

ORIGINAL

IN THE SUPREME COURT OF OHIO

DIALYSIS CLINIC, INC.,

Appellant,

-vs-

WILLIAM W. WILKINS,
TAX COMMISSIONER OF OHIO,

Appellee.

Case No. 2009-2310

On Appeal from the Ohio Board of Tax
Appeals

REPLY BRIEF OF APPELLANT DIALYSIS CLINIC, INC.

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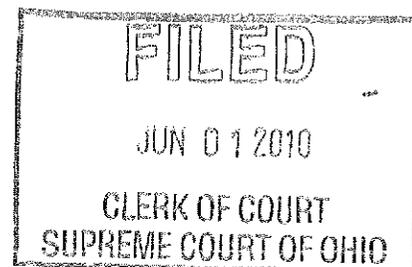


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INTRODUCTION

In his Merit Brief, Appellee William W. Wilkins [Richard A. Levin], Tax Commissioner of Ohio (the “Commissioner”) firmly embraces the flawed analysis underpinning the Board of Tax Appeals’ (the “BTA”) decision below. The BTA’s decision, as well as the Commissioner’s arguments in his Merit Brief, rests squarely on the notion that a quantum of “free care” is required for a charitable healthcare provider to qualify for a real estate tax exemption under *both* R.C. 5709.12 *and* R.C. 5709.121. This is simply not the law.

As set forth below, the Appellant, Dialysis Clinic, Inc. (“DCI”) is a charitable institution. DCI uses the facility at issue, the “West Chester Clinic,” in furtherance of, and incidentally to, its charitable purpose. DCI operates the West Chester Clinic without a view to a profit. In fact, the record demonstrates that the West Chester Clinic has never operated at a profit, losing an average of \$250,000 per year. On this record, DCI is clearly entitled to an exemption under R.C. 5709.121.¹

The Commissioner asserts that DCI is not a charitable institution primarily because DCI does not provide a sufficient quantum of “free care” on a national level. (Commr. Brief pgs. 30-31 (“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 unable to pay for them.”).) Of course, neither this Court nor the General Assembly has ever required such a demonstration. This Court consistently holds that the charitable or non-charitable status of an institution is determined by examination of the “totality of the circumstances.”

True, DCI bills its patients for services and then seeks to collect for those services. DCI is not driven by a mercantile quest for profit, however. DCI undertakes these activities as a result of a

¹ This Reply Brief is devoted to further discussion of DCI’s right to an exemption under R.C. 5709.121. DCI’s position with respect to its right to an exemption under R.C. 5709.12 is fully briefed in DCI’s Merit Brief. (DCI Merit Brief pgs. 21-24.)

healthcare system dominated by government entitlement programs such as Medicare and Medicaid. These programs require that DCI charge the same price to all patients, further requiring that DCI seek payment from all patients. Moreover, because Medicare provides nearly universal coverage for dialysis for patients with end-stage renal disease (“ESRD”), nearly all of DCI’s patients have some level of insurance coverage for DCI’s services. In short, there simply is not a great opportunity to provide “free care.”²

In examining the “totality of the circumstances,” DCI’s use of funds is at least equally as important as its source of funds. Given that Medicare provides essentially universal coverage for dialysis, the primary source of funds for non-profit and for-profit dialysis providers is the same—Medicare. One way non-profit providers distinguish themselves, demonstrating their charitable nature, is through their use of funds.³ Unlike for-profit operators, like DaVita, DCI undisputedly sets aside 50% of its net revenue for research grants and 50% to expand its operations to further its charitable mission of serving all ESRD patients. DCI’s expansion program includes serving underserved, non-profitable areas, like the West Chester Clinic. In any event, net revenues never devolve to the benefit of any individual or entity. In contrast, the net revenues of DaVita, a publicly traded company, directly benefit its shareholders.

As established by unrebutted witness testimony, DCI’s charitable nature shines through even in its pay structure. DCI pays its top people well below market rates. DCI’s founder, Dr. Keith

² In response to this reality, the Commissioner continually asserts that acceptance of Medicare is “voluntary.” Of course, it is not. The testimony was crystal clear that DCI could not accomplish its charitable mission without accepting Medicare. (Supp. 179, Tr. 126-27; Supp. 201, Tr. 214.)

³ Some cases have noted that the use of the property, not the proceeds therefrom, establishes the charitable nature of the property. See, e.g., *Seven Hills Schools v. Kinney* (1986), 28 Ohio St.3d 186, 503 N.E.2d 163. However, none of these cases applied the “totality of the circumstances” test developed in *Bethesda Healthcare, Inc. v. Wilkins*, 101 Ohio St.3d 420, 2004-Ohio-1749, 806 N.E.2d 142. Clearly, in examining the “totality of the circumstances,” an examination of use of funds is appropriate and necessary.

Johnson, and his wife are both on the Board of Directors of DCI, commanding a salary of \$0 for their service. (Supp. 73-74, 100.) In short, no one is getting rich at DCI. The only benefit generated by DCI's operations devolves to the public in the form of services and, hopefully, helpful research projects. This is charity.

Finally, the Commissioner, intentionally or not, simply misapprehends the persuasive authorities previously cited by DCI. As set forth fully below, all of the available persuasive authority, save for one distinguishable plurality decision from Illinois, a decision which is not even controlling in Illinois itself, militates in favor of finding DCI a charitable institution exempt from real estate taxes.

ARGUMENT

I. THE RECORD DEMONSTRATES THAT, UNDER THE TOTALITY OF THE CIRCUMSTANCES, DCI IS A CHARITABLE INSTITUTION.

DCI's status as a charitable institution is determined by examination of the "totality of the circumstances." *Bethesda Healthcare, Inc. v. Wilkins*, 101 Ohio St.3d 420, 425, 2004-Ohio-1749, 806 N.E.2d 142. The Commissioner pays lip service to the idea of a "totality of the circumstances" test, but ultimately relies on one circumstance—the level of free care DCI provides—to sustain his assertion that DCI is not a charity. According to the Commissioner, because nearly all of DCI's patients have some form of insurance coverage, which coverage DCI accepts, DCI is not a charity. Even worse, according to the Commissioner, DCI bills patients with no insurance. However, these activities must be viewed in "the totality of the circumstances," namely within the regulatory framework established by Medicare.

It is true that DCI charges patients uniform fees for service, bills patients according to reimbursement schedules negotiated with their insurance carriers (if they have insurance), and thereafter attempts to collect those bills. However, this is the regulatory regime created by Medicare. DCI is *required* to take these actions by the Medicare system, a system in which it must participate to accomplish its charitable mission. (Supp. 179, Tr. 126-27; Supp. 201, Tr. 214.)

Second, the Commissioner summarily dismisses other badges of charity attendant to DCI's operations. For instance, the Commissioner dismisses DCI's research contributions, noting that in 2003, only 1.18% of *total revenues* went toward research. Of course, research contributions as a percentage of total revenue is a calculation of no value whatsoever, but the Commissioner uses it to diminish DCI's charitable activities.

At its core, a charity does not benefit any private interest. Regardless of its sources of funds, whether such funds derive from charitable donations or fees for service, a charity will never use its funds for private benefit. Because the record firmly establishes that DCI has this core characteristic of a charity, the Commissioner picks around the edges, asserting DCI has not done enough. But this simply obfuscates the heart of the matter. Unlike a for-profit operator, DCI's operations result in no private benefit. This fundamental feature of charity makes DCI vividly different from a for-profit dialysis provider operating solely for the benefit of its shareholders. DCI's operations benefit no private interest—it is a charity.

A. The Commissioner's analysis ignores the requirements of the Medicare program and the realities of treating ESRD.

Throughout his Merit Brief, the Commissioner completely ignores the realities of treating ESRD and, subsequently, misapplies the “totality of the circumstances” test. DCI provides only one service—dialysis—and almost all Americans have health insurance for dialysis under Medicare. This one fact has far-reaching consequences that permeate the “totality of the circumstances” test applicable to this case.

ESRD care in the United States is unique. There is almost universal coverage for Americans under Medicare for ESRD. See Section 426-1, Title 42, U.S. Code; see, also, *Kidney Failure and the Federal Government* (1991) 3, 6.⁴ “The ESRD program is unique within Medicare. It is the only

⁴ In the Omnibus Budget Reconciliation Act of 1987, Congress asked the Institute of Medicine to study the Medicare ESRD program. *Kidney Failure and the Federal Government* at 3. The

case in which the diagnosis of a categorical disease provides the basis for an entitlement for persons of *all ages*.” *Kidney Failure and the Federal Government* at 3 (emphasis added).⁵ An individual begins receiving benefits from the federal government after three months of dialysis or at the time he is admitted to a hospital for a kidney transplant. Section 426-1(b)(1), Title 42, U.S. Code.

The evidence in this case demonstrated the reality that Medicare coverage for ESRD treatment is nearly universal. Institution-wide, 85% of DCI’s patients are covered by government-sponsored health insurance plans and 75-80% of DCI’s patients at the West Chester Clinic are insured by Medicare and/or Medicaid. (Supp. 255; Supp. 188, Tr. 164-65.) The remaining patients (approximately 14% institution-wide) are largely private insurance patients that would be covered under Medicare or Medicaid were they without private insurance. (Supp. 188, Tr. 164-65.) Moreover, in order to fulfill its charitable mission of serving patients with ESRD and promoting ESRD research, DCI *must* accept Medicare beneficiaries. (Supp. 179, Tr. 126-27; Supp. 201, Tr. 214.)⁶

While the Commissioner admits (in a footnote) that “Congress extended Medicare coverage to individuals with ESRD,” it misunderstands the consequences of this fact for DCI’s operations.

Institute of Medicine convened an expert committee to conduct the study. *Id.* at 4. The book *Kidney Failure and the Federal Government* is the committee’s response to Congress’ request. *Id.*

⁵ Those ineligible include some government employees, workers in covered occupations who may not have applied for benefits, such as farm workers, and individuals who have never worked. *Kidney Failure and the Federal Government* at 7.

⁶ “Q: Do you have a sense of what DCI’s mission is, its corporate objective?

A: Well, it has been from day one with Dr. Johnson is to care for these patients that have—do not have kidney function and to help them survive regardless of their ability to pay from day one when he collected money on the streets of Nashville to pay for the treatments, it’s continued to this day.

Q: Do you think you could have established that objective without voluntarily participating in the Medicaid and Medicare programs?

* * *

A: No. We couldn’t because Medicare is a primary payer of dialysis services.” (Supp. 200-01, Tr. 213-14 (omitting overruled objection).)

(Comm. Brief pg. 12., fn. 5.) Accepting Medicare subjects DCI to “an extremely ‘complex statutory and regulatory regime.’” *Dialysis Clinic, Inc. v. Leavitt* (D.D.C. 2007), 518 F.Supp.2d 197, 199, quoting *Good Samaritan Hosp. v. Shalala* (1993), 508 U.S. 402, 404, 113 S.Ct. 2151, 124 L.Ed.2d 368. This complex regulatory regime includes a number of federal fraud and abuse statutes, debt collection requirements, and uniform fee schedules. Congress enacted these statutes “to control program costs and prevent cost shifting to non-Medicare patients by preventing unnecessary utilization of Medicare services and overbilling of the program.” Carol Pryor and Robert Seifert, *Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt* (2003), The Commonwealth Fund 4.⁷ However, these well-intentioned limitations constrain providers, such as DCI, from offering reduced-cost or free care and encourage these providers to collect on both Medicare and uninsured patients’ outstanding bills. *Id.* at vi.

i. Federal Anti-Fraud Statutes

Federal anti-fraud provisions prevent DCI from waiving Medicare beneficiary fees and also prohibit advertising reduced-cost or free care. Violations of these federal anti-fraud provisions expose DCI to both civil and criminal penalties. DCI is civilly prohibited from waiving beneficiary fees, such as deductibles, coinsurance, or copayments, on a routine basis. Section 1395nn, Title 42, U.S. Code; see, also, Pryor and Seifert, at 5. In addition, waiving these fees or offering reduced-cost or free care may subject DCI to criminal penalties. Section 1320a-7b(b)(2), Title 42, U.S. Code (prohibition on knowingly or willfully soliciting or paying anything of value to influence the referral of federal healthcare program business); see, also, Pryor and Seifert, at 5.

ii. Collection of Unpaid Fees

Medicare also imposes requirements on a healthcare provider’s efforts to collect unpaid fees. Providers must use “reasonable efforts” to collect these fees. Section 413.80(e), Title 42, C.F.R.

⁷ This article is available at <http://www.accessproject.org/downloads/unintended.pdf>.

Such efforts must be comparable to efforts to collect from non-Medicare patients and include “subsequent billings, collection letters, phone calls, and personal contacts in order to constitute a genuine, rather than a token, collection effort.”⁸ Centers for Medicare and Medicaid Services, *Medicare Provider Reimbursement Manual Part I*, Chapter 3, Section 304.⁹ Again, this program requirement is intended to prevent Medicare over billing, but it has the unintended consequence of requiring charitable healthcare providers, such as DCI, to try to collect on unpaid medical bills. Pryor and Seifert, at 8.

iii. Uniform Fee Schedule

Federal law also prohibits providers from billing Medicare beneficiaries based on a different fee schedule than non-Medicare patients. Section 1320a-7, Title 42, U.S. Code. Accordingly, providers may violate the law by implementing multiple fee schedules; thus, the industry practice is to use one fee schedule. Pryor and Seifert, at 10. Setting uniform prices is not the same as receiving uniform reimbursements. Providers “charge” all patients the same rate, but negotiate discounted reimbursement rates with private insurers or receive payment according to the Medicare set rate. *Id.* The unintended result is “that uninsured patients would presumably be billed at full charges.” *Id.*

The result of these regulations is that DCI (1) is prohibited from regularly waiving Medicare deductibles or copayments, (2) is prohibited from advertising that it provides free-care to patients that qualify as indigent, (3) must attempt to collect unpaid fees including Medicare deductibles or copayments, and (4) must charge uninsured patients the full charge for services.

The Commissioner naively castigates DCI for its business practices, failing to recognize the effect of these Medicare regulations on DCI. (See Commr. Brief pgs. 35, 39, 41.) In short, DCI’s

⁸ DCI parrots this language in explaining to patients the reasons for its indigency policy and application process. (Supp. 224.)

⁹ This reference manual is available at http://www.cms.gov/manuals/pub151/PUB_15_1.asp.

charitable mission is to help individuals with ESRD. To do this, DCI must accept Medicare. (Supp. 179, Tr. 126-27; Supp. 201, Tr. 214.) By accepting Medicare, DCI is subjected to a complex regulatory regime that requires DCI to try to collect unpaid debts including unpaid Medicare deductibles; prohibits DCI from advertising free or reduced-cost care; and requires DCI to set a uniform fee schedule, which results in DCI charging uninsured patients the full fee for services. The Commissioner's misunderstanding of Medicare and its regulations taints its analysis under both R.C. 5709.121 and R.C. 5709.12.

B. DCI is a charitable institution pursuant to this Court's well-established Ohio law.

1. This Court broadly defines charity and examines the totality of the circumstances including the use of funds.

As set forth above, the Commissioner focuses on DCI's source of funds in asserting that "to be charitable, a healthcare provider should provide free or reduced fee care services to the needy." (Commr. Brief pg. 3.) While "free care" may be a consideration under the "totality of the circumstances test," it is certainly not the only consideration. Equally, if not more important, is the institution's use of funds.

This Court has adopted and used several definitions of charity over the years. Common to every definition is a focus on goodwill and benefit to mankind as determined from an analysis of all of the facts in each individual case. Contrary to the Commissioner's assertions, no definition identifies "free care" as a requirement of charity.

For example, in *Am. Issue Publishing Co. v. Evatt* (1940), 137 Ohio St. 264, 266, 28 N.E.2d 613, this Court defined charity broadly as "that which benefits mankind and betters its condition." Consistent with this broad, flexible definition, this Court has held that "[a]ll the facts in each individual case must be assembled and examined in their entirety and the substance of the scheme or plan of operation exhibited thereby will determine whether the institution involved is entitled to have

its property freed from taxes." *Bethesda Healthcare* at ¶37, quoting *Cleveland Osteopathic Hosp. v. Zangerle* (1950), 153 Ohio St. 222, 225-226, 41 O.O. 243, 91 N.E.2d 261.

This Court has recently broadly defined charity as "[t]he 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 doner or by the instrumentality of the charity." *True Christianity Evangelism v. Zaino*, 91 Ohio St. 3d 117, 119-120, 2001-Ohio-295, 742 N.E.2d 638, quoting *Planned Parenthood Assn. v. Tax Commr.* (1966), 5 Ohio St.2d 117, 214 N.E.2d 222 at paragraph one of the syllabus (emphasis removed). Again, nowhere is "free care" identified as necessary to a finding of charity. Instead, this Court instructs the reader to examine all facts and circumstances of each case, including use of funds.

This Court's consideration of the use of funds in determining an institution's charitable status may be seen in *O'Brien v. Physicians' Hosp. Assn.* (1917), 96 Ohio St. 1, 116 N.E. 975, a case upon which the Commissioner heavily relies. Contrary to the Commissioner's description, however, the central focus of *O'Brien* was whether the money received from paying patients went toward the public welfare or might inure to private interests. *Id.* at 5-7. The Court noted that "[e]very dollar received by the [hospital] from patients who are able to pay, or from other sources, immediately becomes impressed [into an irrevocable trust for public purposes], and cannot be diverted into private profit." *Id.* at 7. In short, the Court determined that accepting fees for service would not abrogate the charitable nature of an institution that uses its funds charitably, so long as those funds did not inure to any private benefit.

The Court's concern with use of funds is again demonstrated in *Vick v. Cleveland Mem. Med. Found.* (1965), 2 Ohio St.2d 30, 206 N.E.2d 2. The *Vick* Court considered a hospital that provided little free care to its patients and earned a very large surplus of \$700,000. *Id.* at 32. There, the Court allowed a charitable property tax exemption because "[t]here is no evidence that the hospital was being operated for private profit or that any funds of the hospital, including the surplus, were being diverted to wrongful uses * * *." *Id.* at 33-34. Indeed, the *Vick* Court echoed *O'Brien* when determining that a public charitable hospital may accept fees for service where "the money received from such source becomes part of the trust fund, and must be devoted to the same trust purposes and cannot be diverted to private profit." *Id.*

DCI is not alone in its understanding of *O'Brien* and *Vick*. The Utah supreme court interpreted the Ohio definition of charity and these cases in a similar manner. In *Utah Cty. v. Intermountain Health Care, Inc.* (Utah 1985), 709 P.2d 265, a case cited by the Commissioner and further discussed in Part II below, the Utah supreme court distinguished this body of Ohio law from the law applicable in Utah. *Utah County*, 709 P.2d at 272, 297, citing *Vick*, 2 Ohio St.2d 30. The court noted that, unlike Utah law, Ohio "does not insist on identifying the element of gift in an organization's practices before it can be held to be a charity." *Id.* at 272. Praising Ohio law as good jurisprudence, the dissent in *Utah County* cited *Vick* and *O'Brien* for the proposition that

hospital property is used for charitable purpose if the hospital is not organized for profit and ***no private gain is in fact derived from its earnings*** or upon dissolution; ***all earnings are used to maintain the hospital facility***; the hospital is open to the public without restriction to race, color, or creed; and admission is not predicated upon ability to pay.

Id. at 297 (Howe, J., dissenting) (emphasis added). Clearly, Ohio law defines charity broadly and examines the totality of the circumstances, including use of funds, to determine whether an institution is charitable.

2. *Applying this Court's broad definition, DCI is a charitable institution.*

Examination of use of funds is particularly appropriate in this case. As set forth above, Medicare provides nearly universal coverage for dialysis treatment of ESRD patients. Therefore, the primary source of funds to a dialysis provider will be the same whether the provider is for-profit or non-profit—Medicare. In this situation, a non-profit provider can meaningfully distinguish itself, demonstrating its charitable nature, through its use of funds. DCI's charitable use of funds, memorialized in its articles of incorporation, benefits mankind without private benefit. (Supp. 37, 40.)

The record clearly demonstrates that DCI sets aside 50% of its net income for research purposes. (Supp. 73, 99; Supp. 182, Tr. 141; Supp. 201, Tr. 216.) This evidence is uncontested. The Commissioner dismisses this evidence noting that “[o]ther than the bare information reported on the corporate tax returns and witness testimony regarding one donation to [UC], [there is] no evidence regarding research contributions.” (Commr. Brief pg. 37.) But this is simply wrong.

The Form 990 tax returns, signed under penalties of perjury, clearly show DCI's research expenditures as a company are no fanciful lark. DCI's Form 990 for 2003 shows that with net income of \$6.3 million, DCI donated \$5.6 million to ESRD research. (Supp. 59, 73.) The contributions to ESRD research were similar in 2004, where DCI recorded net income of \$32 million while donating almost \$5 million to research. (Supp. 86, 99.) Obviously, the percentage of net revenue actually donated to research institutions vary in these two years (89% in 2003 and 15% in 2004). (See Supp. 186-87, Tr. 153-54 (explaining that fifty percent of profits each year is set aside for research and those funds are sometimes aggregated from year to year to maximize research benefits).) What is abundantly clear, however, is that DCI donates millions of dollars every year to fight kidney disease. Likewise, the fact that 50 percent of net revenue is set aside for research, and not to private benefit, is not in dispute.

Live witness testimony, likewise given under oath, further amplified how the set-aside procedure works. Lee Horn testified that any excess revenues beyond operations: "are paid to universities and research organizations to do strictly end-stage renal disease research and used strictly for research purposes * * * [and] not [to any] for-profit entity or [for] anyone to profit from." (Supp. 179-80, Tr. 129-30.) Mr. Dansro similarly testified that any profits "are split into two segments. 50 percent [per year] goes directly to research, possible research, and the other 50 percent [per year] goes back to needs for the operation * * *." (Supp. 182, Tr. 141; Supp. 201, Tr. 216.) This does not represent the amount of money actually donated per year, but rather the amount of profits *irrevocably set aside* each year for research purposes. (Supp. 186-87, Tr. 153-54 ("But the thing with that money is that goes years back. That's not based just on those numbers. The research—the 50 percent money every year gets set aside, so it depends on when the researcher wants to do a research project.")) Mr. Dansro also confirmed that no individuals profit from DCI's operations. (Supp. 183, Tr. 143.) All of the testimony is consistent that no profits inure to private benefit; net revenues are used to fund operations, such as opening new clinics in underserved areas, used for the children's dialysis camp, or used for research in subsequent years.

DCI's employees do not even earn market wages. Lee Horn testified that DCI's pay scale is "quite a bit below the for-profit pay scale, substantially." (Supp. 160, Tr. 52.) In 2003, DCI's President made only \$206,931, while earning \$222,616 in 2004. (Supp. 74, 100.) DCI's founder, Dr. Keith Johnson, earned all of \$0 in both 2003 and 2004. (Supp. 74, 100.) In short, no one is pulling money out of DCI in the form of an exorbitant salary.

DCI simply is what it claims—a charity. The difference between DCI and a for-profit dialysis clinic is quite clear: "the money that [a for-profit clinic] make[s] is going to be shared by the shareholders and other projects that might make them more money, whereas DCI will put their

money towards furtherance of trying to figure out how to 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." (Supp. 202, Tr. 220.)

DCI meets this Court's totality of the circumstances test for a charitable property tax exemption under R.C. 5709.121 because: (1) it is a non-profit charitable institution devoted entirely to the public welfare; (2) the West Chester Clinic is part of those operations, and (3) while the West Chester Clinic is not profitable, any profit DCI may generate as an institution is irrevocably impressed into the public trust. No benefit inures to any private individual.

II. THE MAJORITY OF SISTER STATES' HIGH COURTS WOULD FIND DCI A CHARITABLE INSTITUTION EXEMPT FROM REAL ESTATE TAXES.

The persuasive authorities cited by DCI in its Merit Brief fully support DCI's claim of charity. In his Merit Brief, the Commissioner attempts to both (i) distinguish the cases cited by DCI and (ii) direct the Court to other states' judicial decisions which the Commissioner asserts supports his position. As set forth fully below, the Commissioner failed on both counts. First, the Commissioner failed to meaningfully distinguish the cases cited by DCI. Moreover, upon critical examination, the cases cited by the Commissioner do not support the Commissioner's position.

A. The Commissioner cannot distinguish *Wexford* or *St. Joseph's Living Center*.

The Commissioner unpersuasively attempts to distinguish *Wexford Med. Group v. City of Cadillac* (2006), 474 Mich. 192, 713 N.W.2d 734 and *St. Joseph's Living Ctr. v. Town of Windham* (2007), 290 Conn. 695, 966 A.2d 188. As described fully in DCI's Merit Brief, the facts in *Wexford* are very similar to the facts of this case. While the Commissioner argues that the *Wexford* decision "accorded significant weight to the provider's charity care policy as opposed to the provider's purported charitable activities," the Michigan Supreme Court *explicitly recognized* that the hospital provided charity by accepting Medicaid and Medicare patients because the government funding falls

short of reimbursing the costs the hospital incurred to provide medical care. *Wexford*, 474 Mich. at 217. (Commr. Brief pg. 47.)

In addition, the Commissioner contends that *Wexford* is distinguishable because the Michigan court presumed the property was exempt unless otherwise stated. (Commr. Brief pg. 47.) However, that contention is premised on a portion of a sentence taken out of context. The full discussion reads as follows:

Because there is no statutory language that precludes finding petitioner exempt as a charitable institution, and because exempting petitioner on that basis fully comports with the reasoning of our previous cases, we hold that petitioner does in fact qualify for that exemption. In refusing to grant the exemption, ***the Tax Tribunal adopted a wrong principle and misapplied the law by failing to distinguish ProMed Healthcare v City of Kalamazoo***, 249 Mich. App. 490; 644 N.W.2d 47 (2002), ***and by focusing only on the amount of free medical services plaintiff provided***. Instead, the tribunal should have considered plaintiff's unrestricted and open-access policy of providing free or below-cost care to all patients who requested it.

Id. at 195-96 (emphasis added). The Michigan court did not presume that the hospital was entitled to an exemption. Rather, because the Michigan legislature did not define the term “charitable institution,” the court merely applied a test similar to Ohio’s “totality of the circumstances” test in determining “whether an institution is a ‘charitable institution’ when it performs some level of charitable work.” *Id.* at 202.

The Commissioner also failed to meaningfully distinguish *St. Joseph’s Living Ctr.*, 290 Conn. 695. The Commissioner asserts that the case is irrelevant because Ohio has a separate tax exemption for homes for the elderly, which presumably would have applied had the case arisen in Ohio. (Commr. Brief pg. 48.) This objection does not carry much weight, however, as the Connecticut court analyzed the operation of the nursing home in the context of a charitable tax exemption. See, generally, *id.* As such, the case is persuasive authority for determining what is a charitable institution.

In brief, the Connecticut court recognized that providing care to Medicaid patients without discrimination is a charitable activity. *Id.* at 732 (accepting Medicaid patients “is the modern equivalent of caring for the indigent.”); (see, also, Supp. 157, Tr. 39-41; Supp. 188, Tr. 164-65 (DCI’s percentage of Medicare and Medicaid patients).) In fact, the court found that the center was a charitable institution regardless of the fact that it did not provide free care. *Id.* at 703-04. This case is instructive and persuasive notwithstanding that a different statute may have applied if the case had arisen in Ohio.

In sum, the Commissioner cannot distinguish either *Wexford* or *St. Joseph’s Living Ctr.* Recognizing that modern charitable healthcare is exhibited in ways beyond mere provision of “free care,” these state supreme courts rightly concluded that institutions similar to DCI were charitable institutions and exempt from real estate taxes.

B. The cases cited by the Commissioner are unpersuasive and distinguishable.

The Commissioner cites to Georgia, Illinois, Utah, and Minnesota as examples of states that have found non-profit healthcare providers to be non-exempt under their respective state’s exemption statutes. (Commr. Brief pg. 46.) The Georgia case cited by the Commissioner is instructive, though not for the reasons cited by the Commissioner. See *Georgia Osteopathic Hosp. v. Alford* (1962), 217 Ga. 663, 124 S.E.2d 402. In *Georgia Osteopathic*, the Georgia Supreme Court upheld denial of a tax exemption for a hospital pursuant to the Georgia constitutional provision providing exemption for “an institution of purely public charity.” *Id.* at 667, quoting *Mu Beta Chapter House Corp. v. Davison* (1941), 192 Ga. 124, 126, 14 S.E.2d 744. The court noted that a hospital *can* be a purely charitable institution even if it derived a profit from paying patients but, as in Ohio, the important consideration was where the profits went. *Id.* at 666-67. In *Georgia Osteopathic*, the profits went to the doctors. *Id.* at 668. If this Court were to follow *Georgia*

Osteopathic, as the Commissioner suggests, DCI is a charitable institution because DCI's profits are indisputably used *entirely* to benefit those suffering from ESRD and do not inure to private interests.

Provena Covenant Med. Ctr. v. Dept. of Revenue (Ill. Mar. 18, 2010), No. 107328, 2010 ILL LEXIS 289, a recent decision of the Illinois Supreme Court, is not binding in Illinois and should not be persuasive here. *Provena* at *64 (Burke, J., concurring in part and dissenting in part) (joining “plurality opinion” as to result, but dissenting from portion of the decision which addresses the doctrine of charitable use); see, also, John D. Colombo, *Provena Covenant: The (Sort Of) Final Chapter*, *The Exempt Organization Tax Review*, Vol. 65, No. 5 (2010) 489, 490 (the 3-2 decision is only a plurality decision because two of the seven justices recused themselves). Aside from its lack of precedential value, the *Provena* decision is easily distinguishable and bad jurisprudence.

First, *Provena* is distinguishable because the Illinois court applied a much different standard than the totality of the circumstances test applicable in Ohio. In determining whether the hospital was a charitable institution, the Illinois court applied a five-element, conjunctive test. *Id.* at *29. This test includes a determination that the charity “derive[] its funds mainly from private and public charity * * *.” *Id.* This Court has never required that a charitable institution obtain funding mainly through donations. In addition, the *Provena* decision relies heavily on whether the hospital’s activities “relieve the burdens on government.” *Id.* at *37.¹⁰ This is also a requirement that is not found in Ohio law.

¹⁰ The Illinois high court stated, “[I]t is the *sine qua non* of charitable status that those seeking a charitable exemption be able to demonstrate that their activities will help alleviate some financial burden incurred by the affected taxing bodies in performing their governmental functions. * * * The record is devoid of findings regarding any of [the local] taxing bodies or the services and support they provide to Champaign County residents. As a result, we have no way to judge how, if at all, Provena Hospitals’ use of its [] property in 2002 lessened the burdens those bodies would otherwise have been required to bear.” *Provena* at *38-39.

Moreover, the *Provena* decision implicitly requires that charitable health care organizations provide some unknown level of free care. *Id.* at *33. As the dissent noted, such a requirement usurps the legislative function and results in uncertainty. *Id.* at *65-70 (Burke, J., concurring in part and dissenting in part). “The legislature did not set forth a monetary threshold for evaluating charitable use. We may not annex new provisions or add conditions to the language of the statute. Yet, this is exactly what the plurality does.” *Id.* at *65, citing *Wexford*, 474 Mich. 192 (citations omitted). In addition, the requirement of free care results in taxability fluctuating yearly depending on economic factors beyond the control of the organization, and will “only cause confusion, speculation, and uncertainty for everyone: institutions, taxing bodies, and the courts.” *Id.* at *69-70, citing *Med. Ctr. Hosp. of Vermont, Inc. v. City of Burlington* (1989), 152 Vt. 611, 566 A.2d 1352.

Finally, like the Commissioner, the *Provena* decision inaccurately portrays actions by the hospital as uncharitable when in fact such actions are required by Medicare regulations. The plurality opinion decries the fact that the hospital did not advertise its free or discounted medical care. *Id.* at *10, 41. As explained above, Medicare regulations prohibit such marketing because such advertising may induce potential Medicare beneficiaries to select that provider. See Section 1395nn, Title 42, U.S. Code; Section 1320a-7b(b)(2), Title 42, U.S. Code. In addition, the plurality found that the hospital’s policy of charging uninsured patients the established rate undermined the hospital’s claim of charity. *Id.* at *45. This again misunderstands the effects of Medicare regulations, which require a uniform fee schedule. Section 1320a-7, Title 42, U.S.C.; see, also, Pryor and Seifert, at 10.

Similar to *Provena*, the Utah and Minnesota cases cited by the Commissioner apply different standards to determine whether an institution is entitled to a charitable-use exemption to property tax. See *Utah Cty.*, 709 P.2d 265; *Chisago Health Servs. v. Commr. of Revenue* (Minn. 1990), 462

N.W.2d 386. In *Utah County*, the Utah Supreme Court itself distinguished Ohio law, which a dissenting justice cited as good jurisprudence. *Utah Cty.*, 709 P.2d at 272, 297, citing *Vick*, 2 Ohio St.2d 30. The court noted that, unlike Utah law, Ohio “does not insist on identifying the element of gift in an organization’s practices before it can be held to be a charity.” *Id.* at 272. The dissent in *Utah County* cited *Vick* and *O’Brien* for the proposition that

hospital property is used for charitable purpose if the hospital is not organized for profit and no private gain is in fact derived from its earnings or upon dissolution; all earnings are used to maintain the hospital facility; the hospital is open to the public without restriction to race, color, or creed; and admission is not predicated upon ability to pay.

Id. at 297 (Howe, J., dissenting). The dissent also noted that *Vick* and numerous other jurisdictions do not disqualify a hospital from receiving a charitable exemption “merely because patients who are able to pay are required to do so” as long as the funds are used to further the institution’s charitable purposes. *Id.*

Chisago is also distinguishable. Like Illinois, Minnesota includes in its analysis “the extent to which the entity is supported by donations and gifts.” *Chisago*, 462 N.W.2d at 391, citing *North Star Research Inst. v. Cty. of Hennepin* (1975), 306 Minn.1, 6, 236 N.W.2d 754. Also like Illinois, the Minnesota court questioned whether the medical facilities “lessen the burden of government in the overall field of health care,” a consideration that is not a part of Ohio’s charitable property tax exemption jurisprudence. *Id.* at 392. Further, in examining the charity offered by the healthcare facility in *Chisago*, the Minnesota court took great pains to distinguish *Mayo Found. v. Commr. of Revenue* (1975), 306 Minn. 25, 236 N.W.2d 767, where the community outreach, medical research, and education programs warranted exemption. *Id.* at 390 fn.2, 392, citing *Mayo Found.*, 306 Minn. at 38.

In sum, the cases cited by the Commissioner do not advance his argument. *Georgia Osteopathic Hosp.* is clearly distinguishable because the profits of the hospital in that case inured to a private benefit, namely the physicians who worked at the hospital. And, in *Provena, Utah Cty.*, and *Chisago*, the courts applied standards much different from Ohio's "totality of the circumstances" test. Moreover, neither the Commissioner nor these cases refute the fact that requiring "free care" usurps the legislative function and results in perpetual uncertainty for charitable healthcare providers, local taxing authorities, and the courts. The Court should not find these cases persuasive.

CONCLUSION

The Commissioner urges the Court to abandon its flexible "totality of the circumstances" test in favor of a rigid test that requires an unknown and unknowable quantum of "free care." This would represent a radical departure from this Court's long-established precedents. The "totality of the circumstances" test permits the Court to examine all of the facts in a given case to determine whether a particular applicant for exemption is worthy. DCI is a worthy applicant, and the Court should reverse the BTA.

This Court has recognized the realities of modern healthcare reimbursement mechanisms stating as follows:

[t]oday, in part as a result of the prevalence of medical insurance plans, a substantial proportion of the patients of the average privately owned nonprofit but publicly operated general hospital possess the financial resources to defray the cost of care and treatment of their needs. Both the patients and the tax-exempt hospital are the recipients of a gain or profit to the extent of the tax exemption of the property of the institution. This inexorable fact defeats neither the charity nor the tax exemption.

Planned Parenthood Assn., 5 Ohio St.2d at 121-22. The fact is that in modern America, dialysis for ESRD patients is nearly universally covered by Medicare. Moreover, it is undisputed that DCI could not accomplish its charitable mission without participating in the Medicare system. Therefore, the primary source of funds for a for-profit and non-profit dialysis provider will be the same—Medicare.

What is dramatically different is how the for-profit and non-profit providers use those funds. This Court has already held that a healthcare provider is charitable when "[t]here is no evidence that the hospital was being operated for private profit or that any funds of the hospital, including the surplus, were being diverted to wrongful uses * * * ." *Vick*, 2 Ohio St.2d 30, 33-34. The record is clear that DCI pours all of its revenues into accomplishing its mission to treat and fight kidney disease. No benefit inures to any private interest. For-profit operators, on the other hand, operate solely for private benefit, namely the benefit of their shareholders. Nothing could be more different.

DCI urges this Court to interpret its prior holdings, as did a justice of the Utah supreme court, and hold that

hospital property is used for charitable purpose if the hospital is not organized for profit and ***no private gain is in fact derived from its earnings*** or upon dissolution; ***all earnings are used to maintain the hospital facility***; the hospital is open to the public without restriction to race, color, or creed; and admission is not predicated upon ability to pay.

Utah Cty., 709 P.2d at 297 (Howe, J., dissenting). Interpreting *O'Brien* and *Vick* in this manner, and applying the "totality of the circumstances" test established in *Vick* and *Bethesda Healthcare*, DCI is entitled to a charitable real estate tax exemption.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing has been duly served upon the following by regular U.S. mail postage pre-paid this 1st day of June, 2010:

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