UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DONNA RADASZEWSKI, Guardian, on behalf of Eric Radaszewski, Plaintiff,	)	
vs.	)	No. 01 C 9551
BARRY MARAM, Director, Illinois Department of Healthcare and Family Services, Defendant.	)	Judge John W. Darrah

Closing Argument

Plaintiff's Case

The decision of the Seventh Circuit in this case established the elements that Eric Radaszewski's mother must prove in order to obtain relief under the Americans with Disabilities Act, 42 U.S.C. §12132 (ADA), and Section 504 of the Rehabilitation Act, 29 U.S.C. §794 (Section 504). *Radaszewski v. Maram,* 383 F.3d 599, 608- 616 (7th Cir. 2004). Those elements consist of the following: (1) State treatment professionals have found that treatment in the community is appropriate; (2) The affected individual does not oppose community based treatment; (3) Placement in the community can be reasonably accommodated taking into account the State's resources and the needs of others with similar disabilities. 383 F.3d at 608. This closing argument will demonstrate how the evidence proves that each of the requirements has been met.

A. Findings of State Professionals

The Seventh Circuit found as to this requirement, that "[t]here is little doubt that Eric *can* be cared for appropriately at home. He has been receiving care at home since 1994, and according to the complaint, he benefits from the support of and interaction with his parents in that environment." 838 F.3d at 608. The proof in this case supports that finding. Plaintiff's Exhibit 40, the Administrative Decision of the defendant in this case, on page DHS10097, found that Eric had been cared for at home for a number of years through funding from the Division of Specialized Care for Children (DSCC). Plaintiff's Exhibits 1, 2, 3, 4, 5, 6, 7, 9, 10, 12, 13, 15,

and 16 each contain either recommendations from Department of Health Care and Family Services (HFS) physician consultants for approving Eric's in-home care while he was participating in the Medically Fragile and Technology Dependent Waiver (MFTD) or Forms IDPA 2352's issued by HFS, approving such in-home care. (Donna Radaszewski testified regarding Eric's care in the community (Tr. p. 66, ln. 7 - p. 68, ln.9) and how Eric benefits from living at home. (Tr. p. 76, ln. 19 - p. 77, ln.13).[1]

B. The affected individual does not oppose community based treatment

Based on the testimony of Donna Radaszewski, this Court found that plaintiff had proven by a preponderance of the evidence, that neither Eric nor his mother opposed community based treatment. (Tr. p.65, lns. 12-15)

C. Reasonable Accommodation

The Seventh Circuit determined that Eric's mother could prove the third element, that the relief requested could be reasonably accommodated if she could show: (1) that a nursing facility would not meet Eric's medical needs; (2) the level of care that Eric would require in an institutional setting whether it would be a nursing facility, a hospital or some other type of facility; (3) that the appropriate institutional setting could provide equivalent care to the care Eric was receiving at home; and (4) that Eric is a "qualified individual" under the Americans with

[1] This case arose in 2000 when Eric turned 21. Prior to that time, HFS had provided reimbursement for 16 hours of at - home skilled nursing for Eric with 336 hours of respite care under the MFTD. (Plaintiff's Exhibits 2, 7, 10, 13). The Division of Rehabilitation Services (DRS), a division of the Department of Human Services (DHS) operates the waiver for disabled persons - the HSP pursuant to an interagency agreement with HFS. (Tr. p. 319, lns.10 - 25). When Eric turned 21, he was found eligible for and transitioned into the HSP. (Jt. Exhibit 2). His monthly reimbursement under the HSP was $4,593 based upon the exceptional care rate paid to Alden Lincoln Park, a skilled nursing facility. (Jt. Exhibit. 5). The cost of nursing at home from 2000 to the present is $29.55 per hour. (Testimony of Donna Radaszewski, Tr. p. 56, lns. 10 - 17). Thus the reimbursement provided under the HSP would pay for approximately five hours a day of nursing instead of the 16 hours of nursing Eric received while in the MFTD waiver. Thomas Napolski, a DRS case counselor who was responsible for Eric's case in 2006, testified that the plan of care offered Eric in the HSP based upon the nursing home based reimbursement rate of $4,593 would not meet Eric's needs. (Tr. p. 191, lns. 5-11). It is uncontested that $4,593 is not adequate to allow Eric to remain at home.

Disabilities Act because he meets the essential eligibility requirements of HFS's home and community based waiver program known as the Home Services Program (HSP).[2] Those essential elements as set forth by the Seventh Circuit are that he has severe long term disabilities; he is eligible for Medicaid; he is at risk of placement in an institution; and his home is an appropriate care setting. 383 F.3d at 612. The Seventh Circuit's decision also noted that Eric is not an "unqualified" disabled person because he is not able to handle or benefit from community settings, the State's medical professionals believe he is not able to live in the community or that Eric or his parents do not wish to live in the communty. *Id*. In addition the Seventh Circuit stated that Eric also qualified for the HSP "in the sense that the cost of his continued care at home would not exceed the anticipated cost of caring for him in an appropriate institutional setting. 383 F. 3d at 613. As demonstrated below, the evidence in this case demonstrates that Eric meets each of these requirements.

(1) A nursing home would not meet Eric's medical needs.

The undisputed evidence in this case is that a nursing home would not meet Eric's medical needs. Dr. Michael Peters, Eric's treating physician, testified that a nursing home would not meet Eric's medical needs. (Tr. p. 118, ln. 14 - p. 119, ln. 9). He stated:

> I believe the severe nature of his disabilities, the constellation of problems that he has, quite frankly, I don't think he would get the care he would need. In fact, it would create more problems for putting him in a nursing home setting. So I truly believe he would not do well in that setting.

(Tr. p. 138, lns. 9 - 14). Defendant offered no evidence to the contrary.

Dr. Peters based his opinion on his description of Eric's medical condition of having been diagnosed at age 12 with a brain tumor, a medulloblastoma, in the deep center of his brain that ultimately was treated with surgery, and combinations of radiation and chemotherapy. (Tr. p. 100, lns. 19-23). Thereafter, Eric suffered a stroke, developed a seizure disorder and an obstruction in the ventricular system in the brain that led to placement of drainage catheters from

[2] The waiver in this case has been referred to at trial as the HSP Waiver and the Persons with Disabilities Waiver (PWD) Waiver. Plaintiff will refer to this waiver in this closing argument as the HSP Waiver.

his brain. (Tr. p. 100, ln. 24 - p. 101, ln. 4).[3]

Dr. Peters further testified that Eric's current medical problems relate to those medical events. (Tr. p. 106, lns. 2 - 5). Eric at present has no meaningful pituitary gland function, has an active seizure disorder, and is in a chronic disease state with a chronic immune suppressive condition that causes him to be very prone to infections. (Tr. p. 106, lns. 9 - 18). Because of the hormones that he has been given to compensate for his lack of a pituitary gland function, he has developed deformities of his bones and spinal column. He has trouble breathing properly and is prone to aspirating food into his lungs. He has developed a progressive spinal deformity which is affecting his ability to breathe. (Tr. p. 106, ln. 19 - p. 107, ln. 2). Dr. Peter's Physician's Plan of Treatment states that Eric developed Inappropriate Antidiruretic Hormone (SIADH) in December, 1993, Sleep Apnea in May, 1994 and has suffered recurrent bouts of pneumonia, sepsis, skin infection and sinus infection. (Plaintiff's Ex. 28-A, Certification Period 6/1/07 - 7/30/07, p. 2, 29-A).

Dr. Peters explained that Eric's medical condition is "very complex," (Tr. p. 108, ln. 15), "probably the most complex medical case I have had to take care of during my medical career . . . ." (Tr. p. 111, lns. 15 - 17). He explained that Eric lacks the brain functions that most normal people have in regulating the brainstem and pituitary functions which are vital to maintaining balances and normal function around the body. (Tr. p. 108, lns. 17 - 21). Eric is completely reliant on outside sources of hormonal support: thyroid treatment, an adrenal hormone, a supplemental form of testosterone, and supplemental forms of nutrition to maintain normal salt balances and chloric intake. (Tr. p. 108, ln. 22 - p. 109, ln. 2). Dr. Peters further testified that when Eric gets sick, he often requires antibiotic therapy. Because he has difficulty absorbing and utilizing items properly when given by mouth, his treatments for pneumonia, urinary tract infections and soft-tissue infections require IV administration of these medications. (Tr. p. 109, lns. 3 - 13). He cannot communicate how he feels in most situations, continues to have active seizures, is wheelchair dependent, has suffered from fractures, has a very complex set of

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[3] Plaintiff's Exhibit 28-A, Physician's Plan of Treatment, Certification Period 9/1/07 - 7/30/07, page 2, indicates that Eric suffered a mid-brain stroke in December, 1993, hydrocephalus that same month, and developed his seizure disorder in February, 1992.

medications (20 - 25 on a daily basis and ten additional medications given to treat various symptoms as needed) to maintain his balances, has blood drawn from an intravenous catheter site and currently has a PICC line site in his arm from which blood is drawn and medications administered. He is prone to problems from interactions between the medications he receives. (Tr. p. 109, ln. 14 - p. 111, ln. 3). Dr. Peters further explained that the administration of these medications has to be monitored constantly because they can cause liver inflammation, put stress on Eric's kidneys and can cause further bone marrow suppression. (Tr. p. 111, lns. 9 - 12).

Dr. Peters testified that Eric's medical conditions and needs require experienced and knowledgeable registered nurses to actively assess Eric to monitor changes in his well being, to ensure that he's getting his medications properly, to assess changes in his status so that problems can be brought to Dr. Peters' attention as quickly as possible, to understand the current treatments Eric is receiving and whether they are working, to understand what those treatments are supposed to accomplish, and to monitor for side effects and interactions with other treatments, which in Eric's case is a very complex undertaking. (Tr. p. 113, ln. 8 - p. 114, ln. 4, p. 114, ln. 17 - p. 115, ln. 4.). Dr. Peter's Physician's Plan of Treatment sets forth in detail the specific medical tasks that are required to care for Eric. They include such tasks as administration of IV fluids and medications via PICC line, sterile dressing changes to the PICC line, NG insertion for nutrition, hydration and medications, nasal suctioning, urine testing, glucose testing, use of suction equipment, use of pulse oximeter, administration of TPN via PICC line, providing oxygen as needed to maintain oxygen level above a specified level or for treatment during seizures; assessment of cardio/respiratory, GI, GU, neuro, musculosketal, renal status, response to medication treatment, pain management, nutrition status, hydration, and mental status. (Plaintiff's Exhibit No. 28-A, Certification Period 6/1/07 - 7/31/07, page 3, Paragraph 19). Dr. Peters in each of the Physician's Plans of Treatment that comprise Plaintiff's Exhibit 28-A ordered no less than 16-24 hours of skilled nursing (RN only) each day for Eric and certified that Eric needs one-on-one skilled nursing care.[4]

Dr. Peters testified that he was familiar with the level of care provided in nursing

[4] Plaintiff's Exhibit 28-A consists of approximately 25 Physician's Plans of Care signed by Dr. Peters.

facilities, having cared for 200 - 300 nursing home residents as a family physician. (Tr. p. 117, lns. 6 - 8). He explained that his opinion that a nursing home would not meet Eric's needs is based on the fact that although nursing facilities employ registered nurses, the number of patients that each nurse has to supervise and take care of each day would be too great to permit nurses to adequately care for Eric. Nursing facility nurses do not provide day-to-day care for residents because they are responsible for supervision and administration of medications. (Tr. p. 117, ln. 17 - p. 118, ln. 1). Rather, such care is delegated to nursing assistants who do the bathing and changing of the bed. Although a nursing facility resident might see a therapist once or twice during the day, the residents are on their own for most of the day. (Tr. p. 118, lns. 2 - 7). In Dr. Peters' opinion, that level of attention would be inappropriate to meet Eric's needs. (Tr. p. 118, lns. 9 - 10). Dr. Peters further testified that because of staffing levels at a nursing facility, that Eric would not receive his treatments appropriately. He explained that because of the complexity and extensiveness of Eric's medications and hormonal therapies and the fact that some of them are highly reliant on timing of administration during the day to maintain his metabolisms, Eric requires a level of support that a nursing facility could not provide. (Tr. p. 118, lns. 16 - 24).

Another basis for Dr. Peter's opinion that a nursing facility would not meet Eric's medical needs is the regularity of infections that exist in a nursing facility and the fact that nursing facility staff don't take as many precautions to prevent the spread of infection as are taken in a hospital. (Tr. p. 118, ln. 25 - p. 119, ln. 5). Dr. Peters testified that because Eric is so immune suppressed, that Dr. Peters would "virtually guarantee" that Eric would contract repeated infections in a nursing facility that would be more difficult to treat over time. (Tr. p. 119, lns. 6 - 9).

Dr. Peters also testified that there were no substantial difference between Eric's medical condition in 2000 and at present. (Tr. p. 108, lns. 10 - 11). HFS's administrative hearing decision when Eric turned 21 in 2000 found that the uncontradicted evidence was that Eric would be at risk of danger if he were to be placed in a nursing home. (Plaintiff's Ex. 40, - p. DHS10098, #H).

In addition, State officials found that Eric needed a hospital level of care before he turned 21 in 2000. Prior to Eric's turning 21 in August of 2000, he received 16 hours a day of RN-level

skilled nursing and 336 hours each year of respite care through the MFTD Waiver. (Plaintiff Exhibit 1, p. HFS006908; Pl. Ex. 2; Pl. Ex. 3, p. HFS006961; Pl. Ex. 4, p. HFS007695; Pl. Ex. 5, p. HFS007708; Pl. Ex. 6, p. HFS006993; Pl. Ex. 7; Ex. 9, p. HFS007812; Pl. Ex. 10; Pl. Ex. 12, p. HFS001628; Pl. Ex. 13; 40 - p. DHS10097 , #B). That waiver program is administered under the direction of HFS which is the single state agency responsible for administering the Medicaid Program in Illinois and is operated by DSCC through an interagency agreement between the two agencies. (Plaintiff's Exhibit 42; Pl. Ex. 49, p. 004264; Pl. Ex. 56, p. HFS001873). The amount of nursing services provided in the home in the MFTD is determined by HFS based upon a comprehensive medical assessment of the child and the development of a medical plan of care. (Plaintiff's Exhibit 41, p. 003666, Pl. Ex. 56, p. HFS001879). The primary medical service identified on the plan of care is nursing. (Plaintiff's Exhibit 56, p. HFS001879).

HFS has established procedures to ensure that children served by the MFTD waiver meet medical eligibility including the appropriate level of care and that the services to be provided are medically necessary. (Plaintiff's Exhibit 57, p. HFS001906, Testimony of Barbara Ginder, Tr. p. 360, lns. 6 - 7). According to those procedures applications for participation in the MFTD and subsequent renewals include: (1) a cover letter from the DSCC case coordinator explaining why nursing is needed and what is occurring medically with the child; (2) a Form DPA 3399, "Assessment of Need for Care," which collects medical information regarding treatments, therapies and their frequency and a designation of the alternative level of care prescribed if home care is not available including a hospital, a skilled nursing facility or an intermediate care facility for the mentally retarded; (3) a letter from the child's doctor in response to an inquiry sent to the doctor by DSCC staff requesting a brief narrative of the relevant medical history, diagnosis, prognosis, developmental/functional level, current health status, nursing personnel needs in the home specifying the level of nursing expertise required (RN, LPN, CNA) and the number of hours required per week of each, physical care needs including medications, treatments and nursing procedures, therapies (type, frequency, and duration), and nutrition needs; (4) medical reports, (5) nursing notes, and (6) a report from the nursing agency. (Plaintiff's Exhibits 41 p. 003848; Pl. Ex. 52; Pl. Ex. 56 - p. HFS001119).

Based on this extensive and detailed information, HFS makes the final determination and

approval of all medical eligibility and renewals using an HFS team consisting of a nurse and physician consultants. (Plaintiff's Exhibit 56, p. HFS001875). The HFS physicians often contact the child's attending physician to verify the level of need for services. (Plaintiff's Exhibit 57, p. HFS001906). HFS then issues a Notice of Decision on Request for Medical Service on Form DPA 2352 to the participant, whether the plan is approved or denied. (Plaintiff's Exhibit 56, p. HFS001875). HFS reviews information regarding the child's care needs every six months for the first 18 months of eligibility and then annually. Even when a child is on an annual reevaluation schedule, DSCC submits medical updates to HFS every six months. (*Id*).

Plaintiff's Exhibits 1 - 14 comprise Eric's application for and renewal, approval, and updates of his medical plan of care while he participated in the MFTD waiver, a period extending from July, 1995 and ending in August of 2000, when Eric turned 21. These exhibits prove the following facts. First, HFS' physician consultants throughout this period consistently approved plans of care for Eric of 16 hours of in-home nursing care each day. (Plaintiffs Exhibit 1, p. HFS006908; Pl. Ex. 2, p. HFS006961; Pl. Ex. 4, p. HFS007695; Pl. Ex. 5, p.HFS007708; Pl. Ex. 6, p. HFS006993; Pl. Ex. 9, p. HFS007812; Pl. Ex. 12, p. HFS001628). Second, HFS approved the 16 hours a day of in home nursing care by issueing Forms 2352's, Notices of Decisions. (Plaintiff's Exhibits 2, 7, 10, 13).[5] Third, state officials found in Forms DPA 3399 that the alternative level of care to in home nursing was a hospital and not a skilled nursing facility or an intermediate care facility for the mentally retarded. (Plaintiff's Exhibit 1, p. HFS006929; Pl. Ex. 3, p. HFS006979; Pl. Ex. 4, p. HFS007705; Pl. Ex. 5, p. HFS007726; Pl. Ex.6, p. HFS007012; Pl. Ex. 9, p. HFS007877; Pl. Ex. 12, p. HFS001634).

In addition, each packet contained a Managing Physician's Report signed by Eric's physician setting forth his need for RN nursing care, an explanation of why this level of care was necessary, and a statement that a hospital would be the alternative location of care if home care were to be abandoned. (Plaintiff's Exhibit 1, p. HFS006919; Pl. Ex. 3, p. HFS006964; Pl. Ex. 4, p. HFS007698; Pl. Ex. 5, p. HFS007713; Pl. Ex. 6, p. HFS006997; Pl. Ex. 9, p. HFS007816; Pl. Ex. 12, p. HFS001631). And, each packet contained a Physician's Plan of Treatment and/or

[5] When Eric was hospitalized in February and April of 2000, HFS approved 24 hours of short term nursing care at home to prevent re-hospitalization. (Plaintiff's Exhibits 15 and 16)

other medical information such as nursing notes used by HFS to determine the level of nursing care that Eric required. (Plaintiff's Exhibit 1, pp. HFS006930, HFS006931, HFS006940; Pl. Ex. 3, p. HFS006966; Pl. Ex. 4, p. HFS007700; Pl. Ex. 5, p. HFS007715; Pl.Ex. 6, p. HFS007000; Pl. Ex. 9. p.7820; Pl. Ex. 12, p. HFS001636). Thus, the undisputed evidence is that Eric's medical condition and needs had not changed in August, 2000 when he turned 21 and that HFS had consistently found based on extensive and detailed information that Eric's medical condition required 16 hours of skilled nursing care to safely remain at home based and that the alternative to care at home was a hospital and not a nursing facility.[6]

In its decision, the Seventh Circuit noted that the HFS hearing officer specifically found, based on uncontradicted evidence "that Eric would be at risk of danger if he should be placed in a nursing home." (See, Plaintiff's Exhibit 40, p. DHS10097, #H). 383 F.3d at 610. The Court went on to explain that in view of that finding it assumed that Ms. Radaszewski would be able to prove that Eric, if institutionalized, would require "a more care-intensive setting than a nursing home-a hospital, for example-in order to survive." *Id*. Plaintiff submits that the evidence at trial, uncontradicted by the defendant, proves that a nursing home is not, as the Seventh Circuit discussed, "the appropriate reference points for assessing whether the private-duty nursing that Eric seeks to receive at home is a service that would be provided in an institutional setting." *Id*.

(2) The level of care that Eric would require in any institutional setting

The Seventh Circuit stated that the next question "concerns the level of care that Eric would require in an institutional setting-whether it be a nursing home facility, a hospital, or another type of care facility." *Id*. The court further explained that the evidence presented at Eric's administrative hearing made it "plausible to suppose" that in an institutional setting Eric could not be left unattended or attended only by a person lacking significant medical skills for any amount of time and that Eric requires "skilled assistance in order to safely accomplish many of the bodily functions necessary to remain alive . . . ." *Id*. The uncontradicted evidence

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[6] The packets comprising plaintiff's Exhibits 1 - 14 contain Forms 53.47, Cost Estimates, which indicate each time that the cost of providing care to Eric at home was less than the estimated cost of his care would be in the appropriate institution - a hospital. (Plaintiff's Exhibt 1, p. HFS006934; Pl. Ex. 3, p. HFS006981; Pl. Ex. 4, p. HFS007707; Pl. Ex. 5, p. HFS007711; Pl. Ex. 6. p. HFS007014), Pl. Ex. 9, p. HFS007870).

discussed above demonstrates that Eric requires one-on-one care in any institutional setting and specifically that he could not be left unattended or his care provided by persons lacking the necessary medical skills.

(3) The appropriate institutional setting would be equivalent to the private duty nursing Eric receives at home

The Seventh Circuit explained that even though an institutional facility would not assign private duty nurses to provide Eric's care, a hospital, in lieu of one-on-one nurse caring for Eric, might be able to use monitors and a pool of immediately available skilled professionals tending to multiple patients to provide the frequent, immediate assistance Eric medically requires, so that the level of care provided "is the equivalent of around the clock private duty nursing care." 383 F. 3d at 611. Plaintiff has proven this requirement. Dr. Peters testified that he has substantial experience with the care that hospitals provide. (Tr. p. 116, ln. 23 - p. 117, ln. 1). He opined that a hospital would be the only alternative setting appropriate to Eric if he could not receive care at home. (Tr. p. 115, ln. 25 - p. 116, ln. 3). He explained that hospitals use monitors, oximeters and telemetry to provide hospital staff with instant information on a patients's medical needs with staff assigned to watch the monitors. (Tr. p. 136, lns. 14 - 17) He explained that hospital floors are configured so that a nurse is never more than 20 to 30 feet from a patient's room. (Tr. p. 136, lns. 12 - 14). At Edwards Hospital, where Eric has been hospitalized (Plaintiff's Exhibit 29-A), there is one registered nurse and two certified nurses assistants assigned to four patients (Tr. p. 132, lns. 14 - 25). Defendant provided no testimony to the contrary. Thus, Dr. Peter's testimony establishes the equivalency of the care Eric would receive in a hospital to the nursing care he receives at home.

(4) HFS does provide funding for private duty nursing to adults

The decision of the Seventh Circuit states that relevant to the question of whether continuous private duty nursing is a service that Illinois offers in any setting is the fact that HFS "can and does make a available a limited amount of funding for private duty nursing to adults participating in the HSP." The court went on to explain:

> The cap on the level of funding that HSP would provide to Eric and his family prevents him from receiving the level of private-duty nursing that he needs-recall that the exceptional care rate

> approved for Eric would pay for only four or five hours of private-duty nursing per day rather than the 24 hours per day that his family seeks. But the fact that the State already provides for some private-duty nursing tends to belie the notion that providing such care to Eric so that he may remain at home would require the State to alter the substance of its Medicaid programs by creating an entirely "new" service."

383 F.3d at 612. The evidence in this case shows that HFS, as the Seventh Circuit noted, provides private duty nursing at home to persons in the HSP. Francis Kopel, the chief of HFS's Bureau of Program and Reimbursement Analysis, testified that private duty nursing is "continuous and individual one-on-one care provided to a person who has the medical need for that care." (Tr. p. 291, lns. 1-2). Barbara Ginder, the Chief of HFS's Bureau of Interagency Coordination, the entity that is responsible for overseeing the State's Medicaid waiver programs (Tr. p. 218, lns. 12 - 15, ln 24 - p. 219, ln. 1), also defined private duty nursing as "ongoing and continuous nursing." (Tr. p. 354, lns 14 - 16). Ms. Ginder testified that there is no limitation on the number of hours that an individual in the HSP can have of skilled nursing other than the cost cap that is assigned to them (Tr. p. 224, lns. 21 - 25) and that persons in the HSP could receive eight or more hours a day of skilled nursing at home. (Tr. p. 225, lns. 5 -7). Irrespective of whether HFS calls such services "private duty nursing," in fact the uncontradicted evidence is that extensive one-on-one skilled nursing services are available under the HSP.

(5) Eric is a "qualified individual" under the Americans with Disabilities Act because he meets the essential eligibility requirements of HFS's adult waiver program

Eric was found eligible for the HSP. (Plaintiff's Exhibit 40, p. DHS 10097, #C, Stipulation of the Parties with respect to Defendant's Exhibit 46 as stated by the Court at Tr. p. 273, lns. 4 - 10). In addition, the evidence shows that he meets each of the essential eligibility requirements for the HSP set forth by the Seventh Circuit as follows:

(A) He has severe long term disabilities.

The evidence discussed above proves that Eric has long term disabilities. Eric's disability began in 1992 when he contracted a malignant brain tumor. (Testimony of D. Peters, Tr. p. 100, lns. 19 - 21). Dr. Peters has testified that his disability remains essentially unchanged (Tr. p. 108, lns. 10 - 11 and that there is no prognosis for recovery. (Tr. p. 111, ln. 24 - p. 112, ln. 5). The

defendant has presented no evidence to the contrary.

(B) Eric is eligible for Medicaid.

The parties have stipulated that Eric is eligible for Medicaid. (Stipulation #3).

(C) Eric is at risk of placement in an institution.

Dr. Peters has testified that if care was not available to Eric at home he would have to be institutionalized. (Tr. p 135, lns. 1 - 10, Plaintiff Exhibits 28-A,). The defendant has presented no evidence to the contrary.

(D) Eric's home is an appropriate care setting.

Dr. Peter's has testified that the care Eric receives at home has made a huge impact on him staying well. (Tr. p. 115, lns. 13 - 15). As set forth on pages seven to eight above, state professionals approved home care for Eric as an appropriate setting for Eric consistently while he was in the MFTD waiver.

(E) Eric is not an unqualified disabled person.

This element was discussed above on pages 1 and 2. The testimony of Dr. Peters and Eric's mother demonstrate that Eric is able to benefit and in fact benefits from living in the community. Dr. Peters testified that from a medical standpoint, the medical care provided to Eric in the community is an important part of why Eric has done as well has he has. (Tr. p. 115, lns. 10 - 11). Eric's mother, Donna Radaszewski testified to the activities that Eric engages in at home and his interactions with family, friends, and persons in the community. (Tr. p. 76, ln. 19 - p. 77, ln. 13.) As discussed, HFS's consulting physicians have found that Eric can live in the community. This court has found that Eric wishes to remain in the community. (Tr. p. 65, lns. 12-15).

(6). Eric qualifies for the HSP in the sense that the cost of his care at home would not exceed the anticipated cost of caring for him in an appropriate institutional setting

The evidence indicates that it would cost the State less to provide Eric's care at home then in the appropriate institutional setting, a hospital. Eric's cost of care at home during 2005, the most recent year of complete data (Testimony of Matthew Werner, Tr. p. 566, lns 19 - 20) was $20,499 per month or $676.53 per day. (Defendant's Exhibit #3, p. HFS009601; Plaintiff's Exhibit 55, p. HFS009606) In contrast, the average Medicaid reimbursement cost for a person

over 21 years of age for a hospitalization in excess of 120 days in 2004-2005 was $1,428.75 per day. (Plaintiff's Exhibit 46, Testimony of Barbara Ginder, Tr. p. 236, ln. 25 - p. 237, ln. 2). There has been no reduction in hospital reimbursement rates since that time period. (Testimony of Barbara Ginder, Tr. p. 236, ln. 25 - p. 237, ln. 2). In 2006 Eric was hospitalized for 14 days at a Medicaid reimbursement cost to the State of $22,710 or $1,621 dollars per day. (Plaintiff's Exhibit 55, p. HFS009606).

Under the Illinois Medicaid Program, HFS pays for long term care for adults in the institutional setting they require, including skilled nursing facilities and hospitals. (Pl. Ex. 45, Amended Answer, Par. 33, *Sidell v. Maram*, Plaintiff's Exhibit 45A, Complaint, *Par. 33, Sidell v Maram*). Illinois does not own or operate facilities for long-term care of persons with disabilities other than veterans nursing homes. (Testimony of Francis Kopel, Tr. p. 201, lns. 2 - 16). Thus, the Illinois Medicaid Program covers medically necessary hospitalization (and nursing facility care) for disabled adults, by making payments to private vendors. (Testimony of Francis Kopel, Tr, p. 201, ln. 17 - 20; p. 209, ln. 16 - p. 210, ln. 2).

The Seventh Circuit also found it relevant that participation in the MFTD Waiver required cost neutrality. 383 F. 3d at 613. As discussed on pages 7 - 8 above, the evidence demonstrates that Eric participated in the MFTD Waiver from 1995 until 2000 and that the cost estimates contained in his original application and renewal packets indicated that it cost less to care for Eric at home than in the appropriate institution, a hospital.

Conclusion

Plaintiff submits that the above discussion of the evidence in this case demonstrates that the required elements established in this case by the Seventh Circuit are proven by a preponderance of the evidence. Plaintiff will respond to defendant's fundamental alteration affirmative defense in her reply brief.

s/Bernard H. Shapiro
Bernard H. Shapiro Bar Number 2564009
Attorney for Plaintiff
201 Houston St., Suite 200
Batavia, IL 60510
Telephone: (630) 232-9420
Fax: (630) 232-9402

E-mail: bshapiro@pslegal.org

PRAIRIE STATE LEGAL SERVICES, INC.
Eliot Abarbanel
Bernard H. Shapiro
Sarah Megan
350 South Schmale Road
Suite 150
Carol Stream, IL 60188
630-690-2130

Certificate of Service

I hereby certify that on October 17, 2007, I presented the foregoing Plaintiff's Closing Argument with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

Karen Elaine Konieczny
Karen.Konieczny@Illinois.gov

John E. Huston
John.Huston@Illinois.gov

Christopher Samuel Gange
Christopher.Gange@Illinois.gov

_____
s/Bernard H. Shapiro
Bernard H. Shapiro Bar Number 2564009
Attorney for Plaintiff
201 Houston St., Suite 200
Batavia, IL 60510
Telephone: (630) 232-9420
Fax: (630) 232-9402
E-mail: bshapiro@pslegal.org