No. 121367

IN THE
SUPREME COURT OF ILLINOIS

CHRISTINA YARBROUGH and DAVID GOODPASTER, on behalf of HAYLEY JOE GOODPASTER, a minor, Plaintiffs-Appellees,	Petition for Leave to Appeal from the Illinois Appellate Court, First Judicial District, No. 1-14-1585,
v.	
NORTHWESTERN MEMORIAL HOSPITAL, Defendant-Appellant	There Heard on Application for Leave to Appeal from an Order of the Circuit Court of Cook County, County Department, Law Division, No. 2010 L 296,
and	
NORTHWESTERN MEDICAL FACULTY FOUNDATION, Defendant	The Honorable WILLIAM E. GOMOLINSKI, Judge Presiding

BRIEF OF PLAINTIFFS-APPELLEES CHRISTINA YARBROUGH AND DAVID GOODPASTER, ON BEHALF OF HALEY JOE GOODPASTER, A MINOR

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NATURE OF THE CASE

This is an appeal from the First District of the Appellate Court's affirmative answer to the following question certified under Rule 308 by the Circuit Court of Cook County: "Can a hospital be held vicariously liable under the doctrine of apparent agency set forth in *Gilbert v. Sycamore Mun. Hosp.*, 156 Ill. 2d 511 (Ill. 1993), and its progeny for the acts of the employees of an unrelated, independent clinic that is not a party to the present litigation?"

Plaintiffs-Appellees filed a medical malpractice action in the Circuit Court of Cook County on December 28, 2009 against Northwestern Memorial Hospital ("NMH") and Northwestern Medical Faculty Foundation ("NMFF"). The suit seeks to hold NMH vicariously liable under the doctrine of apparent agency for medical care provided to Haley Joe Goodpaster, a minor, by a non-party clinic, Erie Family Health Center ("Erie") and its employees Janet Ferguson, CNM, Betsy McKelvey, CNM, Virgil Reid, III, M.D., and Raymond Suarez, M.D. For the purpose of answering the certified question, these non-parties are assumed to be independent of and unrelated to Defendant-Appellant NMH.[1]

Plaintiffs allege the Defendants are vicariously liable for medical negligence that occurred on two separate occasions—December 2, 2005 and February 21, 2006—which combined to cause Hayley to be born prematurely on April 8, 2006. Plaintiffs further allege that Hayley's avoidable preterm birth left her with severe, irreversible, and preventable neurologic injuries. Only Defendants' vicarious liability for the alleged negligence that occurred on December 2, 2005 is at issue here. The Defendants have not appealed the trial court's finding that NMH may be liable under apparent agency for the events of February 21, 2006.

[1] Plaintiffs maintain that whether Erie and NMH are, in fact, independent and unrelated is an issue of fact. (See *infra* at 39.)

This Court should affirm the Appellate Court's ruling. *Gilbert v. Sycamore Municipal Hospital*, 156 Ill. 2d 511 (1993), applies to circumstances where a principal and agent are independent and unrelated, and where medical care is rendered off hospital premises. Creating the immunity from liability that NMH seeks—where a hospital would never be liable under apparent agency for medical negligence committed by unrelated, independent entities, including negligence occurring off hospital premises—would run contrary to Illinois law, common sense, and sound public policy. Hospitals that do not wish to incur liability under apparent agency for another person's or entity's negligence should not hold out, or acquiesce in the holding out of, that person or entity as their agent.

STATEMENT OF FACTS

I. Erie's Representations That NMH Would Be Responsible for Her Ultrasound Testing, Birth Classes, and Labor and Delivery Care Led Yarbrough to Believe She Would Receive Ultrasound Testing and Other Prenatal Care from NMH.

Plaintiffs Christina Yarbrough and David Goodpaster reside with their children, including the minor Plaintiff, Hayley Goodpaster, in Chicago, Illinois. (S.R. 41–42.) Yarbrough moved to Chicago in June 2005. (S.R. 43.) In November 2005, Yarbrough suspected she was pregnant after taking a home pregnancy test. (S.R. 44.) At that time, she did not have a relationship with an obstetrician-gynecologist or a family physician. (S.R. 43–44.) Yarbrough searched online for a clinic that would administer a pregnancy test without requiring insurance coverage. (S.R. 44.) She found the web page for Erie, a federally qualified health center (FQHC). (*Id.*)

On November 14, 2005, Yarbrough visited Erie at its West Town location for a pregnancy test. (S.R. 44, 254.) This was the first time Yarbrough saw a health care provider about her pregnancy. (S.R. 44.) After giving a urine sample, Yarbrough awaited the results in

Erie's waiting room. (S.R. 45.) She then spoke with a "professional"—she cannot recall who or what type, but stated that it "might have been a nurse." (*Id.*) This person informed Yarbrough that her results were positive. (*Id.*)

Yarbrough testified the Erie professional then "asked me what my plans were for prenatal care." (S.R. 44.) Yarbrough "asked questions about the doctors there, what hospital I would be going to, things like that." (*Id.*) She received information about NMH and, she testified, was informed she "would have ultrasounds done at Women's Prentice Hospital, which is part of Northwestern, and that's where I would most likely deliver the baby." (S.R. 45; see also S.R. 334.) She received no information about other hospitals. (*Id.*) NMH has not denied that the professional who spoke with Yarbrough was an Erie employee, or alleged that he or she was acting beyond his or her authority.

During the same visit, Yarbrough also received informational materials regarding tours of the birthing/delivery section of NMH, having a car seat checked at NMH, and attending birthing classes at NMH. (S.R. 334.) She said that she "was under the impression that NMH was a very good hospital, very big, very well-known in the city." (S.R. 71.)

The record indicates that the only written information Yarbrough received about Erie itself during this visit was a pamphlet that, as far as she could recall, contained Erie's address and phone number. (S.R. 45.) The only other information Yarbrough knew about Erie was what she learned online, which, her testimony reflects, was limited to Erie's location and its willingness to provide a pregnancy test to patients without insurance. (*Id.*) She was not given any information concerning the physicians who were affiliated with Erie. (*Id.*) Based on the information she was given and her knowledge of NMH's reputation, Yarbrough chose to receive prenatal care at Erie, which she (correctly) believed was being provided in substantial part by NMH. (S.R. 44–46.)

Erie's statements to Yarbrough led her to believe that Erie and NMH would be "working together." (S.R. 71.) She testified, "I was under the impression [Erie] was just Northwestern." (S.R. 45.) Contrary to NMH's contention (Appellant's Br. 9), this impression was not based solely on where the delivery would occur. Although Yarbrough testified that her belief that Erie and NMH were one and the same was "most likely due to the delivery at Northwestern, the delivery privileges," counsel for NMH did not exhaust her testimony on this point. (S.R. 46.) Importantly, Erie told Yarbrough that NMH would provide her prenatal ultrasounds. (S.R. 45.) She then received the December 2, 2005 ultrasound at the Erie-West Town clinic (S.R. 49–50), raising the inference that the ultrasound was being provided by NMH.

As Yarbrough indicated, no one clarified that Erie and NMH were *not* part of the same entity. (S.R. 46.) There is no evidence that NMH or Erie disclosed to her the employment status of any of her caregivers or NMH's independent contractor relationship with Erie.

II. Yarbrough Received a Prenatal Ultrasound Examination at Erie from a Member of the NMH Medical Staff, Who Told Her, Mistakenly, That She Did Not Have a Bicornuate Uterus.

On November 30, 2005, Yarbrough began to experience severe vaginal bleeding. (S.R. 47.) An ambulance transported her to Illinois Masonic Medical Center. (*Id.*) An ultrasound imaging study was obtained and interpreted at Illinois Masonic as showing a bicornuate uterus (S.R. 47–48), elevating Yarbrough's risk of preterm labor.[2]

[2] A bicornuate uterus has two endometrial cavities, rather than one. Ronald E. Iverson, Jr., M.D., et al. Clinical Manifestations and Diagnosis of Congenital Anomalies of the Uterus. *UpToDate*, Oct. 12, 2015.

Yarbrough visited Erie two days later, on December 2, 2005, and met with Betsy McKelvey, a certified nurse midwife (CNM) and Raymond Suarez, M.D. (S.R. 49–50.) According to Yarbrough, Dr. Suarez performed an ultrasound, which he said did not show a bicornuate uterus. (S.R. 50.) Dr. Suarez has no independent recollection of the visit, but he testified that he does not perform ultrasounds (S.R. 189), and is not qualified to diagnose a bicornuate uterus (S.R. 190). Yarbrough was also diagnosed with a shortened cervix during this visit, another risk factor for preterm labor. (S.R. 50.) Plaintiffs allege that Defendants were negligent in treating Yarbrough in that they failed to closely monitor her, perform additional diagnostic testing and a cerclage, and advise bedrest. (S.R. 14.)

Dr. Suarez was a member of the NMH medical staff (i.e., he had privileges to practice there). (S.R. 196.) He stated that NMH and Prentice Women's Hospital were the only hospitals at which he had privileges to practice while working at Erie. (S.R. 188.) Prentice Women's Hospital is part of NMH. (S.R. 45; see also *Northwestern Medicine Prentice Women's Hospital*, https://www.nm.org/locations/prentice-womens-hospital (last visited May 26, 2017)) (R.A. 1).[3]

Dr. Suarez verified that Erie patients were told they would deliver at NMH. (*Id.*) He admitted that he never told patients he did not work for Northwestern. (S.R. 200.) Dr.

[3] In this brief, Plaintiffs include several Internet citations to public records, organizational reports, literary quotations, and published statements of NMH and Erie, which were not cited below. These sources are included to enhance the Court's understanding of the issues at stake, and are compiled in an appendix for the Court's convenience. The Court has discretion to take judicial notice of a fact that the trial court did not. See *People v. Clark*, 406 Ill. App. 3d 622, 632 (2nd Dist. 2010) (citation omitted). Facts appropriate for judicial notice include those that are generally known within the relevant jurisdiction or "capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." *Id.*; see also Ill. S. Ct. R. 321 (appellate court may allow additional exhibits to become part of the record on appeal). Information taken from "mainstream websites" is sufficiently reliable to support judicial notice. *Clark*, 406 Ill. App. 3d at 632–33 (taking judicial notice of Google Maps page). NMH has also cited to the Internet. (See, *e.g.,* Appellant's Br. 5 n.3.)

Suarez did not have an office at Erie and did not wear a lab coat identifying him as an Erie employee. (S.R. 188.)

Nurse McKelvey also provided care to Yarbrough at her ultrasound at Erie on December 2, 2005. (S.R. 49–50.) Nurse McKelvey's deposition is not in the record.

III. Erie Sent Yarbrough to NMH for Her Second, 20-Week Ultrasound.

Yarbrough received a "referral/consultation" form from Erie to obtain a routine 20-week ultrasound at Prentice Ultrasound, which is part of NMH. (S.R. 53, 421.) The form identified Dr. Suarez and Nurse McKelvey as her providers. (S.R. 421.)

Yarbrough received the ultrasound on February 21, 2006. (S.R. 53, 421.) Dr. William Grobman—an admitted employee of NMFF (S.R. 42), an alleged apparent agent of NMH, and a member of the medical staff at NMH—interpreted the ultrasound as not showing a bicornuate uterus. (S.R. 335.) NMFF is a tax-exempt organization comprising physicians who are full-time faculty at the Northwestern University Feinberg School of Medicine and have privileges at NMH. (S.R. 94.)

IV. Erie Later Again Directed Yarbrough to Go to NMH, Where She Gave Birth to Her Daughter, Attended by Providers Who Had Treated Her at Erie.

On April 5, 2006, Yarbrough began feeling painful cramps and back pain. (S.R. 55–56.) She called Erie and was told to go to the emergency room at NMH. (S.R. 56.) She was admitted to NMH, where contractions were detected. (S.R. 57.) Dr. Suarez and Dr. Virgil Reid, who led "Women's Health at Erie" and was also a member of the NMH medical staff, attended her labor at NMH. (S.R. 198.)

Yarbrough delivered Hayley by emergency C-section on April 8, 2005. (S.R. 443.) Dr. Suarez was the delivering physician. (S.R. 57–58.) He told Yarbrough that she did, in fact,

have a bicornuate uterus and an incompetent cervix. (S.R. 58.) Nurse McKelvey later visited Yarbrough at NMH to check on her. (S.R. 59.)

Medicaid paid approximately $66,000 for Hayley's neonatal care at NMH, and also paid for Yarbrough's prenatal and labor and delivery care. (S.R. 62.) Erie assisted Yarbrough with enrolling in Medicaid. (S.R. 45.)

V. Relationships Between NMH and Erie

A. NMH has portrayed itself as a provider of complete obstetrical care.

NMH represents it "provid[es] a complete range of adult inpatient and outpatient services." Northwestern Memorial Hospital, *Northwestern Memorial Hospital Community Health Needs Assessment Hospital Report*, Fiscal Year 2016, at 1, *available at* https://tinyurl.com/jjatwgz (R.A. 2). It contains Illinois's largest birthing center. *Id.* at 2 (R.A. 3).

The website for NMH's corporate parent (S.R. 126), Northwestern Memorial Healthcare (NMHC)—also known as Northwestern Medicine (NM)—portrays NMH as a core part of an integrated health care delivery system. *Northwestern Medicine*, https://www.nm.org/ (last visited May 26, 2017) (R.A. 4). (NMH does not have a freestanding website.) Although one of NMH's corporate designees admitted that most physicians who "are on staff and work within" NMH are not employees (S.R. 162), NM claims "*our* top surgeons and physicians" number 4,000 and provide care in 40 medical specialties. See *id.* NMH and NMFF are subsidiaries of NMHC. See Andrew Wang, Northwestern Memorial Pay Big Bucks for Faculty Foundation Docs, *Crain's Chicago Business* (Nov. 5, 2013), *available at* https://tinyurl.com/kvzpvof (R.A. 5–7).

B. NMH and NMHC have repeatedly and publicly characterized Erie as a "partner" in providing prenatal and other obstetrical care.

The NM website highlights NMH's relationship with Erie, on a page entitled, "Erie Family Health Center *Partnership*." See Northwestern Medicine, *Erie Family Health Center*, https://tinyurl.com/n6kxo7v (last visited May 26, 2017) (emphasis added) (R.A. 8). There, NM states:

> Erie Family Health Center (Erie) was founded in 1957 as a project of volunteer physicians from Northwestern Memorial and Erie Neighborhood House. Erie provides a variety of primary care, case management and dental services to over 37,500 low-income, underinsured and uninsured patients per year. Erie's eleven community-based health centers are portals to culturally sensitive, high quality healthcare—regardless of a patient's ability to pay.

The page contains a link to Erie's website. *Id.*

The "partnership" advertised between NMH and Erie includes OB/GYN services provided at Erie. According to the 2006 Community Service Report, "[o]bstetrical patients * * * benefit from *quality prenatal care* that is available in the community *through a partnership* between Northwestern Memorial and Erie Family Health Center." (S.R. 256) (emphasis added). As advertised in this report, 11.2% of the women who delivered at Prentice Women's Hospital (i.e., at NMH) in 2006 received prenatal care at Erie. (S.R. 256, 333.)[4] All women who received prenatal care at Erie in 2006 delivered their babies at Northwestern Memorial Hospital. (*Id.* at 333.)

The 2005 Community Service Report features a photograph and vignette concerning Dr. Reid and his work at Erie-West Town. (S.R. 253.) As discussed, Dr. Reid was an

[4] S.R. 256 is partially obscured as reproduced in the record. An unobscured version may be found at American Hospital Association, *Community Accountability and Transparency: Helping Hospitals Better Serve Their Communities* 137 (2007), *available at* http://www.ahacommunityconnections.org/content/07accountability.pdf (R.A. 9).

attending physician for Yarbrough during her labor and delivery. The vignette describes Dr. Reid as an OB/GYN "on the medical staff at Northwestern Memorial who leads Women's Health at Erie," and notes he is a clinical assistant professor at NM's Feinberg School of Medicine. (S.R. 253.)

Other NMH webpages describe Erie as a "partner" of NMH. (*E.g.*, S.R. 257.) On a page entitled "Our Health Partners," NMH noted its "formal and long-standing affiliations" with Erie and another FQHC. (*Id.*) "Together with our partners," NMH "develop[s] programs to address the healthcare needs of the patients in medically underserved communities." (*Id.*) Two NMH executives serve on Erie's board. (*Id.*)

NMH has provided financial support to Erie for physician and staff salaries, information technology (IT) assistance, and strategic support through Board membership. (S.R. 329.) NMH has contributed from $333,000 to $600,000 per year to Erie, which amounted to 21.3% to 38.4% of Erie's net funding. (S.R. 334.)

NMHC also advertised its partnership with Erie in its 2005 Community Service Report. (S.R. 252.) According to this report, "[t]hrough partnerships with community health centers and our medical staff," NMHC enhances access to care. (S.R. 252.) NMHC's Community Service Expansion project "funds facility improvements and contributes to the salaries of physicians providing community-based care" at Erie. (*Id.*) As NMHC indicates, physicians working at Erie are also affiliated with NMFF. (See *id.*) NMH uses such reports "to highlight the activities that we do in the community and to highlight some of the advancements that are made at Northwestern Memorial throughout the year." (S.R. 171.)

As also indicated in the 2005 report, NMHC advertised its "longstanding partnerships with neighborhood-based health centers," which "ensure that high-quality primary and specialty care is available to those who live in medically underserved areas."

(S.R. 256.) The 2006 report also publicized a community-based breast health initiative for patients of Erie-West Town, where Yarbrough received prenatal care. (*Id.*) The report advertised that Northwestern Memorial Foundation had given $12 million since 1994 "to support healthcare delivery" at Erie and another FQHC. (*Id.*)

NMH maintains that its use of "partner" is not intended to have legal implications. (S.R. 139.) According to NMH, its use of the term "does not have the same connotation in marketing as it does in legal. It is not a legal partnership. It's just a way of describing collaborative activities and the way we work with another organization." (S.R. 172.) NMH uses that word in its advertising "[b]ecause it's a word that most people understand." (S.R. 173.) The record nowhere indicates that NMH or Erie ever informed the public of NMH's interpretation of "partner."

C. Erie also has publicized a "partnership" with NMH. NMH is aware of this and has not asked Erie to cease doing so.

As of August 31, 2005 and December 22, 2005, Erie maintained a website entitled "Partners of Erie," subtitled "Hospital Affiliations."[5] On both dates, this website stated (1) that Erie "has strong relationships" with NMH and four other hospitals "to ensure that Erie patients receive appropriate care," and (2) that "[c]lients who need to receive services that are not offered at Erie are eligible to receive care at these hospitals." *Id.*

Erie continued to promote its relationship with NMH on its website. (S.R. 258.) In 2011, one page, entitled "Our Partners," states that Erie "partners" with NMH and other

[5] See Erie Family Health Center, Inc., *Partners of Erie* (archived Aug. 31, 2005), https://tinyurl.com/kf87h39 (R.A. 10); Erie Family Health Center, Inc., *Partners of Erie* (archived Dec. 22, 2005), https://tinyurl.com/lv6npjz (R.A. 11). These dates are the closest in proximity to the dates of Yarbrough's first visit to Erie (November 14, 2005) and her ultrasound at Erie (December 2, 2005) that are available at the Internet Archive, a non-profit Internet library that stores websites as they appeared at select times in the past.

hospitals "to increase access to specialized medical care and state-of-the-art medical technologies." (*Id.*) The page indicates that "[p]atients who are in need of services not offered at Erie" are eligible to receive care at NMH. (*Id.*) NMH is aware that Erie discusses its affiliation with NMH on its website. (S.R. 171.) Erie did not secure NMH's permission before doing so; however, NMH has never told Erie to stop doing so. (*Id.*)

D. NMH and Erie's Affiliation Agreement provided for mutual indemnification and joint marketing, and clarified that, contrary to their public representations, their relationship was one of independent contractors.

In 1998, Erie and Northwestern Memorial Corporation (NMC) entered into an Affiliation Agreement. (S.R. 230.) (NMC is the predecessor in interest to NMHC. (S.R. 130.) NMHC is the corporate parent of NMH. (S.R. 126.)) According to the recitals of the agreement, the parties sought to "assume broad-based responsibility" for providing community health services. (S.R. 230.) NMH sought to "build[] on our current substantial commitments and *partnerships*" to increase access to care "by providing access to *comprehensive* health care resources." (*Id.*) (emphasis added). It also sought to enhance teaching opportunities. (*Id.*) To meet these objectives, Erie agreed to "utilize [NMH] as a primary site" for hospital care, and NMC committed NMH to serve as a referral site. (S.R. 230.)

Erie and NMC deemed it necessary to include a provision entitled "Independent Contractor" in their agreement, which reads, "The parties expressly acknowledge that nothing in this Affiliation Agreement is intended nor shall be construed to create an employee/employer, a joint venture or partnership relationship between NMC and EFHC" (S.R. 233), notwithstanding several references to "partner" and "partnership" in the agreement itself (see S.R. 230, 233). There is no indication in the record that NMH, its

parent companies, or Erie communicated the substance of this provision to the public or any patients.

According to Dr. Daniel Derman, NMH's vice president of operations (S.R. 145), the agreement contains the independent contractor clause "for potentially a situation like this [case], where one party was being sued." (S.R. 155.) A separate indemnification clause obligates the parties to compensate one another for "any such damages * * * attributable to the negligent performance by one Party of the terms of this Affiliation Agreement." (S.R. 233.) Both clauses were included in the agreement because they served as a "belt and suspenders." (S.R. 155.)

The parties also agreed to joint marketing. (S.R. 232–33.) Under its "Marketing & Publicity" section, the "Affiliation Agreement" authorizes NMH and Erie to "jointly participate in collective marketing efforts as they relate to the affiliation of the Parties and as they promote the best interests of each Party. [Defendant] and [Erie] agree that each Party may publicize and refer to this Affiliation Agreement and their affiliation with each other with the prior consent of the other Party." (S.R. 232–33.) Dr. Derman denied joint marketing efforts had taken place pursuant to the agreement, yet admitted that NMH has assisted Erie in "promotional activities." (S.R. 155.)

NMC was given a right of first refusal to "partner" in the development of three future Erie clinic locations (S.R. 44, 233, 254), including the West Town location where Yarbrough received prenatal care. (S.R. 197.) By virtue of the agreement, Erie was authorized to participate in NMC's "managed care activities." (S.R. 232.)

The agreement also provides for Erie physicians to teach at Northwestern University's Feinberg School of Medicine (NUMS) and be credentialed at NMH for a duration coterminous with their employment at Erie. (S.R. 231–32.) To be allowed to treat

patients at NMH, Erie physicians must obtain faculty status at NUMS. (S.R. 151.) The physicians then can apply for staff privileges at the hospital, where they are vetted by the medical staff office, credentials committee, and medical executive committee. (*Id.*) Erie providers, in turn, must educate and train NUMS residents and students. (S.R. 232.) Erie providers have access to continuing medical education (CME) and training opportunities at NMH. (*Id.*)

Neither clinical care at Erie nor key aspects of its relationship with NMH are governed by written policies. (S.R. 135, 190.) Erie does not hold any weekly or monthly conferences to discuss patient care. (S.R. 190.)

E. NMH's marketing and public relations activities and priorities

NMH cares about its image, and strives to promote public awareness of and favorable attitudes toward itself. (S.R. 164.) Holli Salls, its vice president for public relations, testified that her responsibilities include "advancing the brand" and "getting Northwestern Memorial Hospital's name *and the good work that our physicians and employees do* to help save lives, to get it out to *people who might have a need for health care*." (*Id.*) (emphasis added).

NMH strives to promote "unaided awareness" of the hospital, meaning it is the first hospital that comes to mind, unprompted. (S.R. 160.) Between 2000 and 2011, unaided awareness of NMH increased 141%. (*Id.*) The hospital "takes great pride in having very high ranking[s], very good marks for its reputation." (S.R. 173.) Its goal is to associate NMH with high-quality medical care and services. (S.R. 164.)

NMH has expressed to Erie that its full range of services is available to Erie patients. (S.R. 152.) NMH "sometimes" provides promotional materials about its services to physicians outside of NMH. (S.R. 169.) It has a "sales force" that meets with different physicians' groups and describes the benefits of referring patients to NMH. (S.R. 170.)

VI. Procedural History

Plaintiffs filed their complaint on December 28, 2009. (S.R. 1.) After the parties took some fact discovery, NMH moved for summary judgment on all claims. (S.R. 29.) The Circuit Court of Cook County, Law Division (Gomolinski, J.) heard argument on the motion on June 17, 2013. (S.R. 537.) The court granted the motion as to actual agency claims, denied the motion as to apparent agency claims regarding NMFF and Dr. Grobman, and took the motion under advisement as it pertained to apparent agency claims regarding Erie. (S.R. 556.) At a July 8, 2013 hearing, the court requested further briefing on hospital liability under apparent agency with respect to non-physician agents. (S.R. 574.)

At the next hearing, on August 2, 2013, the court granted Plaintiffs leave to amend their complaint as to apparent agency claims against NMH. (S.R. 463.) Plaintiffs complied on August 22, 2013. (S.R. 327.) NMH then moved for partial summary judgment on Plaintiffs' amended complaint. (S.R. 368.) The court denied the motion at a February 21, 2014 hearing, finding the issue of NMH's liability in apparent agency for the acts of Erie, by and through its providers, was for the jury:

> because when we have the publications talking about this synergy, talking about this relationship between the parties, talking about the percentage of the babies delivered at [NMH], of those parties who receive prenatal care from this entity, this collaborative relationship to provide medical service, when they boast about the longstanding affiliations and they talk about they shared a relationship with Erie for more than 45 years, the question is is [sic] whether in a reasonable person's mind it creates this issue of fact as to whether or not there is that relationship or there is not. And I think it does.

(S.R. 516.)

NMH then orally moved to certify a question under Rule 308. (S.R. 523.) The court asked the parties to submit certified questions as to "whether or not those employees of Erie are actually agents of Erie * * * and then whether or not the individual corporation is the

apparent agent of Northwestern." (*Id.*) The circuit court then formulated and certified *sua sponte* the question before this Court. (S.R. 536.) NMH appealed. The Appellate Court, First District initially denied the appeal. This Court denied NMH's petition for leave to appeal, but directed the First District to allow the appeal. *Yarbrough v. Northwestern Memorial Hospital*, 25 N.E.3d 586 (Ill. 2014).

The First District answered the certified question affirmatively. (A. 2.) It held that *Gilbert* should not be read to bar recovery in apparent authority merely because the negligence at issue occurred outside the hospital. (A. 9–11.) As the First District noted, "plaintiffs' claim is that there were such close ties between NMH and Erie, despite being separate entities located in separate facilities, that material issues of fact exist regarding the elements of apparent authority." (A. 10.) The key question for the court was whether NMH's conduct led Yarbrough to rely upon the hospital rather than on Erie, which "is precisely what plaintiffs aim to show." (*Id.*) NMH is not relieved from liability simply because Erie or its employees were not sued. (A. 11.)

The First District then addressed NMH's alternative argument that no genuine issue of material fact exists regarding its liability for the acts of Erie physicians. (A. 12–15.) As here, NMH portrayed Plaintiffs as advocating the imposition of apparent agency liability based merely on hospital privileges—which, the court observed, was a mischaracterization of Plaintiffs' argument. (*Id.*) As the court recognized, NMH's conduct gave rise to genuine issues of material fact regarding "whether NMH and/or Erie held themselves out as having such close ties such that a reasonable person would conclude that an agency relationship existed * * * * " (A. 12.) NMH publicized its relationship with Erie to make healthcare available to the community. (A. 13.) And it did this, the First District concluded, "not only to be a good citizen of the community but also to attract patients." (A. 14.) The above conduct

thus could satisfy the holding-out element of *Gilbert*. (*Id.*) Plaintiffs could also meet the second, reliance element of *Gilbert*, the First District concluded, because the record contained evidence indicating Yarbrough's decision to obtain prenatal care at Erie was based on her knowledge of and desire to treat at NMH. (A. 15–16.)

ARGUMENT

I. Introduction

Nearly a quarter-century ago, this Court asked:

> Can a hospital *always* escape liability for the rendering of negligent health care because the person rendering the care was an independent contractor, *regardless* of how the hospital holds itself out to the public, *regardless* of how the treating physician held himself or herself out to the public with the knowledge of the hospital, and *regardless* of the perception created in the mind of the public?

Gilbert v. Sycamore Municipal Hospital, 156 Ill. 2d 511, 522 (1993) (emphasis added). "[A] hospital cannot always escape liability in such a case," the Court concluded. *Id.* It reaffirmed this principle in two subsequent decisions. See *Petrovich v. Share Health Plan of Illinois, Inc.*, 188 Ill. 2d 17, 33 (1999); *York v. Rush-Presbyterian-St. Luke's Medical Center*, 222 Ill. 2d 147, 183, 192–93 (2006).

Yet NMH and its *amici* seek to ensure that a hospital will always escape liability for a medical malpractice claim brought under apparent agency if the negligent care is provided by an "unrelated, independent entity"—regardless of the hospital's affirmative representations in holding out the agent, or acquiescence in the agent holding itself out, as having authority from the principal. NMH and its *amici* also contend that answering the certified question in the affirmative is unfair and will force hospitals to cease providing charity care.

NMH's and *amici's* position contravenes *Gilbert* and its progeny, common sense, and sound public policy. First, liability for the acts of unrelated, independent entities is inherent in the concept of apparent agency. Principals are liable for medical negligence committed by

unrelated, independent agents when the elements of *Gilbert* are satisfied. The record indicates NMH held itself and Erie out as "partners" providing comprehensive prenatal and other obstetrical care, and shows NMH authorized or acquiesced in similar representations by Erie. NMH's conduct led Yarbrough reasonably to rely on NMH to provide care.

Second, NMH construes "unrelated [and] independent" to mean, occurring at a facility not owned or operated by a hospital. (*E.g.*, Appellant's Br. 29.) This attempt to confine *Gilbert* to apparent agents working in facilities owned or operated by a hospital is not grounded in Illinois law, and is contrary to fundamental principles of apparent agency. Whether a principal controls the place where negligent care is provided does not determine whether the principal is liable for that care under apparent agency. See *Petrovich*, 188 Ill. 2d at 25, 41. As NMH itself admits, *Gilbert* does not apply solely within the four walls of a hospital. (Appellant's Br. 29.)

Third, although Plaintiffs have assumed for purposes of answering the certified question that NMH and Erie are independent and unrelated, the record indicates otherwise. NMH and Erie have had a "longstanding affiliation" for 60 years. They have long held themselves out as "partners." NMH credentials and provides training to Erie physicians. (See pp. 8–13, *supra*.)

Lastly, it is highly dubious to claim that applying *Gilbert* to conduct off hospital premises will cause a health care crisis. NMH and its *amici* benefit in numerous ways from providing charity care. (See pp. 40–45, *infra*.) Doing so permits NMH and other Illinois hospitals to be exempt from federal taxation and state sales, use, and property tax. (*Id.*) It facilitates a positive public image and patient referrals. (*Id.*) The light burden Illinois hospitals must shoulder to insulate themselves from apparent agency liability—i.e., clear and accurate communication to the public—will not cause them to forego the benefits of their honorable

charitable efforts. Moreover, this proffered policy justification is necessarily limited, as NMH and its *amici* seek immunity from apparent agency liability for all care provided off hospital premises, not simply for charitable care.

NMH's exposure depends on its own conduct. To have avoided liability for Erie's negligent care of Yarbrough, NMH need simply have refrained from holding out Erie as its agent; responded to any holding out by Erie by publicly clarifying (as it had done privately in its Affiliation Agreement with Erie) that Erie was not its agent, but rather an independent contractor; instructed Erie to correct any representations in which it held itself out as NMH's agent; and, if necessary, sought injunctive relief. It did none of these things. Corporate responsibility, not judicial innovation, is the appropriate remedy here.

II. Holding Hospitals Accountable for Negligent Care Rendered by Unrelated, Independent Providers Is Appropriate When the Elements of *Gilbert* Are Satisfied.

There is no merit to NMH's contention that answering the certified question in the affirmative is unfair because, allegedly, NMH could be liable based on "basic patient education" or a physician's mere mention of NMH. (Appellant's Br. 37.) This misstates the applicable law and creates a straw-man argument. Liability attaches to NMH based on its own conduct, not merely the conduct of other independent actors. When it comes to vicarious liability under apparent authority, NMH is the master of its own fate.

A. General principles of apparent authority

Illinois has recognized liability under the doctrine of apparent authority (used synonymously with apparent agency in Illinois case law) for over 160 years. See *Petrovich*, 188 Ill. 2d at 31; *Doan v. Duncan*, 17 Ill. 272, 274–75 (1855). Under the doctrine, "[a] principal will be bound by not only that authority which he actually gives to another, but also by the authority which he appears to give." *Gilbert*, 156 Ill. 2d at 523. This principle is motivated by

equity concerns: " 'A principal may not choose to * * * clothe[ ] [someone] with the trappings of [agency] and then determine at a later time whether the consequences of their acts offer an advantage.' " *Jacobs v. Yellow Cab Affiliation, Inc.*, 2017 IL App (1st) 151107, ¶ 32 (quoting Restatement (Third) of Agency § 2.03 cmt c. (2006)) (alterations in original).

Vicarious liability based on apparent authority can be established directly or circumstantially ("inferentially") through the conduct of the parties. *Lundberg v. Church Farm*, 151 Ill. App. 3d 452, 461 (2nd Dist. 1986); *Dahan v. UHS of Bethesda, Inc.*, 295 Ill. App. 3d 770, 775 (1st Dist. 1998). An independent contractor agreement not made known to a patient will not defeat hospital liability under apparent authority. See *Petrovich*, 188 Ill. 2d at 35 (" '[A]ppearances speak much louder than the words of whatever private contractual arrangements the physicians and the hospital may have entered into, unbeknownst to the public, in an attempt to insulate the hospital from liability for the negligence, if any, of the physicians.' ") (quoting *Gilbert,* 156 Ill. 2d at 521).

Liability in apparent authority does not attach if the principal does not knowingly acquiesce in the agent's exercise of authority and does not hold the agent out as possessing that authority. *See Jacobs*, 2017 IL App (1st) 151107, ¶ 31 (citation omitted). Principals control their own exposure to liability for the torts of apparent agents: " 'It is not the conduct or words of the apparent agent that create apparent agency, but rather, the words or conduct of the apparent principal.' " *Id.* at ¶ 32 (quoting *Tierney v. Community Memorial General Hospital,* 268 Ill. App. 3d 1050, 1062 (1st Dist. 1994)).

Manifestations that create an apparent agency relationship can be made directly to a third party "or may be made to the community by signs or advertising." *Jacobs*, 2017 IL App (1st) 151107, ¶ 32 (citing Restatement (Second) of Agency § 8 cmt. b (1958)); see also *Sword v. NKC Hosps., Inc.,* 714 N.E.2d 142, 148 (Ind. 1999).

Apparent agency is a fact-laden inquiry. Under *Gilbert* and its progeny, "[a]pparent agency is a question of fact," *Petrovich*, 188 Ill. 2d at 34 (citing *Gilbert*, 156 Ill. 2d at 524), unless the relationship between the parties is so clear as to be indisputable. *Dahan*, 295 Ill. App. 3d at 775 (citing *Letsos*, 285 Ill. App. 3d at 1065).

B. Apparent agency liability does not depend on whether the agent is independent of or unrelated to the principal.

In Illinois, the doctrine of apparent authority may be used to impose vicarious liability in two settings. In one, the alleged apparent agent is related to and not independent of the alleged principal, but has exceeded its authority. See, *e.g.*, *Freeport Journal-Standard Publishing Co. v. Frederic W. Ziv Co.*, 345 Ill. App. 337, 349–51 (2nd Dist. 1952). In the other setting, which appears more frequently in the case law, the alleged apparent agent is independent of and unrelated to the alleged principal. See, *e.g., Gilbert*, 156 Ill. 2d at 515 (characterizing alleged apparent agent physician as independent contractor); *York*, 222 Ill. 2d at 196–97 (same). This scenario also occurs when apparent agency is alleged in non-medical malpractice cases. See, *e.g.*, *First Chicago Insurance Co. v. Molda*, 2015 IL App (1st) 140548, ¶¶ 52–62, *appeal denied*, 39 N.E.3d 1001 (Ill. 2015). A person may be both an agent and an independent contractor for another. *Sobel v. Franks*, 261 Ill. App. 3d 670, 679 (1st Dist. 1994).

Illinois law reflects the Restatement (Third) of Agency. According to the Restatement, the principles of apparent agency "appl[y] to actors who appear to be agents but are not, as well as to agents who act beyond the scope of their actual authority." Restatement (Third) of Agency § 2.03 cmt. a (2006). Liability under apparent authority "trumps restrictions that the principal has privately imposed on the agent," *id.* at cmt. c, and "does not presuppose the present or prior existence of an agency relationship," *id.* at cmt. a.

C. The *Gilbert* framework

Gilbert arose from a wrongful death action against a physician, Dr. Frank, and Sycamore Municipal Hospital. *Gilbert*, 156 Ill. 2d at 517. Like NMH, Sycamore was a full-service acute care facility. *Id.* at 514–15. Dr. Frank was a member of the hospital's medical staff. *Id.* at 515. Like most physicians on staff, he practiced through a professional association. *Id.* The professional association and Sycamore had no noted relationship. The decedent was not informed that Dr. Frank and other physicians were independent contractors of the hospital. See *id.* at 516.

The *Gilbert* Court recognized "two realities of modern hospital care." *Id.* at 520. The first "involves the business of a modern hospital." As the court observed, " '[m]odern hospitals have spent billions of dollars marketing themselves, nurturing the image with the consuming public that they are full-care modern health facilities.' " *Id.* (quoting *Kashishian v. Port*, 481 N.W.2d 277, 282 (Wis. 1992). Since hospitals benefit from the treatment their independently contracted physicians provide, " 'anomaly would attend the hospital's escape from liability' " for the negligence of those physicians. *Id.* at 520–21 (quoting *Hardy v. Brantley*, 471 So. 2d 358, 371 (Miss. 1985)).

The second reality of modern hospital care pertains to the public's reasonable expectations. *Gilbert* 156 Ill. 2d at 521. Most patients are not aware of the employment status of the people working at a hospital. *Id.* (citing *Arthur v. St. Peters Hospital*, 405 A.2d 443, 447 (N.J. Super. 1979)). Generally, a patient seeking treatment at a hospital relies on the reputation of the hospital, not the reputations of the individual care providers who practice there. *Gilbert*, 156 Ill. 2d at 521. This reliance is natural and reasonable " 'unless the patient is in some manner put on notice of the independent status of the professionals with whom it might be expected to come into contact.' " *Id.* (quoting *Arthur*, 405 A.2d at 447).

Against this backdrop, the Court concluded that a hospital may be held vicariously liable for the negligence of independent contractor physicians when:

> "(1) the hospital, or its agent, acted in a manner that would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital; (2) where the acts of the agent create the appearance of authority, the plaintiff must also prove that the hospital had knowledge of and acquiesced in them; and (3) the plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence."

Id. at 525.

Gilbert adopted this test from the Wisconsin Supreme Court's decision in *Pamperin v. Trinity Memorial Hospital*, 423 N.W.2d 848, 855–56 (Wis. 1988). The Wisconsin Supreme Court's subsequent decision in *Kashishian v. Port* clarified that "agent" means, in the context of the above test, "the individual who was alleged to be negligent." 481 N.W.2d 277, 283 (Wis. 1992). Corporations, of course, act only through their agents, and "[a]ny act or omission of an officer or employee within the scope of his employment is the action or omission of the * * * corporation." I.P.I. Civ. 50.11 (2017) (R.A. 12). Here, the agent is Erie, acting through its employees.

The "holding out" element (prongs 1 and/or 2) is satisfied by an express representation that the person alleged to be negligent is the hospital's agent, or by the hospital holding itself out as a provider of the type of medical care at issue and not informing the patient that the care is being provided by independent contractors. *Gilbert*, 156 Ill. 2d at 525. The "justifiable reliance" element (prong 3) "is satisfied if the plaintiff relies upon the hospital to provide complete emergency room care, rather than upon a specific physician." *Id.* Applying these principles, the Court concluded that a genuine issue of material fact existed regarding whether Dr. Frank was Sycamore's apparent agent. *Id.* at 526.

The decedent was not informed that Dr. Frank was an independent contractor, and evidence indicated the decedent relied on Sycamore, not Dr. Frank, for his care. *Id.*

Gilbert was not, as NMH contends (Appellant's Br. 31), a "public policy exception." It *eliminated* an exception—the immunity hospitals had enjoyed from apparent agency liability in medical malpractice cases. Under *Gilbert* and its progeny, hospitals are subject to liability in apparent authority for the acts of their apparent agents, like other private institutions. See, *e.g., Petrovich*, 188 Ill. 2d at 30, 33. The majority of other jurisdictions that have considered the issue have refused to exempt hospitals from the operation of apparent agency liability and have adopted a similar approach to *Gilbert* in medical malpractice cases. See cases collected in *Cefaratti v. Aranow*, 141 A.3d 752, 766 n.26 (Conn. 2016); see also *Kashishian*, 481 N.W.2d at 283 (recognizing the "nationwide acceptance of the application of the doctrine of apparent authority in the hospital context").

This Court has codified the *Gilbert* test for apparent agency liability in two pattern jury instructions—one for when both a principal and agent are sued (I.P.I. Civ. 105.10 (2017)) (R.A. 13–14), and one for when only the principal is sued (I.P.I. Civ. 105.11 (2017)) (R.A. 15). Again, the principal's liability is predicated on its own conduct, not merely the conduct of the agent. See, *e.g.*, *Tierney*, 268 Ill. App. 3d at 1062.

D. A reasonable juror may find that Plaintiffs have satisfied the holding-out element of *Gilbert*, on one or more of four independent bases.

NMH may be held liable for the negligent care Erie provided to Yarbrough, because the record indicates NMH held itself out as a provider of obstetrical care, held Erie out as a provider of obstetrical care, authorized Erie to represent to the public that it was providing obstetrical care as an affiliate or "partner" of NMH, and acquiesced in Erie's representations that it was an agent of NMH. These elements are addressed in inverse order below.

1. NMH knowingly acquiesced in Erie's representations that it was an agent of NMH.

NMH held Erie out as its agent by acquiescing in Erie's representations of agency. To acquiesce is "[t]o accept tacitly or passively; to give implied consent to (an act)." Black's Law Dictionary (10th ed. 2014). A corporation that knowingly acquiesces in unauthorized acts by its agents risks liability under apparent agency. See, *e.g.*, *Freeport Journal-Standard Publishing Co.*, 345 Ill. App. at 350 (" '[A] corporation cannot stand by, after it has learned of an unauthorized act or contract made or entered into by its officer or agent, and have its benefit if it should prove to be favorable and reject it if it should prove unfavorable.' ") (quoting 13 Am. Jur. 935 § 983). The relevant inquiry is whether a principal has acquiesced in an actor's initial representation of itself as an agent of the principal—not whether the principal has acquiesced in specific deeds the actor later performs. See *State Security Insurance Co. v. Burgos*, 145 Ill. 2d 423, 432–33 (1991).[6]

Here, NMH allowed Erie to represent itself as NMH's "partner" in providing health care to the community. Erie stated in 2005, on a website entitled "*Partners* of Erie" (emphasis added), that (1) it "has strong relationships" with NMH and four other hospitals "to ensure that Erie patients receive appropriate care," and (2) that "[c]lients who need to receive

[6] Plaintiffs have not located a reported Illinois medical malpractice case where a court examined whether a given principal could be held liable on the basis of knowing acquiescence in the conduct of an agent. At least one appellate court elsewhere has upheld the imposition of liability on that basis in a medical malpractice case. *See Strach v. St. John Hospital Corp.*, 408 N.W.2d 441 (Mich. Ct. App. 1987), *appeal denied* (Dec. 22, 1987). In *Strach*, the Michigan Court of Appeals held a jury had sufficient evidence to conclude that a hospital had knowingly acquiesced to representations of agency, given that (1) the hospital allowed independent contractor physicians to exercise broad authority over nurses and staff at the hospital, and (2) the defendant physician repeatedly referred at deposition to the physicians who performed the operation at issue as the "St. John team". *Id.* at 449–50. According to the court, "[b]y permitting, or perhaps even encouraging, the use of this vernacular by its staff, St. John Hospital encouraged patients to look to it for treatment." *Id.*

services that are not offered at Erie are eligible to receive care at these hospitals." (R.A. 10–11.) Erie has specifically described a "partnership" with NMH "to increase access to specialized medical care and state-of-the-art medical technologies." (S.R. 258.)

Holli Salls testified that although Erie did not get her permission to discuss its affiliation with NMH on its website, she was aware that Erie did so. (S.R. 171.) According to Ms. Salls, NMH never told Erie not to promote their affiliation. (*Id.*)[7]

NMH has had numerous potential avenues of controlling what Erie tells the public regarding its affiliation with NMH. NMH screens and credentials Erie physicians for membership on the NMH medical staff, for a duration coterminous with their employment at Erie. (S.R. 232.) The physicians are also vetted for membership on the NUMS faculty. (S.R. 151, 231–32.) Erie physicians have access to continuing medical education (CME) and training opportunities at NMH to the same extent as any other member of the NMH medical staff. (S.R. 232.) Given the lack of clinic care policies and meetings to review patient care at Erie (S.R. 190), NMH may be the only entity that oversees clinical care at Erie.

The Affiliation Agreement implies that Erie was required to obtain consent from NMC before publicizing and referring to the Agreement and their affiliation with one another. (S.R. 233.) There is no evidence in the record that NMH or its corporate parent enforced this obligation or did anything other than acquiesce to Erie's conduct after learning Erie publicized its affiliation with NMH on its website. NMH could also have required Erie patients to sign a standard disclosure indicating that Erie and its physicians are not affiliated

[7] NMH's reliance on Dr. Derman's testimony, indicating that if he learned that Erie was representing to patients that it was an agent of NMH, he would not permit it (Appellant's Br. 8; S.R. 154), is misplaced. This testimony is undermined by his admission that he does not know what Erie tells its patients regarding care and treatment at Northwestern, and has never sought to find out. (S.R. 150.)

with NMH—or simply indicated this information on its own website. Yet there is no evidence that NMH sought to use any of these avenues to clarify the nature of its "partnership" with Erie.

Surely, Erie would have been receptive to a request from NMH to stop using, or adequately clarify, terms like "partner" or "partnership" to communicate their affiliation. After all, NMH provides substantial financial support to Erie, has seats on its board, and has a relationship with the institution going back 60 years. (S.R. 329.) Yet there is no evidence such a request was made, and according to Ms. Salls, NMH never told Erie not to promote its affiliation with NMH on its website. (S.R. 171.) Nor is there any evidence that NMH sought injunctive relief to require Erie to clarify its relationship with NMH.

Imposing liability on NMH for knowing acquiescence in Erie's conduct is hardly unfair. NMH acquiesced with full awareness its affiliation with Erie might expose it to liability: the Affiliation Agreement contains an indemnification clause. (S.R. 233.) The independent contractor clause was also included as "belt and suspenders" for "a situation like this [case] where one party was being sued." (S.R. 155).

2. NMH authorized Erie to represent that it was an agent of NMH.

A second basis for concluding that NMH held Erie out as its agent for providing prenatal care is that NMH, by virtue of its control over Erie's representations concerning the parties' affiliation, authorized Erie to represent that Erie was its agent in providing prenatal and obstetrical care to patients like Yarbrough. Although control over the means and manner of an agent's performance is not an element of apparent authority, control over the representations that create an apparent agency relationship may be relevant to establishing the existence of apparent agency. See, *e.g., Jacobs*, 2017 IL App (1st) 151107, ¶¶ 71–72, 77 (upholding defendant affiliation company's liability in apparent agency for accident caused

by cab driver employed by separate corporation, where defendant "voluntarily control[led] the appearance of agency" through contractual provisions dictating the appearance of the separate corporation's taxicabs).

The Affiliation Agreement envisions a collaborative effort between Erie and NMC (by and through its subsidiary, NMH) to increase health care services delivered to the community. As the recitals indicate, NMC and Erie "have missions to increase services to the community." (S.R. 230.) Both entities sought "to assume broad-based responsibility for the provision of health care services to the community." (*Id.*) Erie agreed to funnel patients to NMH, which served as a "referral site" and "primary site" for hospital care for those patients. (*Id.*)

To these ends, the Agreement contains a "Marketing and Publicity" section, which states in full:

> NMC and EFHC will jointly participate in collective marketing efforts as they relate to the affiliation of the Parties and as they promote the best interests of each Party.
>
> NMC and EFHC agree that each Party may publicize and refer to this Affiliation Agreement and their affiliation with each other with the prior consent of the other Party.

(S.R. 232–33.) The agreement does not require that consent be in writing. (See S.R. 230–36.)

Here, the record supports the reasonable inference that NMC—directly or through its subsidiary, NMH—authorized Erie to make representations to patients about its affiliation with NMC/NMH. The Agreement expressly permits Erie to "market" its affiliation with NMH—i.e., promote the services of Erie and NMH. (S.R. 232.)[8] Reasonably,

[8] "Marketing" primarily means "[t]he act or process of promoting and selling, leasing, or licensing products or services"; as distinct from "publicity," which primarily means "public

such marketing efforts could include discussions with patients like Yarbrough about the benefits conferred by Erie's affiliation with NMH. Yarbrough received informational materials at Erie regarding tours of the birthing/delivery section of NMH, having a car seat checked at NMH, and attending birthing classes there. (S.R. 334.) As discussed, Erie publicly promoted its affiliation with its "partner" NMH. NMH knows Erie has marketed and publicized its affiliation with NMH, but has done nothing to stop it. And NMH uses the same language of "partner" and "partnership" to describe its relationship with Erie.

A reasonable juror thus may find that NMC/NMH authorized Erie to market their affiliation and to represent that Erie was a partner of NMH. Representations made on Erie's website and made directly to patients (such as telling Yarbrough that ultrasounds and labor and delivery services would be provided by NMH, and providing literature about NMH services) may reasonably have led a patient to conclude that NMH and Erie had an agency relationship.

3. NMH directly held Erie out as its agent for providing obstetrical care.

A third basis on which to conclude that Plaintiffs can satisfy the holding-out element of *Gilbert* is that NMH directly and expressly held Erie out to the public as an agent in providing obstetrical care. Express representations to the public of an agency relationship can establish a holding out, even if the plaintiff does not see or rely on the advertisements. See, *e.g., Hammer v. Barth*, 2016 IL App (1st) 143066, ¶ 26, *appeal denied*, 50 N.E.3d 1139 (Ill. 2016) (hospital website advertised its competence in over 60 fields of medicine and highlighted its "team of 1000+ doctors"); *Spiegelman v. Victory Memorial Hospital*, 392 Ill. App.

attention; notoriety" or "[o]ne or more efforts made to get public attention." Black's Law Dictionary (10th ed. 2014).

3d 826, 839–42 (1st Dist. 2009) (newspaper advertisements extolled the superior quality of emergency room doctors).

Here, NMH held Erie out as its agent by publicly representing (1) that prenatal care at Erie was provided through a partnership between Erie and NMH, and (2) that one of Plaintiff's treating physicians was on staff at NMH and a key player in that partnership. In its 2006 Community Service Report, NMC stated that "[o]bstetrical patients * * * benefit from quality prenatal care that is available in the community *through a partnership* between Northwestern Memorial and Erie Family Health Center." (S.R. 256) (emphasis added). NMC's 2005 Community Service Report features Dr. Reid—one of Plaintiff's physicians (S.R. 198)—and his work at Erie's West Town location (where Yarbrough received prenatal care). (S.R. 253.) Dr. Reid is identified in the report as "an obstetrician/gynecologist on the medical staff at Northwestern Memorial who leads Women's Health at Erie." (S.R. 253.)

NMH's allegation that it used the word "partner" merely in the marketing sense does not support its contentions that it did not hold Erie out as its partner as a matter of law. NMH's intent is irrelevant to establish what NMH held out to the public. The inquiry is an objective one: what is relevant for determining whether a "holding out" has occurred is whether the principal's conduct "would lead a reasonable person to conclude" the negligent actor was the principal's agent. *Gilbert*, 156 Ill. 2d at 525; see also *Spiegelman*, 392 Ill. App. 3d at 839. NMH chose to use the legally significant term "partner" to characterize its relationship with NMH. Holding oneself out as a "partner" of another, or permitting oneself to be held out as a partner, can be a basis of apparent agency liability. See, *e.g.*, 805 ILCS 206/308(a) (West 2017);[9] *Branscome v. Schoneweis*, 361 F.2d 717, 722 (7th Cir. 1966) (applying Illinois law).

[9] Plaintiffs have not alleged liability on an apparent partnership theory under this statute.

Betraying a concern that the word "partner" does, in fact, have legal consequences, NMH took pains to clarify in its Affiliation Agreement with Erie that the relationship between the two entities did not create a legal partnership. (S.R. 233.) The record is devoid of evidence that Erie or NMH alerted Yarbrough or other patients that Erie and its physicians were independent contractors of NMH. In fact, NMH has long represented, and continues to represent, that Erie is a partner and its relationship with Erie is a partnership. (See pp. 8–10, *supra*.) NMH should not benefit from discrepancies between what it and Erie held out regarding the nature of their relationship, and what they held in.

4. NMH held itself out as a provider of comprehensive obstetrical care.

Finally, a reasonable jury may also find that the holding-out element is satisfied because NMH held itself out as a provider of prenatal and other obstetrical care, without disclosing that that care was provided by independent contractors. As I.P.I. 105.11 provides, a principal may be deemed to satisfy the holding-out element of *Gilbert* when it "held * * * [itself] out as a provider of [type of care, *e.g.*, complete emergency room care] * * * " and neither knew nor should have known that the apparent agent was not an employee of the principal. (R.A. 15.) In its 2004 annual report, NMHC (NMH's corporate parent) represented, "With our continued excellence and expansions in women's health * * * Chicagoans should not have to leave the city for world-class care." (S.R. 251.) As NMHC also represented in the report, NMH provided care to nearly 10,000 newborns that year. (*Id.*) NM represents that "our top surgeons, physicians, and care teams" provide care in over 40 specialties. (See R.A. 4.) NMH has expressed to Erie that its full range of services is available to Erie patients. (S.R. 152.) There is no evidence in the record that NMH clarified to Plaintiff or to others that their prenatal care was being provided by independent contractors. NMH's brief does not argue that Plaintiff knew or should have known that Erie and its

providers were independent contractors. NMH thus repeatedly held itself out to the public as a provider of prenatal and other obstetrical care, which satisfies the holding-out element of *Gilbert*.

E. The facts of this case also satisfy the reliance element of *Gilbert*.

The third prong of the *Gilbert* test for apparent authority is referred to as the reliance element. This element is met "if the plaintiff relies upon the *hospital* to provide medical care, rather than upon a specific physician." *York*, 222 Ill. 2d at 185 (citing *Gilbert*, 156 Ill. 2d at 525). In other words, "the 'critical distinction' is whether the plaintiff is seeking care from the hospital itself or whether the plaintiff is looking to the hospital merely as a place for his or her personal physician to provide medical care." *Id.* (quoting *Gilbert*, 156 Ill. 2d at 525).

A triable issue of fact as to the reliance element exists when there is evidence a plaintiff reasonably believed her treating providers were employees or agents of a hospital. *Schroeder v. Northwest Community Hospital*, 371 Ill. App. 3d 584, 593–94 (1st Dist. 2006). The *Gilbert* test requires only justifiable, not detrimental, reliance. *York*, 222 Ill. 2d at 184, 194.

Here, Yarbrough relied on NMH for treatment, not Erie. The evidence shows that Yarbrough initially sought out Erie for the sole purpose of obtaining a free pregnancy test. It was only after Yarbrough was given unsolicited information about NMH, without knowing or being provided significant information about Erie, that she elected to treat with Erie. For example, Yarbrough was told she would have ultrasounds done at Prentice Women's Hospital (which is part of NMH), and would most likely have her delivery there. (S.R. 45.) After being told this, it would be reasonable for Yarbrough to believe that NMH was the provider of the prenatal ultrasound testing she received at Erie on December 2, 2005. Yarbrough also received pamphlets regarding tours of the labor and delivery portion of NMH and birthing classes there. (S.R. 334.) Plaintiff "was under the impression [Erie] was

just Northwestern" (S.R. 45) and believed, correctly, that they were "working together" (S.R. 71). She "was under the impression that [NMH was] a very good hospital, very big, very well-known in the city." (*Id.*)

A reasonable juror may find that Plaintiff's reasonable belief that an agency relationship existed between Erie and NMH was the key factor in her decision to receive prenatal care at Erie. She did not decide to treat at Erie based on information about Erie's own capabilities: she does not recall having information about Erie itself other than a pamphlet with the address and phone number of the clinic, and her knowledge from Internet research that Erie provided pregnancy tests to uninsured patients. (S.R 44–45.) Rather, she decided to treat at Erie based on what she was told concerning the prenatal care NMH would provide.

Even if a juror were to conclude that Yarbrough relied to some extent on Erie to provide care, liability is not precluded, according to this Court's most recent examination of *Gilbert*, in *York v. Rush Presbyterian-St. Luke's Medical Center*, 222 Ill. 2d 147 (2006). Regarding the element of reliance, the *York* Court noted that "it was only after plaintiff developed an interest in Rush * * * that he sought out a particular orthopedic surgeon at that institution." *Id.* at 196. The record indicated that York did not know who would serve as the attending anesthesiologist until the day of his surgery. *Id.* at 198. York also testified he assumed Rush would select the anesthesiologist, he believed that Rush had good physicians, and he "had faith in the institutions." *Id.* at 198–99. These facts were deemed sufficient for the jury to conclude that York relied on the hospital, rather than a physician he selected, for his medical care. *Id.* at 200–01.

Here, as in *York*, Yarbrough's interest in being treated by NMH arose prior to her decision to receive prenatal care at the Erie Clinic's West Town location. She agreed to treat

at Erie only after being told that she would have prenatal ultrasound testing at NMH and would deliver at NMH, and after being given literature about the birthing facilities at NMH. She knew that NMH was reputed to be a good hospital, and was prominent in the city. She knew nothing about the reputations of Erie or its physicians. Thus, there is a genuine issue of material fact regarding whether Yarbrough relied on NMH, rather than Erie, to provide appropriate prenatal care.

III. If, like NMH, the Court Interprets "Independent and Unrelated" as "Not Owned or Operated by a Hospital," *Gilbert* Still Applies, and a Jury May Still Find NMH Liable for Erie's Negligence.

There is no merit to NMH's argument that it cannot be liable for acts of medical professionals at "unrelated" clinics that occur on premises not owned or operated by NMH. (*E.g.*, Appellant's Br. 24.) This Court's decision in *Petrovich* undermines that argument. The cases NMH chiefly cites in support, *Malanowski v. Jabamoni*, 293 Ill. App. 3d 720 (1st Dist. 2000), and *Robers v. Condell Medical Center*, 344 Ill. App. 3d 1095 (1st Dist. 2003), do not support its suggested doctrinal innovation, which is inconsistent with the doctrine of apparent authority and with *Gilbert* and its progeny.

A. NMH's attempt to abolish hospitals' apparent agency liability for care occurring outside hospital facilities is contrary to *Petrovich* and invites doctrinal confusion.

NMH construes "unrelated, independent" in the certified question to mean "not owned and operated by the hospital." (*E.g.*, Appellant's Br. 29.) NMH repeats 9 times the claim that treatment must be rendered at a hospital for its agents to be liable in apparent agency. (Appellant's Br. 23, 24, 29, 32, 33, 34, 36, 38, 41.) Of course, "[a]n error does not become truth by reason of multiplied propagation * * * * " Mahatma Gandhi, *Young India 1924-1926*, at 1285 (1927). This Court's decision in *Petrovich v. Share Health Plan of Illinois*, 188

Ill. 2d 17 (1999), which NMH cites (Appellant's Br. 20), and the principle that control over an agent is not an element of apparent authority, refute NMH's position.

In *Petrovich*, this Court held that an HMO may be liable for the negligence of a physician if the elements of *Gilbert* are satisfied—even though the HMO did not employ any of the negligent providers or own or operate any of the relevant health care facilities. *Petrovich*, 188 Ill. 2d at 29–42. Plaintiff Inga Petrovich and her husband sued her primary care physician for failing to timely diagnose oral cancer. *Id.* at 25. They also sued Share Health Plan under theories of apparent and implied agency. *Id.* at 22. Share had no ownership or management responsibilities for the facilities where Petrovich's physician provided care, and did not employ any physicians. *Id.* at 25. Instead, Share merely contracted with "independent medical groups and physicians." *Id.*

The *Petrovich* Court rejected Share's argument that HMOs should be immune from the application of *Gilbert*. *Id.* at 29–30 (emphasis added). Courts "should not be hesitant to apply well-settled legal theories of liability to HMOs where the facts so warrant and where justice so requires," it held. *Id.* at 30 (emphasis added). It reaffirmed *Gilbert*, holding that "*Gilbert* fairly imposes vicarious liability upon hospitals *under the same doctrine of apparent authority that applies to other principals*." *Id.* at 33 (emphasis added).

The Court held that Petrovich satisfied the "holding out" prong of *Gilbert* for purposes of summary judgment because "the record contains evidence that Share held itself out as the provider of health care without informing plaintiff that the care was given by independent contractors." *Id.* at 36–37. This evidence included plaintiff's belief that her treating physicians were Share employees, representations in the member handbook that the physicians were "Share physicians," and the fact that Share did not notify plaintiff that its member physicians were independent contractors. *Id.* The *Petrovich* Court also held a

reasonable juror could find that Petrovich satisfied the reliance element of *Gilbert*, in that she sought care *from* Share. *Id.* at 38–42.

Here, similar facts confront the Court. NMH did not own or operate Erie, or employ the Erie providers whose alleged negligence is at issue. NMH refers to its contracted physicians as "our physicians." (*E.g.*, S.R. 164.) Neither NMH nor Erie informed Plaintiff of the existence of their independent contractor agreement, or that her care would be provided by independent contractors. (S.R. 45–46.) As discussed, Yarbrough also sought care from NMH (S.R. 43–46), as Petrovich did from Share. The *Petrovich* Court applied *Gilbert* to Share. This Court should likewise apply *Gilbert* to NMH.

Defendant's insistence that the relevant conduct must occur on premises controlled by a health care entity, for apparent agency liability to attach to that entity, also invites doctrinal confusion. Whether a principal retains the right to control the matter of performance of the work in question is a key element of proof of actual or implied agency. *Petrovich*, 188 Ill. 2d at 42. But this right to control the means or manner of performance is not an element of apparent authority. *Id.* at 31, 35, 42. As the First District stated in affirming a trial court's exclusion of city code and an affiliation agreement from evidence—in a personal injury lawsuit brought under apparent authority against Yellow Cab Affiliation, Inc.—"[t]he Code and the principles of actual agency are *red herrings* that were introduced in these proceedings by the defendants." *Jacobs*, 2017 Il App (1st) 151107, ¶ 64 (emphasis added). Actual agency is "an entirely different legal premise" from apparent authority. *Id.*

B. Defendants do not successfully distinguish *Malanowski* from this case.

NMH seeks to graft onto *Gilbert* a requirement that the conduct at issue must occur at a hospital or a hospital-owned facility. This approach lacks merit. *Malanowski* indicates that this proposed requirement is untenable.

Although Loyola owned the outpatient center in *Malanowski*, it did not manage or oversee the care given there. *Malanowski*, 293 Ill. App. 3d at 725, 730. Physicians practicing at the center were "independent contractors who use the medical office space for their private practices." *Id.* at 725. Loyola had "nothing to say about how the individual physicians practice or how their decisions are made," and claimed no right to manage their care. *Id.*

Loyola's lack of control over the care rendered at the facility led the appellate court to hold that the Malanowskis failed to satisfy the element of control necessary to establish an actual agency claim against Loyola. *Id.* Likewise, the court held that the hospital had no duty to supervise the physicians treating Ms. Malanowski, because it did not provide any clinical management at the outpatient facility. *Id.* at 728–30.

Despite ruling in favor of the defendants on the issue of actual agency, the appellate court ruled in favor of the plaintiffs on the issue of apparent agency. *Id.* at 727. The court disagreed with Loyola's claim that *Gilbert* was limited to negligent treatment in a hospital emergency room, stating, **"**[W]e discern nothing in the *Gilbert* opinion which would bar a plaintiff, who could otherwise satisfy the elements for * * * apparent agency, from recovering against a hospital merely because the negligent conduct of the physician did not occur * * * within the four walls of the hospital." *Id.*

This result undermines NMH's claim that owning and operating the situs of negligent conduct is an essential element of apparent agency in medical malpractice cases. Nothing in *Malanowski*—or any other case—states or implies that apparent authority liability under *Gilbert* is restricted to care rendered at hospital-owned or -operated facilities. Although the situs of care may be relevant, NMH cites no authority indicating that a hospital may escape apparent agency liability altogether merely because the negligent care occurred on property it does not own or control.

Moreover, this case contains persuasive facts not evident in *Malanowski*. The *Malanowski* opinion does not reference any direct representations that were made to the plaintiff or decedent regarding the agency relationship between the outpatient clinic and Loyola University. By contrast, as discussed above, Erie staff directly communicated facts about Erie and NMH that led Yarbrough to reasonably conclude that an agency relationship existed between the two, and that she would be receiving ultrasounds and other prenatal care from NMH. Although the record here does not indicate any signs or branding material that signified a relationship between the two entities, there is evidence of numerous public representations in which NMH and Erie indicated they were partners in providing prenatal and other obstetrical care to the community where Yarbrough lived.

C. *Robers* is distinguishable from this case. In *Robers*, a theory of liability based on knowing acquiescence was not addressed, and there was no holding out by the hospital.

Defendant's argument rests in great part on analogizing this case to *Robers v. Condell Medical Center*, 344 Ill. App. 3d 1095 (2003). (Appellant's Br. 27–29.) This analogy is unavailing. *Robers* did not concern an apparent agency claim based on knowing acquiescence of a principal in holding-out conduct by an agent—a major path to apparent agency liability that the evidence here supports. *Robers* is also distinguishable in numerous other respects.

Robers arose from a medical malpractice claim brought by Thomas Robers against podiatrist Donald Burdick, M.D. and Condell Medical Center (Condell). *Id.* at 1096. Robers alleged that Condell was liable on a theory of apparent authority, because he allegedly chose Dr. Burdick based on (1) a phone book listing for Dr. Burdick that stated that his office was in the Condell Medical Building, (2) a flyer advertising four locations of Condell acute care centers and Condell Hospital (which did not mention Dr. Burdick or the Condell Medical Building), and (3) because Dr. Burdick's office was close to his chiropractor. *Id.*

Dr. Burdick sublet office space in the Condell Medical Building from a physician on staff at Condell. *Id.* The Condell Medical Building was owned and managed by a fellow subsidiary of Condell's parent corporation, not by Condell. *Id.* Yet Dr. Burdick was not employed by or on staff at Condell, and the treatment at issue was provided at the Condell Medical Building, not inside the hospital. *Id.* at 1097. The Medical Building had two entrances: one for an acute care center mentioned in the advertisement, and one (used by Robers) for a separate building housing the professional offices, including the Medical Building, which was not mentioned in the advertisement. *Id.* at 1097. Condell Medical Center was located "miles away" from the Medical Building. *Id.*

The court concluded no reasonable juror could find that Condell had held out Dr. Burdick as its agent. *Id.* at 1098. A reasonable person would not assume that Dr. Burdick was an employee or agent of Condell on the mere basis that the building bore the name "Condell." Having so held, the court did not address the reliance or acquiescence elements of the *Gilbert* test.

Here, by contrast, the record evidences knowing acquiescence by NMH in Erie's holding-out conduct. As discussed, although Yarbrough did not receive prenatal care *at* NMH until her third ultrasound in February 2006, she reasonably believed she was being cared for *by* NMH at Erie. She was told she would receive prenatal ultrasounds at NMH and deliver at NMH, and she received literature about tours and instruction available at NMH. Since she was told prenatal ultrasounds would be provided by NMH, it would have been reasonable for her to conclude that her first prenatal ultrasound she received at Erie, on December 5, 2005, was being provided by NMH. Also unlike *Robers*, Drs. Reid and Suarez were on staff at the hospital, were involved in Yarbrough's prenatal care, and delivered Hayley Goodpaster at NMH.

In *Robers*, Condell did not directly or indirectly advertise its affiliation with Dr. Burdick or the Condell Medical Building, which was held out as a separate entity from the Acute Care Center (because each had a separate entrance). *Robers*, 344 Ill. App. 3d at 1098. Here, as discussed, NMH acted independently to promote its affiliation with Erie. NMH also acted through Erie in promoting the parties' affiliation: the Affiliation Agreement empowered Erie to engage in joint marketing efforts with NMH; and permitted the parties to publicize their affiliation with prior consent. NMH knew that Erie referred to its affiliation with NMH on its website, and Erie and NMH used the same language in referring to one another: "partner." These facts support the inference that NMH authorized Erie to hold itself out as NMH's agent, or acquiesced in Erie's holding-out conduct.

Moreover, *Robers* does not contain the limiting principle that NMH seeks. The *Robers* court's analysis did not concern the corporate ownership of the property where Robers received treatment. Rather, the defendants prevailed not because of a territorial limitation on the hospital's liability, but because the plaintiff did not satisfy the *Gilbert* test. *Gilbert* and its progeny, not the doctrinal innovation urged by NMH, should control here.

IV. The Question of Whether NMH and Erie are Independent and Unrelated Is an Issue of Fact to Be Resolved by a Jury.

For purposes of arguing for an affirmative answer to the certified question, Plaintiffs have assumed that NMH and Erie were independent and unrelated at the time this cause of action accrued. Yet the record gives ample reason to conclude this was (and is) not the case.

Merriam-Webster primarily defines "related" as "connected by reason of an established or discoverable relation,"[10] with "relation" meaning, in pertinent part, "an aspect

[10] *Merriam-Webster*, https://www.merriam-webster.com/dictionary/related (last visited May 1, 2017).

or quality (such as resemblance) that connects two or more things or parts as being or belonging or *working together* or as being of the same kind".[11] Black's Law Dictionary defines "related" even more broadly, as "*[c]onnected in some way*; having relationship to or with something else." Black's Law Dictionary (10th ed. 2014) (emphasis added).

Here, Erie and NMH have long held each other out as partners in providing prenatal and other types of health care to the community. They have a detailed Affiliation Agreement with one another that indicates, among other things, a mutual intent "to assume broad-based responsibility for the provision of health care services to the community" (S.R. 230) and an intent on the part of NMH to "increase our services to the community, building on our substantial commitments and partnerships" (*id.*) The Affiliation Agreement provides for a right of first refusal to "partner" in the development of Erie's West Town location, where Yarbrough was treated. (S.R. 233.) Erie trains NMH residents (S.R. 232), and NMH extends medical staff membership to all qualified Erie providers. (S.R. 231–32.) Erie's conduct led Yarbrough to believe that the two were "working together." (S.R. 71.) The record thus provides a reasonable basis to conclude that Erie and NMH were related and not independent, as they were certainly "connected in some way" and "working together."

V. Granting Hospitals Immunity from Liability in Apparent Agency for All Negligent Care Provided by a Putatively Unrelated, Independent Entity Is Unnecessary and Contravenes Sound Public Policy.

A. NMH and its *amici* benefit substantially from affiliating with charity clinics like Erie.

Plaintiffs do not doubt that NMH and its *amici* (University of Chicago Medical Center, Rush University Medical Center, Advocate Health Care, Northshore University

[11] *Merriam-Webster*, https://www.merriam-webster.com/dictionary/relation (last visited May 1, 2017) (emphasis added).

Health System, Presence Health, and Trinity Health (collectively, "Hospital *Amici*")) wish to provide charity care to the community for its own sake. (Hospital *Amici* Br. 7.) Yet it is misleading to argue that hospitals are motivated to partner with and support FQHCs solely by the desire to be "just good community members" (S.R. 153), given the substantial benefits they gain from such relationships.

According to an article Hospital *Amici* cite (Hospital *Amici* Br. 6), the benefits from affiliating with charity care providers include complying with IRS requirements for maintaining tax exempt status, "[a]lleviat[ing] pressure on emergency departments," reducing the number of uninsured patients, providing the medical staff with "an important professional accomplishment," and "[e]stablish[ing] community support and involvement." (See Hospital *Amici* Br. 6 (citing Lindsey Dunn, Caring for the Uninsured: How Free Clinics, Hospitals Can Partner to Treat a Community's Most Vulnerable, *Becker's Hospital Review* (June 11, 2013), *available at* https://tinyurl.com/hfjs7z7)) (R.A. 17).

An organization that is organized and operated exclusively for charitable purposes qualifies as a tax-exempt organization under federal law. See 26 U.S.C. § 501(c)(3). The meaning of "charitable" includes "[r]elief of the poor and distressed or of the underprivileged * * * lessening the burdens of Government * * * and promotion of social welfare." 26 C.F.R. § 1.501(c)(3)-1 (2017). In short, NMH's commitment to provide services without charge to Erie patients is commendable—and also fulfills a requirement for federal tax-exempt status.

NMH avoids paying substantial state and local taxes, in part, by supporting clinics like Erie and offering free or discounted care to Erie patients. Tangible personal property sold to or used by an Illinois hospital is exempt from state use tax (35 ILCS 105/3), service use tax (35 ILCS 100/3-8), service occupation tax (35 ILCS 115/3-8) and retailers

occupation tax (35 ILCS 120/2-9) if the hospital engages in one or more qualifying charitable activities of a value at least equal to the tax that would otherwise be collected. Eligible activities include free or discounted health care services, financial or in-kind contributions to community clinics, "prenatal or childbirth outreach to low-income or underserved persons," and expenditures related to relieving the government of the burden of providing health care to low-income individuals. See, *e.g.*, 35 ILCS 105/3-8(c) (West 2017). Similar criteria allow exemption from local property taxes. 35 ILCS 200/15-86 (West 2017); see also Ill. Const. art. IX, § 6.

These tax benefits are valuable. A 2009 study estimated the value of state and federal tax exemptions received by 27 non-profit Chicago-area hospitals as $489.5 million annually, while the cost of the charity care provided by those hospitals was $175.7 million annually. Center for Tax and Budget Accountability, *An Update: An Analysis of the Tax Exemptions Granted to Non-Profit Hospitals in Chicago and the Metro Area and the Charity Care Provided in Return* 3 (2009), *available at* https://tinyurl.com/y99ngh5g. (R.A. 21.) The study included comparisons of estimated tax benefits to value of charity care provided for Appellant NMH ($48.1 million in tax benefits vs. $20.8 million in charity care) and *amici* (or their affiliates) Advocate Health Care Network ($99.6 million vs. $29.1 million), University of Chicago Hospitals ($58.6 million vs. $10 million), and Rush University Medical Center/Rush-Oak Park ($37.7 million vs. $5.2 million). *Id.* at 6. (R.A. 24.)[12] Classification as a tax-exempt entity also qualifies NMH and *amici* to receive tax-deductible charitable contributions and tax-exempt bond financing. See *generally* Internal Revenue Service, *Publication 4077: Tax-Exempt*

[12] A statutory enactment that took effect in 2012 required hospitals to provide charitable contributions or services in an amount equivalent to their estimated state property tax liability. See 735 ILCS 200/15-86 (2017). The constitutionality of this statute is currently the subject of litigation. See *Carle Foundation v. Cunningham Township*, 2017 IL 120427.

Bonds for Charitable Organizations (Jan. 2016); Internal Revenue Service, *Publication 1771: Charitable Contributions: Substantiation and Disclosure Requirements* (March 2016).

NMH's argument that it "does not benefit from the patients it attracts" through support of Erie and does not charge Erie patients (Appellant's Br. 35) is disingenuous, because third-party payers reimburse NMH for care given to Erie patients (S.R. 399). As Yarbrough testified, Medicaid paid for her labor and delivery care, and for the care of her infant daughter, at NMH. (*Id.*) Her testimony reflects the hospital charged $66,000 for Hayley's care. (*Id.*) This figure may be higher than average because of Hayley's critical condition at birth. Yet even when deliveries are uncomplicated and result in less reimbursement, parents may go on to seek additional care from the hospital for themselves or their children based on their experience of the care provided during delivery, resulting in additional revenue. Such care also results in additional publicity, recognition, goodwill, and brand advancement for NMH, which it has recognized as important objectives. (See p. 13, *supra.*)

Moreover, in 2006, Erie patients accounted for 11.2% (1,111) of births at NMH.[13] 100% of patients who sought prenatal care at Erie that year delivered at NMH. (S.R. 333.) And in the fiscal year ending August 2016, Medicaid payments constituted 9% of NMHC's

[13] See S.R. 256, 333; R.A. 9. The figure of 1,111 deliveries is arrived at by multiplying the number of deliveries in fiscal year 2006 (9,924) by 0.112, the percentage given of NMH patients who delivered at NMH and received prenatal care at Erie.

patient accounts receivable.[14] By one measure, NMHC realized net income from Medicaid patients of $24,724,000.[15] Clearly, NMH is compensated for care given to Erie patients.

For similar reasons, the argument advanced by *amicus* Illinois Association of Defense Trial Counsel (IADTC)—that liability under *Gilbert* should not attach where a hospital "helps a non-profit clinic and its patients, without any retained profit motive" (IADTC Br. 5)—rings false. It cannot properly be said that "NMH does not profit from Erie's patients * * * * " (*Id.* at 6.) A principal's tort liability in apparent agency "does not depend on whether the principal benefits from the agent's tortious conduct." Restatement (Third) of Agency § 7.08 cmt. b (2006). IADTC fails to mention the aforementioned tax benefits, significant third-party reimbursement, and valuable publicity NMH and other hospitals gain from supporting clinics like Erie. IADTC's analogy to the Good Samaritan Act, 745 ILCS 49/25, which explicitly requires that care be rendered without charge for its protections to attach, is inapposite, yet reflects Appellant's and *amici's* underlying goal: to create immunity from apparent agency claims. No Illinois court has limited *Gilbert* to circumstances under which a heath care entity retains a profit motive.

IADTC's naked assertion that "a lack of professional guidance and control is inherent in any circumstance where two parties have not entered into a profit-driven contract" (IADTC Br. 5), is belied by the myriad mechanisms of control that the Affiliation Agreement establishes, including board service by NMH executives on the Erie board of

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[14] See Ernst & Young LLP, *Consolidated Financial Statements, Northwestern Memorial HealthCare and Subsidiaries,* https://tinyurl.com/korykf4, at 54 (last visited May 26, 2017) (R.A. 28). This percentage is calculated with reference to patient accounts receivable before deducting estimated uncollectibles. *Id.*

[15] See *id.* at 55 (R.A. 29). The figure of $24.7 million is derived by subtracting $84,484,000 of assessment expense for the Illinois Hospital Assessment Program from $109,208,000 of net patient service revenue for Medicaid patients.

directors, Erie staff training by NMH, and NMH vetting of Erie physicians applying for NMH medical staff membership. (S.R. 231–32.)

IADTC also errs in arguing that "there is no indication that Erie is an NMH facility" and that "the physician who allegedly provided negligent treatment was not even an independent contractor of NMH." (IADTC Br. 6.) As discussed, NMH and Erie publicized their partnership on a variety of health ventures, including prenatal care at Erie, without clarifying their relationship publicly. Personnel at Erie led Yarbrough to reasonably believe she would be treating at NMH, and Dr. Suarez and Dr. Reid were on staff at NMH.

Of course, for-profit entities working together to provide patients with care can also be "independent" and "unrelated." NMH and its *amici* provide no policy justification for limiting the liability of a hospital defendant that is not a charity care provider.

B. Indiana's experience with imposing apparent agency liability on a hospital for the negligence of an independent clinic further discredits NMH's quest for immunity.

NMH and Hospital *Amici* imply that a decision in favor of Plaintiffs will cause hospitals to stop providing and supporting charity care, and, in effect, make the Court complicit in the death of poor, ill patients. "It is no exaggeration to say that the Amici's interest in this case . . . can be fairly and accurately described as one of life and death," these *amici* contend. (Hospital *Amici* Br. 2.) NMH lodges a similar allegation. (Appellant's Br. 34–35.)

This claim is unsubstantiated and lacks merit. No such effects resulted from a recent decision of the Indiana Court of Appeals, which held that a hospital may be liable in apparent agency for negligent prenatal care provided at a separate FQHC by the FQHC's employees. *Helms v. Rudicel,* 986 N.E.2d 302 (Ind. Ct. App. 2013). Danielle Helms sued Ball Memorial Hospital (BMH) and several of its independent contractor providers for negligent

prenatal care the providers rendered at Open Door Clinic, an FQHC, and at BMH itself, which led to her child's death. *Helms*, 986 N.E.2d at 305–06. The trial court held that BMH could not be liable for any act of the independent contractor providers at the clinic, since " '[the clinic] and [BMH] are separate entities.' " *Id.* at 307 (alteration in original). But BMH could be held liable for negligent conduct of those providers that took place at BMH itself, the trial court held. *Id.*

BMH argued on appeal that it could not be liable in apparent agency as a matter of law for acts occurring outside of the hospital; that manifestations of a purported agent could not establish an agency relationship; and that holding hospitals liable for the acts of independent contractors was "unfair" and a "harsh burden" under the circumstances. Appellee's-Cross-Appellant's Brief, *Helms v. Rudicel*, No. 18-A-04-1202-CT-00070, 2012 WL 5374072, at *30–35, 39 (Ind. Ct. App. Sept. 25, 2012).

BMH's arguments failed to persuade the Indiana Court of Appeals. It held that there was a genuine issue of material fact as to whether BMH could be liable in apparent agency for prenatal care provided to Helms at the clinic, and for care provided at the hospital itself. (Indiana's test for apparent agency liability in the medical malpractice context is highly similar to the *Gilbert* framework. See *Helms*, 986 N.E.2d at 309–11.) The Indiana Supreme Court denied review with all justices concurring. *Helms v. Rudicel*, 993 N.E.2d 1149 (Ind. 2013).

Helms was announced in 2013. In 2012, Indiana FQHCs served 285,940 people. See Indiana Primary Health Care Association, *Facts and Figures*, http://www.indianapca.org/?page=19 (last visited May 26, 2017). (R.A. 30.) In 2016, they served 473,222, an increase of over 65%. *Id.* In fact, the number of patients served increased every year from 2012–2016. *Id.*

Helms also did not impact Indiana FQHCs' private funding or total revenue. In 2010, Indiana had 19 FQHCs, which reported $6,911,631 in "donations/other" and $4,778,464 in private foundation donations, out of total funding of $185,601,457. *See* Indiana Primary Health Care Association, *Facts and Figures*, https://tinyurl.com/mkema6h (archived Nov. 9, 2014) (R.A. 34). In 2016, 25 FQHCs responded to the same state survey, reporting $9,315,893 in "foundation/private grants and contracts," $28,146,004 in "other revenue," and total funding of $505,576,714. (R.A. 30–31.)[16] If the Court declines to invent the immunity NMH and Hospital *Amici* seek, there is no reason to believe Illinois will experience negative impacts that Indiana has not.

CONCLUSION

Departing from the principles this Court articulated in *Gilbert* and reaffirmed in *Petrovich* and *York* would be unwise legally and as a matter of public policy. The Court should neither credit NMH's and its *amici's* scare tactics, nor permit them to foster the impression that they are closely linked with clinics like Erie without assuming the legal burdens of this association. All NMH and its *amici* must do to avoid liability under *Gilbert* is to communicate accurately with their patients and the public about their relationships with Erie and other putatively independent, unrelated clinics. Plaintiffs respectfully request that the Court affirm the judgment of the Appellate Court, First District and answer the certified question in the affirmative.

Respectfully submitted,

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[16] The figure of $505,576,714 is obtained by adding the reported values for total patient revenue and total grant funds.

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CERTIFICATE OF COMPLIANCE WITH RULE 341

I, Patrick A. Thronson, certify that this Response Brief conforms to the requirements of Illinois Supreme Court Rule 341(a) and (b). The length of this Response Brief is 47 pages.

Dated: May 31, 2017

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APPENDIX

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Northwestern Medicine Prentice Women's Hospital

Hospitals

250 E. Superior St.
Chicago, IL 60611

Main Phone
312.926.2000

TTY
312.926.6363

584.3 mi

DIRECTIONS

REQUEST AN APPOINTMENT

feedback

Overview

From gynecologic and pregnancy care to menopause and bone health, we're here for the health and happiness of women in all the stages of their lives. As part of Northwestern Memorial Hospital, Prentice Women's Hospital exists to provide the highest quality of comprehensive medical care to meet the unique needs of women.

Parking and Valet

Parking is available at discounted rates for patients and visitors of Prentice Women's Hospital.

Parking rates[1]

- $11 for less than 7 hours
- $24 for 7–24 hours

Parking validation

Northwestern Memorial Hospital
Community Health Needs Assessment Hospital Report
Fiscal Year 2016

Northwestern Memorial Hospital gratefully acknowledges the participation of a dedicated group of individuals representing the following organizations who gave generously of their time and expertise to help conduct and develop our fiscal year 2016 Community Health Needs Assessment:

Alliance for Research in Chicagoland Communities
Chicago Department of Public Health
Consortium to Lower Obesity in Chicago Children
CommunityHealth
Erie Family Health Center
Health and Disability Advocates
Kelly Hall YMCA
Logan Square Neighborhood Association
Near North Health Services Corporation
Northwestern University Feinberg School of Medicine
West Humboldt Park Development Council

Introduction

Northwestern Memorial Hospital (NMH) is a not-for-profit corporation that is part of an academic medical center (AMC) in downtown Chicago, Illinois, providing a complete range of adult inpatient and outpatient services in an educational and research environment. For more than 150 years, NMH and its predecessor institutions, Passavant Memorial and Wesley Memorial hospitals, have served residents of Chicago. The commitment to provide healthcare, regardless of the ability to pay, reaches back to the founding principles of Passavant and Wesley and continues to be integral to our *Patients First* mission.

NMH believes that its mission to improve the health of the communities it serves is best accomplished in collaboration with partners both in the community and within the organizations that comprise Northwestern Medicine including Northwestern Memorial HealthCare (NMHC) and Northwestern University Feinberg School of Medicine (Feinberg). NMH's affiliations with community-based healthcare partners enable the organizations to meaningfully improve access to high quality healthcare and implement targeted programs that address the highest priority health needs of the community.

NMH serves as the primary teaching hospital for Northwestern University Feinberg School of Medicine (Feinberg), with more than 2,000 physicians on the medical staff and carrying faculty appointments at Feinberg. Northwestern Medical Group (NMG) has more than 1,100 physicians representing virtually every medical specialty and serving as fulltime faculty of Feinberg. NMH is among only seven percent of the nation's hospitals designated as an AMC hospital, which according to the Association of American Medical

Colleges (AAMC), in aggregate deliver a vastly disproportionate share of the nation's trauma, intensive care and tertiary services; provide a significantly higher proportion of Medicaid care than non-teaching hospitals; and underwrite 41 percent of all hospital-based charity care. Through Northwestern Medicine, NMH shares a vision with Feinberg and its fulltime faculty physicians to work collaboratively as leading AMC to positively impact the future of healthcare through exceptional patient care, excellence in medical education and breakthrough scientific research that can lead to improved treatments and cures.

NMH is an adult acute care hospital located in Chicago's growing downtown area and saw more than 44,000 adults admitted as inpatients in fiscal year 2015. As an adult Level I trauma center in downtown Chicago with 24/7 service, NMH had more than 86,000 Emergency Department (ED) visits in fiscal year 2015. NMH is also the only AMC hospital in Chicago participating in both city and state Level I trauma networks and as a Level III neonatal intensive care unit, allowing us to provide lifesaving care and treatment to the most seriously injured adults and premature and sick infants. NMH has the largest birthing center in Illinois, with more than 12,000 deliveries in fiscal year 2015.

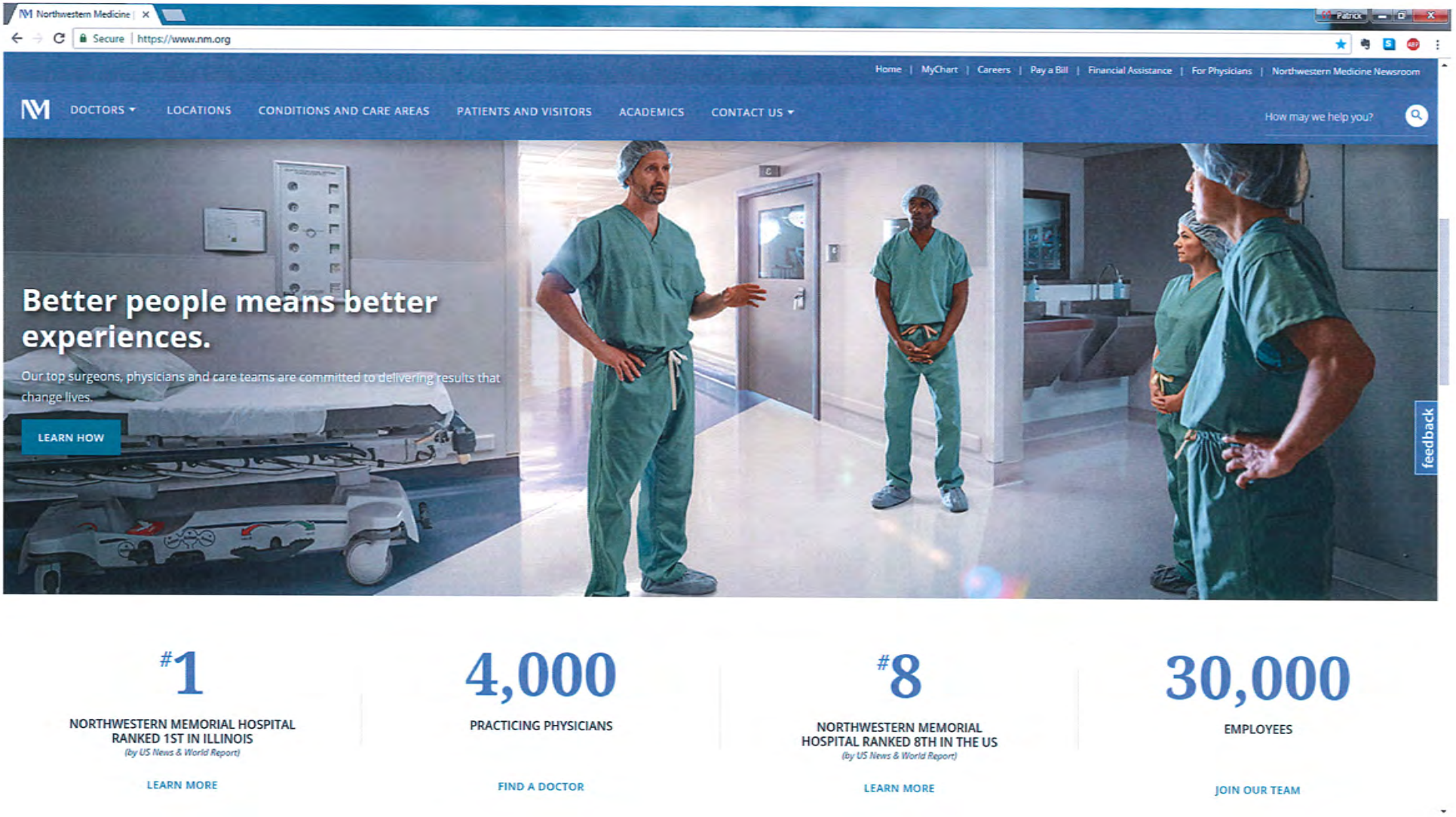
NMH also serves an important role for patients outside of Chicago. As a nationally ranked AMC hospital and a major referral center in the Midwest and beyond, NMH is one of a limited number of places in the region where patients requiring advanced tertiary, quaternary or specialty services can access the care and services they need.

NMH sponsors numerous programs to promote health and wellness, healthcare career training, youth mentoring, language assistance and a multitude of volunteer programs to enhance the quality and accessibility of healthcare services. Our services are carefully designed and structured to meet the needs of our growing and changing community.

NMH Service Area

For the purposes of this Community Health Needs Assessment (CHNA), NMH's community was defined as the City of Chicago (NMH Service Area) which is within Cook County. In total, the City of Chicago accounts for 66 percent of NMH inpatient admissions. The 59 Zip Codes that comprise Chicago are as follows:
Source: EPSi FY15 Q3 YTD (through May 31, 2015)

City of Chicago Residential Zip Codes						
60601	60614	60623	60633	60642	60652	60661
60605	60615	60624	60634	60643	60653	60666
60607	60616	60625	60636	60644	60654	60706
60608	60617	60626	60637	60645	60655	60707
60609	60618	60628	60638	60646	60656	60803
60610	60619	60629	60639	60647	60657	60804
60611	60620	60630	60640	60649	60659	60805
60612	60621	60631	60641	60651	60660	60827
60613	60622	60632				



R.A. 4

November 05, 2013

Northwestern Memorial pays big bucks for faculty foundation docs

By ANDREW L. WANG

The health care system anchored by Northwestern Memorial Hospital is paying nearly a quarter of a billion dollars as part of the deal to acquire the powerful doctors group of Northwestern University, which is likely one of the highest prices ever paid for a physician practice.

Northwestern Memorial HealthCare is paying the tidy sum of $230.5 million upfront, plus annual payments totaling at least $118.5 million through 2016, to acquire Northwestern Medical Faculty Foundation, a 900-doctor practice loaded with specialists, according to a filing submitted last week to investors who own bonds issued by the Streeterville-based hospital network.

The lofty dollar amount reflects the rare size and unusual scope of NMFF, the second-largest doctors' group in the Chicago area before the deal.

"You normally don't see nine-figure transactions involving physician practices," said Adam Lynch, vice president at Chicago-based Principle Valuation, a health care appraisal firm. "If you think about the spectrum of practices out there, you're not going to find many as big as NMFF, so you're not going to see a price close to what they're negotiating."

Northwestern Memorial CEO Dean Harrison and Dr. Eric Neilson, CEO of NMFF and dean of Northwestern University's Feinberg School of Medicine, jointly announced in March the intention to **merge the faculty foundation and the hospital's physicians group,** with only about 122 doctors, into a single entity that would be a subsidiary of the health system. Financial details about the transaction, which was completed on Sept. 1, previously had not been disclosed.

About $193.5 million of the acquisition price covers the net value of the faculty foundation's $631.7 million in unrestricted assets, after subtracting liabilities as of Sept. 1, according to the bond filing. Northwestern Memorial is accounting for the balance of the purchase price, about $37 million, as goodwill. Goodwill reflects the value of intangible assets, such as a brand name and relationships with patients.

the health system paid the university $210.3 million toward the $230.5 million purchase price.

Replace Obamacare, yes. Gut Medicaid, no comment.

Illinois to receive $1 million of Johnson & Johnson settlement

culty foundation booked $57.8 million in operating income on $560.9 million in revenue in 2011, the most year in which financial results were available.

Faculty foundation doctors, who provide most of the care at the health system's two hospitals, 894-bed Northwestern Memorial Hospital in Streeterville and 201-bed Northwestern Lake Forest, voted in favor of the proposal in June.

Health insurers stiffed by budgetless Illinois take plea to federal court

erger continued a series of moves to more closely align the clinical operations of Northwestern Memorial rthwestern University. In a deal inked on Sept. 1, 2012, the hospital network agreed to pay the institution a **one-time grant of $167 million** as well as annual payments to support research and develop new clinical programs. Those annual payments have been replaced by the terms of the acquisition agreement.

Northwestern Medical Faculty Foundation Northwestern University More +

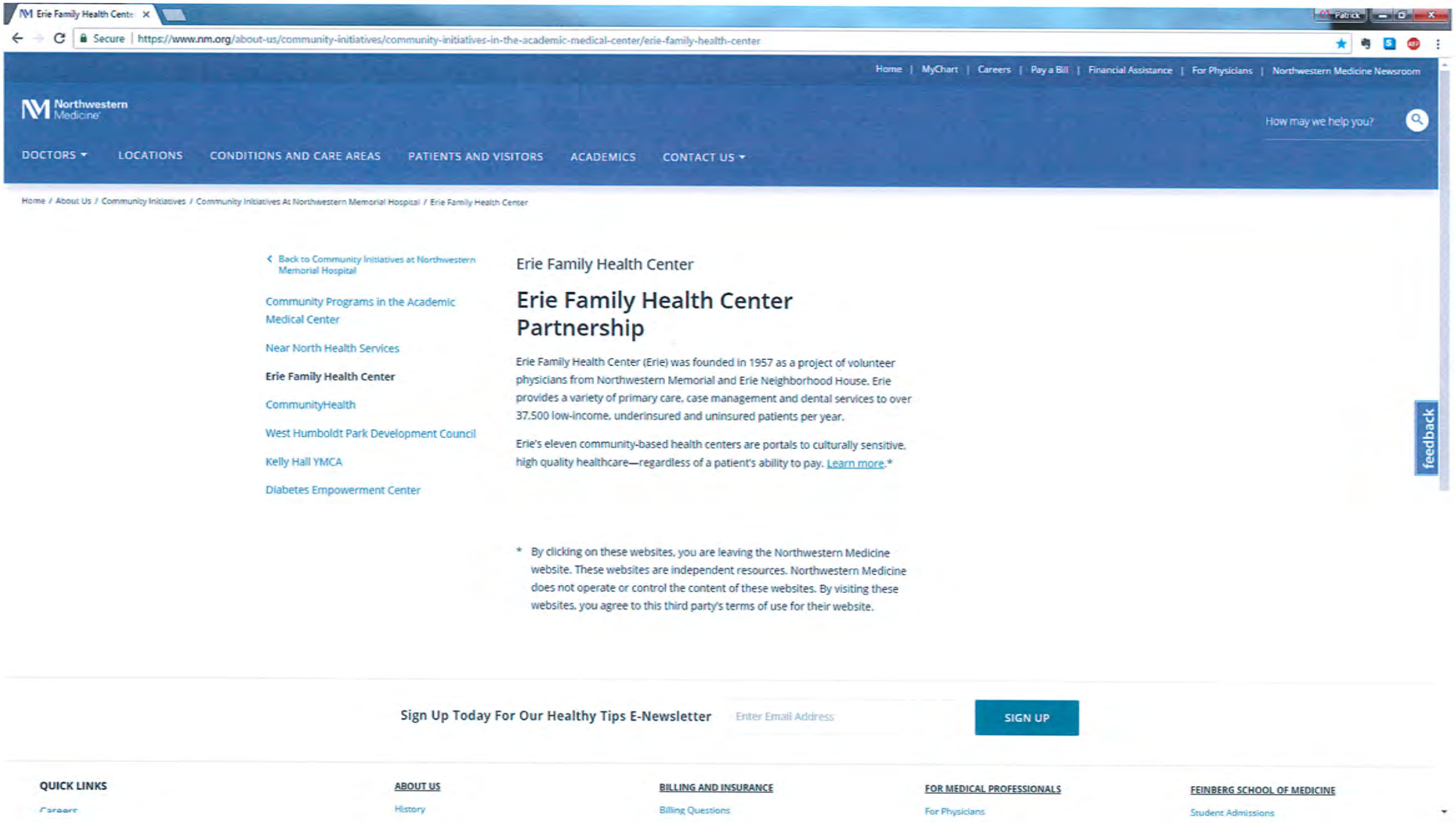
Replace Obamacare, yes. Gut Medicaid, no comment.

R.A. 6

Illinois to receive $1 million of Johnson & Johnson settlement

Replace Obamacare, yes. Gut Medicaid, no comment.

R.A. 7



R.A. 8

600

Patients in fiscal year 2006 who received free primary and specialty care services through 2,790 visits to Northwestern Memorial's partner, the James and Catherine Denny Primary Care and Preventive Medicine Center at the Lawson House YMCA.

50 years

Time since Northwestern Memorial established its first partnership with a Federally Qualified Health Center in Chicago.

11.2%

The percentage of women who received prenatal care at Erie Family Health Center and delivered their babies at Prentice Women's Hospital in fiscal year 2006.

$12 million

The total amount granted by Northwestern Memorial Foundation since 1994 to Northwestern Memorial's Community Service Expansion Project to support healthcare delivery at Near North Health Service Corporation and Erie Family Health Center, both Federally Qualified Health Centers. The grant also covers some costs of specialty care by physicians affiliated with the centers and Northwestern Medical Faculty Foundation, a multispecialty group of physicians who treat Northwestern Memorial patients.

Community

Northwestern Memorial has built longstanding partnerships with neighborhood-based health centers. We believe that our responsibility to improve the health of our community extends beyond the hospital to ensure that high-quality primary and specialty care is available to those who live in medically underserved areas. Our collaborative work with Federally Qualified Health Centers and other local medical centers has created opportunities to respond to health issues and needs that have been identified by the community.

One example of this partnership is a new effort to improve breast cancer awareness among Hispanic women by providing information and resources so they can better understand health risks and make informed choices about preventive care.

Northwestern Memorial, in collaboration with Erie Family Health Center, has provided the information technology infrastructure, educational tools and access to facilities with mammography equipment to help create a community-based breast health initiative for the primarily Hispanic population served by the center at its West Town location. The project, which is generously funded by the Avon Foundation, addresses the need for culturally sensitive health education that responds to an important community health concern. It is estimated that nearly 3,400 of Erie's female patients older than 40 should receive annual mammograms, yet fewer than 1,200 are believed to undergo screenings each year. Through this program, an educational strategy focuses on increasing awareness by helping women understand the importance of mammograms as a routine and often lifesaving measure and monitors the delivery of healthcare. The project soon will be expanded to other Erie sites.

TOP: Obstetrical patients, such as Alejandra Ortiz, benefit from quality prenatal care that is available in the community through a partnership between Northwestern Memorial and Erie Family Health Center.

BOTTOM: Martha Prado Gonzalez, a health promoter at Erie's West Town location, educates women about breast cancer and screening methods.

Erie Family Health Center, Inc.

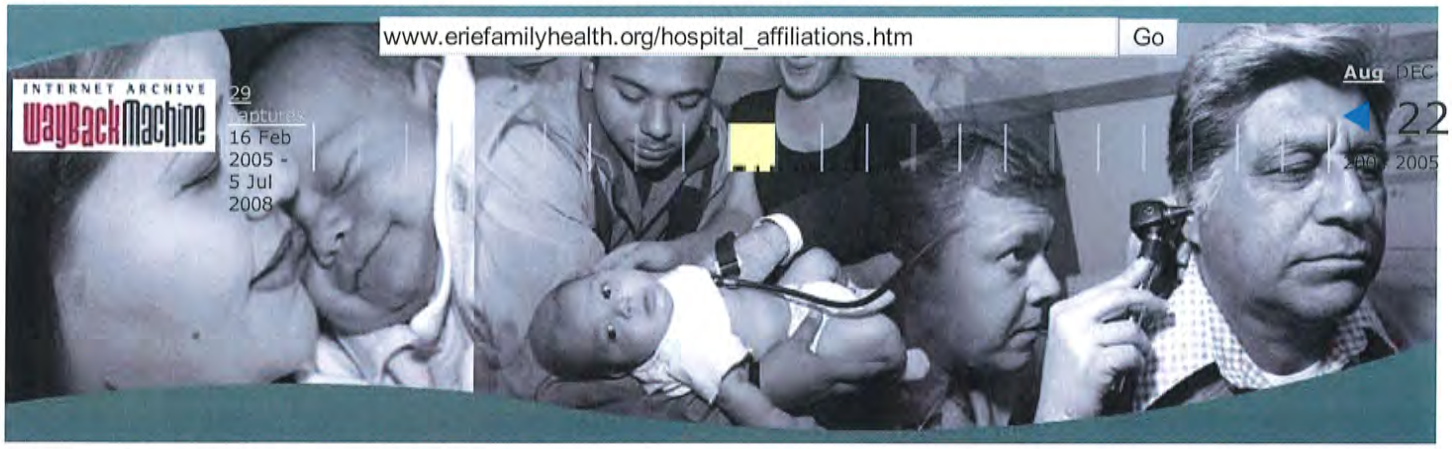
Hospital Affiliations

Erie Family Health Center has strong relationships with the following hospitals to ensure that Erie patients receive appropriate care:

Northwestern Memorial Hospital
Childrens Memorial Hospital
J.H. Stroger Jr. Hospital of Cook County
Advocate Illinois Masonic Medical Center
Resurrection-Saints Mary and Elizabeth Hospital.

Clients who need to receive services that are not offered at Erie are eligible to receive care at these hospitals.

Quality Care: Your Right, Our Mission



Erie Family Health Center, Inc.

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Resurrection-Saints Mary and Elizabeth Hospital.

Clients who need to receive services that are not offered at Erie are eligible to receive care at these hospitals.

Quality Care: Your Right, Our Mission

50.11 A Corporation Acts Through Its Employees

The [(plaintiff) (defendant) is a corporation] [the parties are corporations] and can act only through [its] [their] officers and employees. Any act or omission of an officer or employee within the scope of his employment is the action or omission of the [plaintiff] [defendant] corporation.

Notes on Use

If the agent is the officer of the defendant corporation, this instruction may be given in lieu of IPI 50.02. *Schmidt v. Blackwell*, 15 Ill.App.3d 190, 196; 304 N.E.2d 113, 118 (3d Dist.1973).

When the requirements for holding a corporate master liable for punitive damages have not been fulfilled, this instruction may not be given in this form when its effect would be to permit vicarious liability for punitive damages, since it would impute liability for *any* act done by an employee, rather than only those specifically ordered, participated in or ratified by a superior officer. *Pendowski v. Patent Scaffolding Co.*, 89 Ill.App.3d 484, 488-489; 411 N.E.2d 910, 913-924; 44 Ill.Dec. 544, 547-548 (1st Dist.1980).

105.10 Claims Based On Apparent Agency--Both Principal And Agent Sued--Principal Sued Under Respondeat Superior Only--Medical Malpractice Actions--Reliance On Principal Alleged

Under certain circumstances, the liability of a party may arise from an act or omission of that party's apparent agent.

In the present case, [plaintiff's name] has sued [principal's name] as the principal and [apparent agent's name] as [his] [her] [its] apparent agent. [principal's name] denies that any apparent agency relationship existed.

In order for an apparent agency relationship to have existed, [plaintiff's name] must prove the following:

First, that [principal's name] held [himself] [herself] [itself] out as a provider of [type of care, *e.g.*, complete emergency room care] and that [plaintiff's/decedent's name] neither knew nor should have known that [apparent agent's name] was not an employee of [principal's name].

Second, that [plaintiff's/decedent's name] [or others] did not choose [apparent agent's name] but relied upon [principal's name] to provide [type of care, *e.g.*, complete emergency room care].

If you find that [apparent agent's name] was the apparent agent of [principal's name] at the time of the occurrence, and if you find that [apparent agent's name] is liable, then both [defendant] and [defendant] are liable.

If you find that [apparent agent's name] is not liable, then neither [defendant] nor [defendant] is liable for the acts of [apparent agent's name].

If you find that [apparent agent's name] is liable, but that [he] [she] [it] was not the apparent agent of [principal's name] at the time of the occurrence, then [principal's name] is not liable for the acts of [apparent agent's name].

Notes on Use

This instruction should be used where the issue of apparent agency is in dispute, the principal and agent are sued in the same case, and plaintiff alleges reliance on a "holding out" by the principal. If plaintiff alleges reliance on a "holding out" by an agent and "acquiescence" by the principal, please refer to Gilbert v. Sycamore, 156 Ill.2d 511, 622 N.E.2d 788, 190 Ill.Dec. 758 (1993), for a discussion for the necessary elements. If there is a basis for liability against the principal independent of apparent agency, this instruction should be modified accordingly or replaced by other instructions.

This instruction is intended to apply where apparent agency is alleged relative to a hospital or other such institutional provider. The instruction should not be used without modification where apparent agency is alleged relative to a health maintenance organization or health insurance provider. *See* Petrovich v. Share Health Plan of Illinois, 188 Ill.2d 17, 719 N.E.2d 756, 241 Ill.Dec. 627 (1999). Moreover, the instruction should not be used without modification where apparent agency is alleged in contexts other than medical negligence. *See* O'Banner v. McDonald's Corp., 173 Ill.2d 208, 670 N.E.2d 632, 218 Ill.Dec. 910 (1992).

The bracketed phrase "or others" in the instruction should be used where there is evidence that a person or persons other than the plaintiff or the decedent relied upon the principal

to provide the medical care under consideration. Please refer to the Comment below for a discussion of this issue.

If the issue of apparent agency is in dispute and the principal is sued alone, IPI 105.11 should be used.

Comment

This instruction reflects the opinion of the Illinois Supreme Court in Gilbert v. Sycamore, 156 Ill.2d 511, 622 N.E.2d 788, 190 Ill.Dec. 758 (1993). Gilbert set forth and explained the elements necessary to establish apparent agency, namely, a "holding out" and "justifiable reliance." In Gilbert, the court further held that apparent agency cannot be established in situations where a patient knew or should have known that the physician providing treatment was not an agent or employee of the hospital. *Id.* at 524. In reaching its decision, the Gilbert court referred to "two realities of modern hospital care": first, that health care providers increasingly hold themselves out to the public as providers of health care through their marketing efforts; and, secondly, that patients have come to rely upon the reputations of hospitals in seeking health care. *Id.*

The element of "holding out" is satisfied where it is proven that the principal acted in a manner which would lead a reasonable person to conclude that the physician alleged to be negligent was an agent or employee of the principal. *Id.*

The element of "justifiable reliance" is satisfied where there is reliance upon the hospital to provide care, rather than upon a specific physician. *Id.* A pre-existing physician--patient relationship will not preclude a claim by the patient of reliance upon the hospital. Malanowski v. Jabamoni, 293 Ill.App.3d 720, 727; 688 N.E.2d 732, 738; 228 Ill.Dec. 34 (1st Dist.1997).

Although Gilbert involved an emergency room setting, the Gilbert analysis is not limited to such situations. *See, e.g.*, Malanowski v. Jabamoni, 293 Ill.App.3d 720, 688 N.E.2d 732, 228 Ill.Dec. 34 (1st Dist.1997) (applying Gilbert to an outpatient clinic situation).

In the absence of proof of actual reliance by plaintiff, several appellate decisions hold that the element of justifiable reliance may be satisfied where there is reliance by those acting on behalf of the plaintiff. *See, e.g.*, Monti v. Silver Cross Hospital, 262 Ill.App.3d 503, 507-508; 637 N.E.2d 427, 201 Ill.Dec. 838 (3d Dist.1994) (emergency personnel brought patient to hospital); Golden v. Kishwaukee Community Health Services, 269 Ill.App.3d 37, 46; 206 Ill.Dec. 314, 645 N.E.2d 319 (1st Dist.1994) (plaintiff brought to hospital at direction of plaintiff's friends); Kane v. Doctors Hospital, 302 Ill.App.3d 755, 706 N.E.2d 71, 235 Ill.Dec. 811 (4th Dist.1999) (plaintiff's personal physician arranged for treatment at hospital); Scardina v. Alexian Brothers Medical Center, 308 Ill.App.3d 359, 719 N.E.2d 1150, 241 Ill.Dec. 747 (1st Dist.1999) (plaintiff's physician referred him to a hospital where he was seen by a radiologist). But see, Butkiewicz v. Loyola University Medical Center, slip op. No. 1-98-2899 (1st Dist. Feb. 7, 2000) (disagreeing with Kane, distinguishing Monti, and finding that plaintiff's reliance on his "trusted" physician did not constitute "justifiable reliance" as to the defendant hospital).

105.11 Claims Based On Apparent Agency--Principal Sued, But Not Agent--Principal Sued Under Respondeat Superior Only--Medical Malpractice Actions--Reliance On Principal Alleged

Under certain circumstances, the liability of a party may arise from an act or omission of that party's apparent agent.

In the present case, [plaintiff's name] has sued [principal's name] as the principal. [plaintiff's name] claims that [apparent agent's name] was the apparent agent of [principal's name]. [principals' name] denies that any apparent agency relationship existed.

In order for an apparent agency relationship to have existed, [plaintiff's name] must prove the following:

First, that [principal's name] held [himself] [herself] [itself] out as a provider of [type of care, *e.g.*, complete emergency room care] and that [plaintiff's/decedent's name] neither knew nor should have known that [apparent agent's name] was not an employee of [principal's name].

Second, that [plaintiff's/decedent's name] [or others] did not choose [apparent agent's name] but relied upon [principal's name] to provide [type of care, *e.g.*, complete emergency room care].

If you find that [apparent agent's name] was the apparent agent of [principal's name] at the time of the occurrence, then any act or omission of [apparent agent's name] was the act or omission of [principal's name], and [principal's name] is liable for the acts or omissions of [apparent agent's name].

If you find that [apparent agent's name] was the apparent agent of [principal's name] at the time of the occurrence, then any act or omission of [apparent agent's name] was the act or omission of [principal's name], and [principal's name] is not liable for the acts or omissions of [apparent agent's name].

Notes on Use

This instruction should be used where the issue of apparent agency is in dispute, the principal alone is sued, and plaintiff alleges reliance upon a "holding out" on the part of the principal. If plaintiff alleges reliance upon a "holding out" by the agent and "acquiescence" by the principal, please see Gilbert v. Sycamore, 156 Ill.2d 511, 622 N.E.2d 788, 190 Ill.Dec. 758 (1993), for a discussion of the necessary elements. If there is a basis for liability against the principal independent of apparent agency, this instruction should be modified accordingly or replaced by other instructions. IPI 105.10 should be used where the issue of apparent agency is in dispute and where the principal and agent are sued in the same case.

Comments

Please refer to the comment to IPI 105.10.

Caring for the Uninsured: How Free Clinics, Hospitals Can Partner to Treat a Community's Most Vulnerable

Written by Lindsey Dunn | June 11, 2013 | Print | Email

Beginning next year, Americans will be required to obtain health insurance coverage or pay a fine. After this "individual mandate" — part of the comprehensive healthcare reform law passed in 2010 — goes into effect, roughly 30 million previously uninsured Americans will have health coverage. This is a relief for hospitals and other healthcare providers that traditionally have written off the cost of caring for these patients. However, providers aren't completely off the hook: An estimated 23 million Americans in 2107 will be uninsured, according to the federal government. As a result, health systems must consider how they will continue to treat this population while maintaining their bottom lines.

Many hospitals and health systems provide charity care for uninsured individuals when they require acute care, but the most forward thinking ones are also concerned with caring for this population *before* they present to the emergency department. To provide this type of care, hospitals often work with community providers outside the four walls of the hospital, including safety-net clinics or other community organizations.

Safety-net clinics, which provide free services provided by volunteer healthcare professionals to uninsured patients, offer a number of benefits to health systems, says Hugh Greeley, board chair for Volunteers in Medicine, a non-profit organization that has assisted in the development of more than 100 free clinics since it was established in 1994. The organization was founded by Jack McConnell, MD, a physician who established the first VIM free clinic in Hilton Head, S.C. As success of his clinic — which was supported by community funding and donations and staffed by volunteer clinicians —spread, health systems and other organizations that wanted to create similar clinics in their communities came to Dr. McConnell for assistance. Eventually, he created VIM and brought on Executive Director Amy Hamlin, an experienced public health professional, to help respond to these requests.

Accordingly to Ms. Hamlin, the success of a safety-net clinic lies in its ties to the community. "These clinics are really embedded, owned and sustained by the community," she says. "The community needs safety-net clinics for those people who fall through the tracks, and based on where we are historically, I think they're going to be needed for quite sometime."

10 benefits

In addition to providing ambulatory care to at-risk populations, safety-net clinics provide several less obvious benefits to a health system.

1. Improved patient care. Safety-net clinics ensure patients who may not have otherwise had access to high-quality primary receive the care they need to stay healthy or manage their conditions. Hospitals that support these clinics, either through funding or volunteer relationships, help ensure quality care for all patients. "It is simply the right thing to do, and recommits a hospital to its founding purpose," says Mr. Greeley.

2. Alleviates pressure on emergency departments. Safety-net clinics also reduce uninsured patient visits to an ED for both emergent and non-emergent conditions. Better primary care reduces the chance that a patient will need to visit the ED, and for an uninsured patient that does present for a non-emergent condition, the patient could be referred to the clinic for treatment instead.

3. Helps reduce avoidable readmissions. Often, uninsured patients have difficulty finding a physician to treat them outside of the hospital. A free clinic can provide follow-up care to patients after discharge, thereby reducing the likelihood of a readmission.

4. Possible reduction in the number of uninsured in a community. "The services provided at a free clinic link eligible patients with public insurance programs, thus reducing the number of uninsured patients in a community," says Mr. Greeley.

5. Volunteer outlet for physicians. "One of the unintended benefits of clinics is they provide a great opportunity for physicians to provide care and volunteer outside of their own office," says Mr. Greeley.

6. IRS community benefit. Safety-net clinics also assist a hospital in demonstrating the "community benefit" required to keep its tax exempt statues. "Most hospitals assist by providing start-up support and some sort of continued funding, which helps demonstrate to the IRS their community benefit," says Mr. Greeley.

7. Community Health Needs Assessment. The IRS requires non-profit hospitals conduct a Community Health Needs Assessment every three years and then adopt and implement a plan to meet the community's health. The development of a free clinic requires such a study and "clearly demonstrates that the hospital taken action on the results," says Mr. Greeley.

8. Establishes community support and involvement. "Any hospital that develops a free clinic in conjunction with local businesses, governmental units and, in some cases, religious organizations, realizes significant new community support and involvement," he says.

9. Medical staff accomplishment. The medical staff's involvement in establishing a free clinic provides the staff with an important professional accomplishment, and can help unify the staff and bring about improved alignment.

10. Reduction in morbidity and mortality. Numerous research studies show that patients with

limited access to primary care have higher rates of morbidity and mortality. "A safety-net clinic very directly assists in a very simple way in creating a healthier community," says Mr. Greeley

Developing a free clinic: What role does the hospital play?
For health systems that are eager to experience these benefits, it is worth exploring whether a free clinic could be viable in their communities. "Hospitals are really ideal candidates [to develop a clinic] because of their board and their medical staffs; they have a lot of ties to community," says Ms. Hamlin. While the hospital isn't going to be the owner of the clinic, the clinic must have a close relationship with the hospital to be successful.

"The hospital may contribute financially, or it may contribute planning staff for a needs assessment, or hospitals often have relationships with a clinic to provide labs and other diagnostic tests," she adds.

Ms. Hamlin encourages hospital leaders to select one or two individuals to oversee the process and garner community support. "It has to be someone who just has a fire in his or her belly and is determined to see one of these clinics open," she says. "You are not only building a clinic but also building up a non-profit organization that can support the clinic."

For communities that fit the bill — they have a large uninsured population, significant community interest and a pool or physicians, both current working and retired, who are willing to volunteer — a free clinic could be just what the doctor ordered.

"A hospital-supported clinic assists in creating a healthier community, a stronger hospital, a more satisfied medical staff, while simultaneously assisting with a hospital's tax exempt status, its community needs assessment and in creating operational efficiencies that contribute to the bottom line," says Mr. Greeley.

CTBA | Center for Tax and Budget Accountability

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An Update: An Analysis of the Tax Exemptions Granted to Non-Profit Hospitals in Chicago and the Metro Area and the Charity Care Provided in Return

Prepared by Heather O'Donnell and Ralph Martire
with assistance provided by interns William Crafton and Syed Zaffer

April 2009

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An Update: An Analysis of the Tax Exemptions Granted to Non-Profit Hospitals in Chicago and the Metro Area and the Charity Care Provided in Return

I. INTRODUCTION

Three years ago the Center for Tax and Budget Accountability ("CTBA") released a study estimating the value of the annual tax benefits granted to non-profit hospitals located in Cook County (the "2006 Report").[1] The 2006 Report compared the value of these tax breaks to the cost of charity care provided in return. The Report focused on charity care, which is free or reduced-cost medical care delivered to poor and low-income individuals, because state law is clear: Illinois non-profit, charitable hospitals must provide charity care to qualify for the local property tax exemption, and the state and local sales tax exemption. This study is an update to the 2006 Report.

Since tax exemption is, in essence, the use of public funds for a specific public purpose, it follows that government should understand and evaluate whether the forgone tax revenue is being used to provide the desired public benefit. To help decision-makers attain that goal, this study compares the value of the aggregate tax exemptions of non-profit hospitals in Chicago and the Metropolitan Area, against the cost of charity care those hospitals provide in return. Recognizing the valuable role non-profit hospitals play in the health care safety-net, ever-increasing health care costs, private sector retrenchment from providing employees with health care coverage, and on-going fiscal problems confronted by all levels of government, it is hoped that the data produced in this report will inform this crucial debate in a manner that leads to constructive policy solutions.

II. EXECUTIVE SUMMARY

Publicly-funded health care programs – often referred to as the health care safety-net – are intended to provide access to basic, affordable medical care to poor and low-income Americans. As health care costs continue to rise, private coverage moves farther out of financial reach for many families. Over the last ten years, average premiums for family health care coverage have increased 119 percent.[2] Public programs have stepped in to ensure access to needed health services for the most vulnerable members of society. This, in turn, has put tremendous financial pressure on federal, state and local government budgets, which are already experiencing significant annual budget shortfalls. Growing public health care costs have posed a significant fiscal problem for states like Illinois that have structural imbalances in their tax structure, meaning that annual tax revenue does not keep pace with the inflationary cost alone of providing public services.[3] Illinois' deficit is estimated to be between $4 billion and $9 billion for this fiscal year.[4] Accordingly, it is imperative that all public dollars lawmakers dedicate to foster access to affordable health care are actually applied to that end. This should be the goal in good economic times and bad. However, it is particularly important during severe economic downturns. In difficult economic times when individuals lose their jobs and their employer-sponsored health coverage, the need for essential public services, including health care, increases. At the same time demand for public services is growing, tax revenue that supports services declines, making every available taxpayer dollar that much more important.

The public health care safety-net has three fundamental components, each of which has a specific funding stream: (1) Medicaid, the health care program for low-income families, which is funded principally with federal and state dollars, (2) public hospitals and clinics, which are funded with a mix of federal, state and local tax dollars and (3) publicly-funded charity care, which is also subsidized with federal, state and local tax dollars given to non-profit hospitals in the form of tax breaks.

While Medicaid has been instrumental in stemming the growing tide of the uninsured – in 2007, 59 million Americans received health care coverage through the Medicaid program[5] – many struggling families do not qualify for the program because their income is not low enough. Today, more then 45 million individuals in the U.S. are uninsured, meaning they do not have private or public health insurance.[6] This number is expected to increase as the economy sinks further into recession – the Kaiser Family Foundation has estimated that as unemployment grows with the declining economy, the number of uninsured will grow by between 2.6 million and 5.8 million children and adults, depending on how high the unemployment rate climbs.[7] Charity care, delivered by non-profit, charitable hospitals, is intended to cover a portion of this gap. Charity care is medical care delivered for free or at a reduced cost to uninsured, poor and low-income individuals.

Charity care is funded through tax breaks granted to non-profit, charitable hospitals. Because charity care is funded indirectly through tax breaks rather than by direct appropriations of public dollars, it has not traditionally been viewed as a specific public health care "program." However, government funds that are provided to non-profit hospitals by means of tax breaks for the purpose of using such funds for a particular public service (*e.g.*, charity care), are no different than public dollars that are directly appropriated to other public programs (*e.g.*, Medicaid). The dollar value of the tax breaks given (*i.e.*, foregone tax revenue) are public dollars in the hands of non-profit hospitals that the law requires be used for a specific public purpose: access to affordable health care by poor and low-income, uninsured individuals through the provision of charity care. Lawmakers have a responsibility to ensure that all public dollars, whether direct expenditures, or indirect expenditures in the form of tax breaks, are used for the purposes intended. Moreover, this is particularly important with the use of public funds given in the form of tax breaks for the very reason that there is less transparency in how these dollars are ultimately used.

Currently, there is considerable confusion in Illinois and nationally around what types of tax benefits require charity care. The confusion has been exacerbated by the fact that there are four different types of tax benefits granted to non-profit hospitals, each of which has different legal requirements: (1) federal income tax exemption, (2) state income tax exemption, (3) state and local sales tax exemption and (4) local property tax exemption. This report focuses on charity care provided compared to the value of tax exemptions granted because Illinois law requires non-profit hospitals to provide charity care for the most valuable tax benefits conferred – the local property tax exemption, and the state and local sales tax exemption.[8] This report is intended to (1) review the different standards that must be met for the different tax breaks, (2) summarize recent developments in state law and federal reporting on charity care and (3) compare the value of the public dollars given to non-profit hospitals through tax breaks, to the charity care provided in return.

III. KEY FINDINGS

This study analyzes 27 non-profit hospitals and hospital networks in Chicago and the Metropolitan Area (the "Hospitals Studied"). When hospitals that are included in a hospital network are counted, the study includes 47 hospitals total. The study compares the value of the tax exemptions granted to the Hospitals Studied to the cost of the charity care they reported providing in return. Following are the key findings of this study.

- **The Hospitals Studied receive annual tax breaks worth nearly three times the cost of charity care provided.** The most recent annual value of all tax exemptions granted to the non-profit Hospitals Studied is estimated to be $489.5 million, while the cost of the charity care provided by those Hospitals was $175.7 million.

- **The amount of the excess tax benefit (the amount by which the value of the tax breaks exceeds the charity care provided) received by the Hospitals Studied – $327.2 million – would cover the cost of providing charity care to an additional 47,836 low-income, uninsured patients based on the national average cost of a hospital discharge.**[9]

- **Virtually all of the Hospitals included in both this study and in the 2006 Report increased the aggregate amount of charity care delivered over the last three years.** For the Hospitals Studied in both reports, on average, the cost of charity care reported increased from 1.8 percent of total expenses in the 2006 Report, to 2.2 percent of total expenses in this study. It is important to note that this follow-up study to the 2006 Report includes many hospitals the original study did not because at the time of the 2006 Report, charity care data for many hospitals was not yet available.

- **The Hospitals Studied in both this study and in the 2006 Report increased their aggregate charity care provided by $40.1 million.**

- **The estimated annual value of all tax exemptions received by the Hospitals Studied in both this study and in the 2006 Report increased by $93.9 million.**

- **Illinois state and local tax exemptions accounted for 91 percent of all tax benefits granted to the Hospitals Studied.** The local property tax exemption was the most valuable tax benefit conferred to the Hospitals Studied, amounting to 57 percent ($279.4 million) of the total tax exemptions. The state and local sales tax exemption accounted for 32 percent ($156.1 million) of all the tax breaks conferred. The property and sales tax exemptions, both of which require charity care, totaled 89 percent of the value of the tax subsidies granted by state and local governments.

- **The value of the tax breaks granted to the Hospitals Studied was on average 3.9 percent of total hospital expenses, while the cost of charity care provided by the same Hospitals was on average 2.1 percent of total hospital expenses.**

- **By simply doing a better jot of identifying patients eligible for charity care, the Hospitals Studied could have increased the amount of charity care delivered by $109.5 million, *at no additional cost to such Hospitals.*** The Hospitals Studied reported a bad debt cost of $218.9 million. Bad debt is the amount of uncollectible hospital bills. Many hospital finance experts estimate that approximately 50 percent of hospital bad debt is owed by individuals who would qualify for charity care if they were identified for eligibility prior to going through the collections process.[10] Accordingly, better identification of patients eligible for charity care would have increased the amount of charity care delivered by the Hospitals Studied by $109.5 million, with a corresponding decrease in bad debt.

Chart 1

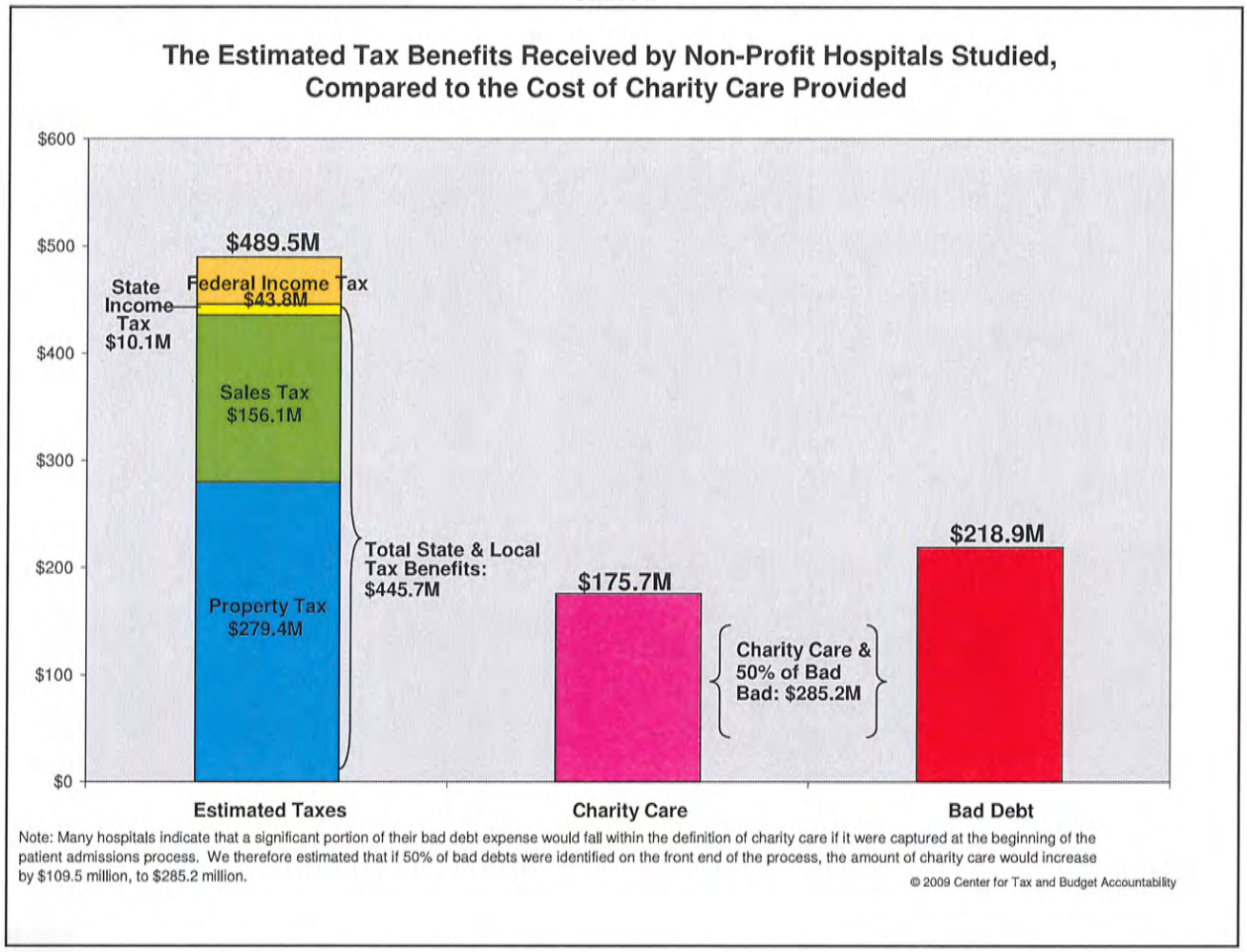

Chart 2: Estimated Value of the Tax Benefits Received Compared to Charity Care Provided (in millions)

Hospital/Hospital Network	Total Estimated Tax Benefits Granted	Charity Care Provided	Excess Tax Benefit
Advocate Health Care Network	$99.6	$29.1	$70.5
Alexian Brothers Hospital Network	$41.7	$12.8	$28.9
Evanston-NorthShore (formerly Evanston Northwestern)	$35.1	$11.6	$23.5
Gottlieb Memorial Hospital	$5.2	$1.7	$3.5
Holy Cross Hospital	$2.2	$3.5	--
Ingalls Memorial Hospital	$10.6	$2.6	$8.0
Jackson Park Hospital	$3.9	$3.1	$0.8
Little Company of Mary	$13.7	$2.7	$11.0
Loretto Hospital	$1.0	$4.8	--
Loyola University Medical Center	$23.5	$11.1	$12.4
Mercy Hospital & Medical Center	$5.8	$3.6	$2.2
Methodist Hospital of Chicago	$0.8	$0.5	$0.3
Mount Sinai	$3.5	$5.8	--
Northwest Community Hospital	$11.2	$4.3	$6.9
Northwestern Memorial Hospital	$48.1	$20.8	$27.3
Norwegian American Hospital	$2.9	$2.7	$0.2
Palos Community Hospital	$12.8	$3.1	$9.7
Resurrection Health Care	$43.4	$21.5	$21.9
Roseland Community Hospital	$0.6	$3.6	--
Rush North Shore Medical Center	$5.7	$1.0	$4.7
Rush University Medical Center/Rush Oak Park	$37.7	$5.2	$32.5
Saint Anthony Hospital	$2.4	$4.0	--
St. Bernard Hospital	$1.9	$2.7	--
South Shore Hospital	$0.6	$1.3	--
Swedish Covenant Hospital	$9.9	$1.4	$8.5
Thorek Hospital	$7.0	$1.2	$5.8
University of Chicago Hospitals	$58.6	$10.0	$48.6
TOTAL	**$489.4**	**$175.7**	**$327.2**

Chart 3: The Estimated Value of Each of the Tax Exemptions for All Hospitals Studied

Hospital	Estimated Value of Property Tax Exemption	Estimated Value of the State and Local Sales Tax Exemption	Estimated Value of Illinois Income Tax Exemption	Estimated Value of Federal Income Tax Exemption	Estimated Value of All Tax Exemptions
Advocate Health Care Network	$56,518,583	$31,764,838	$2,139,173	$9,235,952	$99,658,546
Alexian Brothers Hospital Network	$21,822,588	$7,968,068	$2,243,129	$9,684,786	$41,718,571
Evanston NorthShore (formerly Evanston Northwestern)	$21,945,266	$13,176,660	$0	$0	$35,121,927
Gottlieb Memorial Hospital	$2,868,574	$1,887,846	$79,029	$341,212	$5,176,661
Holy Cross Hospital	$868,024	$1,270,517	$0	$0	$2,138,542
Ingalls Memorial Hospital	$5,870,107	$3,279,185	$257,442	$1,122,223	$10,528,956
Jackson Park Hospital	$1,678,056	$539,805	$322,754	$1,397,839	$3,938,455
Little Company of Mary	$7,088,853	$2,329,801	$818,976	$3,541,079	$13,778,709
Loretto Hospital	$791,327	$176,244	$0	$0	$967,572
Loyola University Medical Center	$10,970,461	$12,557,923	$0	$0	$23,528,384
Mercy Hospital	$3,458,490	$2,301,611	$0	$0	$5,760,101
Methodist Hospital of Chicago	$199,319	$598,418	$0	$0	$797,737
Mount Sinai	$2,140,325	$1,444,388	$0	$0	$3,584,713
Northwest Community Hospital	$6,525,396	$4,670,580	$0	$0	$11,195,975
Northwestern Memorial Hospital	$33,886,354	$14,235,368	$0	$0	$48,121,722
Norwegian American Hospital	$1,964,660	$904,411	$0	$0	$2,869,072
Palos Community Hospital	$5,685,231	$4,090,463	$547,425	$2,363,527	$12,686,646
Resurrection Health Care	$26,641,030	$16,798,921	$9,072	$39,166	$43,488,188
Roseland Community Hospital	$352,844	$299,104	$0	$0	$651,948
Rush North Shore Medical Center	$2,445,954	$3,304,607	$0	$0	$5,750,561
Rush University Medical Center & Rush Oak Park	$24,050,964	$13,646,771	$0	$0	$37,697,735
Saint Anthony Hospital	$1,670,358	$670,885	$0	$0	$2,341,244
St. Bernard Hospital	$1,050,270	$726,413	$18,109	$78,188	$1,872,981
South Shore Hospital	$357,254	$258,817	$0	$0	$616,071
Swedish Covenant Hospital	$6,042,093	$2,820,834	$206,113	$889,901	$9,958,940
Thorek Hospital	$3,100,575	$804,674	$574,848	$2,481,927	$6,962,024
University of Chicago Hospitals	$29,455,449	$13,594,201	$2,931,950	$12,658,796	$58,640,397
Total	**$279,448,407**	**$156,121,354**	**$10,148,020**	**$43,834,597**	**$489,552,378**

Endnotes

[1] Center for Tax and Budget Accountability, "An Analysis of the Tax Exemptions Granted to Cook County Non-Profit Hospitals and the Charity Care Provided in Return," May 2006.
[2] Kaiser Family Foundation and the Health Research and Educational Trust, "Employer Health Benefits Survey 2008 Annual Survey," 2008.
[3] Center on Budget and Policy Priorities, "13 States Face Total Budget Shortfalls of at Least $23 Billion in 2009; 11 Others Expect Budget Problems," December 18, 2007.
[4] Illinois Office of the Comptroller, "FY2010 Budgetary Outlook." http://www.ioc.state.il.us/ioc-pdf/dwhreportFeb2009.pdf; Center for Tax and Budget Accountability's analysis of the Illinois Commission on Government Forecasting and Accountability's updated FY 2009 revenue estimate (published November 2008), FY 2009 state short term borrowing, FY 2008 Medicaid liability carryover to FY 2009 and decrease in potential FY 2009 revenue from the sale of the 10th casino license.
[5] National Association of State Budget Officers, "Fiscal Year 2007 State Expenditure Report," December, 2008.
[6] U.S. Census Bureau data on health insurance coverage for 2007.
[7] Kaiser Commission on Medicaid and the Uninsured, "Rising Unemployment, Medicaid and the Uninsured," January 2009 (estimating the increase in number of uninsured based on unemployment rates of seven percent, up to ten percent).
[8] Art. IX, Sec. 6, Illinois Constitution of 1970, 35 ILCS 15-65, *Methodist Old People's Home v. Korzen*, 39 Ill.2d 149 (1968), 35 I.L.C.S. 120/1g, 86 Il. Admin. Code § 130.2005.
[9] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (2006 data on the national average cost of a hospital discharge).
[10] J. Colombo, *Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps*, 37 Loy. U. Chi. L.J. 493, 519 (2006).

15. Net Patient Service Revenue

Northwestern Memorial recognizes net patient service revenue associated with services provided to patients who have third-party payment coverage with Medicare, Medicaid, Blue Cross, other managed care programs and other third-party payors on the basis of the contractual rates for the services rendered at the time services are provided. Payment arrangements with those payors include prospectively determined rates per admission or visit, reimbursed costs, discounted charges and per diem rates. Reported costs and/or services provided under certain of the arrangements are subject to retroactive audit and adjustment. Net patient service revenue increased by $16,462 and $25,067 in 2016 and 2015, respectively, as a result of changes in estimates due to the prior fiscal year's cost report settlements and the disposition of other payor audits and settlements. Changes in Medicare and Medicaid programs and reduction in funding levels could have an adverse effect on Northwestern Memorial.

Northwestern Memorial also provides care to self-pay patients. Under its Free and Discounted Care Policy, Northwestern Memorial provides medically necessary care to patients in its community with inadequate financial resources at discounts of up to 100% of charges using a sliding scale that is based on patient household income as a percentage (up to 600%) of the federal poverty level guidelines. The Policy also contains a catastrophic financial assistance provision that limits a patient's total financial responsibility to Northwestern Memorial. Since Northwestern Memorial does not pursue collection of these amounts, they are not reported as net patient service revenue. The Policy has not changed in fiscal year 2016 or 2015. Northwestern Memorial implemented presumptive eligibility screening procedures for free care in fiscal year 2014. Northwestern Memorial recognizes net patient service revenue on services provided to these patients at the discounted rate at the time services are rendered.

Net patient service revenue, net of contractual allowances and discounts, is reduced by the provision for uncollectible accounts, and net patient accounts receivable are reduced by an allowance for uncollectible accounts. These amounts are based primarily on management's assessment of historical and expected write-offs and net collections, along with the aging status for each major payor source. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. Based on historical experience, a portion of Northwestern Memorial's self-pay patients who do not qualify for charity care will be unable or unwilling to pay for the services provided. Thus, a provision is recorded for uncollectible accounts in the period services are provided related to these patients. After all reasonable collection efforts have been exhausted in accordance with Northwestern Memorial's policies, accounts receivable are written off and charged against the allowance for uncollectible accounts.

(In Thousands)

15. Net Patient Service Revenue (continued)

For receivables associated with self-pay patients, Northwestern Memorial records an allowance for uncollectible accounts in the period of service on the basis of past experience. These adjustments are accrued on an estimated basis and are adjusted as needed in future periods.

Net patient service revenue (including patient co-pays and deductibles), net of contractual allowances and discounts (but before the provision for uncollectible accounts) by primary payor source was as follows for the years ended August 31:

	2016	2015
Third-party payors	**$ 4,180,832**	$ 3,778,008
Patients	**55,609**	89,294
	$ 4,236,441	$ 3,867,302

Net patient service revenue from third-party payors includes Medicaid revenue received through the Illinois Hospital Assessment Program (see Note 16). In June 2014, this program was extended to June 30, 2018, as part of the Omnibus Medicaid Bill Senate Bill 741. Additionally, this bill authorizes a new supplemental program to cover new Medicaid beneficiaries under the Affordable Care Act. This new program was approved by the Centers for Medicare & Medicaid Services (CMS) in January 2015. This new supplemental program provided an additional $20,292 and $28,856 included in Net patient service revenue for the years ended August 31, 2016 and 2015, respectively.

Northwestern Memorial grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. Patient accounts receivable, by major primary payor source, including related patient co-pays and deductibles, before deducting estimated uncollectibles, were as follows at August 31:

	2016	2015
Medicare	**15%**	17%
Medicaid	**9**	9
Blue Cross	**16**	15
Other managed care	**33**	28
Other third-party payors	**11**	13
Patients	**16**	18
	100%	100%

(In Thousands)

15. Net Patient Service Revenue (continued)

The allowance for uncollectible accounts was $174,234 and $142,385, or 22.4% and 22.5%, of the related patient accounts receivable, net of contractual adjustments as of August 31, 2016 and 2015, respectively.

16. Illinois Hospital Assessment Program

The Illinois Hospital Assessment Program and the Enhanced Illinois Hospital Assessment Program (collectively referred to herein as HAP) have been approved by CMS through June 30, 2018. Under HAP, the state receives additional federal Medicaid funds for the state's health care system, administered by the Illinois Department of Healthcare and Family Services. HAP includes payments from the state to Northwestern Memorial's hospitals. Included in the accompanying consolidated statements of operations and changes in net assets for the years ended August 31, 2016 and 2015, is $109,208 and $101,801, respectively, of Net patient service revenue and $84,484 and $81,489, respectively, of HAP assessment expense.

17. Functional Expenses

Northwestern Memorial provides general health care services primarily to residents within its geographic location and supports research and education programs. Expenses related to providing these services were as follows for the years ended August 31:

	2016	2015
Health care services	**$ 3,024,091**	$ 2,694,860
Research and education	**142,795**	129,421
Fundraising	**12,982**	11,377
General, administrative, and other	**940,634**	836,108
	$ 4,120,502	$ 3,671,766

The research and education costs include $2,873 and $2,421 of expenses supported by federal, state, and corporate grants and $15,174 and $17,678 of expenses supported by other donor-restricted funds in 2016 and 2015, respectively.

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Facts & Figures

The Health Care Need in Indiana

(State Population, 2015 Census Estimate: 6,483,802

Data Source: American Community Survey 2011-2015

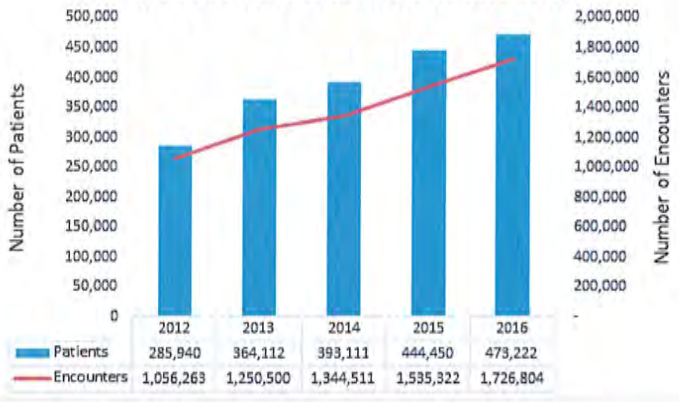
Number of people below poverty level	**978,043**
Percent of total population in poverty	15.08%
Number of low income (less than 200% federal poverty level)	**2,217,727**
Percent of total population that are low income	34.20%
Number uninsured	**828,342**
Percent uninsured in state	12.8%
Number of Hoosiers enrolled in Medicaid and HIP 2.0 (Jan. 2017)	**1,411,985**
Percent of population on Medicaid/HIP	21.7%

Availability of Services

Data Source: Uniform Data System (UDS) 2016 Data Submission

Total Number of Persons Served by FQHCs:	473,222
Persons Enrolled in Medicaid Served by Responding Primary Health Care Sites:	255,976
Percent of Hoosiers with Medicaid served by FQHCs	18%
Uninsured Persons Served by Responding Primary Health Care Sites:	102,892

FQHC Patient and Encounters Trend (5 Year)



Indiana's Federally Qualified Health Centers 2016 Snapshot

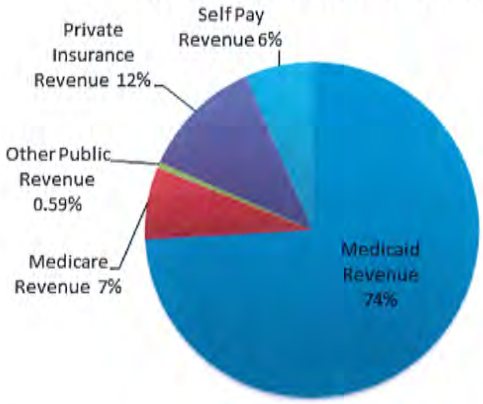
25 FQHCs Reporting for 2016

Funding from Patient Care

Self Pay	$ 14,083,740
Medicaid	$ 160,976,050

Medicare	$ 14,441,698
Private Insurance	$ 25,692,341
Other Public Revenue	$454,620
TOTAL PATIENT REVENUE	**$ 215,258,102**

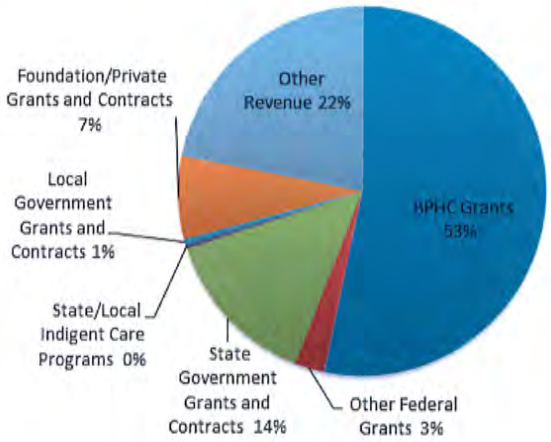
2016 Revenue from Patient Care



Grants and Other Funding Sources

BPHC Grants	$68,382,987
Other Federal Grants	$ 3,324,921
State Government Grants and Contracts	$18,0019,520
State/Local Indigent Care Programs	$ 539,311
Local Government Grants and Contracts	$ 589,976
Foundation/Private Grants and Contracts	$ 9,315,893
Other Revenue	$ 28,146,004
TOTAL GRANT FUNDS	**$ 290,318,612**

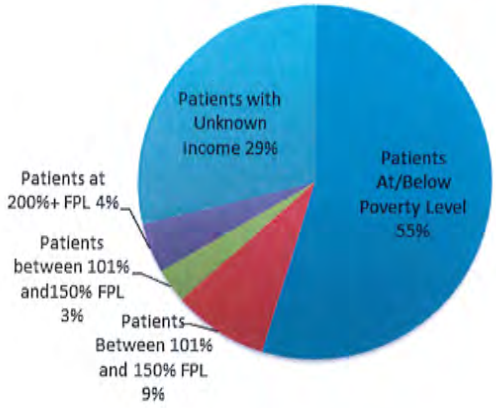
2016 Grants and Other Funding



Patient Income Levels

At/Below Poverty	259,048
101 - 150% Poverty	41,352
151 - 200% Poverty	14,763
200% + Poverty	21,784
Unknown	136,275

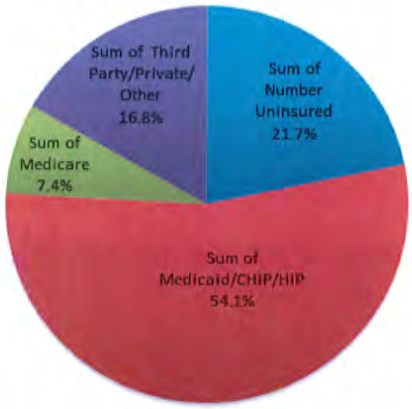
Patient Income 2016



Patient Insurance

Medicaid/CHIP/HIP	255,976
Medicare	34,940
Uninsured	102,892
Private	79,385

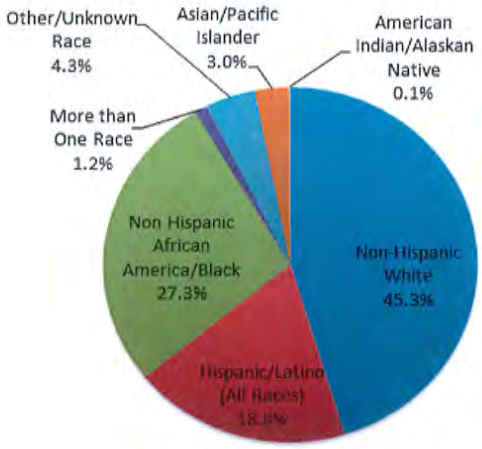
Patient Insurance Status 2016



Race of Patients

White, Non-Hispanic	214,199
Black, Non-Hispanic	129,274
Hispanic, All Races	89,150
American Indian	681
Asian/Pacific Islander	13,979
More than One Race	5535
Unknown	20,404

Patient Race/Ethnicity 2016



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The Health Care Need in Indiana

(State Population, 2010-11: 6,367,900)

Estimated Persons < 139% Poverty:	1,592,900
Estimated Uninsured Persons:	800,500
Estimated Homeless Persons:	6,452

Availability of Services (2010)

(Based on responses from all Federally Qualified Health Centers and 28 State-Funded Centers)

Total Number of Persons Served by All Responding Primary Health Care Sites:	414,722
Total Number of Persons Served by FQHCs:	264,104
Persons Enrolled in Medicaid (Dec. 2008):	1,145,569
Persons Enrolled in Medicaid Served by Responding Primary Health Care Sites:	171,611
Uninsured Persons Served by Responding Primary Health Care Sites:	151,179

Indiana's Federally Qualified Health Centers 2010 Summary*

(19 FQHCs at time of data collection)
*One FQHC did not provide 2010 data; therefore, its 2009 data was included.

Funding Sources

Self Pay	$37,590,294
Medicaid	$62,560,087
Medicare	$6,071,774
Private Insurance	$11,131,976
HRSA Funding	$22,154,421
Other Federal	$15,555,225
State	$16,816,124
City/County	$1,406,876
Private Foundations	$4,778,464
Donations/Other	$6,911,631

Other Public	$624,585
TOTAL FUNDS	**$185,601,457**

Patient Income Levels	
At/Below Poverty	154,362
101 – 150% Poverty	25,545
151 – 200% Poverty	8,566
200% + Poverty	4,894
Unknown	70,737
TOTAL	**264,104**

Insurance	
Medicaid	116,394
Medicare	13,976
Uninsured	98,914
Private	29,687
Public	1,393
Other	3,740
TOTAL	**264,104**

Race & Ethnicity	
White, Non-Hispanic	132,881
Black, Non-Hispanic	58,224
Hispanic, All Races	46,734
American Indian	218
Asian/Pacific Islander	4,626
More than one Race	2,375
Unknown	19,046
TOTAL	**264,104**

Indiana's State-Funded-Only Health Centers 2010 Summary*

***One center did not provide 2010 data; therefore, their 2009 data was included.**

Funding Sources	
Self Pay	$3,688,784
Medicaid	$15,394,026
Medicare	$6,129,173
Private Insurance	$4,642,750
HRSA Funding	$0
State	$3,211,313
City/County	$10,787,123
Private Foundations	$275,065
Donations/Other	$1,442,857
WIC	$190,394
TOTAL FUNDS	**$45,761,485**

Patient Income Levels*	
At/Below Poverty	97,063
101 – 150% Poverty	11,184
151 – 200% Poverty	5,231
200% + Poverty	5,803
Unknown	12,237
TOTAL	**131,518**

* Please note: complete income information was not provided by each center

Insurance*	
Medicaid	55,217
Medicare	19,504
Uninsured	52,265
Other	21,187
Unknown	613
TOTAL	**148,786**

* Please note: complete income information was not provided by each center

Race & Ethnicity	
White, Non-Hispanic	81,090
Black, Non-Hispanic	41,245
Hispanic, All Races	20,737
American Indian	339
Asian/Pacific Islander	993
Unknown	6,214
TOTAL	**150,618**

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IN THE
SUPREME COURT OF ILLINOIS

CHRISTINA YARBROUGH and DAVID GOODPASTER, on behalf of HAYLEY JOE GOODPASTER, a minor,	)	Petition for Leave to Appeal from the Illinois Appellate Court, First Judicial District, No. 1-14-1585,
Plaintiffs-Appellees,	)	
v.	)	
NORTHWESTERN MEMORIAL HOSPITAL	)	There Heard on Application for Leave to Appeal from an Order of the Circuit Court of Cook County, County Department, Law Division, No. 2010 L 296,
Defendant-Appellant	)	
and	)	
NORTHWESTERN MEDICAL FACULTY FOUNDATION,	)	
Defendant	)	The Honorable WILLIAM E. GOMOLINSKI, Judge Presiding

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NOTICE OF ELECTRONIC FILING

TO: Kay L. Schichtel, Esquire
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PLEASE TAKE NOTICE that on May 31, 2017, I filed Plaintiffs-Appellees' Brief of Christina Yarbrough and David Goodpaster, on Behalf of Hayley Joe Goodpaster, a Minor, with the Clerk of the Illinois Supreme Court, Michael A. Bilandic Building, 160 North LaSalle Street, Chicago, IL 60601, by e-filing the same using the i2File electronic filing portal.

Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that he verily believes the same to be true.

Respectfully submitted,

Dated: May 31, 2017

/s/ Patrick A. Thronson
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Attorneys for Plaintiffs-Appellees Christina Yarbrough and David Goodpaster

STATE OF MARYLAND)
) SS.
COUNTY OF BALTIMORE)

PROOF OF SERVICE

The undersigned, being first duly sworn upon oath, deposes and states that a copy of the attached Plaintiffs-Appellees' Brief of Christina Yarbrough and David Goodpaster, on Behalf of Hayley Joe Goodpaster, a Minor, was served on May 31, 2017 by e-mail on the following attorneys at the e-mail addresses indicated below:

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Date: May 31, 2017 /s/ Patrick A. Thronson
Patrick A. Thronson