



CARDOZO

Benjamin N. Cardozo School of Law

LARC @ Cardozo Law

Faculty Articles

Faculty Scholarship

Spring 2023

The Commerciality of Non-Profit Hospitals Requires Them to Be Taxed: Bringing the Debate to a Conclusion

Edward A. Zelinsky

Benjamin N. Cardozo School of Law, zelinsky@yu.edu

Follow this and additional works at: <https://larc.cardozo.yu.edu/faculty-articles>



Part of the [Health Law and Policy Commons](#), [Nonprofit Organizations Law Commons](#), [Taxation-State and Local Commons](#), and the [Tax Law Commons](#)

Recommended Citation

Edward A. Zelinsky, *The Commerciality of Non-Profit Hospitals Requires Them to Be Taxed: Bringing the Debate to a Conclusion*, 42 Va. Tax Rev. 401 (2023).

<https://larc.cardozo.yu.edu/faculty-articles/605>

This Article is brought to you for free and open access by the Faculty Scholarship at LARC @ Cardozo Law. It has been accepted for inclusion in Faculty Articles by an authorized administrator of LARC @ Cardozo Law. For more information, please contact larc@yu.edu.

THE COMMERCIALITY OF NON-PROFIT
HOSPITALS REQUIRES THEM TO BE TAXED:
BRINGING THE DEBATE TO A CONCLUSION

Edward A. Zelinsky

TABLE OF CONTENTS

- I. INTRODUCTION 402
- II. THE ACADEMIC DEBATE ABOUT THE FEDERAL INCOME TAX
EXEMPTION OF CHARITABLE INSTITUTIONS 407
- III. RECOGNIZING THE COMMERCIALITY OF NONPROFIT
HOSPITALS..... 412
- IV. THE IRS’S (UNSUCCESSFUL) SEARCH FOR COMMUNITY
BENEFIT..... 417
- V. SUPPLEMENTING COMMUNITY BENEFIT STANDARD: INTERNAL
REVENUE CODE SECTION 501(R) 423
- VI. THE 2017 AND 2022 CODE PROVISIONS 428
 - A. *Section 168(k)* 428
 - B. *Section 172(b)(1)(D)*..... 430
 - C. *Section 4960*..... 431
 - D. *The Inflation Reduction Act of 2022* 434
 - E. *Conclusion* 435
- VII. NONPROFIT HOSPITALS’ TAX STATUS IN THE STATE COURTS..... 436
 - A. *State Constitutions and Statutes*..... 436
 - B. *AHS Hospital Corporation v. Town of Morristown* 442
 - 1. *The Decision*..... 442
 - 2. *The Aftermath*..... 445
 - C. *Provena Covenant Medical Center v. Department of
Revenue*..... 446
 - 1. *The Decision*..... 446
 - 2. *The Aftermath*..... 448
 - D. *Chisago Health Services v. Commissioner*..... 450
 - E. *Utah County by County Bd. of Equalization v.
Intermountain Health Care, Inc. and Howell v. County Bd.
ex rel. IHC Hospitals, Inc.* 453

1. Community Benefit is Not Charity: <i>Utah County by County Bd. of Equalization v. Intermountain Health Care, Inc.</i>	453
2. The Sub Silentio Dilution of the Concept of Gift: <i>Howell v. County Bd. ex rel. IHC Hospitals, Inc.</i>	457
F. <i>St. Mary's Building Corp. v. Redman</i>	459
G. <i>Other Cases</i>	460
VIII. CONCLUDING QUALIFICATIONS AND OBSERVATIONS	461
A. <i>The difficult political path going forward.</i>	461
B. <i>Corporations as taxable entities.</i>	462
C. <i>Hospitals and sales taxes.</i>	463
D. <i>Endowment taxation</i>	464
E. <i>The tax status of schools.</i>	464
F. <i>Payments-in-Lieu-of-Taxes</i>	465
G. <i>Taxing similar entities similarly.</i>	465
H. <i>The charitable deduction.</i>	466
I. <i>The economic effect of taxing nonprofit hospitals.</i>	466
J. <i>The status of religious hospitals.</i>	467
K. <i>The St. Jude/Shriner's Childrens issue.</i>	469
IX. CONCLUSION.....	471

I. INTRODUCTION

It is now time to conclude our prolonged debate about the tax-exempt status of nonprofit hospitals. The contemporary nonprofit hospital is a commercial enterprise, materially indistinguishable for tax purposes from its profit-making, taxed competitor. The federal income tax and the states' income, sales and property taxes should treat all hospitals alike, regardless of whether such hospitals are nonprofit or for-profit enterprises.¹ In the interests of equity and efficiency, these similar institutions should be taxed similarly.

At the federal level, five changes to the Internal Revenue Code require us to revisit the income tax exemption of nonprofit hospitals and to conclude that that exemption is unjustified in light of the resemblance of contemporary for-profit and nonprofit hospitals.

¹Nonprofit institutions (including hospitals and churches) pay more taxes than many persons believe. EDWARD A. ZELINSKY, *TAXING THE CHURCH: RELIGION, EXEMPTIONS, ENTANGLEMENT, AND THE CONSTITUTION* (2017). These include the federal taxes financing Social Security and Medicare, federal and state taxes on unrelated business income, state unemployment taxes, and real estate conveyance taxes. *Id.* at 49, 53–57, 98–111. The focus of this article is upon the major taxes from which nonprofit hospitals are exempt, i.e., income, property and sales taxes.

Among these Code changes are Section 501(r),² by which Congress attempted to strengthen charitable obligations for nonprofit hospitals and Code Section 4960,³ which imposes a corporate-style tax on salaries paid by tax-exempt organizations (including hospitals) to an organization's five highest compensated employees to the extent any such salary annually exceeds one million dollars (\$1,000,000) per employee.

The failure of Section 501(r) to enforce charitable obligations on nonprofit hospitals suggests that the tax-exempt status of such hospitals cannot be fixed, but should be repealed. Section 4960 further suggests that the highly-compensated managers of lucrative nonprofit hospitals act like equity-owners of these hospitals, paying themselves disguised dividends from corporate profits in the form of inflated salaries.

Also relevant to this debate are Code Section 168(k)⁴ by which Congress permitted the deduction of many capital expenditures and Code Section 172(b)(1)(D),⁵ which temporarily restored to the Internal Revenue Code carrybacks for losses arising before January 1, 2021. An early and important insight of commentators on the tax-exempt status of charities is that, in particular settings, income tax exemption can produce results similar to income taxation implemented with full deduction of capital expenditures and full loss carrybacks.⁶ When Sections 168(k) and 172(b)(1)(D) are coupled with this insight, the benefit that nonprofit hospitals (and other exempt entities) receive from the tax exemption of their net operating incomes is immunity from the vagaries of congressional decision making about the tax treatment of capital expenditures and loss carrybacks. There is no compelling reason why today's nonprofit hospitals, given their commerciality, should be shielded from the vicissitudes of congressional decision making while operationally identical for-profit hospitals are not.

Most recently, the Inflation Reduction Act of 2022,⁷ confirms the importance of the political protection which nonprofit institutions, including nonprofit hospitals, receive from tax-exempt status. By virtue of their tax-exempt status, nonprofit hospitals were effectively bystanders to the vagaries of the 2022 congressional process as the new law incorporated within its minimum corporate tax the 2017 act's

²I.R.C. § 501(r).

³I.R.C. § 4960.

⁴I.R.C. § 168(k).

⁵I.R.C. § 172(b)(1)(D).

⁶See *infra* notes 24, 31–33 and accompanying text.

⁷Inflation Reduction Act, Pub. L. No. 117-169.

generous deductions for capital expenditures and the 2017 act's abolition of loss carrybacks.

In discussion about property taxation, state courts have often stressed the commercial nature of nonprofit hospitals. As this article demonstrates, there has not been "a" discussion about the tax-exempt status of nonprofit hospitals. Rather, there have over time been a series of parallel, sometimes overlapping controversies as states have, in the context of property taxation, conducted their own inquiries about the propriety of taxing nonprofit hospitals. Persuasive state court decisions have recognized that nonprofit hospitals are commercial enterprises which should be taxed like their for-profit competitors.

Integrating these developments and debates into a single narrative, the contemporary nonprofit hospital emerges as a commercial entity which should be taxed by the federal and state tax systems in the same fashion as those systems tax for-profit hospitals. As a political matter, nonprofit hospitals will continue to defend their tax-exempt status. Like any other lucrative, vested interest, nonprofit hospitals will continue to fight hard to protect their valuable tax benefits.⁸ But, on the substantive merits, the case for taxing the contemporary nonprofit hospital is compelling, given the commerciality of today's nonprofit hospitals. Such nonprofit hospitals are not materially distinguishable for tax purposes from their profit-making, taxed competitors.

The first section of this article reviews the scholarly debate about federal income tax exemption of charitable institutions with particular emphasis on the tax exemption of nonprofit hospitals. This debate presaged themes which today justify the taxation of nonprofit hospitals: such hospitals' business-like conduct of health care is commercial, rather than charitable, in nature; nonprofit hospitals are materially indistinguishable from their for-profit, taxpaying competitors; Medicaid and Medicare disbursements are fee-for-service payments to hospitals, not manifestations of charity; hospitals' bad debt write-offs are business practices, not charity care; physicians practicing in hospitals are conducting commercial activity, not charity; hospital executives are compensated inordinately; few patients today receive free medical care; and the IRS's "community benefit" standard lacks

⁸As I suggest, *infra* notes 136–51 and accompanying text, the weakness of code section 501(r) confirms the political ability of the nonprofit hospital industry to defend its tax benefits. Similarly, the aftermaths of the *Provena Covenant* and *Utah County* decisions suggest the formidability of the hospital industry's ability to protect its advantageous tax position. See *infra* notes 254–62, 317–34 and accompanying text.

persuasive content and thus fails to justify the tax exemption of non-profit hospitals. These themes buttress the conclusion that the modern nonprofit hospital is not a charity but is a business. And businesses pay tax.

The second section discusses the evidence that nonprofit hospitals are today commercial enterprises, materially indistinguishable from their for-profit (and taxed) competitors. This article then explores the failed administrative efforts of the IRS to require nonprofit hospitals to generate community benefits as a prerequisite for tax exemption under Code Section 501(c)(3).⁹

The fourth section of this article turns to Congress' recent actions, starting with Code Section 501(r). In Section 501(r), adopted as part of the Affordable Care Act, Congress supplemented the community benefit standard for nonprofit hospitals. Like the administratively-promulgated community benefit standard, Section 501(r) has failed. Notwithstanding this legislation, nonprofit hospitals are in practice highly profitable commercial operations, not charitable entities.¹⁰

This article then discusses Internal Revenue Code Sections 4960, 168(k) and 172(b)(1)(D) as adopted by Congress in 2017 in the Tax Cuts and Jobs Act.¹¹ Section 4960 imposes corporate-style tax on hospitals and other charitable institutions when those entities compensate any of their five highest-paid employees more than one million dollars annually. In the context of nonprofit hospitals, Section 4960 is best understood as recognizing that the earnings of those hospitals are often diverted by overcompensated managers in the form of unreasonable salaries which constitute disguised dividends.

Sections 168(k) and 172(b)(1)(D) likewise buttress the case for taxing all hospitals' net earnings, by highlighting the principal benefit of tax exemption, namely, immunity from the vagaries of congressional decision making about deducting capital expenditures and loss carrybacks.¹² The Inflation Reduction Act of 2022 incorporated within its

⁹I.R.C. § 501(c)(3).

¹⁰ The term "nonprofit" is something of a misnomer. "Nonprofit" entities can make profits. They are just forbidden to distribute them. See I.R.C. § 501(c)(3) ("no part of the net earnings of which inures to the benefit of any private shareholder or individual"); Hansmann, *infra* note 56 (discussing the "nondistribution constraint". "A nonprofit organization is not . . . prohibited from *earning* a profit") (emphasis in original).

¹¹ Tax Cuts and Jobs Act, Pub. L. No. 115-97.

¹² The broad-based income taxation of nonprofit hospitals advocated by this article is different from the provider fees that states levy on hospitals to finance Medicaid payments. Those provider fees are generally defended as benefitting the hospitals by implicitly funding the state and federal Medicaid payments received by those hospitals. In effect, the provider fees hospitals pay are deemed to be returned to the hospitals

minimum corporate tax the 2017 act's generous deductions for capital expenditures and that act's abolition of loss carrybacks. These minimum tax provisions highlighted the unjustified benefits of tax exemption as nonprofit hospitals were protected from the vicissitudes of the 2022 congressional process by virtue of their tax-exempt status.

The sixth section of this article integrates into the discussion the state court property tax decisions which have stripped particular nonprofit hospitals of property tax exemption because these hospitals are commercial in nature. Among these instructive decisions are the opinions of the New Jersey Tax Court in *AHS Hospital Corporation v. Town of Morristown*,¹³ of the Illinois Supreme Court in *Provena Covenant Medical Center v. Department of Revenue*,¹⁴ and of the Utah Supreme Court in *Utah County by County Bd. of Equalization v. Intermountain Health Care, Inc.*¹⁵ Equally instructive were the political aftermaths of these decisions, as the nonprofit hospitals in these states formidably defended their tax exemptions. The final section of this article anticipates objections to my analysis and its conclusion that, today, the typical nonprofit hospital is a lucrative commercial enterprise and should be subject to income, sales and property taxes in the same fashion as its materially indistinguishable for-profit competitor. Among other topics considered in this final section are the status of religious hospitals, the income tax charitable contribution deduction, and the handful of hospitals, like St. Jude and Shriners Childrens, which can today plausibly still claim charitable status. The highly commercial operations of religious hospitals are materially indistinguishable for tax purposes from the business-like operations of their profit-making and secular, nonprofit competitors. Consequently, religious hospitals should be

in the form of Medicaid payments. In contrast, the income taxes promoted by this article would not be, directly or indirectly, channeled back to the hospitals paying such taxes through Medicaid or any other government program. Rather, these income taxes would be unrestricted payments to the treasuries of the states and federal governments for general public outlays, just like the corporate income taxes paid by other corporations including for-profit hospitals. On the states' Medicaid-related hospital provider fees. See Jennifer L. Herbst, Sara J. O'Brien, & Emily G. Chumas, *Hospital Taxes, Medicaid Supplemental Payments, and State Budgets*, 40 J. LEG. MED. 135 (2020); *States and Medicaid Provider Taxes or Fees*, KFF (June 27, 2017), <https://www.kff.org/medicaid/fact-sheet/states-and-medicare-provider-taxes-or-fees/>; *Health Provider and Industry State Taxes and Fees*, NCSL (Oct. 10, 2017), <https://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx>.

¹³ *AHS Hosp. Corp. v. Town of Morristown*, 28 N.J. Tax 456 (2015).

¹⁴ *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 236 Ill. 2d 368 (2010).

¹⁵ *Utah Cnty. Bd. of Equalization v. Intermountain Health Care, Inc.*, 709 P.2d 265 (1985).

taxed like their competitors. The charitable contribution deduction is of minor concern to most nonprofit hospitals since most hospitals derive little of their respective incomes from such contributions. While in theory it may be possible to narrowly tailor an exemption for the few hospitals like St. Jude and Shriners which can credibly claim to be charitable entities, the political process may have trouble in practice fashioning such a nuanced exemption.

As a substantive matter, it is time to close debate about the propriety of taxing nonprofit hospitals. They should be taxed like their equally commercial for-profit counterparts. In the interests of equity and efficiency, these similar entities should be taxed similarly — though this is an outcome which, as a political matter, will not be easily or quickly achieved.

II. THE ACADEMIC DEBATE ABOUT THE FEDERAL INCOME TAX EXEMPTION OF CHARITABLE INSTITUTIONS

This section summarizes the academic debate about the federal income tax exemption of charitable institutions with particular emphasis on the tax status of nonprofit hospitals. This debate presaged themes which today justify the taxation of nonprofit hospitals: such hospitals' business-like conduct of health care is commercial, rather than charitable, in nature; nonprofit hospitals are materially indistinguishable from their for-profit, taxpaying competitors; Medicaid and Medicare disbursements are fee-for-service payments to hospitals, not manifestations of charity; hospitals' bad debt write-offs are business practices, not charity care; physicians practicing in hospitals are conducting commercial activity, not charity; hospital executives are compensated inordinately; few patients today receive free medical care; and the IRS's "community benefit" standard lacks persuasive content and thus fails to justify the tax exemption of nonprofit hospitals. These themes buttress the conclusion that the modern nonprofit hospital is not a charity but is a business. And businesses pay tax.

Professor Boris Bittker and Attorney George Rahdert advanced the seminal defense of the Internal Revenue Code's income tax exemption of nonprofit organizations.¹⁶ They postulated that nonprofit organizations engaged in "public service" activities, broadly conceived, should be wholly exempted from income taxation, because they do not realize "income" in the ordinary sense of that term and because, even if they did, there is no satisfactory way to fit the tax rate

¹⁶ Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L.J. 299 (1976).

to the ability of the beneficiaries to pay.¹⁷ Professor Henry Hansmann convincingly dissented from the Bittker-Rahdert analysis,¹⁸ arguing that, as to “‘commercial’ nonprofits,”¹⁹ a category that includes “probably most hospitals,”²⁰ it would be perfectly easy and natural to carry over the tax accounting that is applied to business firms, taking receipts from sales as the measure of gross income and permitting the usual deductions for expenses incurred in producing the goods or services sold. The resulting net earnings figure could be taxed just as in the case of a business firm.²¹

With the passage of time, Professor Hansmann has gotten the better of this argument, particularly with respect to hospitals. The federal income tax is today applied without apparent controversy to for-profit hospitals using the Code’s corporate tax provisions including the Code’s tax rates for corporations.²² Those provisions and rates could be applied to the similarly commercial operations of nonprofit hospitals. Indeed, that is precisely what the Treasury regulations under Code § 501(r) do when a nonprofit hospital fails one of the requirements imposed by that provision.²³

Professor Hansmann’s discussion also highlighted two other key questions. Will a tax on commercial nonprofit organizations produce any net income for the federal fisc if expenditures are fully deductible and losses can freely be carried back to prior years? Should corporate income tax be imposed in the absence of shareholders?

To explore the first issue, consider the example of a hospital which has net income of \$100 in year one, and which spends that \$100 in year two in a manner which is fully deductible for income tax purposes while otherwise breaking even. Consequently, this hospital incurs a net loss of \$100 in year two by spending in that year the \$100 earned in the year before, thereby generating a \$100 loss in year two.

¹⁷ *Id.* at 305.

¹⁸ Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 *YALE L.J.* 54 (1981).

¹⁹ *Id.* at 59.

²⁰ *Id.*

²¹ *Id.*

²² For example, HCA Healthcare, Inc., the nation’s leading owner of proprietary hospitals, paid in excess of \$2 billion in income taxes in 2021. HCA Healthcare, Inc., Annual Report (Form 10-K) (Dec. 31, 2021) (reporting provision for income taxes of \$2,112,000,000). Community Health Services, Inc., another important chain of for-profit hospitals, paid \$131 million in income taxes for 2021. Community Health Services, Inc., Form 10-K (Annual Report) (Dec. 31, 2021).

²³ Treas. Reg. § 1.501(r)-2(d) (“will be subject to tax computed as provided in section 11”).

If this hospital is a for-profit entity and if the Code permits loss carrybacks, this hospital will pay tax in year one on its \$100 profit in that year and then receive a refund of that tax in year two when year two's loss of \$100 is carried back to year one to wipe out that prior year's tax obligation.

The result (no net tax over the course of two years) is the same if this hospital is a tax-exempt corporation. In that case, no tax is levied on the hospital's net earnings of \$100 in year one and there is no tax consequence to the loss of \$100 incurred by this tax-exempt hospital in year two. Thus, in this example, the combination of deductible capital outlays and loss carrybacks produces the same result as tax-exemption.

The result is different if either the hospital's \$100 outlay in year two is nondeductible or if no loss carryback is allowed from year two back to year one. If either (or both) of those assumptions applies, the tax paid by the for-profit hospital in year one on \$100 in earnings remains in the Treasury as the hospital has no deductible loss in year two or is not permitted a loss carryback to year one. In contrast, the nonprofit hospital pays no tax on its income of \$100 in year one because it is exempt.

Looking at these kind of outcomes, Professor Hansmann concluded that the Code's income tax exemption of charitable institutions is a tax subsidy since the first scenario is implausible; under the Code, capital expenditures are nondeductible and loss carrybacks are limited. Thus, the second scenario (the for-profit hospital pays nonrefunded tax on its \$100 profit in year one) is the baseline for analysis since the conditions of the first scenario (full deductibility of capital expenditures coupled with loss carrybacks) "do not. . .hold."²⁴ A second issue highlighted by Professor Hansmann is the question of equity ownership. If the corporate income tax is defined as a tax on earnings distributable to shareholders, by definition, no tax should be levied on nonprofit entities which have no shareholders.²⁵

²⁴ Hansmann, *supra* note 18, at 63. Professor Hansmann also suggested that the equivalence of taxation and tax exemption in first scenario doesn't hold because the federal treasury may pay no interest on the refund of taxes paid in year one and because the hospital paying tax in year one may have liquidity constraints.

²⁵ See, e.g., Philip T. Hackney, *What We Talk About When We Talk About Tax Exemption*, 33 VA. TAX REV. 115, 149 (2013) ("there are simply too many practical realities of our income tax system that suggest that our public common intention in imposing corporate tax is to tax shareholders . . . The shareholder rationale requires shareholders – individuals who own shares in the corporation. By definition, nonprofit organizations should have no such individuals.").

Professor Hansmann offered three responses to this argument. First, he suggested that it might be persuasive to “view the nonprofit corporation itself as the ultimate owner of its capital, and hence treat *it* as the taxpayer.”²⁶ Second, Professor Hansmann observed that the corporate income tax “has commonly been rationalized on the basis that the corporation itself has taxable capacity apart from its investors – that it is conceptually a separate taxable entity.”²⁷ Third, he argued that it might make sense to “view. . .the recipients of [the nonprofit entity’s] services. . .as the beneficial owner of its invested capital.”²⁸

In the context of nonprofit hospitals, the second of these observations is telling. The underlying premise of the corporate income tax is that certain organizations, because of their size and organizational form, are properly recognized as taxpaying entities. In light of their commercial nature and profitable²⁹ operations, nonprofit hospitals are comparable to the for-profit hospitals subjected to corporate income taxation. Hence, nonprofit hospitals should also be subjected to corporate income taxation so as to treat these similar taxpayers similarly.

Moreover, as I argue subsequently,³⁰ Section 4960 today suggests a fourth reply to the argument that nonprofit corporations lack shareholders: Excessively compensated managers are effectively nonprofit corporations’ equity holders as these managers cause nonprofit corporations to divert corporate earnings to these managers in the form of inordinate salaries. Such outsize salaries constitute disguised dividends, distributions of corporate earnings styled as compensation for services rendered.

Professor Daniel Halperin considered the scenario where tax-exemption and taxation can lead to economically identical outcomes, but advanced a somewhat different narrative than did Professor Hansmann.³¹ Professor Halperin agreed that, because of the nondeductibility of capital expenditures, the Code’s “treatment of [nonprofits’] capital expenditures amounts to a preference of charities.”³² Tax exemption effectively treats nonprofits’ capital expenditures as deductible and subject to carryback. However, he emphasized, the

²⁶ Hansmann, *supra* note 10, at 63 (emphasis in original).

²⁷ *Id.*

²⁸ *Id.*

²⁹ As observed *supra* note 10, nonprofit organizations can earn profits. They are forbidden from making dividend-type distributions of such earnings.

³⁰ See *infra* notes 166–80 and accompanying text.

³¹ Daniel Halperin, *Is Income Tax Exemption for Charities a Subsidy?*, 64 TAX L. REV. 283 (2011).

³² *Id.* at 297.

“exemption of income set aside for future deductible expenditures does not in present value terms necessarily reduce the tax burden” of an entity.³³

Propounding the “donative theory of the charitable exemption,” Professors Mark A. Hall and John D. Colombo postulate “that the primary rationale for the charitable exemption is to subsidize those organizations capable of attracting a substantial level of donative support from the public.”³⁴ From this vantage, they argue that the case for extending tax exemption to nonprofit hospitals is “weak” because “[t]oday, nonprofit hospitals receive in proportionate terms only negligible support from public donations.”³⁵

Contributing to this debate, Professor Evelyn Brody observed that in general “business firms and nonprofit firms converge into similar enterprises, functioning in many similar ways, and, to a large degree, governed by self-perpetuating management.”³⁶ In light of this convergence of profit and nonprofit entities, she identified nonprofit hospitals as prime targets for “repealing [their] tax exemption”³⁷:

Recent years have brought. . . change to the character of nonprofit hospitals. . . Proprietary hospitals can now earn satisfactory returns, thanks primarily to the third-party payment systems funded by both Medicare and Medicaid and by the tax expenditure for employer-provided health insurance. Evidence suggests that nonprofit hospitals provide a level of charity care comparable to that provided by for-profit hospitals.³⁸

Professor Brody concluded that “the commerciality logic might require simply revoking the exemption of nonprofit hospitals” in light of “health care’s pervasive and highly visible commercial taint.”³⁹ Professor Brody also dismissed as ineffective,⁴⁰ the IRS’s efforts, discussed below,⁴¹ to require nonprofit hospitals to provide community benefits.

³³ *Id.* at 294.

³⁴ Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 389–90 (1991).

³⁵ *Id.* at 406–08.

³⁶ Evelyn Brody, *Agents Without Principals: The Economic Convergence of the Nonprofit and For-Profit Organizational Forms*, 40 N.Y.U. L. REV. 457, 471 (1996).

³⁷ Evelyn Brody, *Charities in Tax Reform: Threats to Subsidies Overt and Covert*, 66 TENN. L. REV. 687, 692–93 (1999).

³⁸ *Id.* at 722.

³⁹ *Id.* at 723.

⁴⁰ *Id.* at 722–23.

⁴¹ See *infra* notes 80–114 and accompanying text.

III. RECOGNIZING THE COMMERCIALITY OF NONPROFIT HOSPITALS

In 2006, Senator Chuck Grassley, then chairman of the Senate Committee on Finance, emerged as an influential critic of nonprofit hospitals.⁴² After surveying ten of the nation's leading non-profit health systems, Senator Grassley was blistering in his criticism. Among the targets of the Senator's ire were these hospitals' billing patterns ("charg[ing] poor, uninsured patients more"), their executive compensation practices ("goldplated. . . packages") and their corporate governance ("giving even less attention to how the hospitals are helping the community and the poor").⁴³ Senator Grassley's comments gave political salience to the concerns of health care commentators about the troubling price discrimination and harsh debt collection practices routinely embraced by nonprofit hospitals.⁴⁴

In a similar vein, Steven Brill's influential critique of the American medical system is heavily devoted to what Brill calls "officially non-profit hospitals."⁴⁵ Like Senator Grassley, Attorney Brill was troubled by these hospitals' "hard-nosed" billing practices based on inflated

⁴² Memorandum from Senator Chuck Grassley to Reporters and Editors, *Non-profit hospital responses to Finance Committee* (Sept. 12, 2006) (<https://www.finance.senate.gov/chairmans-news/grassley-releases-non-profit-hospital-responses-expresses-concern-over-shortfalls-in-charity-care-community-benefit>).

⁴³ *Id.* ("Non-profit doesn't necessarily mean pro-poor patient. Non-profit hospitals may provide less care to the poor than their for-profit counterparts. They may charge poor, uninsured patients more for the same services than they charge insured patients. They sometimes give their executives gold-plated [sic] compensation packages and generous perks such as country club memberships. All of this calls into question whether non-profit hospitals deserve the billions of dollars in tax breaks they receive from federal, state, and local governments")

"Not only is there often very little difference between for-profit and non-profit hospitals when it comes to serving the community, but also the release of the answers today shows that there appears to be very little difference on executive compensation. Some non-profit hospital executives enjoy the best hotels and great meals, all subsidized by the taxpayer. I find it especially troubling that executive after executive is having country club dues paid for by non-profit hospitals. While one hospital ended this policy after I inquired, far too many non-profit hospitals still think paying for country clubs should be business as usual. I'm afraid that if non-profit hospital boards are focusing so little attention on what they're paying executives, they're giving even less attention to how the hospitals are helping the community and the poor.").

⁴⁴ See, e.g., *infra* note 103 at 513–22; John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29, 53 (2005), <https://scholarlycommons.law.case.edu/health-matrix/vol15/iss1/5> ("modern empirical evidence shows little difference in the quantifiable behavior of for-profit and nonprofit hospitals with respect to cost, quality of care, and charity care.").

⁴⁵ Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Mar. 4, 2013, at 16.

“chargemaster” prices, by such hospitals’ highly-compensated executives, and by the minimal charity care bestowed by these very profitable (albeit “nonprofit”) hospitals: “the American health care market has transformed tax-exempt ‘nonprofit’ hospitals into the towns’ most profitable businesses and largest employers, often presided over by the regions’ most richly compensated executives.⁴⁶

For Attorney Brill,⁴⁷ this phenomenon is exemplified by the M.D. Anderson Cancer Center operated by the University of Texas. In its operating budget for its fiscal year ending on August 31, 2022, the nonprofit Anderson center projected incoming funds in excess of six billion dollars⁴⁸ and revenue over expenses, i.e., profit, in excess of seven hundred million dollars.⁴⁹

The numbers for other prestigious hospitals are similar. In 2020, for example, the Mayo Clinic earned net operating income of \$727 million on gross revenues \$13.9 billion.⁵⁰ For 2021, the Cleveland Clinic similarly earned \$746 million on revenues of \$12.4 billion.⁵¹

What Attorney Brill labeled “the usual chargemaster profit grabs”⁵² by nonprofit hospitals are also central to Professor Uwe E. Reinhardt’s critique of the American medical system.⁵³ These bloated chargemaster rates “defy reason”⁵⁴ and are only imposed by hospitals upon the unfortunate, self-paying patient who is not protected against the hospitals’ rapacity by the bargaining power of commercial insurers, Medicare or Medicaid. These elevated chargemaster prices (imposed by hospitals claiming to be charitable entities) “can easily bankrupt a family.”⁵⁵

⁴⁶ The scare quotes around “nonprofit” are Mr. Brill’s. *See also id.* (hospitals as “ostensibly nonprofit institutions”).

⁴⁷ *Id.*

⁴⁸ U.T. SYSTEM BOARD OF REGENTS, THE UNIVERSITY OF TEXAS M.D. ANDERSON CANCER CENTER, OPERATING BUDGET, FISCAL YEAR ENDING AUGUST 31, 2022 B.1 (2021) (projecting total funds of \$6,183,941,821).

⁴⁹ *Id.* at B.2 (projecting “Excess of Revenue over Expenses” of \$707,656,533).

⁵⁰ Jay Furst, *MEETING THE CHALLENGES OF A HISTORIC YEAR: 2020 Mayo Clinic Performance Highlights*, MAYO CLINIC (Feb. 26, 2021), <https://newsnetwork.mayo-clinic.org/discussion/meeting-the-challenges-of-a-historic-year-2020-mayo-clinic-performance-highlights/>.

⁵¹ ERNST & YOUNG LLP, CLEVELAND CLINIC HEALTH SYSTEM CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION 5 (2022).

⁵² Brill, *supra* note 45.

⁵³ UWE E. REINHARDT, *PRICED OUT: THE ECONOMIC AND ETHICAL COSTS OF AMERICAN HEALTH CARE* (2019).

⁵⁴ *Id.* at 49.

⁵⁵ *Id.*

A particularly telling indicator of the convergence of for-profit and nonprofit hospitals is their similar participation today in the Medicare and Medicaid programs. In 1983, the IRS identified such participation as a factor distinguishing nonprofit from proprietary hospitals.⁵⁶ No more. Today, as Professor Erin C. Fuse Brown observes, “Medicare and Medicaid patients make up such a large percentage of hospital business (approximately 58%) that nearly all hospitals, including for-profit hospitals, participate.”⁵⁷ The GAO agrees that “accepting patients on Medicare and Medicaid” is today a “common feature[] of all hospitals.”⁵⁸

Medicare and Medicaid pay less (often much less) than do private health care insurers.⁵⁹ But, as Attorney Brill points out, even hospitals which heavily serve Medicare and Medicaid patients have “operating profit margin[s], which would be the envy of shareholders of high-service businesses across other sectors of the economy.”⁶⁰ “Hospitals don’t lose money when they serve Medicare patients.”⁶¹ Bradley Herring, Darrell Gaskin, Hossein Zare and Gerard Anderson come to a similar conclusion about Medicaid: “[T]he hospital’s choice to accept a Medicaid patient seems to us to likely reflect its belief that Medicaid indeed pays more than marginal costs.”⁶²

Consider in this context the revenue stream of the publicly-traded HCA Healthcare, Inc. HCA Healthcare, Inc. owns “175 general, acute care hospitals” along with outpatient facilities.⁶³ In 2021, over 40% of HCA’s revenues came from serving Medicare and Medicaid patients.⁶⁴ Similarly, Community Health Services, Inc., which owns

⁵⁶ Rev. Rul. 83-157, 1983-2 C.B. 94, *see* discussion *infra* notes 105–09 and accompanying text.

⁵⁷ *Infra* note 103, at 550 (parentheses in original).

⁵⁸ U.S. GOV’T ACCOUNTABILITY OFF., GAO-20-679, TAX ADMINISTRATION: OPPORTUNITIES EXIST TO IMPROVE OVERSIGHT OF HOSPITALS’ TAX-EXEMPT STATUS 11 (2020).

⁵⁹ Eric Lopez et al., *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*, KFF (Apr. 15, 2020), <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/> (“Private insurers paid nearly double Medicare rates for all hospital services (199% of Medicare rates, on average), ranging from 141% to 259% of Medicare rates across the reviewed studies.”) (parentheses in original).

⁶⁰ Brill, *supra* note 45.

⁶¹ *Id.* (quoting Jonathan Blum, deputy administrator of the Centers for Medicare and Medicaid Services).

⁶² Bradley Herring et al., *Comparing the Value of Nonprofit Hospitals’ Tax Exemption to Their Community Benefits*, 55 J. HEALTH CARE ORG., PROVISION, AND FIN. 1, 7 (2018).

⁶³ HCA Healthcare, Inc., Annual Report (Form 10-K), at 4 (Feb. 18, 2022).

⁶⁴ *Id.* at 7 (reporting revenues from Medicare, Medicaid, Managed Medicare and Managed Medicaid).

eighty-three hospitals and myriad outpatient facilities,⁶⁵ derives 34.9% of its revenues from Medicare and Medicaid patients.⁶⁶ When America's premier chains of private, for-profit hospitals derive so much of their income from Medicare and Medicaid, nonprofit hospitals cannot plausibly assert that their servicing of Medicare and Medicaid patients is somehow charitable.

Other important indicators of the business-like operations of nonprofit hospitals have been their steady acquisition of physician practices and such hospitals' minimal amounts of charity care. By January, 2022, U.S. hospitals owned 26.4% of all doctors' practices.⁶⁷ While such vertical integration is understandable as a commercial matter, it further confirms that the contemporary nonprofit hospital is run like any other commercial business.

Moreover, studies document that today's nonprofit hospitals often engage in less charity care than their for-profit competitors. A Wall Street Journal study, for example, concluded that nonprofit hospitals "are often not particularly generous," writing off only 2.3% of their receivables.⁶⁸ In contrast, for-profit hospitals on balance forgive a higher percentage of their respective bills, 3.4%.⁶⁹ The conclusion reached by Joseph D. Bruch and David Bellamy is similar: "[T]here was no significant difference between for-profit and nonprofit hospitals in charity care as percent of total expenses."⁷⁰

Professor Jill R. Horwitz defends the tax-exempt status of nonprofit hospitals on the ground that "different hospital types have different goals."⁷¹ However, the most compelling differences Professor Horwitz finds are between, on the one hand, government hospitals

⁶⁵ Community Health Services, Inc., Annual Report (Form 10-K), at 1 (Feb. 17, 2022).

⁶⁶ *Id.* at 9 (reporting revenues from Medicare and Medicaid).

⁶⁷ AVALERE HEALTH, COVID-19'S IMPACT ON ACQUISITIONS OF PHYSICIAN PRACTICES AND PHYSICIAN EMPLOYMENT 2019-2020 18 (2021). *See also* Katy Golvala et al., *Big hospital systems in Conn. buying up private practices, small hospitals*, NEW HAVEN REG., Sept. 24, 2022, at A14.

⁶⁸ Anna W. Matthews et al., *Hospital's Lag Behind in Charity Care*, WALL ST. J., July 26, 2022, at A1. *See also* Anna W. Matthews et al., *Some Hospitals Skimp on Aid*, WALL ST. J., Nov. 18, 2022, at A1.

⁶⁹ *Id.*

⁷⁰ Joseph D. Bruch & David Bellamy, *Charity Care: Do Nonprofit Hospitals Give More than For-Profit Hospitals?*, 36 J. GEN. INTERN. MED. 3279, 3280 (2020). *See also* Dan Diamond, *How hospitals got richer off Obamacare*, POLITICO (July 17, 2017, 5:00 AM), <https://www.politico.com/interactives/2017/obamacare-non-profit-hospital-taxes/>; Jessica Silver-Greenberg & Kate Thomas, *Entitled to Free Treatment But Hounded by Hospitals*, N.Y. TIMES, Sept. 25, 2022, at A1.

⁷¹ Jill R. Horwitz, *Does Nonprofit Ownership Matter?* 24 YALE J. ON REGUL. 139, 172 (2007).

and, on the other, all nongovernmental hospitals including both for-profit and nonprofit hospitals. When Professor Horwitz's data reveals differences between nonprofit and for-profit hospitals, these contrasts do not overcome the fundamental similarities of nonprofit and for-profit hospitals for tax purposes.

For example, Professor Horwitz's data indicates that for-profit hospitals are "7.3 percentage points more likely than nonprofit hospitals. . . to offer open-heart surgery," a lucrative service.⁷² In particular, 40.9% of for-profit hospitals provide open-heart surgery while 33.6% of nonprofit hospitals furnish such surgery.⁷³

Turning to the money-losing activity of emergency psychiatric care, Professor Horwitz tells us that "[o]n average from 1988 to 2000, 41% of for-profit hospitals were predicted to offer psychiatric emergency services, compared to 48% of nonprofit hospitals. . ."⁷⁴ However, this difference is not statistically controlling.⁷⁵ Similarly, there is no statistically significant difference between the MRI services provided by for-profit hospitals and by nonprofit hospitals.⁷⁶

[F]or-profit hospitals were only somewhat more likely than nonprofits to offer profitable services. . .⁷⁷

[H]ospitals, particularly for-profit and nonprofit hospitals, learn from or compete with neighboring hospitals. . . all hospital types copy the profit-making techniques of their for-profit neighbors.⁷⁸

Professor Hurwitz concludes that the differences between nonprofit and for-profit hospitals "counter the claim that nonprofits and for-profits are alike in all important ways."⁷⁹

But "all important ways" should not be the test for taxing nonprofit hospitals. Even considering Professor Hurwitz's data and acknowledging that, in some respects, for-profit and nonprofit hospitals may have differences in the services they provide, the contemporary nonprofit hospital is a predominantly commercial enterprise,

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.* at 173.

⁷⁵ *Id.* ("null hypothesis . . . cannot be rejected . . .").

⁷⁶ *Id.* at 176.

⁷⁷ *Id.* at 175.

⁷⁸ See *supra* note 71, at 178.

⁷⁹ *Id.* at 188. A recent updating of Professor Horwitz's research leads to similar conclusions, i.e., that "non-profit hospitals may differ little from their for-profit counterparts" in the provision of "free or subsidized care" but that the composition of services may vary among for-profit, nonprofit and government hospitals. Jill R. Horwitz & Austin Nichols, *Hospital Service Offerings Still Differ Substantially By Ownership Type*, 41:3 HEALTH AFFAIRS 331 (2022).

materially indistinguishable for tax purposes from its for-profit, taxed competitor.

IV. THE IRS'S (UNSUCCESSFUL) SEARCH FOR COMMUNITY BENEFIT

The conclusion that contemporary nonprofit hospitals should be taxed is buttressed by the (unsuccessful) efforts of the IRS to delineate the requirements for hospitals' charitable status under Code Section 501(c)(3). As nonprofit hospitals emerged as profitable commercial enterprises, the IRS's standard of community benefit ultimately failed as a rationale for tax-exempting nonprofit hospitals.

The Internal Revenue Code does not exempt from income taxation hospitals as such. Rather, a hospital must typically qualify for tax-exemption under Section 501(c)(3) as a charity.

Rev. Rul. 56-185⁸⁰ was the IRS's first effort to identify the characteristics of a hospital justifying its tax exemption as a charity under Section 501(c)(3). While Rev. Rul. 56-185 does not use the term "community benefit," that ruling is the origin of what has come to be called the community benefit standard for nonprofit hospitals seeking federal tax-exempt status as charitable entities.⁸¹

Rev. Rul. 56-185 identified four criteria a hospital must satisfy to qualify as a Section 501(c)(3) charitable institution exempt from federal income taxation. First, the hospital "must be organized as a nonprofit charitable organization for the purpose of operating a hospital for the care of the sick."⁸²

Second, the hospital "must be operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."⁸³ This test, the ruling stated, may be satisfied by "furnish[ing] services at reduced rates which are below cost". The hospital "may also set aside earnings which it uses for improvements and additions to hospital facilities." However, a hospital will not be considered a tax-exempt charity under Rev. Rul. 56-185 if the hospital "refuse[s] to accept patients in need of hospital care who cannot pay for such services."

Third, a hospital seeking tax-exempt status as a 501(c)(3) charity "must not restrict the use of its facilities to a particular group of physicians and surgeons, such as a medical partnership or association, to

⁸⁰ Rev. Rul. 56-185, 1956-1 C.B. 202.

⁸¹ See *infra* note 103 and accompanying text.

⁸² Rev. Rul. 56-185, 1956-1 C.B. 202.

⁸³ *Id.*

the exclusion of all other qualified doctors.”⁸⁴ However, the ruling qualifies (some would say, nullifies) this criterion by stating that a nonprofit hospital may have “some discretionary authority” to restrict the number and qualifications of the physicians practicing at the hospital.⁸⁵

Finally, the “net earnings” of a nonprofit hospital “must not inure directly or indirectly to the benefit of any private shareholder or individual.”⁸⁶

With the benefit of hindsight, we can discern in Rev. Rul. 56-185 many of the issues which emerged over the second half of the twentieth century as hospitals evolved into lucrative commercial enterprises. In 1956, there was no Medicaid, no Medicare and no Affordable Care Act (ACA) subsidies for private medical insurance. Today, Medicaid, Medicare and the ACA have significantly diminished the ranks of those without medical coverage. “Charity care” has less meaning in a world in which most individuals have either private or government-sponsored health coverage.

Moreover, “[i]mprovements and additions to hospital facilities” do not invariably implement charitable purposes. For example, physicians who use hospitals for their medical practices are “private individuals” who “benefit” economically from the hospitals’ activities. And excessive compensation payments to hospital executives constitute dividend-like distributions of hospital earnings to those executives.

The IRS took a second bite of the apple thirteen years later in Rev. Rul. 65-269.⁸⁷ In that ruling, a nonprofit hospital conditioned physicians’ use of the hospital’s facilities upon each physician paying a “reasonable” contribution to the hospital’s “building fund.”⁸⁸ This required contribution, the IRS held, did not jeopardize the hospital’s tax-exempt status as a 501(c)(3) charity.

Like Rev. Rul. 56-185, Rev. Rul. 65-269 looks problematic with the benefit of hindsight. By making compulsory contributions to the hospital’s building fund, the physicians in Rev. Rul. 65-269 paid the hospital to preserve the physicians’ access to the hospital. These payments were either ordinary and necessary business expenses deductible by the doctors for income tax purposes under Code Section

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ Rev. Rul. 65-269, 1965-2 C.B. 159.

⁸⁸ *Id.*

162⁸⁹ or business-related capital expenditures under Code Section 263.⁹⁰ Either way, the doctors' relationships with the hospital in Rev. Rul. 65-269 were commercial in nature from both the doctors' and the hospital's vantage. But Rev. Rul. 65-269 did not recognize the commercial nature of that relationship and of the physicians' payments to the hospital's building fund. In conclusory fashion, Rev. Rul. 65-269 simply held that the required contributions imposed on physicians seeking access to the hospital did not jeopardize the hospital's 501(c)(3) tax-exemption under the third test of Rev. Rul. 56-185.

The next ruling on hospitals as tax-exempt charities was Rev. Rul. 69-545.⁹¹ The IRS characterized Rev. Rul. 69-545 as "modif[ying]" Rev. Rul. 56-185. This understates Rev. Rul. 69-545's weakening of the community benefit standard by attenuating the requirement that tax-exempt hospitals serve patients who cannot afford to pay.

Rev. Rul. 69-545 involved two nonprofit hospitals. Hospital A was a "community hospital" governed by a board "composed of prominent citizens in the community." "Medical staff privileges in the hospital [were] available to all qualified physicians in the area, consistent with the size and nature of its facilities." Hospital A owned "a medical office building on its premises" at which doctors were charged rents "comparable to those of other commercial buildings in the area."

Hospital A's financial relationships with prospective patients was fundamentally different from the second test established in Rev. Rul. 56-185. In that earlier ruling, the hospital provided services "for those not able to pay."⁹² In contrast, Hospital A in Rev. Rul. 69-545 restricted its nonemergency services to patients who, directly or indirectly, paid for their care. In particular, Hospital A operates a full time emergency room and no one requiring emergency care is denied treatment. The hospital otherwise ordinarily limits admissions to those who can pay the cost of their hospitalization, either themselves, or through private health insurance, or with the aid of public programs such as Medicare. Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community that does serve indigent patients.⁹³

⁸⁹ I.R.C. § 162.

⁹⁰ I.R.C. § 263.

⁹¹ Rev. Rul. 69-545, 1969-2 C.B. 117. Courts have accepted Rev. Rul. 69-545's formulation of the "community benefit" standard for nonprofit hospitals. *See, e.g., St. David's Health Care Sys. v. United States*, 349 F.3d 232, 235-36 (5th Cir. 2003) (accepting the "community benefit" standard of Rev. Rul. 69-545).

⁹² Rev. Rul. 56-185, 1956-1 C.B. 202.

⁹³ Rev. Rul. 69-545, 1969-2 C.B. 117.

Hospital A operated profitably and “generally applied” its annual profits “to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research.”⁹⁴

Hospital B in Rev. Rul. 69-545 started as a proprietary institution. Subsequently, the five physicians who owned Hospital B sold it to a nonprofit entity at fair market value. The board of trustees governing this nonprofit entity consisted of these five founding doctors plus the doctors’ lawyer and their accountant. While these five doctors granted hospital staff privileges to four doctors beside themselves, they rejected the applications for hospital staff privileges “of a number of qualified doctors in the community,”⁹⁵ thereby keeping these rejected doctors from admitting their patients to the hospital.

Hospital B further restricted patient admissions by maintain[ing] an emergency room, but on a relatively inactive basis, and primarily for the convenience of the patients of the staff doctors. The local ambulance services have been instructed by the hospital to take emergency cases to other hospitals in the area. The hospital follows the policy of ordinarily limiting admissions to those who can pay the cost of the services rendered.⁹⁶

The five doctors who founded and continued to govern Hospital B were the only physicians permitted to keep offices at the hospital. These doctors paid the hospital below market rents for their respective offices.

In a “modifi[ca]tion”⁹⁷ of the second test of Rev. Rul. 56-185, the IRS held in Rev. Rul. 69-545 that Hospital A was a tax-exempt charity by virtue of its emergency room even though Hospital A otherwise served only patients who could afford to pay:

By operating an emergency room open to all persons and by providing hospital care for all those persons in the community able to pay the cost thereof either directly or through third party reimbursement, Hospital A is promoting the health of a class of persons that is broad enough to benefit the community.⁹⁸

Buttressing the IRS’s conclusion that Hospital A benefitted the community were the governance of Hospital A by a board “composed

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.* A challenge to this aspect of Rev. Rul. 69-545 was dismissed for lack of standing in *Simon v. East Kentucky Welfare Rights Org.*, 426 U.S. 26 (1976).

of independent civic leaders”⁹⁹ and Hospital A’s policy of granting privileges to all physicians, all of whom could rent office space in Hospital A. In contrast, Hospital B did not qualify for federal tax-exemption. Hospital B, the IRS held, was still effectively controlled by the five founding physicians who operated Hospital B for their “private benefit.”¹⁰⁰

Hospital A indeed looks somewhat more charitable than does Hospital B. But, with the benefit of hindsight,¹⁰¹ Hospital A does not look so charitable. Outside of Hospital A’s emergency room, Hospital A accepted only patients who could afford to pay. Moreover, we are today more skeptical of the independence of nominally autonomous boards than were the drafters of Rev. Rul. 69-545.¹⁰² And the physicians with staff privileges at Hospital A (while more numerous than the doctors permitted to practice in Hospital B) used Hospital A to conduct their private medical businesses.

Underpinning the IRS’s conclusion in Rev. Rul. 69-545 is the proposition which has come to be called the “community benefit”¹⁰³ standard:

⁹⁹ Rev. Rul. 69-545, 1969-2 C.B. 117.

¹⁰⁰ *Id.*

¹⁰¹ To some, Hospital A did not look so charitable at the time. See *Simon*, 426 U.S.

¹⁰² Thomas Lee Hazen & Lisa Love Hazen, *Punctilios and Nonprofit Corporate Governance - A Comprehensive Look at Nonprofit Directors’ Fiduciary Duties*, 14 U. PA. J. BUS. L. 347, 398–99 (2012) (“Unfortunately, many nonprofit boards in fact act as a rubber stamp, and this reflects inattention or an ‘abdication’ of directors’ oversight responsibilities. Surprisingly, there is some evidence that the lack of meaningful oversight increases with the size of the nonprofit.”); Melanie B. Leslie, *Helping Nonprofits Police Themselves: What Trust Law Can Teach Us About Conflicts of Interest*, 85 CHI.-KENT L. REV. 551, 564 (2010) (“Nonprofit boards are uniquely vulnerable to groupthink, because information asymmetries are more pronounced, market pressures are relatively weak, and board members may view themselves less as monitors and more as fundraisers and ‘supporters’ of the group’s executive director. In some cases, board members may view membership as conferring an entitlement to self-deal, especially when board membership comes at a price.”). See also *infra* note 180.

¹⁰³ See, e.g., *IHC Health Plans v. Comm’r*, 325 F.3d 1188, 1197 (10th Cir. 2003) (“community benefit” is a “somewhat amorphous” but “workable standard”); Erin C. Fuse Brown, *Fair Hospital Prices Are Not Charity: Decoupling Hospital Pricing and Collection Rules From Tax Status*, 53 U. LOUISVILLE L. REV. 509, 537–38 (2016) (“a community benefit under IRS rules”); Erica A. Clausen & Abbey L. Hendricks, Note, *Cultivating the Benefit of § 501(r)(3): §501(r)(3) Requirements for Nonprofit Hospitals*, 20 LEWIS & CLARK L. REV. 1025, 1028–29 (2016) (discussing “the IRS’s community benefit standard”); Brandon Huber, Note, *Implementing 501(r): Has 501(r) Lived Up to Its Intended Purpose? And What the IRS’ 2017 Revocation Action Means for the Tax-Exempt Hospital Community*, 2 BELMONT HEALTH L.J. 52, 57 (2018) (“which is now more commonly known as the ‘community benefit’ standard”).

The promotion of health, like the relief of poverty and the advancement of education and religion, 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, provided that the class is not so small that its relief is not of benefit to the community.¹⁰⁴

But today, health care in general and hospitals in particular are businesses, not charities.

Rev. Rul. 83-157 further weakened the community benefit standard by holding that Hospital A could be federally tax-exempt without maintaining an emergency room available to all.¹⁰⁵ In Rev. Rul. 83-157 “a state health planning agency has determined that the operation of an emergency room by the hospital is unnecessary because it would duplicate emergency services and facilities that are adequately provided by another medical institution in the community.”¹⁰⁶ The hospital nevertheless remained tax-exempt under Section 501(c)(3) because of “[o]ther significant factors.”¹⁰⁷ These included, in addition to “a board of directors drawn from the community [and] an open medical staff policy,”¹⁰⁸ a new consideration, the hospital’s “treatment of persons paying their bills with the aid of public programs like medicare and medicaid.”¹⁰⁹

Here, again, a factor which in 1983 the IRS deemed to support a hospital’s nonprofit status carries different connotations four decades later. Medicaid and Medicare are today widely accepted by for-profit hospitals because, at their core, Medicare and Medicaid are insurance programs which operate similarly to private health insurance.¹¹⁰

Professor John D. Colombo aptly labelled “the community benefit test. . . a complete failure,”¹¹¹ lacking any content and therefore “essentially useless as a legal test for exemption”¹¹²:

¹⁰⁴ Rev. Rul. 69-545, 1969-2 C.B. 117.

¹⁰⁵ Rev. Rul. 83-157, 1983-2 C.B. 94. Huber, *supra* note 103, at 57 (Rev. Rul. 83-157 “relaxed the [community benefit] standard even further”).

¹⁰⁶ Rev. Rul. 83-157, 1983-2 C.B. 94.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ See *supra* notes 57–64 and accompanying text.

¹¹¹ Colombo, *supra* note 44, at 29.

¹¹² *Id.* at 62.

If providing health care services for a fee is itself charitable, then the test for exemption requires no more than what for-profit organizations do in the course of their business.¹¹³

The community benefit test... failed to isolate any significant quantifiable behavioral difference between for-profit and nonprofit health care providers.¹¹⁴

V. SUPPLEMENTING COMMUNITY BENEFIT STANDARD: INTERNAL REVENUE CODE SECTION 501(R)

The concerns addressed by Senator Grassley and others¹¹⁵ as well as the failure of the community benefit standard led Congress in the ACA to supplement¹¹⁶ that standard with Code Section 501(r). Section 501(r) as it finally emerged from the legislative process does little to curb the commerciality of nonprofit hospitals. The inadequacies of Section 501(r) suggest both that, as a substantive matter, the problematic tax exemption of nonprofit hospitals cannot be repaired, but must be repealed, and that, as a political matter, such repeal will face formidable opposition from the nonprofit hospital lobby.

Section 501(r) now conditions a nonprofit hospital's federal income tax exemption upon the satisfaction of four criteria on top of the community benefit test. First, under Section 501(r), an exempt hospital must periodically "conduct[] a community health needs assessment"¹¹⁷ and must "adopt[] an implementation strategy to meet" those needs.¹¹⁸ A nonprofit hospital's needs assessment must reflect "input from persons who represent the broad interests of the community"¹¹⁹ and must be "made widely available to the public."¹²⁰

Second, under Section 501(r), a nonprofit hospital seeking tax-exempt status must have two written policies: a "written financial assistance policy,"¹²¹ including "eligibility criteria,"¹²² and a "written policy" requiring the hospital "to provide, without discrimination

¹¹³ *Id.* at 41.

¹¹⁴ *Id.* at 42. See also GAO, *supra* note 58, at 1, 28 ("lack of clarity" in community benefit standard).

¹¹⁵ See, Brown, *supra* note 44.

¹¹⁶ S. Rep. No. 111-89, at 336 (2009) ("No inference is intended regarding whether an organization satisfies the present law community benefit standard.").

¹¹⁷ I.R.C. § 501(r)(1)(A),(r)(3)(A)(i).

¹¹⁸ *Id.* at § 501(r)(1)(A),(r)(3)(A)(ii).

¹¹⁹ *Id.* at § 501(r)(3)(B)(i).

¹²⁰ *Id.* at § 501(r)(3)(B)(ii).

¹²¹ *Id.* at § 501(r)(1)(B),(r)(4)(A).

¹²² *Id.* at § 501(r)(4)(A)(i).

...emergency medical" care whether or not the individual receiving such emergency care is eligible under the hospital's financial assistance policy.¹²³ Besides its eligibility criteria, an exempt hospital's financial assistance policy must state whether the hospital's assistance "includes free or discounted care."¹²⁴

That policy must also state "the basis for calculating amounts charged to patients,"¹²⁵ and "the method for applying for financial assistance."¹²⁶ Unless a nonprofit hospital has "a separate billing and collections policy," its financial assistance policy must also identify "the actions the [hospital] may take in the event of non-payment, including collections action and reporting to credit agencies."¹²⁷ Finally, a hospital's financial assistance policy must include the "measures" the hospital will undertake "to widely publicize the policy."¹²⁸

The third requirement imposed by Section 501(r) limits a nonprofit hospital's charges for the patients who qualify under the hospital's financial assistance policy.¹²⁹ As to these patients, the hospital cannot charge "for emergency or other medically necessary care,"¹³⁰ "more than the amounts generally billed to individuals who have insurance covering such care."¹³¹ In addition, as to other care (which is not "medically necessary"), a 501(c)(3) hospital cannot impose upon aid-eligible individuals "gross charges,"¹³² i.e., elevated "chargemaster" rates.¹³³

Finally, Section 501(r) forbids a nonprofit hospital to "engage in extraordinary collection actions" against a patient unless the hospital "has made reasonable efforts to determine" if the patient is eligible for

¹²³ *Id.* at § 501(r)(1)(B),(r)(4)(B).

¹²⁴ *Id.* at § 501(r)(4)(A)(i).

¹²⁵ I.R.C. § 501(r)(4)(A)(ii).

¹²⁶ *Id.* at § 501(r)(4)(A)(iii).

¹²⁷ *Id.* at § 501(r)(4)(A)(iv).

¹²⁸ *Id.* at § 501(r)(4)(A)(v).

¹²⁹ *Id.* at § 501(r)(1)(C),(r)(5).

¹³⁰ *Id.* at § 501(r)(5)(A).

¹³¹ *Id.*

¹³² *Id.* at § 501(r)(5)(B). *See also* Treas. Reg. § 1.501(r)-1(b)(16) ("Gross charges" means "the chargemaster rate").

¹³³ *See supra* notes 45–55 and accompanying text (describing hospital's "chargemaster" rates). Read literally, I.R.C. § 501(r)(5)(B) imposes a blanket ban on all "gross charges." However, the Treasury regulations interpret this statutory ban on "chargemaster" rates as applying only to individuals eligible for assistance under the hospital's financial assistance policy. *See* Treas. Reg. § 1.501(r)-5(c) (ban on gross charges applies to "FAP-eligible individual[s]").

aid under the hospital's financial assistance policy.¹³⁴ The Treasury regulations define such "extraordinary collection efforts" broadly to include most forms of "legal or judicial process."¹³⁵

For five reasons, Code Section 501(r) is no better at ensuring the charitable nature of nonprofit hospitals than is the failed community benefit standard Section 501(r) supplements. A hospital can fully comply with Section 501(r) without materially modifying its commercial practices.

First, Section 501(r)(4) merely requires that a hospital have a "written financial assistance policy."¹³⁶ There are no substantive requirements for this policy. A hospital's financial assistance policy may be tightfisted and may cover few individuals. As Prof. Brown observes, "[t]here is nothing in § 501(r)'s requirements to prevent a hospital from adopting a stingy financial assistance policy."¹³⁷ As long as this policy is reduced to writing, it complies with Section 501(r).

Second, Section 501(r)(6)'s regulation of collection practices is tied to a hospital's (potentially miserly) financial assistance policy.¹³⁸ A hospital need only refrain from collection activity while it determines if an individual qualifies for help under the hospital's financial assistance policy. Once that determination is made, the hospital may pursue collection activities against an aid-eligible individual, as long as the financial assistance policy specifies the collection activities the hospital will undertake.

Third, unlike Rev. Rul. 56-185 which required nonprofit hospitals to "accept patients in need of hospital care who cannot pay for such services,"¹³⁹ Section 501(r)(5)(A)¹⁴⁰ permits hospitals to charge indigent patients for "emergency" and "medically necessary care" "the amounts generally billed to individuals who have insurance" – even if these impoverished individuals lack such insurance. Charging prevailing prices to indigent patients may be sensible commercial business practice, but it is not charity.

Fourth, as to services which are not "medically necessary" for purposes of Section 501(r)(5)(B), nonprofit hospitals must charge aid-

¹³⁴ I.R.C. § 501(r)(1)(D),(r)(6).

¹³⁵ Treas. Reg. § 1.501(r)-6(b)(1)(iv).

¹³⁶ I.R.C. § 501(r)(1)(B),(r)(4)(A).

¹³⁷ Brown, *supra* note 103, at 530 ("Among the sample of hospitals reviewed eligibility cutoffs for financial assistance ranged from 100% of FPL, up to 600% of the FPL").

¹³⁸ I.R.C. § 501(r)(6).

¹³⁹ Rev. Rul. 56-185, 1956-1 C.B. 202.

¹⁴⁰ I.R.C. § 501(r)(5)(A).

eligible individuals “less” than the hospitals’ “gross prices.”¹⁴¹ ¹⁴² However, the statute and regulations fail to specify how much “less” must be charged. Presumably, a \$1 discount from a hospital’s artificially high chargemaster price will be deemed de minimis and therefore noncompliant with Section 501(r)(5)(B). But it is unclear how much below its gross prices a hospital must charge an aid-eligible individual to satisfy Section 501(r)(5)(B).

Finally, Section 501(r) will be difficult for the IRS to enforce as there are no intermediate sanctions buttressing most of the statute. An important development in the law of tax exemption has been the growth of so-called intermediate sanctions, monetary policies levied against noncompliant exempt entities.¹⁴³ The insight underlying the growth of these penalty provisions is that enforcement against tax-exempt institutions is difficult when the IRS’s choices are “all or nothing,” i.e., revoking a noncompliant entity’s tax-exempt status or taking no enforcement action.¹⁴⁴

Intermediate sanctions are designed to give the IRS a middle course, the alternative of permitting the noncompliant institution to retain its tax-exemption but requiring the institution (and often the persons managing it) to pay monetary penalties for their failure to obey the strictures of the Code.¹⁴⁵

Congress established in Code Section 4959 such an intermediate sanction to enforce Section 501(r)(3) and its requirement of a

¹⁴¹ Treas. Reg. § 1.501(r)-5(c).

¹⁴² I.R.C. § 501(r)(5)(B).

¹⁴³ Among the early and still most important of these intermediate sanctions are the penalty taxes applicable to private foundations, qualified plans and their managers. See I.R.C. § 4940–4948 (penalty taxes with respect to private foundations); I.R.C. § 4971–4980 (penalty taxes with respect to qualified plans).

¹⁴⁴ Norman I. Silber, *Nonprofit Interjurisdictionality*, 80 CHI.-KENT L. REV. 613, 625 (2005) (intermediate sanctions “added to the extreme and mostly impractical remedy of revocation of exemption the less catastrophic sanction of financial penalties potentially imposed on directors, disqualified persons, and managers.”).

¹⁴⁵ Ann M. Murphy, *Campaign Signs and the Collection Plate – Never the Twain Shall Meet?* 1 PITT. TAX REV. 35, 57 (2003) (“the Service may have been reluctant to revoke a tax-exempt entity’s status in circumstances where that penalty may be disproportionate to the offense.”) (internal quotation marks omitted); Robert C. DeGaudenzi, *Tax-Exempt Public Charities: Increasing Accountability and Compliance*, 36 CATH. L. 203, 230 (1995) (“Although the I.R.S. is generally reluctant to revoke an abusive charity’s tax exemption, the alternative recourse - inaction - has proven equally inappropriate. Thus, the general consensus that some form of intermediate sanction is necessary cannot be reasonably disputed.”).

community health needs assessment.¹⁴⁶ But Congress failed to provide intermediate sanctions for the rest of Section 501. Thus, as to the other requirements of Section 501(r) (written financial assistance policy,¹⁴⁷ limitations on charges for aid-eligible individuals,¹⁴⁸ and restrictions on billing practices¹⁴⁹), the IRS can, in the face of a violation, only revoke the offending hospital's exemption – or do nothing. And historically, confronted with such an all-or-nothing choice, the IRS has generally elected to do nothing.¹⁵⁰

For these five reasons, Section 501(r) fails to remedy the commercial nature of the contemporary nonprofit hospital and suggests that that nature cannot be remedied.

Section 501(r) and its attenuated requirements for nonprofit hospital tax-exemption also constitute a cautionary political tale. Despite the outspoken advocacy of the influential chairman of the Senate Finance Committee, the legislation which emerged from the political process largely left the status quo intact. Although, as a matter of substance, there is no justification for the tax exemption of nonprofit hospitals, those hospitals will fight formidably to protect it. The attenuated nature of the requirements imposed by Section 501(r) upon nonprofit hospitals indicates that the hospital industry receives its money's worth for its considerable outlays for lobbying services.¹⁵¹

¹⁴⁶ I.R.C. § 4959 (failure to “meet the requirement of section 501(r)(3)” results in penalty tax of \$50,000).

¹⁴⁷ I.R.C. § 501(r)(4).

¹⁴⁸ I.R.C. § 501(r)(5).

¹⁴⁹ I.R.C. § 501(r)(6).

¹⁵⁰ Lauren Rogal, *Executive Compensation in the Charitable Sector: Beyond the Tax Cuts and Jobs Act*, 50 SETON HALL L. REV. 449, 474–75 (2019) (“Upon a finding of private inurement, the I.R.S. may revoke the organization’s exempt status, but this is relatively rare. Between 2011 and 2013, the I.R.S. revoked the exempt status of fewer than 100 organizations for private inurement and related problems.”).

¹⁵¹ In 2018, “[t]he American Hospital Association and its state subsidiaries collectively” spent \$23.9 million for lobbying services. Tony Abraham, *Hospital lobbying in 2018 – by the numbers*, HEALTHCARE.DIVE.COM (Feb. 19, 2019), <https://www.healthcaredive.com/news/hospital-lobbying-in-2018-by-the-numbers/548262/>. In addition, particular nonprofit hospitals individually spend significant amounts for lobbying services. For example, in 2021, the Mayo Clinic spent \$730,000 on lobbying services while the Cleveland Clinic’s expenditures on lobbying services were similar. *Client Profile*, OPEN SECRETS.ORG (last updated Feb. 16, 2023), <https://www.opensecrets.org/federal-lobbying/clients/summary?cycle=2021&id=D000035692>.

VI. THE 2017 AND 2022 CODE PROVISIONS

Other Code provisions adopted in 2017 and in 2022 reinforce the substantive case for terminating the tax-exemption of nonprofit hospitals. Sections 168(k) and 172(b)(1)(D), adopted in 2017 as part of the Tax Cuts and Jobs Act,¹⁵² highlight the major stakes of such exemption, namely, sheltering nonprofit hospitals from the vagaries of congressional decision-making about the deductibility vel non of capital expenditures and about loss carrybacks. Section 4960, also adopted in 2017, suggests that highly-compensated managers of nonprofit hospitals effectively act as the equity of such institutions in that they divert corporate earnings to themselves through inflated salaries. These elevated salaries are labeled wage compensation but are in reality dividend-like diversions of corporate profits.

Most recently, the Inflation Reduction Act of 2022,¹⁵³ incorporated within its minimum corporate tax the 2017 act's generous deductions for capital expenditures and that act's abolition of loss carrybacks. This incorporation confirms the importance of the political protection that nonprofit institutions, including nonprofit hospitals, receive from tax-exempt status.

A. *Section 168(k)*

Just as Section 501(r) requires us to revisit the debate about the tax-exemption for nonprofit hospitals, Code Section 168(k)¹⁵⁴ similarly impacts our evaluation of hospitals' tax-exempt status by highlighting the stakes of tax exemption. As amended in 2017 by the Tax Cuts and Jobs Act,¹⁵⁵ Section 168(k) created a five-year period through December 31, 2022, during which most domestic capital expenditures for personal property were fully deductible for income tax purposes.¹⁵⁶ That deduction will phase out gradually, terminating at the end of 2027.¹⁵⁷ It remains to be seen whether this experiment in full deductibility for many capital expenditures presages a permanent shift in tax policy toward full deductibility or will instead be the high-water mark for the full deductibility for capital expenditures. Under either scenario, tax exemption for commercialized, nonprofit hospitals is

¹⁵² Tax Cuts and Jobs Act, Pub. L. No. 115-97, §§ 13201(a), 13302(a), 131 Stat. 2054, 2105, 2122 (2017).

¹⁵³ Inflation Reduction Act, Pub. L. No. 117-69, 136 Stat. 1818 (2022).

¹⁵⁴ I.R.C. § 168(k).

¹⁵⁵ Tax Cuts and Jobs Act, Pub. L. No. 115-97, § 13201(a), 131 Stat. 2054, 2105 (2017).

¹⁵⁶ I.R.C. § 168(k)(6)(A)(i).

¹⁵⁷ I.R.C. § 168(k)(6)(A)(ii)-(v).

problematic since such exemption shelters nonprofit hospitals from the vagaries of congressional decision-making to which equally commercial for-profit hospitals are subject.

Consider a hospital that in a year makes a profit of \$100. Suppose further that this hospital uses this current profit of \$100 to finance \$100 of capital expenditures for machinery and equipment purchased and put into service in that year. In a world of full deductibility (as was provided by Section 168(k) through 2022), it does not matter for federal income tax purposes whether this hospital is tax-exempt or not. Either way, this hospital owes no federal corporate income tax. If the hospital is tax-exempt, that exemption shields the hospital's profit of \$100 from federal income tax. If this hospital is not exempt, the full deductibility of the \$100 capital expenditure reduces the hospital's taxable income to \$0, thereby eliminating any federal tax liability. In this context, Section 501(c)(3) acts as a political insurance policy, protecting the nonprofit hospital against the vicissitudes of congressional decision-making. A tax-exempt hospital need not concern itself whether Congress (as currently scheduled)¹⁵⁸ allows the income tax to revert to a policy prohibiting deductions for capital expenditures. Even if capital expenditures are nondeductible, a nonprofit hospital owes no tax. If, on the other hand, Congress again embraces (and perhaps expands to real property) the policy of full deductibility for capital expenditures, tax exemption for this hospital is an insurance policy guarding against a future return to a policy of limited or no deductibility.

The question then becomes: Why should the Code bestow this insurance policy on nonprofit hospitals, in light of the highly profitable, commercial nature of these hospitals' operations? The traditional answer is that these hospitals generate community benefits,¹⁵⁹ but this answer is no longer credible (if it ever was) since nonprofit hospitals' operations are materially indistinguishable from the operations of their for-profit competitors. The revised answer is that Section 501(r) ensures the charitable nature of nonprofit hospitals' activities. That answer is equally unpersuasive, given the weaknesses of Section 501(r).¹⁶⁰

The stronger conclusion today is that nonprofit hospitals do not deserve immunity from the risks of congressional decision-making. If future Congresses deny deductibility to capital expenditures, the capital outlays of nonprofit hospitals should receive the same tax

¹⁵⁸ I.R.C. § 168(k)(6)(A).

¹⁵⁹ See *supra* notes 80–114 and accompanying text.

¹⁶⁰ See *supra* notes 115–50 and accompanying text.

treatment as the capital outlays of their for-profit competitors, resulting in the same income tax for both kinds of hospitals.

B. *Section 172(b)(1)(D)*

At the same time that the Tax Cuts and Jobs Act in 2017 expanded the deductibility of capital expenditures, that legislation also abolished net operating loss carrybacks.¹⁶¹ Before this amendment to the Code, Congress had permitted loss carrybacks to the taxpayer's two prior years.¹⁶² During the Covid-19 crisis in 2020, Congress adopted Code Section 172(b)(1)(D),¹⁶³ permitting losses arising in 2018, 2019 and 2020 to be carried back for five years. This temporarily opened the door to the Treasury during the Covid-19 crisis, allowing taxpayers with current losses to reopen prior, profitable years and receive refunds of the taxes they had paid earlier in those profitable years. We are now back to the rule Congress adopted in 2017 and then suspended for the coronavirus crisis, i.e., no loss carrybacks.¹⁶⁴

Section 172(b)(1)(D), like Section 168(k), highlights the stakes of tax-exemption. Full deductibility of capital expenditures brings the income tax treatment of for-profit and nonprofit hospitals closer together by reducing and perhaps eliminating income taxation for proprietary hospitals. In contrast, denying capital loss carrybacks drives the tax treatment of nonprofit and proprietary hospitals apart by preventing for-profit hospitals with current losses from seeking refunds of taxes paid in earlier, profitable years.

In this context, recall the earlier example of hospitals making a profit in year one and experiencing a loss in year two.¹⁶⁵ In this example, tax parity is established between the taxable hospital and the tax-exempt hospital if the taxed hospital can carryback its year two loss to receive a refund of year one's tax payment. In a world without loss carrybacks, this parity is broken since the Treasury keeps the taxable hospital's tax payment from year one while this hospital's year two loss is only carried forward into year three when it will only generate tax benefit if the hospital is profitable in that year. In contrast, the

¹⁶¹ Tax Cuts and Jobs Act, Pub. L. No. 115-97, § 13302(a), (d), 131 Stat. 2054, 2122–23 (2017) (Loss carrybacks were preserved for “farming businesses” and “insurance companies”). I.R.C. § 172(b)(1)(B) and 172(b)(1)(C).

¹⁶² See I.R.C. § 172(a)(2), (b)(1)(A) prior to amendment by Tax Cuts and Jobs Act, 26 U.S.C.A. § 172 (permitting carryback losses to prior two taxable years).

¹⁶³ I.R.C. § 172(b)(1)(D).

¹⁶⁴ I.R.C. § 172(a) (no loss carrybacks for “taxable year[s] beginning after December 31, 2020”).

¹⁶⁵ See *supra* pp. 14–15. -12 13

exempt hospital pays no tax on its year one profits by virtue of its exempt status.

The question again becomes: should the Code bestow favorable treatment on a tax-exempt hospital (excused from paying tax on its year one profits) while denying equivalent treatment to the comparable for-profit hospital required to carry year two's loss forward into year three)? Neither the attenuated community benefit standard nor the equally weak Section 501(r) justifies this more favorable tax treatment for a money-making, nonprofit hospital.

C. Section 4960

Section 4960,¹⁶⁶ which was also adopted in 2017 as part of the Tax Cuts and Jobs Act,¹⁶⁷ likewise requires us to revisit the tax-exempt status of nonprofit hospitals. Under this section, all 501(c)(3) organizations must pay a corporate-style tax on compensation paid in any year to a "covered" employee who earns in excess of one million dollars in that year.¹⁶⁸ For this purpose, a "covered" employee is an individual who currently is or who in a prior taxable year was one of the employer's five highest paid employees.¹⁶⁹ Section 4960 buttresses the view that highly-paid hospital administrators effectively act as the equity of nonprofit hospitals by diverting corporate earnings to themselves for payments which are disguised dividends distributions of corporate earnings that are mislabeled as salaried compensation for services rendered. Section 4940 imposes a corporate-level tax on these disguised dividend payments.¹⁷⁰

¹⁶⁶ I.R.C. § 4960.

¹⁶⁸ I.R.C. § 4960(a). Code section 4958 levies an excise tax on any "excess benefit transaction" with a tax-exempt entity including overpayments for services rendered to such entity. section 4958, unlike Code section 4960, does not impose a corporate-level tax. Rather, section 4958 imposes a penalty tax on the "disqualified person" and the managers engaging in such "excess benefit transaction" with a tax-exempt entity. I.R.C. 4958.

¹⁶⁹ I.R.C. § 4960(c)(2).

¹⁷⁰ In large measure, section 4960 is modeled on Code section 162(m) which denies deductibility to executive compensation payments in excess of one million dollars annually. I.R.C. § 162(m). Just as section 4960 is best understood as imposing corporate-level income tax on executive compensation payments which are in reality disguised dividends, section 162(m) is best understood as recognizing that payments to overcompensated corporate executives are dividend-like diversions of corporate earnings to those executives. Edward A. Zelinsky, *The Tax Policy Case For Denying Deductibility to Excessive Executive Compensation: Disguised Dividends, Reasonable Compensation, and the Protection of the Corporate Income Tax Base*, 58 TAX NOTES 1123 (1993) (defending § 162(m) as denying a deduction for "disguised dividends").

Section 4960(c)(3)(B) specifically excludes from its corporate-level tax any payment “to a licensed medical professional (including a veterinarian) for the performance of medical or veterinary services by such professional.”¹⁷¹ Consequently, payments to superstar physicians are not subject to the Section 4960 tax. However, the regulations subject to this corporate-level tax the salaries of nonprofit hospital administrators even if such administrators are “licensed medical professionals.”

In particular, for purposes of Section 4960, incidental administrative services such as “documenting the care and condition of a patient” are deemed to be the performance of medical services.¹⁷² Thus, a treating physician whose tasks include “examining and updating patient records” performs medical services and so is not a covered employee for purposes of the Section 4960 tax.¹⁷³

On the other hand, under the regulations, a physician whose duties consist of “administrative tasks such as analyzing the budget, authorizing capital expenditures, and managing human resources” is not performing medical services for purposes of Section 4960.¹⁷⁴ This physician’s salary is subject to the Section 4960 tax if the physician is or was one of the employer’s five highest paid employees.

Most of the commentary about Section 4960 has focused on the salaries paid to college football and basketball coaches.¹⁷⁵ At one level, this focus is misplaced. While big-time college athletics is a commercial enterprise,¹⁷⁶ these coaches work in a highly competitive environment. Their respective performances are easily monitored in their teams’ win-loss records. College coaches get sacked when they fail. As Professors Schmalbeck and Zelenak observe, in big-time college athletics programs, “[c]oaches are hired for their ability to win games

¹⁷¹ I.R.C. § 4960(c)(3)(B).

¹⁷² Treas. Reg. § 53.4960-1(g)(1)(i) (2021).

¹⁷³ Treas. Reg. § 53.4960-1(g)(1)(ii)(A) (2021).

¹⁷⁴ Treas. Reg. § 53.4960-1(g)(1)(ii)(B) (2021).

¹⁷⁵ See, e.g., Karla M. Nettleton, *I.R.C. § 4960’s Impact on College Sports: In Light of IRS Guidance Certain Universities Will Need to Engage in Tax Planning*, 32 MARQ. SPORTS L. REV. 117, 129–30 (2022) (discussing college coaches’ salaries).

¹⁷⁶ Richard Schmalbeck & Lawrence Zelenak, *The NCAA and the IRS: Life at The Intersection of College Sports and The Federal Income Tax*, 92 S. CAL. L. REV. 1087, 1089–96 (2019); Pat Forde, *All Aboard?*, 133 SPORTS ILLUSTRATED F2, F4 (Sept. 2022) (“the only fundamental difference between [college football] and the NFL are the athletes’ ages and pay, and the primary day of the week on which they play . . . money now drives every decision in college sports.”).

and fired for any shortcomings in that metric.”¹⁷⁷ Coaches’ salaries thus reflect arms-length negotiation in a competitive market. If lucrative athletic programs were taxed like the professional teams these programs resemble,¹⁷⁸ coaches’ salaries would be deductible as reasonable business expenses.

The large salaries paid to nonprofit hospitals’ managers are different from salaries paid to college athletic coaches. The salaries paid to nonprofit hospitals’ managers are typically set by captured boards, which the managers themselves help to pick. While hospital managers can point to each other’s inflated salaries to claim to be receiving market rate compensation, Section 4960 suggests that these salaries, are not reasonable arm’s-length compensation, and are instead effectively dividend-style payments to entrenched management. If no shareholders implies no corporate tax, Section 4960 suggests that the management of nonprofit hospitals functions as de facto shareholders.

Professor Aprill argues that the hastily-drafted Section 4640 fails to reach some, or perhaps many, large salaries paid to coaches and athletic administrators by public universities which claim tax-exempt status, not under Section 501(c)(3), but under “implied statutory immunity.”¹⁷⁹ My impression is that this is less of a concern in the context of publicly-owned nonprofit hospitals which are typically incorporated as separate 501(c)(3) entities to cabin their potential liabilities. But even if there are some publicly-owned nonprofit hospitals that escape the coverage of section 4960, the underlying insight remains intact. In the context of nonprofit hospitals, section 4960 is best understood as confirming that highly compensated managers are entrenched managers. Through their capture of the boards which set

¹⁷⁷ Schmalbeck & Zelenak, *supra* note 176, at 1097. See also Laine Higgins, *The 2022 College Football Season Is Setting Records—in Coach Firings*, WALL ST. J. (Oct. 4, 2022), <https://www.wsj.com/articles/college-football-season-coach-firings-11664872294>.

¹⁷⁸ Professors Schmalbeck & Zelenak favor the application of the unrelated business income tax at least to the television revenues generated by college sports programs. *Supra* note 176, at 1099-1112. These revenues can be substantial. See, e.g., Laine Higgins, *Big Ten Strikes \$7.5 Billion Deal for TV Rights*, WALL ST. J. (Aug. 18, 2022), <https://www.wsj.com/articles/big-ten-tv-rights-11660829533> (“The Big Ten struck a massive new seven-year contract with Fox, CBS and NBC . . .”); Kris Rhim & Jesus Jimenez, *Big Ten Players Wonder Where They Fit Into a \$1 Billion TV Deal*, N.Y. TIMES (Aug. 20, 2020), <https://www.nytimes.com/2022/08/19/sports/ncaafotball/big-ten-tv-deal-student-athletes.html> (“The Big Ten’s big deal . . . is worth an average of at least \$1 billion a year.”).

¹⁷⁹ Ellen P. Aprill, *Revisiting Federal Tax Treatment of States, Political Subdivisions, and Their Affiliates*, 23 FLA. TAX REV. 73, 79–80, 83 (2019).

their salaries,¹⁸⁰ these hospital managers act as de facto equity, extracting dividend-like payments of corporate earnings from these allegedly nonprofit organizations under the guise of earned compensation. Section 4960 subjects these disguised dividends to corporate-level tax.

D. The Inflation Reduction Act of 2022

The events surrounding the Inflation Reduction Act of 2022 (IRA22)¹⁸¹ confirm the importance of the political protection which nonprofit institutions, including nonprofit hospitals, receive from tax-exempt status.

The central revenue-raising provision of IRA22 is a minimum corporate tax based on a corporation's "adjusted financial statement income,"¹⁸² i.e., the "book" income a corporation publishes to its shareholders and lenders. As part of the legislative process culminating in the Senate's adoption of this new minimum corporate tax, Senator Kyrsten Sinema insisted that this tax should not use the relatively slow depreciation schedules employed for determining book income.¹⁸³ Instead, Senator Sinema secured for purposes of this new minimum tax the deduction of capital expenditures utilizing the more generous provisions of Code section 168(k) added by the 2017 tax

¹⁸⁰ Legal analysts who discuss overcompensation of corporate executives generally attribute such overcompensation in large measure to management's capture of the boards setting the terms of management compensation. The same factors causing board capture in the private sector occur (and may be worse) in the nonprofit sector. See, e.g., Lauren Rogal, *Executive Compensation in the Charitable Sector: Beyond the Tax Cuts and Jobs Act*, 50 SETON HALL L. REV. 449, 464–65 (2019) (Nonprofit "directors have social and professional ties to executives that may foster a culture of deference." "[C]harity principals have additional barriers to monitoring performance. They nearly always serve on a volunteer basis." There are no simple metrics for assessing performance as "charitable impact is more nuanced and susceptible to distortion by a self-interested executive."); Hazen & Hazen, *supra* note 102; Richard A. Posner, *Are American CEOs Overpaid, and, if so, What if Anything Should Be Done About It?*, 58 DUKE L.J. 1013, 1023 (2009) ("[B]oards have weak incentives to limit CEO compensation. The problem is exacerbated by the fact that a board of directors is likely to be dominated by highly paid business executives, including CEOs of other companies."); Charles Yablon, *Overcompensating: The Corporate Lawyer and Executive Pay*, 92 COLUM. L. REV. 1867, 1869–70 (1992) ("A CEO, assisted by a good compensation consultant, can get his board of directors to adopt virtually any compensation package.") ("[C]ompliant boards of directors. . .").

¹⁸¹ P.L. 117-169.

¹⁸² *Id.* § 10101.

¹⁸³ Andrew Duehren, *Democrats, Sinema Agree To Move Forward on Bill*, WALL ST. J. (Aug. 5, 2022) p. A4; *Dems revise tax measure; Changes made to get support of centrist senator*, NEWSDAY (Aug. 6, 2022) p. 4.

act.¹⁸⁴ The net effect of this legislative maneuvering is to reduce the minimum tax imposed by IRA22, thereby preserving the pro-taxpayer benefits of the generous capital expenditure deduction provisions of the 2017 law.

In its treatment of net operating losses under the new book income minimum tax, IRA22 also implements Congress' 2017 decision to abolish loss carrybacks. The new minimum tax only permits corporations to deduct excess losses in subsequent years.¹⁸⁵

These congressional decisions are of great import to corporations that pay federal income tax, reducing their new minimum tax liabilities by permitting more rapid deduction of capital expenditures while simultaneously tightening corporations' new minimum tax obligations by denying loss carrybacks for purposes of the new minimum tax. In contrast, the congressional decisions embodied in IRA22 did not affect tax-exempt corporations like nonprofit hospitals, since their exempt status ensures that they pay no current tax anyways. Non-profit hospitals were effectively bystanders to the vagaries of the IRA22 congressional process by virtue of their tax-exempt status.¹⁸⁶

E. Conclusion

Along with section 501(r), Code sections 168(k), 172(b)(1)(D), and 4960, as well as the provisions of IRA22 pertaining to capital expenditure deductions and net losses, bolster the substantive case for ending the tax-exemption of nonprofit hospitals. Sections 168(k) and 172(b)(1)(D) underscore the stakes involved in such exemption, namely, protecting nonprofit hospitals from the vicissitudes of congressional decision-making. The legislative maneuvering around IRA22 confirms the benefits of this political immunity stemming from exempt status. Section 4960 implies that highly-compensated managers of nonprofit hospitals act as the equity of such institutions, diverting corporate earnings through inflated salaries to themselves for payments that are in reality disguised dividends from those corporate profits.

¹⁸⁴ I.R.C. § 56A.

¹⁸⁵ I.R.C. § 56A(d).

¹⁸⁶ Another important feature of the Inflation Reduction Act of 2022 is its extension through 2025 of Code section 36B's more generous premium assistance tax credit. This credit was previously scheduled to expire at the end of 2022. *See* P.L. 117-169 § 12001 (amending Code section 36B).

VII. NONPROFIT HOSPITALS' TAX STATUS IN THE STATE COURTS

This section expands this article's critique of the tax exemption of nonprofit hospitals to encompass the insights of the case law of the state courts. Persuasive state court decisions find that nonprofit hospitals and their related facilities are not property tax-exempt because such hospitals' business-like conduct of healthcare is commercial, rather than charitable, in nature. Among the themes of this case law are that Medicaid and Medicare disbursements are fee-for-service payments to hospitals, not manifestations of charity; hospitals' bad debt write-offs are business practices, not charity care; physicians practicing in hospitals are conducting commercial activity, not charity; hospital executives are compensated inordinately; few patients today receive free medical care; the "community benefit" standard lacks content and thus fails to justify the tax exemption of nonprofit hospitals. These themes buttress the narrative that the modern nonprofit hospital is not a charity but a business. Businesses pay tax.

A. State Constitutions and Statutes

The states' constitutions address in four basic ways the property tax status of hospitals and related facilities. Some state constitutions authorize or require property tax exemption of hospitals.¹⁸⁷ In other states hospitals are not explicitly granted constitutional property tax exemption but rather must establish such exemption as charitable or religious entities exempted from property tax by the state's constitution.¹⁸⁸ A third group of state constitutions is silent on property tax

¹⁸⁷ See, e.g., CAL. CONST. art. XIII, § 4(b) ("The Legislature may exempt from property taxation in whole or in part: . . . Property used exclusively for religious, hospital, or charitable purposes and owned or held in trust by corporations or other entities (1) that are organized and operating for those purposes, (2) that are nonprofit, and (3) no part of whose net earnings inures to the benefit of any private shareholder or individual."); MINN. CONST. art. X, § 1 ("[P]ublic hospitals . . . shall be exempt from taxation . . ."); MONT. CONST. art. VIII, § 5(1)(b) ("The legislature may exempt from taxation: . . . hospitals . . ."); S.C. CONST. ANN. art. X, § 3(b) ("There shall be exempt from ad valorem taxation: . . . (b) all property of all schools, colleges and other institutions of learning and all charitable institutions in the nature of hospitals and institutions caring for the infirmed, the handicapped, the aged, children and indigent persons, except where the profits of such institutions are applied to private use"). For a review of the state's constitutional provisions pertaining to tax-exemption, see Evelyn Brody, *All Charities are Property-Tax Exempt, But Some are More Exempt than Others*, 44 NEW ENG. L. REV. 621 (2010).

¹⁸⁸ See, e.g., Ariz. Const. art. IX, § 2(E) ("The legislature may exempt the following property by law: 1. The property of an educational, charitable or religious association

or institution that is not used or held for profit.”); ALA. CONST. art. IV, § 91 (“The legislature shall not tax . . . when same are used exclusively for religious worship, for schools, or for purposes purely charitable.”); ALASKA CONST. art. IX, § 4 (“All, or any portion of, property used exclusively for non-profit religious, charitable, cemetery, or educational purposes, as defined by law, shall be exempt from taxation.”); ARK. CONST. art. 16, § 5(b) (“The following property shall be exempt from taxation: public property used exclusively for public purposes; churches used as such; cemeteries used exclusively as such; school buildings and apparatus; libraries and grounds used exclusively for school purposes; and buildings and grounds and materials used exclusively for public charity.”); COLO. CONST. art. X, § 5 (“Property, real and personal, that is used solely and exclusively for religious worship, for schools or for strictly charitable purposes, also cemeteries not used or held for private or corporate profit, shall be exempt from taxation, unless otherwise provided by general law.”); FLA. CONST. art. VII, § 3(a) (“Such portions of property as are used predominantly for educational, literary, scientific, religious or charitable purposes may be exempted by general law from taxation.”); ILL. CONST. art. IX, § 6 (“The General Assembly by law may exempt from taxation . . . property used exclusively . . . for school, religious, cemetery and charitable purposes.”); KAN. CONST. art. 11, § 1(b) (“All property used exclusively for state, county, municipal, literary, educational, scientific, religious, benevolent and charitable purposes . . . shall be exempted from property taxation.”); LA. CONST. art. VII, § 21B(1)(a)(i) (“[T]he following property and no other shall be exempt from ad valorem taxation: . . . Property owned by a nonprofit corporation or association organized and operated exclusively for religious, dedicated places of burial, charitable, health, welfare, fraternal, or educational purposes, no part of the net earnings of which inure to the benefit of any private shareholder or member thereof and which is declared to be exempt from federal or state income tax;”); MO. CONST. art. X, § 6(1) (“[A]ll property, real and personal, not held for private or corporate profit and used exclusively for . . . purposes purely charitable . . . may be exempted from taxation by general law.”); N.Y. TAX LAW art. XVI, § 1 (Consol. 2022) (“Exemptions may be altered or repealed except those exempting real or personal property used exclusively for religious, educational or charitable purposes as defined by law and owned by any corporation or association organized or conducted exclusively for one or more of such purposes and not operating for profit.”); NEB. CONST. art. VIII, § 2(2) (“[T]he Legislature by general law may classify and exempt from taxation . . . property owned and used exclusively for educational, religious, charitable, or cemetery purposes, when such property is not owned or used for financial gain or profit to either the owner or user”); NEV. CONST. art. 10, § 1(8) (“The legislature may exempt by law property used for municipal, educational, literary, scientific or other charitable purposes”); N.M. CONST. art. VIII, § 3 (“[A]ll property used for educational or charitable purposes . . . shall be exempt from taxation.”); N.D. CONST. art. X, § 5 (“[P]roperty used exclusively for schools, religious, cemetery, charitable or other public purposes shall be exempt from taxation.”); OHIO CONST. art. XII, § 2 (“[G]eneral laws may be passed to exempt burying grounds, public school houses, houses used exclusively for public worship, institutions used exclusively for charitable purposes. . . .”); OKL. CONST. art. 10, § 6A (“[A]ll property used for free public libraries, free museums, public cemeteries, property used exclusively for nonprofit schools and colleges, and all property used exclusively for religious and charitable purposes, . . . shall be exempt from taxation until otherwise provided by law.”); PA. CONST. art. VIII, § 2(a)(v) (“The

exemptions and thus implicitly relegates such exemption to statutory law.¹⁸⁹ Finally, some state constitutions explicitly delegate to the legislature the task of defining property tax exemptions.¹⁹⁰

General Assembly may by law exempt from taxation: . . . Institutions of purely public charity"); S.D. CONST. art. XI, § 6 ("The Legislature shall, by general law, exempt from taxation, property used exclusively for agricultural and horticultural societies, for school, religious, cemetery and charitable purposes . . ."); TENN. CONST. art. II, § 28 ("[T]he Legislature may except . . . such [property] as may be held and used for purposes purely religious, charitable, scientific, literary or educational . . ."); TEX. CONST. art. VIII, § 2(a) ("[T]he legislature may, by general laws, exempt from taxation . . . institutions engaged primarily in public charitable functions . . ."); VA. CONST. art. X, § 6(a)(6) ("[T]he following property and no other shall be exempt from taxation, State and local, including inheritance taxes: . . . Property used by its owner for religious, charitable, patriotic, historical, benevolent, cultural, or public park and playground purposes . . ."); W. VA. CONST. art. X, § 1 ("[P]roperty used for educational, literary, scientific, religious or charitable purposes, all cemeteries, public property, the personal property, including livestock, employed exclusively in agriculture as above defined and the products of agriculture as so defined while owned by the producers may by law be exempted from taxation.").

¹⁸⁹ See, e.g., CONN. CONST. (no provision concerning tax exemption though art. VIII, § 3 confirms the charter of Yale College); IOWA CONST. Constitution (no provision concerning tax exemption); R.I. CONST. (no provision concerning tax exemption); VT. CONST. (no provision concerning tax exemption); OR. CONST. (no provision concerning tax exemption); ME. CONST. (no provision concerning tax exemption); MD. CONST. (no provision concerning tax exemption); N.H. CONST. (no provision concerning tax exemption). Michigan's Constitution requires tax exemption for "[p]roperty owned and occupied by nonprofit religious or educational organizations and used exclusively for religious or educational purposes" but makes no mention of other exemptions such as charities or hospitals. MICH. CONST. art. IX, § 4.

¹⁹⁰ DEL. CONST. art. VIII, § 1 (authorizing tax exemptions "which will best promote the public welfare . . ."); GA. CONST. art. VII, § 2, ¶¶ 2, 4 (new tax exemptions must be "approved by two-thirds of the members elected to each branch of the General Assembly in a roll-call vote and by a majority of the qualified electors of the state voting in a referendum thereon;" but exemptions in effect for "religious or burial grounds or institutions of purely public charity" can only be reduced or eliminated "by two-thirds of the members elected to each branch of the General Assembly."); IDAHO CONST. art. VII, § 5 ("[T]he legislature may allow such exemptions from taxation from time to time as shall seem necessary and just, . . ."); MISS. CONST. ANN. art. 4, § 112 ("The Legislature may, by general laws, exempt particular species of property from taxation, in whole or in part."); MASS. CONST. pt. 2, ch. 1, § 1, art. IV ("[R]easonable exemptions may be granted . . ."); WASH. CONST. art. VII, § 1 ("Such property as the legislature may by general laws provide shall be exempt from taxation."); WYO. CONST. art. 15, § 12. (Wyoming's constitution exempts from taxation governmental, library religious and cemetery properties and "such other property as the legislature may by general law provide.").

States' property tax statutes reflect similar diversity. Some statutes exempt from property taxation hospitals as such.¹⁹¹ Other statutes

¹⁹¹ See, e.g., ARIZ. REV. STAT. § 42-11105(A) ("Hospitals for the relief of the indigent or afflicted, appurtenant land and their fixtures and equipment are exempt from taxation if they are not used or held for profit."); ALA. CODE § 40-9-1 ("The following property and persons shall be exempt from ad valorem taxation and none other: . . . (2) All property, real or personal, used exclusively for hospital purposes, to the amount of \$75,000, where such hospitals maintain wards for charity patients or give treatment to such patients . . ."); CAL. REV. & TAX CODE § 214(a) ("Property used exclusively for religious, hospital, scientific, or charitable purposes owned and operated by community chests, funds, foundations, limited liability companies, or corporations organized and operated for religious, hospital, scientific, or charitable purposes is exempt from taxation . . ."); CONN. GEN. STAT. § 12-81 ("The following-described property shall be exempt from taxation: . . . all property of, or held in trust for, any Connecticut hospitals society or corporation or sanatorium, . . ."); D.C. CODE § 47-1002 ("Only the following real property shall be exempt from taxation in the District of Columbia: . . . (9) Hospital buildings, belonging to and operated by organizations which are not organized or operated for private gain, including buildings and structures reasonably necessary and usual to the operation of a hospital;"); FLA. STAT. § 196.197 ("[H]ospitals, nursing homes, and homes for special services shall be exempt to the extent that they meet the following criteria;"); O.C.G.A. § 48-5-41(a) ("The following property shall be exempt from all ad valorem property taxes in this state: . . . (5)(A) All property of nonprofit hospitals used in connection with their operation when the hospitals have no stockholders, have no income or profit which is distributed to or for the benefit of any private person, and are subject to the laws of this state regulating nonprofit or charitable corporations."); IDAHO CODE § 63-602D(2) ("The following property is exempt from taxation: the real property owned and personal property, including medical equipment, owned or leased by a hospital corporation or a county hospital or hospital district that is operated as a hospital and the necessary grounds used therewith."); KAN. STAT. ANN. § 79-201b ("The following described property, to the extent herein specified, shall be and is hereby exempt from all property or ad valorem taxes levied under the laws of the state of Kansas: First. All real property, and tangible personal property, actually and regularly used exclusively for hospital purposes by a hospital as the same is defined by K.S.A. 65-425, and amendments thereto, or a psychiatric hospital as the same was defined by K.S.A. 59-2902, and amendments thereto, as in effect on January 1, 1976, which hospital or psychiatric hospital is operated by a corporation organized not for profit under the laws of the state of Kansas or by a corporation organized not for profit under the laws of another state and duly admitted to engage in business in this state as a foreign, not-for-profit corporation, or a public hospital authority;"); MONT. CODE ANN. § 15-6-201(1)(g) ("The following categories of property are exempt from taxation: . . . property used exclusively for nonprofit health care facilities . . ."); MISS. CODE ANN. § 27-31-1(f) ("All property, real or personal, whether belonging to religious or charitable or benevolent organizations, which is used for hospital purposes, and nurses' homes where a part thereof, and which maintain one or more charity wards that are for charity patients, and where all the income from said hospitals and nurses' homes is used entirely for the purposes thereof and no part of the same for profit."); MD. TAX-PROPERTY CODE ANN. § 7-202(b)(1) ("[P]roperty is not subject to property tax if the property: (i) is necessary for

and actually used exclusively for a charitable or educational purpose to promote the general welfare of the people of the State . . . and (ii) is owned by: 1. a nonprofit hospital"); MICH. COMP. LAWS § 211.7r ("The real estate with the buildings and other property located on the real estate on that acreage, owned and occupied by a nonprofit trust and used for hospital or public health purposes is exempt from taxation"); MINN. STAT. § 272.02, subd. 4. ("All public hospitals are exempt."); N.Y. Real Prop. Tax Law § 420-a(1)(a) ("Real property owned by a corporation or association organized or conducted exclusively for religious, charitable, hospital, educational, or moral or mental improvement of men, women or children purposes, or for two or more such purposes . . . shall be exempt from taxation"); NEB. REV. STAT. § 77-202(1)(d) ("The following property shall be exempt from property taxes: . . . Property owned by educational, religious, charitable, or cemetery organizations, or any organization for the exclusive benefit of any such educational, religious, charitable, or cemetery organization, and used exclusively for educational, religious, charitable, or cemetery purposes"); NEV. REV. STAT. ANN. § 361.083 ("The property on which stands a hospital or other charitable asylum for the care or relief of orphan children, or of sick, infirm or indigent persons, owned by a nonprofit corporation organized or existing pursuant to chapter 82 of NRS, together with the buildings, while occupied for those objects and purposes, is exempt from taxation."); N.D. CENT. CODE § 57-02-08(8) ("All property described in this section to the extent herein limited shall be exempt from taxation: . . . All buildings belonging to institutions of public charity, including public hospitals and nursing homes licensed pursuant to section 23-16-01 under the control of religious or charitable institutions, used wholly or in part for public charity,"); OKL. ST. ANN. tit. 68 § 2887(10) ("The following property shall be exempt from ad valorem taxation: . . . All property of any hospital established, organized and operated by any person, partnership, association, organization, trust, or corporation, as a nonprofit and charitable hospital"); 72 PA. CONS. STAT. § 5020-204(a)(3) ("The following property shall be exempt from all county, city, borough, town, township, road, poor and school tax, to wit: . . . All hospitals, . . . founded, endowed, and maintained by public or private charity"); R.I. GEN. LAWS § 44-3-3(a)(12) ("The following property is exempt from taxation: . . . Property, real and personal, held for, . . . a nonprofit hospital for the sick or disabled;"); S.C. CODE ANN. § 12-37-220(A)(2) ("[T]here is exempt from ad valorem taxation: . . . all property of all schools, colleges, and other institutions of learning and all charitable institutions in the nature of hospitals and institutions caring for the infirmed, the handicapped, the aged, children and indigent persons, except where the profits of such institutions are applied to private use;"); S.D. CODIFIED LAWS § 10-4-9.3 ("Property owned by any corporation, organization, or society and used primarily for human health care and health care related purposes is exempt from taxation."); TEX. TAX CODE § 11.1801(a) ("To qualify as a charitable organization under section 11.18(d)(1), a nonprofit hospital or hospital system must provide charity care and community benefits"); WASH. REV. CODE § 84.36.040(1)(e) ("The real and personal property used by, and for the purposes of, the following nonprofit organizations is exempt from property taxation: . . . Hospitals for the sick;"); W. VA. CODE § 11-3-9(a)(17) (tax exemption for "[p]roperty belonging to any public institution for the education of the deaf, intellectually disabled or blind or any hospital not held or leased out for profit;"); WIS. STAT. § 70.11(4m); WYO. STAT. § 39-11-105(a)(xxv) ("The following property is exempt from property taxation: . . .

do not explicitly address the property tax status of hospitals but permit hospitals to qualify for property tax exemption as charitable or religious entities.¹⁹²

Under all these various patterns, there is instructive case law that denies property tax exemptions to nonprofit hospitals and their affiliated facilities in light of the commercial character of contemporary

Property used for schools, museums, orphan asylums or hospitals to the extent they are not used for private profit.”).

¹⁹² See, e.g., ALASKA STAT. § 29.45.030(a)(3) (“The following property is exempt from general taxation: . . . property used exclusively for nonprofit religious, charitable, cemetery, hospital, or educational purposes;”); ARK. CODE ANN. § 26-3-301(7) (“All property described in this section, to the extent limited, shall be exempt from taxation: . . . All buildings belonging to institutions of purely public charity, together with the land actually occupied by these institutions”); COLO. REV. STAT. § 39-3-108(1) (“Property, real and personal, which is owned and used solely and exclusively for strictly charitable purposes and not for private gain or corporate profit shall be exempt from the levy and collection of property tax”); DEL. CODE ANN. tit. 9 §§ 8105–8106 (exempting specific organizations); IOWA CODE § 427.1(8)(a) (“The following classes of property shall not be taxed: . . . All grounds and buildings used or under construction by literary, scientific, charitable, benevolent, agricultural, and religious institutions and societies solely for their appropriate objects”); ME REV. STAT. ANN. tit. 36 § 652(1)(A) (“The real estate and personal property owned and occupied or used solely for their own purposes by benevolent and charitable institutions incorporated by this State are exempt from taxation.”); MASS GEN. LAWS ch. 59, § 5 (“The following property shall be exempt from taxation . . . real estate owned by or held in trust for a charitable organization”); MO. REV. STAT. § 137.100(5) (“The following subjects are exempt from taxation for state, county or local purposes: . . . All property, real and personal, actually and regularly used exclusively for religious worship, for schools and colleges, or for purposes purely charitable and not held for private or corporate profit”); N.H. REV. STAT. ANN. § 72:23(V) (“The following real estate and personal property shall, unless otherwise provided by statute, be exempt from taxation: . . . The buildings, lands and personal property of charitable organizations and societies organized, incorporated, or legally doing business in this state, owned, used and occupied by them directly for the purposes for which they are established”); OHIO REV. CODE ANN. § 5709.12(B) (“Real and tangible personal property belonging to institutions that is used exclusively for charitable purposes shall be exempt from taxation,”); ORS § 307.130(2) (“[T]he following property owned or being purchased by art museums, volunteer fire departments, or incorporated literary, benevolent, charitable and scientific institutions shall be exempt from taxation”) but see also ORS § 307.804 (property tax exemption for certain “rural health care facilit[ies]”); TENN. CODE ANN. § 67-5-21(a)(1) (“There shall be exempt from property taxation the real and personal property, or any part of the real and personal property, owned by any religious, charitable, scientific, or nonprofit educational institution”); 32 V.S.A. § 3800(a) (tax “exemption for public, pious, and charitable property”); VA. CODE ANN. § 58.1-3609(A) (tax exemption of property “used by such organization for a religious, charitable, patriotic, historical, benevolent, cultural, or public park and playground purpose”).

healthcare. The aftermaths of several of these decisions confirm that nonprofit hospitals will formidably defend their tax exemptions.

B. AHS Hospital Corporation v. Town of Morristown

1. The Decision.

Particularly instructive is the decision of New Jersey's Tax Court in *AHS Hospital Corporation v. Town of Morristown*.¹⁹³ New Jersey's Constitution provides that "[e]xemption from taxation may be granted only by general laws."¹⁹⁴ Pursuant to this constitutional authority,¹⁹⁵ New Jersey by statute exempts "all buildings. . . actually used in the work of associations and corporations organized exclusively for hospital purposes, provided that if any portion of a building used for hospital purposes is leased to profit-making organizations or otherwise used for purposes which are not themselves exempt from taxation, that portion shall be subject to taxation and the remaining portion only shall be exempt. . ."¹⁹⁶ This statute creates a three-part test for the property tax exemption of hospitals: the owner of the building claiming tax-exemption must be organized for hospital purposes; the building must be used as a hospital; and the hospital must not be conducted for profit.¹⁹⁷

AHS Hospital Corporation was doing business as Morristown Memorial Hospital when the Town of Morristown challenged the hospital's property tax exemption.¹⁹⁸ New Jersey's Tax Court found that the hospital's property was largely taxable because the hospital was "intertwined" with profit-making activity and thus failed the third test for property tax exemption, i.e., that the hospital not be operated for profit. The court explicitly observed that the Morristown hospital was typical of the contemporary nonprofit hospital, a highly-

¹⁹³ 28 N.J. Tax 456 (2015).

¹⁹⁴ N.J. CONST. art. VIII, § 1, ¶ 2.

¹⁹⁵ New Jersey's constitution requires the exemption of certain "real and personal property used exclusively for religious, educational, charitable or cemetery purposes." *Id.* New Jersey's statutory exemption of nonprofit hospital property is not tied to such property's charitable or religious use and is thus bottomed on the legislature's authority to grant tax exemption "by general laws." *Id.*

¹⁹⁶ N.J. STAT. § 54:4-3.6. The history of this statute is discussed at *AHS Hospital Corporation*, 28 N.J. Tax at 484-95.

¹⁹⁷ *AHS Hospital Corporation*, 28 N.J. Tax at 467, 496, 500 ("[T]he three prong test of *Paper Mill Playhouse* . . . is now the standard.") (emphasis in original).

¹⁹⁸ *Id.* at 463.

commercialized facility: Like their new for-profit competitors, today's non-profit hospitals have evolved into labyrinthine corporate structures, intertwined with both *non-profit* and *for-profit* subsidiaries and unaffiliated corporate entities.¹⁹⁹ Today's non-profit hospitals generate significant revenue and pay their professionals salaries that are competitive even by *for-profit* standards. Furthermore, private physicians and medical practices associated with non-profit hospitals earn and retain income generated on hospital property. The Hospital in this case is no exception.²⁰⁰ Central to the holding in *AHS Hospital Corporation* was the court's analysis of "the for-profit activities carried out by private physicians" who "all worked throughout the [hospital] without limitation or restriction."²⁰¹ These physicians "use the Hospital facility to generate private medical bills to patients."²⁰² This profit-making activity throughout the hospital vitiated the hospital's claim for property tax exemption.

Similarly, the hospital "maintained relationships"²⁰³ with numerous profit-making institutions including "physician practices (captive P.C.'s) owned by the Hospital"²⁰⁴ and a for-profit Cayman Islands corporation which acted as a "captive . . . self-insurance trust fund to insure the Hospital against professional and general liability."²⁰⁵ Looking at these and other similar relationships, the court concluded that "[b]y entangling its activities and operations with those of for-profit entities, the Hospital allowed its property to be used for profit."²⁰⁶ The hospital routinely loaned money and personnel services to these profit-making entities.²⁰⁷ The upshot was the loss of the hospital's property tax exemption under New Jersey law.²⁰⁸

Also of concern to the New Jersey Tax Court were the salaries paid to the hospital's executives and employee-physicians. The court indicated that the hospital failed as a matter of proof to demonstrate the reasonability of its executives' salaries.²⁰⁹ The court observed that the mere similarity of the managerial salaries paid by Morristown

¹⁹⁹ *Id.* at 465 (emphases in original).

²⁰⁰ *Id.* (emphasis in original).

²⁰¹ *Id.* at 501.

²⁰² *AHS Hospital Corporation*, 28 N.J. Tax at 502.

²⁰³ *Id.* at 507.

²⁰⁴ *Id.* (parenthetical in original).

²⁰⁵ *Id.* at 510.

²⁰⁶ *Id.* at 513.

²⁰⁷ *Id.*

²⁰⁸ *Id.* at 514.

²⁰⁹ *Id.* at 518.

Memorial Hospital to the compensation paid to the executives of other hospitals was not evidence of reasonability: "If the only consideration is what similar hospitals set as salaries, then the salaries would always be reasonable; a conclusion wholly self-serving to all nonprofit hospitals."²¹⁰ Moreover, the Morristown hospital's employee-physicians received bonus payments based on their respective performances.²¹¹ The formulas "demonstrate[] a profit-making purpose" which further buttressed the denial of the hospital's property tax exemption.²¹²

The court also scrutinized the hospital's contracts with third-party vendors that operated the hospital's parking garage, and provided supervisory personnel for activities such as food, laundry, and environmental services. The court found the garage to be property tax-exempt since the garage's operator was paid "a fixed management fee"²¹³ and the garage generated losses.²¹⁴ In contrast, the court deemed the hospital's arrangement with the provider of supervisory personnel to be profit-making in nature because the hospital and the provider split savings from those operations which proved more efficient than anticipated.²¹⁵ Consequently, the parts of the hospital where these supervisors worked were taxable as entwined with profit-making activity.

The court similarly found the hospital's space devoted to its gift shop to be taxable because the shop was "not reasonably necessary to any hospital purpose, but rather it serves as a form of competition to commercially owned facilities."²¹⁶

Completing the court's analysis in *AHS Hospital Corporation* was the court's scrutiny of the hospital's auditorium (tax-exempt since not revenue-generating),²¹⁷ the hospital's fitness center for employees (tax-exempt since employees paid de minimis fees to use this center),²¹⁸ the hospital's daycare center (taxable)²¹⁹ and the hospital's

²¹⁰ *AHS Hospital Corporation*, 28 N.J. Tax at 520.

²¹¹ *Id.* at 523–26.

²¹² *Id.* at 526.

²¹³ *Id.* at 528.

²¹⁴ *Id.* at 529.

²¹⁵ *Id.* at 530.

²¹⁶ *Id.* at 533.

²¹⁷ *Id.* at 535.

²¹⁸ *AHS Hospital Corporation*, 28 N.J. Tax at 535.

²¹⁹ *Id.*

cafeteria (taxable since operated for profit under the contract with the vendor providing supervisory personnel).²²⁰

In conclusion, the court acknowledged that its opinion had broad implications for nonprofit hospitals generally since the highly commercial Morristown hospital was typical of contemporary nonprofit hospitals: Clearly, the operation and function of modern non-profit hospitals do not meet the current criteria for property tax exemption under N.J.S.A. 54: 4-3.6 and the applicable case law.²²¹

2. The Aftermath.

After the New Jersey tax court's 2015 decision, AHS Hospital Corporation and the Town of Morristown agreed that roughly 24% of the hospital's property would be treated as taxable.²²² This agreement yielded an annual tax payment by the hospital of \$1,050,000,²²³ representing one-quarter of the tax the hospital would pay were it owned by HCA Healthcare or another fully-taxed, for-profit hospital chain. This figure is a minimal expenditure for a hospital with annual gross revenues approaching six billion dollars.²²⁴

Starting in 2021, New Jersey requires all nonprofit hospitals in the State to pay an "annual community service contribution."²²⁵ This de facto tax, instead of being based on property values, is assessed on the number of hospital beds. The statutory formula is "\$3 a day for each licensed bed at the hospital in the prior tax year."²²⁶ Under this formula, the Morristown hospital's 735 bed count²²⁷ generates an annual

²²⁰ *Id.* at 535–36.

²²¹ *Id.* at 536.

²²² Tim Darragh, *Atlantic Health to Pay Morristown \$15.5M to Settle Tax Case*, NJ.COM (Nov. 11, 2015), https://www.nj.com/morris/2015/11/atlantic_health_to_pay_morristown_155m_to_settle_t.html.

²²³ *Id.* ("about 24 percent of the hospital property will be taxed at an assessed value of \$40 million, generating an annual tax payment of \$1.05 million . . .").

²²⁴ *Morristown Medical Center (310015)*, AMERICAN HOSPITAL DIRECTORY, https://www.ahd.com/iree_pro-file.php?hcfa_id=89636e449abf2e62e3be182a2cce7994&ek=d6dd122389a7d6830a507ef08045b656 (last visited Apr. 11, 2023) ("Total Patient Revenue: \$5,981,346,797").

²²⁵ N.J. STAT. §§ 54:4-3.6j(c), 40:48J-1 (West 2021).

²²⁶ N.J. STAT. § 40:48J-1(b)(1) (West 2021). The contribution "for a satellite emergency care facility" is "\$300 for each day in the prior tax year." *Id.* The annual community service contribution for each New Jersey hospital and satellite facility increases 2% annually. *Id.*

²²⁷ *Morristown Medical Center Hospital Vital Stats*, ATLANTIC HEALTH, <https://www.atlanticealth.org/about-us/stay-connected/press-center/press-kit/vital-stats.html> (last visited Apr. 10, 2023) ("Morristown Medical Center 2021: . . . 735 licensed beds").

“contribution” to the town of \$804,825.²²⁸ This statutorily-mandated contribution is roughly 80% of the tax upon which the town and AHS agreed in 2015 and roughly 20% of the over \$4 million AHS would pay were the Morristown hospital fully taxable.

In contrast with comparable events in Illinois and Utah, described *infra*, the result in New Jersey is better for the Garden State’s municipalities: every New Jersey nonprofit hospital must now pay to the locality in which it is situated an “annual community service contribution.” From this vantage, the New Jersey tax court’s decision in *AHS Hospital Corporation v. Town of Morristown* triggered a significant legislative step toward the taxation of New Jersey’s nonprofit hospitals. On the other hand, as the example of the Morristown hospital suggests, the statutorily-required “contribution” of \$3 daily per hospital bed is far less than the amount which would be due under full property taxation.

C. *Provena Covenant Medical Center v. Department of Revenue*

1. The Decision.

In *Provena Covenant Medical Center v. Department of Revenue*,²²⁹ Illinois’ Supreme Court held that a Catholic hospital located in Urbana, Illinois was entitled to neither a charitable nor a religious property tax exemption. At the time of the litigation, neither Illinois’ constitution nor Illinois’ property tax statute explicitly addressed hospitals as such.²³⁰ While the Illinois constitution does not exempt hospitals from property taxation, under that constitution,²³¹ Illinois’ General Assembly “may” exempt from taxation, inter alia, property “used exclusively” “for school, religious, cemetery and charitable purposes.” Pursuant to this constitutional authority, Illinois’ legislature at the time of the *Provena Covenant* litigation exempted from taxation property “actually and exclusively used for charitable or beneficent purposes” by “[b]eneficent and charitable organizations”²³² and by “[i]nstitutions of public charity.”²³³ Thus, in Illinois at the time of *Provena Covenant*,

²²⁸ $735 \times 365 \times \$3 = \$804,825$.

²²⁹ 236 Ill. 2d 368 (2010).

²³⁰ As we shall see *infra* note 231, matters changed in response to *Provena Covenant* when the Illinois General Assembly adopted a pro-hospital statute preserving the property tax exemption of such institutions.

²³¹ ILL. CONST. art IX, § 6.

²³² 35 ILL. COMP. STAT. 200/15-65(b) (2009).

²³³ 35 ILL. COMP. STAT. 200/15-65(a) (2009).

"[t]here [was] . . . no blanket exemption under the law for hospitals or health-care providers."²³⁴ Illinois exempted hospitals from property taxation only if they qualified as both owned by charitable institutions and used for charitable purposes.²³⁵

Provena Hospitals was a Catholic-affiliated, Illinois nonprofit corporation that qualified as income tax-exempt under Code Section 501(c)(3).²³⁶ Provena Hospitals owned and operated six hospitals,²³⁷ one of which was Provena Covenant. According to the court, Provena Covenant's "charity care" was modest.²³⁸ In particular, Provena Covenant's annual "net patient service revenue" amounted to \$113,494,000.²³⁹ The charges that the hospital waived for patients unable to pay represented only 0.723% of these revenues, an amount "\$268,276 less than the \$1.1 million in tax benefits which Provena stood to receive if its claim for a property tax exemption were granted."²⁴⁰ Similarly, "[t]he number of patients benefitting from the charitable care program was similarly small . . . equivalent to just 0.27% of the hospital's total annual patient census."²⁴¹ For most of its real estate, Provena Covenant claimed exemption as charitable property or, in the alternative, as religious property.²⁴²

In denying the charitable property tax exemption, the court stressed that the hospital's revenues were "generated, overwhelmingly, by providing medical services for a fee."²⁴³ The court also opined that Provena Covenant failed to demonstrate "that it dispensed charity to all who needed it and applied for it and did not appear to place any obstacles in the way of those who needed and would have availed themselves of the charitable benefits it dispenses."²⁴⁴ Unlike other situations where a "hospital's operations could be said to reduce a burden on the local taxing body [n]o such conclusion was made or could be made based on the record in this case."²⁴⁵

²³⁴ *Tidewell*, 236 Ill. 2d at 394 (2010).

²³⁵ *Id.* at 394.

²³⁶ *Id.* at 374.

²³⁷ *Id.* at 375.

²³⁸ *Id.* at 381.

²³⁹ *Id.* at 377.

²⁴⁰ *Id.* at 381.

²⁴¹ *Tidewell*, 236 Ill. 2d at 382 (2010).

²⁴² *Id.* at 383–84.

²⁴³ *Id.* at 392–93.

²⁴⁴ *Id.* at 393.

²⁴⁵ *Id.* at 397.

According to Illinois' Supreme Court, Provena Covenant's hospital operations were too commercial in nature to qualify for Illinois' property tax exemption for charitable entities: As our review of the undisputed evidence demonstrated, both the number of uninsured patients receiving free or discounted care and the dollar value of the care they received were de minimus. With very limited exception, the property was devoted to the care and treatment of patients in exchange for compensation through private insurance, Medicare and Medicaid, or direct payment from the patient or the patient's family.²⁴⁶

As a practical matter, there was little to distinguish the way in which Provena Hospitals dispensed its "charity" from the way in which a for-profit institution would write off bad debt.²⁴⁷

While Provena Covenant's activities may have benefitted the community, "community benefit is not the test" for Illinois property tax exemption.²⁴⁸ Rather, "[u]nder Illinois law, the issue is whether the property at issue is used exclusively for a charitable purpose."²⁴⁹ These allegedly charitable activities were "well understood by [Provena's] management" to be "effective advertising."²⁵⁰

Illinois' Supreme Court also concluded that the Provena Covenant Hospital was not entitled to a religious property tax exemption.²⁵¹ Again, the commercial nature of the hospital's healthcare activities proved critical to the court's rejection of tax exemption: "the primary purpose" for which the hospital's "property was used was providing medical care to patients for a fee."²⁵² Such activity "is not intrinsically, necessarily, or even normally religious in nature."²⁵³

2. The Aftermath.

Just as the court's decision in *Provena Covenant* is instructive, so too is the legislative response to that decision. As observed, during the *Provena Covenant* litigation, neither Illinois' constitution nor its property tax exemption statute addressed the tax status of hospitals as such. The legal question in *Provena Covenant* was whether, as a

²⁴⁶ *Id.*

²⁴⁷ *Id.* at 398.

²⁴⁸ *Id.* at 403.

²⁴⁹ *Tidewell*, 236 Ill. 2d at 403 (2010).

²⁵⁰ *Id.* at n. 16.

²⁵¹ *Id.* at 408.

²⁵² *Id.* at 410.

²⁵³ *Id.*

statutory matter, the hospital qualified for property tax exemption as a charitable or religious use.

In response to *Provena Covenant*, the Illinois General Assembly adopted a safe harbor statute exempting a hospital from local property taxes “if the value of [the hospital’s] services or activities”²⁵⁴ “that address the health care needs of low-income or underserved individuals or relieve the burden of government with regard to health care services”²⁵⁵ “equals or exceeds the relevant hospital entity’s estimated property tax liability.”²⁵⁶ This legislation amplifies the *Provena Covenant* Court’s observation that the hospital’s charity care was smaller in dollar value than the value of the hospital’s property tax exemption.²⁵⁷ The new statute elevates this judicial observation into an objective and controlling safe harbor test: if qualifying hospital services equal or exceed the value of property tax exemption, such exemption follows automatically. However, if a hospital flunks this safe harbor test, it may still try to persuade the Illinois tax commissioner and the courts that it nevertheless deserves tax exemption as a charitable institution.²⁵⁸

On facts like *Provena Covenant*, the new statute imposes a negligible burden for property tax exemption. Recall that *Provena Covenants’* annual “net patient service revenue” amounted to \$113,494,000²⁵⁹ while the charges that the hospital waived for patients unable to pay represented only 0.723% of these revenues, an amount “\$268,276 less than the \$1.1 million in tax benefits which *Provena* stood to receive if its claim for a property tax exemption were granted.”²⁶⁰ Thus, it would take very little additional charge waivers (\$268,276 out of \$113,494,000) for the *Provena Covenant Hospital* to qualify for exempt status under the new property tax statute.

Moreover, the new Illinois statute provides a detailed definition of charitable care which further facilitates hospitals’ claims for

²⁵⁴ Minn. Comp. Stat. Ann. § 200/15-86(c) (LexisNexis 2012). For further discussion of this new property tax statute, see *Oswald v. Hamer*, 115 N.E. 3rd 181 (Ill. 2018). This new statute is central to litigation now pending in the Illinois appellate court. The *Carle Foundation v. Cunningham Township et al.*, General No. 4-20-0121, 4-20-0135, 4-20-0142, 4-20-0386, 4-20-0387, 4-20-0388 (consolidated) Illinois Appellate Court, 4th District.

²⁵⁵ 35 ILL. COMP. STAT. ANN. § 200/15-86(e) (LexisNexis 2012).

²⁵⁶ 35 ILL. COMP. STAT. ANN. § 200/15-86(c) (LexisNexis 2012).

²⁵⁷ *Provena Covenant Med. Ctr. v. Dep’t of Revenue*, 236 Ill. 2d 368, 381 (2010).

²⁵⁸ 35 ILL. COMP. STAT. ANN. § 200/15-86(i) (LexisNexis 2012).

²⁵⁹ *Provena Covenant*, 236 Ill. 2d at 377.

²⁶⁰ *Id.* at 381.

property tax exempt status.²⁶¹ For example, “providing or subsidizing outreach or educational services to low-income or underserved individuals for disease management and prevention”²⁶² will automatically count under the new statutory formula for hospitals’ property tax exemption. Under these and the new statute’s other lenient tests, it will not be difficult for a hospital like Provena Covenant to automatically qualify for property tax exemption.

One need not be a strong adherent of public choice theory to see in this statute the political influence of Illinois hospitals and their lobbying activities. Indeed, the Illinois Health and Hospital Association, which represents “over 200 hospitals and nearly 50 health systems,” is proud of its role “in negotiating and drafting” the legislation which overturned *Provena Covenant*.²⁶³ Just as the attenuated nature of Code Section 501(r) indicates the political heft of the nonprofit hospital industry, Illinois’ post-*Provena Covenant* legislation confirms the determination and the political ability of nonprofit hospitals to defend the benefits of their property tax exemption.

D. *Chisago Health Services v. Commissioner*

*Chisago Health Services v. Commissioner*²⁶⁴ differs from *AHS Hospital Covenant* and *Provena Covenant*. in two respects First, Minnesota’s Constitution, unlike New Jersey’s and Illinois’ Constitutions), exempts from property taxation “public hospitals” as such. Second, *Chisago Health Services* addresses the tax status, not of a central hospital facility, but rather the tax status of two outpatient clinics owned and operated by a hospital. Rejecting tax exemption for these clinics, Minnesota’s Supreme Court, like the Illinois Supreme Court and New Jersey’s tax court, confronted the commercial nature of contemporary healthcare.

Minnesota’s Constitution provides that “public hospitals” and “institutions of purely public charity” “shall be exempt from taxation” subject to the legislature’s authority to “define or limit the property exempt” from taxation.²⁶⁵ Thus, a “public hospital” in the North Star State is, as a constitutional matter, tax-exempt regardless of the

²⁶¹ 35 ILL. COMP. STAT. ANN. § 200/15-86(e) (LexisNexis 2012).

²⁶² 35 ILL. COMP. STAT. ANN. § 200/15-86(e)(2) (LexisNexis 2012).

²⁶³ Brief for The Illinois Health and Hospital Association as Amicus Curiae Supporting Respondent, *The Carle Foundation v. Cunningham Township et al.*, General No. 4-20-0121, 4-20-0135, 4-20-0142, 4-20-0386, 4-20-0387, 4-20-0388 (consol.) Illinois Appellate Court, 4th District at page 1.

²⁶⁴ *Chisago Health Services v. Commissioner*, 462 N.W.2d 386 (Minn. 1990).

²⁶⁵ Minn. Const. art. X, § 1.

hospital's status vel non as a charity. A healthcare facility that is not exempt as a hospital may qualify for exemption as a charitable entity.

Minnesota's property tax exemption statute further confirms that, regardless of their charitable status, "[a]ll public hospitals" in the North Star State "are exempt."²⁶⁶ Neither Minnesota's Constitution nor its property tax statute defines the term "public hospital". In contrast, the Minnesota property tax exemption statute contains an elaborate definition of "institutions of purely public charity"²⁶⁷ which are exempt.

Chisago Health Services stemmed from efforts to preserve a struggling rural hospital. After reorganization, Chisago Health Services (CHS) owned and operated a hospital plus three ambulatory (i.e., outpatient) clinics. One of these clinics ("the Hospital Annex"²⁶⁸) was adjacent to the hospital. The other two outpatient clinics were located "in the neighboring small towns of North Branch and Wyoming."²⁶⁹ In addition, as part of the reorganization, a group of eleven doctors transferred their practices to CHS and became employees of that corporation.

Before the Minnesota Supreme Court was a dispute over the property tax status of the Hospital Annex and the Wyoming outpatient clinic.²⁷⁰ The court held that neither clinic qualified for property tax exemption as a "public hospital" or as a public charity.

Central to the court's decision was its test for whether the clinics were "reasonably necessary to the functional operation of the Hospital."²⁷¹ Concluding that the two outpatient clients failed this test of "functional[] interdependen[ce]" with the hospital,²⁷² the court focused upon the productivity-based salaries paid to the doctors who practiced in those clinics as CHS employees. Since the doctors' respective employment-based compensation was tied to their individual performances, "there is a substantial nonpublic aspect to the way in which the physicians practice in the medical clinic facilities."²⁷³

²⁶⁶ Minn. Stat. § 272.02(4) (2022).

²⁶⁷ Minn. Stat. § 272.02(7) (2022).

²⁶⁸ *Chisago Health Services*, 462 N.W.2d at 387.

²⁶⁹ *Id.*

²⁷⁰ CHS conceded that the North Branch clinic, located in a rented building, was not property tax exempt. *Chisago Health Servs. v. Comm'r of Revenue*, No. 4999, 1990 WL 18156 (Minn. Tax Feb. 12, 1990), *aff'd* 462 N.W.2d 386 (Minn. 1990). Meanwhile, neither party disputed that the hospital constituted a "public hospital" which was exempt from the property tax. *Id.* at *1.

²⁷¹ *Chisago Health Services*, 462 N.W.2d at 389.

²⁷² *Id.* at 390.

²⁷³ *Id.*

Deferring to the Minnesota tax court as fact-finder, the Minnesota Supreme Court agreed that “the CHS reorganization [w]as primarily one to enhance the Hospital’s economic viability, not its functional purpose.”²⁷⁴ Moreover, the court observed, there is a serious line-drawing problem if “auxiliary properties” like these outpatient clinics are granted tax-exempt status merely because they “help an exempt institution to survive or to prosper financially”²⁷⁵ as “almost any auxiliary facility can be found to improve the financial well-being of a hospital.”²⁷⁶ In addition, granting property tax exemption to these outpatient clinics “tend[s] to give an unfair competitive advantage to the exempted facility over similar facilities privately operated.”²⁷⁷

Having concluded that the functionally unrelated clinics were not exempt as public hospitals, the court then decided that these outpatient clinics were also not exempt under Minnesota property tax law as public charities. The court’s three reasons for this conclusion emphasized the commercial comparability of the hospital-affiliated clinics to profit-making healthcare providers. First, the payments received by the clinics from Medicaid and Medicare were “more accurately characterized as payments for services rendered, not as donations.”²⁷⁸ Second, the clinics’ charitable billing was de minimis, “no more than writing off uncollectible bills, a business practice not unlike that of other health care providers.”²⁷⁹ Third, in terms of its allegedly charitable beneficiaries, these clinics “were operated in essentially the same manner as any private medical clinic, i.e., furnishing outpatient services at market level fees.”²⁸⁰ Hence, neither clinic “qualif [ied] as a purely public charity.”²⁸¹

The tax status of the CHS hospital was not at issue in *Chisago Health Services*. It is important to consider whether, in light of the court’s discussion of the two clinics’ operations, a Minnesota hospital with the same commercial character as these clinics qualifies for tax exemption as “public.” Minnesota’s Constitution does not bestow tax exemption upon any hospital but only upon “public” hospitals. Minnesota’s Supreme Court deemed the CHS clinics to be “nonpublic” in large part because of how the doctors affiliated with the clinics were

²⁷⁴ *Id.*

²⁷⁵ *Id.*

²⁷⁶ *Id.* at 390–91.

²⁷⁷ *Id.* at 391.

²⁷⁸ *Chisago Health Services*, 462 N.W.2d at 391.

²⁷⁹ *Id.*

²⁸⁰ *Id.* at 392.

²⁸¹ *Id.*

compensated. This observation implies that hospitals that compensate physicians in a similar fashion are also not “public” facilities and, therefore, are not tax-exempt.

Likewise, the three factors which led the Minnesota Supreme Court to deny charity status to the two CHS outpatient clinics suggest that similarly commercial nonprofit hospitals are also not property tax-exempt as charities. These three factors (Medicare and Medicaid payments are fees for medical services, not reflections of charity; writing off uncollectible receivables is a business practice, not charity; and services provided for market level payments are not charity) apply to the CHS hospital and to every other nonprofit hospital in Minnesota as they apply to the CHS clinics which the court held to be taxable.

E. Utah County by County Bd. of Equalization v. Intermountain Health Care, Inc. and Howell v. County Bd. ex rel. IHC Hospitals, Inc.

*Utah County by County Bd. of Equalization v. Intermountain Health Care, Inc.*²⁸² was an early (1985) and prescient judicial recognition that the commercial nature of contemporary nonprofit hospitals negates their charitable tax exemptions. Nine years later, *Howell v. County Bd. ex rel. IHC Hospitals, Inc.*²⁸³ sub silentio reversed *Utah County*, demonstrating that nonprofit hospitals will formidably fight to retain their tax-exempt status.

1. Community Benefit is Not Charity: *Utah County by County Bd. of Equalization v. Intermountain Health Care, Inc.*

In *Utah County by County Bd. of Equalization v. Intermountain Health Care, Inc.*, Utah’s Supreme Court, over vigorous dissent,²⁸⁴ held that the modern nonprofit hospital, despite its social “usefulness”²⁸⁵ as a medical service center, is not a charity deserving tax exemption. Through their medical services, nonprofit hospitals generate “community benefit,” but so do “countless private enterprises.”²⁸⁶ Charity requires more than “community benefit . . . in order to qualify as a charity,” the Utah court held, there must, as a state constitutional

²⁸² *Utah Cnty. Bd. Of Equalization v. Intermountain Health Care*, 709 P.2d 265 (Utah 1985).

²⁸³ *Howell v. County Bd. Ex rel. IHC Hosps.*, 881 P.2d 880 (Utah 1994).

²⁸⁴ *Utah County*, 709 P.2d at 279–303 (Stewart, J., dissenting) (Howe, J., dissenting). Thus, the Utah County Court was divided 3–2.

²⁸⁵ *Id.* at 276 (majority opinion).

²⁸⁶ *Id.*

matter, be a “gift to the community”²⁸⁷ – which today’s nonprofit hospitals do not do.

Utah County involved the property tax status of two of the twenty-one hospitals operated by the nonprofit Intermountain Health Care, Inc. (IHC).²⁸⁸ Most of these hospitals “were founded and formerly owned and operated by the Church of Jesus Christ of Latter-Day Saints.”²⁸⁹ Utah’s Constitution conditions the tax exemption of hospital property upon such property being “used exclusively for. . .charitable purposes.”²⁹⁰

Applying a “strict construction”²⁹¹ of the constitutional requirement of charity, the Utah Supreme Court held that “[e]ssential to th[e] definition [of charity] is the element of gift to the community.”²⁹²

A gift to the community can be identified either by a substantial imbalance in the exchange between the charity and the recipient of its services or in the lessening of a government burden through the charity’s operation.²⁹³

According to the court, whether or not such a charitable gift occurs is determined under a “six-factor standard”:²⁹⁴

(1) whether the stated purpose of the entity is to provide a significant service to others without immediate expectation of material reward; (2) whether the entity is supported, and to what extent, by donations and gifts; (3) whether the recipients of the “charity” are required to pay for the assistance received, in whole or in part; (4) whether the income received from all sources (gifts, donations, and payment from recipients) produces a “profit” to the entity in the sense that the income exceeds operating and long-term maintenance expenses; (5) whether the beneficiaries of the “charity” are restricted or unrestricted and, if restricted, whether the restriction bears a reasonable relationship to the entity’s charitable objectives; and (6) whether dividends or some other form of financial benefit, or assets upon dissolution, are available to private interests, and

²⁸⁷ *Id.*

²⁸⁸ *Id.* at 266–67.

²⁸⁹ *Id.* at 280.

²⁹⁰ *Id.* at 267–68 (quoting Utah Constitution, art. XIII, § 2).

²⁹¹ *Utah County*, 709 P.2d at 269.

²⁹² *Id.*

²⁹³ *Id.*

²⁹⁴ *Id.* at 270, n. 6.

whether the entity is organized and operated so that any commercial activities are subordinate or incidental to charitable ones.²⁹⁵

These six constitutional factors, the Utah court observed, must be applied in light of “the transformation” of hospitals from “true charities providing custodial care for those who were both sick and poor”²⁹⁶ into “market institutions”²⁹⁷ run on “a business basis.”²⁹⁸ In light of this transformation of hospitals into commercial enterprises, “the distinction between nonprofit and for-profit hospitals”²⁹⁹ is of “increasing irrelevance.”³⁰⁰

As to the first of these factors, the Utah court observed that IHC’s “stated purpose” is “charitable use.”³⁰¹ In particular, IHC’s articles of incorporation forbid the distribution of corporate earnings to private individuals and also forbid on dissolution of IHC the disbursement of its corporate assets for private benefit.³⁰² As to the second factor identified by the Utah court (support by donations and gifts), the court observed that “current operating expenses for both hospitals are covered almost entirely by revenue from patient charges,”³⁰³ rather than by donations or gifts.

The court deemed the third factor (whether vel non patients are required to pay for services) among “the most significant”³⁰⁴ and adverse to the hospitals’ claim for charitable status:

[T]he vast majority of the services provided by these two hospitals are paid for by government programs, private insurance companies, or the individuals receiving care. Collection of such remuneration does not constitute giving, but is a mere reciprocal exchange of services for money. Between 1978 and 1980, the value of the services given away as charity by these two hospitals constituted less than one percent of their gross revenues.³⁰⁵

²⁹⁵ *Id.* at 269–70 (quotations and parentheticals omitted). The Utah Tax Commission’s revision of this six-factor test proved critical to the subsequent reversal of *Utah County* in *Howell*.

²⁹⁶ *Id.* at 270.

²⁹⁷ *Id.* (internal quotations omitted).

²⁹⁸ *Id.*

²⁹⁹ *Utah County*, 709 P.2d at 271.

³⁰⁰ *Id.*

³⁰¹ *Id.* at 272.

³⁰² *Id.* at 273.

³⁰³ *Id.*

³⁰⁴ *Id.* at 274.

³⁰⁵ *Id.*

It is precisely because such a vast system of third-party payers has developed to meet the expense of modern hospital care that the historical distinction between for-profit and nonprofit hospitals has eroded. For-profit hospitals provide many of the same primary care services as do those hospitals organized as nonprofit entities. They do so at similar rates as those charged by defendants. The doctors and administrators of nonprofit hospitals have the same opportunity for personal remuneration for their services as do their counterparts in for-profit hospitals.³⁰⁶

Similarly detrimental to the hospitals' claim for charitable status was the court's analysis of its fourth factor, profitability. The IHC hospitals generate profit as their revenues exceed their expenses: "Because the vast majority of their services are paid for, the nonprofit hospitals in this case accumulate capital as do their profit-seeking counterparts."³⁰⁷

The fifth factor worked in the hospitals' favor as there are no restrictions on who may benefit as an IHC patient.³⁰⁸ In contrast, the sixth and final factor cut against the hospitals as "numerous forms of private commercial enterprise, such as pharmacies, laboratories, and contracts for medical services, are conducted as a necessary part of the defendants' hospital operations."³⁰⁹

Considering these six constitutionally-based factors, Utah's Supreme Court concluded that the two IHC hospitals generate "community benefit"³¹⁰ as these "useful[]"³¹¹ institutions "meet great and important needs of persons within their communities for medical care."³¹² But, as a constitutional matter, charitable status demands more, namely, a "gift or a nonreciprocal contribution to the community."³¹³ In this respect, the IHC hospitals are indistinguishable from their for-profit competitors as the nonprofit IHC facilities charge the same prices as such profit-making competitors.³¹⁴ "[A]msgiving or unpaid services"³¹⁵ is critical "for the granting of a charitable tax

³⁰⁶ *Id.* at 274–75.

³⁰⁷ *Utah County*, 709 P.2d at 275.

³⁰⁸ *Id.* at 276.

³⁰⁹ *Id.*

³¹⁰ *Id.*

³¹¹ *Id.*

³¹² *Id.*

³¹³ *Id.* at 277.

³¹⁴ *Id.*

³¹⁵ *Utah County*, 709 P.2d at 278.

exemption."³¹⁶ Thus, *Utah County* held that the nonprofit but noncharitable IHC hospitals were not entitled to tax exemption as they failed Utah's constitutionally-based test of charitable "gift."

2. The Sub Silentio Dilution of the Concept of Gift: *Howell v. County Bd. ex rel. IHC Hospitals, Inc.*

Nine years after *Utah County*, in *Howell v. County Bd. ex rel. IHC Hospitals, Inc.*,³¹⁷ the Utah Supreme Court unanimously³¹⁸ upheld the tax-exemption of IHC's hospitals. A critical intervening event was the promulgation by Utah's Tax Commission³¹⁹ of "objective"³²⁰ standards purporting to implement the six-factor test of *Utah County*. Those administratively promulgated standards diluted *Utah County's* constitutionally-based test of "gift." Deferring to the Tax Commission's standards, the Utah Supreme Court in *Howell* purported to follow *Utah County* and its definition "gift." More convincingly, *Howell* sub silentio overruled *Utah County*, diluting the "gift" standard articulated in that earlier decision by deferring to the tax commission's standards on a question of state constitutional law.

Central to *Howell* is the court's observation that the "Tax Commission understandably concluded that" *Utah County's* six "factors were too elusive for routine administrative application."³²¹ Having thus undercut *Utah County*, the *Howell* court further signaled its direction by citing with approbation Rev. Rul. 69-545.³²² In that ruling, as we saw, the IRS weakened the "community benefit" standard by granting federal tax-exemption to a hospital which restricted its nonemergency care to patients who could afford to pay for their medical services.

The Tax Commission's core attenuation of *Utah County* and its "strict,"³²³ constitutionally-based gift standard was the promulgation of a formula similar to the standard the Illinois legislation adopted to

³¹⁶ *Id.*

³¹⁷ *Howell*, 881 P.2d at 880.

³¹⁸ Justices Stewart and Howe, who dissented in *Utah County*, joined the *Howell* opinion as did Justice Durham who wrote the Court's opinion in *Utah County*.

³¹⁹ On the formation and powers of the Utah Tax Commission, see UTAH CODE ANN. § 59-1-201 *et seq.*

³²⁰ *Howell*, 881 P.2d at 883.

³²¹ *Id.* at 885.

³²² *Id.* at 886 (citing Rev. Rul. 69-545). For discussion of Rev. Rul. 69-545, see *supra* notes 91-104 and accompanying text.

³²³ *Utah Cnty. Bd. Of Equalization v. Intermountain Health Care*, 709 P.2d 265, 269 (Utah 1985).

overturn *Provena Covenant*.³²⁴ Under this administrative formula, a Utah nonprofit hospital is deemed to be charitable if “the value of unreimbursed care to indigent patients” “exceed[s], on an annual basis, what would otherwise be the hospital’s property tax liability for the year.”³²⁵ Under this unchallenging test, writing off a relative handful of additional accounts receivable can establish a Utah hospital’s charitable status. It was of no concern to the *Howell* court that for-profit hospitals similarly write-off bad receivables.

Also unpersuasive is *Howell*’s justification of the court’s deference to an administrative agency’s construction of the Utah Constitution, indeed, that agency’s effective repudiation of the Court’s constitution-based decision in *Utah County*. The *Howell* court could have openly acknowledged that in *Howell* the *Utah County* dissenters subsequently commanded a majority of the court. Instead, the *Howell* court deferred to the Tax Commission’s interpretation of the Utah Constitution as being “well within the bounds of [the Commission’s] authority.”³²⁶ It is, to say the least, unconventional for a state supreme court to defer to the constitutional interpretation of a state tax agency.

Courts may reinterpret their precedents to maintain the appearance of legal continuity even as they change the law.³²⁷ But *Howell* is unconvincing as an exercise in such judicial reinterpretation. Rather than confronting and refashioning the considerations which were central to *Utah County*, *Howell* simply ignores them: “the transformation” of hospitals into “market institutions”³²⁸ run on “a business basis;”³²⁹ the “increasing irrelevance”³³⁰ of “the distinction between nonprofit and for-profit hospitals;”³³¹ the prevailing billing practices of nonprofit hospitals as “the vast majority of the services provided by” nonprofit hospitals are paid for by government programs, private insurance companies, or the individuals receiving care” while “the value of the services given away as charity” is de minimis relative to such hospitals’ “gross revenues;”³³² the substantial profits earned by

³²⁴ See *supra* notes 254–62 and accompanying text.

³²⁵ *Howell*, 881 P.2d at 888.

³²⁶ *Id.* at 890.

³²⁷ Edward A. Zelinsky, *ERISA Preemption After Gobeille v. Liberty Mutual: Completing the Retrenchment of Shaw*, 34 HOFSTRA LAB. & EMP. L.J. 301, 310 (2017) (describing “the time-honored course of reinterpreting precedents to impose a retrospective sense of continuity upon a body of case law even as legal doctrine is changed.”).

³²⁸ *Id.* (internal quotation marks deleted).

³²⁹ *Id.*

³³⁰ *Id.* at 271.

³³¹ *Id.*

³³² *Id.* at 274.

nonprofit hospitals;³³³ the “numerous forms of private commercial enterprise, such as pharmacies, laboratories, and contracts for medical services,” which “are conducted as a necessary part of the [nonprofit] hospital operations.”³³⁴ All of these considerations highlighted in *Utah County* are simply ignored in *Howell*.

While *Howell* is unconvincing as an exercise in judicial reinterpretation, *Howell* and the Tax Commission standards which *Howell* embraces are (like Code Section 501(r) and the Illinois legislation adopted in the wake of *Provena Covenant*) instructive manifestations of the ability of nonprofit hospitals to defend their tax-exempt status.

F. *St. Mary's Building Corp. v. Redman*

In *St. Mary's Building Corp. v. Redman*,³³⁵ Indiana's Tax Court confirmed the taxable status of a hospital-owned building (“Epworth Crossing”) used for “breast imaging and therapy” as well as for “a primary care physician's practice” and “an urgent care and an imaging and laboratory center.”³³⁶

Indiana's constitution provides that the Hoosier State's “General Assembly may exempt from property taxation” . . . (1) [p]roperty being used for. . . charitable purposes.”³³⁷ Utilizing this authority, Indiana's legislature has declared that “[a]ll or part of a building is exempt from property taxation if it is owned, occupied, and used by a person for. . . charitable purposes.”³³⁸ While neither Indiana's constitution nor Indiana's statute addresses the property tax status of hospitals as such, the Indiana property tax statute does confront the status of properties used by physicians to practice medicine. That statute³³⁹ invokes themes which are by now familiar to the reader: Areas in which physicians practice are not per se tax-exempt. Participation in Medicaid or Medicare is not a charitable activity.

Against this factual and legal background, Indiana's tax court held that the activities conducted at the hospital-owned Epworth Crossing, by themselves, did not satisfy Indiana's test for charity, i.e., that the property claimed to be used for charity “(1) relieve human want through charitable acts different from the everyday purposes

³³³ *Id.* at 275.

³³⁴ *Id.* at 276.

³³⁵ 135 N.E.3d 681 (2019).

³³⁶ *Id.* at 683.

³³⁷ Ind. Const. art. 10, § 1(c)(1).

³³⁸ Ind. Code Ann. § 6-1.1-10-16(a) (LexisNexis 2021).

³³⁹ *Id.* § 6-1.1-10-16(h).

and activities of man in general and 2) confer a public benefit sufficient to justify the loss of tax revenue.”³⁴⁰

Seeking tax-exempt status for Epworth Crossing, the hospital which owned this facility claimed that Epworth Crossing generated over \$11 million of “uncompensated care” over three years.³⁴¹ The court was unconvinced. Most of this amount was “attributable to bad debt and unreimbursed Medicare/Medicaid costs.”³⁴² This data related to “the collectability of a debt” rather than to “charitable intent or purpose.”³⁴³ While the Hoosier State’s tax court made these observations in the context of a medical services building owned by a hospital, rather than the hospital itself, these observations erode the claim that nonprofit hospitals are charitable by virtue of their bad debt write-offs and their participation in the Medicare and Medicaid programs. According to the Indiana Tax Court, those practices were not enough to make Epworth Crossing a tax-exempt charitable property.

G. Other Cases

Other state court cases both confirm³⁴⁴ and reject³⁴⁵ tax-exempt status for hospital and medical service facilities. On balance, a fair

³⁴⁰ 135 N.E. 3d 681, 689 (2019).

³⁴¹ *Id.* at 691.

³⁴² *Id.*

³⁴³ *Id.* (internal quotation marks deleted).

³⁴⁴ *Downtown Hosp. Ass’n v. Tenn. State Bd. of Equalization*, 760 S.W.2d 954 (1988) (hospital is tax-exempt as “any nonprofit organization or association which devotes its efforts to improvement of conditions in the community is a charitable institution and exempted from property taxation.”); *Medical Ctr. Hosp. of Vt., Inc. v. City of Burlington*, 152 Vt. 611 (1989) (nonprofit hospital is tax-exempt by virtue of “‘open-door’ policy” by which health care “was made available by the plaintiff to all who needed it, regardless of their ability to pay” “even if it charges for most or all of its services”); *Rhode Island Hosp. v. City of Providence*, 693 A.2d 1040 (1997) (part of office building leased by hospitals to “private physicians and other tenants” is tax-exempt); *Callaway Cmty. Hosp. Ass’n v. Craighead*, 759 S.W.2d 253 (1988) (“a charitable use includes a hospital so long as it is operated in a not-for-profit manner and is available to rich and poor alike. A hospital which meets the test is a charity without further proof that a certain number or percentage of indigent patients are served.”); *Hardesty v. N. Ark. Med. Servs.*, 585 S.W.3d 177 (2019) (hospital property is tax exempt).

³⁴⁵ *Matkovich v. Univ. Healthcare Found., Inc.*, 238 W. Va. 345 (2016) (cancer center not tax exempt because center “has leased a portion of the Center to for-profit business entities that use the property for admittedly non-charitable purposes.”) (original parenthetical deleted); *St. Clare Hosp. v. City of Monroe*, 209 Wis. 2d 364 (1997) (hospital clinic is not property tax exempt since “used as a doctor’s office”); *In re Appeal of Brandywine Hosp., L.L.C.*, Ct. of C. P. Chester Cnty., Pa. (Nos. 17-11220, 17-11222,

reading of this state case law confirms that contemporary hospitals' business-like conduct of health care is commercial, rather than charitable, in nature; because of their commercial nature, nonprofit hospitals are materially indistinguishable for tax purposes from their for-profit, taxpaying competitors; Medicaid and Medicare disbursements are fee-for-service payments to hospitals, not manifestations of charity; hospitals' bad debt write-offs are business practices, not charity care; physicians practicing in hospitals are conducting commercial activity, not charity; hospital executives are compensated inordinately; few patients today receive free medical care; and the "community benefit" standard lacks persuasive content and thus fails to justify the tax exemption of nonprofit hospitals. These themes support the conclusion that the modern nonprofit hospital is not a charity but is a business. And businesses pay tax.

VIII. CONCLUDING QUALIFICATIONS AND OBSERVATIONS

This final section anticipates and responds to potential criticisms of this article's analysis and, where necessary, qualifies and expands that analysis.

A. *The difficult political path going forward.*

Perhaps the most important limitation of this article's analysis is the absence of a straightforward path for implementing the federal and state taxation of nonprofit hospitals. The attenuated nature of Code Section 501(r)³⁴⁶ and the aftermaths in Illinois³⁴⁷ and Utah³⁴⁸ of *Provena Covenant* and *Utah County* caution that, going forward, nonprofit hospitals will continue to formidably defend their unjustified tax exemptions.

At the federal level, the most direct means of ending the tax-exempt status of nonprofit hospitals would be amending the Internal

17-11223 et al) (Oct. 14, 2021, Jeffrey R. Sommer, J.) (tax exemption denied when hospital executives were highly compensated but "almost no one received uncompensated care."); *Greater Anchorage Area Borough v. Sisters of Charity*, 553 P.2d 467 (1976) (office building connected to hospital not tax exempt when rented to physicians at market rates since "the office space is not used exclusively for hospital purposes."); *Underhill v. Edwards*, 400 So. 2d 129 (1981) ("The evidence demonstrates without dispute that the lessee-doctors do not conduct their medical practices on a charitable basis, but, instead, conduct their practices in an ordinary manner for professional compensation and profit.").

³⁴⁶ See *supra* notes 136–51 and accompanying text.

³⁴⁷ See *supra* notes 254–62 and accompanying text.

³⁴⁸ See *supra* notes 317–34 and accompanying text.

Revenue Code. Just as Congress decided that Blue Cross and Blue Shield insurers had become too commercial to be tax-exempt,³⁴⁹ Congress could amend the Code to specify that nonprofit hospitals are no longer tax-exempt.

Short of this, the IRS could revise its administrative guidance³⁵⁰ to reflect the commercial nature of the contemporary nonprofit hospital. Just as the nonprofit hospital lobby will oppose federal legislation revoking hospitals' tax-exempt status, that lobby will resist revision of the IRS's generous rulings on the tax-exempt treatment of nonprofit hospitals.

Matters will be even messier at the state level as fifty different processes play out. In many states, the amendment of state statutes or state constitutions will be necessary to tax nonprofit hospitals. In other states, existing authorities can be reinterpreted, administratively or judicially, to tax contemporary nonprofit hospitals. More lenient state standing rules³⁵¹ will often enable state taxpayers to litigate for judicial recognition that the contemporary nonprofit hospital is a commercial business which should be taxed as such.

In short, this article's analysis will at best buttress a messy and prolonged process of reassessing the tax exemption of nonprofit hospitals. Implementing this article's lessons will, as a political matter, not be easy, quick or inevitable.

B. Corporations as taxable entities.

A possible objection to this article's analysis would reject, as a normative matter, the treatment of corporations as taxable entities. Some commentators argue that nonprofit corporations should not be taxed as they lack shareholders.³⁵² These critics will likely reject this article's riposte – well-paid hospital management is a de facto class of shareholders receiving disguised dividends in the form of excessive salaried compensation.³⁵³

Even if this characterization of hospital management as de facto shareholders is unpersuasive, it is still compelling to treat the contemporary nonprofit hospital as a taxable entity. While most academic commentators on the corporate tax disagree, there is a widely-shared

³⁴⁹ I.R.C. § 833.

³⁵⁰ See *supra* notes 80–114 and accompanying text.

³⁵¹ Edward A. Zelinsky, *Putting State Courts in the Constitutional Driver's Seat: State Taxpayer Standing After Cuno and Winn*, 40 HASTINGS CONST. L. Q. 1 (2012).

³⁵² See, e.g., Hackney, *supra* note 25.

³⁵³ See *supra* notes 166–80 and accompanying text.

popular belief that corporations and corporate-like entities, when they reach a certain size or character, are properly viewed as separate taxable entities.³⁵⁴ The Internal Revenue Code reflects this belief in Sections 1361(b)(1)(A)³⁵⁵ and 7704.³⁵⁶ Code Section 1361(b)(1)(A) provides that corporations with over 100 shareholders must be taxed at the entity-level as C corporations, rather than treated as pass-thru S corporations. Section 7704 provides that publicly-traded partnerships must also be taxed at the entity level as corporations.

The minimum tax provisions of the Inflation Reduction Act of 2022 are plausibly understood as further confirming Congress's view that corporations have basic tax obligations as taxpaying entities.

It may make sense, both as a matter of policy and a matter of politics, to establish a minimum threshold which a nonprofit hospital must surmount to be taxed as a commercial corporate entity, e.g. gross annual revenues of \$50 million. But the point remains: large commercial enterprises are recognized by the tax law as themselves constituting separate taxpayers. That recognition should extend to commercialized nonprofit hospitals which are for tax purposes materially indistinguishable from their taxpaying, for-profit competitors.

C. Hospitals and sales taxes.

This article has largely focused on the income and property taxation of hospitals. What about sales taxes? For-profit hospitals pay income and property taxes, but generally do not collect sales taxes since services are in most states sales tax-free.³⁵⁷ Parity between for-profit hospitals and their commercialized nonprofit competitors requires that neither should collect sales taxes as long as the other does not.

³⁵⁴ Hansmann, *supra* note 18, at 63 (corporation "is conceptually a separate taxable entity."); Richard Winchester, *A Tax Theory of the Firm*, 88 U. CIN. L. REV. 1 (2019) ("Under the second approach for taxing business profits, the firm and its owners are treated as separate and distinct taxpaying units. Accordingly, the firm has an independent obligation to pay tax on any profits it derives, regardless if it retains those earnings or distributes them to its owners."); Omri Marian, *Jurisdiction to Tax Corporations*, 54 B.C. L. REV. 1613, 1626 (2013) ("the corporate entity is a truly separate being from the individuals involved with it.").

³⁵⁵ I.R.C. § 1361(b)(1)(A).

³⁵⁶ I.R.C. § 7704.

³⁵⁷ JEROME HELLERSTEIN & WALTER HELLERSTEIN, STATE TAXATION ¶ 15.01 (3rd ed. 2022) ("Historically, the American retail sales tax has been confined largely to sales of tangible personal property and has applied only selectively to sales of services . . . [T]he unwarranted dichotomy in the retail sales tax structure between tangible personal property and services has spawned many of the most troublesome legal controversies that the sales tax raises.")

Such parity also implies that, if sales taxes were extended to hospital services, such taxes should apply whether the hospital furnishing such services is a for-profit or a nonprofit entity.

D. Endowment taxation.

I have argued elsewhere that the modest federal income taxation of private foundations and of certain college and university endowments should extend to similar entities including donor-advised funds, community foundations, all college and university endowments, and other comparable investment entities such as hospital endowments.³⁵⁸ The underlying argument for such taxation tracks the argument for taxing nonprofit hospitals in the same fashion as their profit-making competitors: equity and efficiency requires that similar entities be taxed similarly.

But if nonprofit hospitals were taxed as this article suggests, it would not make sense to tax separately hospital endowments in the same fashion as private foundations and selected college endowments are taxed. Rather, if nonprofit hospitals are taxed on their operational incomes, the investment incomes of such hospital endowments should be aggregated and taxed together with the operational incomes of the hospital and other entities affiliated with the hospital.

E. The tax status of schools.

Another inquiry prompted by this article's analysis is: Why stop taxation with hospitals? Why not also tax colleges and universities? This is a fair line of questioning as the modern college and university has similarities to (as well as differences from) the contemporary nonprofit hospital. Big-time collegiate athletic programs, for example, are not materially different from for-profit professional athletic teams.³⁵⁹ Considerations of parity suggest that, since the latter pay tax, so should the former.

For now, this article acknowledges and defers for future consideration the question whether today's institutions of higher education have, like nonprofit hospitals, become commercialized enterprises properly subject to taxation in whole or in part.

³⁵⁸ Edward A. Zelinsky, *Section 4968 and Taxing All Charitable Endowments: A Critique and a Proposal*, 38 VA. TAX REV. 141 (2018); Edward A. Zelinsky, *Expand the Taxation of Educational and Other Charitable Endowments*, 173 TAX NOTES FEDERAL 799 (2021).

³⁵⁹ Schmalbeck & Zelenak, *supra* note 176.

F. Payments-in-Lieu-of-Taxes.

Another phenomenon worthy of mention is the growing movement for hospitals, colleges and universities to make payments-in-lieu-of-taxes (PILOTs) to the municipalities housing such institutions.³⁶⁰ In the ultimate world envisioned by this article – a world in which nonprofit hospitals are fully taxed – PILOTs from hospitals will be a thing of the past. There is no need for hospitals to contribute funds in place of taxes when taxes themselves are being paid.

In the meanwhile, PILOTs (as well as New Jersey's "annual community service contribution")³⁶¹ can be viewed as interim measures, a transition to a world of full taxation– though the hospitals contributing under PILOT regimes undoubtedly reject the view that their PILOTs presage full tax payments down the road.

G. Taxing similar entities similarly.

A key premise of this article is that nonprofit hospitals should be taxed in the same fashion as for-profit hospitals because these materially similar entities should be taxed similarly. As Professor Tessa R. Davis has recently noted,³⁶² there is a "rich literature[] on whether and when neutrality is a proper goal in taxation." As to this literature, context matters. For example, in the context of the dormant commerce clause of the U.S. Constitution, the concept of discriminatory taxation has become incoherent because states' direct expenditures can achieve economically identical results as "discriminatory" taxes.³⁶³

In contrast, in the context explored in this article – the similarity of nonprofit and for-profit hospitals - it is unfair and inefficient to treat these comparable institutions differently, exempting the former but taxing the latter. Both the community benefit standard and Code Section 501(r) fail to justify the current tax exemption of nonprofit hospitals which, in all material respects, are indistinguishable from the for-profit hospitals that are taxed.

³⁶⁰ Julia A. Quiqley, *Payments in Lieu of Trouble: Nonprofit PILOTs as Extortion or Efficient Public Finance?* 26 N.Y.U. ENVTL. L.J. 272 (2018); DAPHNE A. KENYON & ADAM H. LANGLEY, *PAYMENTS IN LIEU OF TAXES: BALANCING MUNICIPAL AND NONPROFIT INTERESTS* (2010).

³⁶¹ N.J. Stat. §§ 54:4-3.6j(c), 40:48J-1.

³⁶² Tessa R. Davis, *Taxing Choices*, 16 FIU L. REV. 327, 340 (2022).

³⁶³ Edward A. Zelinsky, *The Incoherence of Dormant Commerce Clause Nondiscrimination: A Rejoinder to Professor Denning*, 77 MISS. L.J. 653 (2007).

H. *The charitable deduction.*

Besides exemption from federal income taxation, the other benefit to a corporation of charitable status is that donors to the corporation who itemize their deductions for federal income tax purposes can deduct their contributions to the corporation pursuant to Code Section 170.³⁶⁴ However, the tax incentive created by Section 170's charitable deduction is of secondary import for contemporary nonprofit hospitals which receive most of their income from the performance of services and relatively little from donors' charitable contributions.³⁶⁵

I. *The economic effect of taxing nonprofit hospitals.*

The economic effect of property taxation would generally be manageable for contemporary nonprofit hospitals in light of their robust revenues. Consider, for example, the economics of the Morristown medical center.³⁶⁶ Full property taxation of this facility would require the hospital to pay the town somewhat greater than \$4 million annually. This payment would be a significant financial contribution to the town which in 2022 raised approximately \$25 million in annual local property taxes.³⁶⁷ The hospital's yearly revenues are roughly \$6 billion. A property tax liability of \$4 million would be of minor economic consequence to the Morristown hospital in light of its \$6 billion in revenues.

The same is true of Provena Covenant which, under the Illinois Supreme Court's decision, would have paid yearly property taxes of \$1.1 million.³⁶⁸ This tax would have been less than 1% of the hospital's annual revenues of over \$113 million. While this property tax payment would have been a manageable burden for the hospital, it would have been potentially significant revenue for the city of Urbana which, in 2020, raised \$32.6 million in local taxes.³⁶⁹

Unlike the modest burdens of local property taxes, the income tax liabilities of nonprofit hospitals would be considerable if such

³⁶⁴ I.R.C. § 170.

³⁶⁵ Hall & Colombo, *supra* note 35; Utah Cnty. Bd. Of Equalization v. Intermountain Health Care, 709 P.2d 265, 273 (Utah 1985).

³⁶⁶ See *supra* notes 224–28 and accompanying text.

³⁶⁷ Town of Morristown, N.J., 2022 Municipal Budget, sheet 3, townofmorristown.org (May 10, 2022) (projecting municipal property tax revenues of \$24,499,952.77).

³⁶⁸ Provena Covenant Med. Ctr. v. Dep't of Revenue, 236 Ill. 2d 368, 381 (2010).

³⁶⁹ City of Urbana, Ill., Annual Budget Fiscal Year 2021/22, 7, https://www.urbanailinois.us/sites/default/files/attachments/00%20Combined%20PDF%20for%20Final%20for%20web_0.pdf (Sept. 30, 2021).

hospitals were taxed on their earnings by the federal and state governments. Consider again the \$727 million in profits the Mayo Clinic earned in 2020.³⁷⁰ Given a basic federal corporate tax rate of 21%³⁷¹ and a Minnesota state corporate tax rate of 9.8%³⁷², the clinic's payment of income taxes to the federal and state fiscs would be financially significant for the clinic and would likely impact the clinic's operations.

Hospitals with little or no income would pay little or no income tax. Such low- or no-income hospitals would also have a compelling argument for minimal property tax valuations using income-based valuation methods for their properties.³⁷³

But state and federal income taxes are significant for all corporations which pay them. Corporations are taxed as separate entities because of the public services they receive and because the capacity of corporations to pay justifies taxing them, notwithstanding the resulting economic costs which flow from such taxation. As long as there is corporate taxation, it should, in the interests of equity and efficiency, apply to materially similar enterprises including nonprofit hospitals.

J. *The status of religious hospitals.*

The analysis so far has in large measure focused on nonprofit hospitals claiming tax-exemption as charitable institutions. What about religiously affiliated hospitals? The highly commercial operations of religious hospitals are indistinguishable from the business-like operations of their profit-making and secular, nonprofit competitors. Consequently, religious hospitals should be taxed like their competitors.

The principal reason for exempting churches³⁷⁴ from taxation is to avoid the unacceptable level of church-state entanglement which results when particularly intrusive taxes are enforced against

³⁷⁰ Furst, *supra* note 50.

³⁷¹ I.R.C. § 11.

³⁷² Minn. Stat. § 290.06, subdivision 1 (2023). The Mayo Clinic has facilities throughout the country and abroad. MAYO CLINIC, <https://www.mayoclinic.org> (last visited Apr. 10, 2023). If the clinic were to be taxed on its income, the income earned in those other states and countries would be allocated to and taxed by those jurisdictions at their respective corporate tax rates. For purposes of illustration, Minnesota's corporate tax rate (where the clinic is headquartered) is a good indicator of the corporate tax rates to which this allocated income would be subject.

³⁷³ JOAN YOUNGMAN, LEGAL ISSUES IN PROPERTY VALUATION AND TAXATION: CASES AND MATERIALS 179 (2006) (discussing property valuations based on "the income capitalization approach").

³⁷⁴ The term "church" is being used generically to include all religious congregations including synagogues, temples and mosques.

churches.³⁷⁵ Some taxes, if applied to religious institutions, would unacceptably enmesh the tax collector and religious institutions in questions of sectarian doctrine or practice, e.g., What is an “ordinary and necessary”³⁷⁶ expense of ecclesiastical activity? How should unique, single-purpose religious properties be valued for tax purposes?³⁷⁷ In these contexts, religious institutions are exempted from taxation largely to avoid the unacceptable church-state entanglement which would arise from enforcing taxation in these settings.

On the other hand, the federal government and most states tax the unrelated businesses of exempt institutions including the unrelated businesses owned by churches. In terms of church-state entanglement, the federal government and these states pursue unrelated business income taxation (UBIT)³⁷⁸ because UBITs do not entail the same type of entanglement in sectarian practice and doctrine as would the direct taxation of churches’ income and property. Rather, UBITs apply to religiously owned businesses the same neutral, secular inquiries as apply when equivalent businesses are owned by nonreligious entities and individuals. Enforcing UBITs does not enmesh the tax collector with religious creeds or protocols.

Religiously affiliated hospitals are highly commercial in their operations and are thus indistinguishable from their profit-making and secular, nonprofit competitors. In the interests of equity and efficiency, religiously affiliated hospitals should be taxed using the same neutral, secular principles as today govern the taxation of for-profit hospitals, just as religiously owned unrelated businesses are taxed using the same neutral, nonsectarian rules which control the taxation of businesses in general.

Recall in this context the observations of the Illinois Supreme Court in *Provena Covenant*. Despite its religious affiliation, the hospital was in the commercial business of providing health care: “[T]he primary purpose” for which the hospital’s “property was used was providing medical care to patients for a fee.”³⁷⁹ Such activity, the court observed, “is not intrinsically, necessarily, or even normally religious in nature.”³⁸⁰

Consider as well the background of *Utah County*. Most of IHC’s hospitals “were founded and formerly owned and operated by the

³⁷⁵ Zelinsky, *supra* note 1, at 114.

³⁷⁶ I.R.C. § 162(a). See Zelinsky, *supra* note 1, at 134–37.

³⁷⁷ Zelinsky, *supra* note 1, at 128–34.

³⁷⁸ Zelinsky, *supra* note 1, at 49–50, 98–99.

³⁷⁹ *Provena Covenant Med. Ctr. v. Dep’t of Revenue*, 236 Ill. 2d 368, 410 (2010).

³⁸⁰ *Id.*

Church of Jesus Christ of Latter-Day Saints" before these hospitals were transferred to IHC.³⁸¹ There is no indication that the earlier operation of those hospitals was materially different when they were church-governed. The modern hospital is a commercial enterprise, even when the hospital is religiously affiliated.

Also instructive in this context are Justice Sotomayor's comments, concurring in *Advocate Health Care Network v. Stapleton*.³⁸² The issue in that case was whether, under a particularly inelegant provision of ERISA, Catholic hospitals' pension plans were exempt from regulation by virtue of their status as "church plan[s]."³⁸³ Justice Sotomayor agreed with her colleagues that the relevant statutory language required such ERISA exemption. But she also emphasized that these religiously affiliated hospitals "look and operate much like secular businesses" as they "operate for-profit subsidiaries, employ thousands of employees, earn billions of dollars in revenue, and compete in the secular market with companies that must bear the cost of complying with ERISA."³⁸⁴ These commercial characteristics suggest that religiously-affiliated hospitals should be taxed along with their for-profit and secular, nonprofit competitors.

K. *The St. Jude/Shriner's Childrens issue.*

Consider finally the (rare) cases of hospitals which can today plausibly be defended as bona fide charities. The best-known example of such a hospital is St. Jude which waives all payments by patients³⁸⁵ and, unlike most contemporary nonprofit hospitals, attracts substantial support from charitable donations.³⁸⁶ Another prominent example

³⁸¹ Utah Cnty. Bd. Of Equalization v. Intermountain Health Care, 709 P.2d 265, 280 (Utah 1985)..

³⁸² 137 S.Ct. 1652 (2017).

³⁸³ I.R.C. §§ 1002(33), 1003(b)(2).

³⁸⁴ 137 S.Ct. at 1663 (internal citations omitted).

³⁸⁵ ST. JUDE HOSPITAL, https://www.stjude.org/about-st-jude/unique-operating-model.html?sc_icid=us-mm-model (last visited Apr. 10, 2023) ("If a family has insurance, we will bill the insurance company, but no family ever receives a bill from St. Jude for care and no family is asked to pay co-pays or deductibles. More than 50 percent of our patients are under- or uninsured."). The financial assistance policy of Shriner's Childrens is somewhat different: "you may be billed for co-payments, insurance deductibles and co-insurance. If you cannot pay, your access to care at Shriners Children's will not be affected." SHRINER'S CHILDREN, BILLING, INSURANCE & FINANCIAL ASSISTANCE, <https://www.shrinerschildrens.org/en/patient-information/billing-insurance-and-financial-assistance> (last visited Apr. 10, 2023).

³⁸⁶ For a skeptical analysis of St. Jude, see David Armstrong & Ryan Gabrielson, *St. Jude Hoards Billions While Many of Its Families Drain Their Savings*, PROPUBLICA (Nov.

is Shriners Childrens.³⁸⁷ The Hall-Colombo “donative theory of the charitable exemption”³⁸⁸ suggests that in these few cases tax exemption is appropriate in light of such hospitals’ substantial donor support.

In important respects, St. Jude, Shriners Childrens and any other hospital operating similarly does not need tax-exempt status. Gifts³⁸⁹ are income tax-free to the donee as are capital contributions.³⁹⁰ Under either characterization, donations are tax-free to the hospital receiving them, even if the hospital is a taxable entity. Moreover, rank-and-file donors are not incited by the charitable tax deduction since such small donors do not itemize on their federal income tax returns. And, at the end of the day, St. Jude and Shriners Childrens, like all major enterprises, benefit from tax-supported public services.

On the other hand, St. Jude, Shriners Childrens and any other hospital operating similarly benefit from charitable status insofar as the charitable deduction stimulates the larger donations of taxpayers who itemize. And these hospitals are protected from taxation to the extent the payments they receive from third parties, i.e., insurers and government programs like Medicaid, exceed the cost of the care they provide.

In theory, a statute or administrative policy taxing most nonprofit hospitals could carve out St. Jude, Shriners Childrens and similar hospitals meeting specified criteria, letting them remain tax exempt. A potential precedent for such a targeted exception is the case of Newman’s Own Foundation.³⁹¹ In 1969, Congress enacted a general prohibition on private foundations owning businesses.³⁹² When Congress was convinced in 2018 that this prohibition unjustly hurt the Newman’s Own Foundation, Congress adopted a narrow provision allowing continued ownership of the Newman’s Own brand by the Newman foundation.³⁹³

12, 2021), <https://www.propublica.org/article/st-jude-hoards-billions-while-many-of-its-families-drain-their-savings>.

³⁸⁷ SHRINERS CHILDRENS, <https://www.shrinerschildrens.org/en> (last visited Apr. 10, 2023).

³⁸⁸ Hall & Colombo, *supra* note 34.

³⁸⁹ I.R.C. § 102(a).

³⁹⁰ I.R.C. § 118(a).

³⁹¹ Edward A. Zelinsky, *Saving Butch Cassidy’s charitable legacy*, OUPBLOG (Feb. 12, 2018), <https://blog.oup.com/2018/02/paul-newman-charity-legacy>; Richard Blumenthal & Christopher S. Murphy, *Senators Seek Relief for Philanthropic Groups*, 2018 TNT 12–16 (Jan. 17, 2018).

³⁹² I.R.C. § 4943.

³⁹³ I.R.C. § 4943(g).

One could envision a similarly targeted statute which would grant charitable status only to the few hospitals meeting stringent criteria for such status. For example, a statute could require a hospital to waive all payments from patients (including co-payments) and could require the hospital to obtain a minimum percentage of its gross revenues, e.g., 20%, from charitable contributions.

However, the history of Section 501(r) cautions about the political difficulty of Congress adopting such a narrowly tailored exemption. More likely, just as lobbying by nonprofit hospitals watered down Section 501(r), the hospitals will deploy their political heft to oppose stringent limits on their charitable status.

The Newman's Own Foundation was largely on its own when it sought legislative relief. The result was a narrow exception to Code Section 4943, applying to few, if any, other foundations. In contrast, the attenuated nature of Section 501(r) suggests that the entire nonprofit hospital industry would throw its full lobbying weight against efforts to tighten the requirements for nonprofit hospitals to be deemed charitable.

In short, a political donnybrook will likely ensue if a concerted effort is made to eliminate the tax-exempt status of most nonprofit hospitals. Theoretically, the ultimate outcome of this battle royale could be a very limited exemption, recognizing the charitable status of a few hospitals resembling St. Jude and Shriners Childrens. But that may be too subtle an outcome to emerge from what will be a political melee.

IX. CONCLUSION

As a substantive matter, it is now time to end our lengthy debate about the tax-exempt status of nonprofit hospitals. Today's nonprofit hospital is a commercial enterprise, materially indistinguishable for tax purposes from its profit-making, taxed competitor. The federal income tax and the states' income, sales and property taxes should treat all hospitals alike, regardless of whether such hospitals are nonprofit or for-profit enterprises. In the interests of equity and efficiency, these similar institutions should be taxed similarly.

As a political matter, achieving this result will not be easy, quick or inevitable. But, in terms of substance, there is no room left to reasonably debate the tax status of nonprofit hospitals. These hospitals should be taxed like their materially indistinguishable, for-profit competitors.

Edward A. Zelinsky is the Morris and Annie Trachman Professor of Law at the Benjamin N. Cardozo School of Law. For their many helpful criticisms, Professor Zelinsky thanks the participants in the Cardozo faculty seminar, particularly Professor Michael Pollack, as well as Professor Ellen P. Aprill, Professor Evelyn Brody, Professor Erin C. Fuse Brown, Professor John D. Colombo, Professor Mark A. Hall, and Professor Lawrence Zelenak. For their helpful observations, Professor Zelinsky also thanks Henry Chauncey, Jr., Dr. David D'Atri and Attorney Alan Yuspeh. For their research assistance, Professor Zelinsky thanks Cardozo students Sara Adams, Yeruchem Altusky, Sarah Batterman, Yanni Thanopoulos, Henry Thomas and Joshua Weiner.