

TAXATION AND TELEHEALTH: WOULD A TELEHEALTH EXCLUSIVE FACILITY OWNED BY A NONPROFIT HOSPITAL BE EXEMPT FROM PROPERTY TAX IN INDIANA?

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I. INTRODUCTION

Taxation exemption in the United States traces its roots to before the formation of our republic.¹ Organizations which provide charitable relief, such as hospitals, fire departments, and orphanages, were established to address a lack of direct governmental involvement in the societal issues faced by colonists.² These organizations were designed to provide basic services to the public at large, and it is suggested that their wide popularity may have been spurred by early Americans' desires to see private efforts prevail over that of the government, out of a general fear of returning to monarchical rule.³ In turn, charitable organizations were likely able to shoulder the heavy load of social welfare that our newly founded government could not.⁴ In recognition of how vital these organizations have been and will continue to be in the future, the federal government allows for qualifying organizations to receive exemption from federal income taxation, and this practice has generally been followed by the states.⁵

Section 501(c)(3) of the Internal Revenue Code provides, in part, that a corporation "organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes . . ." is entitled to receive exemption from federal income taxation, provided that the statutory requirements and forms are properly completed and submitted.⁶ Hospitals which organize as a charitable organization under Section 501(c)(3) must satisfy several statutory and regulatory requirements to receive exemption from federal income taxation.⁷ However, exemption from state sales taxation varies from state to state and depends largely on whether the hospital is organized as a 501(c)(3) entity.

First, charitable hospitals must satisfy the organizational and operational tests

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1. Paul Arnsberger et al., *A History of the Tax-Exempt Sector: An SOI Perspective*, STAT. INCOME BULL.105, 105 (2008), <https://www.irs.gov/pub/irs-soi/tehistory.pdf> [<https://perma.cc/PQY6-ZTYA>].

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. I.R.C. § 501(c)(3).

7. *Charitable Hospitals - General Requirements for Tax-Exemption Under Section 501(c)(3)*, INTERNAL REVENUE SERV., <https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3> [<https://perma.cc/E8SC-3F4T>] (last updated Aug. 3, 2021).

under Section 501(c)(3). These tests generally require the charitable hospitals to be organized exclusively for one or more exempt purposes - demonstrated by the hospital's organizational documents- and operate exclusively for that exempt purpose and "engage[] primarily in activities that accomplish one or more exempt purposes as specified in Section 501(c)(3)."⁸ Demonstration of such operation is not sufficiently shown by merely stating that the operation of the hospital is exclusively to promote health.⁹ Rather, the hospital must also show that it operates to "promote the health of a class of persons that is broad enough to benefit the community," known as the Community Benefits Standard articulated in Revenue Ruling 69-545, 1969-2 C.B. 117.¹⁰ These requirements are in addition to those placed on hospitals under Section 501(r), and only when all statutory and regulatory requirements are satisfied will a charitable hospital be permitted to receive exemption from federal income taxation.¹¹

At the state level, a corporation's exemption status from federal income taxation can generally be relied on to garner exemption from income taxation.¹² A similar reliance is generally acceptable to also receive exemption from state sales tax.¹³ Therefore, proof of federal income tax exemption status stemming from the hospital's classification as a charitable corporation under Section 501(c)(3) is generally all that is required for a hospital to receive exemption from state income and sales tax. However, reliance on Section 501(c)(3) exemption status alone may not be sufficient to warrant state and local property tax exemption for a hospital, especially as applied to any additional property that it owns outside of the main facility campus. Therefore, understanding whether an exempt hospital, and its additional property, is afforded exemption from state and local property taxation requires referring to state law, specifically the exemption statutes in Indiana.

8. *Id.*

9. *Id.*

10. *Id.*; see Rev. Rul. 69-545, 1969-2 C.B. 117, <https://www.irs.gov/pub/irs-tege/rr69-545.pdf> [<https://perma.cc/4FAT-K6GE>], which lays out the six requirements a hospital must show to suffice the community benefit standard.

11. See I.R.C. § 501(r).

12. George E. Constantine et al., *The Difference Between Nonprofit and Tax-Exempt Status*, VENABLE (1999), <https://www.venable.com/insights/publications/1999/10/the-difference-between-nonprofit-and-taxexempt-sta> [<https://perma.cc/BP8Y-XP4M>].

13. Ron Barrett, *Sales and Use Tax Exemptions for Nonprofits*, COGENCYGLOBAL (Aug. 29, 2019), <https://www.cogencyglobal.com/blog/sales-and-use-tax-exemptions-for-nonprofits> [<https://perma.cc/S7L7-PEBN>] ("The key to earning a sales tax exemption is being designated a charitable, tax-exempt 501(c)(3) nonprofit organization under the Internal Revenue Code.").

II. THE ISSUE

A. Property Tax Exemption Status Afforded to a Satellite Telehealth Exclusive Facility Owned by a Nonprofit Hospital

Under Indiana law, a nonprofit hospital may receive tax exemptions from state income taxes and sales taxes.¹⁴ Moreover, nonprofit hospitals, which are organized and operated to “relieve the destitute and deserving” are classified as charitable, and therefore, eligible to receive a charitable purposes tax exemption from state and local property taxation.¹⁵ However, additional property owned and operated by an exempt hospital “does not automatically receive a charitable purpose exemption” from state and local property taxation.¹⁶ As such, instead of automatically receiving the charitable purposes exemption already obtained by the main hospital facility, the other property must first satisfy one of three requirements under Indiana law.¹⁷

These statutory requirements state that property tax exemption under Section 16(a) does not exempt “other property that is not substantially related to or supportive of the inpatient facility of the hospital”¹⁸ unless the other property either:

“(1) provides or supports the provision of charity care (as defined in IC 16-18-2-52.5), including providing funds or other financial support for health care services for individuals who are indigent (as defined in IC 16-18-2-52.5(b) and IC 16-18-2-52.5(c)); or (2) provides or supports the provision of community benefits (as defined in IC 16-21-9-1), including research, education, or government sponsored indigent health care (as defined in IC 16-21-9-2).”¹⁹

In short, other property owned and operated by an exempt hospital is afforded a charitable purposes exemption from property taxation if the property substantially relates to or is supportive of the exempt hospital’s inpatient facility. If that standard cannot be met, the other property may be entitled to exemption upon proof that it provides or supports the provision of charity care or provides or supports the provision of community benefits. Therefore, the issue to be determined is whether a telehealth-exclusive facility owned by an exempt nonprofit hospital would be found exempt from property taxes under Indiana

14. *Community Benefit State Law Profile: Indiana*, HILLTOP INST. 1, 2 (2016), https://hilltopinstitute.org/wpcontent/uploads/hcbp/hcbp_docs/HCBP_CBL_IN.pdf [<https://perma.cc/MYK4-BDGE>].

15. *Indianapolis Osteopathic Hosp., Inc. v. Dep’t of Loc. Gov. Fin.*, 818 N.E.2d 1009, 1015 (Ind. T.C. 2004).

16. *Id.*

17. *See* IND. CODE § 6-1.1-10-16(h) (1975).

18. *Id.*

19. *See id.*

Code Section 6-1.1-10-16.

III. BACKGROUND

A. Indiana's Approach to Telehealth and the Effect of COVID-19 on the Use of Telehealth

The use of telehealth services in Indiana has been a long-accepted practice since the beginning of 2013.²⁰ COVID-19 greatly expanded the use of telehealth services across the country, in part due to the social distancing guidelines imposed by the CDC, with usage increasing by 154 percent in late March of 2020 compared to the same period in 2019.²¹ In Indiana, lawmakers responded to the increased use of telehealth by expanding the application of telehealth practice to include licensed practitioners instead of only prescribers.²² Furthermore, the bill prohibited Medicaid from specifying originating sites and distant sites for purposes of Medicaid reimbursement, which increases the scope of where a provider can be located and where a patient can be located for the purposes of Medicaid reimbursement.²³

Prior to COVID-19, the use of outpatient telehealth services was primarily aimed at increasing access to care for rural and underserved areas.²⁴ However, due to the inability to have in-person appointments during the pandemic, many providers utilized telehealth to reach patients at home, when they previously had been seen in person.²⁵ Throughout the COVID-19 pandemic, experts noted the clear benefits of telehealth in connecting patients with providers.²⁶ Its use has been embraced by both providers and patients, namely due to reduced travel and shorter waiting times.²⁷ Moreover, “[a]pproval ratings for [synchronous video telehealth] as a replacement for in-person visits are high among both patients and providers.”²⁸

Telehealth services have been on the rise in recent years, with the most-used services being direct-to-consumer (“DTC”) services from companies like Teladoc, MDLIVE, and Amwell.²⁹ Telehealth services appear to be here to stay,

20. See S.B. 554, 118th Gen. Assemb., 1st Reg. Sess. (Ind. 2013).

21. Lisa M. Koonin et al., *Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic—United States, January–March 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1595, 1599 (2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6943a3.htm#> [<https://perma.cc/6NCM-6BYN>].

22. See S.B. 3, 122nd Gen. Assemb., 1st Reg. Sess. (Ind. 2021).

23. *Id.*

24. Joshua J. Brotman & Robert M. Kotloff, *Providing Outpatient Telehealth Services in the United States*, 159 CHEST 1548, 1555 (2021).

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*

29. *Id.*

in some capacity. This is not limited to DTC companies but including health care providers at for-profit and nonprofit hospitals, with many experts predicting a notable increase in the use of telehealth services following the pandemic.³⁰ But what if a provider wanted to provide telehealth services in a new way? Specifically, at the conclusion of the pandemic – when in-person visits and normal provider-patient interactions can fully return – what if a nonprofit hospital decided to open a telehealth-exclusive facility in a rural, medically underserved area? Looking outside of any health policy specific questions which would arise from such a proposal, would such a facility be exempt from property taxes under Indiana law? To find an answer, let us consider a hypothetical facility.

B. A Hypothetical Facility

Consider a hypothetical facility (“Facility”) located in a medically underserved area. Factoring out areas that are categorized as medically underserved with a Governor’s Exception, Indiana has 46 fully and partially medically underserved areas.³¹ The Facility also will be in a rural health area, as it would be designed to connect those in the underserved population with providers located at the main hospital.

Utilizing the Health Resources & Services Administration (“HRSA”) Data Warehouse, Indiana has a total of 24 medically underserved areas located in rural areas of the State.³² Each area is assigned an Index of Medical Underservice (“IMU”) score between 0 and 100, with 0 representing the most need and 100 representing the least need.³³ An area is classified as medically underserved based on designation criterion developed by HRSA’s Bureau of Health Workforce, and a score of less than or equal to 62 is needed to qualify for designation as a medically underserved area.³⁴ Organized from lowest IMU score to highest IMU score, the median score was 57.2, which corresponds to the Cass County Service Area.³⁵ Therefore, the hypothetical facility will be in the Cass County Service

30. See Tania Elliot & Margot C. Yopes, *Direct-to-Consumer-Telemedicine*, 7 J. ALLERGY & CLINICAL IMMUNOLOGY: IN PRACT. 2546, 2553 (2019) (“Most US health institutions and hospital systems are currently using some form of telehealth, and more than 90% of health care executives surveyed across the United States have virtual care on their roadmap for growth.”); see also Cara Murez, *Health Care After COVID: The Rise of Telemedicine*, U.S. NEWS (Jan. 5, 2021, 8:49 AM), <https://www.usnews.com/news/health-news/articles/2021-01-05/health-care-after-covid-the-rise-of-telemedicine> (innovative approaches to health care through increased use of telehealth and telemedicine are “likely to linger long after the pandemic ebbs”).

31. *MUA Find*, HEALTH RES. & SERV. ADMIN., <https://data.hrsa.gov/tools/shortage-area/mua-find> [<https://perma.cc/4YKY-QKPB>] (last visited Oct. 14, 2021).

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.* (The lowest score (highest need) is 0; the highest score (lowest need) is 100. In order to qualify for designation, the IMU score must be less than or equal to 62.0. The score applies to the MUA or MUP as a whole, and not to individual portions of it.).

Area because it is a medically underserved area located in a rural county.

Around 90.6 percent of Cass County citizens are insured, breaking down to 50.5 percent covered by employee plans, 15.1 percent covered by Medicaid, 13.1 percent covered by Medicare, 10.6 percent are on non-group plans, and 1.26 percent are on VA plans.³⁶ Moreover, the ratio of patients to primary care physicians is 2,370 to 1, which strains provider resources and access to care for citizens.³⁷ Locating a telehealth-exclusive facility that connects patients in this service area with providers at the main hospital facility will likely result in decreased wait times for in-person visits to area hospitals, increase access to care for Cass County citizens, and help reduce the spread of diseases and viruses, such as the flu and COVID-19.

One of the main barriers to the success of telehealth services is the lack of broadband access in rural areas.³⁸ However, assume that the facility contemplated here would limit connectivity issues by having its own facility in the underserved area that individuals could travel to and be seen virtually by a provider. But, even if such a facility would benefit this underserved area, the desirability of the investment by a nonprofit hospital would be affected by the potential unavailability of property tax exemption for the facility.

Specifically, the difficulty of showing how a facility located off a hospital's main campus is substantially related to or supportive of the hospital's inpatient facility, along with the heightened standard imposed by the Indiana Tax Court's recent ruling regarding the "predominate use test" to determine charitable care and community benefit,³⁹ could deter nonprofit hospitals from establishing a telehealth facility that is easily accessible to rural Hoosiers because of potential property tax exposure.

36. *Cass County*, DATA USA, <https://datausa.io/profile/geo/cass-county-in> [<https://perma.cc/3TT2-84AM>] (last visited Oct. 12, 2021).

37. *Indiana*, CNTY. HEALTH RANKING & ROADMAPS, <https://www.countyhealthrankings.org/app/indiana/2021> [<https://perma.cc/F8YV-TAWM>] (last visited Oct. 14, 2021).

38. See Victoria Bailey, *Limited Broadband Poses a Significant Barrier to Telehealth Access*, MHEALTH INTEL (Aug. 6, 2021), <https://mhealthintelligence.com/news/limited-broadband-poses-a-significant-barrier-to-telehealth-access> [<https://perma.cc/EA26-EQN4>] ("While telehealth can offer the convenience of receiving care at home, individuals living in rural areas are at a significant disadvantage due to the lack of broadband connectivity.").

39. *Indiana Tax Court Denies Property Tax Exemption of Off-Campus Medical Office Building*, HALL RENDER (Dec. 3, 2019), <https://www.hallrender.com/2019/12/03/indiana-tax-court-denies-property-tax-exemption-of-off-campus-medical-office-building/> [<https://perma.cc/4VD2-XW2F>].

IV. ANALYSIS OF INDIANA STATUTES AND CASE LAW DEALING WITH
PROPERTY TAX EXEMPTIONS FOR ADDITIONAL PROPERTY OWNED
BY NONPROFIT HOSPITALS

A. Hospital Exemptions: Indiana Code §§ 6-1.1-10-16(a), (h)

In Indiana, all or part of a building is entitled to exemption from property tax if it is “owned, occupied, and used by a person for . . . charitable purposes.”⁴⁰ In order to be entitled to a charitable purposes exemption, there must be an expectation of some benefit that flows to the public because of that exemption.⁴¹ Under Indiana Property Tax statutes, the term Charity is given the broadest constitutional definition allowed.⁴² However, other property owned by an exempt hospital does not automatically receive a charitable purposes exemption.⁴³ “Indeed, the charitable purposes exemption does not apply to other property owned by a hospital ‘that is not substantially related to or supportive of [its] inpatient facility[.]’”⁴⁴

Therefore, in order for other property owned by an exempt hospital to be entitled to a charitable purposes exemption under Indiana Code Section 6-1.1-10-16(a), the property must first satisfy the substantially related to or supportive of standard in Indiana Code Section 6-1.1-10-16(h), and the hospital must demonstrate that the other property is used for a charitable purpose.

B. Indiana Case Law Regarding Other Property Owned by an Exempt Hospital and the Substantially Related to or Supportive of Standard

In Indianapolis Osteopathic Hospital Inc. v. Department of Local Government Finance, the Indiana Tax Court addressed what it meant for other property to substantially relate to or support the owning exempt hospital’s inpatient facility. In that case, the Health Institute of Indiana (“HI”) owned a 158,000 square foot facility on the campus of Westview Hospital.⁴⁵ 74 percent of the facility was used as a Healthplex, “59% of the time as a community-oriented fitness facility” and “the remaining 41% of the time to provide outpatient rehabilitation services, research, and community education.”⁴⁶ Accordingly, the other 26 percent of the facility was used as a medical pavilion (“MP”).⁴⁷ Around 11 percent of the MP was leased to physicians employed by Westview Hospital, and 37 percent of the space in the MP was “used by various Westview Hospital

40. See IND. CODE § 6-1.1-10-16(a) (2021).

41. See *Indianapolis Osteopathic Hosp., Inc. v. Dep’t of Loc. Gov’t Fin.*, 818 N.E.2d 1009, 1014 (Ind. T.C. 2004).

42. See *Indianapolis Elks Bldg. Corp. v. State Bd. of Tax Comm’rs*, 251 N.E.2d 673, 682 (Ind. Ct. App. 1969).

43. *Indianapolis Osteopathic Hosp., Inc.*, 818 N.E.2d at 1015.

44. *Id.* (quoting IND. CODE § 6-1.1-10-16(h)).

45. *Id.* at 1011.

46. *Id.* at 1012.

47. *Id.* at 1011.

departments, including physical and occupational therapy, MRI, mammography, integrated medicine, and patient registration; and 44% of the facility was vacant.”⁴⁸ Additionally, around 1 percent of the facility was used as a boardroom, which was used 98 percent of the time by Westview and another hospital for administrative purposes, as well as various other nonprofit community groups.⁴⁹ HII and Westview argued that the Healthplex portion of the facility was entitled to 100 percent exemption from property tax and that the MP portion of the facility was entitled to 91 percent exemption from property tax.⁵⁰

The Court began its analysis by first explaining the charitable purposes exemption under Indiana Code Section 6-1.1-10-16(a). The Court explained that when a charitable purposes exemption is sought, the entity seeking the exemption must “not only demonstrate that it owns, occupies, and uses its property for a charitable purpose, but also that the charitable purpose is the property’s predominant use.”⁵¹ Then, because the facility in question was other property owned by Westview—and therefore subject to the substantially related to and supportive of standard under Indiana Code Section 6-1.1-10-16(h)—the Court discussed the relevance of the predominant use test to the issue before it.

In 1983, the Indiana legislature adopted the predominant use test to determine whether a property qualifies for exemption under Indiana Code Section 6-1.1-10-10.⁵² The predominant use test is codified by statute under Indiana Code Section 6-1.1-10-36.3, which states in relevant part: “[P]roperty is predominantly used or occupied for one or more stated purposes if it is used or occupied for one or more of those purposes during more than fifty percent (50%) of the time that it is used or occupied in the year that ends on the assessment date of the property.”⁵³ The statute goes on to say that “[i]f a section of this chapter states one (1) or more purposes for which property must be used or occupied in order to qualify for an exemption, then the exemption applies as follows: (1) Property that is exclusively used or occupied for [a charitable] purpose[] is totally exempt[.]”⁵⁴

Turning to the arguments presented by HII and Westview, determining whether the Healthplex portion of the facility—through promoting health by physical activity—constituted a charitable purposes exemption from property tax was an issue of first impression for the Court.⁵⁵ Ultimately, the Indiana Court of Appeals found a Tennessee Court of Appeals decision to be informative, which acknowledged that while “such centers often have strong medical philosophies, employing physicians and exercise physiologists and offering programs tailored expressly for hospital inpatients and outpatients, they are, nonetheless, not limited

48. *Id.* at 1013.

49. *Id.* at 1011.

50. *Id.* at 1016.

51. *Id.* at 1014.

52. *Id.* at 1019 (quoting *State Bd. of Tax Comm’rs v. New Castle Lodge # 147, Loyal Order of the Moose, Inc.*, 765 N.E.2d 1257, 1259 (Ind. 2002)).

53. IND. CODE § 6-1.1-10-36.3(a) (1983).

54. IND. CODE § 6-1.1-10-36.3(b) (1983).

55. *Indianapolis Osteopathic Hosp., Inc.*, 818 N.E.2d at 1017.

to use by those requiring ‘traditional’ medical care.”⁵⁶ The Court adopted this portion of the holding in *Middle Tennessee Medical Center* as its own, and consequently affirmed the Indiana Tax Board’s denial of a charitable purposes exemption for the Healthplex portion of the facility.⁵⁷

Regarding the MP portion of the facility, the Court disagreed with the Indiana Tax Board’s finding that while “the only portion of the MP eligible to receive an exemption was the [37%] portion used by various Westview Hospital departments,[that portion] did not meet the predominant use test.”⁵⁸ Instead, the Court found the record showed that “37% of the space in the MP is used 100% of the time by various Westview Hospital departments, [and] the boardroom is predominantly used (i.e., 98% of the time) for hospital administrative meetings.”⁵⁹ The Court then determined that because “the charitable purposes exemption may apply to all or part of another building owned by a hospital if it is substantially related to or supportive of [its] inpatient facility[.]” cite the Health Pavilion was entitled to a 38 percent exemption because the use of that percentage of the facility by the Westview Hospital departments and for hospital administrative meetings, both of which constituted a substantial relation to Westview’s inpatient facility.⁶⁰

The Court’s map to providing a charitable purposes exemption in *Indianapolis Osteopathic Hospital* was because the 37 percent portion of the Health Pavilion that was used by Westview Hospital departments was substantially related to or supportive of Westview’s inpatient facility. So, because that portion was used 100 percent of the time by those departments, it was predominately used for a charitable purpose, and thus, entitled to a charitable purpose exemption.⁶¹

Three years after *Indianapolis Osteopathic Hospital*, the Court was faced with another charitable purposes exemption issue in *Methodist Hospitals, Inc. v. Lake County Property Tax Assessment Board of Appeals*. There, the Court determined whether two Primary Care Associates medical offices (“PCA”), owned by Methodist Hospital, qualified for a charitable purposes property tax exemption.⁶²

Methodist Hospital owned and operated two acute care hospitals located in Gary, Indiana (Northlake Campus) and the other in Merrillville, Indiana

56. *Id.* (quoting *Middle Tenn. Med. Ctr. v. Assessment Appeals Comm’n State of Tenn.*, No. 01A01-9307-CH-00324, 1994 WL 32584, at *4 (Tenn. Ct. App. 1994)).

57. *Indianapolis Osteopathic Hosp. Inc.*, 818 N.E.2d at 1018.

58. *Id.* at 1017.

59. *Id.* at 1019.

60. *Id.*

61. It would follow that the same analysis from the court in *Indianapolis Osteopathic Hospital* would be used for the boardroom portion of the facility and its use (98 percent of the time) for hospital administrative meetings, thereby totaling the exemption to 38 percent.

62. *Methodist Hosp.’s, Inc. v. Lake Cnty. Prop. Tax Assessment Bd. App.*, 862 N.E.2d 335 (Ind. T.C. 2007).

(Southlake Campus).⁶³ In addition to these primary facilities, Methodist Hospital also owned two PCA offices, one located in Griffith, Indiana and the other in Merrillville, Indiana—which was located on the Southlake Methodist Campus. The PCAs employed both physicians and other staff members who were employees of Methodist Hospital and were used as primary care medical offices.⁶⁴ The on-site physicians at the PCAs specialized in obstetrics/gynecology, pediatrics, internal medicine, and family medicine.⁶⁵ Residents in the area surrounding the PCA offices would “seek out the medical services offered at the PCAs from Monday through Saturday, but Methodist did not send patients to the PCAs.⁶⁶ However, the PCA physicians were able to admit the patients seen at the PCAs to Methodist’s acute care hospitals and treat inpatients at the main hospital.⁶⁷ Methodist Hospital also performed all the billing and collection work for the PCA offices, depositing the payments from patients for services rendered at the PCA offices “into the same bank account it uses for its acute care hospitals.”⁶⁸

Methodist argued that the PCA facilities were entitled to a property tax exemption: “(1) because it uses the PCAs to provide traditional medical services, (2) because the PCAs provide medical services as a part of Methodist’s “overall continuum of care[,]” and (3) because the PCA physicians do not use the offices “for personal gain.”⁶⁹

The Court began by discussing Indiana Code Section 6-1.1-10-16(a)’s charitable purposes exemption and Indiana Code Section 6-1.1-10-16(h)’s limitation of automatic exemption for other property owned by exempt hospitals. Next, in order to determine whether the standard under Section 16(h) was satisfied, the Court had to establish: “a) what is a hospital’s inpatient facility; and b) what does it mean to be ‘substantially related to or supportive of’ a hospital’s inpatient facility?”⁷⁰ This was done by attributing “the plain, ordinary, and usual meaning of non-technical words in a statute [as] defined by their ordinary and accepted dictionary meaning.”⁷¹

The Court found that it was “clear from the language used in Indiana Code § 6-1.1-10-16(h) that an inpatient facility is not an entire hospital, but only a portion of a hospital.”⁷² The term “Inpatient” is defined according to Webster’s Dictionary as “a patient in a hospital or infirmary who receives lodging and food as well as treatment.”⁷³ The term “Facility” is similarly defined as “something . . . that is built, constructed, installed or established to perform

63. *Id.* at 336.

64. *Id.*

65. *Id.* at 340 n.2.

66. *Id.* at 336.

67. *Id.*

68. *Id.*

69. *Id.* at 339.

70. *Id.* at 338.

71. *Id.*

72. *Id.* at 339.

73. *Id.* (quoting *Inpatient*, Webster THIRD NEW INTERNATIONAL DICTIONARY (3d ed. 2002)).

some particular function or to serve or facilitate some particular end[.]”⁷⁴ Therefore, the Court defined an inpatient facility as a “portion of a hospital where admitted patients are provided overnight accommodations, meals, and medical treatment.”⁷⁵

The Court applied the same form of analysis to define substantial, related, and support, concluding that standard under Section 16(h) meant “the other property is associated, to a considerable degree, to a hospital’s inpatient facility or that the other property provides considerable aid to, or promotes to a considerable degree, the interests of a hospital’s inpatient facility.”⁷⁶

Taking the construction of the statutory language and applying it to the facts, the Court disagreed with all three of Methodist’s arguments. The Court began its analysis by finding that evidence showing that Methodist “employs those who work at the PCAs, bills PCA patients, and performs other banking and administrative functions on behalf of the PCAs” failed to establish a clear relationship between the PCA facilities Methodist’s inpatient facility and likewise failed to show “how the PCAs promote the overall interests of Methodist’s inpatient facility.”⁷⁷

Moreover, the Court held evidence showing that the PCA facilities provided medical services to individuals from “[a]ll over the entire region and admit[ed] PCA patients into Methodist’s hospitals” only demonstrated that the PCA facilities offered those services; which, by itself failed to show how the PCA facilities were “substantially related to or supportive of Methodist’s inpatient facilities.”⁷⁸ The Court also held that the evidence showing the physicians at the PCAs did not use the offices for personal gain did “little to expose what relationship or degree of support exists between the PCAs and Methodist’s inpatient facilities.”⁷⁹

However, the Court did state that evidence of PCA physicians providing medical care to Methodist’s inpatients demonstrated “some relationship or degree of support” between the PCAs and Methodist’s inpatient facilities, but because the record also showed that PCA physicians provided medical care “substantially, to the general public,” the Court declined to find that the PCA facilities were “substantially related to or supportive of Methodist’s inpatient facilities.”⁸⁰ In its conclusion that the PCA facilities were not entitled to a charitable purposes property tax exemption, the Court seemed to suggest sufficient evidence would have shown that the PCA facilities were “substantially used to provide medical

74. *Id.* (quoting *Facility*, Webster THIRD NEW INTERNATIONAL DICTIONARY (3d ed. 2002).

75. *Id.*

76. *Id.*

77. *Methodist Hosp.’s., Inc. v. Lake Cnty. Prop. Tax Assessment Bd. App.*, 862 N.E.2d 335, 339 (Ind. T.C. 2007).

78. *Id.* at 338. (“In other words, this Court will not presume that a substantial relationship or supportive network arises merely because two entities are engaged in the same type of business activity.”)

79. *Id.* at 340.

80. *Id.*

care to Methodist's inpatients."⁸¹

Here, it seems that the Court's map to denying a charitable purposes exemption for the PCA facilities centered on the insufficiency of the evidence in showing that: (1) the PCAs were considerably associated with or provided considerable aid to Methodist's inpatient facility, and; (2) the PCAs were not substantially related to or supportive of said inpatient facility. [cite?] Such a finding would appear to stop the analysis and render applying the predominant use test unnecessary.

The following year after *Methodist Hospitals*, the Indiana Tax Revenue Board faced a property tax exemption issue in *St. Margaret Mercy Healthcare Centers, Inc. v. Lake County Property Tax Assessment Board of Appeals*.⁸²

This case involved St. Margaret Mercy ("Mercy"), owned by the sisters of St. Francis Health Services, Inc., which operated two acute care hospitals in Hammond, Indiana, (the "North Campus") and Dyer, Indiana (the "South Campus").⁸³ Mercy argued that three physicians' offices (the "Practices")—located in Munster (the "Munster Office"), Whiting (the "Sibley Clinic"), and Hammond (the "Woodmar Clinic"), respectively and owned by Mercy, were entitled to a charitable purposes exemption because the practices were substantially related to and supportive of Mercy's inpatient facility.⁸⁴ Responding to the Balanced Budget Act of 1997, coupled with an increasingly competitive market and a move toward risk reimbursement systems, Mercy "developed a strategic plan to establish an integrated healthcare delivery system with primary care and specialty physicians."⁸⁵ The focus of the strategic plan was to "form a geographically broad network of employed and independent physicians so St. Margaret Mercy could provide access to care in as many communities as possible."⁸⁶

To effectuate this plan, Mercy determined its market share needed to increase to 40 percent.⁸⁷ To do so, Mercy aimed to increase its "physician network to at least 40 employed primary care physicians and to create a Management Services Organization (MSO) that would be capable of providing business services to employed physicians and other physicians that would be affiliated with the hospital."⁸⁸ For the physicians employed by the hospital and for the physician practices that were acquired, a requirement of seeing all patients, regardless of ability to pay, was placed in the employment contracts, in addition to the requirement that physicians refer all patients needing inpatient facilities to Mercy's hospitals, subject to patient and payer preference.⁸⁹

81. *Id.*

82. *St. Margaret Mercy Healthcare Ctr. v. Lake Cnty. Prop. Tax Assessment Bd. App., Pet. 45-023-00-2-8-00010* (Ind. Tax Rev. Bd., July 8, 2008).

83. *Id.* at 9.

84. *Id.* at 7-9.

85. *Id.* at 10.

86. *Id.*

87. *Id.* at 9.

88. *Id.*

89. *Id.*

Mercy argued that the three physician practices were entitled to a charitable purposes exemption because they provide family practice medical services and internal medicine services to patients, generating “significant revenues at the hospital[s].”⁹⁰ In response, the Lake County Tax Assessment Board argued that, under *Methodist Hospitals*, merely referring patients to Mercy hospitals is insufficient to show that the physician practices were associated, to a considerable degree, with the hospital’s inpatient facility because the practices were acquired with the intention of increasing the inpatient and outpatient income for the hospital, and therefore were aimed at making a pecuniary profit.⁹¹

Furthermore, Lake County argued that *Methodist Hospitals* require the physician practices to be “substantially used to provide medical care to” Mercy’s inpatients, and the practices here “only provided an avenue for patients to receive and pay for services at St. Margaret [Mercy] instead of a competition facility.”⁹² Moreover, even if this was enough to demonstrate a sufficient relationship of support or relation to Mercy’s hospitals, “no specific evidence of the number of referrals from any [physician practice]” to St. Margaret Mercy hospitals was provided.⁹³

The Board began its analysis by declining to interpret *Methodist Hospitals* to “require that the physician practices only treat patients seen in St. Margaret Mercy’s inpatient facilities, or that St. Margaret Mercy’s physician practices must predominantly treat patients that are seen in its inpatient facilities for such facilities to be exempt.”⁹⁴ However, Mercy “must show more than that its physician practices are employed by the hospital and are required to admit patients to the hospital” to be entitled to an exemption.⁹⁵

The Board determined that Mercy presented sufficient evidence to show that the physician practices sufficiently relate to its inpatient facilities, concluding that the evidence:

established that the physician practices generated significant referrals to its inpatient facilities in 2000. Moreover, the physician practices contributed substantial revenue that supported the inpatient facilities. In fact, the evidence suggests that without the patient referrals and financial contribution of the physician’s practices, St. Margaret Mercy’s inpatient facilities may not have remained financially viable and may not have continued to exist. Similarly, the Petitioner’s evidence showed that the physician’s practices lost money on their own. Therefore, the primary purpose of those practices, if not the only purpose, must be to support the hospitals.⁹⁶

90. *Id.* at 14.

91. *Id.* at 15.

92. *Id.* at 16.

93. *Id.*

94. *Id.* at 22.

95. *Id.*

96. *Id.* at 23.

It would appear then that Mercy's reliance on inpatient referrals from the physician practices to remain financially viable was a key factor leading the Board to find that the practices were sufficiently related to the hospital's inpatient facilities.

The Indiana Tax Board's most recent decision on extending the charitable purposes exemption to other property owned by an exempt hospital was in the 2019 *St. Mary's Building Corp. v. Warrick County Assessor* case.⁹⁷ Here, St. Mary's Building Corporation – a 501(c)(2) nonprofit corporation and subsidiary of St. Mary's Health, Inc., (the "Hospital") – owned Epworth Commons, a medical building located off the Hospital's main campus.⁹⁸ The Building Corporation sought a charitable purposes exemption for 82 percent of Epworth Commons, the proportion of the facility which was leased to St. Mary's Breast Cancer, LLC, St. Mary's Medical Group, LLC., and the Hospital.⁹⁹

The Board, relying on the Court's decision in *Methodist Hospitals*, concluded that the operations of Epworth Commons were not substantially related to or supportive of St. Mary's Health because: (1) the administrative control of Epworth Commons by St. Mary's Health was insufficient to show the facility supported St. Mary's Health's inpatient facility, (2) Epworth Commons' involvement in St. Mary's Health's overall mission was also insufficient to show support, and (3) Epworth Commons providing services more for the general public than St. Mary's Health inpatients evidenced a separation from supporting the hospitals inpatient facilities.¹⁰⁰ Importantly, the Board found that St. Mary's Health billed the medical services performed at Epworth Crossing as "hospital outpatient services."¹⁰¹ As such, the Board determined that "[i]t does not logically follow that outpatient services are evidence of an inpatient use of a building," and that St. Mary's Health merely operated Epworth Crossing as an outpatient facility as part of the Hospital's overall mission.¹⁰² This did little to show how "the operations at Epworth Crossing relate to the Hospital's inpatient facility."¹⁰³

The Board likewise declined to follow petitioner's reliance on *Indianapolis Osteopathic Hospital Inc v. Department of Local Government Finance*.¹⁰⁴ The Board drew "important distinctions" between *Indianapolis Osteopathic* and the facts before it, namely that the medical pavilion was located on the respective hospital's main campus while Epworth Commons was not.¹⁰⁵ However, it should be noted that the proximity or location of the facility in *Indianapolis Osteopathic*

97. *St. Mary's v. Warrick Cnty. Assessor*, Pet. 87-019-15-2-8-01458-16 (Ind. Tax Rev. Bd., Feb. 23, 2018) (*aff'd* *St. Mary's Bldg. Corp. v. Redman*, 135 N.E.3d 681) (Ind. T.C. 2019)).

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

Hosp. Inc was not a factor in the Court’s decision to find a charitable exemption extended to the portion of the MP used by Westview Hospital departments.¹⁰⁶ Moreover, one of the PCAs in *Methodist Hospitals* was located on Methodist’s Southlake Campus.¹⁰⁷ Furthermore, the Board found that the facts of *Indianapolis Osteopathic* demonstrated “a level of integration between the hospital departments at the medical pavilion and the inpatient facility of Westview Hospital,” whereas the facts before it could not demonstrate such a relationship between Epworth Crossing and the inpatient facility of St. Mary’s Health.¹⁰⁸

C. Applying the Case Law to the Hypothetical Telehealth Facility

The telehealth facility, for purposes of the forthcoming application, would be set up and function as follows: (1) be owned by an exempt hospital, (2) be located in the Cass County Service Area, (3) serve individuals in that area regardless of ability to pay, (4) offer any service which could adequately be performed through telehealth, and (5) such services would be provided by the exempt hospital’s employees, who would be located at the exempt hospital main campus.

Applying these parameters to the above case law, the telehealth facility must first show evidence that it is associated considerably with the main hospital’s inpatient facilities or that it provides considerable aid to or supports the main hospital inpatient facilities. Evidence of such a relationship appears to include physicians who provide services to the hospital’s inpatients and provide services at the telehealth facility.¹⁰⁹ However, it is the facility itself, not the physicians, which must be substantially used to provide medical care to the hospital’s inpatients.¹¹⁰ Therefore, although physicians that virtually see patients at the telehealth facility will in most cases also see patients who are inpatients of the hospital, this will likely be insufficient to show that the telehealth facility is being used to provide substantial care to the inpatients of the hospital.

Evidence of high referrals to the hospital’s inpatient facility from services rendered at the telehealth facility may establish a sufficient connection to show a substantial relationship, but it is unclear if this alone would be enough. While such evidence was present in *St. Margaret Mercy Healthcare Centers*, the

106. *Indianapolis Osteopathic Hosp., Inc v. Dep’t of Local Gov’t Fin.*, 818 N.E.2d 1009, 1018-19 (Ind. T.C. 2004).

107. *Methodist Hosps., Inc. v. Lake Cty. Prop. Tax Assessment Bd. App.*, 862 N.E.2d 335, 336 (Ind. T.C. 2007).

108. *St. Mary’s v. Warrick Cnty. Assessor*, Pet. 87-019-15-2-8-01458-15, at 30 (Ind. Tax Rev. Bd., Feb. 23, 2018) (*aff’d* *St. Mary’s Bldg. Corp. v. Redman*, 135 N.E.3d 681 (Ind. T.C. 2019)).

109. *See Methodist Hosp.’s., Inc. v. Lake Cnty. Prop. Tax Assessment Bd. App.*, 862 N.E.2d 335, 340 (Ind. T.C. 2007) (“To the extent that PCA physicians have provided medical care to Methodist’s inpatients, Methodist has shown that some relationship or degree of support exists between the PCAs and Methodist’s inpatient facilities.”).

110. *Id.* (Substantial service provided to the general public does not show “that the PCAs were substantially related to or supportive of Methodist’s inpatient facilities (i.e., substantially used to provide medical care to Methodist’s inpatients).”).

evidence also showed that the hospital relied heavily on these referrals to remain financially viable.¹¹¹ The purpose of acquiring those physician practices was not solely based on the goal of increasing access to care, but to increase the inpatient services offered by the hospital. This differs greatly from the facts in *St. Mary's Building Corp.*, in which the hospital conceded that it would remain viable without the services provided at Epworth Crossing, and the hospital's CFO testified that "the purpose of the Epworth Crossing facility was generally to provide additional access for people to reach St. Mary's health services."¹¹²

A consistent theme in each case outlined above is the principal that mere ownership and administrative involvement by an exempt hospital in the operations of a facility classified as other property—including employing the physicians and staff that run the facility—is insufficient to show a substantial relationship to the inpatient facilities of the hospital. Secondly, claiming that the hospital and the facility are sufficiently related through the facility being operated to further the hospital's overall mission is, alone, insufficient. Specific evidence of how the facility's operations relate, aid, support, or promote the inpatient facility of the hospital is needed to satisfy the requirement under Section 16(h). However, what evidence is needed is not entirely clear. It largely depends on what services are being provided at the telehealth facility and if those same services are also provided to the inpatients of the hospital. Thirdly, whether the facility is referring a high volume of individuals to the hospital's inpatient facility and whether the hospital is relying on those referrals to remain financially viable also appear to be of great importance.

Therefore, while limited to the scope contemplated by this Note, it is at best unclear whether the exempt hospital would be able to demonstrate, with sufficient evidence, that the telehealth facility is substantially related to or supportive of its inpatient facilities.

D. Statutory Exceptions Under Indiana Code § 6-1.1-10-16(h)

Indiana Code Section 6-1.1-10-16(h) provides two exceptions for other property which is not "substantially related to or supportive of" the exempted hospitals inpatient facility.¹¹³ Under subsection (h)(1), an exemption may be granted if the additional property is found to support the provision of charity care, as defined by Indiana Code Section 16-18-2-52.5.¹¹⁴ This exception requires "the unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services" be provided to: "(1) a person classified by the hospital as financially indigent or medically indigent on an inpatient or outpatient

111. *St. Margaret Mercy Healthcare Ctr., Inc. v. Lake Cnty. Prop. Tax Assessment Bd.* App., Pet. 45-023-00-2-8-00010, at 16 (Ind. Tax Rev. Bd., July 8, 2008).

112. *St. Mary's v. Warrick Cnty. Assessor*, Pet. 87-019-15-2-8-01458-15, at 12 n.11 (Ind. Tax Rev. Bd., Feb. 23, 2018) (*aff'd* *St. Mary's Bldg. Corp. v. Redman*, 135 N.E.3d 681 (Ind. T.C. 2019)).

113. IND. CODE § 6-1.1-10-16(h) (2018).

114. *See* IND. CODE § 6-1.1-10-16(h)(1) (2018).

basis,” and “(2) financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.”¹¹⁵ Moreover, Indiana Code Section 6-1.1-10-16(h)(2) provides an exemption for additional property found to provide a community benefit as defined by Indiana Code Section 16-21-9-1.¹¹⁶ A community benefit means “the unreimbursed cost to a hospital of providing charity care, government-sponsored indigent health care, donations, education, government-sponsored program services, research, and subsidized health services.”¹¹⁷

Looking again to *St. Margaret Mercy Healthcare Centers*, Mercy also argued that the physician practices were entitled to an exemption by providing charity care and community benefits.¹¹⁸ To support its argument, Mercy offered its charity care policy, which required the physician practices to provide care at a reduced cost or at no cost to qualifying patients. The employment contracts also required that the physicians “see any and all patients who present without regard to their financial ability to pay,” and “doctors risked termination if they fail[ed] to provide patient services” without regarding the individual’s ability to pay.¹¹⁹ In turn, this policy resulted in the physician practices providing “more care to Medicaid patients than the national average and [the] employed physicians did not see as many privately insured patients as their peers.”¹²⁰ Mercy also provided a Consolidated Summary of Social Accountability Expenditures, which quantified the benefits provided to the poor and the community by the hospital.¹²¹ However, information regarding the community benefits attributable to the physician practices was not provided.¹²²

The Board first found that while the two exceptions to Indiana Code Section 6-1.1-10-16(h) “do [] not specify a minimum amount of charity care and community benefit necessary to qualify for exemption...there must be some meaningful contribution” shown for the purpose of affording tax-exemption status is to be properly served.¹²³ As applied to the evidence presented by Mercy and contained in the record, the Board was able to find that the hospital presented sufficient evidence showing the physician practices supported its provision of charity care because “the physicians must accept any patient, ‘[d]irect evidence was presented which quantified the financial contribution the offices make to support [the hospital’s] provision of charity care,’” and the physician practices served “previously un-met or underserved needs in the community.”¹²⁴

115. See IND. CODE § 16-18-2-52.5(a) (1994).

116. IND. CODE § 6-1.1-10-16(h)(2) (1975).

117. IND. CODE § 16-12-9-1 (1994).

118. *St. Margaret Mercy Healthcare Ctrs., Inc. v. Lake Cnty. Prop. Tax Assessment Bd.* App., Pet. 45-023-00-2-8-00010, at 22 (Ind. Tax Rev. Bd., July 8, 2008).

119. *Id.*

120. *Id.*

121. *Id.* at 23.

122. *Id.* at 22.

123. *Id.* at 23.

124. *Id.* at 25 (Testimony demonstrated that St. Margaret Mercy “identified its market area and

The Board in *St. Mary's Building Corp.*, however, found differently. Following its conclusion that Epworth Crossing could not establish exemption based on the substantially supportive standard under Indiana Code Section 6-1.1-10-16(h), the Board turned to whether Epworth Crossing could claim exemption through the exceptions under subsections (h)(1) & (2). The Board first had to articulate the scope of the predominate use test under Indiana Code Section 6-1.1-10-36.3. The Assessor argued that because the exceptions above are based on the hospital's expenditures on charity care as measured by unreimbursed costs, the test requires that the expenditures on charity care be predominately through unreimbursed costs.¹²⁵ However, the Board found this view to be incorrect and stated that the test requires the Board to "determine if the property was used most of the time to deliver charity care and community benefits," as the focus is the time spent delivering charity care and not the amount of charity care.¹²⁶

The evidence before the Board indicated that Epworth Crossing provided medical services which were sometimes reimbursed and sometimes not. But no evidence showing the amount of time the facility provided unreimbursed services versus the amount of time the facility provided reimbursed services was offered, and the Board could not allow for an exemption.¹²⁷ As such, the Board (and the Tax Court on appeal), concluded that at most, Epworth Crossing was shown to provide some form or amount of charitable health services; this conclusion did not determine what amount of those services were charity care, how those services constituted charity care, or how much time the facility was used to provide such care.

E. Statutory Application to the Telehealth Facility

The facility's location in a rural and medically underserved area appears to be beneficial evidence for establishing charity care and community benefit. While the Epworth Crossing facility provided services to everyone regardless of their ability to pay, its location in Warrick County, at least, implicitly suggested that its ability to provide charity care was limited to some extent.¹²⁸ However, the physician practices in *St. Margaret Mercy* were specifically placed in areas of underservice and that lacked access to primary care--a fact the Board determined relevant when concluding which practices were entitled to a charitable purpose exemption.¹²⁹

put physicians in locations that needed primary care" and placed physicians in medically underserved areas.).

125. *St. Mary's v. Warrick Cnty. Assessor*, Pet. 87-019-15-2-8-01458-16 (Ind. Tax Rev. Bd., Feb. 23, 2018) (*aff'd* *St. Mary's Bldg. Corp. v. Redman*, 135 N.E.3d 681 (Ind. T.C. 2019)).

126. *Id.*

127. *Id.*

128. *Id.* (noting Warrick County has a population with 11.8 percent uninsured and 7.5 percent in poverty).

129. *St. Margaret Mercy Healthcare Ctrs., Inc. v. Lake Cnty. Prop. Tax Assessment Bd.* App., Pet. 45-023-00-2-8-00010, at 25 (Ind. Tax Rev. Bd., July 8, 2008).

Furthermore, the telehealth facility must ensure that it presents evidence demonstrating it was predominately used for providing charity care and community benefits at unreimbursed costs. Sufficient evidence was a key factor leading to the Board's denial of a charitable purposes exemption for Epworth Crossing. However, some practitioners have argued that the Tax Court's interpretation of the predominate use test in *Redman* may result in Indiana assessors denying property tax exemptions because of the test's heightened standard.¹³⁰

V. THE ARGUMENT

A. Broadening Exemption Status to Include All Property Owned and Operated by Nonprofit Hospitals

As it stands, other property owned by an exempt hospital in Indiana faces an uphill battle to qualify for a charitable purposes exemption. To an extent, it is logical to place parameters on how far a nonprofit hospital can take exemption status. However, having three different standards that appear to overlap with each other (e.g., the predominate use test) may lead to inconsistent rulings and have a negative impact on innovative approaches to health by nonprofit hospitals. Of extreme importance—as far as this Note is concerned—is the fact that nearly all the opinions on this issue have analyzed a facility or facilities that were located either on or relatively close to the main hospital's campus. But with modern medical approaches to health beginning to embrace the possibilities of telehealth, Indiana could find itself behind the curve because of unresolved issues regarding where the exemption requesting facility is in relation to the main hospital facility.¹³¹

A second area of concern is also advanced by the potential negative effects to competition in the telehealth facility market, both between nonprofit hospitals and private-for-profit telehealth groups, and between states. In the first instance, because state and local property tax exemptions are of extreme importance to nonprofit hospitals in furthering their charitable missions, nonprofit hospitals would have a barrier to entering the telehealth facility market because of the additional requirements placed on them to demonstrate that their additionally owned property is eligible for property tax exemption. Stated differently, the additional statutory requirements for additionally owned property would likely dissuade nonprofit hospitals from entering this market, which would lessen market participation to include private telehealth companies and for-profit hospitals. As for-profit entities, these participants likely would not find much financial sense in locating their facilities in rural, medically underserved areas,

130. HALL RENDER, *supra* note 39.

131. See *St. Mary's Med. Ctr., Inc. v. State Bd. of Tax Comm'rs*, 534 N.E.2d 277, 279 (Ind. T.C. 1989) *aff'd sub nom.*, *St. Mary's Med. Ctr. v. State Bd. of Tax Comm'rs*, 571 N.E.2d 1247, 1248 (Ind. 1991) ("Move the office building down the road two miles and a serious question arises, even under the most liberal statutory construction, as to whether it would then significantly further, or be incidental to the operation of appellant's hospital.").

which would only enhance the current problems with access to care for Hoosiers living in those areas. Moreover, nonprofit hospital systems outside of Indiana would likely not find Indiana as an attractive option for entering this market and instead would favor entry in states which have less restrictive laws regarding property tax exemption on the books.

Therefore, to avoid further confusion and likely litigation regarding the telehealth facility and to potentially increase both nonprofit hospital and Indiana participation in this market, Indiana may benefit by expanding the Code provisions relating to property tax exemption for nonprofit hospitals to include all property which is owned by the exempt hospital and operated in furtherance of the exempt hospital's mission of providing charitable care and meeting the community benefit standard required to maintain its 501(c)(3) status as a charitable organization. Such code provisions are common in other jurisdictions and do not appear to be specific to any region of the country.

B. Illinois

Illinois' approach to property tax exemption is addressed first by Section Six of Article IX to the Illinois Constitution, which grants the Illinois General Assembly permissive authority to "exempt from taxation only the property of the State, units of local government and school districts and property used exclusively for agricultural and horticultural societies, and for school, religious, cemetery and charitable purposes."¹³² While this constitutional provision does not grant the Illinois legislature the power to "add to or broaden the exemptions specified in section 6," it may "place restrictions, limitations, and conditions on [property tax] exemptions as may be proper by general law."¹³³ This is exemplified under Section 15-65 of the Illinois Code, which requires the subject property "not [be] leased or otherwise used with a view to profit."¹³⁴ Therefore, eligibility for a charitable exemption under Illinois law requires both, charitable ownership and charitable use.¹³⁵

Property is exclusively used for charitable purposes when charitable purposes are the primary ones for which the property is utilized. Secondary or incidental charitable benefits will not suffice, nor will it be enough that the institution professes a charitable purpose or aspires to using its property to confer charity on others.¹³⁶ As a result, the Illinois Supreme Court in *Provena Covenant Medical Center* upheld the denial of the hospital's property tax exemption because it was unable to demonstrate that it was used exclusively for charitable purposes.¹³⁷

In response to the "considerable uncertainty surrounding the test for charitable property tax exemption, especially regarding the application of a

132. ILL. CONST. art. IX, § 6.

133. *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 925 N.E.2d 1131, 1144 (Ill. 2010).

134. 35 ILL. COMP. STAT. 200/15-65 (2009).

135. *Provena Covenant*, 925 N.E.2d at 1147.

136. *Id.*

137. *Id.* at 1154.

quantitative or monetary threshold” following *Provena Covenant Medical Center*, the Illinois legislature adopted a formulaic standard for determining charitable exemptions for property.¹³⁸ The standard provides that “if the value of services or activities listed in subsection (e) for the hospital year equals or exceeds the relevant hospital entity’s estimated property tax liability,” then it “shall be issued a charitable exemption for that property.”¹³⁹ The factors considered in this calculation under subsection (e) are quite broad, including:

“[f]ree or discounted services measured at cost”; health services to low-income and underinsured individuals; subsidy of state or local governments; support for State health care programs for low-income individuals; subsidy for treating dual-eligibility Medicare/Medicaid patients; relief of the burden of government-related health care of low-income individuals; and “[a]ny other activity by the relevant hospital entity that the Department determines relieves the burden of government or addresses the health of low-income or underserved individuals.”¹⁴⁰

However, exclusive use for charitable purposes remains the ultimate factor in determining whether a hospital is entitled to an exemption, and evidence showing that a facility which uses “some of its revenue for providing gratuitous services” but “ordinarily expects to be fully compensated for its services” is insufficient to demonstrate it is entitled to an exemption.¹⁴¹

This standard would benefit the telehealth facility primarily because of its location. Because the statute allows for tax authorities to consider additional criteria that it determines to “address[] the health of low-income or underserved individuals,” the telehealth facility is likely to satisfy this standard by virtue of being in and providing services to a medically underserved area.¹⁴² Moreover, while requiring that the facility seeking an exemption be owned by a charitable institution, emphasis is placed on how the facility is used and whether that use is exclusively charitable. This standard, therefore, does not contemplate a separate test for a facility that is owned by a nonprofit hospital versus a facility owned by a nonprofit group, and instead requires only that the facility have charitable ownership and be used exclusively for charitable purposes. This standard would bring clarity for facilities which are owned by a nonprofit hospital because the requirement that a facility be substantial related to or supportive of the main hospital’s inpatient facility would be replaced by the requirement that the facility be used exclusively for charitable purposes, the costs of which either equals or exceeds the facility’s estimated amount of property tax liability.

138. See 35 ILL. COMP. STAT. 200/15-86 (2012).

139. *Id.*

140. *Oswald v. Hamer*, 115 N.E.3d 181, 190 (Ill. 2018) (citing 35 ILCS 200/15-86(e)(1)-(7) (2015)).

141. See *Midwest Palliative Hospice & Care Ctr. v. Beard*, 125 N.E.3d 1196, 1204 (Ill. Ct. App. 2019).

142. 35 ILCS 200/15-86, *supra* note 138.

C. Ohio

Ohio does not extend any specific exemptions to nonprofit hospitals, rather provides exemptions to property used for charitable purposes.¹⁴³ While not specifically referenced by statute, Section 5709.12(B) provides that “[r]eal and tangible personal property belonging to institutions that is used exclusively for charitable purposes shall be exempt from taxation.”¹⁴⁴ The Ohio Supreme Court has recognized that “the provision of medical or ancillary healthcare services qualifies as charitable if those services are provided on a nonprofit basis to those in need, without regard to race, creed, or ability to pay.”¹⁴⁵ Therefore, where the core activity of a hospital or facility is providing healthcare services, it would qualify as a charitable institution “only if it provided services on a nonprofit basis to those in need, without regard to race, creed, or ability to pay.”¹⁴⁶ Moreover, the owner of the property seeking exemption qualifies as a charitable entity under Section 501(c)(3) of the Internal Revenue Code is not solely determinative of whether the property is entitled to an exemption.¹⁴⁷ Ultimately, the crucial factor in determining whether property is used for charitable purposes hinges upon whether the property provides services to the general public regardless of race, creed, ability to pay, “or [is open] to serve that part of the general public that has a special need.”¹⁴⁸

Because this standard focuses on the use of the facility seeking exemption, the hypothetical telehealth facility will likely find it easier to qualify for property tax exemption because it would be in a medically underserved area and would provide medical services to individuals who lacked adequate access to those services. Moreover, while a property owner cannot qualify for exemption based solely on its owner’s status as a Section 501(c)(3) entity, it is possible the hypothetical telehealth facility could rely on the owning nonprofit hospital’s exemption status under Ohio law to be extended, provided, the facility is used “in furtherance of the owner’s charitable purposes.”¹⁴⁹ As a result, the hypothetical facility would not be required to demonstrate that the services it provides substantially relate to or support those at the main hospital’s inpatient facility, which likely would lead to innovative methods for delivering healthcare services to at-risk populations and medically underserved areas.

D. Arkansas

The Arkansas Court of Appeals in *Hardesty v. Northern Arkansas Medical Services*, extended property tax exemptions to additionally owned property operated as an outpatient facility. Under *Hardesty*, property tax exemption is

143. See OHIO REV. CODE § 5709.12 (2017).

144. OHIO REV. CODE § 5709.12(B) (2017).

145. *Church of God in N. Ohio, Inc. v. Levin*, 918 N.E.2d 981, 985 (Ohio 2009).

146. *Dialysis Clinic, Inc. v. Levin*, 938 N.E.2d 329, 336 (Ohio 2010).

147. *Id.*

148. *Dialysis Ctrs. of Dayton, LLC v. Testa*, 80 N.E.3d 477, 482 (Ohio 2017).

149. OHIO REV. CODE § 5709.121(A)(2) (2021).

extended to additional property, on which the main hospital operates an outpatient facility, so long as the facility: “(1) is open to the general public, (2) no one may be refused services on account of inability to pay, and (3) all profits from paying patients are applied to maintaining the hospital and extending and enlarging its charity.”¹⁵⁰ In that case, the Court agreed with the hospital’s argument that “generating income does not destroy the charitable usage of the hospital or its clinics” as long as the income generated is “used solely to further its charitable purposes.”¹⁵¹ Moreover, “a particular percentage of free medical care” is not required to be shown.¹⁵²

Implementing this standard allows other property owned by a nonprofit hospital to qualify for property tax exemption, even if it received reimbursement or payment for its services, so long as it used those funds to cover services for individuals unable to pay. This would ease the hospital’s burden of proving that the facility’s predominant use was for unreimbursed services and would likely ease the record keeping requirements for the facility. Thus, provided the hospital is able to prove that any income generated from reimbursement or payment was used to cover visits for individuals who could not pay, it would be entitled to exemption from property tax.

Furthermore, like Indiana, Arkansas also maintains that “the property’s use determines entitlement to a tax exemption rather than the use of its revenues.”¹⁵³ This reflects the basic principle of the predominant use test yet stops short of mandating the property be used to provide charity care for over 50 percent of the time to claim an exemption. Instead, the property “must be a place open to the public where no one may be refused services on account of inability to pay and where all profits from paying patients are applied to maintaining the hospital and extending and enlarging its charity.”¹⁵⁴

E. Oklahoma

In Oklahoma, property tax exemption is provided for directly by statute. 68 Oklahoma Statute Section 2887 lists the types of property that are exempt from ad valorem taxation.¹⁵⁵ Subsection (10) is directed to nonprofit hospitals, and exempts from property taxation:

“[a]ll property of any hospital established...as a nonprofit and charitable hospital, provided the property and net income from such hospital are used directly, solely, and exclusively within this state for charitable purposes and that no part of such income shall inure to the benefit of any individual, person, partner, shareholder, or stockholder, and provided

150. *Hardesty v. N. Ark. Med. Serv.’s*, 585 S.W.3d 177, 3 (Ark. Ct. App. 2019) (quoting *Burgess v. Four States Mem’l. Hosp.*, 465 S.W.2d 693, 679 (Ark. 1971)).

151. *Hardesty*, 585 S.W.3d at 4.

152. *Id.* at 7.

153. *Id.* at 8.

154. *Id.* (internal citation omitted).

155. *See* 68 OKLA. STAT. § 2887 (2021).

further that such hospital facilities shall be open to the public without discrimination as to race, color or creed and regardless of ability to pay, and that such hospital is licensed and otherwise complies with the laws of this state relating to the licensing and regulation of hospitals[.]”¹⁵⁶

Simply put, if additional property is owned by a nonprofit hospital and used in a manner which provides charity care—even if some of the services provided are either reimbursed or paid for out of pocket by patients—the property is entitled to exemption from property taxation so long as any profit made is used to further provide for charity care. This language is clear, unambiguous, and generally unfettered by difficult statutory tests to determine the percentage of time a property is used for charity care purposes.

F. Addressing Concerns to Competition: A Model Code Solution

As referenced above, competition in this hypothetical market may revolve around determining which States have more relaxed statutes governing property tax exemptions. Where exemption under Section 501(c)(3) is governed by a set standard of community benefit, property tax exemption at the state level centers around charity care, the definition of which varies from state to state.¹⁵⁷ Not only does each state have differing definitions of what constitute charity care, the test used by courts in determining property tax exemption cases vary from being qualitative in nature, based on sets of factors, or a hybrid of both.¹⁵⁸ Moreover, many states do not have specific exemption standards for nonprofit hospital property, but rather provide blanket exemption standards for charity or charitable institutions.¹⁵⁹ This approach has been argued to not recognize the difference between nonprofit hospitals and standard charities, including the type of benefits offered to the community, the difference in funding sources, and effect of profits between nonprofit hospitals and standard charities.¹⁶⁰

The differing, and often confusing, standards used to determine what is precisely meant by charity care has a negative impact on nonprofit hospital systems across the country.¹⁶¹ This, along with the importance of property tax exemptions as capital for the operations of nonprofit hospitals, arguably results in nonprofit hospital systems choosing to build and operate facilities in states with unambiguous and clear defined standards, which in turn, presents a disadvantage to medically underserved populations in states whose laws lack such clarity. This potential imbalance could be adequately addressed by adopting a uniform standard of charity care, which would bring clarity and consistent rulings across

156. See 68 OKLA. STAT. § 2887(10) (1983).

157. See Lowell R. Mintz, *The Rules of the Fight Must Be Fair: States Should Pass a Uniform Code for Nonprofit Hospital Tax Exemption of Real Property*, 26 J. L. & HEALTH 415, 423 (2013).

158. *Id.*

159. *Id.*

160. *Id.* at 435.

161. *Id.*

the country and benefit medically underserved areas in states like Indiana.¹⁶²

VI. CONCLUSION

As approaches to delivering health care and increasing access to care for individuals through telehealth increases in both popularity and demand, nonprofit hospitals in Indiana will likely find themselves at a disadvantage should they desire to open a satellite telehealth facility because of the uncertainty surrounding the state and local property taxation exemption status of said facility. As applied to the current Indiana statutes regarding property tax exemption for other property owned by an exempt hospital, it is unclear whether such a facility would meet any of the required statutory tests to be entitled to an exemption, and it is also unclear which statutory tests apply. This general confusion, coupled with the unresolved issue regarding the location of the exempt hospital facility and the satellite facility, will lead to unnecessary litigation and further confusion in attempting to determine whether the telehealth facility would be entitled to a charitable purposes exemption.

Rather than avoiding the unanswered issues and increasing likelihood of future litigation, it is prudent for the Indiana legislature to act by amending the current property tax exemption statutes to allow for all property owned by an exempt hospital to be entitled to a charitable purposes exemption. Of course, said property must be owned by an exempt hospital and be operated in furtherance of the exempt hospital's mission of providing charitable care and meeting the community benefit standard required to maintain the main hospitals 501(c)(3) status as a charitable organization. Such action will address the current need for increasing access to care in designated medically underserved areas, especially areas in rural counties with disparate access to broadband services. Additionally, providing a clear pathway for other owned property to receive a charitable purposes exemption for property taxes allows nonprofit hospitals to further their charitable mission by meeting the needs of care in an increasingly digital age of health care.

Furthermore, placing an emphasis on how reimbursed costs and profits are being redistributed into the facility to further its provision of charity care to those patients who cannot pay allows the facility to focus on its mission of providing services to those who need it, rather than having to spend time ensuring that they are providing charity care more than 50 percent or more of the time or what amount of unreimbursed costs they currently operate with. Finally, allowing all property owned by an exempt hospital to be covered—if providing charity care is demonstrated—takes the emphasis off relating substantially to the inpatient facility of the exempt hospital, which is a confusing and difficult standard to apply to a telehealth facility, and other similarly situated outpatient centric facilities.

162. *Id.* at 448.