17-073

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

ORIGINAL

SECTION I IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Illinois Back & Neck Institute		
Street Address: 360 W Butterfield Rd Suite:100		
City and Zip Code: Elmhurst 60126		
County: DuPage	Health Service Area: 7	Health Planning Area: A-05

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Illinois Back & Neck Institute LLC
Street Address: 360 W Butterfield Rd Suite:100
City and Zip Code: Elmhurst 60126
Name of Registered Agent: Neema Bayran
Registered Agent Street Address: 360 W Butterfield Rd. Suite:100
Registered Agent City and Zip Code: Elmhurst 60126
Name of Chief Executive Officer: Neema Bayran, MD
CEO Street Address: 360 W Butterfield Rd Suite:100
CEO City and Zip Code: Elmhurst 60126
CEO Telephone Number: 847-501-0730

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Neema Bayran MD
Title: Chief Executive Officer
Company Name: Illinois Back & Neck Institute
Address: 360 W Butterfield Rd Suite:100, Elmhurst 60126
Telephone Number: 847-501-0730
E-mail Address: neema@paincenteril.com
Fax Number: N/A

Additional Contact [Person who is also authorized to discuss the application for permit]

Name: Amalia Rioja
Title: Attorney
Company Name: Baker & McKenzie LLP
Address: 300 East Randolph Street, Suite 5000 , Chicago, IL, 60601

Telephone Number: 312-861-2887
E-mail Address: amalia.rioja@bakermckenzie.com
Fax Number: N/A

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]

Name: Neema Bayran, MD
Title: Chief Executive Officer
Company Name: Illinois Back & Neck Institute, LLC
Address: 360 W Butterfield Rd. Suite:100 Elmhurst 60126
Telephone Number: 847-501-0730
E-mail Address:neema@paincenteril.com
Fax Number: N/A

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: 360 Butterfield LLC
Address of Site Owner: 18-5 E Dundee Road, Suite 200, Barrington, IL 60010
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Illinois Back & Neck Institute LLC
Address: 360 West Butterfield Rd., Elmhurst, IL, 60126

☐ Non-profit Corporation ☐ Partnership
☐ For-profit Corporation ☐ Governmental
☒ Limited Liability Company ☐ Sole Proprietorship ☐ Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The Illinois Back & Neck Institute, LLC (the "Applicant") proposes the establishment of a multidisciplinary ambulatory surgery treatment Center ("ASTC") with one operating room (the "Project"). The proposed ASTC will be located at 360 West Butterfield Rd. Suite 100, Elmhurst, Illinois 60126. The Project's site is located within Health Service Area 7 and Hospital Planning Area A-05.

Four categories of services will be provided which include: (i) Pain management; (ii) orthopedic surgery; (iii) podiatry and (iv) gastroenterology.

The ASTC will be wholly owned by qualified physician investors. As such, no hospital or surgery center management company will be involved in this Project.

The total cost of the project is $1,502,945.00. Of this amount, $482,000.00 represents the fair market value of the lease agreement that we will be in place between the Applicant and site owner.

The remainder of the Project cost will be funded by cash obtained through equity financing (*i.e.*, equity contributions), which will be achieved by the Applicant through selling membership units in its limited liability company to qualified physician investors.

The Applicant is proposing the establishment of a new health care facility; therefore, this is a substantive project.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$15,025.00	$5,420.00	$20,445.00
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	$250,000.00	$52,000.00	$302,000.00
Contingencies	$20,000.00	$8000.00	$28,000.00
Architectural/Engineering Fees	$13,000.00	$2,500.00	$15,500.00
Consulting and Other Fees	$50,000.00	$10,000.00	$60,000.00
Movable or Other Equipment (not in construction contracts)	$550,000.00	$45,000.00	$595,000.00
Bond Issuance Expense (project related)	0	0	0
Net Interest Expense During Construction (project related)	0	0	0
Fair Market Value of Leased Space or Equipment	$362,000.00	$120,000.00	$482,000.00
Other Costs To Be Capitalized	0	0	0
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL USES OF FUNDS	$1,260,025.00	$242,920.00	$1,502,945.00
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$898,025.00	$122,920.00	$1,020,945.00
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$320,000.00	$120,000.00	$482,000.00
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$1,260025.00	$242,920.00	$1,502,945.00

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $ 150,000.00.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☒ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140) : December 2017

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.
☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☒ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM

State Agency Submittals [Section 1130.620©]

Are the following submittals up to date as applicable:
☐ Cancer Registry
☐ APORS
☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical	$1,260025.00		1850		1850		
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical	$1,260025.00		1850		1850		
NON REVIEWABLE							
Administrative	$242,920.00		1004		1004		
Parking							
Gift Shop							
Total Non-clinical	$242,920.00		1004		1004		
TOTAL	$1,502,945.00		2854		2854		

APPEND DOCUMENTATION AS ATTACHMENT 9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization - *NOT APPLICABLE*

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		**CITY:**			
REPORTING PERIOD DATES:		**From:**		**to:**	
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

SECTION II. DISCONTINUATION - *NOT APPLICABLE*

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 – Discontinuation (State-Owned Facilities and Relocation of ESRD's)

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document whether or not the discontinuation of each service or of the entire facility will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Background

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.230 – Purpose of the Project, and Alternatives

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate.**

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

   c. The project involves the conversion of existing space that results in excess square footage.

   d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC operating room and recovery	1850 dgsf per 1 treatment room	1660-2200 dgsf per treatment room	350	yes

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATIDN AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.
3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION V. MASTER DESIGN AND RELATED PROJECTS

This Section is applicable only to proposed master design and related projects.

Criterion 1110.235(a) - System Impact of Master Design

Read the criterion and provide documentation that addresses the following:

1. The availability of alternative health care facilities within the planning area and the impact that the proposed project and subsequent related projects will have on the utilization of such facilities;

2. How the services proposed in future projects will improve access to planning area residents;

3. What the potential impact upon planning area residents would be if the proposed services were not replaced or developed; and

4. The anticipated role of the facility in the delivery system, including anticipated patterns of patient referral, any contractual or referral agreements between the applicant and other providers that will result in the transfer of patients to the applicant's facility.

Criterion 1110.235(b) - Master Plan or Related Future Projects

Read the criterion and provide documentation regarding the need for all beds and services to be developed, and document the improvement in access for each service proposed. Provide the following:

1. The anticipated completion date(s) for the future construction or modernization projects;

2. Evidence that the proposed number of beds and services is consistent with the need assessment provisions of Part 1100; or documentation that the need for the proposed number of beds and services is justified due to such factors, but not limited to:

   a. limitation on government funded or charity patients that are expected to continue;
   b. restrictive admission policies of existing planning area health care facilities that are expected to continue;
   c. the planning area population is projected to exhibit indicators of medical care problems such as average family income below poverty levels or projected high infant mortality.

3. Evidence that the proposed beds and services will meet or exceed the utilization targets established in Part 1100 within two years after completion of the future construction or modernization project(s), based upon:

   a. historical service/beds utilization levels;
   b. projected trends in utilization (include the rationale and projection assumptions used in such projections);
   c. anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and
   d. anticipated changes in delivery of the service due to changes in technology, care delivery techniques or physician availability that would support the projected utilization levels.

Criterion 1110.235© - Relationship to Previously Approved Master Design Projects

READ THE CRITERION which requires that projects submitted pursuant to a master design permit are consistent with the approved master design project. Provide the following documentation:

1. Schematic architectural plans for all construction or modification approved in the master design permit;
2. The estimated project cost for the proposed projects and also for the total construction/modification projects approved in the master design permit;
3. An item by item comparison of the construction elements (i.e. site, number of buildings, number of floors, etc.) in the proposed project to the approved master design project; and
4. A comparison of proposed beds and services to those approved under the master design permit.

APPEND DOCUMENTATION AS ATTACHMENT 18, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing the establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion, and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria and provide the required information APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

1. Applicants proposing to establish, expand and/or modernize the Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Medical/Surgical		
☐ Obstetric		
☐ Pediatric		
☐ Intensive Care		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.530©(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.530©(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.530©(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.530©(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.530©(5) - Planning Area Need - Service Accessibility	X		
1110.530(d)(1) - Unnecessary Duplication of Services	X		
1110.530(d)(2) - Maldistribution	X	X	
1110.530(d)(3) - Impact of Project on Other Area Providers	X		
1110.530(e)(1), (2), and (3) - Deteriorated Facilities			X
1110.530(e)(4) - Occupancy			X

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.530(f) - Staffing Availability	X	X	
1110.530(g) - Performance Requirements	X	X	X
1110.530(h) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

B. Criterion 1110.630 - Comprehensive Physical Rehabilitation

1. Applicants proposing to establish, expand and/or modernize the Comprehensive Physical Rehabilitation category of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Comprehensive Physical Rehabilitation		

3. READ the applicable review criteria outlined below and submit the required documentation for the criteria:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.630©(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.630©(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.630©(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.630©(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.630©(5) - Planning Area Need - Service Accessibility	X		
1110.630(d)(1) - Unnecessary Duplication of Services	X		
1110.630(d)(2) - Maldistribution	X		
1110.630(d)(3) - Impact of Project on Other Area Providers	X		
1110.630(e)(1), (2), and (3) - Deteriorated Facilities			X
1110.630(e)(4) - Occupancy			X
1110.630(f)(1) - Staffing Availability	X	X	
1110.630(g) - Performance Requirements	X	X	X
1110.630(h) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

C. Criterion 1110.730 - Acute Mental Illness and Chronic Mental Illness

1. Applicants proposing to establish, expand and/or modernize the Acute Mental Illness and Chronic Mental Illness categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Acute Mental Illness		
☐ Chronic Mental Illness		

3. READ the applicable review criteria outlined below and submit the required documentation for the criteria:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.730©(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.730©(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.730©(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.730©(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.730©(5) - Planning Area Need - Service Accessibility	X		
1110.730(d)(1) - Unnecessary Duplication of Services	X		
1110.730(d)(2) - Maldistribution	X		
1110.730(d)(3) - Impact of Project on Other Area Providers	X		
1110.730(e)(1), (2), and (3) - Deteriorated Facilities			X
1110.730(e)(4) - Occupancy			X
1110.730(f)(1) - Staffing Availability	X	X	
1110.730(g) - Performance Requirements	X	X	X
1110.730(h) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT-21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

D. Criterion 1110.1230 - Open Heart Surgery

1. Applicants proposing to establish, expand and/or modernize the Open Heart Surgery category of service must submit the following information.

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Open Heart Surgery		

*3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:***

1. Criterion 1110.1230(a), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

2. Criterion 1110.1230(b), Establishment of Open Heart Surgery

Read the criterion and provide the following information:

a. The number of cardiac catheterizations (patients) performed in the latest 12-month period for which data is available.
b. The number of patients referred for open heart surgery following cardiac catheterization at your facility, for each of the last two years.

3. Criterion 1110.1230©, Unnecessary Duplication of Services

Read the criterion and address the following:

a. Contact all existing facilities within 90 minutes travel time of your facility which currently provide or are approved to provide open heart surgery to determine what the impact of the proposed project will be on their facility.
b. Provide a sample copy of the letter written to each of the facilities and include a list of the facilities that were sent letters.
c. Provide a copy of all of the responses received.

4. Criterion 1110.1230(d), Support Services

Read the criterion and indicate on a service by service basis which of the services listed in this criterion are available on a 24-hour inpatient basis and explain how any services not available on a 24-hour inpatient basis can be immediately mobilized for emergencies at all times.

5. Criterion 1110.1230(e), Staffing

Read the criterion and for those positions described under this criterion provide the following information:

a. The name and qualifications of the person currently filling the job.
b. Application filed for a position.
c. Signed contracts with the required staff.
d. A detailed explanation of how you will fill the positions.

APPEND DOCUMENTATION AS ATTACHMENT 22, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

E. Criterion 1110.1330 - Cardiac Catheterization

1. Applicants proposing to establish, expand and/or modernize the Cardiac Catheterization category of service must submit the following information.

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ Cardiac Catheterization		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

1. Criterion 1110.1330(a), Peer Review

Read the criterion and submit a detailed explanation of your peer review program.

2. Criterion 1110.1330(b), Establishment or Expansion of Cardiac Catheterization Service

Read the criterion and, if applicable, submit the following information:

a. A map (on 8 ½" x 11" paper) showing the location of the other hospitals providing cardiac catheterization services within the planning area.

b. The number of cardiac catheterizations performed for the last 12 months at each of the hospitals shown on the map.

c. Provide the number of patients transferred directly from the applicant's hospital to another facility for cardiac catheterization services in each of the last three years.

3. Criterion 1110.1330©, Unnecessary Duplication of Services

Read the criterion and, if applicable, submit the following information.

a. Copies of the letter sent to all facilities within 90 minutes travel time that currently provide cardiac catheterization. This letter must contain a description of the proposed project and a request that the other facility quantify the impact of the proposal on its program.

b. Copies of the responses received from the facilities to which the letter was sent.

4. Criterion 1110.1330(d), Modernization of Existing Cardiac Catheterization Laboratories

Read the criterion and, if applicable, submit the number of cardiac catheterization procedures performed for the latest 12 months.

5. Criterion 1110.1330(e), Support Services

Read the criterion and indicate on a service by service basis which of the listed services are available on a 24-hour basis and explain how any services not available on a 24-hour basis will be available when needed.

6. Criterion 1110.1330(f), Laboratory Location

Read the criterion and, if applicable, submit line drawings showing the location of the proposed laboratories. If the laboratories are not in close proximity, explain why.

7. Criterion 1110.1330(g), Staffing

Read the criterion and submit a list of names and qualifications of those who will fill the positions detailed in this criterion. Also, provide staffing schedules to show the coverage required by this criterion.

8. Criterion 1110.1330(h), Continuity of Care

Read the criterion and submit a copy of the fully executed written referral agreement(s).

9. Criterion 1110.1330(i), Multi-institutional Variance

Read the criterion and, if applicable, submit the following information:

a. A copy of a fully executed affiliation agreement between the two facilities involved.

b. Names and positions of the shared staff at the two facilities.

c. The volume of open heart surgeries performed for the latest 12-month period at the existing operating program.

d. A cost comparison between the proposed project and expansion at the existing operating program.

e. The number of cardiac catheterization procedures performed in the last 12 months at the operating program.

f. The number of catheterization laboratories at the operating program.

g. The projected cardiac catheterization volume at the proposed facility annually for the next 2 years.

h. The basis for the above projection.

APPEND DOCUMENTATION AS ATTACHMENT 23 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

F. Criterion 1110.1430 - In-Center Hemodialysis

1. Applicants proposing to establish, expand and/or modernize the In-Center Hemodialysis category of service must submit the following information:

2. Indicate station capacity changes by Service: Indicate # of stations changed by action(s):

Category of Service	# Existing Stations	# Proposed Stations
☐ In-Center Hemodialysis		

3. READ the applicable review criteria outlined below and submit the required documentation for the criteria:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.1430©(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.1430©(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.1430©(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.1430©(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.1430©(5) - Planning Area Need - Service Accessibility	X		
1110.1430(d)(1) - Unnecessary Duplication of Services	X		
1110.1430(d)(2) - Maldistribution	X		
1110.1430(d)(3) - Impact of Project on Other Area Providers	X		
1110.1430(e)(1), (2), and (3) - Deteriorated Facilities and Documentation			X
1110.1430(f) - Staffing	X	X	
1110.1430(g) - Support Services	X	X	X
1110.1430(h) - Minimum Number of Stations	X		
1110.1430(i) - Continuity of Care	X		
1110.1430(j) - Relocation (if applicable)	X		
1110.1430(k) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT 24, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

4. **Projects for relocation** of a facility from one location in a planning area to another in the same planning area must address the requirements listed in subsection (a)(1) for the "Establishment of Services or Facilities", as well as the requirements in Section 1130.525 – "Requirements for Exemptions Involving the Discontinuation of a Health Care Facility or Category of Service" and subsection 1110.1430(j) - Relocation of an in-center hemodialysis facility.

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
☐ Cardiovascular
☐ Colon and Rectal Surgery
☐ Dermatology
☐ General Dentistry
☐ General Surgery
☐ Gastroenterology
☐ Neurological Surgery
☐ Nuclear Medicine
☐ Obstetrics/Gynecology
☐ Ophthalmology
☐ Oral/Maxillofacial Surgery
☒ Orthopedic Surgery
☐ Otolaryngology
☒ Pain Management
☐ Physical Medicine and Rehabilitation
☐ Plastic Surgery
☐ Podiatric Surgery
☐ Radiology
☐ Thoracic Surgery
☐ Urology
☐ Other_____

3. *READ the applicable review criteria outlined below and* ***submit the required documentation for the criteria:***

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.1540©(2) – Service to GSA Residents	X	X
1110.1540(d) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.1540(e) – Service Demand – Expansion of Existing ASTC Service		X
1110.1540(f) – Treatment Room Need Assessment	X	X
1110.1540(g) – Service Accessibility	X	
1110.1540(h)(1) – Unnecessary Duplication/Maldistribution	X	
1110.1540(h)(2) – Maldistribution	X	
1110.1540(h)(3) – Impact to Area Providers	X	

1110.1540(i) – Staffing	X	X
1110.1540(j) – Charge Commitment	X	X
1110.1540(k) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

H. Criterion 1110.2330 - Selected Organ Transplantation

This section is applicable to projects involving the establishment or modernization of the Selected Organ Transplantation service.

1. Applicants proposing to establish or modernize the Selected Organ Transplantation category of service must submit the following information:

2. Indicate changes by Service: Indicate # of rooms changed by action(s):

Transplantation Type	# Existing Beds	# Proposed Beds
☐ _____		
☐ _____		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Modernize
1110.2330©(1) – Planning Area Need - 7 Ill. Adm. Code 1100 (formula calculation)	X	
1110.2330©(2) – Planning Area Need - Service to Planning Area Residents	X	
1110.2330©(3) – Planning Area Need - Service Demand - Establishment of Category of Service	X	
1110.2330©(4) – Planning Area Need - Service Accessibility	X	
1110.2330(d)(1) – Unnecessary Duplication of Services	X	
1110.2330(d)(2) – Maldistribution	X	
1110.2330(d)(3) – Impact of Project on Other Area Providers	X	
1110.2330(e)(1), (2), and (3) – Deteriorated Facilities		X
1110.2330(e)(4) – Utilization		X
1110.2330(f) – Staffing Availability	X	
1110.2330(g) – Surgical Staff	X	
1110.2330(h) – Collaborative Support	X	
1110.2330(i) – Support Services	X	
1110.2330(j) – Performance Requirements	X	X
1110.2330(k) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 26, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

I. Criterion 1110.2430 - Kidney Transplantation

This section is applicable to all projects involving the establishment of the Kidney Transplantation service.

1. Applicants proposing to establish or modernize the Kidney Transplantation category of service must submit the following information:

2. Indicate changes: Indicate # of key rooms by action:

Category of Service	# Existing Beds	# Proposed Beds
☐ Kidney Transplantation		

3. READ the applicable review criteria outlined below and submit required documentation for the criteria printed below in bold:

APPLICABLE REVIEW CRITERIA	Establish	Modernize
1110.2430©(1) – Planning Area Need - 7 Ill. Adm. Code 1100 (formula calculation)	X	
1110.2430©(2) – Planning Area Need - Service to Planning Area Residents	X	
1110.2430©(3) – Planning Area Need - Service Demand - Establishment of Category of Service	X	
1110.2430©(4) – Planning Area Need - Service Accessibility	X	
1110.2430(d)(1) – Unnecessary Duplication of Services	X	
1110.2430(d)(2) – Maldistribution	X	
1110.2430(d)(3) – Impact of Project on Other Area Providers	X	
1110.2430(e)(1), (2), and (3) – Deteriorated Facilities		X
1110.2430(e)(4) – Utilization		X
1110.2430(f) – Staffing Availability	X	
1110.2430(g) – Surgical Staff	X	
1110.2430(h) – Support Services	X	
1110.2430(i) – Performance Requirements	X	X
1110.2430(j) – Assurances	X	

APPEND DOCUMENTATION for "Surgical Staff" and "Support Services", AS ATTACHMENT 27 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

J. Criterion 1110.2530 - Subacute Care Hospital Model

Category of Service	# Proposed Beds
☐ Subacute Care Hospital	

This section is applicable to all projects proposing to establish a subacute care hospital model.

1. Criterion 1110.2530(a), Distinct Unit

a. Provide a copy of the physical layout (an architectural schematic) of the subacute unit (include the room numbers) and describe the travel patterns to support services and patient and visitor access.

b. Provide a summary of shared services and staff and how costs for such will be allocated between the unit and the hospital or long-term care facility.

c. Provide a staffing plan with staff qualifications and explain how non-dedicated staffing services will be provided.

2. Criterion 1110.2530(b), Contractual Relationship

a. If the applicant is a licensed long-term care facility or a previously licensed general hospital, the applicant must provide a copy of a contractual agreement (transfer agreement) with a general acute care hospital. Provide the travel time to the facility that signed the contract. Explain how the procedures for providing emergency care under this contract will work.

b. If the applicant is a licensed general hospital, the applicant must document that its emergency capabilities continue to exist in accordance with the requirements of hospital licensure.

3. Rule 1110.2540(b), State Board Prioritization of Hospital Applications

Read this rule, which applies only to hospital applications, and provide the requested information as applicable.

a. Financial Support

Will the subacute care model provide the necessary financial support for the facility to provide continued acute care services? Yes___ No _____

If yes, submit the following information:

(1) Two years of projected financial statements that exclude the financial impact of the subacute care hospital model as well as two years of projected financial statements which include the financial impact of the subacute care hospital model;

(2) the assumptions used in developing both sets of financial statements;

(3) a narrative description of the factors within the facility or the area which will prevent the facility from complying with the financial ratios within the next two years without the proposed project;

(4) a narrative explanation as to how the proposed project will allow you to meet the financial ratios;

(5) if the projected financial statements (which include the subacute impact) at the applicant facility fail to meet the Part 1120 financial ratios, provide a copy of a binding agreement with another institution which guarantees the financial viability

Subacute Care Hospital Model (continued)

of the subacute hospital model for a period of five years; and

(6) historical financial statements for each of the last three calendar years.

b. Medically Underserved Area (as designated by the Department of Health and Human Services)

Is the facility located in a medically underserved area? Yes ☐ No ☐

If yes, provide a map showing the location of the medically underserved area and of the applicant facility.

c. Multi-Institutional System

Provide copies of all contractual agreements between your facility and any hospitals or long-term care facilities in your planning area which are within 60 minutes travel time of your facility which provide for exclusive best effort arrangements concerning transfer of patients between your two facilities. **Note: Best effort arrangement means the acute care facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred to the applicant facility.**

d. Medicare/Medicaid

Provide the Medicare patient days and admissions, the Medicaid patient days and admissions, and the total patient days and admissions for the latest calendar or fiscal year (specify the dates).

e. Casemix and Utilization

Provide the following information:

(1) the number of admissions and patient days for each of the last five years for each of the following:

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnosis which included physiological monitoring on a continuous basis

(2) for multi-institutional systems provide the above information from each of the signatory facilities. If more than one signatory is involved, provide separate sheets for each one.

f. HMO/PPO Utilization

Provide the number of patient days at the applicant facility for the last 12 months being reimbursed through contractual relationships with preferred provider organizations or HMOs.

g. Notice of License Revocation/Decertification

Did IDPH issue the applicant facility a notice of license revocation Yes ☐ No ☐

Was the applicant facility decertified from a Federal Title XVIII or XIX program within the past 5 years Yes ☐ No ☐

Subacute Care Hospital Model (continued)

h. Joint Commission on Accreditation of Healthcare Organizations

Is the applicant facility accredited by the Joint Commission? Yes ☐ No ☐
If yes, provide a copy of the latest Joint Commission letter of accreditation.

i. Staffing

Provide documentation that the following staff will be available for the subacute care hospital model. Documentation must consist of letters of interest from individuals for each of the positions. Indicate if any of the individuals who will fill these positions are presently employed at the applicant facility.

- Full-time medical director exclusively for the model
- Two or more full-time (FTEs) physical therapist
- One or more occupational therapists
- One or more speech therapists

j. Audited Financial Reports

Submit audited financial reports of the applicant facility for the latest three fiscal years.

4. Rule 1110.2540©, State Board Prioritization-Long-Term Care Facilities

This rule applies only to LTC facility applications. Read the criterion and submit the required information, as applicable.

a. Exceptional Care

Has the applicant facility had an Exceptional Care Contract with the Illinois Department of Public Aid for at least two years in the past four years? Yes ____ No _____

If yes, provide copies of the Exceptional Care Contract with the Illinois Department of Public Aid for each these four years.

b. Medically Underserved Area (as designated by the Department of Health and Human Services)

Is the facility located in a medically underserved area? Yes ☐ No ☐

If yes, provide a map showing the location of the medically underserved area and of the applicant facility.

c. Medicare/Medicaid

Provide the Medicare patient days and admissions, the Medicaid patient days and admissions, and the total patient days and admissions for the latest calendar or fiscal year (specify the dates).

d. Case Mix and Utilization

Provide the following information:

(1) the number of admissions and patient days for each of the last five years for each of the following:

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)

- Other complex diagnoses which included physiological monitoring on a continuous basis

Subacute Care Hospital Model (continued)

(2) for multi-institutional systems, provide the same information from each of the signatory facilities. If more than one signatory is involved, provide a separate sheet for each one.

e. HMO/PPO Utilization

Provide the number of patient days at the applicant facility for the last 12 months being reimbursed through contractual relationships with preferred provider organizations or HMO's.

f. Notice of License Revocation/Decertification

Did IDPH issue the applicant facility a notice of license revocation Yes ☐ No ☐

Was the applicant facility decertified from a Federal Title XVIII or XIX program within the past 5 years Yes ☐ No ☐

g. Staffing

Provide documentation that the following staff will be available for the subacute care hospital model. Documentation shall consist of letters of interest from individuals for each of the positions. Indicate if any of the individuals who will fill the positions are currently employed by the applicant facility.

- Full-time medical director exclusively for the model
- Two or more full time (FTEs) physical therapists
- One or more occupational therapists
- One or more speech therapists

h. Financial Reports

Submit copies of the applicant facility's financial reports for the last three fiscal years.

i. Joint Commission on Accreditation of Healthcare Organizations

Is the applicant facility accredited by the Joint Commission? Yes ☐ No ☐
If yes, provide a copy of the latest Joint Commission letter of accreditation.

j. Multi-Institutional Arrangements

Provide copies of all contractual agreements between your facility and any hospitals or long-term care facilities in your planning area which are within 60 minutes travel time of your facility which provide for exclusive best effort arrangements concerning transfer of patients between your two facilities. **Note: Best effort arrangement means the referring facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred to the applicant facility.**

5. Section 1110.2540(d), State Board Prioritization of Previously Licensed Hospitals - Chicago

This section must be completed only by applicants whose site was previously licensed as a hospital in Chicago. Provide the following information:

a. letters from health facilities establishing a referral agreement for subacute hospital patients;

b. letters from physicians indicating that they will refer subacute patients to your proposed facility;

c. the number of admissions and patient days for each of the last five years for each of the

following types of patients (this information must be provided from each referring facility):

- Ventilator cases
- Head trauma cases
- Rehabilitation cases including spinal cord injuries
- Amputees
- Other orthopedic cases requiring subacute care (Specify diagnosis)
- Other complex diagnoses, which included physiological monitoring on a continuous basis.

APPEND DOCUMENTATION AS ATTACHMENT 28, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

K. Community-Based Residential Rehabilitation Center

This section is applicable to all projects proposing to establish a Community-based Residential Rehabilitation Center Alternative Health Care Model.

A. Criterion 1110.2830(a), Staffing

Read the criterion and provide the following information:

1. A detailed staffing plan that identifies the number and type of staff positions dedicated to the model and the qualifications for each position;
2. How special staffing circumstances will be handled;
3. The staffing patterns for the proposed center; and
4. The manner in which non-dedicated staff services will be provided.

B. Criterion 1110.2830(b), Mandated Services

Read the criterion and provide a narrative description documenting how the applicant will provide the minimum range of services required by the Alternative Health Care Delivery Act and specified in 1110.2820(b).

C. Criterion 1110.2830©, Unit Size

Read the criterion and provide a narrative description that identifies the number and location of all beds in the model. Include the total number of beds for each residence and the total number of beds for the model.

D. Criterion 1110.2830(d), Utilization

Read the criterion and provide documentation that the target utilization for the model will be achieved by the second year of the model's operation. Include supporting information such as historical utilization trends, population growth, expansion of professional staff or programs, and the provision of new procedures that may increase utilization.

E. Criterion 1110.2830(e), Background of Applicant

Read the criterion and provide documentation that demonstrates the applicant's experience in providing the services required by the model. Provide evidence that the programs offered in the model have been accredited by the Commission on Accreditation of Rehabilitation Facilities as a Brain Injury Community-Integrative Program for at least three of the last five years.

APPEND DOCUMENTATION AS ATTACHMENT 29, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

L. 1110.2930 - Long Term Acute Care Hospital

1. Applicants proposing to establish, expand and/or modernize Long Term Acute Care Hospital Bed projects must submit the following information:
2. Indicate the bed service(s) and capacity changes by Service:
   Indicate the # of beds by action(s):

Category of Service	# Existing Beds	# Proposed Beds
☐ LTACH		
☐ Intensive Care		
☐ _____		

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.2930©(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.2930©(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.2930©(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.2930(cb)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.2930©(5) - Planning Area Need - Service Accessibility	X		
1110.2930(d)(1) - Unnecessary Duplication of Services	X		
1110.2930(d)(2) - Maldistribution	X		
1110.2930(d)(3) - Impact of Project on Other Area Providers	X		
1110.2930(e)(1), (2), and (3) - Deteriorated Facilities			X
1110.2930(e)(4) - Occupancy			X
110.2930(f) - Staffing Availability	X	X	
1110.2930(g) - Performance Requirements	X	X	X
1110.2930(h) - Assurances	X	X	

APPEND DOCUMENTATION AS ATTACHMENT-30, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

M. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☐		
☐		
☐		

*3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:***

Project Type	Required Review Criteria
New Services or Facility or Equipment	© - Need Determination - Establishment
Service Modernization	(d)(1) - Deteriorated Facilities
	AND/OR
	(d)(2) - Necessary Expansion
	PLUS
	(d)(3)(A) - Utilization - Major Medical Equipment
	OR
	(d)(3)(B) - Utilization - Service or Facility

APPEND DOCUMENTATION AS ATTACHMENT-31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

N. Freestanding Emergency Center Medical Services

These criteria are applicable only to those projects or components of projects involving the freestanding emergency center medical services (FECMS) category of service.

A. Criterion 1110.3230 – Establishment of Freestanding Emergency Center Medical Services

Read the criterion and provide the following information:

1. Projected Utilization – Provide the projected number of patient visits per day for each treatment station in the FEC based upon 24-hour availability, including an explanation of how the projection was determined. [1110.3230(b)(3)(B) and (C)]

2. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data. [1110.3230(a)(5)(A)]

3. The identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated. [1110.3230(a)(5)(B)]

4. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital, (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status. [1110.3230(a)(5)(C)]

5. Certification signed by two authorized representative(s) of the applicant entity(s) that they have reviewed, understand and plan to comply with both of the following requirements [1110.3230(a)(6)(A) and (B)]:
   - A) The requirements of becoming a Medicare provider of freestanding emergency services; and
   - B) The requirements of becoming licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

6. Area Need; Service to Area Residents - Document the proposed service area and projected patient volume for the proposed FEC [1110.3230(b)(2)]:
   - A) Provide a map of the proposed service area, indicating the boundaries of the service area, and the total minutes travel time from the proposed site, indicating how the travel time was calculated.
   - B) Provide a list of the projected patient volume for the proposed FEC, categorized by zip code. Indicate what percentage of this volume represents residents from the proposed FEC's service area.
   - C) Provide either of the following:
     - a) Provide letters from authorized representatives of hospitals, or other FEC facilities, that are part of the Emergency Medical Services System (EMSS) for the defined service area, that contain patient origin information by zip code, (each letter shall contain a certification by the authorized representative that the representations contained in the letter are true and correct. A complete set of the letters with original notarized signatures shall accompany the application for permit), or
     - b) Patient origin information by zip code from independent data sources (e.g., Illinois Health and Hospital Association COMPdata or IDPH hospital discharge data), based upon the patient's legal residence, for patients receiving services in the existing service area's facilities' emergency departments (EDs), verifying that at least 50% of the ED patients served during the last 12-month

Freestanding Emergency Center Medical Services (continued)

period were residents of the service area.

7. Area Need; Service Demand – Historical Utilization [1110.3230(b)(3)(A)]
   A) Provide the annual number of ED patients that have received care at facilities that are located in the FEC's service area for the latest two-year period prior to submission of the application
   B) Provide the estimated number of patients anticipated to receive services at the proposed FEC, including an explanation of how the projection was determined.

8. Area Need; Service Accessibility - Document one of the following (using supporting documentation as specified in accordance with the requirements of 77 Ill. Adm. Code 1110.3230(b)(4)(B) Supporting Documentation) [1110.3230(b)(4)(A)]:
   i) The absence of the proposed ED service within the service area;
   ii) The area population and existing care system exhibit indicators of medical care problems,
   iii) All existing emergency services within the 30-minute normal travel time meet or exceed the utilization standard specified in 77 Ill Adm. Code 1100.

9. Unnecessary Duplication - Document that the project will not result in an unnecessary duplication by providing the following information [1110.3230©(1)]:
   A) A list of all zip code areas (in total or in part) that are located within 30 minutes normal travel time of the project's site;
   B) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population); and
   C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide emergency medical services.

10. Unnecessary Maldistribution - Document that the project will not result in maldistribution of services by documenting the following [1110.3230©(2)]:
   A) Historical utilization (for the latest 12-month period prior to submission of the application) for existing ED departments within 30 minutes travel time of the applicant's site; or
   B) That there is not an insufficient population to provide the volume or caseload necessary to utilize the ED services proposed by the project at or above utilization standards.

11. Impact on Area Providers [1110.3230©(3)] – Document that, within 24 months after project completion, the proposed project will not lower the utilization of other service area providers below, or further below, the utilization standards specified in 77 Ill. Adm. Code 1100 (using supporting documentation in accordance with the requirements of 77 Ill. Adm. Code 1110.3230©(4)).

12. Staffing Availability - Document that a sufficient supply of personnel will be available to staff the service (in accordance with the requirements of 1110.3230(e)).

Freestanding Emergency Center Medical Services (continued)

B. Criterion 1110.3230 – Expansion of Existing Freestanding Emergency Center Medical Services

Read the criterion and provide the following information:

1. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data. [1110.3230(a)(5)(A)]

2. The identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated. [1110.3230(a)(5)(B)]

3. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status. [1110.3230(a)(5)(C)]

4. Provide copies of Medicare and EMS licensure, in addition to certification signed by two authorized representative(s) of the applicant entity(s), indicating that the existing FEC complies with both of the following requirements [1110.3230(a)(6)(A) and (B)]:
   A) The requirements of being a Medicare provider of freestanding emergency services; and
   B) The requirements of being licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

5. Area Need; Service to Area Residents - Document the proposed service area and projected patient volume for the expanded FEC [1110.3230(b)(2)]:
   A) Provide a map of the proposed service area, indicating the boundaries of the service area, and the total minutes travel time from the expanded FEC, indicating how the travel time was calculated.
   B) Provide a list of the historical (latest 12-month period) patient volume for the existing FEC, categorized by zip code, based on the patient's legal residence. Indicate what percentage of this volume represents residents from the existing FEC's service area, based on patient's legal residence.

6. Staffing Availability - Document that a sufficient supply of personnel will be available to staff the service (in accordance with the requirements of 1110.3230(e)).

C. Criterion 1110.3230 – Modernization of Existing Freestanding Emergency Center Medical Services

Read the criterion and provide the following information:

1. The historical number of visits (based on the latest 12-month period) for the existing FEC.

2. The identification of the municipality of the FEC and FECMS and the municipality's population as reported by the most recently available U.S. Census Bureau data. [1110.3230(a)(5)(A)]

3. The identification of the hospital that owns or controls the FEC and the distance of the proposed FEC from that hospital, including an explanation of how that distance was calculated.[1110.3230(a)(5)(B)]

Freestanding Emergency Center Medical Services (continued)

4. The identification of the Resource Hospital affiliated with the FEC, the distance of the proposed FEC from that Resource Hospital, (including an explanation of how that distance was calculated), and identification of that Resource Hospital's EMS system, including certification of the hospital's Resource Hospital status. [1110.3230.(a)(5)(c)]

5. Provide copies of Medicare and EMS licensure, in addition to certification signed by two authorized representative(s) of the applicant entity(s), indicating that the existing FEC complies with both of the following requirements [1110.3230(a)(6)(A) and (B)]:
   A) The requirements of being a Medicare provider of freestanding emergency services; and
   B) The requirements of being licensed under the Emergency Medical Services Systems Act [210 ILCS 50/32.5].

6. Category of Service Modernization - Document that the existing treatment areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized due to such factors as, but not limited to high cost of maintenance, non-compliance with licensing or life safety codes, changes in standards of care, or additional space for diagnostic or therapeutic purposes. Documentation shall include the most recent IDPH Centers for Medicare and Medicaid Services (CMMS) Inspection reports, and Joint Commission on Accreditation of Healthcare Organizations reports. Other documentation shall include the following, as applicable to the factors cited in the application, copies of maintenance reports, copies of citations for life safety code violations, and other pertinent reports and data.

APPEND DOCUMENTATION AS ATTACHMENT 32, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

O. BIRTH CENTER – REVIEW CRITERIA

These criteria are applicable only to those projects or components of projects involving a birth center.

Criterion 77 IAC 1110.3130 (a) – "Location"

1. Document that the proposed birth center will be located in one of the geographic areas, as provided in the Alternative Healthcare Delivery Act.

2. Document that the proposed birth center is owned or operated by a hospital; or owned or operated by a federally qualified health center; or owned and operated by a private person or entity.

Criterion 77 IAC 1110.3130 (b) – "Service Provision to a Health Professional Shortage Area"

Document whether the proposed site is located in or will predominantly serve the residents of a health professional shortage area. If it will not, demonstrate that it will be located in a health planning area with a demonstrated need for obstetrical service beds or that there will be a reduction in the existing number of obstetrical service beds in the planning area so that the birth center will not result in an increase in the total number of obstetrical service beds in the health planning area.

Criterion 77 IAC 1110.3130 © – "Admission Policies"

Provide admission policies that will be in effect at the facility and a signed statement that no restrictions on admissions due to payor source will occur.

Criterion 77 IAC 1110.3130 (d) – "Bed Capacity"

Document that the proposed birth center will have no more than 10 beds.

Criterion 77 IAC 1110.3130 (e) – "Staffing Availability"

Document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

Criterion 77 IAC 1110.3130 (f) – "Emergency Surgical Backup"

Document that either:

1. The birth center will operate under a hospital license and will be located within 30 minutes ground travel time from the hospital; **OR**

2. A contractual agreement has been signed with a licensed hospital within 30 minutes ground travel time from the licensed hospital for the referral and transfer of patients in need of an emergency caesarian delivery.

Criterion 77 IAC 1110.3130 (g) – "Education"

A written narrative on the prenatal care and community education services offered by the birth center and how these services are being coordinated with other health services in the community.

Criterion 77 IAC 1110.3130 (h) – "Inclusion in Perinatal System"

1. Letter of agreement with a hospital designated under the Perinatal System and a copy of the hospital's maternity service; **OR**

2. An applicant that is not a hospital shall identify the regional perinatal center that will provide neonatal intensive care services, as needed to the applicant birth center patients; and a letter of intent, signed by both the administrator of the proposed birth center and the administrator of the regional perinatal center, shall be provided.

Criterion 77 IAC 1110.3130 (i) – "Medicare/Medicaid Certification"

The applicant shall document that the proposed birth center will be certified to participate in the Medicare and Medicaid programs under titles XVIII and XIX, respectively, of the federal Social Security Act.

Criterion 77 IAC 1110.3130 (j)- "Charity Care"

The applicant shall provide to HFSRB a copy of the charity care policy that will be adopted by the proposed birth center.

Criterion 77 IAC 1110.3130 (k) – "Quality Assurance"

The applicant shall provide to HFSRB a copy of the quality assurance program to be adopted by the birth center.

APPEND DOCUMENTATION AS ATTACHMENT-33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VII. 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable [**Indicate the dollar amount to be provided from the following sources**]:

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital

	improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions. e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent; f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt; g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information

regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost In dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI. Charity Care Information

Charity Care information MUST be furnished for ALL projects [1120.20©].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	
2	Site Ownership	
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
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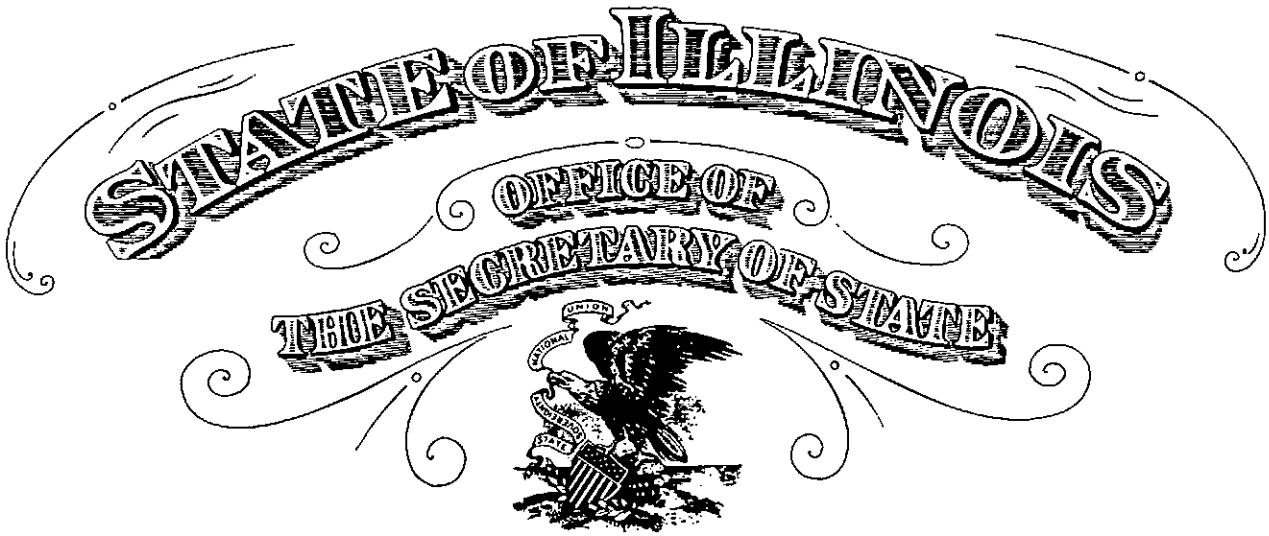
ATTACHMENT 1

Applicant Ownership Information

Please find attached a Certificate of Good Standing document issued by the Illinois Secretary of State for the Illinois Back & Neck Institute, LLC, an Illinois limited liability company, which is the entity that will own and operate the proposed ASTC.

File Number 0456293-3



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ILLINOIS BACK & NECK INSTITUTE LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON OCTOBER 01, 2013, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 3RD *day of* NOVEMBER *A.D.* 2017 .

Authentication #: 1730701980 verifiable until 11/03/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

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ATTACHMENT 2

Site Ownership

The proposed ASTC will be constructed in a building located at 360 W. Butterfield Road, Suite 100, Elmhurst, Illinois 60126. The building is owned by 360 Butterfield LLC (the "Site Owner"). Evidence of ownership by the Site Owner is provided in the form of a lease agreement between the Site Owner, as landlord and the Illinois Back & Neck Institute, LLC, the tenant. A copy of the lease agreement is attached hereto.

LEASE

360 BUTTERFIELD, LLC
(Landlord)

and

THE PAIN CENTER OF ILLINOIS, LTD.
(Tenant)

PREMISES

360 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS

(Suite #100)

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February 9, 2016

THIS LEASE is made in Elmhurst, Illinois, as of the date described herein.

I. Lease of Premises

360 BUTTERFIELD, L.L.C. (hereinafter called "Landlord") is the owner of an office building ("Building") commonly known as 360 West Butterfield Road, Elmhurst, DuPage County, Illinois, (the "Real Estate") (the Building and the Real Estate being herein collectively referred to as the "Property") and for and in consideration of the rents herein reserved and of the covenants and agreements herein contained on the part of Tenant to be performed, does hereby lease to: **THE PAIN CENTER OF ILLINOIS, LTD**, an Illinois Corporation ("Tenant"); and Tenant hereby accepts the lease of that certain office space in the Building commonly described as Suite 100 (said space being herein referred to as the "Premises") for a term of nine (9) years and eight (8) months, commencing on February 1, 2016 ("Commencement Date"), and ending on September 30, 2025 ("Term"). It is mutually agreed that the Premises contain two thousand eight hundred fifty four (2,854) rentable square feet.

II. Base Rent

Tenant shall pay to Landlord [18-5 E. Dundee Road, Suite 200, Barrington, IL 60010], or to such other person or at such other place, as Landlord shall designate in writing, as rent for the Premises and in legal tender at the time of payment, Base Rent as follows:

A. For the period from April 1, 2016 to November 30, 2016 (the "Abatement Period"), both inclusive, Base Rent shall be waived;

B. For the period from December 1, 2016 to November 30, 2017, both inclusive, Base Rent shall be equal to FORTY SIX THOUSAND THREE HUNDRED SEVENTY SEVEN AND 50/100 Dollars ($46,377.50) payable in equal monthly installments of THREE THOUSAND EIGHT HUNDRED SIXTY FOUR AND 79/100 Dollars ($3,864.79) per month in advance on the first day of every calendar month commencing October 1, 2016.

C. For the period from December 1, 2017 to November 30, 2018, both inclusive, Base Rent shall be equal to FORTY SEVEN THOUSAND SEVEN HUNDRED SIXTY EIGHT AND 83/100 Dollars ($47,768.83) payable in equal monthly installments of THREE THOUSAND NINE HUNDRED EIGHTY AND 74/100 Dollars ($3,980.74) per month in advance on the first day of every calendar month commencing October 1, 2017.

D. For the period from December 1, 2018 to November 30, 2019, both inclusive, Base Rent shall be equal to FORTY NINE THOUSAND TWO HUNDRED ONE AND 89/100 Dollars ($49,201.89) payable in equal monthly installments of FOUR THOUSAND ONE HUNDRED AND 16/100 Dollars ($4,100.16) per month in advance on the first day of every calendar month commencing October 1, 2018.

E. For the period from December 1, 2019 to November 30, 2020, both inclusive, Base Rent shall be equal to FIFTY THOUSAND SIX HUNDRED SEVENTY SEVEN AND 95/100 Dollars ($50,677.95) payable in equal monthly installments of FOUR THOUSAND TWO HUNDRED TWENTY THREE AND 16/100 Dollars ($4,223.16) per month in advance on the first day of every calendar month commencing October 1, 2019.

F. For the period from December 1, 2020 to November 30, 2021, both inclusive, Base Rent shall be equal to FIFTY TWO THOUSAND ONE HUNDRED NINETY EIGHT AND 28/100 Dollars ($52,198.28) payable in equal monthly installments of FOUR THOUSAND THREE HUNDRED FORTY NINE AND 86/100 Dollars ($4,349.86) per month in advance on the first day of every calendar month commencing October 1, 2020.

G. For the period from December 1, 2021 to November 30, 2022, both inclusive, Base Rent shall be equal to FIFTY THREE THOUSAND SEVEN HUNDRED SIXTY FOUR AND 23/100 Dollars ($53,764.23) payable in equal monthly installments of FOUR THOUSAND FOUR HUNDRED EIGHTY AND 35/100 Dollars ($4,480.35) per month in advance on the first day of every calendar month commencing October 1, 2021.

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December 1 November 30

H. For the period from -2022 to , 2023, both inclusive, Base Rent shall be equal to FIFTY FIVE THOUSAND THREE HUNDRED SEVENTY SEVEN AND 16/100 Dollars ($55,377.16) payable in equal monthly installments of FOUR THOUSAND SIX HUNDRED FOURTEEN AND 76/100 Dollars ($4,614.76) per month in advance on the first day of every calendar month commencing October 1, 2022.

December 1 November 30

I. For the period from 2023 to , 2024, both inclusive, Base Rent shall be equal to FIFTY SEVEN THOUSAND THIRTY EIGHT AND 48/100 Dollars ($57,038.48) payable in equal monthly installments of FOUR THOUSAND SEVEN HUNDRED FIFTY THREE AND 21/100 Dollars ($4,753.21) per month in advance on the first day of every calendar month commencing October 1, 2023.

December 1 November 30

J. For the period from 2024 to , 2025, both inclusive, Base Rent shall be equal to FIFTY EIGHT THOUSAND SEVEN HUNDRED FORTY NINE AND 63/100 Dollars ($58,749.63) payable in equal monthly installments of FOUR THOUSAND EIGHT HUNDRED NINETY FIVE AND 80/100 Dollars ($4,895.80) per month in advance on the first day of every calendar month commencing October 1, 2023.

Monthly Base Rent shall be due and owing on the first day of each calendar month during the Term of this Lease. Notwithstanding the foregoing, Tenant shall pay the first month's rent, upon execution of this Lease.

Tenant or Tenant's representative or agent, shall be entitled to enter into the Premises upon execution of this Agreement, at no additional cost, for purposes of performing the Work managing the buildout, for setting up its furniture, and for otherwise preparing the Premises for occupancy.

If the Term commences on a day other than the first day of the calendar month or ends on a day other than the last day of the calendar month, the Base Rent for such month shall be pro rated. Tenant's covenant to pay rent shall be independent of every other covenant set forth in this Lease and rent shall be paid without deduction, set-off, discount or abatement, unless otherwise agreed to in writing by the Parties.

All charges, costs and sums required to be paid by Tenant to Landlord under this Lease in addition to Base Rent shall be deemed "Additional Rent," and Base Rent and Additional Rent shall herein collectively be referred to as "rent." Should Tenant's rent not be paid by the 7th day of the month in which it was due then Tenant shall pay one time to Landlord, as a penalty, an additional five percent (5%) of the scheduled rent payment. Interest shall also accrue on a monthly basis on the unpaid balance at a rate of the greater of three percent per annum in excess of the prime rate as offered by Bank of America, Charlotte, North Carolina, or its successor, or twelve percent (12%) per annum, or if less, then the maximum rate allowed under Illinois Law. The late payment penalty and interest shall be due and payable, and shall continue to accrue as applicable, with reasonable notice from Landlord. Notwithstanding the foregoing, with respect to the first two (2) late payments in any calendar year, Landlord shall provide written notice to Tenant (such notice capable of being delivered via email) of the rent's unpaid status and Tenant shall be entitled to a grace period of five (5) days after such notice from Landlord before Tenant shall be liable for the late fees and penalty under this section.

III. Additional Rent

A. As used in this Section 3 the following terms shall have the following meanings:

a. "Base Taxes" shall mean those general real estate taxes which have been assessed against the Real Estate and are payable during the calendar year 2016.

b. "Base Expenses" shall mean Expenses (as hereinafter defined) which Landlord or its beneficiary or beneficiaries shall pay or become obligated to pay during the calendar year 2016.

c. "Expenses" shall mean all operating expenses of the Property. Expenses shall include all costs, expenses and disbursements of every kind, nature and description which Landlord or its beneficiary or beneficiaries shall pay or become obligated to pay in connection with ownership, management, operation, maintenance and repair of and the necessary replacements in the Property and of the personal property, fixtures, machinery, equipment, systems and apparatus located therein or used in connection therewith, except the following: (i)

Taxes [Taxes are defined in Section 3(A)(d) below]; (ii) cost of alterations of any premises in the Building for other tenants of the Building; (iii) costs of capital improvements of the Property (except that operating expenses shall specifically include the cost, as advised by Landlord, of any labor or cost savings device or installation installed subsequent to the date hereof amortized over its useful life in accordance with generally accepted accounting principles and further provided same reduce Expenses); (iv) interest and principal payments on mortgages; (v) cost and expenses incurred in connection with negotiations with prospective tenants of the Building; (vi) the rental value of Landlord's office or storage space in the Building, if applicable; (vii) real estate brokerage and leasing commissions, (vii) legal fees incurred in the enforcement of leases of tenants to the Building; (viii) costs directly relating to the leasing of space in the Building (including tenant improvements, costs incurred in relocating tenants, advertising and promotional expenses incurred in connection with the listing of available space in the Building i.e. "open houses" and "brokers parties"); (ix) salaries or fringe benefits of personnel above the grade of property manager; (x) compensation paid to clerks, attendants or other persons in commercial concessions operated by Landlord; (xi) the cost of any work or services performed or other expenses incurred in connection with installing, operating and maintaining any specialty service or facility such as a skydeck, broadcasting facility, restaurant, athletic or recreational club not made available to tenants of the Building without the payment of an additional charge for the use of same; (xii) with respect to any contract for services (including any contract entered into by Landlord or on its behalf with respect to the management of the Building) or material entered into by Landlord with an affiliate of Landlord, that portion of the cost and expense thereof which is in excess of the cost and expense which Landlord would have incurred if dealing at arm's length with an independent third party (provided, however, that the foregoing shall not be construed to mean that Landlord must choose the lowest cost services or materials available in the general market for same, Landlord having and reserving the right to choose such services and materials as it deems necessary); (xiii) costs and expenses to the extent reimbursed from third parties (other than tenants to the Building in connection with payment of their proportionate share of Expenses); (xiv) the cost of any special service or benefit rendered to a tenant of the Building which is not made available or offered to other tenants of the Building; (xv) expenses reimbursed to Landlord pursuant to warranties and/or the like; (xvi) franchise and income taxes imposed upon Landlord; (xvii) cost incurred by Landlord in refinancing the Real Property; (xviii) depreciation charges; (xix) costs and expenses not related to the owning, managing, operating, maintaining and repairing the Real Property; and (xx) reserves for future Expenses. Without limiting the generality of the foregoing which is included in Expenses, Expenses shall include, but shall not be limited to, the following:

1. Wages and salaries of all employees engaged in operating and maintenance or security of the Property, including taxes, insurance and benefits relating thereto;

2. All supplies and materials purchased in operation and maintenance of the Property;

3. Cost of all utilities for the Property including the cost of water and power, gas, heating, lighting, air conditioning and ventilating for the Building;

4. Cost of all maintenance and service agreements for the Real Estate and Building and the equipment therein or thereon, including, but not limited to, management, alarm service, security service, trash removal, snow removal, repair or replacement of any heating, ventilating and air conditioning equipment, repair or replacement of the roof of the building, repair or replacement of utility systems, interior and exterior landscaping, wages and union benefits of employees (including the amount of any social security taxes, unemployment insurance, contributions and "fringe" benefits), window cleaning, elevator maintenance, pest control, reasonable legal and accounting services, and janitorial service;

5. Cost of all insurance relating to the Property, including the cost of casualty, rental and liability insurance applicable to the Building and Real Estate and Landlord's personal property or personal property of its beneficiary or beneficiaries used in connection therewith;

6. Cost of repairs and general maintenance (excluding repairs and maintenance paid by proceeds of insurance or by Tenant or other third parties); and

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7. Cost, as amortized by Landlord, of any labor saving or cost saving device or installation installed subsequent to the date hereof.

In the event that the Building is not fully occupied during any calendar year all or any portion of which occurs during the Term, the variable Expenses for that year shall be equitably adjusted to reflect the Expenses as though the Building were fully occupied.

d. "Taxes" shall mean all real estate taxes, assessments (whether they be general or special), sewer rents, rates and charges, transit taxes, taxes based upon government charge, general, special, ordinary or extraordinary which may now or hereafter be levied or assessed against the Property or the personal property, fixtures, machinery, equipment, systems and apparatus located therein or used in connection therewith and which are payable during the calendar year in question. In case of special taxes or assessments which may be payable in installments, only the amount of each installment paid during a calendar year shall be included in Taxes for that year. There shall be included in Taxes for any year the amount of all fees, costs and expenses (including attorneys' fees) paid by Landlord or its beneficiary during such year in seeking or obtaining any refund or reduction thereof. If at any time during the Term of this Lease (or any renewal or extension thereof) the method of taxation prevailing at the commencement of the Term shall be altered so that any new tax, assessment, levy, imposition or charge, or any thereof, shall be measured by or be based in whole or in part upon this Lease, or the Real Estate, or the Premises, or the Property, or the rent, additional rent or other income from any or all of the foregoing and shall be imposed upon the Landlord, then all such taxes, assessments, levies, impositions or charges, or the part thereof, to the extent that they are so measured or based, shall be deemed to be included within the term Taxes for the purposes hereof to the extent that such Taxes would be payable if the Property were the only property of Landlord subject to such Taxes. There shall be excluded from Taxes all federal income taxes, federal excise profit taxes, franchise, capital stock and federal or state estate or inheritance taxes of Landlord. It is agreed that Tenant will be responsible for taxes on its personal property.

e. "Tenant's Proportionate Share" shall mean three point zero percent (3.0%).

B. In the event that Expenses for any calendar year, all or any portion of which occurs during the Term, exceeds the Base Expenses, Tenant shall pay Tenant's Proportionate Share of the years' increase in the Expenses for such year over Base Expenses. Landlord shall, after the close of each calendar year, give Tenant a statement of each year's actual Expenses. If such years' Expenses are greater than the Base Expenses, Tenant shall pay Landlord, within thirty (30) days of statement receipt, Tenant's Proportionate Share of such increase less the sums received by Landlord pursuant to Subparagraph (C) below. In the event that actual Taxes for any calendar year, all or any portion of which occurs during the Term, exceeds the Base Taxes, Tenant shall pay Tenants' Proportionate Share of the years' increase in the Taxes for such year over Base Taxes. If such years' Taxes are greater than the Base Taxes, Tenant shall pay Landlord within thirty (30) days of statement receipt, Tenant's Proportionate Share of such increase less the sums received by Landlord pursuant to Subparagraph (C) below. Any increase payable by Tenant under this provision, including amounts to be paid under Subparagraph (C) below shall be deemed "Additional Rent."

C. For each calendar year (all or any portion of which occurs during the Term) commencing with 2016, Landlord shall provide Tenant a comparison of the Base Expenses and the projected Expenses and a comparison of the Base Taxes and the projected Taxes payable for such year prior to January 1 of such year or as soon thereafter as is reasonably practicable or in the event of the first calendar year, as soon after the execution of this Lease as is reasonably practicable; and Tenant shall thereafter pay projected Additional Rent for such year which shall be paid in monthly installments at the same time that Base Rent is paid hereunder and each such installment shall equal one-twelfth (1/12th) of Tenant's Proportionate Share of any projected increase in Expenses over the Base Expenses and one-twelfth (1/12th) of Tenant's Proportionate Share of any projected increase in Taxes over the Base Taxes. If the amount paid by Tenant pursuant to this Subparagraph (C) is less than Tenant's Proportionate Share of actual increase in Expenses over Base Expenses, Tenant shall pay to Landlord within thirty (30) days of statement receipt, the amount of the difference. If the amount paid by Tenant pursuant to this Subparagraph (C) is in excess of Tenant's Proportionate Share of actual increase in Expenses over Base Expenses, the amount of such excess shall be credited to the next payments of Additional Rent pursuant to this Subparagraph (C), or if the Term has ended shall first be credited to any amounts due

Landlord and then paid to Tenant. If the amount paid by Tenant pursuant to this Subparagraph (C) is less than Tenant's Proportionate Share of actual increase in Taxes over Base Taxes, Tenant shall pay to Landlord within thirty (30) days of statement receipt, the amount of the difference. If the amount paid by Tenant pursuant to this Subparagraph (C) is in excess of Tenant's Proportionate Share of actual increase in Taxes over Base Taxes, the amount of such excess shall be credited to the next payments of Additional Rent pursuant to this Subparagraph (C), or if the Term has ended shall first be credited to any amount due Landlord and then paid to Tenant.

D. If the Term ends on any day other than the last day of a calendar year, the Expense adjustment referred to in subparagraphs (B) and (C) above and the Tax adjustment referred to in subparagraphs (B) and (C) above shall be pro rated based on the number of days in such calendar year included in the Term. That is, Tenant shall only pay the Expense adjustment or Tax adjustment for the calendar days of the Term included in such commencement or termination year. Tenant and Landlord's obligation to complete the Expense and Tax adjustment referred to in subparagraphs (B) and (C) above shall survive the termination of this lease, until such time that Landlord provides the reconciliation amounts for the calendar year in which the Term ended.

E. Tenant, at its expense, shall have the right at all reasonable times to examine the books and records of Landlord relating to this Lease for any year or years for which additional rent payments as set forth in this Section become due provided such examination for any calendar year ("Subject Year") occurs within sixty (60) days following Tenant's receipt of the statement of Expenses and Taxes for such Subject Year. Should a tenant of the Building cause an examination to be made of the books and records of Landlord and should such examination reveal that Tenant is entitled to a reduction in the payment of Additional Rent pursuant to this Section 3, Landlord shall advise Tenant of that fact and the amount of such reduction shall be credited to the next payments of Additional Rent pursuant to this Section 3, or if the Term has ended shall first be credited to any amount due Landlord and then paid to Tenant.

IV. Security Deposit

As additional security for the faithful and prompt performance of its obligations hereunder, Tenant has concurrently with the execution of this Lease paid to Landlord's managing agent the sum of THREE THOUSAND EIGHT HUNDRED SIXTY FOUR AND 79/100 Dollars ($3,864.79). Said security deposit may be applied by Landlord for the purpose of curing any default or defaults of Tenant hereunder (without prejudice to any other remedy or remedies which Landlord may have on account thereof) provided notice of such default has been provided to Tenant hereunder and Tenant has failed to timely cure such default, in which event Tenant shall replenish said deposit in full by promptly paying to Landlord the amount so applied. Landlord shall not pay any interest on said deposit, except as required by law and said security deposit may be commingled with other funds of said managing agent. If Tenant is not then in default, Landlord has not applied said deposit to cure a default, or Landlord has applied said deposit to cure a default and Tenant has replenished the same, then said deposit, or such applicable portion thereof, shall be paid to Tenant within thirty (30) days after the termination of this Lease. Said deposit shall not be deemed an advance payment of rent or a measure of Landlord's damages for any default hereunder by Tenant. Should the Property be conveyed by Landlord, the remaining amount of the deposit shall be turned over to Landlord's grantee and thereafter Landlord shall not be responsible for the return of the deposit and Tenant agrees to look to Landlord's grantee for such return. In the event any bankruptcy, insolvency, reorganization or other creditor-debtor proceedings shall be instituted by or against Tenant, or its successors or assigns, said security deposit shall be deemed to be applied first to the payment of any Base Rent or Additional Rent due Landlord for all periods prior to the institution of such proceedings, and the balance, if any, of said security deposit may be retained or paid to Landlord in partial liquidation of Landlord's damages.

V. Use

Tenant shall occupy and use the Premises for the general office and medical purposes. Tenant shall not occupy or use the Premises or permit the Premises to be occupied or used for any purpose, act or thing which is in violation of any public law, ordinance or governmental regulation, which may be dangerous to persons or property or which may invalidate or increase the amount of premiums for any policy of insurance carried on the Building or covering its operation or violate the terms thereof provided, however, that if any additional amounts of insurance premiums are caused by Tenant's occupancy or use of the Premises, Tenant shall pay to Landlord said additional

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amount. Tenant shall not knowingly do or permit anything to be done upon the Premises, or knowingly bring or keep anything thereon which is in violation of rules, regulations or requirements of the Elmhurst Fire Department, Illinois Inspection and Rating Bureau, Fire Insurance Rating Organization, or any other similar authority having jurisdiction over the Building. Tenant shall not do or permit anything to be done upon the Premises which in any way may create a nuisance, disturb any other tenant of the Building or the occupants of neighboring property or injure the reputation of the Building. Tenant shall not use the Premises for housing accommodations, for lodging or sleeping purposes or for any immoral or illegal purposes. Tenant shall not at any time do or permit any of the following to be done in the Premises or the Building: the manufacture, sale, purchase, use or gift of any spirituous, fermented, intoxicating or alcoholic liquors or the commercial cooking or sale of food in any form.

VI. Landlord's Obligations and Services

Landlord shall, subject however to reimbursement as set forth in Section 3 hereof, furnish the following services to Tenant while it is occupying the Premises:

a. Heated and cold water at those points of supply provided for general use in the Building and in the Premises, it being understood that after Tenant takes possession of the Premises, Tenant is solely responsible for all plumbing and plumbing fixtures serving only the Premises.

b. Heat and air conditioning in the common areas of the building in such amounts as are reasonably considered by Landlord to be standard, under normal business operations.

c. Maintenance of the heating and air conditioning equipment such that the equipment shall provide heat and air conditioning in such amounts as are considered by Landlord to be standard, under normal business operations and in the absence of occupancy of the Premises by more than one person per 150 square feet. In the event either: 1) Landlord determines that, as a result of the use by Tenant in the Premises of electric power in excess of five (5) watt hours per square foot of the Premises per day for Tenant's incidental uses, or occupancy of the Premises by more than one person per 150 square feet supplementary heat or air conditioning is required to maintain a comfortable temperature in the Premises; or 2) Tenant desires such additional heat or air conditioning, then Landlord shall have the right to install supplementary heating or air conditioning equipment in the Premises subject to Tenant's prior approval and agreement, and Tenant shall reimburse Landlord for the cost of the installation of such equipment, promptly upon being billed therefore by Landlord, and Tenant shall thereafter repair and maintain said supplementary equipment.

d. Routine maintenance and electric lighting service for all public areas and special service areas of the Building in the manner and to the extent deemed by Landlord to be standard and in accordance with applicable law.

e. Janitor service on a five (5) working day basis per week, and such service shall include the Premises. Janitorial service may be provided on weekends for the upcoming Monday.

f. Snow and ice removal for the surface parking areas, driveways, and walkways located on the Property.

g. Window washing of all windows in the Premises both inside and out, weather permitting, at intervals to be determined by Landlord.

h. The supply of electrical power to the connection points for the Premises. Tenant shall be responsible for procuring electrical power from ComEd on its own, and at its own expense.

i. Maintenance of the fire sprinkler system and fire alarm systems.

Any additional work or services of the character described above, and any unusual amount of such work or service, including service furnished outside the stipulated hours, required or requested by Tenant, shall be paid for by Tenant at Landlord's actual cost reasonably incurred in providing such services, plus twenty percent (20%).

Landlord does not warrant that any service will be free from interruptions caused by damage, fire or other casualty, repair, renewals, improvements, changes of service, alterations, strikes, lockouts, labor controversies, accidents, inability to obtain fuel, electricity, water or supplies or other cause, provided they are beyond the reasonable control of Landlord. Landlord agrees to give Tenant notice of any extended interruptions of which it has prior knowledge. No such interruption of service shall be deemed an eviction or disturbance of Tenant's use and possession of the Premises or any part thereof, or render Landlord liable to Tenant for damages, by abatement of rent or otherwise, or relieve Tenant from performance of Tenant's obligations under this Lease. Tenant hereby waives and releases all claims against Landlord for damages for such interruption or stoppage of service.

Notwithstanding the foregoing provisions to the contrary, in the event: (i) that there is an interruption in a service furnished by Landlord (which is not the result of a casualty to the Building or the Premises covered pursuant to the provisions of Section 16 *Casualty Damage*), (ii) the interruption in said service continues for more than five (5) continuous non-holiday weekdays ("Business Days") following notice by Tenant to Landlord of the existence of such interruption, (iii) Tenant is not in default beyond any applicable cure period provided for in this lease, and (iv) the interruption in said service results in Tenant being unable to use the Premises, then and in that event, Tenant's Rent shall, for the period commencing on the expiration of said five (5) continuous business days and ending at the time that such service is restored (or until Tenant is reasonably able to conduct its business at the Premises), abate.

In the event that: (i) that there is an interruption in a service furnished by Landlord which is not the result of a casualty to the Building or the Premises covered pursuant to the provisions of Section 16 *Casualty Damage*, (ii) the interruption in said service continues for more than sixty (60) continuous calendar days following notice by Tenant to Landlord of the existence of such interruption, (iii) Tenant is not in default beyond any applicable cure period provided for in this lease, and (iv) the interruption in said service results in Tenant being unable to use the Premises, then and in that event, Tenant shall have the right to terminate this lease upon written notice to Landlord received by Landlord no later than the sixty fifth (65) calendar day following notice by Tenant to Landlord of the existence of such interruption. In such event termination shall be effective as of the date Landlord receives same, without release however of Tenant for Rents, claims or other matters pertaining to the period prior to the effective date of termination for which Tenant is responsible for under this lease.

VII. Landlord's Covenants

Landlord covenants and agrees to use reasonable efforts to perform all of Landlord's Obligations, as detailed in Section 6, and to also maintaining the Building's exterior, roof, structural members, mechanical systems, plumbing (to the point of entry to the Premises) and foundation in good repair and condition, providing snow removal in the parking lot and areas providing access to and from the Building, and to maintaining and repairing the parking lot.

VIII. Tenant's Obligations

A. Tenant shall be responsible for procuring and maintaining the following services, and shall be responsible for all costs associated with the following services.

   a. Tenant shall make arrangements directly with Commonwealth Edison Company for all energy consumption within the Premises, and shall be responsible for all costs for this service. Tenant shall be directly metered and billed by Commonwealth Edison Company for all such energy consumption within the Premises.

   b. Tenant shall make arrangements directly with one of the telephone/internet/television companies servicing the Building for such telephone, internet and television service in the Premises as may be desired by Tenant. Tenant shall be responsible for all costs associated with such services.

   c. If Tenant desires, Tenant shall make arrangements directly with a provider, reasonably approved by Landlord, for telegraphic, telephonic, burglar alarm, computer installations or signal service, which services shall be at Tenant's sole expense. Landlord shall direct where and how all connections and wiring for such service shall be introduced and run through the Building. In the absence of such directions, Tenant shall make no borings, cutting or installation of wires or cables in or about the Premises. Tenant shall be responsible for all costs associated with such services.

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d. Tenant shall hold Landlord harmless from all costs and expenses Landlord may incur for Tenant's failure to pay any bills or to perform any of its obligations with respect to the purchase of services under this Subsection A.

B. Tenant shall be responsible for and shall pay for all non-capital interior maintenance, repairs, replacements, alterations, additions, and improvements as to the Premises (except as otherwise provided for in this Lease, such as the Initial Alterations) including the plumbing, sewage and drainage serving the Premises only, doors, walls, ceilings, light fixtures, electrical systems serving the Premises only, lamps, bulbs, tubes, starters and ballasts; fire extinguishers, and emergency exit signs, but excluding: structural matters, Building systems, glass fixtures, Building and Landlord's equipment and appurtenances, and heating, ventilation and air conditioning equipment serving the Premises. Such work shall be the obligation of Tenant and, under this Section, shall be performed at Tenant's reasonable cost and expense either by employees of the said managing agent or contractors or by persons approved by Landlord.

C. All alterations, additions or improvements made by Landlord or Tenant in or upon the Premises shall constitute Landlord's property and shall, unless Landlord advises Tenant prior to commencing the alterations, additions, or improvements that same must be removed upon termination of this Lease, remain upon the Premises at the termination of this Lease without compensation to Tenant. Notwithstanding the foregoing, Tenant shall retain title to its trade fixtures, medical equipment and cabinetry, furniture, and personal property, the removal of which shall be governed by Section 26 of this Lease.

D. The Tenant will repair all damage or injury to: 1) the Premises; and 2) the Property, including fixtures, appurtenances and equipment thereof, caused by the Tenant's installation or removal of its property.

E. Tenant shall, at Tenant's own expense, comply with all laws and ordinances, and all orders, rules and regulations of all governmental authorities and of all insurance bodies and their fire prevention engineers at any time in force, applicable to the Premises or to the Tenant's use thereof, except that Tenant shall not hereby be under any obligation to comply with any law, ordinance, rule or regulation requiring any substantial structural alteration of or in connection with the Premises, unless such alteration is required by reason of Tenant's use of the Premises, or a condition which has been created by or at the sufferance of Tenant, or is required by reason of a breach of any of Tenant's covenants and agreements hereunder.

IX. Tenant's Further Obligations

A. Tenant shall:

a. Before leaving the Premises unattended, close and securely lock all doors.

b. Comply with all reasonable rules and regulations Landlord may adopt from time to time for the protection and welfare of the Property and its tenants and occupants.

c. At all times maintain a minimum air temperature within the Premises of 50 degrees F in order to prevent freezing of water pipes.

B. Tenant shall not:

a. Exhibit, sell or offer for sale, use, rent or exchange in the Premises any article, thing or service except those ordinarily embraced within the use of the Premises specified in this Lease, without the prior written consent of Landlord.

b. Use or permit to be brought into or kept in the Premises or the Building any inflammable oils or fluids (except small quantities of cleaning materials and materials used in the operation and conduct of Tenant's business), any explosive or other articles deemed hazardous to person or property, any petroleum or petroleum products, any "hazardous substances," as that term is defined in the Comprehensive

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Environmental Response Compensation and Liability Act (42 U.S.C. Section 9601 [14]) ("CERCLA") or perform any other act which may result in a claim of liability under CERCLA.

c. Install or operate any refrigerating, heating or air conditioning apparatus without the prior written permission of Landlord which permission shall not be unreasonably withheld, conditioned or delayed, except one (1) standard-size refrigerator for use by Tenant staff in the Premises.

d. Place any radio or television antenna on the roof or on or in any part of the inside or outside of the Building other than the inside of the Premises; or operate or permit to be operated any musical or sound producing instrument or device inside or outside the Premises which may be heard outside the Premises; or operate any electrical device from which may emanate electrical waves which may knowingly interfere with or impair radio or television broadcasting or reception from or in the Property or elsewhere. Landlord expressly permits Tenant to install and operate a wireless internet network.

e. Bring or permit to be in the Building any bicycle or other vehicle, or dog (except in the company of a blind person) or other animal or bird, make or permit any objectionable noise, vapors, or odors to emanate from the Premises or solicit or canvass any occupant of the Property.

f. Take or permit to be taken in or out of the Building, furniture, equipment or similar items except under the supervision of Building employees; or, whether temporarily, accidentally or otherwise, allow anything to remain in, place or store anything in, or obstruct in any way, any passageway, exit, stairway, elevator, shipping platform or truck concourse. Tenant shall lend its full cooperation to keep such areas free from all obstruction and in a clean and slightly condition and move all supplies, furniture and equipment as soon as received directly to the Premises and move all such items and waste (other than waste customarily removed by Building employees, being taken from the Premises) directly to any shipping area at or about the time arranged for removal therefrom.

g. Attach or permit to be attached additional locks or similar devices to any door, transom or window; change existing locks or the mechanism thereof, or make or permit to be made any keys for any door other than those provided by Landlord. (If more than two keys for one lock are desired, Landlord will provide them upon payment therefor by Tenant).

h. Overload any floors.

i. Make alterations or additions in or to the Premises without submitting plans and specifications to Landlord and securing Landlord's prior written consent in each such instance, which consent of Landlord shall not be unreasonably withheld, conditioned or delayed. Such work shall be done at Tenant's expense and shall be subject to the terms and conditions set forth in, without limitation, Section 8 and Section 26(A)(c) of this Lease. All installations, alterations and additions shall be constructed in a good and workmanlike manner and only good grades of material shall be used, and shall comply with all insurance requirements, and with all ordinances and regulations of the City of Elmhurst or any department or agency thereof, and with the requirements of all statutes and regulatious of the State of Illinois or any department of agency thereof. All alterations shall be made by Landlord's contractors or contractor's approved in writing and in advance by Landlord. Tenant shall not permit the Premises, the Building or the Property to become subject to any mechanics', laborers' or materialmen's lien on account of labor or material furnished to Tenant or claimed to have been furnished to Tenant in connection with work of any character performed or claimed to have been performed on the Premises by, or at the direction or sufferance of, Tenant.

j. Waste water by tying, wedging or otherwise fastening open any faucets.

k. Fasten any carpeting to the floors other than by the method approved by Landlord.

l. Operate any coin or token operating vending machine or similar devise for the sale of any goods, wares, merchandise, food, beverages or services, including but not limited to, pay telephones, pay lockers, pay toilets, scales, amusement devices or machines for the sale of beverages, foods, candy, cigarettes or other commodities.

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m. Enter or permit to be entered into or upon the roof of the Building or any storage, heating, ventilation, air conditioning, mechanical or machinery housing areas.

n. Distribute literature, flyers, handouts or pamphlets of any type in any of the common areas of the Property without the prior written consent of Landlord.

o. Advertise the business, profession or activities of Tenant conducted in the Building in any manner which violates the letter or spirit of any code of ethics adopted by any recognized association or organization pertaining to such business, profession or activities, and shall not use the name of the Building for any purposes other than that of the business address of Tenant, and Tenant shall never use any picture or likeness of the Building in any circulars, notices, advertisements or correspondence without Landlord's prior written consent.

p. Obstruct, or use the public areas of the Building for storage, or for any purpose other than ingress and egress. Tenant shall not place any object against glass partitions, doors or windows in the corridor area.

q. In any manner deface or damage the Property, Building or the Premises.

X. Inspection

The Landlord shall have the right at all reasonable times during the Term of this Lease to repair and make replacements to the Property and Landlord shall have the right at all reasonable times during the Term of this Lease to enter the Premises at a reasonable time with reasonable notice for the purpose of inspecting the same and of making such repairs or replacements therein or to the Property as may be required by this Lease or as the Landlord may deem necessary, provided, however, that the Landlord shall use all reasonable efforts not to disturb the Tenant's use and occupancy.

Landlord may, upon one (1) business days' prior notice, enter upon the Premises for said purposes and may exercise any or all of the foregoing rights hereby reserved without being deemed guilty of an eviction or disturbance of Tenant's use or possession of the Premises and without being liable in any manner to Tenant. If an emergency exists, Landlord may enter without notice. If Tenant is not available to admit Landlord in an emergency, Landlord may use reasonable force commensurate with the circumstances, to enter the Premises. Landlord must respect Tenant's business operations and not unreasonably or substantially interfere with the practice in any way, unless required by a governmental authority or as a matter of safety.

XI. Rights Reserved to Landlord

Landlord shall have the following rights exercisable without notice and without liability to Tenant for damage or injury to property, person or business, (all claims for damage being hereby released) and without effecting an eviction or disturbance of Tenant's use or possession or giving rise to any claim for set-offs, or abatement of rent:

a. To change the name or street address of the Building or Property.

b. To install and maintain signs on the exterior and interior of the Building except on floors leased entirely by Tenant.

c. To have pass keys to the Premises.

d. To decorate, remodel, repair, alter or otherwise prepare the Premises for re-occupancy during the last six (6) months of the Term hereof, if during or prior to such time Tenant vacates the Premises, or at any time after Tenant abandons the Premises.

e. With a representative of Landlord or Tenant present, to enter the Premises at reasonable hours to exhibit the Premises to prospective tenants of the Premises (only during the last six months of the Term),

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purchasers or others. In doing so, Landlord may not unreasonably or substantially interfere with Tenant's practice.

f. To have access to all mail chutes according to the rules of the United States Post Office.

g. To require all persons entering or leaving the Building or Premises during such hours as Landlord may from time to time reasonably determine to identify themselves to a watchman by registration or otherwise and to establish their right to enter or leave, and to exclude or expel any peddler, solicitor or beggar at any time from the Premises or the Building.

h. To approve the weight, size and location of safes, bookcases, computers and other heavy articles in and about the Premises and the Building and to require all such items and other office furniture and equipment to be moved in and out of the Premises and Building only at such times as will not unreasonably deny or obstruct the rights and use of other tenants, and in all events, at the Tenant's sole risk and responsibility.

i. At any time or times, to decorate and to make repairs, alterations, additions and improvements, structural or otherwise, in or to the Property, Premises or Building or any part thereof, provided such actions do not harm Tenant's use of Premises, unless required by a government authority.

j. To do or permit to be done any work in or about the exterior of the Building or any adjacent or nearby building or land.

k. To grant to anyone the exclusive right to conduct any business or render any service in the Building or Property, provided such exclusive right shall not operate to exclude Tenant from the use expressly permitted by this Lease.

l. To close the Building or Property at 6:30 p.m. or at such other reasonable time as Landlord may determine, but not to the Tenant or Tenant's employees, customers and clients.

m. To designate and/or approve prior to installation, all types of window shades, blinds, drapes, awnings or other similar items, and all internal lighting that may be visible from the exterior of the Building, or from interior common areas of the Building.

n. To change the arrangement of entrances, doors and corridors in the Building.

o. To install, operate, and maintain a building security system which monitors, by closed circuit television or otherwise, all persons entering and leaving the Building.

p. To install and maintain pipes, ducts, conduits, wires, and structural elements located in the Premises which serve other parts of the Building or other tenants.

q. To schedule Tenant's move into and out of the Building.

r. To grant exclusive parking spaces to tenants of the Building.

XII. Quiet Enjoyment

Subject to the notice and cure periods in the Lease, so long as Tenant is not in default in the performance of its covenants and obligations under this Lease, Tenant's quiet and peaceable enjoyment of the Premises shall not be disturbed or interfered with by Landlord or by any person claiming by, through or under Landlord.

XIII. Insurance

A. Landlord shall, at all times during the Term, procure and maintain: (i) policies of insurance covering loss or damage to the Property in an amount equal to the full replacement cost of the Building, including leasehold improvements in the Premises, which shall provide protection against loss by fire and other all risk casualties

including earthquake and flood and such other property insurance as may be required by Landlord's mortgagee or as otherwise desired by Landlord, and (ii) commercial general liability insurance applicable to the Building and the Common Areas, providing a minimum limit of $1,000,000.00 per occurrence.

B. Tenant shall procure and maintain, at its expense, (i) all risk (special form) property insurance in an amount equal to the full replacement cost of Tenant's Property located in the Premises; (ii) a policy or policies of general liability and umbrella or excess liability insurance applying to Tenant's operations and use of the Premises, providing a minimum limit of $1,000,000.00 per occurrence and in the aggregate, naming Landlord and Landlord's Building manager as additional insureds, (iii) workers' compensation insurance in accordance with the laws of the State in which the Property is located. Tenant shall maintain the foregoing insurance coverages in effect commencing on the earlier to occur of the Commencement Date and the date Tenant takes possession of the Premises, and continuing to the end of the Term.

C. The insurance requirements set forth in this Section 13 are independent of the waiver, indemnification, and other obligations under this Lease and will not be construed or interpreted in any way to restrict, limit or modify the waiver, indemnification and other obligations or to in any way limit any party's liability under this Lease. In addition to the requirements set forth in Sections 13 and 14, the insurance required of Tenant under this Lease must be issued by an insurance company with a rating of no less than A VIII in the current Best's Insurance Guide or that is otherwise acceptable to Landlord, and admitted to engage in the business of insurance in the state in which the Building is located; be primary insurance for all claims under it and provide that any insurance carried by Landlord, Landlord's Building manager, and Landlord's lenders is strictly excess, secondary and noncontributing with any insurance carried by Tenant; and provide that insurance may not be cancelled, nonrenewed or the subject of change in coverage of available limits of coverage, except upon thirty (30) days' prior written notice to Landlord and Landlord's lenders. Tenant will deliver to Landlord a legally enforceable certificate of insurance on all policies procured by Tenant in compliance with Tenant's obligations under this Lease on or before the date Tenant first occupies any portion of the Premises, at least ten (10) days before the expiration date of any policy and upon the renewal of any policy. Landlord shall have the right to approve all deductibles and self insured retentions under Tenant's policies, which approval shall not be unreasonably withheld, conditioned or delayed.

D. Neither Landlord nor Tenant shall be liable (by way of subrogation or otherwise) to the other party (or to any insurance company insuring the other party) for any loss or damage to any of the property of Landlord or Tenant, as the case may be, with respect to their respective property, the Building, the Property, or the Premises or any addition or improvements thereto, or any contents therein, to the extent covered by insurance carried or required to be carried by a party hereto even though such loss might have been occasioned by the negligence or willful acts or omissions of the Landlord or Tenant or their respective employees, agents, contractors or invitees. Landlord and Tenant shall give each insurance company which issues policies of insurance, with respect to the items covered by this waiver, written notice of the terms of this mutual waiver, and shall have such insurance policies properly endorsed, if necessary, to prevent the invalidation of any of the coverage provided by such insurance policies by reason of such mutual waiver. For the purpose of the foregoing waiver, the amount of any deductible applicable to any loss or damage shall not be deemed covered by, and recoverable by the insured under the insurance policy to which such deductible relates. As such, the amount of any deductible applicable to any loss or damage shall be due and payable by the party causing such loss or damage.

XIV. Indemnity

To the extent not expressly prohibited by law, Landlord and Tenant each (in either case, the "Indemnitor") agree to hold harmless and indemnify the other and the other's agents, partners, shareholders, members, officers, directors, beneficiaries and employees (collectively, the "Indemnitees") from any losses, damages, judgments, claims, expenses, costs and liabilities imposed upon or incurred by or asserted against the Indemnitees, including without limitation reasonable attorneys' fees and expenses, for death or injury to, or damage to property of, third parties, other than the Indemnitees, that may arise from the negligence or willful misconduct of Indemnitor or any of Indemnitor's agents, members, partners or employees. Such third parties shall not be deemed third party beneficiaries of this Lease. If any action, suit or proceeding is brought against any of the Indemnitees by reason of the negligence or willful misconduct of Indemnitor or any of Indemnitor's agents, members, partners or employees, then Indemnitor will, at

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Indemnitor's expense and at the option of said Indemnitees, by counsel reasonably approved by said Indemnitees, resist and defend such action, suit or proceeding. In addition, to the extent not expressly prohibited by law, Tenant agrees to hold harmless and indemnify Landlord and Landlord's Indemnitees from any losses, damages, judgments, claims, expenses, costs and liabilities imposed upon or incurred by or asserted against Landlord or Landlord's Indemnitees, including reasonable attorneys' fees and expenses, for death or injury to, or damage to property of, third parties (other than Landlord's Indemnitees) that may arise from any act or occurrence in the Premises, except to the extent caused by the negligence or willful misconduct of Landlord or Landlord's Indemnitees.

XV. Damages from Certain Causes

To the extent not expressly prohibited by law, Landlord shall not be liable to Tenant or Tenant's employees, contractors, agents, invitees or customers, for any injury to person or damage to property sustained by Tenant or any such party or any other person claiming through Tenant resulting from any accident or occurrence in the Premises or any other portion of the Building, caused by the Premises or any other portion of the Building becoming out of repair or by defect in or failure of equipment, pipes, or wiring, or by broken glass, or by the backing up of drains, or by gas, water, steam, electricity, or oil leaking, escaping or flowing into the Premises (except where due to Landlord's grossly negligent or willful failure to make repairs required by law and or to be made pursuant to other provisions of this Lease, after the expiration of a reasonable time after written notice to Landlord of the need for such repairs), nor shall Landlord be liable to Tenant for any loss or damage that may be occasioned by or through the acts or omissions of other tenants of the Building or of any other persons whomsoever, including, but not limited to riot, strike, insurrection, war, court order, requisition, order of any governmental body or authority, acts of God, fire or theft.

Notwithstanding the foregoing, Tenant shall have no responsibility to maintain the safety of the common areas of the Building, and Landlord shall indemnify and hold harmless Tenant for any injury to person or damage to property sustained by any party within the common areas of the Building and Property, except where Tenant is responsible for the creation of any unsafe or hazardous condition in the common areas.

XVI. Casualty Damage

If the Premises or any part thereof shall be damaged by fire or other casualty, Tenant shall give prompt written notice thereof to Landlord. In case that: (a) the Building shall be so damaged that substantial alteration or reconstruction of the Building shall, in Landlord's reasonable opinion, be required (whether or not the Premises shall have been damaged by such casualty); (b) the Premises have been damaged by such casualty and there is less than two (2) years of the Term remaining; or (c) in the event Landlord's mortgagee should require that the insurance proceeds payable as a result of a casualty be applied to the payment of the mortgage debt or in the event of any material uninsured loss to the Building, then Landlord may, at its option, terminate this Lease by notifying Tenant in writing of such termination within forty-five (45) days after the date of such casualty. If Landlord does not thus elect to terminate this Lease, Landlord shall commence and proceed with reasonable diligence to restore the Building, and the improvements located within the Premises to substantially the same condition in which it was immediately prior to the happening of the casualty. If the Landlord does not commence such restoration within sixty (60) days of the date of the casualty and proceed therewith with reasonable diligence, or if Landlord has not completed the restoration within 270 days of the date of the casualty, due allowance being made for delay in the commencement or completion of restoration occasioned by causes beyond the Landlord's control, the Tenant may terminate this Lease as of the date of such damage (as its sole and exclusive remedy) by serving notice on the Landlord after the expiration of such period. Notwithstanding the foregoing, Landlord's obligation to restore the Building, and the improvements located within the Premises shall not require Landlord to expend for such repair and restoration work more than the insurance proceeds actually received by Landlord as a result of the casualty. When the repairs described in the preceding two sentences have been completed by Landlord, Tenant shall complete the restoration of all furniture, fixtures and equipment which are necessary to permit Tenant's reoccupancy of the Premises. Landlord shall not be liable for any inconvenience or annoyance to Tenant or injury to the business of Tenant resulting in any way from such damage or the repair thereof, except that Rent shall be abated from the date of the damage or destruction for any portion of the Premises that is unusable by Tenant, which abatement shall be in the same proportion that the Rentable Area of the Premises which is unusable by Tenant bears to the total Rentable Area of the Premises; provided that Tenant shall not be entitled to any abatement of Rent if the damage or destruction within the Premises is restored within five (5) Business Days after Landlord's receipt of written notice from Tenant of the occurreoce of the damage or destruction.

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XVII. Condemnation

If Landlord receives notice that the Premises or any part thereof shall be taken or condemned for any public or quasi public use under governmental law, ordinance or regulation, or by right of eminent domain, or by private purchase in lieu thereof shall be damaged by fire or other casualty, Landlord shall give prompt written notice thereof to Tenant. If the whole or any substantial part of the Premises, or if the Building or any portion thereof which would leave the remainder of the Building unsuitable for use comparable to its use on the Commencement Date, or if the land on which the Building is located or any material portion thereof, shall be taken or condemned for any public or quasi public use under governmental law, ordinance or regulation, or by right of eminent domain, or by private purchase in lieu thereof, then Landlord may, at its option, terminate this Lease and Rent (both Base Rent and Additional Rent) shall be abated during the unexpired portion of this Lease, effective when the physical taking of said Premises or said portion of the Building or land shall occur. If this Lease is not terminated, the rent for any portion of the Premises so taken or condemned shall be abated during the unexpired Term effective when the physical taking of said portion of the Premises shall occur. All compensation awarded for any taking or condemnation, or sale proceeds in lieu thereof, shall be the property of Landlord, and Tenant shall have no claim thereto, the same being hereby expressly waived by Tenant. Nothing contained in this Section 17 shall be deemed to limit or prevent Tenant from bringing its own suit or action for recovery of Tenant's moving expenses, business dislocation damages, Tenant's personal property, and fixtures, alterations and improvements made or paid for by Tenant or the like so long as same does not impair or reduce the award payable to Landlord or diminish Landlord's claim. Landlord shall inform Tenant promptly if Landlord has knowledge of the pendency of any such taking of all or a part of the Premises or Property and shall keep Tenant informed about such action. Notwithstanding anything herein to the contrary, in the event of any condemnation of any portion of the Premises, which condemnation, in Tenant's reasonable business judgment, would make it inefficient or economically unreasonable for Tenant to continue to use the Premises for its business operations, then Tenant shall have the right, upon written notice to Landlord delivered no later than ten (10) Business Days after the taking, to terminate this Lease, in which event from and after the date of termination, this Lease shall be terminated and the parties shall have no further rights or obligations under this Lease.

XVIII. Events of Default.

A. The following events shall be deemed to be "Events of Default" under this Lease:

a. Tenant fails to pay any Rent when due within seven (7) days after Tenant's receipt of written notice from Landlord that such payment was not made when due;

b. Tenant fails to perform any other provision of this Lease not described in this Section 18, and such failure is not cured within thirty (30) days (or immediately if the failure involves a hazardous condition) after notice from Landlord, however, other than with respect to a hazardous condition, if Tenant's failure to comply cannot reasonably be cured within thirty (30) days, Tenant shall be allowed additional time (not to exceed thirty (30) additional days) as is reasonably necessary to cure the failure so long as Tenant begins the cure within thirty (30) days and diligently pursues the cure to completion;

c. Tenant fails to observe or perform any of the covenants with respect to:

i. Assignment and subletting as set forth in Section 21;

ii. Mechanic's liens as set forth in Section 9(B)(i),

iii. Insurance as set forth in Section 13; or

iv. Delivering subordination agreements or estoppel certificates as set forth in Section 30 or Section 27(E);

d. The leasehold interest of Tenant is levied upon or attached under process of law;

e. Tenant or any guarantor of this Lease dies or dissolves;

f. Tenant abandons or vacates the Premises; or

g. The entry of a decree or order for relief by a court having jurisdiction in respect of the Tenant in any involuntary case under the Federal Bankruptcy Laws as now constituted or hereafter amended, or any other applicable federal or state bankruptcy, insolvency or other similar law, or for the appointment of a receiver, liquidator, assignee, custodian, trustee, sequestrator (or other similar official) for the Tenant or any substantial part of the property of the Tenant, or for the winding up or liquidation of the affairs of the Tenant and the continuance of any such decree or order unstayed and in effect for a period of sixty (60) consecutive days.

B. If Tenant believes that Landlord has breached or failed to comply with any provision of this Lease applicable to Landlord, Tenant will give written notice to Landlord describing the alleged breach or noncompliance. Landlord will not be deemed in default under this Lease if Landlord cures the breach or noncompliance within thirty (30) days after receipt of Tenant's notice or, if the same cannot reasonably be cured within such thirty (30) day period, if Landlord in good faith commences to cure such breach or noncompliance within such period and then diligently pursues the cure to completion. Tenant will also send a copy of such notice to the holder of any Encumbrance of whom Tenant has been notified in writing, and such holder will also have the right to cure the breach or noncompliance within the period of time described above.

XIX. Remedies.

A. Upon the occurrence of any Event of Default, Landlord shall have the following rights and remedies, in addition to those allowed by law or equity, any one or more of which may be exercised without further notice to or demand upon Tenant and which may be pursued successively or cumulatively as Landlord may elect:

a. Landlord may, but shall not be obligated to, cure any Default by Tenant hereunder and wherever Landlord so elects, all costs and expenses paid by Landlord in curing such default, including without limitation reasonable attorney's fees and collection fees, shall be so much Additional Rent due on the next rent date for such payment together with interest at the rate set forth in Section 2 hereof from the date of advance to the date of repayment by Tenant to Landlord, provided written notice of such default was provided to Tenant and Tenant failed to timely cure such default.

b. Landlord may terminate this Lease by giving to Tenant at least thirty (30) days' notice of Landlord's election to do so, in which event the Term shall end, and all right, title and interest of Tenant hereunder shall expire, on the date stated in such notice;

c. Landlord may terminate the right of Tenant to possession of the Premises without terminating this Lease by giving notice to Tenant that Tenant's right to possession shall end on the date stated in such notice, whereupon the right of Tenant to possession of the Premises or any part thereof shall cease on the date stated in such notice; and

d. Landlord may enforce the provisions of this Lease by a suit or suits in equity or at law for the specific performance of any covenant or agreement contained herein, or for the enforcement of any other appropriate legal or equitable remedy, including recovery of all moneys due or to become due from Tenant under any of the provisions of this Lease.

Landlord shall not be required to serve Tenant with any notices or demands as a prerequisite to its exercise of any of its rights or remedies under this Lease, other than those notices and demands specifically required under this Lease. **TENANT AGREES THAT IT WAIVES ANY RIGHT TO TRIAL BY JURY IN ANY LAWSUIT BROUGHT BY LANDLORD TO RECOVER POSSESSION OF THE PREMISES FOLLOWING LANDLORD'S TERMINATION OF THIS LEASE OR THE RIGHT OF TENANT TO POSSESSION OF THE PREMISES PURSUANT TO THE TERMS OF THIS LEASE AND ON ANY CLAIM FOR DELINQUENT RENT WHICH LANDLORD MAY JOIN IN ITS LAWSUIT TO RECOVER POSSESSION.**

B. If Landlord exercises either of the remedies provided in Sections 19A(b) or 19A(c), Tenant shall surrender possession and vacate the Premises and immediately deliver possession thereof to Landlord, and Landlord may re-enter and take complete and peaceful possession of the Premises, with process of law, and Landlord may remove all occupants and property therefrom, using such force as may be necessary to the extent allowed by law, without being deemed guilty in any manner of trespass, eviction or forcible entry and detainer and without relinquishing Landlord's right to Rent or any other right given to Landlord hereunder or by operation of law. Any and all property which may be removed from the Premises by the Landlord pursuant to the authority of the Lease or of law, to which the Tenant is, or may be entitled, may be handled, removed or stored in a commercial warehouse or otherwise by the Landlord, at the risk, cost and expense of the Tenant, and Landlord shall in no event be responsible for the value, preservation or safekeeping thereof. The Tenant shall pay to the Landlord, upon demand, any and all expenses incurred in such removal and all storage charges against such property, so long as the same shall be in the Landlord's possession or under the Landlord's control. Any such property of the Tenant not removed from the Premises or retaken from storage by the Tenant after fifteen (15) business days' prior notice given after the end of the Term, however terminated, shall be conclusively deemed to have been forever abandoned by the Tenant.

C. Upon the occurrence of an Event of Default, if Landlord terminates the right of Tenant to possession of the Premises without terminating this Lease, Landlord shall have the right to immediate recovery of all amounts then due hereunder. Such termination of possession shall not release Tenant, in whole or in part, from Tenant's obligation to pay Rent hereunder for the full Term, and Landlord shall have the right, from time to time, to recover from Tenant, and Tenant shall remain liable for, all Rent accruing as it becomes due under this Lease during the period from the date of such notice of termination of possession to the stated end of the Term. In any such case, Landlord shall make reasonable efforts, in accordance with Section 19(E) hereof, to re-let the Premises. In attempting to re-let the Premises, Landlord may make repairs, alterations and additions in or to the Premises and redecorate the same to the extent reasonably deemed by Landlord necessary or desirable, and Tenant upon demand shall pay the reasonable cost of all of the foregoing together with Landlord's reasonable expenses of re-letting. The rents from any such re-letting shall be applied first to the payment of the expenses of reentry, redecoration, repair and alterations and the expenses of re-letting (including reasonable attorneys' fees and brokers' fees and commissions) and second to the payment of Rent herein provided to be paid by Tenant. Any excess or residue shall operate only as an offsetting credit against the amount of Rent due and owing as the same thereafter becomes due and payable hereunder.

D. If this Lease is terminated by Landlord for an Event of Default, Landlord shall be entitled to recover from Tenant all Rent accrued and unpaid for the period up to and including such termination date, as well as all other additional sums payable by Tenant, or for which Tenant is liable or for which Tenant has agreed to indemnify Landlord, which may be then owing and unpaid, and all reasonable costs and expenses, including court costs and reasonable attorneys' fees incurred by Landlord in the enforcement of its rights and remedies hereunder. In addition, Landlord shall be entitled to recover as damages for loss of the bargain, and not as a penalty: (1) the unamortized portion of any concessions offered by Landlord to Tenant in connection with this Lease, including without limitation: leasing commissions paid by Landlord in connection with this Lease and Landlord's contribution to the cost of tenant improvements, if any, installed by either Landlord or Tenant pursuant to this Lease or any work letter in connection with this Lease, (2) the aggregate sum which at the time of such termination represents the excess, if any, of the present value of the aggregate Rent which would have been payable after the termination date had this Lease not been terminated, including, without limitation, the amount projected by Landlord to represent Additional Rent for the remainder of the Term, over the then present value of the then aggregate fair rent value of the Premises for the balance of the Term, such present worth to be computed in each case on the basis of a one percent (1%) per annum discount from the respective dates upon which such Rent would have been payable hereunder had this Lease not been terminated, and (3) any damages in addition thereto, including without limitation reasonable attorneys' fees and court costs, which Landlord sustains as a result of the breach of any of the covenants of this Lease other than for the payment of Rent subject to the notice and cure periods in this Lease.

E. Landlord shall use commercially reasonable efforts to mitigate any damages resulting from an Event of Default by Tenant under this Lease. Landlord's obligation to mitigate damages after an Event of Default by Tenant under this Lease shall be satisfied in full if Landlord undertakes to lease the Premises to another tenant

(a "Substitute Tenant") in accordance with the following criteria: (1) Landlord shall have no obligation to solicit or entertain negotiations with any other prospective tenants for the Premises until Landlord obtains full and complete possession of the Premises including, without limitation, the final and unappealable legal right to relet the Premises free of any claim of Tenant; (2) Landlord shall not be obligated to lease or show the Premises, on a priority basis, or offer the Premises to a prospective tenant when other premises in the Building suitable for that prospective tenant's use are (or soon will be) available; (3) Landlord shall not be obligated to lease the Premises to a Substitute Tenant for a rent less than the current fair market rent then prevailing for similar uses in comparable buildings in the same market area as the Building, nor shall Landlord be obligated to enter into a new lease under other terms and conditions that are unacceptable to Landlord under Landlord's then current leasing policies for comparable space in the Building; (4) Landlord shall not be obligated to enter into a lease with a Substitute Tenant whose use would: (i) violate any restriction, covenant, or requirement contained in the lease of another tenant of the Building; (ii) adversely affect the reputation of the Building; or (iii) be incompatible with the operation of the Building; and (5) Landlord shall not be obligated to enter into a lease with any proposed Substitute Tenant which does not have, in Landlord's reasonable opinion, sufficient financial resources to operate the Premises in a first class manner and to fulfill all of the obligations in connection with the lease thereof as and when the same become due.

F. The receipt by Landlord of less than the full Rent due shall not be construed to be other than a payment on account of Rent then due, nor shall any statement on Tenant's check or any letter accompanying Tenant's check be deemed an accord and satisfaction, and Landlord may accept such payment without prejudice to Landlord's right to recover the balance of the Rent due or to pursue any other remedies provided in this Lease. The acceptance by Landlord of Rent hereunder shall not be construed to be a waiver of any breach by Tenant of any term, covenant or condition of this Lease. No act or omission by Landlord or its employees or agents during the Term shall be deemed an acceptance of a surrender of the Premises, and no agreement to accept such a surrender shall be valid unless in writing and signed by Landlord.

G. Tenant shall pay all of Landlord's reasonable costs, charges and expenses, including the fees of counsel, agents and others retained by the Landlord, incurred in enforcing Tenant's obligations hereunder.

H. If Landlord breaches or fails to comply with any provision of this Lease applicable to Landlord, and such breach or noncompliance is not cured within the period of time described in Section 18, then Tenant may exercise any right or remedy available to Tenant at law or in equity, except to the extent expressly waived or limited by the terms of this Lease. Notwithstanding the foregoing, in no event shall Landlord be liable for consequential or punitive damages as a result of a breach or default under or otherwise in connection with this Lease. In the event Tenant brings suit against Landlord to enforce the terms of this Lease and prevails in such suit, Landlord shall pay Tenant's reasonable costs, charges and expenses, including the fees of counsel, incurred in enforcing Landlord's obligations hereunder.

XX. Exoneration Clause

Tenant shall look solely to the then interest of Landlord in the Real Estate and the Building, or of any successor in interest to Landlord, as owner of said Real Estate and Building, for the satisfaction of any remedy of Tenant for failure to perform any of Landlord's obligations under this Lease, either express or implied, or under any law whether now existing or hereinafter enacted. Neither Landlord nor any disclosed or undisclosed principal of Landlord (or any officer, director, stockholder, partner or agent of Landlord or any such principal) nor any successor of any of them shall have any personal liability for any such failure under this Lease or otherwise.

XXI. Assignment and Subletting

Tenant shall not mortgage this Lease. Tenant agrees that, subject to the further provisions hereof, in the event Tenant should desire to assign this Lease or sub-lease any portion of the Premises, Tenant shall give Landlord written notice of such desire at least thirty (30) days in advance of the date on which Tenant desires to make such assignment or sub-lease. The written notice delivered to Landlord under this Section 21 shall also contain information about the proposed assignee's/sub-lessee's financial condition, business experience and proposed use of the Premises. Landlord

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shall then have a period of fifteen (15) business days following receipt of such notice within which to notify Tenant in writing that Landlord elects either:

a. To terminate this Lease (except as to an assignment or sub-lease to a "Permitted Transferee" hereinafter defined) as of the date so specified by Tenant for the portion of the Premises to be assigned or sub-leased in which event Tenant will be relieved of all further obligation hereunder as to such space; or

b. To permit Tenant to assign this Lease or sub-lease a portion of the Premises, subject, however, to written approval of the proposed assignee / sub-lessee by Landlord; or

c. To refuse to consent to Tenant's assignment of this Lease or sub-lease of the Premises under reasonable circumstances, (except to a Permitted Transferee) and to continue this Lease in full force and effect as to the entire Premises.

If Landlord should fail to notify Tenant in writing of such election within said fifteen (15) day period, Landlord shall be deemed to have elected option (c) above. Any attempted assignment or sub-lease by Tenant in violation of the terms and covenants of this Section shall be void and an Event of Default under Section 18.

Landlord's consent to any assignment or sub-lease shall not be unreasonably withheld; provided, however, Tenant agrees that should Tenant believe that Landlord has unreasonably withheld such consent, Tenant's sole remedy in such event shall be for injunctive relief and Landlord shall not be liable for damages in any event. In making its determination as to whether to consent to any proposed assignment or sub-lease, Landlord may consider, among other things, the credit-worthiness, business reputation and business experience of the proposed assignee, the intended manner of use of the Premises by the proposed assignee/sub-lessee, the estimated vehicular traffic on or about the Premises and the Property which would be generated by the proposed assignee/sub-lessee or by its manner of use of the Premises, and any other factors which Landlord may reasonably deem relevant. No consent by Landlord to any assignment or sub-lease shall be deemed to be a consent to any further assignment or sub-lease.

Notwithstanding the foregoing provisions of this Section, Landlord's consent shall not be required as to a sublet of the Premises (or portion thereof) or an assignment of Tenant's interest in this Lease to a "Permitted Transferee" (hereinafter defined) provided: (A) the "Use" of the Premises will be the same as that of Tenant and in conformance with the terms and provisions of this Lease regarding the permitted use of the Premises, and in conformance with all other terms and provisions of this Lease, and (B) Tenant is not in default of any of the terms and provisions of this Lease. For purposes of this Section the term Permitted Transferee shall mean: (i) a parent or wholly owned subsidiary of Tenant, (ii) any entity controlled by Tenant (fifty one percent (51%) of all of the issued and outstanding voting stock of such entity shall be deemed control for purposes of this clause (ii)), (iii) any entity resulting from a merger or consolidation of Tenant with another corporation or other corporations (regardless of which corporation is the surviving corporation), (iv) any entity to which all or substantially all of Tenant's assets or stock are transferred, and (v) an individual or entity renting space from Tenant within the Premises for the purpose of being a part of Tenant's practice and conducting its business in association with Tenant. The provisions of this Section are conditioned upon at least twenty (20) days prior written notice to Landlord of the proposed assignment of Tenant's interest in this Lease or sublet of the Premises to a Permitted Transferee. Notwithstanding the forgoing provisions to the contrary, Landlord reserves the right, without release of Tenant, to require any assignee of Tenant's interest in this Lease and/or any sublessee of the Premises or any portion thereof, to assume in writing, delivered to Landlord in advance of any assignment or subletting and for Landlord's benefit, an assumption of the obligations of Tenant under this Lease, or in the case of a sublet of less than all of the Premises, such allocable portion thereof as reasonably determined by Landlord.

In the event of any assignment or subletting of the Premises, other than to a Permitted Transferee, which results in rent being paid to Tenant in excess of the rent Tenant is required to pay Landlord under this Lease ("Excess Rent"), Landlord shall be entitled to receive one hundred percent (100%) of such Excess Rent from Tenant. Any assignment or subletting of the Premises, whether or not consented to by Landlord, shall not release Tenant of any of its obligations under this Lease.

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XXII.Notices

In every case, under the provisions of this Lease, it shall be necessary or desirable for Landlord or Tenant to serve any notice or demand upon the other party to this Lease, such notice or demand shall be in writing and shall be:

a. [Intentionally deleted]; or

b. Mailed by United States certified or registered mail, postage prepaid, addressed to the

Landlord:
360 BUTTERFIELD, LLC
Attn: Robert Gienko, Jr.
18-5 E. Dundee Road, Suite 200
Barrington, IL 60010

with a copy to:
RCG Management Services, LLC
18-5 E. Dundee Road, Suite 200
Barrington, IL 60010
Ph: 773-484-3660

Tenant:
THE PAIN CENTER OF ILLINOIS, LTD.
360 W. Butterfield Road, Suite 100
Elmhurst, IL 60126
Ph: 312-593-1580
Fax:
email: nbayran@gmail.com

with a copy to:
Hart & David, LLP
360 W. Butterfield Road, Suite 325
Ph: 630-395-9496
Fax: 630-395-9451
Email: jhart@hartdavidlaw.com

In this event, the notice or demand shall be deemed to have been served the same day as delivery of the same to the United States Postal Service; or

c. By an overnight or express delivery service (including Federal Express, UPS or DHL), postage prepaid, addressed to the other party at the address in Section 22(b) above, in which event the notice or demand shall be deemed to have been served the same day as delivery of the same to the delivery service; or

d. Via facsimile to the party at the facsimile number in Section 22(b) above; or

e. Via email to the party at the email address in Section 22(b) above; or

f. [Intentionally deleted].

All notices or demands shall be signed by or on behalf of the Landlord or Tenant, as applicable, and all such addresses or methods of notice shall be valid, unless otherwise directed by notice to the other party of any update in address or delivery method.

XXIII. Force Majeure Clause

Wherever there is provided in this Lease a time limitation for performance by the Landlord of any Initial Alteration, construction, repair, maintenance or service, the time provided for shall be extended for as long as and to the extent that delay in compliance with such limitation is due to an act of God, strikes, governmental control or other factors beyond the reasonable control of the Landlord.

XXIV. Condition of Premises

Tenant agrees to accept the Premises in an "As Is, Where Is" condition, except as otherwise described in this Section.

It is understood that Tenant shall remodel the Premises for its use, as depicted in the attached Exhibit A. Tenant shall be responsible for the cost and supervision of all such improvements (the "Work") to the Premises to prepare it for occupancy. Prior to commencement of any Work, Tenant shall submit to Landlord for Landlord's approval its proposed plan for improvements, which improvements shall be in accordance with the Building Standards. All such Work shall be performed by a contractor chosen by Tenant but approved by Landlord, such approval not to be unreasonably withheld, and provided such contractor is duly licensed, bonded, insured and has a good reputation. The construction contract with the contractor shall be subject to the approval of Landlord and shall provide for sworn contractor statements, lien waivers, and such other documentation as reasonably required by Landlord.

Landlord agrees to pay Tenant or the contractor directly, as agreed upon between the parties, an allowance in an amount not to exceed ONE HUNDRED FORTY TWO THOUSAND SEVEN HUNDRED AND 00/100 Dollars ($142,700.00) (the "Landlord's Contribution") (calculated by multiplying $50.00 times 2,854 being the net rentable area of the Premises) to be applied toward payment or reimbursement of costs incurred in connection with the Work. The Landlord's Contribution is for Tenant personally and may not be applied or used for the benefit of any subtenant approved by Landlord nor will Landlord's Contribution inure to the benefit of any permitted assignee of Tenant. It shall be a condition to the application of such Landlord's Contribution that Tenant not be in default under any of the terms, covenants and conditions of the Lease at any time such Contribution is requested. The Landlord's Contribution is applicable only in connection with the initial preparation of Suite 100 for occupancy. In the event that Tenant causes any work or service to be performed by any contractor or person or furnished by a supplier other than Landlord for which Tenant is entitled to reimbursement hereunder, then it shall be a condition of Landlord's obligation to pay Tenant, or the contractors, that Tenant supply Landlord with satisfactorily completed contractor's affidavits and final waivers of lien from those persons entitled to lien rights against the Premises and Property covering all labor and materials expended and used, along with invoices for the amounts due in connection with such work. If the cost of the Work (including architectural and project management fees) is less than Landlord's Contribution, Tenant shall not be entitled to any credit for the difference and such unused balance shall be retained by Landlord and such amount shall be reduced from Tenant's Personal Guarantee amount. Landlord shall not receive a Construction Management Fee under any circumstances. Landlord agrees that for each "draw" requested by Tenant's chosen general contractor for the Work, that Landlord shall pay a portion of each such draw equal to the proportion of Landlord's Contribution to the entire cost of the Work. Such payment shall be made by Landlord after Tenant makes its portion of the payment and Landlord receives appropriate affidavits or lien waivers, as described herein.

Other than minor "punch-list" items identified prior to taking possession, Tenant's taking possession of the Premises shall serve as conclusive evidence that the Work was completed in a satisfactory manner for any elements of the work that can be observed upon reasonable visual inspection.

XXV. Signs

Landlord shall keep and maintain a good and sufficient directory in the building lobby, or other location as Landlord deems appropriate. No exterior signs may be maintained in or on the Premises or Building, either interior or exterior, without the Landlord's express written consent. All interior signs shall be of such style and form and placed in such location as Landlord shall designate. Any signage will be at Tenant's sole cost and expense, except that Landlord, at its sole cost, shall provide initial signage for outside Tenant's suite door and signage in the building directory. Any replacements or alterations to this signage, or any other Tenant signage installed at any time, shall be

at the sole cost and expense of Tenant, unless the damage of the interior signage is due to Landlord or other attendants in the Building.

XXVI. Termination and Holding Over

A. At the termination of this Lease by lapse of time or otherwise:

a. Tenant shall surrender all keys of the Premises to Landlord and make known to Landlord the explanation of all combination locks remaining on the Premises.

b. Tenant shall return to the Landlord the Premises and all equipment and fixtures of Landlord in as good condition as when Tenant originally took possession, ordinary wear and loss or damage by fire or other casualty exempted, failing which Landlord may restore the Premises, equipment and fixtures to such condition and Tenant shall pay the cost thereof. Conditions existing because Tenant's failure to perform maintenance, repairs or replacements as required of Tenant under this Lease shall not be deemed "ordinary" wear.

c. Tenant shall promptly remove all of its movable property (movable property being any property not attached to the Building) and the alterations, additions or improvements to be removed by Tenant as set forth in Section 8 hereof, and pay the cost of such removal and pay for any repairs occasioned as a result of such removal unless Landlord otherwise agreed in writing. Notwithstanding the foregoing, provided that Tenant is not in default under this Lease and that Landlord approved any such work in accordance with the terms of this Lease, Tenant shall have no obligation to remove any walls, plumbing, or mechanical systems installed within the Premises during the Term.

B. No receipt of money by Landlord from Tenant after the termination of this Lease, the service of any notice, the commencement of any suit or final judgment for possession shall reinstate, continue or extend the Term of this Lease or affect any such notice, demand, suit or judgment.

C. In the event of a holdover by Tenant after expiration or termination of this Lease without the written consent of Landlord, Tenant shall pay as liquidated damages 1.5 times rent for the entire holdover period. No holding over by Tenant after the term of this Lease shall be construed to extend the Lease; in the event of any unauthorized holding over, Tenant shall indemnify Landlord against all claims for damages by any other tenant to whom Landlord may have leased all or any part of the Premises effective upon the termination of this Lease or otherwise.

Provided no uncured Event of Default exists (other than the unapproved holdover), Tenant shall retain title to and be permitted to remove its trade fixtures, dental equipment and cabinetry, furniture and personal property after the expiration of this Lease.

XXVII. Miscellaneous

A. Tenant's taking possession shall be conclusive evidence that the Premises were then in good order and satisfactory condition, except for latent defects in the Premises. No promise of Landlord to alter, remodel, improve, repair, decorate or clean the Premises or Building, or any part thereof, and no representation respecting the condition of the Premises or the building have been made to Tenant by Landlord except as made herein.

B. No waiver of default of Tenant by Landlord shall be implied, and no express waiver shall affect any default other than the default specified in such waiver and that only for the time and to the extent therein stated.

C. If any provision of this Lease or application to any party or circumstances shall be determined by any court of competent jurisdiction to be invalid and unenforceable to any extent, the remainder of this Lease or the application of such provisions to such person or circumstance, other than those as to which it is so determined invalid or unenforceable to any extent, shall not be affected thereby, and each provision hereof shall be valid and shall be enforced to the fullest extent permitted by law.

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D. The headings of sections are for convenience only and do not define, limit or construe the contents of such sections or subsections of this Lease unless otherwise indicated.

E. Each of the parties agree, at the request of the other, to execute such instruments or documents as any party may reasonably request, acknowledging: the date of acceptance of possession of the Premises, the date of commencement of rent, the commencement of the Term, the commencement and expiration dates of this Lease, the annual rate of rent for any year; annual Base Rent; and the compliance or non-compliance by any party with any of the terms or provisions of this Lease, and to evidence such other or further matters as may be so reasonably requested.

F. Tenant and Landlord represent that they have not dealt with any real estate broker in connection with this Lease other than HD CAPITAL REALTY, LLC (representing Tenant) and REAL ESTATE CONSULTANTS OF ILLINOIS, LLC. (representing Landlord) (collectively "Brokers") and, to its knowledge, no other broker initiated or participated in the negotiation of this Lease, submitted or showed the Premises to Tenant or is entitled to any commission in connection with this Lease. Tenant hereby indemnifies, defends, and holds Landlord and its beneficiary harmless from and against any and all claims of any real estate broker, except Brokers, for commissions in connection with representing Tenant with this Lease. Landlord hereby indemnifies, defends, and holds Tenant and its beneficiary harmless from and against any and all claims of any real estate broker, except Brokers, for commissions in connection with representing Landlord with this Lease.

G. [Intentionally Deleted]

H. This Lease shall not be recorded, but the parties agree, at the request of either, to execute a short form lease for recording, containing the names of the parties, the description of the Premises and the Term.

I. Time is of the essence of this Lease.

J. The term "Landlord," as used in this Lease, shall be limited to mean and include only the owner or owners at the time in question of the fee of the Property and, in the event of any transfer or transfers of the Property, Landlord herein named (and in case of any subsequent transfer or transfers, the then grantor) shall be automatically freed and relieved from and after the date of such transfer, of all liability as respects the performance of any covenants or obligations on the part of Landlord contained in this Lease thereafter to be performed; provided that any funds in the hands of any such Landlord or the then grantor at the time of such transfer in which Tenant has an interest, shall be turned over to the grantee.

K. Only machinery or mechanical devices of a nature directly related to Tenant's ordinary use of the Premises shall be installed, placed or used in the Premises and the installation and use of all such machinery and mechanical devices is subject to the other covenants contained in this Lease.

L. All persons entering or leaving the Building may be required to do so under such regulations and controls as Landlord may from time to time impose. Without limiting the generality of the foregoing, all persons entering or leaving the Building between the hours of 7:30 P.M. and 8:00 A.M. Monday through Friday or at any time on Saturday, Sunday or holidays may be required to identify themselves to a watchman by registration or otherwise and to establish their right to enter or leave the Building.

M. In the event Landlord is looking to sell the Building or obtain financing (including re-financing) for the Building, Tenant shall furnish to Landlord within ten (10) business days after written request therefore from Landlord, a copy of Tenant's then most recent certified and audited (if applicable) financial statement. It is mutually agreed that the Landlord may deliver a copy of such statements to any mortgagees or prospective mortgagee of Landlord, or any prospective purchaser of the Property, but otherwise Landlord shall treat such statements and information therein as confidential.

N. No rights to light or air over any real estate, whether belonging to Landlord or any other party, are granted to Tenant by this Lease.

O. Subject to the Landlord's rights to grant exclusive parking spaces to tenants of the Building, Tenant shall have the right, in common with all tenants of the Building, to the reasonable use of the parking facilities from time to time located on the Property.

P. Based on Landlord's actual knowledge, Landlord is not aware of any code violations at the Property or the Premises, which are Landlord's sole responsibility to remedy, which would prevent Tenant from obtaining its building permit for the Premises. If any such violation does exist and such violation is the sole cause of Tenant not receiving its building permit, the abatement period shall be automatically extended until such time that the Landlord has remedied said violation.

XXVIII. Hazardous Substances

Landlord represents and warrants that to the best of Landlord's knowledge there are no Hazardous Materials which require environmental clean-up existing on the Premises as of the Lease Commencement Date. Landlord further represents and warrants that it is not aware of any hazardous substance contained on the property which would adversely affect Tenant's use or occupancy of the Premises or the operation of Tenant's business from the Premises, or access to parking serving the Premises. Should Landlord be found to have breached this representation and warranty, then Landlord shall indemnify, defend and hold harmless Tenant against any claims, suits causes of action, costs, fees including attorneys fees and costs arising out of or in connection with any clean-up work, inquiry or enforcement proceeding in connection therewith.

XXIX. Waiver of Jury Trial

THE PARTIES HERETO SHALL AND HEREBY DO WAIVE THEIR RESPECTIVE RIGHTS TO A TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM BROUGHT BY EITHER OF THE PARTIES HERETO AGAINST THE OTHER ON ANY MATTERS WHATSOEVER ARISING OUT OF OR IN ANY WAY CONNECTED WITH THIS LEASE, THE RELATIONSHIP OF LANDLORD AND TENANT, TENANT'S USE OR OCCUPANCY OF THE PREMISES, OR FOR THE ENFORCEMENT OF ANY REMEDY UNDER ANY STATUTE, EMERGENCY OR OTHERWISE.

XXX. Landlord's Title and Subordination

A. Subject to the provisions and conditions of this Lease, the Landlord covenants that it has the right to make this Lease for the Term. Nothing contained in this Lease shall empower the Tenant to do any act which can, shall or may encumber the title of the Landlord.

B. Tenant agrees that this Lease is subject and subordinate to all ground leases, underlying leases and all mortgages which may now or hereafter affect the Property and all renewals, modifications, consolidations, replacements and extensions thereof. This clause shall be self-operative, and no further instrument of subordination need be required by any mortgagee or ground lessor. In confirmation of such subordination, Tenant shall execute promptly any instrument of subordination that Landlord may reasonably request. Notwithstanding the foregoing, Landlord shall use reasonable efforts to request the existing mortgagee execute a non-disturbance agreement with Tenant.

XXXI. Entire Agreement, Execution and Successors

A. This Lease, including any Exhibits attached hereto, constitutes the entire agreement between the parties hereto with respect to the subject matter of this Lease and supersedes all prior agreements and understandings between the parties related to the Premises, including all lease proposals, letters of intent and similar documents. Tenant expressly acknowledges and agrees that Landlord has not made and is not making, and Tenant, in executing and delivering this Lease, is not relying upon, any warranties, representations, promises or statements, except to the extent that the same are expressly set forth in this Lease. This Lease may be modified only by a written agreement signed by Landlord and Tenant. Landlord and Tenant expressly agree

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that there are and shall be no implied warranties of merchantability, habitability, suitability, fitness for a particular purpose or of any other kind arising out of this Lease, all of which are hereby waived by Tenant, and that there are no warranties which extend beyond those expressly set forth in this Lease.

B. This Lease shall not be binding and in effect until a counterpart hereof has been executed and delivered by the parties, each to the other. Submission of this instrument for examination or signature by Tenant does not constitute a reservation of or option to lease.

C. Once properly executed, this Lease shall bind and inure to the benefit of the parties hereto and, subject to the Section 27(J), their successors and assigns.

XXXII. Option to Extend

A. Tenant shall have and is hereby granted two (2) options (the "Extension Options") to extend the Term two times for a period of five (5) additional years (referred to as the "Extension Periods") provided (i) Tenant gives written notice, which notice shall be irrevocable, to Landlord of its election to exercise such Extension Option no later than six (6) months prior to the expiration of the current Lease Term; and (ii) no uncured default under the Lease has occurred during the Term, and no event exists at the time of the exercise of such option or arises subsequent thereto, which event, by notice, the passage of time or otherwise, would constitute a default under the Lease if not cured within any applicable cure period granted under the Lease.

B. All terms and conditions of the Lease, including without limitation, all provisions governing the payment of Additional Rent, shall remain in full force and effect during the Extension Period, except that Base Rent payable during the Extension Periods shall be at the respective current market rental rate with respect to comparable space in the area in which the Property is located (the "Market Rate") at the time of the commencement of the Extension Period. Landlord and Tenant shall negotiate in good faith to determine the amount of Base Rent for the Extension Period within thirty (30) days of the date of Landlord's receipt of Tenant's written notice of its election to exercise the Extension Option.

C. In the event Landlord and Tenant are unable to agree upon the Base Rent for the Extension Period within said thirty (30) day period, then Base Rent for the Extension Period shall be based upon the Market Rate as determined by a board of three (3) licensed real estate brokers, one of whom shall be named by Landlord, one by Tenant, and the two so appointed shall select a third. Each member of the board of brokers shall be licensed in the State of Illinois as a real estate broker, specializing in the field of commercial office leasing in the area in which the Premises is located, having no less than ten (10) years' experience in such field, and recognized as ethical and reputable within the field. Landlord and Tenant agree to make their appointments promptly within five (5) days after the expiration of the thirty (30) day period, or sooner if mutually agreed upon. The two brokers selected by Landlord and Tenant shall promptly select a third broker within ten (10) days after they both have been appointed, and each broker, within fifteen (15) days after the third broker is selected, shall submit his or her determination of said Market Rate. The Market Rate shall be the mean of the two closest rental rate determinations. Landlord and Tenant shall each pay the fee of the broker selected by it, and they shall equally share the payment of the fee of the third broker.

D. An amendment modifying this Lease to set forth the Annual Base Rent for the Premises during the Extension Period shall be executed by Landlord and Tenant within ten business (10) days of the parties' agreement.

E. In the event Tenant assigns or sublets the Premises in violation of the terms of this Lease, this option to extend shall become null and void.

XXXIII. Personal Guarantee

This lease shall not be valid until the corresponding Lease Guarantee (which is attached hereto as Exhibit B) has been fully executed by Dr. Neema Bayran, M.D. and delivered to Landlord. The amount of the Personal Guarantee shall be the unamortized balance of the Leasing Costs (defined below) as of the date of Default, plus any costs incurred by Landlord, including reasonable attorneys' fees in the enforcement of this Guaranty.

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XXXIV. Termination Option

Provided that Tenant is not in default under this Lease beyond the expiration of any applicable notice and cure periods, Tenant shall have a one (1) time option to terminate this Lease (the "Termination Option") effective on November 30, 2021 (the "Early Termination Date"). Tenant shall exercise the Termination Option by delivering to Landlord written notice (the "Termination Notice") of such election to terminate this Lease no earlier than December 1, 2020 and no later than January 31, 2021 time being of the essence. If Tenant so exercises the Termination Option, Tenant shall be obligated to pay to Landlord the "Termination Payment" equal to ONE HUNDRED SEVENTEEN THOUSAND NINE HUNDRED FOURTEEN AND 07/100 ($117,914.07) in two (2) equal installments. The first installment, in an amount equal to one half of the Termination Payment, shall be due and payable concurrently with Tenant's delivery of the Termination Notice to Landlord, time being of the essence. The balance of the Termination Payment shall be due and payable on the Early Termination Date, time being of the essence. If Tenant properly delivers the Termination Notice and pays the Termination Payment in a timely manner, then this Lease shall be deemed to have expired by lapse of time on the Early Termination Date. Tenant shall return the Premises to Landlord on the Early Termination Date in accordance with the terms of this Lease. Unless Landlord otherwise agrees in writing, Tenant may not exercise the Termination Option, and no exercise thereof shall be effective, if an Event of Default shall exist under this Lease as of the date on which the Termination Notice is given or as of the Early Termination Date. Upon Tenant's delivering the Termination Notice, any and all rights of Tenant to extend the Term whether pursuant to an expansion option, or otherwise, shall immediately be void and of no further force or effect. All obligations of either party to the other which accrue under this Lease on or before the Early Termination Date shall survive such termination. Landlord and Tenant acknowledge that the Termination Payment is not a penalty, but is a reasonable estimate of the damages to be suffered by Landlord as a consequence of Tenant's exercise of the Termination Option. Tenant hereby acknowledges and agrees that Tenant shall not be entitled to any rebate or return of any portion of the Termination Payment as a consequence of the actual costs incurred by Landlord in re-letting the Premises being less than the Termination Payment.

This lease is has been entered into by the parties on the date first written above.

LANDLORD:
360 BUTTERFIELD, LLC

By: Robert C Gienko Jr.
Print: Robert C. Gienko, Jr.
Its: Manager

TENANT:
THE PAIN CENTER OF ILLINOIS, LTD.

By: Nbayran
Print: Neema Bayran, M.D.
Its: President

Exhibit A

SPACE PLAN

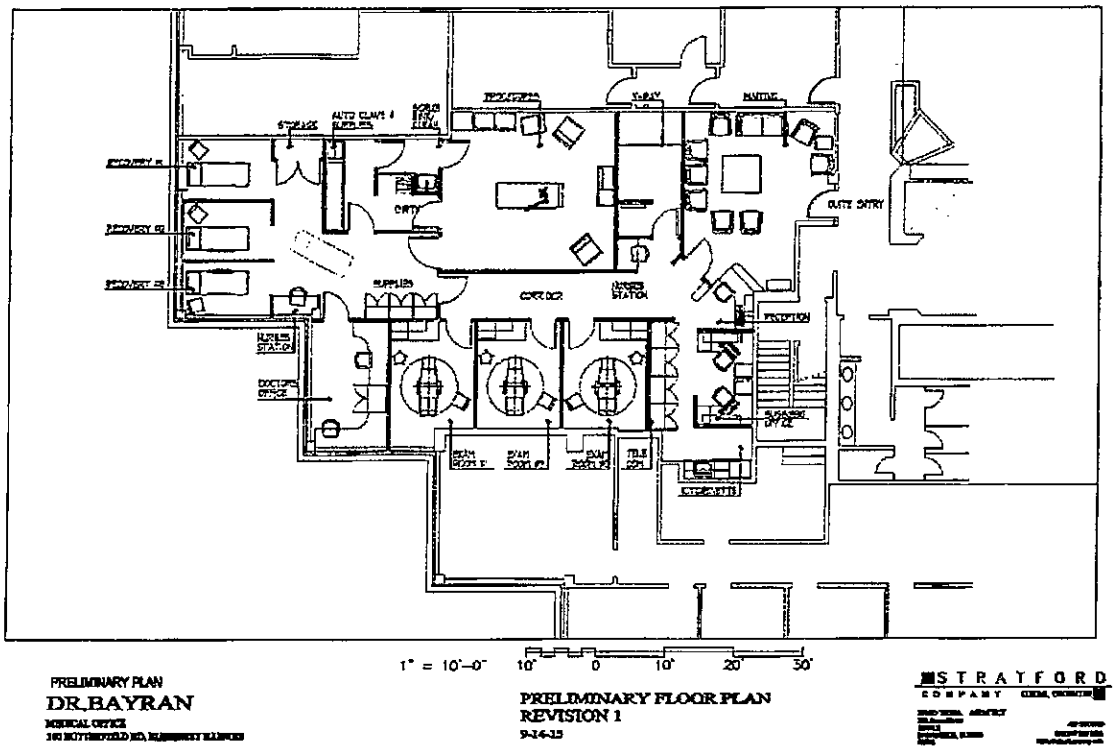

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Exhibit B

FOR VALUE RECEIVED, and in order to induce 360 BUTTERFIELD, LLC, an Illinois Limited Liability Company, ("Landlord") to enter into that certain Lease (the "Lease") dated September __, 2015 with THE PAIN CENTER OF ILLINOIS LTD., an Illinois corporation ("Tenant"), pertaining to Tenant's lease of certain premises commonly referred to as Suite 100 at 360 W. Butterfield Road, Elmhurst, IL ("Leased Premises"), the undersigned, NEEMA BAYRAN, M.D., ("Guarantor") whose legal residence is _____, hereby guarantees to Landlord, full and prompt payment of rent, and any and all other sums and charges payable by Tenant, under said Lease and all Lease Amendments, and further hereby guarantees full and timely performance and observance of all the covenants, terms, conditions, and agreements therein provided to be performed and observed by Tenant, all such obligations of payment and performance being hereinafter collectively called the "Obligations"; and Guarantor hereby covenants and agrees to and with Landlord that if default shall at any time be made by Tenant in the payment or the performance and observance of any of the Obligations, Guarantor will forthwith pay such Obligation to Landlord, and any arrears thereof, and will forthwith faithfully perform and fulfill all Obligations and will forthwith pay to Landlord all reasonable attorneys' fees incurred by Landlord in the enforcement of this Guaranty; it being expressly understood that the obligations of Guarantor shall be limited to guaranteeing such payment and performance of the Obligations and the payment of all reasonable out-of-pocket costs, attorneys' fees and expenses actually incurred by Landlord in enforcing such payment and performance.

This Guaranty is an absolute and unconditional guaranty of payment and of the performance. It shall be enforceable against Guarantor without the necessity of any suit or proceedings on Landlord's part of any kind or nature whatsoever against Tenant and without the necessity of any notice of non-payment, non-performance or non-observance or of any notice of acceptance of this Guaranty or of any other notice or demand to which Guarantor might otherwise be entitled, all of which Guarantor hereby expressly waives; and Guarantor hereby expressly agrees that the validity of this Guaranty and the obligations of Guarantor hereunder shall not be terminated, affected, diminished or impaired by reason of the assertion or the failure to assert by Landlord against Tenant of any of the rights or remedies reserved to Landlord pursuant to the provisions of the Lease or by relief of Tenant from any of Tenant's obligations under the Lease or otherwise (including, but not by way of limitation, the rejection of the Lease in connection with proceedings under the bankruptcy laws now or hereafter in effect).

This Guaranty shall be a continuing guaranty and the liability of Guarantor hereunder shall not be affected, modified or diminished by reason of any assignment, amendment or modification, expansion of the Premises, renewal or extension of the Lease, or any holdover by Tenant or by reason of any modification, amendment, or waiver of or change in any of the terms, covenants, conditions or provisions of the Lease, or by reason of any extension of time that may be granted by Landlord to Tenant, or a changed or different use of the Leased Premises consented to in writing by Landlord, or by reason of any dealings or transactions or matters or things occurring between Landlord and Tenant, whether or not notice thereof is given to Guarantor. The liability of Guarantor shall continue during any holdover, whether or not consented to by Landlord, and during the extension or renewal of the term and/or the Lease, whether or not notice thereof is given to Guarantor.

Guarantor further agrees that if at any time all or part of any payment theretofore applied by Landlord to any of the Obligations is or must be rescinded or returned by Landlord for any reason whatsoever (including without limitation, the insolvency, bankruptcy or reorganization of Tenant), such Obligations shall, for the purposes of this Guaranty, to the extent that such payment is or must be rescinded or returned be deemed to have continued in existence, notwithstanding such application by Landlord, and this Guaranty shall continue to be effective or reinstated, as the case may be, as to such Obligations, all as though such application by Landlord has not been made.

Any amounts received by Landlord, from whatever source, on account of the Obligations may be applied by it toward the payment of such of the Obligations, and in such order of application as Landlord my from time to time elect.

Without limiting the generality of the foregoing, until all Obligations have been paid to Landlord, Guarantor shall not be subrogated to any of the rights of the Landlord under the Lease or in or to the Leased Premises or to any other rights of the Landlord by reason of the performance by Guarantor of any of his obligations hereunder, and Guarantor agrees to look solely to the Tenant for recoupment. Without limiting the generality of the foregoing, Guarantor agrees that until all of Tenant's obligations under the Lease are fully performed, Guarantor waives any rights that Guarantor may have against Tenant by reason of any one or more payments or acts in compliance with the obligations of Guarantor under Guaranty of Lease.

The assignment by Landlord of the Lease and/or the avails and proceeds thereof made either with or without notice to Guarantor shall in no manner whatsoever release Guarantor from any liability as Guarantor.

All of Landlord's rights and remedies under the Lease or under this Guaranty are intended to be distinct, separate and cumulative and no such right and remedy therein or herein mentioned is intended to be in exclusion of or a waiver of any of the others.

All references herein to "Tenant" shall be deemed to mean "Tenant and its successors and assigns," but Tenant shall not hereby be permitted to assign the Lease except as expressly provided in the Lease.

This Guaranty shall be binding upon Guarantor and its successors and assigns, and shall inure to the benefit of Landlord and its successors and assigns.

Subject as hereinafter provided, Landlord's consent to any assignment or assignments, and successive assignments by Tenant of the Lease made either with or without notice to Guarantor shall in no manner whatsoever release Guarantor from any liability as Guarantor.

The validity and interpretation of this Guaranty shall be construed in accordance with and governed under the laws of the State of Illinois.

Guarantor covenants and agrees that in any actinn or proceeding brought in respect of this guaranty, (1) Guarantor hereby waives trial by jury, and (2) service of any summons and complaint or other process in any such action or proceeding may be made by certified mail directed to Guarantor at the address below, personal service being hereby waived. Guarantor hereby consents and submits to the jurisdiction of any court sitting in DuPage County and State of Illinois or in the jurisdiction in which the premises demised by the Lease is located, in any action or proceeding brought in respect of this guaranty, and Guarantor waives any objections to such jurisdiction based on forum non conveniens or any other legal or equitable doctrine.

LIMITATION OF AMOUNT. The amount of this Guarantee shall be the unamortized balance of the Leasing Costs (hereinafter defined) as of the date of Default, had the Leasing Costs been loaned to Tenant as of the Commencement Date and had such loaned amount been repaid in equal monthly installments commencing on the day following the Abatement Period in amounts sufficient to fully amortize such loaned amount over the term of the Lease, plus any costs incurred by Landlord, including reasonable attorneys' fees, in the enforcement nf this Guaranty. The term "Leasing Costs" shall mean the sum of (i) the total brokerage commission payable by Landlord in connection with the Lease, plus (ii) the total amount of the Landlord's Contribution paid by Landlord; and (iii) the value of any free rent provided by Landlord.

This Lease Guaranty is dated this ~~September~~ February 9, ~~2015~~ 2016

Signature: Neena Bayran
Printed Name:
Address:

STATE OF IL
ss.:
COUNTY OF DuPage

On this _____ day of ~~June 2015,~~ February 9, 2016 before me, the undersigned notary public, personally appeared Neena Bayran, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument, who acknowledged to me that he executed the same in his capacity, and that by his signature on the within instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Lisa Marie Anderson
Notary Public

OFFICIAL SEAL
LISA MARIE ANDERSON
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/04/16

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ATTACHMENT 3

Operating Entity/Licensee Information

1. Certificate of Good Standing

Please find attached a Certificate of Good Standing issued by the Illinois Secretary of State for the Illinois Back & Neck Institute, LLC, an Illinois limited liability company, which is the entity that will owns and operate the proposed ASTC.

2. Ownership Disclosures

The following individuals hold a 5 percent (5%) or greater ownership interest in the Applicant entity for the Illinois Back & Neck Institute, LLC.

Name	Entity or Individual	Ownership Percentage
Neema Bayran, MD	Individual	95%
Intesar Hussain, MD	Individual	5%
	Total:	100%

File Number 0456293-3

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ILLINOIS BACK & NECK INSTITUTE LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON OCTOBER 01, 2013, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 3RD *day of* NOVEMBER *A.D.* 2017 .

Authentication #: 1730701980 verifiable until 11/03/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

89

Membership Certificate

Number 100

This certifies that Dr. Neema Bayran is the lawful owner of a 95% Interest in Illinois Back & Neck Institute LLC, an Illinois limited liability company.

THE INTEREST REPRESENTED BY THIS CERTIFICATE IS SUBJECT TO THE OPERATING AGREEMENT AMONG THE COMPANY AND ITS MEMBERS, A COPY OF WHICH IS ON FILE AT THE COMPANY'S PRINCIPAL OFFICE. NO TRANSFER, SALE, ASSIGNMENT, PLEDGE, HYPOTHECATION, OR OTHER DISPOSITION OF THE INTEREST REPRESENTED BY THIS CERTIFICATE MAY BE MADE EXCEPT IN ACCORDANCE WITH THE PROVISIONS OF THE OPERATING AGREEMENT.

THE INTEREST REPRESENTED BY THIS CERTIFICATE HAS NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, OR UNDER ANY OTHER APPLICABLE SECURITIES LAWS AND MAY NOT BE TRANSFERRED, SOLD, ASSIGNED, PLEDGED, HYPOTHECATED, OR OTHERWISE DISPOSED OF EXCEPT UNDER A REGISTRATION STATEMENT EFFECTIVE UNDER SUCH ACT AND LAWS OR UNDER AN EXEMPTION FROM REGISTRATION UNDER SUCH ACT.

Dated: June 1, 2017.

_____

Dr. Neema Bayran, Managing Member

Membership Certificate

Number 101

This certifies that Dr. Intesar Hussain is the lawful owner of a 5% Interest in Illinois Back & Neck Institute LLC, an Illinois limited liability company.

THE INTEREST REPRESENTED BY THIS CERTIFICATE IS SUBJECT TO THE OPERATING AGREEMENT AMONG THE COMPANY AND ITS MEMBERS, A COPY OF WHICH IS ON FILE AT THE COMPANY'S PRINCIPAL OFFICE. NO TRANSFER, SALE, ASSIGNMENT, PLEDGE, HYPOTHECATION, OR OTHER DISPOSITION OF THE INTEREST REPRESENTED BY THIS CERTIFICATE MAY BE MADE EXCEPT IN ACCORDANCE WITH THE PROVISIONS OF THE OPERATING AGREEMENT.

THE INTEREST REPRESENTED BY THIS CERTIFICATE HAS NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, OR UNDER ANY OTHER APPLICABLE SECURITIES LAWS AND MAY NOT BE TRANSFERRED, SOLD, ASSIGNED, PLEDGED, HYPOTHECATED, OR OTHERWISE DISPOSED OF EXCEPT UNDER A REGISTRATION STATEMENT EFFECTIVE UNDER SUCH ACT AND LAWS OR UNDER AN EXEMPTION FROM REGISTRATION UNDER SUCH ACT.

Dated: June 1, 2017.

Dr. Neema Bayran, Managing Member

ATTACHMENT 4

Organizational Relationship

Illinois Back & Neck Institute, LLC, an Illinois limited liability company

Neema Bayran, MD 90%

Intesar Hussain 5%

V

V

No subsidiary companies

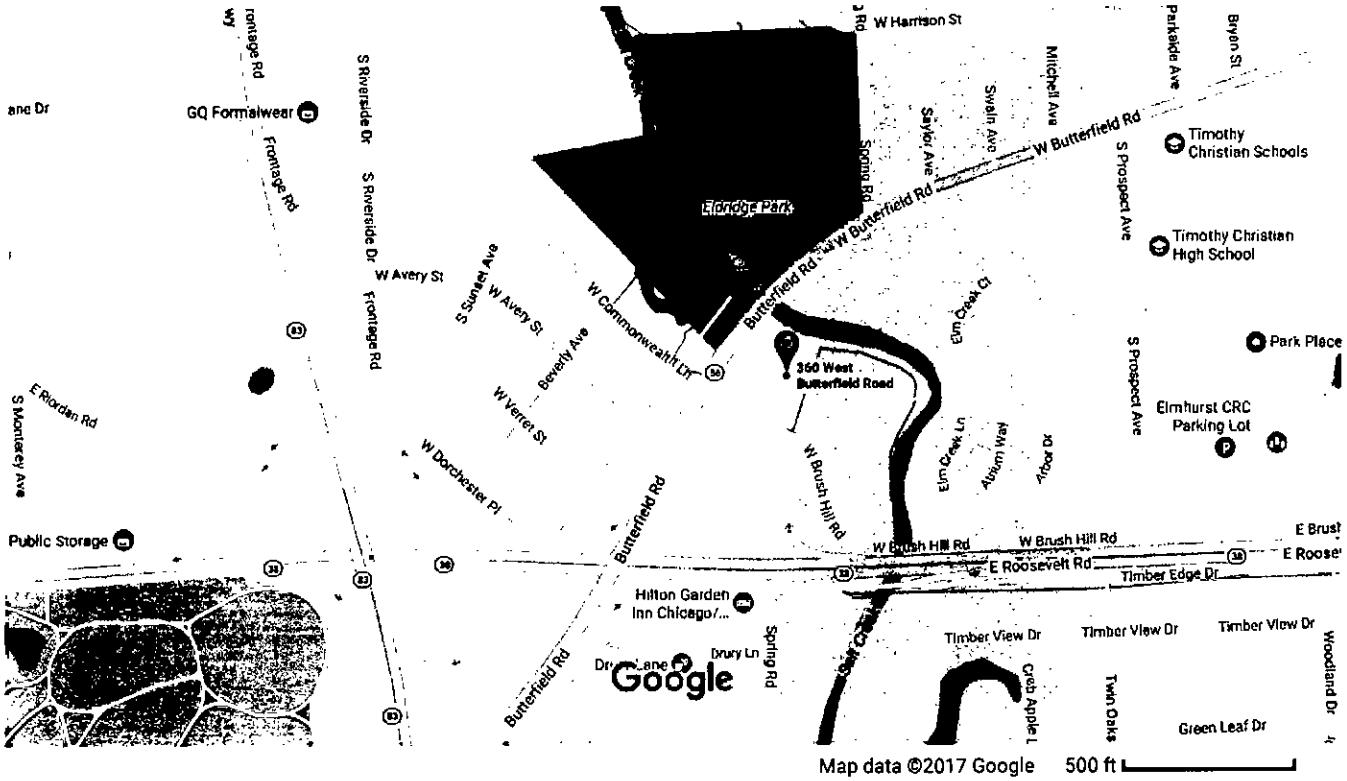
ATTACHMENT 5

Flood Plain Requirements

The proposed Project's site is not located within a flood plain, as evidenced by the attached flood plain map. Although the Federal Emergency Management Agency ("FEMA") website shows that flood plains do exist in Panel 17031C0456J, the Project site is not in or near the designated flood plains. Accordingly, the Project is in compliance with the requirements of Illinois Executive Order #2005-5.

A series of maps are provided after this page, identifying the proposed site for the ASTC showing that the Project site is not located within a flood plain.

Google Maps 360 W Butterfield Rd

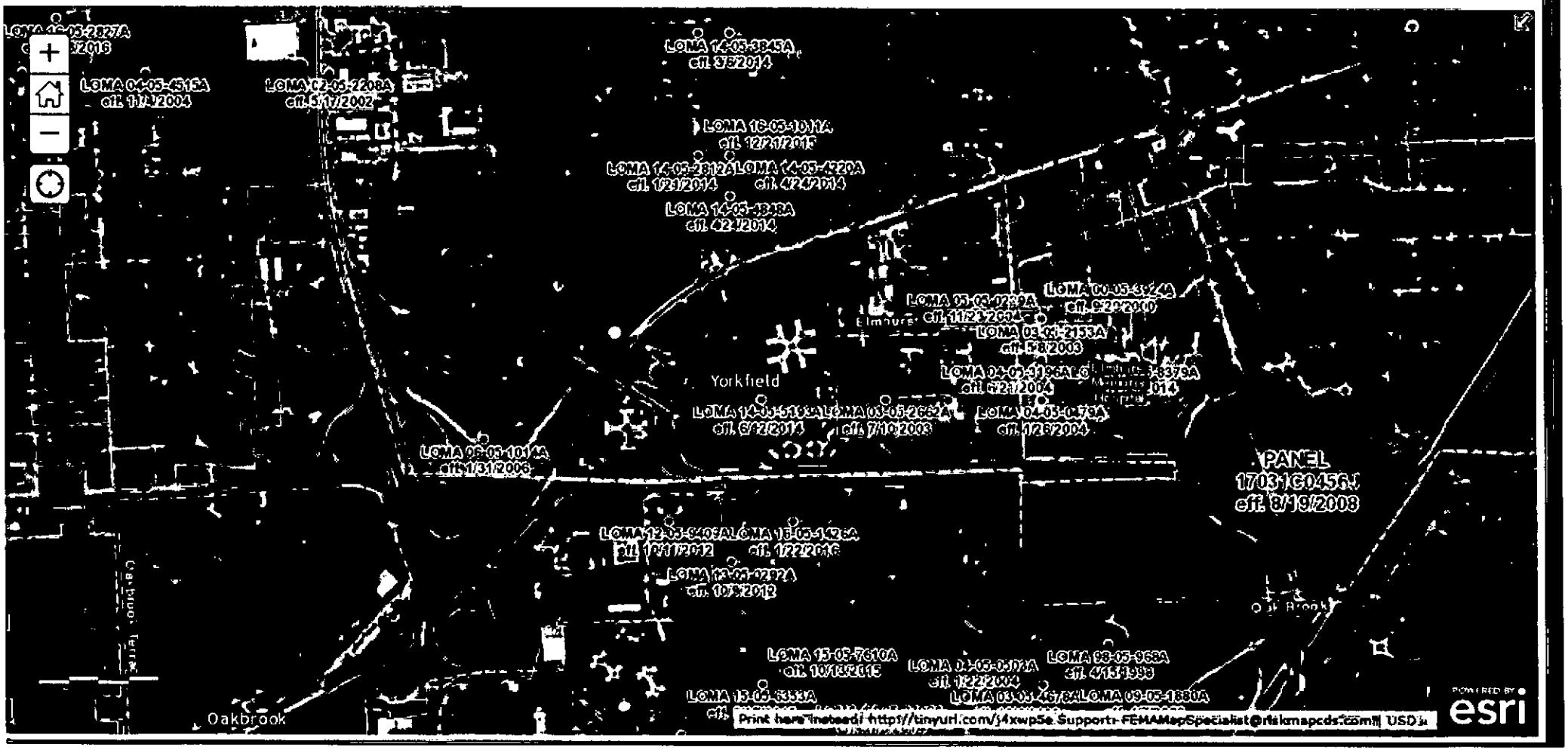


94

Home ▾ FEMA's National Flood Hazard Layer (Official)

Modify Map Sign In

Details | Basemap | Share Print | Measure 360 Butterfield Rd, Elmhurst, Illinois, USA



ATTACHMENT 6

Illinois Historical Preservation Letter

Please find attached a "clearance letter" from the Illinois Historical Preservation Agency (the "HPA"), which concludes that the Applicant's proposed ASTC will not adversely affect historic resources.

Illinois Historic Preservation Agency

1 Old State Capitol Plaza, Springfield, IL 62701-1512

FAX (217) 524-7525
www.illinoishistory.gov

DuPage County
Elmhurst
CON - Interior Rehabilitation to Establish a Multidisciplinary Ambulatory Surgery Treatment Center,
Illinois Back and Neck Institute
360 W. Butterfield Road, Suite 100
IHPA Log #016062617

July 13, 2017

Amalia Rioja
Baker & McKenzie LLP
300 E. Randolph St., Suite 5000
Chicago, IL 60601

Dear Ms. Rioja:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact David Halpin, Cultural Resources Manager, at 217/785-4998.

Sincerely,

Rachel Leibowitz, Ph.D.
Deputy State Historic
Preservation Officer

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ATTACHMENT 7

Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$15,025.00	$5,420.00	$20,445.00
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	$250,000.00	$52,000.00	$302,000.00
Contingencies	$20,000.00	$8000.00	$28,000.00
Architectural/Engineering Fees	$13,000.00	$2,500.00	$15,500.00
Consulting and Other Fees	$50,000.00	$10,000.00	$60,000.00
Movable or Other Equipment (not in construction contracts)	$550,000.00	$45,000.00	$595,000.00
Bond Issuance Expense (project related)	0	0	0
Net Interest Expense During Construction (project related)	0	0	0
Fair Market Value of Leased Space or Equipment	$362,000.00	$120,000.00	$482,000.00
Other Costs To Be Capitalized	0	0	0
Acquisition of Building or Other Property (excluding land)	0	0	0
TOTAL USES OF FUNDS	$1,260,025.00	$242,920.00	$1,502,945.00
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$898,025.00	$122,920.00	$1,020,945.00
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$320,000.00	$120,000.00	$482,000.00
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$1,260025.00	$242,920.00	$1,502,945.00

Medical Equipment List

Item Description	Quantity
ANESTHESIA INSTRUMENTS	Various
ANESTHESIA MACHINE	1
ARTHROSCOPY PUMP	Multiple
INFUSOR PUMP	2
BONE FREEZER	1
CABINET, 24" WARMING	2
C-ARM	1
CART, ANESTHESIA	2
CART, BROSELOW	1
CART, CRASH	1
CART, LOADING	1
CART, MH	1
ICE MACHINE	1
INSTRUMENTS	Various
INSTRUMENT CONTAINERS	Various
LED SURGICAL LIGHTS	2
LEG HOLDERS	2
MED RECORD SHELVING	1
METROMAX TOP TRACK UNITS	1
MINI C-ARM	1
MONITOR W/ STAND, PRINTER	6
OPTIVOSR - LOUPES	1
POSITIONERS	2
RECLINERS	3
REFRIGERATOR, LOCKABLE MEDS	1
RIGID INSTRUMENT RACK	1
SHOULDER HOLDER	2
STERILIZER, 16" FLASH	1
STERILIZER, 20" FLASH	1
STERILIZER, 36" TERMINAL W/ LOADING CAR & RACK RETURN	1
STRETCHERS	4
TABLE, OR	1
TABLE, OR ACCESSORIES	2
TABLE, SURGICAL HAND	2
TABLE, WORK, MOBILE	1
TIME CLOCK, B4	1
TOURNIQUET SYSTEM	2
TOWER, ARTHROSCOPY	1
TRACTION TOWER	2

ULTRASONIC CLEANER	1
V-PRO STERILIZER	1
WASHING/DISINFECTOR W/ 3 LEVEL MANIFOLD RACK	1

ATTACHMENT 8

Financial Commitment Document - *Not Applicable*

ATTACHMENT 9

Cost Space Requirements

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical	$1,260,025.00		1,850		1,850		
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical	$1,260,025.00		1,850		1,850		
NON REVIEWABLE							
Administrative	$242,920.00		1,004		1,004		
Parking							
Gift Shop							
Total Non-clinical	$242,920.00		1,004		1,004		
TOTAL	$1,502,945.00		2,854		2,854		

GENERAL NOTES

DR. BAYRAN

MEDICAL OFFICE BUILD-OUT
360 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS 60126

PROJECT DESCRIPTION

MEDICAL OFFICE BUILD-OUT TO AN EXISTING OFFICE BUILDING LOCATED ON THE FIRST FLOOR, SUITE 100

PROJECT INFORMATION

APPLICABLE CODES. ALL WORK UNDER THIS CONTRACT SHALL COMPLY WITH THE PROVISIONS OF THE SPECIFICATIONS AND DRAWINGS, AND SHALL SATISFY ALL APPLICABLE CODES, ORDINANCES AND REGULATIONS OF ALL GOVERNING BODIES INVOLVED. ALL PERMITS AND LICENSES NECESSARY FOR THE PROPER EXECUTION OF THE WORK SHALL BE PROCURED AND PAID FOR BY THE CONTRACTOR INVOLVED. APPLICABLE CODES INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING

SEE SHEET T1.1 FOR PROJECT CODE INFORMATION & OCCUPANT LOAD

CODES

2012 INTERNATIONAL BUILDING CODE	2015 INTERNATIONAL ENERGY CONSERVATION CODE
2014 INTERNATIONAL ELECTRIC CODE	1997 ILLINOIS ACCESSIBILITY CODE
2017 INTERNATIONAL MECHANICAL CODE	LOCAL AMENDMENTS TO THE ABOVE CODES
2012 INTERNATIONAL FIRE PREVENTION CODE	2012 NFPA 101 LIFE SAFETY CODE

CURRENT STATE OF ILLINOIS PLUMBING CODE rev. 4.24.14 with CITY OF ELMHURST ADOPTED AMENDMENTS.

DRAWING INDEX

ARCHITECTURAL:

- T1.0 Cover Sheet
- T1.1 Code Chart & Notes
- AD1.0 Demolition Plan
- A00 Emergency Egress Plan
- A1.0 Floor Plan + Reflected Ceiling
- A1.1 Interior elevations
- A1.2 Enlarged plan + ADA requirements
- A1.3 Floor Plan Finishes + Schedules

ENGINEERING:

- E0.1 ELECTRICAL SPECIFICATIONS, NOTES & DETAILS
- E1.0 FLOOR PLAN POWER & LIGHTING
- M0.1 MECHANICAL SPECIFICATIONS, NOTES & DETAILS
- M1.0 FLOOR PLAN MECHANICAL
- P1.0 FLOOR PLAN WASTE, VENT & SUPPLY

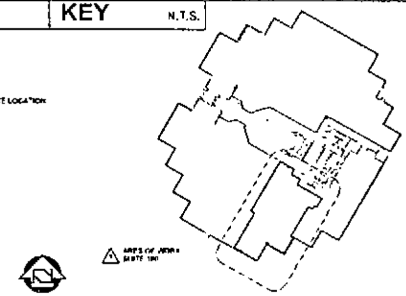
PROJECT DIRECTORY

OWNER	ARCHITECT	MECHANICAL/ELECTRICAL/PLUMBING
DR. BATRAN	LANDMARK DESIGN GROUP, LLC	CARTLAND KRAUS
7480 W. COLLEGE DRIVE	P.O. BOX 1512	780 TELSER ROAD
PALOS HEIGHTS, IL 60463	DES PLAINES, IL 60017	LAKE ZURICH, IL 60047
(708) 448-[illegible]	(847) 571-[illegible]	(847) [illegible]

ABBREVIATIONS

VICINITY MAP N.T.S.

KEY N.T.S.



STATEMENTS OF COMPLIANCE

ARCHITECTURAL

THIS DOCUMENT WAS PREPARED BY LANDMARK DESIGN GROUP, LLC. THIS DOCUMENT DOES NOT EITHER IN WHOLE OR IN PART CONSTITUTE ANY DIRECTION OR INSTRUCTION TO THE AWARDED GENERAL CONTRACTOR WITH REGARD TO CONSTRUCTION MEANS, METHODS OR TECHNIQUES BY THIS DOCUMENT.

I BRUCE OHMEN, DULY LICENSED IN THE STATE OF ILLINOIS BY THE DEPARTMENT OF PROFESSIONAL REGULATION, DO HEREBY STATE THAT THIS DOCUMENT WAS PREPARED BY ME OR UNDER MY DIRECT SUPERVISION AND TO THE BEST OF MY KNOWLEDGE AND BELIEF DOES CONFORM TO THE APPLICABLE BUILDING CODES AND ORDINANCES, AND ARE IN COMPLIANCE WITH THE ENVIRONMENTAL BARRIERS ACT (410 ILCS 25) AND THE ILLINOIS ACCESSIBILITY CODE (71 ILADM. CODE 400).

DATE: 03 / 25 / 2016

BRUCE OHMEN
ILLINOIS REGISTRATION NUMBER: 001-015798
DATE OF EXPIRATION - 11 / 30 / 2016

Dr. BAYRAN
MEDICAL OFFICE BUILD-OUT
360 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS 60126

TITLE SHEET

LANDMARK DESIGN GROUP, LLC

T1.0

TESTING AND INSPECTIONS

THE CONTRACTOR SHALL CONTACT THE OWNERS INDEPENDENT TESTING AGENCY TO PERFORM TESTING AND INSPECTION IN ACCORDANCE WITH THE REQUIREMENTS OF CHAPTER 17 STRUCTURAL TESTS AND INSPECTIONS OF THE 2006 INTERNATIONAL BUILDING CODE AS DESCRIBED IN CHARTS AS FOLLOWS. (COPYRIGHT BY INTERNATIONAL CODE COUNCIL INC.)

THE FOLLOWING MINIMUM TESTING AND INSPECTIONS SHALL BE PERFORMED:

SOILS:

TABLE 1704.7
REQUIRED VERIFICATION AND INSPECTION OF SOILS

CONCRETE WORK:

TABLE 1704.4
REQUIRED VERIFICATION AND INSPECTION OF CONCRETE CONSTRUCTION

MASONRY WORK:

TABLE 1704.5.1
LEVEL 1 SPECIAL INSPECTION

STEEL CONSTRUCTION:

TABLE 1704.3
REQUIRED VERIFICATION AND INSPECTION OF STEEL CONSTRUCTION

FABRICATORS:

WHERE FABRICATION OF STRUCTURAL LOAD-BEARING MEMBERS AND ASSEMBLIES IS BEING PERFORMED ON THE PREMISES OF A FABRICATOR'S SHOP, SPECIAL INSPECTION OF THE FABRICATED ITEMS SHALL BE REQUIRED UNLESS THE WORK IS DONE ON THE PREMISES OF A FABRICATOR REGISTERED AND APPROVED TO PERFORM SUCH WORK WITHOUT SPECIAL INSPECTION. APPROVED FABRICATORS SHALL SUBMIT A CERTIFICATE OF COMPLIANCE TO THE BUILDING OFFICIAL.

INSPECTION AGENCY:

IF REQUIRED:
BCS MIDWEST, LLC - CHICAGO
1175 BARCLAY BOULEVARD
BUFFALO GROVE, IL 60089
847-279-0366

PROJECT & CODE INFORMATION

PLUMBING

FABRICATORS:

WHERE FABRICATION OF STRUCTURAL LOAD-BEARING MEMBERS AND ASSEMBLIES IS BEING PERFORMED ON THE PREMISES OF A FABRICATOR'S SHOP, SPECIAL INSPECTION OF THE FABRICATED ITEMS SHALL BE REQUIRED UNLESS THE WORK IS DONE ON THE PREMISES OF A FABRICATOR REGISTERED AND APPROVED TO PERFORM SUCH WORK WITHOUT SPECIAL INSPECTION. APPROVED FABRICATORS SHALL SUBMIT A CERTIFICATE OF COMPLIANCE TO THE BUILDING OFFICIAL.

DOORS - ALL DOORS WILL COMPLY WITH SECTION ... OF THE ILLINOIS ACCESSIBILITY CODE AND ANSI SECTION 4.13.

CONTROLS AND OPERATING MECHANISMS - ALL CONTROLS AND OPERATING MECHANISMS ALONG ACCESSIBLE ROUTES AND IN ACCESSIBLE SPACES SHALL COMPLY WITH ANSI SECTION 4.25.

ALARMS - ALL EMERGENCY WARNING SYSTEMS SHALL COMPLY WITH ANSI SECTION 4.28 AND SHALL BE BOTH AUDIO AND VISUAL.

MATERIAL AND SYMBOL LEGEND

EARTH
GRANULAR FILL
SAND OR GROUT
CONCRETE
CONCRETE MASONRY UNIT
BRICK
STONE
STEEL
PLYWOOD
DIMENSIONAL LUMBER
BLOCKING
FINISH GRADE WOOD
BATT INSULATION
RIGID INSULATION
STUD WALL
DEMOLITION KEY NOTE
KEY NOTE
DOOR TAG
WALL TYPE TAG
WINDOW TAG
FINISH TAG
REVISION TAG
ROUND OR DIAMETER
CENTERLINE
SECTION CUT TAG
SECTION KEY
SHEET NUMBER
DETAIL TAG
DETAIL NUMBER
SHEET NUMBER
ELEVATION TAG
ELEVATION NUMBER
SHEET NUMBER
ELEVATION LEVEL LINE
COLUMN LINE GRIDS
DOOR TAG
ROOM NAME
NORTH ARROW

CLIENT Dr. BAYRAN
MEDICAL OFFICE BUILD-OUT
360 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS 60126

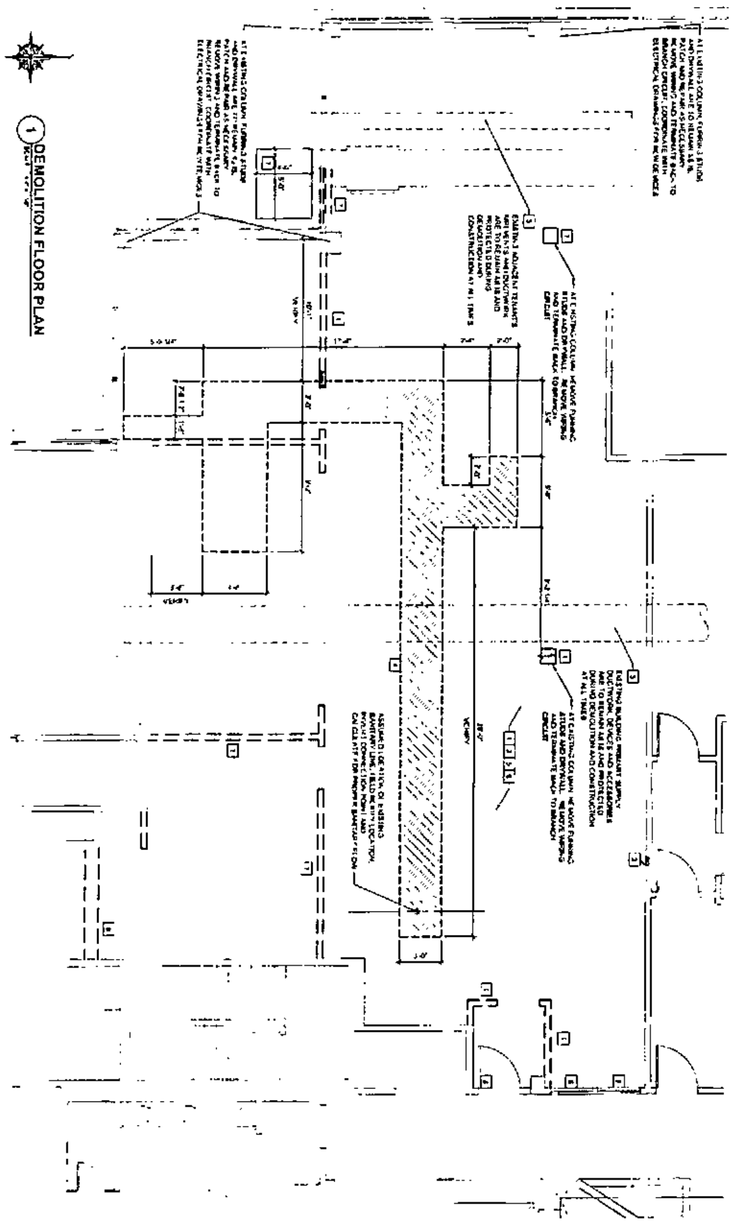
PROJECT CODE INFORMATION

LANDMARK DESIGN GROUP, LLC

T1.1

101

501



KEYED DEMO NOTES:

DEMOLITION NOTES

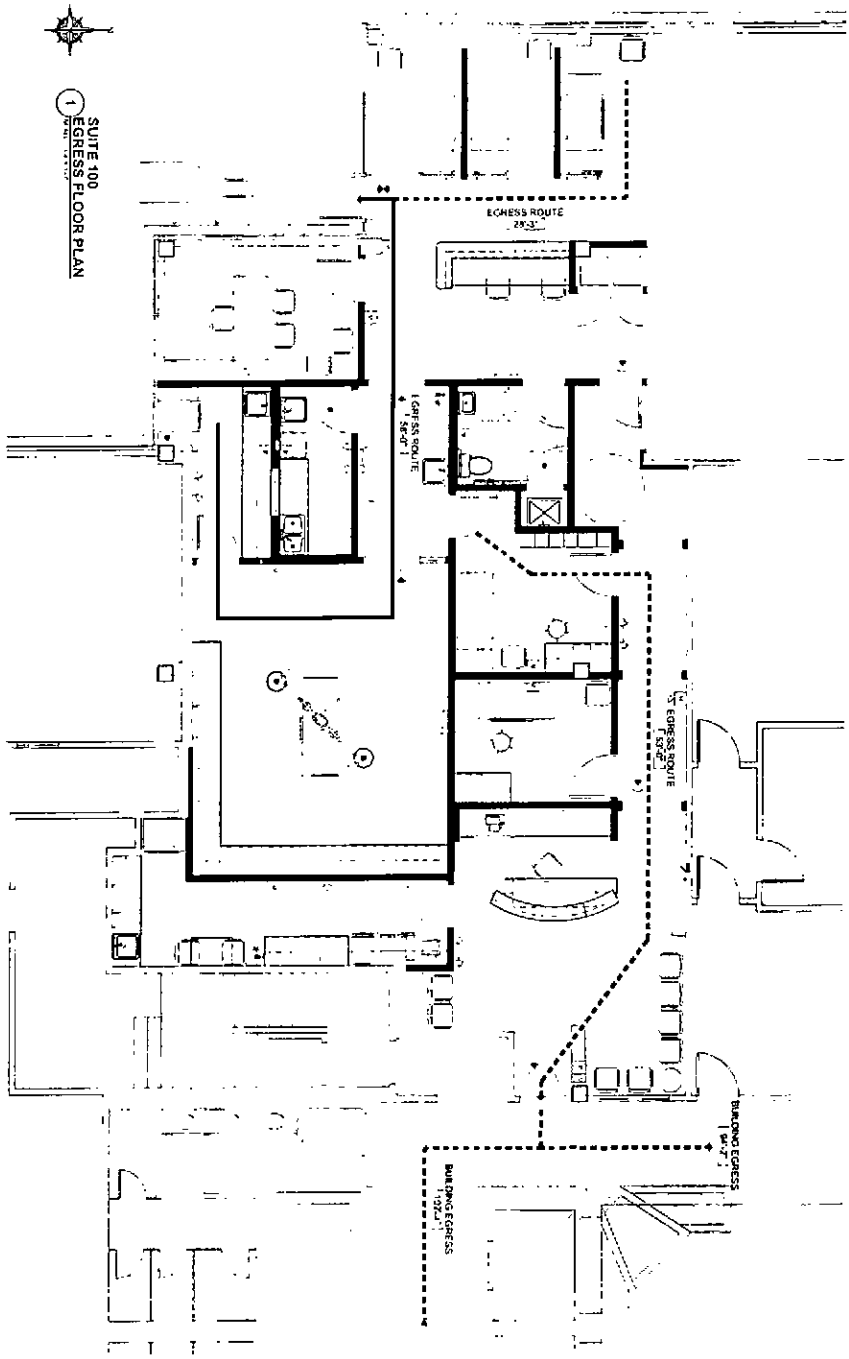
LANDMARK
DESIGN GROUP, LLC
PO BOX 1512
DES PLAINES IL 60017
(847) 971-9424
www.landmarkdgi.com

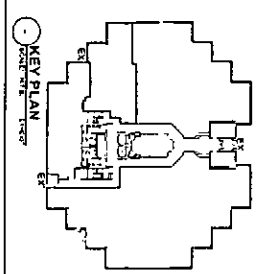
CLIENT: Dr. BAYRAN

AD1.0

DEMOLITION FLOOR PLAN

MEDICAL OFFICE BUILD-OUT
380 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS 60126





EGRESS NOTES:

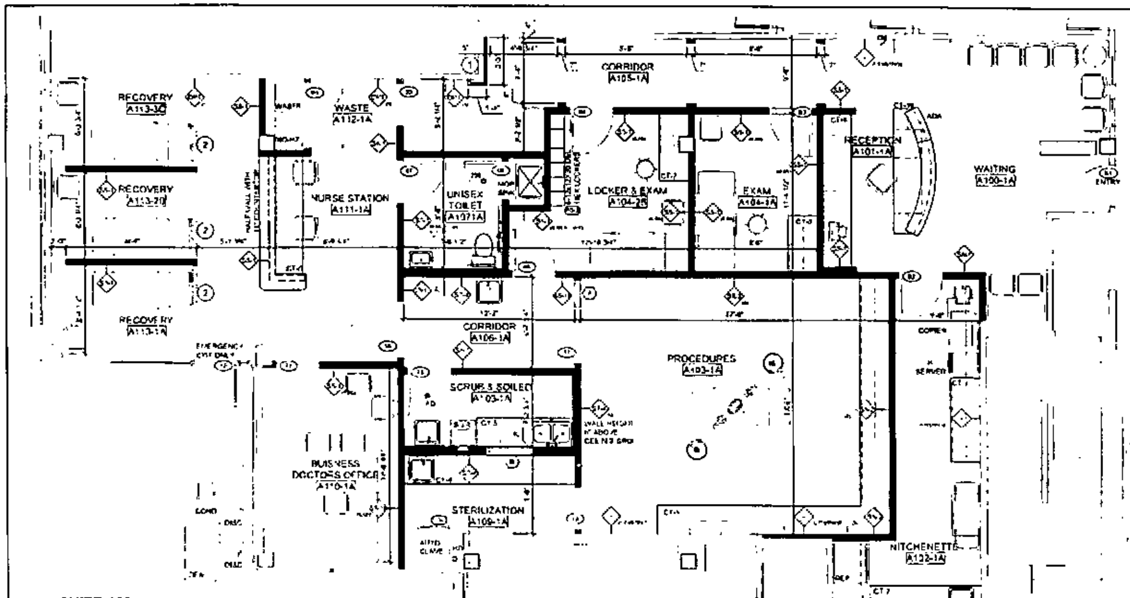
LANDMARK DESIGN GROUP, LLC
P.O. BOX 1512
DES PLAINES, IL 60017

CLIENT: Dr. BAYRAN

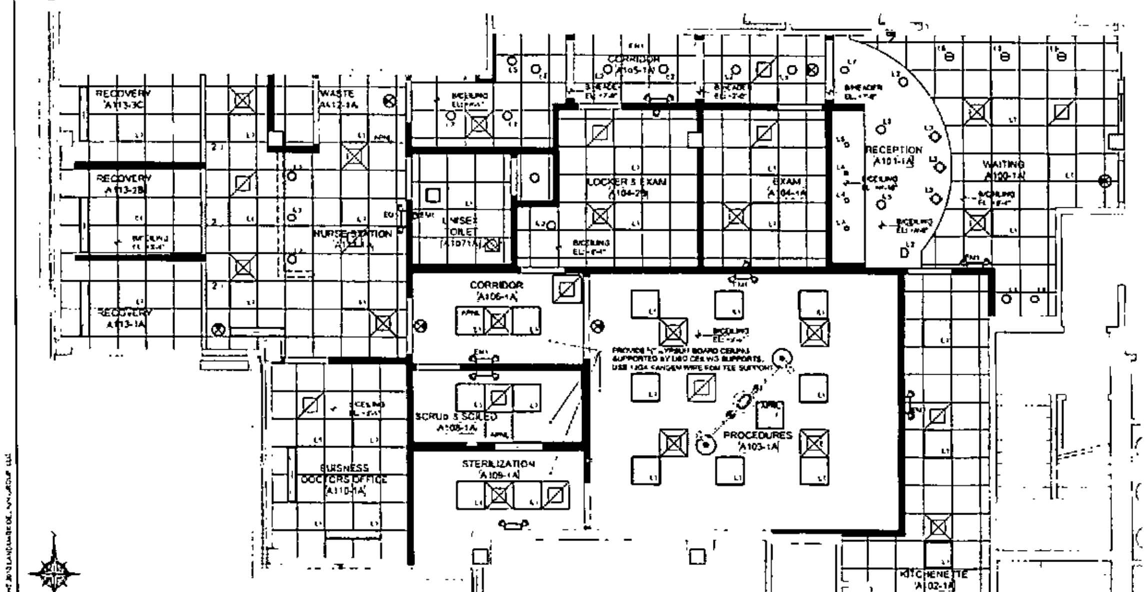
A00

EGRESS PLAN

MEDICAL OFFICE BUILD-OUT
360 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS 60126



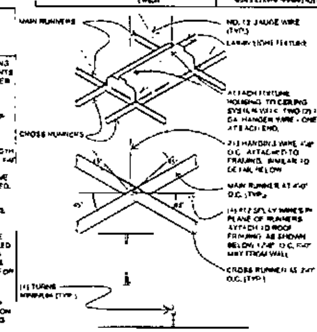
1 SUITE 100 PROPOSED FLOOR PLAN



2 SUITE 100 PROPOSED REFLECTED PLAN

WALL TYPE NOTES

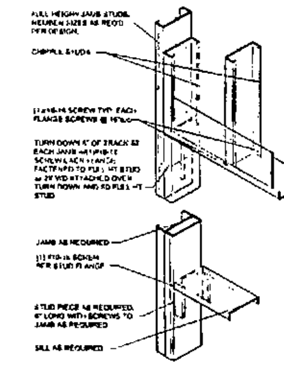
PARTITION LEGEND



3 REFLECTED PLAN DETAIL

FIXTURE LEGEND

GENERAL NOTES



4 HEAD & SILL DETAIL

KEYED BUILD NOTES:

LEGEND

LANDMARK DESIGN GROUP, LLC

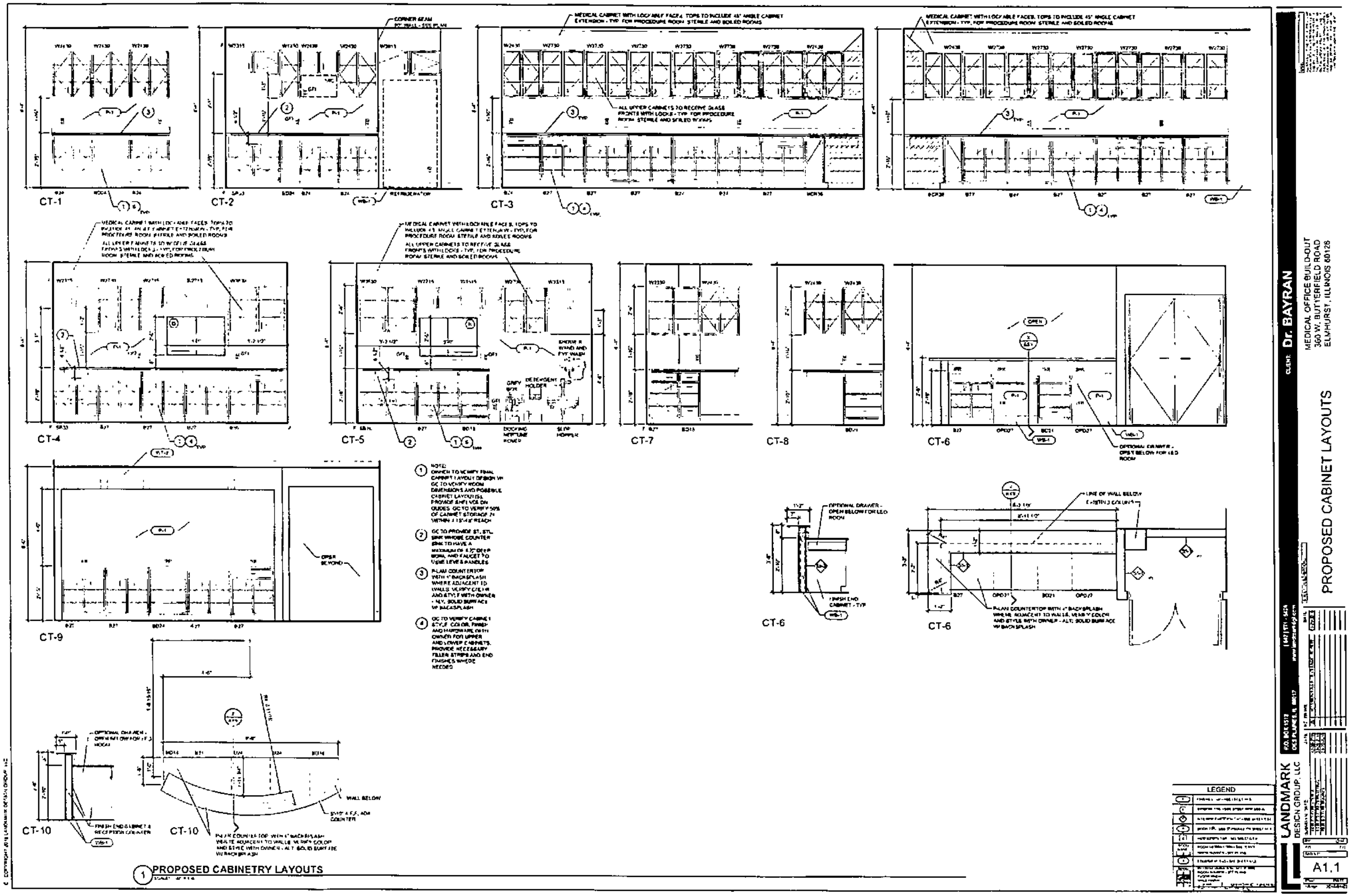
CLIENT: Dr. BAYRAN

MEDICAL OFFICE BUILD-OUT
360 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS 60126

PROPOSED FLOOR PLANS

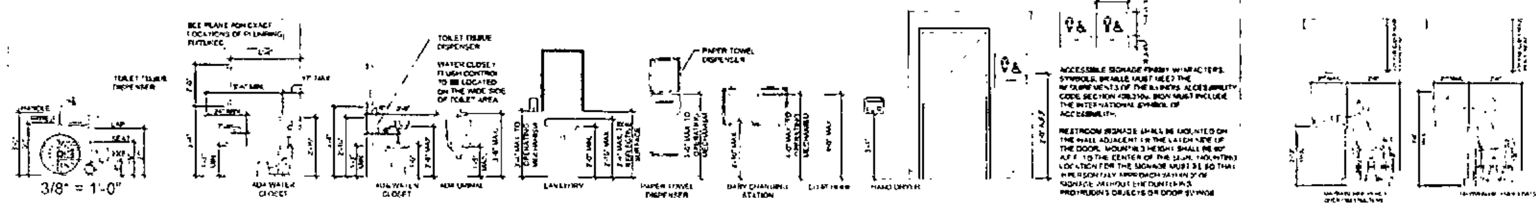
A1.0

107


CT-1
CT-2
CT-3
CT-4
CT-5
CT-6
CT-7
CT-8
CT-9
CT-10
REFRIGERATOR
DOCKING
NEPTUNE
ROVER
SLOP
HOPPER
OPEN
OPEN BEYOND
WALL BELOW
LEGEND
NOTE:
1 OWNER TO VERIFY FINAL CABINET LAYOUT DESIGN W/ GC TO VERIFY ROOM DIMENSIONS AND POSSIBLE CABINET LAYOUT(S). PROVIDE SHELVES ON GUIDES. GC TO VERIFY 50% OF CABINET STORAGE IS WITHIN 15"-48" REACH
2 GC TO PROVIDE ST. STL. SINK WHERE COUNTER SINK TO HAVE A MAXIMUM OF 6 1/2" DEEP BOWL AND FAUCET TO USE LEVER HANDLES
3 P-LAM COUNTERTOP WITH 4" BACKSPLASH WHERE ADJACENT TO WALLS. VERIFY COLOR AND STYLE WITH OWNER - ALT. SOLID SURFACE W/ BACKSPLASH
4 GC TO VERIFY CABINET STYLE, COLOR, FINISH AND HARDWARE WITH OWNER FOR UPPER AND LOWER CABINETS. PROVIDE NECESSARY FILLER STRIPS AND END FINISHES WHERE NEEDED
1 PROPOSED CABINETRY LAYOUTS
LANDMARK
DESIGN GROUP, LLC
P.O. BOX 1512
DES PLAINES, IL 60017
CLIENT: Dr. BAYRAN
MEDICAL OFFICE BUILD-OUT
360 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS 60126
PROPOSED CABINET LAYOUTS
A1.1

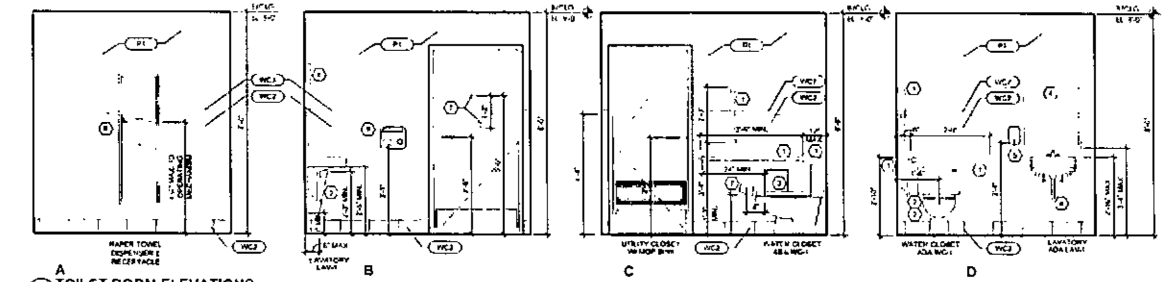
TYPICAL ACCESSIBLE MOUNTING HEIGHTS

(NOTE: G.C. TO FOLLOW LOCAL JURISDICTION'S CODES AND REQUIREMENTS CONTACT ARCHITECT WITH ANY DISCREPANCIES)

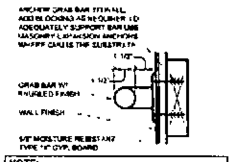


ACCESSIBLE SIGNAGE FINISH, CHARACTERS, SYMBOLS, BRAILLE MUST MEET THE REQUIREMENTS OF THE ILLINOIS ACCESSIBILITY CODE SECTION. SIGN MUST INCLUDE THE INTERNATIONAL SYMBOL OF ACCESSIBILITY.

RESTROOM SIGNAGE SHALL BE MOUNTED ON THE WALL ADJACENT TO THE LATCH SIDE OF THE DOOR. MOUNTING HEIGHT SHALL BE 60" A.F.F. TO THE CENTER OF THE SIGN. MOUNTING LOCATION FOR THE SIGNAGE MUST BE SO THAT A PERSON MAY APPROACH WITHIN 3" OF SIGNAGE WITHOUT ENCOUNTERING PROTRUDING OBJECTS OR DOOR SWINGS.

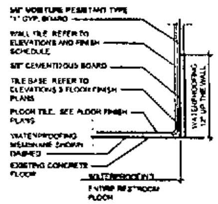


1 TOILET ROOM ELEVATIONS

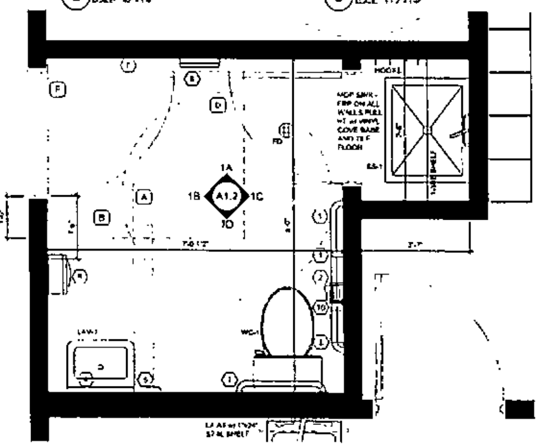


NOTE: GRAB BARS SHALL BE DESIGNED & INSTALLED FOR A CONCENTRATED LOAD OF 250 LBS. APPLIED AT ANY POINT & ANY DIRECTION AT TOP OF GRAB BAR.

2 GRAB BAR BLOCKING DETAIL



3 BASE DETAIL



GENERAL NOTES:

A. CONTRACTOR SHALL FIELD VERIFY ALL DIMENSIONS & EXISTING CONDITIONS PRIOR TO COMMENCING WORK. IF ANY DISCREPANCIES EXIST, CONTRACTOR SHALL NOTIFY PROJECT MANAGER IMMEDIATELY.

B. WOOD BLOCKING SHALL BE INSTALLED BEHIND ALL-MOUNTED EQUIPMENT, FIXTURES, SHELVING, AND RAILS. ALL WOOD BLOCKING TO BE FIRE TREATED (F.T.)

C. ALL RESTROOM ACCESSORIES SHALL BE MOUNTED WITH VANDAL-RESISTANT METAL FASTENERS INTO WOOD BLOCKING.

D. REFER TO FINISH LEGEND ON SHEET A4.1 FOR MORE INFORMATION ON FINISHES.

E. REFER TO TOILET ACCESSORIES SCHEDULE ON SHEET A4.1 FOR MORE INFORMATION ON TOILET ACCESSORIES.

F. ALL MOISTURE RESISTANT GYP. BD INSTALLED BEHIND TILE WALL FINISH TO BE SPECIALLY DESIGNED FOR USE AS A SUBSTRATE FOR INTERIOR TILE APPLICATIONS.

CLEAR FLOOR SPACE

TAG	ITEM	REQUIRED
A	TOILET	60" X 60"
B	SINK	30" X 48"
C	URINAL	30" X 48"
D	TURNING RADIUS	60" D
E	PUSH SIDE OF 3'-0" DOOR FRONT APPROACH	48" X 60"
F	PULL SIDE OF 3'-0" DOOR FRONT APPROACH 18" PULL SIDE OF DOOR 12" PUSH SIDE OF DOOR	48" X 56"
G	DRINKING FOUNTAIN	30" X 48"

FIRE PROTECTION NOTE

ANY WOOD TO BE USED AS RISERS, NAILERS OR BLOCKING MUST BE FIRE RETARDANT TREATED WOOD

INTERIOR FINISHES NOTE

ALL INTERIOR FINISHES FOR THIS BUILDING ARE TO BE CLASS C, FLAME SPREAD 76-200; SMOKE DEVELOPED 0-450. (IBC 2009 CHAPTER 8)

TOILET ACCESSORIES SCHEDULE

MARK	ACCESSORY	MANUFACTURER	SERIES / MODEL NUMBER	FINISH	NOTES
1	42" GRAB BAR @ SIDE 36" GRAB BAR @ BACK 24" VERT. GRAB BAR @ SIDE	BOBRICK	SERIES B-5806	SATIN STAINLESS STEEL	1, 3 (ADA)
2	TOILET TISSUE DISPENSER	BOBRICK	SERIES B-6697	SATIN STAINLESS STEEL	1, 3
3	SANITARY NAPKIN DISPOSAL	BOBRICK	SERIES B-5270	SATIN STAINLESS STEEL	1, 3
4	MIRROR	BOBRICK	SERIES B-165-1530 MIRROR W/ STAINLESS STEEL FRAME	SATIN STAINLESS STEEL	1
5	SOAP DISPENSER	BOBRICK	SERIES B-2111	SATIN STAINLESS STEEL	1, 3 (ADA)
6	PAPER TOWEL DISPENSER	BOBRICK	SERIES B-262	SATIN STAINLESS STEEL	3, 5 (ADA)
7	COAT HOOK	BOBRICK	SERIES B-2116	SATIN STAINLESS STEEL	- (ADA)
8	TRAP WRAP	TRUEBRO PRODUCTS	KIT C/W BOW	WHITE	-
9	HAND DRYER	XLERATOR	XL-SG-ECO	BRUSHED STAINLESS STEEL	3, 2 (ADA)
10	OPTIONAL PULL CHAIN NURSE CALL STATION	CORNELL OR EQUAL	P-104-1WP	EMERGENCY STATION WITH WATER RESISTANT OPTION. COORDINATE WITH ELECTRICAL	

NOTES:
1. PROVIDE IN WALL BLOCKING AS REQUIRED FOR ATTACHMENT.
2. REFER TO ELECTRICAL DRAWINGS FOR ELECTRICAL ROUGH-INS.
3. SURFACE MOUNTED.
4. PROVIDE ADA COMPLIANT LEVER HANDLES.
5. OWNER TO PROVIDE WASTE BASKET.

(ADA symbol) ADA COMPLIANT FIXTURE

LEGEND

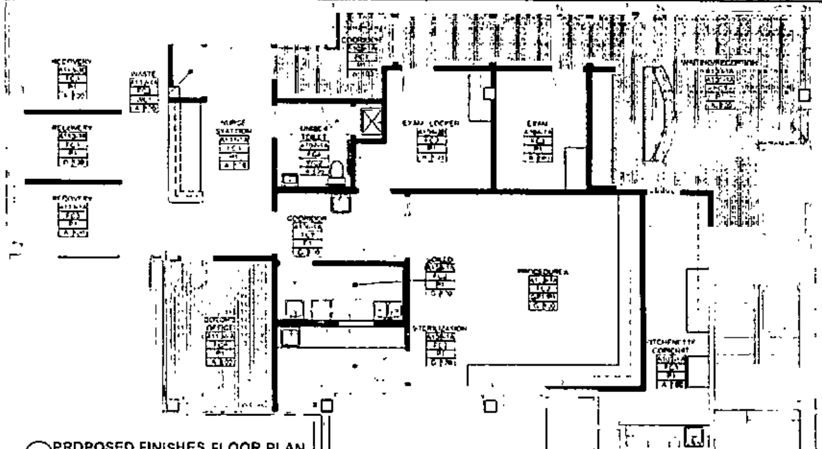
CLIENT Dr. BAYRAN

MEDICAL OFFICE BUILD-OUT
360 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS 60126

PROPOSED CABINET LAYOUTS

LANDMARK DESIGN GROUP, LLC

A1.2

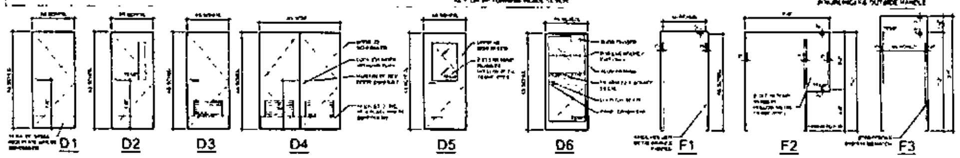


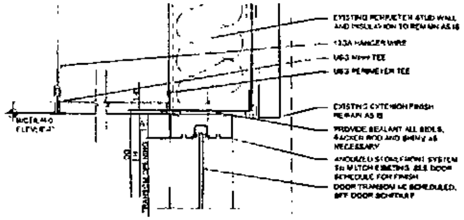
8 PROPOSED FINISHES FLOOR PLAN

DOOR SCHEDULE

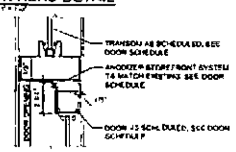
NOTES:

HARDWARE:

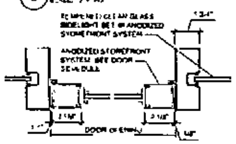




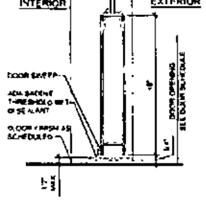
7 DOOR HEAD DETAIL



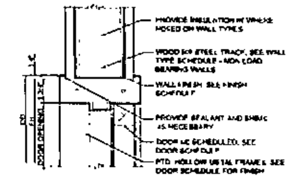
6 DOOR TRANSOM DETAIL



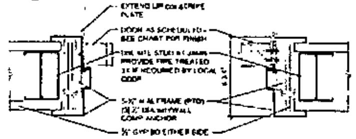
5 DOOR JAMB DETAIL



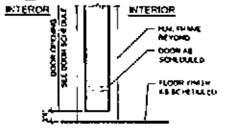
4 DOOR THRESHOLD DETAIL



3 DOOR HEAD DETAIL



2 DOOR JAMB DETAIL



1 DOOR THRESHOLD DETAIL

ROOM FINISH SCHEDULE

SUGGESTED INTERIOR FINISH LEGEND

FLOOR

BASE

WALL

CEILING

MISC

NOTES

EQUIPMENT LEGEND

NOTES

CLIENT: **Dr. BAYRAN**

MEDICAL OFFICE BUILD-OUT
350 W. BUTTERFIELD ROAD
ELMHURST, ILLINOIS 60126

FINISHES AND SCHEDULES

LANDMARK
DESIGN GROUP, LLC

SHEET
A1.3

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ATTACHMENT 10

Discontinuation of Services - *Not Applicable*

ATTACHMENT 11

Criterion 1110.1540(b) - Background of Applicant

The Applicant is fit, willing, and able, and has the qualifications, background, character, and financial resources to adequately provide proper medical services for the community. The Applicant also demonstrates that the Project promotes the orderly and economic development of health care facilities or services in the State of Illinois.

(1)(a) List of all Health Care Facilities Owned/Operated by the Applicant

The Applicant, Illinois Back & Neck Institute LLC was formed in 2013 and currently owns and operates the following facilities:

- Illinois Back & Neck Institute, 360 W. Butterfield Road, Suite 100, Elmhurst, IL 60126
- Pain Center of Illinois, 830 N. Ashland Unit, C2, Chicago, IL 60622

(1)(b) List of all Health Care Facilities Owned/Operated by Persons with Ownership of 5% or Greater or Who are Officers or Directors of the Applicant.

The Applicant is owned by physician investors who will own the proposed ASTC in equal percentages

Name	Member Who Owns more than 5% in IBNI	Member of Board of Managers	More than 5% Ownership in Other Healthcare Facilities
Neema Bayran, MD	Yes	Yes	95%
Intesar Hussain, MD	Yes	Yes	5%

(2) Certification Regarding Any Adverse Action and Authorization State Agencies to Access Documents for Verification Purposes

A certified letter is contained in this attachment. The certification provides as follows: (1) no adverse action has been taken against the Applicant or any facility, owner, or officer/director of the Applicant, nor does any such person have an adverse criminal or civil ruling, decision or other determination that would preclude them from owning and operating a health care facility; and (2) the State Board and the Illinois Department of Public Health are authorized to obtain information regarding this CON permit application.

Attachment 11

August 17, 2017

Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson St, 2nd Floor
Springfield, IL 62761
Attention: State Board Chairperson Kathryn J. Olson

RE: Background of Applicant

Dear Chairperson Olson:

Pursuant to State Board Review Criterion 1110.1540(b)(3), addressing the background of the applicant Illinois Back & Neck Institute LLC (the "Applicant"), I hereby certify that no adverse action has been taken against the Applicant or any facility owned and/or operated by the Applicant during the three years prior to the filing of the certificate of need permit application to establish ambulatory surgical treatment center at 360 W. Butterfield Road, Suite 100, Elmhurst, IL 60126. Furthermore, a listing of each applicant, corporate officer or director, LLC member, partner, and owner of at least five percent (5%) of the proposed facility is attached. I hereby certify that the individuals who have been identified on this list: (i) have not been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to (a) the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; (or) (b) has been the subject of any juvenile delinquency or youthful offender proceeding; (ii) have not been charged with fraudulent conduct or any act involving moral turpitude; (iii) do no have any unsatisfied judgements against him or her; or (iv) are not in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order, or directive of any court or governmental agency.

The Applicant hereby permits the Illinois Health Facilities and Services Review Board ("State Board") and the Illinois Department of Public Health ("IDPH") to have access to any documents necessary to verify the information submitted in the certificate of need permit application, including, but not limited to: (i) official records of IDPH or other State of Illinois agencies; (ii) the licensing or certification records of other states, when applicable; and (iii) the records of nationally recognized accreditation organizations.

Respectfully submitted,

Neema Bayran, M.D.
Chief Executive Officer
Illinois Back & Neck Institute, LLC

Notary:

Subscribed and sworn to me this 20 day of October, 2017

Notary Public

OFFICIAL SEAL
EOITH M DIAZ
Notary Public - State of Illinois
My Commission Expires Jul 23, 2018

Seal:

ATTACHMENT 12

Criterion 1110.230(a) - Purpose of the Project

1. Purpose.

The Applicant, Illinois Back & Neck Institute, LLC, herein requests State Board approval to establish a multi-specialty ambulatory surgical treatment center ("ASTC"), which will be located within leased space. The scope of services that will be provided at the proposed surgery center will include three categories of service: orthopedics, pain management, and podiatry. The proposed ASTC will provide these health services in an easily-accessible location, centrally located to the Applicant's patient base. The proposed ASTC will improve the health care and well-being of the population that resides in the geographic area.

The Applicant will own the proposed ASTC directly. The ASTC, therefore, will be indirectly owned by a group of physicians who are physician members of Illinois Back & Neck Institute, LLC, ("IBNI"), a reputable orthopedic physician practice group in Chicago. IBNI's physicians have a long history of providing outstanding high quality services in the areas of orthopedics, and pain management at two locations. IBNI is multi-specialty orthopedic group that offers hand and upper extremity, spine, foot and ankle, major joints, trauma, and general adult and pediatric orthopedic services. The proposed ASTC will be located within one of the group's existing medical offices, specifically, the office building at 360 W. Butterfield Road, Elmhurst, IL. The group's other offices are located at 830 N. Ashland, Unit C2, Chicago, IL 60622.

By adding a suite to provide on-site ambulatory surgery care, IBNI will be able to offer its patients a continuum of care at a familiar site.

2. Planning Area and Market Area

The proposed ASTC will be located at 360 W. Butterfield Road, Suite 100, Elmhurst, IL 60126. The Project's site is located within Health Service Area [7] and Hospital Planning Area [A-07]. The Applicant proposes a geographic service area (the "GSA") that includes all zip codes that are within forty-five (45) minute drive time radius surrounding the site.

Several maps showing the project site and the boundary of the proposed GSA showing its boundary are provided immediately following this Attachment 12.

3. Existing Health Problems and Issues

The purpose of this Project is to establish an ASTC that offers two categories of outpatient surgical services: (1) orthopedics; and (2) pain management. The Applicant will operate the proposed ASTC in a manner that ensures the safety of its patients, always giving high quality care to patients in a convenient and familiar location. The ASTC will enhance access to outpatient health care services once it becomes an enrolled provider in the Illinois Medicaid program and implements a charity care program. The Project will also help reduce the cost of healthcare overall, by offering patients an affordable alternative to hospital-based surgical services, which often results in lower copayments for patients and less-costly reimbursement by all payer types.

4. Sources of Documentation

Evidence to support the need for this Project follows this attachment.

5. Impact of Project

The Project will improve access to care and reduce the costs of publicly-funded healthcare to programs such as Medicare and Medicaid. The Project will also give IBNI's current patients a new option for outpatient surgical care. The ASTC will be located in a medical office building presently occupied by IBNI, where IBNI's physicians have been practicing medicine since 2017. The Applicant is directly owned by certain physician investors who are also members of the IBNI physician practice group. These physician investors will use the ASTC as an extension of their current medical office practice and be able to meet the needs of their current and expanding patient base.

The Project, however, is intended to meet the medical needs of all individuals residing within the GSA who need and seek outpatient surgical care in the two requested categories of service. Any physicians who are not members of the IBNI practice, who would like to use the ASTC to meet their patients' needs, will be able to do so, upon seeking and receiving approval from the IBNI governing body pursuant to its privileging and credentialing process. Regardless, the Applicant will ensure that all services provided at the ASTC are given without regard to an individual patient's income level, race, ethnicity, cultural background, gender identify and/or religious faith. In order to increase access to outpatient healthcare services, the Applicant will enroll in the Medicaid program and plans to establish a charity care program at the ASTC. The Applicant's commitment to servicing Medicaid beneficiaries and person in need of charity care is explain further in Attachment 12(b) and Attachment 44. In sum, the Applicant's goal for this Project is to provide quality surgical care to its current patients, expand its services to establish the ASTC, which will continue its mission and purpose from the physician office to the outpatient surgical care.

Since 2009, the Applicant has operated a high-quality medical practice in an office-based setting and has become a well-known and well-regarded orthopedic provider in Chicago and the surrounding suburbs. The goal of the Applicant's physicians has always been and continues to be to provide the best care to its patients suffering from bone, joint, and muscle injuries and conditions in a setting that is safe and where patients are treated with respect and compassion. This approach will continue at the proposed ASTC.

6. Project Goals

The Project's goals are to (1) provide quality, cost-effective alternative services to higher-cost hospital-based care; (2) to increase access and availability to surgical services to all individuals living in the proposed GSA by providing high-quality care in a convenient location; and (3) to give physician investors the ability to provide services in a safe, modern surgical setting that is an extension of their growing medical office practice.

In addition, the Project involves modernizing the existing medical office space with state-of-the-art equipment and technology. The proposed ASTC will be located within a relatively new medical office building. The current building was completed by IBNI in 2017 and was utilized as a medical office shortly thereafter. The proposed ASTC will be constructed in unused space on the first floor of the building and will be part of an addition to the main floor space. Photographs of the buildings interior and exterior are provided below:

Please see the attached.

The proposed project does not involve the replacement of any medical equipment. All equipment needed for the surgical center will be purchased, either new or from a reputable dealer of used medical equipment. The Applicant will apply the highest standards as to the quality and condition of any used medical equipment before any such equipment is purchased and used at the proposed ASTC.

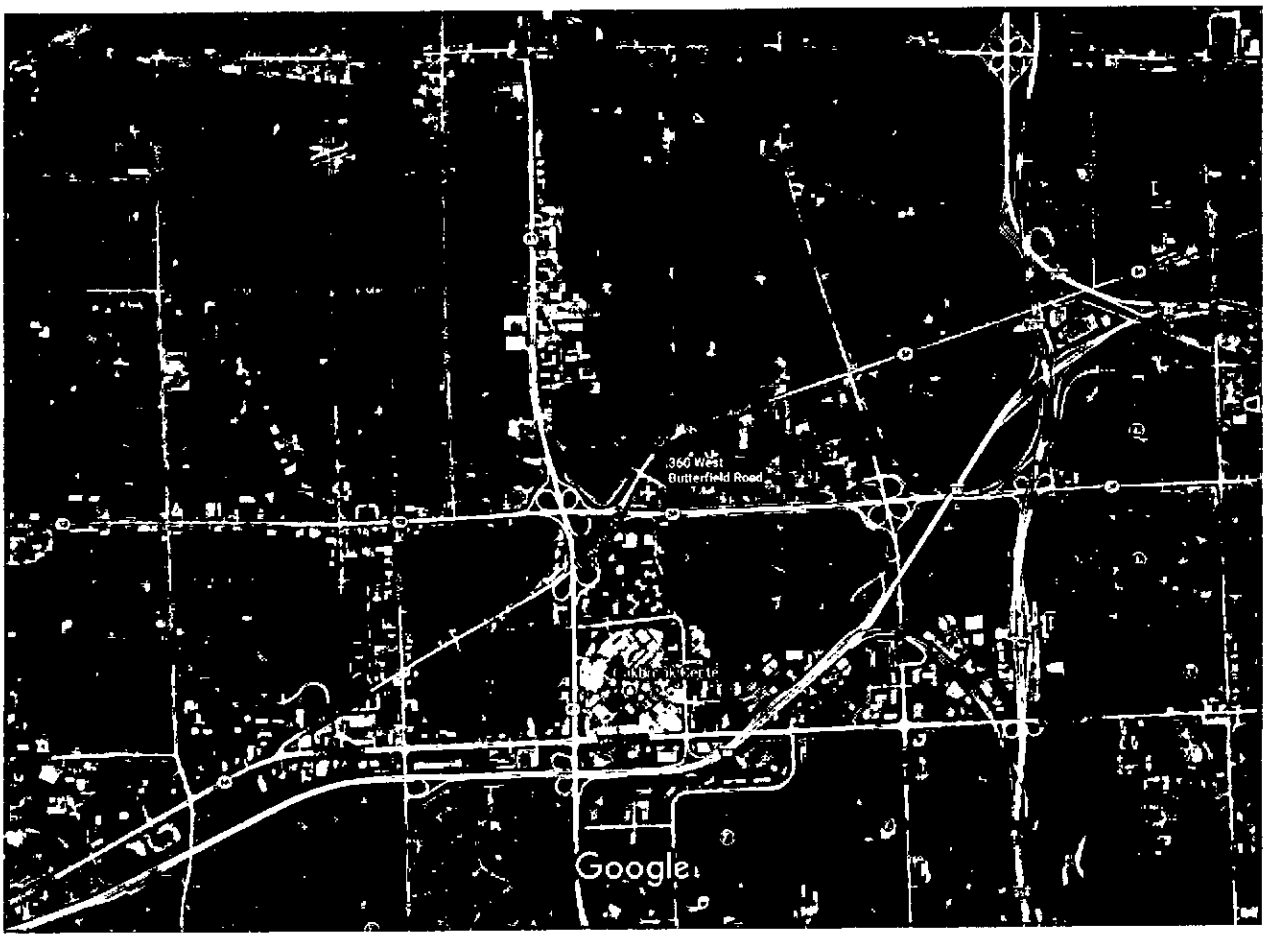
ATTACHMENT 12(a)

Geographic Service Area: 45 Minute Radius from Project Location
Project Location Identified Below

Google Maps

360 W Butterfield Rd

360 West Butterfield Road, Suite 100, Elmhurst, IL 60126

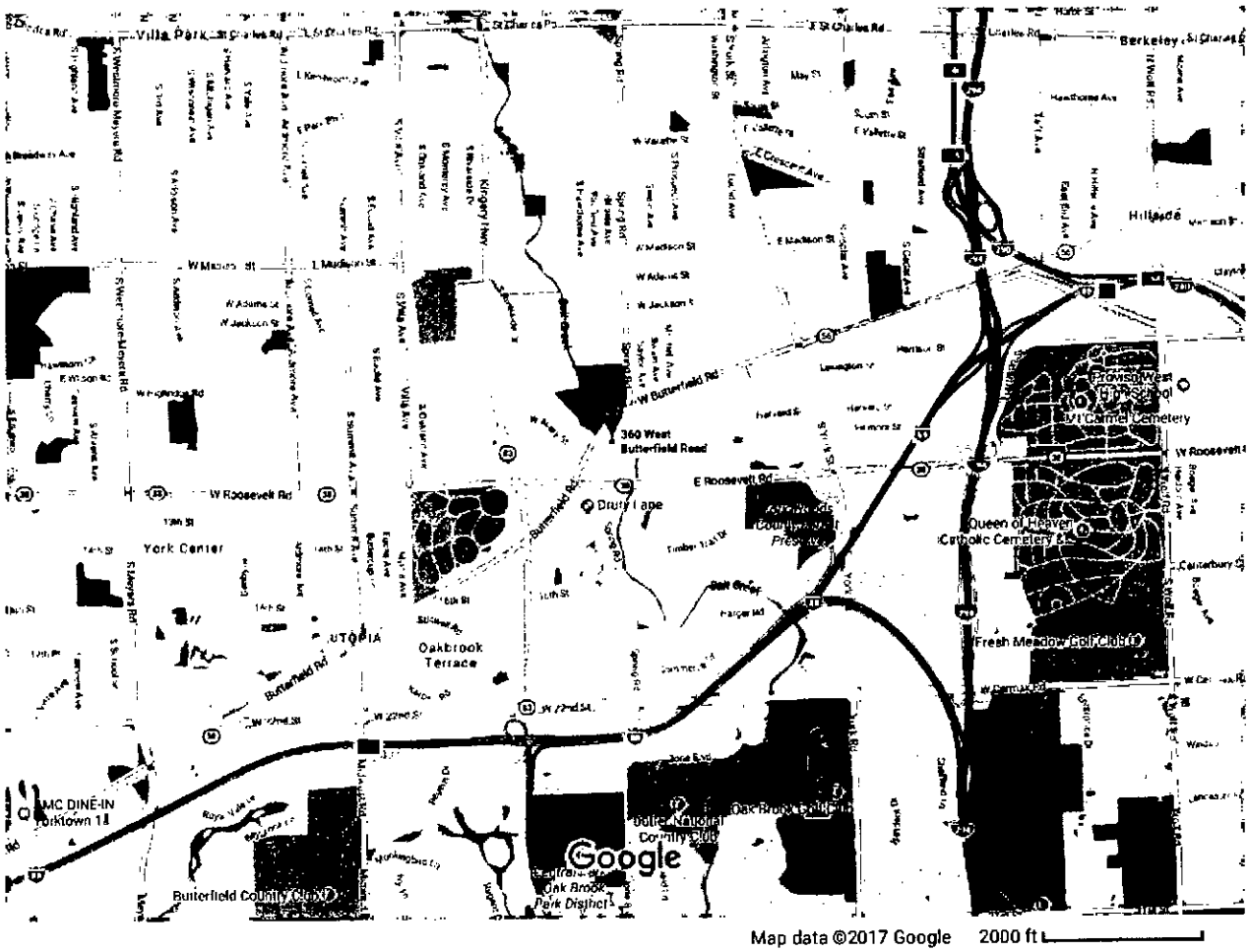


Imagery ©2017 Google, Map data ©2017 Google 2000 ft

Google Maps

360 W Butterfield Rd

360 West Butterfield Road, Elmhurst, IL 60126



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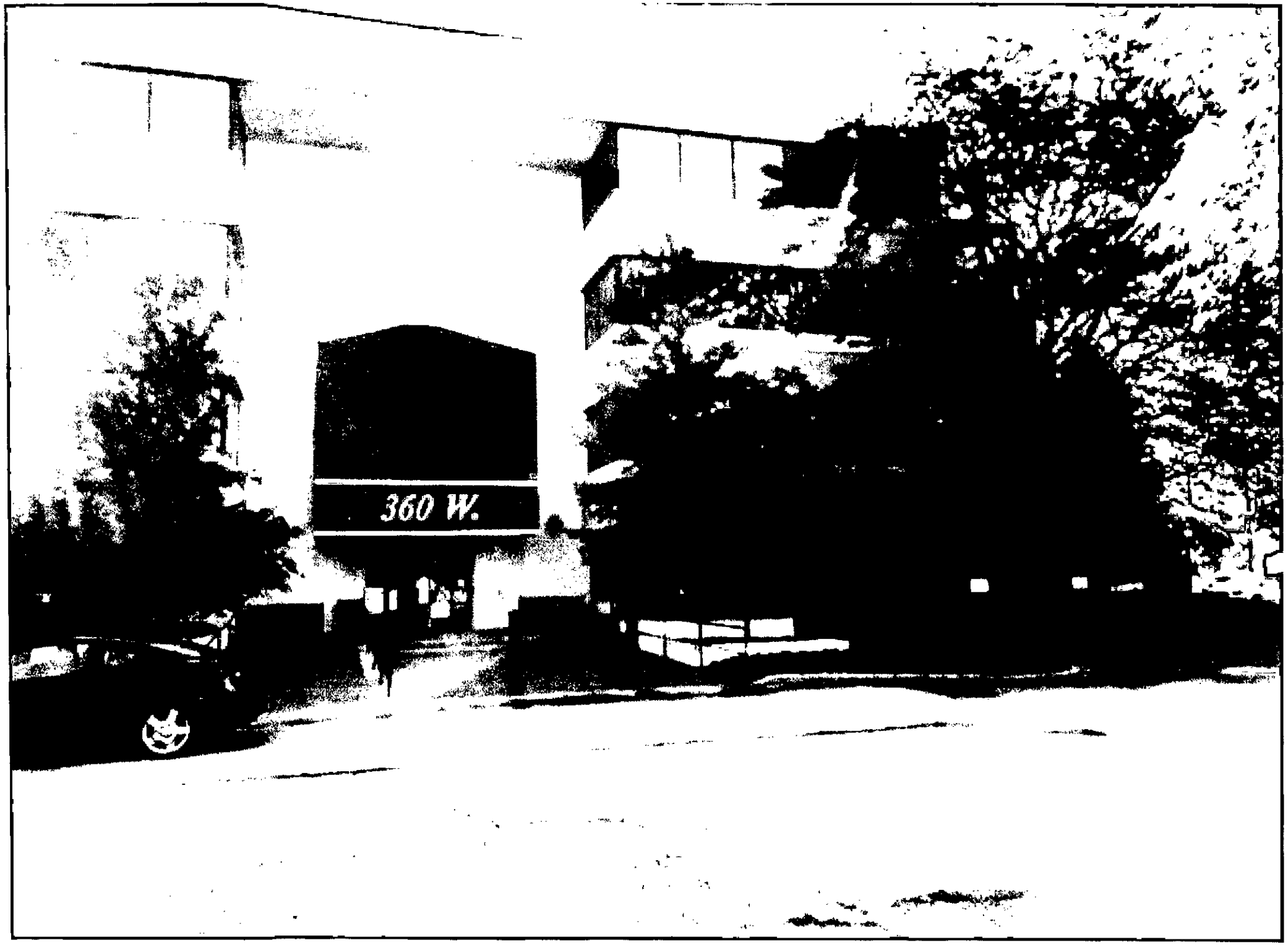
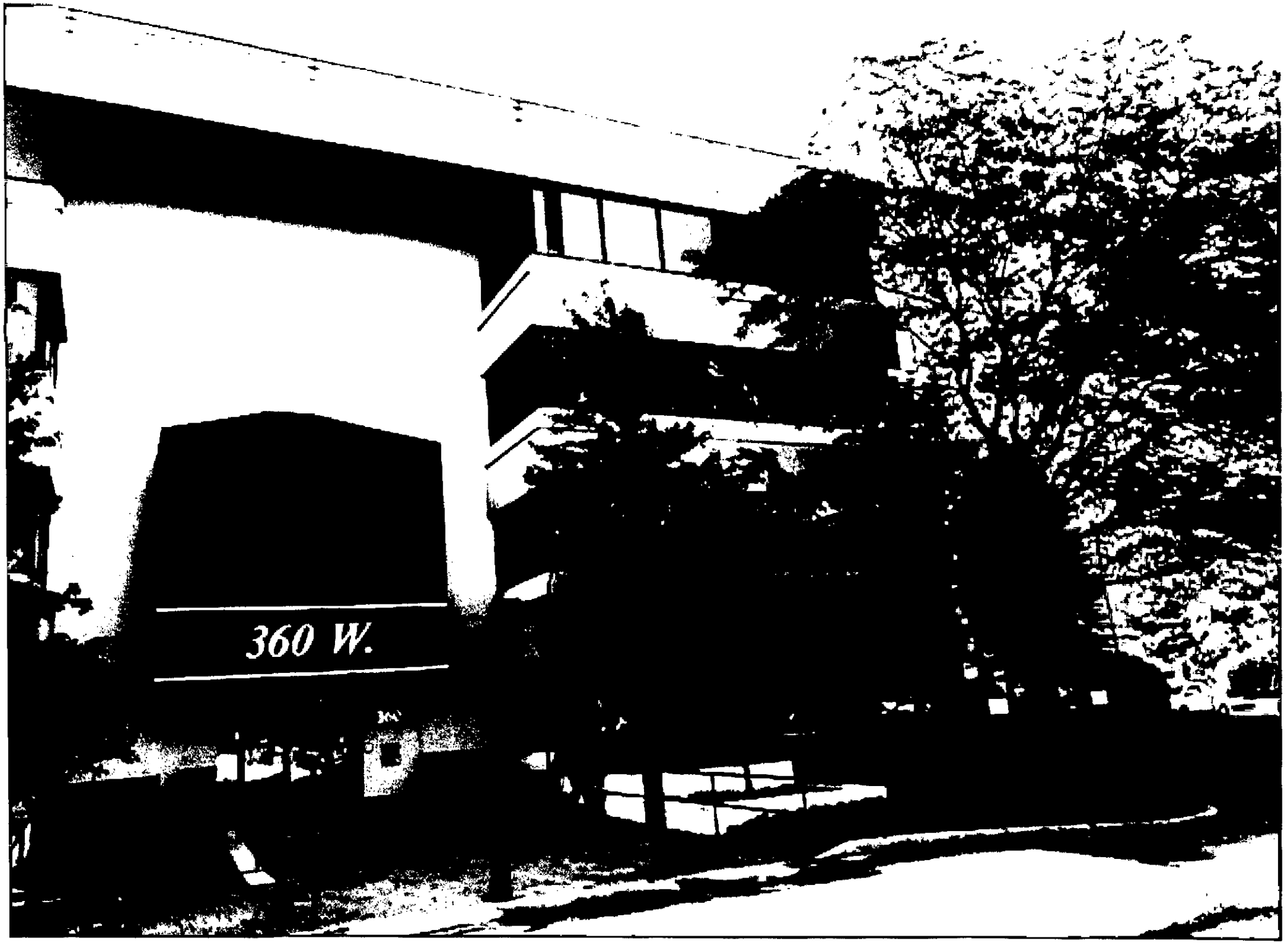

360 W.


360 W.


360 W.


125

ASCA Ambulatory Surgery Center Association

Ambulatory Surgery Centers

A Positive Trend in Health Care

Ambulatory surgery centers (ASCs) are health care facilities that offer patients the convenience of having surgeries and procedures performed safely outside the hospital setting. Since their inception more than four decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs. At a time when most developments in health care services and technology typically come with a higher price tag, ASCs stand out as an exception to the rule.

A TRANSFORMATIVE MODEL FOR SURGICAL SERVICES

As our nation struggles with how to improve a troubled and costly health care system, the experience of ASCs is a great example of a successful transformation in health care delivery.

Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the US.

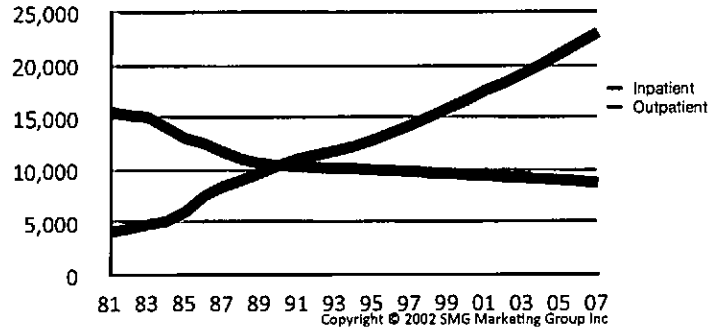
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling delays, limited operating room availability, slow operating room turnover times, and challenges in obtaining new equipment due to hospital budgets and policies, physicians were looking for a better way—and developed it in ASCs.

Today, physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain increased control over their surgical practices.[1] In the ASC setting, physicians are able to schedule procedures more conveniently, assemble teams of specially trained and highly skilled staff, ensure that the equipment and supplies being used are best suited to their techniques, and design facilities tailored to their specialties and to the specific needs of their patients. Simply stated, physicians are striving for, and have found in ASCs, professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in an ASC (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

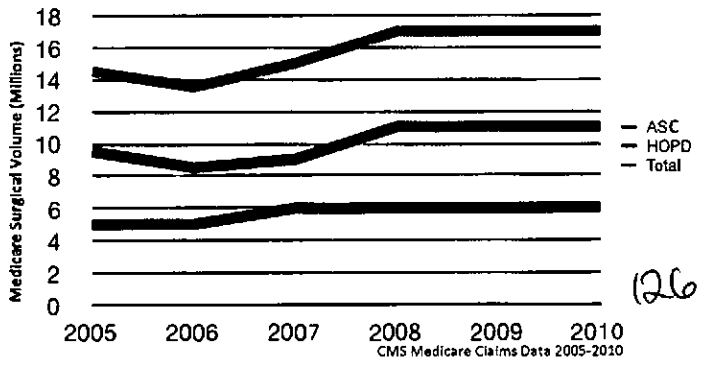
Given the history of their involvement in making ASCs a reality, it is not surprising that physicians continue to have at least some ownership in virtually all (90%) ASCs. But what is more interesting to note is how many ASCs are jointly owned by local hospitals that now increasingly recognize and embrace the value of the ASC model. According to the most recent data available, hospitals have ownership interest in 21% of all ASCs and 3% are owned entirely by hospitals.[2]

ASCs also add considerable value to the US economy, with a 2009 total nationwide economic impact of $90 billion, including more than $5.8 billion in tax payments. Additionally, ASCs employ the equivalent of approximately 117,700 full-time workers.[3]

Surgical Trends by Volume



ASC vs. HOPD Volume



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ASCs PROVIDE CARE AT SIGNIFICANT COST SAVINGS

Not only are ASCs focused on ensuring that patients have the best surgical experience possible, they also provide cost-effective care that save the government, third party payors and patients money. On average, the Medicare program and its beneficiaries share in more than $2.6 billion in savings each year because the program pays significantly less for procedures performed in ASCs when compared to the rates paid to hospitals for the same procedures. Accordingly, patient co-pays are also significantly lower when care is received in an ASC.

If just half of the eligible surgical procedures moved from hospital outpatient departments to ASCs, Medicare would save an additional $2.4 billion a year or $24 billion over the next 10 years. Likewise, Medicaid and other insurers benefit from lower prices for services performed in the ASC setting.

Currently, Medicare pays ASCs 58% of the amount paid to hospital outpatient departments for performing the same services For example, Medicare pays hospitals $1,670 for performing an outpatient cataract surgery while paying ASCs only $964 for performing the same surgery.

This huge payment disparity is a fairly recent phenomenon. In 2003, Medicare paid hospitals only 16% more, on average, than it paid ASCs. Today, Medicare pays hospitals 72% more than ASCs for outpatient surgery. There is no health or fiscal policy basis for providing ASCs with drastically lower payments than hospital outpatient departments.

In addition, patients typically pay less coinsurance for procedures performed in the ASC than for comparable procedures in the hospital setting. For example, a Medicare beneficiary could pay as much as $496 in coinsurance for a cataract extraction procedure performed in a hospital outpatient department, whereas that same beneficiary's copayment in the ASC would be only $195.

Without the emergence of ASCs as an option for care, health care expenditures would have been tens of billions of dollars higher over the past four decades. Private insurance companies tend to save similarly, which means employers also incur lower health care costs when employees utilize ASC services. For this reason, both employers and insurers have recently been exploring ways to incentivize the movement of patients and procedures to the ASC setting.

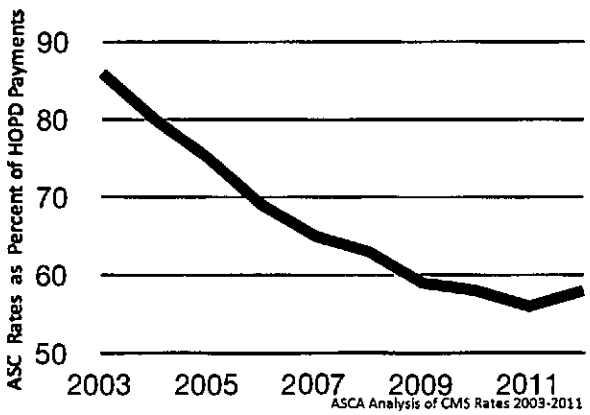
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased by hospitals and converted into hospital outpatient departments. Even if an ASC is not physically located next to a hospital, once it is part of a hospital, it can terminate its ASC license and become a unit of the hospital, entitling the hospital to bill for Medicare services provided in the former ASC at the 72% higher hospital outpatient rates.

Cost Comparison:
ASC v. Hospital Outpatient Department

	Patient Cost		Medicare Cost	
	ASC Co-pay	HOPD Co-pay	Total Procedure Cost ASC	Total Procedure Cost HOPD
Cataract	$193	$490	$964	$1,670
Upper GI Endoscopy	$68	$139	$341	$591
Colonoscopy	$76	$186	$378	$655

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

The Gap Between ASC and HOPD Payments Has Widened Significantly



ASCA Analysis of CMS Rates 2003-2011

THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price of the planned surgical procedure and the specific portion for which the patient would be responsible. This will empower health care consumers as they evaluate and compare costs for the same service amongst various health care providers.

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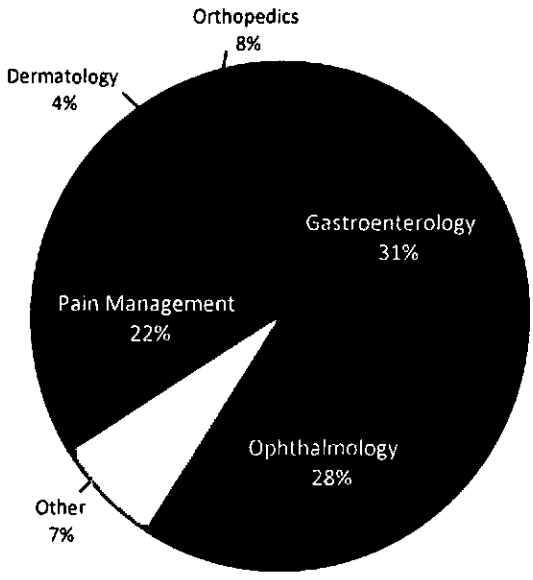
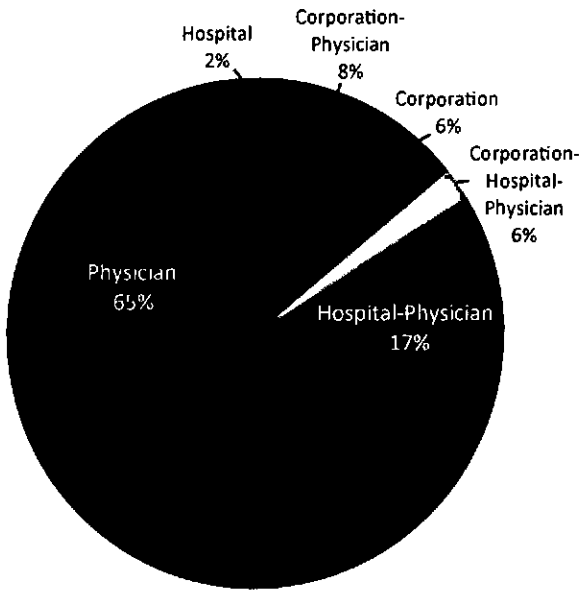
Medicare Case Volume by Specialty



ASCA Analysis of CMS Claims Data 2010

ASC Ownership



ASCA's 2011 ASC Employee Salary & Benefits Survey

ASCs = Efficient Quality Care + Convenience + Patient Satisfaction

The ASC health care delivery model enhances patient care by allowing physicians to:

- Focus exclusively on a small number of processes in a single setting, rather than having to rely on a hospital setting that has large-scale demands for space, resources and the attention of management
- Intensify quality control processes since ASCs are focused on a smaller space and a small number of operating rooms, and
- Allow patients to bring concerns directly to the physician operator who has direct knowledge about each patient's case rather than deal with hospital administrators who almost never have detailed knowledge about individual patients or their experiences

Physician ownership also helps reduce frustrating wait-times for patients and allows for maximum specialization and patient–doctor interaction. Unlike large-scale institutions, ASCs

- Provide responsive, non-bureaucratic environments tailored to each individual patient's needs
- Exercise better control over scheduling, so virtually no procedures are delayed or rescheduled due to the kinds of institutional demands that often occur in hospitals (unforeseen emergency room demands)
- Allow physicians to personally guide innovative strategies for governance, leadership and most importantly, quality initiatives

As a result, patients say they have a 92% satisfaction rate with both the care and service they receive from ASCs .[4] Safe and high quality service, ease of scheduling, greater personal attention and lower costs are among the main reasons cited for the growing popularity of ASCs.

ASCs ARE HIGHLY REGULATED TO ENSURE QUALITY AND SAFETY

ASCs are highly regulated by federal and state entities. The safety and quality of care offered in ASCs is evaluated by independent observers through three processes: state licensure, Medicare certification and voluntary accreditation.

Forty three states and the District of Columbia, currently require ASCs to be licensed in order to operate. The remaining seven states have some form of regulatory requirements for ASCs such as Medicare certification or accreditation by an independent accrediting organization. Each state determines the specific requirements ASCs must meet for licensure and most require rigorous initial and ongoing inspection and reporting.

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All ASCs serving Medicare beneficiaries must be certified by the Medicare program. In order to be certified, an ASC must comply with standards developed by the federal government for the specific purpose of ensuring the safety of the patient and the quality of the facility, physicians, staff, services and management of the ASC.The ASC must demonstrate compliance with these Medicare standards initially and on an ongoing basis.

In addition to state and federal inspections, many ASCs choose to go through voluntary accreditation by an independent accrediting organization. Accrediting organizations for ASCs include The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) and the American Osteopathic Association (AOA). ASCs must meet specific standards during on-site inspections by these organizations in order to be accredited. All accrediting organizations also require an ASC to engage in external benchmarking, which allows the facility to compare its performance to the performance of other ASCs.

In addition to requiring certification in order to participate in the Medicare program, federal regulations also limit the scope of surgical procedures reimbursed in ASCs. Even though ASCs and hospital outpatient departments are clinically identical, the Center for Medicare & Medicaid Services (CMS) applies different standards to the two settings.

ASCs: A COMMITMENT TO QUALITY

Quality care has been a hallmark of the ASC health care delivery model since its earliest days. One example of the ASC community's commitment to quality care is the ASC Quality Collaboration, an independent initiative that was established voluntarily by the ASC community to promote quality and safety in ASCs.

The ASC Quality Collaboration is committed to developing meaningful quality measures for the ASC setting. Six of those measures have already been endorsed by the National Quality Forum (NQF). The NQF is a non-profit organization dedicated to improving the quality of health care in America, and the entity the Medicare program consults when seeking appropriate measurements of quality care. More than 20% of all ASCs are already voluntarily reporting the results of the ASC quality measures that NQF has endorsed.

Since 2006, the ASC industry has urged the CMS to establish a uniform quality reporting system to allow all ASCs to publicly demonstrate their performance on quality measures. Starting on October 1, 2012, a new quality reporting system for ASCs will begin and will encompass five of the measures that ASCs are currently reporting voluntarily.

Reporting Measures

Measure	Data Collection Begins
Patient Burn	Oct 1, 2012
Patient Fall	Oct 1, 2012
Wrong Site, Side, Patient, Procedure	Oct 1, 2012
Hospital Admission	Oct 1, 2012
Prophylactic IV Antibiotic Timing	Oct 1, 2012
Safe Surgery Check List Use	Jan 1, 2012
Volume of Certain Procedures	Jan 1, 2012
Influenza Vaccination Coverage for Health Care Workers	Jan 1, 2013

76 Federal Regulation 74492 - 74517

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Specific Federal Requirements Governing ASCs

In order to participate in the Medicare program, ASCs are required to meet certain conditions set by the federal government to ensure that the facility is operated in a manner that assures the safety of patients and the quality of services.

ASCs are required to maintain complete, comprehensive and accurate medical records. The content of these records must include a medical history and physical examination relevant to the reason for the surgery and the type of anesthesia planned. In addition, a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and the procedure to be performed. Prior to discharge each patient must be evaluated by a physician for proper anesthesia recovery.

CMS requires ASCs to take steps to ensure that patients do not acquire infections during their care at these facilities. ASCs must establish a program for identifying and preventing infections, maintaining a sanitary environment and reporting outcomes to appropriate authorities. The program must be one of active surveillance and include specific procedures for prevention, early detection, control and investigation of infectious and communicable diseases in accordance with the recommendations of the Centers for Disease Control and Prevention. Thanks to these ongoing efforts, ASCs have very low infection rates.[5]

A registered nurse trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever a patient is in the ASC. To further protect patient safety, ASCs are also required to have an effective means of transferring patients to a hospital for additional care in the event of an emergency. Written guidelines outlining arrangements for ambulance services and transfer of medical information are mandatory. An ASC must have a written transfer agreement with a local hospital, or all physicians performing surgery in the ASC must have admitting privileges at the designated hospital. Although these safeguards are in place, hospital admissions as a result of complications following ambulatory surgery are rare.[5]

Continuous quality improvement is an important means of ensuring that patients are receiving the best care possible. An ASC, with the active participation of its medical staff, is required to conduct an ongoing, comprehensive assessment of the quality of care provided.

The excellent outcomes associated with ambulatory surgery reflect the commitment that the ASC industry has made to quality and safety. One of the many reasons that ASCs continue to be so successful with patients, physicians and insurers is their keen focus on ensuring the quality of the services provided.

Medicare Health and Safety Requirements

Required Standards	ASCs	HOPDs
Compliance with State licensure law	☑	☑
Governing body and management	☑	☑
Surgical services	☑	☑
Quality assessment and performance improvement	☑	☑
Environment	☑	☑
Medical staff	☑	☑
Nursing services	☑	☑
Medical records	☑	☑
Pharmaceutical services	☑	☑
Laboratory and radiologic services	☑	☑
Patient rights	☑	☑
Infection control	☑	☑
Patient admission, assessment and discharge	☑	☑

Source: 42 CFR 416 & 482

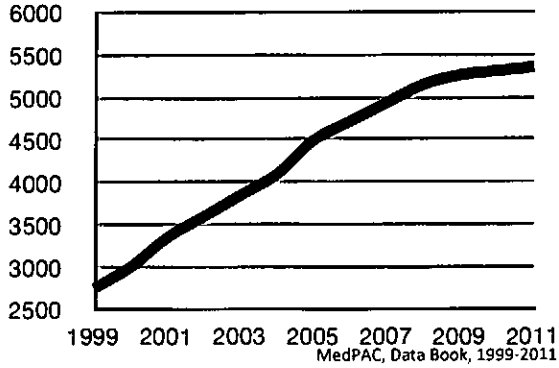
CONTINUED DEMAND FOR ASC FACILITIES

Technological advancement has allowed a growing range of procedures to be performed safely on an outpatient basis (unfortunately, however, Medicare has been slow to recognize these advances and assure that its beneficiaries have access to them). Faster acting and more effective anesthetics and less invasive techniques, such as arthroscopy, have driven this outpatient migration. Procedures that only a few years ago required major incisions, long-acting anesthetics and extended convalescence can now be performed through closed techniques utilizing short-acting anesthetics, and with minimal recovery time. As medical innovation continues to advance, more and more procedures will be able to be performed safely in the outpatient setting.

Over the years, the number of ASCs has grown in response to demand from the key participants in surgical care—patients, physicians and insurers. While this demand has been made possible by technology, it has been driven by patient satisfaction, efficient physician practice, high levels of quality and the cost savings that have benefited all.

However, in a troubling trend, the growth of ASCs has slowed in recent years. If the supply of ASCs does not keep pace with the demand for outpatient surgery that patients require, that care will be provided in the less convenient and more costly hospital outpatient department.[12]

Number of Medicare Certified ASCs



MedPAC, Data Book, 1999-2011

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ASCs CONTINUE TO LEAD INNOVATION IN OUTPATIENT SURGICAL CARE

As a leader in the evolution of surgical care that has led to the establishment of affordable and safe outpatient surgery, the ASC industry has shown itself to be ahead of the curve in identifying promising avenues for improving the delivery of health care.

With a solid track record of performance in patient satisfaction, safety, quality and cost management, the ASC industry is already embracing the changes that will allow it to continue to play a leading role in raising the standards of performance in the delivery of outpatient surgical services.

As always, the ASC industry welcomes any opportunity to clarify the services it offers, the regulations and standards governing its operations, and the ways in which it ensures safe, high-quality care for patients.

POLICY CONSIDERATIONS

Given the continued fiscal challenges posed by administering health care programs, policy makers and regulators should continue to focus on fostering innovative methods of health care delivery that offer safe, high-quality care so progressive changes in the nation's health care system can be implemented.

Support should be reserved for those policies that foster competition and promote the utilization of sites of service providing more affordable care, while always maintaining high quality and stringent safety standards. In light of the many benefits ASCs have brought to the nation's health care system, policymakers should develop and implement payment and coverage policies that increase access to, and utilization of, ASCs.

END NOTES

1 "Ambulatory Surgery Centers." Encyclopedia of Surgery. Ed. Anthony J. Senagore. Thomson Gale, 2004.

2 2004 ASC Salary and Benefits Survey, Federated Ambulatory Surgery Association, 2004.

3 Oxford Outcomes ASC Impact Analysis, 2010.

4 Press-Ganey Associates, "Outpatient Pulse Report," 2008.

5 ASCA Outcomes Monitoring Project, 3rd Quarter 2011.

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BMC Health Services Research

BioMed Central

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Disparities in the use of ambulatory surgical centers: a cross sectional study

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Published: 21 July 2009

BMC Health Services Research 2009, 9:121 doi:10.1186/1472-6963-9-121

Received: 30 March 2009
Accepted: 21 July 2009

This article is available from: http://www.biomedcentral.com/1472-6963/9/121

Abstract

Background: Ambulatory surgical centers (ASCs) provide outpatient surgical services more efficiently than hospital outpatient departments, benefiting patients through lower co-payments and other expenses. We studied the influence of socioeconomic status and race on use of ASCs.

Methods: From the 2005 State Ambulatory Surgery Database for Florida, a cohort of discharges for urologic, ophthalmologic, gastrointestinal, and orthopedic procedures was created. Socioeconomic status was established at the zip code level. Logistic regression models were fit to assess associations between socioeconomic status and ASC use.

Results: Compared to the lowest group, patients of higher socioeconomic status were more likely to have procedures performed in ASCs (OR 1.07 CI 1.05, 1.09). Overall, the middle socioeconomic status group was the most likely group to use the ASC (OR 1.23, CI 1.21 to 1.25). For whites and blacks, higher status is associated with increased ASC use, but for Hispanics this relationship was reversed (OR 0.84 CI 0.78, 0.91).

Conclusion: Patients of lower socioeconomic status treated with outpatient surgery are significantly less likely to have their procedures in ASCs, suggesting that less resourced patients are encountering higher cost burdens for care. Thus, the most economically vulnerable group is unnecessarily subject to higher charges for surgery.

Background

In an effort to lower medical costs and improve the efficiency of health care,[1] increasing numbers of surgeries are being performed on an outpatient basis.[2] Little data exists to guide the decision as to where a procedure should be performed.[3,4] For this reason, the choice of surgical setting is often relegated to patient or provider preference. For many patients, personal spending on health care is a significant concern.[5] Many patients have significant co-payments,[6] and for the 45 million uninsured,[7] the total cost of health care drives treatment decisions. The push towards high deductible health plans will further place the cost of care on patients.[8] Thus, patients increasingly find their personal expenditures to be a significant factor in health care decision making.

Decreasing out of pocket payments is especially important for patients of lower socioeconomic status because the high cost of medical care falls disproportionately on them. Though lower income families spend less out of pocket on health care compared to high income families, the burden of these payments is considerably higher.[9]

In 2003, one third of individuals living below federal poverty standards spent more than 10% of their income on health related expenses.[8] These expenditures have serious consequences, with half of personal bankruptcies related to medical expenses.[10]

Decreasing personal expenditures for medical care can be achieved through the use of ambulatory surgical centers (ASCs). ASCs provide a lower cost alternative to hospitals for the provision of surgical services. [11-13] Medicare increased this cost advantage for more procedures under new reimbursement guidelines instituted in January 2008.[11] Since many insurance companies develop guidelines similar to Medicare reimbursements for their own policies,[14] and encourage their patients to use these environments,[15] patients with co-payments or co-insurance experience substantial reductions in their out of pocket expenses with greater use of ASCs for outpatient surgery.[3,16]

As lower cost alternatives to hospitals, ASCs provide an advantageous environment for patients of lower socioeconomic status to receive outpatient surgery. However, disparities in the use of ASCs, if evident, are likely to have downstream consequences, including higher expenditures for patients with less ability to afford their care. For this reason, we evaluated the extent to which the use of ASCs varied according to socioeconomic status and race/ethnicity.

Methods

Using the Agency for Healthcare Research and Quality's State Ambulatory Surgery Database for Florida, all ambulatory surgery procedures at both hospital based facilities and ASCs were obtained for 2005. The dataset provides patient level discharge data for 100% of the ambulatory patients from facilities in state.[17]

Measuring Socioeconomic Status

The primary exposure of interest was socioeconomic status measured at the level of patient zip codes. Zip code level demographic information was obtained from the US census bureau. Using the method of Diez-Roux,[18] a summary measure of the socioeconomic status at the zip code level was created. Briefly, six constructs were used to represent the socioeconomic status of each small area, including median household income in 1999, the value of owner occupied housing, percent of households with dividend or rental income, the percentage of people who had graduated from high school, the percentage who graduated from college, and the percentage of residents who are employed in managerial, professional, and related occupations. These six components were then standardized into a z-score, and the scores were combined into an overall marker of neighborhood score. The overall scores for zip codes in Florida ranged from -16.19 to 19.43, with higher numbers reflecting more advantaged socioeconomic status. Quintiles of socioeconomic status were then created. Distribution of the components of the neighborhood score is shown in Table 1.

Study Cohort

We limited our scope of study to procedures commonly performed in both ASCs and hospitals, including lower gastrointestinal endoscopy, upper gastrointestinal endoscopy, cataract surgery, knee arthroscopy, and ambulatory urologic procedures, (Appendix 1). These procedures accounted for 1,138,127 of the 2,662,157 total records (43% of all ambulatory surgeries performed in 2005). Of these discharges, full demographic data was available on 1,122,137 discharges (99% of the possible population). These discharges made up our final study population.

Statistical Analysis

We first compared the distribution of variables across socioeconomic status cohorts through the use of chi-square tests. Then we assessed our primary outcome of interest, the location of ambulatory surgical procedures: ASC or hospital. We fit logistic regression models using the quintiles of socioeconomic status as the primary exposure of interest. All models were then adjusted for the type of surgical procedure performed, patient insurance status (Medicare or commercial insurance, no insurance or self-pay, and Medicaid or other governmental insurance), age (20 yr ranges), race/ethnicity (white, black, hispanic, other), gender, comorbidity (based on the Elixhauser method),[19] and the level of urbanization of the patient's neighborhood (five category classification of the Urban Influence Codes).[17] SASD classifies race/ethnicity as white, black, hispanic and we grouped other smaller categories together resulting in four mutually exclusive race/ethnhicity groups. We then tested the significance of interactions between socioeconomic status and race/ethnicity through a second set of models that allowed the impact of socioeconomic status to vary by race/ethnicity. These models were run with interaction terms between the race/ethnicity variable and the quintile of socioeconomic status. The significance of the interaction was tested through the type 3 Wald test of the interaction coefficients.

All analysis was performed with SAS Version 9.1.2 (SAS Institute, Cary, NC) using two-sided tests. The probability of Type 1 error was set at 0.05. This study, dealing with publicly available data was exempt from institutional review board approval in accordance with the Code of Federal Regulations, Title 45, Section 46.101.

Results

Socioeconomic quintiles were balanced with the number of discharges ranging from 208,557 for the lowest group to 236,385 for the highest group (Table 1). The age and

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Table 1: Socioeconomic status characteristics for all discharges available for study (n = 1,138,127)

	Socioeconomic Status (Quintiles)				
	1 (Lowest)	2	3	4	5 (Highest)
Number of Discharges	208557 (18%)	222873 (20%)	236339 (21%)	233973 (21%)	236385 (21%)
Median SES Summary Score (range)	-3.9 (-16.2 to -1.9)	-0.8 (-1.9 to 0.2)	1.1 (0.2 to 2.2)	3.6 (2.3 to 4.9)	7.5 (5.0 to 19.4)
Wealth/Income					
Median household income ($)	29621	34732	37972	41899	55292
Median value of housing units ($)	73500	87600	97600	123200	170400
Households with interest, dividend, or rental income	23%	32%	38%	44%	53%
Education					
Adult residents who completed ≥ high school	67%	77%	82%	87%	92%
Adult residents who completed ≥ college	16%	22%	27%	35%	48%
Employment					
Employed residents with management, professional, and related occupations	21%	26%	29%	36%	45%

racial structures of the cohorts varied significantly with the lowest socioeconomic status groups being younger and more ethnically diverse than the higher groups (Table 2). Medicaid and other governmental insurance was more prevalent in the lowest socioeconomic status group compared to higher groups (11% in lowest versus 3% in highest; $p < 0.001$). Use of ASCs was lowest for the lowest socioeconomic group (60%) versus the other groups (64% to 67% $p < 0.001$).

The likelihood of an individual's surgery being performed in a freestanding ASCs varied by their socioeconomic status (Table 3). In unadjusted analysis, patients of the lowest socioeconomic status were significantly less likely to use the ASC than patients of higher status. Adjustment for age, race, gender, insurance, comorbidity, procedural, and urbanization differences decreased the magnitude of the effect of socioeconomic status on the location of surgery. However, the lowest status group continued to be significantly less likely to use the ASC than more advantaged patient groups. Overall, the middle socioeconomic status group was the most likely group to use the ASC (OR 1.23, CI 1.21 to 1.25).

Significant interactions were found between socioeconomic status groups and race. Using the lowest quintile group as the reference, we found that for both black and white patients the likelihood of having surgery performed in an ASC increased from the lowest socioeconomic status group to the higher groups (Table 4). For Hispanic patients, the trends in ASC use were reversed. Patients from higher socioeconomic status groups were less likely to have procedures performed in ASCs compared to patients from lower groups. Using the lowest group as the reference, the OR for surgery in an ASC ranged from 0.89 (95% CI 0.83, 0.95) for the 2nd quintile to 0.84 (95% CI 0.78, 0.91) for the 5th quintile. For patients of other racial/ethnic groups, ASC use did not appear to vary by socioeconomic status.

Discussion

Disadvantaged populations, as measured by zip code level socioeconomic status, are more likely to have outpatient surgery performed in hospitals than in ASCs. Patient race and ethnicity appear to modify the association between socioeconomic status and ASC use. For black and white patients, increased socioeconomic status continues to be significantly associated with ASC use. Conversely, Hispanic patients from lower socioeconomic status areas were more likely to use ASCs compared those residing in the higher groups. Because of the cost savings provided by ASC use for patients through lower overall costs and lower

Table 2: Patient characteristics by socioeconomic status quintile * All p-values based on Wald chi-square tests.

	Socioeconomic Status (Quintiles)					p-value*
	1 (Lowest)	2	3	4	5 (Highest)	
Number of Discharges	208557 (18%)	222873 (20%)	236339 (21%)	233973 (21%)	236385 (21%)	
No. at ASC	124183 (60%)	143567 (64%)	157743 (67%)	151954 (65%)	152636 (65%)	<0.001
Procedure						<0.001
Cataract Surgery	49360 (24%)	52094 (23%)	55089 (23%)	53681 (23%)	49351 (21%)	
Urologic	26881 (13%)	27327 (12%)	29075 (12%)	28349 (12%)	27520 (12%)	
Upper GI	35659 (17%)	35800 (16%)	37711 (16%)	35453 (15%)	32941 (14%)	
Lower GI	87010 (42%)	96355 (43%)	102946 (44%)	104226 (45%)	113070 (48%)	
Knee Arthroscopy	9647 5%)	11297 (5%)	11518 (5%)	12264 (5%)	13503 (6%)	
Age						<0.001
≤ 19	7750 (4%)	6442 (3%)	5659 (2%)	5489 (2%)	6064 (3%)	
20–39	16006 (8%)	16211 (7%)	15474 (7%)	15600 (7%)	14902 (6%)	
40–59	62732 (30%)	64420 (29%)	66793 (28%)	67199 (29%)	75172 (32%)	
60–79	100871 (48%)	108634 (49%)	117674 (50%)	113312 (48%)	110414 (47%)	
80+	21198 (10%)	27166 (12%)	30739 (13%)	32373 (14%)	29833 (13%)	
Race/Ethnicity						<0.001
White	130718 (63%)	174813 (79%)	197407 (85%)	197427 (85%)	204753 (88%)	
Black	35198 (17%)	16886 (8%)	10097 (4%)	8661 (4%)	5981 (3%)	
Hispanic	34416 (17%)	22541 (10%)	20216 (9%)	18205 (8%)	13576 (6%)	
Other	5555 (3%)	5930 (3%)	5805 (2%)	6638 (3%)	7620 (3%)	
Insurance Status						<0.001
Medicare/Commercial	180433 (87%)	201681 (91%)	218819 (93%)	218483 (93%)	224437 (95%)	
Self Pay/No Insurance	5741 (3%)	4790 (2%)	4027 (2%)	4251 (2%)	4000 (2%)	
Medicaid/Other Governmental	22361 (11%)	16361 (7%)	13448 (6%)	11194 (5%)	7902 (3%)	
No. Female	114616 (55%)	120988 (54%)	126251 (53%)	123491 (53%)	120934 (51%)	<0.001
Comorbidity						<0.001
0	165450 (79%)	182736 (82%)	194925 (82%)	194940 (83%)	199529 (84%)	

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Table 2: Patient characteristics by socioeconomic status quintile * All p-values based on Wald chi-square tests. *(Continued)*

1	26321 (13%)	25967 (12%)	26726 (11%)	26442 (11%)	25436 (11%)
2	12134 (6%)	10531 (5%)	10763 (5%)	9463 (4%)	8691 (4%)
3+	4651 (2%)	3639 (1%)	3925 (2%)	3128 (2%)	2729 (1%)
Urban/Rural					<0.001
Non-Urban adjacent to urban (ref)	108704 (52%)	121515 (55%)	122051 (52%)	130293 (56%)	152543 (65%)
Large Metropolitan	56499 (27%)	86496 (39%)	101347 (43%)	96531 (41%)	83842 (35%)
Small Metropolitan	25063 (12%)	13396 (6%)	12330 (5%)	6322 (2%)	0
Micropolitan	18291 (9%)	1466 1%)	611 (<1%)	827 (<1%)	0

* All p-values based on Wald chi-square tests.

co-payments,[20] ASC use would be especially important for patients of the lowest socioeconomic status groups.

Given the improved efficiencies of ASCs over hospital outpatient departments, patients could be expected to abandon hospital based outpatient surgery. However, such a trend has not developed. Instead hospital use for outpatient surgery has remained stable, and use of ASCs has grown.[21] Barriers to the use of ASCs may exist that keep certain groups of patients in hospital outpatient departments.

One possible barrier raised by our results is patient profiling. Such profiling may be valid as in selecting patients with less comorbidity for surgery in ASCs,[22] or may be inappropriate if barriers are created for groups based on economic status, race, or ethnicity. [23-25] Since the findings of decreased ASC use in the least affluent patients were robust to control for comorbidity, sources of inappropriate profiling need to be considered.

Data from observation of physician encounters with patients supports the contention that patient profiling based on race and ethnicity may be responsible for differences in ASC use. These studies show that physicians will often recommend different procedures for the same clinical situation when the race or gender of the patient is changed.[26] In addition, economic profiling of patients by the physician may occur. Since most ASCs are for profit enterprises with significant physician ownership,[27,28] physicians have active incentives to ensure high reimbursement through these facilities. As such, similar to results seen for specialty hospitals,[29] they may discourage the use of ASCs among patients with poor insurance and lower socioeconomic status.

In addition to physician factors, structural factors in the health care system may be responsible for the utilization patterns found. As for profit enterprises,[28] investors in ASCs have financial incentives to avoid ventures where lack of reimbursement potential is perceived. These facilities may not be established in areas of lower socioeconomic status due to investor concerns about the insurance mix in the population. Thus, a physical barrier to ASC use based on community economic profiling may exist that limits the access of less advantaged patients to ASCs.

Table 3: Likelihood of procedure being performed in an ASC (Odds Ratio with 95% CI)

Socioeconomic Status (Quintiles)	Crude OR (95%CI)	Adjusted OR (95%CI)*
1st (Lowest)	reference	reference
2nd	1.23 (1.22, 1.25)	1.13 (1.12, 1.15)
3rd	1.36 (1.35, 1.38)	1.23 (1.21, 1.25)
4th	1.26 (1.24, 1.27)	1.08 (1.06, 1.09)
5th (Highest)	1.24 (1.22, 1.25)	1.07 (1.05, 1.09)

* Adjusted for Age, Race, Gender, Insurance Status, Type of Procedure, Comorbidity, and Level of Urbanization. Models based on n = 1,122,137 discharges

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Table 4: Racial/Ethnic Differences in Location of Surgery

Socioeconomic Status (Quintiles)	White OR (95% CI)*	Black OR (95% CI)*	Hispanic OR (95% CI)*	Other OR (95% CI)*
1st (Lowest)	reference	reference	reference	reference
2nd	1.20 (1.13, 1.27)	1.24 (1.16, 1.33)	0.89 (0.83, 0.95)	1.04 (1.01, 1.07)
3rd	1.28 (1.20, 1.36)	1.28 (1.18, 1.38)	1.10 (1.02, 1.18)	1.13 (1.10, 1.16)
4th	1.14 (1.07, 1.21)	1.03 (0.95, 1.11)	0.88 (0.82, 0.94)	0.95 (0.92, 0.98)
5th (Highest)	1.13 (1.06, 1.20)	1.17 (1.07, 1.27)	0.84 (0.78, 0.91)	0.98 (0.95, 1.00)

* reflects interaction between Socioeconomic Status and Race/Ethnicity adjusted for Age, Gender, Insurance Status, Type of Procedure, Comorbidity, and Level of Urbanization Models based on n = 1,122,137 discharges

Regardless of the cause of the disparity, the findings in this study support the contention that more financially vulnerable groups are encountering a higher aggregate cost burden for their care than more advantaged groups. The benefits of ASCs in cost, convenience, and efficiency are not equitably distributed. Both physician and structural factors may be ultimately responsible for the association between socioeconomic status and ASC utilization found in this paper. Indeed, the finding of different effects of race on the likelihood of ASC use by socioeconomic status could be a result of either physician level or system level factors. Further research into the underlying reasons for these observations is needed to correct these biases in the delivery of health care.

Study Limitations

Zip code tabulation areas (ZCTAs) were used to geocode the discharge records. Zip code level evaluations of socioeconomic status have been demonstrated to result in different parameter estimates than evaluations based on census block groups. With the larger population base in zip codes, estimates would likely be biased towards the null. Furthermore, since ZCTAs were used as the geographic unit of analysis in this study, spatial and temporal discrepancies between the zip codes reported in the SASD and the ZCTA from the census bureau exist. ZCTAs and zip codes may share the same 5 digit code while not representing the same geographic entity.[30] Usually, the spatial discontinuity between these measures of geography is small.[31,32] A potentially larger problem exists in zip code changes over time. While we used data with patient reported zip code information from 2005, the ZCTAs were last updated in 2002.[32] Thus, there is potential for mismatch between the two measures of geography. However, less than one percent of our cohort was lost due to issues of missing data, suggesting that the temporal discontinuity issue was not a significant factor in our study.

A further issue to be addressed is our inclusion of only one state, Florida, in the analysis. Florida has a more elderly population than many other states, more for profit facility ownership, no certificate of need requirements, and higher per capita health care use than other states. Despite these issues, data from Florida provided a valuable substrate for our study due to the ability to gather discharges from both the ASC and hospital environments. Furthermore, the factors that make Florida a potentially unique market, including the lack of certificate of need requirements, allow us to see ASC utilization patterns independent of regulatory forces. ASC use, and disparities in use, may be lower in states with certificate of need requirements.

Finally, patients of lower socioeconomic status often carry high burdens of comorbid illness and more severe underlying disease.[33,34] As such, they may be less appropriate candidates on average for surgery in ASCs. Although we correct for comorbidity in our analysis, subtle differences in severity of comorbid conditions cannot be addressed and may result is residual confounding. However, we believe the impact of these issues is minimized as all patients in the study had ambulatory surgery.

Conclusion

Regardless of the cause of the disparity, patients of lower socioeconomic status likely encounter a higher cost burden for their care than people from more advantaged neighborhoods. The benefits of ASCs in cost, convenience, and efficiency are not equitably distributed. Both physician and structural factors may be ultimately responsible for the association between socioeconomic status and ASC utilization found in this paper. Indeed, the finding of different effects of race on the odds of surgery in an ASC by socioeconomic status could be a result of either physician level or system level factors. Further research into the underlying reasons for these disparities is needed to correct this inequity in health care.

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Competing interests

The authors declare that they have no competing interests.

Authors' contributions

SS conceived of the study, performed data acquisition, provided data analysis, and drafted the paper. AS helped draft the manuscript. ZY assisted in data acquisition and data analysis. JW assisted in manuscript preparation. BH assisted in study conception, data analysis, and manuscript preparation. All authors read and approved the final manuscript.

Acknowledgements

SAS is supported by National Institutes of Health (T32 DK007782-08)

References

1. CMS: **Medicare program; hospital outpatient prospective payment system and CY 2007 payment rates; CY 2007 update to the ambulatory surgical center covered procedures list; Medicare administrative contractors; and reporting hospital quality data for FY 2008 inpatient prospective payment system annual payment update program–HCAHPS survey, SCIP, and mortality. Final rule with comment period and final rule.** *Fed Regist* 2006, **71(226)**:67959-68401.
2. Schappert SM, Burt CW: **Ambulatory care visits to physician offices, hospital outpatient departments, and emergency departments: United States, 2001–02.** *Vital Health Stat 13* 2006:1-66.
3. Casalino LP, Devers KJ, Brewster LR: **Focused Factories? Physician-Owned Specialty Facilities.** *Health Aff* 2003, **22(6)**:56-67.
4. Vila H Jr, Soto R, Cantor AB, Mackey D: **Comparative outcomes analysis of procedures performed in physician offices and ambulatory surgery centers.** *Arch Surg* 2003, **138(9)**:991-995.
5. Alexander GC, Casalino LP, Meltzer DO: **Patient-physician communication about out-of-pocket costs.** *Jama* 2003, **290(7)**:953-958.
6. Gabel J, Claxton G, Gil I, Pickreign J, Whitmore H, Finder B, Hawkins S, Rowland D: **Health benefits in 2005: premium increases slow down, coverage continues to erode.** *Health Aff (Millwood)* 2005, **24(5)**:1273-1280.
7. DeNavas-Walt C, Proctor BD, Lee CH: **Income, Poverty, and Health Insurance Coverage in the United States: 2004.** *Volume P60.* Edited by Bureau USC: U.S. Government Printing Office; 2005.
8. Banthin JS, Bernard DM: **Changes in financial burdens for health care: national estimates for the population younger than 65 years, 1996 to 2003.** *Jama* 2006, **296(22)**:2712-2719.
9. Shen YC, McFeeters J: **Out-of-pocket health spending between low-and higher-income populations: who is at risk of having high expenses and high burdens?** *Med Care* 2006, **44(3)**:200-209.
10. Himmelstein DU, Warren E, Thorne D, Woolhandler S: **Illness and injury as contributors to bankruptcy.** *Health Aff (Millwood)* 2005, W5-63-W65-73.
11. **Medicare program; revised payment system policies for services furnished in ambulatory surgical centers (ASCs) beginning in CY 2008. Final rule.** *Fed Regist* 2007, **72(148)**:42469-42626.
12. **Medicare program: changes to the hospital outpatient prospective payment system and CY 2008 payment rates, the ambulatory surgical center payment system and CY 2008 payment rates, the hospital inpatient prospective payment system and FY 2008 payment rates; and payments for graduate medical education for affiliated teaching hospitals in certain emergency situations Medicare and Medicaid programs: hospital conditions of participation; necessary provider designations of critical access hospitals. Interim and final rule with comment period.** *Fed Regist* 2007, **72(227)**:66579-67226.
13. **Payment for procedures in outpatient departments and ambulatory surgical centers.** *OIG Report OEI-05-00-00340* 2003.
14. Marks SD, Greenlick MR, Hurtado AV, Johnson JD, Henderson J: **Ambulatory surgery in an HMO. A study of costs, quality of care and satisfaction.** *Med Care* 1980, **18(2)**:127-146.
15. Kamil J: **Are cost controls bad medicine? NO: Managing resources can save more lives.** *San Francisco Chronicle. San Francisco* 2006:11.
16. Herzlinger RE: **Specialization and Its Discontents: The Pernicious Impact of Regulations Against Specialization and Physician Ownership on the US Healthcare System.** *Circulation* 2004, **109(20)**:2376-2378.
17. **Introduction to the HCUP State Ambulatory Surgery Database (SASD)** [http://www.hcup-us.ahrq.gov/db/state/sasddist/Introduction_to_SASD.pdf]
18. Diez Roux AV, Merkin SS, Arnett D, Chambless L, Massing M, Nieto FJ, Sorlie P, Szklo M, Tyroler HA, Watson RL: **Neighborhood of residence and incidence of coronary heart disease.** *N Engl J Med* 2001, **345(2)**:99-106.
19. Elixhauser A, Steiner C, Harris DR, Coffey RM: **Comorbidity measures for use with administrative data.** *Med Care* 1998, **36(1)**:8-27.
20. Lynk WJ, Longley CS: **The effect of physician-owned surgicenters on hospital outpatient surgery.** *Health Aff* 2002, **21(4)**:215-221.
21. Strope SA, Daignault S, Hollingsworth JM, Ye Z, Wei JT, Hollenbeck BK: **Physician ownership of ambulatory surgery centers and practice patterns for urological surgery: Evidence from the State of Florida.** *Medical Care* 2008, **47(4)**:403-10.
22. Winter A: **Comparing The Mix Of Patients In Various Outpatient Surgery Settings.** *Health Aff* 2003, **22(6)**:68-75.
23. LaVeist TA, Morgan A, Arthur M, Plantholt S, Rubinstein M: **Physician referral patterns and race differences in receipt of coronary angiography.** *Health Serv Res* 2002, **37(4)**:949-962.
24. Ibrahim SA, Whittle J, Bean-Mayberry B, Kelley ME, Good C, Conigliaro J: **Racial/ethnic variations in physician recommendations for cardiac revascularization.** *Am J Public Health* 2003, **93(10)**:1689-1693.
25. Gordon HS, Street RL Jr, Sharf BF, Souchek J: **Racial differences in doctors' information-giving and patients' participation.** *Cancer* 2006, **107(6)**:1313-1320.
26. Schulman KA, Berlin JA, Harless W, Kerner JF, Sistrunk S, Gersh BJ, Dube R, Taleghani CK, Burke JE, Williams S, *et al.*: **The effect of race and sex on physicians' recommendations for cardiac catheterization.** *N Engl J Med* 1999, **340(8)**:618-626.
27. **2004 ASC Salary and Benefits Survey, Federated Ambulatory Surgery Association** [http://www.ascassociation.org/advocacy/]
28. Becker S, Biala M: **Ambulatory surgery centers – current business and legal issues.** *Journal of Health Care Finance* 2000, **27(2)**:1-7.
29. Cram P, Pham HH, Bayman L, Vaughan-Sarrazin M: **Insurance status of patients admitted to specialty cardiac and competing general hospitals: are accusations of cherry picking justified?** *Med Care* 2008, **46(5)**:476-475.
30. Krieger N, Waterman P, Chen JT, Soobader MJ, Subramanian SV, Carson R: **Zip code caveat: bias due to spatiotemporal mismatches between zip codes and US census-defined geographic areas – the Public Health Disparities Geocoding Project.** *Am J Public Health* 2002, **92(7)**:1100-1102.
31. Grubesic TH, Matisziw TC: **On the use of ZIP codes and ZIP code tabulation areas (ZCTAs) for the spatial analysis of epidemiological data.** *Int J Health Geogr* 2006, **5**:58.
32. **Zip Code Tabulation Areas (ZCTAs).** *U.S. Census Bureau* 2008.
33. Byers TE, Wolf HJ, Bauer KR, Bolick-Aldrich S, Chen VW, Finch JL, Fulton JP, Schymura MJ, Shen T, Van Heest S, *et al.*: **The impact of socioeconomic status on survival after cancer in the United States: findings from the National Program of Cancer Registries Patterns of Care Study.** *Cancer* 2008, **113(3)**:582-591.
34. Marengoni A, Winblad B, Karp A, Fratiglioni L: **Prevalence of chronic diseases and multimorbidity among the elderly population in Sweden.** *Am J Public Health* 2008, **98(7)**:1198-1200.

Pre-publication history

The pre-publication history for this paper can be accessed here:

http://www.biomedcentral.com/1472-6963/9/121/prepub

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Medicare Cost Savings Tied to Ambulatory Surgery Centers

ASCA
Ambulatory Surgery Center Association

Produced with cost savings analysis from Berkeley UNIVERSITY OF CALIFORNIA

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Acknowledgements

Dr. Brent Fulton, Assistant Adjunct Professor and Research Economist, and Dr. Sue Kim, Research Scientist, both from the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California-Berkeley, conducted the cost savings analysis presented in this report.

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Table of Contents

EXECUTIVE SUMMARY

Even in today's divisive political environment, there's at least one important area of consensus among policymakers: the threat posed by rising health care costs to both our national economy and the federal and state governments' balance sheets. This concern is particularly acute in the Medicare program, where costs are expected to rise dramatically as new treatments are developed and a generation of Baby Boomers enters retirement. Burgeoning health care costs, it seems certain, will be near the top of Washington, DC's agenda for years to come.

As they work to reduce health care costs and extend the solvency of programs like Medicare, policymakers will confront tough choices in the months and years ahead. Yet, they must also be alert for reforms that cut costs while maintaining quality services for beneficiaries. This analysis by Professor Brent Fulton and Dr. Sue Kim of the University of California at Berkeley explores one possible way for policymakers to generate substantial Medicare savings without reducing services or quality of care.

This study examines ambulatory surgery centers (ASCs). ASCs are technologically advanced medical facilities that provide same-day surgical procedures, including important diagnostic and preventive services like colonoscopies. Today, more than 5,300 Medicare-certified ASCs serve communities throughout our nation. These ASCs perform many of the same procedures as hospital outpatient departments (HOPDs). ASCs, however, are able to provide care much more efficiently and without the often costly overhead associated with hospitals. According to an industry calculation, the Medicare program currently reimburses ASCs at 58 percent of the HOPD rate, meaning that Medicare—and the taxpayers who fund it—realize savings every time a procedure is performed in an ASC instead of an HOPD.

When one considers the millions of same-day surgical procedures performed in ASCs through the Medicare program each year, the nationwide savings add up quickly. In this study, University of California at Berkeley's Professor Brent Fulton and Dr. Sue Kim analyze the numbers to determine how much ASCs save the Medicare program and its beneficiaries. They begin by analyzing government data to identify how much money ASCs saved Medicare in recent years, and then, forecast how much more ASCs will save Medicare in the future. The key findings are the following:

- During the four-year period from 2008 to 2011, ASCs saved the Medicare program and its beneficiaries $7.5 billion. ASCs saved Medicare and its beneficiaries $2.3 billion in 2011 alone.

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- $6 billion of these savings were realized by the federal Medicare program. The remaining $1.5 billion went directly to Medicare beneficiaries. In other words, Medicare patients nationwide saved $1.5 billion thanks to the less expensive care offered at ASCs.
- ASCs have the potential to save the Medicare program and its beneficiaries up to $57.6 billion more over the next decade.
- Beneficiaries themselves also stand to save considerably in future years. Because Medicare reimburses ASCs at a lower rate than HOPDs, patients also pay a smaller coinsurance amount in an ASC. The authors use the example of cataract surgery, noting that a Medicare beneficiary will save $148 on his or her coinsurance by electing to undergo surgery in an ASC instead of a hospital.

These findings have important implications for policymakers' ongoing discussion about how to most effectively reduce health care costs and the national budget deficit. The clearest implication is that, while public officials may indeed confront tough choices in the years ahead, the choice to encourage ASC use within the Medicare program is an easy decision. These findings suggest that ASCs offer a "win-win" for patients and the Medicare system, since they provide substantial savings without any corresponding reduction in quality or benefits.

While the future savings offered by ASCs are easily attainable, however, they are not inevitable. Indeed, a discrepancy in Medicare reimbursement policy could jeopardize the savings ASCs provide. Medicare uses two different factors to update ASC and HOPD payments—despite the fact that the two settings provide the same surgical services. ASC payments are updated based on the consumer price index for all urban consumers (CPI-U), which measures changes in the costs of all consumer goods; HOPD rates, meanwhile, are updated on the hospital market basket, which specifically measures changes in the costs of providing health care, and so, more accurately reflects the increased costs that outpatient facilities face.

Since consumer prices have inflated more slowly than medical costs, the gap in ASC and HOPO reimbursement rates has widened over time. If the reimbursement rate for ASCs continues to fall relative to their HOPD counterparts, ASC owners and physicians will face increasing pressure to leave the Medicare system and allow their facilities to be acquired by nearby hospitals. When an ASC is acquired by a hospital, the Medicare reimbursement rate jumps roughly 75 percent. This threatens to turn the cost-saving advantage of ASCs into a perverse market incentive that drives ASCs from the Medicare program.

Already, the widening disparity in reimbursement has led more than 60 ASCs to terminate their participation in Medicare over the last three years. If the reimbursement gap continues to widen, more ASCs will leave the Medicare program. As a result, more Medicare cases will be driven to the HOPD, causing costs to both the Medicare program and its beneficiaries to rise.

Thus, realizing the full potential savings that ASCs offer will likely require policymakers to step in and halt this continuing "slide" in ASC reimbursement rates. Because Medicare saves money virtually every time a procedure is performed in an ASC instead of an HOPD, any policies that reduce the widening reimbursement gap between ASCs and HOPOs, and that otherwise encourage the migration of cases from the hospital setting into ASCs, will increase total savings for the Medicare program and its beneficiaries.

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I. AN INTRODUCTION TO AMBULATORY SURGERY CENTERS

Only 40 years ago, virtually all surgeries and diagnostic procedures were performed in hospitals. Today, however, standalone facilities known as Ambulatory Surgery Centers (ASCs) provide outpatient surgical care in an atmosphere removed from the competing demands that are often encountered in an acute care hospital.

ASCs, as this report details, offer patients a cost-effective alternative to hospital outpatient departments (HOPDs). The first ASC opened in 1970, and today, there are more than 5,300 Medicare-certified ASCs in the United States. The overwhelming majority of these ASCs are at least partially owned by physicians, which allows for better control over scheduling, as procedures are not often delayed or rescheduled due to staffing issues or competing demands for operating room space from emergency cases.

ASC surgeons perform a diverse range of procedures, many of them diagnostic or preventive in nature. For example:

- ASCs perform more than 40 percent of all Medicare colonoscopies, contributing to a decade-long decline in colorectal cancer mortality.
- The ASC industry also led the development of minimally invasive procedures and the advancement of technology to replace the intraocular lens, a procedure that is now used nearly one million times each year to restore vision for Medicare patients with cataracts. Once an inpatient hospital procedure, it can now be performed safely at an ASC at a much lower cost.

Ambulatory Surgery Centers are modern health care facilities focused on providing a range of same-day surgical care, the same types of procedures that were once performed exclusively in hospitals. Today, as a result of medical advancements and new technologies—including minimally invasive surgical techniques and improved anesthesia—a range of procedures can be performed safely and effectively on an outpatient basis.

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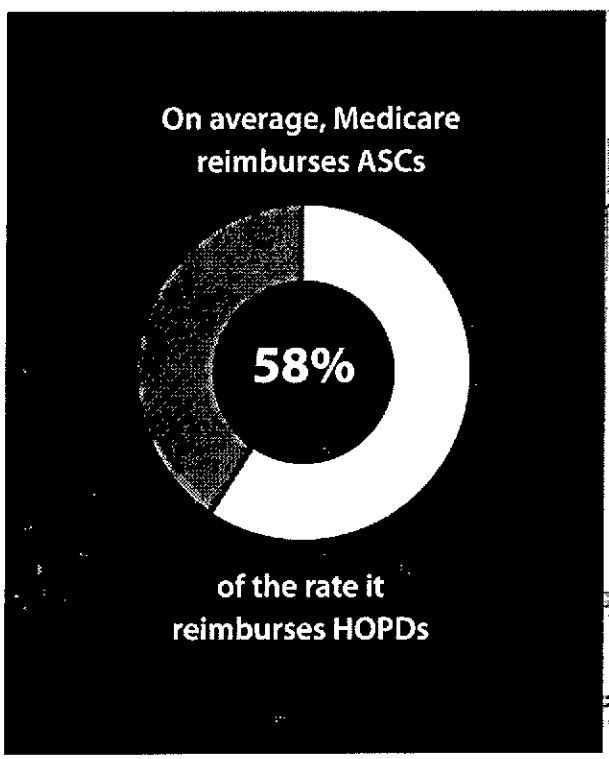
II. ASCS: SAVING THE SYSTEM

The more than 5,300 Medicare-certified ASCs in the United States today provide identical services to those performed at HOPDs throughout the country. ASCs are able to perform these surgeries much more efficiently than HOPDs. ASCs do not incur the often substantial administrative and overhead costs associated with a hospital. This enables ASCs to provide these services at substantially less cost to the Medicare program—and to its beneficiaries—than their hospital counterparts.

Today, Medicare reimburses ASCs at an average of 58 percent of the rate it reimburses HOPDs for the same procedures.

The savings that accrue over time, even for individual procedures, are significant. For example, in 2011, Medicare beneficiaries (excluding Medicare Advantage beneficiaries) had 1,709,175 cataract surgeries, of which, 1,120,388 were performed in ASCs and the other 588,787 in HOPDs. The parallel reimbursements per surgery were $951 for an ASC and $1,691 for an HOPO, meaning that every time a patient elected to receive treatment in an ASC, the Medicare program saved $740. When applied across the 1,120,388 cataract surgeries performed in ASCs during 2011, the total savings for this single procedure reached $829 million.



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III. COST SAVINGS ANALYSIS

Data and Methodology

Professor Fulton and Dr. Kim conducted the following analysis, which looks at government data from the Centers for Medicare & Medicaid Services (CMS), to answer two fundamental questions. First, how much money did the Medicare program and its beneficiaries save from 2008 to 2011 because surgical and diagnostic procedures were performed at ASCs instead of HOPDs? Second, how much more could the Medicare program and its beneficiaries save over the next decade (2013–2022) if additional procedures move from HOPDs to the ASC setting during that timeframe?

Government data was used to ascertain the volume of procedures performed in ASCs, HOPDs and physician offices from 2008 through 2011, as well as the reimbursement rates for procedures done at ASCs and HOPDs. The volume data reports are from the Medicare Physician Supplier Procedure Specific file available from CMS. It excludes Medicare Advantage enrollees. The ASC reimbursement rates are from the ASC Addendum AA[1], and the HOPD reimbursement rates are from Hospital Outpatient Prospective Payment System Addendum.[2]

When forecasting future cost savings, the Berkeley analysts relied on CMS' predicted number of Medicare beneficiaries from 2013 to 2022. This data set also excludes Medicare Advantage enrollees.[3]

To ensure a realistic baseline for their analysis and predictions, the analysts limited the data set to the 120 procedures most commonly performed at ASCs in 2011, which represented 73 percent of the total volume of all procedures performed in ASCs in 2011.[4]

Past Savings

To estimate the savings generated by ASCs from 2008 to 2011, the analysts calculated the differences in reimbursement rates for each of the 120 procedures, then multiplied those differences by the number of procedures performed at ASCs. For example, the cataract surgery discussed in the previous section, when performed in an ASC, generated a total of $829 million in savings in 2011. They applied the same method for all of the 120 procedures in each year from 2008 to 2011. They broke the numbers into savings that accrued to the Medicare program and savings that directly benefited beneficiaries. The beneficiary share of the total savings was 20 percent over the four-year period. Professor Fulton's and Dr. Kim's analysis found the following:

- During the four-year period from 2008 to 2011, the lower ASC reimbursement rate generated a total of $7.5 billion in savings for the Medicare program and its beneficiaries.
- $6 billion of these savings were realized by the federal Medicare program. The remaining $1.5 billion was saved by Medicare beneficiaries themselves. In other words, Medicare patients nationwide saved $1.5 billion thanks to the less expensive care offered at ASCs.
- These savings increased each year, rising from $1.5 billion in 2008 to $2.3 billion in 2011. The increase results from the total number of procedures growing from 20.4 million to 24.7 million (or 6.6 percent annually) between 2008 and 2011 as well as the reimbursement rate gap widening between HOPDs and ACSs. These savings were realized despite the share of total Medicare procedures performed in ASCs decreasing over this period, falling from 22.9 percent in 2008 to 21.7 percent in 2011.

1 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html
2 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html
3 http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2011.pdf (p.51).
4 The data set was initially narrowed to 148 procedures, which represented about 90% of the total volume. Twenty-seven procedures were dropped because of missing data on the number of procedures or reimbursement rates. One additional procedure was dropped the ASC share was 100%, and it thus provided no basis for comparison with HOPDs.

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These findings are illustrated in the following chart.

Descriptor	Annual Change	Total (2008—2011)	2008	2009	2010	2011
Number of procedures per 1,000 Medicare beneficiaries	5.6%		573.9	587.3	600.3	674.9
Procedures (million)						
ASC	4.7%	19.5	4.7	4.7	4.8	5.4
HOPD	5.9%	22.3	5.3	5.3	5.4	6.3
Physician office	7.7%	45.5	10.4	10.8	11.3	13.0
Total # of procedures	6.6%	87.3	20.4	20.8	21.5	24.7
ASC share*	1.5%	22.3%	22.9%	22.7%	22.3%	21.7%
Savings ($billion) **						
Program	16.6%	$6.0	$1.2	$1.4	$1.5	$1.9
Beneficiaries	14.8%	$1.5	$0.3	$0.4	$0.4	$0.5
Total***	16.3%	$7.5	$1.5	$1.8	$1.9	$2.3

Notes:

*The ASC share reported in the table is influenced by (or weighted for) high-volume procedures, such as cataracts. The analysts also calculated the ASC share based on a simple average across the 120 procedures. The ASC shares for 2008 to 2011 were 30.4%, 31.0%, 31.4% and 31.8%, respectively, each year, and averaged 31.1% over the four years.

**Savings are reported in nominal dollars.

***Totals may not sum and percentages may not total to 100% due to rounding.

Future Savings

The ASC industry is certain to continue generating savings to both the Medicare program and its beneficiaries over the next decade. The magnitude of these savings, however, will hinge on whether, and how much, the ASC share of surgeries grows within the Medicare program. That growth rate will, in turn, depend on market trends, demographic factors and how policymakers act—or decline to act—to encourage the use of ASCs within the Medicare program.

To estimate the savings Medicare would realize from having more procedures performed in ASCs from 2013 to 2022, Professor Fulton and Dr. Kim applied the methodology above to six scenarios. These six scenarios, which incorporate different assumptions about both the growth of ASC share and the overall growth of Medicare procedure rates, provide a range of possible savings offered by ASCs in the next decade.

The analysts divided the scenarios into two subsets. For subset A, they assumed that the number of procedures per 1,000 Medicare beneficiaries would remain constant at the 2010 rate. For subset B, they assumed that the 2011 rate would increase by 3 percent annually for each procedure.[5] Within each subset, the analysts examined three scenarios:

1. The ASC share of each procedure in 2011 will remain constant between 2013 and 2022. *This is a baseline assumption that assumes ASC share does not grow at all in the coming decade.*

2. The ASC share of each procedure will increase by 2 percent per year from 2013 through 2022, equivalent to the average increase across procedures from 2008 through 2011.[6] The analysts capped the share for any given procedure at 90 percent to avoid implausible assumptions.

3. The ASC share growth for each procedure will vary depending on that procedure's historical share growth rate. The analysts assumed three growth rates and, again, capped the share for any single procedure at 90 percent.

   - The "low" group included procedures that had negative or no growth in the share of procedures performed at ASCs during 2008–2011. The analysts assumed that the ASC share of these procedures will increase 1 percent annually from 2013–2022. This group included approximately 30 percent of the procedures.

   - The "middle" group included procedures that had up to 5 percent growth in share of procedures performed at ASCs during 2008–2011. It was assumed that the ASC share of these procedures will increase 5 percent annually from 2013–2022. This group included approximately 43 percent of the procedures.

   - The "high" group included procedures that had greater than 5 percent growth in share of procedures performed at ASCs during 2008–2011. This group had a median ASC share growth rate of about 11 percent annually during 2008–2011. The analysts projected that the ASC share of these procedures will increase 10 percent annually from 2013–2022. This group included approximately 27 percent of the procedures.

The estimated savings are tabulated in the following table. The savings analysis and predictions for each individual procedure are tabulated in the appendix.

5 The number of procedures per 1,000 Medicare beneficiaries significantly increased between 2010 and 2011 (see table on page 9). For the lower-savings estimates (subset A), the lower 2010 rate was used as a baseline. For the higher-savings estimates (subset B), the 2011 rate was used as the baseline.

6 The 2% annual average increase is based on a simple average across the 120 procedures, meaning the average is not influenced by (or weighted for) for high-volume procedures, such as cataracts.

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Projected Savings ($Billion)	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-2017	2018-2022	2013-2022
A. Volume of Procedures per 1,000 Medicare Beneficiaries Remains Constant and:													
A1. ASC share remains constant	$2.3	$2.5	$2.8	$3.0	$3.2	$3.3	$3.5	$3.7	$4.0	$4.2	$13.7	$18.7	$32.5
A2. ASC share increases at 2% annually	$2.4	$2.7	$3.0	$3.3	$3.6	$3.8	$4.1	$4.4	$4.8	$5.2	$14.9	$22.5	$37.3
A3. ASC share increases either 1%, 5% or 10% annually (depending on the procedure)	$2.5	$2.8	$3.1	$3.5	$3.8	$4.2	$4.6	$5.0	$5.5	$6.0	$15.7	$25.3	$41.0
B. Volume of Procedures per 1,000 Medicare Beneficiaries Increases by 3% Annually and:													
B1. ASC share remains constant	$2.8	$3.1	$3.5	$3.9	$4.3	$4.7	$5.1	$5.5	$6.0	$6.6	$17.6	$27.9	$45.5
B2. ASC share increases at 2% annually	$2.9	$3.3	$3.8	$4.3	$4.8	$5.4	$5.9	$6.6	$7.4	$8.2	$19.1	$33.4	$52.6
B3. ASC share increases either 1%, 5% or 10% annually (depending on the procedure)	$3.0	$3.5	$4.0	$4.6	$5.2	$5.8	$6.6	$7.4	$8.3	$9.4	$20.2	$37.5	$57.6

Note: Savings are reported in nominal dollars. In all scenarios, the Berkeley analysts inflated the reimbursement amounts over time using a forecasted Consumer Price Index for All Urban Consumers, which averaged 2.4% from 2013–2022.

Conclusions

ASCs saved the Medicare program and its beneficiaries $7.5 billion over the four-year period from 2008 to 2011. Even under the most conservative assumptions, the future savings generated by ASCs are substantial.

- Under the baseline scenario, which assumes that neither ASC share nor Medicare procedure volume will grow over the next decade, ASCs will save the Medicare program an additional $32.5 billion during that time.
- As the share of procedures performed in ASCs grows within the Medicare program, so do the savings. If ASC share within the Medicare system increases even slightly, as in scenarios B2 and B3, the savings could exceed $57.6 billion over 10 years—an average savings of $5.76 billion each year.
- Medicare beneficiaries also save money by choosing ASCs, since a lower Medicare reimbursement rate means that patients, in turn, pay a smaller coinsurance. While the forward-looking portion of this study does not examine coinsurance rates for each procedure, it is clear that the savings realized by the Medicare program imply additional savings for beneficiaries. Using the example of cataract surgeries: a Medicare beneficiary will pay coinsurance of $338.20 for such a surgery to be performed in an HOPD, but only $190.20 for that same surgery in an ASC—a $148 savings that goes directly to the patient.

Further, the above estimates are quite conservative. Even the most "optimistic" scenario assumes that ASC share growth per procedure grows only modestly more quickly than historical averages, and that Medicare volume grows at a modest, and historically consistent, rate. If policy decisions or other factors cause either growth rate to accelerate further, the savings generated by ASCs within the Medicare system would certainly exceed the $57.6 billion estimated here.

in savings generated by ASCS from 2008 to 2011

Up to

additional savings in Medicare program generated by ASCs over the next 10 years

Up to

average future yearly savings

A final note: although this study examined only data from the Medicare program, ASCs typically also charge private payers, including those in the Medicare Advantage program, less than their HOPD counterparts. Thus, similar cost savings also exist in the commercial health insurance market and in the Medicare Advantage program. We believe it is important to quantify these private-side savings as well and encourage others to examine this subject in future studies.

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IV. POLICY IMPLICATIONS AND CONSIDERATIONS

An aging population, along with inflation in health care costs, means that the federal government's expenditures through the Medicare program are projected to increase substantially in the coming years. Consequently, policymakers in Washington, DC, are exploring potential ways to reduce projected Medicare outlays and extend the program's solvency. We believe that this study offers an important contribution to that discussion. Two specific policy concerns stand out.

AVOIDING ASC TO HOPD CONVERSIONS

Our first and most important observation is that, while the future savings offered by ASCs are easily attainable, they are not inevitable. Because they provide identical services to HOPDs but do so at an average of 58 percent of the reimbursement rate that the Medicare program pays HOPDs for those services, ASCs represent a source of value to the program and the taxpayers who fund it. A discrepancy in the way Medicare reimbursement rates are updated, however, threatens to marginalize ASCs' role within the program.

CMS currently applies different measures of inflation to determine the adjustments it provides to its payment systems for ASCs and HOPDs each year. For ASCs, that measure is the CPI-U, which is tied to consumer prices. The index for HOPD reimbursements, on the other hand, remains tied to the hospital market basket, which measures inflation in actual medical costs. Since consumer prices have inflated more slowly than medical costs, the gap in ASC and HOPD reimbursement rates has widened over time. As the reimbursement rate for ASCs continues to fall relative to their HOPD counterparts, ASC owners and physicians will face increasing pressure to leave the Medicare system and allow their facilities to be acquired by nearby hospitals.

When an ASC is acquired by a hospital, in what is known as "an ASC to HOPD conversion," the Medicare reimbursement rate jumps roughly 75 percent and all savings to the Medicare program and its beneficiaries are promptly lost. The continuing reduction in reimbursement led more than 60 ASCs to terminate their participation in Medicare over the last three years. If policymakers allow this gap in reimbursements to continue widening, the cost-saving advantage that ASCs offer could morph into a perverse market incentive that drives ASCs from the Medicare program.

Some in Congress have introduced legislation, which is titled the "Ambulatory Surgical Center Quality and Access Act," that aims to fix this problem. This bill would correct the imbalance in reimbursement indices and ensure that ASC reimbursements do not continue to fall relative to their HOPD counterparts. Additionally, it would establish an ASC value-based purchasing (VBP) program designed to foster collaboration between ASCs and the government and create additional savings for the Medicare system in the process.

ASCS AS PART OF BROADER COST-SAVINGS EFFORTS

Many of the policy options aimed at reducing Medicare costs that are being considered in Congress today involve important "trade-offs," where reduced outlays come at the expense of retirees' benefits. Often-discussed options such as raising the Medicare retirement age or increasing cost-sharing, for example, generate savings as a direct result of reducing the amount of benefits delivered by the Medicare program. The savings offered by ASCs, however, do not involve such trade-offs; they make it possible for the Medicare program, and its beneficiaries, to realize significant savings without any corresponding reduction in benefits.

There are more than 5,300 Medicare-certified ASCs throughout the country, all of which represent an important source of efficiency for the Medicare program and the taxpayers who fund it. We recommend that policymakers explore all potential options for encouraging further growth of ASC share within the Medicare system.

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APPENDIX: METHODOLOGY AND CHART OF INDIVIDUAL PROCEDURE SAVINGS

The following table shows detailed statistics for the 120 procedures. In the table, the procedures are first sorted by the annual ASC share increase assumptions in Scenarios A3 and B3, which were 1, 5, and 10 percent annually (see Column "% ASC Share Growth Assumptions for A3 and B3"). Within the 1, 5, and 10 percent buckets, the procedures are then sorted based on the savings they generated in 2011 (see Column "Savings 2011").

The table shows the average annual change in the ASC share from 2008 through 2011, the 2011 ASC share of procedures and projected ASC share in 2022 if the share increases by 2 percent annually or in the range of 1 to 10 percent annually. In addition, it shows the 2011 and projected 2022 volume per 1,000 Medicare beneficiaries. Most importantly, those columns are followed by two sets of three columns that show the projected savings estimates in 2022 when the number of procedures per 1,000 Medicare beneficiaries remains constant and when the number of procedures per 1,000 Medicare beneficiaries increases by 3 percent per year. Within each set, the ASC share assumptions are based on the assumptions presented in the table on page 11.

The first row of the table illustrates that cataract surgeries (HCPCS 66984) alone generated a savings of $829 million in 2011. In 2011, the ASC share of this procedure was 56 percent, and that share either increases to 62 or 69 percent depending on the scenario. Depending on whether the number of cataract surgeries per 1,000 Medicare beneficiaries increases and the share of procedures performed in ASCs, the projected savings for Medicare and its beneficiaries range from $1.5 billion to $2.95 billion in 2022.

The last row of the table shows column totals and averages (see page 9). In 2011, there were $2.3 billion in savings for the 120 procedures, and the projected savings in 2022 range from $4.2 billion to $9.4 billion, depending on the scenario.

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No.	HCPCS	HCPCS Description	Savings 2011 ($million)	Average Annual ASC Share Change 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			% ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	A2. Savings for 2022 (ASC share increases 2% per year) ($million)	A3. Savings for 2022 (ASC share increase varies) ($million)	B1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	B2. Savings for 2022 (ASC share increases 2% per year) ($million)	B3. Savings for 2022 (ASC share increase varies) ($million)		
1	66984	Cataract surg w/iol 1 stage	$829	-3.56%	56%	69%	62%	54.9	76.0	$1,500	$1,870	$1,670	$2,370	$2,950	$2,650	1%	$740
2	66982	Cataract surgery complex	$63	-0.96%	52%	65%	59%	4.4	6.1	$116	$144	$129	$180	$224	$201	1%	$740
3	64483	Inj foramen epidural l/s	$60	-3.02%	35%	44%	39%	20.6	28.5	$106	$132	$119	$173	$215	$193	1%	$229
4	62311	Inject spine l/s (cd)	$53	-13.67%	26%	33%	29%	24.1	33.4	$73	$91	$82	$152	$188	$169	1%	$229
5	66821	After cataract laser surgery	$43	-2.96%	43%	54%	48%	16.2	22.4	$86	$107	$96	$124	$154	$138	1%	$169
6	29881	Knee arthroscopy/surgery	$25	-0.25%	39%	48%	43%	2.0	2.7	$51	$64	$57	$71	$89	$79	1%	$903
7	28285	Repair of hammertoe	$22	-0.22%	37%	46%	41%	2.4	3.3	$38	$47	$43	$64	$79	$71	1%	$681
8	43235	Uppr gi endoscopy diagnosis	$21	-0.18%	34%	43%	38%	6.1	8.5	$38	$47	$42	$59	$73	$66	1%	$268
9	64622	Destr paravertebrl nerve l/s	$18	-4.98%	35%	44%	40%	3.6	5.0	$28	$34	$31	$52	$64	$58	1%	$386
10	52000	Cystoscopy	$16	-0.03%	8%	10%	9%	24.4	33.8	$33	$41	$37	$47	$58	$52	1%	$224
11	62310	Inject spine c/t	$14	-13.54%	30%	37%	33%	5.5	7.6	$18	$23	$20	$39	$49	$44	1%	$229
12	29848	Wrist endoscopy/surgery	$11	-0.10%	51%	63%	57%	0.7	0.9	$20	$25	$23	$32	$40	$36	1%	$903
13	29823	Shoulder arthroscopy/surgery	$10	-2.73%	28%	35%	31%	0.7	0.9	$14	$17	$16	$29	$36	$32	1%	$1,460
14	63650	Implant neuroelectrodes	$9	-20.87%	24%	29%	26%	1.2	1.7	$10	$12	$11	$26	$32	$29	1%	$846
15	20680	Removal of support implant	$7	-1.14%	26%	32%	29%	1.1	1.5	$14	$17	$15	$21	$27	$24	1%	$720
16	28296	Correction of bunion	$7	-0.91%	41%	50%	45%	0.5	0.7	$15	$18	$17	$20	$25	$23	1%	$1,002
17	52005	Cystoscopy & ureter catheter	$7	-0.11%	25%	31%	28%	0.9	1.3	$12	$15	$13	$19	$24	$22	1%	$794
18	45381	Colonoscopy submucous inj	$7	-4.10%	43%	54%	48%	1.5	2.0	$7	$9	$8	$19	$23	$21	1%	$281
19	36561	Insert tunneled cv cath	$6	-1.43%	7%	8%	7%	2.6	3.7	$12	$15	$13	$17	$21	$19	1%	$927
20	29875	Knee arthroscopy/surgery	$5	-1.21%	46%	57%	51%	0.3	0.4	$8	$10	$9	$14	$17	$15	1%	$903
21	30520	Repair of nasal septum	$5	-0.30%	30%	37%	34%	0.6	0.8	$8	$9	$8	$14	$17	$15	1%	$773
22	52281	Cystoscopy and treatment	$5	-0.75%	9%	11%	10%	2.7	3.7	$11	$13	$12	$14	$17	$15	1%	$530
23	58558	Hysteroscopy biopsy	$4	-2.25%	13%	17%	15%	1.1	1.5	$7	$9	$8	$10	$13	$12	1%	$696
24	65426	Removal of eye lesion	$3	-0.03%	59%	73%	66%	0.2	0.2	$5	$6	$6	$8	$10	$9	1%	$736
25	64626	Destr paravertebrl nerve c/t	$3	-7.96%	38%	48%	43%	0.8	1.2	$4	$5	$5	$8	$10	$9	1%	$229
26	14041	Skin tissue rearrangement	$3	-2.49%	13%	16%	15%	1.0	1.4	$5	$6	$6	$7	$9	$8	1%	$519
27	43251	Operative upper GI endoscopy	$2	-0.85%	35%	44%	39%	0.6	0.9	$4	$5	$4	$6	$8	$7	1%	$268
28	64627	Destr paravertebral n add-on	$2	-0.43%	39%	48%	43%	1.9	2.6	$3	$3	$3	$6	$8	$7	1%	$80
29	44361	Small bowel endoscopy/biopsy	$2	-1.36%	53%	66%	60%	0.3	0.5	$4	$5	$4	$6	$7	$6	1%	$307
30	62264	Epidural lysis on single day	$2	-17.63%	29%	36%	32%	0.4	0.5	$2	$2	$2	$5	$6	$5	1%	$386

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No.	HCPCS	HCPCS Description	Savings 2011 ($million)	Average Annual ASC Share Change 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			% ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
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31	13132	Repair of wound or lesion	$2	-4.69%	6%	7%	6%	5.3	7.4	$2	$3	$3	$5	$6	$5	1%	$140
32	62319	Inject spine w/cath l/s (cd)	$2	-18.47%	30%	38%	34%	0.4	0.5	$2	$2	$2	$4	$6	$5	1%	$386
33	64520	N block lumbar/thoracic	$1	-13.74%	23%	29%	26%	0.6	0.8	$1	$2	$2	$3	$4	$4	1%	$229
34	64450	N block other peripheral	$1	-1.62%	1%	2%	1%	10.2	14.1	$1	$1	$1	$3	$4	$3	1%	$226
35	11042	Deb subq tissue 20 sq cm/<	$1	-14.48%	1%	1%	1%	28.9	40.0	$1	$2	$2	$2	$3	$2	1%	$82
36	20552	Inj trigger point 1/2 muscl	$1	-7.74%	1%	2%	1%	8.3	11.5	$1	$1	$1	$2	$2	$2	1%	$163
37	43239	Upper gi endoscopy biopsy	$143	0.58%	45%	55%	76%	32.8	45.5	$243	$303	$416	$409	$509	$700	5%	$268
38	45380	Colonoscopy and biopsy	$107	1.11%	48%	59%	82%	21.8	30.2	$197	$245	$336	$306	$380	$523	5%	$281
39	45385	Lesion removal colonoscopy	$82	2.10%	46%	58%	79%	17.2	23.9	$162	$202	$278	$236	$293	$403	5%	$281
40	45378	Diagnostic colonoscopy	$66	0.27%	40%	49%	68%	16.2	22.4	$157	$195	$268	$190	$236	$324	5%	$281
41	29826	Shoulder arthroscopy/surgery	$38	1.27%	33%	40%	56%	2.2	3.1	$53	$66	$91	$110	$137	$188	5%	$1,460
42	G0105	Colorectal scrn; hi risk ind	$30	2.48%	52%	64%	88%	6.3	8.7	$54	$68	$93	$85	$105	$145	5%	$249
43	64721	Carpal tunnel surgery	$25	1.01%	40%	50%	68%	3.0	4.2	$50	$62	$85	$72	$90	$124	5%	$577
44	64623	Destr paravertebral n add-on	$24	4.03%	36%	44%	61%	8.1	11.2	$31	$39	$53	$69	$86	$118	5%	$229
45	G0121	Colon ca scrn not hi risk ind	$24	2.22%	45%	56%	77%	5.8	8.0	$42	$52	$72	$68	$84	$115	5%	$249
46	29827	Arthroscop rotator cuff repr	$23	3.71%	32%	39%	54%	1.4	1.9	$44	$55	$75	$66	$82	$112	5%	$1,460
47	29880	Knee arthroscopy/surgery	$21	1.64%	41%	51%	71%	1.5	2.1	$44	$55	$76	$59	$73	$100	5%	$903
48	45384	Lesion remove colonoscopy	$19	0.93%	42%	52%	71%	4.5	6.3	$40	$49	$68	$56	$69	$95	5%	$281
49	67904	Repair eyelid defect	$17	3.55%	63%	79%	90%	1.2	1.7	$32	$40	$46	$48	$60	$69	5%	$603
50	64484	Inj foramen epidural add-on	$16	3.71%	34%	42%	58%	11.2	15.6	$23	$29	$40	$46	$58	$79	5%	$117
51	26055	Incise finger tendon sheath	$16	1.20%	44%	55%	76%	1.9	2.7	$28	$35	$49	$46	$58	$79	5%	$517
52	43248	Uppr gi endoscopy/guide wire	$14	0.86%	53%	67%	90%	2.6	3.6	$25	$31	$42	$39	$49	$66	5%	$268
53	29824	Shoulder arthroscopy/surgery	$11	0.45%	33%	42%	57%	1.0	1.4	$15	$19	$26	$32	$40	$55	5%	$903
54	49505	Prp i/hern init reduc >5 yr	$11	2.77%	15%	19%	26%	1.9	2.7	$23	$28	$39	$30	$38	$52	5%	$997
55	67917	Repair eyelid defect	$10	3.72%	60%	74%	90%	0.8	1.0	$18	$23	$27	$28	$35	$43	5%	$603
56	23412	Repair rotator cuff chronic	$10	3.46%	33%	41%	56%	0.6	0.8	$20	$25	$34	$27	$34	$47	5%	$1,426
57	14060	Skin tissue rearrangement	$9	0.50%	18%	22%	30%	2.6	3.6	$18	$22	$30	$25	$31	$43	5%	$519
58	55700	Biopsy of prostate	$8	2.92%	12%	14%	20%	5.1	7.0	$17	$21	$29	$24	$30	$42	5%	$393
59	66180	Implant eye shunt	$8	3.44%	52%	65%	89%	0.3	0.4	$16	$20	$27	$22	$27	$38	5%	$1,303
60	43450	Dilate esophagus	$8	1.82%	54%	67%	90%	1.9	2.7	$8	$11	$14	$22	$27	$36	5%	$198

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61	25447	Repair wrist joint(s)	$7	1.12%	47%	58%	80%	0.4	0.5	$14	$17	$23	$21	$26	$36	5%	$1,184
62	43249	Esoph endoscopy dilation	$7	1.08%	30%	38%	52%	2.2	3.1	$12	$15	$20	$19	$24	$33	5%	$268
63	66170	Glaucoma surgery	$6	4.40%	61%	76%	90%	0.4	0.5	$13	$16	$19	$18	$23	$27	5%	$736
64	29822	Shoulder arthroscopy/surgery	$6	2.28%	36%	45%	61%	0.5	0.7	$10	$13	$17	$18	$23	$31	5%	$903
65	14040	Skin tissue rearrangement	$6	1.83%	16%	20%	27%	2.1	2.9	$13	$16	$22	$18	$23	$31	5%	$519
66	28270	Release of foot contracture	$5	3.02%	28%	35%	48%	0.8	1.1	$9	$12	$16	$15	$19	$26	5%	$681
67	15260	Skin full graft een & lips	$5	4.70%	18%	22%	31%	1.5	2.0	$10	$12	$17	$14	$18	$25	5%	$519
68	45383	Lesion removal colonoscopy	$5	1.36%	36%	45%	62%	1.3	1.8	$10	$13	$18	$14	$17	$24	5%	$281
69	66711	Ciliary endoscopic ablation	$5	1.70%	79%	90%	90%	0.3	0.4	$7	$8	$8	$14	$16	$16	5%	$539
70	67924	Repair eyelid defect	$5	3.72%	61%	76%	90%	0.3	0.5	$9	$11	$13	$13	$17	$20	5%	$603
71	52353	Cystouretero w/lithotripsy	$4	4.90%	13%	16%	21%	0.8	1.2	$8	$10	$14	$12	$15	$21	5%	$1,126
72	67028	Injection eye drug	$4	3.19%	1%	1%	2%	54.4	75.4	$6	$8	$11	$11	$14	$19	5%	$169
73	52234	Cystoscopy and treatment	$4	1.27%	19%	24%	33%	0.7	0.9	$7	$9	$13	$11	$13	$18	5%	$794
74	64718	Revise ulnar nerve at elbow	$4	3.70%	36%	45%	62%	0.5	0.7	$6	$8	$11	$11	$13	$18	5%	$577
75	28308	Incision of metatarsal	$3	1.92%	38%	48%	65%	0.4	0.5	$5	$7	$9	$10	$12	$17	5%	$681
76	26123	Release palm contracture	$3	1.37%	47%	58%	80%	0.2	0.3	$8	$10	$13	$10	$12	$17	5%	$897
77	26160	Remove tendon sheath lesion	$3	0.77%	44%	55%	75%	0.4	0.6	$6	$8	$11	$10	$12	$17	5%	$517
78	67950	Revision of eyelid	$3	2.29%	64%	80%	90%	0.2	0.3	$5	$7	$7	$9	$12	$13	5%	$603
79	52224	Cystoscopy and treatment	$3	4.95%	8%	11%	14%	1.3	1.9	$7	$9	$12	$9	$12	$16	5%	$794
80	52310	Cystoscopy and treatment	$3	0.06%	9%	11%	16%	1.8	2.5	$6	$8	$10	$9	$11	$15	5%	$530
81	67961	Revision of eyelid	$3	1.27%	55%	69%	90%	0.2	0.3	$5	$6	$9	$9	$11	$14	5%	$603
82	52235	Cystoscopy and treatment	$3	2.23%	14%	18%	24%	0.7	1.0	$6	$7	$10	$9	$11	$15	5%	$794
83	66986	Exchange lens prosthesis	$3	0.17%	63%	78%	90%	0.2	0.2	$5	$6	$7	$8	$10	$12	5%	$740
84	64479	Inj foramen epidural c/t	$3	0.16%	31%	38%	53%	1.1	1.5	$5	$6	$9	$8	$10	$14	5%	$229
85	66250	Follow-up surgery of eye	$2	1.83%	37%	46%	64%	0.3	0.4	$4	$5	$7	$6	$7	$10	5%	$539
86	14061	Skin tissue rearrangement	$2	1.01%	16%	19%	27%	0.7	0.9	$4	$5	$7	$6	$7	$10	5%	$519
87	17311	Mohs 1 stage h/n/hf/g	$1	3.76%	1%	2%	2%	14.8	20.5	$2	$2	$3	$3	$4	$5	5%	$162
88	13121	Repair of wound or lesion	$1	0.48%	6%	7%	10%	2.8	3.8	$1	$1	$1	$2	$2	$3	5%	$95
89	15823	Revision of upper eyelid	$41	6.61%	68%	85%	90%	2.4	3.4	$84	$105	$111	$117	$146	$155	10%	$671
90	50590	Fragmenting of kidney stone	$13	10.88%	18%	23%	52%	1.5	2.1	$25	$31	$72	$36	$45	$103	10%	$1,265

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91	67042	Vit for macular hole	$13	7.78%	42%	53%	90%	0.7	0.9	$26	$32	$55	$36	$45	$77	10%	$1,234
92	52332	Cystoscopy and treatment	$10	5.10%	13%	16%	36%	2.6	3.6	$15	$18	$42	$27	$34	$78	10%	$794
93	67041	Vit for macular pucker	$9	7.36%	40%	50%	90%	0.5	0.6	$19	$24	$42	$24	$30	$54	10%	$1,234
94	65855	Laser surgery of eye	$8	10.98%	22%	28%	63%	4.0	5.6	$18	$23	$52	$24	$30	$68	10%	$257
95	67900	Repair brow defect	$8	7.23%	68%	85%	90%	0.4	0.6	$14	$18	$19	$24	$30	$32	10%	$801
96	31255	Removal of ethmoid sinus	$8	11.19%	39%	49%	90%	0.6	0.8	$17	$21	$38	$22	$28	$51	10%	$933
97	67036	Removal of inner eye fluid	$6	10.53%	38%	47%	90%	0.4	0.5	$13	$16	$31	$18	$23	$43	10%	$1,234
98	31267	Endoscopy maxillary sinus	$6	11.09%	37%	46%	90%	0.5	0.7	$11	$14	$26	$18	$22	$44	10%	$933
99	30140	Resect inferior turbinate	$6	16.88%	39%	48%	90%	0.5	0.7	$12	$15	$28	$16	$20	$37	10%	$773
100	67108	Repair detached retina	$6	11.99%	34%	43%	90%	0.4	0.5	$11	$14	$29	$16	$20	$42	10%	$1,234
101	47562	Laparoscopic cholecystectomy	$5	11.18%	6%	7%	16%	1.8	2.5	$11	$14	$32	$16	$19	$44	10%	$1,442
102	66761	Revision of iris	$5	5.24%	27%	34%	78%	2.2	3.1	$11	$13	$31	$15	$19	$43	10%	$237
103	67040	Laser treatment of retina	$5	8.70%	33%	41%	90%	0.3	0.4	$10	$12	$27	$13	$17	$36	10%	$1,234
104	52204	Cystoscopy w/biopsy(s)	$5	7.61%	19%	24%	55%	0.8	1.1	$9	$11	$25	$13	$16	$37	10%	$794
105	20610	Drain/inject joint/bursa	$4	18.62%	0.5%	1%	1%	153.1	212.0	$8	$10	$24	$12	$14	$33	10%	$149
106	31256	Exploration maxillary sinus	$4	8.96%	37%	46%	90%	0.3	0.4	$7	$9	$18	$12	$14	$28	10%	$933
107	31276	Sinus endoscopy surgical	$4	22.38%	33%	41%	90%	0.4	0.5	$10	$12	$27	$11	$14	$31	10%	$933
108	64640	Injection treatment of nerve	$4	75.05%	13%	16%	36%	1.8	2.4	$6	$8	$18	$10	$13	$29	10%	$437
109	67255	Reinforce/graft eye wall	$3	6.57%	50%	63%	90%	0.3	0.3	$4	$6	$8	$9	$12	$17	10%	$706
110	69436	Create eardrum opening	$3	11.68%	40%	50%	90%	0.3	0.5	$6	$8	$14	$7	$9	$17	10%	$522
111	45330	Diagnostic sigmoidoscopy	$2	15.64%	17%	21%	48%	1.3	1.7	$5	$6	$14	$7	$9	$20	10%	$324
112	68815	Probe nasolacrimal duct	$2	9.08%	51%	64%	90%	0.2	0.3	$4	$5	$6	$7	$9	$12	10%	$603
113	46221	Ligation of hemorrhoid(s)	$2	59.92%	11%	14%	33%	1.7	2.4	$4	$5	$11	$6	$8	$18	10%	$296
114	67840	Remove eyelid lesion	$2	15.10%	8%	10%	24%	1.4	2.0	$4	$4	$10	$5	$6	$15	10%	$422
115	45331	Sigmoidoscopy and biopsy	$1	5.08%	34%	43%	90%	0.7	0.9	$3	$3	$7	$4	$5	$11	10%	$175
116	67210	Treatment of retinal lesion	$1	10.61%	7%	9%	21%	2.9	4.0	$3	$4	$9	$4	$5	$11	10%	$169
117	67228	Treatment of retinal lesion	$1	11.58%	7%	9%	20%	2.3	3.2	$2	$3	$6	$3	$4	$8	10%	$169
118	11642	Exc face-mm malig+marg 1.1-2	$1	7.98%	3%	4%	10%	3.5	4.9	$2	$2	$4	$3	$4	$8	10%	$226
119	64480	Inj foramen epidural add-on	$1	17.51%	29%	36%	83%	0.8	1.0	$2	$2	$5	$3	$3	$8	10%	$117
120	51700	Irrigation of bladder	$0.5	29.91%	3%	4%	10%	4.0	5.5	$1	$1	$3	$1	$2	$4	10%	$99
		Total or Mean**	**$2,307**	**3.46%**	**32%**	**40%**	**52%**	**5.62**	**7.78**	**$4,203**	**$5,231**	**$6,013**	**$6,604**	**$8,212**	**$9,383**	**N/A**	**$589**

NOTES:

*Increases volume per 1,000 Medicare beneficiaries by 3% annually.

**The reported totals are for savings. The remaining columns are simple means across the 120 procedures, for which the mean is not influenced by (or weighted for) high-volume procedures, such as cataracts. Savings are reported in nominal dollars. N/A: not applicable.

Medicare Cost Savings Tied to Ambulatory Surgery Centers

ASCA
Ambulatory Surgery Center Association

Produced with cost savings analysis from

Berkeley
UNIVERSITY OF CALIFORNIA

ATTACHMENT 13

Criterion 1110.230(c) - Alternatives

Pursuant to 77 Ill. Adm. Code Section 1110.230(c), the Applicant considered the following alternatives to the proposed project:

1. Taking No Action

The first alternative considered by the Applicant was to maintain the status quo and not establish a new ASTC in Elmhurst, Illinois.

Total Project Cost: $0

Reasons for Rejecting this Alternative: The Applicant rejected this alternative because it fails to address the health care needs of the community and patients in the local geographic service area served by the Applicant's physician owners.

2. Utilize Existing Provider

A second alternative considered by the Applicant was to utilize an existing provider instead of establishing a new ASTC in the local geographic area.

Total Project Cost: Unknown

Reasons for Rejecting this Alternative:

The Applicant determined that its Elmhurst, Illinois, location was the best site for a surgery center. The Applicant currently has an existing medical office where the proposed ASTC will be located. As such, it has an established patient base in the area. In addition, the Applicant's physician owners have admitting privileges at West Lake Hospital, St. Joseph Hospital (Joliet), Alexian Brothers, and Elmhurst Hospital (application pending), where they are well-established and where patients are already familiar with their services. In addition, pursuing an existing ASTC did not seem reasonable given that the Applicant would not have the ability or authority to design and create the center that would best fit the needs of its patients.

3. Establish an ASTC at an Alternative Location

The Applicant also considered establishing an ASTC at an alternative location or established two ASTC with different categories of series.

Total Project Cost: Likely much higher than current Project's estimated cost.

Reasons for Rejecting this Alternative: The Applicant considered alternate locations where the physicians have medical office space at830 N. Ashland, Unit C2, Chicago, IL 60622. The other locations did not have space for an expansion without significant additional cost and challenging issues (such as available parking for patients). The Applicant concluded that the best solution was expanding its Elmhurst, Illinois medical office space.

Documentation

As discussed above, the Applicant considered several alterative options before submitting the CON permit application. The explanation above compares various alterative options analyzed by the Applicant, pursuant to the State Board's rules, each one considered the cost and other relevant factors for each alterative. Where the cost of the alternative could not be determined, "unknown" is provided next to the project cost.

ATTACHMENT 14

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC operating room and recovery	1,850 dgsf per 1 treatment room	1,660-2,200 dgsf per treatment room	350	Yes

The State Board's guidelines regarding total department square footage ("DGSF") for a proposed ambulatory surgical treatment center ("ASTC") is provided in the table above.

The Applicant is proposed the establishment of an ASTC with one operating room, recovery stations, exam room, clean and soiled processing rooms, and support areas, including nurse stations, patient lockers and toilets. Non-clinical areas include a reception area, lobby, patient waiting room, three recovery rooms, business and administrative offices, public toilets and mechanical rooms (the "Project"). The Project will be a modernization and expansion of a leased medical office space with the interior being built out by the Applicant. The proposed total DGSF for the Project is 1,850, which meets the state standard requirements. Therefore, the Project plans meet the State Board's applicable standard, as noted above.

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ATTACHMENT 15

Criterion 1110.234 - Project Services Utilization

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD 1,500 hrs x #ORs	MEET STANDARD?
YEAR 1 (2018)	ASTC	1,357 procedures	1,525	2,035.5 Hours	Yes
YEAR 2 (2019)	ASTC	1,450 procedures	1,900	2,900 Hours	Yes

Summary
The State Board has established utilization standards for certain departments, clinical service areas, and facilities. Specifically, the Applicant must document that, by the end of the second year of operation, the annual utilization of the clinical service areas shall meet or exceed the applicable utilization standards. For ambulatory surgical treatment centers, the Applicant must demonstrate 1,500 hours of surgical time for each operating room requested. As the table above demonstrates, the Applicant will meet this standard by the end of the second year of operation following the project completion, which is estimated to occur on or January 2018.

Hours
Based on industry standards, the average amount of time dedicated for each procedure will average3-4 hours per case for orthopedic procedures, which includes 15 minutes for set-up time, 60 minutes to complete the surgical procedure, and 15 minutes for clean-up time. The pain procedures range from 20 minutes to 2.5 hours and average around 30 to 45 minutes. Therefore, the average time per procedure will be 2 hours, which is consistent with the national average for multi-specialty surgery centers that specialize in orthopedic, and pain management medicine.

The Applicant anticipates a December 2017 project completion date. During CY 2018, the Applicant anticipates to see 1,357 procedures completed, at an average time per patient of 1.5 hours, which will yield a total utilization of 2,035.5 hours for the one operating room. By the end of CY 2019, the Applicant expects to exceed the ASTC utilization standard. The Applicant expects that during CY 2019, the Applicant will conduct approximately 1,450 procedures at an average time of 2 hours, which yields a total utilization of 2,900 hours for the one operating room. This total exceeds applicable utilization standard.

Accordingly, the Applicant has demonstrated sufficient surgical volume by the end of the first full year of operation to support the one operation room as proposed for the ASTC.

ATTACHMENTS 16 to 24 - *NOT APPLICABLE*

ATTACHMENT 25

Criterion 1110.1540(c) - Geographic Service Area Need

(a) Geographic Service Area (GSA) Zip Codes and Patient Origin Data

The proposed ASTC will serve the geographic area consisting of all the zip code areas identified below, all of which are within a 45 minutes multidirectional travel time form the Project site. The table below provides patient origin information by zip code for the prior twelve months.

(b) Note Regarding Patient Origin Data

ATTACHMENT 25

Criterion 1110.1540(d) - Service Demand - Establishment of ASTC

The physician referral letters in support of the proposed ASTC are attached hereto. The letters contain the total number of patients referred to health care facilities within the past 12 months and the projected number of referrals to the proposed ASTC during the first full year of operation. The following table summarize this information, and show the facilities to which referring physician sent patients are mostly qualifying health care facilities [?].

Specialty	Physician	Hospital/ASTC	# of Cases Performed in Past 12 months	Anticipated # of Cases Referred to New ASTC
Orthopedics	Dr. Kevin Tu			
Orthopedics	Dr. Ginno Lias (sp?)			
Orthopedics	Dr. Greg Markarian			
Neurosurgery	Dr. Sean Salehi	see attached		
Neurosurgery	Dr. Sergey Neckrysh	see attached		
Orthopedic Spine	Dr. Anis Mekhail			
Pain Management	Dr. Intesar Hussain			
Pain Management	Dr. Neema Bayran			

16d

August 23, 2017

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Illinois Back & Neck Institute ASTC in Elmhurst, IL

Dear Ms. Avery:

I am an orthopedic surgeon. Over the past twelve months, I performed a total of 122 outpatient surgery cases. Surgery cases in this category of service will constitute the majority of my surgical work in the future. During the past twelve months, I referred my surgical cases to the following hospitals and ambulatory surgical treatment centers ("ASTCs").

Name of Healthcare Facility	Type of Healthcare Facility	Hospital/Licensed ASTC (Number of Casses) Most Recent 12 Month Period
Advocate Christ Hospital	Outpatient Surg	12
Christ Medical Ctr	Inpatient Ctr Hospital	500
Palos Community Hospital	Hospital	60
TOTAL		

Based on my historical referrals, I anticipate referring 30-50 surgical cases each year to the ASTC proposed by Illinois Back & Neck Institute, LLC once it becomes operations. I certify that these patients will reside within the CON Permit Applicant's proposed geographic service area. I further certify that aforementioned referrals have no been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and correct to the best of my knowledge.

Respectfully Submitted,

M.D.

Notary:

Subscribed and sworn to me this 9 day of October, 2017

Notary Public

OFFICIAL SEAL
MARGO CATALANO
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:06/17/21

Seal:

165

August 23, 2017

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Illinois Back & Neck Institute ASTC in Elmhurst, IL

Dear Ms. Avery:

I am an orthopedic surgeon. Over the past twelve months, I performed a total of 200 outpatient surgery cases. Surgery cases in this category of service will constitute the majority of my surgical work in the future. During the past twelve months, I referred my surgical cases to the following hospitals and ambulatory surgical treatment centers ("ASTCs").

Name of Healthcare Facility	Type of Healthcare Facility	Hospital/Licensed ASTC (Number of Casses) Most Recent 12 Month Period
Elmhurst Memorial Hospital	Hospital	80
Loyola Ambulatory Center	Surgery Center	120
TOTAL		200

Based on my historical referrals, I anticipate referring 60 surgical cases each year to the ASTC proposed by Illinois Back & Neck Institute, LLC once it becomes operations. I certify that these patients will reside within the CON Permit Applicant's proposed geographic service area. I further certify that aforementioned referrals have no been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and correct to the best of my knowledge.

Respectfully Submitted,

_____, M.D.

Notary:

Subscribed and sworn to me this 20th day of October, 2017

_____
Notary Public

Seal:

OFFICIAL SEAL
EDITH M DIAZ
Notary Public - State of Illinois
My Commission Expires Jul 23, 2018

166

August 23, 2017

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Illinois Back & Neck Institute ASTC in Elmhurst, IL

Dear Ms. Avery:

I am an orthopedic surgeon. Over the past twelve months, I performed a total of 200 outpatient surgery cases. Surgery cases in this category of service will constitute the majority of my surgical work in the future. During the past twelve months, I referred my surgical cases to the following hospitals and ambulatory surgical treatment centers ("ASTCs").

Name of Healthcare Facility	Type of Healthcare Facility	Hospital/Licensed ASTC (Number of Casses) Most Recent 12 Month Period
Weiss Hosp	Hospital	18
Amita Hospital	Hospital	30
Lakeshore Surgery Cent	Surgery Cent	100
Hyde Park [illegible]	[illegible]	30
Grand Surgery Center	Surgery	20
TOTAL		

Based on my historical referrals, I anticipate referring 60 surgical cases each year to the ASTC proposed by Illinois Back & Neck Institute, LLC once it becomes operations. I certify that these patients will reside within the CON Permit Applicant's proposed geographic service area. I further certify that aforementioned referrals have no been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and correct to the best of my knowledge.

Respectfully Submitted,

GREG MARKIM, MD

_____, M.D.

Notary:

Subscribed and sworn to me this 20 day of October, 2017

_____
Notary Public

Seal:

OFFICIAL SEAL
EDITH M DIAZ
Notary Public - State of Illinois
My Commission Expires Jul 23, 2018

107

August 23, 2017

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Illinois Back & Neck Institute ASTC in Elmhurst, IL

Dear Ms. Avery:

I am a new Surgeon ~~an orthopedic~~ surgeon. Over the past twelve months, I performed a total of 50 outpatient surgery cases. Surgery cases in this category of service will constitute the majority of my surgical work in the future. During the past twelve months, I referred my surgical cases to the following hospitals and ambulatory surgical treatment centers ("ASTCs").

Name of Healthcare Facility	Type of Healthcare Facility	Hospital/Licensed ASTC (Number of Cases) Most Recent 12 Month Period
Center for minimally invasive surgery	ASTC	60
Elmhurst hospital	Hospital	10
Maywood "	"	20
LaGrange "	"	20
Gottlieb "	"	15
TOTAL		125

Based on my historical referrals, I anticipate referring 20 surgical cases each year to the ASTC proposed by Illinois Back & Neck Institute, LLC once it becomes operations. I certify that these patients will reside within the CON Permit Applicant's proposed geographic service area. I further certify that aforementioned referrals have no been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and correct to the best of my knowledge.

Respectfully Submitted,

_____, M.D.

Notary:

Subscribed and sworn to me this 3 day of Sept, 2017.

_____
Notary Public

Seal:

OFFICIAL SEAL
DONNA P SVOBODA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 07/21/20

OFFICIAL SEAL
DONNA P SVOBODA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 07/21/20

168

August 23, 2017

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Illinois Back & Neck Institute ASTC in Elmhurst, IL

Dear Ms. Avery:

I am an ~~orthopedic~~ NEUROLOGICAL surgeon. Over the past twelve months, I performed a total of 42 outpatient surgery cases. Surgery cases in this category of service will constitute the majority of my surgical work in the future. During the past twelve months, I referred my surgical cases to the following hospitals and ambulatory surgical treatment centers ("ASTCs").

Name of Healthcare Facility	Type of Healthcare Facility	Hospital/Licensed ASTC (Number of Casses) Most Recent 12 Month Period
UIC MC	HOSPITAL	40
MAGNA SURGICAL CENTER	ASC	2
TOTAL		

Based on my historical referrals, I anticipate referring 45 surgical cases each year to the ASTC proposed by Illinois Back & Neck Institute, LLC once it becomes operations. I certify that these patients will reside within the CON Permit Applicant's proposed geographic service area. I further certify that aforementioned referrals have no been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and correct to the best of my knowledge.

Respectfully Submitted,

S. [signature], M.D.

Notary:

Subscribed and sworn to me this 8 day of Nov, 2017.

[signature]
Notary Public

Seal:

OFFICIAL SEAL
EDITH M DIAZ
Notary Public - State of Illinois
My Commission Expires Jul 23, 2018

169

November 6, 2017

Ms. Courtney Avery, Administrator

Illinois Health Facilities and Services Review Board

525 West Jefferson Street, Second Floor

Springfield, Illinois 62761

Re: Illinois Back & Neck Institute ASTC in Elmhurst, IL

Dear Ms. Avery:

I am an anesthesiologist and interventional pain management physician. Over the past twelve months, I performed a total of 2,240 outpatient procedures. Surgery Cases in this category of service will constitute the majority of my procedural work in the future. During the past twelve months, I referred my surgical cases to the following hospitals and ambulatory surgical treatment center ("ASTCs").

Name of Healthcare Facility	Type of Healthcare Facility	Hospital/Licensed ASTC (Number of Cases) Most Recent 12 Month Period
Parkview Orthopedics	Office	1,440
Global Pain & Spine Clinic	Office	500
The Pain Center of Illinois	Office	300
Total		**2,240**

Based on my historical referrals, I anticipate referring 1000 surgical cases each year to the ASTC proposed by Illinois Back & Neck Institute, LLC once it becomes operational. I certify that these patient will reside within the CON permit Applicant's proposed geographic service area. I further certify that aforementioned referrals have not been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and correct to the best of my knowledge.

Respectfully Submitted,

M.D. INTESAR HUSSAIN M.D.

Notary:

Subscribed and sworn to this 8 day of Nov., 2017

Notary Public

Seal:

OFFICIAL SEAL
EDITH M DIAZ
Notary Public - State of Illinois
My Commission Expires Jul 23, 2018

170

August 23, 2017

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, Second Floor
Springfield, Illinois 62761

RE: Illinois Back & Neck Institute ASTC in Elmhurst, IL

Dear Ms. Avery:

I am an anesthesiologist and interventional pain management physician. Over the past twelve months, I performed a total of 2220 outpatient surgery cases. Surgery cases in this category of service will constitute the majority of my surgical work in the future. During the past twelve months, I referred my surgical cases to the following hospitals and ambulatory surgical treatment centers ("ASTCs").

Name of Healthcare Facility	**Type of Healthcare Facility**	**Hospital/Licensed ASTC (Number of Casses) Most Recent 12 Month Period**
Parkview Orthopedics	Office Based Procedure room	1500
The Pain Center Of Illinois	Office Based PR	600
Illinois Spine Institute	Office Based PR	120
TOTAL		**2220**

Based on my historical referrals, I anticipate referring 1000 surgical cases each year to the ASTC proposed by Illinois Back & Neck Institute, LLC once it becomes operations. I certify that these patients will reside within the CON Permit Applicant's proposed geographic service area. I further certify that aforementioned referrals have no been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and correct to the best of my knowledge.

Respectfully Submitted,

Neema Bayrcia
_____, M.D.

Notary:

Subscribed and sworn to me this 8 day of Nov., 2017

_____
Notary Public

Seal:

OFFICIAL SEAL
EDITH M DIAZ
Notary Public - State of Illinois
My Commission Expires Jul 23, 2018

171

ATTACHMENT 25

Criterion 1110.1540(f) - Service Demand - Establishment of ASTC

Number of Procedure Rooms Proposed:

The Applicant is proposing the establishment of a multi-specialty ambulatory surgical treatment center with one operating room.

Summary:

The State Board has established utilization standards for certain departments, clinical service areas, and facilities. Specifically, the Applicant must document that, by the end of the second year of operation, the annual utilization of the clinical service areas shall meet or exceed the applicable utilization standards. For ambulatory surgical treatment centers, the Applicant must demonstrate 1,500 hours of surgical time for each operating room requested. As the table above demonstrates, the Applicant will meet this state standard by the end of the first full year of operation following project completion, which is estimated to occur on or before January 2018.

Estimated Time Per Procedure:

Based on industry standards, the average amount of time dedicated for each procedure will average 3-4 hours per case for orthopedic procedures, which includes 15 minutes for set-up time, 60 minutes to complete the surgical procedure, and 15 minutes for clean-up time. The pain procedures range from 20 minutes to 2.5 hours and average around 30 to 45 minutes. Therefore, the average time per procedure will be 2 hours, which is consistent with the national average for multi-specialty surgery centers that specialize in orthopedic and pain management medicine.

The Applicant anticipates a [DATE] project completion date. As a result, the first year of operation will result in only a 60-70% of the anticipated cases. Thus, during CY 2017, the Applicant anticipates to see 1525 procedures completed, at an average time per patient of 1.5 hours, which will yield a total utilization of 1900 for the one operating room. However, by the end of the first full year of operation, CY 2018, the Applicant expects to exceed the ASTC utilization standard. The Applicant expects that during CY 2018, the Applicant will conduct approximately 900 [NUMBER] procedures at an average time of 2 hours, which yields a total utilization of 1920for the one operating room. This total exceeds applicable utilization standard.

Accordingly, the Applicant has demonstrated sufficient surgical volume by the end of the first full year of operation to support the one operation room as proposed for the ASTC.

ATTACHMENT 25

Criterion 1110.1540(g) - Service Accessibility

Categories of Surgical Services Proposed for the ASTC

1. Orthopedic Surgery
2. Pain Management

Discussion

Pursuant to Criterion 1110.1540(g)(3), an Applicant must demonstrate need for a proposed ASTC by demonstrating that existing underutilized services in the proposed geographic area have restrictive admission policies.

(a) Medicaid

As discussed in this application, the proposed ASTC will enhance access to surgical services by making outpatient surgical care more available to Medicaid beneficiaries and other low income individuals in a area close to their residence. For example, patients currently enrolled in the Medicaid program may need to travel a long distance form the project site to find a surgery center that accepts Medicaid patients. The following table shows the closers surgery centers, which shows that few accept much if any Medicaid patients. As such, we believe a strong need exists for an ASTC to service this needy population.

ASTC	City	Distance from Project Site (Minutes)	Medicaid Percentage
Advantage Health Care	Wood Dale	15	0
Aiden Center for Day Surgery	Addison	17	0
DMG Surgical Center	Lombard	7	0
Elmhurst Medical and Surgical Center	Elmhurst	2	0
Elmhurst Medical and Surgical Center	Elmhurst	2	0
Loyola Ambulatory Surgery Center at Oak Brook Terrace	Oak Brook Terrace	4	4.6

Source: Illinois Department of Public Health, Hospital Report Card and Consumer Guide to Health Care Website, available at www.healthcarereportcard.illinois.gov/

Based on the data in the above table, it is clear that the Applicant's potential role as a Medicaid provider is necessary and unique in this market area, as only 1 out of 6 surgery centers within the local area of the Project site report any Medicaid matters, and the one center that serves this population reports a less than 5% Medicaid patient base.

(b) Workers Compensation

The same disparities in access to care exist with regard to ASTCs that accept workers compensation cases. The Applicant expects to have at least [15%] of its payer mix to consist of workers compensation cases.

(c) Disparities in Access to Care

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According to the BMC Health Services Research, patients of lower socioeconomic status treated with outpatient surgery are significantly less likely to have their procedures in ASCs, suggesting that less resourced patients are encountering higher cost burdens for care. Thus, the most economically vulnerable group is unnecessarily subject to higher charges for surgery. *Disparities In the Use of Ambulatory Surgical Centers: A Cross-Sectional Study* (BMC Health Services Research July 2009)(S. Strope, A. Sarma, Z. Ye, J. Wei and B. Hollenbeck). Compared to the lowest group, patients of higher socioeconomic status were more likely to have procedures performed in ASCs Overall, the middle socioeconomic status group was the most likely group to use the ASCs. As such, the report demonstrates that there is a need to bridge the gap that exists based on socioeconomic status and race for access to quality outpatient surgery that provides a lower cost and effective treatment option for patients.

ATTACHMENT 25

Criterion 1110.1540(h) - Unnecessary Duplication of Services/Maldistribution

(a) Population of Geographic Service Area by Zip Code

The following table shows the total population of the GSA by zip code, and reflects the most recent population numbers available for the State of Illinois.

[INSERT CENSUS DATA]

(b) ASTCs and Hospitals in GSA Providing Same Services as Proposed ASTC

The following chart shows all of the hospitals and surgery centers in the proposed geographic service area, which offer the same surgical categories of services proposed by the Applicant.

[INSERT DATA]

Analysis and Discussion

The Applicant shall document that the Project will not result in a maldistribution of series. Maldistribution exists when the geographic service area has an excess supply of facilities and ASTC services characterized by such factors as, but not limited to:

(a) a ratio of surgical/treatment rooms to population that exceeds one and one-half times the State average;

(b) historical utilization (for the latest 12-month period prior to submission of the application) for existing surgical treatment rooms for the ASTC services proposed by the Project that are below the utilization standard specified in 77 Ill. Adm. Code 1100; or

(c) insufficient population to provide the volume or caseload necessary to utilize the surgical treatment rooms proposed by the project at or above utilization standards specified in 77 Ill. Adm. Code 1100.

While the data for all existing hospitals and surgery centers shows that there is capacity in the geographic service area, the Applicant's proposed ASTC will not adversely affect existing hospitals and surgery centers in the market area that are directly impacted by this project. Specifically, every referring physicians who supports the project is taking their cases out of [three] hospitals and [two] surgery centers. Importantly, none of the hospitals is underperforming.

Hospital	Capacity (ORs)	Hours	Met State Standard?
			[Yes]

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Neema Bayran, MD

Board Certified Interventional Pain Management Physician
Diplomate of the American Board of Anesthesiology and Pain Management
Board Certified Independent Medical Examiner

The Pain Center of Illinois

Chicago and Elmhurst, Illinois
830 N Ashland Ave. C-1N
Chicago, Illinois 60622
Ph: (312) 624-8364 Fax: (312) 929-3323

CERTIFICATION

Board Certified Anesthesiologist- The American Board of Anesthesiology

Board Certified Interventional Pain Management- The American Board of Anesthesiology

American Board of Independent Medical Examiners – Board Certified Independent Medical Examiner

American Medical Association Guides to evaluation of Permanent Impairment, Sixth Edition- ABIME Board Certified

CLINICAL PRACTICE

The Pain Center of Illinois Ltd.	01/2008-Present
University of Illinois at Chicago (Assistant Professor)	07/2002 to 2010
Advanced Pain Centers	04/2007 to 06/2008
Advanced Pain and Anesthesia Consultant	07/2002 to 03/2007

Hospital Affiliation

Alexian Brothers Medical Center- Elk Gove Village, Illinois

Presence St. Joseph Hospital – Joliet, Illinois

West Lake Hospital- Melrose Park, Illinois

Education

University of Illinois at Chicago – Chicago, Illinois

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1) Lu, Y; Laurito, C.; Beyranvand, N.; Sadoughi, A.R.;
Yeomans, D.C.; (2001) Antinocicepetive Pharmacology
Produced by Noradrenergic Descending Modulation for Responses to Different
Rates of Noxious Radiant Heating,
Regional Anesthesia and Pain Medicine, Vol. 26, pp.114

PRESENTATIONS

1) Beyranvand, N.; Lu, Y; Laurito, C. ;Yeomans, D.C.;
Antihyperalgesia induced by Exposure of Mouse Skin to Herpes Simplex Virus, which encodes Antisense For CGRP;
MARC Meeting-2000

2) Beyranvand, N.; Lu, Y; Laurito, C. ; Sadoughi, A.R.;
Yeomans, D.C.; Antinocicepetive Pharmacology Produced
By Noradrenergic Descending Modulation for Responses to
Different Rates of Noxious Radiant Heating;
MARC Meeting
(2001)

INTESAR HUSSAIN M.D.

EMPLOYMENT

- **The Pain Center of Illinois** (08/2012-Present)
  Attending Physician, Anesthesiology and Pain Medicine

  Proficient in:

  - Acute and chronic pain management
  - Intrathecal pump implantation and maintenance
  - Spinal cord stimulator trial
  - Permanent stimulator placement
  - Ketamine infusion management
  - Epidural steroid injections
  - Selective nerve root blocks
  - Medial branch blocks
  - Radiofrequency ablation
  - Discography
  - Peripheral nerve blocks
  - Sympathetic nerve blocks
  - Trigger point injections
  - Large and small joint injections

EDUCATION

- **University of Illinois College of Medicine at Rockford** (08/2002-05/2006)
  Doctorate of Medicine

- **University of Chicago** (08/1997-06/2001)
  Bachelor of Arts in Biological Sciences

GRADUATE TRAINING

- **Manhattan Center for Pain Management, Continuum Health Partners** (07/2011-06/2012)
  Columbia University/St. Luke's - Roosevelt Hospital Center– New York, New York
  Fellow in Pain Medicine

- **University of Medicine and Dentistry of New Jersey** (07/2008-06/2011)
  New Jersey Medical School - Newark, NJ
  Anesthesiology Residency, **Chief Resident** (07/2010 – 06/2011)

- **Advocate Lutheran General Hospital** (07/2006-06/2008)
  Park Ridge, IL
  Internal Medicine Resident

MEDICAL LICENSURE

Illinois State Medical License - Active

PROJECTS

- **University of Medicine and Dentistry of New Jersey, Department of Anesthesiology**
  System based Project: General Anesthesia for MRI Patients: What's the Protocol? (2010)
  Examining the protocol for administering anesthesia in a remote location such as the MRI suite.

  System based Project: Blood Transfusion Protocol: Errors and Solutions (2009)
  Examining the process of transfusing blood in the operating room.

  Clinical Research: Validation of transesophageal echocardiography with transabdominal ultrasound to measure renal resistive index and to predict acute kidney injury
  Dr. Douglas Jackson, Dr. Vanny Le, Dr. Sheldon Goldstein
  Department of Anesthesiology, UMDNJ-NJMS

  Case Report: Pneumocephalus following neuraxial anesthesia
  Dr. Lawrence Chinn, Dr. Jyotsna Rimal, UMDNJ-NJMS

PRESENTATIONS

American Society of Anesthesiologists Annual Meeting – San Diego, CA

- *Poster Presentation* (October 2010)
  An Unusual Intraoperative Arrhythmia: Transient left bundle branch block in a patient undergoing anesthesia

University of Medicine and Dentistry: Department of Anesthesiology

- *Resident Case Conference* (January 2010)
  Sellick's Maneuver

- *Grand Rounds(November 2009)*
  Cardiac Tamponade

- *Pediatric Case Conference* (August 2009)
  Craniosynostosis: Presentation and Management

TRAINING/TEACHING EXPERIENCE

- Neuromodulation Foundations for Fellows Spinal Cord Stimulator Workshop and Lab (St. Jude Medical) – San Francisco, CA (9/2011)
  Learned patient selection and spinal cord stimulator implantation.

- Medtronic Pain Fellows Theory and Technique Workshop on Neuromodulation – Minneapolis, MN (11/2011)
  Learned theory and placement of spinal cord stimulators and intrathecal pumps.

- Spinal Cord Stimulator Pain Fellows Cadaver Course (Boston Scientific) – New Orleans, LA (10/2011)
  Learned patient selection and spinal cord stimulator implantation.

- ASRA Special Sessions Workshop - Principles of Ultrasonography: Physics and Scanning Techniques – New Orleans, LA (10/2011)
  Learned various techniques in ultrasound-based pain medicine. Practiced scanning lumbar and cervical spine as well as large and small joints, on live models.

- Education Committee – Resident Member (7/2009 – 6/2011)
  The University Hospital, UMDNJ-NJMS, Newark, NJ

- Help Desk Analyst (2001-2002)
  GE-Zurich, Inc.

- Intern (6-9/1998)
  Museum of Science and Industry

- Tutor (1997-1998)
  Neighborhood Schools Program, University of Chicago

- Research Assistant (1997-1998)
  University of Chicago Medical Center

MEMBERSHIPS AND ASSOCIATIONS

American Society of Regional Anesthesia and Pain Medicine

CERTIFICATIONS

American Board of Anesthesiology (2013)
American Board of Anesthesiology – Pain Medicine Subspecialty Certification (2014)
American Heart Association Basic Life Support / Advanced Cardiac Life Support - current through 6/2017

HOBBIES AND INTERESTS

Fitness Training
Reading
Automobile engineering and design

LANGUAGES

Urdu
Hindi

ATTACHMENT 25

Criterion 1110.1540(j) - Charge Commitment

Owner's Certification

A letter from Applicant, which certifies the Applicant's commitment to maintain the referenced charges for the proposed ASTC's first two (2) years of operation, is attached hereto. A table attached to the letter provides a list of procedures that will be performed at the ASTC, along with the appropriate CPT/HCPCS code for each procedure and the charge associated with each.

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December 7, 2017

Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson St., 2nd Floor
Springfield, IL 62761
Attention: State Board Chairperson Kathryn J. Olson

Re: Charge Commitment

Dear Chairperson Olson:

Pursuant to 77 Ill. Adm. Code § 1110.1540(j), a statement of all charges, except for any professional fee, is attached to this letter. I hereby commit that the attached charge schedule will not be increase, at a minimum, for the first two (2) years of operation following the establishment and opening of the proposed ASTC, which will be located at 360 W. Butterfield Road, Suite 100, Elmhurst, Illinois 60126.

Respectfully Submitted,

Neema Bayran, M.D.
Chief Executive Officer
Illinois Back & Neck Institute, LLC

Notary:

Subscribed and sworn to me this _____day of _____, 2017

_____
Notary Public

Seal:

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ATTACHMENTS 26-33 - *NOT APPLICABLE*

ATTACHMENT 34

Criterion 1120.120 Availability of Funds

The Project will be funded entirely through cash made available to the CON permit Applicant resulting from physician investors purchasing units in the Applicant's limited liability company. As such, Criterion 1120.120 is not applicable.

A signed notarized statement provided by the Applicant is attached hereto. The statement certifies that the Project will be funded entirely by available cash funding.

August 23, 2017

Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson St., 2nd Floor
Springfield, IL 67261
Attention: State Board Chairperson Kathryn J. Olson

Re: Criterion 1120.140, Economic Feasibility, Reasonableness of Financing Arrangements

Dear Chairperson Olson:

Illinois Back & Neck Institute, LLC (the "Applicant") will fund the development of the proposed ambulatory surgical treatment center, which will be located at 360 W. Butterfield Road, Suite 100, Elmhurst, Illinois 60126 (the "Project"), entirely with cash. The cash to cover the total estimated project costs and related costs will come from the sale and purchase of investment securities, specifically, the purchase of units in the Applicant's limited liability company. the fund will be available once each physician investor named in the accompanying certificate of need permit application completes the purchase of their respective number of units in the Applicant's limited liability company, which shall occur on a date following the granting of a certificate of need permit by the Illinois Health Facilities and Services Review Board. The Applicant will not be lending funds to the physician investors to complete the purchase of units in the Applicant's company.

Respectfully Submitted,

Neema Bayran, M.D.
Chief Executive Officer
Illinois Back & Neck Institute, LLC

Notary:

Subscribed and sworn to me this 20 day of October, 2017

Notary Public

Seal:

OFFICIAL SEAL
EDITH M DIAZ
Notary Public - State of Illinois
My Commission Expires Jul 23, 2018

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ATTACHMENT 35

Criterion 1120.130 Financial Viability Waiver

The Project will be entirely funded with cash made available to the Applicant resulting from physician investors purchasing units in the Applicant's limited liability company. As such, Criterion 1120.130 is not applicable.

ATTACHMENT 36

Criterion 1120.130 - Viability ratios

The Project will be entirely funded with cash made available to the Applicant resulting from physician investors purchasing units in the Applicant's limited liability company. As such, Criterion 1120.130 is not applicable.

ATTACHMENT 37

Criterion 1120.140 - Economic Feasibility

A. Reasonableness of Financing Arrangements

A signed and notarized statement from the Applicant is attached immediately following this attachment. The statement attests that the project is being funded entirely by available cash and that no financing will be secreted to pay for the construction and development of the proposed ASTC.

B. Conditions of Debt Financing

The only debt in this Project arises from a sublease that will be executed between the site owner and the Applicant. The following documents are attached hereto:

1. A copy of the Letter of Intent to Lease, which upon permit issuance, will be replaced with formal lease agreement between the Applicant and site owner. *Not needed as we have a lease.*

2. A signed and notarized statement from the Applicant, which certifies that the Project involves the leasing of a health care facility, and that expenses related to the lease are less costly than construction of a new facility.

C. Reasonableness of the Project and Related Costs

The following table describes the area/department impacted by the proposed project and provides a cost and square footage allocation related to this Project.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

The following information represents the projected direct annual operating costs for the first full year operating at target utilization, but more than two years following the date of project completion.

Year 2017
Operating Expenses: $_____

Procedures: _____

Operating Expenses/Procedure: $_____

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October 6, 2017

Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson St., 2nd Floor
Springfield, IL 67261
Attention: State Board Chairperson Kathryn J. Olson

Re: Criterion 1120.140, Economic Feasibility, Reasonableness of Financing Arrangements

Dear Chairperson Olson:

Illinois Back & Neck Institute, LLC (the "Applicant") will fund the development of the proposed ambulatory surgical treatment center, which will be located at 360 W. Butterfield Road, Suite 100, Elmhurst, Illinois 60126 (the "Project"), entirely with cash. The cash to cover the total estimated project costs and related costs will come from the sale and purchase of investment securities, specifically, the purchase of units in the Applicant's limited liability company. the fund will be available once each physician investor named in the accompanying certificate of need permit application completes the purchase of their respective number of units in the Applicant's limited liability company, which shall occur on a date following the granting of a certificate of need permit by the Illinois Health Facilities and Services Review Board. The Applicant will not be lending funds to the physician investors to complete the purchase of units in the Applicant's company.

Respectfully Submitted,

Neema Bayran, M.D.
Chief Executive Officer
Illinois Back & Neck Institute, LLC

Notary:

Subscribed and sworn to me this _____day of _____, 2017

_____
Notary Public

Seal:

E. Total Effect of the Project on Capital Costs

The following information represents the total projected annual capital cost for the first full year operating at target utilization, but no more than two years following the date of project completion:

Year 2017

Capital Cost: $0

Procedures: ____0____

Capital Cost/Procedure: $0

There is no projected annual capital cost for the first full year of operation.

August 23, 2017

Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson St., 2nd Floor
Springfield, IL 67261
Attention: State Board Chairperson Kathryn J. Olson

Attachment 37
P48

Re: Criterion 1120.140, Economic Feasibility, Conditions o. [illegible]

Dear Chairperson Olson:

Pursuant to State Board review criteria 1120.140(b), I hereby provide this signed and notarized statement, which certifies that the proposed project to establish an ambulatory surgical treatment center located at 360 W. Butterfield Road, Suite 100, Elmhurst, Illinois 60126 involves the leasing of a health care facility, and that expenses related to the lase are less costly than constructing a new facility.

Respectfully Submitted,

Neema Bayran, M.D.
Chief Executive Officer
Illinois Back & Neck Institute, LLC

Notary:

Subscribed and sworn to me this 20 day of October, 2017

Notary Public

Seal:

OFFICIAL SEAL
EDITH M DIAZ
Notary Public - State of Illinois
My Commission Expires Jul 23, 2018

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ATTACHMENT 38

Criterion 1110.230(b) - Safety Net Impact Statement

I. Overview

Pursuant to the Illinois Health Facilities Planning Act, 20 ILCS 3960/5.4 (the "Act"), any application related to a "substantive" project must include a Safety Net Impact Statement ("Impact Statement"). Substantive projects include the establishment of a health care facility, including ASTCs. As such, the Applicant hereby submits this Impact Statement in compliance with the Act's requirements.

II. Analysis

Section 5.4(c) of the Act provides that each CON applicant submitting a "substantive" project application must include an Impact Statement with its application for a permit. The Impact Statement must describe all of the following: (1) the project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge, (2) the project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant, and (3) how the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant. Each of these elements of the required Impact Statement is discussed below.

1. Impact on Essential Safety Net Services in the Community

Section 5.4(c)(1) of the Act requires an applicant to address whether the project will have a material impact on essential safety net services in the community, to the extent that it is feasible for an applicant not to have such knowledge. For the following reasons, the Applicant believes that the proposed project will not have an adverse impact on essential safety net services in the community.

- The proposed ASTC will give better access to healthcare generally, by providing another option for patients to obtain outpatient surgical services in a convenient and easily accessible location.
- The Applicant will enroll in the Medicaid program, adding to the list of qualified providers who accept Medicaid patients.
- The applicant will establish a charity care program.
- The ASTC will not provide any services that will harm, in any way, federally qualified health centers in the region. FQHCs do not provide surgical services.

For the above-referenced reasons, the proposed ASTC will not adversely impact existing providers of safety net services.

2. Impact on the Ability of Other Providers or Healthcare Systems to Cross-Subsidize Safety Net Services.

Section 5.4(c)(2) of the Act requires that an applicant discuss the project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant. Under this section cross-subsidization is understood to mean the practice of charging higher prices to one group of consumers in order subsidize lower prices for another group (*i.e.*, cost shifting to paying populations to offset losses incurred from assistance programs like charity care).

As previously noted, the Applicant's proposed ASTC will not harm, in any way, safety net providers in the market area. In fact, the ASTC should have a net positive effect in the community. For example, the closest surgery centers to the proposed site provide little to no outpatient surgical care for Medicaid patients.

ASTC	City	Distance from Project Site (Minutes)	Medicaid Percentage
Advantage Health Care	Wood Dale	15	0
Aiden Center for Day Surgery	Addison	17	0
DMG Surgical Center	Lombard	7	0
Elmhurst Medical and Surgical Center	Elmhurst	2	0
Elmhurst Medical and Surgical Center	Elmhurst	2	0
Loyola Ambulatory Surgery Center at Oak Brook Terrace	Oak Brook Terrace	4	4.6

Source: Illinois Department of Public Health, Hospital Report Card and Consumer Guide to Health Care Website, available at www.healthcarereportcard.illinois.gov/

As a Medicaid provider, the Applicant's ability to serve Medicaid beneficiaries is unique in this market area, as demonstrated by the information above. The Applicant's is committed to serving this vulnerable population and meeting their health needs in a compassionate and responsible way.

3. No Discontinuation of Safety Net Services

Section 5.4(c)(3) of the Act provides that an applicant must describe how the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the Applicant.

The permit request is for the expansion and modernization of an existing medical facility and not a discontinuation of a facility or services. As such, this part of the Statement is not applicable to the Project.

4. Additional Safety Net Impact Statement Information

The Act provides that the Statement must include all of the following:

(i) for the three (3) fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant (the amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act; non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the HFSRB),

(ii) for the three (3) years prior to the application, a certification of the amount of care provided to Medicaid patients (hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payer Source" and "Inpatient and Outpatient Net Revenue by Payer Source" as required by the HFSRB under Section 13 of the Act and published in the Annual Hospital Profile), and

(iii) information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

In satisfaction of this requirement, please find attaching to this Statement a certification signed by the Applicant's primary representative.

(a) Charity Care & Medicaid Tables

The Applicant is an established provider and is enrolled in Medicaid. As such, the Applicant provides services to Medicaid beneficiaries and offers charity care to needy patients. Below is a summary of historical data regarding Medicaid. In addition, the Applicant has provided services for free or at a significant discount for low-income patients who faced financial hardships. However, the Applicant did not have a formal charity program and did not track or document its charity care cases. The Applicant is currently developing financial assistance policy, a draft of which is attached hereto.

HISTORICAL MEDICAID CARE			
MEDICAID			
	Year 2015	Year 2016	Year 2017
Medicaid (# of patients)			41
Medicaid (revenue)	$		
Total			

The chart below provides an estimate of payer mix during the first two years of operation after the ASTC becomes operational. During the first two years of operation, the Applicant expects a lower amount of Medicaid and charity care patients, as the local community becomes aware of the Applicant's services. The Applicant expects the Medicaid and charity care patients to increase thereafter as the Applicant's marketing plans are implemented. Please note that the information below are only estimates based on the Applicant's current Chicago facility.

FORECASTED PAYER MIX			
	Year 2017	Year 2018	Year 2019
Private/Commercial Insurance	[percentage]		
Medicare			
Medicaid			
Self-Pay			
Third Party			
Worker's Compensation			
Charity Care	7		
TOTAL	100%	100%	100%

Illinois Back & Neck Institute

Financial Assistance Policy

In order to serve patients who may not have health insurance or other means to pay for necessary surgical services, Illinois Back & Neck Institute (IBNI) offers a comprehensive program of financial assistance for people in need of surgical services. Our Patient Assistance Program may be able to provide you with free or reduced-cost surgical services, if you meet the program's eligibility requirements.

Government Health Care Programs

IBNI participates in several government-sponsored health care programs, including the Illinois Medical Assistance Program (i.e., Medicaid). Before you can be considered for our patient Assistance Program, you must apply for Medicaid coverage, unless we independently determine that you are not likely to qualify for the program. If you would like more information regarding the Medicaid program, please contact the surgery center's manager.

Patient Assistance Program Eligibility

If you need help covering the cost of surgical procedures to be performed at our surgery center, you must apply for financial assistance before any such procedures are performed. There is no cost or fee required to apply for coverage by our Patient Assistance Program.

Eligibility for the program is based on your total household income. If your total household income is at or below 200% of the federal poverty level (FPL), as set forth annually by the U.S. Department of Health and Human Services, surgical services will be provided without expectation of payment. If your total household income is over 200% FPL, but less than 300% FPL, surgical services will be provided at a discounted cost, which will be determined on a sliding scale based on your total household income. Sliding scale discounts range from 10% to 90% of the cost of care. To apply, complete the attached Financial Assistance Screening Application and mail it to Illinois Back & Neck Institute, 360 W. Butterfield Road, Elmhurst, IL 60126 c/o Financial Assistance Program.

Coverage Not Guaranteed

IBNI must balance each patient's need for financial assistance with our responsibility to maintain the financial viability of the surgery center. To allow us to continue serving patients in our community, IBNI may not be able to cover the cost of your care even if you qualify for coverage by this program. Contact the surgery center's manager if you have questions about this policy.

Financial Assistance Screening Application

Patient Name: _____ Account #: _____

Current Address: _____ Phone Number: _____

By submitting this application, you are informing us that you are unable to pay for surgical services that you hope to receive at Illinois Back & Neck Institute (IBNI). Before IBNI will consider covering all or part of your costs, you must complete this form, answering every question, and provide certain information as identified below.

1. Are you employed at this time? **YES** ☐ **NO** ☐

If yes, what is your annual income? _____

Please provide a copy of your last two pay stubs along with this application.

2. Do you have any self-employment income? **YES** ☐ **NO** ☐

If yes, what it the total amount of this income? _____

3. Do you have any retirement, social security, or disability income? **YES** ☐ **NO** ☐

If yes, what is the total amount of this income?

4. Are you married? **YES** ☐ **NO** ☐

If yes, is your spouse covered under medical insurance that might pay for your health care costs? **YES** ☐ **NO** ☐

5. Do you have any credit cards (e.g., Visa, MasterCard, Discover, American Express) that you could use to pay your physician bill? **YES** ☐ **NO** ☐

6. Do you have a savings or checking account? **YES** ☐ **NO** ☐

7. Is someone providing room and board for you? **YES** ☐ **NO** ☐

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If yes, what is their name and relationship to you?

Name: _____ Relationship: _____

8. Will this person confirm in writing the level of support they give you? **YES** ☐ **NO** ☐

If yes, please provide a name, address, and phone number for this person

_____

_____

_____

9. If you have no support, how do you pay for your living expenses? Please provide a brief description below:

_____

_____

_____

10. What is your estimated annual income from all sources?

$_____

If you have additional sources of income, please provide further explanation on a separate page.

11. If appropriate, please fill out the attached "Medical Expenses & Outstanding Balances" form below, which identifies and describes the expenses that you have not been able to pay or that have outstanding balances.

12. Is there anything else that you wan to explain that my be relevant to our determination? If yes, please provide a brief explanation below:

I attest that the above information and all documentation provided are complete and accurate as shown. I realize that at any time, should any of this information provide to be false, I will accept responsibility for full payment of the balance. I understand that a credit inquiry may be conducted in order to evaluate my eligibility.

Requested By:

_____

Patient's Printed Name

Patient Signature:

_____ _____

Patient Signature (or Guardian's Signature) Date

_____

Guardian's Printed Name (if applicable)

Witness:

_____

Print Witness' Name

Witness Signature:

_____ _____

Witness' Signature Date

Coverage Not Guaranteed

IBNI MUST BALANCE EACH PATIENT'S NEED FOR FINANCIAL ASSISTANCE WITH OUR RESPONSIBILITY TO MAINTAIN THE FINANCIAL VIABILITY OF THE SURGERY CENTER. TO ALLOW US TO CONTINUE SERVING PATIENTS IN OUR COMMUNITY, IBNI MAY NOT BE ABLE TO COVER THE COST OF YOUR CARE EVEN IF YOU QUALIFY FOR COVERAGE BY THIS PROGRAM. CONTACT THE SURGERY CENTER'S MANAGER IF YOU HAVE QUESTIONS ABOUT THIS POLICY.

Initial: _____

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Medical Expenses & Outstanding Balances

Patient Name: _____ Account #: _____

Current Address: _____ Phone Number: _____

Name of Medical Facility, Physician, Physician Group, or Other Type of Health Care Provider	Month/Year of First Bill	Dollar Amount Remaining Due to Medical Facility, Etc.

ATTACHMENT 39

Charity Care and Medicaid Participation

The Applicant is an established provider and is enrolled in Medicaid. As such, the Applicant provides services to Medicaid beneficiaries and offers charity care to needy patients. Below is a summary of historical data regarding Medicaid. The Applicant has provided services for free or at a significant discount for low-income patients who faced financial hardships. However, the Applicant did not have a formal charity program and did not track or document its charity care cases. The Applicant is currently developing financial assistance policy, a draft of which is attached to Attachment 38.
In addition, the Applicant is developing financial assistance policy, a draft of which is included in Attachment 38.

HISTORICAL MEDICAID CARE			
MEDICAID			
	Year 2015	Year 2016	Year 2017
Medicaid (# of patients)			41
Medicaid (revenue)	$		
Total			

The table below provides an estimate of payer mix during the first two years of operation after the ASTC becomes operational. During the first two years of operation, the Applicant expects a lower amount of Medicaid and charity care patients, as the local community becomes aware of the Applicant's services. The Applicant expects the Medicaid and charity care patients to increase thereafter as the Applicant's marketing plans are implemented. Please note that the information below are only estimates based on the Applicant's current Chicago facility.

FORECASTED PAYER MIX			
	Year 2017	Year 2018	Year 2019
Private/Commercial Insurance	[percentage]		
Medicare			
Medicaid			
Self-Pay			
Third Party			
Worker's Compensation			
Charity Care	7		
TOTAL	100%	100%	100%

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Baker McKenzie.

Baker & McKenzie LLP

300 East Randolph Street, Suite 5000
Chicago, IL 60601
United States

Tel: +1 312 861 8000
Fax: +1 312 861 2899
www.bakermckenzie.com

Amalia S. Rioja
Tel: +1 312 861 2887
Amalia.Rioja@bakermckenzie.com

REC'

DEI

HEAL
SERVICES REVIEW BOARD

RECEIVED

DEC 1 2 2017

HEALTH FACILITIES &
SERVICES REVIEW BOARD

December 8, 2017

Illinois Health Facilities and Services Review Board
Illinois Department of Public Health
525 West Jefferson St., 2nd Floor
Springfield, IL 62761
Attention: State Board Chairperson Kathryn J. Olson

Re: Certificate of Need Application - Illinois Back & Neck Institute LLC

Dear Chairperson Olson:

We are submitting for your review and consideration an application for a Certificate of Need pursuant to the Illinois Health Facilities Planning Act (20 ILCS 3960/1 *et seq.*) on behalf of the Illinois Back & Neck Institute LLC for a proposed ambulatory surgery treatment center (ASTC), which will be located at 360 W. Butterfield Road, Suite 100, Elmhurst, Illinois 60126.

We respectfully request expedited consideration of this application because the proposed ASTC constitutes a substantive project. Thank you for your consideration.

Sincerely,

Amalia Rioja

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