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INTRODUCTION

This appeal concerns a real property tax exemption application filed by the Appellant Dialysis Clinic, Inc. (“DCI”) for the 2004 tax year. DCI claims that its outpatient dialysis clinic situated in West Chester, Ohio (the “West Chester clinic”) is entitled to an exemption from real property taxation pursuant to R.C. 5709.121 or R.C. 5709.12. Strikingly, DCI claims that it is a “charitable institution” under R.C. 5709.121, yet, at the national level, a mere 0.64% of DCI’s total patient treatments included the provision of free or reduced fee care services. Even more alarming, DCI contends that its West Chester clinic property is “used exclusively for charitable purposes” pursuant to R.C. 5709.12, yet at the same time, DCI admits that it did not even treat “any charity patients” at West Chester. DCI pejoratively labels those without health insurance as “problem patients.” Perhaps even more unfortunate, patients at the West Chester clinic that lack health insurance are billed the maximum charge of \$800, while those lucky enough to have health insurance are billed at a deep discount from the maximum charge (i.e., between \$175 and \$475 depending on the rate negotiated by the insurer).

Seeking to do an end run around its own record, the unstated premise in DCI’s argument (as well as that of the amicus curiae Ohio Hospital Association (“OHA”)), is that the delivery of healthcare services by a non-profit entity constitutes a per se charitable endeavor. This is the only manner by which DCI can lay claim to an exemption, because the inescapable reality is that DCI does not bear the traditional hallmarks of what this Court has come to regard as “charity” in the healthcare arena. One of this Court’s most firmly-established principles is that a healthcare provider should effectuate its charitable endeavors by rendering sufficient services to those unable to pay for them. *O’Brien v. Physicians Hosp. Assn.* (1917), 96 Ohio St. 1, 9; *Aultman Hosp. Assn. v. Evatt* (1942), 140 Ohio St. 114, 115; *Cleveland Osteopathic Hosp. v. Zangerle* (1950), 153 Ohio St. 222, 226; *Lincoln Memorial Hosp. v. Warren* (1968), 13 Ohio St.2d 109,

110; *Vick v. Cleveland Memorial Med. Found.* (1965), 2 Ohio St.2d 30, 32; *Bethesda Healthcare, Inc. v. Wilkins*, 2004-Ohio-1749, ¶ 39; *Community Health Professionals, Inc. v. Levin*, 2007-Ohio-2336, ¶ 22.

Healthcare providers have traditionally been regarded as charities because a core component of their work centered on providing free care to the indigent. See *Utah County v. Intermountain Healthcare, Inc.* (Utah 1985), 709 P.2d 265, 270. In the 1800s and early 1900s, most, if not all, healthcare providers truly were almshouses for the poor. See *Clark v. Southview Hosp. & Family Health Ctr.* (1994), 68 Ohio St.3d 435, 442. See also Starr, *The Social Transformation of American Medicine* 149-150, (1982); Tax Commissioner (“TC”) Appx. 426-427. These entities were largely funded by donations and staffed by unpaid doctors who dedicated their efforts to treating the indigent. Hall and Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption* (1991), 66 Wash. L. Rev. 307, 318; TC Appx. 306-307. Thus, it is quite understandable why these entities have been historically characterized as charitable organizations. See Brooks, *Billions Saved in Taxes While Millions Underserved – What Has Happened to Charitable Hospitals?* (2008), 8 Hous. Bus. & Tax L.J. 391, 403; TC Appx. 84.

However, with the advent of broad-based health insurance, especially through the creation of the Medicare and Medicaid programs in 1965, the notion that a non-profit healthcare provider is per se charitable simply no longer holds true. See Crimm, *Evolutionary Forces: Changes in For-Profit and Not-For-Profit Health Care Delivery Structures; a Regeneration of Tax Exemption Standards* (1995), B.C. L. Rev. 1, 12-17; TC Appx. 176-177 Unlike in the 1800s and early 1900s, healthcare providers of today operate on a fee-for-service basis and are reimbursed for the medical services that they provide through the Medicare and Medicaid programs, as well

as through an array of commercial insurers. Burns, *Are Nonprofit Hospitals Really Charitable?: Taking the Question to the State and Local Level* (2004), 29 Iowa J. Corp. L. 665, 669; TC Appx. 111. Without question, this Court has recognized the historical transformation of healthcare delivery methods. To wit, in *Clark*, the Court abolished the doctrine of charitable immunity for hospitals, reasoning that: “[T]he average nonprofit hospital of today is a large well run corporation, and, in many instances, the hospital is so ‘businesslike’ in its monetary requirements for entrance and in its collections of accounts that a shadow is thrown upon the word, ‘charity’ * * * .” 68 Ohio St.3d at 443.

Seemingly ignorant of the foregoing historical narrative, DCI curiously argues that “[w]ithout the work of charities like DCI, the full cost and responsibility of caring for individuals with ESRD would fall entirely upon the government.” DCI Br. 30. This statement is hard to take seriously because DCI readily concedes that the majority of its revenue derives from Medicare payments. In other words, it is the government, not DCI, that is overwhelmingly responsible for providing medical coverage to those that are in need of dialysis treatment. DCI impugns the Board of Tax Appeals (“BTA”) for allegedly failing to comprehend “the modern realities of healthcare,” but it is the very existence of these modern realities that illuminate the weakness of DCI’s argument. In stark contrast to the healthcare providers from the 1800s and early 1900s, the record confirms that DCI dispenses virtually no free or reduced fee care to its patients.

This Court’s existing healthcare jurisprudence in the tax exemption arena is moored to the historical literature described above—that is, the caselaw recognizes that to be “charitable,” a healthcare provider should provide free or reduced fee care services to the needy. Under the “totality of the circumstances” analysis that applies to claims brought under R.C. 5709.121 and

R.C. 5709.12, one of the core inquiries is whether a healthcare provider furnishes sufficient services to those members of our society that lack the financial means to pay for such services. Indeed, almost one-hundred years ago, the Court recognized that the “[f]irst concern of a public charitable hospital must be for those who are unable to pay.” *O’Brien*, 96 Ohio St. at 9.

The Court’s adherence to the principle announced in *O’Brien* has been unrelenting. In *Aultman Hosp. Assn.*, 140 Ohio St. at 115, the Court granted an exemption under a prior iteration of R.C. 5709.12 to a hospital that rendered free care services to one-sixth of its patient population. Following in the footsteps of *O’Brien* and *Aultman Hosp. Assn.*, the Court later declared in 1950 that one of the primary objectives of a healthcare provider that seeks to establish itself as a “charitable institution” should be focused on the “care of the poor, needy and distressed who are unable to pay * * * .” *Cleveland Osteopathic Hosp.*, 153 Ohio St. at 226. See also *Lincoln Memorial Hosp.*, 13 Ohio St.2d at 110 (exemption denied under R.C. 5709.12 where non-paying patients were decidedly in the minority); *Vick*, 2 Ohio St.2d at 32 (property exempt under R.C. 5709.12 where 6% to 7% of patients were non-paying and charity work was performed). In contemporary times, this Court has remained steadfast in its devotion to the principle that a healthcare provider should effectuate its charitable endeavors by “render[ing] sufficient services to persons who are unable to afford them * * * .” See *Community Health Professionals*, 2007-Ohio-2336, ¶ 22; *Bethesda Healthcare*, 2004-Ohio-1749, ¶ 39.

Mindful of this Court’s clear guidance, the BTA concluded that the “totality of the circumstances” foreclosed DCI from receiving an exemption under either R.C. 5709.121 or R.C. 5709.12. The BTA openly acknowledged that this Court has never declared an “absolute percentage” in terms of the amount of free or reduced fee care that a health care provider must furnish to those who are unable to pay. Nonetheless, the BTA found that DCI’s failure to

provide any meaningful amount of free or reduced fee care at both the national level (0.64% of total patient treatments) and at the West Chester clinic (0.00%) weighed heavily against DCI's claim of exemption.

Implicitly conceding that it failed to provide virtually any free or reduced fee care services to its patients, DCI assails the BTA for relying on the foregoing percentages (i.e., 0.64% and 0.00%) as a component in denying DCI's exemption claim. Yet, at its essence, DCI's argument is really an indictment of this Court's firmly-entrenched healthcare jurisprudence. If the BTA truly erred by inquiring into whether DCI rendered sufficient services to those that lack the financial means to pay for such services, what are we to make of the precedential value of *O'Brien*, *Aultman Hosp.*, *Cleveland Osteopathic Hosp.*, *Vick*, *Lincoln Memorial Hosp.*, *Bethesda Healthcare*, and *Community Health Professionals*? Under DCI's strained reading of the caselaw, *O'Brien* and its progeny would be rendered a dead letter. DCI's contention that the BTA departed from established precedent by focusing on DCI's failure to provide any meaningful levels of free or reduced fee care services ignores the foregoing uniform body of decisions.

DCI then compounds its error by further ignoring the BTA's additional findings and analysis. The BTA set forth multiple paragraphs of analysis that faulted DCI for items wholly unrelated to the dispensation of free or reduced fee care. To wit, the BTA faulted DCI for its inability to document any of its supposed research efforts. And even if it had, the BTA noted that any purported research was vicarious in nature. See *Hubbard Press v. Tracy* (1993), 67 Ohio St.3d 564, 566. Additionally, the BTA criticized DCI's indigence policy for subjecting economically distressed patients to a litany of collection efforts including, but not limited to, referral to collection agencies and court action. The plain language of the indigence policy states that it "is not a charity or gift to patients. DCI retains all rights to refuse to admit and treat a

patient who has no ability to pay.” Perhaps most telling, aside from DCI’s non-profit status, the BTA was unable to discern any meaningful distinction between DCI and its for-profit competitors. Just like a for-profit corporation, DCI: billed its patients for services rendered; voluntarily contracted with governmental and private insurers for reimbursements; and wrote-off its uncollected charges as “bad debt.”

Tacitly acknowledging that its claim of exemption rises and falls on the application of R.C. 5709.121, DCI devotes the majority of its brief to discussing how it functions as a “charitable institution.” Yet, this assertion is shorn of any probing analysis of the evidentiary record adduced below. Apparently, under DCI’s view, the polestar in determining whether an entity qualifies under R.C. 5709.121 as a “charitable institution” is whether the entity has met the “stringent” requirements under 26 U.S.C. § 501(c)(3).¹ As we explain later, the notion that § 501(c)(3) contains “stringent” requirements borders on the risible.² Moreover, an entity’s non-profit status has little bearing on whether the entity is exempt under Ohio real property tax law. See e.g. *NBC-USA Housing, Inc.-Five v. Levin*, Slip Opinion No. 2010-Ohio-1553 (exemption denied to § 501(c)(3) entity); *Northeast Ohio Psychiatric Inst. v. Levin*, 2009-Ohio-583 (same). DCI also lauds its corporate charter. Yet, more is required to receive a tax exemption under R.C. 5709.121 than a bare recitation of a noble purpose in a corporate charter. See *Northeast Ohio Psychiatric Inst.*, 2009-Ohio-583, ¶ 14 (observing “that the status of an institution as ‘charitable’

¹ See DCI Br. 1: “Curiously, while acknowledging that ‘DCI is [501(c)(3)] not-for-profit corporation that may operate the subject property without a view to profit,’ the BTA nevertheless found that DCI is not a charitable institution.”

² See Dorn, Reich, and Sutton, *Anything Goes: Approval of Nonprofit Status by the IRS* 4 (2009), Stanford University Center on Philanthropy and Civil Society (“[o]btaining recognition by the IRS as a public charity is an embarrassingly easy thing to do. It is hardly an exaggeration to say that when it comes to oversight of the application process to become a public charity, nearly anything goes.”); TC Appx. 271.

under R.C. 5709.121 depends upon the ‘charitable activities of the taxpayer seeking the exemption’ * * * .”).

DCI’s arguments with respect to R.C. 5709.12 are similarly unavailing. DCI repeats in mantra form that the West Chester clinic accepts all patients regardless of their ability to pay. Yet, the obligation to accept all patients without regards to their ability to pay is a requirement imposed by Medicaid’s reimbursement scheme, of which DCI is a willing participant. See Ohio Adm. Code 5101:3-1-17.2(A). Moreover, DCI’s own indigence policy states that it “retains all rights to refuse to admit and treat a patient who has no ability to pay.” As for DCI’s alleged donations to research, the record confirms that the West Chester clinic did not donate a single dollar to research nor did it perform any research on the property. DCI also laments that its West Chester clinic loses money on its operations because its patients cannot pay the full cost of treatment. However, this assertion is patently false. In fact, DCI’s very own witness, Roy Dansro, administrator of the subject property, testified that the West Chester clinic loses money due to lack of patient volume, not because it treats an appreciable level of indigent patients. The record is equally clear DCI profits from its clinics that experience a high patient volume.

DCI’s reliance on authority from out-of-state jurisdictions is equally unhelpful in this matter. Unlike *O’Brien* and its progeny, the foreign authority cited by DCI simply fails to incorporate this Court’s firmly-settled view that a healthcare provider should effectuate its charitable endeavors by rendering sufficient services to those that lack the financial means to pay for such services. As explained in further detail below, one of the many compelling sources of foreign authority that this Court can draw guidance from is the Illinois Supreme Court’s recent decision in *Provena Covenant Medical Ctr. v. Dept. of Revenue* (Ill. Mar. 18, 2010), No. 107328, 2010 Ill. LEXIS 289.

In sum, this Court's existing healthcare jurisprudence forecloses DCI from receiving an exemption under either R.C. 5709.121 or R.C. 5709.12. If at all, the only manner by which DCI can claim entitlement to an exemption is if this Court endorses the unprecedented notion that the delivery of healthcare services by a non-profit entity constitutes a per se charitable endeavor. The Tax Commissioner urges this Court to reject DCI's argument as it would radically expand the parameters of real property tax exemption law in this state and, consequently, render *O'Brien* and its progeny a dead letter. Equally troubling, if DCI's views were to prevail in this matter, the state's school districts and local government recipients (i.e., the ADAMH Board per Chapter 340 of the Ohio Revised Code) would be deprived of the vital property tax revenues that they depend on to fund their crucial services.

STATEMENT OF THE CASE AND FACTS

A. DCI's national operations.

DCI is a Tennessee-based entity that provides dialysis services to individuals with end stage renal disease ("ESRD"). Supplement ("Supp.") 45. Dialysis is a "process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane." Ohio Adm. Code 5101:3-13-01.9(A)(6). ESRD denotes a condition that "occurs from the destruction of normal kidney tissues over a long period of time. The loss of kidney function in ESRD is usually irreversible and permanent." Ohio Adm. Code 5101:3-13-01.9(A)(8).

DCI is exempt from federal income tax pursuant to § 501(c)(3) of the Internal Revenue Code. Supp. 41-42. Nationally, DCI operates approximately 195 outpatient dialysis clinics throughout 26 states. Supp. 45. Data presented by DCI for the period of October 2006 through September 2007 indicates that it performed 1,836,058 dialysis treatments during the period. Supp. 255. Of this number, the patient mix breaks down as 72.8% Medicare, 6.4% Medicaid,

5.2% “M/M HMO”, 1.4% “Veteran administration”, 14.2% “Other Plans” and 0.64% persons with no insurance (identified as “indigent”). Ex. C; Supp. 255.³

For the 2003 return year, DCI’s federal tax return, Form 990⁴, stated that it generated a net income of \$6,306,492 on total revenues of \$479,127,641, with roughly 1.18% of the total revenue allocated for research. Supp. 59, 73. For the 2004 return year, DCI’s Form 990 stated that it generated a net income of \$32,167,517 on total revenues of \$514,053,981, with roughly 0.97% of the total revenue allocated for research. Supp. 86, 99. Other than a bare line-item for “research” attached to the 2003 and 2004 federal Form 990s, no documentation was presented to identify the entity(s) that received the research funds. BTA Decision and Order (“BTA Decision”) fns. 1 and 8; DCI Appx. 5, 13. Likewise, no documentation was presented to explain how the research funds were used. BTA Decision fns. 1 and 8; DCI Appx. 5, 13.

In an October 5, 2006 letter to the Tax Commissioner’s office, DCI stated that it operated a summer camp in June of 2006 for 97 children with end stage renal disease. Supp. 45. No further documentation was presented regarding the nature of this camp, where it was held, or whether payment was required for attendance. Additionally, no documentation was presented to explain whether the camp was held in any other year(s) besides 2006.

B. DCI’s operations at the West Chester clinic and in the greater Cincinnati area.

DCI operates five dialysis clinics in the greater Cincinnati area: (1) Forest Park; (2) Maysville; (3) Walnut Hills; (4) West Chester; and (5) Western Hills. Supp. 184-185; Hearing Transcript (“Tr.”) 146-152. The West Chester clinic, the property that is the subject of

³ Exhibit C represents the sum-total in the record of this national data as no witness presented by DCI had any personal knowledge of the contents. See Supp. 171; Hearing Transcript (“Tr.”) 97.

⁴ “A Form 990 is an annual reporting return that certain federally tax-exempt organizations must file with the IRS. It provides information on the filing organization’s mission, program, and finances.” *State ex rel. Petro v. Gold*, 166 Ohio App.3d 371, 2006-Ohio-943, fn. 3.

this appeal, is situated on the far northern rim of Cincinnati near Interstate 75. Supp. 113. Roy Dansro, administrator of DCI's five Cincinnati area dialysis clinics, described the demographics of West Chester as "middle class to higher than middle class." Supp. 185; Tr. 153. The West Chester clinic opened in October of 2003 and is equipped with 14 dialysis stations. Supp. 45, 184; Tr. 146-147. Treatment at the West Chester clinic is done strictly through hospital referrals. Supp. 182, 200; Tr. 139, 213. The West Chester clinic does not advertise the availability of its services to citizens in the greater Cincinnati area that may be in need of dialysis treatment. Supp. 182; Tr. 140. The West Chester clinic failed to demonstrate that it performed any research on the premises, nor did it demonstrate that it contributed any money for research purposes. From its inception to the current period, the number of patients at West Chester has been roughly as follows: ten patients in 2004; somewhere in the "mid 20s" for 2005; somewhere in the "30s" for 2006; somewhere in the "40 * * * to upper 40s" for 2007; and 38 for 2008. Supp. 202; Tr. 220-221.

Mr. Dansro testified that the West Chester clinic has averaged a loss of roughly \$250,000 per year since it began operating. Supp. 183; Tr. 143-144. The loss of revenue is not driven by any free or reduced fee care that is conferred upon the patients receiving treatment at the West Chester clinic. As explained by Mr. Dansro, the loss in revenue is caused by the relatively small number of patients that get treated at the West Chester clinic. Supp. 186, 198-199; Tr. 154, 205-207. The lack of patient volume at the West Chester clinic is driven by the patients' ability to end dialysis treatment via a kidney transplant. Supp. 186, 198-199; Tr. 154, 205-208. A critical aspect of a successful kidney transplant operation involves adhering to the necessary treatment regimens. Supp. 199; Tr. 207. Mr. Dansro testified that patients at the West Chester clinic are well-suited to undergo a kidney transplant operation because they are generally better-educated,

which enables them to understand the necessary treatment regimens involved in successfully completing the operation. Supp. 199; Tr. 207.

Unlike the West Chester clinic, there are other DCI clinics in the greater Cincinnati area that have generated net income. The Maysville clinic, situated in a “rural area,” once generated a profit when it served “about 70” patients. Supp. 182, 184-185; Tr. 140-141, 148-150. However, according to Mr. Dansro, the recent establishment of a dialysis clinic owned and operated by DaVita, Inc., one of DCI’s for-profit competitors in the area, eroded the patient population and caused it to operate at a loss. Supp. 184-185; Tr. 149-150. The Western Hills clinic, located in a “pretty dense” and “middle class” area, has also generated net income. Supp. 185; Tr. 150-152. For the last two years, it has averaged a profit of \$90,000 to \$150,000. Supp. 185; Tr. 150-152. Its patient population has held steady “in the neighborhood of 64” throughout the years. Supp. 185; Tr. 150-152. The third DCI clinic to have operated at a profit is the Walnut Hills clinic. Supp. 185; Tr. 152-153. The Walnut Hills area is “kind of a mix between poor and middle class.” Supp. 185; Tr. 152-153. At 140 patients, it is the largest of DCI’s Cincinnati area clinics. Supp. 185; Tr. 152-153. It has averaged a profit of “about \$200,000 a year.” Supp. 185; Tr. 152-153.

C. The West Chester clinic does not provide any free or reduced fee care at the property. The West Chester clinic provides dialysis treatment to its patients on a fee-for-service basis and is reimbursed for providing such treatment through Medicare, Medicaid, and private insurers.

1. Medicare reimburses the West Chester clinic for the dialysis treatments that it provides to its patients on a fee-for-service basis.

The West Chester clinic provides no free or reduced fee care at its facility. Supp. 46. All of its patients have some form of health insurance coverage. Supp. 190; Tr. 172. The majority of the West Chester clinic’s revenue derives from reimbursements provided through the

Medicare program. Supp. 188; Tr. 165.⁵ Participation in the Medicare system is a completely voluntary decision on the part of the healthcare provider and payments made under Medicare are disbursed according to a fixed rate. Supp. 193-194, 264; Tr. 182, 186, 266.

At the national level, 75% of DCI's patients are covered by Medicare. Supp. 157; Tr. 41. At the West Chester clinic, approximately "55 to 70 percent" of the patients are covered by Medicare. Supp. 188; Tr. 164. Mr. Dansro testified that for a Medicare patient at the West Chester clinic, the full amount that is charged to the patient is \$160. Supp. 193; Tr. 182-183. Under the Medicare reimbursement scheme, 80% of the bill will be picked up by Medicare. Supp. 193; Tr. 182-183. The remaining 20% becomes the patient's liability. Supp. 93; Tr. 183. For those Medicare patients that meet Medicaid eligibility requirements (about 70% of the Medicare patients at the West Chester clinic), Medicaid picks up that remaining 20%. Supp. 189, 260; Tr. 166-167, 250. ESRD patients that qualify for both Medicare and Medicaid benefits are commonly referred to as being "dual-eligible." Ohio Adm. Code 5101:3-13-01.9(A)(7); Supp. 264; Tr. 264-265. In addition, the Centers for Medicare and Medicaid Services of the Department of Health and Human Services are also charged with reimbursing the unpaid patient portion of the bill, allowable as a Medicare bad debt, up to an amount equaling the facilities' costs in providing the service. 42 C.F.R. § 413.178.-2. Medicaid reimburses the West Chester clinic for the dialysis treatments that it provides to its patients on a fee-for-service basis.

⁵ "Medicare is a federally funded health insurance program for the elderly and disabled." *Thomas Jefferson Univ. v. Shalala* (1994), 512 U.S. 504, 506 (interpreting 42 U.S.C. § 1395 et seq.). In 1972, Congress extended Medicare coverage to individuals with ESRD. See *Kidney Ctr. of Hollywood v. Shalala* (D.C. Cir. 1998), 133 F.3d 78, 81. The enabling legislation for administration of the Medicare program with respect to individuals with ESRD is codified at 42 U.S.C. § 1395rr. For a further explanation of how the Medicare program operates with respect to the treatment of individuals with ESRD, please see *Dialysis Clinic, Inc. v. Leavitt* (D. D.C. 2007), 518 F. Supp.2d 197.

As mentioned above, Medicaid reimbursements provide another source of revenue at the West Chester clinic.⁶ Participation in the Medicaid system is voluntary and payments are disbursed according to a fixed rate as determined by the applicable fee schedule. Supp. 264; Tr. 263-266. About 10% of the patients at the West Chester clinic are solely Medicaid beneficiaries. Supp. 188; Tr. 165. A patient that is covered solely by Medicaid is charged \$155. Supp. 193; Tr. 183. In contrast to the Medicare scheme, patients that are solely covered by Medicaid do not become liable for 20% of the bill. Supp. 193; Tr. 184. The Medicaid payment is treated as payment-in-full and the West Chester clinic is prohibited from seeking payment from any other source. Supp. 193, 264; Tr. 184, 266.

3. Private insurers reimburse the West Chester clinic for the dialysis treatment that it provides to its patients on a fee-for-service basis.

Aside from patients that are covered either by Medicare and/or Medicaid, the remainder of the West Chester clinic's patients rely on private insurance carriers to cover their treatment costs. Supp. 190; Tr. 172. Some of the larger insurers that have contracted with the West Chester clinic to provide healthcare coverage include: BlueCross BlueShield; Anthem; Humana; and UnitedHealthCare. Supp. 193; Tr. 184-185. For patients that are covered solely by private insurance carriers, the amount of a patient's bill can fluctuate from \$175 to \$475 depending on the insurance carrier. Supp. 193; Tr. 185. The bill fluctuates because each insurance carrier negotiates its own rate with DCI. Supp. 193; Tr. 185.

⁶ "Medicaid is a federal-state program to assist the poor, elderly, and disabled in obtaining medical care." *Long Term Care Pharm. Alliance v. Ferguson* (1st Cir. 2004), 362 F.3d 50, 51. The enabling legislation for administration of the Medicaid program in Ohio is set forth at Chapter 5111 of the Ohio Revised Code. For further information on administration of the Medicaid program with respect to those with ESRD, see Ohio Adm. Code 5101:3-13-01.9

4. Patients without insurance are labeled as “problem patients” and are billed the “commercial rate charge” of \$800.

If a person were to walk into the doors of the West Chester clinic without any governmental (i.e., Medicare and/or Medicaid) or private insurance coverage, they would be charged the maximum rate of \$800. Supp. 193-194; Tr. 185-187. The maximum charge of \$800 is referred to as the “commercial rate charge.” Supp. 194; Tr. 186. Mr. Dansro described this billing process as follows:

Q.: I believe you mentioned a charge of \$800 before?

A.: That’s the commercial rate charge.

Q.: What do you mean by “commercial rate charge”?

A.: I guess if you or I came in for dialysis treatment and we didn’t have insurance capable of paying for the services, you would be charged \$800 for that.

Supp. 193-194; Tr. 185-186. Mr. Dansro labeled patients that lack health insurance as “problem patients.” Supp. 191; Tr. 174-175.

D. The plain language of DCI’s indigence policy states that it “is not a charity or gift to patients. DCI retains all rights to refuse to admit and treat a patient who has no ability to pay.”

According to the testimony of DCI’s in-house counsel, William Lee Horn, DCI created an “indigence policy”⁷ in order to “satisfy regulatory requirements” associated with the Medicare program. Supp. 157; Tr. 39-40. The indigence policy states in relevant part that:

To establish a uniform and equitable system to determine if a DCI patient is indigent such that DCI may deem certain charges for DCI’s services provided to an indigent patient as an uncollectible bad debt. If DCI determines that a patient’s indigence as established by this policy renders certain charges to that patient as uncollectible bad debt, then DCI may “write-off” certain categories of charges to the patient as opposed to subjecting an indigent patient to the reasonable collection efforts.

⁷ Another term commonly used in place of “indigence policy” is “free care policy.” Supp. 167; Tr. 79.

* * *

All patients are personally responsible to pay for the treatment and services that DCI provides to them. DCI will make reasonable collection efforts against patients who do not pay. **DCI's reasonable collection efforts may include, but not be limited to, DCI billing the patient, sending collection letters, making telephone calls to the patient, discussing the patient's obligation and account with him or her, referring delinquent patient accounts to a collection agency, and/or taking court action.** (Emphasis added.)

* * *

DCI's indigence policy is not a charity or gift to patients. DCI retains all rights to refuse to admit and treat a patient who has no ability to pay. (Emphasis added.)

* * *

DCI's indigence policy is not intended to replace a patient's primary, secondary or supplemental insurance coverage. DCI will not allow a patient to participate in its indigence policy until DCI has ruled-out all other payment sources and the patient has exhausted all other reasonable means to obtain and maintain coverage for his or her total cost of care.

Supp. 209-211. To qualify under DCI's indigence policy, the patient must complete a financial analysis form ("FAF"). Supp. 167-168; Tr. 81-83. The FAF is a multi-page questionnaire that poses several questions to the patient regarding: living arrangements; family size; liquid assets; liabilities; gross annual income; types of income; and monthly household expenses. Supp. 218-223.

No testimony or documentation was provided to explain whether DCI posted its indigence policy in a conspicuous place located on the premises of the West Chester clinic for its patients to see. Likewise, no testimony or documentation was provided to explain whether, as a matter of course, DCI affirmatively advised its patient of the existence of its indigence policy. The triggering event for obtaining a copy of the indigence policy and FAF presumably occurs when the patient indicates that he or she lacks health insurance to pay for dialysis treatment. Supp. 168; Tr. 82.

Even if a patient lacks insurance to pay for dialysis treatment, DCI will bill them for the services rendered as a matter of course. Supp. 165, 167; Tr. 71, 78-79. The BTA found that if a “patient qualifies under the indigence policy and is unable to pay for treatment, * * * the patient will be billed for the outstanding amount and then, ‘after a certain amount of time,’ DCI’s accounts-receivable billing department will write-off the charge as an uncollectible bad-debt expense from the accounts-receivable ledger.” BTA Decision 6; DCI Appx. 9.

Based on DCI’s own admissions (Supp. 46), the BTA found that DCI did not treat any indigent patients at the West Chester clinic: “As DCI concedes, it provides no free or charitable service at the subject property.” BTA Decision 12; DCI Appx. 15. At the national level, the BTA found that DCI rendered 1,836,058 treatments during 2006 and 2007. BTA Decision 7; DCI Appx. 10; Supp. 255-256. Of those treatments, 0.64% (or 11,840) were deemed indigent and, thus, received free or reduced fee care services. BTA Decision 16; DCI Appx. 19; Supp. 255-256.

E. DCI writes-off a portion of the unpaid patients’ bills as “bad debt.”

While DCI’s indigence policy is used to determine whether a patient can afford the costs of dialysis treatment, DCI’s “bad debt policy” is used to “provide guidance on when to and how to remove a patient responsible balance(s) from the Accounts Receivable subsidiary ledger once determined as a bad debt.” Supp. 272. According to Mr. Horn, the bad debt policy operates as such: “[O]nce the patient has received services and been billed for services, if they are unable to pay, then after a certain amount of time, we would write-off the amount they are unable to pay, that we have been unable to collect from whatever source might be available.” Supp. 176; Tr. 78. Bad debt is calculated by measuring the amount that is “charged” to the patient, as opposed

to measuring the “cost” of providing treatment. Supp. 194; Tr. 189. The authority for writing off a Medicare bad debt is set forth in 42 C.F.R. § 413.178, 413.89.⁸

The BTA found that DCI presented no information regarding its Medicare bad debt write-offs for the relevant application year (i.e. 2004). BTA Decision 15; DCI Appx. 18. However, based upon a review of documentation pertaining to the 2006 and 2007 tax years, the BTA found that of the \$526,891,082 that DCI generated in charges on a system-wide basis, 1.27% (or \$6.7 million) was written off as Medicare bad debt. BTA Decision 15-16; DCI Appx. 18-19; Supp. 255.

F. The West Chester clinic does not conduct research on the property nor does it contribute money for research purposes.

Mr. Horn testified that DCI allocates its net income in two ways: (1) 50% is set aside to research ESRD and (2) 50% is set aside to replace equipment, develop new clinics, and cover losses of underperforming clinics. Supp. 160; Tr. 50. In the Cincinnati area, the net income that is set aside by DCI for research purposes goes solely to the University of Cincinnati (“UC”). Supp. 201; Tr. 215. The West Chester clinic has never contributed money to UC for research purposes because it has consistently operated at a loss of roughly \$250,000 per year. Supp. 183; Tr. 143-144. In addition, no research occurs at the West Chester clinic. Supp. 180; Tr. 132.

As explained by Mr. Dansro, the West Chester clinic and UC have a “very close tie in” with one another. Supp. 182-183; Tr. 141-142. In fact, it was UC, not DCI, that decided to locate a clinic in the West Chester area:

Q.: In your role as administrator, do you have any idea as to how the decision to build the West Chester facility was made?

A.: Yes. The division chair of nephrology [from UC] contacted Dr. Johnson, who is the President—the founding father of DCI, and asked if DCI would build a clinic in

⁸ See also 26 U.S.C. § 166 for the general bad debt write off provision of the Internal Revenue Code.

the West Chester area because that was an area that UC was going to be more involved in.

Supp. 183; Tr. 142. All of the medical doctors at DCI's Cincinnati area clinics are nephrologists from UC. Supp. 182-183; Tr. 141-142. DCI pays a monthly fee to UC for the medical directorships. Supp. 183; Tr. 142. Mr. Dansro was uncertain as to whether the medical directors' employment contracts with UC prohibited them from receiving any of the funds that DCI gave to UC for research purposes. Supp. 200; Tr. 211.

G. DaVita, Inc., a for-profit competitor of DCI, also provides dialysis treatments in the greater Cincinnati area.

DCI is not the only provider of dialysis treatments in the greater Cincinnati area. Supp. 200; Tr. 212⁹. For example, a for-profit entity known as DaVita also attends to the needs of those with ESRD. Supp. 200; Tr. 212. DCI considers DaVita as one of its competitors. Supp. 200; Tr. 212. Mr. Dansro testified that DCI has experienced a diminution in its patient volume as a result of DaVita's presence in the region. Supp. 186; 157. When the BTA's attorney examiner asked Mr. Dansro to explain the differences between DaVita and DCI, Mr. Dansro responded as follows:

Q.: What is the difference between what services you provide and what services, as far as you know, are provided by this other clinic, DaVita?

A.: Well, it's – it's the same. It's the same. The only difference is the money that they make is going to be shared by the shareholders and other projects that might make them money, whereas DCI will put their money towards furtherance of trying to figure out how we can combat kidney diseases and come up with ways to prevent it, because it gets worse and worse every year, the number of people on dialysis.

⁹ Official licensure information provided online at the website of the Ohio Department of Health, and therefore information that this Court may judicially notice (see *Malone v. Berry*, 174 Ohio App.3d 122, 2007-Ohio-6501, ¶ 13 (taking judicial notice of the contents of a website)), shows that there are thirty-one dialysis clinics in Hamilton County and another nine in Butler County. Website available at http://publicapps.odh.ohio.gov/eid/Search_Results.aspx

ARGUMENT

The Tax Commissioner’s First Proposition of Law: Neither the General Assembly nor this Court has ever declared that the delivery of health care services by a non-profit entity constitutes a per se charitable endeavor under R.C. 5709.121 or R.C. 5709.12.

A. Tax exemption statutes are strictly construed against the party claiming exemption.

Pursuant to Article XII, Section 2 of the Ohio Constitution, all real property in this state is subject to uniform taxation. The principle of uniformity may be disregarded only to the extent that the General Assembly provides an express exemption from taxation. The General Assembly’s power to exempt real property from taxation emanates from the same constitutional provision. See *Bethesda Healthcare*, 2004-Ohio-1749, ¶ 20. Section 2 provides in relevant part that: “Without limiting the general power, subject to the provisions of Article I of this constitution, to determine the subjects and methods of taxation or exemptions therefrom, general laws may be passed to exempt * * * institutions used exclusively for charitable purposes * * * .”

In recognition of the principle of uniformity, this Court has long held that statutes granting a real property exemption from taxation are to be strictly construed because they “are in derogation of equal rights.” *Cincinnati College v. State* (1850), 19 OHIO 110, 115. For over 150 years, the principle of strict construction has continued unabated. See e.g. *First Baptist Church of Milford v. Wilkins*, 2006-Ohio-4966, ¶ 10; *Welfare Fedn. of Cleveland v. Glander* (1945), 146 Ohio St. 146, 177. “A right to exemption from taxation must appear with reasonable certainty in the language of the Constitution or valid statute and must not depend upon a doubtful construction of such language.” *Hosp. Service Assn. of Toledo v. Evatt* (1944), 144 Ohio St. 179, 182. “In all doubtful cases exemption is denied.” *A. Schulman, Inc. v. Levin*, 2007-Ohio-5585,

¹⁰ As noted in the brief of the amicus curiae Ohio School Boards Assn. et al. (“OSBA”), DaVita also engages in charitable programs and research, as well providing assistance to patients without insurance. OSBA Br. 23.

¶7. As this Court explained in *Philada Home Fund v. Bd. of Tax Appeals* (1966), 5 Ohio St.2d 135, 139, the rationale for a tax exemption is the “present benefit to the general public sufficient to justify the loss of tax revenue.”

B. The Ohio Revised Code does not explicitly exempt real property from taxation merely because it is used by a non-profit entity to render healthcare services.

Chapter 5709 of the Ohio Revised Code provides the statutory basis for exempting real property in this state. Importantly, the introductory sentence to this Chapter recognizes that “All real property in this state is subject to taxation, except only such as is expressly exempted therefrom.” R.C. 5709.01(A). The General Assembly has codified a litany of exemptions in Chapter 5709. For example, the following types of real property are exempt from taxation: schools, churches, and colleges (R.C. 5709.07); government and public property (R.C. 5709.08); certain publicly owned athletic facilities (R.C. 5709.081); county arenas and convention centers (R.C. 5709.083); nature preserves (R.C. 5709.09); municipal utility works (R.C. 5709.11); rural water systems (R.C. 5709.111); oil and gas recovery equipment (R.C. 5709.112); property used for charitable or public purposes (R.C. 5709.12); property belonging to a charitable institution that is used in furtherance of its charitable purpose (R.C. 5709.121); property used for children’s homes (R.C. 5709.13); graveyards (R.C. 5709.14); veterans monuments and funds (R.C. 5709.15); monuments and memorials (R.C. 5709.16); prehistoric buildings or historic buildings (R.C. 5709.18); and pollution control facilities (R.C. 5709.25).

Despite the apparent depth and breadth of the exemptions provided for in Chapter 5709, with the sole exception of nursing homes falling under the definition of “homes for the aged” in R.C. 5701.13 and exempted under R.C. 5709.12, the General Assembly has never been persuaded into enacting an explicit exemption for real property owned by non-profit healthcare providers.

C. Historically, healthcare providers were almshouses for the poor. However, this no longer holds true in light of contemporary healthcare delivery models. Today's non-profit healthcare providers, such as DCI, are businesslike in their operations.

If at all, the property of non-profit healthcare providers may be exempt pursuant to the provisions of R.C. 5709.121 as property used in furtherance of or incidental to the charitable purposes of a “charitable institution.” Property may also be exempt pursuant to R.C. 5709.12(B) as property “used exclusively for charitable purposes.” Historically, healthcare providers unquestionably embraced the hallmarks of what this Court has come to regard as “charity.”¹¹ However, with the advent of Medicare, Medicaid, third-party payers, and employer-based health insurance, this no longer holds true. We briefly review the historical literature for the benefit of the Court.

The scholarly commentary is in universal agreement that healthcare providers in the 1800s and early 1900s were almost exclusively almshouses for the poor. See e.g. Crimm, 37 B.C. L. Rev. at 12-17; TC Appx. 176-177; Hall and Colombo, 66 Wash. L. Rev. at 318; TC Appx. 306; Starr, *The Social Transformation of American Medicine* 149-150, (1982); TC Appx. 426-427. These providers “performed a ‘welfare’ function rather than a medical or curing function: the poor were housed in large wards, largely cared for themselves, and often were not expected to recover.” *Utah County*, 709 P.2d at fn. 7 (citing Starr). During that time, the providers’ revenue derived almost exclusively from voluntary donations, rather than government or third party reimbursements. See Starr at 150, (1982); TC Appx. 427; Hall and Colombo, 66 Wash. L. Rev. at 318; TC Appx. 306. Moreover, the physicians at these facilities often worked without

¹¹ See *Planned Parenthood Assn. v. Tax Commr.* (1966), 5 Ohio St.2d 117, paragraph 1 of the syllabus: “In the absence of a legislative definition, ‘charity,’ in the legal sense, is the attempt in good faith, spiritually, physically, intellectually, socially and economically to advance and benefit mankind in general, or those in need of advancement and benefit in particular, without regard to their ability to supply that need from other sources, and without hope or expectation, if not with positive abnegation, of gain or profit by the donor or by the instrumentality of the charity.”

compensation. See Hall and Colombo, 66 Wash. L. Rev. at 318; TC Appx. 306. Thus, it is quite understandable why these entities have historically been characterized as charitable organizations. See Brooks, 8 Hous. Bus. & Tax L.J. at 403; TC Appx. 84. Unlike the poor, the affluent in that period received medical treatment in their homes directly from private physicians. See Newell, *Healthcare Joint Ventures: Pushing Tax-Exempt Law to the Limits?* (2002), 18 J. Contemp. Health L. & Pol’y. 467, 470; TC Appx. 404; Starr at 150; TC Appx. 427.

From the early 1900s onward, the character of healthcare providers began to change: “From refuges mainly for the homeless poor and insane, they evolved into doctors’ workshops for all types and classes of patients. From charities, dependent on voluntary gifts, they developed into market institutions, financed increasingly out of payments from patients.” Starr at 146; TC Appx. 423. This transformation was sparked by the professionalization of nursing and doctoring as well as advancements in medical science and technology. See *Id.*; Burns, 29 Iowa J. Corp. L. at 666; TC Appx. 109-110. Whereas private physicians were once considered the major purveyors of quality medical treatment, hospitals soon supplanted them and came to be regarded as respected practitioners of the medical arts. See Starr at 146; TC Appx.423. During this transformation: “Many people were now coming to hospitals who could afford to pay, and since the real value of hospital care had increased, charges would not drive them away.” *Id.* at 161; TC Appx. 438. A concomitant consequence of the transformation in the methods of healthcare delivery was that hospitals were no longer regarded as almshouses for the poor; rather, “[h]ospitals had gone from treating the poor for the sake of charity to treating the rich for the sake of revenue and only gave thought to the people in between.” *Id.* at 159; TC Appx. 436.

The transformation in healthcare delivery was further enhanced by access to health insurance. See Crimm, 37 B.C. L. Rev. at 15; TC Appx. 177. In the 1940s, BlueCross and

BlueShield created what is regarded as one of the first health insurance programs. *Id.* Soon thereafter, private commercial insurers adopted BlueCross and BlueShield's business model and entered the marketplace. *Id.* Access to health insurance broadened substantially in 1965 when the federal government enacted the Medicare and Medicaid programs. *Id.* at 16; TC Appx. 177. Medicare covers roughly 39 million individuals, whereas Medicaid covers roughly 40 million. Channick, *Come the Revolution: Are We Finally Ready for Universal Health Insurance?* (2003), 39 Cal. W. L. Rev. 303, 312; TC Appx. 133. The Centers for Medicare and Medicaid Services fund roughly \$800 billion of the United States' healthcare costs. Kreager, *The Physician's Right in § 15.50(B) To Buy Out a Covenant Not To Compete in Texas* (2009), 61 Baylor L. Rev. 357, 395, fn. 135; TC Appx. 400-402. As explained by one commentator:

Medicare and Medicaid also played a role in the changing definition of 'charitable' and the erosion of the amount of nonprofit hospitals' charity care. Medicare and Medicaid are responsible for some payment of health care services performed for the elderly and poor. With government coverage, the expectation of free or reduced-cost coverage from nonprofit hospitals decreased significantly. Before Medicare and Medicaid, the elderly and poor relied on their own resources, limited public programs, or on hospital charity for care. Medicare and Medicaid increased access to hospitals for those who previously could not obtain access and lessened the burden on hospitals to provide charity care. Thus, the creation of Medicare and Medicaid in 1965 had a fundamental effect on hospitals in that a substantial portion of the free care previously subsidized by tax-exempt hospitals now was reimbursed through these programs.

Burns, 29 Iowa J. Corp. L. at 669 (footnotes and internal quotations omitted); TC Appx. 111. With the advent of Medicare, Medicaid, and third-party payers, "nonprofit hospitals have increasingly taken on the appearance of business enterprises by serving mostly paying patients, decreasing their reliance on donations or volunteer labor, and striving to generate as much surplus revenue as possible through commercial transactions." Hall and Colombo, 66 Wash. L. Rev. at 319; TC Appx. 306-307.

D. This Court has recognized that non-profit healthcare providers closely resemble their for-profit competitors.

Consistent with the foregoing historical narrative, this Court has likewise concurred that the modern realities of healthcare delivery are not what they used to be. In recognition of these modern realities, the Court abolished the doctrine of charitable immunity for hospitals in 1994. See *Clark*, 68 Ohio St.3d 435. Before that decision, the doctrine of charitable immunity prevented hospitals from being subjected to liability for the negligent acts of their employees. See *Taylor v. Protestant Hosp. Assn.* (1911), 85 Ohio St. 90. During the *Taylor*-era, the rationale for the doctrine of charitable immunity was premised on the notion that: “Since [a hospital] ministers to those who cannot pay as well as those who can, thus acting as a good Samaritan, justice and sound public policy alike dictate that it should be exempt from the liability of attaching to masters whose only aim is to engage in enterprises of profit or self-interest * * * .” *Clark*, 68 Ohio St.3d at 441 (quoting *Morrison v. Henke* (Wis. 1917), 160 N.W. 173, 175).

In *Clark*, the Court explained that the *Taylor* decision “was painfully reflective of the realities of the time[.]” Specifically, *Clark* observed that:

The hospital of the early mid-nineteenth century would not be recognizable as such to a modern observer. ‘Respectable’ people who fell sick or who were injured were treated by their doctors at home; only the lowest classes of society sought help in the ‘hospital,’ which was most often a separate wing on the almshouse. As late as 1873, there were only 178 hospitals in the United States, with a total of 50,000 beds. These hospitals were private charities, and their trustees were usually unable to raise sufficient funding to provide a pleasant stay. The hospital of the time was dirty, crowded and full of contagious disease. The ‘nurses’ were usually former patients. Doctors, who were not paid, tended the ill for a few hours per week out of a sense of charity mixed with the knowledge that they could ‘practice’ their cures on the poor and charge young medical students for instruction in the healing arts. These young ‘house doctors’ also worked without pay, practicing cures on the ill.

Id. at 442 (quoting Note, *Pamperin v. Trinity Mem. Hosp. and the Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency* (1990), 1990 Wisc. L. Rev. 1129, 1131).

Whereas the *Taylor* decision was premised on the notion that hospitals of the 1800s were bona fide almshouses for the poor, the *Clark* decision explained that this characterization was no longer valid in light of the modern realities of healthcare delivery:

Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action.

Id. at 442 (quoting *Bing v. Thunig* (N.Y. 1957), 143 N.E.2d 3, 8). Thus, in abolishing the doctrine of charitable immunity for hospitals, the *Clark* Court observed that:

the average nonprofit hospital of today is a large well run corporation, and, in many instances, the hospital is so ‘businesslike’ in its monetary requirements for entrance and in its collections of accounts that a shadow is thrown upon the word, ‘charity,’ and the base of payment mentioned above is broadened still more.

Id. at 443 (quoting *Avellone v. St. John’s Hosp.* (1956), 165 Ohio St. 467, 474).

The Tax Commissioner’s Second Proposition of Law: This Court’s healthcare jurisprudence instructs that a core component attendant in the “totality of the circumstances” analysis is whether, under both R.C. 5709.121 and R.C. 5709.12, the health care provider renders sufficient services to persons who lack the financial means to pay for such services.

As the foregoing discussion demonstrates, DCI’s implication that it meets the demands of R.C. 5709.121 or R.C. 5709.12 merely because it renders healthcare services on a non-profit basis is wholly without merit. While healthcare providers have evolved from charities into bona fide businesses, this Court’s jurisprudence has remained steadfast in articulating the criteria that must be considered in determining whether a healthcare provider meets the test for exemption under R.C. 5709.121 or R.C. 5709.12. It is a question that turns not on the mere status of the facility as a healthcare provider but instead on the “totality of the circumstances.” *Community Health Professional*, 2007-Ohio-2336, ¶ 22 (quoting *Bethesda Healthcare*, 2004-Ohio-1749, ¶ 39). As confirmed by this Court’s long-line of decisions, one of the key factors attendant in the

“totality of the circumstances” analysis is whether a healthcare provider furnishes sufficient services to those members of our society that lack the financial means to pay for such services.

Almost one-hundred years ago, in a case involving the predecessor to R.C. 5709.12, this Court declared that the “first concern of a public charitable hospital must be for those who are unable to pay.” *O’Brien*, 96 Ohio St. at 9. The Court recognized that the admission of paying patients was not an automatic bar to claiming exemption. Nonetheless, the Court observed that the healthcare provider could not qualify for exemption if it “receive[d] pay[ing] patients in such numbers as to exhaust its accommodations, so that it cannot receive and extend hospital service to the usual and ordinary number of indigent patients applying for admission * * * .” *Id.* at 8-9.

Guided by the reasoning in *O’Brien*, this Court’s decisions in *Aultman Hosp. Assn*, 140 Ohio St. 114, and *Cleveland Osteopathic Hosp.*, 153 Ohio St. 222, similarly recognized that a healthcare provider seeking to exempt its property as being used exclusively for charitable purposes should have, as one of its core objectives, the furnishing of free or reduced fee care services to those that lack the financial means to pay for such services. In *Aultman Hosp. Assn.*, the Court granted exemption where it found that the provider rendered charity care to at least one-sixth (i.e., 16.67%) of its patient population. 140 Ohio St. at 115 (citing *O’Brien*). While a charge was made to those able to pay, the indigent were admitted free of charge. *Id.*

In contrast, in *Cleveland Osteopathic Hosp.*, a non-profit hospital sought to exempt itself under a prior iteration of R.C. 5709.12. The provider received the sum of \$182,242.07 for professional services provided by surgeons and physicians, the sum of \$134,355.51 from “regular patients,” and the sum of \$102,003.64 from the “Cleveland Hospital Service Association.”¹² Of this total, the provider disbursed \$8,172.78 in “free service.” In other words,

¹² For an explanation of how a hospital service association (“HSA”) operated during this time,

the provider rendered approximately 1.95% in free care to its patient population. The Court denied the exemption because the provider's modus operandi involved the treatment of private paying patients who were charged the commercial rate for services. In denying the exemption, the Court observed that:

the adjective 'charitable' attached to 'hospital' conveys the idea of a place where service and assistance are given the sick, injured and ailing, with open doors and benevolent concern for afflicted souls who lack the ability to pay for the attentions they receive.

153 Ohio St. at 226. While the Court recognized that the admission of paying patients was not an automatic bar to claiming exemption, the Court noted that "a hospital to qualify as a charitable institution, the property of which is exempt from taxation, should have as an important objective the care of the poor, needy and distressed who are unable to pay * * * ." *Id.* (citing *O'Brien*).

The reasoning of *Cleveland Osteopathic Hosp.* was emphatically reaffirmed in 1968 when this Court decided the case of *Lincoln Memorial Hosp.*. There, the hospital failed to render sufficient services to the indigent. In denying the exemption under R.C. 5709.12, the Court explained that "it is obvious from the financial setup described that a large majority of those who availed themselves of the hospital facilities were patients who paid for the attention and accommodations they received and that nonpaying charitable patients were decidedly in the minority." 13 Ohio St.2d. at 110 (citing *Cleveland Osteopathic Hosp.*). See also *Vick*, 2 Ohio St.2d at 32 (property exempt under R.C. 5709.12 where 6% to 7% of patients were non-paying and charity work was performed).

please see *Hosp. Serv. Assn. of Toledo v. Evatt* (1944), 144 Ohio St. 179. In that case, the HSA operated under a Blue Cross Plan and was designated as the exclusive agent for thirteen charitable hospitals. Pursuant to the terms of the contract, the HSA was responsible for providing subscribers, collecting monthly fees, and distributing the collected funds to the participating hospitals. The Court found that such a financial arrangement did not entitle the applicant to an exemption from real property taxation.

The Court's contemporary healthcare jurisprudence has likewise remained firmly committed to the core belief that, under R.C. 5709.121 and R.C. 5709.12, a healthcare provider should render sufficient services to those members of our society that lack the financial means to pay for such services. For example, in *Bethesda Healthcare*, 2004-Ohio-1749, the Court denied exemption where a healthcare provider rendered a mere 0.15% of free or reduced fee care services to the individuals that used its property. *Id.* at ¶ 38-39. The property, a fitness center, was managed by a § 501(c)(3) organization that was formed by two hospitals. The property was open to the public and made available for free cholesterol screenings as well as for programs hosted by the Arthritis Foundation. Of the 5,400 individuals that were members of the fitness center, the provider offered only eight scholarships to those that could not afford the membership fee.

While the provider sought exemption under both R.C. 5709.121 and R.C. 5709.12, the Court analyzed the claim under R.C. 5709.121 because no challenge was made to the provider's status as a "charitable institution." Much like the analysis that applies to a claim brought under R.C. 5709.12, the Court inquired into the manner by which the provider's property was being used. Indeed, the plain language of R.C. 5709.121 requires an examination of whether the property is being "**use[d]** in furtherance of or incidental to" the charitable institution's purposes without a view to profit. R.C. 5709.121(A)(2) (emphasis added).

Applying R.C. 5709.121's analytical framework, the Court recognized that the receipt of private paying patients did not automatically negate the provider's exemption claim. *Id.* at ¶ 35 (citing *O'Brien*, *supra*). Nonetheless, because the provider furnished free or reduced fee care services to a mere 0.15% of its members, the Court denied the provider's claim for exemption:

Whether an institution renders sufficient services to persons who are unable to afford them to be considered as making charitable use of the property must be determined

on the totality of the circumstances; there is no absolute percentage. Here the small number of members able to use the Fitness Center without payment of membership dues does not indicate a charitable use under the facts of this case.

Id. at ¶ 39.

Later, in *Community Health Professionals*, 2007-Ohio-2336, the Court further clarified the contours of R.C. 5709.121. In particular, the Court observed that the appropriate inquiry as to whether a healthcare provider can qualify as a “charitable institution” involves an analysis of whether the provider “charges patients for services rendered, accepts payment from private and government sources, writes off unpaid amounts, and * * * ” offers free or reduced fee care services. Id. at ¶ 22.

The unmistakable conclusion to be drawn from the foregoing review of this Court’s healthcare jurisprudence is that a core inquiry under both R.C. 5709.121 and R.C. 5709.12 is whether a healthcare provider furnishes sufficient services to those that lack the financial means to pay for such services—the evidence overwhelmingly confirms that DCI fails in this regard. Moreover, as explained below, several other compelling factors weigh heavily against DCI’s claim of exemption. In short, under the totality of the circumstances, DCI’s claims of exemption under both R.C. 5709.121 and R.C. 5709.12 should be denied.

A. DCI is not a “charitable institution” under R.C. 5709.121.

Where an institution seeks exemption under both R.C. 5709.121 and R.C. 5709.12, the Court “must first determine whether the institution seeking exemption is a charitable or noncharitable institution.” See *Bethesda Healthcare*, 2004-Ohio-1749, ¶ 28 (quoting *Olmsted Falls Bd. of Edn. v. Tracy* (1997), 77 Ohio St.3d 393, 396). Mindful of this framework, we first explain why DCI is not a “charitable institution” pursuant to R.C. 5709.121.

To prevail on a claim brought under R.C. 5709.121, an applicant must prove that: (1) its property belongs to a charitable institution; (2) the property is made available under the direction

or control of the institution for use in furtherance of or incidental to its charitable purposes; and (3) not be made available with a view to profit. See *OCLC Online Computer Library Ctr. v. Kinney* (1984), 11 Ohio St.3d 198, 200. Though the General Assembly has never defined the concept of “charity,” this Court has observed that:

In the absence of a legislative definition, ‘charity,’ in the legal sense, is the attempt in good faith, spiritually, physically, intellectually, socially and economically to advance and benefit mankind in general, or those in need of advancement and benefit in particular, without regard to their ability to supply that need from other sources, and without hope or expectation, if not with positive abnegation, of gain or profit by the donor or by the instrumentality of the charity.

Planned Parenthood Assn., 5 Ohio St.2d at paragraph 1 of the syllabus. “[T]he status of an institution as ‘charitable’ under R.C. 5709.121 depends upon the ‘charitable activities of the taxpayer seeking the exemption’ * * * .” *Northeast Ohio Psychiatric Inst. v. Levin*, 2009-Ohio-583, ¶ 14 (quoting *OCLC Online Computer Library Ctr.*, 11 Ohio St.3d at 201). In the context of healthcare, it is particularly appropriate to consider whether the institution “charges patients for services rendered, accepts payment from private and government sources, writes off unpaid amounts, and * * * ” offers free or reduced fee care services. *Community Health Professionals*, 2007-Ohio-2336, ¶ 22.¹³

1. At the national level, DCI failed to render sufficient services to those unable to afford them.

A review of DCI’s activities compels the conclusion that it is not a charitable institution. The most revealing aspect of DCI’s non-charitable status is its overwhelming inability to demonstrate that, on a system-wide basis, it rendered sufficient services to those who were

¹³ DCI suggests that *Community Health Professionals* as well as *Miracit Dev. Corp. v. Zaino* (Mar. 10, 2005), Franklin County App. No. 04AP-322, 2005-Ohio-1021, pave the way for its exemption under R.C. 5709.121. However, DCI shortcuts the analysis of these two cases by failing to point out that the status of the respective institutions as “charitable” under R.C. 5709.121 was not challenged. Here, the Tax Commissioner strenuously disagrees with, and the BTA rejected, DCI’s claim that it is a “charitable institution.” BTA Decision 16; DCI Appx. 19.

unable to pay for them. Specifically, for the 2004 tax year (i.e., the tax year at issue in this appeal), DCI presented no evidence regarding the number of indigent patients that received free or reduced fee care services at its 195 clinics. For 2006 and 2007, the BTA found that out of DCI's total patient treatments, 0.64% of those treatments included the rendering of free or reduced fee care services—that is, 11,840 free or reduced fee care treatments out of 1,836,058 total treatments. BTA Decision 16; DCI Appx. 19. Put simply, DCI's national operations are out-of-step with this Court's firmly-rooted healthcare jurisprudence—just like in *Lincoln Memorial Hosp.*, it is undisputed “that a large majority of those who availed themselves of [DCI's] facilities were patients who paid for the attention and accommodations they received and that nonpaying charitable patients were decidedly in the minority.” 13 Ohio St.2d at 110.

As the BTA correctly found, the inescapable reality is that DCI's activities closely resemble those of its for-profit competitors. BTA Decision 13; DCI Appx. 16. To wit, DCI operates on a fee-for-service business model—that is, it charges its patients for providing dialysis treatment. Patients are billed as a matter of course and DCI pursues all avenues of payment from its patients. Supp. 165, 167; Tr. 71, 78-79. In fact, DCI forbids its patients from participating in its indigence policy unless all avenues of payment have been exhausted. Supp. 211. While such actions would be understandable from a for-profit business, it is difficult to conceive how such actions resemble those of a “charitable institution.” As stated by the appellate court in *Provena Covenant Med. Ctr.*: “‘Charity’ is an act of kindness or benevolence. There is nothing particularly kind or benevolent about selling somebody something.” 894 N.E.2d 452, 467 (internal citations omitted), *aff'd.*, 2010 Ill. LEXIS 289.

2. Bad debt write-offs attributable to unpaid patient co-pays and deductibles in governmental or private insurance reimbursement schemes are not tantamount to charity.

Much like any other for-profit business, DCI is permitted to write-off on its Form 990 a portion of its uncollected charges as a “bad debt.” The general bad debt write-off provision is set forth at 26 U.S.C. § 166. In the healthcare arena, federal law also permits ESRD providers to write-off unpaid patient co-pays and deductibles that are attributable to the Medicare reimbursement scheme as bad debt. See 42 C.F.R. § 413.178, 413.89. Based upon a review of documentation pertaining to the 2006 and 2007 tax years, the BTA found that of the \$526,891,082 that DCI generated in charges on a system-wide basis, 1.27% was written off as a Medicare bad debt. BTA Decision 15-16; DCI Appx. 18-19. DCI characterizes these Medicare bad debt write-offs as charitable; however, this notion is untenable for several reasons.

First, unpaid patient co-pays and deductibles attributable to reimbursements through the Medicare program are not the exclusive province of non-profit healthcare providers—*for-profit* healthcare providers also incur such bad debt as a result of their participation in the Medicare program. Hanson, *Are We Getting Our Money’s Worth? Charity Care, Community Benefits, and Tax Exemptions at Nonprofit Hospitals* (2005), 17 Loy. Consumer L. Rev. 395, 412; TC Appx. 389. At its essence, “[b]ad debt is simply the cost of doing business in an industry.” *Id.* Under DCI’s view, nearly every business in Ohio would be eligible for a tax exemption if one of the hallmarks of a charitable institution included the act of writing off an uncollectible debt from a non-paying customer.

Second, DCI overstates the degree of its Medicare bad debt by using its charges, as opposed to its costs. Supp. 194; Tr. 189. Both the Catholic Health Association and VHA Inc. recognize that a healthcare provider’s bad debt should be calculated as a measure of the provider’s costs, not charges. Hanson, 17 Consumer L. Rev. at 412; TC Appx. 389. Likewise,

the appellate court in *Provena Covenant Med. Ctr.* observed that calculating bad debt by measuring charges as opposed to costs is distortive because it unduly inflates the degree of the alleged loss. 894 N.E.2d at 473. Similarly, one scholar has opined that “as a matter of theory, using charges to measure charity care is patently ridiculous.” Colombo, *Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps* (2006), 37 Loy. U. Chi. L.J. 493, 511; TC Appx. 152. In fact, as noted above, Medicare actually reimburses providers for the costs of their Medicare bad debt, 42 C.F.R. § 413.89, but not for the totally discretionary figure representing “charges.”

Third, even assuming that 1.27% was an accurate measure of DCI’s Medicare bad debt, the BTA rightly concluded that, under the reasoning of *Bethesda Healthcare*, this was an insufficient percentage to serve as the basis for concluding that DCI was a charitable institution. BTA Decision 16; DCI Appx. 19.

3. Undocumented and unquantified shortfalls allegedly attributable to costs in excess of Medicaid and Medicare reimbursement are not tantamount to charity.

DCI also argues, separate from its bad debt argument, that alleged shortfalls attributable to costs in excess of Medicaid and Medicare reimbursement should also be considered by the Court in determining whether it should receive a charitable exemption. DCI Br. 2-3, 25. Again, this argument runs into numerous difficulties. For one, DCI simply failed to document any alleged shortfall. Its own in-house counsel, Mr. Horn, could only reference an “understanding * * * based upon what various people throughout the company have told me, Medicare rates do not cover what it costs us to provide service” but repeatedly acknowledged he had no first hand knowledge. Supp. 175; Tr. 110-112. Nor was state witness Eric Edwards, “a Medicaid rules and policy expert for the Ohio Department of Job and Family Services” (BTA Decision fn. 6; DCI Appx. 11), able to address whether Medicaid reimbursements covered all costs related to dialysis

treatment when asked the question on cross-examination. Supp. 265; Tr. 270. DCI further failed to present any figures to quantify this alleged shortfall—neither DCI’s Ex. C (Supp. 255-256) nor DCI’s Form 990’s (Supp. 59, 86) contain any such figure, they simply address bad debt. Therefore at the very least, DCI has failed to sustain its burden of proof on this issue.

Moreover, even had such documentation materialized, shortfalls related to contractually reimbursed services do not rise to the level of charity. Though this Court has never expressly confronted the question, we note that the Supreme Courts of Illinois and Minnesota have explicitly rejected the notion that Medicare shortfalls are tantamount to charity. See *Provena Covenant Med. Ctr.*, 2010 Ill. LEXIS 289, 47-48 (observing that participation in Medicare was voluntary and provided the hospital with a reliable revenue stream); *Chisago Health Services v. Comm. of Revenue* (Minn. 1990), 462 N.W.2d 386, 391 (explaining that there was “little conceptual difference between [Medicare] discounts and the business discounts negotiated by HMO’s [sic] and health insurers on behalf of their insureds * * * .”). See also Hanson, 17 Loy. Consumer L. Rev. at 414; TC Appx. 389-390:

the rationale [for treating shortfall as charity] is dubious at best. In those states where there is a Medicaid or Medicare shortfall, every Medicaid and Medicare provider, whether for-profit or non-profit, bears the burden of low reimbursements. What’s more, both the federal and state governments typically disburse additional payments to hospitals to offset the costs of providing care to Medicaid and Medicare patients. Tax exemptions were never intended to serve that purpose.

Indeed, just as this Court observed with respect to Blue Cross patients in denying a charitable exemption to a Blue Cross Plan, most Medicare patients “would doubtless resent the imputation that they or any of them are the objects of charity. The very purpose of the insurance is to guard against the insured becoming an object of charity.” *Hosp. Service Assn. of Toledo*, 144 Ohio St. at 184.

4. DCI's indigence policy vests it with the right to refuse treatment to patients that are unable to pay.

DCI's indigence policy further cements the conclusion that it is not a charitable institution. Throughout its brief, DCI repeats in mantra-form that it accepts all patients regardless of their ability to pay. DCI Br. 3, 8-9, 11-15, 17. However, this statement rings hollow when measured against the unambiguous language of its indigence policy. Specifically, the policy states in plain terms that it **"is not a charity or gift to patients. DCI retains all rights to refuse to admit and treat a patient who has no ability to pay."** Supp. 210 (emphasis added). Even more alarming, the policy subjects non-paying patients to a litany of collection efforts including, but not limited to, sending collection letters, making phone calls, referral to collection agencies, and even court action. Supp. 210. While such actions would be understandable, if not expected, from a typical business, it strains logic to conclude that a purported "charitable institution" would undertake such actions. Such actions are antithetical to this Court's notion of "charity"—that is, the "attempt in good faith * * * to advance and benefit mankind in general, or those in need of advancement and benefit in particular, without regard to their ability to supply that need from other sources * * *." *Planned Parenthood Assn.*, 5 Ohio St.2d at paragraph one of the syllabus.¹⁴ Finally, notwithstanding the plain language of DCI's indigence policy, we note that accepting all patients without regard to their source of payment is a requirement imposed by the state's Medicaid reimbursement scheme, of which DCI is a willing participant. See Ohio Adm. Code 5101:3-1-17.2(A).

¹⁴ Strangely, DCI cites to *Planned Parenthood Assn.* in support of its exemption claim. Yet, DCI fails to mention that exemption was granted in that case to an entity that dispensed free services to 13% of its visitors. 5 Ohio St.2d at 120. In contrast to the entity in *Planned Parenthood*, DCI palpably fails to render free or reduced fee care services to the needy.

5. DCI's status as a § 501(c)(3) tax-exempt organization has and/or the language of its charter has little bearing on whether it is a "charitable institution."

Seeking to do an end run around the record adduced at the BTA hearing, DCI stakes its claim as a "charitable institution" largely on its status as a § 501(c)(3) organization and the statement of purpose recited in its articles of incorporation. Untethered to any source of authority, DCI baldly asserts that the Internal Revenue Service ("IRS") has set a "high bar for Federal income tax exemption." DCI Br. 16. According to DCI, attaining § 501(c)(3) tax-exempt status requires meeting "stringent" guidelines. DCI Br. 5. These contentions are devoid of merit.

First, this Court has never agreed with the proposition that the status of an institution as "charitable" is determined by reference to whether the institution is recognized by the IRS as a § 501(c)(3) organization. By its own terms, the scope of R.C. 5709.121 is not coextensive with the limits of § 501(c)(3). Lest there be any doubt, this Court has consistently denied real property exemptions to § 501(c)(3) organizations. See e.g. *NBC-USA Housing, Inc.-Five, Northeast Ohio Psychiatric Inst., Bethesda Healthcare*. This notion was emphatically reinforced just last month, where the Court stated that "tying charitable use so tightly to Congress' policy goals is wrong because Congress does not define the scope of charitable use under Ohio law." *NBC-USA Housing, Inc.-Five*, 2010-Ohio-1553, ¶ 20.

Second, the notion that § 501(c)(3) of the Internal Revenue Code contains "stringent" requirements borders on the risible. A 2009 study conducted by Stanford University found that "[o]btaining recognition by the IRS as a public charity is an embarrassingly easy thing to do. It is hardly an exaggeration to say that when it comes to oversight of the application process to become a public charity, nearly anything goes." Dorn, Reich, and Sutton at 4; TC Appx. 271. The data compiled by the study is unassailable—from 1998 to 2008, the IRS conferred §

501(c)(3) tax-exempt status to **over 97%** of the applications that it received. *Id.* at 9-10; TC Appx. 276-277.

DCI's reliance on the statements contained in its corporate charter is similarly unavailing. The determination of an institution as "charitable" depends upon the nature of the institution's activities, *Northeast Ohio Psychiatric Inst.*, 2009-Ohio-583, ¶ 14, not on the contents of a piece of paper filed with the Secretary of State's office. *Cf. State ex rel. Russell v. Sweeney* (1950), 153 Ohio St. 66. As stated in *Shaker Med. Ctr. Hosp. v. Blue Cross of Northeast Ohio* (1962), 115 Ohio App. 497, 504, "it is not the form of the articles of incorporation that is controlling but rather the manner in which the hospital is operated."

6. DCI failed to establish, through probative and competent evidence, the nature and extent of its research contributions.

DCI further argues that it qualifies as a "charitable institution" due to its purported research contributions. DCI Br. 17-18. This argument rests on a very slender reed. As the BTA found: "Other than the bare information reported on corporate tax returns and witness testimony regarding one donation to [UC], we find no evidence regarding research or contributions." BTA Decision fns. 1 and 8; DCI Br. Appx. 5, 16. At most, DCI's Form 990s establish that in 2003, it netted \$6,306,492 on total revenues of \$479,127,641, with roughly 1.18% of the total revenue allocated for "research." Supp. 59, 73. Likewise, in 2004, DCI generated a net income of \$32,167,517 on total revenues of \$514,053,981, with roughly 0.97% of the total revenue allocated for "research." Supp. 86, 89. Aside from oral testimony concerning DCI's association with UC, no documentation was presented to identify the entity(s) that received the research funds nor was any documentation presented to explain how the research funds were used.

Moreover, even assuming *arguendo* that DCI had presented probative and competent documentary evidence concerning its research contributions, the BTA found that such activities

would be “vicarious” in nature because DCI does not perform research. BTA Decision 13; DCI Br. Appx. 16. Whether the recipients of DCI’s research contributions engaged in charitable activities is irrelevant: “It is only the use of property in charitable pursuits that qualifies for tax exemption, not the utilization of receipts or proceeds that does so.” *Hubbard Press*, 67 Ohio St.3d at 566. See also *OCLC Online Computer Library Ctr.*, 11 Ohio St.3d at 200-201 (rejecting claim of vicarious charitable exemption).

B. Even assuming arguendo that DCI is a “charitable institution,” DCI still cannot meet the second prong of R.C. 5709.121 because the property at West Chester is not made available for use in furtherance of or incidental to DCI’s alleged charitable purpose.

Notwithstanding DCI’s status as a non-charitable institution, DCI fails under the second prong of R.C. 5709.121 because the West Chester clinic property is not used in furtherance of or incidental to DCI’s alleged charitable purpose. “When considering R.C. 5709.121 and the question of whether a charitable institution uses its property in furtherance of or incidentally to its charitable purposes, this court focuses on the relationship between the actual use of the property and the purpose of the institution.” *Community Health Professionals*, 2007-Ohio-2336, ¶ 21. An applicant cannot enjoy the benefits of R.C. 5709.121 where no charitable activities occur on the subject property. See *White Cross Hosp. Assn. v. Bd. of Tax Appeals* (1974), 38 Ohio St.2d 199, 200. This Court’s decision in *Bethesda Healthcare* is instructive with respect to analyzing claims for exemption under the second prong of R.C. 5709.121. In that case, no challenge was made to the healthcare provider’s status as a “charitable institution.” 2004-Ohio-1749, ¶ 30. Nonetheless, the healthcare provider’s exemption claim was rejected because it furnished free or reduced fee care services to a mere 0.15% of its members. *Id.* at ¶ 38-39.

There are no charitable activities that occur at the West Chester clinic. In fact, DCI readily concedes this point. In a letter to the Tax Commissioner, DCI’s in-house attorney admitted that the West Chester clinic did not have “any charity patients.” Supp. 46. Thus, under *Bethesda*

Healthcare, if the rendering of 0.15% in free or reduced fee services is insufficient to prove entitlement under R.C. 5709.121, a fortiori, the rendering of 0.00% in free or reduced fee care services provides an even stronger basis for denying exemption under R.C. 5709.121.¹⁵

In addition to providing no free or reduced fee care services, a host of other factors demonstrate why the West Chester clinic is not used in furtherance of or incidental to DCI's alleged charitable purpose. For example, **those without health insurance** (and most in need of free or reduced fee care services) at the West Chester clinic are billed, as a matter of course, the maximum rate of \$800, whereas **those with health insurance** are typically billed between \$175 to \$475 depending on the rate negotiated by the insurer. Supp. 193-194; Tr. 185-186. Further compounding the treatment of those without health insurance, Mr. Dansro referred to this slice of DCI's patients as "problem patients." Supp. 191; Tr. 174-175. Moreover, the West Chester clinic does not advertise the availability of its services to those in need of dialysis treatment. See *Utah County*, 709 P.2d at 274 (failure to advertise availability of free or reduced fee services weighed heavily against hospital's charitable exemption claim); *Provena Covenant Med. Ctr.*, 2010 Ill. LEXIS 289, 41 (same). Thus, even assuming arguendo that the West Chester clinic did furnish free or reduced fee care services to the indigent, it would have been incredibly difficult for them to find out about the availability of such services. As for DCI's alleged contributions to

¹⁵ Implicitly conceding that *Bethesda Healthcare* dooms DCI's claim of exemption, OHA goes to great lengths to distinguish away the consequences of that case. Curiously, OHA argues *Bethesda Healthcare* has no application to this appeal because the property at issue, a fitness center, did not involve the dispensation of "medical or ancillary healthcare services." OHA Br. 17. This argument strains credulity. First, a fitness center unquestionably encompasses the dispensation of ancillary healthcare services as it serves to improve the overall physical well-being of its members. Second, the property itself was owned by an entity that had, as its stated purpose, "the provision of ambulatory care and other health services." 2004-Ohio-1749, ¶ 2. Finally, and perhaps most telling, the reasoning of the *Bethesda Healthcare* case was cited to by the Court in *Community Health Professionals*, 2007-Ohio-2336, ¶ 22, which, ironically, is a case that both DCI and the OHA place significant reliance on.

research, the record is clear that the West Chester clinic did not contribute any money to research nor did it perform any research. Supp. 180 183; Tr. 132, 143-144.

In sum, the West Chester clinic is not used in furtherance of or incidental to DCI's alleged charitable purpose and, thus, DCI is not entitled to the benefits of R.C. 5709.121.

C. DCI cannot prevail under R.C. 5709.12 because it does not use its property exclusively for charitable purposes.

Having examined why DCI cannot meet the demands of R.C. 5709.121, we now proceed to explain why, under the “totality of the circumstances,” DCI cannot prevail under R.C. 5709.12. Under R.C. 5709.12(B), “Real * * * property belonging to institutions that is used exclusively for charitable purposes shall be exempt from taxation * * * .” Much like the test that applies to the second prong of R.C. 5709.121, the inquiry under R.C. 5709.12(B) centers on the manner in which the property is being “used.” It is well-settled that the “character of the property’s use must be determined in light of its *primary* use, not secondary or ancillary activities.” *Church of God in N. Ohio v. Levin*, 2009-Ohio-5939, ¶ 22 (citing *True Christianity Evangelism v. Zaino* (2001), 91 Ohio St.3d 117, 120-121). See also *NBC-USA Housing, Inc.-Five*, 2010-Ohio-1553, ¶ 18. As explained by *O’Brien* and its progeny, a core inquiry with respect to the delivery of healthcare services under R.C. 5709.12 is whether the provider renders sufficient services to those who are unable to afford them.

1. DCI provided no free or reduced fee care services to its patients at the West Chester clinic.

A review of the evidentiary record leaves little doubt as to what the West Chester clinic is primarily used for—namely, the furnishing of dialysis treatments on a fee-for-service basis. BTA Decision 13; DCI Appx. 16. Payment for services is the rule at DCI, not the exception. As previously mentioned above, it is undisputed that the West Chester clinic did not treat “any charity patients.” Supp. 46. Thus, because DCI’s West Chester property does not render

sufficient services to those who are unable to afford them, the DCI's use of the property at the West Chester clinic is out of step with the teaching of *O'Brien* and its progeny.

2. Several other factors militate heavily in favor of a finding that DCI's property at the West Chester clinic is not used exclusively for charitable purposes.

Most, if not all, of the other arguments offered as to why the West Chester clinic is not used in furtherance of or incidental to DCI's alleged charitable purposes under R.C. 5709.121(A)(2) apply with equal force to whether the property at the West Chester clinic is used exclusively for charitable purposes under R.C. 5709.12(B). Namely, the **uninsured** at the West Chester clinic are billed the maximum rate of \$800 while the **insured** enjoy deep discounts from the maximum rate, paying anywhere from \$175 to \$475. Supp. 193-194; Tr. 185-186. Mr. Dansro, administrator of the West Chester clinic, referred to those without health insurance as "problem patients." Supp. 191; Tr. 174-175. The West Chester clinic, just like its for-profit competitors, writes-off uncollected bills from non-paying patient as a bad debt. The West Chester clinic does not contribute funds towards research nor does it conduct any research on the property. Even assuming *arguendo* that the West Chester clinic rendered free or reduced fee care services to the indigent, the West Chester clinic does not advertise the availability of any free or reduced fee care services to the public because patients at the West Chester clinic arrive strictly through hospital referrals.

As for the indigence policy in effect at the West Chester clinic, no testimony or documentation was provided to explain whether the indigence policy was located in a conspicuous place for the patients to see. Likewise, no testimony or documentation was provided to explain whether, as a matter of course, patients at the West Chester clinic were affirmatively advised as to the existence of the indigence policy. The triggering event for

obtaining a copy of the indigence policy and FAF presumably occurs when the patient indicates that he or she lacks health insurance to pay for dialysis treatment.

Understandably, DCI's brief makes no mention of these inconvenient truths. Masterful in its omission of the facts adduced at the BTA hearing, DCI's argument for exemption under R.C. 5709.12(B) rests largely on generalities and platitudes. Yet, even in one of its lone moments of specificity, DCI's argument for exemption still fails to persuade. Particularly, in support of its claim with respect to R.C. 5709.12(B), DCI contends that it loses roughly \$250,000 per year at the West Chester clinic because its patients cannot pay the full cost of treatment. DCI Br. 22. To be sure, Mr. Dansro testified, without any supporting documentation, that the West Chester clinic loses roughly \$250,000. Supp. 183; Tr. 143-144. However, the suggestion that the West Chester clinic loses money because its patients cannot pay the full cost of treatment is patently false. Mr. Dansro's testimony plainly indicates that the reason the West Chester clinic loses money is due to lack of patient volume, not because the patients are unable to afford the cost of dialysis treatment. Supp. 186, 198-199; Tr. 154, 205-207.

Indeed, Mr. Dansro testified that **all** of the patients at the West Chester clinic are covered by a governmental and/or private insurer. Supp. 190; Tr. 172. He further testified that the City of West Chester is situated in a "middle class to higher than middle class" area of greater Cincinnati. Supp. 185; Tr. 153. The West Chester patients are generally better educated than patients from other regions in Cincinnati. Supp. 199; Tr. 207. Mr. Dansro explained that this attribute (i.e., education) makes the West Chester patients well-suited for kidney transplants because they are able to understand the necessary treatment regimens involved in successfully completing the operation. Supp. 199; Tr. 207. Naturally, once a West Chester patient

successfully undergoes a kidney transplant, the patient is no longer dependent on the dialysis treatment that is offered at the West Chester clinic.

In sum, the reason that the West Chester clinic loses money is not because the patients cannot afford the costs of dialysis treatment. Rather, the reason is due to lack of patient volume, which, in-turn, is highly correlative to the number of patients that are able to complete a successful kidney transplant. Lest there be any doubt as to the truth of this dynamic concerning the lack of patient volume at the West Chester clinic, Mr. Dansro further testified that his most profitable clinics are the ones that have served, or continue to serve, a high patient volume (i.e., the Maysville clinic, the Western Hills clinic, and the Walnut Hills clinic). Supp. 182, 184-185; Tr. 140-141, 148-153. The operations at the Walnut Hills clinic underscore this point. It is situated in an area of Cincinnati that is “kind of a mix between poor and middle class.” Supp. 185; Tr. 152-153. At 140 patients, the Walnut Hills clinic is the largest of DCI’s greater Cincinnati area clinics, and it has averaged a profit of “about \$200,000 a year.” Supp. 185; Tr. 152-153.

D. Caselaw from other jurisdictions is in accord with this Court’s healthcare jurisprudence.

Contrary to DCI’s attempts to argue otherwise, the contours of this Court’s healthcare jurisprudence are congruent with the decisional law of other courts. The Utah Supreme Court’s decision in *Utah County*, 709 P.2d 265, is instructive in this regard. There, the court found that a healthcare provider’s “property [consisting of twenty-one hospitals] was not exempt from taxation because [the property] was not being used exclusively for charitable purposes under the Utah Constitution.” *Id.* at 278. The court first reviewed the historical literature regarding the transformation of healthcare delivery models and emphatically refuted the myth that healthcare providers were ipso facto charitable entities:

Because the ‘care of the sick’ has traditionally been an activity regarded as charitable in American law, and because the dissenting opinions rely upon decisions from other jurisdictions that in turn incorporate unexamined assumptions about the fundamental nature of hospital-based medical care, we deem it important to scrutinize the contemporary social and economic context of such care. We are convinced that traditional assumptions bear little relationship to the economics of the medical-industrial complex of the 1980’s. Nonprofit hospitals were traditionally treated as tax-exempt charitable institutions because, until late in the 19th century, they were true charities providing custodial care for those who were both sick and poor. The hospitals’ income was derived largely or entirely from voluntary charitable donations, not government subsidies, taxes, or patient fees. The function and status of hospitals began to change in the late 19th century; the transformation was substantially completed by the 1920’s. ‘From charities, dependent on voluntary gifts, [hospitals] developed into market institutions financed increasingly out of payments from patients.’

Id. at 270 (footnotes omitted). The court explained that “[a]n essential element of charity is giving” and concluded that it could not discern anything charitable about the provider’s activities. Id. at 269. The “vast majority” of the services provided by the hospitals were funded by governmental and private reimbursements, as well as the patients themselves. Id. at 274. In stark contrast to DCI’s view, the court explained that “[c]ollection of such remuneration does not constitute giving, but is a mere reciprocal exchange of services for money.” Id. The court also faulted the provider for failing to render sufficient services to those unable to afford them, noting that the value of the services given away was “less than one percent of their gross revenues.” Id. Moreover, the record showed that to the extent that free services were offered, the free services were “deliberately not advertised out of fear of a ‘deluge of people’ trying to take advantage” of such services. Id.

Much like DCI, the provider countered that the “great expense of modern hospital care and the universal availability of insurance and government health care subsidies make the idea of a hospital solely supported by philanthropy an anachronism.” Id. However, the Court explained that this very fact illuminated the frailty of the provider’s claim for exemption:

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

Id. at 274-275.¹⁶

Mirroring the reasoning of *Utah County* is the Illinois Supreme Court's recent decision in *Provena Covenant Med. Ctr.*, 2010 Ill. LEXIS 289. In that case, the provider sought a charitable exemption for its inpatient hospital. The charity care at the provider's facility was "modest," representing only 0.723% of its revenue. Id. at 14. Additionally, "only 302 of [the provider's] 10,000 inpatient and 100,000 outpatient admissions were granted reductions in their bills under the charitable care program." Id. at 15. Like DCI, the uninsured at the provider's facility were charged the "established rate" and billed at a charge of more than double the actual cost of care. Id. at 45. Following DCI's model, the provider also did not advertise the existence of its charity care policy. Id. at 41.

In its analysis, the court stated that there was no blanket exemption for hospitals or health-care providers, and, upon a review of the facts, denied the provider's request for a charitable exemption. Id. at 30. The court found that the paucity of free or reduced fee care services that was furnished to the uninsured weighed heavily against the provider's claim of exemption:

Provena failed to meet its burden of showing that it used the parcels in the PCMC complex actually and exclusively for charitable purposes. As our review of the undisputed evidence demonstrated, both the number of uninsured patients receiving

¹⁶ We note that roughly nine years after *Utah County* was decided, the Utah State Tax Commission promulgated uniform tax exemption standards for nonprofit hospitals and nursing homes. See *Howell v. County Bd. of Cache County ex rel. IHC Hosps., Inc.* (Utah 1994), 881 P.2d 880. These standards were challenged on constitutional grounds, however, the Utah Supreme Court upheld the constitutionality of these standards because they comported with the framework announced in *Utah County*. Id. at 890.

free or discounted care and the dollar value of the care they received were *de minimus*. With very limited exception, the property was devoted to the care and treatment of patients in exchange for compensation through private insurance, Medicare and Medicaid, or direct payment from the patient or the patient's family.

Id. at 41 (italics in original). The court also faulted the provider for its collection practices which closely resembled that of a for-profit corporation:

Provena Hospitals did not advertise the availability of charitable care at PCMC. Patients were billed as a matter of course, and unpaid bills were automatically referred to collection agencies. Hospital charges were discounted or waived only after it was determined that a patient had no insurance coverage, was not eligible for Medicare or Medicaid, lacked the resources to pay the bill directly, and could document that he or she qualified for participation in the institution's charitable care program. As a practical matter, there was little to distinguish the way in which Provena Hospitals dispensed its 'charity' from the way in which a for-profit institution would write-off bad debt.

Id. at 42. The Court also rejected the notion that the receipt of Medicare and Medicaid was tantamount to charity:

It would, in fact, be anomalous to characterize services provided to Medicare and Medicaid patients as charity. That is so because, as the Department correctly points out, charity is, by definition, a type of gift and gifts, as we have explained, must by definition, be gratuitous. Hospitals do not serve Medicare and Medicaid patients gratuitously. They are paid to do so.

Id. at footnote 12.

In addition to the Supreme Courts of Utah and Illinois, the Supreme Courts of Georgia and Minnesota have also scrutinized the claims of non-profit healthcare providers and found the respective properties not exempt under the states' charitable exemption statutes. See *Ga. Osteopathic Hospital, Inc. v. Alford* (Ga. 1962), 124 S.E.2d 402, 406 (explaining that a hospital was not a "purely charitable institution" because "while there was some evidence that it did on occasion treat indigent patients, the general practice of the institution was to collect all that it could from its patients, and only charge off as charity those bills it was unable to collect."); *Chisago Health Services*, 462 N.W.2d at 391-392 (reasoning that certain hospital-owned

property did not belong to an “institution[] of purely public charity” because a majority of the medical services rendered were reimbursed by the government and uncollectible bills were written off like any other healthcare provider).

Contrary to the foregoing approaches taken from Utah, Illinois, Georgia, and Minnesota, DCI implores this Court to adopt the approaches taken in Michigan and Connecticut. See *Wexford Med. Group v. City of Cadillac* (Mich. 2006), 713 N.W.2d 734 and *St. Joseph’s Living Ctr. v. Town of Windham* (Conn. 2007), 966 A.2d 188. Unfortunately for DCI, these two decisions offer little guidance in resolving the merits of this controversy—both *Wexford* and *St. Joseph’s Living Ctr.* are readily distinguishable because they repudiate this Court’s firmly-settled view that a core objective of a charitable healthcare provider should be directed towards rendering sufficient services to those members of our society that lack the financial means to pay for such services.

In *Wexford*, the court reversed two lower tribunals in concluding that a healthcare provider was a “charitable institution” even though the provider rendered free or reduced fee care services to a mere 13 patients out of a total of roughly 80,000 patient visits over the course of two years. 713 N.W.2d at 737. Turning principles of strict construction on their head, the court reasoned that the exemption was warranted “[b]ecause there is no statutory language that precludes finding petitioner exempt as a charitable institution * * * .” *Id.* at 736. Presumably, under the court’s view, property in Michigan is exempt unless expressly stated otherwise—such logic flies in the face of the principle of uniformity set forth in Article XII, Section 2 of the Ohio Constitution. As a further distinguishing characteristic, the *Wexford* court accorded significant weight to the provider’s charity care policy as opposed to the provider’s purported charitable activities. *Id.* In contrast to Michigan law, this Court’s jurisprudence instructs that a piece of

paper is not determinative of whether an entity is a charitable institution; rather, the status of an institution as “charitable” under R.C. 5709.121 depends on the character of the institution’s charitable **activities**. See *Northeast Ohio Psychiatric Inst.*, 2009-Ohio-583, ¶ 14.

DCI fares no better under its citation to *St. Joseph’s Living Ctr.* There, the stated purpose of the property at issue was to provide long-term skilled care to the elderly. 966 A.2d at 221. The property derived its revenue primarily from Medicare, Medicaid, and private payers. Additionally, the court found that the property “generally does not provide free care.” *Id.* at 196. The court found that the property was **not being used exclusively for its charitable purpose** because it provided short-term rehabilitative care to the general public, as opposed to its stated purpose of attending to the elderly. *Id.* at 221. Notwithstanding the court’s denial of the tax exemption, the reasoning of *St. Joseph’s Living Ctr.* is of little guidance here because, unlike in Connecticut, the Ohio General Assembly has provided an express statutory exemption for property that is used to provide skilled nursing care to the elderly via the “home for the aged exemption” set forth at R.C. 5709.12 and R.C. 5701.13. See *NBC-USA Housing, Inc.-Five*, 2010-Ohio-1553, fn. 1. Thus, if the facts of *St. Joseph’s Living Ctr.* presented themselves to this Court, the taxable status of the property would have to be analyzed under the “home for the aged” exemption as opposed to the “charitable institution” exemption set forth at R.C. 5709.121 or the “charitable use” exemption set forth at R.C. 5709.12(B). As a final distinguishing characteristic, *St. Joseph’s Living Ctr.* simply fails to incorporate this Court’s firmly-rooted principle that an objective of a charitable healthcare provider should be directed towards rendering sufficient services to those members of our society that lack the financial means to pay for such services.

In short, *Wexford* and *St. Joseph's Living Ctr.* are out of step with this Court's long-line of caselaw in the healthcare arena. To the extent that the Court requires guidance from out-of-state authority to resolve the controversy at bar, we encourage the Court to look closely at the approaches taken in Utah, Illinois, Georgia, and Minnesota, as they closely adhere to this Court's jurisprudential principles.

The Tax Commissioner's Third Proposition of Law: If non-profit healthcare providers seek a blanket exemption from real property taxation, the General Assembly is the proper forum in which to make such a request.

If at all, the decision as to whether non-profit healthcare providers should receive blanket exemptions from real property taxation is a matter for the General Assembly to decide. This Court has long-held that public policy decisions lie within the exclusive province of the General Assembly. See e.g. *Indian Hill v. Atkins* (1950), 153 Ohio St. 562, 573 (decision to "permit controversies between taxing districts * * * is clearly a matter of public policy for determination by the General Assembly."). See also *Chambers v. St. Mary's School* (1998), 82 Ohio St.3d 563, 567 (collecting cases). Almost one-hundred years have elapsed since *O'Brien* was first decided, and the General Assembly has refrained from enacting legislation that cuts against this Court's admonition that a core objective of a charitable healthcare provider should focus on furnishing sufficient services to those members of our society that lack the financial means to pay for such services. See e.g. *O'Brien*, 96 Ohio St. 1. "Legislative inaction in the face of long-standing judicial interpretations of a [statute] evidences legislative intent to retain existing law." *Coryell v. Bank One Trust Co. N.A.*, 2004-Ohio-723, ¶ 29 (J. Stratton, dissenting) (quoting *State v. Cichon* (1980), 61 Ohio St.2d 181, 183-184)).

This Court's recent decision in *NBC-USA Housing, Inc.-Five*, supra, is illustrative of the foregoing principle of judicial restraint. In that case, the applicant sought exemption under R.C.

5709.12(B) for property used to provide housing to low-income handicapped and aged tenants. The applicant contended that the property was “used exclusively for charitable purposes,” however, the Court rejected this argument. Drawing upon its forty years of caselaw in this area, the Court explained that “a distinctly residential use of real property defeats a claim of charitable exemption, even where attendant circumstances indicate the existence of charitable motives.” 2010-Ohio-1553, ¶ 9. The Court noted that in order for residential housing to qualify for a real property exemption, the property must be used in accordance with the “home for the aged” criteria as enacted by the General Assembly in R.C. 5709.12 and R.C. 5701.13. *Id.* at ¶ 16.

The same principle applies here. This Court’s firmly-settled healthcare jurisprudence instructs that a core objective of a charitable healthcare provider should center on rendering sufficient services to those members of our society that lack the financial means to pay for such services. In spite of almost 100 years of caselaw on this point, the General Assembly has never signaled its disagreement with the Court’s jurisprudential principles. Thus, just like in *NBC-USA Housing, Inc.-Five*, the Court should continue to adhere to the fundamental precepts announced in its previous healthcare decisions. If, the General Assembly decides, like it did with the “home for the aged” exemption, that corrective measures are necessary to counteract this Court’s decisional law, the General Assembly can enact legislation that provides a per se exemption for non-profit healthcare providers. However, corrective measures have so far not occurred; thus, this Court should retain the core principles announced in *O’Brien* and its progeny.

CONCLUSION

The BTA’s decision and order upholding the Tax Commissioner’s denial of DCI’s request for a real property tax exemption should be affirmed as reasonable and lawful.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I certify that a copy of the Merit Brief, as well as the Appendix, of Appellee William W. Wilkins [Richard A. Levin], Tax Commissioner of Ohio, was served by U.S. mail this 12th day of

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I also sent courtesy copies to counsel of record for all known amici curiae on this 12th day of May, 2010.



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