No. 107328

IN THE

SUPREME COURT OF ILLINOIS

PROVENA COVENANT MEDICAL CENTER and PROVENA HOSPITALS,	)	On Appeal from the Appellate Court of Illinois, Fourth District
Plaintiffs-Appellees-Petitioners,	)	No. 4-07-0763
v.	)	The Honorable THOMAS R. APPLETON Justice Presiding
THE DEPARTMENT OF REVENUE OF THE STATE OF ILLINOIS, and BRIAN A. HAMER, in his official capacity as DIRECTOR of the Illinois Department of Revenue,	)	There on Appeal from the Circuit Court of Sangamon County, Illinois
Defendants-Appellants-Respondents.	)	No. 06MR597
	)	The Honorable PATRICK J. LONDRIGAN Judge Presiding

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

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POINTS AND AUTHORITIES

STATEMENT OF INTEREST OF *AMICUS CURIAE*

The American Hospital Association ("AHA") on behalf of its members submits this brief *amicus curiae* in support of the Plaintiffs-Appellees-Petitioners Provena Hospitals and Provena Covenant Medical Center (collectively, the "Hospitals"). The Hospitals appeal the Appellate Court of Illinois (Fourth Judicial District)'s ruling reversing the Circuit Court of Sangamon County and reinstating the administrative decision by the Illinois Department of Revenue (the "Department"), through its Director, Brian A. Hamer, to deny the Hospitals a charitable property tax exemption.

Founded more than a century ago, the AHA is a national not-for-profit association that represents the interests of nearly 5,000 hospitals, health care systems, networks, and other care providers, as well as 37,000 individual members, all of whom are committed to finding innovative and effective ways of improving the health of the communities they serve. Among the AHA's broad membership are all types of not-for-profit hospitals and health care networks that serve individual patients and communities by providing care to those in need regardless of ability to pay. The AHA educates its members on health care issues and trends and advocates on their behalf in state and federal legislative, regulatory and judicial fora to ensure that its members' perspectives and needs are understood and taken into account in the formulation of health care policy.

Because of their abiding commitment to advancing the health of the communities they serve, the AHA's members have a great interest in the ultimate outcome of this case; indeed, the AHA participated as an *amicus curiae* before the Department, the Circuit Court, and the Appellate Court. Permitting the Department's final administrative decision to stand would seriously impair AHA members' ability to meet the essential

health care needs of their communities. The Circuit Court was correct to reverse the administrative decision; the Appellate Court was wrong to reinstate it. Upholding the Department's denial of a property tax exemption to the Hospitals – and thereby endorsing the unsound principle on which its decision rests – would throw into grave doubt the continued tax-exempt status of every not-for-profit hospital in Illinois. Should every not-for-profit hospital in Illinois be subjected to the same faulty rationale the Department invoked to deny these Hospitals a property tax exemption, the resulting financial drain on Illinois not-for-profit hospitals will jeopardize access to care in Illinois. The stakes in this matter are high. All Illinois citizens – but especially those who benefit from government-sponsored health programs like Medicare and Medicaid and those among the growing ranks of the uninsured – rely on not-for-profit hospitals to offer quality care to all. Nor is the effect of the Department's ill-considered decision likely to stop at Illinois' borders: If upheld, the Department's decision may well influence decisions by taxing authorities in other parts of the country.

In view of the far-reaching and serious implications of the Department's decision for AHA's members, AHA offers its views to aid the Court in its review of that decision.

ARGUMENT

Courts and policymakers around the country have long understood that tax exemption is vital to not-for-profit hospitals' ability to deliver essential care to the communities they serve. Tax exemption enables these hospitals to dedicate their earnings to advancing their charitable objectives by, among other things, increasing access to quality care, expanding the range of their services (many of which are themselves unprofitable), conducting research, educating health care professionals, instituting

programs to improve public health and to respond to unmet societal health needs, and upgrading facilities to provide state-of-the-art technology to all patients. Tax exemption is thus the foundation on which the long-standing relationship between government and not-for-profit hospitals has been built – and this foundation has remained firm in Illinois for nearly a century. *See Congregational Sunday Sch. & Publ'g Soc'y* v. *Board of Review*, 290 Ill. 108, 113, 125 N.E. 7, 10 (1919) ("The fundamental ground upon which all exemptions in favor of charitable institutions are based is the benefit conferred upon the public by them, and a consequent relief, to some extent, of the burden upon the state to care for and advance the interests of its citizens.").

The Department revoked the Hospitals' property tax exemption. According to the Department, the Hospitals' property was not devoted principally to a charitable purpose because the Hospitals provided an insufficient level of free care to patients. The Appellate Court's decision offered an equally truncated view. Neither the Department nor the Appellate Court examined or found relevant the Hospitals' other charitable activities – such as their Crisis Nursery, subsidy for graduate medical education, and volunteer classes and services – not to mention the huge number of Medicare and Medicaid patients the Hospitals serve and for which they are reimbursed, if at all, in an amount insufficient to cover their costs.

Both the Department's decision and the Appellate Court's ignore the policy rationale underlying the historic and crucial relationship between the government and not-for-profit hospitals. Their novel, narrow – and mistaken – concept of charitable purposes is one with serious potential to harm public health in Urbana and throughout Illinois, as well as cause ripple effects throughout the country.

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

The Court should reverse the Appellate Court and reject the Department's ill-considered administrative ruling denying the Hospitals a charitable property tax exemption. As the Circuit Court properly held below, a tax exemption is warranted.

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

Just as they did a century ago, not-for-profit hospitals today significantly "lessen[ ] the burdens of government," by, among other things, serving as an indispensable health care safety net for this country's uninsured and underinsured. *Crerar* v. *Williams*, 145 Ill. 625, 643, 34 N.E. 467, 470 (1893). That "safety net" is more important now than ever: Hospitals now "do more to assist the poor, sick, elderly and infirm than any other entity in the health care sector." *Taking the Pulse of Charitable Care & Community Benefits at Nonprofit Hospitals*, Hearing Before the S. Comm. on Finance, 109th Cong. 1 (2006) (statement of Kevin Lofton, Chairman-elect, Board of Trustees, AHA) ["AHA

Testimony"].[1] In a very real sense, hospitals represent the health care "backbone of the communities they serve," providing care twenty-four hours a day, seven days a week, 365 days a year to all those in need – irrespective of ability to pay. *Id.* at 1.

AHA's members understand and embrace the critical role not-for-profit hospitals play in our modern health care system. According to a national study on community benefit from 2006, "*[o]ne hundred percent* of the general/medical hospitals [surveyed] operate[ ] an emergency room" that provides care to "all members of the community regardless of the patient's ability to pay." *Community Benefit Information from Non-Profit Hospitals: Lessons Learned from the 2006 IRS Compliance Check Questionnaire, A Report Prepared for the AHA By Ernst & Young LLP*, Nov. 27, 2006, at i ["*Community Benefit Lessons Learned"*] (emphasis added);[2] *accord id.* at 3. The study similarly showed that *one hundred percent* of surveyed hospitals also offered preventative care and wellness programs designed to address unmet medical needs before they require treatment in an emergency room. *See id.* at ii & 5; *see also infra* 16-21 (describing such community health-oriented programs).

The same study demonstrated that not-for-profit hospitals' efforts do not end there. It showed that, in addition to emergency care facilities and preventative care programs, not-for-profit hospitals "provid[ed] uncompensated care to, on average, 12% of their total patients" in 2006, at a cost of approximately "$14 million per hospital." *See id.* at i-ii; *accord id.* at 4. And in 2007, hospitals absorbed more than $34 *billion* in uncompensated care costs, excluding the many billions more they spent on valuable community service

[1] *Available at* http://finance.senate.gov/hearings/testimony/2005test/091306kltest.pdf.

[2] *Available at* http://www.aha.org/aha/content/2006/pdf/061127-ErnstYcombenreport.pdf.

programs and other activities designed to promote and protect health and well-being. *See* AHA, *Uncompensated Hospital Care Cost Fact Sheet*, at 4 (Nov. 2008).[3]

The critical safety net that not-for-profit hospitals provide to their communities is increasingly important as the number of uninsured Americans has grown by nearly 50 percent over the last twenty years. The most recent Census Bureau figures from 2007 show that *45.7 million* Americans are uninsured. *See* Carmen DeNavas-Walt *et al.*, U.S. Census Bureau, Current Population Reports, *Income, Poverty, & Health Insurance Coverage in the United States: 2007*, at 19 (GPO Aug. 2008)[4]; *see also id.* at 20 (figure 6). Among these uninsured are approximately 8.1 million children. *See id.* at 20.

The rising tide of uninsured Americans over the last two decades – and the impact of their number on not-for-profit hospitals – cannot be viewed in isolation. Hospitals are facing ever-escalating operating costs. They must deliver care to an aging population while battling increased rates of chronic disease, facing health care worker shortages, ensuring disaster readiness of staff and equipment, and confronting the rising costs of medical liability insurance and prescription drugs. And while the Department's decision wholly discounts the mounting underpayments from government health care programs to not-for-profit hospitals providing care to the indigent, elderly, and others served by the programs, A55, the true relevance of these hospitals cannot be understood without taking that issue into account.

In 2007, 58 percent of hospitals lost money treating Medicare patients; 67 percent lost money treating Medicaid patients. *See* AHA, *Underpayment By Medicare &*

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[3] *Available at* http://www.aha.org/aha/content/2008/pdf/08-uncompensated-care.pdf.

[4] *Available at* http://www.census.gov/prod/2008pubs/p60-235.pdf.

Medicaid Fact Sheet, at 2 (Nov. 2008).[5] The reimbursement numbers explain why: For every dollar spent on Medicare patients in 2007, a hospital recovered 91¢. *Id.* And hospitals recovered only 88¢ per dollar spent on Medicaid patients that year. *Id.* This chronic under-reimbursement translated into a total shortfall of $21.5 billion for Medicare patients and $10.4 billion for Medicaid patients – in a single year. *Id.* at 3. The upshot of these profound shortfalls is not surprising: Thirty percent of these hospitals sustained negative operating margins in 2007 – meaning fully a third of them lost money on their hospital operations. *See* AHA, *Analysis of AHA Annual Survey Data 2007*. Without not-for-profit hospitals' abiding commitment to their communities, governments alone would be required to meet their communities' health care needs, at staggering cost.

When these realities are viewed together, one ineluctable conclusion emerges: measuring only a single component of the Hospitals' charitable purposes, as the Department did, improperly excludes from consideration several other important components of its charitable mission and demonstrates a profound misunderstanding of the myriad charitable benefits that not-for-profit hospitals bring to their communities today. A41. Not-for-profit hospitals like those in this case provide far more than "[i]ncidental acts of beneficence." A53. In fact, a realistic appraisal of the current health care environment makes clear that not-for-profit hospitals currently do more to relieve the burdens of government than did their century-old counterparts, when Illinois first exempted not-for-profit hospital property from taxation. Experts on the topic recognize that charity care provided by hospitals today is "all that stands between a thorny policy dilemma and an access crisis for millions of Americans." PricewaterhouseCoopers,

[5] *Available at* http://www.aha.org/aha/content/2008/pdf/08-medicare-shortfall.pdf.

Health Research Institute, *Acts of Charity: Charity Care Strategies for Hospitals in a Changing Landscape* (PWC, *"Acts of Charity"*), at 1 (2005)[6]; AHA Testimony at 5.

II. THE DEPARTMENT ADVANCED, AND THE APPELLATE COURT ENDORSED, A FAR TOO LIMITED VIEW OF NOT-FOR-PROFIT HOSPITALS' CHARITABLE PURPOSES.

It is undisputed that these Hospitals do not profit from delivering medical care to patients. But according to the Department, in a comment later echoed by the Appellate Court, the "primary basis" for denying the Hospitals request for a tax emption is that they provided a mathematically "insufficient" level of free care in 2002 to merit a tax exemption. A41, A46. Using this simplistic – and profoundly mistaken – assumption as the starting point, the Department marched through the guidelines from *Methodist Old Peoples Home* v. *Korzen*, 39 Ill. 2d 149, 156-157, 233 N.E.2d 537, 541-542 (1968), to conclude that the Hospitals do not qualify for a tax exemption.[7] But by reducing the analysis to consideration of a single aspect of a not-for-profit hospital's charitable purposes – the amount of free care provided – the Department improperly disregarded the broad and flexible definition of charity followed in this and other states.

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

In the final administrative decision, the Department concluded that it would "defy logic" to grant the Hospitals a property tax exemption given that their primary purpose is the exchange of medical services for fees – not charity. A54. Its "primary basis" for this finding was the fact that the medical center's 2002 revenues exceeded $113 million while

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[6] *Available at* http://www.pwc.com/extweb/pwcpublications.nsf/docid/1766F3BFD7D4C80A8525726F007E46F6.

[7] The Appellate Court similarly focused only on the dollar value of "free care." A20-A24.

the Department viewed the cost incurred for the Hospitals' "charitable activities" as "only $831,724." A41. *See also* A5. The Department's view appears to boil down to a dollar comparison between the $831,724 that the provision of free care cost the Hospitals (according to the Department) and the $1,100,000 in property tax for which the Hospitals sought an exemption. A52-A53. It is clear that the sole charitable activity the Department considered was the cost of the medical center's charity care – not the numerous other charitable activities undertaken by the Hospitals. A45.

The Department has it quite wrong. The Hospitals' charitable activities extend well beyond the singular metric used by the Department, and the "cost" to the hospitals of providing charitable benefit to their communities was higher by several orders of magnitude than the sum attributed to the Hospitals by the Department. By focusing narrowly and exclusively on the quantity of free care provided by the Hospitals, the Department adopted a view of charity that breaks faith with the broad range of charitable undertakings entitled to property tax exemption that this state has employed for a century. *See Sisters of Third Order of St. Francis* v. *Board of Review*, 231 Ill. 317, 321, 83 N.E. 272, 273 (1907) ("It is an institution of public charity; and where an institution devoted to beneficence of that character is * * * exempt from taxation, it does not lose its immunity by reason of the fact that those patients received by it who are able to pay are required to do so, * * * so long as all the money received by it is devoted to the general purposes of the charity, and no portion of the money received by it is permitted to inure to the benefit of any private individual * * * ."); *see also Lutheran Gen. Health Care Sys.* v. *Department of Revenue*, 231 Ill. App. 3d 652, 664, 595 N.E.2d 1214, 1222 (1992) ("The [Illinois Supreme Court] has also held that the fact that an institution charges fees for its

services from those who are able to pay does not preclude exemption where no profit is made and the amounts received are applied in furthering the institution's charitable purpose."). In Illinois, "[c]harity, in the legal sense, is not confined to mere almsgiving or relief of poverty and distress, but has a wider signification, which embraces the improvement and promotion of the happiness of man." *Congregational Sunday Sch. & Publ'g Soc'y*, 290 Ill. at 113, 125 N.E. at 10.

The Department's narrow and novel "free care" test – now stamped with the Appellate Court's blessing – not only marks a departure from Illinois precedent, but it sets Illinois on a path seriously out of step with the mainstream view of charity shared by a majority of states[8] and the federal government.[9] As AHA has pointed out elsewhere,

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[8] Consideration of other states' views is particularly appropriate here since the various states' charity laws – including Illinois' – descend from a common English ancestor. *See* Charles A. Borek, *Decoupling Tax Exemption for Charitable Organizations*, 31 Wm. Mitchell L. Rev. 183, 195 (2004) ("As the preeminent English exposition on the law of charity, the Statute of Charitable Uses became the principal source of such law in the United States after the American Revolution. * * * [T]he most important perspective inherited from the English law was its expansive view of what was 'charitable.' "); *Taylor* v. *Keep*, 2 Ill. App. 368, 1878 WL 10421, at *6 (1878) ("The words *charity* and *charitable uses*, at least in this State, where the statute * * * commonly known as the Statute of Charitable Uses, is held to be in force, must be determined with reference to the provisions of that statute.").

[9] The federal government, recognizing that not-for-profit hospitals must be flexible and creative in tailoring their services to the communities they serve and that "free care" is only one aspect of their charitable activities, has also adopted a broad definition of "charity" for determining hospital exemptions under 26 U.S.C. § 501(c)(3). The IRS has stated that "[t]he promotion of health * * * is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community." Rev. Ruling 69-545 (1969). In accord with this expansive view of charity, the current IRS Form 990, the annual information return submitted by exempt organizations, includes a Schedule H for tax-exempt hospitals that requires the hospitals report, among other things, the community benefit they provide through free care, health improvement, education, research, patient bad debt, and Medicare underpayments. *See*, IRS, Instructions for Form

courts across the country, in decisions stretching back far into the last century, have uniformly rejected the "free-care" standard the Department invoked here to deny the Hospitals a property tax exemption. *See* AHA Testimony at 3; *see also, e.g., Harvard Cmty. Health Plan, Inc.* v. *Board of Assessors*, 427 N.E.2d 1159, 1163 (Mass. 1981) ("[T]he promotion of health, whether through the provision of health care or through medical education and research, is today generally seen as a charitable purpose."); *Community Mem. Hosp.* v. *City of Moberly* 422 S.W.2d 290, 297 (Mo. 1967) (Non-profit hospital entitled to tax exemption where "the purpose of respondent here is not to make profits but to devote any income in its operation to the charitable purpose of operating a hospital for the benefit of all who come to its doors whether as pay or indigent patients."); *Nuns of Third Order of St. Dominic* v. *Younkin*, 235 P. 869, 872 (Kan. 1925) ("[I]t is uniformly held that [a] hospital is conducted exclusively for charitable purposes" when its earnings from "whatever source are used in the maintenance, extension, and improvement of the hospital.").

Nearly fifty years ago, for example, the Virginia Supreme Court declared that "[a] tax exemption cannot depend upon any such vague and illusory concept as the percentage of free service actually rendered," but where not-for-profit hospitals are concerned, depends instead upon "the nature of the[se] institutions and the purpose of their operations." *City of Richmond* v. *Richmond Memorial Hosp.*, 116 S.E.2d 79, 81-82 (Va. 1960). That court concluded that "[n]on-profit hospitals which are devoted to the care of the sick, which aid in maintaining public health, and contribute to the advancement of medical science are and should be regarded as charities." *Id.* at 84.

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990 Schedule H (Hospitals) (Dec. 2008), *available at* http://www.irs.gov/pub/irs-pdf/i990sh.pdf.

Time has not taken a toll on this view. To the contrary, the passage of time has only strengthened states' broad definition of charity: Even today, courts across the country adhere to the expansive view of charity espoused in cases like *Richmond Memorial*. *See, e.g.*, *New Habitat, Inc.* v. *Tax Collector of Cambridge*, 889 N.E.2d 414, 420 (Mass. 2008) (where organization's purpose is a traditionally charitable one, such as relief of suffering for injured individuals, "the organization may charge substantial, reasonable fees for its services" and remain tax-exempt so long as "all fees and revenue derived from the property are expended solely for the successful operation of the [organization]"); *ElderTrust of Fla., Inc.* v. *Town of Epsom*, 919 A.2d 776, 783 (N.H. 2007) (holding that "charging fees" does not prevent charitable tax exemption "as long as the fees 'directly fulfill the organization's charitable purpose, or are necessary for the organization to accomplish its purpose' ") (citation omitted); *Mingledorff* v. *Vaughan Reg'l Med. Ctr., Inc.*, 682 So.2d 415, 422 (Ala. 1996) (holding that "hospitals * * * whose overall objective is to provide health services to the public at large, with no reservation as to those who cannot afford to pay and with no eye toward the attainment of profit or private advantage" qualify for exemption); *Eyota Kid's Korner, Inc.* v. *County of Olmsted*, 1992 WL 389787, at *3 (Minn. Tax Ct. Dec. 29, 1992) (explaining that " '[p]urely public charity' has been given a broad meaning in many other Minnesota exemption cases" and collecting cases).

The Supreme Court of Michigan, in a case remarkably similar to the one under review, likewise recently rejected a strict ledger-based analysis of the sort employed by the Department. *See Wexford Med. Group* v. *City of Cadillac*, 713 N.W.2d 734, 736 (Mich. 2006) (rejecting focus "on the amount of free medical services" provided because

"[a] 'charitable institution' need not meet any monetary threshold of charity to merit the charitable institution exemption" so long as "the overall nature of the institution is charitable"). That court recognized that limiting the focus to the number of patients provided free care would overlook the provider's other significant endeavors to further public health through a variety of health-based community services, educational services, and efforts to treat communicable diseases like HIV-AIDS and hepatitis and maladies like diabetes and obesity. *Id.* at 737.

As the Supreme Court of Alaska aptly put it, "[i]t is quite clear that what is done out of good will and a desire to add to the improvement of the moral, mental, and physical welfare of the public generally comes within the meaning of the word 'charity.' " *Fairbanks North Star Borough* v. *Denά Nenά Henash*, 88 P.3d 124, 132 (Alaska 2004) (internal quotation marks & citation omitted). That court, emphasizing that the "concept of charity – as an activity that improves public welfare – reflects the public policy behind tax exemptions," went on to hold that "[c]haritable activities provide a public benefit *whether or not* the beneficiaries are indigent." *Id.* at 135 (emphasis added).[10]

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[10] Numerous decisions from states around the country have come to a similar conclusion. *See Western Mass. Lifecare Corp.* v. *Board of Assessors*, 747 N.E.2d 97, 104 (Mass. 2001) ("An organization does not necessarily have to serve the poor or needy in order to qualify for the charitable exemption."); *Under the Rainbow Child Care Center, Inc.* v. *County of Goodhue*, 741 N.W.2d 880, 890, 895 (Minn. 2007) (The concept of charity "in the context of tax exemptions does not require that the charitable benefit be provided to all recipients entirely free of charge," so long as some services are provided on a charitable basis.); *Carroll Area Child Care Ctr., Inc.* v. *Carroll County Bd. of Review*, 613 N.W.2d 252, 255, 259 (Iowa 2000) ("[T]his state is committed to the broad definition of charity" as " 'encompass[ing] all humanitarian activities' " and is "not limited to the needy.") (citation omitted); *Plainfield Elks Lodge No. 2186* v. *State Bd. of Tax Comm'rs*, 733 N.E.2d 32, 34, 36 n.6 (Ind. Tax Ct. 2000) (The definition of "charity" does not "turn[ ] on the percentage of its gross income used for charitable, educational or other

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

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

The rigid "free care" test the Department presses here completely disregards important aspects of not-for-profit hospitals' charitable purposes. While it recognized that, as a "general proposition," "a hospital and the services it offers may improve the well being of the community in which it operates," the Department nevertheless concluded that "[p]roperty tax exemptions do not turn on these general propositions." A55-A56. The Appellate Court similarly dismisses these contributions. A26-A27. But in simply writing off the community benefits provided by the Hospitals as an irrelevant "general proposition," A55-A56, the Department and the Appellate Court shut their eyes to fundamental aspects of charitable care that not-for-profit hospitals provide to their communities.

Recognizing that community involvement is key to not-for-profit hospitals' charitable objectives, many states – including this one – actually *require* them to file annual reports detailing the community benefits they provide. *See, e.g.*, Cal. Health & Safety Code § 127345; Idaho Code Ann. § 63-602D(7); 210 Ill. Comp. Stat. 76/20. For its part, the AHA affirmatively encourages its members to tailor their care to their local

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benevolent purposes."); *Evangelical Lutheran Good Samaritan Soc'y* v. *County of Gage*, 151 N.W.2d 446, 449 (Neb. 1967) (" '[T]he courts have defined "charity" to be something more than mere alms-giving or the relief of poverty and distress, and have given it a significance broad enough to include practical enterprises for the good of humanity.' ") (quotation omitted).

communities' needs and, toward that end, "passed a resolution calling on hospitals to take steps to foster additional community involvement and to increase transparency in the service of that benefit." AHA Testimony at 4; *see also* Letter from Rich Umbdenstock to Chief Executive Officers, AHA Member Institutions, *Reporting Community Benefit – Policy Clarification & Guidance* 1 (Sept. 7, 2006) ("AHA believes it is essential that every hospital voluntarily, publicly and proactively report its community benefit.").

Hospitals have responded to this call. In a 2006 survey of 132 not-for-profit hospitals, the AHA found that "[o]ne hundred percent of the [surveyed] hospitals indicated that they provide additional community programs in addition to uncompensated care and charity care programs, including such offerings as community medical screening programs, immunization programs and health education." *Community Benefit Lessons Learned* at ii; *accord id.* at 5. Many of these efforts are directed at wellness and preventative care – that is, they aim to address members of their communities' unmet basic care needs and chronic conditions before they require emergency treatment at a hospital. *See, e.g.*, AHA, TrendWatch, *Coverage Counts: Supporting Health & Opportunity for Children*, at 6 (Feb. 2007) (discussing importance of programs aimed at improving access for uninsured children to preventative care). Toward this end, more than half of the surveyed hospitals performed studies on the unmet health care needs within their communities, while nearly 90 percent had programs to improve access to health care for the uninsured, and over 90 percent "produce[d] or distribute[d] newsletters or other publications that provide information to the community on health care issues." *Community Benefits Lessons Learned* at 5.

The Hospitals in this case have also responded to their communities' critical health care needs through specially tailored programs. For just one example, as the Department found, the Hospitals sponsor the Crisis Nursery of Champaign/Urbana, which "is an emergency shelter and a child abuse and neglect prevention center." A67 (finding 49). This unique program operates 24 hours a day and "provides food, clothing, and safe and confidential care for children from birth to 5 years old at no cost to individuals in need of help." *Id.*; *see also* Crisis Nursery – Urbana-Champaign, Programs & Services, *available at http://www.crisisnursery.net*. The Hospitals also provide graduate medical education and classes and services to the community at large, among other charitable contributions. A109 (finding 174). The Department itself stipulated that "[a] nonprofit hospital may confer a community benefit and lessen the burdens on government through acts of charity other than the provision of free or discounted medical care." A67 (finding 48).

Other not-for-profit hospitals have similarly implemented a variety of creative health care solutions directly responsive to the unique health care problems facing their communities, including preventative care programs. For example, recognizing that low-income children lacked access to dental care in a multi-county area of northeastern Pennsylvania, Wayne Memorial Hospital in Honesdale, Pennsylvania opened a dental clinic in 1995 with full-time staffing. "The clinic provides needed dental health services for approximately 5,000 low-income children in a multi-county area of Northeast Pennsylvania. * * * Without this program, many of the children currently served at the clinic would not get preventive oral health care or even needed treatment for tooth decay." *Caring For Communities, Hospitals in Action, Case Examples, at*

http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/case examples/access/2008/waynememorialhospital.html.

Wayne Memorial Hospital does not stand alone in offering community-based care programs targeted to local community needs:

- With over 22 percent of the adult population identifying as smokers in Michigan, Mercy Memorial Hospital System in Monroe, Michigan opened "[a] free smoking cessation program that includes counseling and medication, such as nicotine patches and newer drugs when they are available." *Caring For Communities, Hospitals in Action, Case Examples*, *at* http://www.caringforcommunities.org/caringfor communities/hospitalsaction/caseexamples/health/2008/mercymemhospsys.html. This program is open to all members of the community who wish to quit smoking; hundreds have come through the program, which had a quit rate in 2006 and 2007 well above the national success rate for smoking cessation programs. *Id.*

- Recognizing the need to streamline investigations of child abuse so that abused children only need to make a single statement to a single interviewer, the Shore Health System in Easton, Maryland opened the Children's Advocacy Center at Memorial Hospital to provide an effective, collaborative forum for investigating child abuse in the Mid-Shore area. In partnership with the Talbot County Department of Social Services, the Center has investigated over 150 cases of child abuse in a five-county area since its creation in 2003. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/case examples/social/2008/shorehs.html.

- In an effort to combat the problem of millions of Americans with undiagnosed diabetes, King's Daughters Hospital in Temple, Texas, has established an annual free drive-thru diabetes screening where community members can be screened for diabetes without leaving the comfort and privacy of their vehicle; each year some participants have been diagnosed with diabetes. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/ hospitalsaction /caseexamples/health/2008/kingsdaughters.html.

- To combat obesity and limit the progression of diabetes, Kings County Hospital Center in Brooklyn, New York, operates a hospital-based fitness center that provides patients with free, supervised programs of exercise training. Its Wellness Center recorded over 3,400 patient visits in 2006 in its effort "to limit progression of disease severity, improve symptomatology, increase functional capacity, promote health by reducing risk factors for cardiovascular disease, and encourage individuals to lead a more physically active lifestyle." *Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/ hospitalsaction /caseexamples/health/2008/kingscounty.html.

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

- After discovering that many individuals have forgone prescription drug assistance for which they otherwise qualified simply because of the cumbersome application process involved, Concord Hospital in Concord, New Hampshire, instituted a Prescription Assistance Program in 2000. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2007/concord.html. The Program has obtained 90,000 medications for 4,100 patients, thus helping "low-income families in 47 local communities receive more than $25.5 million in needed medications." *Id.*

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

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

- Saint Vincent's Hospital in Manhattan operates the SRO/Homeless Program, which "[p]rovides outreach, direct medical, mental health and substance abuse services, health education and screenings, case finding and case management" to Manhattan's homeless and marginally housed. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/caseexamples/social/2006/saintvincentsny.html.

- Northern Hospital of Surry County opened one of the first free medical clinics to serve the medical needs of the indigent population in 1993. Medical care, including free lab work and x-rays, is provided to 40-50 patients per week by volunteering doctors and nurses, all of whom are on staff at Northern Hospital of Surry County. *See Caring For Communities, Hospitals in Action, Case Examples, at* http://www.caring forcommunities.org/caringforcommunities/hospitalsaction/caseexamples/access/2008/ nohospsurryco.html.

Not-for-profit hospitals also conduct important medical research and provide crucial medical training. Approximately one-third of AHA's not-for-profit hospital members conduct medical research, "with those hospitals spending an average of $19 million on the medical research programs." *Community Benefit Lessons Learned* at 4. Another "[f]orty-two percent * * * conduct[ ] medical trial studies," and yet another "[s]ixty-four percent * * * conduct[ ] professional medical education and training programs," with these hospitals spending an average of $7 million annually. *Id.* The Northwestern Memorial Hospital, for example, invested $40.6 million in medical education and training and $39.7 million in research during 2007 alone. *See* Northwestern Mem. Hosp., *2007 Cmty Serv. Report* at 2, 10-11.[11] This substantial investment allowed the hospital to train more than 800 medical students, residents, and fellows, as well as to launch more than 500 new research studies. *Id.* at 10-11. Similarly, in 2007, the Cleveland Clinic dedicated over $151 million to the medical education of more than 1,000 interns, residents, and fellows and almost $55 million to medical research (not including grants and other funding), with over 300 researchers conducting

[11] *Available at* http://www.nmh.org/nmh/pdf/nmh_2007_csr.pdf.

more than 2,000 wide-ranging clinical trials focused on conditions ranging from breast and liver cancer to coronary artery disease, Parkinson's disease, asthma, diabetes, depression, and eating disorders. *See* Cleveland Clinic, *Community Outreach Report 2007* at 23, 27, 28 Cleveland Clinic, Community Benefits.[12]

None of these community benefits programs would be considered relevant to the Department's and Appellate Court's analysis of whether hospitals were operating as "charitable" entities. Yet *all* of these programs are and remain critical to the areas these hospitals serve. They are creatively tailored to meet identified community needs. They are conceived and implemented with compassion for the plight of the less fortunate members of the surrounding community. And they most certainly are *not* the mere "general proposition" (A55-A56) the Department claims; these and other programs are concrete testaments to creative and compassionate care for those most in need.

Not-for-profit hospitals also serve and benefit their communities in ways far beyond this representative discussion of diverse community care initiatives. Notwithstanding the Department's discounting of the more than $10.5 million in unreimbursed care the Hospitals provided to Medicaid and Medicare patients and the additional millions of dollars of "bad debt" that they, like all not-for-profit hospitals incur annually in caring for their communities' poorest members (A109 (finding 76); A54-A55), these contributions also significantly further not-for-profit hospitals' charitable

[12] *Available at* http://my.clevelandclinic.org/Documents/Community%20Relations/Community%20Connections_07.pdf *and* http://my.clevelandclinic.org/about/community/report.aspx.

purpose.[13] *See* United States Government Accountability Office, Report 08-880, *Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements* at 28 (Sept. 2008) (documenting percentages of surveyed nonprofit hospitals' total operating expenses devoted to charity care, bad debt, and unreimbursed Medicare and Medicaid costs). Courts from a number of states have recognized this fact, and Illinois should do the same. *See Wexford Medical Group*, 713 N.W.2d at 747 (because "the reimbursements petitioner receives from government funding fall well short of defraying the costs petitioner incurs to render medical care," "not only are Medicare and Medicaid patients receiving a gift from petitioner, but petitioner is not fully recouping its costs from the government"); *accord McLaren Reg'l Med. Ctr.* v. *City of Owosso*, 738 N.W.2d 777, 786 (Mich. App. Ct. 2007) (following *Wexford*); *St. Margaret Seneca Place* v. *Board of Prop. Assessment Appeals & Review, County of Allegheny*, 640 A.2d 380, 384 (Pa. 1994) (rejecting argument that government shortfalls should not be considered part of provision of charitable care; under open admission policy, "[i]f there is a vacant bed and the next applicant is a Medicaid recipient, that applicant will be accepted, despite the understanding and expectation that this causes financial loss to the institution"); *Lewistown Hosp.* v. *Mifflin County Bd. of Assessment Appeals*, 706 A.2d 1269, 1272 (Pa. Cmwlth. Ct. 1998) (rejecting argument that Medicare and Medicaid shortfalls should not be counted as part of hospital's charity care).[14]

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[13] *See supra* n.9 (discussing how federal government's broad definition of "charity" for determining hospital exemptions under 26 U.S.C. § 501(c)(3) incorporates unreimbursed care and community care initiatives).

[14] Illinois already recognizes – by statute – that the "unreimbursed cost to a hospital or health system of providing * * * government-sponsored indigent health care * * * [and]

Hospitals must provide care to Medicare and Medicaid patients in order to secure a federal tax exemption. *See* AHA, *Underpayment By Medicare & Medicaid Fact Sheet*, at 1 (Nov. 2008). The cost of providing this care – reimbursed in 2007 at 91¢ on the dollar for Medicare and 88¢ on the dollar for Medicaid – has dramatically increased this decade: from a $3.8 billion underpayment to hospitals in 2000 to a $31.9 billion underpayment in 2007, an increase of *over 730 percent*. *Id.* at 2.[15] Even as hospitals lose money for providing care to these patients, the number of such patients seeking care is growing every year. Carmen DeNavas-Walt, *et al*., *Income, Poverty & Health Insurance Coverage in the United States: 2007*, at 19 (noting that in 2007, "the number of people covered by government health insurance increased to 83.0 million, up from 80.3 million in 2006").

As a result of underpayments for caring for Medicare patients, a recent report to Congress warned that hospital margins for treating this patient group would reach *negative* 4.4 percent in 2008. *See* Medicare Payment Advisory Comm'n, *Report to Congress: Medicare Payment Policy*, at xii, 46, 60 (Mar. 2008). Not-for-profit hospitals are willing to sustain these negative margins because of their commitment to caring for

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government-sponsored program services" are part of the package of "community benefits" that a not-for-profit hospital brings to its community. 210 Ill. Comp. Stat. 76/10. Other states agree. *See*, *e.g.*, Cal. Health & Safety Code § 127345 ("community benefit" includes "[h]ealth care services, rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Childrens Services Program, or county indigent programs"); Ind. Code 16-21-9-1 (" 'community benefits' means the unreimbursed cost to a hospital of providing charity care, government sponsored indigent health care, donations, education, government sponsored program services, research, and subsidized health services").

[15] Like the IRS, many states affirmatively require not-for-profit hospitals to report underpayments for care to Medicare patients; they recognize the charitable nature of providing such care to the elderly and the impoverished within their communities. *See, e.g.*, Idaho Code Ann. § 63-602D(7); N.H. Rev. Stat. Ann. § 7:32-e(V).

our nation's most vulnerable citizens; roughly half of the Medicare patients a hospital treats are elderly patients with incomes at or below 200 percent of the federal poverty level. *See id.* at 11.

By the same token, the bulk of a hospital's "bad debt" results from providing care to low-income patients who, for any number of reasons, fail to establish their eligibility to receive charity care or other forms of financial assistance. A recent report confirms that studies have shown that "the great majority of [hospitals'] bad debt was attributable to patients with incomes below 200% of the federal poverty level." Congressional Budget Office, *Nonprofit Hospitals & the Provision of Community Benefits*, at 10 n.34 (Dec. 2006). This finding, the report concluded, warrants consideration of not-for-profit hospitals' bad debt in measuring the extent of their community benefits. *See id.*; *see also* PWC, *Acts of Charity* at 2 (finding that hospitals do not report the "true value of the charity care" they provide because of "[t]he burdensome and expensive process that hospitals must go through to classify a patient as charity care often means the amount of charity care blurs with bad debt" and that "92% of hospitals surveyed said that at least part of their bad debt could be classified as charity care"); *accord id.* at 10 (explaining that charity care is "underestimated because of the difficulty in qualifying patients and the complications surrounding sliding scale discounts"); IRS, *Form 990 Redesign for Tax Year 2008*, *supra* n.9, at 3 ("Under current financial reporting standards, many organizations have a difficult time determining whether certain expenses are properly charity care or bad debt, because they are unable to obtain the information required to classify charity care expenses properly and timely for financial reporting purposes.").

*** * ***

Neither the Department nor the Appellate Court paid any heed to any of the substantial charitable contributions made by not-for-profit hospitals – whether they be community care and outreach, Medicare and Medicaid underreimbursement, or bad debt. A24-A26; A54-A56; A68-A73. Thus, the Department and the Appellate Court ignore the full scope and depth of the charity that not-for-profit hospitals such as those involved in this case provide to their communities. The consequence of this is obvious: The Department's invocation of a "free-care" test to deny the Hospitals a property tax exemption can "only be described as a triumph of form over substance." *Lutheran Gen. Health Care Sys.*, 231 Ill. App. 3d at 662, 595 N.E.2d at 1222.

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

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

First, the Department mistook effective management for lack of a charitable purpose when it took issue with the disparity between the Hospitals' revenues and the amount of "free care" it provided. *See, e.g.*, A41, A45, A51, A54. Not-for-profit hospitals are "not required to use only red ink in keeping [their] books and ledgers," *Milwaukee Protestant Home for the Aged* v. *City of Milwaukee*, 164 N.W.2d 289, 294 (Wis. 1969), and the fact that "a given charity manages, through * * * careful management, to generate a surplus while carrying out its charitable purposes does not necessarily deprive the charity of a property tax exemption," *Fairbanks North Star*

Borough, 88 P.3d at 131.[16] As one commentator—a professor at the University of Illinois College of Law—has articulated it :

> In capital-intensive organizations such as hospitals, profits are necessary to set aside money in excess of depreciation for future replacement of plant and equipment, to provide contingency funds for unforeseen liabilities, and to invest in improved services. Even if a nonprofit targeted a "break-even" operation, prudent budgeting would often produce a profit: no managing board would properly execute its duty of care if it approved a budget without some cushion for unexpected expenses or lower than expected revenues. [John D. Colombo, *Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps*, 37 Loy. U. Chi. L. Rev. 493, 517 (2006) (footnote omitted).]

Indeed, "[t]o deny an otherwise qualifying institution charitable status because it is efficiently organized and managed, so as to operate in the black, would be not only illogical but also extremely detrimental to the incentive for sound management in such institutions." *Milwaukee Protestant Home*, 164 N.W.2d at 294 n.11 (internal quotation marks & citation omitted). This is in part because a not-for-profit hospital that cannot cover its costs will obviously go out of business, *see* Colombo, *supra*, at 513, but also because "the profit made by these institutions, if any, is payable to nobody" – it is instead "turned back into improving facilities or extending the benevolence in which the institutions are primarily engaged." *Milwaukee Protestant Home*, 164 N.W.2d at 295. Accordingly, "the profit element [is] immaterial." *Id.* (internal quotation marks & citation omitted). The tax law of this State would be misguided if it penalized not-for-profit entities for attempting to maintain a healthy operating margin.

[16] In a not-for-profit hospital, any "surplus" the hospital receives in a given year stays within the hospital's reserves and helps guard against shortfalls that will likely result in other years. Not-for-profit hospitals are unlike for-profit companies, which distribute profits into the pockets of those who invested in the company.

Second, in finding the Hospitals' primary purpose was the exchange of medical services for fees, the Department placed undue emphasis on the nominal amount of donations received by the Hospitals, stressing that they received "virtually no funds from public and private donations." A50-A51. The Appellate Court, while acknowledging that to view the absence of donations dispositive would "effectively end the charitable exemption for nonprofit hospitals," nevertheless held this factor against the Hospitals. A12. That perspective ignores the reality that "[t]here are many charities which rely on generating their own income apart from contributions; most hospitals and nursing homes no longer rely on charity, but are self-sustaining." *Dental Home Care, Inc.* v. *Commissioner of Revenue*, 1978 WL 1009, at *8 (Minn. Tax Ct. May 15, 1978). Consequently, "[m]aking significant donations a central part of the test for property tax exemption * * * would be the equivalent of ending exemption for most hospitals and other health care providers." Colombo, *supra*, at 520. This Court should reject the Department's use of such an anachronistic standard in denying the Hospitals a charitable tax exemption.

Third, the Department looks askance at the Hospitals' reliance on third-party providers to deliver care to patients. A46. Once again, this is error. Reliance on third-party providers is a longstanding and accepted practice employed by hospitals around the country. *See* Colombo, *supra*, at 521-522 ("Charities contract with for-profit entities for all sorts of common services in order to perform their charitable function."); *see generally* Barry R. Furrow *et al.*, 1 *Health Law* 109-110 (West 2d ed. 2000) ("For many years, physicians have provided hospital-based medical services * * * under contract with hospitals."). Thus, "if using independent for-profit contractors to help provide services

endangers [property tax] exemption, then virtually all charitable organizations are at risk." Colombo, *supra*, at 522. In this case, the Department's findings of fact recognized not only that all patients who seek health care are provided health care (A62, finding 22), but also that less than six percent of the main hospital building was used by for-profit entities (A73, finding 80). Accordingly, that a small percentage of the Hospitals' property is used by third-party health care providers to provide care to patients cannot reasonably undermine the requested property tax exemption.

Finally, the Department's and Appellate Court's criticism of the Hospitals' charity care policy as lacking sufficient nuance is misplaced. A22, A49-A50. In 2002, the year at issue, hospitals around the country – including these Hospitals – "were unsure whether they could offer discounts *at all* because of Medicare regulations around uniform rates and anti-kickback statutes." PWC, *Acts of Charity* at 15 (emphasis added). AHA asked the federal government to respond to this uncertainty. In February 2004, the federal government did. The Office of the Inspector General ("OIG") and the Centers for Medicare and Medicaid Services ("CMS") both issued guidance confirming that hospitals could offer free or discounted care to uninsured patients without running afoul of federal law or risking loss of Medicare reimbursements. *Id.*; *see also* Office of Inspector General, HHS, *Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills* (Feb. 2, 2004);[17] CMS, *Questions on Charges for the Uninsured* (Feb. 17, 2004).[18] Until this guidance had been issued, it makes no sense to chastise hospitals for not applying free and discounted care more broadly, or with more "nuance."

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[17] *Available at* http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA021904 hospitaldiscounts.pdf.

[18] *Available at* http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_ Uninsured.pdf

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

The Department's inflexible free-care approach to property tax exemption for not-for-profit hospitals may result in some short-run benefits. It will produce a slightly longer tax roll and, by extension, a slightly larger public fisc. But that circumstance will not last long, as hospitals seek ways to meet their new tax liability. In the end, the effects of not-for-profit hospitals' increased tax liability will be felt most acutely by the communities those hospitals serve. These communities' health care needs will not disappear along with not-for-profit hospitals' tax exemptions. And with government support for not-for-profit hospitals removed, government itself may ultimately have to meet these needs – at its own expense.[19]

Not-for-profit hospitals facing a new property tax burden must fund that additional liability from somewhere. Hospitals may initially attempt to pass their new tax burden along in the form of higher charges to be borne by insurance companies in the first instance; the insurers will, however, ultimately pass these added costs along as well to their enrollees, including employers who purchase health insurance for their employees.

But, in many areas, hospitals will face difficulties passing these added costs along to commercial health plans that wield significant bargaining power in the health care marketplace. These commercial health plans are unlikely to share in the new burden imposed on not-for-profit hospitals. And hospitals that principally serve Medicare and Medicaid patients will have limited ability to pass the costs of their new liability on to commercial insurers in any event.

[19] As the Department recognized, "[n]either the federal, state, nor local governments own or operate a general acute care hospital in Champaign County." A62 (finding 21).

Ultimately, in order to shoulder their new tax burden, hospitals may be forced to reassess the extent of the services they offer to their communities. Some hospitals have already stopped providing high-cost services – like trauma units – that cannot function absent a subsidy. *See, e.g.*, 210 Ill. Comp. Stat. 76/10 (recognizing that "emergency and trauma care, neonatal intensive care, community health clinics and * * * immunization programs" are all "subsidized health services" that a hospital receives less than cost for offering). If they are forced to shoulder a new tax liability, not-for-profit hospitals may be required to reconsider community clinics and other outreach and preventative efforts that help manage chronic conditions and thereby prevent crisis situations that bring children to emergency departments or elderly into the hospital. Other hospitals may have no choice but to sacrifice the very important – but (according to the Department) insubstantial – community benefit programs they have implemented to meet the unique care needs of their communities that reduce the severe strain already placed on not-for-profit hospitals' emergency room facilities. *See supra* at 16-21. Still others may be forced to delay capital investments in new technology or facility improvements.

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

CONCLUSION

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

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SUPREME COURT RULE 341(c) COMPLIANCE

I certify that this brief conforms to the requirements of Supreme Court Rules 341(a) and (b). The length of this brief is 31 pages.

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CERTIFICATE OF SERVICE

The undersigned, being first duly sworn upon oath, deposes and states that on this 4th day of February 2009, three copies of the foregoing Brief *Amicus Curiae* of the American Hospital Association in Support of Plaintiffs-Appellees-Petitioners were served on each of the below-named parties by depositing such copies with an overnight carrier at 555 Thirteenth Street, N.W., Washington, D.C. 20004, before 7:00 pm, in envelopes bearing sufficient postage:

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