	$0	$7,792,176
Resurrection Health Care	$29,728,731	$15,129,965	$0	$44,858,697
Roseland Community Hospital	$277,921	$250,926	$0	$528,846
Rush North Shore Medical Center	$2,952,301	$2,581,283	$0	$5,533,584
Rush University Medical Center & Rush Oak Park**	$12,770,646	$9,654,600	$0	$22,425,246
Saint Anthony Hospital	$3,842,563	$416,412	$209,601	$4,468,575
St. Bernard Hospital	$1,176,647	$563,378	$0	$1,740,025
St. James Hospitals	$6,692,834	$7,803,360	$0	$14,496,194
South Shore Hospital	$461,649	$227,847	$31,674	$721,170
Thorek Hospital	$2,260,510	$724,621	$292,101	$3,277,231
University of Chicago Hospitals	$27,340,837	$10,038,378	$1,016,053	$38,395,267
TOTAL	**$209,141,343**	**$102,484,766**	**$2,625,897**	**$314,252,006**

Note: Totals may not add up due to rounding.

**The estimated value of the tax exemptions for Rush University Medical Center and Rush Oak Park may be overstated due to the inclusion of significant University facilities in the non-profit corporation.

Appendix B: Estimated State and Local Taxes as a Percentage of Total Expenses for Hospitals Studied

Hospital/Hospital Network	Property Tax as a Percentage of Total Hospital Expenses	Sales Tax as a Percentage of Total Hospital Expenses	Illinois Income Tax as a Percentage of Total Hospital Expenses	All State & Local Taxes as a Percentage of Total Hospital Expenses
Advocate Health Care Network	2.8%	1.1%	0.0%	3.9%
Alexian Brothers Hospital Network	3.7%	1.3%	0.1%	5.1%
Evanston Northwestern Healthcare	2.2%	0.9%	0.0%	3.1%
Gottlieb Memorial Hospital	2.4%	1.4%	0.0%	3.7%
Holy Cross Hospital	2.3%	0.9%	0.0%	3.3%
Jackson Park Hospital	1.0%	0.5%	0.0%	1.6%
Little Company of Mary Hospital	3.9%	1.1%	0.3%	5.3%
Loyola University Medical Center	1.9%	1.6%	0.0%	3.5%
Mercy Hospital & Medical Center	1.0%	1.2%	0.0%	2.2%
Mount Sinai	0.8%	0.5%	0.0%	1.3%
Palos Community Hospital	1.7%	1.5%	0.0%	3.2%
Resurrection Health Care	2.1%	1.1%	0.0%	3.2%
Roseland Community Hospital	0.6%	0.5%	0.0%	1.1%
Rush North Shore Medical Center	2.1%	1.8%	0.0%	3.9%
Rush University Medical Center & Rush Oak Park**	0.7%	0.6%	0.0%	1.3%
Saint Anthony Hospital	4.5%	0.5%	0.2%	5.3%
St. Bernard Hospital	1.0%	0.5%	0.0%	1.5%
St. James Hospitals	2.4%	2.8%	0.0%	5.1%
South Shore Hospital	1.2%	0.6%	0.1%	1.8%
Thorek Hospital	4.6%	1.5%	0.6%	6.7%
University of Chicago Hospitals	4.1%	1.5%	0.2%	5.7%
Average Percentage	**2.2%**	**1.1%**	**0.1%**	**3.4%**

Note: Percentages may not add up due to rounding.

** The estimated value of all tax exemptions for Rush University Medical Center and Rush Oak Park may be overstated due to the inclusion of University facilities in the non-profit corporation. For the same reason, estimated taxes as a percentage of total hospital expenses may be understated.

Appendix C: Charity Care and Bad Debt Provided by the Hospitals Studied

Hospital/Hospital Network	The Cost of Charity Provided	Bad Debt Expense	Total Uncompensated Care	Charity Care & 50% Bad Debt
Advocate Health Care Network	$20,267,000	$27,286,000	$47,553,000	$33,910,000
Alexian Brothers Hospital Network	$5,198,375	$8,070,105	$13,268,480	$9,233,428
Evanston Northwestern Healthcare	$9,905,463	$12,158,491	$22,063,954	$15,984,709
Gottlieb Memorial Hospital	$986,957	$1,217,953	$2,204,910	$1,595,934
Holy Cross Hospital	$1,661,892	$3,857,842	$5,519,734	$3,590,813
Jackson Park Hospital	$1,667,904	$5,765,751	$7,433,655	$4,550,780
Little Company of Mary Hospital	$2,288,368	$2,913,880	$5,202,248	$3,745,308
Loyola University Medical Center	$8,999,172	$12,373,823	$21,372,995	$15,186,084
Mercy Hospital & Medical Center	$3,388,818	$4,618,247	$8,007,065	$5,697,942
Mount Sinai Hospital	$4,477,500	$15,272,527	$19,750,027	$12,113,764
Palos Community Hospital	$3,570,000	$2,705,820	$6,275,820	$4,922,910
Resurrection Health Care	$13,871,149	$39,147,533	$53,018,682	$33,444,915
Roseland Community Hospital	$3,050,000	$3,833,687	$6,883,687	$4,966,844
Rush North Shore Medical Center	$388,000	$2,212,988	$2,600,988	$1,494,494
Rush University Medical Center & Rush Oak Park	$2,520,552	$14,931,862	$17,452,414	$9,986,483
Saint Anthony Hospital	$1,460,349	$3,077,969	$4,538,318	$2,999,333
St. Bernard Hospital	$2,286,647	$2,500,910	$4,787,557	$3,537,102
St. James Hospitals	$6,615,164	$3,259,688	$9,874,852	$8,245,008
South Shore Hospital	$1,606,436	$1,354,097	$2,960,533	$2,283,484
Thorek Hospital	$1,208,000	$447,569	$1,655,569	$1,431,784
University of Chicago Hospitals	$9,751,414	$14,762,284	$24,513,698	$17,132,556
TOTAL	**$105,169,160**	**$181,769,025**	**$286,938,185**	**$196,053,673**

Note: Totals may not add up due to rounding.

Appendix D: Charity Care and Bad Debt as a Percentage of Total Expenses for Hospitals Studied

Hospital/Hospital Network	Charity Care as a Percentage of Total Hospital Expenses	Total Uncompensated Care as a Percentage of Total Hospital Expenses	Charity Care and 50% of Bad Debt as a Percentage of Total Hospital Expenses
Advocate Health Care Network	1.0%	2.3%	1.7%
Alexian Brothers Hospital Network	1.2%	3.0%	2.1%
Evanston Northwestern Healthcare	1.4%	3.0%	2.2%
Gottlieb Memorial Hospital	0.9%	1.9%	1.4%
Holy Cross Hospital	1.4%	4.5%	2.9%
Jackson Park Hospital	2.2%	9.9%	6.0%
Little Company of Mary Hospital	1.4%	3.2%	2.3%
Loyola University Medical Center	1.6%	3.7%	2.6%
Mercy Hospital & Medical Center	1.9%	4.6%	3.3%
Mount Sinai Hospital	2.0%	8.7%	5.3%
Palos Community Hospital	1.5%	2.6%	2.0%
Resurrection Health Care	1.0%	3.8%	2.4%
Roseland Community Hospital	6.2%	14.1%	10.2%
Rush North Shore Medical Center	0.3%	1.8%	1.0%
Rush University Medical Center & Rush Oak Park**	0.1%	1.0%	0.6%
Saint Anthony Hospital	1.7%	5.4%	3.5%
St. Bernard Hospital	1.9%	4.0%	3.0%
St. James Hospitals	2.3%	3.5%	2.9%
South Shore Hospital	4.0%	7.4%	5.7%
Thorek Hospital	2.5%	3.4%	2.9%
University of Chicago Hospitals	1.4%	3.6%	2.5%
Average Percentage	**1.8%**	**4.5%**	**3.2%**

Note: Percentages may not add up due to rounding.

**Charity care, bad debt and total uncompensated care as a percentage of total hospital expenses for Rush University Medical Center and Rush Oak Park may be understated due to the inclusion of significant University facilities in the non-profit corporation.

Appendix E: The Community Benefits Reported by the Hospitals Studied

Hospital/Hospital Network	Charity Care	Language Assistant Services	Government Sponsored Indigent Health Care	Donations	Volunteer Services	Education	Government Sponsored Program Services	Research	Subsidized Health Services	Bad Debts	Other Community Benefits	Total
Advocate Health Care Network	$20,267,000	$669,000	$136,063,000	$1,031,000	$2,244,000	$39,722,000	$69,000	$0	$18,232,000	$27,286,000	$0	$245,583,000
Alexian Brothers Hospital Network	$5,198,375	$72,038	$7,682,626	$799,735	$682,293	$2,564,419	$0	$0	$924,811	$8,070,105	$1,343,034	$27,337,436
Evanston Northwestern Healthcare	$9,905,463	$501,390	$70,794,820	$107,676	$1,313,017	$13,194,900	$0	$5,724,997	$7,313,122	$32,414,000	$953,807	$142,223,192
Gottlieb Memorial Hospital	$986,957	$118,667	$9,785,841	$0	$201,659	$0	$0	$0	$452,082	$6,089,766	$0	$17,634,972
Holy Cross Hospital	$1,661,892	$0	$7,142,681	$0	$0	$0	$0	$0	$975,850	$16,312,230	$0	$26,092,653
Jackson Park Hospital	$1,667,904	$600	$324,484	$0	$3,520	$697,798	$804,947	$0	$3,510,705	$14,097,191	$0	$21,107,149
Little Company of Mary Hospital	$2,288,368	$2,054	$12,134,998	$0	$677,829	$0	$0	$0	$7,908,691	$10,808,159	$990,326	$34,810,425
Loyola University Medical Center	$8,999,172	$307,876	$26,606,000	$144,217	$0	$500,367	$0	$561	$0	$31,565,875	$515,650	$68,639,718
Mercy Hospital & Medical Center	$3,388,818	$57,838	$2,474,729	$239,700	$143,701	$1,373,461	$0	$0	$2,101,596	$4,618,247	$17,192	$14,415,282
Mount Sinai Hospital	$4,477,500	$575,600	$0	$3,413,700	$74,900	$6,609,700	$0	$152,200	$7,065,000	$51,492,000	$2,039,300	$75,899,900
Palos Community Hospital	$3,570,000	$1,400	$41,300,000	$31,458	$7,098	$293,743	$0	$0	$834,780	$7,800,000	$83,360	$53,921,839
Resurrection Health Care	$13,871,149	$432,183	$197,342,979	$610,190	$52,138	$35,777,953	$0	$204,621	$7,838,830	$133,019,140	$2,547,982	$391,697,165
Roseland Community Hospital	$3,050,000	$0	$0	$100,000	$5,303	$40,000	$548,600	$0	$0	$9,690,817	$29,075	$13,463,795
Rush North Shore Medical Center	$388,000	$24,784	$6,149,000	$106,334	$455,150	$991,640	$0	$49,834	$1,075,822	$7,270,000	$149,000	$16,659,564
Rush University Medical Center/Oak Park Hospital	$2,520,552	$242,665	$30,195,213	$273,539	$1,378,824	$31,225,823	$0	$7,240,000	$5,019,972	$46,458,810	$1,527,866	$126,083,264
Saint Anthony Hospital	$1,460,349	$600	$2,162,636	$0	$1,101	$56,684	$1,751,091	$0	$0	$8,958,000	$82,113	$14,472,574
St. Bernard Hospital	$2,286,647	$0	$737,941	$0	$0	$14,366	$0	$0	$2,875,148	$6,638,997	$18,460	$12,571,559
St. James Hospitals	$6,615,164	$13,347	$25,665,702	$169,140	$0	$1,951,918	$0	$0	$732,854	$10,431,000	$1,420,955	$47,000,080
South Shore Hospital	$1,606,436	$499	$1,117,432	$59,042	$0	$0	$0	$0	$333,622	$3,885,500	$0	$7,002,531
Thorek Hospital	$1,208,000	$12,074	$0	$7,070	$10,106	$12,000	$0	$0	$551,515	$1,268,259	$102,515	$3,171,539
University of Chicago Hospitals	$9,751,414	$388,014	$91,192,452	$265,332	$202,091	$36,029,099	$0	$7,500,000	$34,962,403	$50,677,253	$680,399	$231,648,457

As discussed in the study, many of the community benefits as reported above by the non-profit Hospitals Studied are not for the purpose of providing basic health care to low-income individuals who cannot afford it. Therefore, such community benefits are not considered charitable activities for purposes of the local property tax exemption in Illinois.

Additionally, the vast majority of the non-profit Hospitals Studied reported bad debt on their Community Benefit Reports at charges rather than cost, contrary to what is required by Illinois law. Therefore, the amount of bad debt as indicated above is grossly overstated for purposes of Illinois community benefits reporting for most non-profit hospitals.

Appendix F: Cook County, Illinois Non-Profit Hospitals Studied

Following is a list of the Cook County non-profit general hospitals and hospital networks for which the study estimated the value of the federal, state and local tax exemptions and compared such value to the cost of charity care provided. Also outlined are the assumptions made and problems encountered for each hospital.

1. Advocate Health Care Network

   Advocate Health Care Network includes eight non-profit hospitals – Advocate Bethany Hospital, Advocate Christ Medical Center, Advocate Good Samaritan Hospital, Advocate Good Shepherd Hospital, Advocate Illinois Masonic Medical Center, Advocate Lutheran General Hospital, Advocate South Suburban Hospital and Advocate Trinity Hospital, all of which are located in Cook County except Good Samaritan, which is located in DuPage County and Good Shepherd, which is located in Lake County. Because the Advocate hospitals file tax returns, financial statements and Community Benefit Reports on a network and consolidated basis, the study was unable to demonstrate tax benefits, charity care or community benefits on a hospital-by-hospital basis. Accordingly, all the Advocate hospitals are included in the study.

   One of the Advocate tax returns used to obtain financial data was the return for Advocate Health and Hospital Corporation. It appeared that other non-hospital entities were included in this return, such as clinics, home health agencies, hospices, and the like. In such case, the estimated value of Advocate Health Care Network's tax exemptions may be overstated

   Lutheran General Hospital had an EBITDA loss for 2001, resulting in a three-year average EBITDA loss. Accordingly, 2001 was omitted from the EBITDA calculation and a two-year average EBITDA was determined.

   Advocate Northside Health Network (Advocate Illinois Masonic Medical Center) had EBITDA losses for 2001 and 2002, resulting in a three-year average EBITDA loss. Accordingly, the alternative method using operating revenue was used to determine the hospital's pro forma EBITDA for purposes of estimating the value of Advocate Health Care Network's property tax exemption.

   Additionally, Advocate's Community Benefit Report was filed on a hospital network basis, as permitted by the Illinois Community Benefits Act. It is not clear if the charity care and other community benefits reported included non-hospital amounts. If the amounts reported did include entities other than the eight hospitals, the value of charity care provided for the Advocate hospitals is overstated for purposes of this study.

2. Alexian Brothers Hospital Network

   The Alexian Brothers Hospital Network includes the Alexian Brothers Medical Center, St. Alexius Medical Center, and Alexian Brothers Behavioral Health Hospital. Despite the inclusion of a specialty hospital – Alexian Brothers Behavioral Health Hospital – in this hospital network, the study included all three hospitals because the Community Benefit Report for the network and the tax returns included the same entities.

3. Evanston Northwestern Healthcare Corporation

   This hospital network includes Evanston Hospital, Glenbrook Hospital and Highland Park Hospital. Highland Park is located in Lake County while the other two hospitals are in located Cook County. It

appeared that both the tax returns and the Community Benefit Reports include the same entities. The study therefore included all such hospitals.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

4. Gottlieb Memorial Hospital

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

5. Holy Cross Hospital

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

Holy Cross Hospital had a three-year average EBITDA loss. Accordingly, the alternative method using operating revenue was used to determine the value of the hospital's property tax exemption.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

6. Jackson Park Hospital

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

A two-year average EBITDA was used because the hospital had an extraordinary loss in 2003, resulting in a negative three-year average EBITDA.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

7. Little Company of Mary Hospital and Health Centers

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

8. Loyola University Medical Center

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

9. Mercy Hospital and Medical Center

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

A two-year average EBITDA was used in calculating the value of the property tax exemption because an extraordinary EBITDA loss in 2000 resulted in a negative three-year average EBITDA.

10. Mount Sinai Hospital

The Community Benefit Report included Mount Sinai Hospital as well as other entities. It was unclear if the charity care and other community benefits reported included amounts from the other entities. In such case, charity care may be overstated.

The tax returns were filed by Mount Sinai Hospital and Medical Center, which appeared to be the hospital only.

A two-year average EBITDA was used in calculating the value of the property tax exemption because an extraordinary EBITDA loss occurred in 2002.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

11. Palos Community Hospital

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

12. Resurrection Health Care

The Resurrection Health Care hospital network includes the following hospitals: Holy Family Medical Center, Saint Joseph Hospital, West Suburban Medical Center, Westlake Hospital, Saints Mary and Elizabeth Medical Center, Saint Francis Hospital, Our Lady of the Resurrection Medical Center, and Resurrection Medical Center. The Community Benefit Report is filed on a consolidated basis and includes several other health care entities, meaning that charity care reported may be overstated. The tax returns were filed on a hospital-by-hospital basis.

Holy Family Medical Center had a three-year average EBITDA loss. Accordingly, the alternative method using operating revenue was used in calculating its pro forma EBITDA. Saint Elizabeth Hospital had an EBITDA loss in 2002. As such, a two-year average EBIDTA was used. West

Suburban Medical Center had an EBITDA loss in 2000, and therefore a two-year average EBITDA was used for purposes of valuing the property tax exemption.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

13. Roseland Community Hospital

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

14. Rush North Shore

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

15. Rush University Medical Center and Rush Oak Park Hospital

These two hospitals filed a combined Community Benefit Report.

The tax returns for Rush University Medical Center include significant University facilities other than the hospital, such as the Rush College of Nursing and other academic operations. Therefore, the value of the hospitals' tax exemptions may be overstated. For the same reasons, charity care as a percentage of total hospital expenses may be understated.

Rush Oak Park had an EBITDA loss for 2003. Accordingly, a two-year average EBITDA was used rather than three.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

16. Saint Anthony Hospital

The tax return was filed by Catholic Health Partners, which appeared to be Saint Anthony Hospital. In such case, the Community Benefit Report was filed by the same entity as the tax return.

A two-year average EBITDA was used for purposes of estimating the property tax exemption due to an EBITDA loss in 2003.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

17. St. Bernard Hospital

    It appeared that the Community Benefit Report and the tax returns are filed only by the hospital.

    A two-year average EBITDA was used for purposes of estimating the property tax exemption due to an EBITDA loss in 2002.

    Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

18. St. James Hospitals – Olympia Fields and Chicago Heights

    The St. James Hospitals do not file tax returns because they are classified as churches. Accordingly, the study used consolidating financial statement schedules, which break down financial information on a hospital-specific basis, to calculate the value of tax exemption. In addition, financial data for the 2004 year-end was the only year for which the data was available. Therefore, the study was unable to compute a three-year average for EBITDA or supply expense. The Community Benefit Reports included only the hospitals.

    Due to an EBITDA loss, the alternative method of using operating revenues to determine the hospital's pro forma EBITDA was used in estimating the value of the property tax exemption.

    Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

19. South Shore Hospital

    It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

    Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

20. Thorek Hospital

    It appeared that the Community Benefit Report and the tax returns are filed only by the hospital.

    Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

21. University of Chicago Hospitals

It appeared that the Community Benefit Report and the tax returns are filed by the hospital only.

Bad debt as reported on the Community Benefit Report appeared to be reported at charges. To calculate bad debt at cost, bad debt stated at charges was multiplied by the hospital's cost to charge ratio as reported on its Medicare Cost Report filed with the Center for Medicare and Medicaid Services.

Appendix G: Cook County Non-Profit Hospitals Not Included in the Study

Following is a list of the non-profit hospitals for which the relevant data was not available, and therefore, were not included in the study.

1. Adventist Midwest Health

   This hospital network includes Adventist LaGrange Memorial Hospital which is located in Cook County and two other hospitals – Adventist Hinsdale Hospital and Adventist Glen Oaks Hospital – which are both located in DuPage County. LaGrange Memorial Hospital is classified as a church and is not required to file a tax return. The alternative source of information, the audited financial statements, however, were filed on a consolidated basis and included numerous hospitals in other states, making it impossible to calculate the value of the tax exemptions for only the Illinois hospitals. Accordingly, the study was not able to obtain the data needed for LaGrange Memorial Hospital or the hospital network to estimate hospital tax exemption.

2. St. Francis Hospital, Blue Island

   St. Francis Hospital is part of a larger consolidated group – SSM Health Care. SSM Health Care's tax returns and financial statements did not provide hospital-specific data. Accordingly, the study was unable to value the tax benefits of St. Francis Hospital.

The following non-profit hospitals' Community Benefit Reports were not yet due at the time of writing this report:

1. Ingalls Memorial Hospital
2. Methodist Hospital of Chicago
3. Northwest Community Hospital
4. Northwestern Memorial Hospital
5. Norwegian-American Hospital
6. Swedish Covenant Hospital

In addition, Loretto Hospital, whose Community Benefit Report was due December 31, 2005, had not yet been filed at the time of writing this report.

Appendix H: Sponsor of the Study

This study was funded by the Service Employees' International Union.

Endnotes

[1] Medicaid and SCHIP are means-tested government programs, meaning that eligibility is based on income below a certain level (tied to the federal poverty level). Accordingly, individuals who earn income just above these levels but nevertheless do not earn enough to afford health insurance remain uninsured.
[2] *See* Rev. Rul. 69-545, 1969-2 C.B. 117 (established the community benefit standard); Rev. Rul. 56-185, 1956-1 C.B. 202 (required non-profit hospitals to provide charity care to patients unable to pay for hospital services to the extent of the hospital's financial ability); *Methodist Old People's Home v. Korzen*, 39 Ill. 2d 149, (1968) (charity provided should reduce the burdens of government).
[3] See *Bob Jones v. United States*, 461 U.S. 574, 591 (1983) ("Charitable exemptions are justified on the basis that the exempt entity confers a public benefit – a benefit that society or the community may not itself choose or be able to provide, or which supplements and advances the work of public institutions already supported by tax revenues."); *Methodist Old People's Home*, at 156, ("Charity is a gift to be applied…in some way reducing the burdens of government.")
[4] See *Alivio Medical Center v. Illinois Department of Revenue*, 299 Ill. App. 3 647 (1998).
[5] Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Year 2006 to 2015,* (January 25, 2005); S. Heffler, et al., *U.S. Health Spending Projections for 2004-2014,* Health Affairs, (February 23, 2005).
[6] Illinois' structural deficit was identified in a study done for CTBA by economics professor, Dr. Fred Giertz, Executive Director of the National Tax Association at the University of Illinois Urbana. CTBA has identified the extent of the structural deficit problem in Illinois through modeling developed by Dr. Giertz. Numerous publications explaining the structural deficit can be found on CTBA's website at www.ctbaonline.org.
[7] Center for Tax and Budget Accountability, *Illinois has Cut Real Spending on All Services Except Healthcare, Pensions and Education Since 1995*.
[8] *See* Illinois State Budget Book FY2007 (Recommended).
[9] Cook County Bureau of Health Services.
[10] *See* the Cook County, *Illinois Comprehensive Annual Financial Report for the Fiscal Year Ended November 30, 2004*.
[11] Cook County Bureau of Health Services.
[12] *See* N. Kane and W. Wubbenhorst, *Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption*, The Milbank Quarterly, Vol. 78, No. 2, 2000.
[13] American Hospital Association, *Annual Survey, 2004*. (Community hospitals are defined as nonfederal, general short-term and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals).
[14] Illinois Hospital Association, *Illinois Hospitals as of September 2004*.
[15] Based on American Hospital Association Annual Survey data, 1990 – 2004.
[16] Based on U.S. Census Bureau data, 1990 – 2004.
[17] *Id.*
[18] *Id.* at 35.
[19] Congressional Budget Office, *Congressional Budget Office Cost Estimate: S. 1932, Deficit Reduction Act of 2005*, January 27, 2006.
[20] *See* The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*.
[21] The Center for Tax and Budget Accountability and Northern Illinois University, *The State of Working Illinois*, October 2005 *Id*, *The State of Working Illinois*, October 2005.
[22] See *Id.* (highlighting trends in Illinois' workforce).
[23] *Id.*
[24] 26 U.S.C. § 501.
[25] Rev.Rul. 56-185, 1956-1, C.B. 202.
[26] See *Sonora Community Hospital*, 46 T.C. 519 (1966); *Lorain Ave. Clinic*, 31 T.C. 141 (1958); and *Intercity Hospital Ass'n v. Squire*, 56 F. Supp. 472 (W.D. Wash. 1944).
[27] *See* Congressional Budget Office, *Health Care Trends and the Tax Treatment of Health Care Institutions*, August 1994.
[28] *See* D.M. Fox and S.C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, Journal of Health Politics, Policy and Law, 16 (1991), at 262.
[29] Rev. Rul. 69-545, 1969-2 C.B. 117 (1969).

[30] *Id.*
[31] See *Eastern Kentucky Welfare Rights Organization v. Simon*, 506 F.2d 1278 (D.C. Circuit 1974), *vacated on other grounds*, 426 U.S. 26 (1976).
[32] *But see*, Rev. Rul. 83-157, 1983-2 C.B. 94 (1983) (A non-profit hospital is not required to operate an emergency room when the state or local health planning agency has determined that it would be unnecessary and duplicate emergency services adequately provided by another medical institution in the community).
[33] *See* Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer, Key Facts About Americans Without Health Insurance*, November 2004; Kaiser Commission on Medicaid and the Uninsured, *Sicker and Poorer: The Consequences of Being Uninsured*, May 2002.
[34] *Id.*
[35] *See* D.U. Himmelstein, et al., *MarketWatch: Illness and Injury as Contributors to Bankruptcy*, Health Affairs, February 2005.
[36] Advisory from the Committee on Ways and Means, Subcommittee on Oversight, *Houghton Announces First Hearing in a Series on Tax Exemption: Pricing Practices of Hospitals*, June 15, 2004, http://waysandmeans.house.gov/hearings.asp?formmode=view&id=1673.
[37] 35 I.L.C.S. 5/201.
[38] 35 I.L.C.S. 2/205.
[39] 35 I.L.C.S. 120/1g.
[40] Constitution of the State of Illinois, Art. IX, § 6, 35 ILCS 200/15-10.
[41] See, e.g., *Methodist Old People's Home*, 39 IL2d 149 (1968), *Alivio Medical Center v. Illinois Department of Revenue*, 299 Ill. App. 3d 647 (1998), *Riverside Medical Center v. Illinois Department of Revenue*, 342 Ill. App. 3d 603 (2003),and *Eden Retirement Center v. Illinois Department of Revenue*, 213 Ill. 2d 273 (2004).
[42] *Sisters of the Third Order of St. Francis v. Board of Review of Peoria County*, 231 Ill. 317, 322 (1907).
[43] *Methodist Old People's Home*, at 156.
[44] In order to qualify for property tax exemption under the *Methodist* ruling, an Illinois non-profit hospital must show: (1) the use of the property benefits 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 organization has no capital, capital stock or shareholders, and earns no profits or dividends; (3) it derives its funds mainly from public and private charity and holds such funds in trust for the objectives and purposes expressed in its charter; (4) it dispenses 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; (5) the property is actually and factually so used; and (6) the exclusive (*i.e.*, primary) use of the property is for charitable purposes. *Id*.
[45] *See* Federal Register, Vol. 70, No. 33, February 18, 2005, for the 2005 poverty guidelines. (Under the federal poverty guidelines, a single person earning $9,570; a family of two earning $12,830, a family of three earning $16,090, and a family of four earning $19,350 are living in poverty, or 100 percent of the federal poverty level). Charity care policies are based on 100 percent, 200 percent, 300 percent, etc. of poverty.
[46] The Champaign County Board of Review's decision can be found at www.co.champaign.il.us/SOAOFF/PROVENA.pdf.
[47] *See* N. Kane, *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, Journal of Law, Medicine & Ethics, 26 (1998): 116-37 (discussing state and local challenges to non-profit hospital tax exemption and community benefit requirements). *See also*, Illinois Community Benefits Act, 210 I.L.C.S. 76.
[48] See *Id*.
[49] 210 I.L.C.S. 76.
[50] *Id*. at §§ 10, 20.
[51] *Id.* at § 10.
[52] *See* Community Catalyst, *Not There When You Need It: The Search for Free Hospital Care,* October 2003.
[53] 210 I.L.C.S. 76/10.
[54] American Hospital Association, *Uncompensated Hospital Care Cost Fact Sheet*, November 2005.
[55] *Id.* at 2.
[56] See also *Alivio Medical Center v. Illinois Department of Revenue*, 299 Ill. App. 3d 647 (1998) (bad debt is not tantamount to charity).
[57] See *Alivio Medical Center.*
[58] *Id. at 652.*
[59] Illinois Hospital Association, *Hospital and Health Care Financial Statistics*, September 15, 2005.

[60] *See* Appendix F for a list of the hospitals analyzed and Appendix G for those which the study was unable to obtain sufficient data for analysis.
[61] *See* the American Institute of Certified Public Accountants guidelines.
[62] *See* N. Kane and W. Wubbenhorst, *Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption*, The Milbank Quarterly, Vol. 78, No. 2, 2000.
[63] See *Id. at 193.*
[64] The information was obtained from numerous conversations with the Cook County Assessor's Office during 2005.
[65] The capitalization rate is based on numerous telephone conversations with the Assessor's Office.
[66] The average Cook County tax rate was calculated based on data reported by the Office of the Cook County Clerk, *Cook County Clerk Releases 2003 Tax Rates*, October 6, 2004.
[67] *See* W.N. Gentry and J.R. Penrod, *The Tax Benefits of Not-for-Profit Hospitals*, National Bureau of Economic Research (February 1998).
[68] *See* N. Kane, *supra*.
[69] Illinois Hospital Association, *Hospital and Health Care Financial Statistics*, September 15, 2005.
[70] See *Riverside Medical Center v. Department of Revenue*, 342 Ill. App. 3d 603, 610 (2003).
[71] *See* Office of the Attorney General, *Community Benefits Act Compliance Information*, February 4, 2004.
[72] *See* www.63.241..27.79/dsh00.pdf.
[73] Illinois Hospital Association, *Hospital and Health Care Financial Statistics*, September 15, 2005.