2018 IL App (1st) 180436-U

SIXTH DIVISION
November 30, 2018

No. 1-18-0436

NOTICE: This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1).

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

ELLEN F. STOLFA, as Independent Administrator of the Estate of Bernadette Peters, Deceased, Plaintiff-Appellant, v. CONTINENTAL CASUALTY COMPANY, successor in interest to HEALTH CARE SERVICES CORPORATION and BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant-Appellee.	)	Appeal from the Circuit Court of Cook County. 15 L 11909 Honorable Margaret Ann Brennan, Judge Presiding.

JUSTICE CONNORS delivered the judgment of the court.
Presiding Justice Delort and Justice Cunningham concurred in the judgment.

ORDER

¶ 1 *Held:* The trial court's order that granted defendant's motion for summary judgment was proper where plaintiff presented no evidence to support her breach of contract claim; affirmed.

¶ 2 This appeal stems from a breach of contract action brought by plaintiff policyholder against defendant insurance company, alleging that defendant breached the policy by denying certain benefits. The circuit court granted summary judgment in favor of defendant. On appeal, plaintiff asserts that summary judgment was improper because the requirements of the policy

were met, and thus defendant should not have denied plaintiff's claim for benefits. We find the trial court's decision was proper and affirm.

¶ 3 BACKGROUND

¶ 4 In 1998, Bernadette Peters was issued long term care insurance policy number 6995207187 (the policy) by Blue Cross Blue Shield of Illinois. Subsequently, defendant Continental Casualty Company (defendant) assumed responsibility for the liabilities under the policy pursuant to a reinsurance agreement with the parent company of Blue Cross Blue Shield of Illinois. The policy provided coverage benefits subject to certain terms and conditions and contained a maximum lifetime limit of $146,000 and a maximum daily expense limit of $100 per day.

¶ 5 Peters first submitted her claim for "Qualified Long-Term Care" benefits to defendant in April 2011. The policy defined "Qualified Long Term Care" as:

> "Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and Maintenance or Personal Services, which:
>
> 1. are required by a Chronically Ill individual, and
>
> 2. are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner."

Additionally, the policy stated that the applicable "Elimination Period" was 90 days. The policy defined "Elimination Period" as follows:

> "The number of days in which covered Qualified Long-Term Care services are provided to You before this policy begins to pay benefits. It is shown on the Policy Schedule and can be satisfied by any combination of days of a Long-Term Care Facility stay or days of Home and Community-Based Care. These days of care or services need

not be continuous but must be accumulated within a continuous period of 730 days. This Elimination Period has to be satisfied only once while Your policy is in effect."

¶ 6 The policy defined a person as "Chronically Ill" when she is certified by a licensed health care practitioner as:

"1. being unable to perform (without substantial assistance from another individual) at least 2 Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity, or

2. requiring substantial supervision to protect Yourself from threats to health and safety due to severe Cognitive Impairment."

"Cognitive Impairment" was defined as "[a] deficiency in Your short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness." The policy also explained that Peters would not be considered Chronically Ill for any period unless within the 12 months prior to that period, a licensed health care practitioner certified that she met the above requirements.

¶ 7 The policy listed the six applicable "Activities of Daily Living" (ADLs) as follows:

"1. Eating. Feeding Yourself by getting food into Your body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

2. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

3. Bathing. Washing Yourself by sponge bath; or in either a tub or shower, including the task of getting in or out of the tub or shower.

4. Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

5. Transferring. Moving in or out of a bed, chair, or wheelchair.

6. Continence. The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag."

¶ 8 In support of her April 2011 claim for benefits, Peters submitted the following to defendant: an Individual Long Term Care Claim Form Claimant's Statement (Claim Form), a handwritten note from caregiver Maureen Roberts, and an Individual Long Term Care Plan of Care Form (Plan of Care Form), completed by Dr. Jeffrey Lindahl. The Plan of Care Form was a pre-printed, fill-in-the-blank form that was created and provided by defendant, and that had defendant's logo in the top lefthand corner. On the Claim Form dated April 23, 2011, Peters stated that she was filing for home health care benefits and that she was seeking permanent care for bathing, shopping, cleaning, appointments, and medication. Roberts's handwritten note stated that she was a "friend and neighbor" of Peters and had been helping Peters as much as she could, but now needed more help. Roberts's note stated that Peters needed help with cooking, cleaning, bathing, shopping, appointments, and taking her medication. The note also mentioned Peters being "on oxygen." The Plan of Care Form that was completed by Dr. Lindahl and dated April 10, 2011, stated that Peters was diagnosed with "arthritis, COPD, [and] CHF" approximately one year prior, which limited her mobility and endurance. In the section that asked, "Has any form of cognitive impairment been diagnosed?" Dr. Lindahl answered "No." Additionally, in the functional capacity section, the following eight ADLs were listed: eating, bathing, dressing, administration of medication, toileting, mobility, transferring, and continence. Dr. Lindahl described Peters's functional capacity as "OK" for eating, dressing, toileting, transferring, and continence. However, Dr. Lindahl listed that Peters needed assistance with

bathing (needed help with stability and getting in and out of the shower), administration of medication (was forgetting to take her medications), and mobility (used a walker for balance and back pain).

¶ 9 Alisa Mueller, the care manager responsible for handling Peters's claim, requested that Peters identify all the health care services providers that provided care related to the claim. Peters identified the following: Addolorata Villa, Northwest Community Hospital Home Health Care, Phoenix Home Care, A Senior Corp, and Comfort Keepers.

¶ 10 In a letter dated June 17, 2011, defendant informed Peters that no benefits were available to her because although her providers (Addolorata Villa, Northwest Community Hospital Home Health Care, Phoenix Home Care, A Senior Corp, and Comfort Keepers) met the policy requirements, defendant had received no "evidence to indicate that [Peters had] a qualifying impairment as a Chronically Ill individual requiring the provision of Qualified Long Term Care as [Peters] did not receive substantial assistance with at least 2 [ADLs] for at least 90 days or substantial supervision due to Cognitive Impairment." The letter also stated that if Peters felt this information was incorrect, then she could request a review by stating the reasons that she felt the claim was improperly denied and submitting documentation to support her position. Peters responded through counsel in a letter dated November 30, 2011, stating, "A review of Ms. Peters['s] records shows that she has been qualified as "Chronically Ill" since at least December 2010" and asking that defendant reconsider its decision. No additional documentation was included with the letter from Peters's counsel.

¶ 11 On January 27, 2012, defendant denied Peters's reconsideration request. Defendant explained that the policy provided benefits for Qualified Long Term Care required by a Chronically Ill individual, and recited the policy's definitions for these terms. The letter also

listed the policy's six ADLs and their descriptions, *i.e.*, eating, dressing, bathing, toileting, transferring, and continence, and defined Cognitive Impairment. The letter explained that in order to receive benefits, the following two components must have been met: "a) a determination that Ms. Peters has a qualifying impairment as a Chronically Ill individual, and b) a determination Ms. Peters *required and received* Qualified Long[-]Term Care pursuant to a Plan of Care due to this impairment for which coverage is available based on the policy requirements." (Emphasis in original.) The letter noted that the information defendant received did not show that Peters had a Cognitive Impairment for which she received substantial supervision, and thus defendant reviewed her claim to determine if Peters met the requirements to be considered Chronically Ill. Defendant determined that the documentation Peters provided "[did] not indicate that Ms. Peters required and received substantial assistance with at least 2 [ADLs] for a period of at least 90 days as required by her policy." Specifically, the Plan of Care Form completed by Dr. Lindahl indicated that Peters needed assistance with only one ADL defined by her policy: bathing. Defendant further stated that Dr. Lindahl's assessment was corroborated by Roberts's handwritten statement and Peters's Claim Form, which both indicated that Peters only needed assistance with one policy-defined ADL—bathing— in addition to other activities not mentioned in the policy, such as shopping, cleaning, appointments, and medication. The letter concluded:

> "At this time, we have received no clinical documentation indicating that Ms. Peters requires and receives substantial assistance from another individual with at least 2 [ADLs] as defined by her policy nor have we received any documentation demonstrating that Ms. Peters has been diagnosed with a severe Cognitive Impairment for which she

requires and receives substantial supervision. Thus, we are unable to overturn the original denial determination of benefits.

In the event that Ms. Peters care needs change or increase, we would be pleased to review any new information submitted. In order to consider benefits, we will require documentation substantiating the provision of qualifying care and services to Ms. Peters as a Chronically Ill individual."

¶ 12 Peters filed her original complaint against defendant for breach of contract on December 12, 2012. On June 2, 2014, defendant filed a motion for summary judgment, arguing that there was no evidence that Peters was Chronically Ill when she applied for benefits in April 2011, and that there was no evidence that Peters exhausted the 90-day Elimination Period required for coverage. As a result of this motion, Peters agreed to voluntarily dismiss her complaint so that she could supplement her case with additional evidence.

¶ 13 After communications between representatives for Peters and defendant, a benefits evaluation assessment (BEA) was conducted on March 19, 2015, and Peters submitted additional medical records, including an April 18, 2014, letter from Dr. Lindahl. Dr. Lindahl's letter stated that "Peters has been having an increasingly difficult time performing her own daily self care for several years now." The letter mentioned that Roberts had been helping Peters with showering and personal hygiene because Peters was unstable and unable to do it alone. Dr. Lindahl also stated that on September 19, 2011, Peters underwent an evaluation that "showed a mild cognitive disorder that had a considerable impact on her safety and functional independence." Also, Peters frequently forgot to take her medication, had become dependent on oxygen, and was unable to leave the house without assistance. Dr. Lindahl's letter also stated that Peters had a colostomy

due to colon cancer, which required a bag to be changed and cleaned several times per day, and that Peters was unable to do this herself.

¶ 14 In a letter from defendant's counsel, dated April 23, 2015, defendant stated that it had determined that Peters was then Chronically Ill based on her inability to perform at least two ADLs, *i.e.*, bathing, dressing, and continence, for at least 90 days. The letter further identified two issues that needed to be addressed: "(1) a determination of the date Mrs. Peters first became Chronically Ill and (2) Mrs. Peters' care moving forward." As to the first issue, the letter stated, "while I believe [defendant] has all of Mrs. Peters' physician records, I want to make sure that all the records for any other health-related care or services she has received up through the present time have been provided as well." The letter further explained that these records "will also be needed to provide proof of loss for any satisfaction of the 90-day Elimination Period and recovery of expenses." The letter stated defendant's desire to ensure that Peters and Roberts were aware of the type of care that was covered by the policy and the steps that needed to be followed.

¶ 15 On June 25, 2015, Peters's counsel sent "copies of proof of payment for caregivers for Bernadette Peters from 2011 until present" to defendant's counsel. The proof of payment consisted of dozens of pages of copies of checks issued to a number of people including Roberts from 2011 to the then-present, one page of handwritten notes, and a one-page handwritten timesheet for three care providers.

¶ 16 Defendant responded to Peters's submission in a letter dated July 29, 2015. Defendant's letter reiterated that Peters had been deemed Chronically Ill based on her need for assistance with three ADLs, *i.e.* bathing, dressing, and incontinence, and that defendant would provide round-the-clock care for Peters if her care complied with the terms and conditions of the policy. The

letter stated that the remaining question was whether Peters was Chronically Ill prior to the BEA from March 19, 2015, and if so, when she became Chronically Ill. Defendant explained the evidence that Peters had presented thus far as follows:

> "Bathing. The records show that Mrs. Peters needed and received assistance with bathing at the time she filed her claim in 2011. ***
>
> Dressing. The records do not show that Mrs. Peters needed assistance with Dressing at the time she filed her claim in 2011. *** There are records from the 2011 and earlier time period which show that Mrs. Peters required intermittent assistance with Dressing, but the records show that Mrs. Peters was subsequently determined to be independent with respect to Dressing after each such instance. We have seen no records or evidence that establish that Mrs. Peters needed substantial assistance with Dressing after 2011 but before the March 19, 2015 assessment. Please provide us with any evidence you have supporting Mrs. Peters' need, if any, for substantial assistance with Dressing before March 19, 2015.
>
> Incontinence. The records do not show that Mrs. Peters needed assistance with Incontinence at the time she filed her claim in 2011. *** We have seen no records or evidence that establish that Mrs. Peters needed substantial assistance with Incontinence after 2011 but before the March 19, 2015 assessment. Please provide us with any evidence you have supporting Mrs. Peters' need, if any, for substantial assistance with Incontinence before March 19, 2015."

¶ 17 Defendant requested that Peters provide evidentiary support to show when, in fact, Peters began to need assistance with the three foregoing ADLs. The letter stated that it was defendant's position that a September 20, 2011, report by Dr. Katherine Wood, wherein she opined that

Peters had "a cognitive disorder of mild severity compared to age-matched peers," was insufficient to establish Cognitive Impairment under the policy because such a designation required a severe cognitive impairment, not a mild one. The letter further referenced Dr. Wood's subsequent evaluation of Peters, which again resulted in findings of a mild cognitive impairment. Defendant's letter further noted that almost all of the expenses for which Peters was seeking coverage pertained to care provided in her home, and thus would fall under the Home and Community-Based Care Benefit.

¶ 18 The letter quoted the policy's definition of "Home and Community-Based Care," as:

> "Qualified Long-Term Care which is provided:
>
> 1. in a Home Convalescent Unit by a Home Health Care Agency; or
> 2. in an Alternate Care Facility; or
> 3. in an Adult Day Care facility."

The letter and policy also stated that Peters's own home qualified as a Home Convalescent Unit. Further, the letter and policy defined Home Health Care Agency as:

> "An entity which provides home health care or hospice services and:
>
> 1. has an agreement as a provider of home health care services or hospice care under the Medicare program; or
> 2. is licensed or accredited by state law as a Home Health Care Agency or hospice, if such licensing or accreditation is required by the state in which the care is received.
>
> For purposes of this policy, a licensed therapist, a registered nurse, a licensed practical nurse, or a licensed vocational nurse operating within the scope of his or her license will be considered a Home Health Care Agency."

¶ 19 The letter further explained that the individuals that Peters identified as her caregivers, such as Roberts and an individual named Alatha[1] Toledo, did not appear to meet the policy requirements for a Home Health Care Agency, but requested information regarding their qualifications to provide care. Defendant also included copies of the appropriate caregiver timesheet forms and a list of qualifying Home Health Care Agencies located near Peters.

¶ 20 On November 23, 2015, Peters re-filed her complaint against defendant, alleging one count of breach of contract. Peters passed away on April 8, 2016. On November 10, 2016, an amended complaint was filed with Peters's niece, Ellen F. Stolfa, named as the independent administrator of Peters's estate (plaintiff). Plaintiff's amended complaint alleged that, "[i]n December 2010, claim was made to [defendant] for payment of benefits under policy # 6995207187" and that "[Peters] was significantly disabled and unable to perform the activities of daily living without assistance since December, 2010." The amended complaint stated that all of the bills, proper documentation, and supporting material had been duly submitted to defendant and that defendant "failed and refused to pay any of the benefits and medical expenses incurred since December, 2010." Defendant answered plaintiff's amended complaint on December 22, 2016.

¶ 21 Subsequently, defendant served plaintiff with interrogatories and requests to produce, asking for: an itemized list of plaintiff's claimed damages, *i.e.* expenses that plaintiff claimed were covered by the policy, a factual basis for plaintiff's contention that any persons identified as providing care were a Home Health Care Agency, and identification of anyone who provided Qualified Long Term Care other than those who were previously identified. In response to defendant's request for an itemization of damages, plaintiff produced a two-page document,

[1] It is unclear whether Ms. Toledo's first name is Alatha or Agatha because it is spelled both ways in various parts of the record and briefs.

titled "Special's List" (Specials List). The Specials List included three columns—one containing the names of medical providers, one containing dates, and one containing amounts. The Specials List stated that Alatha Toledo had provided Peters with care from November 1, 2013 to December 8, 2014, and January 4, 2015, to June 28, 2016, for a total of $28,755, and that Consancia M. Medina provided care from July 7, 2015 to June 29, 2016, for a total of $87,374. Plaintiff also produced records that consisted almost entirely of copies of checks.

¶ 22 Plaintiff filed its responses to defendant's interrogatories on August 16, 2017, reflecting that the only amount of damages that plaintiff sought were included in the Specials List. Additionally, in response to an interrogatory that requested plaintiff explain the factual basis for her contention that Toledo and others qualified as a Home Health Care Agency as defined in the policy, plaintiff stated, "The qualifications of these persons are unknown at present[.] [T]herefore[,] it is unknown if they qualify under the terms of the policy."

¶ 23 On October 13, 2017, defendant filed its motion for summary judgment that forms the basis of this appeal, arguing that there was no evidence that the policy's 90-day Elimination Period had been exhausted. Defendant noted that plaintiff was seeking benefits for Home and Community-Based Care, and pointed out that the policy defined such care as, "Qualified Long-Term care which is provided *** in a Home Convalescent Unit by a Home Health Care Agency." Defendant stressed that Qualified Long-Term Care only consisted of the services required by a Chronically Ill individual. Defendant contended that even assuming *arguendo* that Peters was Chronically Ill at the time she first submitted her claim to defendant in April 2011, there is no evidence that Peters received the remaining 68 days[2] of Home and Community-Based Care needed to exhaust the 90-day requirement. Additionally, defendant argued that plaintiff

[2] Defendant argued that plaintiff would still have to show 68 days of care based on its assumption that 22 days of the 90-day requirement had been proven. Specifically, there was evidence that Peters twice stayed at the Addolorata Villa for 22 days during 2010 and 2011.

had not presented any evidence that either Medina or Toledo, both of whom were on the Specials List, met the requirements of a Home Health Care Agency. Defendant also argued that even if plaintiff could satisfy the 90-day elimination period, there was no evidence that either Medina or Toledo were employed by a Home Health Care Agency or met the individual license requirement needed to be deemed a Home Health Care Agency.

¶ 24 Attached to defendant's motion was, *inter alia*, an affidavit from Alisa Mueller, the care manager responsible for handling Peters's claim. Mueller's affidavit stated that she applied the policy's definition of Chronically Ill to all the materials she received in connection with Peters's claim. Mueller averred she contacted all of the health care service providers that Peters identified as providing care related to her claim. Mueller then reviewed the documents submitted by the providers and "noted that they did not indicate that Mrs. Peters had been certified by a Licensed Health Care Provider as being Chronically Ill for any 90-day period of time." Specifically, Mueller determined that the providers' documents showed that Peters received care during 4 time periods that amounted to less than 90 days. Mueller's affidavit summarized the services Peters received as follows:

> "a. Mrs. Peters was a resident in the Addolorata Villa facility from June 2, 2010-June 12, 2010 and received home health care services from Northwest Community Hospital Home Health Care between June 14, 2010 and July 27, 2010. Among other things, I noted that this time period was less than 90 days, and that the nursing discharge assessment I received and reviewed is attached as Exhibit I.
>
> b. Mrs. Peters was [a] resident in the Addolorata Villa facility from December 11, 2010-December 23, 2010, and received home health care services from Phoenix Home Care between December 24, 2011 and January 5, 2012. Among other things, I noted that this

time period was less than 90 days. In addition, the discharge assessment indicates that Mrs. Peters was independent with respect to her ADLs. A true and accurate copy of the discharge assessment I received and reviewed is attached as Exhibit J.

c. Mrs. Peters received services from A Senior Corp and Northwest Community Hospital Home Health Care between February 2, 2011 and March 15, 2011. Among other things, I noted that this time period was less than 90 days and the nursing discharge assessment information showed that Mrs. Peters was certified as independent with respect to her ADLs upon her discharge. A true and accurate copy of the discharge assessment I received and reviewed is attached as Exhibit K.

d. Mrs. Peters received services from Comfort Keepers between April 1, 2011 and April 16, 2011. Among other things, I noted that this time period was less than 90 days."

¶ 25 Mueller's affidavit further stated that, after review of all the materials, she recommended that the claim be denied because Peters was not Chronically Ill as defined by the policy. Regarding the care allegedly administered to Peters by Medina and Toledo, and as reflected in the Specials List, Mueller's affidavit stated, "There was nothing in the records or file to show that Alatha Toledo and Consancia Medina worked for or qualified as a Home Health Care Agency under the Policy." Further, Mueller stated that she "never received any information in regards to the specific days/hours worked from any of the caregivers or any documentation as to the care they are providing each visit that would show that Mrs. Peters was receiving Qualified Long Term Care."

¶ 26 On December 6, 2017, plaintiff filed her response, contending that Peters was qualified for benefits in April 2011 when she initially submitted her claim, retroactive to December 2010. Plaintiff explained that because Roberts dated Peters's impairments to before April 2011, *i.e.*, the

date the claim was actually submitted, it was reasonable to use December 2010 as the start date. Plaintiff also argued that the 90-day Elimination Period began in December 2010. Plaintiff contended that she had already presented pages of checks showing payment to various caregivers, who were retained in light of the denial of coverage for a nurse. Plaintiff stated that defendant had the appropriate documentation in April 2011, but chose to deny coverage and belabor the process. Plaintiff further asserted, "The coverage issue is simple and neither Mrs. Peters, nor Maureen Roberts had the ability to generate the kind of unnecessary documentation [defendant] demanded." Plaintiff included, in the wherefore clause of her response, a request that the court deny defendant's motion for summary judgment and enter judgment in her favor in the amount of $146,000, which was the full limit of policy benefits.

¶ 27 On December 19, 2017, defendant's reply was filed, stating that beginning in April 2011, defendant had repeatedly informed Peters, Roberts, and Peters's counsel that the policy had terms that must be complied with prior to the payment of any benefits. Defendant emphasized that in order to defeat its motion for summary judgment, plaintiff had to show some evidence that the policy's requirements were satisfied. However, defendant asserted that plaintiff had failed to do so. Defendant pointed out that plaintiff argued that there was coverage for caregivers Medina and Toledo, but that plaintiff failed to produce any evidence in support. Specifically, defendant argued that plaintiff utterly failed to show that she had exhausted the 90-day Elimination Period or that the assistance provided by Medina and Toledo constituted Home and Community-Based Care. Defendant reiterated that plaintiff failed to produce any evidence that Medina or Toledo was a licensed therapist, registered nurse, licensed practical nurse, or licensed vocational nurse operating within the scope of her license, as required by the policy. Defendant also took issue with the fact that plaintiff only provided copies of payment checks to

Medina and Toledo instead of evidence regarding the care they provided or the days on which they worked.

¶ 28 The trial court granted defendant's motion for summary judgment on January 30, 2018, and entered an order dismissing the case with prejudice, but did not state a basis for its decision. Further, the record on appeal does not contain a transcript from any hearings on that date, and thus it is unclear if a hearing occurred.

¶ 29 Defendant filed its timely notice of appeal on February 28, 2018.

¶ 30 ANALYSIS

¶ 31 On appeal, plaintiff asserts that, "[defendant] breached its contract with Ms. Peters by denying proper coverage and benefits to which she was entitled." Specifically, plaintiff argues that Peters was Chronically Ill beginning in June 2010, the 90-day Elimination Period was satisfied, and Medina's and Toledo's care for Peters amounted to Home and Community-Based Care.

¶ 32 "The construction of an insurance policy and a determination of the rights and obligations thereunder are questions of law for the court and appropriate subjects for disposition by summary judgment." *Liberty Mutual Fire Insurance Co. v. St. Paul Fire and Marine Insurance Co.*, 363 Ill. App. 3d 335, 338 (2005). Summary judgment is appropriate only where "the pleadings, depositions, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." 735 ILCS 5/2-1005(c) (West 2012). We review *de novo* a ruling on a motion for summary judgment. *Clark Investments, Inc. v. Airstream, Inc.*, 399 Ill. App. 3d 209, 213 (2010).

¶ 33 At the outset, we find it pertinent to point out that plaintiff does not argue that a genuine issue of material fact exists regarding whether Peters met the policy's requirements. Instead,

plaintiff asserts that Peters, in fact, met the policy's requirements and that defendant breached the policy when it denied benefits. Plaintiff goes so far as to request that we reverse the trial court's grant of summary judgment in favor of defendant and enter judgment in her favor for the full amount of the policy's benefits. In response, defendant asserts that in order to prevail in this appeal, plaintiff needs to show some evidence in the record supporting her claim that defendant breached the policy by denying her claim and refusing to pay benefits after she submitted all the proper documentation, supporting materials, and bills. Our review of the record indicates that, in fact, plaintiff has failed to present any evidence that defendant breached the policy because she cannot show her own performance under the policy, and thus summary judgment in favor of defendant was proper.

¶ 34 "In order to show a breach of contract, a plaintiff must show that (a) a contract exists between plaintiff and defendant, (b) plaintiff performed her obligations under the contract, (c) defendant did not perform [its] obligations under the contract, and (d) damages resulted from the breach." *Walker v. Ridgeview Construction Co., Inc.*, 316 Ill. App. 3d 592, 595-96 (2000). Here, plaintiff has alleged that defendant breached the policy by failing to pay the Home and Community-Based Care benefit for payments made to Medina from July 2015 to June 2016 in the amount of $87,374, and to Toledo from late 2013 through June 2016 in the amount of $28,755. Defendant argues that there are two reasons why plaintiff's claim for these expenses fails: (1) the policy's 90-day Elimination Period was not exhausted, and (2) the care provided by Medina and Toledo did not constitute Home and Community-Based Care.

¶ 35 According to the policy, in order to exhaust the 90-day Elimination Period, plaintiff had to show that Qualified Long-Term Care services were provided for 90 days. These 90 days did not have to be consecutive, but had to occur within the same two-year timeframe. Further, the

policy defined Qualified Long-Term Care as "[n]ecessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and Maintenance or Personal Services, which: (1) are required by a Chronically Ill individual, and (2) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner." In other words, plaintiff had to show that Peters was Chronically Ill before the 90-day clock would start to run. In her appellate brief, plaintiff contends that Peters was Chronically Ill beginning in June 2010. Defendant points out that this is the first time plaintiff has made such an argument. In plaintiff's response to the summary judgment motion, she asserted that Peters was Chronically Ill beginning in December 2010. "It is well settled that issues not raised in the trial court are deemed forfeited and may not be raised for the first time on appeal." *Martinez v. River Park Place, LLC*, 2012 IL App (1st) 111478, ¶ 29. Plaintiff did not assert that she was Chronically Ill beginning in June 2010 in any pleading, memorandum, argument, or motion in the trial court, and thus plaintiff has forfeited that contention.

¶ 36 Further, we find there is no evidence that Peters was Chronically Ill in December 2010. In plaintiff's response to the motion for summary judgment, she asserted that because Roberts dated Peters's impairments to prior to April 2011, *i.e.*, the date the claim was actually submitted, it was reasonable to use December 2010 as the start date. We reject plaintiff's argument because Roberts's note does not contain any dates and does not state when Peters's need for assistance began. Further, we find no other evidence in the record to indicate that Peters was Chronically Ill beginning in December 2010.

¶ 37 Perhaps recognizing that there was no basis for such a contention, plaintiff again changes her argument in her reply brief and asserts that Peters was Chronically Ill when she first submitted her claim to defendant in April 2011. Our review of the evidence similarly indicates

that plaintiff was not Chronically Ill when she submitted her claim in April 2011. In order to satisfy the policy's definition of Chronically Ill, plaintiff was required to have been certified by a licensed health care practitioner as being unable to perform two ADLs without substantial assistance for a period of 90 days, or requiring substantial supervision due to severe cognitive impairment. The Plan of Care Form completed by Dr. Lindahl was dated April 2011, and specifically stated that plaintiff had not been diagnosed with any form of cognitive impairment. Thus, Peters could have only satisfied the Chronically Ill requirement through her inability to perform two ADLs. The policy recognized the following six ADLs: eating, dressing, bathing, toileting, transferring, and continence. According to the Plan of Care Form completed by Dr. Lindahl, Peters needed assistance with bathing, administration of medication, and mobility. Although these three activities may have seemed to satisfy the policy's requirements, they actually do not because although administration of medication and mobility were listed on the Plan of Care Form completed by Dr. Lindahl, only bathing was an ADL recognized under the policy. Perhaps a question of fact existed regarding whether defendant acted improperly by providing health care practitioners with an arguably misleading form that listed ADLs, such as administration of medication and mobility, that were not recognized by its policy. However, plaintiff has not made such an argument, and thus we need not address such speculation any further.

¶ 38 Further, we find that Dr. Lindahl's April 18, 2014, letter did not seek to change or amend the findings reflected in the Plan of Care Form that Dr. Lindahl completed in April 2011. Dr. Lindahl's letter stated that Peters underwent a clinical neurology evaluation on September 19, 2011, which showed "a mild cognitive disorder that had a considerable impact on her safety and functional independence." This is evidence that Peters had a mild cognitive disorder, but not a

severe cognitive impairment, which the policy requires for coverage. Further, Dr. Lindahl's letter did not correct any information that was submitted in the Plan of Care Form he completed in 2011, but instead, added evidence that Peters needed substantial assistance with continence, specifically stating that "Peters ha[d] a colostomy [bag] due to colon cancer which needs to be changed and cleaned several times a day, and she is unstable to do this herself which also requires the assistance of a caregiver." Dr. Lindahl's letter did not provide any information as to how long Peters had the colostomy bag that caused her to needed substantial assistance.

¶ 39 However, even if we assume *arguendo* that plaintiff was Chronically Ill beginning in April 2011, there is no evidence that she satisfied the 90-day Elimination Period or that compensation paid to Medina and Toledo was covered by the policy. In support of its motion for summary judgment, defendant attached the affidavit of Mueller, the care manager assigned to Peters's claim. Plaintiff did not present a counteraffidavit. It is well-settled that "facts contained in an affidavit in support of a motion for summary judgment which are not contradicted by counteraffidavit are admitted and must be taken as true for purposes of the motion." *Purtill v. Hess*, 111 Ill. 2d 229, 241 (1986).

¶ 40 Mueller's affidavit stated that after reviewing all of the information that was submitted in support of Peters's claim, which included information from both Peters and the health care service providers she identified, Mueller determined that plaintiff had not satisfied the 90-day Elimination Period. Mueller's affidavit set forth with specificity the dates during which Peters received the care for which she sought coverage. Plaintiff's lack of counteraffidavit requires us to take the facts in Mueller's affidavit as true. *Id.* Mueller's affidavit and supporting documentation validates defendant's position that Peters did not accumulate 90 days of any combination of Long-Term Care Facility stays or Home and Community-Based Care stays.

¶ 41 Even assuming *arguendo* that plaintiff adequately showed that Peters was Chronically Ill beginning in April 2011 and that the 90-day Elimination Period was satisfied, plaintiff still failed to show that the expenses paid to Medina and Toledo were covered by the policy. Although plaintiff previously attempted to seek reimbursement for numerous other expenses, she has only argued on appeal that she is due reimbursement for payments to Medina in the amount of $87,374 and to Toledo in the amount of $28,755, for a total of $116,129. Defendant asserts that the Medina and Toledo expenses are not covered by the policy because these expenses were not for Home and Community-Based Care. The policy, in relevant part, defined Home and Community-Based Care as Qualified Long-Term Care that is provided in a Home Convalescent Unit by a Home Health Care Agency. It is undisputed that Peters's own home qualified as a Home Convalescent Unit. Thus, we look to whether Medina and Toledo, who provided Qualified Long-Term Care to Peters in her home, satisfied the policy's requirement of a Home Health Care Agency. The policy defined a Home Health Care Agency as follows:

> "An entity which provides home health care or hospice services and:
>
> 1. has an agreement as a provider of home health care services or hospice care under the Medicare program; or
>
> 2. is licensed or accredited by state law as a Home Health Care Agency or hospice, if such licensing or accreditation is required by the state in which the care is received.
>
> For purposes of this policy, a licensed therapist, a registered nurse, a licensed practical nurse, or a licensed vocational nurse operating within the scope of his or her license will be considered a Home Health Care Agency."

¶ 42 We find that there is no evidence in the record that either Medina or Toledo worked for a Home Health Care Agency or qualified as one. As such, we find that plaintiff's claim fails, rendering summary judgment in favor of defendant proper. First, there is no evidence that Medina or Toledo worked for an entity. All payments to them were in the form of checks issued to them in their individual capacity. Second, there is no evidence that, as individuals, Medina and Toledo were licensed. The policy recognized that individuals could be considered a Home Health Care Agency if the individual was "a *licensed* nurse, a *licensed* therapist, a *registered* nurse, a *licensed* practical nurse, or a *licensed* vocational nurse." (Emphasis added.) In her opening brief, plaintiff contends that, "[t]here is no policy provision that says caregivers need to be licensed" and argues that "the qualifications of Ms. Medina and Ms. Toledo are irrelevant to the current action." Plaintiff's argument is contrary to the foregoing definition, which explicitly requires an individual to be licensed in order to be treated as a Home Health Care Agency under the policy. In Mueller's affidavit, she stated, "There was nothing in the records or file to show that Alatha Toledo or Consancia Medina worked for or qualified as a Home Health Care Agency under the [p]olicy." We reiterate that plaintiff did not file a counteraffidavit to rebut these assertions, and thus we take them as true. *Id.* Further, our own review of the record indicates that there is no evidence of what licensure, if any, Medina or Toledo possessed. In her reply brief, plaintiff refers to a Home Health Agency as "anyone with a contract to provide home health care." This is simply inaccurate. It is apparent from the policy language that plaintiff's purported definition of a Home Health Care Agency is a distortion of the policy language that refers to an entity that provides home health care or hospice services and "has an agreement as a provider of home health care services or hospice care *under the Medicare program*." (Emphasis added.) Because we have already determined that Medina and Toledo were not entities and did

not work for entities, this provision is inapplicable. As such, plaintiff has failed to present any evidence that the care provided by Medina and Toledo qualified for benefits under the policy.

¶ 43 Plaintiff only cites to two cases in the entirety of her opening brief: *Commonwealth Edison Co. v. Elston Avenue Properties, LLC*, 2017 IL App (1st) 153228, and *Hoel v. Crum and Forster Insurance Co.*, 51 Ill. App. 3d 624 (1977). We find neither case to be helpful in resolving this appeal. Plaintiff cites to *Elston Avenue Properties, LLC*, for its analysis of the factors that must be considered when determining whether a breach is material. In this case, we are not faced with determining whether any alleged breach was material, because we have not found that a breach occurred. As such, *Elston Avenue Properties, LLC* is inapplicable. Further, plaintiff cites *Hoel* for its proposition that, "[i]f the insurer is shown to have breached portions of an insurance contract inuring to the benefit of the insured he cannot insist that the insured by [*sic*] bound by the provisions which inure to the benefit of the insurer." *Hoel*, 51 Ill. App. 3d at 632. We find that *Hoel* is irrelevant because we have not found that defendant, *i.e.* the insurer, breached the policy, which is necessary in order to invoke the provision to which plaintiff cites. As such, we decline to apply *Hoel* to this case.

¶ 44 Based on the foregoing, it is clear to this court that plaintiff cannot show that she performed under the contract. She cannot show that Peters was Chronically Ill as of April 2011, that the 90-day Elimination Period was exhausted, or that Medina and/or Toledo were licensed professionals in the health care field. As a result, plaintiff cannot show that defendant breached the policy, and thus cannot satisfy the requisite elements for a breach of contract claim. See *Walker*, 316 Ill. App. 3d at 595-96. Although the result here is frustrating in light of the fact that Peters undoubtedly needed assistance and paid defendant for her premiums, it is important to note that such a result was entirely avoidable had plaintiff presented materials validating her

claim and evidencing her compliance with the policy's terms. Plaintiff was given numerous opportunities to provide the requisite documentation, but failed to do so even after defendant sent correspondence that specifically detailed what was required under the policy in order for benefits to be paid.

¶ 45 As a final matter, we note that plaintiff also argues on appeal that her cross-motion for summary judgment should have been granted. Defendant responds that plaintiff never filed a cross-motion for summary judgment. Our review of the record indicates that defendant is correct and no cross-motion for summary judgment was ever filed in circuit court. Perhaps plaintiff's reference to a cross-motion for summary judgment was intended to refer to plaintiff's concise request in the wherefore clause of her response that the court deny defendant's motion and enter judgment in her favor. However, plaintiff's scantly-worded request in the conclusion of her response does not constitute a cross-motion for summary judgment. Plaintiff's response neither included any argument as to why she was entitled to summary judgment, nor legal authority in support thereof. Thus, we need not address plaintiff's contentions regarding a cross-motion that does not exist. To be clear, even if plaintiff had filed a cross-motion for summary judgment, such a motion would be meritless where we have already concluded that plaintiff failed to show a genuine issue of material fact, rendering summary judgment in favor of defendant proper.

¶ 46 CONCLUSION

¶ 47 Based on the foregoing, we affirm the trial court's decision to grant defendant's motion for summary judgment.

¶ 48 Affirmed.