

ORIGINAL

In the
Supreme Court of Ohio

RURAL HEALTH COLLABORATIVE OF SOUTHERN OHIO, INC.,	:	
	:	
	:	Case No. 2014-0963
	:	
Appellee,	:	
	:	Appeal from Ohio Board of Tax Appeals
v.	:	
	:	
JOSEPH W. TESTA, TAX COMMISSIONER OF OHIO	:	BTA Case No. 2012-3421
	:	
	:	
Appellant.	:	

APPENDIX TO APPELLANT TAX COMMISSIONER'S MERIT BRIEF

MARK A. ENGEL (0019486)
Bricker & Eckler LLP
9277 Centre Pointe Drive, Suite 100
West Chester, Ohio 45069
Telephone: (513) 870-6565
Facsimile: (513) 870-6699
mengel@bricker.com

*Counsel for Appellee
Rural Health Collaborative
of Southern Ohio, Inc.*

MICHAEL DEWINE (0009181)
Attorney General of Ohio
DAVID D. EBERSOLE (0087896)*
BARTON HUBBARD (0023141)
Assistant Attorneys General
*Counsel of Record
30 East Broad Street, 25th Floor
Columbus, Ohio 43215-3428
Telephone: (614) 644-8909
Facsimile: (877) 636-8331
dave.ebersole@ohioattorneygeneral.gov

*Counsel for Appellant
Joseph W. Testa, Tax Commissioner of Ohio*

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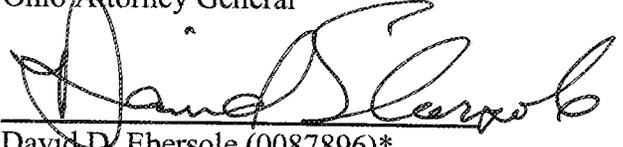
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Respectfully submitted,

Michael DeWine
Ohio Attorney General



David D. Ebersole (0087896)*

Barton A. Hubbard (0023141)

*Counsel of Record

Assistant Attorneys General

30 East Broad Street, 25th Floor

Columbus, Ohio 43215

Telephone: (614) 644-8909

Facsimile: (877) 636-8331

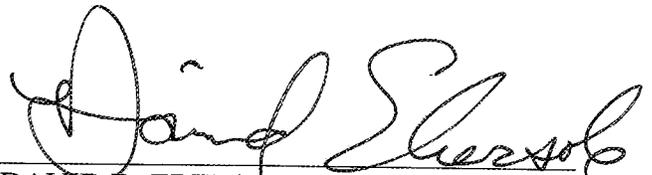
*Counsel of Appellant Joseph W. Testa,
Tax Commissioner of Ohio*

CERTIFICATE OF SERVICE

I hereby certify that the foregoing Appendix to Appellant Tax Commissioner's Merit Brief was served upon the following by U.S. regular mail on this 21st day of October, 2014:

MARK A. ENGEL
Bricker & Eckler LLP
9277 Centre Pointe Drive, Suite 100
West Chester, Ohio 45069

*Counsel for Appellee
Rural Health Collaborative
of Southern Ohio, Inc.*



DAVID D. EBERSOLE (0087896)

Assistant Attorney General

which operates a dialysis clinic there. RHC established the dialysis clinic to fill an unserved need for dialysis services in the Adams, Brown, and Highland County area; previously, the closest dialysis services were located an hour or more away, in Portsmouth, Cincinnati, and Columbus. RHC seeks exemption pursuant to R.C. 5709.12 and R.C. 5709.121. The Supreme Court recently explained these sections as follows: “[P]ursuant to R.C. 5709.12(B), any institution, charitable or noncharitable, may qualify for a tax exemption if it is making exclusive charitable use of its property. But if the property belongs to a charitable or educational institution, R.C. 5709.121 defines what constitutes exclusive use of property in order to be exempt from taxation.” *Cincinnati Community Kollel v. Testa*, 135 Ohio St.3d 219, 2013-Ohio-396, ¶23.

Relying heavily on the Supreme Court’s denial of exemption of a similar facility owned and operated by DCI, *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St.3d 215, 2010-Ohio-5071, the commissioner denied exemption of the subject property, finding that the property is not used for a charitable purpose because DCI’s indigent care policy “explicitly reserves the right to refuse to treat indigent patients.” Final Determination at 3. RHC thereafter appealed to this board. At this board’s hearing, RHC presented extensive testimony from individuals associated with RHC and DCI regarding the use of the property and DCI’s provision of charitable care.

In our review of this matter, we are mindful that the findings of the Tax Commissioner are presumptively valid. *Alcan Aluminum Corp. v. Limbach* (1989), 42 Ohio St.3d 121. Consequently, it is incumbent upon a taxpayer challenging a determination of the commissioner to rebut the presumption and to establish a clear right to the requested relief. *Belgrade Gardens v. Kosydar* (1974), 38 Ohio St.2d 135; *Midwest Transfer Co. v. Porterfield* (1968), 13 Ohio St.2d 138. In this regard, the taxpayer is assigned the burden of showing in what manner and to what extent the commissioner’s determination is in error. *Federated Dept. Stores, Inc. v. Lindley* (1983), 5 Ohio St.3d 213.

Although RHC makes arguments with regard to both R.C. 5709.12 and R.C. 5709.121, it primarily seeks exemption under R.C. 5709.121(A)(2), which requires that the property “(1) be under the direction or control of a charitable institution or state or political subdivision, (2) be otherwise made available ‘for use in furtherance of or incidental to’ the institution’s ‘charitable *** or public purposes,’ and (3) not be made available with a view to profit.” *Cincinnati Nature Center Assn. v. Bd. of Tax Appeals* (1976), 48 Ohio St.2d 122, 125. We first, therefore, determine whether RHC is a charitable institution. With regard thereto, *Planned Parenthood Assn. v. Tax Commr.* (1966), 5 Ohio St.2d 117, paragraph one of the syllabus, provides “‘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.”

The court in *Dialysis Clinic*, supra, explained that “[w]e have held that the determination of an owner’s status as a ‘charitable institution’ under R.C. 5709.121 requires a review of the ‘charitable activities of the taxpayer seeking the exemption.’ Id. at ¶27 (citing *OCLC Online Computer Library Ctr., Inc. v. Kinney* (1984), 11 Ohio St.3d 198). Specific to an entity whose core activities involved the provision of a healthcare service, the court further explained that such institution would only qualify as “charitable” if it “provided service ‘on a nonprofit basis to those in need, without regard to race, creed, or ability to pay.’” Id. at ¶29 (citing *Church of God in N. Ohio v. Levin*, 124 Ohio St.3d 36, 2009-Ohio-5939, ¶19). However, it cautioned that “[a] threshold amount of unreimbursed care is not required.” Id. at ¶40.

In *Dialysis Clinic*, DCI sought exemption for a dialysis clinic it owned and operated. The court, in a four to three majority opinion, in affirming this board’s decision, found that DCI did not qualify as a “charitable institution” under R.C. 5709.121. The court noted that DCI based its argument almost solely on its status as a

federal tax exempt organization, and rejected that argument, as it has in the past. *Id.* at ¶25 (“DCI’s argument would conflate Ohio’s property-tax exemption with standards under federal law for tax-exempt charities.”), citing *NBC-USA Hous., Inc.-Five v. Levin*, 125 Ohio St.3d 394, 2010-Ohio-1553, ¶20. In looking to DCI’s activities, the court further found insufficient evidence of charitable activities. *Id.* at ¶14 (“*** DCI did not present a charity-care figure ***.”). The court further found that, consistent with its determination regarding DCI’s status as a “charitable institution,” its use of the property did not qualify as exclusive charitable use under R.C. 5709.12(B).

The parties disagree on the applicability of the court’s decision in *Dialysis Clinic* to the present matter. The appellee commissioner argues that the case “is indistinguishable from the present case,” Appellee’s Brief at 1. RHC, on the other hand, argues that the party in interest is different in this case, that RHC does not rely on its or DCI’s federal tax exempt status in establishing its charitable status, and that more evidence has been presented regarding the charitable use of the subject property. We agree with RHC – the focus in this matter is whether RHC is a charitable institution, not DCI. Notwithstanding the court’s repeated statement that proceedings related to previous tax years are not relevant to a separate tax year, see, e.g., *Hubbard Press v. Tracy* (1993), 67 Ohio St.3d 564, and the fact that a different entity (RHC) is seeking exemption in this matter, the record in the present case has substantially more evidence regarding RHC’s activities and purposes, and DCI’s activities at the subject property.

As explained by Kimberly Patton, CEO of IHealth Source of Ohio and RHC board member, at this board’s hearing, RHC was created to address the collective health needs of the area its members serve.² In addition to establishing the subject dialysis clinic, RHC has also filed applications for grants for tobacco cessation funding, pregnancy care and education, diabetes prevention and education, and

² RHC’s articles of incorporation provide that its purposes are: “(i) to enhance the quality, availability and efficiency of comprehensive health services for the people of southern Ohio by enabling and mobilizing community partnerships and resources; (ii) identifying and addressing healthcare needs which can be most effectively and efficiently responded to collectively (or ‘in a collective manner’); and (iii) supporting and furthering the missions of the member organizations.” H.R., Ex. 7 at 3.

managed care planning, and has jointly discussed addressing community health needs, such as opiate use, availability of rabies vaccines, and blood drives. In addition, RHC discussed the need for a dialysis clinic in the area, and established such a clinic at the subject property. And, indeed, our review of RHC's activities indicates that such actions are congruent with its purpose. The majority of the services facilitated by RHC's collaborative activities are made available to the community at large without charge. H.R. at 380-383. Accordingly, upon review of the record, we find that RHC is a charitable institution whose purpose is to benefit the community by providing improved health care. Cf. *Northeast Ohio Psych. Inst. v. Levin*, 121 Ohio St.3d 292, 2009-Ohio-583 (finding entity whose *sole* activity was leasing a building to another charitable entity was not a charitable institution).

Having found that RHC is a charitable institution, we next turn to a determination of whether the subject property is "made available under the direction or control of such institution *** for use in furtherance of its charitable *** purposes and not with a view to profit." As the court instructed in *Cincinnati Community Kollet*, supra, at ¶28, "the focus of the inquiry should be on the relationship between the actual use of the property and the purpose of the institution. See *Community Health Professionals, Inc. v. Levin*, 113 Ohio St.3d 432, 2007-Ohio-2336, ***." It is clear that the subject property is made available by RHC for use in furtherance of its purpose to improve the availability of health care in its three-county area, by providing dialysis services to a population that otherwise would not have such services available in the near proximity. Ms. Patton testified that RHC discussed the need for dialysis services in the area and ultimately determined that the best course of action would be for RHC to establish a facility and lease it to a dialysis operator.³

Further, the record demonstrates that the property is made available without a view to profit. RHC's financial statements indicate that the lease payments

³ Ms. Patton explained that the water requirements for a dialysis treatment center were specific and intensive, and, as such, an existing building was not available to house such activities. H.R. at 391. Andrew Mazon, DCI administrator for the subject clinic, further explained that the water filtration required for dialysis treatment requires "a huge filtration system." Id. at 193.

made by DCI to RHC exceeded the expenses of operating the building for most of the years 2006 through 2013.⁴ H.R., Ex. 11. With regard to DCI's activities on the property, i.e., providing dialysis treatment services, we initially note Ms. Patton's testimony that RHC interviewed three potential dialysis service providers, including DCI and two for profit entities, and the financial risk associated with operating a clinic in the Adams County area appears to have been the main reason one for profit provider would not operate there.⁵ H.R. at 390. We also note that RHC's lease with DCI was renegotiated twice because DCI was losing a "sizable amount of money operating the clinic ***;" and its financial situation had not improved several years later. Id. at 189-190. While the commissioner argues that DCI as a national organization does profit from its activities generally, it seems clear that its operation of the subject dialysis clinic is not a profitable enterprise. Its financials for the subject clinic indicate it has had an excess of expenses over revenues every year from 2006 to 2013. H.R., Ex. 15. Notably, a portion of those expenses relate to the write-off of care to patients who do not have adequate coverage through government or private insurers, and cannot independently pay their service balances. H.R., Ex. 14.

The commissioner further argues that DCI does not provide sufficient charitable care at the subject clinic, defined as "services being provided 'on a nonprofit basis to those in need, *without regard to race, creed, or ability to pay.*' (Emphasis added.) *Church of God in N. Ohio, Inc.*], supra, ¶19." *Dialysis Clinic*, supra, at ¶26. In *Bethesda Healthcare, Inc. v. Wilkins*, 101 Ohio St.3d 420, 2004-Ohio-1749, the Supreme Court held that "[w]hether 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." Id. at ¶39. The court, in *Dialysis Clinic*, supra, further explained that "[i]n the age of Medicare and Medicaid, the usual and ordinary indigent patient may have access to government benefits, and the modern healthcare provider is not

⁴ In 2009, the revenue from "dialysis operations" exceeded the expenses related thereto by \$9,862. H.R., Ex. 11.

⁵ Ms. Patton further testified that Adams County is one of the top five poorest counties in Ohio, and that Brown and Highland counties are economically depressed. H.R. at 392.

required to forgo the pursuit of those benefits to qualify for charitable status.” *Id.* at ¶42.

The commissioner argues that the *Dialysis Clinic* court’s finding with regard to DCI’s indigence policy is definitive as to the charitable use of the subject property, which operates with the same policy. DCI’s policy states that, although DCI provides service without regard to a patient’s ability to pay, such indigency 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.” H.R., Ex. 6 at 2. Testimony elicited at this board’s hearing indicated that no patient has been denied services at the subject clinic because of an inability to pay. H.R. at 231-233. RHC provided a summary of patient records showing the amount of care “written off” during the years 2006 through 2013.⁶ H.R., Ex. 14. Upon review of the records presented, we find that, based on a totality of the circumstances, RHC has presented sufficient evidence of charitable care provided at the subject clinic. We further note that the evidence presented in this case differs from that presented in *Dialysis Clinic*, *supra*, where the court noted that “DCI did not present a charity care figure.” *Id.* at ¶14.

Based upon the foregoing, we find that appellant has sufficiently demonstrated its right to exemption pursuant to R.C. 5709.121(A)(2). Accordingly, the commissioner’s final determination is hereby reversed.

I hereby certify the foregoing to be a true and complete copy of the action taken by the Board of Tax Appeals of the State of Ohio and entered upon its journal this day, with respect to the captioned matter.



A.J. Grocber, Board Secretary

⁶ The information presented differentiates between “Medicare write-off” and “non-Medicare write-off.” Mr. Mazon testified that Medicare will reimburse a portion of write-offs on DCI’s annual cost report. H.R. at 246.

2009 WL 4100065 (Ohio Bd.Tax.App.)

Board of Tax Appeals

State of Ohio

DIALYSIS CLINIC, INCORPORATED, APPELLANT

v.

WILLIAM W. WILKINS, TAX COMMISSIONER OF OHIO, APPELLEE

Case No. 2006-V-2389

November 24, 2009

***1 (Real Property Tax Exemption)**

DECISION AND ORDER

Appearances:

For the Appellant

Dinsmore & Shohl, LLP
Sean P. Callan
255 East Fifth Street, Suite 1900
Cincinnati, Ohio 45202

For the Appellee

Richard Cordray
Attorney General of Ohio
Ryan P. O'Rourke
Assistant Attorney General
State Office Tower, 25th Floor
30 East Broad Street
Columbus, Ohio 43215

Ms. Margulies, Mr. Johrendt, and Mr. Dunlap concur.

This matter is before the Board of Tax Appeals upon a notice of appeal filed by appellant **Dialysis Clinic, Incorporated** ("DCI"). DCI appeals from a final determination of the Tax Commissioner, in which the commissioner denied DCI's application for exemption of real property from taxation for tax year 2004, and remission of penalties for 2004 and 2005. On review, the commissioner's determination is affirmed.

This matter is considered by the Board of Tax Appeals upon the notice of appeal, the statutory transcript ("S.T."), and the record of the evidentiary hearing ("H.R.") held in this matter. The parties also provided legal arguments through briefs filed with the board.

DCI seeks exemption for one of its outpatient **dialysis clinics** located in West Chester, Ohio. In support of its exemption application, DCI's then-staff attorney Amy Wheeler submitted the following October 2006 correspondence to the commissioner, which states, in relevant part, as follows:

"DCI is a Tennessee non-profit, public benefit corporation qualified as a tax exempt organization under Section 501(c)(3) of the Internal Revenue Code. DCI's mission is to care for and rehabilitate patients suffering from chronic renal failure while constantly striving to improve the methods and quality of treatment. To this end, DCI operates approximately 195 outpatient **dialysis clinics** in 26 states, supports and participates in kidney-related research, and promotes professional and public education in this field of medicine. Each year, DCI sets aside a significant portion of its profits to be utilized for research ***. For its fiscal year ended September 30, 2005, DCI set aside \$13,622,000 for research on net profits of \$21,378,000. ¹ Additionally, DCI operates a summer camp for children *** who have chronic renal failure or who have received a kidney transplant. The camp *** had 97 campers in June 2006.

"DCI opened its **clinic** *** in October 2003. The Facility has 14 **dialysis** stations and currently serves approximately 30 patients providing **dialysis** services three days per week. *** DCI is, and has always been, the sole occupant of the Facility.

"DCI receives reimbursement for the services it provides from three main sources: Medicare, Medicaid and private insurers. Sixty-two percent of the Facility's patients are covered by Medicare and nine percent are covered by Medicaid. For many Medicare and Medicaid patients, DCI writes off the patient's responsibility based on indigency in accordance with DCI policy.

*2 "DCI is limited by federal and state laws in the ways in which it can provide charity care. Federal law prohibits healthcare providers from influencing patient choices of one provider over another by offering free items or services. Thus, DCI is not able to provide free items or services to patients who are eligible for Medicare and Medicaid. Because Medicare has a separate program for individuals with chronic renal failure, most patients are eligible for coverage. However, for those who are not eligible (mostly individuals who never worked or illegal aliens) or who have a waiting period before Medicare/Medicaid coverage begins, DCI does provide charity care. Amounts of charity care are kept at the local **clinics** and are not aggregated across the company. The Facility currently does not have any charity patients." S.T. at 114-115.

Attached to its exemption application is a copy of a 1995 amendment to DCI's restated charter, which states that the corporation's purpose is as follows:

"To operate **dialysis clinics**, to dialyze patients and to render such additional care as patients with chronic renal failure may require; to provide training and supplies to enable selected patients to undertake **dialysis** at home, and to do all acts and things necessary and incidental thereto.

"To receive and maintain a fund or funds of real and personal property or both, and to use and to apply the whole or any part of the income therefrom and the principal thereof exclusively for charitable, scientific or educational purposes related to kidney disease, either directly or by contributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code and its regulations as they now exist or as they may be hereinafter amended.

"To conduct research relating to kidney disease, **dialysis**, and transplantation, and to do any act or thing which may promote the effective treatment of kidney disease." S.T. at 154.

In his final determination, the commissioner decided to review DCI's request for exemption pursuant to R.C. 5709.12(B), noting DCI failed to specify any statutory basis for exemption on its application. S.T. at 1, 120. The commissioner found DCI to be a non-profit institution, but not a charitable one, and concluded R.C. 5709.121 is, therefore, inapplicable. S.T. at 1-2. The commissioner looked at evidence of DCI's use of the subject and found "no evidence of charitable care provided at the property." The commissioner denied exemption, stating:

"It is noted that merely collecting Medicaid or Medicare reimbursements is not a charitable act, but is receiving full agreed payment under a guaranteed insurance payment for medical services. The Medicaid fees paid are ones agreed to between the health care provider and the Medicaid insurer. Such insured payments are no different than payments agreed to and paid under commercial insurance agreements, whereby the insurer may contract with the care provider to pay a lower fee for services than that charged to uninsured patients. Further, medical care does not become charitable merely because a medical billing is deemed uncollectible and written off; such action being no more than an accounting tool by which a company may offset its business losses. *** Therefore, the write-offs submitted for the subject property or those submitted for the entire DCI system are insufficient to determine the amount of indigent patients seen without regard to ability to pay." S.T. at 3-4.

*3 In its notice of appeal, DCI asserts the commissioner erred by finding it was not a charitable institution, by finding that it does not use the subject property for a charitable purpose, and by finding that the property is not exempt from taxation.

At the hearing before this board, DCI presented two exhibits and the testimony of Mr. Lee Horn, in-house counsel for DCI, and Mr. Roy Dansro, DCI's regional administrator for the Cincinnati area. The Tax Commissioner presented five exhibits and two witnesses who work for the Ohio Department of Job and Family Services, Ms. Deborah Clement Saxe and Mr. Eric Edwards. Consistent with the facts as stated by his predecessor, Horn testified that DCI's mission is to provide treatment for end-stage renal disease without a profit motive. H.R. at 36, 101; S.T. at 153, 155, 158. He said DCI developed an indigence policy to satisfy Medicare requirements, which prohibit charging less for services than the amount charged to Medicare patients. H.R. at 39-40. To be considered under DCI's indigence policy, patients must complete a financial analysis form, which is then used to determine ability to pay.

The policy states: "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." Appellant's Ex. 4 at 2. The policy further states "all patients are personally responsible to pay for the treatment and services that DCI provides them." Id. It explains that reasonable collection actions will be taken against those who do not pay, including court action. "DCI has an affirmative obligation to collect copays and deductibles per managed care contracts." Id. Finally, the stated purpose of the indigence policy is to:

**** [E]stablish 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 reasonable collection efforts." Appellant's Ex. 4 at 1.

Horn testified that the policy addresses "the requirement that we not charge or offer services to patients cheaper than the Medicare rate." H.R. at 47. He further explained that indigent patients must first exhaust all possible insurance payment options before amounts owed will be considered under the policy. H.R. at 47, 70-71. If a patient qualifies under the indigence policy and is unable to pay for treatment, Horn testified that 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. H.R. at 78-81, Appellant's Ex. 5.

*4 Horn also testified as to the insurers that reimbursed DCI for services provided to patients during the period October 2006 to September 2007. H.R. at 90-101.² He said that on a company-wide basis, Medicare insured almost 75 percent of DCI patients for the 2006 to 2007 period. Horn obtained this percentage from a document he said he received from the company's controller, which also indicates private insurers covered 12.6 percent of DCI's patients, with Medicaid, HMOs, and the Veteran's Administration insuring, respectively, 6.2, 5, and 1.3 percent of patients. Appellee's Ex. C. This exhibit also indicates that DCI provided 1,836,058 treatments per year to a monthly average of 13,082 patients, generating \$526,891,082 in charges.³ Of this, 11,840 treatments per year were provided for a monthly average of 96 indigent patients with no insurance. Id. DCI

characterized approximately \$6.7 million of the charges for this period as a "bad debt charity write off" for those patients insured by Medicare.⁴

Finally, Horn testified that DCI voluntarily agrees to accept patients insured by Medicare and Medicaid. H.R. at 119-120. He also said DCI did not conduct research or its summer camp at the subject facility in West Chester. H.R. at 132.

DCI's other witness, Dansro, manages the subject in West Chester, three other **dialysis clinics** located throughout the Cincinnati area in Walnut Hills, Western Hills, and Forest Park, as well as a **clinic** in Maysville, Kentucky. H.R. at 135. Dansro testified that DCI's **dialysis** service is the same as that of a for-profit provider, but DCI invests excess revenue toward construction of new **clinics** and research to combat kidney disease. H.R. at 141, 220. He cited \$1.7 million in research funding he said DCI gave to the University of Cincinnati Medical College from 2004 to 2008. H.R. at 142, 215-217. He said that while DCI does not turn away patients without the ability to pay, all DCI patients are referred to its **clinics** after being treated and discharged from hospitals, so they rarely lack insurance.⁵ H.R. at 139, 168. In fact, Dansro said all patients treated at the subject since it opened in late 2003 have had some type of insurance. H.R. at 172, 221-222. He testified that of the approximately 350 total patients at the five **clinics** he manages, presently between six and nine receive treatment without insurance or the ability to pay. H.R. at 173-174. However, it is unclear from Dansro's testimony how long any patient receives treatment without insurance since he also testified that DCI's social workers supervise these patients in applying for Medicare and Medicaid.⁶ Id.

Finally, Dansro testified that **clinics** with fewer patients tend to lose money, such as the subject with 10 to 40 patients, while **clinics** with a higher volume tend to generate revenues in excess of expenses, such as Walnut Hills with 140 patients. H.R. at 152-156; 206-207. Based on data compiled by an employee under Dansro's supervision, the West Chester **clinic** generated \$552,488 in charges during 2004 with approximately 10 total patients and \$866,646 during 2005 with approximately 25 total patients. H.R. at 197-198, 221; Appellee's Ex. B. For these two years combined, insurers were responsible for approximately \$1.4 million in charges, with approximately \$8,000 billed to patients. Id.

*5 We begin our review by observing that the findings of the Tax Commissioner are presumptively valid. *Alcan Aluminum Corp. v. Limbach* (1989), 42 Ohio St.3d 121, 123. Consequently, it is incumbent upon a taxpayer challenging a determination of the Tax Commissioner to rebut that presumption. *Belgrade Gardens v. Kosydar* (1974), 38 Ohio St.2d 135, 143; *Midwest Transfer Co. v. Porterfield* (1968), 13 Ohio St.2d 138, 142. Moreover, the taxpayer is assigned the burden of showing in what manner and to what extent the commissioner's determination is in error. *Federated Dept. Stores, Inc. v. Lindley* (1983), 5 Ohio St.3d 213, 215. When no competent and/or probative evidence is developed and properly presented to the board to establish that the commissioner's determination is "clearly unreasonable or unlawful," the determination is presumed to be correct. *Alcan Aluminum*, at 123.

The rule in Ohio is that all real property is subject to taxation. R.C. 5709.01. Exemption from taxation is the exception to the rule. *Seven Hills Schools v. Kinney* (1986), 28 Ohio St.3d 186. The burden of establishing that real property should be exempt is on the taxpayer. Exemption statutes must be strictly construed. *American Society for Metals v. Limbach* (1991), 59 Ohio St.3d 38, 40; *Faith Fellowship Ministries, Inc. v. Limbach* (1987), 32 Ohio St.3d 432; *White Cross Hospital Assn. v. Bd. of Tax Appeals* (1974), 38 Ohio St.2d 199; *Gohlman v. Robert E. Bentley Post* (1952), 158 Ohio St. 295; *Nati. Tube Co. v. Glander* (1952), 157 Ohio St. 407; and *Willys-Overland Motors, Inc. v. Evatt* (1943), 141 Ohio St. 402.

In its appeal, DCI claims that the subject property should be exempt from taxation pursuant to R.C. 5709.12(B) and R.C. 5709.121. Under R.C. 5709.12(B), all "[r]eal and tangible personal property belonging to institutions that is used exclusively for charitable purposes shall be exempt from taxation ***." Thus, to grant an exemption under this section of the statute, it must be determined that (1) the property belongs to an institution, and (2) the property is being used exclusively for charitable purposes. *Highland Park Owners, Inc. v. Tracy* (1994), 71 Ohio St.3d 405, 406-407. The phrase "used exclusively" has been interpreted by the court to mean primary use. *True Christianity Evangelism v. Zaino* (2001), 91 Ohio St.3d 117, 120.

Moreover, if an institution is found to be "charitable," it can then be held to a more relaxed standard of "exclusive charitable use" found in R.C. 5709.121. That statute provides:

"Real property and tangible personal property belonging to a charitable *** institution *** shall be considered as used exclusively for charitable *** purposes by such institution, *** if it meets one of the following requirements:

"(A) It is used by such institution, *** or by one or more other such institutions, the state, or political subdivisions under a lease, sublease, or other contractual arrangement:

*6 "(1) As a community or area center in which presentations in music, dramatics, the arts, and related fields are made in order to foster public interest and education there;

"(2) For other charitable, educational, or public purposes;

"(B) It is made available under the direction or control of such institution, *** for use in furtherance of or incidental to its *** charitable *** purposes and not with a view to profit."

Thus, in deciding whether property is exempt under the charitable use provisions of R.C. 5709.12(B) and 5709.121, the first determination is whether a charitable or noncharitable institution is seeking exemption. If the institution is noncharitable, its property may be exempt if it uses the property exclusively for charitable purposes. *Highland Park Owners, Inc.*, supra. If the institution is charitable, its property may be exempt if it uses the property exclusively for charitable purposes or it uses the property under the terms set forth in R.C. 5709.121.⁷ *Olmsted Falls Bd. of Edn. v. Tracy* (1997), 77 Ohio St.3d 393, 396; *Episcopal Parish v. Kinney* (1979), 58 Ohio St.2d 199; *White Cross Hosp. Assn. v. Bd. of Tax Appeals* (1974), 38 Ohio St.2d 199.

Furthermore, "[w]hen charges are made for the services being offered, we must consider the overall operation being conducted to determine whether the property is being used exclusively for charitable purposes." *Bethesda Healthcare, Inc. v. Wilkins*, 101 Ohio St.3d 420, 2004-Ohio-1749, at ¶36. "Whether an institution renders sufficient services to persons who are unable to afford them to be considered as making charitable use of property must be determined on the totality of the circumstances; there is no absolute percentage." *Id.* at ¶39.

While the General Assembly has not defined what activities of an institution constitute charitable purposes, the Supreme Court of Ohio held in *Planned Parenthood Assn. of Columbus, Inc. v. Tax Commr.* (1966), 5 Ohio St.2d 117, paragraph one of the syllabus, that:

"[I]n 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."

In the present matter, we first find that DCI does not qualify for exemption under R.C. 5709.12(B) as an institution that uses the property exclusively for charitable purposes. *Highland Park Owners, Inc.*, supra. As DCI concedes, it provides no free or charitable service at the subject property. Consequently, for DCI to qualify for exemption, it must be found that DCI is the type of institution permitted the broader definition of "exclusive charitable use" found under R.C. 5709.121, where the threshold requirement is that the property owner be a charitable or educational institution, state or political subdivision. *True Christianity Evangelism v. Tracy* (1999), 87 Ohio St. 3d 48, 50. Although the record indicates DCI is a not-for-profit corporation that may operate the subject property without a view to profit, we are unable to find that DCI is a charitable institution.

*7 When we look at the “relationship between the actual use of the property and the purpose of the institution,” *Community Health Professionals, Inc.*, supra, we find DCI does not use the subject property in furtherance of or incidentally to its charitable purpose because it conducts no charitable activity at the clinic. Instead, like the operations of a for-profit corporation, it charges all patients for dialysis services, voluntarily enters contracts with government and private insurers to set charges for the provision of these services, and does not donate any of its services without charge or at a reduced charge. The only distinction we can find between DCI’s clinics and for-profit dialysis clinics is the manner in which a portion of excess revenue is used. From the limited record, it appears that the owner’s intent is to raise funds from its clinic operations to apply in part toward further clinic development and alleged research.⁸ However, any charitable purpose based on this use is vicarious. “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 v. Tracy* (1993), 67 Ohio St.3d 564, 566. See, also, *Seven Hills Schools*, supra; *Vick v. Cleveland Memorial Medical Foundation* (1965), 2 Ohio St.2d 30, 33.

Further, DCI explicitly states that its “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.” Appellant’s Ex. 4 at 2. The policy also states “all patients are personally responsible to pay for the treatment and services that DCI provides them.” Id. If payment is not received for services provided, then DCI pursues collection action, including court action, which presumably means obtaining judgment and recording a lien against non-paying patients. While DCI characterizes as charity its accounting practice of eventually writing off a portion of some patient charges deemed uncollectible bad debt, we find no evidence of DCI acting as a donor at any time by relinquishing its legal right to payment from patients for services provided.

In an Illinois tax exemption case involving a hospital, *Provena Covenant Med. Center v. Dept. of Revenue* (August 26, 2008), 384 Ill. App.3d 734, the court discusses the relationship between charity and gift giving as follows:

“‘Charity’ is an act of kindness or benevolence. There is nothing particularly kind or benevolent about selling somebody something. ‘Charity’ is ‘generosity and helpfulness[,] esp[ecially] toward the needy or suffering’ (Merriam-Webster’s Collegiate Dictionary 192 (10th ed. 2000)) — not merely helpfulness, note, but generosity. ‘Generosity’ means ‘liber[ality] in giving.’ Merriam-Webster’s Collegiate Dictionary 484 (10th ed. 2000). To be charitable, an institution must give liberally. Removing giving from charity would debase the meaning of charity, and we resist such an assault upon language. See C. Borek, *Decoupling Tax Exemption for Charitable Organizations*, 31 Wm. Mitchell L. Rev. 183, 187 (2004) (“the ‘legal’ meaning [of ‘charitable’] has so stretched the term beyond its etymological boundaries as to render the concept vacant, unoccupied by any useful legal notion of what ‘charitable’ means”).

*8 “***

“[A] gift is, by definition, free goods or services: ‘something voluntarily transferred by one person to another without compensation’ (Merriam- Webster’s Collegiate Dictionary 491 (10th ed. 2000)). Defining ‘gift’ in any other way would do violence to the meaning of the word. One can make a gift by charging nothing at all. Or one can make a gift by undercharging a person, that is, charging less than one’s cost (using cost as a baseline prevents the creation of an artificial gift through inflation of prices (37 Loy. U. Chi. L.J. at 511-12)), and in that case, part of the goods or services is given without compensation. ***. Provena quotes [a case that states]: ‘Charity,’ in law, is not confined *** to mere almsgiving.’ That is true. But it is confined to giving. Charity is a gift, and one can give a gift to a rich person as well as to a poor person, the object being ‘the improvement and promotion of the happiness of man.’ * * * Regardless of whether the recipient of the goods or services is rich or poor or somewhere in between, it is nonsensical to say one has given a gift to that person, or that one has been charitable, by billing that person for the full cost of the goods or services — whether the goods or services be medical or otherwise. For a gift (and, therefore, charity) to occur, something of value must be given for free.” Id. at 25-26 (internal case citations omitted).

Based on a review of the record, we find no evidence quantifying any meaningful act of DCI “giving” anything to patients. *Planned Parenthood Assn. of Columbus, Inc.*, supra. Again, DCI concedes it provides no free or charitable service at the subject property. DCI’s policy states that it “retains all rights to refuse to admit and treat a patient who has no ability to pay.” Even if

DCI agrees to temporarily provide treatment to a patient without the ability to pay, it appears that it does so with the expectation that the patient will qualify for some type of insurance and payments will soon begin. *Id.*

As to the alleged charitable Medicare write-offs, the record provides no evidence as to the relevant application year. Instead, in 2006 to 2007, DCI generated \$526,891,082 in charges and characterized approximately \$6.7 million, or 1.27 percent, of these charges as a "bad debt charity write off for those patients insured by Medicare. However, we are unable to find these write offs charitable since federal law expressly prohibits DCI from providing charitable care to patients insured by Medicare. Reply brief at 10.

Further, even if we were to accord this evidence any weight, since DCI presented no evidence as to actual costs, we are unable to determine from the record whether the amounts written off were anything more than simply excess charges over costs. And finally, even if we were to accept DCI's position as to the written-off bad debt, we would find 1.27 percent to be insufficient to meet the charitable service standards required for exemption. See, for example, *Bethesda Healthcare, Inc.*, supra. That finding would be buttressed by the fact that DCI provided, subject to its indigence policy, a monthly average of 96 uninsured indigent patients with less than one percent (.64 percent) of the 1,836,058 total dialysis treatments provided that year to a monthly average of 13,082 patients. We would also find this company-wide amount deficient. Consequently, we are unable to find DCI acts as a donor "without hope or expectation, if not with positive abnegation, of gain or profit." *Planned Parenthood Assn. of Columbus, Inc.*, supra.

*9 While the alleged research efforts of this organization may be laudable and while the individuals availing themselves of the dialysis services provided certainly benefit, DCI is not providing its services without an expectation that it will be compensated. Thus, DCI is not a charitable organization and the subject property is not entitled to exemption from taxation. Accordingly, it is the decision and order of the Board of Tax Appeals that the Tax Commissioner's final determination must be, and is, affirmed.

I Hereby Certify the Foregoing to be a True and Complete Copy of the Action Taken by the Board of Tax Appeals of the State of Ohio and Entered upon its Journal this Day, with Respect to the Captioned Matter.

Sally F. Van Meter
Board Secretary

Footnotes

- 1 The record does not contain DCI's federal tax return in support of the referenced 2005 tax year, but does contain copies of returns for 2003 and 2004. S.T. at 19-45 and 46-72. DCI states it netted \$32,167,517 on revenues of \$514,053,981 for tax year 2004, with approximately \$6 million apparently listed for research expenses. S.T. at 46, 47, 59, 63. For tax year 2003, DCI states it netted \$6,306,492 on revenues of \$479,127,641, with \$7 million apparently listed for research expenses. S.T. at 19, 20, 33. The record provides no further details or support regarding these stated research expenses.
- 2 He said he was unable to testify regarding insurers for the relevant exemption application period. *Id.*
- 3 Of these total charges, Medicare and private insurers make up 55.8 and 31.7 percent, respectively. *Id.*
- 4 See appellant's Ex. 5 at procedure 1001, attachment 1001A, cost code A101.
- 5 For patients without insurance, Dansro testified that DCI's charge is \$800 per treatment. Private insurers have negotiated charges of \$175 to \$475 per treatment, with Medicaid-insured patients charged the maximum reimbursement amount of \$155 per treatment. While Medicare patients are responsible for a 20 percent copayment of the Medicare rate, which is \$160 per treatment, approximately 85 percent of DCI's Cincinnati area Medicare patients have a secondary insurer that covers the copayment. H.R. at 166-168, 183-186.
- 6 Medicare established a special program to insure patients, regardless of age or income, who require dialysis due to end-stage renal disease, according to the testimony of the commissioner's witness, Eric Edwards, a Medicaid rules and policy expert for the Ohio Department of Job and Family Services. H.R. at 261-262, 269; S.T. at 115. He testified that patients can experience a one- to three-month long waiting period after completing a Medicare application before becoming eligible for benefits. *Id.*

7 To determine whether property is exempt in accordance with R.C. 5709.121, "property must [1] be under the direction or control of a charitable institution or state or political subdivision, [2] be otherwise made available 'for use in furtherance of or incidental to' the institution's 'charitable *** or public purposes,' and [3] not be made available with a view to profit." *Cincinnati Nature Center v. Bd. of Tax Appeals* (1976), 48 Ohio St.2d 122, 125. "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, Inc. v. Levin*, 113 Ohio St.3d 432, 2007-Ohio-2336, at 21.

8 Other than the bare information reported on corporate tax returns and witness testimony regarding one donation to the University of Cincinnati, we find no evidence regarding research or contributions by DCI. See footnote 1, supra; H.R. at 142.

2009 WL 4100065 (Ohio Bd.Tax.App.)

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1.47 Presumptions in enactment of statutes.

In enacting a statute, it is presumed that:

- (A) Compliance with the constitutions of the state and of the United States is intended;
- (B) The entire statute is intended to be effective;
- (C) A just and reasonable result is intended;
- (D) A result feasible of execution is intended.

Effective Date: 01-03-1972

5321.02 Retaliatory action by landlord prohibited.

(A) Subject to section 5321.03 of the Revised Code, a landlord may not retaliate against a tenant by increasing the tenant's rent, decreasing services that are due to the tenant, or bringing or threatening to bring an action for possession of the tenant's premises because:

- (1) The tenant has complained to an appropriate governmental agency of a violation of a building, housing, health, or safety code that is applicable to the premises, and the violation materially affects health and safety;
- (2) The tenant has complained to the landlord of any violation of section 5321.04 of the Revised Code;
- (3) The tenant joined with other tenants for the purpose of negotiating or dealing collectively with the landlord on any of the terms and conditions of a rental agreement.

(B) If a landlord acts in violation of division (A) of this section the tenant may:

- (1) Use the retaliatory action of the landlord as a defense to an action by the landlord to recover possession of the premises;
- (2) Recover possession of the premises; or
- (3) Terminate the rental agreement.

In addition, the tenant may recover from the landlord any actual damages together with reasonable attorneys' fees.

(C) Nothing in division (A) of this section shall prohibit a landlord from increasing the rent to reflect the cost of improvements installed by the landlord in or about the premises or to reflect an increase in other costs of operation of the premises.

Effective Date: 11-04-1974

5709.12 Exemption of property used for public or charitable purposes.

(A) As used in this section, "independent living facilities" means any residential housing facilities and related property that are not a nursing home, residential care facility, or residential facility as defined in division (A) of section 5701.13 of the Revised Code.

(B) Lands, houses, and other buildings belonging to a county, township, or municipal corporation and used exclusively for the accommodation or support of the poor, or leased to the state or any political subdivision for public purposes shall be exempt from taxation. Real and tangible personal property belonging to institutions that is used exclusively for charitable purposes shall be exempt from taxation, including real property belonging to an institution that is a nonprofit corporation that receives a grant under the Thomas Alva Edison grant program authorized by division (C) of section 122.33 of the Revised Code at any time during the tax year and being held for leasing or resale to others. If, at any time during a tax year for which such property is exempted from taxation, the corporation ceases to qualify for such a grant, the director of development shall notify the tax commissioner, and the tax commissioner shall cause the property to be restored to the tax list beginning with the following tax year. All property owned and used by a nonprofit organization exclusively for a home for the aged, as defined in section 5701.13 of the Revised Code, also shall be exempt from taxation.

(C)

(1) If a home for the aged described in division (B)(1) of section 5701.13 of the Revised Code is operated in conjunction with or at the same site as independent living facilities, the exemption granted in division (B) of this section shall include kitchen, dining room, clinic, entry ways, maintenance and storage areas, and land necessary for access commonly used by both residents of the home for the aged and residents of the independent living facilities. Other facilities commonly used by both residents of the home for the aged and residents of independent living units shall be exempt from taxation only if the other facilities are used primarily by the residents of the home for the aged. Vacant land currently unused by the home, and independent living facilities and the lands connected with them are not exempt from taxation. Except as provided in division (A)(1) of section 5709.121 of the Revised Code, property of a home leased for nonresidential purposes is not exempt from taxation.

(2) Independent living facilities are exempt from taxation if they are operated in conjunction with or at the same site as a home for the aged described in division (B)(2) of section 5701.13 of the Revised Code; operated by a corporation, association, or trust described in division (B)(1)(b) of that section; operated exclusively for the benefit of members of the corporation, association, or trust who are retired, aged, or infirm; and provided to those members without charge in consideration of their service, without compensation, to a charitable, religious, fraternal, or educational institution. For the purposes of division (C)(2) of this section, "compensation" does not include furnishing room and board, clothing, health care, or other necessities, or stipends or other de minimis payments to defray the cost thereof.

(D)

(1) A private corporation established under federal law, as defined in 36 U.S.C. 1101, Pub. L. No. 102-199, 105 Stat. 1629, as amended, the objects of which include encouraging the advancement of science generally, or of a particular branch of science, the promotion of scientific research, the improvement of the qualifications and usefulness of scientists, or the increase and diffusion of scientific knowledge is

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conclusively presumed to be a charitable or educational institution. A private corporation established as a nonprofit corporation under the laws of a state that is exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and that has as its principal purpose one or more of the foregoing objects also is conclusively presumed to be a charitable or educational institution.

The fact that an organization described in this division operates in a manner that results in an excess of revenues over expenses shall not be used to deny the exemption granted by this section, provided such excess is used, or is held for use, for exempt purposes or to establish a reserve against future contingencies; and, provided further, that such excess may not be distributed to individual persons or to entities that would not be entitled to the tax exemptions provided by this chapter. Nor shall the fact that any scientific information diffused by the organization is of particular interest or benefit to any of its individual members be used to deny the exemption granted by this section, provided that such scientific information is available to the public for purchase or otherwise.

(2) Division (D)(2) of this section does not apply to real property exempted from taxation under this section and division (A)(3) of section 5709.121 of the Revised Code and belonging to a nonprofit corporation described in division (D)(1) of this section that has received a grant under the Thomas Alva Edison grant program authorized by division (C) of section 122.33 of the Revised Code during any of the tax years the property was exempted from taxation.

When a private corporation described in division (D)(1) of this section sells all or any portion of a tract, lot, or parcel of real estate that has been exempt from taxation under this section and section 5709.121 of the Revised Code, the portion sold shall be restored to the tax list for the year following the year of the sale and, except in connection with a sale and transfer of such a tract, lot, or parcel to a county land reutilization corporation organized under Chapter 1724. of the Revised Code, a charge shall be levied against the sold property in an amount equal to the tax savings on such property during the four tax years preceding the year the property is placed on the tax list. The tax savings equals the amount of the additional taxes that would have been levied if such property had not been exempt from taxation.

The charge constitutes a lien of the state upon such property as of the first day of January of the tax year in which the charge is levied and continues until discharged as provided by law. The charge may also be remitted for all or any portion of such property that the tax commissioner determines is entitled to exemption from real property taxation for the year such property is restored to the tax list under any provision of the Revised Code, other than sections 725.02, 1728.10, 3735.67, 5709.40, 5709.41, 5709.62, 5709.63, 5709.71, 5709.73, 5709.78, and 5709.84, upon an application for exemption covering the year such property is restored to the tax list filed under section 5715.27 of the Revised Code.

(E) Real property held by an organization organized and operated exclusively for charitable purposes as described under section 501(c)(3) of the Internal Revenue Code and exempt from federal taxation under section 501(a) of the Internal Revenue Code, 26 U.S.C.A. 501(a) and (c)(3), as amended, for the purpose of constructing or rehabilitating residences for eventual transfer to qualified low-income families through sale, lease, or land installment contract, shall be exempt from taxation.

The exemption shall commence on the day title to the property is transferred to the organization and shall continue to the end of the tax year in which the organization transfers title to the property to a qualified low-income family. In no case shall the exemption extend beyond the second succeeding tax year following the year in which the title was transferred to the organization. If the title is transferred to the organization and from the organization to a qualified low-income family in the same tax year, the

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exemption shall continue to the end of that tax year. The proportionate amount of taxes that are a lien but not yet determined, assessed, and levied for the tax year in which title is transferred to the organization shall be remitted by the county auditor for each day of the year that title is held by the organization.

Upon transferring the title to another person, the organization shall file with the county auditor an affidavit affirming that the title was transferred to a qualified low-income family or that the title was not transferred to a qualified low-income family, as the case may be; if the title was transferred to a qualified low-income family, the affidavit shall identify the transferee by name. If the organization transfers title to the property to anyone other than a qualified low-income family, the exemption, if it has not previously expired, shall terminate, and the property shall be restored to the tax list for the year following the year of the transfer and a charge shall be levied against the property in an amount equal to the amount of additional taxes that would have been levied if such property had not been exempt from taxation. The charge constitutes a lien of the state upon such property as of the first day of January of the tax year in which the charge is levied and continues until discharged as provided by law.

The application for exemption shall be filed as otherwise required under section 5715.27 of the Revised Code, except that the organization holding the property shall file with its application documentation substantiating its status as an organization organized and operated exclusively for charitable purposes under section 501(c)(3) of the Internal Revenue Code and its qualification for exemption from federal taxation under section 501(a) of the Internal Revenue Code, and affirming its intention to construct or rehabilitate the property for the eventual transfer to qualified low-income families.

As used in this division, "qualified low-income family" means a family whose income does not exceed two hundred per cent of the official federal poverty guidelines as revised annually in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C.A. 9902, as amended, for a family size equal to the size of the family whose income is being determined.

(F)

(1)

(a) Real property held by a county land reutilization corporation organized under Chapter 1724. of the Revised Code shall be exempt from taxation. Notwithstanding section 5715.27 of the Revised Code, a county land reutilization corporation is not required to apply to any county or state agency in order to qualify for the exemption.

(b) Real property acquired or held by an electing subdivision other than a county land reutilization corporation on or after April 9, 2009, for the purpose of implementing an effective land reutilization program or for a related public purpose shall be exempt from taxation until sold or transferred by the electing subdivision. Notwithstanding section 5715.27 of the Revised Code, an electing subdivision is not required to apply to any county or state agency in order to qualify for an exemption with respect to property acquired or held for such purposes on or after such date, regardless of how the electing subdivision acquires the property.

As used in this section, "electing subdivision" and "land reutilization program" have the same meanings as in section 5722.01 of the Revised Code, and "county land reutilization corporation" means a county land reutilization corporation organized under Chapter 1724. of the Revised Code and any subsidiary wholly owned by such a county land reutilization corporation that is identified as "a wholly owned subsidiary of a county land reutilization corporation" in the deed of conveyance transferring title to the subsidiary.

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(2) An exemption authorized under division (F)(1) of this section shall commence on the day title to the property is transferred to the corporation or electing subdivision and shall continue to the end of the tax year in which the instrument transferring title from the corporation or subdivision to another owner is recorded, if the use to which the other owner puts the property does not qualify for an exemption under this section or any other section of the Revised Code. If the title to the property is transferred to the corporation and from the corporation, or to the subdivision and from the subdivision, in the same tax year, the exemption shall continue to the end of that tax year. The proportionate amount of taxes that are a lien but not yet determined, assessed, and levied for the tax year in which title is transferred to the corporation or subdivision shall be remitted by the county auditor for each day of the year that title is held by the corporation or subdivision.

Upon transferring the title to another person, the corporation or electing subdivision shall file with the county auditor an affidavit or conveyance form affirming that the title was transferred to such other person and shall identify the transferee by name. If the corporation or subdivision transfers title to the property to anyone that does not qualify or the use to which the property is put does not qualify the property for an exemption under this section or any other section of the Revised Code, the exemption, if it has not previously expired, shall terminate, and the property shall be restored to the tax list for the year following the year of the transfer. A charge shall be levied against the property in an amount equal to the amount of additional taxes that would have been levied if such property had not been exempt from taxation. The charge constitutes a lien of the state upon such property as of the first day of January of the tax year in which the charge is levied and continues until discharged as provided by law.

In lieu of the application for exemption otherwise required to be filed as required under section 5715.27 of the Revised Code, a county land reutilization corporation holding the property shall, upon the request of any county or state agency, submit its articles of incorporation substantiating its status as a county land reutilization corporation.

(G) **[Effective 9/15/2014]** Real property that is owned by an organization described under section 501(c)(3) of the Internal Revenue Code and exempt from federal income taxation under section 501(a) of the Internal Revenue Code and that is used by that organization exclusively for receiving, processing, or distributing human blood, tissues, eyes, or organs or for research and development thereof shall be exempt from taxation.

Amended by 130th General Assembly File No. TBD, HB 483, §101.01, eff. 9/15/2014, applicable to tax year 2014 and every tax year thereafter.

Amended by 130th General Assembly File No. TBD, SB 172, §1, eff. 9/4/2014.

Amended by 129th General Assembly File No. 127, HB 487, §101.01, eff. 9/10/2012.

Effective Date: 09-06-2002; 06-30-2005; 2008 SB353 04-07-2009

5709.121 Exclusive charitable or public purposes defined.

(A) Real property and tangible personal property belonging to a charitable or educational institution or to the state or a political subdivision, shall be considered as used exclusively for charitable or public purposes by such institution, the state, or political subdivision, if it meets one of the following requirements:

(1) It is used by such institution, the state, or political subdivision, or by one or more other such institutions, the state, or political subdivisions under a lease, sublease, or other contractual arrangement:

(a) As a community or area center in which presentations in music, dramatics, the arts, and related fields are made in order to foster public interest and education therein;

(b) For other charitable, educational, or public purposes.

(2) It is made available under the direction or control of such institution, the state, or political subdivision for use in furtherance of or incidental to its charitable, educational, or public purposes and not with the view to profit.

(3) It is used by an organization described in division (D) of section 5709.12 of the Revised Code. If the organization is a corporation that receives a grant under the Thomas Alva Edison grant program authorized by division (C) of section 122.33 of the Revised Code at any time during the tax year, "used," for the purposes of this division, includes holding property for lease or resale to others.

(B)

(1) Property described in division (A)(1)(a) of this section shall continue to be considered as used exclusively for charitable or public purposes even if the property is conveyed through one conveyance or a series of conveyances to an entity that is not a charitable or educational institution and is not the state or a political subdivision, provided that all of the following conditions apply with respect to that property:

(a) The property has been listed as exempt on the county auditor's tax list and duplicate for the county in which it is located for the ten tax years immediately preceding the year in which the property is conveyed through one conveyance or a series of conveyances;

(b) The property is conveyed through one conveyance or a series of conveyances to an owner that does any of the following:

(i) Leases the property through one lease or a series of leases to the entity that owned or occupied the property for the ten tax years immediately preceding the year in which the property is conveyed or to an affiliate of that entity;

(ii) Contracts to have renovations performed as described in division (B)(1)(d) of this section and is at least partially owned by a nonprofit organization described in section 501(c)(3) of the Internal Revenue Code that is exempt from taxation under section 501(a) of that code.

(c) The property includes improvements that are at least fifty years old;

(d) The property is being renovated in connection with a claim for historic preservation tax credits available under federal law;

(e) The property continues to be used for the purposes described in division (A)(1)(a) of this section after

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its conveyance; and

(f) The property is certified by the United States secretary of the interior as a "certified historic structure" or certified as part of a certified historic structure.

(2) Notwithstanding section 5715.27 of the Revised Code, an application for exemption from taxation of property described in division (B)(1) of this section may be filed by either the owner of the property or its occupant.

(C) For purposes of this section, an institution that meets all of the following requirements is conclusively presumed to be a charitable institution:

(1) The institution is a nonprofit corporation or association, no part of the net earnings of which inures to the benefit of any private shareholder or individual;

(2) The institution is exempt from federal income taxation under section 501(a) of the Internal Revenue Code;

(3) The majority of the institution's board of directors are appointed by the mayor or legislative authority of a municipal corporation or a board of county commissioners, or a combination thereof;

(4) The primary purpose of the institution is to assist in the development and revitalization of downtown urban areas.

Amended by 129th General Assembly File No.127, HB 487, §101.01, eff. 9/10/2012.

Effective Date: 12-13-2001; 06-30-2005; 2008 HB562 09-22-2008; 2008 HB458 12-31-2008

5715.271 Burden of proof of entitlement to exemption on property owner.

In any consideration concerning the exemption from taxation of any property, the burden of proof shall be placed on the property owner to show that the property is entitled to exemption. The fact that property has previously been granted an exemption is not evidence that it is entitled to continued exemption.

Effective Date: 10-17-1985

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annots)
Subchapter II. Federal Old-Age, Survivors, and Disability Insurance Benefits (Refs & Annots)

42 U.S.C.A. § 426-1

§ 426-1. End stage renal disease program

Currentness

(a) Entitlement to benefits

Notwithstanding any provision to the contrary in section 426 of this title or subchapter XVIII of this chapter, every individual who--

(1)(A) is fully or currently insured (as such terms are defined in section 414 of this title), or would be fully or currently insured if (i) his service as an employee (as defined in the Railroad Retirement Act of 1974 [45 U.S.C.A. § 231 et seq.] after December 31, 1936, were included within the meaning of the term "employment" for purposes of this subchapter, and (ii) his medicare qualified government employment (as defined in section 410(p) of this title) were included within the meaning of the term "employment" for purposes of this subchapter;

(B) (i) is entitled to monthly insurance benefits under this subchapter, (ii) is entitled to an annuity under the Railroad Retirement Act of 1974 [45 U.S.C.A. § 231 et seq.], or (iii) would be entitled to a monthly insurance benefit under this subchapter if medicare qualified government employment (as defined in section 410(p) of this title) were included within the meaning of the term "employment" for purposes of this subchapter; or

(C) is the spouse or dependent child (as defined in regulations) of an individual described in subparagraph (A) or (B);

(2) is medically determined to have end stage renal disease; and

(3) has filed an application for benefits under this section;

shall, in accordance with the succeeding provisions of this section, be entitled to benefits under part A and eligible to enroll under part B of subchapter XVIII of this chapter, subject to the deductible, premium, and coinsurance provisions of that subchapter.

(b) Duration of period of entitlement

Subject to subsection (c) of this section, entitlement of an individual to benefits under part A and eligibility to enroll under part B of subchapter XVIII of this chapter by reasons of this section on the basis of end stage renal disease--

(1) shall begin with--

(A) the third month after the month in which a regular course of renal dialysis is initiated, or

(B) the month in which such individual receives a kidney transplant, or (if earlier) the first month in which such individual is admitted as an inpatient to an institution which is a hospital meeting the requirements of section 1395x(e) of this title (and such additional requirements as the Secretary may prescribe under section 1395r(b) of this title for such institutions) in preparation for or anticipation of kidney transplantation, but only if such transplantation occurs in that month or in either of the next two months,

whichever first occurs (but no earlier than one year preceding the month of the filing of an application for benefits under this section); and

(2) shall end, in the case of an individual who receives a kidney transplant, with the thirty-sixth month after the month in which such individual receives such transplant or, in the case of an individual who has not received a kidney transplant and no longer requires a regular course of dialysis, with the twelfth month after the month in which such course of dialysis is terminated.

(c) ¹ Individuals participating in self-care dialysis training programs; kidney transplant failures; resumption of previously terminated regular course of dialysis

Notwithstanding the provisions of subsection (b) of this section--

(1) in the case of any individual who participates in a self-care dialysis training program prior to the third month after the month in which such individual initiates a regular course of renal dialysis in a renal dialysis facility or provider of services meeting the requirements of section 1395r(b) of this title, entitlement to benefits under part A and eligibility to enroll under part B of subchapter XVIII of this chapter shall begin with the month in which such regular course of renal dialysis is initiated;

(2) in any case in which a kidney transplant fails (whether during or after the thirty-six-month period specified in subsection (b)(2) of this section) and as a result the individual who received such transplant initiates or resumes a regular course of renal dialysis, entitlement to benefits under part A and eligibility to enroll under part B of subchapter XVIII of this chapter shall begin with the month in which such course is initiated or resumed; and

(3) in any case in which a regular course of renal dialysis is resumed subsequent to the termination of an earlier course, entitlement to benefits under part A and eligibility to enroll under part B of subchapter XVIII of this chapter shall begin with the month in which such regular course of renal dialysis is resumed.

(c) ¹ Continuing eligibility of certain terminated individuals

For purposes of this section, each person whose monthly insurance benefit for any month is terminated or is otherwise not payable solely by reason of paragraph (1) or (7) of section 425(c) of this title shall be treated as entitled to such benefit for such month.

CREDIT(S)

§ 426-1. End stage renal disease program, 42 USCA § 426-1

(Aug. 14, 1935, c. 531, Title II, § 226A, as added June 13, 1978, Pub.L. 95-292, § 1(a), 92 Stat. 307; amended Sept. 3, 1982, Pub.L. 97-248, Title II, § 278(b)(2)(C), 96 Stat. 561; Jan. 12, 1983, Pub.L. 97-448, Title III, § 309(b)(1), 96 Stat. 2408; Apr. 7, 1986, Pub.L. 99-272, Title XIII, § 13205(b)(2)(B), 100 Stat. 317; Aug. 15, 1994, Pub.L. 103-296, Title II, § 201(a)(3)(D)(ii), 108 Stat. 1497.)

Footnotes

1 So in original. Two subsecs. (c) have been enacted.

42 U.S.C.A. § 426-1, 42 USCA § 426-1

Current through P.L. 113-163 (excluding P.L. 113-128) approved 8-8-14

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42 CFR 413.178 - Bad debts.

B (/cfr/text/42/chapter-IV/subchapter-B) > Part 413
 (/cfr/text/42/part-413) > Subpart H (/cfr/text/42/part-
 413/subpart-H) > Section 413.178

There are 9 Updates
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(GPOAccess) ([http://www.ecfr.gov/cgi-bin/text-idx?
 c=ecfr&tpl=/ecfrbrowse/Title42/42cfr413_main_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr413_main_02.tpl))

CFR (/cfr/text/42/413.178?qt-cfr_tabs=0#qt-cfr_tabs)

Updates (/cfr/text/42/413.178?qt-cfr_tabs=1#qt-cfr_tabs)

Authorities (U.S. Code) (/cfr/text/42/413.178?qt-cfr_tabs=2#qt-cfr_tabs)

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§ 413.178 Bad debts.

(a) CMS will reimburse each facility its allowable Medicare bad debts, as defined in § 413.89(b) (/cfr/text/42/413.89#b), up to the facility's costs, as determined under Medicare principles, in a single lump sum payment at the end of the facility's cost reporting period.

(b) A facility must attempt to collect deductible and coinsurance amounts owed by beneficiaries before requesting reimbursement from CMS for uncollectible amounts. Section 413.89 (/cfr/text/42/413.89) specifies the collection efforts facilities must make.

(c) A facility must request payment for uncollectible deductible and coinsurance amounts owed by beneficiaries by submitting an itemized list that specifically enumerates all uncollectible amounts related to covered services under the composite rate.

(d) Exceptions.

(1) Bad debts arising from covered ESRD services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

(2) For services furnished on or after January 1, 2011, bad debts arising from covered ESRD items or services that, prior to January 1, 2011 were paid under a reasonable charge-based methodology or a fee schedule, including but not limited to drugs, laboratory tests, and supplies are not reimbursable under the program.

[62 FR 43668 ([http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?
 dbname=1997_register&position=all&page=43668](http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=1997_register&position=all&page=43668)), Aug. 15, 1997, as amended at 70 FR 47489
 ([http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?
 dbname=2005_register&position=all&page=47489](http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2005_register&position=all&page=47489)), Aug. 12, 2005; 71 FR 69785
 ([http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?
 dbname=2006_register&position=all&page=69785](http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2006_register&position=all&page=69785)), Dec. 1, 2006; 75 FR 49199
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 Title 42 (CFR) / Text 42 / Chapter IV / 42 CFR 413.89 - Bad debts, charity, and courtesy allowances

CFR (/cfr/text)
 (/cfr/text/42/chapter-IV) > Subchapter B (/cfr/text/42/chapter-IV/subchapter-B) > Part 413 (/cfr/text/42/part-413) > Subpart F (/cfr/text/42/part-413/subpart-F) > Section 413.89

There are 9 titles appearing in the Code. The title of 42 CFR is listed below or at eCFR (GPO Access) (http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/cfrn/rowse/1/cfr/42/413.89/main_02.tpl)

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§ 413.89 Bad debts, charity, and courtesy allowances.

(a) Principle. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. However, subject to the limitations described under paragraph (h) of this section and the exception for services described under paragraph (i) of this section, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

(b) Definitions—

(1) Bad debts. Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

(2) Charity allowances. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

(3) Courtesy allowances. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) Normal accounting treatment: Reduction in revenue. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

(d) Requirements for Medicare. Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) Criteria for allowable bad debt. A bad debt must meet the following criteria to be allowable:

- (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
- (2) The provider must be able to establish that reasonable collection efforts were made.
- (3) The debt was actually uncollectible when claimed as worthless.
- (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) Charging of bad debts and bad debt recoveries. The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

(g) Charity allowances. Charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs. These charity allowances include the costs of uncompensated services furnished under a Hill-Burton obligation. (Note: In accordance with section 106(b) of Pub. L. 97-248 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under Medicare except that it does not apply to costs which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals.) The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

(h) Limitations on bad debts—

(1) Hospitals. In determining reasonable costs for hospitals, the amount of bad debt otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced—

- (i) For cost reporting periods beginning during fiscal year 1998, by 25 percent;
- (ii) For cost reporting periods beginning during fiscal year 1999, by 40 percent;
- (iii) For cost reporting periods beginning during fiscal year 2000, by 45 percent; and
- (iv) For cost reporting periods beginning during a subsequent fiscal year, by 30 percent.

(2) Skilled nursing facilities. For cost reporting periods beginning during fiscal year 2006 or during a subsequent fiscal year, the amount of skilled

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nursing facility bad debts for coinsurance otherwise treated as allowable costs (as defined in paragraph (e) of this section) for services furnished to a patient who is not a dual eligible individual is reduced by 30 percent. A dual eligible individual is defined for this section as an individual that is entitled to benefits under Part A of Medicare and is determined eligible by the State for medical assistance under Title XIX of the Act as described under paragraph (2) of the definition of a "full-benefit dual eligible individual" at § 423.772 (/cfr/text/42/423.772) of this chapter.

(3) ESRD facilities--

(i) Limitation on bad debt. The amount of ESRD facility bad debts otherwise treated as allowable costs described in § 413.178 (/cfr/text/42/413.178).

(ii) Exception. Bad debts arising from covered services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program. Additional exceptions for ESRD bad debt payments are described in § 413.178(d) (/cfr/text/42/413.178#d).

(i) Exception. Bad debts arising from covered services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 33898, July 31, 1992; 60 FR 63189, Dec. 8, 1995; 63 FR 41005 (http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=1998_register&position=all&page=41005), July 31, 1998; 66 FR 32195 (http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2001_register&position=all&page=32195), June 13, 2001. Redesignated at 69 FR 49254 (http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2004_register&position=all&page=49254), Aug. 11, 2004, and amended at 71 FR 48142 (http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2006_register&position=all&page=48142), Aug. 18, 2006; 71 FR 69785 (http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2006_register&position=all&page=69785), Dec. 1, 2006; 75 FR 49198 (http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2010_register&position=all&page=49198), Aug. 12, 2010]
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5160-13-01.9 Fee-for-service ambulatory health care clinics (AHCCs): end-stage renal disease (ESRD) dialysis clinics.

Requirements outlined in rule 5101:3-13-01 of the Administrative Code apply to all fee-for-service AHCCs.

(A) Definitions.

(1) "Ambulatory health care ESRF dialysis clinic" is a renal dialysis facility that meets the requirements outlined in paragraph (C) of this rule and provides chronic maintenance dialysis for end-stage renal disease (ESRD).

(2) "Chronic maintenance dialysis," in accordance with rule 3701-83-23 of the Administrative Code, means the regular provision of dialysis for an end stage renal disease patient with any level of patient involvement.

(3) "Composite payment rate" is a prospective system for the comprehensive payment of all modes of outpatient (in-facility and method I home) maintenance dialysis services. The composite payment rate covers most items and services related to the treatment of a patient's ESRD. The composite rate covers the complete dialysis treatment, specific laboratory tests, diagnostic services, laboratory services, and drugs (including injections and immunizations) in specific quantities and frequencies, as described in appendix A to this rule. The composite rate does not cover physician professional services, separately billable laboratory services, or separately billable drugs. Dialysis composite rates are listed in rule 5101:3-1-60 of the Administrative Code.

(4) "Continuous ambulatory peritoneal dialysis" (CAPD) is a type of peritoneal dialysis in which the patient's peritoneal membrane is used as a dializer. CAPD is usually performed three to five times a day in four to six hour cycles.

(5) "Continuous cycling peritoneal dialysis" (CCPD) is a type of peritoneal dialysis in which the patient's peritoneal membrane is used as a dializer. CAPD is usually accomplished three times a night in approximately three hours cycles, using an automatic peritoneal dialysis cyler.

(6) "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. The two types of dialysis procedures currently in common use are hemodialysis and peritoneal dialysis.

(7) "Dual-eligible," for the purposes of this rule, means a patient who is eligible for both medicare and medicaid coverage of ESRD services.

(8) "End-stage renal disease" (ESRD) 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.

(9) "End-stage renal disease patient," in accordance with rule 3701-83-23 of the Administrative Code, means an individual who is at a stage of renal impairment that appears irreversible and permanent and who requires a regular course of dialysis or renal transplantation to ameliorate uremic symptoms and maintain life.

(10) "ESRD services" are diagnostic, therapeutic, rehabilitative, or palliative services, including:

(a) Services furnished at an ambulatory health care ESRD dialysis clinic by or under the general or direct

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supervision of a physician.

(b) Services furnished outside an ambulatory health care ESRD dialysis clinic by clinic personnel under the general or direct supervision of a physician to a patient who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(c) Services specified by revenue center codes delineated in appendix A to this rule.

(11) "Free-standing" is defined in accordance with rule 5101:3-13-01 of the Administrative Code.

(12) "Freestanding dialysis center" or "dialysis center," in accordance with rule 3701-83-23 of the Administrative Code, means a facility that provides chronic maintenance dialysis to ESRD patients on an outpatient basis, including the provision of dialysis services in the patient's place of residence. A freestanding dialysis center does not include a hospital or other entity that performs dialysis services that are reviewed and accredited or certified as part of the hospital's accreditation or certification as required by section 3727.02 of the Revised Code.

(13) "Home dialysis" is dialysis performed by an appropriately trained patient and patient caregiver at home. Home dialysis, in accordance with rule 3701-83-23 of the Administrative Code, means dialysis performed by an appropriately trained patient, with or without minimal assistance, at the patient's place of residence.

(14) "Home dialysis training" is a program that trains ESRD patients to perform home dialysis with little or no professional assistance, and trains other individuals to assist patients in performing home dialysis.

(15) "Hospital-based ESRD facilities" are an integral and subordinate part of a hospital, as evidenced by the cost report, in accordance with Chapter 5101:3-2 of the Administrative Code.

(16) "Hemodialysis" is a renal dialysis procedure in which blood passes through an artificial kidney machine and the waste products diffuse across a manmade membrane into a bath solution known as dialysate after which the cleansed blood is returned to the patient's body. Hemodialysis is usually accomplished in three to four hours sessions, three times a week.

(17) "In-facility dialysis" is dialysis furnished on an outpatient basis at an approved renal dialysis facility.

(18) "Intermittent peritoneal dialysis" (IPD) is a type of peritoneal dialysis in which waste products pass from the patient's body through the peritoneal membrane into the peritoneal cavity where the dialysate is introduced and removed periodically by machine. IPD is usually conducted for approximately thirty hours per week in three or fewer sessions of ten or more hours.

(19) "Method I" is medicare terminology used to describe the provision of home dialysis services whereby a renal dialysis facility assumes responsibility for providing all home dialysis equipment, supplies and support services.

(20) "Peritoneal dialysis" is a renal dialysis procedure in which waste products pass from a patient's body through the peritoneal membrane into the peritoneal (abdominal) cavity where the dialysate is introduced and removed periodically. The three types of peritoneal dialysis are continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), and intermittent peritoneal dialysis (IPD).

(21) "Physician professional services," in accordance with rule 5101:3-4-14 of the Administrative Code, are age-specific services performed in an outpatient setting that are related to a patient's ESRD

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(22) "Renal dialysis center" is a hospital unit approved by medicare to furnish the full spectrum of services required for the care of ESRD dialysis patients.

(23) "Renal dialysis facility" is a unit approved by medicare to furnish dialysis services directly to ESRD patients.

(24) "Self-dialysis" is dialysis performed by an appropriately trained ESRD patient with little or no professional assistance.

(25) "Self-dialysis training" is a program that trains ESRD patients to perform self-dialysis with little or no professional assistance, and trains other individuals to assist patients in performing self-dialysis.

(26) "Staff-assisted dialysis" is dialysis performed by the staff of a renal dialysis center or facility.

(B) Any organization applying to be a medicaid fee-for-service ambulatory health care dialysis clinic provider on and after January 1, 2008 must:

(1) Meet the criteria for fee-for-service AHCC providers in accordance with paragraph (C) of rule 5101:3-13-01 of the Administrative Code; and

(2) Be certified by medicare as a dialysis facility;

(3) Be licensed by the director of the Ohio department of health in accordance with Chapter 3701-83 of the Administrative Code and demonstrate to the director of health that it meets the requirements of section 3702.30 of the Revised Code and either meets the requirements of Chapter 3701-83 of the Administrative Code or has submitted an acceptable accreditation inspection report, in accordance with rule 3701-83-05 of the Administrative Code; and in accordance with rule 3701-83-02 of the Administrative Code, complies with rules 3701-83-23 to 3701-83-24 of the Administrative Code. Non-Ohio providers must be licensed by their respective state's authority if applicable.

(4) Provide services in accordance with division level 5101:3 of the Administrative Code.

(C) Dialysis clinic claims, billing, payment/reimbursement.

(1) Fee-for-service ambulatory health care dialysis clinic providers that have executed the standard medicaid provider agreement and meet all eligibility requirements specified in paragraph (C) of this rule may bill the department for ESRD dialysis services.

(2) All medicaid providers, including fee-for-service ambulatory health care dialysis clinics, must determine whether medicare or other third party insurers are responsible for the coverage of a medicaid patient's dialysis treatment for the date of treatment. Medicaid is the payer of last resort for ESRD services.

(a) Medicaid coverage of ESRD services for patients, including dual-eligibles, begins with the initial onset of dialysis treatment.

(i) If CMS determines that the patient is medicare eligible at the onset of the disease, medicaid coverage as the primary payer begins with the initial onset of dialysis and continues until medicare coverage begins (usually three months).

(ii) If CMS determines that the patient is not medicare eligible at the onset of the disease, medicaid coverage continues as long as the dialysis treatments are medically necessary and the patient is eligible for medicaid.

(b) The medicaid provider must pursue medicare eligibility for the patient through CMS within the first three months of a medicaid eligible patient's initial dialysis treatment.

(i) The provider must retain proof in the medical record that the patient has applied for medicare coverage and is ineligible.

(ii) The department may conduct a retrospective review to verify that the provider assisted the patient to apply for medicare coverage.

(iii) Fee-for-service ambulatory health care dialysis clinic providers shall bill medicare cross-over claims in accordance with rule 5101:3-1-05 of the Administrative Code.

(3) Dialysis clinic claims for "clinic facility dialysis services" are payable only if submitted in accordance with national uniform billing committee (NUBC) requirements, using revenue center code(s) and appropriate procedure code(s) as described in appendix A to this rule.

(4) Dialysis clinics must document in the patient's medical record the medical necessity, defined in accordance with rule 5101:3-1-01 of the Administrative Code, of each service provided and billed to the department. to verify that the services were rendered as billed on the claim.

(5) The department reimburses ambulatory health care dialysis clinics for dialysis treatment, dialysis support, and dialysis treatment with self-care training using composite rates, as described in appendix A to this rule. The composite rates include specific laboratory tests, diagnostic services, and drugs (including injections and immunizations) in specific quantities and frequencies, as described in appendix A to this rule. Items included in the composite rates may not be billed separately by the dialysis clinic or by any laboratory for the same date of dialysis treatment. Laboratory services may be performed in the clinic or by an outside laboratory if the clinic or laboratory is clinical laboratory improvement act (CLIA) certified. Laboratory tests are included in the composite rate regardless of where the tests are performed. Composite rates do not include a physician's professional supervision. Physician professional supervision may only be billed by physicians, in accordance with rule 5101:3-4-14 of the Administrative Code. Dialysis clinic composite rates are listed in rule 5101:3-1-60 of the Administrative Code.

(a) Composite rates for medicaid coverage of dialysis treatment.

(i) Dialysis treatment is available to patients in both clinic and home settings.

(ii) Limits.

(a) The department will reimburse dialysis clinics for in-facility and method I home dialysis at a maximum frequency of one treatment per recipient per day. These rates are to be used only by clinics providing care to patients who have elected medicare's method I payment system.

(b) Treatment sessions for hemodialysis and IPD are limited to three treatments per week. This limitation may be exceeded only if additional treatments are determined to be medically necessary, defined in accordance with rule 5101:3-1-01 of the Administrative Code, by the physician who is primarily responsible for dialysis services and the medical necessity for the services is documented in the medical record.

(c) Treatment sessions for CCPD and CAPD are limited to a daily composite rate. Treatments for CCPD and CAPD must be determined to be medically necessary by the physician who is primarily responsible for the dialysis services. The medical necessity for the services must be documented in the patient's medical record.

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(b) Composite rates for medicaid coverage of dialysis support services.

(i) The patient may elect to make his/her own arrangements for securing necessary supplies and equipment in either the home or the clinic setting.

(ii) Only dialysis clinics using medicare's method II payment system may bill the department using the composite rate for support services.

(iii) The composite rate for support services does not include durable medical equipment (DME) or laboratory services. Payment for supplies will be made to the DME supplier at rates listed under rule 5101:3-10-03 of the Administrative Code entitled "medicaid supply list."

(iv) The department will reimburse a dialysis clinic for support services composite rates at a maximum frequency of once per month.

(c) Composite rates for medicaid coverage of dialysis treatment with self-care training.

(i) The composite rate for dialysis treatment with self-care training reflects training costs per session.

(ii) Limits.

(a) Hemodialysis treatment services with self-care training is limited to fifteen sessions or three months of training, whichever comes first.

(b) IPD treatment services with self-care training is performed in ten to twelve hour sessions and is limited to four weeks of training.

(c) CAPD treatment services with self-care training is performed five days a week and is limited to a maximum of fifteen training sessions.

(d) CCPD treatment services with self-care training is performed five to six days a week and is limited to a maximum of fifteen training sessions.

(6) The department reimburses dialysis clinics for medically necessary laboratory tests (as described in Chapter 5101:3-11 of the Administrative Code), diagnostic services, and prescribed drugs (including therapeutic injections as described in rule 5101:3-4-13 of the Administrative Code) and immunizations (as described in rule 5101:3-4-12 of the Administrative Code) not included in the composite rates or that exceed the frequency described in the composite rates as described in appendix A to this rule, if:

(a) The medical record documents the medical necessity for the laboratory test, diagnostic service, and/or drug; and

(b) The laboratory test, diagnostic service, and/or drug is a covered medicaid service.

(7) Laboratory tests, diagnostic services, and drugs provided in excess of the frequency described in the composite rates are subject to review and potential recovery.

(8) The department reimburses physician professional services associated with the medical management of ESRD patients in accordance with rule 5101:3-4-14 of the Administrative Code.

(9) The department reimburses durable medical equipment providers for supplies associated equipment and all related medical supplies necessary for the home dialysis patient who elects to receive such services under method II, in accordance with rule 5101:3-10-10 of the Administrative Code.

Appx. 37

(10) The department reimburses for medical transportation to and/or from dialysis treatment in accordance with Chapter 5101:15 of the Administrative Code.

(11) The following services are non-covered:

(a) All blood products;

(b) All services exceeding the limitations defined in Chapters 5101:3-1, 5101:3-4, 5101:3-05, 5101:3-06, 5101:3-8, 5101:3-9, 5101:3-13, 5101:3-14, 5101:3-15, and 5101:3-24 of the Administrative Code;

(c) Services determined by the department as not medically necessary or that are duplicative of a service provided concurrently by another medicaid provider;

(d) Any service not provided in accordance with the criteria and protocols set forth by the Ohio law for advanced practice nurses, registered nurses, and physician assistants;

(e) All services itemized as non-covered in rule 5101:3-4-28 of the Administrative Code.

APPENDIX A

See Appendix at

[http://www.registerofohio.state.oh.us/pdfs/5101/3/13/5101\\$3-13-01\\$9 PH FF N APP1 20071221 1225.pdf](http://www.registerofohio.state.oh.us/pdfs/5101/3/13/5101$3-13-01$9 PH FF N APP1 20071221 1225.pdf)

Replaces: Part of 5101:3-13-01, Part of 5101:3-13-07

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Promulgated Under: 119.03

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Rule Amplifies: 5111.01 , 5111.02 , 5111.021

Prior Effective Dates: 4/2/83, 3/30/01, 10/01/03

362 F.3d 50
United States Court of Appeals,
First Circuit.

LONG TERM CARE PHARMACY
ALLIANCE, Plaintiff, Appellee,

v.

Christine FERGUSON, Director, Commonwealth
of Massachusetts Division of Health Care
Finance and Policy, Defendant, Appellant.

No. 03-1895. | Heard Jan. 6,
2004. | Decided March 17, 2004.

Synopsis

Background: Trade association for pharmacies that provided drugs only to nursing homes and other institutional patients brought action challenging state's emergency rule reducing Medicaid reimbursements to pharmacies. The United States District Court for the District of Massachusetts, Joseph L. Tauro, J., 260 F.Supp.2d 282, preliminarily enjoined implementation of the regulation, and state appealed.

Holdings: The Court of Appeals, Boudin, Chief Judge, held that:

[1] action was not moot;

[2] Medicaid Act provision requiring use of a "public process" to set rates of payment for hospital and nursing facility services in which "providers" can comment on proposed rates did not give notice and comment rights to "closed" pharmacies; and

[3] provision requiring reimbursement rates for services in general be "sufficient to enlist enough providers to provide services generally available in the area" did not give private right of action to Medicaid providers to challenge state reimbursement rates.

Vacated and remanded.

West Headnotes (4)

[1] Injunction

⇒ Health care; Medicare and Medicaid

Action challenging state emergency rule reducing Medicaid reimbursements to pharmacies was not moot after agency provided notice and opportunity to comment, as ordered by district court in order granting preliminary injunction, where agency had not adopted final version of the rate based on finding that rates were sufficient to enlist enough providers to provide services similar to those generally available in the area, as required by injunction. Social Security Act, § 1902(a)(30)(A), as amended, 42 U.S.C.A. § 1396a(a)(30)(A).

7 Cases that cite this headnote

[2] Health

⇒ Providers. Proceedings Regarding

Medicaid Act provision requiring use of a "public process" to set rates of payment for hospital and nursing facility services in which "providers" can comment on proposed rates did not give notice and comment rights to "closed" pharmacies that provided drugs only to nursing home and other institutional patients. Social Security Act, § 1902(a)(30)(A), as amended, 42 U.S.C.A. § 1396a(a)(30)(A).

10 Cases that cite this headnote

[3] Health

⇒ Judicial Review; Actions

Medicaid Act provision requiring reimbursement rates for services in general be "sufficient to enlist enough providers to provide services generally available in the area" did not give private right of action to Medicaid providers to challenge state reimbursement rates. Social Security Act, § 1902(a)(30)(A), as amended, 42 U.S.C.A. § 1396a(a)(30)(A).

17 Cases that cite this headnote

[4] Health

— Judicial Review: Actions

Providers such as pharmacies do not have a private right of action under Medicaid Act provision requiring reimbursement rates for services in general be “sufficient to enlist enough providers to provide services generally available in the area”; if they think that state reimbursement is inadequate, and cannot persuade the Secretary to act, they must vote with their feet. Social Security Act, § 1902(a)(30)(A), as amended, 42 U.S.C.A. § 1396a(a)(30)(A).

14 Cases that cite this headnote

Attorneys and Law Firms

*51 Romeo G. Camba, Assistant Attorney General, with whom Thomas F. Reilly, Attorney General, and William Porter, Assistant Attorney General, were on brief for appellant.

David J. Farber with whom John Rosans, Patton Boggs LLP, Mark E. Robinson, Daniel S. Savin, Melissa G. Liazos and Bingham McCutchen LLP were on brief for appellee.

Before BOUDIN, Chief Judge, LYNCH and LIPEZ, Circuit Judges.

Opinion

BOUDIN, Chief Judge.

This is an appeal from a preliminary injunction entered by the district court. That court enjoined the Commonwealth of Massachusetts from implementing an emergency regulation reducing the rates that the state pays under the state's Medicaid program to pharmacies to reimburse them for prescription drugs furnished for the use of Medicaid patients. The background events are as follows.

Medicaid is a federal-state program to assist the poor, elderly, and disabled in obtaining medical care. 42 C.F.R. § 430.0 (2002). Under the Medicaid Act, which is Title XIX of the Social Security Act, 42 U.S.C. §§ 1396–1396v (2000), the federal government provides financial support to states that establish and administer state Medicaid programs in accordance with federal law through a state plan approved by

the U.S. Department of Health and Human Services (“HHS”). 42 U.S.C. § 1396 (2000); 42 C.F.R. §§ 430.0, 430.10–20 (2002). One requirement is that the state have a scheme for reimbursing health care providers. 42 U.S.C. §§ 1396a(a), 1396d(a) (2000).

Massachusetts participates in Medicaid and its plan, known as “MassHealth,” is administered by an entity (“the Division”) based in the state's Executive Office of Health and Human Services (“the Executive Office”). Mass. Gen. Laws, ch. 118E, §§ 1, 7, 8, 9, 9A, 11 (2002). The Division fixes the rates it will pay to reimburse providers for numerous health services. These include the furnishing by pharmacies of prescription drugs for Medicaid patients. 114.3 C.M.R. §§ 6.00–49.00 (2003).

This reimbursement is calculated separately for the cost of the drug to the pharmacy and for the cost of dispensing it. 114.3 C.M.R. §§ 31.02, 31.04, 31.07 (2003). The former, with which this case alone is concerned, is governed by federal, 42 C.F.R. §§ 447.331, 447.332 (2002), and state formulas of some complexity, 114.3 C.M.R. § 31.04 (2003); but the only method at issue here calls for reimbursement for the pharmacy's “estimated acquisition cost.” Massachusetts defines this cost as an estimate of the price “generally and currently paid by eligible pharmacy providers” for the most common package size. *Id.* § 31.02.

This general and current price is calculated as a percentage of a so-called “wholesaler's acquisition cost” (“WAC”) for each drug in question. Although how the WAC numbers are derived is not fully explained by the parties, the Commonwealth says that it is effectively the wholesale catalogue price for the drug but that the real price may often be a few percentage points lower for non-generic drugs (and many points lower for generics) because of common *52 discounts (*e.g.*, for speedy payment).¹ Whether there may be other pertinent costs not included in WAC, and how profits are provided, is less clear.

In 2002 a new HHS report suggested that a number of states were overpaying for drugs. Office of the Inspector Gen., Dep't of Health & Human Servs., *Medicaid Pharmacy—Actual Acquisition Cost of Generic Prescription Drug Products* (2002). Massachusetts was then using a WAC plus 10% formula to reimburse pharmacies. The state legislature for fiscal year 2003 ordered a reduction, directing the Division to determine whether WAC minus 2% would suffice to ensure enough participating pharmacies to supply patient needs. The

Division held hearings in September 2002 and sought data from Massachusetts pharmacies as to their costs of acquisition of individual drugs. The pharmacies generally refused to provide the data, claiming that such data was proprietary.

At the hearings, chain pharmacies such as Brooks and CVS conceded that they usually obtained branded drugs at WAC minus 2% for prompt payment (and paid even less for generics), but the three largest chains said they would no longer serve MassHealth if payment were reduced to WAC minus 2%. They claimed *inter alia* that MassHealth prescriptions involved extra work and that certain costs like overhead and storage were not included in the WAC figures. In sum, they said that they would lose money if they continued at the proposed reduced rate.

In a report issued in October 2002, the Division concluded that the pharmacies acquired the branded drugs at WAC and generics at less and that while other costs were incurred the Massachusetts pharmacies had not documented them. Div. of Health & Human Servs., Commonwealth of Massachusetts, *Report to the General Court Reimbursement for Prescribed Drugs* 15 (2002). The recommendation was to reduce payments to WAC plus 6% partly to cover other (unquantified) costs and partly to “ensure that MassHealth members will have sufficient access to prescribed drugs.” *Id.* This new WAC plus 6% rate was implemented immediately and is not at issue in this case.

On March 14, 2003, the Division adopted emergency amendments to its regulations, lowering the rate to WAC plus 5% effective April 1, 2003. According to the Division, only one pharmacy had dropped out of MassHealth under the WAC plus 6% rate, persuading the Division that a small further reduction would save money and not curtail supply. The notice adopting the new change, and other changes not here involved, proposed a public hearing in May 2003 but made clear that the Division believed it was entitled to implement the new WAC plus 5% rate in advance of any hearing.

To challenge that contention and the proposed lower rate, the Long Term Care Pharmacy Alliance (“Long Term”) brought the present action in the district court. Long Term represents a set of “closed” pharmacies that provide drugs not to the general public but only to nursing home and other institutional patients. Seeking a preliminary injunction, Long Term claimed that the Division's failure to provide a *53 prior hearing violated one provision of the Medicaid Act

and its 1% reduction within five months and without new evidence or findings violated another provision of the statute. The respective statutory provisions are 42 U.S.C. § 1396a(a)(13)(A) (2000) and 42 U.S.C. § 1396a(a)(30)(A) (2000).

In a nutshell, the first of these Medicaid Act provisions—which we will call subsection (13)(A)—requires *inter alia* that a “public process” be used to set “rates of payment ... for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded,” in which “providers,” among others, can comment on “proposed” rates. The second provision, subsection (30)(A), in substance requires *inter alia* that rates for services in general be “sufficient to enlist enough providers to provide services similar to those generally available in the area.”²

The district court granted the preliminary injunction on April 1, 2003. *Long Term Care Pharmacy Alliance v. Ferguson*, 260 F.Supp.2d 282 (D.Mass.2003). It directed that the reduced WAC plus 5% rate not be applied to prescription drugs supplied to MassHealth nursing home patients until after notice and comment rulemaking under subsection (13)(A) and not be applied to such drugs provided to any MassHealth patient until, following the rulemaking, the Commonwealth made findings satisfying the subsection (30)(A) requirements. *Id.* at 295. The Commonwealth appealed from this preliminary injunction which remains in effect today.

Because the Division gave notice of the new rates shortly before adoption and thereafter held public hearings, the question arises whether this case is moot. Neither party argues for mootness, but in a footnote the Commonwealth anticipates a mootness objection and argues against it. If the controversy were now academic, this would hazard our Article III jurisdiction, *Mangual v. Rotger-Sabat*, 317 F.3d 45, 60 (1st Cir.2003), requiring us to dismiss *sua sponte*, *Allende v. Shultz*, 845 F.2d 1111, 1115 n. 7 (1st Cir.1988), unless the case fell within the exception for issues that are “capable of repetition, yet evading review.” *S. Pac. Terminal Co. v. ICC*, 219 U.S. 498, 515, 31 S.Ct. 279, 55 L.Ed. 310 (1911).

[1] The case is not moot. Although notice and opportunity for comment have both now been provided, the Division has not adopted a final (non-emergency) version of the rate based on the finding under subsection (30)(A) deemed by the district court to be required. Possibly, the Division has withheld a post-hearing order and made no finding precisely

because it wants to vindicate its authority for use in the future. Still, the injunction currently precludes the Division from implementing the reduced WAC plus 5% rate; and it does so based on an alleged violation of subsection (30)(A) not yet cured. And, if subsection (13)(A) applied, even more specific findings would also be required by regulations pertaining to services covered by that section. See note 2, above. The “controversy” is therefore not moot and we need not consider whether the recurring issues exception would otherwise apply.

Turning then to the district court’s decision to issue the injunction, there is no reason to repeat the familiar four-part test for preliminary injunctions, *New Comm Wireless Servs., Inc. v. SprintCom, Inc.*, 287 F.3d 1, 8–9 (1st Cir.2002), or parse the various standards of review that may be implicated. *54 *Water Keeper Alliance v. U.S. Dept. of Defense*, 271 F.3d 27, 30 (1st Cir.2001). In this case, the only issues that need be decided to resolve the controversy are issues of law subject to plenary review. *Id.*

[2] We begin with subsection (13)(A) which was the basis for the first part of the district court’s injunction and requires, in relevant part, that a state plan provide:

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published....

42 U.S.C. § 1396a(a)(13)(A) (2000).

Broadly speaking, subsection (13)(A) requires something on the order of notice and comment rulemaking for states in their setting of rates for reimbursement of “hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded” provided under the Medicaid Act. *Am. Soc. of Consultant Pharmacists v.*

Concannon, 214 F.Supp 2d 23, 28–29 (D.Me.2002); accord *Children’s Seashore House v. Waldman*, 197 F.3d 654, 659 (3d Cir.1999), cert. denied, 530 U.S. 1275, 120 S.Ct. 2742, 147 L.Ed.2d 1006 (2000). The Commonwealth assumes that if Long Term’s members are providing “nursing facility services,” such members (represented by Long Term) are entitled to sue as “providers” in federal court to enjoin violations of subsection (13)(A) that affect their interest.

It is quite possible that under emergency conditions subsection (13)(A) may not automatically require notice and comment *before* a new rate goes into effect.³ But the Commonwealth has not argued on appeal that exceptional circumstances excused a procedural requirement that would otherwise apply. And the findings required by the regulation would remain an obstacle. Instead, the Commonwealth’s main response is that Long Term’s members simply do not provide services encompassed by subsection (13)(A) and so the notice and comment provisions have no application to rates set for reimbursing its members.

In the abstract, this is not a surprising position. The Commonwealth, through its reimbursement program, buys prescription drugs for MassHealth patients. In the absence of a statute, nothing whatever would require the state to provide notice and comment, or any other kind of process, before deciding how much it was willing to pay for any or all drugs. Retail pharmacies that supply MassHealth customers directly are subject to the same WAC plus something rate and have no protection under subsection (13)(A) (or under the first prong of the district court’s *55 injunction). See *Am. Soc. of Consultant Pharmacists*, 214 F.Supp 2d at 31.

However, subsection (13)(A) does provide notice and comment rights as to rates set for “nursing facility services”; and Long Term’s members seek to bring themselves within this statutory umbrella. They say also that their own operations are different from, and more expensive than, those of retail pharmacies supplying MassHealth patients who walk into drug stores—because of the extra packaging and tracking needed for residents of nursing homes. Apparently nursing homes use the specialized closed pharmacies precisely to do these tasks on a cost-efficient basis.

The statutory coverage issue is not straightforward. The critical phrase in the statute is “nursing facility services” which is in turn defined to mean

services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

42 U.S.C. § 1396d(f) (2000). This language gives some aid to the Commonwealth because drugs are certainly not provided “only” in nursing facilities on an inpatient basis. On the other hand, drugs are somewhat closer to the core function of nursing home operations than, say, the provision of a gift shop or fresh flowers in the rooms.

The district court points to another section of the statute obligating nursing facilities to provide “nursing and related services” of a high order, medically related social services, and “pharmaceutical services,” 42 U.S.C. § 1396r(b)(4) (A) (2000); but this language is inconclusive. It says that providing drugs is essential in a nursing home, something we already know; so presumably the nursing home would be reimbursed for drugs it supplied itself and could insist on reimbursement rates that were adopted under subsection (13) (A) after notice and an opportunity to comment.

Yet it cannot be enough to trigger subsection (13)(A) that Long Term's members happen to be doing something (providing drugs) for which reimbursement rates would require notice and comment rulemaking *if done directly by the nursing home*. Here the supplier claiming reimbursement is not the nursing home but the closed pharmacies. As we have noted, retail pharmacies that provide prescription drugs for Medicaid patients who walk into drugstores are not covered by subsection (13)(A). The “who” provides may be as important to subsection (13)(A) as the “what.”

Language being less than plain, we ordinarily would look to purpose and legislative history, *Stout v. Banco Popular de Puerto Rico*, 320 F.3d 26, 31 (1st Cir.2003), but we have been furnished with nothing that is helpful. Indeed, Congress may not have had a specific intention as to nursing homes and closed pharmacies: it could have thought that embattled care facilities like hospitals and nursing homes needed special protection from arbitrary rates but that ordinary pharmacies did not and never considered the problem of a care facility outsourcing a small part of its customary function, with

claims under subsection (13)(A) being made not by the facility but by the third-party provider. On balance, the more straightforward reading of “nursing home services” encompasses services provided *by* the nursing home and not services provided *to* the nursing home or its patients by third-party independent suppliers like closed pharmacies. As a matter of crude analogy, the closed pharmacies look more like suppliers to the nursing home than providers of nursing home services; and, whatever extra benefits they provide, Long Term's members, in supplying the raw drugs to the nursing homes, look a lot like retail drug stores supplying MassHealth patients. Statutory language, without a rationale for the result, is rarely conclusive but it is a start.

Turning to imputed purpose, it is easy to imagine why Congress wanted special protection for care facilities. Their sunk-cost structure makes them especially vulnerable to slow destruction by long-term underfunding; by contrast, the market reaction is likely to be quick and decisive if the Commonwealth seeks to underpay for drugs, whether provided by ordinary retailers or closed pharmacies. If WAC plus 5% is not enough to elicit an adequate supply, the Division will simply be forced to pay more and promptly so. Thus, whether or not Congress even thought specifically about closed pharmacies, the likely purpose for its broader distinction suggests a rationale that leaves closed pharmacies on the unprotected side of the line and outside subsection (13) (A). We so hold.

[3] This brings us to subsection (30)(A) which presents an interpretive problem of quite a different kind. Whereas subsection (13)(A) has a narrow subject (rates for three specified sets of services) and confers procedural rights on designated persons or entities (including “providers”), subsection (30)(A) has much broader coverage, sets forth general objectives, and mentions no category of entity or person specially protected. The state plan, says subsection (30)(A), must

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i) (4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy,

and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A) (2000).

This subsection, unlike subsection (13)(A), is not confined to particular services. Although the statute does not provide any procedure for the determination of such “methods and procedures,” implementing regulations for the subsection require public notice of any “significant proposed change” in the “methods and standards for setting payment rates for services,” and also opportunity for comment, 42 C.F.R. § 447.205 (2002) (although not necessarily in advance, see 46 Fed. Reg. 58,677, 58,678 (Dec. 3, 1981)). The statute also includes a set of substance goals for the “methods and procedures” including the enlistment of enough providers to furnish service generally available in the community. 42 U.S.C. § 1396a(a)(30)(A) (2000).

The Commonwealth's broadest response is that the pharmacies have no right to sue to enforce subsection (30)(A) or its implementing regulations. Of course, the Secretary of HHS (“the Secretary”) can enforce compliance with the provision and implementing regulations already mentioned, in a number of ways—by disapproving a state plan, 42 C.F.R. § 430.15 (2002), and by cutting off funds, 42 U.S.C. § 1396e (2000); 42 C.F.R. § 430.35 (2002). By contrast, nothing in subsection (30)(A) expressly provides that those who furnish Medicaid services have any enforcement rights or, indeed, have any specific rights to procedural (e.g., notice and comment) or *57 substantive (e.g., just and reasonable rates) protections.

Private rights of action were once freely inferred from federal statutes that regulated conduct—and here subsection (30)(A) certainly regulates the plan provider—but the ready inference in favor of private enforcement no longer applies. Compare *J.I. Case Co. v. Borak*, 377 U.S. 426, 84 S.Ct. 1555, 12 L.Ed.2d 423 (1964), with *Cort v. Ash*, 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975), with *Alexander v. Sandoval*, 532 U.S. 275, 121 S.Ct. 1511, 149 L.Ed.2d 517 (2001). In the past, Long Term's best argument would have been to rely upon section 1983 as providing an explicit automatic private right of action for injunctive relief wherever federal law regulates conduct by a state entity:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress....

42 U.S.C. § 1983 (2000).

However, the Supreme Court recently closed that door as well in *Gonzaga University v. Doe*, 536 U.S. 273, 283, 122 S.Ct. 2268, 153 L.Ed.2d 309 (2002). There, the Supreme Court assimilated its earlier cases restricting implied rights of action in non-state cases with section 1983 precedent; it repeated an earlier statement that section 1983 requires a violation of a private federal right and not just a federal law, *id.* at 282–83, 122 S.Ct. 2268 (citing *Blessing v. Freestone*, 520 U.S. 329, 340, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997)); and it indicated that nothing short of “an unambiguously conferred right” could support a claim under section 1983 based on a federal funding statute. *Id.*

Prior to *Gonzaga* this court had held that at least in some circumstances, subsection (30)(A) could support a right of action by a provider. *Visiting Nurse Ass'n v. Bullen*, 93 F.3d 997, 1003–05 (1st Cir.1996), *cert. denied*, 519 U.S. 1114, 117 S.Ct. 955, 136 L.Ed.2d 842 (2000). But *Gonzaga*, which charted a firm course among prior Supreme Court precedents in some tension with one another, see 536 U.S. at 279–286, 122 S.Ct. 2268, compels us to reexamine *Bullen*. An intervening Supreme Court decision trumps the usual rule that a panel decision is to be followed by a successor panel. *Stewart v. Dura Constr. Co.*, 230 F.3d 461, 467 (1st Cir.2000).

Subsection (30)(A), unlike subsection (13)(A), has no “rights creating language” and identifies no discrete class of beneficiaries—two touchstones in *Gonzaga's* analysis, 536 U.S. at 287–88, 122 S.Ct. 2268, and of those earlier cases on which *Gonzaga* chose to build. E.g., *Cannon v. Univ. of Chicago*, 441 U.S. 677, 690 n. 13, 99 S.Ct. 1946, 60 L.Ed.2d 560 (1979). The provision focuses instead upon the state

as “the person regulated rather than individuals protected,” *Sandoval* 532 U.S. at 289, 121 S.Ct. 1511, suggesting no “intent to confer rights on a particular class of persons,” or at least not providers. *Id.* (quoting *California v. Sierra Club*, 451 U.S. 287, 294, 101 S.Ct. 1775, 68 L.Ed.2d 101 (1981)). See also *Evergreen Presbyterian Ministries Inc. v Hood*, 235 F.3d 908, 923–29 (5th Cir.2000).

Admittedly, some traces of legislative history suggest that Congress assumed or favored the ability of providers to get relief for inadequate payment rates. *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990), relied on *58 such legislative history in construing an earlier version of section (13)(A)—known as the Boren Amendment—to create a private right of action for Medicaid service providers “to have the State adopt rates that it finds are reasonable and adequate rates to meet the costs of an efficient and economical health care provider.” 496 U.S. at 524, 110 S.Ct. 2510.⁴ In *Bullen*, we held that because the Boren Amendment and subsection (30)(A) contained nearly identical substantive requirements, *Wilder* supported the use of section 1983 to enforce subsection (30)(A).

However, following *Wilder* Congress in 1997 repealed the Boren amendment and replaced it with narrower language in the present subsection (13)(A) for the very purpose of increasing the flexibility of the states. See *Children’s Seashore House*, 197 F.3d at 657. Although *Gonzaga* did not overrule *Wilder’s* construction of the now repealed Boren amendment, *Gonzaga* requires clear statutory language for the creation of private rights enforceable under section 1983 at least where based upon federal funding statutes. 536 U.S. at 283, 290, 122 S.Ct. 2268. Subsection (30)(A) does not provide explicit rights for providers.

Long Term suggests that the failure to provide a private right of action would render subsection (30)(A) a nullity. That concern was noted by the Supreme Court in *Wilder*, 496 U.S. at 514, 110 S.Ct. 2510, a decision on which *Bullen* itself relied. But in the present case the Secretary has ample authority to enforce subsection (30)(A) in the ways already described. Under *Gonzaga*, the presence of an explicit enforcement mechanism weighs against inferring private rights of action. 536 U.S. at 289–90, 122 S.Ct. 2268. This is decidedly not a situation lacking an outside watchdog.

Five justices joined the Court’s *Gonzaga* opinion outright but two more, in an opinion by Justice Breyer, stressed similar criteria without endorsing the majority’s strong tilt

against implied private rights. Yet Justice Breyer noted, as one more point favoring the result in *Gonzaga*, the fact that “much of the statute’s key [substantive] language is broad and nonspecific,” suggesting that exclusive agency enforcement might fit the scheme better than a plethora of private actions threatening disparate outcomes. *Id.* at 292, 122 S.Ct. 2268 (Breyer, J., joined by Souter, J., concurring in the judgment).

Subsection (30)(A) presents the same concern. The criteria (avoiding overuse, efficiency, quality of care, geographic equality) are highly general and potentially in tension. And read literally the statute does not make these directly applicable to individual state decisions; rather state plans are to provide “methods and procedures” to achieve these general ends. 42 U.S.C. § 1396a(a)(30)(A) (2000). Thus, the generality of the goals and the structure for implementing them suggests that plan review by the Secretary is the central means of enforcement intended by Congress.

[4] Prior to *Gonzaga*, whether subsection (30)(A) authorized private rights for providers was a close question; the circuits were split on the issue, and well reasoned opinions had been written on *59 both sides.⁵ If *Gonzaga* had existed prior to *Bullen*, the panel could not have come to the same result. Whether *Gonzaga* is a tidal shift or merely a shift in emphasis, we are obligated to respect it, and it controls this case. Providers such as pharmacies do not have a private right of action under subsection (30)(A); if they think that state reimbursement is inadequate—and cannot persuade the Secretary to act—they must vote with their feet.

On a contingent basis, the Commonwealth argues that even if Long Term’s claims under both subsections were not barred as a matter of law, the district court still erred in granting the injunction. It asserts that the district court wrongly presumed injury from supposed violations of technical requirements (lack of prior comments and a formal finding); speculated about potential harm to “third parties” (nursing home patients); and ignored alleged means by which Long Term members could recoup if the Division had erred in adopting the new rate.

Our legal conclusions spare us the need to pursue these issues, but several observations are in order. Nothing we have seen suggests that the Division is unconcerned about assuring that nursing home residents receive their drugs, is indifferent to the survival of pharmacies that provide them, or has acted with indifference to those concerns solely in order to save the state money. It was the legislature that proposed WAC minus

2% and the Division that resisted; the rate it now defends is 7 percentage points higher than the legislature's target.

Nor, in the abstract, is there anything patently wrong with the Division's arguing that it has power to act on an emergency basis, or its desire to see whether supply can be maintained after a 1% reduction. See *Methodist Hosps. v. Sullivan*, 91 F.3d 1025, 1030 (7th Cir.1996). Admittedly, it is open to dispute whether this was an emergency so severe as to preclude prior comments. And, the lack of a formal finding that WAC plus 5% would elicit adequate supply has perhaps proved to be imprudent.

At the same time, the position of the pharmacies is little short of remarkable. They have apparently declined to give the Division the full range of raw cost data that it needs in order to fine tune its rates,⁶ and when the Division responded by making its best guess and then trying a modest market test through a further small reduction, Long Term's members sued, offering dire predictions of disaster—but again no adequate cost data. If pharmacy interests alone were of concern, the lack of equity is so patent that an injunction would be unthinkable.

*60 Of course, the district judge was primarily concerned not with the pharmacies but with nursing home residents, and

this was a proper concern in granting or denying a preliminary injunction. *New Comm. Wireless Servs. Inc.* 287 F.3d at 8–9. But even if one mistrusted the Division's priorities, the Secretary of HHS and the nursing homes are presumptively better guardians of the residents' overall interests than are these plaintiffs. Medicaid money that is spent unnecessarily on drugs is unavailable for other uses.

Our earlier discussion leads us to conclude that Long Term's members, and thus Long Term, have no claim under either subsection and that the preliminary injunction must be vacated. This may well entail dismissal of the case as a whole, but that issue has not been briefed and is a matter for the district court in the first instance. Under the circumstances, our mandate will issue forthwith, although without prejudice to petitions for rehearing or rehearing en banc in the usual course. See *U.S. Pub. Interest Research Group v. Atl. Salmon of Me., LLC* 339 F.3d 23, 35 (1st Cir.2003).

The preliminary injunction is vacated and the matter remanded to the district court. The mandate will issue immediately.

It is so ordered.

Footnotes

- 1 An August 2001 report by HHS' Office of the Inspector General, based on data from 8 states (not including Massachusetts), relied on by the Division in its initial rate setting, also concluded that actual acquisition costs were on average below WAC, although these numbers apparently did not include hospital and nursing facility service pharmacies. Office of the Inspector Gen., Dep't of Health & Human Servs., *Medicaid Pharmacy—Actual Acquisition Cost of Brand Name Prescription Drugs* (2001).
- 2 Under federal regulations, more specific findings that rates are adequate are required for services covered by subsection (13)(A). 42 C.F.R. § 447.353 (2002).
- 3 Cf. 5 U.S.C. § 553(b)(B) (2000) (APA exception to requirement of notice and comment for “good cause” including when it would be “impracticable”); *Utility Solid Waste Activities Group v. EPA*, 236 F.3d 749, 754–55 (D.C. Cir.2001) (impracticable “when an agency finds that due and timely execution of its functions would be impeded by the notice otherwise required”) (quoting U.S. Dept of Justice, *Attorney General's Manual on the Administrative Procedure Act* 30–31 (1947)).
- 4 See *Wilder*, 496 U.S. at 517–18, 110 S.Ct. 2510 (quoting S.Rep. No. 94–1246, at 4, U.S.C.C.A.N.1976, at 5651); *Ark. Med. Soc'y v. Reynolds*, 6 F.3d 519, 526 (8th Cir.1993). But see *Pa. Pharmacists Ass'n v. Houston*, 283 F.3d 531, 541 (3d Cir.), cert. denied, 537 U.S. 821, 123 S.Ct. 100, 154 L.Ed.2d 30 (2002) (finding the legislative history inconclusive).
- 5 *Cooperv. Pa. Pharmacists Ass'n*, 283 F.3d at 541–42. and *Walgreen Co. v. Hood*, 275 F.3d 475, 478 (5th Cir.2001), cert. denied, 536 U.S. 951, 122 S.Ct. 2645, 153 L.Ed.2d 823 (2002) (no right of action), with *Westside Mothers v. Haveman*, 289 F.3d 852, 863–64 (6th Cir.), cert. denied, 537 U.S. 1045, 123 S.Ct. 618, 154 L.Ed.2d 516 (2002), *Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir.1996), *Bullan*, 93 F.3d at 1005–06. and *Ark. Med. Soc'y*, 6 F.3d at 525–28 (right of action). *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir.1997), assumed a right of action but the issue was apparently not raised.
- 6 Long Term members supplied some data, but the Division said it was incomplete and inadequate to permit verification. And, assuming that concerns about proprietary information are real, there are numerous techniques (e.g., averaging by the Division of anything released publicly) to ameliorate or eliminate such problems. Cf. 8 Wright & Miller, *Federal Practice and Procedure*, § 2043 (2d ed.1994) (discussing various methods courts can use to protect proprietary information under Fed.R.Civ.P. 26(c)).

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5717.04 Appeal from certain decisions of board of tax appeals to supreme court; parties who may appeal; certification.

This section does not apply to any decision and order of the board made pursuant to section 5703.021 of the Revised Code. Any such decision and order shall be conclusive upon all parties and may not be appealed.

The proceeding to obtain a reversal, vacation, or modification of a decision of the board of tax appeals shall be by appeal to the supreme court or the court of appeals for the county in which the property taxed is situate or in which the taxpayer resides. If the taxpayer is a corporation, then the proceeding to obtain such reversal, vacation, or modification shall be by appeal to the supreme court or to the court of appeals for the county in which the property taxed is situate, or the county of residence of the agent for service of process, tax notices, or demands, or the county in which the corporation has its principal place of business. In all other instances, the proceeding to obtain such reversal, vacation, or modification shall be by appeal to the court of appeals for Franklin county.

Appeals from decisions of the board determining appeals from decisions of county boards of revision may be instituted by any of the persons who were parties to the appeal before the board of tax appeals, by the person in whose name the property involved in the appeal is listed or sought to be listed, if such person was not a party to the appeal before the board of tax appeals, or by the county auditor of the county in which the property involved in the appeal is located.

Appeals from decisions of the board of tax appeals determining appeals from final determinations by the tax commissioner of any preliminary, amended, or final tax assessments, reassessments, valuations, determinations, findings, computations, or orders made by the commissioner may be instituted by any of the persons who were parties to the appeal or application before the board, by the person in whose name the property is listed or sought to be listed, if the decision appealed from determines the valuation or liability of property for taxation and if any such person was not a party to the appeal or application before the board, by the taxpayer or any other person to whom the decision of the board appealed from was by law required to be sent, by the director of budget and management if the revenue affected by the decision of the board appealed from would accrue primarily to the state treasury, by the county auditor of the county to the undivided general tax funds of which the revenues affected by the decision of the board appealed from would primarily accrue, or by the tax commissioner.

Appeals from decisions of the board upon all other appeals or applications filed with and determined by the board may be instituted by any of the persons who were parties to such appeal or application before the board, by any persons to whom the decision of the board appealed from was by law required to be sent, or by any other person to whom the board sent the decision appealed from, as authorized by section 5717.03 of the Revised Code.

Such appeals shall be taken within thirty days after the date of the entry of the decision of the board on the journal of its proceedings, as provided by such section, by the filing by appellant of a notice of appeal with the court to which the appeal is taken and the board. If a timely notice of appeal is filed by a party, any other party may file a notice of appeal within ten days of the date on which the first notice of appeal was filed or within the time otherwise prescribed in this section, whichever is later. A notice of appeal shall set forth the decision of the board appealed from and the errors therein complained of. Proof of the filing of such notice with the board shall be filed with the court to which the appeal is being taken. The court in which notice of appeal is first filed shall have exclusive jurisdiction of the appeal.

Appx. 48

In all such appeals the commissioner or all persons to whom the decision of the board appealed from is required by such section to be sent, other than the appellant, shall be made appellees. Unless waived, notice of the appeal shall be served upon all appellees by certified mail. The prosecuting attorney shall represent the county auditor in any such appeal in which the auditor is a party.

The board, upon written demand filed by an appellant, shall within thirty days after the filing of such demand file with the court to which the appeal is being taken a certified transcript of the record of the proceedings of the board pertaining to the decision complained of and the evidence considered by the board in making such decision.

If upon hearing and consideration of such record and evidence the court decides that the decision of the board appealed from is reasonable and lawful it shall affirm the same, but if the court decides that such decision of the board is unreasonable or unlawful, the court shall reverse and vacate the decision or modify it and enter final judgment in accordance with such modification.

The clerk of the court shall certify the judgment of the court to the board, which shall certify such judgment to such public officials or take such other action in connection therewith as is required to give effect to the decision. The "taxpayer" includes any person required to return any property for taxation.

Any party to the appeal shall have the right to appeal from the judgment of the court of appeals on questions of law, as in other cases.

Amended by 130th General Assembly File No. 37, HB 138, §1, eff. 10/11/2013.

Amended by 128th General Assembly File No. 9, HB 1, §101.01, eff. 10/16/2009.

Effective Date: 10-05-1987

In the
Supreme Court of Ohio

RURAL HEALTH COLLABORATIVE
OF SOUTHERN OHIO, INC.,

Appellee,

v.

JOSEPH W. TESTA,
TAX COMMISSIONER OF OHIO

Appellant.

Case No. **14-0963**

Appeal from Ohio Board of Tax Appeals

Case No. 2012-3421

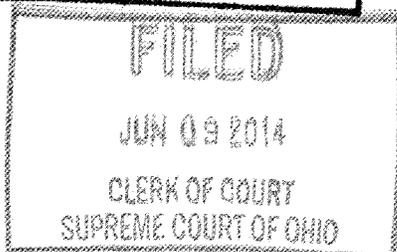
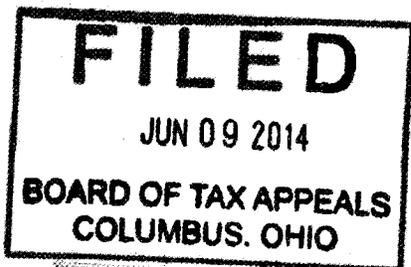
NOTICE OF APPEAL

MARK A. ENGEL
Bricker & Eckler LLP
9277 Centre Pointe Drive, Suite 100
West Chester, Ohio 45069

Counsel for Appellee
Rural Health Collaborative of
Southern Ohio, Inc.

MICHAEL DEWINE (0009181)
Attorney General of Ohio
DAVID D. EBERSOLE (0087896)*
BARTON A. HUBBARD (0023141)
Assistant Attorneys General
*Counsel of Record
30 East Broad Street, 25th Floor
Columbus, Ohio 43215-3428
Telephone: (614) 466-2941
Facsimile: (866) 294-0472
david.ebersole@ohioattorneygeneral.gov

Counsel for Appellant
Joseph W. Testa, Tax Commissioner of Ohio



HAND DELIVERED

Dialysis Clinic, Inc. is the same entity that was denied real property tax exemption for tax year 2004 for a dialysis clinic in West Chester, Ohio through this Court's decision in *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St.3d 215, 2010-Ohio-5071. In fact, Dialysis Clinic, Inc. maintained the same indigence policy during tax year 2006 that this Board held discriminatory in *Dialysis Clinic, Inc.* for tax year 2004. *Id.* at ¶¶ 34-35. The major distinguishing factor between this case and *Dialysis Clinic, Inc.* is the presence of a lease whereby the non-charitable institution Rural Health leases the subject property to Dialysis Clinic, Inc.

Despite the controlling Ohio Supreme Court precedent set forth in *Dialysis Clinic, Inc.*, the BTA in this case held that the land and dialysis clinic qualified for real property tax exemption under R.C. 5709.121(A)(2), as "used exclusively for charitable purposes." The appellant Commissioner complains of the following errors in the Decision and Order of the Board of Tax Appeals:

1. The BTA erred, as a matter of fact and law, in granting real property tax exemption for the subject property under R.C. 5709.121(A)(2), as "used exclusively for charitable purposes."
2. The BTA's decision ignored the controlling holding of the Ohio Supreme Court decision in *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St.3d 215, 2010-Ohio-5071. Under this controlling guidance, the BTA should have affirmed the appellant Tax Commissioner's final determination which denied Rural Health's claim to real property tax exemption in its entirety, as failing to meet the qualifications for real property tax exemption under R.C. 5709.12 when considered separately and, additionally, when considered in conjunction with R.C. 5709.121.

3. The Board's decision further erred by failing to recognize or apply the *stare decisis* standards established by the Ohio Supreme Court as set forth in *Westfield Ins. Co. v. Galatis*, 100 Ohio St. 3d 216, 2003-Ohio-5849; and *Ohio Apt. Assn. v. Levin*, 127 Ohio St. 3d 76, 2012-Ohio-4414. Under the *Galatis* test, as reaffirmed in *Ohio Apt. Assn.*, for this Court to overturn its previous decision in *Dialysis Clinic, Inc.*, the following criteria must be affirmatively demonstrated: "(1) the decision was wrongly decided at that time, or changes in circumstances no longer justify continued adherence to the decision, (2) the decision defies practical workability, and (3) abandoning the precedent would not create an undue hardship for those who have relied upon it." *Ohio Apt. Assn.* at ¶ 30 (quoting paragraph one of the syllabus in *Galatis*).
4. The Board's decision erred in failing to find that the *stare decisis* standard, as set forth in *Galatis* and reaffirmed in *Ohio Apt. Assn.*, has not been met here. *First*, the Court's holding in *Dialysis Clinic, Inc.* was not wrongly decided by either the Court or by the BTA in its decision in that case. *Second*, no changes in circumstances have occurred that would render continued adherence to the decision no longer justified. *Third*, the *Dialysis Clinic, Inc.* decision does not defy practical workability. *Fourth*, abandoning the precedent *would* create an undue hardship because real property tax exemptions are in derogation of equal rights, and place a disproportionate tax burden on all other taxpayers.
5. The BTA erred, as a matter of fact and law, in failing to consider, and by its silence ignoring, whether *Dialysis Clinic, Inc.* was a charitable institution within the meaning of R.C. 5709.121. *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St.3d 215, 2010-Ohio-

5071, affirming *Dialysis Clinic, Inc. v. Wilkins*, BTA Case No. 2006-V-2389, 2009 WL 41000065 (Nov. 24, 2009). The BTA further erred by failing to determine that Dialysis Clinic, Inc. was not a charitable institution, and, therefore, failed to satisfy R.C. 5709.121's express requirements. *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St.3d 215, 2010-Ohio-5071, Subheading C ("The BTA acted reasonably and lawfully in determining that DCI is not a charitable institution"). Indeed, the BTA should have determined that Dialysis Clinic, Inc. was not a "charitable institution" within the meaning of R.C. 5709.121.

6. In failing to consider whether Dialysis Clinic, Inc. was a charitable institution within the meaning of R.C. 5709.121, the BTA erred by failing to determine that the following factors, among others, weigh on Dialysis Clinic, Inc.'s status as a non-charitable institution: (1) Dialysis Clinic, Inc.'s discriminatory indigence policy that explicitly states it is "not a charity or gift to patients [and that] DCI retains all rights to refuse to admit and treat a patient who has no ability to pay"; (2) Dialysis Clinic, Inc. annually earns millions of dollars in surplus revenue over expenses from rendering dialysis care to patients, including, most recently, \$60 million and \$57 million in excess revenue over expenses for fiscal year ends 2013 and 2012, respectively; and (3) Dialysis Clinic, Inc. "may not establish its own core activity as charitable by pointing to a benefit that it confers upon another entity whose activity is charitable," as is potentially the case with the donation of surplus revenue to kidney research. *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St.3d 215, 2010-Ohio-5071, ¶¶ 32-34.

7. The BTA erred, as a matter of fact and law, in determining that Rural Health is a charitable institution within the meaning of R.C. 5709.121. *Northeast Ohio Psych. Institute v. Levin*, 121 Ohio St.3d 292, 2009-Ohio-583; *OCLC Online Computer Library Center, Inc. v. Kinney*, 11 Ohio St.3d 198 (1984); *Chagrin Realty, Inc. v. Testa*, BTA Case No. 2011-2523 (Apr. 29, 2014). In determining that Rural Health is a charitable institution, the BTA erred, as a matter of fact and law, in failing to determine that the core activity of Rural Health, an institution with no employees, is the lease of the subject property to Dialysis Clinic, Inc. In determining that Rural Health is a charitable institution, the BTA further erred in relying upon Rural Health's summary documentation, which constitutes hearsay and is not the best evidence of the information presented. Still further, the BTA erred, as a matter of fact and law, by failing to determine that Rural Health is not a charitable institution, and that, therefore, Rural Health failed to satisfy R.C. 5709.121's express requirements. Indeed, the BTA should have determined that Rural Health was not a "charitable institution" within the meaning of R.C. 5709.121.
8. In holding that the subject property satisfies the requirements for exemption pursuant to R.C. 5709.121(A)(2), the BTA erred, as a matter of fact and law, through its misapplication of *Cincinnati Community Kolliel v. Testa*, 135 Ohio St.3d 219, 2013-Ohio-396. Through the BTA's erroneous application of *Cincinnati Community Kolliel*, the requirement for exemption under R.C. 5709.121(A)(2) that real property be "made available under the direction or control [of a charitable institution] for use in furtherance or incidental to [a charitable institution's charitable purposes] and not with a view to profit" would be satisfied in nearly any instance. The BTA's

erroneous application of *Cincinnati Community Kollet* is particularly evident where, as here, the BTA failed to recognize the longstanding principle that tax exemption statutes are a matter of legislative grace in derogation of the rights of all other taxpayers that must be strictly construed against the taxpayer claiming exemption. *Anderson/Maltbie Partnership v. Levin*, 127 Ohio St.3d 178, 2010-Ohio-4904 (2010), ¶ 16; *Cincinnati College v. State*, 19 Ohio 110 (1850) (“All laws exempting any of the property in the state from taxation, being in derogation of equal rights, should be construed strictly.”).

9. In holding that the subject property satisfies the requirements for exemption pursuant to R.C. 5709.121(A)(2), the BTA erred, as a matter of fact and law, by failing to consider, and by its silence ignoring, whether the subject property was “made available under the direction or control of” the owner of the subject property, Rural Health, within the meaning of R.C. 5709.121(A)(2), as required to qualify for real property tax exemption under that statutory provision. *Cincinnati Nature Center Ass'n v. BTA*, 48 Ohio St.2d 122, 125 (1976). The BTA further erred by failing to determine that the subject property is not made available under the direction or control of Rural Health, and that, therefore, Rural Health failed to satisfy R.C. 5709.121(A)(2)’s express requirements. *See Christian Ministires, Inc. [sic] v. Testa*, BTA Case No. 2012-2213 (Mar. 13, 2014), at 3-4.
10. The BTA’s errors in (1) failing to consider whether the property is made available under the direction or control of Rural Health within the meaning of R.C. 5709.121(A)(2) and (2) failing to determine that the property is not made available under the direction or control of Rural Health within the meaning of R.C.

5709.121(A)(2) are particularly evident given that Rural Health transferred possession and control of the property to another entity, Dialysis Clinic, Inc., pursuant to a lease agreement. *See* R.C. 5321.02; R.C. 5709.121(A)(1).

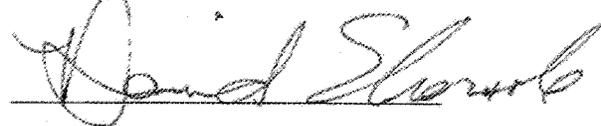
11. In holding that the subject property satisfies the requirements for exemption pursuant to R.C. 5709.121(A)(2), the BTA erred, as a matter of fact and law, in holding that the subject property was used “in furtherance of or incidental to charitable purposes,” even though Dialysis Clinic, Inc. wrote off non-reimbursable charges for dialysis treatments constituting only 1% of its total dialysis service revenues from the clinic on the subject property during calendar year 2006. In holding that the subject property is used “in furtherance of or incidental to charitable purposes,” the BTA further erred by failing to consider the totality of the circumstances. *Bethesda Healthcare v. Wilkins*, 101 Ohio St.3d 420, 2004-Ohio-1749, ¶ 39; *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St.3d 215, 2010-Ohio-5071. Still further, the BTA erred in relying upon Rural Health’s summary documentation prepared for this litigation, which constitutes hearsay and is not the best evidence of the information presented.
12. The BTA erred, as a matter of fact and law, in failing to hold that the subject property was used with a view to profit and, therefore, that the subject property failed to qualify for real property tax exemption as “used exclusively for charitable purposes.” *See Seven Hills Schools v. Kinney*, 28 Ohio St.3d 186, 187-88 (1986); *American Chemical Soc. V. Kinney*, 69 Ohio St.2d 167, 172-73 (1982) (Brown, J., dissenting).
13. The BTA erred, as a matter of fact and law, in failing to hold that the subject property is not used exclusively for charitable purposes pursuant to R.C. 5709.12(B) because the ownership and claimed exempt use of the property do not coincide in the same

entity. *First Baptist Church of Milford, Inc. v. Wilkins*, 110 Ohio St.3d 496, 2006-Ohio-4966, ¶ 12, quoting *Zangerle v. State ex rel. Gallagher*, 120 Ohio St.139 (1929) and *Lincoln Mem. Hosp., Inc. v. Warren*, 13 Ohio St.2d 109 (1968).

Wherefore, the appellant Commissioner requests that the Court reverse as unreasonable and unlawful the BTA's decision granting exemption for the subject realty, and remand the matter for issuance of an Order denying the application for real property tax exemption in its entirety to Rural Health Collaborative of Southern Ohio, Inc. for tax year 2006.

Respectfully submitted,

MICHAEL DEWINE
Attorney General of Ohio



MICHAEL DEWINE (0009181)
Attorney General of Ohio
DAVID D. EBERSOLE (0087896)*
BARTON A. HUBBARD (0023141)
Assistant Attorneys General
*Counsel of Record
30 East Broad Street, 25th Floor
Columbus, Ohio 43215-3428
Telephone: (614) 466-2941
Facsimile: (866) 294-0472
david.ebersole@ohioattorneygeneral.gov

Counsel for Appellant
Joseph W. Testa, Tax Commissioner of Ohio

Respectfully submitted,

MICHAEL DEWINE
Attorney General of Ohio



DAVID D. EBERSOLE (0087896)*

BARTON A. HUBBARD (0023141)

Assistant Attorneys General

* Counsel of Record

30 East Broad Street, 25th Floor

Columbus, Ohio 43215

Telephone: (614) 466-2941

Facsimile: (866) 294-0472

david.ebersole@ohioattorneygeneral.gov

Counsel of Appellant

Joseph W. Testa, Tax Commissioner of Ohio

CERTIFICATE OF SERVICE

I hereby certify that the foregoing Notice of Appeal and Praecipe were filed by hand delivery with the Ohio Supreme Court, 65 South Front St., Columbus, Ohio 43215, and the Ohio Board of Tax Appeals, 30 E. Broad St., 24th Floor, Columbus, Ohio 43215, and were served upon Mark Engel, Bricker & Eckler LLP, 9277 Centre Pointe Drive, Suite 100, West Chester, by certified mail return receipt requested this 9th day of June, 2014.



DAVID D. EBERSOLE (0087896)
Assistant Attorney General

OHIO BOARD OF TAX APPEALS

Rural Health Collaborative of Southern Ohio, Inc.,)	CASE NO. 2012-3421
)	
)	(REAL PROPERTY TAX EXEMPTION)
Appellant,)	
)	DECISION AND ORDER
vs.)	
)	
Joseph W. Testa, Tax Commissioner of Ohio,)	
)	
Appellee.)	

APPEARANCES:

For the Appellant	-	Bricker & Eckler LLP Mark A. Engel 9277 Centre Pointe Drive, Suite 100 West Chester, Ohio 45069
For the Appellee	-	Michael DeWine Attorney General of Ohio David D. Ebersole Assistant Attorney General 30 East Broad Street, 25th Floor Columbus, Ohio 43215

Entered **MAY 08 2014**

Mr. Williamson, Mr. Johrendt, and Mr. Harbarger concur.

Appellant appeals a final determination of the Tax Commissioner denying appellant's application for exemption from real property taxation for certain real property, i.e., parcel number 050-00-00-038.003, located in Adams County, Ohio, for tax year 2006. We proceed to consider the matter upon the notice of appeal, the statutory transcript certified by the commissioner, the record of the hearing before this board ("H.R."), and the parties' briefs.

The appellant in this matter, Rural Health Collaborative of Southern Ohio, Inc. ("RHC"), is an organization made up of three health care providers¹ in the area, which holds title to the property and leases it to Dialysis Clinic, Inc. ("DCI"),

¹ RHC is made up of Adams County Regional Hospital, Highland District Hospital, and Health Source of Ohio. Brown County Hospital was formerly a member, but withdrew from the collaborative in 2010 when it became a for profit entity. H.R. at 14-15.



which operates a dialysis clinic there. RHC established the dialysis clinic to fill an unserved need for dialysis services in the Adams, Brown, and Highland County area; previously, the closest dialysis services were located an hour or more away, in Portsmouth, Cincinnati, and Columbus. RHC seeks exemption pursuant to R.C. 5709.12 and R.C. 5709.121. The Supreme Court recently explained these sections as follows: “[P]ursuant to R.C. 5709.12(B), any institution, charitable or noncharitable, may qualify for a tax exemption if it is making exclusive charitable use of its property. But if the property belongs to a charitable or educational institution, R.C. 5709.121 defines what constitutes exclusive use of property in order to be exempt from taxation.” *Cincinnati Community Kollel v. Testa*, 135 Ohio St.3d 219, 2013-Ohio-396, ¶23.

Relying heavily on the Supreme Court’s denial of exemption of a similar facility owned and operated by DCI, *Dialysis Clinic, Inc. v. Levin*, 127 Ohio St.3d 215, 2010-Ohio-5071, the commissioner denied exemption of the subject property, finding that the property is not used for a charitable purpose because DCI’s indigent care policy “explicitly reserves the right to refuse to treat indigent patients.” Final Determination at 3. RHC thereafter appealed to this board. At this board’s hearing, RHC presented extensive testimony from individuals associated with RHC and DCI regarding the use of the property and DCI’s provision of charitable care.

In our review of this matter, we are mindful that the findings of the Tax Commissioner are presumptively valid. *Alcan Aluminum Corp. v. Limbach* (1989), 42 Ohio St.3d 121. Consequently, it is incumbent upon a taxpayer challenging a determination of the commissioner to rebut the presumption and to establish a clear right to the requested relief. *Belgrade Gardens v. Kosydar* (1974), 38 Ohio St.2d 135; *Midwest Transfer Co. v. Porterfield* (1968), 13 Ohio St.2d 138. In this regard, the taxpayer is assigned the burden of showing in what manner and to what extent the commissioner’s determination is in error. *Federated Dept. Stores, Inc. v. Lindley* (1983), 5 Ohio St.3d 213.

Although RHC makes arguments with regard to both R.C. 5709.12 and R.C. 5709.121, it primarily seeks exemption under R.C. 5709.121(A)(2), which requires that the property “(1) be under the direction or control of a charitable institution or state or political subdivision, (2) be otherwise made available ‘for use in furtherance of or incidental to’ the institution’s ‘charitable *** or public purposes,’ and (3) not be made available with a view to profit.” *Cincinnati Nature Center Assn. v. Bd. of Tax Appeals* (1976), 48 Ohio St.2d 122, 125. We first, therefore, determine whether RHC is a charitable institution. With regard thereto, *Planned Parenthood Assn. v. Tax Commr.* (1966), 5 Ohio St.2d 117, paragraph one of the syllabus, provides “‘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.”

The court in *Dialysis Clinic*, supra, explained that “[w]e have held that the determination of an owner’s status as a ‘charitable institution’ under R.C. 5709.121 requires a review of the ‘charitable activities of the taxpayer seeking the exemption.’ *Id.* at ¶27 (citing *OCLC Online Computer Library Ctr., Inc. v. Kinney* (1984), 11 Ohio St.3d 198). Specific to an entity whose core activities involved the provision of a healthcare service, the court further explained that such institution would only qualify as “charitable” if it “provided service ‘on a nonprofit basis to those in need, without regard to race, creed, or ability to pay.’” *Id.* at ¶29 (citing *Church of God in N. Ohio v. Levin*, 124 Ohio St.3d 36, 2009-Ohio-5939, ¶19). However, it cautioned that “[a] threshold amount of unreimbursed care is not required.” *Id.* at ¶40.

In *Dialysis Clinic*, DCI sought exemption for a dialysis clinic it owned and operated. The court, in a four to three majority opinion, in affirming this board’s decision, found that DCI did not qualify as a “charitable institution” under R.C. 5709.121. The court noted that DCI based its argument almost solely on its status as a

federal tax exempt organization, and rejected that argument, as it has in the past. *Id.* at ¶25 (“DCI’s argument would conflate Ohio’s property-tax exemption with standards under federal law for tax-exempt charities.”), citing *NBC-USA Hous., Inc.-Five v. Levin*, 125 Ohio St.3d 394, 2010-Ohio-1553, ¶20. In looking to DCI’s activities, the court further found insufficient evidence of charitable activities. *Id.* at ¶14 (“*** DCI did not present a charity-care figure ***”). The court further found that, consistent with its determination regarding DCI’s status as a “charitable institution,” its use of the property did not qualify as exclusive charitable use under R.C. 5709.12(B).

The parties disagree on the applicability of the court’s decision in *Dialysis Clinic* to the present matter. The appellee commissioner argues that the case “is indistinguishable from the present case.” Appellee’s Brief at 1. RHC, on the other hand, argues that the party in interest is different in this case, that RHC does not rely on its or DCI’s federal tax exempt status in establishing its charitable status, and that more evidence has been presented regarding the charitable use of the subject property. We agree with RHC – the focus in this matter is whether RHC is a charitable institution, not DCI. Notwithstanding the court’s repeated statement that proceedings related to previous tax years are not relevant to a separate tax year, see, e.g., *Hubbard Press v. Tracy* (1993), 67 Ohio St.3d 564, and the fact that a different entity (RHC) is seeking exemption in this matter, the record in the present case has substantially more evidence regarding RHC’s activities and purposes, and DCI’s activities at the subject property.

As explained by Kimberly Patton, CEO of Health Source of Ohio and RHC board member, at this board’s hearing, RHC was created to address the collective health needs of the area its members serve.² In addition to establishing the subject dialysis clinic, RHC has also filed applications for grants for tobacco cessation funding, pregnancy care and education, diabetes prevention and education, and

² RHC’s articles of incorporation provide that its purposes are: “(i) to enhance the quality, availability and efficiency of comprehensive health services for the people of southern Ohio by enabling and mobilizing community partnerships and resources; (ii) identifying and addressing healthcare needs which can be most effectively and efficiently responded to collectively (or ‘in a collective manner’); and (iii) supporting and furthering the missions of the member organizations.” H.R., Ex. 7 at 3.

managed care planning, and has jointly discussed addressing community health needs, such as opiate use, availability of rabies vaccines, and blood drives. In addition, RHC discussed the need for a dialysis clinic in the area, and established such a clinic at the subject property. And, indeed, our review of RHC's activities indicates that such actions are congruent with its purpose. The majority of the services facilitated by RHC's collaborative activities are made available to the community at large without charge. H.R. at 380-383. Accordingly, upon review of the record, we find that RHC is a charitable institution whose purpose is to benefit the community by providing improved health care. Cf. *Northeast Ohio Psych. Inst. v. Levin*, 121 Ohio St.3d 292, 2009-Ohio-583 (finding entity whose sole activity was leasing a building to another charitable entity was not a charitable institution).

Having found that RHC is a charitable institution, we next turn to a determination of whether the subject property is "made available under the direction or control of such institution *** for use in furtherance of its charitable *** purposes and not with a view to profit." As the court instructed in *Cincinnati Community Kollel*, supra, at ¶28, "the focus of the inquiry should be on the relationship between the actual use of the property and the purpose of the institution. See *Community Health Professionals, Inc. v. Levin*, 113 Ohio St.3d 432, 2007-Ohio-2336, ***." It is clear that the subject property is made available by RHC for use in furtherance of its purpose to improve the availability of health care in its three-county area, by providing dialysis services to a population that otherwise would not have such services available in the near proximity. Ms. Patton testified that RHC discussed the need for dialysis services in the area and ultimately determined that the best course of action would be for RHC to establish a facility and lease it to a dialysis operator.³

Further, the record demonstrates that the property is made available without a view to profit. RHC's financial statements indicate that the lease payments

³ Ms. Patton explained that the water requirements for a dialysis treatment center were specific and intensive, and, as such, an existing building was not available to house such activities. H.R. at 391. Andrew Mazon, DCI administrator for the subject clinic, further explained that the water filtration required for dialysis treatment requires "a huge filtration system." Id. at 193.

made by DCI to RHC exceeded the expenses of operating the building for most of the years 2006 through 2013.⁴ H.R., Ex. 11. With regard to DCI's activities on the property, i.e., providing dialysis treatment services, we initially note Ms. Patton's testimony that RHC interviewed three potential dialysis service providers, including DCI and two for profit entities, and the financial risk associated with operating a clinic in the Adams County area appears to have been the main reason one for profit provider would not operate there.⁵ H.R. at 390. We also note that RHC's lease with DCI was renegotiated twice because DCI was losing a "sizable amount of money operating the clinic ***;" and its financial situation had not improved several years later. *Id.* at 189-190. While the commissioner argues that DCI as a national organization does profit from its activities generally, it seems clear that its operation of the subject dialysis clinic is not a profitable enterprise. Its financials for the subject clinic indicate it has had an excess of expenses over revenues every year from 2006 to 2013. H.R., Ex. 15. Notably, a portion of those expenses relate to the write-off of care to patients who do not have adequate coverage through government or private insurers, and cannot independently pay their service balances. H.R., Ex. 14.

The commissioner further argues that DCI does not provide sufficient charitable care at the subject clinic, defined as "services being provided 'on a nonprofit basis to those in need, *without regard to race, creed, or ability to pay.*' (Emphasis added.) *Church of God in N. Ohio, Inc.*[, *supra*,] ¶19." *Dialysis Clinic, supra*, at ¶26. In *Bethesda Healthcare, Inc. v. Wilkins*, 101 Ohio St.3d 420, 2004-Ohio-1749, the Supreme Court held that "[w]hether 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." *Id.* at ¶39. The court, in *Dialysis Clinic, supra*, further explained that "[i]n the age of Medicare and Medicaid, the usual and ordinary indigent patient may have access to government benefits, and the modern healthcare provider is not

⁴ In 2009, the revenue from "dialysis operations" exceeded the expenses related thereto by \$9,862. H.R., Ex. 11.

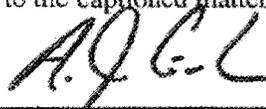
⁵ Ms. Patton further testified that Adams County is one of the top five poorest counties in Ohio, and that Brown and Highland counties are economically depressed. H.R. at 392.

required to forgo the pursuit of those benefits to qualify for charitable status.” Id. at ¶42.

The commissioner argues that the *Dialysis Clinic* court’s finding with regard to DCI’s indigence policy is definitive as to the charitable use of the subject property, which operates with the same policy. DCI’s policy states that, although DCI provides service without regard to a patient’s ability to pay, such indigency 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.” H.R., Ex. 6 at 2. Testimony elicited at this board’s hearing indicated that no patient has been denied services at the subject clinic because of an inability to pay. H.R. at 231-233. RHC provided a summary of patient records showing the amount of care “written off” during the years 2006 through 2013.⁶ H.R., Ex. 14. Upon review of the records presented, we find that, based on a totality of the circumstances, RHC has presented sufficient evidence of charitable care provided at the subject clinic. We further note that the evidence presented in this case differs from that presented in *Dialysis Clinic*, supra, where the court noted that “DCI did not present a charity care figure.” Id. at ¶14.

Based upon the foregoing, we find that appellant has sufficiently demonstrated its right to exemption pursuant to R.C. 5709.121(A)(2). Accordingly, the commissioner’s final determination is hereby reversed.

I hereby certify the foregoing to be a true and complete copy of the action taken by the Board of Tax Appeals of the State of Ohio and entered upon its journal this day, with respect to the captioned matter.



A.J. Groeber, Board Secretary

⁶ The information presented differentiates between “Medicare write-off” and “non-Medicare write-off.” Mr. Mazon testified that Medicare will reimburse a portion of write-offs on DCI’s annual cost report. H.R. at 246.

