IN RE: APPEAL OF BRANDYWINE HOSPITAL, LLC FROM THE DECISION OF THE CHESTER COUNTY BOARD OF ASSESSMENT APPEALS FOR PROPERTY LOCATED AT 213 REECEVILLE ROAD, CALN TOWNSHIP, CHESTER COUNTY, PENNSYLVANIA	:	IN THE COURT OF COMM CHESTER COUNTY, PENN NOS. 17-11220, 17-11222, 17-11223, 18-11854, 18-11855 and 18-11857 CIVIL ACTION
IN RE: APPEAL OF JENNERSVILLE HOSPITAL, LLC FROM THE DECISION OF THE CHESTER COUNTY BOARD OF ASSESSMENT APPEALS FOR PROPERTY LOCATED AT 1015 WEST BALTIMORE PIKE, PENN TOWNSHIP, CHESTER COUNTY, PENNSYLVANIA	:	CHESTER COUNTY, PENNSYLVANIA NOS. 17-11227 and 18-11859 CIVIL ACTION
IN RE: APPEAL OF PHOENIXVILLE HOSPITAL, LLC FROM THE DECISION OF THE CHESTER COUNTY BOARD OF ASSESSMENT APPEALS FOR PROPERTY LOCATED AT 140 NUTT ROAD, BOROUGH OF PHOENIXVILLE, CHESTER COUNTY, PENNSYLVANIA	:	IN THE COURT OF COMMON PLEAS CHESTER COUNTY, PENNSYLVANIA NOS. 17-11226 and 18-11858 CIVIL ACTION

DECISION AND ORDER

I. INTRODUCTION

In this case, the court is asked to decide whether the standards set forth by the Legislature and prior courts for determining the tax-exempt status of a hospital have been met by Appellants, Phoenixville Hospital LLC ("Phoenixville"), Brandywine Hospital LLC ("Brandywine") and Jennersville Hospital LLC ("Jennersville").

Over time, when presented with this question, courts have been directed to consider various guidelines such as those set forth in the Pennsylvania Constitution, Article VIII, Section 2(a)(v); the General County Assessment Law (1933), 72 P.S.

§5020.204(3); the "test" found in *Hospital Utilization Project v. Commonwealth*, 487 A.2d 1306 (Pa. 1985); the Institutions of Purely Public Charity Act ("Act 55"), 10 P.S. §371 *et. seq.* (1997); and the General County Assessment Law, 53 P.S. §8801 *et. seq.* (2010). However, as detailed *infra*, these outdated, competing, and often contradictory sources no longer offer appropriate direction as each one fails to reflect the current state of medical care and the delivery of such care in the 21st century.

A. Historical Background - Taxes

Taxes are not penalties. Rather, they are contributions made by all to promote the common welfare through the support of government activities. Taxes generate the revenue necessary to provide civic services. One of the primary public services of government is the provision of a public education. Every person in Pennsylvania is entitled to a free public education from kindergarten through twelfth grade. Education costs money. Real estate taxes are the primary source of income for education. There can be no doubt that the reliance on this system to fund public education in Pennsylvania results in large disparities between school districts and their ability to deliver a free and equal education to all that is suitable for the new millennium. The cost and business of education is a "zero sum game." As more businesses are deemed tax-exempt, the burden on individual homeowners increases. What often goes unsaid, but remains a truism nonetheless, is that when any person or, in this case, a health care conglomeration, pays nothing someone else, or more accurately, everyone else must pay more. Thus, any review of an exemption application must be considered carefully.

The Pennsylvania Constitution allows for a legislatively approved exception to the general rule that all real estate in Pennsylvania is to be taxed uniformly upon the same class of subjects. See, *Alliance Home of Carlisle, Pa. v. Board of Assessment Appeals*, 591 Pa. 436, 919 A.2d 206 (2007). "Previous to the constitution and Act of 1874, the legislature, by special act, relieved from taxation just what property it saw fit, whether the property was charitable, religious, or even devoted solely to purposes of corporate or private gain." This "special act" process was abused. One objective of the then new constitution was to arrest this abuse of power by the legislature. *White v. Smith,* 189 Pa. 222, 42 A. 125, 125 (1899). While the constitution exempts nothing, it does permit the legislature to exempt properties as long as the exemption falls within the lines laid down by the General Assembly. See, *City of Philadelphia v. Barber,* 160 Pa. 123, 28 A. 644 (1894). Thus, Article VIII, Section 2(a)(v) of the Pennsylvania Constitution authorizes, but does not require, the General Assembly to exempt certain property of certain charitable organizations from real estate taxes.

Philosophically, there are many reasons why some businesses that are entirely devoted to public charity should be exempt from taxation. In the not too distant past, the government and, in particular, the counties took on the duty of providing care, including medical care, to the indigent. County poorhouses and county hospitals were commonplace and often funded through taxes. Equally as notable was the largess of one or more prominent citizens in various counties who would fund and endow local hospitals.[1] The courts recognized the importance of this service and the fact that an institution which by its charitable activities relieves the government of part of its burden

[1] The most noteworthy local example was Pierre S. DuPont, then Chairman of the DuPont companies, who in 1918, saddened by the death of friend and employee Lewes A. Mason, donated more than one million dollars to build a hospital, then Chester County Hospital, now Penn Medicine in West Chester, Chester County.

is conferring a pecuniary benefit upon society. An exemption from taxation is a recognition of the community largess and support for services the government otherwise would have to provide. See, *Young Men's Christian Ass'n of Germantown v. City of Philadelphia,* 323 Pa. 401, 187 A. 204 (1936), *disproved of on other grounds, West Allegheny Hosp. v. Bd. of Prop. Assessment Appeals and Review,* 500 Pa. 236, 455 A.2d 1170 (1982).

In the period from 1874 and the adoption of the "new" constitution through to 1933 and the adoption of the General County Assessment Law and again until 1985 and the announcement of the HUP test, there has a dramatic shift away from community largess to massive health care systems and networks. This mandates a rethinking of the old approach. Unless and until the Legislature or appellate courts state with certainty, "All hospitals are tax exempt," a court must match a modern analysis to an ancient framework. With each passing year and change in the financing and delivery of medical services, the evidence presentation becomes more strained. Thus, a determination of exemption becomes solely a matter of interpretation of the testimony of accountants and "professional business witnesses."

B. Historical Background - Exemption

With the adoption of the Constitution of 1874, the Legislature enacted laws exempting "institutions of learning, benevolence or charity" from taxation. Hospitals were not directly mentioned. The most direct legislative language was crafted and placed in the General County Assessment Law, Act of May 22, 1933, P.L. 853, 72 P.S. §5020–1 *et seq.* As subsequently amended, this statute renders "exempt from all

county, city, borough, town, township, road, poor and school tax" various institutions and property, including

> (3) All hospitals, associations and institution of learning, benevolence, or charity, ... with the grounds thereto annexed and necessary for the occupancy of the same ... founded, endowed and maintained by public or private charity.

To qualify, however, the entire revenue derived by the same must "be applied to support and to increase the efficiency and facilities thereof, the repair and the necessary increase of grounds and buildings thereof, and for no other purpose." *Id.* §5020–204(a)(3).

This appeared to create a straight-forward test for cases such as this: (1) is the hospital endowed or maintained by public or private charity; and (2) is the entire revenue derived by the same applied to support and to increase the efficiency and facilities thereof. However, the answers are not clear in the case of all hospitals. The uncertainty led to a new decisional framework known as the *HUP* test, a five-point test used by the Supreme Court to determine whether a hospital qualifies as an "institution of purely public charity."

The adoption of the Consolidated County Assessment Law in 2010 took the various real estate tax assessment and exemption laws that were broken down by county classification and, as the name suggests, consolidated them in Title 53. Section 8812(a)(3) addresses hospitals. If founded, endowed and maintained by public or private charity may be exempt from taxation so long as:

> (i) The entire revenue derived by the entity is applied to support the entity and to increase the efficiency and facilities of the entity, the repair and necessary increase of grounds and buildings of the entity and for no other purpose. 53 P.S. §8812 (a)(3)(i) ....

> (b)(1) Except as otherwise provided ... all property from which any income or revenue is derived, other than from recipients of the bounty of the institution or charity, shall be subject to taxation ....

The "test" (referred to throughout as the "*HUP* test") provides that for an entity to qualify as a purely public charity it must possess the following characteristics: Advancing a charitable purpose; donating or rendering gratuitously a substantial portion of its services; benefits a substantial and indefinite class of persons who are the legitimate subjects of charity; relives the government of some of its burden; and, operates entirely free from private profit motive. See, *Hospital Utilization Project*, *supra.* While seemingly straightforward, its application has been often uneven. The Supreme Court adopted a flexible interpretation of its own decision holding that the question is a "mixed question of law and fact" upon which the trial court's decision would be binding absent an abuse of discretion. See, *G.D.L. Plaza v. Council Rock School District*, 526 A.2d 1173 (Pa. 1987). Further, the Supreme Court notes that "prior cases have limited value as precedent" because of the changing nature of the concept of charity and the many variable circumstances. See, *G.D.L. Plaza*, *supra*. citing *Presbyterian Homes Tax Exemption Case*, 428 Pa. 145, 236 A.2d 776 (1968).

A decade later, the General Assembly enacted the Institutions of Purely Public Charity Act, *supra*. The purpose of the Act was to legislatively amend the five-point HUP test. Act 55 begins with the following statement of findings and declaration of legislative intent:

> **§ 372. Legislative intent**
>
> (a) Findings.—The General Assembly finds and declares as follows:

(1) It is in the best interest of this Commonwealth and its citizens that the recognition of tax-exempt status be accomplished in an orderly, uniform, and economical manner.

(2) For more than 100 years, it has been the policy of this Commonwealth to foster the organization and operation of institutions of purely public charity by exempting them from taxation.

(3) Because institutions of purely public charity contribute to the common good or lessen the burden of government, the historic policy of exempting these institutions from taxation should be continued.

(4) Lack of specific legislative standards defining the term "institutions of purely public charity" has led to increasing confusion and confrontation among traditionally tax-exempt institutions and political subdivisions to the detriment of the public.

(5) There is increasing concern that the eligibility standards for charitable tax exemptions are being applied inconsistently, which may violate the uniformity provision of the Constitution of Pennsylvania.

(6) Recognizing the interest of the taxpayers in a fair and equitable system of property tax assessment and the attendant statutory requirements for the political subdivision responsible for maintaining real property assessment rolls to administer the system of property assessment, this act shall not in any way limit the responsibilities, prerogatives or abilities of political subdivisions with respect to the determination of or challenges to the taxable status of a parcel of property based on the use of the parcel or part of the parcel of property.

(7) Institutions of purely public charity benefit substantially from local government services. These institutions have significant value to the Commonwealth and its citizens, and the need exists for revenues to maintain local government services provided for the benefit of all citizens, including institutions of purely public charity. It is the intent of this act to encourage financially secure institutions of purely public charity to enter into voluntary agreements or maintain existing or continuing agreements for the purpose of defraying some of the cost of various local government services. Payments made under such agreements shall be deemed to be in compliance with any fiduciary obligation pertaining to such institutions of purely public charity, its officers or directors.

(b) Intent.—It is the intent of the General Assembly to eliminate inconsistent application of eligibility standards for charitable tax

> exemptions, reduce confusion and confrontation among traditionally tax-exempt institutions and political subdivisions and ensure that charitable and public funds are not unnecessarily diverted from the public good to litigate eligibility for tax-exempt status by providing standards to be applied uniformly in all proceedings throughout this Commonwealth for determining eligibility for exemption from State and local taxation which are consistent with traditional legislative and judicial applications of the constitutional term "institutions of purely public charity."

This attempt at a codification of a judicial decision created as much confusion as it sought to resolve. For example, Section 5 of Act 55 sets forth its own five-point test. Although, generally, the criteria track those of the *HUP* test, the statute goes further. See, §375(b)-(f). Pursuant to Act 55, an institution that meets its five-point test "shall be considered to be founded, endowed and maintained by public or private charity." See §375(a) and 72 P.S. § 5020–204(a)(3). It negates the first question to be asked under the Assessment Law. The elimination of the "requirement" that tax-exempt entities be founded, endowed, and maintained by public or private charity is troubling to any current analysis given the importance this factor has played in previous judicial decisions. Can a business that receives little to no community support really be a charity?

Act 55 also purports to reserve to a county, presumably to the Court of Common Pleas, the right to "make a determination" whether a property or a portion of property is being used to advance the charitable purpose of an institution of purely public charity or to assess a part of, or totality of a property, as taxable based on the use of the property for purposes other than the charitable purpose of that institution. *Id.* at §375(h)(1). Act 55 still permits taxing jurisdictions, such as school districts, to file a challenge whether a particular parcel of property is being used to advance the charitable purpose of an institution of purely public charity." *Id.*

Section 6 of Act 55, entitled "[p]resumption process," then places the burden on the taxing authority to prove, by a preponderance, "that the institution of purely public charity does not comply with the requirements of section 5." *Id.* at §376(a), (b). This is a reversal of standard assessment law where the challenger carries the burden of proof and persuasion. See also, *Southeastern Pa. Transp. Auth. v. Bd. of Revision of Taxes,* 574 Pa. 707, 833 A.2d 710, (2003) ([a]ny organization seeking exemption from taxation has the affirmative burden to prove it is entitled to the exemption" (citing, *inter alia,* 72 P.S. §7236)).

However, in *Community Options v. Board of Property Assessment,* 571 Pa. 672, 813 A.2d 680, 683 (2002), the Supreme Court stated that: "An entity seeking a statutory exemption for [sic] taxation must first establish that it is a 'purely public charity' under Article VIII, Section 2 of the Pennsylvania Constitution before the question of whether that entity meets the qualifications of a statutory exemption can be reached." Thus, the questions of who has the burden and what analysis should come first remains an elusive proposition, particularly when something that was clearly in the forefront of the mind of the legislature, community hospitals, no longer exists and large multi-state health systems and corporations attempt to shoehorn themselves into an antiquated system.

Finally, Act 55 defines an "institution," as a "domestic or foreign nonprofit corporation, association or trust or similar entity." 10 P.S. §373. The definition is significant because it makes clear that when conducting an exemption analysis, individual parcels owned by a single qualifying institution of purely public charity are not to be evaluated as if the parcels represented separate discreet businesses. *See, Chartiers Valley School District v. Board of Property Assessment, Appeals,*

Review and Registry of Allegheny County, 794 A.2d 981 (Pa. Cmwlth. 2002) In *Chartiers*, the Court held that Act 55 defines the basic unit of evaluation as a corporation, association, or trust or other similar entity. The basic unit of evaluation may not be aggregated. Similarly, it may not be divided. The focus of any evaluation is a corporation, not multiple corporations and not parts of a corporation.

Thus, is the analysis one of each hospital individually giving no consideration to the parent corporation or is it an analysis of Tower Health giving no consideration to each individual hospital? *Sacred Heart Healthcare System v. Commonwealth*, 673 A.2d 1021 (Pa. Cmwlth. 1996), held that the activities of related organizations or multiple corporations may not be considered when considering a single corporation's right to an exemption. As developed *infra,* Tower Health is draining huge sums of money from the individual hospitals which result in the hospital "showing" a large net loss. Absent the actions of the parent corporation, the individual analysis would be affected.

The confusion noted above is no more evident than in the instance of large multi-state health systems and corporations which attempt to shoehorn themselves into an antiquated system - - community hospitals - - that no longer exists. The analysis that follows attempts as much as possible to analyze this request for tax exemption based on existing law. The fact that the existing laws are flawed and do not reflect the vast change in the American healthcare landscape from community-based charity-oriented hospitals to massive conglomerations of healthcare networks, doctor providers, surgical suites, and insurance plans, does not make this task any easier. The court anticipates this Decision will be appealed. It thus presents the opportunity for the appellate courts and the legislatures to review the significant changes that have

occurred in this area and to perhaps acknowledge that the existing tests, no matter where found, can no longer be applied to health care entities in the United States and particularly in Pennsylvania and guide the courts when analyzing requests for exemption.

II. PROCEDURAL SETTING

Each of the individual hospitals listed in the caption are organized as limited liability corporations. Each of the hospitals lists as the sole member of the LLC as Tower Health. Each of the hospitals, as outlined *infra*, filed tax exemption appeals. The cases were consolidated for discovery. Each hospital retained the same "experts" for testimony. In fact, other than the two hospital chief executive officers, Stephen Tullman for Phoenixville and Claire Mooney for Brandywine and Jennersville, all other identified witnesses were the same. As a result, trial was scheduled for each hospital in succession and over a two-week period August 2, 2021 to August 13, 2021 and each appeal was heard by the undersigned. Because all of the witnesses' testimony was virtually identical for each hospital and the same for Tower Health we write in support of decision as a whole. The facts in support of the decision are separated in the applicable section and, if appropriate, noted within the body of the discussion.

A. The Acquisition, Tower Health and Hospital Operations

Tower Health Systems is the current name of an institution created in 1882 as Reading Hospital. Prior to 2017, it operated under some variant of the name Reading Hospital, Reading Health Systems or Tower Health. On May 30, 2017, Reading Hospital entered into an agreement with Community Health Systems, a for-profit

corporation, to purchase five (5) hospitals from CHS/Community Health Systems, Inc. The hospitals acquired were Phoenixville Hospital, Brandywine Hospital, Jennersville Hospital, Pottstown Hospital and Chestnut Hill Hospital. These entities are referred to in part as "the acquired hospitals." Three of the acquired hospitals are located in Chester County and all are the subject of tax exemption appeals before this court.

The purchase of these hospitals created Reading Health Systems, now known as Tower Health Systems ("Tower Health"). With the consummation of the transaction, Tower Health transformed itself from a single hospital institution which was active in and around one Pennsylvania city, into a much larger regional healthcare market participant. Facts developed during the trial also showed that around this time Reading Health also acquired a variety of physician groups known as Tower Health Medical Group.

Tower Health funded the purchase of the hospitals and medical groups with the proceeds of a $590,500,000 bond issuance sponsored by the Berks County Industrial Development Authority (the "Bond"). It used the proceeds to not only fund the acquisition but as operating capital. None of the acquired hospitals received any proceeds from the bond issuance, yet each of the hospitals are referred to in the official statement for the bond issuance as an "obligated group." Each member of the obligated group was required to and did pledge all of its revenue as collateral for payment of the principal and interest under the Bond which was purchased by institutional and individual investors.

Post-closing, Tower Health began assimilating the various hospitals and the other acquired physician practices into one large, integrated regional health system. Each of the Chester County hospitals, Phoenixville, Brandywine and Jennersville, did

maintain a separate legal status as a limited liability company. Tower Health is the sole member of each LLC.

Tower Health does not generate or have revenue in its own right. Whatever money it receives is a through a series of charges levied against each hospital. Tower Health realizes these funds through transfers or more likely book entries for those obligations. There are three main charges that each pays to Tower Health. They are a management fee, central business office fee, and interest payment obligation fee. Tower Health charges each of the hospitals (members of the obligated group) an interest payment obligation fee to fund the interest payments due under the Bond. One can easily surmise that Tower Health will impose an additional charge upon the hospitals when the Bond's principal payment obligations commence next year, 2022.

The exhibits introduced at trial as PH-15, 16 and 17 for Phoenixville, BH-15,16 and 17 for Brandywine, and JH-18, 19 and 20 for Jennersville reveal that without any apparent justification, Tower Health began to draw cash from each hospital at an alarming rate. In fiscal year 2018, Tower Health imposed upon Phoenixville Hospital a management fee of $387,000 per month, or $3,500,000 per year. By 2020, that management fee had increased to $1,800,000 per month or $21,700,000 per year. Additionally, the central business office charges increased from $2,500,000 to $3,800,000 over the same period. Similarly, at Brandywine, the management fees were $2,718,000 for 2018; $7,422,480 in 2019; and $15,587,155 in 2020. At Jennersville, the initial 2018 management fee was $1,080,000 per year. The fee increased to $3,094,200 in 2019 and $6,101,534 in 2020. A rough aggregation of the management fees charged to each Chester County hospital in FY 2020 was $43,000,000.

Tower Health's witnesses testified that they believed the hospitals received valuable services in exchange for these ever-increasing charges. In cross-examination, none of the executives could point to any analysis or study which supported the ever-increasing charges. The central business office did provide IT services as well as billing and collection services, all of which one presumes were covered by that central business management fee. The interest charges were kept separate and apart from such charges. For example, in 2018 when Phoenixville Hospital paid $5,000,000 to Tower Health in interest charges, we see that similar interest payments assessed and accounted for at each institution. If Tower Health was syphoning, for example, $21,000,000 out of Phoenixville and similar figures from Brandywine and Jennersville for reasons other than executive compensation, that was never explained.

The evidence at the trial demonstrated that for a period of time following the assimilation, Tower Health executives received substantial increases in compensation and bonuses for their work associated with the expansion. Testimony revealed that Tower Health paid its executives many millions of dollars in compensation on a yearly basis. The testimony of the witnesses was that Tower Health uses approximately one-half of the management fee charged to the hospitals just to fund executive compensation.

The Tower Health executives did nothing more, according to the testimony, than facilitate the assimilation. These executives were not involved in the daily operation of the hospital. These executives did not provide medical services or care. Yet the evidence at trial also revealed that there were other executives at each hospital who were responsible for the operation of each hospital and patient care. For

example, Phoenixville Hospital had a president and chief executive officer who were both responsible for the operation of the hospital. Phoenixville Hospital also had a leadership team tasked with the responsibility of overseeing the care and delivery of the services by nurses and doctors.

Tower Health executives, according to the evidence, were paid up to $2,500,000 a year in base compensation simply for the "assimilation" of each hospital. There is no testimony in the record as to how those services helped an individual hospital deliver medical care to people in their service area.

B. Compensation Based on Financial Performance

It was very clear from the testimony of all the witnesses that the health system was set up to reward executives at all levels particularly if they showed a profit. The evidence at trial showed that the hospital had an annual incentive bonus plan for executive, director, and manager level employees. At Tower Health and each hospital, that amounts to about forty (40) or so people.

The compensation plan is weighted 70% in favor of financial performance of the hospital and its parent Tower Health. The remaining 30% is based upon each hospital's performance with regard to certain patient care or patient satisfaction and criteria. The incentive amounts tied to financial performance are substantial. For example, the top four (4) Phoenixville Hospital executives could earn annual bonuses totaling approximately $350,000. Thus, 70% of that calculation, or $250,000, is tied directly to the financial performance of Tower Health and the hospital. See *e.g.*, Ex. PASD 24-32, BH 24-32, and JH 27-34.

As noted earlier, the management fees Tower Health charges directly to Phoenixville Hospital directly fund the compensation of Tower Health executives. Over time, these fees have increased from $387,000 per month to $1,800,000 per month. Five (5) executives received compensation at or above $1,000,000. In the fiscal year ending June 30, 2018, the CEO of Tower Health received compensation of approximately $2,400,000. As an aside, evidence reveals that the compensation arrangement drew the interest of the Internal Revenue Service. The IRS can impose a 21% excise tax against not-for-profit entities that pay executives more than $1,000,000 per year. Tower Health has been notified by the IRS of its "Estimated Excise Tax Liability" for certain fiscal years.

The hospital's testimony was that it is hard to reach its financial goals in large part due to COVID-19 and other constraints in delivering medical care services. It contends its financial targets were not met in 2019 or 2020 and therefore the bonuses while large, were illusory. Interestingly, the hospital witnesses testified at great length that they could not hire anyone to be an executive if they did not offer very high compensation packages, including incentive performance bonuses based upon fees.

The picture created by the witnesses is: (1) it pays very high wages to executives; (2) it offers incentive bonuses based upon attainment of financial goals; (3) it must do so because this is the industry norm; and (4) if they did not offer this level of compensation and performance bonuses, they could not hire anyone.

C. Uncompensated Care

There was a great deal of testimony offered at trial regarding "uncompensated care." Each hospital focused the majority of its testimony on the care provided either

to a Medicare or a Medicaid patient. The point the hospitals sought to address was that "undercompensated Medicare costs comprised a predominant portion of the hospital's alleged uncompensated care to patients." However, as well discussed further *infra*, the hospitals' evidence on this point was ever-shifting and always confusing. Part of the confusion lies with how dramatically the payment for health care services in America has changed since the creation of the exemption "tests" by our courts and legislature over 30 years ago.

Despite all the accounting machinations offered at trial, which involved attempts to include various types of Medicare and Medicaid and to ignore other government programs and direct insurance reimbursement agreements with private providers, the hospitals' evidence was almost no one received uncompensated care.

The only documentary evidence which each of the hospitals introduced as proof of free care, reduced care, or care in excess of the costs was sales tax exemption application. In Phoenixville they introduced Exhibit PH-6. The hospital filed, under oath, a sales tax exemption application with the Commonwealth in which it provided responses to the following questions:

> "How many people received services from the hospital in the past year?"
> Response: 199,405.
> "How many people received goods or services for free?"
> Response: 152.

This equates to 0.00076% of their patients. Phoenixville submitted evidence to the Commonwealth for the sales tax and to this court of the number of patients who received a reduced fee for services. Phoenixville's evidence was 10,483 people or 0.050% of its patients received care at a reduced fee. However, the hospital did not

explain how much of a reduction was provided as it does not have a standard fee for a particular service.

The percentages were similar for Brandywine and Jennersville. At Brandywine 167,235 people received services. Of that number Brandywine, under oath, stated 127 received hospital services for free. That equates to 0.00076% of patients. Further, Brandywine stated that 8,792 patients who received care paid a reduced fee. That number equals 0.052%. Ex. BH-6. At Jennersville 107,340 people received services. Of that number, Jennersville, under oath, stated 82 received hospital services for free. That equates to 0.00076% of patients. Further, Jennersville stated that 5,643 patients who received care paid a reduced fee. That number equals 0.053%. Ex. JH-6.

Perhaps recognizing these figures did not show a "substantial" donation of services, the hospitals produced testimony that it satisfies the uncompensated care requirement by providing care to those insured through government health programs. The hospitals never differentiated between un- and under- compensated care.

Without falling too far into the rabbit hole that was testimony from accountants attempting to convert dollars and patients into percentages, any analysis must start with the price of a particular service. For example, what does the hospital charge for a hip replacement. The hospital, not the doctor.

Each hospital expert testified that there was a "master charge sheet" reflecting the hospital's gross charge for a particular medical service. The master charge sheet was never introduced into evidence. There was no oral testimony from any witness as to the master charge sheet's content. The taxing authorities sought this evidence in discovery, and it was not provided.

The only substantive testimony about the master charge sheet came from a hospital President. In Phoenixville, for example, Stephen Tillman, testified the master charge sheet has no meaning or value. Mr. Tillman testified that the numbers, essentially, are pulled out of thin air and created only because it is required to have a charge sheet to satisfy federal regulations. As an aside, those federal regulations require hospitals to publish for consumers their charges for goods and services. Each of these hospitals objected to making their price structure public. Despite federal legislation to publish and provide the actual costs to all patients, it appears that each of the Tower Health hospitals in Chester County have not done so. See, Sarah Kliff and Josh Katz, *Why Hospitals and Health Insures Didn't Want You to See Their Prices*, New York Times (Aug. 22, 2021).

Mr. Tillman's testimony was that the master charge sheet prices are much higher than the hospital's cost to provide the service. Each hospital uses the master charge sheet as a starting point for the hospital to negotiate with the wide variety of third-party payors. That is true whether the third-party payor is a private payor such as Blue Cross, or a public payor such as Medicare, Medicare Advantage, Medicare Plus, Medicaid, TRICARE, or any one of the varieties of direct payors through the Affordable Care Act. In other words, the hospital freely and openly negotiates with a variety of third-party payors to accept a certain amount for a certain service.

Further, the testimony was that the charge levied by each hospital was different for each payor. In an effort to meet the criteria of the *HUP* test, the Hospital argues that because these negotiations result in the acceptance of payments that are less than what is initially requested on the master charge sheet, which are inflated to begin with, it must be considered to have offered uncompensated care.

For example, Phoenixville Hospital alleged that its uncompensated care to patients totaled $8,531,412 and its "overall" uncompensated cost was $12,132,632. This figure, however, bears no relationship to the those provided on Exhibit PH-6, the sales tax exemption application. If it did have a correlation that was supportable in documentation it would mean that Phoenixville's 152 people who they swore to the Commonwealth received free (uncompensated) care incurred bills of $56,127.71 each.

Further, comparing Medicare payments with what Blue Cross pays based upon the master sheet charge process reveals that Medicare pays approximately 9% of the hospital's master charge amount whereas Blue Cross pays 5.73%. *See e.g.,* Ex. PH-47, BH-47, JH-49. Under cross-examination, the hospital witnesses testified that they did not consider Blue Cross payments as uncompensated care. None of the witnesses knew if an individual covered by Medicare had assets to pay the "master charge rate." Nor did anyone know whether a patient who was insured with Medicare may have also had supplemental private insurance coverage.

D. Phoenixville Hospital Property Tax Parcel No. 15-13-0784.0000.

After acquisition, Phoenixville Hospital owned three parcels, only one of which is the subject of this appeal. The current assessment of the subject tax parcel is $32,397,090.00. Improvements on this parcel include an acute care hospital facility, paved parking lots, a medical office building referred to as "MOB I," and two (2) elevated enclosed walkways. One of the elevated enclosed walkways connects MOB I to the acute care hospital facility. The second walkway connects MOB I to an adjacent medical office building referred to as "MOB II." While MOB II is owned by Phoenixville Hospital, it is located on a different tax parcel. The hospital campus also

includes a parking deck structure owned by the Phoenixville Hospital. It too is located on a separate tax parcel. MOB II and the parking deck are taxable and are not at issue in this case. During the course of this appeal, it became apparent to the hospital that MOB I, although located on the subject tax parcel, should not be considered for tax exemption. Physicians and physician groups that are not employed by the hospital provide services to patients in MOB I and receive payments from those patients for the services that they provide. It is, therefore, taxable and Board Exhibit 6 revealed that it was previously assessed as a separate tax parcel in the amount of $5,489,280.00.

E. Brandywine Hospital Property

Prior to the finalization of the acquisition, Brandywine Hospital owned three parcels with addresses of 201 Reeceville Road (39-03-0018.000), 213 Reeceville Road (sold and all appeals subsequently withdrawn) and 255 Reeceville Road (29-07-0168.0100). On July 28, 2017, Brandywine Hospital LLC filed Applications of exemptions for the three properties. At the time of the filing Brandywine Hospital LLC did not fully exist nor own the properties.

The acquisition of Brandywine Hospital was part of a large transaction involving six (6) hospitals and physician groups. The agreement contained over twenty (20) conditions precedent which needed to be satisfied. After several extensions, the sale went to settlement October 17, 2017. Subsequently Brandywine LLC condominiumed the property at 213 Reeceville Road. Brandywine noted at trial that it was withdrawing the appeal concerning this property for all years. As a result of the withdrawal, it will not be discussed.

The parcel addressed as 255 Reeceville Road (29-07-168.0100-AB) had at the time of acquisition a lease agreement with another non-profit for a portion of the building. Brandywine seeks a partial exemption for this property for the applicable year. Subsequently this property was sold to a third party and there is no claim for exemption past the 2020 tax year. Whether partially or fully exempt, there was no testimony from the Appellant regarding how much of this property was used for the purported tax-exempt activities.

The main parcel located at 201 Reeceville Road (39-03-0018.000) is 171-bed acute care hospital. It is currently assessed at $16,802,804.00 resulting in an implied fair market value of approximately $35,000,000.00. Ex. B-1.

F. Jennersville Hospital Property

Jennersville seeks tax exemption under two case numbers. The two filings were a result of the timing of the filings. Jennersville acquired the property at 1015 West Baltimore Pike, Parcel 58-03-0018.0000 from the West Grove Hospital Company, LLC on October 1, 2017. The first Jennersville appeal now designated as 2017-11227-AB was filed with the Board of Assessment on July 31, 2017, which was two months prior to acquisition. Jennersville' s application was denied by the Board of Assessment. Jennersville then filed a second appeal before the Board of Assessment on July 27, 2018. This appeal was also denied. This denial was timely appealed to the Court of Common Pleas and is docketed at 2018-11859-AB. The parcel contains 12.4 acres and is improved with an acute care hospital. Ex. B-1.

IV. ISSUES

A. Did the Hospitals have standing to bring the 2018 Tax Appeal?

B. Are the Hospitals entitled to a tax exemption?

V. HOLDINGS

A. No, the Hospitals did not have standing to bring the 2018 tax appeal.

B. No, the Hospitals have not met the criteria for tax exemption.

VI. RATIONALE

A. The 2017 Appeals

All of the hospitals filed their initial appeals to the Board of Assessment in July of 2017. Each hospital sought a real estate tax exemption for the tax year 2018. The General County Assessment Law limits who can file such an appeal to those that are "aggrieved." To be considered aggrieved, the filing party must have a direct and immediate interest in the assessment. *See,* 53 Pa. C.S. §8844(c)(1); *Appeal of Marple Newtown School District*, 453 A.2d 68 (Pa. Cmwlth. 1982).

At the time it filed its appeal, Phoenixville Hospital did not own the property subject to the appeal. The Hospital had no obligation nor a direct and immediate interest in any assessment. Each hospital may have had a contingent interest in their respective properties. However, the future ownership of the subject parcels was far from certain and certainly not guaranteed.

For each hospital, their potential ownership was contingent upon the fulfillment of a significant, multi-party contractual agreement containing over twenty (20) conditions precedent. *See e.g.,* PASD-5. The massive and complicated financial

undertaking, which required the issuance of BCIDA Bonds and regulatory approvals, meant there was no certainty that the transfer of ownership would take place or when it would take place. One indicia of the tenuous nature of the transaction was that settlement was continued several times. Eventually, the financing and sale of the hospital properties consummated October 17, 2017. Because the hospitals did not own nor hold even equitable title in the real estate, the Board of Assessment denied each hospital's appeal. Each hospital filed an appeal to the Court of Common Pleas. Those appeals for each hospital bear the 2017 file numbers.

In order for the hospitals to even be heard, they must possess the requisite legal standing to file their application. The Commonwealth Court defined standing as any person who has a direct, immediate, pecuniary and substantial interest in the property. See, *In Re Appeal of Marple Newton School District*, 453 A.2d 68 (Pa. Cmwlth. 1982). See also, 72 P.S. §5349(c). The Supreme Court recognized that the real owner does not necessarily mean the actual titled owner but could include the concept of equitable owner. *Marcus Hook Dev. Park, Inc. v. Board of Assessment Appeals*, 449 A.2d 70 (Pa. Cmwlth. 1986).

In the instant cases, each hospital was, on the date of filing in 2017, owned by a for profit company. The conglomeration of these hospitals was part of a multi-party transaction involving the IDA, several doctor groups, and many hospitals, some of which were not located in Chester County. As noted in the factual recitation, Reading Health, now Tower Health, was seeking to change from a one-city hospital into a regional health care network. To accomplish this metamorphosis, Reading/Tower Health needed the $590,000,000 in funds to be generated by the issuance and sale to public and private investors. The bond issuance required several layers of protections

and the backing of the Berks County Industrial Development Authority. This was not a simple purchase of real estate.

At the time of the filing of the initial appeals in 2017, the hospitals did not have a "direct immediate" interest in the tax assessment of the property. In July of 2017, each of the properties were owned by Community Health Systems, or subsidiary thereof, as a for-profit hospital. Each of the now hospital appellants had no obligation to pay real estate tax on their respective subject parcels until consummation of the entire deal nearly two months after the filings. In July of 2017 at the filing of the initial appeal before the Board, the LLCs which eventually held title owned nothing. For example, the property that became Jennersville Hospital was still titled as West Grove Hospital Company LLC. See, Ex. AGSD-1.

Second, the Asset and Membership Interest Purchase Agreement called for the completion of the purchases by July 31, 2017. See, *e.g.* PASD-5, AGSD-1. We know that settlement did not occur on that date. There were over 20 conditions precedent listed in Sections 7 and 8 of the Agreement which needed to be completed prior to settlement. Thus, there was no guarantee that the settlement would ever take place. This is not the same position as a non-owner lessee as exited in *Marple Newtown*, *supra*. Nor do the three hospitals' interest rise to the level of an equitable owner which was analyzed by the Supreme Court in *Appeal of Baltimore & Ohio Railroad from Tax Assessment*, 175 A.2d (Pa. 1961). At their best Reading Health/Tower Health and/or each of the hospitals had an agreement creating a possibility that hospital LLCs would acquire the respective real estate. This is not a sufficient interest to establish standing for the appeals. Thus, each hospital's appeal to this court, docketed at 2017-11226-

AB (Phoenixville), 2017-11220-AB, 2017-11222-AB, 2017-11223-AB (Brandywine) and 2017-11227-AB (Jennersville), collectively the "2017 Appeals" are denied.

B. 2018 Appeals

Each of the taxing authorities agreed that the hospitals did have appropriate standing for each of the respective tax parcels when the appeal to the Board of Assessment were filed in July of 2018. The appeals, if granted, would then be effective for the 2019 tax year and beyond pursuant to both the "tax assessment day rule" as explained in *In Re Appeal of Springfield Hospital Folio No. 42-00-06625-01*, 179 A.3d 632 (Pa. Cmwlth. 2018) and the pending appeal rule enunciated in *In Re P-Ville Associates*, 87 A.3d 898 (Pa. Cmwlth. 2014).

C. Tax Exemption

1. General County Assessment Law Analysis

The hospitals, in seeking a tax exemption, bear the burden of proving that they are entitled to exemption. *Four Freedoms House of Philadelphia, Inc. v. Philadelphia*, 279 A.2d 155 (Pa. 1971). Any analysis under the General County Assessment Law 72 P.S. §5453.202 (hereinafter "Assessment Law") will be strictly construed. *YMCA v. Reading,* 167 A.2d 155 (Pa. 1971). The three criteria under the Assessment Law which the hospitals must prove are that it is one of purely public charity, was founded by public or private charity and is maintained by public or private charity. See, *Woods School Tax Exemption Case*, 178 A.2d 600 (Pa. 1962).

At the outset, the hospitals note that they are each organized as not-for-profit LLCs under federal tax law. The hospital witnesses also made a point to testify that

the hospitals lost money as a business. Non-profit status under federal tax law and/or a business that is not profitable are not synonymous with charitable or charity. The Superior Court held that federal tax exemptions do not enter into the consideration of whether a property is entitled to real estate tax exemption under Pennsylvania law. *Richmond Civic Club v. Board of Property Assessment, Appeals & Review*, 215 A.2d 310 (Pa. Super. 1965).

Each of the hospitals were presented as a money-losing operation. They argued that the pandemic had cost them elective procedures which placed them in an untenable economic situation. However, this glosses over the testimony relating to the management fees drawn by Tower Health. For example, in FY 2018, Phoenixville Hospital realized an operating loss of $1,446,770. That operating loss included the FY 2018 management fee of $3,483,000 charged to the hospital by Tower Health. Phoenixville, as were all the other hospitals, was also charged for IDA Bond interest on an obligation incurred by Tower Health from which no bond proceeds were allocated to the individual hospitals. These payments, to answer for the debt of Tower Health, further contributed to the "operating loss" in any given fiscal year.

As noted in our discussion of the facts, Tower Health presented no justification for taking such large sums as a management fee from each of the subject hospitals. Mathematics reveals that but for the management fee demanded by Towner Health, which appears to be primarily for the purpose of paying Tower Health executives. Phoenixville did make "a profit" or, more accurately from an accounting standpoint, showed a surplus of revenue over expense.

Evidence was also developed that the Internal Revenue Service treats the hospitals as not for profit business. See, Ex. PH-4, BH-4 and JH-4. But the IRS also

has noted that the operation and executive compensation is excessive and subjects Tower Health to a 21% excise tax. See *e.g.*, Ex. PASD-21; see also IRS Section 4960. The excise tax is applied when five or more executives are compensated in excess of $1,000,000. We know from the evidence each hospital's management charge resulted in the Tower Health Executives receiving approximately $6,000,000 in FY 2018. See *e.g.*, PH-18 and the testimony Robert Ehinger. Clint Matthews, CEO of Tower Health alone earned, without inclusion of bonuses, $2,500,000 in FY 2018. Perhaps had each hospital not been required to pay exorbitant amounts to Tower Health for management fees and interest they would not have been "failing businesses."

2. HUP Test Analysis

As noted, under the Assessment Law the courts had been reluctant to grant exemption to any entity that was not a "purely public charity". The Supreme Court, in the *Hospital Utilization Project v. Commonwealth*, supra. held that to qualify as such it must possess five criteria: advance a charitable purpose, donate or render gratuitously a substantial portion of its services, benefit a substantial and indefinite class of persons, relieve the government of some of its burden and operate entirely free from private profit motive.

3. Charitable Purpose

The hospitals chose to address only whether it met the charitable purpose test. In short, the hospital argued that the very fact that it is an acute care hospital with an open admission policy advances a charitable purpose. This statement with the

accompanying testimonial evidence fails to speak to whether it meets all the criteria set forth in the variety of tests that govern exemption from real estate taxation.

4. Donates or Renders Gratuitously a Substantial Portion of Services

The hospitals contend that that it donates or renders gratuitously a substantial portion of its services. In support thereof, at trial it presented evidence of the amounts of "uncompensated care" and percentages of such care contrasted with its total operating expenses. Factually, that argument carries little weight. As noted in our discussion of the facts, the only exhibit to offer concrete evidence of the amounts of uncompensated/free care or care provided at less than full value is Exhibit PH-6, BH-6 and JH-6 (sales tax exemption application). Each of the hospitals' percentage of uncompensated care was approximately 0.00076% of services rendered. That is clearly not substantial.

The *HUP* test does require a review of the totality of the circumstances. We address the same. To support their argument, the hospitals presented Robert Cepielik as an "expert witness". Mr. Cepielik offered a series of estimates and calculations in support of "uncompensated care." See also, Ex. PH-97, PH-98, BH-88, BH-89, JH-92, JH-93. The argument was that Medicare and Medicare insurance payments by the government equaled uncompensated care. However, that is not an accurate reflection of what these insurance payments represent.

First, Medicare is a government insurance program available to anyone over the age of 65. This insurance program is offered to all citizens regardless of the individual's financial circumstances. This is true whether an individual has the resources of Warren Buffett and Bill Gates or is a pauper. It is not a true indicator of

charity care. There also was no analysis offered of whether any of the Medicare patients also had private "supplemental" coverage. In fact, the President of Phoenixville Hospital testified that the hospital has no idea of the extent to which its Medicare patients could or could not afford the "usual" fee. Robert Ehinger, SVP of Financial Operations for Tower Health, testified that the Medicare figures given to the expert for review did not include Managed Care patients or any calculation of whether there was supplemental insurance available to some or all of the Medicare patients. Finally, Mr. Cepielik based his expert report and conclusion in large part on the hospital's Trend Reports. Mr. Cepielik testified that he could find no inaccuracies in the Trend Report. Yet the hospitals argued that the Trend Report was unreliable.

Rather, it appeared that the unreliable testimony came from the hospitals' witnesses. While arguing they relied upon the Trend Report, the witnesses acknowledge the Trend Report was not prepared in accordance with GAAP, generally accepted accounting principles.[2] Mr. Cepielik testified that he relied upon "Non-GAAP numbers" or "GAAP like" numbers. There is no such thing. This is a binary selection. Figures relied upon either were or were not prepared in accordance with GAAP. These were not.

The hospitals cannot carry a persuasion burden when they try to have it both ways. On the one hand they wish us to credit Mr. Cepielk's testimony. Yet on the other hand they argue the testimony offered in reliance upon a Trend Report they acknowledge was unreliable and upon numbers not properly audited.

[2] While discussed here under the *HUP* test analysis, the GAAP requirement is found in Section 373 of Act 55 discussed *infra*.

Over the years, the traditional concept of charity, providing something for no renumeration, has been replaced by an accounting analysis of the care provided to patients which include considerations such as who is "insured" through a government medical program such as Medicaid. On its face, one might conclude that the government paying for health care through insurance is equal to paying for health care directly.

In 1985, when the *HUP* test was adopted, data shows that 11% of Americans had health insurance through a public program.[3] In 2019, the tax year in which this case was brought, 46% of Americans were insured through government health insurance programs, including the Affordable Care Act, TRICARE (a military family coverage), Medicare, Medicaid, Veterans Administration, CHAMPVA, and Railroad Retirement.[4] Even these figures, the Census Bureau notes, are inconclusive as the estimates by type of coverage are not mutually exclusive. Many people are covered by more than one type of health insurance either during a given year or as part of a health coverage strategy. The most common example is a person who receives Medicare health insurance and also purchases a supplemental private insurance plan to ensure full coverage.

The testimony and data clearly lead to a conclusion that the government is assuming more of obligation or burden to provide health care. One could conclude that in 1985, the Supreme Court recognized in *HUP* that if the government was only paying for 11% of the population's health care, a given hospital is relieving the government of 89% of its burden. In 2019, the government was now paying nearly

[3] Healthcare Financial Review, 1992.
[4] U.S. Census Bureau Current Population Survey, 2020 Annual & Economic Supplement.

one-half of the population's health care costs. Rather than relieving the government of a burden, the financial model in place is to increase greater burden on the government and reliance on government insurance payments.

The Trend Report revealed that at each hospital, the government insurance program of Medicare "reimbursed" each hospital at a rate of 9.1% of the Master Charge Sheet. Blue Cross, a private insurance plan reimbursed the hospital at 5.73% of the Master Charge Sheet. See *e.g.,* Ex. PH-47, BH-47, JH-51. A clear financial reason to take more government insurance patients is the higher reimbursement rate. Each hospital submitted data that established a pattern of growth for government insurance programs. But that overall Medicare patients (including those with supplemental private insurance) constituted about 28% of patients and Medicaid 9%. See *e.g.*, Ex. PH-55, JH-93.

Almost out of necessity there has been a push by government at all levels to rein in medical costs. Medicare and Medicaid, among all government insurance programs, are designed to cover all the costs institutions incur in providing services. An institution that treats patients efficiently and at a cost lower that the stated reimbursement percentage gets the same payment as an inefficient institution. See *e.g.,* Ex. AGSD-8. We recall from the factual recitation that this "reimbursement rate" is calculated as a percentage of the master charge sheet. As Mr. Tillman testified, the master charge sheet is meaningless. Thus, the reimbursement percentage stated above is likely higher or is closer to actual costs of services.

There was no testimony as to the cost of a procedure or what any of the now multiple insurance plans pay for that procedure. That information was solely within the control of the Hospital. It could have produced the agreements and financial

arrangements, under a confidentiality agreement if necessary, thus allowing a proper analysis but it did not. The conclusion left to be reached is that such information would not support their exemption argument. Although uncompensated Medicare costs may be considered in an exemption analysis, the evidence offered at trial leaves the court merely to speculate as to the amounts of uncompensated care.

Perhaps because of the unreliability of the master charge sheet and evidence presented the hospital included "bad debt" as part of their "donations." Certainly when the hospital provided service to these patients there was no charitable intent. The hospital provided services and expected to be paid in full. In fact, each hospital showed in their budget a line item for bad debt. Bad debt is a business expense, not a charitable contribution.

Mr. Cepielik testified that the bad debt write-offs were on accounts for patients that the hospitals determined had the financial means to pay. To write these amounts off is not charity when the hospitals decided not to pursue the collection of these accounts even though there was, in the hospital's determination, a means to pay. The ever increasing "bad debt" write-offs do not equal an increase in donated care, to those "who otherwise could not afford to pay."

Moreover, as a practical matter, there is no evidence supporting a conclusion of Medicare or Medicaid shortfalls. The master charge sheets offered to support this contention are of no value, per the testimony of Phoenixville Hospital's President. The hospital charge sheets merely serve as a starting point for negotiations with a variety of third-party payors. There was no testimony regarding reimbursement rates of other government insurance programs. It appears the hospitals entered in negotiations with a wide variety of insurance programs and agreed to accept a fee for each service.

Accepting a fee for services in an amount equal to that which you have agreed to accept is business not charity.

We acknowledge that under a variety of previous court rulings that "uncompensated" Medicare costs and bad debts may be considered as part of the overall totality of the circumstances. However, each tax exemption case is to be determined on the specific facts and circumstances. *School District of the City of Erie v. Hamot Medical Center*, 601 A.2d 407 (Pa. Cmwlth. 1992).

As we see from a review of prior cases, courts have given varied weight to providing Medicare services and bad debt. In *St. Margaret Seneca Place v. Board of Property Assessment*, 640 A. 2d 380 (Pa. 1994), 48% of the patient/residents receive Medicaid reimbursements. In *Couriers-Susquehanna, Inc. v. County of Dauphin*, 645 A.2d 290 (Pa. Cmwlth. 1994), 60% of patient reimbursements were from Medicaid. In *Mt. Macrina Manor, Inc. v. Fayette County Board of Assessment Appeals*, 683 A.2d 935 (Pa. Cmwlth. 1996), the patients receiving Medicare reimbursement was 51%. In each of the aforementioned cases the tax exemption was approved.

In contrast, the court in *Menno Haven, Inc. v. Franklin County Board of Assessment & Revision of Taxes*, 919 A.2d 333 (Pa. Cmwlth 2007) denied tax exemption where 25% of the patients were Medicare eligible. Among the hospitals subject to these appeals Medicare patients equated to between 9% and 11%. The data and testimony in these three hospitals who are the subject of these appeals does not support a conclusion that these hospitals donate or render gratuitously a substantial portion of their services.

5. Operates Free of a Profit Motive

An institution that is in its nature and purposes a purely public charity loses its character as such if it receives a revenue from the recipients of its bounty sufficient to keep it in operation. However, it must not go beyond self-support. *See Episcopal Academy v. Philadelphia,* 150 Pa. 565, 25 A. 55 (1892) (holding as "long as the trustees of the school manage it as a charity, giving the benefit of what might otherwise be profit to the reduction of tuition fees, or the increase of the number of free scholars, in furtherance of the 'education of youth,' the purpose of their trust, their school house is entitled to exemption").

When the hospitals were acquired by Tower Health, each of the respective management teams were offered participation in the incentive compensation plan. See, *e.g.* Testimony of Russell Showers. The then existing hospital executives were offered sign-on bonuses to provide them an incentive to stay with Tower.[5] Secondly, compensation going forward was structured in such a way to highlight annual bonuses. The largest single component of the annual bonuses (40%) was based upon attaining a certain profit margin. See *e.g.*, Testimony of Russell Showers, also Ex. PH-31, JH-22, 28, 29, 30, 31, 33 and 34.

The incentive amount tied to financial performance was substantial, particularly for upper management. The top four hospital executives could earn up to $345,000 in yearly bonuses, 70% of which ($250,000) was directly tied to financial performance. See, Testimony of Bruce Loch; also, *e.g.* Ex. PASD-19. The hospital's expert witness on compensation, Clifford Simmons, testified that this incentive compensation plan

[5] Of note, since the conclusion of testimony and during the draft of this decision and opinion, Tower let Claire Mooney, President of Brandywine and Jennersville go, closed Jennersville, and offered Brandywine for sale to "anyone". Thus, the incentive to stay was perhaps unknown to be illusory.

was specifically designed to impact the behavior of the employees and management team. The plan was to focus their attention on the incentive compensation to drive their behavior to make more money.

It was very clear from the testimony of all the witnesses that the health system was set up to be profitable and to reward executives at all levels when it was. Its goal went far beyond self-support.

We could summarize the expert witnesses who testified on this subject, as stating, "Yes, we do have an incentive compensation plan driven by financial performance." They went on, "Yes, we designed it that way to incentivize these employees to drive profit/surpluses." Concluding, "If we did not have this financial incentive plan, then we could not attract and hire qualified executives." We do not find merit in the argument offered, without evidentiary support, that without a profit/surplus based financial incentive plan the Hospital would be unable to hire executives.

Regardless of the myriad of matrices created and testified to, the evidence showed that the Hospital had annual incentive or bonus plans for executive, director, and manager level employees. The incentive amounts tied to financial performance that were substantial as outlined, *supra*. These incentive bonuses were designed to reward people for making a profit/surplus.

The evidence demonstrated that Clint Matthews and the Board of Tower Health were no more that corporate health care raiders. No one questioned the executives of Tower Health for what they were being paid $2,500,000 per year or why they drained $22,000,000 per year from, for example, Phoenixville Hospital. Within three weeks of trial, Tower dismissed as employees the President of Jennersville and Brandywine Hospital along with other executives and announced that Jennersville would close.

Other Hospitals have been sold, are for sale, or will just be given away as seems will be the case with Brandywine Hospital. The goal as evident from the financial documentation offered at trial was simple and direct - drain the juice out of the hospitals until there was nothing left but a dried-out husk and then leave, close the doors, or sell what was left. Jennersville is now closed, Brandywine for sale and while this harvesting strategy may not have killed Phoenixville, it is left with little more than a skeleton.

The hospitals argue that during the pandemic none of the incentive criteria was met and the plan was "suspended" by the "circuit breaker". The bonus compensation plan remained in place, whether paid or not. The fact that the executive compensation plan was suspended only further serves to emphasize that the hospitals did not operate entirely free from private profit motive. Contrary to the hospitals' arguments, the "circuit breaker" demonstrates that a bad year resulted in financial consequences to the executives. Whereas a good year or a "profitable" year resulted in large payouts to selected people.

In *Pinnacle Health Hospitals v. Dauphin County Board of Assessment*, 708 A.2d 1284 (Pa. Cmwlth. 1998), the Court held that Harrisburg Hospital was a taxable entity because it did not operate entirely free from profit motive. In reaching its conclusion, the Commonwealth Court focused on what was referred to as the "Management Incentive Compensation Plan." Under the *Pinnacle* plan, high level employees were paid an incentive bonus for achieving short and long-term financial targets and objectives. The Court concluded that "[t]he bonus plan's emphasis on the "bottom line" rather than the promotion of charity indicated a profit motive." The court opined that the bonus plan's design was intended to improve business performance, not the

hospital's ability to render charity care. Similarly, in *Guthrie Clinic, LTD v. Sullivan County Board of Assessment*, 898 A.2d 1194 (Pa. Cmwlth. 2006), the Court held that tying a physicians compensation plan even in part to financial productivity was evidence of a profit motive violating the *HUP* test.

In the case at bar, each hospital's annual incentive bonus plan for all executive, director and manager level employees was weighted 70% toward the financial performance of their individual hospitals and Tower Health. The Court's reasoning in *Pinnacle* and *Guthrie Clinic* compels us to conclude that the hospitals herein and Tower Health violate the criteria.

The money for the large salaries and bonuses were derived from the exorbitant management fees assessed by Tower Health against each hospital. In addition, Robert Ehinger, a hospital witness, testified that these management fees also compensated some executives for their work at Reading Hospital. This arrangement, to take one of the Chester County hospitals' revenue to pay large compensation and to fund obligations outside of the particular hospital is also fatal to the private profit motive criteria.

Quite simply, the revenue of Phoenixville, Brandywine and Jennersville Hospitals was taken by Tower and applied for purposes other than the support of the hospital. By taking the funds for the payment of Tower Health's obligations under the IDA bond also weighs against the hospitals' claims for exemption. The testimony reflects that Tower Health assessed each hospital for interest payments on the IDA bond. The proceeds from that bond were used by Tower to acquire a number of assets, not just these three hospitals located in Chester County. Not one penny from

the bonds were applied to support and to increase the efficiency and facilities of each hospital.

Tower Health, in and of itself, has no income. It is charging each of these hospitals for the "privilege" of having been acquired. These interest payments, like the executive compensation, provides no benefit to the individual hospital. In *School District of the City of Erie v. Hamot Medical Center,* 602 A.2d 497 (Pa. Cmwlth. 1992), the Commonwealth Court held that a hospital that made substantial payments to a controlling outside entity did not meet the free from private profit criteria.

In this case, like in *Hamont*, substantial payments were directed to Tower Health. Absent these payments, Tower Health had no income and could not pay its executives or honor its bond obligations. As noted earlier in this discussion, the IRS reported approximately $6,000,000 in salaries having been paid to the administrative team for fiscal year ending June 30, 2018. Because of Tower's compensation of executives, a 10% excise tax was imposed against Tower, as discussed above, however; Tower then assessed the penalties against each hospital. Therefore, we can conclude that the payments from each hospital to Tower clearly was not then applied to the hospitals' benefit, but rather to their detriment.

D. Act 55 Analysis

As discussed above, Act 55 was in part an attempt to codify the *HUP* test. The Act follows the criteria set forth in *HUP* and lays out the type of evidence that is needed to satisfy the test. See, *Ceramic Art and Cultural Institute v. Berks County Board of Assessment Appeals*, 227 A.3d 46 (Pa. Cmwlth. 2020). Without reviewing

the same criteria again, the hospital focused its testimony on the "community service" criteria.

In order to meet the community service factor, the hospital proffered Robert Cepielik as a witness for each individual hospital. As discussed *supra,* Mr. Cepielik based his testimony upon the Trend Report, a Statistical Systems Report, a letter from the Wisconsin Physicians Service Insurance Company, a Medicare Cost Report and Contractual Download reports. Act 55 requires that when performing the analysis of community service criteria all calculations must be made in accordance with generally accepted accounting principles (GAAP). Mr. Cepielik admitted each time he was cross-examined that none of the five documents he relied upon were prepared in accordance with GAAP. Rather he used "GAAP-like" or "non-GAAP numbers" in issuing his report and providing his opinion.

This analysis does not meet the mandated requirement of the Act. Obtaining GAAP numbers is not at all difficult. All that was needed was for Mr. Cepielik to ask his client, the hospitals, for their audited financial statements. Because audited financial statements are prepared in accord with GAAP, if they had been used the testimony may have addressed this factor. Once again, here is evidence the audited financial statements that were completely within the control of the hospitals was not entered into evidence. There is no doubt audited financial statements would be needed to submit to the IDA for bond and its proceeds. Audited financial statements are commonplace in the corporate world. We are left only to conclude that the failure to use their own audited statement was intentional. The evidence would not have been favorable to the hospitals.

E. Consolidated County Assessment Analysis

Without reiterating the analysis that has already been done relating to exemption factors that overlap or contained within other section previously analyzed, we will conclude our analysis with the Consolidated County Assessment provisions relating to using the property to derive income from other sources. Pursuant to 53 P.S. §8812(b)(1) real estate is taxable if "any income or revenue is derived, other than from the recipients of the bounty of the institution or charity." Succinctly, the hospital cannot use property it owns to derived income from sources other than patients.

In each hospital's case, there was testimony, and in some cases admissions by the hospital, that they and others derive income from third party physicians. Each hospital admitted that they do not employ any doctors other than a few residents in training. Instead, the hospitals grant privileges to physicians to provide medical care to patients. Approximately 10% of these doctors are employed by the acquired "Tower Health Medical Group". This "medical group" is owned by Tower Health, not the individual hospitals. The remaining 90% of the doctors are employed by independent third party for-profit medical practices. A rough count of the groups produced for each hospital is that there are roughly 475 or more third party physicians who have privileges to treat patients at the hospitals.

The testimony of each hospital's President was that these doctors control all the medical care provided whether directly or through directives to nurses. These doctors then bill each patient directly for the service they render. These bills are above and beyond what the hospital may charge the same patient. Additionally, each hospital then pays certain medical groups to provide independent contracted service such as in

the emergency or operating rooms. As an example, one of the hospitals, Phoenixville, paid the independent doctors over $6,000,000 in FY 2018. See *e.g.*, Ex PH-54. This income was not derived from the recipients of the hospital's services.

Therefore, it is clear that substantial income and revenue is being derived throughout the hospital by and from people other than the recipients of bounty provided by the hospital. The hospital, in an offhanded comment, remarked "you can't have a hospital without doctors." No one is suggesting that you can. But you can structure your organization so that either the hospital employs its own physicians or use those physicians already employed by Tower Health Medical Group. This court takes no position on the legality or efficacy of this arrangement. Tower Health and the hospitals are entirely free to structure their corporate and financial operations in the manner they do. The only conclusion we draw is that the current structure violates the Consolidated County Assessment Law and the hospitals' appeal for an exemption must be denied.

An appropriate Order follows.

BY THE COURT:

Date: October 14, 2021

Jeffrey R. Sommer J.

IN RE: APPEAL OF BRANDYWINE HOSPITAL, LLC FROM THE DECISION OF THE CHESTER COUNTY BOARD OF ASSESSMENT APPEALS FOR PROPERTY LOCATED AT 213 REECEVILLE ROAD, CALN TOWNSHIP, CHESTER COUNTY, PENNSYLVANIA	:	IN THE COURT OF COMMON PLEAS CHESTER COUNTY, PENNSYLVANIA NOS. 17-11220, 17-11222, 17-11223, 18-11854, 18-11855 and 18-11857 CIVIL ACTION
IN RE: APPEAL OF JENNERSVILLE HOSPITAL, LLC FROM THE DECISION OF THE CHESTER COUNTY BOARD OF ASSESSMENT APPEALS FOR PROPERTY LOCATED AT 1015 WEST BALTIMORE PIKE, PENN TOWNSHIP, CHESTER COUNTY, PENNSYLVANIA	:	CHESTER COUNTY, PENNSYLVANIA NOS. 17-11227 and 18-11859 CIVIL ACTION
IN RE: APPEAL OF PHOENIXVILLE HOSPITAL, LLC FROM THE DECISION OF THE CHESTER COUNTY BOARD OF ASSESSMENT APPEALS FOR PROPERTY LOCATED AT 140 NUTT ROAD, BOROUGH OF PHOENIXVILLE, CHESTER COUNTY, PENNSYLVANIA	:	IN THE COURT OF COMMON PLEAS CHESTER COUNTY, PENNSYLVANIA NOS. 17-11226 and 18-11858 CIVIL ACTION

ORDER

AND NOW, this 14th day of October, 2021, after trials *de novo* held August 2-6, 2021 In Re Appeal of Phoenixville Hospital, August 6, 9 and 10, 2021 In Re Appeal of Brandywine Hospital, and August 10-13 In Re Appeal of Jennersville Hospital, it is hereby ORDERED that, based upon the testimony, evidence, arguments and post-trial briefs presented, the requests for tax exemption of Brandywine Hospital,

Jennersville Hospital and Phoenixville Hospital in the above case numbers are **DENIED** for the reasons set forth in the foregoing Decision.

BY THE COURT:

Jeffrey R. Sommer J.