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March 16, 2012

BY E-MAIL AND U.S. MAIL

Frank Urso, Esq.
General Counsel
Illinois Health Facilities and Services Review Board
122 South Michigan Avenue
7th Floor
Chicago IL 60603

Re: Clarification of Issues Surrounding Condition to Project #11-098 ("Project")
Ritacca Laser Center, Vernon Hills

Dear Frank:

We represent Dr. Daniel Ritacca ("Dr. Ritacca") and Ritacca Laser Center ("the Center"). There appears to be a need to clarify the condition that was placed on this ambulatory surgery treatment center ("ASTC") located at 230 Center Drive, Vernon Hills, Illinois, which was recently reclassified by the Health Facilities and Services Review Board ("HFSRB" or "Board") as a multi-specialty ASTC. The permit letter is attached as Exhibit A.

Our hope is to clarify that the condition on the Center's permit is to limit the Center's practice to ophthalmology, plastic surgery, and General/Other (pain management) and not to limit, in any way, the scope of the Center's practice of ophthalmology, plastic/reconstructive surgery, and/or pain management. Recent exchanges between Dr. Ritacca and Board staff have called that issue into question. Dr. Ritacca has no intention of violating any valid conditions imposed by the Board, but wants to be certain there is no limitation beyond that which was presented to Dr. Ritacca at the January 10, 2012 Board meeting.

On January 10, 2012, Dr. Ritacca appeared before the HFSRB seeking authority to expand the services provided at the Center by adding pain management. 'Pain management' is not one of the categories of services explicitly identified in Board regulations. *See* 77 Ill. Admin. Code 1110.1540(a)(1). Rather, the HFSRB considers 'pain management' as a specialty under the 'catch-all' of General/Other, which includes "any procedure that is not included in the other specialties." 77 Ill. Admin. Code 1110.1540(a)(1)(D). The Board unanimously approved the Project. The Board vote tallies from the January 10, 2012 meeting are attached as Exhibit B.

During consideration of the project, the following exchange took place between Dr. Ritacca and Vice Chairman John Hayes regarding the Center's transition from a limited specialty ambulatory surgery center and a multi-specialty ambulatory surgery center:

> VICE-CHAIRMAN HAYES: This is a limited specialty ambulatory surgery center?
>
> MR. KNIERY: It is right now, yes.
>
> VICE-CHAIRMAN HAYES: Under our rules, you'll be going to a multi-specialty with adding this new service.
>
> MR. KNIERY: Yes.
>
> VICE-CHAIRMAN HAYES: Would you be - - accept an amendment that basically would require you, if you wanted to enter a new - - beyond the pain management and beyond ophthalmology and plastic surgery, ***if you wanted to enter another specialty***, that you would have to come to the Board and do that?
>
> MR. (sic) RITACCA: Absolutely, Vice-Chairman.

Transcript of January 10, 2012 HFSRB Meeting (relevant portion attached as Exhibit C) (emphasis added). The condition imposed related to the addition of ***other surgical specialties***, not to limit his performance of procedures that are part of the Center's ophthalmologic practice, its plastics/reconstructive/aesthetics practice, or its pain management practice. Nor was the condition to require approval for the addition of procedures related to any of these schools of medicine.

In fact, during the discourse regarding this application, Dr. Ritacca raised this issue and made it explicitly clear that there are procedures that are part of his plastics/reconstructive practice that could be seen to 'cross-over' into other specialties, and he did not want to be prohibited from performing those types of procedures (*e.g.*, repairing a hernia during the course of a reconstructive procedure). Dr. Ritacca made it a point to voice his concern that the Board not limit his performance of procedures related to ophthalmology, plastic surgery, and/or pain management. The Board voted and approved his project ***after*** he clarified that the condition was not an effort to limit him in that manner.

Mr. Carvalho intervened to clarify the condition being discussed and framed the issue quite well: that the limitation the Board was seeking to place on the Center was that, unlike other multi-specialty ASTCs, the Center would not be able to add ***other surgical specialties*** without coming before the Board. Dr. Ritacca agreed to this but, again, clarified that various procedures (*e.g.*, performing the repair of a hernia during abdominoplasty) does not and should

not constitute 'general surgery.' Mr. Carvalho then acknowledged that was a separate issue and reiterated that the Board's condition did not relate to the boundaries of the Center's authorized categories but, rather, was to limit the Center expanding beyond the three categories already approved.

Dr. Ritacca's interest is in being able to have physicians at the Center engage in the practice of ophthalmology, plastic/reconstructive surgery, and pain management to the full extent allowed by each school of medicine. For example, Dr. Ritacca has no interest in establishing a podiatric practice, but should be able to perform a cosmetic repair on a hammer-toe in his capacity as a plastic/reconstructive surgeon. Dr. Ritacca is not seeking to establish an oral/maxillofacial practice, but this should not prohibit him from performing a legitimate and recognized plastic/reconstructive procedure requiring the setting of a jaw. These, and countless other procedures, are reimbursed by public and private insurers as part of the appropriate practice of a plastic/reconstructive surgeon, despite the fact that they could also be reimbursed as the practice of a podiatrist or a maxillofacial surgeon. It is not the role of the Board, nor is it appropriate to place Board staff in a position, to make medical assessments regarding in which school of medicine a particular procedure should be classified.

Moreover, Dr. Ritacca should not have to seek Board approval every time a properly licensed plastic surgeon proposes to perform an aesthetic/reconstructive procedure if the procedure could be properly considered ***either*** plastic surgery ***or*** be classified under another specialty. Dr. Ritacca should not have to come before the Board when a new procedure to manage pain is developed to obtain verification from the Board that it is proper for him as a physician to perform this new procedure. It would convert the Board from being a health planning entity into the role of managing individualized medical practices.

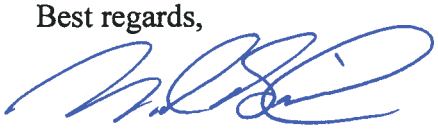
Dr. Ritacca was willing to limit the Center's practice to three surgical specialties: (1) ophthalmology; (2) plastic surgery; and (3) General/Other (pain management). However, recent interaction with Board staff has left Dr. Ritacca with the concern that he will have to obtain Board approval to provide various ***procedures*** at the Center. The reason for this is that while Dr. Ritacca considers these procedures appropriately a part of his practice (and a part of the surgical specialties he has been approved to provide), the Board staff has concluded these ***procedures*** exceed the boundaries of ophthalmology, plastic surgery, and/or pain management. Setting aside our disagreement with staff's conclusion, this is simply not the condition that Dr. Ritacca agreed to and a review of the transcript verifies this is not the condition that the Board imposed, or even sought to impose, upon Dr. Ritacca.

We hope this issue can be clarified by your simple verification in response to this correspondence. If it would be of assistance, we are more than happy to have an in-person meeting with you, as Board counsel, and the appropriate staff or Board members. We are prepared to be as specific as necessary in describing the types of procedures that are at issue and their nexus to the proper practice of ophthalmology, plastic/reconstructive surgery, and/or pain

management. It is not Dr. Ritacca's desire to skirt any rules and, certainly, he does not want to act in disregard of his responsibilities. Of all of the options available, Dr. Ritacca concluded that issuing this correspondence seemed to be the most direct, most amicable, and most appropriate way to resolve his concerns.

We look forward to your response, we appreciate your taking the time to consider this matter, and we invite any questions you have or clarification you might seek.

Best regards,



Mark J. Silberman

MJSmjs
encs

cc: Dr. Daniel J. Ritacca

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 • (217) 782-3516 • FAX: (217) 785-4111

January 24, 2012

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Teresa Dino
Ritacca Laser Ctr. Ltd.
230 Center Drive, Suite 101
Vernon Hills, IL 60061

RE: PERMIT: #11-098 Ritacca Laser Center, Vernon Hills

Dear Ms. Dino:

On January 10, 2012, the Illinois Health Facilities and Services Review Board (HFSRB) approved the application for permit for the referenced project based upon the project's substantial conformance with the applicable standards and criteria of Part 1110 and 1120. In arriving at a decision, HFSRB Board considered the findings contained in the State Agency Report, the application material, and public hearing and public participation testimony.

- **PROJECT: #11-098 – Ritacca Laser Center, Vernon Hills** – The permit holders are approved to add Pain Management Services to an existing limited-specialty Ambulatory Surgery Treatment Center (ASTC) located at 230 Center Drive, Vernon Hills, Illinois, and be reclassified as a multi-specialty ASTC

- **PERMIT HOLDERS:** Ritacca Laser Center, Ltd., and Daniel J. Ritacca, M.D.

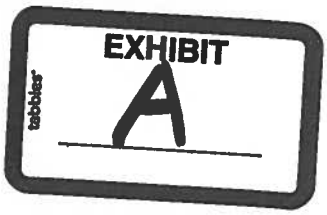
- **CONDITIONS AND STIPULATIONS:** The permit holders must submit a Certificate of Need application to the Illinois Health Facilities and Service Review Board before adding additional surgical specialties outside of Ophthalmologic, Plastic, or Pain Management services.

- **PERMIT AMOUNT**: $0

- **PROJECT OBLIGATED BY**: January 10, 2013

- **PROJECT COMPLETION DATE**: August 31, 2012

This permit is valid only for the defined construction or modification, site, amount and the named permit holder and **is not transferable or assignable.** In accordance with the Planning Act, the permit is valid until such time as the project has been completed, provided that all post permit requirements have been fulfilled, pursuant to the requirements of 77 Ill. Adm. Code 1130.



The permit holder is responsible for complying with the following requirements in order to maintain a valid permit. Failure to comply with the requirements may result in expiration of the permit or in State Board action to revoke the permit.

1. OBLIGATION-PART 1130.720

   The project must be obligated **by the Project Obligation Date,** unless the permit holder obtains an "Extension of the Obligation Period" as provided in 77 Ill. Adm. Code 1130.730. Obligation is to be reported as part of the first annual progress report for permits requiring obligation within 12 months after issuance. For major construction projects which require obligation within 18 months after permit issuance, obligation must be reported as part of the second annual progress report. If project completion is required prior to the respective annual progress report referenced above, obligation must be reported as part of the notice of project completion. The reporting of obligation must reference a date certain when at least 33% of total funds assigned to project cost were expended or committed to be expended by signed contracts or other legal means.

2. ANNUAL PROGRESS REPORT-PART 1130.760

   An annual progress report must be submitted to HFSRB every 12-month from the permit issuance date until such time as the project is complete.

3. PROJECT COMPLETION REQUIREMENTS-PART 1130.770

   The permit holder must submit a written notice of project completion as defined in Section 1130.140. Each permit holder shall notify IHFSRB within 30 days following the project completion date and provide supporting documentation within 90 days following the completion date and must contain the information required by Section 1130.770.

   This permit does not exempt the project or permit holder from licensing and certification requirements, including approval of applicable architectural plans and specifications prior to construction. **Please note the Illinois Department of Public Health will not license the proposed facility until such time as all of the permit requirements have been completed.**

   Should you have any questions regarding the permit requirements, please contact Mike Constantino at 217-782-3516.

Sincerely,

Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board

cc: Dale Galassie, Chairman

Results of January 10, 2012 meeting of the
Illinois Health Facilities and Services Review Board

Members Present: Vice-Chairman John Hayes, Ron Eaker, Alan Greiman, Robert Hilgenbrink, Kathy Olson, David Penn, and Richard Sewell.

Members Absent: Chairman Dale Galassie, James Burden

Post Permit Items Approved by Chairman (none)

Permit renewal Requests (none)

Extension Requests (none)

Exemption Requests (none)

Declaratory Rulings (none)

Alteration Requests(none)

Health Care Worker Self-Referral Act (none)

Applications Subsequent to Initial Review

11-070 Neomedica Bridgeport (Change of ownership)	
11-071 FMNCA Dialysis Services Burbank (Change of ownership)	
11-072 Neomedica Evergreen Park (Change of ownership)	
11-073 Neomedica Hazel Crest (Change of ownership)	
11-074 Neomedica Hoffman Estates (Change of ownership)	
11-075 FMC Lakeview (Change of ownership)	
11-076 Neomedica Marquette Park (Change of ownership)	
11-077 Neomedica Melrose Park (Change of ownership)	
11-078 FMC Midway (Change of ownership)	
11-079 FMC Niles (Change of ownership)	**Approved together**
11-080 Neomedica Cumberland (Change of ownership)	**7-0-2 absent**
11-081 FMC Northcenter (Change of ownership)	
11-082 Neomedica North Kilpatrick (Change of ownership)	
11-083 FMC Polk (Change of ownership)	
11-084 Neomedica Rolling Meadows (Change of ownership)	
11-085 FMC Roseland (Change of ownership)	
11-086 FMC Ross Dialysis-Englewood (Change of ownership)	
11-087 FMC South Chicago (Change of ownership)	
11-088 Neomedica South Holland (Change of ownership)	
11-089 Neomedica South Shore (Change of ownership)	
11-090 FMC West Belmont (Change of ownership)	
11-092 North Main (Change of ownership	**Approved together**
11-093 RAI Centre West – Springfield (Change of ownership)	**7-0-2 absent**
11-094 RAI Lincoln Highway (Change of ownership)	
11-096 FMC Cicero (Establish a 16-station ESRD Facility)	**Intent to Deny**
	4-3-2 absent
11-097 Shiloh Dialysis (Establish a 12-station ESRD Facility)	**Approved 6-1-2 absent**
11-099 FMC Prairie Meadows (Establish a 12-station ESRD Facility)	**Applicant Deferred**
11-102 Lake Park Dialysis (Discontinue ESRD Facility; Establish 32-station ESRD Facility	**Approved 6-1-2 absent**
11-100 Oak Surgical Institute (Add Surgical Specialty; Establish Multi-Specialty ASTC)	**Intent to Deny** **4-3-2 absent**
11-095 Palos Hills Surgery Center (Establish an ASTC)	**Intent to Deny** **4-3-2 absent**
11-098 Ritacca Laser Center, Ltd. (Add Surgical Specialty; Establish Multi-Specialty ASTC)	**Approved 6-0-3 absent**

Applications Subsequent to Intent to Deny

11-038 FMC Naperbrook (Establish 16-Station ESRD Facility) Establish 16-Station ESRD Facility)	**Approved 6-0-3 absent**

EXHIBIT B

break until 3:10, and we'll reconvene then.

(Recess).

VICE-CHAIRMAN HAYES: I'd like to call Item H-32, 11-098, Ritacca Laser Center, Limited. The applicants are at the table there, and could you swear in the applicant, and we'll have the State Agency Report then.

(Oath given)

MR. CONSTANTINO: Thank you, Mr. Chairman.

The applicant, Ritacca Laser Center, Ltd., proposes to add pain management services to an existing limited specialty ASTC in approximately 4,500 gross square feet of space. This ASTC currently offers ophthalmologic and plastic surgery. There is no cost to this project. The anticipated project completion date is August 31st, 2012.

The ASTC consists of two operating rooms and six recovery stations. Should the State Board approve this project, the facility will be classified as a multi-specialty ASTC. No public hearing was requested and no letters of support was received by the State Board Staff. One Impact Letter was received from Grand Oak Surgery Center.

Finally, there are existing facilities within the proposed TSA not operating at target occupancy.

Thank you, Mr. Chairman.

I would like to apologize for the mistake we made on your agenda for the last project. That was my mistake. I apologize for that.

VICE-CHAIRMAN HAYES: I accept. Thank you, Mike.

The applicants, could they identify themselves and give a presentation.

MR. KNIERY: Thank you, Mr. Vice-Chair. My name is John Kniery. I'm with Foley and Associates, healthcare consultants. To my left is Dr. Daniel Ritacca, and to my right is Dr. Jay Joshi. I'd like to have Dr. Ritacca make some opening comments about the facility and what brings us here today, and then I'll address a couple of the negative findings.

MR. RITACCA: Thank you very much for your time, Mr. Chairman and the Board. I'd like to thank the Staff for the support for this project.

Ritacca Laser Center specializes in eyes and plastic and reconstructive surgery, and we opened approximately two years ago. In December of 2008, fire destroyed our surgery center, which caused us to seek renewal of our permit. Even though this partially whipped out my practice, this impact was met with increasing

surgical volume and progress over the last two years, and approximately 2,000 hours are currently taking place in the two OR system, which I believe 80 percent would be 3,000 hours. Dr. Joshi approached me approximately in the last year. He's a pain specialist, Board-certified in anesthesia, with distinguished work in health organizations in Geneva at the World Health Organization and Fraud and Waste Reform in America. He's a consultant of pain management, and I felt with his help, I could get to this 80 percent level, and as I improved the volume my practice as well. He shares office space with me in the building where the surgery center is, and because of the 50 percent rule and the limited specialty, and I am presenting today to the Board.

I have conferred with two area hospitals and am encouraged and believe that the addition of a pain facility that accepts Medicaid and Blue Cross in the area is needed. I asked Condell to write me a letter to that effect, and they support my endeavors. No public hearing was requested, and I believe our opposition to the project does not accept major insurance or Medicaid.

I'm going to allow Dr. Joshi to make a statement.

MR. JOSHI: Thank you, Board members, and

thank you for hearing us. My name is Jay Joshi. I'm an anesthesiologist and an ABA, Board-certified interventional pain physician. Why is that important? Because it's the only accreditation that is recognized by the American College of because I think in the future, you're going to be approached by other people who are going to call themselves pain physicians. The reality is, the vast majority of pain physicians in America are not accredited by an American College of Medical Specialties accreditation. The reason for that is if you look at the landscape of pain, you'll find that by the Department of -- the Office of Internal Medicine published a study earlier this year. The demographics of chronic pain state that about one-third of America has some kind of chronic pain, over one hundred million people in America. The amount of people that just have the accreditation that's recognized in America is about 4,000. That doesn't mean they're good or bad or whatever. That just means how many people are recognized? You understand the deviation. You see, there is a huge deficiency of people that are actually accredited that do interventional pain management. How many of those do comprehensive or multi-modal pain management? That number is extremely small. It's a topic I've become very, very compassionate about. I even did work on this before I

graduated medical school. I did a lot of healthcare policy and world health organization. I've really put my money where my mouth is, even before I had money to put in my mouth, and I've worked on -- met some of our esteemed Congressmen of Illinois to try and get some reform, as well to try to increase patient satisfaction, patient care, decrease the healthcare over utilization, and streamline care, so especially for our population like Medicare, Medicaid patients, where we have a major problem in America. How do we take care of these patients? A lot of physicians don't even accept those insurance plans. Those are the things I've tried to work on.

I was a Medical Director for Pain at Alexian Brothers, and it was something -- another topic that I tried to streamline. At that hospital, just in the last year, I can tell you that I saw more Medicaid patients than anyone, any other pain physicians on staff there, and I think I actually saw more Medicaid patients than all the pain physicians on staff there combined.

We don't have those services. It's a major problem. Some of the pain physicians on staff at the hospital and the community don't even take Medicare anymore. So, it's a major problem, because chronic pain is more prevalent, obviously, as we all get older. We see it

in younger patients, too, from car accidents and things like that. As we all get older, we're all going to have it. Arthritis is one major form of chronic pain. We're all going to have it and management of that is really important. If you don't manage it, you start seeing the numbers that we see right now, which include a total cost, indirect and direct care, of $635 billion a year. To me that's insane. It can be lower if we sort of streamline care and actually take care of patients early on, instead of allowing them to enter this horrible, disabled sort of situation.

I have an office in the Schaumburg area, and Lake County is an area that's incredibly under served by qualified pain physicians, to the point where just the people who actually have the same credentials I do, in terms of just education, not in terms of anything else, just the credentials, I think we're only able to identify maybe 10 or 15 or something like that, for a population of over a million people. Obviously, that number is -- if you sort of look at just the demographics you're seeing maybe 300,000 who have chronic pain and ten people to manage it. That's insane. Out of those people, again, some of those people don't take Medicare. Some of those people don't take Medicaid. I looked very hard to find facilities where

I could take patients in Lake County. Of all of the places I approached and I called, all the surgery centers -- there's a couple, only two even remotely in the area, and I say "remotely". I'm talking half an hour, 40 minutes away, that offer pain, and none of them would let me even step foot on the property, because they don't want me there because of the competition. They just want to keep their little thing. So, they wouldn't even allow me. One of them is up for sale, so they won't -- obviously, they weren't interested in having anyone there.

The only person, the only surgery center that said, "Hey, we want to actually take care of your patients. We actually will take Medicare and Medicaid patients," was Dr. Ritacca. The only problem, obviously, is he didn't have a pain certification. So, it's taken us about probably close to a year now to be -- have the opportunity to be here today, and that's why we're here today. So, thank you for your time and, obviously, I'm open to questions.

One other point I want to mention. There's a veteran's hospital up by north Chicago. We've been approached for a year now to help provide services to the patients out at the VA up there. The only problem is we haven't been able to have a facility up in Lake County.

Our closest facility is down in Schaumburg. So, those patients would literally have to drive down an hour each way to be able to see us, and when you say see someone, it's not just procedures. There's follow-ups, there's -- sometimes there are medications and medication checks. You have to make sure that they're actually doing well. So, all those visits, they would have to drive down an hour to see us, and it's incredibly inconvenient. A lot of the VA patients are elderly patients that have a lot of health issues, and it's really hard for them to drive an hour each way. So, we've really been waiting for a facility in Lake County that's only 20 minutes away and something much more reasonable for those patients.

Thank you.

VICE-CHAIRMAN HAYES: Excuse me. Could I take a little break here? I'd like to note that Member Penn has left the meeting, while we still have a majority and quorum.

Proceed.

MR. KNIERY: Thank you. I would just like to address the findings in the State Agency Report briefly, if I may. As you review the report, you'll note that there are basically two issues: Under utilization of existing facility per population center, and the second is low

utilization of the area facilities, namely Granville Surgery Center.

The first issue, Dr. Ritacca and his physician associates have been rebuilding the utilization rates from the loss as a result of a facility fire. As reported in the application -- they will report also in the next annual questionnaire form -- their utilization has been around 2,000 hours and is growing on an annualized basis. As previously indicated, also Ritacca Laser Center is now whole again. So, it is projected that they will be able to continue improving their utilization rates to near optimal levels through ongoing operations and with existing case load. This project also supports the facility's ability to reach and maintain the optimal utilization by bringing on additional specialty and by using an existing healthcare resource.

The second issue, the area low utilization. We think that the focus of the Board and this criteria specifically is to utilize existing capacity in existing area surgery centers before establishing a new center and expending additional healthcare dollars. Although there appears to be an existing facility with utilization rates less than the State's optimal targets, Ritacca Laser Center is such a facility and should be utilized before a new

surgery center is established. To that end, we have a doctor who has approached the 50 percent licensing rule under ambulatory surgical treatment centers, which limits his own practice. He will need to be either licensed or find alternative locations to perform these procedures or a percent of these procedures. This project fulfills the Board's intent and rules by utilizing the existing healthcare resource of Ritacca Laser Center with the lowest amount of healthcare capital.

And it is important to point out that this project did receive a letter of support from Condell Medical Center, a local area hospital.

If I can direct your attention quickly to the chart in the State Agency Report on page 13 and 14, Table 2, I believe it is, there appears to be a total of 14 surgery centers, for instance. However, I'd like to point out that only 8 of those are actually within 30 minutes. From those, there are only two centers that actually do pain, pain specialty, Grand Oak Surgical Center, I believe, and Ravine Way Surgery Center. Ravine Way is nearly 30 minutes away at just over 28 minutes, and Dr. Joshi referred to Grand Oak Surgery Center, which was approved two and a half years before Dr. Ritacca's center, is just recently opened. As you see, don't even have their latest

year of utilization. They opened that recently, and they are already in the process of trying to find a buyer for that facility.

So, I'd like to turn it over -- back over to Dr. Ritacca for just one brief comment on charity care.

MR. SEWELL: Before you do that, not your last point, but the point before that, I was just totally lost. I'm sorry.

MR. CARVALHO: Why don't you -- you'd rather explain it than let me do it. So, why don't you explain that issue about if the physician does a certain amount of activity in their office that goes beyond 50 percent, then they have to have a license as a surgery center, not being able to do it as they have been doing it in just a doctor's office. Why don't you explain that?

MR. KNIERY: I can't say it much better than that. Let me try. There is a rule --

MR. CARVALHO: Okay. I guess I will. Right now in Illinois there are many things that a doctor is allowed to do in their office, office procedures, that might also be done in a surgery center, and so the way regulation works is we, as the Department of Public Health, don't regulate that activity if it's just occurring in a doctor's office, because the medical community doesn't want

that type of regulation. But the question became, well, at some point it's functioning as a surgery center, not as a doctor's office. What should that point be? And so the compromise written into the law is that after a certain amount of activity occurs in a doctor's office that looks like surgery, it now has to go in and get licensed as a surgery center, not work under the exception of a doctor's office exception. And so I think from what John said is that Dr. Joshi's activity -- the mix of stuff that he's doing in his office, the stuff that would account for surgery versus the stuff that doesn't account for surgery, the mix is approaching the point where he's going to start to look like a surgical center for our purposes, "our" being the Department of Health, and so then he's faced with a choice. He has to start doing the stuff that would look like surgery someplace else, or he has to himself try to become a surgical center, and that's when the Department of Public Health rule kicks in with yours, because he can't just become a surgical center by calling himself that. He has to apply to you. So, that's the interplay of our Department of Public Health law and rules and your law and rules.

MS. OLSON: I didn't understand whose utilization rate. You're talking about Dr. Joshi's

utilization rate?

MR. KNIERY: Correct, in his current practice. If you want me to go into it, I definitely can. The 50 percent rule comes from the Ambulatory Surgery Treatment Center licensing requirements, and it says -- and I'll quote -- "Any institution or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures, as evidenced by use of the facilities for the performance of surgical procedures, which constitutes more than 50 percent of the activities at this location," end quote, should be considered a surgery center.

MS. OLSON: I get it.

MR. CARVALHO: Just to keep all the thoughts together at one point, if you recall, Member Eaker mentioned in another application the issue of facility fee, and what he was alluding to, if you, as a physician, are doing those surgical procedures in your office before your office has been converted to a surgery center, you are not eligible for being paid a facility fee. If you're doing them in an office that has been converted to a surgical center -- exact same procedures -- you now are eligible or the facility is eligible for a payment of a facility fee, and so, sometimes that issue comes up in your discussions

about is this saving money or not saving money or -- but that's the key. The facility fee doesn't go to the same stuff, just when it's in a doctor's office.

MR. KNIERY: The nice thing about this process, also we have provided those charges from what Dr. Joshi has projected he will charge, and we also, per your rules, are holding those constant for at least two years. So, that's a health saving facet that's built in your rules that we are applying for But I would like Dr. Ritacca to make a brief comment about the charity care policy at Ritacca Health Center.

DR. RITACCA: After sitting through the meeting today, I realized the concern of the Board members on charity care and public health, and I felt it was necessary to address that issue on charity care at my facility. Personally, for the last 15 years, I've helped establish Lake County's Gang Tattoo Removal Program, where we laser and surgically remove tattoos from gang members professionally for free. I helped Mr. John Hernandez (unintelligible) a gang outreach, as well as gang outreach programs throughout the state and even through Indiana and Missouri, because I get gang members all the way from there to remove their tattoos. I've done this voluntarily. I've never thought about how important this would be except

today at this meeting. There's often times I have feared for my life -- but I do it anyway -- because I don't know if I'm offending another gang member by removing his fellow member's tattoo. I didn't want to bring attention to this, but now I think it's important.

For the last 30 years, I taught at Cook County Hospital in three departments. For the last 10 years I've done it voluntarily, without even a mention for gas money or for parking. I've taught the specialty of dermatology plastics around the eyes, ophthalmology and maxillofacial surgery, and in regards to the tattoos, I've probably removed 1,000 gang-related tattoos, and I've helped these people return to normal lives.

The question may be, why haven't you done it in the surgery center? That's a good question, and I probably will do from now on, but I do it mostly for convenience of the patient and time, and in the surgery center, it would take me probably over an hour. In the suite next to the surgery center, it takes me about 15 minutes.

On page 99, Dr. Feldman from the John Stroger Hospital has written a letter to the Board, graciously praising my efforts in helping his students as well as addressing the needs of the under served, which I have done

up until this moment without boasting.

Thank you very much.

MR. KNIERY: I think at this time we'd be more than happy to answer any questions you may have.

VICE-CHAIRMAN HAYES: Board member questions? David?

MR. CARVALHO: Two quick questions. You mention your efforts to find places and you wouldn't find places that would accept Medicare and Medicaid. Hospitals accept Medicare and Medicaid. What is the impediment to doing what you want to do in a hospital.

DR. JOSHI: I have taken patients to hospitals. That's where I take them right now. I take them to Alexian Brothers in the Schaumburg area. The distance between there -- I have patients up in Gurnee, Grayslake. That's like -- I don't know -- an hour, hour and 15 minutes. That's a huge distance to bring them down.

The other issue is hospitals are far more expensive. I have patients who are Medicare patients, patients who are Blue Cross, whatever the case may be, Medicaid patients, patients who have sometimes 20 percent co-pay, and I have seen the EO's that the hospital charges for simple 10-minute procedure. They charge them $5,000. So that means my patient is stuck with a thousand dollars

from the hospital, which to me is an absolutely insane cost for a 15-minute procedure. I mean, the whole entire procedure in an office is maybe sometimes one-fifth, sometimes, of their 20 percent co-pay at the hospital.

The hospital -- we all share the procedure rooms. The patient before me could have been a MRSA patient, and so now I've got to contend with a perfectly healthy person, coming in for an elective procedure that they end up paying $1,000 for a co-pay, going into a room that someone has MRSA was in. I have done that. That's what I do, but, again, it's very far away from Lake County. Lake County is truly -- you all know where Lake County is. It's truly a geographic area that has been incredibly under served by people with my -- in my specialty, with my credentials, and the whole goal then is to target those patients in Lake County, those VA patients in Lake County, the Medicare patients in Lake County, and keep that population from driving an hour. And local hospitals support this project, too.

MR. CARVALHO: As luck would have it, my division is the Division of Patient Safety and Quality, and we're responsible for the issue of healthcare-acquired infections and dealing with it. The patients you see in your center, the patient before could also have MRSA.

MR. JOSHI: True.

MR. CARVALHO: In fact, recent reports from CMS have suggested that the rate of healthcare-acquired infections and the risk of infection in surgical centers has been grossly under estimated, due to lack of collection of appropriate data. So, I don't think you want to make the case that hospitals are where people get MRSA and surgery centers are where they don't, because I don't think that's an accurate statement.

Could I ask a question of Staff? On page 7 of our SAR, there's a chart that has a bunch of zeroes that I'm not sure I understand. One shows zero charity patients and the cost of charity care being $4,000. Are there typos in that chart?

MR. CONSTANTINO: No. This is what was provided to us by the applicants, David.

MR. CARVALHO: Okay. I guess the question is for the applicant. This chart shows zero charity patients, zero Medicaid patients, zero revenue, but the cost of charity care was 4,000. Could you explain both the -- your point was that this was a facility that takes Medicaid, but the chart has zero Medicaid. Just please explain the chart.

DR. RITACCA: Yes. Thank you for asking that.

That's a good question.

I've taken Medicaid now for as long as I've been open. We'll say two and a half years. My accounts receivable for Medicaid is close to $300,000. I've not received one penny of it.

MR. CARVALHO: This is cash accounting? It's a fact that you have billed Medicaid, but you haven't received the money?

DR. RITACCA: Correct. I've tried -- and I probably have scores of pages -- working with Medicaid, and I can give names to the Medicaid office, why I can't get paid, and hopefully -- close to three years -- we are working through this problem. So that's -- hope that number for Medicaid will no longer be zero, but I continue to take Medicaid, which I think that shows my good faith and believing in the system, because I'm not sure how many other physicians would continue to finance surgery for all of this time and not get paid and continue to take Medicaid.

MR. KNIERY: If I may elaborate, also, on a comment that Dr. Ritacca made a little while ago, Dr. Ritacca -- the charity care that he was mentioning earlier, this is care he provides personally through his practice. That's what he was saying, and I told him, I

wish you would have been doing this as part of the surgery center and you could report it as such. But he is -- I will speak for him. He is very committed to taking care of this population.

VICE-CHAIRMAN HAYES: This is a limited specialty ambulatory surgery center?

MR. KNIERY: It is right now, yes.

VICE-CHAIRMAN HAYES: Under our rules, you'll be going to a multi-specialty with adding this new service.

MR. KNIERY: Yes.

VICE-CHAIRMAN HAYES: Would you be -- accept an amendment that basically would require you, if you wanted to enter a new -- beyond the pain management and beyond ophthalmology and plastic surgery, if you wanted to enter another specialty, that you would have to come back to the Board and do that?

MR. RITACCA: Absolutely, Vice-Chairman.

I would just like to mention a few things about plastic and reconstructive surgery. Sometimes we can enter into another specialty -- and I don't want to misconstrue. When we move somebody's jaw, I don't want it to look like we're maxillofacial. When we fix a hernia, I don't want it to look like we're general surgery. So, I do not plan to do any of those. I do not have the space nor

do I have the time. I'm looking to get to the 80 percent rule. I'm very content to doing plastic and reconstructive surgery. So, as Mr. Constantino can tell you, there was at one point that we do vein surgery. I have a vascular surgeon that fixed his varicose veins. It was construed as general surgery. I have no plans on doing any other specialty, but in the future, if the need arises in my specialty, plastics and reconstructive, that I feel like the Board is misinterpreting this as another procedure, I will come in front of you, yes.

MR. KNIERY: Does that answer your question?

VICE-CHAIRMAN HAYES: Yes.

MR. CARVALHO: Dr. Ritacca, let me just clarify what we're asking. You may have misunderstood. Theoretically, under ordinary procedures, by virtue of adding a third specialty -- if this were approved without condition, you could add thereafter anything. Not that you could branch out a little, you could really add anything, and the Chair has asked would you accept a condition on this application that you couldn't add -- the things that you could otherwise add but for this condition? In other words, you would be restricted to the three specialties that you would at that point have received approval for.

DR. RITACCA: I absolutely agree with this,

but I hope you understand as -- the confusion. When we do an abdominoplasty and we fix a hernia, I'm not doing general surgery.

MR. CARVALHO: That's a slightly different issue, which is an issue that you currently have authority to do two categories and what are the boundaries of those categories. That's an issue that I know you've addressed with us. The difference -- this is a slightly different issue that I think you now understand, is that theoretically, you do do ophthalmology. If this were approved and you could receive the third category, you could then start doing ophthalmology and you could start -- I don't want to speculate. And that's the thing that the Chairman was suggesting. Would you accept the condition that limits you to the three?

DR. RITACCA: Yes.

VICE-CHAIRMAN HAYES: Thank you.

Seeing no other questions, I'd like to -- may I have a motion to approve Project 11-098 to establish a multi-specialty ASTC in Vernon Hills, with a condition that if there is additional specialties beyond ophthalmology, plastic surgery, and pain management, that the applicants would come before the Board for additional specialties?

MR. GREIMAN: So moved.

MR. SEWELL: Second.

MR. ROATE: Motion made by Justice Greiman, seconded by Mr. Sewell.

Mr. Eaker?

MR. EAKER: Yes.

MR. ROATE: Justice Greiman?

MR. GREIMAN: Yes.

MR. ROATE: Mr. Hayes?

VICE-CHAIRMAN HAYES: Yes.

MR. ROATE: Mr. Hilgenbrink?

MR. HILGENBRINK: Yes.

MR. ROATE: Ms. Olson?

MS. OLSON: Yes.

MR. ROATE: Mr. Penn? Absent.

Mr. Sewell?

MR. SEWELL: Yes.

MR. ROATE: That's six votes in the affirmative.

VICE-CHAIRMAN HAYES: Motion passes. Thank you.

DR. RITACCA: God bless you, and thank you.

(Pause)

VICE-CHAIRMAN HAYES: Now we'd like to move to our next item on our agenda, which is I-01. This is