I. Health Reform (Affordable Care Act) Implementation

A. Added Requirements for Tax-Exempt Hospitals

As a result of legislative changes in the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) (“PPACA”) as modified by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), tax-exempt hospitals face a number of new requirements, violations of which could result in significant economic costs and/or loss of federal tax-exempt status. The new provisions address concerns long held by a number of legislators (especially Senator Charles Grassley, R-Ia.), to the effect that most tax-exempt hospitals were not functioning in a sufficiently charitable manner to merit the benefits of continued exemption. After many failed attempts over several decades, and with surprisingly little protest this time, federal tax law has been changed to materially heighten the standards to which tax-exempt hospitals are held accountable.

The requirements, in newly added Code Section 501(r), apply to any Section 501(c)(3) organization operating a state-licensed hospital or otherwise having hospital care as its principal purpose or function, including public hospitals that have obtained recognition under Section 501(c)(3). The requirements fall under four general headings.

1. Community Health Needs Assessment (CHNA). At least every three years, tax-exempt hospitals must conduct a community health needs assessment. The assessment must take into account input from persons who represent the broad interests of the community served by the hospital, including persons having specialized knowledge or expertise in public health.

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1 The author submitted comments on behalf of such “dual status” hospitals (those whose income is exempt under Section 115 and are recognized under Section 501(c)(3)) requesting the IRS to include in the Section 501(r) final regulations a simple process under which such hospitals may voluntarily relinquish their exempt status under Section 501(c)(3) and avoid the requirements of Section 501(r). After initially requiring a Section 115 ruling, the IRS informally adopted a simpler approach allowing dual status hospitals to confirm voluntary relinquishment.
health, and must be made available to the public. The hospital also must adopt an implementation strategy to meet the needs identified via the assessment. Hospitals that fail to comply with the community needs assessment provisions will be subject to a tax of $50,000 per tax year. This requirement is effective for tax years beginning after March 23, 2012 (i.e., a calendar year taxpayer would have to have done an assessment in 2011, 2012, or 2013 to be in compliance).

The IRS issued final regulations in December 2014 providing detail on how to meet the CHNA requirement. The regulations require a hospital to take into account, at a minimum, input from (1) at least one state, local, or regional government public health department, (2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving their interests, and (3) written comments received on the hospital’s most recent CHNA and implementation strategy. A CHNA is considered to have been “conducted” on the date it is posted on the hospital’s website, and the hospital generally must adopt an implementation strategy by the end of the same tax year (or by when a Form 990 would be due without extension).

a. While it was developing this CHNA guidance, the IRS National Office held up all hospital Forms 1023 without formal acknowledgement or explanation.

2. Financial Assistance Policies. Effective immediately (i.e., organization’s first tax year beginning after March 23, 2010), hospitals must have written financial assistance policies that include (a) eligibility criteria, and whether care will be provided free of charge or at a discount, (b) the basis for calculating patient charges, (c) the method of applying for financial assistance, (d) if the hospital does not have a separate billing and collections policy, the actions the hospital may take in the event of non-payment, and (e) measures to widely publicize the policy within the community served by the hospital. Hospitals also must have a separate written policy requiring the provision of emergency care on a non-discriminatory basis, without regard to eligibility under the hospital’s financial assistance policy.

Final Regulations issued in December 2014 provide hospitals with additional guidance as to how they can satisfy these requirements. The Final Regulations do not mandate any specific eligibility criteria, but

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2 IRC 4959.

3 T.D. 9708 (Dec. 29, 2014)(the “Final Regulations”).

4 Id.
rather indicate that a financial assistance policy must specify the financial assistance available under it and all the eligibility criteria an individual must satisfy in order to be eligible for each level of assistance. The policy also must indicate that, if an individual is determined to be eligible for assistance, he will not be charged more than the amounts generally billed to individuals who have insurance covering the care. According to the Final Regulations, the financial assistance policy must describe the information and documentation the hospital may require the person to submit as part of the application process. It also must indicate the time frame within which the hospital may take any extraordinary collection actions in the event of nonpayment. Finally, the Final Regulations provide details concerning how hospitals must widely publicize their financial assistance policies. Generally, the policy, a plain language summary of the policy, and the application must be made widely available on the web, summaries must be made available in public locations and conspicuous public displays informing visitors and the community of the policy’s existence must be maintained. Depending on the demographics of the community served by the hospital, each of these documents/displays may have to be provided in languages other than English. The Final Regulations extend the reach of the financial assistance policy to include physician services rendered in the hospital if the hospital owns, directly or indirectly, the practice. Hospitals must include in the financial assistance policy a listing of all providers delivering emergency or medically necessary care in the hospital and whether they are covered by the policy.

3. **Limitations on Patient Charges.** Effective immediately (i.e., organization’s first tax year beginning after March 23, 2010), hospitals must limit the amounts charged to patients qualifying for financial assistance to not more than the amounts generally charged to individuals having insurance coverage for such services, and may not use gross charges. According to the Final Regulations, hospitals may compute “amounts generally charged” by using either the “look back method” or the “prospective method.” Under the look-back method, the amounts generally billed are determined by multiplying the hospital’s gross charges for the care provided by the percentage, which is the sum of all Medicare fee-for-service, Medicaid fee-for-service and private pay amounts for emergency or medically necessary care paid in full to the hospital during the previous 12 months, divided by the gross charges for those claims. The Final Regulations allow hospitals with substantial Medicaid business to use Medicaid alone. Under the prospective method, the amounts generally billed are equal to the amount Medicare and the Medicare beneficiary would be expected to pay for the care if the patient were a Medicare fee-for-service beneficiary. The Final Regulations allow a hospital to change the method under which it computes amounts generally billed, but they must amend their financial assistance policy accordingly.
4. **Limits on Collection Practices.** Effective immediately (i.e., organization’s first tax year beginning after March 23, 2010), hospitals may not use extraordinary collection actions before making reasonable efforts to determine whether a patient is eligible for assistance under the hospital’s financial assistance policy. The Final Regulations define extraordinary collection actions as actions that require legal or judicial process or involve selling an individual’s debt to another party or reporting adverse information to a credit reporting agency or credit bureau. Examples of extraordinary collection actions include, but are not limited to, placing liens on a person’s property, foreclosing on a person’s property, attaching or seizing a person’s bank account or any other personal property, commencing a civil action against a person, causing the person’s arrest, causing the person to be subject to a writ of body attachment, and garnishing a person’s wages.

The Final Regulations also provide detailed rules outlining what constitute “reasonable efforts”. In general, a hospital must notify a person of its financial assistance policy during a 120-day “notification period”. However, it must continue to accept and process applications during a longer, 240-day “application period.” In making reasonable efforts, a hospital must distribute a plain language summary of the financial assistance policy and offer an application to patients prior to discharge. In addition, the hospital must include a plain language summary of the policy with the first billing statement and inform the patient of its financial assistance policy in all other written and oral communications regarding the bill during the notification period. In addition, a hospital must warn people in writing, at least 30 days before payment is due, of the extraordinary collection actions it may take if payment or an application is not received, with the notice including a plain language summary of its financial assistance policy.

5. **Penalties, Corrections, and Disclosure:** Organizations operating more than one hospital must meet the above requirements separately with respect to each hospital facility, and any hospital facility that does not separately meet the requirements is not to be treated as described in Section 501(c)(3). The Final Regulations provide helpful guidance on how penalties for failure to satisfy Section 501(r) will apply, and provide some flexibility for minor and inadvertent omissions and errors. Note, however, that new Code Section 4959 imposes a $50,000 penalty excise tax for failure to meet the community health needs assessment part of the Section 501(r) requirements.

   a. The IRS published Rev. Proc. 2015-21, providing correction and disclosure guidelines under which certain failures to comply with Section 501(r) that are neither willful nor egregious and are corrected and disclosed would be excused.
6. **Reporting and Disclosure:** In addition, hospitals also face added reporting and disclosure obligations. In particular, hospitals will need to include, as part of their Form 990 annual information returns, a description of how they are addressing the needs identified in their community health needs assessments and, as to those needs that are *not* being addressed, an explanation as to why. For the first time, hospitals also will need to include along with their Form 990 information returns their audited financial statements, whether prepared on a separate or consolidated basis, thus making such financial statements subject to the existing public disclosure requirements applicable to annual information returns.

7. **IRS Reports:** Finally, the IRS will have to review at least every three years each tax-exempt hospital’s community benefit activities. TE/GE established a unit in Ogden, Utah to carry out this activity. Treasury and the Department of Health and Human Services will have to submit an annual report to Congress on charity care levels, bad debt expenses and government program shortfalls (means tested and not) for tax-exempt, for-profit, and governmental hospitals, and, after five years, they must report on trends in the annual reports. The first report, covering 2011 and containing mostly global expenditure data by sector, was delivered in January 2015.

8. **Senator Grassley’s Concerns:** Despite issuance of the Final Regulations, Senator Grassley, Chair of the Judiciary Committee, has concerns about compliance. On January 22, 2015, he wrote a letter to a Missouri health system seeking information about reports that they may be engaging in aggressive collection actions including lawsuits, without following the requirements in Section 501(r). In addition, as a member of the Finance Committee, he submitted questions for the record to Commissioner Koskinen during a FY 2016 budget hearing about IRS audit efforts to ensure compliance with Section 501(r)’s financial assistance policy requirement.

B. **End of Physician-Owned Hospitals**

While grandfathering in physician-owned hospitals in existence and having a provider agreement before December 31, 2010 (and strictly limiting expansion of capacity), PPACA effectively brought an end to new physician-owned hospitals. Tax-exempt community hospitals (and for-profit chains) likely will benefit from a reduction in competition from what often were single specialty hospitals that critics claimed “cherry picked” through self-referral of less acute insured patients by physician owners.

C. **Accountable Care Organizations’ Tax Status Uncertain**

PPACA creates financial incentives for “Accountable Care Organizations” (“ACOs”) as defined in regulations issued by the Secretary of Health and Human Services (“HHS”). HHS has issued proposed and final regulations implementing the Medicare Shared Savings Program (“MSSP”) based on the ACO model. In concert with the HHS proposed regulations, the IRS issued Notice
2011 describing how it sees existing tax law applying to tax-exempt organizations participating in the MSSP and other ACO activities. After HHS issued final regulations, the IRS issued Fact Sheet 2011-11, confirming that Notice 2011-20 continues to reflect its expectations.

D. 2011 Revisions to Form 990 and Schedule H—Everybody in the Water

1. Clearer Definition of Hospital After receiving many comments on the initial draft of the revised Form 990, the IRS wisely chose to define “hospital” for purposes of Schedule H with reference to state licensure as a hospital. No longer do we look to the old Section 170 definition that includes medical clinics and research organizations. This will allow the IRS to respond to Congress with more definitive statements about what hospitals do in furtherance of their exempt purposes.

2. Definitions of Charity Care and Community Benefit Though initially controversial (and now overshadowed by Section 501(r)), the IRS for the first time specified what counts and what doesn’t count as charity care and community benefit and how to report it on Schedule H.

E. 2012/13 Revisions to Schedule H—Just When You Thought It Was Safe…

1. No More Delays (Except for CHNA Questions for Certain Hospitals) Hospitals were required to complete new questions necessitated by Section 501(r), except the eight questions dealing with CHNAs, which remained optional for those hospitals with tax years beginning before March 24, 2012. For those hospitals answering the CHNA-related questions, the 2012 Schedule H required the hospital to disclose whether it incurred an excise tax for failure to conduct a CHNA.

2. Still One H, But Many New Questions and Could be Many Part V Section Bs Although tax-exempt corporations operating one or more hospitals and filing a Form 990 still complete only a single Schedule H, the expanded Part V Section B (containing the new PPACA questions) requires reporting on a facility by facility basis. Note that these questions do not apply to non-hospital facilities. For 2012, Schedule H permitted hospitals to create “facility reporting groups” if they are able to check the same checkboxes for all of Part V, Section B. Thus, the hospital may file a single Section B for all facilities in that reporting group.

3. Attach Audited Financial Statements Hospitals required to file Schedule H whose tax year begins after March 23, 2010 must attach their most recent audited financial statements. Those filing electronically are requested to file their financial statements in Adobe PDF format.

4. Change to Treatment of Restricted Grants The 2013 Instructions to Schedule H require hospitals to treat restricted grants received as direct offsetting revenue, which is likely to reduce the reported amount of net
community benefit expense for certain hospitals, including those with active research programs.

F. Medical Resident FICA Clarity

1. IRS Concedes Pre-April 2005 Medical Resident FICA The IRS threw in the towel with respect to pre-April 1, 2005 medical resident FICA claims based on the so-called “student exception.” The agency announced on March 2, 2010 that certain medical residents who worked at hospitals, universities and other institutions were not subject to employment (FICA) tax on wages earned for services rendered in connection with their education. To qualify, the institutions that employed medical residents or the individual residents must have timely filed FICA refund claims for tax periods ending before April 1, 2005, i.e., the effective date of new Treasury Regulations.

2. Prior to that date, Treasury Regulations provided that the status of an employee was determined on the basis of his or her relationship with the organization for which the services were provided. An employee had “student” status for services performed as an “incident to and for the purpose of pursuing a course of study” at the school, college, or university. In the case of medical residents performing services at a teaching hospital, however, the IRS took the position that the student exception did not apply, such that the residents were subject to FICA tax on the wages they earned. Despite the IRS position, many teaching hospitals filed FICA refund claims for the employer’s and the employee’s share of FICA tax. Those claims had met with inconsistent results in courts around the country, with several Courts of Appeals finding that medical residents qualified for the student exception. Because the statute of limitations to file FICA refund claims for tax periods ending before April 1, 2005 has long expired, neither employers nor medical residents may file new FICA refund claims to take advantage of the IRS announcement.

3. Supreme Court Upholds IRS Current Position on Resident FICA Under Treasury Regulations that became effective April 1, 2005, full-time employees are not eligible for the student exception because their services are not “incident to and for the purpose of pursuing a course of study.” The IRS position is that medical residents are ineligible for the student exception because they are full-time employees under the current Treasury Regulations. In 2009, on challenge by the Mayo Foundation for Medical Education and Research and Mayo Clinic, the Eighth Circuit Court of Appeals upheld the IRS application of the “full-time employee” standard to medical residents. The Supreme Court affirmed in Mayo Foundation For Medical Education And Research v. U.S., No. 09-837 (Jan. 11, 2011), ending a long running national dispute worth an estimated $700 million annually.
G. IRS Position on RHIOs

The IRS was slow to reach a position on the qualification for Section 501(c)(3) exemption of Regional Health Information Organizations (“RHIOs”). IRS was concerned that some of these organizations might serve the commercial interests of insurers and thus operate for substantial private benefit. TE/GE released a brief set of Q&As in April 2009 stating that properly organized RHIOs may lessen the burdens of government. The American Recovery and Reinvestment Act of 2009 included in its legislative history acknowledgement that certain organizations that facilitate exchange of health information and satisfy HHS standards lessen the burdens of government and may qualify under Section 501(c)(3). In the Q&As, the IRS announced that it had issued favorable determinations and individual cases were being considered on a facts and circumstances basis.

H. Health Plan Developments

1. **PPACA Imposes Premium Taxes (i.e., “Annual Fees”) on Health Plans**
   Insurance companies and HMOs providing health coverage are subject, beginning in 2014, to a tax on their gross premium revenues (after certain adjustments) for health coverage in the U.S. Thanks to the Reconciliation Act, only 50% of the revenues of tax-exempt insurance providers is taken into account. The IRS issued final regulations\(^5\) implementing the premium taxes on Dec. 16, 2013. T.D. 9463. Taxes are calculated and reported on new IRS Form 8963.

2. **PPACA Creates Tax-Exempt Health Insurance CO-Ops**
   New Code Section 501(c)(29) establishes tax exemption for qualified nonprofit health insurance issuers that qualify for financial assistance under the Consumer Operated and Oriented Plan program established by the Department of Health and Human Services. These entities are intended to issue qualified health plans in the individual and small group market. The IRS issued final regulations in January 2015 authorizing it to prescribe procedures by which Qualified Nonprofit Health Insurance Issuers (“QNHIIs”) participating in CO-OP programs established by the Centers for Medicare and Medicaid Services may apply to be recognized as tax-exempt under section 501(a) as an organization described in Section 501(c)(29). Treas. Reg. §1.501(c)(29)-1, T.D. 9709 (2015). The IRS also issued Rev. Proc. 2015-17, providing application procedures for QNHIIs. Note that Section 501(c)(29) provides for tax exemption for such QNHIIs only if they have received a grant or loan under relevant Affordable Care Act provisions. Section 644 of The American Taxpayer Relief Act of 2012 (H.R. 8) rescinded budget authority for grants and loans effective immediately, so organizations that planned to become Section 501(c)(29) organizations but had not yet received a grant or loan will not have this opportunity.

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\(^5\) T.D. 9643 (Nov. 27, 2013).
3. **IRS Rules Health Plan ASO Services are Related Activities** In Private Letter Ruling 201012052 (Mar. 26, 2010), the IRS ruled that the administrative services only (“ASO”) type coverage a Section 501(c)(3) health plan provides to large self-insured employers is a related activity with respect to the plan. The rationale is that the services making up the ASO type coverage are an integral part of the overall coverage and health care delivery arrangements the health plan usually provides to employer groups. The IRS had reached the same conclusion with respect to a Section 501(c)(4) health plan in Technical Advice Memorandum 200245064 (Nov. 8, 2002)(generally regarded as the technical advice memorandum underlying the IRS position in the Vision Service Plan litigation).

4. **VSP Litigation Concludes:** Vision Service Plan (“VSP”)-California's tax exemption under Section 501(c)(4) was revoked by the IRS for insufficient promotion of social welfare purposes. The Eastern District of California upheld the revocation in a rambling summary judgment opinion, the Ninth Circuit affirmed in an unpublished memorandum opinion, and the Supreme Court denied Certiorari. During and after those proceedings, five affiliated VSP entities (each a separate entity with its own EIN) filed suit to dispute whether they are primarily operated for the promotion of social welfare under Section 501(c)(4), and their cases were consolidated in the Southern District of Ohio. Subsequently, six additional cases were consolidated for a total of eleven cases. VSP-California began making stronger legal arguments in support of its exemption by the time it reached the Supreme Court. While we might have expected that those arguments would be heard at trial in the next set of cases, the Southern District reached a summary judgment for the IRS in six of those cases in 2010, finding that the legal issue of whether their method of doing business qualified under Section 501(c)(4) had been decided against their parent in the California action and the issue was therefore precluded by collateral estoppel. *In Re: Vision Service Plan Tax Litigation*, 105 AFTR 2010-2979 (S.D. Ohio).

**II. State Law Issues**

A. **Don’t be a Provena--:** Denial of Property Tax Exemption Affirmed by Illinois Supreme Court

On March 18, 2010, the Illinois Supreme Court (Court), in the case of *Provena Covenant Medical Center et al. v. The Department of Revenue*, ruled that Provena Covenant Medical Center (PCMC) did not provide enough free care to qualify for a charitable property tax exemption. Additionally, the Court found that there was insufficient information regarding Provena Hospitals (Provena) in the administrative record, which contributed in part to a finding that Provena was not a “charitable institution.” Notably, the decision issued by the Court was a plurality decision, and thus, because there was not a majority, the opinion is not directly binding on other institutions or organizations. Nevertheless, the criteria relied upon by the Court threatened to make it more difficult for private, not-for-profit hospitals in Illinois to obtain and maintain property tax exemption, prompting the state legislature to act (see below).
PCMC is one of six hospitals owned by Provena. Provena, a 501(c)(3) tax-exempt entity and an Illinois not-for-profit corporation, is one of four subsidiaries of Provena Health, created when the Servants of the Holy Heart and two other groups affiliated with the Roman Catholic Church consolidated their health care operations. In 2002, Provena applied for property tax exemption for 43 separate real estate parcels on the grounds that the parcels were owned by an institution of public charity and that the property was used actually and exclusively for charitable or beneficent purposes, as required by the property tax exemption statute. In the alternative, Provena argued that it should be granted property tax exemption as a religious organization. The county board of review recommended that the application be denied and in February of 2004, the Illinois Department of Revenue denied the application, stating that the property was not entitled to exemption based on ownership or use.

Provena appealed the denial of its property tax exemption and the case eventually made it up to the Illinois Supreme Court, where the sole issue before the Court was whether the 43 parcels of real property qualified for a property tax exemption under the Illinois Property Tax Code. Under Illinois law, the party claiming an exemption must prove by clear and convincing evidence that the property in question is both (1) owned by a charitable institution, and (2) used exclusively for charitable purposes. Similarly, to obtain an exemption as a religious organization, the property in question must be used exclusively for religious purposes.

The Court reasoned, based on an earlier Supreme Court case not involving a hospital, that status as a “charitable institution” is evidenced by the following distinctive characteristics:

1. it has no capital, capital stock, or shareholders;
2. it earns no profits or dividends but rather derives its funds mainly (emphasis added) from private and public charity and holds them in trust for the purposes expressed in the charter;
3. it dispenses charity to all who need it and apply for it;
4. it does not provide gain or profit in a private sense to any person connected with it; and
5. it does not appear to place any obstacles in the way of those who need and would avail themselves of the charitable benefits it dispenses.

After determining that Provena “clearly” satisfied the first and fourth factors above, the Court focused on the remaining factors and concluded that Provena failed to meet criterion two, three, and five above because its funds were not derived mainly from private and public charity (rather, as is the case with most hospitals, they were generated overwhelmingly by providing medical services for a fee) and it failed to show by clear and convincing evidence that it dispensed charity to all who needed it and applied for it. In reaching the above conclusion, the Court noted that, although the record included a great deal of evidence to support a finding that PCMC itself was a charitable institution, it lacked any evidence regarding Provena’s charitable status. Due to this lack of evidence and the fact that PCMC is only one of numerous institutions owned by Provena, the Court could not conclude that Provena, as the owner of the 43 parcels of property, was a charitable institution under Illinois law.
In order for a property to obtain tax exemption as a charitable organization, in addition to meeting the charitable ownership requirement discussed above, it must be used exclusively for charitable purposes. Courts have agreed that, in practice, the primary purpose for which property is utilized must be charitable. The Court found that Provena did not use the 43 parcels of property exclusively for charitable purposes, citing the following in support of its conclusion:

6. Both the number of uninsured patients receiving free or discounted care and the dollar value of the care received were *de minimus*.

7. Provena did not advertise the availability of charitable care at PCMC. Rather, patients were billed as a matter of course and unpaid bills were automatically referred to collection agencies in the same manner as a for-profit institution would write off bad debt.

8. Although PCMC participated in the Medicare and Medicaid programs, the discounted care provided to Medicare and Medicaid patients is not considered charity for purposes of assessing property tax exemption eligibility.

After deciding that Provena was not entitled to a property tax exemption as a charitable institution, the Court went on to summarily dismiss Provena’s argument that it should be exempt as a religious organization reasoning that religious purposes were not its primary motivation.

Although the issuance of the Court’s decision ended Provena’s eight-year dispute related to its property tax exemption for 2002, it failed to provide clear criteria that must be met in order for an entity to obtain property tax exemption as a charitable institution. The Court made clear that a hospital must be owned by a charitable organization and exclusively operated for charitable purposes; however, it did not establish a bright line test either for how much charity funding a hospital must receive or how much charity care a hospital must provide in order to qualify for property tax exemption as a charitable institution.

**B. Illinois State Legislature Saves the Day**

For those hoping for a more definitive ruling that would resolve future tax exemption concerns, the Provena opinion fell dramatically short. After the Illinois Department of Revenue denied the applications of three more hospitals in 2011, the Governor imposed a three-month moratorium on decisions to give the hospital community time to work out proposed standards with the state legislature. Effective June 24, 2012, the Illinois legislature enacted a new law establishing specific standards for not-for-profit hospitals seeking property tax exemptions. In general, a charitable exemption is allowed for hospital property if the value of certain of the hospital’s qualified services and activities equals or exceeds the hospital’s estimated property tax liability for the year. The qualified services and activities that get taken into consideration under this new law include (i) charity care, (ii) health services to low-income and underserved individuals, (iii) subsidy of state or local governments, (iv) support for state health care programs for low-income individuals, (v) dual-eligible subsidy, (vi) relief of the burden of government related to health care of low-income individuals, and (vii) any other activity by the relevant hospital entity that the Department of Revenue determines relieves the burden of government or addresses the health of
low-income or underserved individuals. To calculate whether it is eligible for exemption, the
hospital may use either (1) the value of the services or activities for the hospital year, or (2) the
average value of those services or activities for the three fiscal years ending with the hospital
year. If the relevant entity is a hospital owner that operates more than one hospital, the value of
the services or activities must be calculated on the basis of only those services and activities
relating to the hospital that includes the subject property, and the relevant hospital entity’s
estimated property tax liability must be calculated only with respect to the properties comprising
that hospital.

C. A Modest Proposal to Throw Out Section 501(r) and Start Over

On February 9, 2015, the Alliance for Advancing Nonprofit Health Care sent to the CEOs of
every nonprofit hospital and health system a proposal to repeal Section 501(r) and replace it with
a hospital by hospital annual community benefit expenditure test that would compare
expenditures to federal income taxes the hospital would otherwise pay and make hospitals pay
taxes for any shortfall. The proposal has not been well-received by the American Hospital
Association or the Catholic Health Association and at the very least seems particularly ill-timed.

D. Complaint Filed Against Jackson Health

In August 2014, advocates for the poor and uninsured in Miami filed a complaint with the IRS
on Form 13909 that Jackson Health System failed to meet its obligations under Section 501(r).
Though it appears that Jackson may be a non-dual-status public hospital and therefore not
covered by 501(r), tax-exempt hospitals now are on notice that critics can file a complaint under
that section.

E. Blue Shield of California State Exemption Revocation.

It was reported in March 2015 that the California Franchise Tax Board revoked the tax
exemption of Blue Shield of California, the state’s third largest insurer in August 2014. The
Franchise Tax Board has not publicly explained its decision, and Blue Shield reportedly is
appealing.