

# SURVEY OF ILLINOIS LAW: HEALTHCARE LAW

W. Eugene Basanta,<sup>\*</sup> Robert John Kane,<sup>\*\*</sup> Rick L. Hindmand,<sup>\*\*\*</sup> Keith E. Emmons,<sup>†</sup> Brian J. McKenna,<sup>††</sup> and Nancy K. McKenna<sup>†††</sup>

## I. INTRODUCTION

Health Care remains among the most active and diverse fields in law. This year's Survey reviews significant state and federal health care law with respect to health care professional practice changes, physician fee splitting and employed physician restrictive practice covenants. Senior Illinois health care attorneys, all of whom are current or former members of the Illinois State Bar Association's Health Care Section Council, wrote the various articles to inform Illinois lawyers of significant developments in this dynamic practice area.

---

\* W. Eugene Basanta, the Southern Illinois Healthcare Professor of Law, Southern Illinois University School of Law; Professor, Southern Illinois University School of Medicine, Department of Medical Humanities, Director, Southern Illinois University Center for Health Law and Policy. The author acknowledges the valuable work of his research assistant, Southern Illinois University School of Law student, Jennifer Wagner.

\*\* Robert John Kane, JD, is an Adjunct Professor of Medical Humanities at Southern Illinois University School of Medicine and President-Elect of the Illinois Association of Healthcare Attorneys. Sections are reprinted for a similar article in the March 2010 issue of the *Journal of Legal Medicine*, Vol. 31, Issue 1 (2010). He is also Co-Author/Editor of the Law of Medical Practice in Illinois (Thomson/West 2007).

\*\*\* Rick L. Hindmand is a member of McDonald Hopkins LLC, practicing in its Chicago office, where he represents physicians and other health care providers in connection with corporate, transactional and compliance matters. He is a member of the ISBA Health Care Section Council and a past chair of the Chicago Bar Association Health Law Committee.

† Keith E. Emmons serves as editor and is a shareholder in Meyer Capel, P.C., Champaign, Illinois, where he represents health care practitioners, group medical practices, managed care organizations and hospitals. He is a Past-Chair and current member of the ISBA Health Care Section Council and a Past-President of the Illinois Association of Healthcare Attorneys. He wishes to thank Susan R. Young, Meyer Capel Paralegal for her continuing effort and exemplary legal scholarship in providing editing assistance for this article.

†† Brian J. McKenna is an Attorney, a Certified Public Accountant and Chartered Financial Analyst on the faculty at Governors State University. He is a former IRS Agent and General Tax Attorney—Litigation for Santa Fe Railway.

††† Nancy K. McKenna is an Attorney and a Registered Nurse on the faculty at Saint Xavier University. She is the former Vice President and Deputy General Counsel for Provena Health System.

II. “THREE STRIKES YOU’RE OUT!” *LEBRON V. GOTTLIEB  
MEMORIAL HOSPITAL*: ILLINOIS SUPREME COURT AGAIN  
REJECTS MEDICAL MALPRACTICE DAMAGE CAPS

Over the years, Illinois, like other states, has periodically encountered what is identified as a “medical malpractice crisis.”<sup>1</sup> Each such crisis has involved dramatic increases in professional liability insurance premiums brought on (it is argued) by an inordinate and unjustified rise in malpractice lawsuits against physicians and excessive damage awards by juries.<sup>2</sup> In turn, fears arise that physicians will leave the state and that patients will be left without access to adequate care.<sup>3</sup> The response to each such situation has been the same—calls for fundamental changes in the tort law system as it relates to medical liability claims.<sup>4</sup>

The array of “reforms” proposed in response to each crisis has been broad. It has included, among others, limitations on contingency fees of attorneys, heightened qualifications for expert witnesses, additional regulation of liability insurers, enhanced authority for medical disciplinary boards, and the implementation of various alternative dispute resolution mechanisms for medical liability disputes.<sup>5</sup>

Among the most often considered reforms have been statutory limits or “caps” on the damage awards available to plaintiffs in malpractice actions. Illinois first enacted such a cap in 1975 as part of a general medical malpractice reform statute.<sup>6</sup> Under the 1975 act, the maximum recoverable “on account of injuries by reason of medical, hospital or other healing art malpractice” was set by the General Assembly at \$500,000.<sup>7</sup> In *Wright v. Central Du Page Hospital Association* the Illinois Supreme Court found this provision unconstitutional.<sup>8</sup> “[L]imiting recovery only in medical malpractice actions to \$500,000 is arbitrary and constitutes a special law in violation of

- 
1. ROBERT J. KANE, ROSS D. SILVERMAN, & LAWRENCE E. SINGER, *THE LAW OF MEDICAL PRACTICE IN ILLINOIS* §22:1 (3d ed. 2007)(hereinafter *THE LAW OF MEDICAL PRACTICE IN ILLINOIS*); Theodore R. Leblang, *The Medical Malpractice Crisis—Is There a Solution? Symposium Introduction and Overview*, 27 J. LEG. MED. 1 (2006).
  2. *THE LAW OF MEDICAL PRACTICE IN ILLINOIS*, *supra* note 1, §22:1.
  3. Michelle M. Mello, David M. Studdert, & Troyen A. Brennan, *The New Medical Malpractice Crisis* 348 NEW ENG. J. MED. 2281, 2282 (2003).
  4. Reed N. Olsen, *The Reform of Medical Malpractice Law: Historical Perspectives*, 55 AM. J. ECON. & SOC. 257, 262–64 (1996).
  5. Leblang, *supra* note 1, at 7.
  6. P.A. 79-960, 79th Ill. Gen. Assembly (1975).
  7. *Id.*, §4 (codified at 70 Ill. Rev. Stat. §101).
  8. *Wright v. Cent. Du Page Hosp. Ass’n*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

section 13 of article IV of the 1970 Constitution. . . .”<sup>9</sup> The General Assembly next enacted a cap provision in the Civil Justice Reform Amendments of 1995.<sup>10</sup> The cap provision in this legislation applied to noneconomic damages in all negligence and products liability cases, not just those involving medical care. Specifically, the 1995 Amendments provided that, “In all common law, statutory or other actions that seek damages on account of death, bodily injury, or physical damage to property based on negligence, or product liability based on any theory or doctrine, recovery of non-economic damages shall be limited to \$500,000 per plaintiff.”<sup>11</sup> This provision was reviewed by the Illinois Supreme Court in *Best v. Taylor Mach. Works*.<sup>12</sup> In *Best*, the court again held, as in *Wright*, that the cap violated the special legislation provisions of the Illinois Constitution.<sup>13</sup> Additionally, the court found that the cap infringed on the judiciary in violation of the separation of powers provisions in the Illinois Constitution.<sup>14</sup> The cap was, the court said, a form of “legislative remittitur” which undercuts the inherent “power, and obligation, of the judiciary to reduce excessive verdicts.”<sup>15</sup>

Damage caps re-emerged as a topic of debate in response to fears of another malpractice crisis in Illinois in 2004 and 2005.<sup>16</sup> As in the past, sharply escalating insurance premiums generated concerns about the loss of physicians from Illinois and the potential that patients would not have access to adequate care.<sup>17</sup> In response, and “to preserve the public health, safety, and welfare of the people of Illinois,”<sup>18</sup> the General Assembly enacted legislation in 2005 setting a \$500,000 limit on noneconomic damages recoverable by a malpractice plaintiff against a physician, together with a \$1 million cap on the recovery of noneconomic damages from a hospital.<sup>19</sup> In *Lebron v. Gottlieb*

---

9. *Id.* at 329, 347 N.E.2d at 743.

10. P.A. 89-7, 89th Ill. Gen. Assembly (1995).

11. *Id.*, § 15 (codified at 735 ILL. COMP. STAT. ANN. 5/2-1115.1 (West 2007)).

12. *Best v. Taylor Mach. Works*, 179 Ill. 2d 367, 689 N.E.2d 1057 (1997).

13. *Id.* at 410, 689 N.E.2d at 1078.

14. *Id.* at 416, 689 N.E.2d at 1081.

15. *Id.* at 413, 689 N.E.2d at 1080.

16. In 2004, the American Medical Association identified Illinois as one of 20 states experiencing a medical liability crisis. AM. MED. ASS’N, AMERICA’S MEDICAL LIABILITY CRISIS: A NATIONAL VIEW (2004). Among the factors used by the AMA to make this determination was the degree to which access to care for patients had been impacted. *See also* Mello et al., *supra* note 3.

17. Leblang, *supra* note 1, at 5.

18. P.A. 94-677, § 101(5), 94th Ill. Gen. Assembly (2005).

19. *Id.*, § 330 (codified at 735 ILL. COMP. STAT. ANN. 5/2-1706.5 (West 2007)).

*Memorial Hospital* the Illinois Supreme Court, in a four to two decision, once again struck down malpractice damage cap legislation.<sup>20</sup>

Plaintiffs, a mother and her minor child, filed a medical malpractice and declaratory judgment action against the defendants, a hospital, a nurse, and a physician, alleging that the acts and omissions of the defendants during the infant's delivery by Caesarean section resulted in severe brain injury, cerebral palsy, inability to develop normal neurological function, and the necessity of being fed through a gastrostomy tube.<sup>21</sup> In Count V of the complaint, plaintiffs sought a declaration that the cap on noneconomic damages contained in Public Act 94-677 violated the Illinois Constitution.<sup>22</sup> Plaintiffs alleged that the child "has sustained disability, disfigurement, pain and suffering to the extent that damages for those injuries will greatly exceed the applicable limitations on noneconomic damages under [the Act]."<sup>23</sup> Plaintiffs asserted that this damage limitation contravened the separation of powers clause of the Illinois Constitution<sup>24</sup> by allowing the General Assembly to override judicial authority to determine when a remittitur is appropriate under the facts of a given case.<sup>25</sup> Finally, plaintiffs alleged that the limitation on damages was improper special legislation in that it granted limited liability "specially and without just cause to a select group of health care provider[s]."<sup>26</sup>

Plaintiffs filed a motion for partial judgment on the pleadings as to Count V.<sup>27</sup> The defendants responded with their own motions for judgment on the pleadings as to Count V asserting that the damages limitation did not violate the Illinois Constitution.<sup>28</sup>

---

20. *Lebron v. Gottlieb Memorial Hosp.*, Nos. 105741 & 105745, 2010 WL 375190 (Ill. Feb. 4, 2010). Justice Fitzgerald wrote the court's opinion and was joined by Justices Freeman, Kilbride, and Burke. Justices Karameier and Garman concurred in part and dissented in part. Justice Thomas took no part in the decision.

Shortly after the decision in *Lebron*, the Supreme Court of Georgia declared the state's \$350,000 medical malpractice noneconomic damage cap unconstitutional under the Georgia Constitution. The court ruled that, by limiting damages, it improperly interfered with the right to trial by jury in a civil case. *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 286 Ga. 731, 691 S.E.2d 218 (2010). The Missouri Supreme Court also ruled in March 2010 that its \$350,000 cap on medical malpractice damages created in 2005 cannot be applied retroactively to cases that occurred before the cap went into effect. *Klotz v. St. Anthony's Med. Center*, No. SC90107, 2010 WL 1049422 (Mo. Sup., Mar. 23, 2010).

21. *Lebron*, 2010 WL 375190, at \*1.

22. 735 ILL. COMP. STAT. ANN. 5/2-1706.5 (West 2009).

23. *Lebron*, 2010 WL 375190, at \*1.

24. ILL. CONST. 1970, art. II, § 1.

25. *Lebron*, 2010 WL 375190, at \*1.

26. *Id.*

27. *Id.*

28. *Id.*

The trial court, granting plaintiffs' motion, ruled that the damages limitation did violate the separation of powers clause of the Illinois Constitution and declared the entire Act invalid due to its non-severability provision.<sup>29</sup> The court relied on the holding in *Best v. Taylor Machine Works*<sup>30</sup> and said that, as in *Best*, the damages limitation acts as an impermissible legislative remittitur.<sup>31</sup> The court declined to reach plaintiffs' other constitutional arguments and made a Rule 304(a) finding of appealability pursuant to a motion by defendants.<sup>32</sup> Appeals for all defendants were filed directly with the Illinois Supreme Court and consolidated. The Illinois Attorney General intervened in defense of the constitutionality of the Act, and numerous *amicus curiae* briefs were filed for both sides.<sup>33</sup>

The Supreme Court reviewed the judgment on the pleadings *de novo* since it was a judgment as a matter of law.<sup>34</sup> Additionally, because the trial court's judgment rested on its decision that section 2-1706.5 violated the Illinois Constitution, the Supreme Court, citing *People v. Johnson*,<sup>35</sup> found that this ruling was subject to *de novo* review.<sup>36</sup>

In his opinion for the court's majority, Justice Fitzgerald initially noted that statutes enjoy a presumption of validity and that the burden of proof rests with the challenging party.<sup>37</sup> The trial court had held that the statute was invalid both on its face and as applied to the plaintiffs. The Supreme Court, however, found that because a facially invalid statute cannot be applied validly, and since there had been no findings of fact, the trial court's "as applied" ruling could not stand and proceeded to evaluate the facial validity of the statute.<sup>38</sup>

Defendants argued that, contrary to the trial court's ruling, the decision in *Best* did not control resolution of the constitutional separation of powers issue in the present case and that, in any case, the facts in *Best* were distinguishable from those in the instant case.<sup>39</sup> The defendants first argued that the holding in *Best* was based on the court's finding that the cap legislation involved there was special legislation. As such, the defendants

---

29. *Id.* at \*2. See P.A. 94-677, § 995, 94th Ill. Gen. Assembly (2005).

30. *Best v. Taylor Mach. Works*, 179 Ill. 2d 367, 689 N.E.2d 1057 (1997).

31. *Lebron*, 2010 WL 375190, at \*2.

32. *Id.*

33. *Id.*

34. *Id.*

35. *People v. Johnson*, 225 Ill. 2d 573, 870 N.E.2d 415 (2007).

36. *Lebron*, 2010 WL 375190, at \*2.

37. *Id.* (citing *In re Marriage of Miller*, 227 Ill. 2d 185, 879 N.E.2d 292 (2007)).

38. *Lebron*, 2010 WL 375190, at \*3.

39. *Id.* at \*4.

asserted, the separation of powers analysis in *Best* was mere dicta and not entitled to much weight.<sup>40</sup>

As to this argument, Justice Fitzgerald agreed that the separation of powers analysis had not been necessary to the *Best* decision, but disagreed that the analysis was due little weight.<sup>41</sup> He distinguished between two types of dicta: *obiter dictum*, an opinion which is made as an aside and not necessary to the outcome and therefore not binding under *stare decisis*, and judicial *dictum*, which is an opinion on an issue that was passed upon deliberately by the court and argued by the parties. A judicial *dictum* is entitled to much weight and should be followed unless clearly erroneous.<sup>42</sup> Since the separation of powers analysis in *Best* was briefed by the parties involved, deliberately passed upon by the court, and the conclusion expressed as a holding, the court stated it was a judicial *dictum* and should be followed unless erroneous.<sup>43</sup>

The defendants did not argue that the separation of powers analysis in *Best* was erroneous. Rather, they argued that, because *Best* involved a broad-based statute, whereas the statute at issue in the instant case was narrowly tailored to fit the health care industry, *Best* was distinguishable and not controlling.<sup>44</sup> The court disagreed, stating that even though the cap affected a smaller number of cases, it was in effect a legislative remittitur that encroached on judicial authority.<sup>45</sup>

The court responded to the Attorney General's argument that the rational basis test as used in *Best* applied in the instant case by observing that the rational basis test was relevant to the issue of whether the statute was special legislation. When the issue is separation of powers, the relevant inquiry is whether the judicial sphere is invaded.<sup>46</sup> The Attorney General then argued that the statute was part of a multidimensional exercise of the General Assembly's police power in response to a threat to the state; namely, the health care crisis. Plaintiffs argued, and the court agreed, that the multidimensional nature of the statute did not make a difference in the constitutional analysis.<sup>47</sup>

Defendants posited additional arguments, such as that the General Assembly has the power to change the common law and that it may enact legislation that affects the conduct of litigation if it serves legitimate legislative

---

40. *Id.* at \*8.

41. *Id.*

42. *Id.* (citing *Exelon Corp. v. Dep't of Revenue*, 234 Ill. 2d 266, 917 N.E.2d 899 (2009)).

43. *Lebron*, 2010 WL 375190, at \*9.

44. *Id.*

45. *Id.* at \*10.

46. *Id.* at \*10–11.

47. *Id.* at \*12.

goals.<sup>48</sup> The court stated that, while these were legitimate goals of the legislature, the true issue in the present case was the constitutionality of the legislature's action and that constitutional boundaries must be respected.<sup>49</sup>

Defendants also argued that the decision in *Unzicker v. Kraft Food Ingredients Corp.* should guide the court.<sup>50</sup> In *Unzicker*, the court rejected a separation of powers challenge to a statute involving joint and several liability, holding that it did not amount to a legislative remittitur since it did not limit the plaintiff's recovery; it merely stated that certain defendants can only be held liable for noneconomic damages up to a certain amount (i.e., their percentage of fault if less than twenty-five percent). Section 2-1706.5, by contrast the court said, directly limits plaintiff's damages, orders a judgment that is not in conformity with the jury's decision, and does not take the facts into account to determine if the jury award is excessive as a matter of law.<sup>51</sup>

Defendants also argued that invalidating section 2-1706.5 would adversely affect other statutes that limit common law liability, such as the Good Samaritan Act.<sup>52</sup> The court declined to pass on the constitutionality of statutes not in question, but commented that none of the statutes defendants cited required a court to reduce a jury's award of noneconomic compensatory damages to a set limit without considering the facts of the case.<sup>53</sup>

Defendants cited many statutes from numerous other states setting caps on noneconomic damages in medical malpractice actions. Noting that these statutes were disparate in nature, the court declined to pass on the reasonableness of other states' legislation.<sup>54</sup> The court disapproved of what it called the "everybody is doing it" test for constitutionality.<sup>55</sup> The court also rejected the defendants' argument that since other jurisdictions had rejected the separation of powers challenge to limitations on damages clauses, that this court should do so.<sup>56</sup> The holding in *Best* was controlling, and so the court neither required guidance from other states nor should its constitutional analysis depend on the actions of other states.<sup>57</sup>

The majority then addressed the contentions of the dissenting justices and dismissed their dire predictions of the future of health care in Illinois if

---

48. *Id.* at \*14–15.

49. *Id.*

50. *Unzicker v. Kraft Food Ingredients Corp.*, 203 Ill. 2d 64, 783 N.E.2d 1024 (2002).

51. *Lebron*, 2010 WL 375190, at \*13.

52. *Id.* at \*16.

53. *Id.*

54. *Id.* at \*17.

55. *Id.*

56. *Id.*

57. *Id.* at \*18.

noneconomic damages are not capped.<sup>58</sup> The court did address one particular point raised by the dissent, namely, that the court lacked subject matter jurisdiction since the plaintiffs in the instant case lacked standing to sue and the statute was not ripe for review.<sup>59</sup> Under Illinois law, lack of standing is an affirmative defense, which the defendant must plead and prove.<sup>60</sup> A lack of standing claim will be forfeited if not raised in a timely manner as will ripeness.<sup>61</sup> Here, the hospital and the nurse had not asserted lack of standing or ripeness before the trial court, so they had forfeited those issues. The physician-defendant had raised both as affirmative defenses and moved for judgment on the pleadings, which the trial court denied. However, he did not renew his arguments on appeal, and so the court deemed them waived.<sup>62</sup> The court commented in a footnote that lack of standing would be more of an issue in federal court, where it is a threshold question under Article III of the U.S. Constitution. However, Illinois is not required to follow federal law with regard to standing and the court had consistently refused to do so.<sup>63</sup>

Justice Karmeier, in his dissent, argued that the health care crisis was of great import, referencing President Obama's recent health care reform efforts.<sup>64</sup> He then argued that second guessing the wisdom of the legislature's reform efforts was in itself constitutionally impermissible.<sup>65</sup> Additionally, he stated his concern whether the instant case was the proper one for disposing of the separation of powers question with respect to section 2-1706.5. His concerns were both jurisprudential, in that the resolution of the case may eliminate the need for a constitutional decision, and justiciability, in that he believed standing and ripeness were issues. He did not feel that the public interest exception to ripeness applied.<sup>66</sup> He also opined that the holding in *Best* should be overruled and stated that the doctrine of remittitur was itself constitutionally suspect and should not enjoy the protection given by the majority.<sup>67</sup> Additionally, he noted that many other jurisdictions had held that caps on noneconomic damages do not amount to remittitur and felt that was the better approach. Looking to sister states for guidance made good sense in

---

58. *Id.*

59. *Id.* at \*19.

60. *Id.* See *In re Estate of Schlenker*, 209 Ill. 2d 456, 808 N.E.2d 995 (2004).

61. *Lebron*, 2010 WL 375190, at \*19. See *Skolnick v. Alzheimer & Gray*, 191 Ill. 2d 214, 730 N.E.2d 4 (2000); *in re General Order of October 11, 1990*, 256 Ill. App. 3d 693, 628 N.E.2d 726 (1st Dist. 1993).

62. *Lebron*, 2010 WL 375190, at \*20.

63. *Id.*

64. *Id.* at \*21 (Karmeier, J., dissenting).

65. *Id.* at \*23–24.

66. *Id.* at \*25–30.

67. *Id.* at \*32–33.



his opinion.<sup>68</sup> Finally, he argued that the legislature may change the common law when it sees fit and enjoys broad discretion in doing so.<sup>69</sup>

The impact of the Illinois Supreme Court's decision in *Lebron* is uncertain. Fears were immediately expressed that the malpractice crisis would return to Illinois.<sup>70</sup> The Illinois Hospital Association, for example, stated that the *Lebron* ruling:

will renew the malpractice lawsuit crisis and make it more difficult for Illinoisans to access or afford health care as liability costs for physicians and hospitals are driven to unsustainable levels. Hospitals across the state will again face even greater challenges recruiting and retaining physicians, especially specialists such as neurosurgeons and obstetricians, who were leaving Illinois during the height of the crisis.<sup>71</sup>

In turn, the court's decision raises a variety of issues for the General Assembly. First, with respect to caps, it seems clear that absent an amendment to the Illinois Constitution, any further attempt to impose a cap on medical malpractice damages would be futile.<sup>72</sup> Over the span of 35 years, the Illinois Supreme Court has three times rejected such legislation. Second, the General Assembly must decide what, if anything, to do about the other malpractice reform measures that were included in the 2005 legislation, all of which became invalid with the *Lebron* decision because of the legislation's non-severability provision.<sup>73</sup> These other measures included insurance regulatory reforms, revisions to enhance the authority and resources available to the Illinois Department of Financial and Professional Regulation and the Medical Disciplinary Board to oversee physicians, other reforms to the malpractice litigation process, such as more robust expert witness standards, and creation of the "Sorry Works! Pilot Program."<sup>74</sup> The General Assembly could go back

---

68. *Id.* at \*33–35.

69. *Id.* at \*36.

70. See Sean P Carr, *Milliman: 18% Cost Increase With Illinois Medical Liability Cap Struck*, INS. NEWS, Feb. 24, 2010, available at: <http://insurancenewsnet.com/article.aspx?id=166262&type=propertycasualty>.

71. Illinois Hospital Association, Statement on the Supreme Court Ruling in *Lebron v. Gottlieb Memorial Hospital*, Feb. 4, 2010 available at: <http://www.ihatoday.com/issues/liability/supremecourtruling.pdf>.

72. Following the court's decision in *Lebron*, Illinois Senator David Luetefeld introduced a resolution calling for an amendment to the Illinois Constitution allowing the General Assembly to place limits on liability for non-economic damages in medical malpractice lawsuits. Sen. Joint Res. Const. Amend. 103, 96th Ill. Gen. Assembly (2010).

73. P.A. 94-677, § 995, 94th Ill. Gen. Assembly (2005).

74. P.A. 94-677, §§ 310, 315, 330, & 401–495, 94th Ill. Gen. Assembly (2005). Subsequent to the *Lebron* ruling, the Illinois Department of Insurance urged insurers in Illinois to continue to comply with the 2005 act's insurance reforms. "Given the public interest served by improved stability and

and re-enact some or all of these changes.<sup>75</sup> Third, the General Assembly could consider alternative reform proposals to mitigate some of the perceived problems in the current medical malpractice litigation system. For example, the legislature might try to create a system of special health courts to handle malpractice claims.<sup>76</sup> Of course any such proposals would also likely face judicial scrutiny. Finally, Illinois like other states may now look even more to the federal government to address the medical liability litigation as part of national health reform legislation.<sup>77</sup> The Illinois Hospital Association commented after *Lebron* as follows:

This decision and its dire repercussions for the health care delivery system highlight the critical need for the President and Congress to embrace serious and meaningful medical liability reform as part of health care reform. All plausible forms of medical liability reform, such as arbitration, specialized courts and early settlement offer approaches, should be explored as part of health reform.<sup>78</sup>

The *Lebron* decision and its effect on health care reform will continue to be an important topic for attorneys and those in the healthcare field alike.

---

affordability of medical malpractice insurance in Illinois, the Department requests continued, voluntary compliance by insurers with the insurance reforms.” Press Release, Illinois Department of Insurance, Illinois Department of Insurance Encourages Insurers to Comply with 2005 Medical Malpractice Reforms, Feb. 24, 2010, *available at*: [http://www.insurance.illinois.gov/newsrsls/2010/02202010\\_a.asp](http://www.insurance.illinois.gov/newsrsls/2010/02202010_a.asp).

75. In the 96th Illinois General Assembly, several bills were introduced to re-enact some of the reforms included in the 2005 legislation that were struck down in the *Lebron* decision. *See, e.g.*, SB 3536, 96th Ill. Gen. Assembly (2010); HB 5841, 96th Ill. Gen. Assembly (2010); HB 6844, 96th Ill. Gen. Assembly (2010). However, none of these bills passed.
76. The idea of special health courts has been promoted for some time by the interest group COMMON GOOD. *See* <http://commongood.org/> (last visited Nov. 7, 2010). In 2005, Illinois Senator David Leuctefeld introduced legislation in the General Assembly to establish such special health courts. Steve Stanek, *Supporters to Push Med Mal Court in State Assembly*, THE MADISON ST. CLAIR RECORD (Jan. 12, 2005), <http://www.madisonrecord.com/news/139498-supporters-to-push-med-mal-court-in-state-assembly>.
77. Congress enacted national health reform with the Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No. 111-148, 124 Stat. 119 (2010). The PPACA was signed into law on March 23, 2010 by President Obama. Among its provisions, the PPACA earmarks \$50 million to fund state pilot programs to explore alternative reforms to the malpractice system beyond such traditional approaches as damage caps. These alternatives could include, for example, health courts, early offers, apology programs, and medical review panels. Amy L. Sorrel, *Health Reform Has Liability Insurers Looking at Tort Alternatives*, AM. MED. NEWS (June 7, 2010), <http://www.ama-assn.org/amednews/2010/06/07/prl20607.htm>.
78. Illinois Hospital Association, Statement on the Supreme Court Ruling in *Lebron v. Gottlieb Memorial Hospital*, *supra* note 68.

### III. SCOPE OF HEALTH CARE, PROFESSIONAL PRACTICE CHANGES

For a number of years, the legislative and regulatory processes were impeded because of a dispute over executive branch authority to promulgate rules as opposed to making legislative changes. This situation was ostensibly resolved by enactment of a clarification to the Illinois Administrative Procedure Act (Act) requiring all adopted rules to follow the procedures under the Act.<sup>79</sup> This section will briefly summarize and address a number of recent case law changes and legislative changes concerning the practice of health care professionals.

#### A. Legislative Changes

Legislative changes discussed below primarily concern legislation effecting the practice of professions including, newly expanded scope practice for health care professionals.

##### 1. *Perinatal Mental Health Disorders Prevention and Treatment*

Public Act 95-469 created the “Perinatal Mental Health Disorders Prevention and Treatment Act” to mandate that health care professionals take specific steps to diagnose and treat mental health disorders of pregnant women or new mothers “commonly referred to as post partum depression.”<sup>80</sup> Licensed health care professionals,<sup>81</sup> meaning physicians, advanced practice nurses, and physician assistants, are required to provide education and screening. Specific requirements are as follows:

- Licensed health care professionals providing *prenatal care* to women shall provide education to women and, if possible and with permission, to their families about perinatal mental health disorders.<sup>82</sup>
- Licensed health care professionals providing *prenatal care* at a prenatal visit shall invite each pregnant patient to complete a questionnaire<sup>83</sup> and

---

79. P.A. 96-002, effective February 26, 2009.

80. P.A. 95-469, effective January 1, 2008 (codified at 405 ILL. COMP. STAT. 95/1 (2008)).

81. 405 ILL. COMP. STAT. ANN. 95/10 (West 2009) (definition of “licensed health care professional”).

82. 405 ILL. COMP. STAT. ANN. 95/15(1) (West 2009) (emphasis added).

83. 405 ILL. COMP. STAT. ANN. 95/10 (West 2009) (definition of “Questionnaire”).

shall review the completed questionnaire. This assessment of perinatal mental health disorder must be repeated as necessary.<sup>84</sup>

- Licensed health care professionals providing *postnatal care* to women shall invite each patient to complete a questionnaire and shall review the completed questionnaire.<sup>85</sup>

The Act imposes a new duty on licensed health care professionals, who provide care for infants. This new duty is to request “the *infant’s mother* to complete a questionnaire at any well-baby check-up at which the mother is present prior to the infant’s first birthday.”<sup>86</sup> The health care professional providing care to the infant and not the mother must then “review the completed questionnaire in order to ensure that the health and well-being of the infant are not compromised by an undiagnosed perinatal mental health disorder in the mother.”<sup>87</sup> Physicians and others treating infants by law *now* have two patients with specified duties: one, the infant, and second, the mother.

## 2. *Free Clinic Immunity Expansion to Clinics without Walls*

Public Act 95-874 expanded the Good Samaritan Act<sup>88</sup> to provide good faith immunity from civil liability for the services provided by a free clinic without walls.<sup>89</sup> The Good Samaritan Act already provides good faith civil immunity for the services of health care professionals and providers who provide care and treatment at a Free Medical Clinic which posts a clear notice of the limitations on liability.<sup>90</sup> Additionally, services provided to a patient referred to a physician’s office, or hospital from such a clinic, are also covered by this immunity. To receive this good faith immunity from civil liability, health care professionals and providers “may not receive any fee or other compensation in connection with any services provided.”<sup>91</sup> Willful and wanton misconduct on behalf of health care professionals and providers is not protected by this immunity.

Public Act 95-874 recognized that modern health care delivery does not require a clinic with walls, a premise, or even a building. A Free Clinic can

---

84. 405 ILL. COMP. STAT. ANN. 95/15(3) (West 2009) (emphasis added).

85. 405 ILL. COMP. STAT. ANN. 95/15(4) (West 2009) (emphasis added).

86. 405 ILL. COMP. STAT. ANN. 95/15(5) (West 2009).

87. *Id.*

88. 745 ILL. COMP. STAT. ANN. 49 (West 2009).

89. P.A. 95-874, effective August 21, 2008 (codified at 745 ILL. COMP. STAT. 49/30.5 (2008)).

90. 745 ILL. COMP. STAT. ANN. 49/30 (West 2009).

91. 745 ILL. COMP. STAT. ANN. 49/30(d-5) (West 2009).

refer patients to health care professionals and providers in their own offices or buildings. In order for the professionals and providers to receive good faith civil immunity for services provided to Free Clinic patients, the patient must be given a separate document “signed by the patient or member parent or guardian of the minor” containing an explanation of the limit on civil liability.<sup>92</sup> This separate document must specifically be:<sup>93</sup>

A clear, concise, and understandable explanation of the exemption from civil liability provided in this Act in writing, in at least 14 point bold type to each person who is enrolled as a patient or member of that free clinic or, in the case of a minor patient or member by the parent or guardian of the minor.

### *3. Hospital Medical Staff Summary Suspension Revisions*

Public Act 96-445 amended Section 10.4 of the Hospital Licensing Act<sup>94</sup> concerning medical staff privileges to address the issuance of summary suspension of medical staff privileges and the use of independent peer review in the credentialing process in a hospital.

Subsection 10.4(b)(2)(C)(i) which authorizes summary suspension of medical staff membership or clinical privileges “if the continuation of practice of a medical staff member constitutes an immediate danger to the public, including patients, visitors and hospital employees and staff” is revised to further clarify the summary suspension process.<sup>95</sup>

Under Public Act 96-445, for a summary suspension to be imposed by law the following condition must be met: “there is actual documentation or other reliable information that an immediate danger exists. This documentation or information must be available at the time the summary suspension decision is made and when the decision is reviewed by the Medical Executive Committee.”<sup>96</sup>

---

92. *Id.*

93. *Id.*

94. P.A. 96-445, effective August 14, 2009 (codified at 210 ILL. COMP. STAT. ANN. 85/10.4 (West 2009)).

95. P.A. 96-445, effective August 14, 2009 (codified at 210 ILL. COMP. STAT. ANN. 85/10.4(b)(2)(C)(i) (West 2009)).

96. P.A. 96-445, effective August 14, 2009 (codified at 210 ILL. COMP. STAT. ANN. 85/10.4(b)(2)(C)(i) (West 2009)).

If summary suspension is imposed, then the following must occur:<sup>97</sup>

The Medical Executive Committee, or other comparable governance committee of the medical staff specified in the bylaws, must meet as soon as is reasonably possible to review the suspension . . . if the physician requests such review.

Finally, the Medical Executive committee's or other committee's review of the summary suspension and recommended actions must be considered by the hospital governing board "on an expedited basis."<sup>98</sup>

Subsection 10.4(b)(2)(C-5) is added to require all peer review used for credentialing purposes to "be conducted in accordance with the medical staff bylaws and applicable rules, regulations, or policies of the medical staff."<sup>99</sup> Further, any adverse peer review report must be shared with the medical staff member reviewed. Finally, any timely response to the adverse report by the medical staff member reviewed shall be considered throughout the credentialing process including by the hospital governing board.

## B. Health Care Professionals Practice Expansions

### 1. *Pharmacists*

Illinois pharmacists and pharmacies are licensed under the Pharmacy Practice Act (Act).<sup>100</sup> After previous major expansions were made in the scope of practice for pharmacists in 2007, Public Act 96-673 amended the Pharmacy Practice Act to clarify the criteria for licensure as a pharmacy technicians and interns (now student pharmacists).<sup>101</sup>

### 2. *Dentists*

Illinois dentists are licensed under the Dental Practice Act (Act).<sup>102</sup> Dentistry is generally the care and treatment of the "human oral cavity and adjacent tissues and structures." Public Act 96-0014 expanded the options

---

97. *Id.*

98. *Id.*

99. P.A. 96-445, effective August 14, 2009 (codified at 210 ILL. COMP. STAT. ANN. 85/10.4(b)(2)(C-5) (West 2009)).

100. 225 ILL. COMP. STAT. ANN. 85 (West 2009); 68 Ill. Adm. Code Part 1330.

101. P.A. 96-673, effective January 1, 2010 (codified at 225 ILL. COMP. STAT. ANN. 85 (West 2009)).

102. 225 ILL. COMP. STAT. ANN. 25 (West 2009); 68 Ill. Adm. Code Part 1220.

applicants have for completing national dental examinations in order to be licensed in Illinois.<sup>103</sup>

Additionally, Public Act 96-617 specifies that the National Board of Dental Examiners may recommend rule changes to the Department based upon a “review of emerging scientific technology” concerning proper application and use of such technology.<sup>104</sup>

Further, this Public Act also amends Section 16 of the Act to identify that required cardiopulmonary resuscitation certification training qualifies as continued education hours under the Act’s requirements.<sup>105</sup>

### 3. *Advanced Practice Nurses*

Illinois advanced practice nurses are licensed under the new “Nurse Practice Act” (Act).<sup>106</sup> Advanced practice nurses (APN) generally provide patient care services within the practice field of their collaborating physician, podiatrist, department in a hospital, or ambulatory surgical treatment center.

Under a collaborative agreement, a collaborating physician or podiatrist may delegate prescriptive authority for any medications generally prescribed by the physician including Schedule III through V Controlled Substances as in the previous Act.<sup>107</sup>

The Act also allows a physician to delegate limited Schedule II Controlled Substances prescriptive authority.<sup>108</sup> Delegation of Schedule II prescriptive authority is limited to five oral medications regularly prescribed by the collaborating physician. Public Act 96-189, amends the Nurse Practice Act, the Pharmacy Practice Act, and the Illinois Controlled Substances Act to further clarify this authority granted by previous Public Act 95-639.<sup>109</sup>

Further, Public Act 96-516 adopts an exception to the Nursing Practice Act’s prohibition on nurse delegation of medication to allow delegation to unlicensed persons who are administering prepackaged medications to detainees in correctional facilities.<sup>110</sup>

---

103. P.A. 96-0014, effective June 29, 2009.

104. P.A. 96-617, effective August 24, 2009 (codified at 225 ILL. COMP. STAT. ANN. 25/7.5 (West 2009)).

105. P.A. 96-617 effective August 24, 2009 (codified at 225 ILL. COMP. STAT. ANN. 25/16 (West 2009)).

106. P.A. 95-639, effective January 1, 2008 (codified at 225 ILL. COMP. STAT. ANN. 65 (West 2009)). Revised rules were published as a new Part 68 Ill. Adm. Code 1300 in the *Illinois Register* on October 2, 2009.

107. 225 ILL. COMP. STAT. ANN. 65/65-40(a) (West 2009).

108. 225 ILL. COMP. STAT. ANN. 65/65-40(d) (West 2009).

109. P.A. 95-639, effective October 5, 2007.

110. P.A. 96-516, effective August 14, 2009 (codified at 225 ILL. COMP. STAT. ANN. 65/50-15 (West 2009)). 225 ILL. COMP. STAT. ANN. 60 (West 2009), 68 Ill. Adm. Code Part 1285.

#### 4. *Physicians*

Physicians are licensed under the Medical Practice Act of 1987.<sup>111</sup> Public Act 96-608 amended Section 22(A)(14) of the Medical Practice Act of 1987 to specifically address the issue of fee splitting and the CAM case to be discussed later.<sup>112</sup> The existing subsection 22(A)(14) provides grounds for discipline when a physician unlawfully splits a professional fee with another individual or corporately organizes a practice to allow a non-physician control over the practice. With amendments to address the first issue of fee splitting the Illinois General Assembly found it necessary to also address the corporate practice issue because the text intertwines both issues. P.A. 96-608 effectively replaced Subsection 22(A)(14) with a cross-reference to a new section 22.2,<sup>113</sup> which set forth the revised standards fee splitting and corporate organization. These changes were made while still preserving the prohibition against the corporate practice of medicine which simply prohibits a non-licensed physician from owning or operating a medical practice.

In summary, new Section 22.2 authorizes fee splitting and corporate practice under the following exceptions to the prohibition:

1. With another professional who concurrently provides services with full knowledge of the patient.<sup>114</sup> [Examples: Global fee, employment]
2. With a corporation or other legal entity provided all the owner are licensed physicians or licensed optometrists.<sup>115</sup>
3. With a medical corporation, professional services corporation, professional association or limited liability company as currently authorized by law.
4. An entity otherwise allowed by law to provide physician services or employ physicians.<sup>116</sup> [Examples: Hospitals, hospital affiliates and ambulatory surgical treatment centers]

---

111. P.A. 96-608, effective August 24, 2009.

112. *Id.*

113. P.A. 96-608, effective August 24, 2009 (to be codified at 225 ILL. COMP. STAT. ANN. 60/22.2 (West 2009)).

114. P.A. 96-608, effective August 24, 2009 (to be codified at 225 ILL. COMP. STAT. ANN. 60/22.2(b) (West 2009)).

115. P.A. 96-608, effective August 24, 2009 (codified at 225 ILL. COMP. STAT. ANN. 60/22.2(c)(1) (West 2009)).

116. P.A. 96-608, effective August 24, 2009 (codified at 225 ILL. COMP. STAT. ANN. 60/22.2(c)(3) (West 2009)).



5. Specific acts for which fees may not be split such as marketing and network participation.<sup>117</sup>

In addition, physicians and physicians' corporate practices are specifically allowed to split professional fees with billing and collection services when done as "payment for collection or processing of charges provided the licensee controls the amount charged and that fees collected are properly deposited."<sup>118</sup> Furthermore Section 22.2(e) states that "a security interest in accounts receivable may be established for advances to the licensee or practice."<sup>119</sup>

Additionally, P.A. 96-618 amended the Medical Practice Act of 1987<sup>120</sup> (Act) and other Acts to set forth criteria for delegation of patient care tasks and duties.<sup>121</sup> The primary limitation on delegation is stated as follows:<sup>122</sup>

No physician may delegate any patient care task or duty that is statutorily or by rule mandated to be performed by a physician.

Specific practice areas that can be delegated to physician assistants and advanced practice nurses are set forth in Section 54.5 of the Act.<sup>123</sup>

In summary, new Section 54.2 of the Act provides the following criteria for delegation of tasks and duties in the office setting:

A physician may delegate patient care tasks or duties to an unlicensed person who possesses appropriate training and experience provided a health care professional, who is practicing within the scope of such licensed professionals individual licensing Act is on site to provide assistance.<sup>124</sup> Any delegation of patient care tasks or duties must be in the context of a physician-patient relationship.<sup>125</sup>

---

117. P.A. 96-608, effective August 24, 2009 (codified at 225 ILL. COMP. STAT. ANN. 60/22.2(f) (West 2009)).

118. P.A. 96-608, effective August 24, 2009 (codified at 225 ILL. COMP. STAT. ANN. 60/22.2(d) (West 2009)).

119. P.A. 96-608, effective August 24, 2009 (codified at 225 ILL. COMP. STAT. ANN. 60/22.2(e) (West 2009)).

120. 225 ILL. COMP. STAT. ANN. 60 (West 2009); 68 Ill. Adm. Code Part 1285.

121. P.A. 96-618, effective January 1, 2010 (codified at 225 ILL. COMP. STAT. ANN. 60/54.2 (West 2009)).

122. P.A. 96-618, effective January 1, 2010 (codified at 225 ILL. COMP. STAT. ANN. 60/54.2(a) (West 2009)).

123. *Id.*

124. P.A. 96-618, effective January 1, 2010 (codified at 225 ILL. COMP. STAT. ANN. 60/54.2(b) (West 2009)).

125. P.A. 96-618, effective January 1, 2010 (codified at 225 ILL. COMP. STAT. ANN. 60/54.2(c) (West 2009)).

Finally, Section 54.2 provides specific authority for the Department of Financial and Professional Regulation to adopt rules concerning “the use of light emitting devices for patient care or treatment.”<sup>126</sup>

#### 5. *Physician Assistants*

P.A. 96-268 significantly revises the Physician Assistants Act of 1987<sup>127</sup> (Act) to replace the current requirement that a supervising physician establish written guidelines for the practice of a physician assistant with a requirement that the supervising physician enter into a “written supervision agreement” with a physician assistant, identical to the “written collaborative agreement” mandated for an advanced practice nurse to practice outside a hospital or ambulatory surgical treatment center setting.<sup>128</sup>

Further, the Act was revised to allow a supervising physician to delegate the same prescriptive authority to a physician assistant that the physician licensed to practice medicine in all its branches could delegate to an advanced practice nurse up to and including limited Schedule II controlled substances. No changes were made to the physician supervision requirements in the Act.

#### C. Caselaw Changes

Of significance, a number of judicial decisions are discussed related to liability and health care practice issues. These decisions concern issues critical to both health care professionals and providers.

##### 1. *Center For Athletic Medicine, Ltd. (“CAM”) v. Independent Medical Billers Of Illinois (“IMBI”) and Medorizon, Inc.*

In *Center For Athletic Medicine, Ltd. (CAM) v. Independent Medical Billers of Illinois (IMBI) and Medorizon, Inc.*,<sup>129</sup> the Illinois First District Appellate Court decided that a billing agreement between physicians and a billing service based upon compensation to the billing service in the form of a percentage of the professional fees violated the fee splitting provision in the

---

126. P.A. 96-618, effective January 1, 2010 (codified at 225 ILL. COMP. STAT. ANN. 60/54.2(e) (West 2009)). See also 68 Ill. Adm. Code § 1285.336 (use of lasers).

127. 225 ILL. COMP. STAT. ANN. 95(West 2009), 68 Ill. Adm. Code Part 1350.

128. P.A. 96-268, effective August 11, 2009 codified at 225 ILL. COMP. STAT. ANN. 95/4, 7.5 and 21 (West 2009).

129. *Ctr. for Athletic Med., Ltd. v. Ind. Med. Billers of Ill., Inc.*, 383 Ill. App. 3d 104, 889 N.E.2d 750 (1st Dist. 2008).

Medical Practice Act of 1987,<sup>130</sup> making the agreement void and unenforceable. A medical practice sued over the alleged breach of contract by a billing service resulting in the medical practice not receiving complete and accurate reimbursement for professional services provided from insurance companies and other payors. The billing service was paid a percentage of the professional service fees recovered from the insurance companies and other payors.

The trial court dismissed the lawsuit because the contract required payment of a percentage of physician professional service fees as payment in violation of the Medical Practice Act prohibition on physician fee splitting. Among other decisions, the trial court relied heavily on the Illinois Supreme Court's decision in *HealthLink*.<sup>131</sup>

CAM appealed the decision to the appellate court arguing, among other things, that the prohibition on fee splitting does not apply to payment for billing services which seek reimbursement after services are rendered. Thus, the billing services are in no position to steer referrals which is the public policy reason for the prohibition on fee-splitting.

The appellate court determined that the plain language of the prohibition in the Medical Practice Act is broader than these public policy concerns. The Illinois Supreme Court refused to hear the case on appeal.<sup>132</sup>

Shortly after the Illinois Supreme Court refused to hear the case, legislation was introduced to revise the law to allow percentage based contracts with billing services, and other services.<sup>133</sup> In the subsequent year, P.A. 96-608 was enacted to specifically authorize billing service agreements on a percentage basis.<sup>134</sup>

## 2. *Solon v. Midwest Medical Records Association, Inc.*

In *Solon v. Midwest Medical Records Association, Inc.*,<sup>135</sup> the Illinois First District Appellate Court addressed the issue of whether it is reasonable *per se* for a provider of medical record copies to charge the full amount of the \$20 processing fee, or if the provider is limited to a lesser charge if the evidence shows that the lesser charge is all that is reasonable.

---

130. 225 ILL. COMP. STAT. ANN. 60/22(A)(14) (West 2009).

131. *Vine St. Clinic v. HealthLink, Inc.*, 222 Ill. 2d 276, 856 N.E.2d 422 (2006).

132. *Ctr. For Athletic Med., Ltd. v. Indep. Med. Billers of Ill., Inc.*, 229 Ill. 2d 619, 897 N.E.2d 250 (2008).

133. House Bill 6728, 95th Illinois General Assembly, *available at* <http://www.ilga.gov/legislation>.

134. P.A. 96-608, effective August 24, 2009 (codified at 225 ILL. COMP. STAT. ANN. 60/22 and 22.2 (West 2009)).

135. *Solon v. Midwest Med. Records Ass'n*, 386 Ill. App. 3d 78, 898 N.E.2d 207 (1st Dist. 2008).

Sections 8-2001 and 8-2003 of the Code of Civil Procedure<sup>136</sup> provide that health providers may make copies of a patient's medical records upon the written request of any patient. The health care provider shall be reimbursed by the requesting patient for all reasonable expenses incurred in connection with the copying but not to exceed a \$20 handling charge. Additionally, the patient must reimburse the health care provider for the cost of the copies at a maximum per-page rate as well as shipping costs.

The plaintiffs argued that the plain language of the statute only permits health care providers to receive reimbursement for "reasonable expenses" incurred in connection with copying the records and that amount may not exceed \$20.

The court agreed with this argument and further stated that the legislature intended to repay health care providers for the *actual* costs they incurred in processing the records request, rather than pay a flat fee regardless of the costs incurred.<sup>137</sup> The court was also persuaded by the phrase "not to exceed" and understood that to mean that the statute imposes a maximum amount of recoverable expenses rather than a flat fee. Thus, the court held that it is not *per se* reasonable to charge a flat \$20 handling fee under Sections 8-2001 and 8-2003.

The dissent, however, concluded that the flat handling fee is *per se* reasonable.<sup>138</sup> The dissenting judge looked to various Illinois House and Senate transcripts discussing the statutory amendment and concluded that the intent of "the \$20 handling fee to be a one-time charge for obtaining records that was a *per se* reasonable method to avoid excessive and variable fees."<sup>139</sup>

Furthermore, the dissent argued to construe the statute otherwise would require "a court to determine a reasonable handling fee whenever an individual requests copies of his or her medical records [which] is absurd, inconvenient and unjust."<sup>140</sup>

This was appealed to the Illinois Supreme Court.<sup>141</sup> On appeal to the Illinois Supreme Court the arguments were essentially the same as before the appellate court.<sup>142</sup> However, the result was different as the Illinois Supreme Court agreed with the dissent in the appellate decision. The Court found that

---

136. 735 ILL. COMP. STAT. ANN. 5/8-2001 & 8-2003 (West 2009). Sections 8-2001 and 8-2003 have since been combined into a revised Section 8-2001. See P.A. 95-478, effective January 1, 2008.

137. *Solon*, 386 Ill. App. 3d 78, 898 N.E.2d at 207.

138. *Id.* at 84, 898 N.E.2d at 212.

139. *Id.* at 85, 898 N.E.2d at 213.

140. *Id.* at 86, 898 N.E.2d at 214.

141. *Solon v. Midwest Med. Records Ass'n*, 231 Ill. 2d 655, 902 N.E.2d 1091 (2009).

142. The May 21, 2009 oral argument can be accessed at <http://www.state.il.us/court/Media/On-Demand.asp>.

the statute was ambiguous and subject to interpretation.<sup>143</sup> The handling fee was found to be reasonable in light of the legislative history of the statutory change that established the handling fee. Specifically, the Court stated:

Accordingly, we conclude that the \$20 handling fee is per se reasonable. The alternative interpretation would force every health-care provider to undergo an assessment of the appropriate charge for each individual copy request, inevitably resulting in a lack of uniform charges and natural inequities. Such a result is absurd, unjust, and inconvenient and not in line with the intent of the legislature, especially where, as here, the language was expressly agreed upon by competing interest parties after lengthy negotiations.<sup>144</sup>

### 3. *Tedrick v. Community Resource Center, Inc.*

In *Tedrick v. Community Resource Center, Inc.*,<sup>145</sup> the Illinois Fifth District Appellate Court decided that defendants (including physicians) may have a duty to warn a patient's wife of his violent propensities even though the wife knew of the patient's threats to harm her.

The appellate court decision is a significant expansion of the liability risk for physicians treating mental health conditions.

The plaintiff brought a wrongful death action on behalf of a woman's estate and children against her husband's health care providers. Prior to the woman's murder by her husband, the husband had been having paranoid delusions about killing himself and his wife. Both the husband and wife had provided information concerning the husband's mental health history to the health care workers performing the assessments. The husband's mother revealed that the husband had expressed a plan to kill himself and his wife.

The appellate court decided that the lawsuit should proceed based upon two legal theories creating obligations to non-patients: (1) "transferred negligence" theory,<sup>146</sup> and (2) "voluntary undertaking" theory.<sup>147</sup>

Under the transferred negligence theory,<sup>148</sup> the appellate court recognized that the Illinois Supreme Court has accepted "that a nonpatient, third party who was injured as a result of a negligent act performed against a patient could

---

143. *Solon v. Midwest Med. Records Ass'n, Inc.*, 236 Ill. 2d 433, 925 N.E.2d 1113, 1119 (2010).

144. *Id.* at 446, 925 N.E. 2d at 1121.

145. *Tedrick v. Cmty. Res. Ctr.*, 373 Ill.App.3d 761, 869 N.E.2d 421 (5th Dist. 2007).

146. *Id.* at 763, 869 N.E.2d at 424.

147. *Id.*

148. *Id.* at 770, 869 N.E.2d at 429.

maintain an action against medical providers.”<sup>149</sup> Further, the appellate court noted:

The Illinois Supreme Court recognized the concept of transferred negligence but limited its reach to circumstances where there was a special, intimate relationship between the parties harmed.<sup>150</sup>

Knowing that the Illinois Supreme Court has only accepted transferred negligence concept in the special relationship between a mother and her infant,<sup>151</sup> the appellate court concluded:

We conclude that the special relationship between husband and wife, under circumstance of this case, is comparable to that found in *Renslow* [mother and infant] and believe that the Illinois Supreme Court would concur.<sup>152</sup>

Finally, under the voluntary undertaking theory, the appellate court summarized the voluntary undertaking theory as follows:

One who gratuitously undertakes to render service to another is subject to liability for bodily harm caused to the other if he fails to exercise due care or to act with competence and skill that he possesses while performing the undertaking.<sup>153</sup>

The duty as described by the appellate court “is limited to the extent of the undertaking.” Based upon this theory, the appellate court found:

We conclude that the third amended complaint contains sufficient factual allegations regarding the defendant’s assumption of a duty to warn Teresa Street about the violent propensities of her husband to survive a motion to dismiss.<sup>154</sup>

---

149. *Id.*

150. *Id.*

151. *Id.* See also *Renslow v. Mennonite Hosp.*, 67 Ill. 2d 348, 367 N.E.2d 1250 (1977).

152. *Tedrick*, 373 Ill. App. 3d at 772, 869 N.E.2d at 431 (bracket added).

153. *Id.* at 769, 869 N.E.2d at 428.

154. *Id.*

This case was appealed to the Illinois Supreme Court.<sup>155</sup> The Illinois Supreme Court heard oral argument in this case.<sup>156</sup>

On September 24, 2009, the Illinois Supreme Court decided the issues addressed in this case. The Illinois Supreme Court clearly rejected the Appellate Court's decision.<sup>157</sup> The Supreme Court based its rejection on "long-established principles" set in the Court's previous decisions of *Kirk v. Michael Reese Hospital and Medical Center*<sup>158</sup> and *Doe v. McKay*.<sup>159</sup> The Court implied that the Appellate Court ignored these "long-established principles" in imposing a duty under a theory of voluntary undertaking.<sup>160</sup> As to the theory of "transferred negligence," the Court concluded "that the marriage relationship of Richard and Teresa is not comparable to the relationship between a mother and fetus."<sup>161</sup>

The state legislative and executive branches, like the federal legislative and executive branches, will continue to struggle with how to legally shape the delivery of health care services to meet the needs of the citizens of Illinois through regulation of health care professionals and providers.

#### IV. ILLINOIS MEDICAL AND OPTOMETRY FEE SPLITTING STATUTES, AMENDED TO ALLOW PERCENTAGE BILLING CONTRACTS

On August 24, 2009, Illinois Governor Patrick Quinn approved Public Act 96-0608, which amended the fee splitting prohibitions of the Illinois Medical Practice Act and the Illinois Optometric Practice Act to allow percentage billing contracts and to provide additional detail regarding the scope of the prohibitions. This section of this article focuses principally on the medical fee splitting prohibition in the Medical Practice Act, and provides a brief discussion of several differences between the new medical and optometry fee splitting sections, which are generally similar.

---

155. *Tedrick v. Cmty. Res. Ctr.*, 225 Ill. 2d 677, 875 N.E.2d 1125 (2007). Consolidated cases 104861, 104876.

156. The September 16, 2008 oral argument can be accessed at <http://www.state.il.us/court/Media/On-Demand.asp>.

157. *Tedrick*, 235 Ill. 2d at 155, 920 N.E.2d at 220.

158. *Kirk v. Michael Reese Hosp. and Med. Ctr.*, 117 Ill. 2d 507, 513 N.E.2d 387 (1987).

159. *Doe v. McKay*, 183 Ill. 2d 272, 700 N.E.2d 1018 (1998).

160. *Tedrick*, 235 Ill. 2d at 176, 920 N.E.2d at 231.

161. *Id.* at 177, 920 N.E.2d at 232.

### A. Prior Medical Fee Splitting Statute

The prior medical fee splitting provision was contained in Section 22(A)(14) of the Illinois Medical Practice Act of 1987,<sup>162</sup> which subjected licensees (i.e., physicians and chiropractors)<sup>163</sup> to potential discipline for “dividing with anyone other than physicians with whom the licensee practices in a partnership, Professional Association, limited liability company, or Medical or Professional Corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered.” That section set forth exceptions for group practices, joint ventures of medical corporations and concurrent physician services.

In 2006, the Illinois Supreme Court interpreted the prior medical fee splitting statute for the first time, in *Vine Street Clinic v. HealthLink, Inc.*<sup>164</sup> The Illinois Supreme Court held in *Vine Street* that Section 22(A)(14) prohibited the administrator of a network of health care providers from charging participating physicians a percentage of their medical fees as payment for administrative services, but that a subsequent administrative fee based on the volume of claims processed in the prior year and the specialty of the physician did not violate Section 22(A)(14).

Illinois courts interpreted the prior fee splitting statute to prohibit a broad range of business arrangements involving payment by a physician or physician group to a nonphysician (and in some cases even to another physician) under a formula based on physician practice revenue or collections. In particular, Illinois appellate courts had held that Section 22(A)(14) and a predecessor statute prohibited the payment of a percentage of collections generated by promotional activities of a marketing firm,<sup>165</sup> a percentage of net income for management services and the referral of patients,<sup>166</sup> a percentage of future professional income as the purchase price for a medical practice,<sup>167</sup> and administrative fees directly related to professional revenues even when the fees are not calculated on a percentage basis.<sup>168</sup>

---

162. 225 ILL. COMP. STAT. ANN. 60/22(A)(14) (West 2009), as in effect immediately prior to the effective date of Public Act 96-0608.

163. This section of this Survey article uses the term “physicians” to apply to all licensees (i.e., physicians and chiropractors) under the Medical Practice Act.

164. *Vine St. Clinic v. HealthLink, Inc.*, 222 Ill. 2d 276, 856 N.E.2d 422 (2006).

165. *E&B Mktg. Enter., Inc. v. Ryan*, 209 Ill. App. 3d 626, 568 N.E.2d 339 (1st Dist. 1991).

166. *Practice Mgmt. Ltd. v. Schwartz*, 256 Ill. App. 3d 949, 628 N.E.2d 656 (1st Dist. 1993).

167. *Lieberman & Kraff, M.D., S.C. v. Desnick*, 244 Ill. App. 3d 341, 614 N.E.2d 379 (1st Dist. 1993).

168. *TLC The Laser Ctr. Inc. v. Midwest Eye Inst. II, Ltd.*, 306 Ill. App. 3d 411, 714 N.E.2d 45 (1st Dist. 1999).



The prior fee splitting statute created particular concerns for Illinois physicians and medical billing companies. Compensation for billing services in Illinois as well as other states is typically based on a percentage of fees collected. In recent years, however, Illinois courts invalidated percentage billing arrangements under the medical fee splitting statute. For example, in *Center for Athletic Medicine, Ltd. v. Independent Medical Billers of Illinois, Inc.*,<sup>169</sup> the Appellate Court of Illinois, First District, invalidated a percentage billing contract, leaving a contracting physician group with no remedy on its claim that the billing company breached the contract and caused over \$4.4 million in damages. Thus, under the prior fee splitting prohibition, percentage billing contracts were widespread but were unenforceable in Illinois, so that neither the billing company nor the physician practice would have a remedy for breach by the other party. Furthermore, Illinois physicians who entered into the percentage arrangements could, at least in theory, face disciplinary exposure under the prior fee splitting statute.

#### B. New Medical Fee Splitting Prohibition

Public Act 96-0608 added a new provision (Section 22.2)<sup>170</sup> to the Illinois Medical Practice Act, setting forth the fee splitting prohibition and related exceptions. Subsection (a) of this new section sets forth the general fee splitting prohibition as follows:

A licensee under this Act may not directly or indirectly divide, share or split any professional fee or other form of compensation for professional services with anyone in exchange for a referral or otherwise, other than as provided in this Section 22.2.<sup>171</sup>

Section 22.2 also added a provision (subsection (f))<sup>172</sup> prohibiting the payment of a percentage of professional fees, revenues or profits for any of the following purposes, unless the payment is to owners or physicians of physician practice entities recognized under Section 22.2(c):

- marketing or management of a physician practice;
- including a physician on any preferred provider list;

---

169. 383 Ill. App. 3d 104, 889 N.E.2d 750 (1st Dist. 2008).

170. 225 ILL. COMP. STAT. ANN. 60/22.2 (West 2009).

171. 225 ILL. COMP. STAT. ANN. 60/22.2(a) (West 2009).

172. 225 ILL. COMP. STAT. ANN. 60/22.2(f) (West 2009).

- allowing a physician to participate in any network of health care providers;
- negotiating service terms, fees or charges; or
- including the physician in a program providing an incentive for patients or beneficiaries to use a physician's services.

Section 22(A)(14)<sup>173</sup> continues to provide that a fee splitting violation will be a ground for discipline, but now cross-references new Section 22.2, rather than setting forth the fee splitting prohibition directly.

### C. Fee Splitting Exceptions

Section 22.2 establishes fee splitting exceptions for concurrent professional services, medical billing contracts and security interests in medical accounts receivable. In addition, Section 22.2(c) recognizes certain physician practice structures that are outside the scope of the fee splitting prohibition. These exceptions are discussed briefly below.

Section 22.2(b)<sup>174</sup> recognizes the right of licensed health care workers who concurrently render services to receive adequate compensation for their services, so long as the patient has full knowledge of the division and the division is in proportion to the services personally performed and the responsibility assumed. The prior statute contained a similar concurrent services exception, although it was limited to physicians.

The new exception for medical billing arrangements is contained in Section 22.2(d),<sup>175</sup> and allows payment by a physician (or physician practice) for billing, administrative preparation or collection services, but only if three conditions are satisfied. First, the billing company's compensation must be consistent with fair market value. Second, the physician or physician practice must control the amount of fees charged and collected. Third, all collections must either be paid directly to the physician (or physician practice) or deposited directly into an account in the name and under the sole control of the physician (or physician practice), or into a trust account by a licensed collection agency in compliance with the Illinois Collection Agency Act.

Section 22.2(c)<sup>176</sup> allows physician practice entities to pool, share, divide or apportion professional fees and other revenues. This subsection (c) recognizes that the following four categories of physician practice entities

---

173. 225 ILL. COMP. STAT. ANN. 60/22(A)(14) (West 2009).

174. 225 ILL. COMP. STAT. ANN. 60/22.2(b) (West 2009).

175. 225 ILL. COMP. STAT. ANN. 60/22.2(d) (West 2009).

176. 225 ILL. COMP. STAT. ANN. 60/22.2(c) (West 2009).

qualify for this exception: (1) entities owned entirely by Illinois-licensed physicians, (2) medical or professional corporations, professional associations and medical limited liability companies, (3) entities allowed by Illinois law to provide physician services or employ physicians (hospitals, hospital affiliates and physician-owned surgery centers are specifically referenced), and (4) entities that are combinations or joint ventures of the entities within categories (1) through (3) above.

Section 22.2(e)<sup>177</sup> allows physicians to grant security interests in their accounts receivable or fees as security for bona fide advances, as long as the physician retains control and responsibility for collection of the accounts receivable and fees.

#### D. Optometry Fee Splitting Statute

Public Act 96-0608 also amended the fee splitting restriction for optometrists by adding Section 24.2 of the Optometric Practice Act.<sup>178</sup> This optometry fee splitting provision is generally similar to the medical fee splitting provision, although these sections differ in several ways. First, Section 24.2 of the Optometric Practice Act includes additional exceptions allowing the payment of rent for the use of space and fair market value payments for the use of staff, administrative services, franchise agreements, marketing or the use of equipment. A second difference is that the phrase “whether or not the worker is employed” is part of the optometry subsection (b)<sup>179</sup> exception for concurrent professional services.

Public Act 96-0608 brings Illinois fee splitting law more in line with accepted practices within the medical billing industry and with the evolution of physician practice structures in Illinois. In addition to allowing percentage billing contracts, the Act provides some needed clarification on the scope of the fee splitting prohibition. In particular, the new fee splitting prohibition expands and clarifies the types of physician practice organizations that are exempt from the fee splitting prohibition, recognizes that non-physician professionals can receive adequate compensation for their concurrent services, and clarifies that security interests are allowed in physician accounts receivable and fees. The fee splitting prohibition continues to prohibit a broad scope of business arrangements involving the payment of compensation to non-physicians based on professional fees billed or collected.

---

177. 225 ILL. COMP. STAT. ANN. 60/22.2(e) (West 2009).

178. 225 ILL. COMP. STAT. ANN. 80/24.2 (West 2009).

179. 225 ILL. COMP. STAT. ANN. 80/24.2(b) (West 2009).

V. *SUNBELT RENTALS, INC. V. EHLERS*, IMPLICATIONS FOR  
PHYSICIAN RESTRICTIVE PRACTICE COVENANTS

The validity and enforcement of restrictive practice covenants remains a significant issue for physicians and physician employers such as group medical practices and hospitals. A significant body of Illinois common law generally supports the validity of such contractual employment restrictions. The Illinois Supreme Court comprehensively addressed the issue in *Mohanty v. St. John Heart Clinic, S.C.*<sup>180</sup> Most recently, the Illinois Fourth District Appellate Court in an opinion authored by Justice Steigmann attracted significant attention to the subject with its holding in *Sunbelt Rentals, Inc. v. Ehlers*,<sup>181</sup> by rejecting the so-called “legitimate-business-interest” test as an element in determining the enforceability of restrictive employment covenants. While *Sunbelt Rentals* is not a physician employment case, Justice Steigmann extensively referenced the ample body of Illinois medically-related jurisprudence to support his conclusion that “courts at any level, when presented with the issue of whether a restrictive covenant should be enforced, should evaluate only the time-and-territory restrictions contained therein.”<sup>182</sup>

A. The *Sunbelt* Facts

Neil N. Ehlers, III, became an employee of Sunbelt Rentals, Inc. in May 2003, as a sales representative. In June 2003, Ehlers entered into a written employment agreement with Sunbelt which contained restrictive covenants that prohibited him, for one year after employment termination, from (1) providing or soliciting “the provision of products or services, similar to those provided by [Sunbelt] at the ‘designated stores’”; (2) “engaging, directly or indirectly, in the business substantially similar to the business as conducted at the designated stores, within the ‘territory’”; or (3) “become employed or engaged by, or act as agent for any person, corporation, or other entity that is directly or indirectly engaged in a business in the ‘territory,’” which is substantially similar to or competitive with Sunbelt. The ‘territory’ was described as “the geographical area within a [50-] mile radius of any of [Sunbelt’s] stores” which Ehlers “performed or was responsible for performing services” during a 12-month period immediately preceding termination of the agreement. The agreement further provided that in the event of a breach,

---

180. *Mohanty v. St. John Heart Clinic, S.C.*, 225 Ill. 2d 52, 866 N.E.2d 85 (2006).

181. *Sunbelt Rentals, Inc. v. Ehlers*, 394 Ill. App. 3d 421, 915 N.E.2d 862, 791 (4th Dist.).

182. *Id.* at 431, 915 N.E.2d at 869.

Sunbelt was entitled to an injunction to restrain violation of the restrictive covenants.

On January 16, 2009, Ehlers tendered his written resignation to Sunbelt without providing a reason for his departure and Sunbelt terminated his employment as of that date. On January 20, 2009, Sunbelt learned Ehlers accepted a sales position with Sunbelt's direct competitor, Midwest Aerials & Equipment, Inc. ("Midwest"), and sent Ehlers a letter (copy to Midwest) to "cease and desist" violating the terms of the restrictive covenants in his employment contract.

In February 2009, Sunbelt Rentals, Inc. sued Ehlers and Midwest seeking preliminary and permanent injunctive relief. Sunbelt claimed (1) Ehlers violated the restrictive covenants of his employment agreement with Sunbelt when he accepted Midwest's employment offer, and (2) Midwest tortiously interfered with Sunbelt's employment agreement with Ehlers. The Circuit Court of McLean County granted Sunbelt's motion for a preliminary injunction, relying on the Illinois Supreme Court's decision in *Mohanty v. St. John Heart Clinic, S.C.*<sup>183</sup> The court found that the time-and-territory terms of the restrictive covenants in Sunbelt's employment agreement with Ehlers were reasonable and enjoined Ehlers and Midwest from violating those restrictive covenants.

In so finding, the trial court recognized the "legitimate-business-interest" test this court set forth in *Springfield Rare Coin Galleries, Inc. v. Mileham*, 250 Ill.App.3d 922, 929–30, 189 Ill.Dec. 511, 620 N.E.2d 479, 485 (1993), but did not specifically apply that test because it further found that the "legitimate-business-interest" test had been encompassed by the time-and-territory reasonableness test recently used by the supreme court in *Mohanty*.<sup>184</sup>

Ehlers and Midwest appealed and argued the trial court abused its discretion by issuing a preliminary injunction because (1) the court failed to follow controlling precedent, and (2) Sunbelt did not have a "legitimate business interest" sufficient to support the imposition of a preliminary injunction. Ehlers argued the restrictive covenants in his employment agreement were overbroad and unenforceable.

---

183. *Mohanty*, 225 Ill.2d at 52, 866 N.E.2d at 85.

184. *Sunbelt*, 394 Ill. App. 3d at 425, 915 N.E.2d at 865.

## B. The *Sunbelt* Holding

The Illinois Fourth District Appellate Court ruled:

Because we (1) reject the “legitimate-business-interest” test and (2) conclude that the restrictive covenants in Ehlers’ employment agreement were reasonable as to time and territory, we affirm.<sup>185</sup>

The appellate court noted the trial court’s decision to grant injunctive relief to enforce a restrictive covenant not to compete depended on the validity of the covenant, a question of law the court could review *de novo*. The court summarized the origins of the “legitimate-business-interest” test, starting with the case *Nationwide Advertising Service, Inc. v. Kolar*.<sup>186</sup> The court noted the Illinois Supreme Court cases cited in *Kolar* did not use the “legitimate-business-interest” test. The court noted the *Kolar* case had been cited for more than three (3) decades by all of the districts of the Illinois Appellate Court, when deciding restrictive covenant cases. The court held:

However, the Supreme Court of Illinois has never embraced the “legitimate-business-interest” test, and its application by the appellate court is inconsistent with recent Supreme Court decisions concerning restrictive covenants.<sup>187</sup>

The appellate court then cited Illinois Supreme Court cases that deal with restrictive covenants, starting with a case from 1896, *Hursen v. Gavin*,<sup>188</sup> and ending with the most recent Illinois Supreme Court decision (2006), *Mohanty v. St. John Heart Clinic*.<sup>189</sup> In *Mohanty*, the court found restrictive covenants containing temporal and territorial restrictions of three (3) years and a two (2) mile radius and five (5) years and a five (5) mile radius, respectively, were not unreasonable. The *Sunbelt* court noted the Supreme Court in *Mohanty* “made no mention of the “legitimate-business-interest” test, despite over three decades of its use by the appellate court.”<sup>190</sup>

---

185. *Id.* at 422, 915 N.E.2d at 863.

186. *Nationwide Advert. Serv., Inc. v. Kolar*, 28 Ill. App. 3d 671, 673, 329 N.E.2d 300, 301–02 (1975).

187. *Sunbelt*, 394 Ill. App. 3d at 428, 915 N.E.2d at 867.

188. *Hursen v. Gavin*, 162 Ill. 377, 44 N.E. 735 (1896).

189. *Mohanty v. St. John Heart Clinic, S.C.*, 225 Ill. 2d 52, 866 N.E.2d 85 (2006).

190. *Sunbelt*, 394 Ill. App. 3d at 429, 915 N.E.2d at 868.

The court in *Sunbelt* quoted the *Mohanty* case regarding the issue of whether restrictive covenants in physician contracts are against public policy in Illinois:

[W]e note that this court has a long tradition of upholding the right of parties to freely contract. [Citation.] Consequently, our decisions have held that a private contract, or provision therein, will not be declared void as contrary to public policy unless it is “clearly contrary to what the constitution, the statutes or the decisions of the courts have declared to be the public policy” or it is clearly shown that the contract is “manifestly injurious to the public welfare” [Citations.] \* \* \* As a result, plaintiffs carry a heavy burden of showing that restrictive covenants in physician employment contracts are against the public policy of this state. *Mohanty*, 225 Ill.2d at 64–65, 310 Ill.Dec. 274, 866 N.E.2d at 92–93.<sup>191</sup>

The court in *Sunbelt* also quoted the *Mohanty* decision in regard to the allegations of physicians in that case claiming their restrictive covenants were “unreasonably overbroad in their temporal and activity restrictions”:

As noted earlier in this opinion, this court has a long tradition of upholding covenants not to compete in employment contracts involving the performance of professional services when the limitations as to time and territory are not unreasonable. *Cockerill v. Wilson*, 51 Ill.2d 179, 183–84 [, 281 N.E.2d 648] (1972); *Canfield v. Spear*, 44 Ill.2d 49[, 254 N.E.2d 433] (1969); *Bauer v. Sawyer*, 8 Ill.2d 351[, 134 N.E.2d 329] (1956). “In determining whether a restraint is reasonable it is necessary to consider whether enforcement will be injurious to the public or cause undue hardship to the promisor, and whether the restraint imposed is greater than is necessary to protect the promisee.” [Citations.] *Mohanty*, 225 Ill.2d at 76, 310 Ill.Dec. 274, 866 N.E.2d at 98–99.<sup>192</sup>

In *Sunbelt*, Justice Steigmann also refers to a previous Fourth District appellate case, *Lifetec, Inc. v. Edwards*,<sup>193</sup> noting he wrote a specially concurring opinion. Justice Steigmann noted that case “questioned the validity of the “legitimate-business-interest” test and urged its abandonment by the appellate court.”<sup>194</sup> He then cited three (3) other cases that cited to and agreed with the decision in *Lifetec*.

---

191. *Id.* at 429–30, 915 N.E.2d at 868.

192. *Id.* at 430, 915 N.E.2d at 869.

193. *Lifetec, Inc. v. Edwards*, 377 Ill. App. 3d 260, 268, 880 N.E.2d 188, 195 (2007).

194. *Sunbelt*, 394 Ill. App. 3d at 430, 915 N.E.2d at 869.

Accordingly, because (1) the Supreme Court of Illinois has never embraced the “legitimate-business-interest” test and (2) its application is inconsistent with the Supreme Court’s long history of analysis in restrictive covenant cases, we reject the “legitimate-business-interest” test.<sup>195</sup>

The *Sunbelt* court states that because the decision rejected the validity of the “legitimate-business-interest” test, “we need not address the argument of Ehlers and Midwest that the trial court was bound by precedent to apply it in this case. Any error by the trial court in this regard simply no longer matters at this stage of proceedings.”<sup>196</sup> The court further states:

In determining whether a restraint is reasonable, a court must (1) consider whether enforcement will be injurious to the public or cause undue hardship to the promisor and (2) whether the restraint imposed is greater than is necessary to protect the promisee. *Mohanty*, 225 Ill.2d at 76, 310 Ill.Dec. 274, 866 N.E.2d at 98–99.<sup>197</sup>

As for Ehlers’ claim the restrictive covenants violated public policy as an unreasonable restraint on trade, the court noted, “Public policy concerns are incorporated into the restrictive covenant time-and-territory assessments, which this court has concluded are reasonable.”<sup>198</sup> The court closes the decision with the options that were available to Ehlers’ before he entered into his employment agreement with Sunbelt:

Here, Ehlers had two options if he thought the restrictive covenants in his employment contract with Sunbelt would cause him undue hardship. He could have (1) opted not to sign the employment agreement or (2) asked Sunbelt to eliminate or modify the terms of the restrictive covenants. By failing to opt for either choice, Ehlers risked the enforcement of such restrictive covenants after he chose to sign the employment agreement. We reject his attempted exercise of a third option—namely, suing to try to undo the contract he signed when, as here, that contract’s restrictive covenants are reasonable both as to time and territory.”<sup>199</sup>

---

195. *Id.* at 431, 915 N.E.2d at 870.

196. *Id.* at 432, 915 N.E.2d at 870.

197. *Id.* at 421, 915 N.E.2d at 862.

198. *Id.* at 432, 915 N.E.2d at 871.

199. *Id.* at 433, 915 N.E.2d at 871.



### C. Context of the Decision

The *Sunbelt* decision may be regarded by some as a significant departure from traditional Illinois employment law jurisprudence. Further, on the face of the decision, it would appear that medical employers will have one less significant element to prove in enforcing restrictive employment covenants against departing physician employees. However, a review of long standing Illinois appellate authority and the *Mohanty* decision suggests that elimination of the legitimate-business-interest test may be simply a matter of “old wine in new bottles” and, what Justice Steigmann referred to as “Public policy concerns incorporated into restrictive covenant time-and-territory assessments . . .” can be viewed as simply re-casting the previously recognized the legitimate-business-interest standard as a matter of public policy analysis.

Prior to *Sunbelt*, Illinois courts repeatedly upheld covenants not to compete in medically-related cases without making a specific inquiry into whether a medical employer demonstrated a protectable business interest. Instead, a medical professional’s practice was consistently treated as possessing an assumed protectable business interest. “[F]or many years the courts in Illinois have found medical practices have a protectable interest in the patients of their physicians and this interest is inferred from the nature of the profession.”<sup>200</sup> Accordingly, one could argue that the medical-employer’s protectable business interest has long been an element for which proof was not required in enforcing restrictive practice covenants against physician-employees.

Nonetheless, business interests did not go without consideration in such cases. As noted in *Mohanty*, “Historically, covenants restricting the performance of medical professional services have been held valid and enforceable in Illinois as long their durational and geographic scope are not unreasonable, **taking into consideration the effect on the public and any undue hardship on the parties to the agreement.**”<sup>201</sup>

It is reasonable to view “the effect on the public” standard to include such public policy analytical concepts as impermissible restraints of trade. This

---

200. *Prairie Eye Ctr., Ltd. v. Butler*, 329 Ill. App. 3d 293, 301, 768 N.E.2d 414, 421 (4th Dist. 2002). *See also Gillespie v. Carbondale & Marion Eye Ctrs., Ltd.*, 251 Ill. App. 3d 625, 627, 622 N.E.2d 1267, 1269 (5th Dist. 1993) (*quoting* *Retina Services, Ltd. v. Garoon*, 182 Ill. App. 3d 851, 538 N.E.2d 651 (1989)).

201. *Mohanty v. St. John Heart Clinic, S.C.*, 225 Ill.2d 52, 67, 866 N.E.2d 85, 94 (2006). (Citations omitted) [emphasis added].

concept has been long accepted as a public policy rationale for judicial reticence in enforcing restrictive employment covenants.<sup>202</sup>

Further, “any undue hardship on the parties to the agreement” can clearly be interpreted as a judicial balancing of contractual burdens assumed by the parties as memorialized in their employment agreement. By way of example, the *Mohanty* Court justified balancing the parties’ competing business interest claims in favor of enforcing the restrictive practice covenants against the individual physicians as follows: “Restrictive covenants protect the business interests of established physicians and, in this way, encourage them to take on younger, inexperienced doctors.”<sup>203</sup>

The *Mohanty* Court concluded with the following finding:

Thus, we cannot say that barring the plaintiff from the practice of medicine within the restricted area for the stated time periods would seriously diminish the number of cardiologists available to provide the necessary patient care. Therefore, we conclude that the three- and five-year time restrictions on the plaintiffs’ ability to practice medicine within the limited geographical area was reasonable and necessary to protect the Clinic’s interests.”<sup>204</sup>

The Illinois Supreme Court’s reference to “the Clinic’s interests” in this context can be viewed as describing the Clinic-employer’s legitimate business interest in its continuing medical practice and the protection of that medical practice from competing former physician-employees.

Notwithstanding the notoriety of the *Sunbelt* decision, counsel participating in cases involving the enforcement of physician restrictive practice covenants may conclude that elimination of the legitimate-business-interest test will ultimately leave their legal analysis essentially where it was before the Fourth District’s opinion. As suggested in the *Mohanty* dissent, more sweeping change in this area of the law will likely require action by the Illinois General Assembly.

---

202. See *Hursen v. Gavin*, 162 Ill. 377, 44 N.E. 735 (1896).

203. *Mohanty*, 225 Ill.2d at 69, 866 N.E.2d at 95.

204. *Id.* at 79, 866 N.E.2d at 100.

VI. *PROVENA COVENANT MEDICAL CENTER V. THE DEPARTMENT OF REVENUE*, HOSPITAL PROPERTY TAX EXEMPTIONS AND THE CHARITABLE USE REQUIREMENT

On March 18, 2010, the Illinois Supreme Court rendered its decision<sup>205</sup> in the property tax appeal filed by Provena Covenant Medical Center (PCMC) holding that PCMC was not entitled to a property tax exemption under section 15-65 of the Property Tax Code (35 ILL. COMP. STAT. ANN. 200/15-65 (West 2002)).<sup>206</sup> Section 15-65 provides, in relevant part, as follows: “All property of the following is exempt when actually and exclusively used for charitable or beneficent purposes, and not leased or otherwise used with a view to profit: (a) Institutions of public charity.”<sup>207</sup>

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

A. Summary of the Facts

Provena Hospitals owns and operates six hospitals including PCMC.<sup>208</sup> In 2002, Provena Hospitals, the legal entity owning the subject property, applied for a property tax exemption with respect to all 43 parcels which were a part of the PCMC complex, the division that actually used the property under section 15-65(a).<sup>209</sup> Ultimately, the Department of Revenue denied the exemption application.<sup>210</sup> The circuit court of Sangamon County disagreed with the Department of Revenue holding that Provena Hospitals was entitled

---

205. *Provena Covenant Med. Ctr. v. Dep’t of Revenue*, 236 Ill. 2d 368, 925 N.E.2d 1131 (2010).

206. *See* 35 ILL. COMP. STAT. ANN. 200/15-65 (West 2002). Article IX, § 6 of the 1970 Illinois Constitution provides that the General Assembly may exempt from taxation property “used exclusively for . . . charitable purposes.” Section 15-65 executes the constitutional grant to exempt property but imposes the additional requirement that the property must be owned by a “charitable institution.” The Court’s reading of the “charitable use” requirement involves both a statutory interpretation of section 15-65 of the Property Tax Code and also section 6 of article IX of the 1970 Illinois Constitution. ILL. CONST. art. IX, § 6.

207. 35 ILL. COMP. STAT. ANN. 22/15-65 (West 2002).

208. *Provena*, 236 Ill. 2d at 368, 925 N.E.2d at 1131.

209. *Id.*

210. *Id.*

to the exemption under both charitable as well as religious grounds.<sup>211</sup> The appellate court subsequently reversed and the Illinois Supreme Court agreed to hear the case.<sup>212</sup>

Provena Hospitals is the relevant entity for purposes of the “charitable ownership” requirement and PCMC is the relevant unit for purposes of the “charitable use” requirement. PCMC maintains between 260–268 licensed beds.<sup>213</sup> It admits 10,000 inpatients annually and 100,000 outpatients.<sup>214</sup> The emergency room treats 27,000 visitors every year.<sup>215</sup> In 2002, Provena Hospitals realized a net loss of \$4.8 million on revenues of \$713.9 million.<sup>216</sup> PCMC realized a net profit of \$2.1 million on revenues of \$113.4 million.<sup>217</sup> PCMC waived charges of \$1.7 million for 302 patients under its sliding-scale charity care program.<sup>218</sup> The cost of the services provided under the charity program was \$831,000 (47% of the waived charges) which was \$268,000 less than the value of the property tax exemption.<sup>219</sup> The court calculated the cost of the charity care program to be 0.723% of PCMC’s revenues.<sup>220</sup>

#### B. Institutions of Public Charity (Charitable Ownership)

The Illinois Supreme Court adopted the five criteria established in the case of *Methodist Old Peoples Home v. Korzen* as the distinctive characteristics of a charitable institution:

- (1) it has no capital, capital stock, or shareholders;
- (2) it earns no profits or dividends but rather derives its funds mainly from private and public charity and holds them in trust for the purposes expressed in the charter;
- (3) it dispenses charity to all who need it and apply for it;
- (4) it does not provide gain or profit in a private sense to any person connected with it; and
- (5) it does not appear to place any obstacles in the way of those who need and would avail themselves of the charitable benefits it dispenses.<sup>221</sup>

---

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.*

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.*

The court stated that a determination of whether a hospital was a “charitable institution” required that the entity satisfy certain conditions which must be determined on a case-by-case basis. The court did not address the question of whether all five factors were required to be present in order to satisfy the statutory requirement of ownership by a “charitable institution.” However, it appears as though the court would have accepted something less than all of the five criteria as being sufficient.<sup>222</sup>

The court ruled that Provena Hospitals was not a “charitable institution” because it satisfied only two of the five criteria. Provena Hospitals did not have shareholders (#1) and was not operated for private inurement (#4). However, since the hospital derived over 95% of its revenues from providing medical services for a fee, the Court reasoned that it did not “derive its funds mainly from private and public charity” and failed the second criteria.<sup>223</sup> Additionally, the Court ruled that Provena Hospitals failed to establish by clear and convincing evidence that it “dispenses charity to all who need it and apply for it” (#3) or that it did not “place any obstacles in the way of those who need and would avail themselves of the charitable benefits” (#5).<sup>224</sup> The Court agreed with the Department of Revenue that Provena Hospitals, the corporate entity and the true owner of the real estate parcels, did not introduce sufficient evidence of its charitable expenditures to establish that it was a charitable institution.<sup>225</sup>

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

The Court described the constitutional and statutory requirement of “used exclusively for . . . charitable purposes” to mean that charitable or beneficent purposes are the primary ones for which the property is utilized.<sup>226</sup> A “charitable or beneficent purpose” was defined as a “a gift . . . for the benefit of an indefinite number of persons . . . by relieving their bodies from disease, suffering or constraint . . . or otherwise lessening the burdens of

---

222. The Court recognized that private nonprofit hospitals have qualified as a charitable institution under the Illinois Property Tax Code. *See* *People ex rel. Cannon v. S. Ill. Hosp. Corp.*, 404 Ill. 66, 69–70 (1949), but that there is no blanket exemption for hospitals. *See* *Coyne Elec. Sch. v. Paschen*, 12 Ill. 2d 387, 394 (1957). These comments would be incongruous with criteria #2 which requires that the hospital “derives its funds mainly from private and public charity.” If this criteria were literally applied to every private nonprofit hospital in Illinois, it would create a blanket denial of the exemption as these hospital derive their funds primarily from the delivery of medical services.

223. *Provena*, 236 Ill. 2d at 368, 925 N.E.2d at 1131.

224. *Id.*

225. *Id.*

226. *Id.*

government.”<sup>227</sup> While the Court did acknowledge that PCMC’s operations may have reduced the burdens faced by the Federal and State governments in providing health care, PCMC failed to establish any lessening of the burdens of the specific local units of government that stood to gain by the collection of the local property taxes. The Court stated that the hospital was:

required to demonstrate that its use of the property helped alleviate the financial burdens faced by the county or at least one of the other entities supported by the county’s taxpayers.<sup>228</sup>

The Court further noted that, even if there was proof that PCMC provided the *types* of service that lessened the burdens of local government, PCMC would be required to prove that the “terms of service” also relieved the burdens of local government. The fee-for-service arrangement utilized by PCMC would not meet this additional “terms of service” requirement. The Court stated that “services extended . . . for value received . . . do not relieve the [s]tate of its burden.”<sup>229</sup>

The Court ruled that PCMC failed to meet its burden of showing that the property was “actually and exclusively used for charitable or beneficent purposes” as required by Section 15-65.<sup>230</sup> The property was primarily devoted to the care and treatment of patients in exchange for compensation through private insurance, Medicare and Medicaid, or direct payment from the patient or the patient’s family. The Court determined that the number of uninsured patients receiving free or discounted care and the dollar value of the care they received were *de minimis*.<sup>231</sup>

PCMC contended that the bad debts that it incurred should be considered in measuring the dollar-value of charity care. The Court acknowledged that PCMC did treat all patients requesting services without regard to the person’s ability to pay for the services. However, because PCMC subsequently sought payment for these services, the Court reasoned that: “As a practical matter, there was little to distinguish the way in which Provena Hospitals dispensed its ‘charity’ from the way in which a for-profit institution would write off bad debt.”<sup>232</sup> It is clear that the Illinois courts will not consider hospital bad debts as any form of charity for purposes of the Illinois Property Tax Code.

---

227. *Id.*

228. *Id.*

229. *Id.* at 397, 925 N.E.2d 1131 at 1148 *quoting* Provena Covenant Med. Ctr. v. D’t of Revenue, 384 Ill. App. 734, 744, 894 N.E.2d 452, 464, *quoted in*, Williams v. Munson, 43 Ill. 2d 203, 208, 251 N.E.2d 249, 254 (1969).

230. Provena, 236 Ill.2d 368, 394, 925 N.E.2d 1131, 1147 (2010).

231. Provena, 236 Ill.2d 368, 925 N.E.2d 1131 (2010).

232. *Id.*

PCMC contended that any discounts from “published rates” should be viewed as charity care. The court rejected this argument on the grounds that the “published rates” included a gross profit margin.<sup>233</sup> The court reasoned that discounts between 25%-50% off of these “published rates” would still allow PCMC to cover the costs of its services.<sup>234</sup> Further, the court observed that the hospital recouped these discounts through “cross-subsidies” from the higher fees paid by insured patients.<sup>235</sup> The court held:

[i]t is essential to a gift that it should be without consideration. When patients are treated for a fee, consideration is passed. The treatment therefore would not qualify as a gift. If it were not a gift, it could not be charitable.<sup>236</sup>

The court viewed any consideration received as full consideration and, therefore, there was no element of a gift and no charity.

PCMC next contended its treatment of Medicare and Medicaid patients should be characterized as charity care because the payments it received for treating such patients did not cover the full costs of care.<sup>237</sup> The court rejected this argument on the grounds that participation in Medicare and Medicaid was optional, that these programs generated a reliable stream of revenue, allowed the hospital to generate income from potentially under-utilized hospital resources and produced favorable tax treatment under federal law.<sup>238</sup> Similar to other discounted services, the court observed that gifts are gratuitous and that hospitals do not serve Medicare and Medicaid patients gratuitously.<sup>239</sup> PCMC argued that “charitable use” should include the broader federal concept of “community benefits.” PCMC asserted that the subsidies it provided for, among other services, ambulance service, a crisis nursery, graduate medical education, behavioral health services, and emergency services training constituted “community benefits” which should be characterized as “charitable use” for purpose of the Section 15-65.<sup>240</sup> The court rejected this argument stating that community benefit is not the test.<sup>241</sup> The court reasoned that private for-profit companies frequently offer comparable services as a benefit for employees and customers and as a means for generating publicity and goodwill for the organization.<sup>242</sup>

---

233. *Id.*

234. *Id.*

235. *Id.*

236. *Id.*

237. *Id.*

238. *Id.*

239. *Id.*

240. *Id.*

241. *Id.*

242. *Id.*

The court did recognize that the four parcels used by the Crisis Nursery constituted the strongest claim for being used exclusively for charitable purposes.<sup>243</sup> However, since Provena Hospitals failed the initial requirement of being a “charitable institution,” the claim for a property tax exemption must fail even if these four parcels were used exclusively for charitable purposes. The court rejected Provena Hospital’s final argument that it qualified for a religious exemption under section 15-40(a)(1) of the Property Tax Code.<sup>244</sup> The court observed that the property in question must be used exclusively for religious purposes and that advancing religion was not identified as the corporation’s dominant purpose. In this case, the primary purpose for which the property was used was providing medical care to patients for a fee.

In a separate opinion, Justice Burke, writing for herself and Justice Freeman, concurred with the plurality opinion that Provena Hospital failed to establish that it was a charitable institution under section 15-65 or that it qualified for a religious exemption under section 15-40.<sup>245</sup> However, Justice Burke dissented from the plurality opinion with respect to the issue of charitable use. The plurality noted that the “dollar value of the care” provided was “*de minimis*.”<sup>246</sup> The dissent rejected the concept of a “quantum of care requirement and monetary threshold” as conditions for evaluating charitable use.<sup>247</sup> The dissent believed that these were matters best left to the legislative branch.<sup>248</sup> The dissent relied upon decisions from the Supreme Courts of Michigan and Vermont<sup>249</sup> in rejecting a “quantum of care” requirement on the grounds that such a standard would be both arbitrary and unworkable.<sup>250</sup> A judicially-mandated “quantum of care” requirement would create chaotic uncertainty and infinite confusion and there would be no certainty, nor uniformity in the application of the statute.

Justice Burke also disagreed with the plurality’s conclusion that Provena was “required to demonstrate that its use of the property helped alleviate the financial burdens faced by the county or at least one of the other entities supported by the county’s taxpayers.”<sup>251</sup> The dissent stated that alleviating some burden on government is the reason underlying the tax exemption on properties, not the test for determining eligibility and that Provena did

---

243. *Id.*

244. See 35 ILL. COMP. STAT. ANN. 200/15-40(a)(1) (West 2002).

245. *Provena*, 236 Ill. 2d at 411, 925 N.E.2d at 1156 (Burke, J., concurring).

246. *Id.* at 397, 925 N.E.2d at 1149.

247. *Id.* at 412, 925 N.E.2d at 1159 (Burke, J., dissenting).

248. *Id.*

249. *Id.*, (citing *Wexford Med. Grp. v. City of Cadillac*, 474 Mich. 192, 713 N.W.2d 734 (Mich. 2006); *Med. Ctr. Hosp. of Vermont, Inc. v. City of Burlington*, 152 Vt. 611, 566 A.2d 1352 (Vt. 1989)).

250. *Provena*, 236 Ill.2d at 415, 925 N.E.2d at 1159 (Burke, J., dissenting).

251. *Id.*



demonstrate that it alleviated some burden on government.<sup>252</sup> Justice Burke concluded that the discussion of charitable use did not command a majority of the court and, therefore, is not binding under the doctrine of *stare decisis*.

#### D. Analysis of the Decision

This *Provena* decision is the latest entry into a long-running debate regarding the appropriate tax treatment of nonprofit hospitals. In 2006, the Joint Committee on Taxation, a nonpartisan committee of Congress, estimated that nonprofit hospitals received tax benefits of \$12.6 billion<sup>253</sup> measured in 2002 dollars. In support of the recent health care reform legislation, the federal government reports that there were \$2.2 billion of uncompensated health care services provided to residents of Illinois.<sup>254</sup> In short, there are literally billions of dollars at stake in terms of both tax relief provided to nonprofit hospitals and the charity care returned to the community by these nonprofit hospitals. The precise measurement of these costs and benefits will undoubtedly become a central aspect of this continuing debate.

While the Court enunciated five distinctive characteristics of a “charitable institution,” the application of these five characteristics to an Illinois private nonprofit hospital boils down to a single question: Did the hospital demonstrate through its charitable expenditures that it provided charity care to all in need who applied for it?<sup>255</sup> If the hospital can prove that it is dispensing charity, then any potential obstacles would be insignificant as the needy are successfully requesting and receiving charity.

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

1. The “lessening of the burdens of government” requirement is reduced to a quid pro quo equation—the value of charity care to the local units

---

252. *Id.*

253. The following are values of exemptions for nonprofit hospitals and their supporting organizations in 2002: \$2.5 billion in federal income tax, \$1.8 billion in federal bond financing, \$1.8 billion in federal charitable contributions, \$500 million in state corporate income tax, \$2.8 billion in state and local sales taxes, and \$3.1 billion in local property tax. CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND TAX ARBITRAGE (Dec. 6, 2006) available at <http://www.cbo.gov/ftpdocs/76xx/doc7696/12-06-HospitalTax.pdf>.

254. The Affordable Care Act: Immediate Benefits for Illinois, available at <http://www.healthreform.gov/reports/statehealthreform/illinois.html>.

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

- of government otherwise losing the tax revenues must be equal to or greater than the tax savings realized by the hospital;
2. The characterization of all hospital bad debt as equivalent to ordinary for-profit corporate bad debt and devoid of any charity element;<sup>256</sup>
  3. The characterization of all hospital discounted services as equivalent to ordinary discounts in a bargained-for exchange and devoid of any charity element;<sup>257</sup>
  4. The rejection of the “community benefits” standard used to measure charity care and the adoption of the more stringent standard of a free medical services requirement.<sup>258</sup>

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

- 
256. Hospital bad debt typically arises from two sources: insured patients who do not pay their co-pays and uninsured patients. *Challenges Facing the Hospital Revenue Cycle—Bad Debt, Charity, and Collections Top the List*, Health Care Collector: The Monthly Newsletter for Health Care Collectors, Vol. 23, No. 9 (February 2010). While the bad debts incurred with respect to the insured patients resembles corporate bad debts, the bad debts incurred from uninsured patients are distinct. Hospitals are required to treat all patients who present and are in need of medical services irrespective of their ability to pay for these services. See 210 ILL.COMP. STAT. ANN. 80/1 (West 2002); 210 ILL.COMP. STAT. ANN. 70/1 (West 2002); 42 U.S.C. § 1395dd. There is no comparable requirement for any for-profit business and virtually every for-profit business would only agree to provide trade credit to uninsured patients if they were proven to be credit-worthy. A recent IRS survey of 544 nonprofit hospitals reported that 44% of the hospitals include bad debt in the calculation of uncompensated care. IRS EXEMPT ORGANIZATIONS (TE/GE) HOSPITAL COMPLIANCE PROJECT FINAL REPORT, p.98 (February 2009) available at <http://www.irs.gov/charities/charitable/article/0,,id=203109,00.html>. Clearly, a case can be made for the inclusion of some bad debts in the determination of charity care.
257. Hospital discounted services, also known as shortfalls, arise in a number of ways. For example, a discount offered to a private insurance company clearly resembles the ordinary discounts that might be found in the bargained-for exchange. These discounts hardly resemble any form of charity. However, discounts offered to uninsured patients could be viewed as a below-market exchange which is part charity and part valuable consideration. The middle-ground in the discounted services debate pertains to discounts offered under federal and state programs. PCMC reported a Medicare shortfall of \$7.4 million and a Medicaid shortfall of \$3.1 million. The IRS survey of 544 nonprofit hospitals reported that 51% of the hospitals include discounted services in the calculation of uncompensated care. *Supra* note 49, at 10.
258. The “community benefit” standard was developed by the Internal Revenue Service in 1969 as a more comprehensive measure of the services that nonprofit hospitals provide to a community. J. Colombo, *Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps*, 37 LOY. U. CHI. L.J. 493, 496–497 (2006). Illinois has adopted this standard in its community hospital reporting requirements. 210 ILL. COMP. STAT. ANN. 76/1 (West 2006). While the plurality opinion rejected this more comprehensive approach, it is probable that this will continue to be the measure of hospital benefits under federal law and any legislative amendment in Illinois would address how to define and calculate charity care.

## VII. CONCLUSION

The Illinois Supreme Court calendar year of 2009 marked many important decisions in the area of Healthcare Law. With continued state and national focus on the subject, it is likely that 2010 will serve as another active year for healthcare professionals and the attorneys who work in the field. Healthcare Law is ever changing and this article attempts to track those changes as they occurred in 2009.

