



# HEALTH CARE LAWYER

The newsletter of the Illinois State Bar Association's Section on Health Care Law

## All the latest developments in health care law

By W. Eugene Basanta and Jennifer Wagner

### Cases

### Federal decisions

#### ERISA preempts action against health plan

Plaintiff, his wife, and child had health insurance with the defendant-insurer provided through a health benefit plan covered by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq. After obtaining the required pre-certification by the insurer and the insurer's repeated assurances that no additional premiums were due, plaintiff's wife underwent a costly medical procedure. Then, hav-

ing initially made part payment to two providers for the procedure, the insurer suddenly canceled the plaintiff's coverage, refused to pay any further amounts, and demanded repayment of the bills it had already paid. The plaintiff filed suit in state court alleging breach of contract, promissory estoppel, negligent misrepresentation, and state statutory violations. When the insurer removed the case to federal court, the plaintiff moved for remand to state court. The insurer opposed remand on the basis that the plaintiff's

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## Provena Covenant Medical Center v. The Department of Revenue: Hospital property tax exemptions and the charitable use requirement

By Brian J. McKenna and Nancy K. McKenna \*

On March 18, 2010, the Illinois Supreme Court rendered its decision in the property tax appeal filed by Provena Covenant Medical Center (PCMC) holding that PCMC was not entitled to a property tax exemption under section 15-65 of the Property Tax Code, 35 ILCS 200/15-65.<sup>1</sup> Section 15-65 provides, in relevant part, as follows:

All property of the following is exempt when actually and exclusively used for charitable or beneficent purposes, and not leased or otherwise used with a view to profit:

- (a) Institutions of public charity.<sup>2</sup>

The five members of the supreme court par-

ticipating in the decision unanimously ruled that Provena failed to demonstrate that it satisfied the statutory requirement that it was an "institution of public charity." A plurality of the court further ruled that the hospital failed to demonstrate that it satisfied the constitutional and statutory requirement that the subject property was "actually and exclusively used for charitable or beneficent purposes." This article explores the requirements necessary to establish a property tax exemption by a nonprofit hospital and the unresolved issues that are expected to continue to persist under Illinois law.

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## All the latest developments in health care law

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claims were completely preempted by ERISA. The federal district court denied the motion to remand and subsequently dismissed the plaintiff's suit without prejudice.

In considering the motion to remand and the insurer's preemption argument, the trial court explained the so-called "well-pleaded complaint rule" and the complete preemption exception to this rule. Simply stated, while a defendant cannot remove a case from state to federal court just by asserting a federal defense to the plaintiff's claim, if that claim involves an area of law completely preempted by federal law, then federal jurisdiction exists even if the plaintiff's complaint makes no mention of a federal claim. In the instant case, the insurer argued that the plaintiff's action was one for benefits under an ERISA plan and that such actions are completely preempted under 29 U.S.C. 1132(a)(1)(B). This statutory section provides an ERISA plan participant with the right to bring an action in federal court to recover benefits due and to enforce rights under a plan.

Looking to several prior decisions, including the Seventh Circuit's decision in *Jass v. Prudential Health Care Plan*, 88 F.3d 1492 (7th Cir. 1996) and the Supreme Court's decision in *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004), the district court concluded that the plaintiff's claims were preempted by ERISA and that remand to state court should be denied. The plaintiff, as a plan participant, could bring an action under ERISA, his claims against the insurer were within the scope of section 1132(a)(1)(B) as claims for benefits allegedly due under an ERISA plan, and resolving these claims would require the court to interpret and apply the terms of the plaintiff's health insurance policy with the defendant. As such, the claims were completely preempted by ERISA. *Werner v. Group Health Plan, Inc.*, No. 09-CV-891-JPG (S.D. Ill., Apr. 20, 2010).

### **Claim against hospital for failure to search requires no expert testimony**

An incident in the defendant-hospital's emergency room resulted in a suit in federal court by the administrator of the deceased patient's estate. When the patient, who suffered from a variety of mental conditions, became agitated in the hospital's ER, hospital personnel recommended that he be placed

in the psychiatric ward. After a nurse discovered that the patient was armed with a pistol, the police were contacted. The patient blockaded himself in a hospital room. During the ensuing stand-off, a police officer shot and killed the patient. The estate sued the officer, the city, and the hospital in federal court. The basis of the claimed liability for the hospital was its failure, given the known mental condition of the patient, to search him and determine if he possessed any items with which he might harm himself or others.

The hospital moved for summary judgment arguing that under Illinois law the plaintiff-estate had to present expert testimony to support its claim and that the estate had not disclosed any expert who would testify in this regard. In response, the administrator argued that the estate's claim was for ordinary negligence requiring no expert testimony. The district court agreed with the plaintiff and denied the motion.

Judge Kennelly cited several Illinois state court decisions as relevant in distinguishing between claims involving professional negligence and those involving ordinary negligence. Among the cases referenced was *Jones v. Chicago HMO Ltd.*, 191 Ill. 2d 278, 730 N.E.2d 1119 (2000) in which the court explained that, unlike a case involving ordinary negligence, in a case based on professional negligence, expert testimony is required to establish both the professional standard of care and a deviation from that standard. The fact that medical professionals at the hospital had dealt with the deceased patient before he was shot, however, did not, the court said, automatically make this a case involving professional negligence.

The federal court cited *Heastie v. Roberts*, 226 Ill. 2d 515, 877 N.E.2d 1064 (2007), a case where a patient apparently burned himself with something concealed in his pocket while involuntarily restrained at the defendant-hospital. Part of the plaintiff's claim in *Heastie* involved the hospital's failure to search the plaintiff for contraband. The Illinois Supreme Court held that, while the decision to restrain the plaintiff in *Heastie* involved the exercise of professional medical judgment, the decision to search (or not search) him for contraband did not. As a result, the court ruled that the failure to search

claim was one for ordinary negligence and did not need to be supported by the testimony of an expert.

Similarly, in the present case, the federal court concluded the administrator's suit was based on allegations that the hospital breached an administrative duty when it failed to search the patient for weapons, and not on any deficient medical judgment or care provided. Therefore, no expert evidence was needed and summary judgment was denied. *Coleman v. Wiencek*, No. 08 C 5275 (N.D. Ill., Mar. 22, 2010).

## Illinois decisions

### **Expert testimony not required for emotional distress claim**

The Illinois Supreme Court has ruled that a plaintiff may recover for the negligent infliction of emotional distress in a medical malpractice action against a physician without the need for expert testimony to support the claim. As a result, the decision of the appellate court was affirmed.

The plaintiff's premature son, born just under 24 weeks, died during childbirth. He was partially delivered in a breech position when the defendant, the plaintiff's obstetrician, was not at the hospital. There was no other physician present to assist and the baby remained partially delivered for over an hour. When the defendant-physician arrived at the hospital, the baby was delivered, but was already dead at the time.

The plaintiff brought suit against several parties including the defendant-physician, as well as the nurses involved in the birth and the hospital. A jury found the defendant and the nurses not liable, but ruled against the hospital on the plaintiff's claim for emotional distress awarding the plaintiff \$175,000.

The plaintiff, contending the jury was exposed to prejudicial information and error in the jury instructions, filed a post-trial motion challenging the verdict. While this motion was pending, the nurses and the hospital settled the matter with the plaintiff for \$175,000. A second trial was eventually granted against the defendant-physician. At the second trial, the jury found the defendant liable for the negligent infliction of emotional distress and awarded the plaintiff \$700,000. The defendant appealed a denial

of judgment notwithstanding the verdict and a request for set-off.

On appeal, the defendant argued that the plaintiff had failed to prove negligent infliction of emotional distress by expert testimony. The defendant asserted that under Illinois law, expert testimony is necessary to establish that the emotional distress was severe, that it was a reasonably foreseeable consequence of the alleged negligence, and to distinguish the emotional distress caused by the circumstances of the delivery from that caused by the death of plaintiff's son. In response, the plaintiff claimed no such expert testimony was necessary.

Looking to the Fifth District Appellate Court's decision in *Clark v. Owens-Brockway Glass Container, Inc.*, 297 Ill. App. 3d 694, 697 N.E.2d 743 (5th Dist. 1998), the Third District held that in general, Illinois does not require expert testimony to prove negligent infliction of emotional distress and upheld the trial court's ruling. *Thornton v. Garcini*, 382 Ill. App. 3d 813, 888 N.E.2d 1217 (3d Dist. 2008). The physician sought Illinois Supreme Court review.

Writing for a unanimous court, Justice Kilbride explained that the physician's claim on appeal was that he was entitled to a judgment notwithstanding the verdict based on plaintiff's failure to produce expert testimony to establish that her emotional distress was caused by the delay in delivering her child. Defendant pointed to the Illinois Supreme Court's decision in *Corgan v. Muehling*, 143 Ill. 2d 296, 574 N.E.2d 602 (1991) which, he argued, established that claims for negligent infliction of emotional distress must be proven by expert testimony to ensure that any verdict for emotional distress is supported by competent evidence. The plaintiff asserted that *Corgan* does not require expert testimony to establish such a claim.

Quoting the Fifth District Appellate Court's opinion in *Clark*, Justice Kilbride agreed with the plaintiff. "*Corgan* does not require expert testimony to establish emotional distress. The absence of medical testimony does not preclude recovery for emotional distress. Rather, '[t]he existence or nonexistence of medical testimony goes to the weight of the evidence but does not prevent this issue from being submitted to the jury.'" In so holding, the court also expressly rejected the contrary position taken by the Second District Appellate Court in *Hiscott v. Peters*, 324 Ill.App.3d 114, 754 N.E.2d 839 (2d Dist. 2001). Further, the court found that the

plaintiff's testimony was sufficient to permit the jury to conclude that her emotional distress was the result of the defendant's delay in delivering the deceased baby and not from the infant's death. *Thornton v. Garcini*, No. 107028 (Ill. Sup., Apr. 22, 2010).

#### Illinois Supreme Court upholds nursing home arbitration agreement

Plaintiff, the administrator of her deceased aunt's estate, filed suit against the defendant-nursing home following her aunt's death at the facility. At the time of admission, decedent signed an agreement to arbitrate any dispute that might arise with defendant, waiving her right to a jury or bench trial. The agreement was not required in order to be admitted to the facility and it could be rescinded within the first thirty days by the decedent or her legal representative. The agreement also noted that it was governed by the Federal Arbitration Act (FAA), 9 U.S.C. §2, which states that any contract that mandates arbitration is enforceable except upon grounds at law or in equity that would call for the revocation of any contract.

Following the decedent's death, when the plaintiff filed survival and wrongful death claims in state court, defendant moved to compel arbitration. Plaintiff opposed the motion, arguing that the arbitration agreement violated Illinois public policy as expressed in the Nursing Home Care Act, 210 ILCS 45/3-606 & 3-607 which provides that a waiver of a right to trial by jury is null and void. Plaintiff argued that the policy behind this statute was a general defense to all contracts in Illinois and that it therefore was grounds at law for revoking any contract sufficient to overcome FAA preemption. The trial court denied the motion to compel arbitration. It held that that the agreement was against public policy and that, while decedent may have been bound by the agreement, it did not bind someone bringing a claim on behalf of her estate. The Fifth District Appellate Court affirmed, considering only whether the Nursing Home Care Act's expression of public policy was a state law contract defense applying to all contracts which overcame FAA preemption. The court held that the public policy was generally applicable and did not specifically target arbitration. It thus concluded that the Nursing Home Care Act fell within the savings provision of the FAA. *Carter v. SSC Odin Operating Company, LLC*, 381 Ill. App. 3d 717, 885 N.E.2d 1204 (5th Dist. 2008).

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The Illinois Supreme Court originally denied leave to appeal, whereupon defendant filed a petition for a writ of *certiorari* with the United States Supreme Court. While the petition was pending, the Second District Appellate Court decided *Fosler v. Midwest Care Center II, Inc.*, 391 Ill. App. 3d 397, 911 N.E.2d 1003 (2d Dist. 2009). In *Fosler*, the court held that the antiwaiver provisions of the Nursing Home Care Act were preempted by the FAA, in direct opposition to the decision the Fifth District reached in the case at bar. The petition for a writ of *certiorari* was denied. Noting the split in the appellate courts, the Illinois Supreme Court granted defendant's motion for reconsideration of denial of its petition for leave to appeal.

The supreme court reviewed the appellate court's determination regarding the antiwaiver provisions in the Nursing Home Care Act *de novo*, since it involved statutory interpretation and federal preemption. The case at bar involved conflict preemption, and the intent of Congress was to encourage courts to enforce arbitration agreements and to prevent state statutes from targeting arbitration clauses for disfavored treatment compared to other contract provisions in general.

The court reviewed several decisions of the United States Supreme Court for guidance. In *Southland Corp. v. Keating*, 465 U.S. 1 (1984), the Court first held that the FAA preempts state law when that law violates the supremacy clause. In *Perry v. Thomas*, 482 U.S. 483 (1987), the Court stated that a state law could overcome preemption "if that law arose to govern issues concerning the validity, revocability, and enforceability of contracts generally. A state-law principle that takes its meaning precisely from the fact that a contract to arbitrate is at issue does not comport with this requirement". (Emphasis in original.) In *Doctor's Associates, Inc. v. Casarotto*, 517 U.S. 681 (1996), the Court again ruled that the FAA preempts a state law that specifically targets arbitration agreements. Finally, in *Preston v. Ferrer*, 552 U.S. 346 (2008), the Court concluded that under the FAA, parties can choose an arbitral forum and any state law that lodges jurisdiction in another forum is preempted, whether the law at issue specifically mentions arbitration or not.

The Illinois Supreme Court held that the antiwaiver provisions of the Nursing Home Care Act were legally indistinguishable from those at issue in *Southland*, *Preston*, and *Perry*. It rejected plaintiff's assertion that a stat-

ute must target arbitration directly in order to be preempted, stating this was not a correct reading of *Perry* and *Casarotto*. While the decisions in *Perry* and *Casarotto* did indicate that statutes singling out arbitration were to be preempted, it did not also mean that statutes avoid preemption if they do not specifically target arbitration. This was made clear by the decisions in *Southland* and *Preston*, where the statutes at issue made no mention of arbitration, but were still held to be preempted.

The court also noted that the decision of the appellate court in the instant case was at odds with the plain language of the FAA, which allows an arbitration agreement to be voided only on "such grounds as exist at law or in equity for the revocation of any contract." Therefore, state laws which do not apply to all contracts cannot be held as grounds for revocation of "any contract" within the meaning of the savings clause of the FAA. Since the provisions at issue in the Nursing Home Care Act serve only to invalidate arbitration agreements in the context of nursing care contracts, they do not apply to all contracts. The purpose of the savings clause in the FAA was to allow for general contract defenses such as unconscionability, fraud, and duress that can apply to any contract. In general, the federal goal is to encourage and enforce arbitration agreements by preempting state law to the contrary. *Carter v. SSC Odin Operating Company, LLC*, No. 106511 (Ill. Sup., Apr. 15, 2010).

#### **Court resolves medical records copying charge dispute**

Plaintiffs filed a class action against defendant, a management company which contracts with health care providers to process requests for medical records. Plaintiffs alleged several counts. At issue on appeal was whether charging the statutorily allowed maximum of \$20 as a flat handling charge, in addition to per page charges, was *per se* reasonable. The Illinois Code of Civil Procedure in 735 ILCS 5/8-2001 & 8-2003 limits the handling charge that companies such as the defendant may charge to parties requesting medical records to \$20. Defendant filed a motion to dismiss, which was denied, and defendant sought leave to appeal with the certified question of whether charging the maximum amount as specified in the statute is *per se* reasonable, or whether the provider must charge less if the evidence shows that a lesser charge is reasonable. A divided ap-

pellate court found that the language of the statute was unambiguous and that the maximum charge applied as a flat fee was not *per se* reasonable. . *Solon v. Midwest Medical Records Ass'n*, 386 Ill. App. 3d 78, 898 N.E.2d 207 (1st Dist. 2008).

In its analysis, the Illinois Supreme Court initially noted that when a statute is unambiguous, it must be given its plain meaning with no assistance from extrinsic evidence, such as legislative history. However, if the statute's language can be understood in two or more ways by reasonable people, then it is ambiguous and a court may consider extrinsic aids in order to determine legislative intent. The court may also consider the consequences of construing the statute in a certain way in order to avoid absurd or unjust results.

In this case, the court found that the statute at issue was capable of two reasonable interpretations. One was that the health care provider may be reimbursed for reasonable expenses as long as those expenses do not exceed the statutorily prescribed maximum amounts, which was \$20 for the handling charge. Therefore, the provider would be reimbursed for the lesser of actual expenses, reasonable expenses, or the amount of the statutory cap. A second valid interpretation, the court said, was that the provider may be reimbursed for reasonable expenses which were defined to not exceed the prescribed maximum. Therefore, the provider was free to charge less, but as long as the charges did not exceed the maximum under the statute, they were presumptively reasonable.

Finding the statute ambiguous, the court turned to its legislative history to determine the General Assembly's intent. After looking at statements from the legislative sponsors of the bill, the court concluded that the legislature prescribed the maximum amount of the handling charge in order to define what was reasonable. Under the previous version of the statute, which contained no set maximum, patients were being charged unreasonable and arbitrary amounts for their medical records. The General Assembly thus felt it was wise to define by law what a reasonable handling charge would be.

The court found support for this view in a Texas case, *In re Metro ROI, Inc.*, 203 S.W.3d 400 (Tex. App. 2006), in which the Texas Court of Appeals found that a similar statute was an indication of what their legislature felt was a reasonable fee. Additionally, a New York court in *In re Casillo*, 151 Misc. 2d 420,

580 N.Y.S.2d 992 (N.Y. Sup. 1992) found that a similar statute was passed in order to create a uniform definition of what a reasonable fee was and to stop spiraling costs being imposed on patients. Because the statements from the Illinois legislature evidenced the same intent, the court decided that the Illinois statute should be construed similarly to those in Texas and New York. The court held that a flat \$20 handling charge was *per se* reasonable. *Solon v. Midwest Medical Records Ass'n*, No. 107719 (Ill. Sup., Mar. 18, 2010).

### **No liability for misinterpreted Pap smear under Tort Immunity Act**

In Illinois, the Local Governmental and Governmental Employees Tort Immunity Act, 745 ILCS 10/6-105 & 6-106 (Tort Immunity Act) immunizes local governmental entities, such as municipal hospitals, and their employees from tort liability for failing to make a physical or mental examination or for an inadequate examination to determine the presence of a disease or illness, as well as for a failure to diagnose an illness. The Third District Appellate Court in April applied these provisions of the Tort Immunity Act to bar liability in an action for wrongful death in connection with a deceased patient's misread Pap smear.

The decedent underwent a Pap smear in June of 2000, which was interpreted as normal by two defendants, one a licensed cytotechnician and the other a physician. By December of 2000 however, she was diagnosed with stage IIIb cervical cancer. She died in April of 2002. Shortly thereafter, her husband filed suit against various defendants, including the cytotechnician, the physician, and their employer, a municipal entity. All of these defendants moved for summary judgment arguing that, under the Tort Immunity Act, the suit was precluded both by the immunity provisions of sections 6-105 and 6-106 and by the one year limitations period under 745 ILCS 10/8-101. The trial court granted the motion on the basis of both the Tort Immunity Act's immunity and statute of limitations provisions.

On appeal to the Third District, the court rejected the plaintiff's efforts to avoid the immunity provisions of the Act. The plaintiff argued his claims were outside the reach of section 6-105 which relates to an "examination," as he alleged that the defendants failed to "correctly interpret or supervise the interpretation of Pap Smear slides." As to section 6-106, which applies to failures to diagnose,

the plaintiff argued that a Pap smear does not diagnose cancer, but merely is a screening test.

Looking to *Michigan Avenue National Bank v. County of Cook*, 191 Ill. 2d 493, 732 N.E.2d 528 (2000) as well as several appellate court decisions, Justice Schmidt writing for the court, held that a Pap smear "is a screening test that is clearly part of the diagnostic process and precisely the conduct that both sections 6-105 and 6-106 immunize." Without reaching the statute of limitations issue, the court affirmed summary judgment for the defendants under the immunity sections of the Tort Immunity Act. *Hemming v. Nehring*, No. 3-08-0751 (Ill. App. 3d Dist., Apr. 8, 2010).

### **No punitive damages under the Nursing Home Act in a survival action**

As the representative of the estate of decedent, plaintiff sued the defendant-nursing home under the Survival Act, 755 ILCS 5/27-6 for personal injuries decedent suffered while in the defendant's care. Plaintiff alleged several claims including a claim that the willful and wanton conduct of defendant violated the Nursing Home Care Act, 210 ILCS 45/1-101 et seq. With respect to this claim, plaintiff's complaint reserved the right to seek punitive damages for the willful and wanton conduct pursuant to 735 ILCS 5/2-604.1. Defendant moved to strike the portion of the complaint reserving the right to seek punitive damages, and the trial court granted the motion. The court granted leave to file an interlocutory appeal and certified the question of whether, in an action brought by the legal representative of the estate of a deceased nursing home resident, common law punitive damages are available when bringing an action based on the Survival Act for willful and wanton violations of the Nursing Home Care Act when such violations caused personal injuries that resulted in death.

The appellate court began by noting that the Survival Act does not create a cause of action, but rather allows a representative of a decedent's estate to maintain any statutory or common law actions that had accrued at the time of the decedent's death but which would have abated upon death. The Survival Act, the court said, does not authorize or prohibit punitive damages, but it does set forth specific claims that are shielded from abatement. One of these claims is for personal injuries prior to death. 755 ILCS 5/27-6.

The court next surveyed decisions of the Illinois Supreme Court on point. In *Mattyasovszky v. West Towns Bus Co.*, 61 Ill. 2d 31, 330 N.E.2d 509 (1975), the supreme court held that common law punitive damages are not recoverable under the Survival Act, and also decided not to recognize a common law wrongful death action that would allow for punitive damages since there were no strong equitable considerations, such as unavailability of remedy, to warrant such an action. The *Mattyasovszky* court therefore held that a common law action for punitive damages does not survive the death of the decedent. In *National Bank v. Norfolk & Western Ry. Co.*, 73 Ill. 2d 160, 383 N.E.2d 919 (1978), the court held that punitive damages were recoverable after death under the Public Utilities Act, 220 ILCS 5/1-101 et seq. since that act expressly provided for damages for punishment for willful violations. The court stated that *Mattyasovszky* did not eliminate "statutory liability for punitive damages upon the death of an injured person", nor did it stand for the proposition that punitive damages are not recoverable when an injury results in death. In *Froud v. Celotex Corp.*, 98 Ill. 2d 324, 456 N.E.2d 131 (1983), the court considered whether *Mattyasovszky* could be reconciled with *National Bank* and stated that the two cases are distinguishable and declined to overrule *Mattyasovszky*. The court stated that the decision in *National Bank* meant that when a punitive damages provision is "part and parcel" of the act at issue, the punitive damages claim is to "be litigated regardless of whether the injured person continues to live." Finally, in *Ballweg v. City of Springfield*, 114 Ill. 2d 107, 499 N.E.2d 1373 (1986), the supreme court again declined to overrule *Mattyasovszky* and *Froud* and stated that "Illinois law is clear that punitive damages are not recoverable under the Survival Act."

Plaintiff argued that the Nursing Home Care Act statutorily authorizes punitive damages and that such a claim therefore survived decedent's death. However, the court observed that the Act does not refer explicitly to punitive damages; rather, it states that a resident may "maintain an action under this Act for any other type of relief, including injunctive and declaratory relief, permitted by law." 210 ILCS 45/3-603. In the court's view, the Act permits a plaintiff to seek remedies beyond those provided, but this is not the same as the Act itself providing any such additional remedy. The court observed that the statute at issue in *National Bank* was completely different from that at bar in that it un-

equivocally provided for punitive damages; the Nursing Home Care Act simply does not do so. Since the Nursing Home Care Act does not expressly provide for punitive damages, the court held that punitive damages are not recoverable in a survival action. Additionally, the court said, the legislative history of the Act supported its holding. The court noted that a provision in the Act was repealed which had previously allowed for treble damages and that the General Assembly had rejected several attempts to amend the Act to provide for punitive damages.

Plaintiff and *amici* also argued that equitable considerations demanded that a claim for punitive damages survive in an action under the Act. They cited three factors from *Grunloh v. Effingham Equity, Inc.*, 174 Ill. App. 3d 508, 528 N.E.2d 1031 (4th Dist. 1988) in support: (1) whether the defendant's conduct offends public policy, (2) whether the defendant's conduct is criminal as opposed to willful or wanton, and (3) whether plaintiff would otherwise receive inadequate compensation. The court stated that none of the *Grunloh* factors applied in the instant case because *Grunloh* was based on a misreading of *Raisl v. Elwood Industries, Inc.*, 134 Ill. App. 3d 170, 479 N.E.2d 1106 (1st Dist. 1985). In *Raisl*, the court did not establish a test for survivability; rather, punitive damages in that case were expressly allowed by statute. The *Raisl* court suggested that *Mattysosvsky and Froud* allowed survival only when strong equitable considerations were present. The court in the instant case concluded that *Mattysosvsky* had rejected outright the availability of punitive damages under the Survival Act and did not create an exception for equitable considerations.

In the present case, the court concluded that plaintiffs in survival actions are not left without a remedy in the absence of punitive damages. The court stated that the deterrent purpose of the Act is not frustrated just because the recovery is not large; also, due to the legislature's refusal to write punitive damages into the Act, the court felt it was not appropriate to invade the legislative province and create survival of punitive damage claims under the Act based on equitable considerations. Since the Act provided no statutory basis for punitive damages and since no strong equitable considerations existed, the court answered the certified question in the negative. *Vincent v. Alden-Park Strathmoor, Inc.*, No. 2-09-0625 (Ill. App. 2nd Dist., Apr. 7, 2010).

### **Nursing director may be sued individually for malpractice**

Plaintiff, independent administrator of decedent's estate, filed a complaint against the defendant-nursing home and its director of nursing personally due to injuries decedent suffered prior to her death, including several deep and infected pressure sores. Attached to the complaint was a certificate signed by a registered nurse opining that the actions of defendant-nursing director, fell below the standard of care with regard to the care of the decedent. The trial court dismissed with prejudice the three counts against the director reasoning that the counts fell under the Nursing Home Care Act, 210 ILCS 45/1--101 et seq. which only applies to licensees and owners of nursing homes. Plaintiff responded that the counts against the director were actually based on healing art malpractice and professional negligence under 735 ILCS 5/2--622 and were supported by the required certificate of merit. Plaintiff also argued that the counts against the director concerned specific actions committed by her and not simply acts of a supervisory nature in her capacity as nursing director. The trial court denied the motion to reconsider finding that plaintiff could not file a complaint against the director in the instant case. Plaintiff filed notice of an interlocutory appeal.

After first rejecting the director's claim that plaintiff was barred from objecting to the motion to dismiss because a first amended complaint had been filed, the court turned to the merits of the appeal and noted that defendant-director appeared to have based her motion to dismiss on 735 ILCS 5/2--619(a)(9) in which the moving party "admits the legal sufficiency of the complaint, but asserts an affirmative defense or other matter to defeat the plaintiff's claim." Plaintiff argued that the Nursing Home Care Act does not prohibit a cause of action against a medical professional independent of the Act. Additionally, plaintiff argued that the allegations set forth in the complaint touched on the nursing director's personal actions, and as such fell under the ambit of section 2--622 dealing with healing arts malpractice.

The court reviewed *de novo* the section 2--619 motion to dismiss and held that the trial court had erred. The court noted that the Nursing Home Care Act does not impose liability on individuals, as the supreme court noted in *Eads v. Heritage Enterprises, Inc.*, 204 Ill. 2d 92, 778 N.E.2d 771 (2003). Therefore, the court had to determine whether the fac-

tual allegations against the director were for healing art malpractice independent of the Nursing Home Care Act. Since plaintiff had alleged a duty, breach of that duty, proximate cause, and injury in the original complaint, as well as attaching a certificate of merit addressing the standard of care, the court held that she had met her burden. The term "healing art" the court said, generally concerns issues of medical judgment. Plaintiff's original complaint listed eighteen acts of negligence concerning the director's medical judgment, and so the court held it was error to dismiss the counts against her. Additionally, the court found that the allegations against the director involved her individual professional capacity and not merely her actions in her capacity as nursing director. Because the negligence alleged in the complaint involved medical judgment and was not ordinary negligence, it did not fall under the Nursing Home Care Act; rather, the court held it sounded in healing art malpractice. *Childs v. Pinnacle Health Care, LLC*, No. 2-09-0648 (Ill. App. 2d Dist., Mar. 17, 2010).

### **Five-year lookback applied to transfer of assets by Medicaid applicant**

Plaintiff appealed from a decision by the Illinois Department of Human Services which imposed a penalty period during which plaintiff was ineligible for Medicaid. After moving into a group care facility in 2003, plaintiff had created a land trust holding three parcels of real estate. Under the trust terms, she was entitled to all of the earnings and proceeds of the trust. Shortly thereafter, plaintiff transferred all of her beneficial interest in the trust to her three daughters. Approximately three years later, plaintiff applied for Medicaid assistance. The Department found she was eligible for Medicaid assistance, but imposed a period of ineligibility for five years as a result of a five-year "lookback" with respect to asset transfers and the discovery of the transfer of the beneficial interest in the trust. A formal hearing was held during which plaintiff indicated her belief that she was only subject to a three year lookback since she did not believe the transfer of assets constituted a "payment" under the State Medicaid Manual, Health Care Financing Administration Publication No. 45-3, Transmittal 64, §3259 (November 1994) (Transmittal 64)). The Department found that the trust was a revocable trust, that the assignment was a transfer of assets inuring to the assignees' benefit, and as such was a payment that required a five-year lookback. Plaintiff appealed to the circuit court,

which upheld the Department's decision.

On appeal, the appellate court examined the legislative intent behind the Medicaid Act of 1965. As explained by the Illinois Supreme Court in *Gillmore v. Illinois Department of Human Services*, 218 Ill. 2d 302, 843 N.E.2d 336 (2006), medically needy persons who are not automatically eligible for cash grants are required to spend down their assets before receiving assistance; further, to combat the rising cost of Medicaid, Congress mandated three and five-year lookback periods to determine if the applicant made any transfers solely for the purpose of becoming eligible for Medicaid. If a transfer occurred solely for the purpose of Medicaid eligibility, the applicant must wait until the end of the lookback period in order to avoid a penalty ineligibility period.

The issue on appeal was whether plaintiff was subject to the three or five-year lookback period. Plaintiff argued that the transfer of assets was personal property and not a payment and therefore fell under the three year period. The court looked to Transmittal 64 and its definition of "payment," which states in pertinent part that "a payment may include actual cash, as well as noncash or property disbursements, such as the right to use and occupy real property." Further, the Illinois Administrative Code states that the five-year lookback period applies "to payments from a revocable trust that are not treated as income (as described in Section 120.347)." 89 Ill. Adm. Code §120.387(e)(1)(A). The court found that three elements must be satisfied in order to trigger the five-year lookback period: (1) transfer from a revocable trust, (2) the transfer is not an income payment under section 120.347(f)(2), and (3) the transfer is a payment though not an income payment.

The parties did not dispute the first or second elements, but rather, whether the transfer here was a payment or a gift of personal property. The court did not address plaintiff's assertion that the penal nature of section 120.387 required strict construction, since that would not be helpful to the analysis. Plaintiff argued that under Illinois law, the beneficiary of a land trust holds a personal property interest in the trust and therefore the transfer was one of personal property. However, the court rejected plaintiff's argument, stating that the characterization of a beneficial interest in a land trust as personal property did not necessarily exclude it from being a payment from a revocable trust subject to a Medicaid lookback. Under section

120.387(d), a transfer requiring a lookback occurs when "an institutionalized person.... gives away real or personal property," 89 Ill. Adm. Code §120.387(d). The court stated that Illinois law focuses on the beneficial interest in the trust, rather than the real property which forms the principal of the trust. The court also rejected plaintiff's argument that, because the transfer only involved a beneficial interest and not the corpus of the trust, it was not a payment. Basically, plaintiff claimed the beneficial interest and the corpus of the trust were wholly unrelated, and the court disagreed. In fact, as the court pointed out, and plaintiff did not dispute, if no transfer had occurred prior to her Medicaid application, the Department would have treated the real property in the trust as an available asset. Thus, the court stated that if the real property was an asset prior to the transfer of the beneficial interest, there was no basis for believing the asset disappeared upon the assignment of beneficial interest to plaintiff's children, and as such, the assignment can be categorized as a payment.

The court then commented on the Department's analysis of plaintiff's case in order to show the reasoning that was used in arriving at the decision. The court found that the term "payment" as used in various regulatory sections indicated the same action whether it was referring to income payments or other payments. Under *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 513, 702 N.E.2d 545 (1998), "where the same words appear in different parts of the same statute, they should be given the same meaning unless something in the context indicates that the legislature intended otherwise." The court found that the term "payment" was used throughout the regulations to describe a transfer of assets subject to scrutiny. Because plaintiff had initiated a transfer of assets from a revocable trust, she was subject to Department scrutiny, which under the regulations, required a five-year lookback period. Further, as Transmittal 64 allows for "payment" to include "noncash or property disbursements, such as the right to use and occupy real property" plaintiff's case fell squarely within the scrutiny provisions of the Department, since that was precisely what she did when she transferred her beneficial interest. Therefore, the court held as a matter of law that plaintiff's assignment of a beneficial interest in her land trust was subject to a five-year lookback period for Medicaid eligibility. Because plaintiff did not wait five years to apply for Med-

icaid, the Department properly imposed a statutory penalty period for assistance. *Zander v. Adams*, No. 1-09-0979 (Ill. App. 1st Dist., Mar. 15, 2010).

### **Appellate court applies repose period in indemnity action**

The First District Appellate Court recently reaffirmed its view that the four year medical liability statute of repose found in 735 ILCS 5/13-212(a) applies to an implied indemnity action arising out of a malpractice action. In doing so, the court reasoned that the Illinois Supreme Court's decision in *Travelers Casualty & Surety Co. v. Bowman*, 229 Ill. 2d 461, 893 N.E.2d 583 (2008) did not call for a different result.

This case arose out of an underlying medical malpractice claim filed in connection with gastric bypass surgery against two physicians, a surgical group, and the hospital where the surgery was performed in 2003. After the patient died, his representative filed an amended complaint in 2005 in which she alleged that the physician-defendants had been negligent in their treatment of the patient. The amended complaint also claimed that the surgical group was vicariously liable as the physicians' employer and, alternatively that the hospital was liable for the physicians' actions under a theory of apparent agency.

In 2008 the hospital filed a counterclaim against the physicians and the surgical group alleging that it had paid \$1 million to settle the malpractice suit. The hospital asserted an implied indemnity claim against the physicians and the surgical group based upon the apparent agency allegations in the malpractice action (which had been dismissed as settled). The trial court dismissed the hospital's claim as time-barred under 735 ILCS 5/212(a) which sets a four year repose period for all medical liability claims against providers "arising out of patient care." The hospital appealed, claiming that its suit was grounded in the quasi-contractual implied duty to indemnify and not medical malpractice.

On appeal, the court cited the Illinois Supreme Court's decision in *Hayes v. Mercy Hospital & Medical Center*, 136 Ill. 2d 450, 557 N.E.2d 873 (1990), as well as its own prior ruling in *Ashley v. Evangelical Hospitals Corp.*, 230 Ill. App. 3d 513, 594 N.E.2d 1269 (1st Dist. 1992) for the proposition that in an implied indemnity action in the context of a malpractice suit is based on the indemnitor's liability in tort for the injuries the patient has sustained and thus is an "action for damages. . . arising out of patient care. . ." under 735 ILCS

5/212(a).

The hospital argued that the Illinois Supreme Court's 2008 ruling in the *Travelers Casualty & Surety Co.* case changed this. The *Travelers* case involved a claim by an insurer for indemnity on a written performance bond it had provided in connection with a construction contract against the breaching contractor after the insurer had paid on the bond. The company moved to dismiss, arguing that the insurer's claims were barred by the four-year statute of limitations in 735 ILCS 5/13-214(a) applicable to construction improvements to real property. In response, the insurer argued that the 10-year statute of limitations for written contracts in 735 ILCS 5/13-206 should apply. The Illinois Supreme Court ruled in favor of the insurer, noting that it had long held that the nature of the plaintiff's injury, rather than the facts from which the claim arises determines what limitations period governs.

Based on the *Travelers'* holding, the hospital in the present case argued the law in this area had been revised and that in determining whether its claim for implied indemnity is barred by the medical malpractice statute of repose, the court should focus on the quasi-contractual liability it was owed by the physicians and not on their liability in the underlying medical malpractice action. The appellate court disagreed, focusing on the broad reading given to the language in the malpractice statute of repose to include "any injuries that have their origin in, or are incidental to, a patient's medical care and treatment." From this point, the court held that, "the language in *Travelers* setting forth what courts should generally consider when determining which limitations period governs is wholly inapplicable" and that in determining "whether an injury has its origin in or is incidental to a patient's medical care and treatment and, thus, falls within the scope of the medical malpractice statute of repose, courts must look past the nature of the injury itself and, instead, examine the facts from which the injury arose."

As a result, the court reaffirmed its ruling in *Ashley* that actions for implied indemnity are subject to the four-year period of repose contained in 735 ILCS 5/13-212(a). Dismissal of the hospital's claim was affirmed. *Uldrych v. VHS of Illinois, Inc.*, No. 1-08-3278 (Ill. App. 1st Dist., Mar. 2, 2010).

#### **Appellate court considers fee for chiropractor's deposition**

Plaintiff filed a lawsuit for injuries she

sustained in an automobile accident. She sought treatment from a chiropractor. The defendant subpoenaed the treating chiropractor to give a discovery deposition regarding the services he provided to plaintiff. The chiropractor's employer responded that he was to be paid \$550 per hour for his testimony with a two hour minimum as well as prepayment. Defense counsel offered \$300 per hour with no prepayment or minimum. This offer was refused. The chiropractor's employer submitted financial records to the trial court, and after review, the court ruled that an hourly fee of \$66.95 was reasonable with no prepayment or minimum. The chiropractor refused to be deposed and sought leave to appeal the trial court's order regarding his hourly fee. The court denied his request leave to appeal and held him in contempt with a fine of \$50. The fine was stayed pending appeal under Illinois Supreme Court Rule 304(b)(5) which allows appeal of a contempt citation with a monetary penalty.

The chiropractor argued on appeal that the trial court's determination of his hourly fee was an abuse of discretion and that the court erred in finding him in contempt because his refusal to be deposed was in good faith. The appellate court first addressed whether the chiropractor was a "physician" under Illinois Supreme Court Rule 204(c) and therefore entitled to a reasonable fee for deposition testimony. The court noted that the Illinois Supreme Court Rules are to be interpreted in accordance with the plain and ordinary meaning of the words used. The court then looked to dictionary definitions of the word "physician" and to a 1917 Illinois Supreme Court decision in *People ex rel. Gage v. Siman*, 278 Ill. 256, 115 N.E. 817 (1917) which defined "physician" to mean "one versed in or practicing the art [of] medicine, and the term is not limited to the disciples of any particular school." Also, the court noted, the Illinois Medical Practice Act, (225 ILCS 60/2 expressly includes chiropractors. Finally, the supreme court in *Vuagniaux v. Department of Professional Regulation*, 208 Ill. 2d 173, 802 N.E.2d 1156 (2003) stated that "those holding the degree of doctor of chiropractic possess precisely the same professional stature as those holding degrees as doctors of medicine or doctors of osteopathy. All are regarded as physicians." The court thus held that the term "physician" as used in Rule 204(c) encompasses chiropractors and that chiropractors are entitled to reasonable fees for their deposition testimony.

Next the court considered whether the hourly fee set by the trial court was reasonable. The court reviewed the trial court's decision for abuse of discretion. The trial court had considered business records provided by the chiropractor's employer as well as his personal W-2 form. While the record contained no copy of the W-2 form and there was little to determine how the trial court arrived at its determination, the court said the standard is a deferential one and affirmed the trial court's calculation.

The court further affirmed the trial court's determination that no prepayment or minimum was necessary. The committee comments to Rule 204(c) provide that fees "should be paid only after the doctor has testified, and it should not exceed an amount which reasonably reimburses the doctor for the time he or she actually spent testifying at deposition." Since the trial court's order was a reflection of the intended purpose of the rule, it was affirmed.

Finally, the court vacated the order of contempt against the chiropractor. He argued that he refused to testify in order to make a good faith challenge to the trial court's ruling and not out of disrespect for the court. The appellate court had noted in the past that exposure to contempt is a valid method of testing a court's order, and held that in this case, the refusal to testify was a good faith effort to obtain a ruling on the reasonable fee issue with chiropractors, for which no precedent existed. *Montes v. Mai*, \_\_\_ Ill. App. 3d \_\_\_, 925 N.E.2d 258 (1st Dist. 2010). ■



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## Provena Covenant Medical Center v. The Department of Revenue

Continued from page 1

### Summary of the Facts

Provena Hospitals owns and operates six hospitals including PCMC. In 2002, Provena Hospitals, the legal entity owning the subject property, applied for a property tax exemption with respect to all 43 parcels which were a part of the PCMC complex, the division that actually used the property under section 15-65(a). Ultimately, the Illinois Department of Revenue denied the exemption application and Provena sought judicial review by filing suit in the circuit court. The circuit court disagreed with the Department of Revenue, holding that Provena Hospitals was entitled to the exemption on both charitable and religious grounds.<sup>3</sup> The appellate court subsequently reversed.<sup>4</sup> Thereafter, the Illinois Supreme Court agreed to hear the case.<sup>5</sup>

Provena Hospitals is the relevant entity for purposes of the “charitable ownership” requirement and PCMC is the relevant unit for purposes of the “charitable use” requirement. PCMC maintains between 260-268 licensed beds. It admits 10,000 inpatients annually and 100,000 outpatients. The emergency room treats 27,000 visitors every year. In 2002, Provena Hospitals realized a net loss of \$4.8 million on revenues of \$713.9 million. PCMC realized a net profit of \$2.1 million on revenues of \$113.4 million. PCMC waived charges of \$1.7 million for 302 patients under its sliding-scale charity care program. The cost of the services provided under the charity program was \$831,000 (47 percent of the waived charges) which was \$268,000 less than the value of the property tax exemption. The supreme court calculated the cost of the charity care program to be 0.723 percent of PCMC’s revenues.

### Institutions of Public Charity (Charitable Ownership)

In its *Provena* decision, the Illinois Supreme Court utilized the five criteria established in the case of *Methodist Old Peoples Home v. Korzen*, as the distinctive characteristics of a charitable institution:<sup>6</sup>

- (1) it has no capital, capital stock, or shareholders;
- (2) it earns no profits or dividends but rather derives its funds mainly from private and public charity and holds them in trust for the purposes expressed in the charter;

- (3) it dispenses charity to all who need it and apply for it;
- (4) it does not provide gain or profit in a private sense to any person connected with it; and
- (5) it does not appear to place any obstacles in the way of those who need and would avail themselves of the charitable benefits it dispenses.

The supreme court stated that a determination of whether a hospital is a “charitable institution” requires that the entity satisfy certain conditions which must be determined on a case-by-case basis.<sup>7</sup> The court did not address the question of whether all five factors are required to be present in order to satisfy the statutory requirement of ownership by a “charitable institution”. However, it appears as though the court would have accepted something less than all of the five criteria as being sufficient.<sup>8</sup>

The court found that Provena Hospitals was not a “charitable institution” because it satisfied only two of the five criteria. Provena Hospitals did not have shareholders (#1) and was not operated for private inurement (#4).<sup>9</sup> However, since the hospital derived over 95 percent of its revenues from providing medical services for a fee, the court reasoned that it did not “derive its funds mainly from private and public charity” and failed the second criteria.<sup>10</sup> Additionally, the court held that Provena Hospitals failed to establish by clear and convincing evidence that it “dispenses charity to all who need it and apply for it” (#3) or that it did not “place any obstacles in the way of those who need and would avail themselves of the charitable benefits” (#5).<sup>11</sup> The court agreed with the Department of Revenue that Provena Hospitals, the corporate entity and the true owner of the real estate parcels, did not introduce sufficient evidence of its charitable expenditures to establish that it was a charitable institution.<sup>12</sup>

### Actually and Exclusively Used for Charitable or Beneficent Purposes (Charitable Use)

The supreme court described the constitutional and statutory requirement of “used exclusively for . . . charitable purposes” to mean that charitable or beneficent purposes are the primary ones for which the property

is utilized.<sup>13</sup> A “charitable or beneficent purpose” was defined as “a gift . . . for the benefit of an indefinite number of persons . . . by relieving their bodies from disease, suffering or constraint . . . or otherwise lessening the burdens of government.”<sup>14</sup> While the court did acknowledge that PCMC’s operations may have reduced the burdens faced by the federal and state governments in providing health care, PCMC failed to establish any lessening of the burdens of the specific local units of government that stood to gain by the collection of the local property taxes.<sup>15</sup> The court stated that the hospital was, “required to demonstrate that its use of the property helped alleviate the financial burdens faced by the county or at least one of the other entities supported by the county’s taxpayers.”<sup>16</sup> The court further noted that, even if there was proof that PCMC provided the *types* of service that lessened the burdens of local government, PCMC would be required to prove that the “terms of service” also relieved the burdens of local government. The fee-for-service arrangement utilized by PCMC would not meet this additional “terms of service” requirement. The court stated that “services extended . . . for value received . . . do not relieve the [s]tate of its burden.”<sup>17</sup>

The court ruled that PCMC failed to meet its burden of showing that the property was “actually and exclusively used for charitable or beneficent purposes” as required by Section 15-65. The property was primarily devoted to the care and treatment of patients in exchange for compensation through private insurance, Medicare and Medicaid, or direct payment from the patient or the patient’s family.<sup>18</sup> The court determined that the number of uninsured patients receiving free or discounted care and the dollar value of the care they received were *de minimus*.<sup>19</sup>

PCMC contended that the bad debts that it incurred should be considered in measuring the dollar-value of charity care. The court acknowledged that PCMC did treat all patients requesting services without regard to the person’s ability to pay for the services. However, because PCMC subsequently sought payment for these services, the court reasoned that, “[a]s a practical matter, there was little to distinguish the way in which Provena Hospitals dispensed its ‘charity’

from the way in which a for-profit institution would write off bad debt.<sup>20</sup> In light of this ruling, it is now clear that the Illinois courts will not consider hospital bad debts as any form of charity for purposes of exemption under the Illinois Property Tax Code.

PCMC contended that any discounts from “published rates” should be viewed as charity care.<sup>21</sup> The court rejected this argument on the grounds that the “published rates” included a gross profit margin. The court reasoned that discounts of between 25 percent-50 percent off of these “published rates” would still allow the PCMC to cover its costs of services.<sup>22</sup> Further, the court observed that the hospital recouped these discounts through “cross-subsidies” from the higher fees paid by insured patients.<sup>23</sup> The court held that, “[i]t is essential to a gift that it should be without consideration. . . . When patients are treated for a fee, consideration is passed. The treatment therefore would not qualify as a gift. If it were not a gift, it could not be charitable.”<sup>24</sup> In the court’s view, any consideration received was full consideration and, therefore, there was no element of a gift and no charity.

PCMC next contended its treatment of Medicare and Medicaid patients should be characterized as charity care because the payments received for treating such patients do not cover the full costs of care.<sup>25</sup> The court rejected this argument on the grounds that participation in Medicare and Medicaid is optional, that these programs generate a reliable stream of revenue, allow the hospital to generate income from potentially underutilized hospital resources, and produce favorable tax treatment under federal law.<sup>26</sup> Similar to other discounted services, the court observed that gifts are gratuitous and that hospitals do not serve Medicare and Medicaid patients gratuitously.

PCMC argued that “charitable use” should include the broader federal tax code concept of “community benefits.” PCMC asserted that the subsidies it provided for, among other services, ambulance service, a crisis nursery, graduate medical education, behavioral health services, and emergency services training constituted “community benefits” which should be characterized as “charitable use” for purpose of the section 15-65.<sup>27</sup> The court also rejected this argument stating that community benefit is not the test.<sup>28</sup> The court reasoned that private, for-profit companies frequently offer comparable services as a benefit for employees and customers and as a means for generating publicity and

goodwill for the organization.<sup>29</sup>

The court did recognize that the four parcels used by the Crisis Nursery constituted the strongest claim for being used exclusively for charitable purposes.<sup>30</sup> However, since Provena Hospitals failed the initial requirement of being a “charitable institution,” the claim for a property tax exemption must fail even if these four parcels were used exclusively for charitable purposes.

Provena Hospital’s final argument, that it qualified for a religious exemption under 35 ILCS 200/15-40(a)(1), was likewise unsuccessful. The court observed that the property in question must be used exclusively for religious purposes and that advancing religion was not identified as the corporation’s dominant purpose. In this case, the primary purpose for which the property was used was providing medical care to patients for a fee.<sup>31</sup>

In a separate opinion, Justice Burke, writing for herself and Justice Freeman, concurred with the plurality opinion that Provena Hospital failed to establish that it was a charitable institution under section 15-65 or that it qualified for a religious exemption under section 15-40.<sup>32</sup> However, Justice Burke dissented from the plurality opinion with respect to the issue of charitable use. The plurality noted that the “dollar value of the care” provided was “*de minimus*.” The dissent rejected the concept of a “quantum of care requirement and monetary threshold” as conditions for evaluating charitable use.<sup>33</sup> The dissent believed that these were matters best left to the legislative branch. Justice Burke relied upon decisions from the Supreme Courts of Michigan and Vermont in rejecting a “quantum of care” requirement on the grounds that such a standard would be both arbitrary and unworkable.<sup>34</sup> A judicially-mandated “quantum of care” requirement would create, she opined, chaotic uncertainty and infinite confusion and there would be neither certainty nor uniformity in the application of the statute.<sup>35</sup>

Justice Burke also disagreed with the plurality’s conclusion that Provena was “required to demonstrate that its use of the property helped alleviate the financial burdens faced by the county or at least one of the other entities supported by the county’s taxpayers.” The dissent stated that alleviating some burden on government is the reason underlying the tax exemption on properties, not the test for determining eligibility and that Provena did demonstrate that it alleviated some burden on government.<sup>36</sup> Finally, Justice Burke

concluded that the discussion of charitable use in the *Provena* decision did not command a majority of the court and, therefore, is not binding under the doctrine of *stare decisis*.<sup>37</sup>

### Analysis of the *Provena* decision

The Illinois Supreme Court’s *Provena* decision is the latest entry into a long-running debate regarding the appropriate tax treatment of nonprofit hospitals. In 2006, the Joint Committee on Taxation, a nonpartisan committee of Congress, estimated that nonprofit hospitals received tax benefits of \$12.6 billion measured in 2002 dollars.<sup>38</sup> In support of the recent health care reform legislation, the federal government reports that there was \$2.2 billion of uncompensated health care services provided to residents of Illinois.<sup>39</sup> In short, there are literally billions of dollars at stake in terms of both tax relief provided to nonprofit hospitals and the charity care returned to the community by these nonprofit hospitals. The precise measurement of these costs and benefits will undoubtedly become a central aspect of this continuing debate.

While the Illinois Supreme Court enunciated five distinctive characteristics of a “charitable institution,” the application of these five characteristics to an Illinois private, nonprofit hospital boils down to a single question: Did the hospital demonstrate through its charitable expenditures that it provided charity care to all in need who apply for it?<sup>40</sup> If the hospital can prove that it is dispensing charity, then any potential obstacles to exemption would be insignificant as the needy are successfully requesting and receiving charity care.

There are at least four aspects of the *Provena* plurality opinion discussing “charitable use” that are expected to merit further discussion and analysis:

1. The “lessening of the burdens of government” requirement is reduced to a quid pro quo equation – the value of charity care to the local units of government otherwise losing the tax revenues must be equal to or greater than the tax savings realized by the hospital;
2. The characterization of all hospital bad debt as equivalent to ordinary for-profit corporate bad debt and devoid of any charity element;<sup>41</sup>
3. The characterization of all hospital discounted services as equivalent to ordinary discounts in a bargained-for exchange and devoid of any charity element;<sup>42</sup>

4. The rejection of the "community benefits" standard used to measure charity care and the adoption of the more stringent standard of a free medical services requirement.<sup>43</sup>

At a minimum, these four issues will continue to be discussed as the larger question of tax relief for nonprofit hospitals becomes more focused. ■

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1. *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 2010 Ill. LEXIS 289 (Ill. Sup., Mar. 18, 2010).

2. Article IX, section 6, of the 1970 Illinois Constitution (Ill. Const. 1970, art. IX, §6) provides that the General Assembly may exempt from taxation property "used exclusively for . . . charitable purposes." Section 15-65 executes the constitutional grant to exempt property but imposes the additional requirement that the property must be owned by a "charitable institution." The Illinois Supreme Court's reading of the "charitable use" requirement involves both a statutory interpretation of section 15-65 of the Property Tax Code and also section 6 of article IX of the 1970 Illinois Constitution.

3. *Provena Covenant Med. Ctr. v. Dep't of Revenue*, No. 2006-MR-597 (Ill. Cir. Ct. July 20, 2007). On August 8, 2007 the trial court issued its written order and judgment. See 2007 WL 4913149 (Ill. Cir. 2007).

4. *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 384 Ill. App. 3d 734, 894 N.E.2d 452 (4th Dist. 2008).

5. *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 229 Ill. 2d 694, 900 N.E.2d 1126 (2008).

6. *Methodist Old Peoples Home v. Korzen*, 39 Ill. 2d 149, 233 N.E.2d 537 (1968). While the *Provena* court interpreted *Methodist Old Peoples Home*, as establishing a five criteria standard, the Third District Appellate Court read the case as establishing a six-factor test: " (1) it is set up for the benefit of an indeterminate number of persons; (2) it has no capital, capital stock or shareholders and earns no profits or dividends; (3) it derives its funds primarily from public and private charity and holds those funds in trust for the objectives and purposes expressed in the charter; (4) it dispenses charity to all who need and apply for it, does not provide gain or profit in the private sense to any person connected with it, and does not appear to place obstacles of any character in the way of those who need and would avail themselves of the charitable benefits it dispenses; (5) the property is actually and factually used exclusively for the charitable purpose, regardless of any intent expressed in the organization's charter or bylaws; and (6) charity use is the primary purpose for which the property is used and not a secondary or incidental purpose."

*Riverside Medical Center v. Dep't of Revenue*, 342 Ill. App.3d 603, 607, 759 N.E.2d 361,365 (3d Dist. 2003).

7. *Provena*, 2010 Ill. LEXIS 289, at \*30 (Ill. Sup., Mar. 18, 2010).

8. The court recognized that private nonprofit hospitals have qualified as a charitable institution under the Illinois Property Tax Code. See *People ex rel. Cannon v. Southern Illinois Hospital Corp.*, 404 Ill. 66, 69-70, 88 N.E.2d 20, 21-22 (1949), but that there is no blanket exemption for hospitals. See *Coyne Electrical School v. Paschen*, 12 Ill. 2d 387, 394, 146 N.E.2d 73, 77 (1957). These comments would be incongruous with criteria #2 which requires that the hospital "derives its funds mainly from private and public charity." If this criterion were literally applied to every private nonprofit hospital in Illinois, it would create a blanket denial of the exemption as these hospitals derive their funds primarily from the delivery of medical services.

9. *Provena*, 2010 Ill. LEXIS 289, at \*30-31.

10. *Id.* at \*33

11. *Id.* at \*33-34

12. *Id.* at \*34.

13. *Id.* at \*35.

14. *Id.* at \*36 quoting *Methodist Old Peoples Home v. Korzen*, 39 Ill. 2d 149, 233 N.E.2d 537 (1968).

15. *Id.* at \*38-39.

16. *Id.* at \*39.

17. *Id.* at \*39-40 quoting the appellate court in *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 384 Ill. App. 734, 744, 894 N.E.2d 452, 462 (4th Dist. 2008) which, in turn, quoted *Willows v. Munson*, 43 Ill. 2d 203, 208, 251 N.E.2d 249, 252 (1969).

18. *Id.* at \*41.

19. *Id.*

20. *Id.* at \*42.

21. *Id.* at \*45.

22. *Id.*

23. *Id.*

24. *Id.* at \*47.

25. *Id.*

26. *Id.* at \*47-48.

27. *Id.* at \*49-50.

28. *Id.* at \*50.

29. *Id.* at \*53.

30. *Id.* at \*58-59.

31. *Id.* at \*61-62.

32. *Id.* at \*64.

33. *Id.* at \*65.

34. *Wexford Medical Group v. City of Cadillac*, 474 Mich. 192, 713 N.W.2d 734 (2006); *Medical Center Hospital of Vermont, Inc. v. City of Burlington*, 152 Vt. 611, 566 A.2d 1352 (1989).

35. *Id.* at \*70.

36. *Id.* at \*70-71.

37. *Id.* at \*71.

38. The following values of exemptions for nonprofit hospitals and their supporting organizations in 2002: \$2.5 billion in federal income tax, \$1.8 billion in federal bond financing, \$1.8 billion in federal charitable contributions, \$500 million in state corporate income tax, \$2.8 billion in state and local sales taxes, and \$3.1 billion in local property tax. See Congressional Budget Office, *Nonprofit Hospitals and Tax Arbitrage* (Washington, D.C.: Dec. 2006).

39. <<http://www.healthreform.gov/reports/>

statehealthreform/illinois.html>.

40. Virtually every Illinois private nonprofit hospital will satisfy both criteria #1 (no capital stock) and criteria #4 (no private inurement) while failing criteria #2 (charity as the primary source of revenues). This leaves only criteria #3 (dispensing charity) and criteria #5 (no obstacles). These two requirements can be easily collapsed into a single requirement. The *Riverside Medical Center Court* interpreted *Methodist Old Peoples Home* as requiring six-factors but it combined the *Provena* court criteria (#3 and #5) into a single factor (#4).

41. Hospital bad debt typically arises from two sources: insured patients who do not pay their co-pays and uninsured patients. *Challenges Facing the Hospital Revenue Cycle- Bad debt, charity, and collections top the list*, Health Care Collector: The Monthly Newsletter for Health Care Collectors, Vol. 23, No. 9 (Feb. 2010) While the bad debts incurred with respect to the insured patients resembles corporate bad debts, the bad debts incurred from uninsured patients are distinct. Hospitals are required to treat all patients who present and are in need of medical services irrespective of their ability to pay for these services. 210 ILCS 80/1; 210 ILCS 70/1; 42 U.S.C. § 1395dd. There is no comparable requirement for any for-profit business and virtually every for-profit business would only agree to provide trade credit to uninsured patients if they were proven to be credit-worthy. A recent IRS survey of 544 nonprofit hospitals reported that 44 percent of the hospitals include bad debt in the calculation of uncompensated care. *IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report*, p.98, (Feb. 2009) available at <<http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html>>. Clearly, a case can be made for the inclusion of some bad debts in the determination of charity care.

42. Hospital discounted services, also known as shortfalls, arise in a number of ways. For example, a discount offered to a private insurance company clearly resembles the ordinary discounts that might be found in the bargained-for exchange. These discounts hardly resemble any form of charity. However, discounts offered to uninsured patients could be viewed as a below-market exchange which is part charity and part valuable consideration. The middle-ground in the discounted services debate pertains to discounts offered under federal and state programs. PCMC reported a Medicare shortfall of \$7.4 million and a Medicaid shortfall of \$3.1 million. The IRS survey of 544 nonprofit hospitals reported that 51 percent of the hospitals include discounted services in the calculation of uncompensated care. *Supra*, n. 11.

43. The "community benefit" standard was developed by the Internal Revenue Service in 1969 as a more comprehensive measure of the services that nonprofit hospitals provide to a community. J.Colombo, *Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps*, 37 Loy. U. Chi. L.J. 493, 496-497 (2006). Illinois has adopted this standard in its community hospital reporting requirements. 210 ILCS 76/1 *et seq.* While the plurality opinion rejected this more comprehensive approach, it is probable that this will continue to be the measure of hospital benefits under federal law and any legislative amendment in Illinois would address how to define and calculate charity care.

# Upcoming CLE programs

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## July

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