[ORIGINAL] 18-002

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HEALTH FACILITIES & SERVICES REVIEW BOARD

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT
SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Retina Surgery Center
Street Address: 8780 W. Golf Rd., Suite 102
City and Zip Code: Niles 60714
County: Cook Health Service Area: VII Health Planning Area: A-08

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

Exact Legal Name: Retina Surgery Center, LLC
Street Address: 8780 W. Golf Rd., Suite 102
City and Zip Code: Niles 60714
Name of Registered Agent: Mark M. Lyman
Registered Agent Street Address:227 W. Monroe St. Suite 2650
Registered Agent City and Zip Code: Chicago 60606
Name of Chief Executive Officer: John Michael, MD
CEO Street Address: 8780 W. Golf Rd.
CEO City and Zip Code: Niles 60714
CEO Telephone Number: 847-297-8900

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: Brian Niehaus
Title: Senior Consultant
Company Name: The Advis Group
Address: 19065 Hickory Creek Dr. Suite 115 Mokena, IL 60448
Telephone Number: 708-478-7030
E-mail Address: bniehaus@TheAdvisGroup.com
Fax Number:708-478-7094

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

Name:
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

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: John Michaels, MD
Title: CEO
Company Name: Retina Surgery Center, LLC
Address: 8780 W. Golf Rd., Suite 102, Niles, IL 60714
Telephone Number: 847-297-8900
E-mail Address: 'johncmichael@aol.com'
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Golf Western, LLC
Address of Site Owner:8780 W. Golf Rd. Niles, IL 60714
Street Address or Legal Description of the Site: 8780 W. Golf Rd., Suite 102, Niles, IL 60714 **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: Retina Surgery Center, LLC
Address: 8780 W. Golf Rd., Suite 102, Niles, IL 60714

☐ 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.

Retina Institute of Illinois, P.C. proposes to establish a new Ambulatory Surgical Treatment Center (ASTC) located at 8780 W. Golf Rd., Suite 102, Niles, IL 60714. The applicant proposes to establish a limited specialty, single room ASTC offerings ophthalmologic surgical services with a specialization in retina surgeries.

The proposed project is classified as "substantive", as it proposes to establish a new ASTC.

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	n/a	n/a	
Site Survey and Soil Investigation	n/a	n/a	
Site Preparation	n/a	n/a	
Off Site Work	n/a	n/a	
New Construction Contracts	n/a	$267,500	$267,500
Modernization Contracts	$774,975	$124,525	$899,500
Contingencies	$77,400	$12,400	$89,800
Architectural/Engineering Fees	$24,000	$9,000	$33,000
Consulting and Other Fees	$7000		
Movable or Other Equipment (not in construction contracts)	$841,110	$72,166	$913,276
Bond Issuance Expense (project related)	$16,844	$7,156	$24,000
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	$14,037	$5,963	$20,000
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$1,748,366	$498,710	$2,247,076
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	**$1,000,000.00**		**1,000,000.00**
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources	**$748,366.00**	**$498,710.00**	**$1,247,076**
TOTAL SOURCES OF FUNDS	**$1,748,366**	**$498,710**	**$2,247,076**
NOTE: ITEMIZATIDN 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 $ _____.

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):

_____

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(c)]

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							
ASTC	$1,755,366		3,411	3,411			
Total Clinical	$1,755,366		3,411	3,411			
NON REVIEWABLE							
Administrative/Building Commons Space/ Stairs/shafts/etc.	$498,710		733	733			
Shell Space			647	647			
Total Non-clinical	$498,710		1,508	1,508			
TOTAL	**$2,247,076**		**4,919**	**4,919**			

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:					

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Retina Surgery Center, LLC* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
John Michael, MD PRINTED NAME	PRINTED NAME
President PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 24 day of January 2018	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

*Insert the EXACT legal name of the applicant

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

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 OROER 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?

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 DOCUMENTATION 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 Not Applicable

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 pattems 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(c) - 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:

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(c)(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.

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 viabillty 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(c)].

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.

Section I, Identification, General Information, and Certification
Applicants

An Illinois Certificate of Good Standing is included in this Attachment for Retina Surgery Center, LLC as Attachment-1 Exhibit-1.

File Number 0652935-6

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

RETINA SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON OCTOBER 02, 2017, 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* 9TH *day of* OCTOBER *A.D.* 2017 .

Authentication #: 1728201378 verifiable until 10/09/2018

Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Section I, Identification, General Information, and Certification
Site Ownership

The site, 8780 Golf Rd., Suite 102, Niles, IL 60714 is owned by Golf Western, LLC;

In order to evidence ownership, the applicant has included the following:

- Attachment 2-Exhibit 1: A copy of the current lease from Golf Western, LLC to Retina Surgery Center, LLC

LEASE

THIS LEASE, ("Lease") is made and entered into the _____ day of _____ 2018 between Golf Western, LLC, an Illinois limited liability company ("LESSOR") and Retina Surgery Center, LLC, an Illinois limited liability company, ("LESSEE").

WITNESSETH

LESSOR is the owner of the real property and all improvements thereon located at and commonly known as 8780 W. Golf Rd., Niles, Illinois and for and in consideration of the covenants herein, LESSOR does hereby demise and lease to LESSEE the real property known as 8780 W. Golf Rd., Suite 102, Niles, Illinois ("Premises").

1. Use of Premises. LESSEE shall use the Premises exclusively for providing health care services including the medical diagnosis, treatment, surgery, and care of patients and other services related thereto.

2. Term and Termination.

a. The term of this Lease shall commence on the date LESSEE obtains a Certificate of Need from the State of Illinois ("Effective Date") necessary to operate its business at the Premises and shall end on December 31, 2028 ("Initial Term"). After the expiration of the Initial Term, this Lease shall automatically renew for four (4) consecutive five (5) year terms. The Initial Term and any renewal term shall be referred to herein as the "Term".

b. Upon termination of this Lease, LESSEE shall remove all personal property and debris from the Premises and leave the Premises in a broom clean condition and return all keys.

3. Monthly and Additional Rent.

a. Monthly rent shall commence on the Effective Date at the fair market rental rate for the Premises ("Base Rent") and paid to LESSOR on the first day of each month. The Base Rent amount shall be finalized and agreed upon consistent with this Lease by LESSOR and LESSEE on or before the Effective Date and set forth in the Addendum to Lease attached hereto as Exhibit A which shall be executed by LESSOR and LESSEE and incorporated herein. In the event Base Rent first becomes due on a day other than the first day of the month, said first month's rent shall be prorated. Base Rent shall increase ten percent (10%) at the commencement of each subsequent five (5) year Term or such other amount as mutually agreed to between the parties.

b. As Additional Rent, LESSEE shall timely pay all costs and expenses during the Term which are assessed, levied, confirmed, or imposed on the Premises, including but not limited to, (a) all real property taxes and assessments, including special assessments; (b) occupancy and rent taxes; (c) water, water meter, and sewer rents, rates, and charges; (d) license and permit fees; (e) service charges, with respect to police protection, fire protection, sanitation, and water supply; (f) charges for utilities, communications, and other services rendered to or used in the Premises; and (g) any and all federal, state, county, and municipal governmental and quasi-governmental levies, fees, rents, assessments, or taxes and charges, general and special, ordinary

and extraordinary, foreseen and unforeseen, of every kind and nature whatsoever, and any interest or costs with respect thereto, which are assessed, levied, confirmed, imposed upon, payable out of, or in respect of, or would be charged with respect to, the Premises ("Additional Rent").

4. Net Lease. It is the intention of the parties that this Lease shall be a "Net Lease" and that all Base Rent shall be paid to LESSOR without diminution. The parties agree that all costs or expenses of whatsoever character or kind, general or special, ordinary or extraordinary, foreseen or unforeseen, and of every kind and nature whatsoever that may be necessary in or about the operation and occupancy of the Premises, and all improvements by LESSEE erected thereon, shall be paid by LESSEE, and all provisions of this Lease relating to any costs related to the Premises are to be construed in light of such intention and purpose that this Lease be a "Net Lease". LESSEE'S obligation to pay Base Rent or other charges payable under this Lease shall not terminate prior to the intended expiration of the Term as set forth herein.

5. Repairs, Maintenance and Improvements.

a. Except for the structural components of the Premises, the LESSEE, at its sole cost and expense, shall maintain the Premises in good order and condition, including but not limited to, the heating, air conditioning and ventilating system, the electrical system, the plumbing system, and all components associated with the foregoing to the extent such equipment exclusively serves the Premises.

b. LESSEE shall, at its own expense, keep and maintain the Premises in good order, maintenance and repair and shall keep the Premises in a clean, healthful and safe condition and in compliance with all applicable laws, ordinances and other governmental regulation, orders and directions during the Term of this Lease.

c. Except as otherwise provided herein, LESSOR shall have no obligations to maintain or repair the Premises during the Term. However, should LESSEE fail to perform its obligations as set forth above, LESSOR may, at LESSOR'S election, perform any maintenance and make all necessary repairs, restorations or replacements at LESSEE'S expenses and the costs thereof shall become additional rent payable in full by LESSEE on the first day of the month following the completion of such maintenance, repairs, restoration or replacements by LESSOR.

d. At its sole cost and expense, LESSEE may make improvements to the Premises provided such are completed in a good workmanlike manner, in compliance with all applicable permits and building and zoning laws and ordinances. All improvements made to the Premises by LESSEE must be approved in advance by LESSOR, such approval shall not be unreasonably withheld.

6. Insurance. At all times during the Term, LESSOR and LESSEE shall procure, keep and maintain in full force Comprehensive General Public Liability Insurance insuring against claims for personal injury, death or property damage occurring in connection with the use and occupancy of the Premises, Casualty and Property Damage Insurance written on an all risk, extended coverage basis, insuring against loss or damage, all in amounts mutually agreeable to the parties hereto.

7. Mechanic's Liens. LESSEE shall not suffer or permit the Premises to become subject to any mechanic's, laborers' or material lien on account of labor or material furnished or claimed to have been furnished to the Premises in connection with any work or improvement made or to have been made by, through or under LESSEE or at the direction or sufferance of LESSEE. In the event any such lien attaches to the Premises, LESSOR shall have the right, at its option, to pay and discharge said lien and, thereafter, the amount so paid by LESSOR shall become additional rent due and payable by LESSEE on the first day of the month following the month of such payment.

8. Default.

a. If LESSEE shall fail to pay any amount due and payable hereunder or if LESSEE shall fail to promptly keep and perform any other affirmative covenant of this Lease, strictly in accordance with the terms of this Lease, and shall continue in default for a period of ten (10) days after written notice thereof by LESSOR to LESSEE, then and in any such event, LESSEE shall be considered in Default and LESSOR may (i) declare this Lease terminated, or (ii) relet the Premises applying said rent from the new LESSEE on this Lease and LESSEE shall be responsible for no more than the difference, if any, between the rent to be paid by LESSEE for the then remaining balance of the then current Term.

b. No remedy herein conferred upon or reserved to LESSOR shall be considered to exclude or suspend any other remedy but the same shall be cumulative and shall be in addition to every other remedy given hereunder now or hereafter existing at law or in equity or by statute. No delay or omission by LESSOR in exercising any right or remedy arising from LESSEE'S default shall impair or bar such right of LESSOR, or be construed as a waiver by LESSOR of such default.

9. Hold-Over. If, at the termination of this Lease, whether by lapse of time or otherwise, LESSEE retains possession of the Premises, then LESSOR, at its option, within thirty (30) days after the termination of such Term, may serve written notice upon LESSEE that such holding over constitutes either (a) renewal of this Lease for one (1) year, and from year-to-year thereafter, at the then-current Base Rent plus ten percent (10%), or (b) create a month-to-month tenancy, upon the terms of this Lease. If no such written notice is served by LESSOR then a tenancy at sufferance with rental as stated above shall have been created. The provisions of this paragraph shall not constitute a waiver by LESSOR of any right of reentry as hereinafter set forth, nor shall receipt of any rent or any other act in apparent affirmance of LESSEE'S tenancy operate as a waiver of the right of LESSOR to terminate this Lease for breach of any of the covenants herein.

10. Waiver of Subrogation. Whenever (a) any loss, cost, damage or expense resulting from fire, explosion or other casualty or occurrence is incurred by either of the parties to this Lease in connection with the Premises or the contents therein, and (b) such party is then covered in whole or in part by insurance with respect to such loss, cost, damage or expense, then to the extent of any amount recovered by reason of such insurance, such party releases the other from any liability with respect to such loss and waives any right of subrogation which might otherwise exist in or accrue to any person on account thereof, provided that such release of liability and waiver of right of subrogation shall not be operative in any case where the effect thereof is to invalidate such insurance coverage or increase the costs thereof.

11. Condemnation.

a. In the event that the whole of the Premises or so much thereof as to render the balance of the Premises completely unusable for the purposes hereinabove set forth, shall be taken or condemned by any public authority having the power of eminent domain, or conveyed to such public authority in lieu of the exercise of its power of eminent domain, then the Term of this Lease shall cease upon but not before the date when possession of the Premises, or such portion thereof so taken, shall be required by the condemning authority, and all rent shall be paid up to that day. LESSEE shall have no right to share in such award except as provided below.

b. All damages awarded for such taking or compensation made for such conveyance whether for the whole or any part of the Premises shall belong to and be the sole property of the LESSOR whether such damages or compensation are paid for the diminution in value to the leasehold or to the fee of the Premises; provided, however, that LESSOR shall not be entitled to any separate award made to LESSEE for loss of business, depreciation to or cost of removal of equipment or fixtures, regardless of whether such separate award is made as a result of LESSEE'S contest of LESSOR'S right to receive the entire award for diminution in value of the leasehold or of the fee.

12. Subletting and Assignment. LESSEE shall not assign this Lease, either in whole or in part, nor sublease, transfer, or hypothecate the leasehold interest of LESSEE or any interest therein, without first obtaining LESSOR'S consent thereto in writing, such consent not to be unreasonably withheld. No permitted assignment or subleasing shall relieve LESSEE of its obligations in this Lease contained, nor shall any assignment or transfer of this Lease be effective until there shall have been delivered to LESSOR a document executed by LESSEE and proposed assignee, wherein and whereby such assignee assumes for the benefit of LESSOR due performance of the obligations of LESSEE in respect of the payments to be made by LESSEE and the obligations to be performed by LESSEE under the terms of this Lease to the end of the Term.

13. Subordination. Except LESSEE'S rights in Section 11(b) and as otherwise hereinafter provided, the rights and interest of LESSEE under this Lease shall be subject and subordinate to any mortgage or trust deed that may be placed upon the Premises and to any and all advances to be made thereunder, and to the interest thereon, and all renewals, and extensions thereof. Any mortgagee or trustee may elect, by written notice only, to give the rights and interest of LESSEE under this Lease priority over the lien of its mortgage or deed of trust. In such event, the rights and interest of the mortgagee shall be deemed to be subordinate to and not have priority over the rights of the LESSEE regardless of whether this Lease is dated prior to or subsequent to the date of said mortgage or trust deed. In addition, LESSEE shall, upon the request of LESSOR, or any such mortgagee or trustee, execute and deliver whatever instructions may be required to confirm the purposes of this Section, and in the event LESSEE fails so to do within ten (10) days after demand in writing, LESSEE does hereby make, constitute and irrevocably appoint LESSOR as its attorney in fact and in its name, place, and stead to do so. No further instrument is necessary for LESSEE'S subordination of the Lease to be effective and LESSEE agrees to execute and deliver a Subordination, Non-Disturbance and Attornment Agreement to LESSOR'S mortgagee.

14. Miscellaneous.

a. LESSEE agrees to indemnify, defend and hold LESSOR and its shareholders, directors and officers harmless from and against any and all liabilities, obligations, claims, charges, penalties, damages, causes of action, judgments, suits, costs and other expenses (including reasonable attorney's fees) imposed upon or incurred by or asserted against LESSOR or its shareholders, directors and officers arising directly or indirectly from (i) the use and occupancy of or damage to the Premises by LESSEE, (ii) any accident, injury to or death of persons or loss of or damage to property occurring on or about the Premises, (iii) breach by LESSEE of any of its covenants under this Lease and/or any suit brought by LESSOR to enforce the provisions hereof, and (iv) any penalty, damages or charges imposed for any violation of any laws or ordinances by LESSEE.

b. LESSOR, except for its negligent acts or omissions, shall not be responsible or liable to LESSEE for any loss or damage resulting to LESSEE or its property from burst, stopped or leaking water, gas, sewer or steam pipes or electrical or heating failures or for any damage or loss of property within the Premises from any cause whatsoever.

c. This Lease shall not be recorded.

d. Time is of the essence of this Lease and all provisions herein relating thereto shall be strictly construed.

e. Any notice required or permitted under this Lease shall be deemed sufficiently given or served if personally delivered or via email or facsimile with confirmation at the address of the Premises or last known email address or facsimile number.

f. This Lease constitutes the entire agreement of the parties, all prior agreements are terminated and all understandings are merged herein.

g. This Lease shall be binding upon the parties hereto and their respective successors, assigns, heirs, beneficiaries and personal representatives.

h. This Lease shall be governed by the laws of the State of Illinois.

i. This Lease may be terminated at anytime by LESSEE prior to the Effective Date for any reason whatsoever or modified upon mutual agreement of the parties.

IN WITNESS WHEREOF, the parties hereto have executed this Lease on the date first written above.

LESSOR:	LESSEE:
Golf Western, LLC, an Illinois limited liability company	Retina Surgery Center, LLC, an Illinois limited liability company
_____	_____
John Michael, as Manager	John Michael, as Manager

EXHIBIT A

ADDENDUM TO LEASE

This Addendum to Lease ("Addendum") is entered into this _____ day of _____ 2018 regarding the Lease for the premises located at 8780 W. Golf Rd., Suite 102, Niles, Illinois dated _____, 20____ ("Lease") between Golf Westem, LLC, an Illinois limited liability company ("LESSOR") and Retina Surgery Center, LLC, an Illinois limited liability company, ("LESSEE").

RECITALS

WHEREAS, the parties hereto desire to enter into this Addendum setting forth the Base Rent to be paid pursuant to the Lease.

NOW THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. The recitals set forth above are hereby incorporated in this Addendum.

2. The Base Rent amount is $7,378.50 per month and subject to increases pursuant to Section 3(a) in the Lease.

3. All other provisions and terms in the Lease shall remain in full force and effect.

4. In the event of any conflict or inconsistency between the terms of the Lease and this Addendum, the terms and conditions in this Addendum shall control and prevail.

LESSOR:	LESSEE:
Golf Western, LLC, an Illinois limited liability company	Retina Surgery Center, LLC, an Illinois limited liability company
_____	_____
John Michael, as Manager	John Michael, as Manager

Exhibit 1

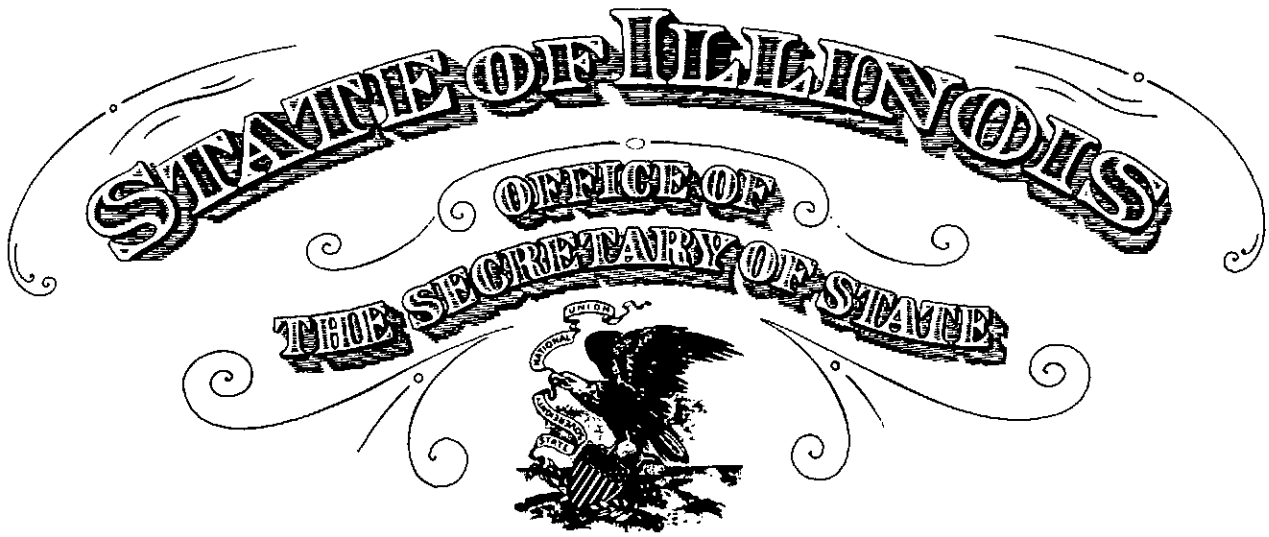
Section I, Identification, General Information, and Certification
Operating Entity/Licensee

Please see the attached Certificates of Good Standing for Retina Surgery Center, LLC. Persons with 5% or greater interest in the facility are listed below.

Retina Surgery Center, LLC	
John Michael, M.D.	100%

Attachment - 3

File Number 0652935-6



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

RETINA SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON OCTOBER 02, 2017, 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.

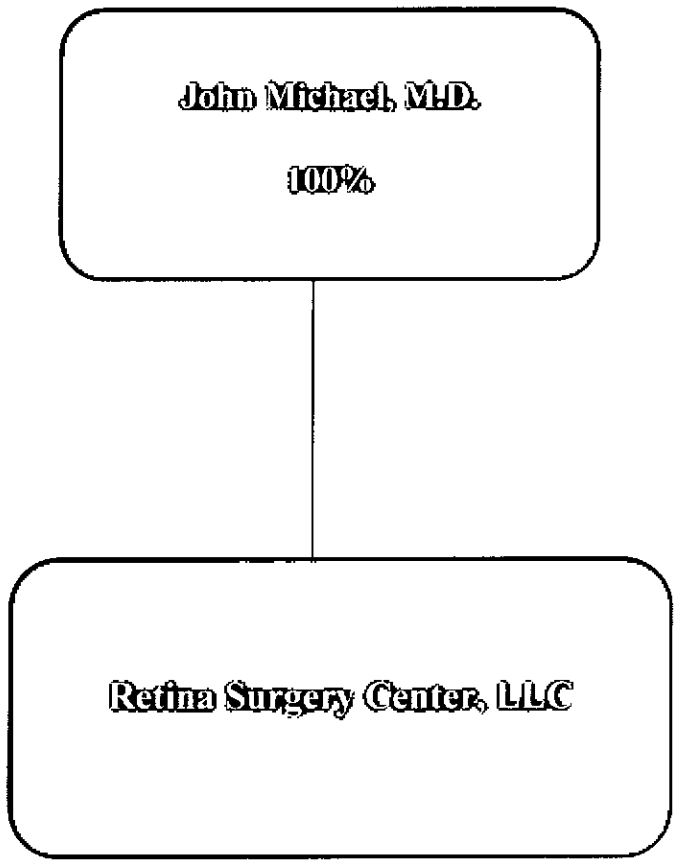
In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 9TH *day of* OCTOBER *A.D.* 2017 .

Authentication #: 1728201378 verifiable until 10/09/2018
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Section I, Identification, General Information, and Certification
Organizational Relationships



Attachment - 4

Section I, Identification, General Information, and Certification
Flood Plain Requirements

This project complies with Illinois Executive Order #2005-5.

Please find included with this Attachment:

- A Flood Plain map generated using FEMA's flood map generator for 8780 Golf Rd. Niles, IL 60714 indicating that the location is out of the flood zone.

FEMA's National Flood Hazard Layer (Official)

Oata from Flood Insurance Rate Maps (FIRMs) where available digitally. New NFHL FIRMette Print app available: http://tinyurl.com/j4xwp5e

USGS The National Map: Orthoimagery | National Geospatial-Intelligence Agency (NGA); Delta State University; Esri | Print here instead: http://tinyurl.com/j4xwp5e Support: FEMAMapSpecialist@riskmapcds.com | USGS The National Map: Orthoimagery

Section I, Identification, General Information, and Certification

Historic Resources Preservation Act Requirements

The Historic Preservation Act determination from the Illinois Historic Preservation Agency is attached at Attachment – 6.

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois Department of Natural Resources

One Natural Resources Way Springfield, Illinois 62702-1271
www.dnr.illinois.gov

Bruce Rauner, Governor
Wayne A. Rosenthal, Director

FAX (217) 524-7525

Cook County
Niles
CON - Rehabilitation to Establish an Ambulatory Surgical Treatment Center
8780 Golf Road
SHPO Log #011101117

October 23, 2017

Jake Beechy
Murer Consultants, Inc.
19065 Hickory Creek Dr., Suite 115
Mokena, IL 60448

Dear Mr. Beechy:

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

Section I, Identification, General Information, and Certification
Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	n/a	n/a	
Site Survey and Soil Investigation	n/a	n/a	
Site Preparation	n/a	n/a	
Off Site Work	n/a	n/a	
New Construction Contracts (Base Building Upgrades)	n/a	$267,500	$267,500
Modernization Contracts	$774,975	$124,525	$899,500
Contingencies (10%)	$77,400	$12,400	$89,800
Architectural/Engineering Fees	$24,000	$9,000	$33,000
Consulting and Other Fees (Equipment Planning) any other consultants?	$7,000		
Movable or Other Equipment (not in construction contracts)	$841,110	$72,166	$913,276
Medical Equipment	$736,000		
Medical Gas Alarms, manfolds, vacuum pumps	$50,000		
IT / Sound / Security /Nurse Call / AV	$55,110	$23,166	
Signage		$13,000	
Furniture / Appliances		$36,000	
Bond Issuance Expense (project related)	$16,844	$7,156	$24,000
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	$14,037	$5,963	$20,000
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$1,748,366	$498,710	$2,247,076
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	**$ 1,000,000**	**$ 0**	**$ 1,000,000**
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Debt Financing	**$ 748,366**	**$ 498,710**	**$ 1,247,076**
TOTAL SOURCES OF FUNDS	**$ 1,748,366**	**$ 498,710**	**$ 2, 247,076**

Attachment - 7

Section I, Identification, General Information, and Certification
Cost Space Requirements

Cost Space Table							
		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							
ASTC	$1,755,366		3,411		3,411		
Total Clinical	$1,755,366		3,411		3,411		
NON REVIEWABLE							
Administrative/Building Commons Space/ Stairs/shafts/etc.	$498,710		733	733			
Shell Space			647	647			
Total Non-clinical	$498,710		1,508	1,508			
TOTAL	**$2,247,076**		**4,919**	**4,919**			

Section I, Identification, General Information, and Certification
Background of the Applicant

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable:

   Retina Surgery Center, LLC does not own or operate any other licensed health care facility.

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:

   Retina Surgery Center, LLC does not own or operate any other licensed health care facility.

3. See Attachment 11-Exhibit 1, which includes authorization from Retina Surgery Center, LLC certifying that there have been no adverse actions against its facilities listed above and permitting HFSRB and IDPH access to any documents necessary to verify the information submitted in this application.

4. Not Applicable.

John C. Michael, M.D.
Rumya R. Rao, M.D.
Matthew M. Wessel, M.D.
Preeti R. Poley, M.D.

RETINA INSTITUTE OF ILLINOIS

Diseases & Surgery of the Retina, Macula, and Vitreous

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36100 Brookside Dr.,
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Gurnee, IL 60031
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Fax:(847) 855-2503

December 29, 2017

Kathryn J. Olson
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson,

In keeping with 77 Ill. Adm. Code § 1110.230(a) (Background of the Applicant – Information Requirements) please find this letter of certification and authorization.

Specifically, this letter certifies that Retina Surgery Center LLC does not own any healthcare facilities and has had no adverse actions taken against them in the three years (3) prior to the filing of this application.

Furthermore, Retina Surgery Center, LLC authorizes the Health Facilities and Services Review Board and the Illinois Department of Public Health to access any documents necessary to verify the information submitted, including, but not limited to: official records of the IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.

Sincerely,

John Michael, M.D.
Retina Surgery Center, LLC

Notarization:
Subscribed and sworn to before me this 8th day of January, 2016. 2018

Lisa Marie Janosek
Signature of Notary
SEAL

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

Section III, Background, Purpose of the Project, and Alternatives – Information Requirements
Criterion 1110.230(a) – Purpose of the Project, Safety Net Impact Statement and Alternatives

PURPOSE OF THE PROJECT

1. The Applicant, Retina Surgery Center, LLC, herein requests HFSRB's approval to establish an Ambulatory Surgical Treatment Center ("ASTC"), to be known as known as Retina Surgery Center ("RSC"). The applicant proposes to develop the facility with one (1) operating room and four (4) recovery rooms, including shell space for an additional operating room and 4 recovery rooms. The ASTC will offer ophthalmology services, with a focus on providing specialized retina surgeries.

The primary purpose of the project is to enable the applicant to meet the current and future needs of its patients and the community for high quality, cost efficient and accessible outpatient ophthalmologic surgical care. The establishment of the facility will enable the Applicant to meet this objective by addressing existing issues identified by the Applicants.

Specifically, the project aims to meet the following objectives:

A. Meet the Community Need for Specialized Retina Surgical Services

Dr. Michael and the additional physicians associated with this project (See, attached Physician Referral Letters in Appendix I) focus on retina procedures that require specialized equipment and expertise not present at many of existing ASTCs in the area. Specialized equipment necessary for the procedures includes vitrectomy machine, operating microscope, laser, cryoretinopexy, special gases, specific reusable and disposable operating room instruments, gases, and indirect ophthalmoscopes.

Currently, only area hospitals and two nearby ASTCs have been identified as providers of the equipment required to conduct the retina surgeries anticipated to be performed at the proposed facility by the applicant. Northwest Surgicenter and Belmont/Harlem Surgery Center have been identified by Retina Surgery Center, LLC as possessing the necessary equipment to perform the retina surgeries. However, there are significant difficulties with the two ASTCs that cause a direct detriment to patient care. For example, Northwest Surgicenter has a D.O.R.C. machine for retina surgeries, which is the not the Alcon machine preferred by the RSC physicians. Furthermore, none of the hospital operating rooms currently utilized by the applicant utilizes the D.O.R.C. machine, making the transition difficult and not ideal for patient outcomes. Similarly, Belmont/Harlem as many restrictive admission policies, as discussed in attachment-25, that directly affect the applicant's ability to provide high quality care to its patients.

In contrast to the above facilities, the proposed ASTC will increase service accessibility by providing increased community access to high quality care in a convenient setting, reduced costs from the hospital outpatient setting, and optimized surgical processes while expanding the ability to offer patients a continuum of care at a familiar site of service, Retina Surgery Center, LLC.

B. Continue Transition from Hospital to ASC Setting

ASTCs provide quality care at a fraction of the cost of hospital outpatient departments by requiring lower overhead costs and focusing solely on the efficient treatment of patients with specialized staff. As the nation continues to drive down the costs of health care, ASTCs are a proven vehicle to achieve cost savings for patients and payors. Current research demonstrates that the ASTC setting is less costly, more efficient, and more convenient for patients and their family.

Research by Elizabeth Munnich and Stephen Parenta, published in Health Affairs Vol. 33, Issue 5, May 2014, concludes that ASTCs provide better care at lower costs than hospital for appropriate patients. On average, the study found procedures performed in ASCs take 31.8 fewer minutes than those performed in hospitals—a 25 percent difference relative to the mean procedure time. Higher risk patients were found to have 2.5% fewer readmissions when treated in an ASTC versus a hospital, and similar patients were less likely to visit an emergency department or be admitted to a hospital following an outpatient surgery when treated in an ASTC rather than a hospital.

ASTCs reduce out-of-pocket expenses for patients by generally charging lower rates than hospitals for surgical procedures (See Chart A Below). The Medicare Payment Advisory Council (MedPac) stated in report to Congress that "ASCs can offer greater convenience to patients and providers. In addition, program spending and beneficiary cost sharing are lower in ASTCs than in HOPDs on a per service basis. Therefore, a migration of surgical services from HOPDs to ASTCs could reduce aggregate program spending and beneficiary cost sharing." (MEDPAC: Report to Congress: Medicare Payment Policy, Section 2C: Ambulatory surgical centers March 2010).

CHART A: ASTC vs. Hospital Reimbursement Examples

HCPCS Code	HCPCS Descriptions	ASC	OPPS	Difference ($)	Difference (%)
66825	Repositioning of IOL	$ 978.21	$1,868.23	$ 890.02	191%
66840	Lensectomy (aspiration)	$ 978.21	$1,868.23	$ 890.02	191%
67025	Injection of Vit sub/Silicone oil	$ 978.21	$1,868.23	$ 890.02	191%
67036	Pars Plana Vitrectomy	$1,750.01	$3,495.22	$ 1,745.21	200%
67039	PPV w/Focal Endolaser	$1,750.01	$3,495.22	$ 1,745.21	200%
67040	PPV w/PRP endolaser	$1,750.01	$3,495.22	$ 1,745.21	200%
67041	PPV w/ERM peel	$1,750.01	$3,495.22	$ 1,745.21	200%
67042	PPV w/ILM peel (hole/edema)	$1,750.01	$3,495.22	$ 1,745.21	200%
67101	RD repair Cryotherapy	$ 198.46	$1,868.23	$ 1,669.77	941%
67105	RD Repair Laser	$ 170.83	$ 473.38	$ 302.55	277%
67107	RD repair Scleral buckle	$1,750.01	$3,495.22	$ 1,745.21	200%
67108	RD repair PPV	$1,750.01	$3,495.22	$ 1,745.21	200%
67110	RD Repair Pneumatic	$ 496.34	$1,868.23	$ 1,371.89	376%
67113	Repair of complex RD	$1,750.01	$3,495.22	$ 1,745.21	200%
67141	RD Prophylaxis Cryo to Holes/tears	$ 145.17	$ 262.19	$ 117.02	181%
67145	RD Prophylaxis laser to holes/tears	$ 254.05	$ 473.38	$ 219.33	186%
67210	Focal Laser	$ 254.05	$ 473.38	$ 219.33	186%
67221	PDT	$ 158.63	$ 473.38	$ 314.75	298%
67228	PRP	$ 177.29	$ 473.38	$ 296.09	267%
67515	Sub Tenons Injection	$ 44.86	$ 262.19	$ 217.33	584%

Research has confirmed the MedPac projections. Drs. Brent Fulton and Sue Kim concluded that ASTCs saved the Medicare program and its beneficiaries $7.5 billion from 2008 to 2011. The researchers noted that the study was focused upon the Medicare program, but noted that because ASTCs generally "charge private payers less than their hospital outpatient department counterparts, similar savings also exist in the commercial health market." (Medicare Savings Tied to Ambulatory Surgery Centers, University of California-Berkley School of Public Health, September 2013).

Removed from the hospital setting, ASTCs allow surgeons to be more efficient due to faster room turnover, specialized focuses, and designated surgical times that are not impacted by emergent and trauma cases that can create longer wait times for patients. With easier access to facility parking, reduced wait times, and optimized procedure flow, ASTC services result in higher patient satisfaction. A 2008 Press Ganey survey found an average patient satisfaction of 92% for care and service in ASTCs. (Press Ganey Associates, "Outpatient Pulse Report," 2008.)

C. Provide for Emergency Operative Capabilities for Traumatic Injuries

Another premise upon which RSC is proposing the required ASTC is to address an issue for area patients who required immediate access to care for traumatic eye injuries. Dr. Michael is a leader in the field regarding retina detachments, which in many cases is a very time sensitive and complex injury. Patients with traumatic eye injuries do not have the luxury of waiting to schedule an appointment at another ASTC which may not come to fruition due to scheduling concerns and unreliability of staff at the two area ASTCs that have the appropriate equipment.

By establishing an ASTC within the same building as his practice location, Dr. Michael will be better able to provide the necessary immediate services in a convenient and comfortable setting which the patient would be accustomed.

D. Provide Increased Quality And Care Initiatives For Patients Requiring Intravitreal Injections

There is much evidence to suggest that intravitreal injections can be safely performed in an office based setting. This is further shown by the quality of care that Dr. Michael is able to provide his patients, as he current provides this procedure in his office-based setting. However, in an effort to increase the quality of care for his patients, the applicant proposes to transition these injections to the OR setting. Studies show that performing the IVR injections in an operating room setting have shown a dramatic decrease in complications following the injection. (Freiberg, et al., 2017)

Based upon the study, the researchers found that the amount of post injection complications was four to six times lower than injections performed in an office-based setting. This recently published information, which was conducted between 2003 – 2016, evidences the direct increase in patient quality that can be afforded by performing the injections in the operating room, as proposed by the applicant.

2. **Market Area / GSA.**

As demonstrated on Attachment 25 Exhibit 2, PHSC intends to serve primarily Chicago's Northwest and West metropolitan areas surrounding Chicago. Section 1110.1540(b) of the HFSRB's rules states that the Geographic Service Area (GSA) includes all zip codes within 45-minutes driving time under normal conditions from the intended site of PHSC. The applicants have attached a map of the areas within 45 minutes at Attachment 12 – Exhibit 1.

Below are the approximate 45 minute travel times from RSC around the GSA. These were developed using MapQuest.

- Northwest to Wauconda – 45 minutes
- North to Zion - 45 minutes
- Northeast to Beach Park - 45 minutes
- East to Evanston - 45 minutes

- Southeast to Chicago's Logan Square Neighborhood - 45 minutes
- South to Palos Park - 45 minutes
- Southwest to Wheaton - 45 minutes
- West to Gilberts - 45 minutes

3. **Existing Problems.**

As outlined in the above responses, the applicants are addressing the following issues through the expansion of the ASTC:

A. The Community Need for Specialized Retina Surgical Services
B. Transition Surgeries from the Hospital to ASTC Setting to Reduce Costs
C. Provide for Emergency Operative Capabilities for Traumatic Injuries

4. **Source Documents.**

- MEDPAC, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 95 (Mar. 2010), *available at* http://www.medpac.gov/documents/Mar10_EntireReport.pdf.
- Cost and Benefits of Competing Healthcare Providers: Trade-Offs in the Outpatient Surgery Market, Elizabeth L. Munnich and Stephen T. Parente, University of Notre Dame, May 2013.
- Medicare Savings Tied to Ambulatory Surgery Centers, University of California-Berkley School of Public Health, Brent Fulton and Sue Kim, School of Public Health, University of California Berkely, September 2013.
- Market Analysis by Sg2 for Outpatient Surgeries in ASTCs
- ASTC Market White Paper by Pinnacle III
- Freiberg, Florentina & Brynskov, Troels & Munk, Marion & Sørensen, Torben & Wolf, Sebastian & Wirth, Magdalena & Becker, Matthias & Michels, Stephan. (2017). Low Endophthalmitis Rates After Intravitreal Anti-Vascular Endothelial Growth Factor Injections In An Operation Room: A Retrospective Multicenter Study. Retina. 1. 10.1097/IAE.0000000000001488.

5. **Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.**

As described above, RSC will enhance the continuum of care for patients by enabling treatment prior to, during, and after surgery, thus improving quality of care, lowering costs, and lessening the burden on patients. It has also created a venue for immediate treatment for patients. Additionally, RSC has improved access to ensure timely patient care and to better accommodate the growing demand for its services.

Likewise, patients are increasingly likely to seek treatment at ASTCs instead of hospital outpatient departments because of reduced costs. RSC has helped meet this increase in demand and reduce costs for the patient, payors, and healthcare system as a whole. The proposed project will not only provide specialized services for patients which are otherwise lacking in the community, but will likely reduce wait times, and provide more convenient and faster scheduling for patients.

6. **Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals.**

The above responses detail the goals of the project to address identified issues to improve the health and well-being of the community. The significant objectives and timeframes for completing the project are as follows:

- The first goal is to finalize the drawings and obtain the necessary permit approvals by June 2018

- The second goal is to begin construction in July 2018 and complete the shell and core for the ASTC by January 2019.
- The third goal is to have the expansion of the facility approved for occupancy and operational by February 2019.

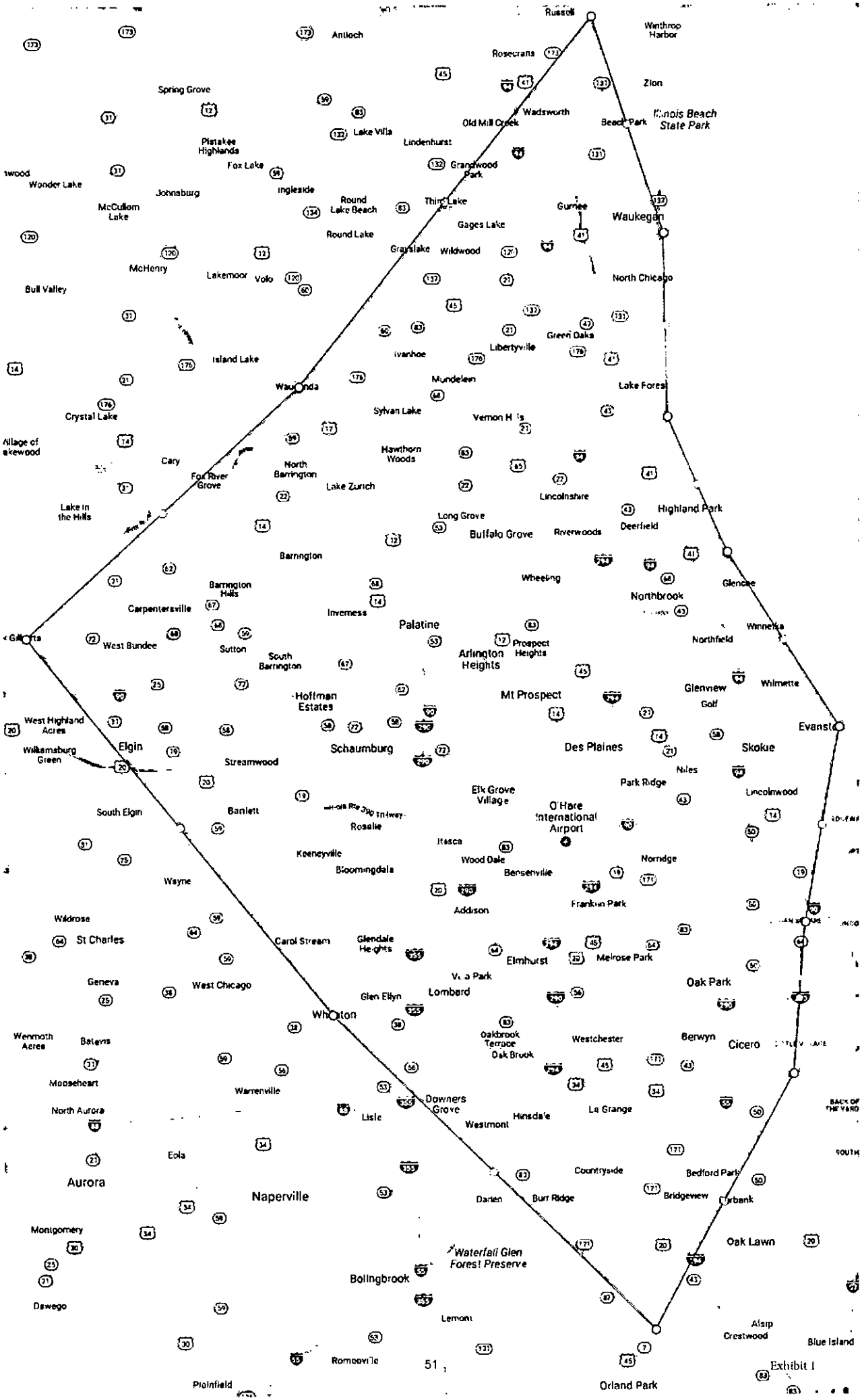

Russell
Winthrop Harbor
Antioch
Rosecrans
Zion
Spring Grove
Waukegan
Illinois Beach State Park
Old Mill Creek
Beach Park
Lake Villa
Lindenhurst
Grandwood Park
Pistakee Highlands
Fox Lake
Wonder Lake
Johnsburg
Ingleside
Round Lake Beach
Third Lake
Gurnee
McCullom Lake
Gages Lake
Round Lake
Grayslake
Wildwood
McHenry
Lakemoor
Volo
North Chicago
Bull Valley
Libertyville
Green Oaks
Ivanhoe
Island Lake
Mundelein
Lake Forest
Crystal Lake
Sylvan Lake
Vernon Hills
Hawthorn Woods
Cary
Fox River Grove
North Barrington
Lake Zurich
Lincolnshire
Highland Park
Lake in the Hills
Long Grove
Buffalo Grove
Riverwoods
Deerfield
Barrington
Wheeling
Glencoe
Barrington Hills
Northbrook
Carpentersville
Inverness
Palatine
Winnetka
West Dundee
Sutton
South Barrington
Arlington Heights
Prospect Heights
Northfield
Hoffman Estates
Mt Prospect
Glenview
Wilmette
Golf
West Highland Acres
Evanston
Elgin
Schaumburg
Des Plaines
Skokie
Williamsburg Green
Streamwood
Niles
Park Ridge
Lincolnwood
Elk Grove Village
South Elgin
Bartlett
O'Hare International Airport
Roselle
Itasca
Keeneyville
Wood Dale
Norridge
Bloomingdale
Bensenville
Wayne
Addison
Franklin Park
Wildrose
St Charles
Carol Stream
Glendale Heights
Elmhurst
Melrose Park
Villa Park
Oak Park
Geneva
West Chicago
Glen Ellyn
Lombard
Wheaton
Oakbrook Terrace
Oak Brook
Westchester
Berwyn
Cicero
Wenmoth Acres
Batavia
Mooseheart
Warrenville
Downers Grove
North Aurora
Lisle
Hinsdale
La Grange
Westmont
Eola
Countryside
Bedford Park
Aurora
Naperville
Darien
Burr Ridge
Bridgeview
Burbank
Montgomery
Oak Lawn
Waterfall Glen Forest Preserve
Bolingbrook
Oswego
Lemont
Alsip
Crestwood
Blue Island
Romeoville
Plainfield
Orland Park

Exhibit 1

By Elizabeth L. Munnich and Stephen T. Parente

DOI: 10.1377/hlthaff.2013.1281
HEALTH AFFAIRS 33,
NO. 5 (2014): 764–769

Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up

Elizabeth L. Munnich (beth.munnich@louisville.edu) is an assistant professor of economics at the University of Louisville, in Kentucky.

Stephen T. Parente is a professor of finance and associate dean at the Carlson School of Management, University of Minnesota, in Minneapolis.

ABSTRACT **During the past thirty years outpatient surgery has become an increasingly important part of medical care in the United States. The number of outpatient procedures has risen dramatically since 1981, and the majority of surgeries performed in the United States now take place in outpatient settings. Using data on procedure length, we show that ambulatory surgery centers (ASCs) provide a lower-cost alternative to hospitals as venues for outpatient surgeries. On average, procedures performed in ASCs take 31.8 fewer minutes than those performed in hospitals—a 25 percent difference relative to the mean procedure time. Given the rapid growth in the number of surgeries performed in ASCs in recent years, our findings suggest that ASCs provide an efficient way to meet future growth in demand for outpatient surgeries and can help fulfill the Affordable Care Act's goals of reducing costs while improving the quality of health care delivery.**

Technological developments in medicine have dramatically changed the provision of surgical care in the United States during the past thirty years. Advances in anesthesia and the development of laparoscopic surgery in the 1980s and 1990s made it possible for patients to be discharged the same day as their surgery, whereas previously they would have had to spend several days in the hospital recovering.[1,2] The introduction of the Medicare inpatient prospective payment system in 1983 created additional incentives for hospitals to shift patient care from inpatient to outpatient departments.[3]

Between 1981 and 2005 the number of outpatient surgeries nationwide—performed either in hospital outpatient departments or in freestanding ambulatory surgery centers (ASCs)—grew almost tenfold, from 3.7 million to over 32.0 million. Outpatient procedures represented over 60 percent of all surgeries in the United States in 2011, up from 19 percent in 1981.[4]

The expansion of health insurance coverage under the Affordable Care Act (ACA) presents opportunities to explore new ways to accommodate the increased demand for outpatient services. In addition, the ACA's goals of reducing the cost and improving the quality of health care delivery makes it increasingly important to find alternatives to existing methods of care delivery that cost less and are in more flexible settings.

ASCs are such an alternative to hospital outpatient departments. The number of ASCs has grown quickly to meet the rising demand for outpatient surgery services since the 1980s.[5] Whereas outpatient departments provide a range of complex services, including inpatient and emergency services, ASCs provide outpatient surgery exclusively. Since most ASCs focus on a limited number of services, they may provide higher-quality care at a lower cost than hospitals that offer a broad range of services.[6] Similar to retail clinics that meet primary care needs, ASCs offer convenient, relatively low-cost access to health care services.[7]

This article addresses the possibilities for ASCs

to generate substantial cost savings in outpatient surgery by presenting new evidence on the cost advantages of these centers relative to hospital outpatient departments. This is particularly important in light of the anticipated growth in demand for outpatient surgeries, in part as a result of the ACA.

Background On Ambulatory Surgery Centers

The number of outpatient surgeries has grown considerably in the United States since the early 1980s. Outpatient surgery volume across both hospital-based and freestanding facilities grew by 64 percent between 1996 and 2006, according to the National Survey of Ambulatory Surgery.[8]

Physicians receive the same payment for an outpatient procedure, regardless of whether it occurred in an ASC or a hospital. However, payments to facilities differ between settings. In general, reimbursements for outpatient procedures in hospitals are higher than those for procedures in ASCs, to account for the fact that compared to ASCs, hospitals must meet additional regulatory requirements and treat patients whose medical conditions are more complex.[9] However, there is little evidence about the extent of cost advantages of ASCs, since these facilities have not historically reported cost or volume data. In spite of the limited availability of information about ASC costs, the Centers for Medicare and Medicaid Services has adjusted the relative facility payments over time to reflect speculative cost differentials across the two types of outpatient surgery facilities.[10]

Changes in reimbursement levels for outpatient procedures have likely contributed to fluctuations in the number of ASCs in recent years. In 2000 Medicare's traditional cost-based reimbursement system for outpatient care in hospitals was replaced with the outpatient prospective payment system, which reimburses hospitals on a predetermined basis for what the service provided is expected to cost.

Noting the dramatic growth in outpatient surgeries performed in ASCs relative to hospitals around the same time, the Centers for Medicare and Medicaid Services subsequently made efforts to reduce ASCs' payments. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 froze ASCs' payment updates, and between 2008 and 2012 Medicare phased in a new system for ASCs' payments based on the outpatient prospective payment system.[9,11] The rates were set so that for any outpatient procedure, payments to ASCs would be no more than 59 percent of payments made to hospitals, phased in fully by 2012. This policy change reduced incentives to treat patients in ASCs, which may have contributed to slower growth in this sector in recent years (Exhibit 1).

In spite of reduced incentives for treating patients outside of hospitals, growth in outpatient volume was greater in ASCs than in hospitals during the period 2007–11. For example, volume among Medicare beneficiaries grew by 23.7 percent in ASCs, compared to 4.3 percent in hospital outpatient departments (Exhibit 2). This suggests that physicians and patients still increasingly prefer outpatient surgery in ASCs to that in hospitals, because of either perceived advantages in cost and quality or resource constraints that inhibit hospitals' ability to meet the growing demand for outpatient surgeries.

ASCs have been praised for their potential to provide less expensive, faster services for low-risk procedures and more convenient locations for patients and physicians, compared to outpatient departments.[11–14] However, if hospitals are better equipped to treat high-risk patients, treating higher-risk patients in ASCs could have negative consequences for patient outcomes.

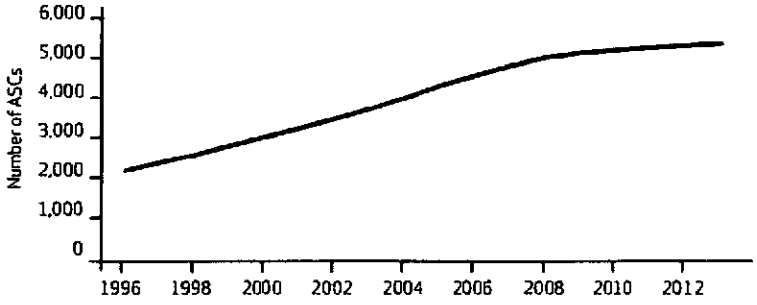
There is little evidence about the quality of care provided in ASCs or their ability to function as substitutes for hospitals in providing outpatient surgery. Comparisons of outcomes between these two types of outpatient facilities are complicated by the fact that ASCs tend to treat a healthier mix of patients than hospitals do. Thus, any differences in observed outcomes between the two settings could reflect differences in underlying patient health instead of differences in quality of care.

Elsewhere, we used variations in ASC use generated by changes in Medicare reimbursements to outpatient facilities to show that patients treated in ASCs fare better than those treated in hospitals.[15] In particular, we considered the likelihood that patients undergoing one of the five highest-volume outpatient procedures[16] visited an emergency department or were admitted to the hospital after surgery. These outcomes have been used in the medical literature as proxies for quality in outpatient surgical care.[17,18] These measures are also interesting from a policy perspective: As of October 2012, as part of the Ambulatory Surgical Center Quality Reporting Program,[19] ASCs are required to report transfers of patients directly from the ASC to a hospital and hospital admissions of ASC patients upon discharge from the facility.

Our findings indicate that the highest-risk Medicare patients were less likely than other high-risk Medicare patients to visit an emergency department or be admitted to a hospital following an outpatient surgery when they were treated in an ASC, even among similar patients

EXHIBIT 1

Number Of Medicare-Certified Ambulatory Surgery Centers (ASCs), 1996–2013



SOURCE Kay Tucker, director of communications, Ambulatory Surgery Center Association, October 29, 2013.

undergoing the same procedure who were treated by the same physician in an ASC and a hospital. These results indicate that ASCs provide high-quality care, even for the most vulnerable patients.

In this article we examine the question of whether or not ASCs are less costly than hospital outpatient departments. The answer to this question is not straightforward, since little is known about surgery cost and volume in ASCs. The often-cited cost differential between ASCs and outpatient departments is frequently attributed to differences in reimbursement rates for the two types of facilities, which reflect hospitals' greater complexity of patients and procedures. But for an average patient undergoing a high-volume procedure, are ASCs more efficient than hospital outpatient departments?

Study Data And Methods

Our analysis incorporated one important aspect of cost in the outpatient surgery setting: the time it takes to perform procedures in ASCs and hospital outpatient departments. For data on that time, we used the National Survey of Ambulatory Surgery. This survey of outpatient surgery in hospitals and freestanding surgery centers in the United States was conducted by the Centers for Disease Control and Prevention from 1994 to 1996 and in 2006.

The 2006 data include patients' diagnoses, demographic characteristics, and surgical procedures, as well as information about length of surgery and recovery for 52,000 visits at 437 facilities. There are four length-of-surgery measures: time in the operating room; time in surgery (a subset of time in the operating room); time in postoperative care; and total procedure time (time in the operating room, time in postoperative care, and transport time between the operating room and the recovery room).

Previous research has documented differences in surgery time between ASCs and hospital outpatient departments.[12,20] However, observed differences in procedure time may reflect underlying differences in patients' characteristics, instead of differences in efficiency between the two types of facilities. To address this concern, we estimated the relationship between outpatient setting and procedure time, controlling for a patient's primary procedure, number of procedures, and characteristics such as underlying health and demographics.[21]

EXHIBIT 2

Number Of Outpatient Surgery Visits, By Facility Type, 2007 And 2011

Type	2007	2011	Change (%)
Ambulatory surgery center	373,284	461,718	23.7
Freestanding	260,466	344,292	32.2
Hospital-based	112,818	117,426	4.1
Hospital outpatient department	1,173,309	1,224,218	4.3
All types	1,546,593	1,685,936	9.0

SOURCE Authors' analysis of a 5 percent sample of Medicare claims data. NOTE The numbers of outpatient department visits include only those that involved at least one surgical procedure.

Study Results

It is the nature of outpatient procedures that the patient spends most of his or her time in a surgical facility preparing for and recovering from surgery, not actually undergoing the surgery (Exhibit 3). This suggests that organization, staffing, and specialization may play a large role in the cost differenees between ASCs and hospital outpatient departments.

Our estimates of the time savings for ASC treatment suggest that ASCs are substantially faster than hospitals at performing outpatient proeedures, after procedure type and observed patient characteristics are eontrolled for (Exhibit 4). On average, patients who were treated in ASCs spent 31.8 fewer minutes undergoing procedures than patients who were treated in hospitals—a difference of 25 percent relative to the mean procedure time of 125 minutes (Exhibit 3). Thus, for an ASC and a hospital outpatient department that have the same number of staff and of operating and recovery rooms, the ASC can perform more procedures per day than the hospital can.

We estimated the cost savings for an outpatient procedure performed in an ASC using the results presented above and estimates of the cost of operating room time. Estimated charges for this time are $29–$80 per minute, not including fees for the surgeon and anesthesia provider.[22] Our

calculation suggests that even excluding physician payments and time savings outside of the operating room, ASCs could generate savings of $363–$1,000 per outpatient case.

These results support the claim that ASCs provide outpatient surgery at lower costs than hospitals. However, they provide little information about what is driving these cost differences.

Terrence Trentman and coauthors discuss several factors that affect patient flow and could result in differences in preoperative and recovery times for outpatient procedures between in ASCs and hospitals.[20] For example, compared to the situation in hospitals, in ASCs surgeons are more likely to be assigned to a single operating room for all cases, which reduces delays; the operating room is often closer to the preoperative and recovery rooms, because facilities are smaller; teams of staff have clearer and more consistent roles, with less personnel turnover; and staffing is not done by shifts—that is, staff members go home only after all cases are finished, which creates incentives to work quickly. In addition, hospitals may be more likely to have emergency add-on and bring-back cases for more complex cases that compete with outpatient procedures for operating room time.

These differences suggest that hospitals would have to adopt a substantially different and highly specialized organizational model to achieve the same efficiencies as ASCs.

Discussion

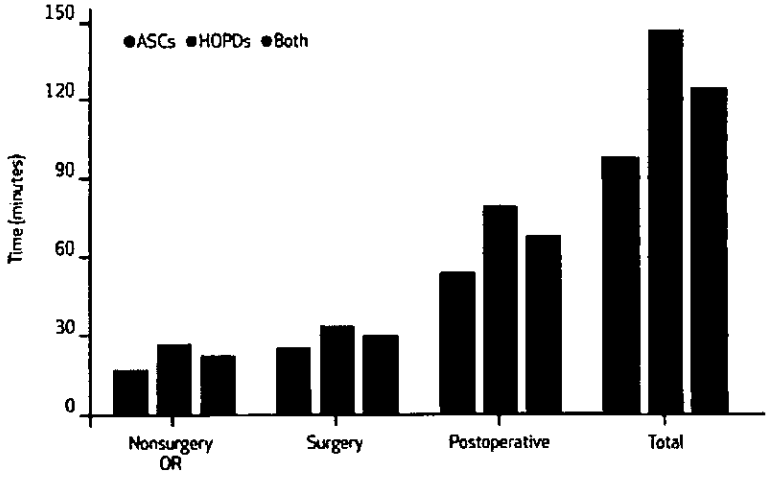
The findings presented here provide evidence that ASCs are a lower-cost alternative to hospitals for outpatient surgical procedures. The tremendous growth in the number of ASCs since the 1980s suggests that these facilities are quite flexible in meeting the growing demand for outpatient services. This is not surprising, given that ASCs have a smaller footprint than hospitals, which makes them less costly to build—particularly in urban environments, where available land may be scarce or difficult to acquire.

The Congressional Budget Office projects that as a result of the ACA, an additional twenty-five million people will have health insurance by 2016.[23] The question of whether the current supply of health care providers will be able to accommodate the anticipated surge in demand for services resulting from the ACA has received a considerable amount of attention.[24]

To get a sense of the magnitude of the anticipated growth in the outpatient surgery market following the ACA, we used a microsimulation model to project hospital outpatient surgical volume through 2021 (for details about the model, see the online Appendix).[25] Our estimates indicated that outpatient surgical volume in hospitals alone will increase by 8–16 percent annually between 2014 and 2021, compared to annual

EXHIBIT 3

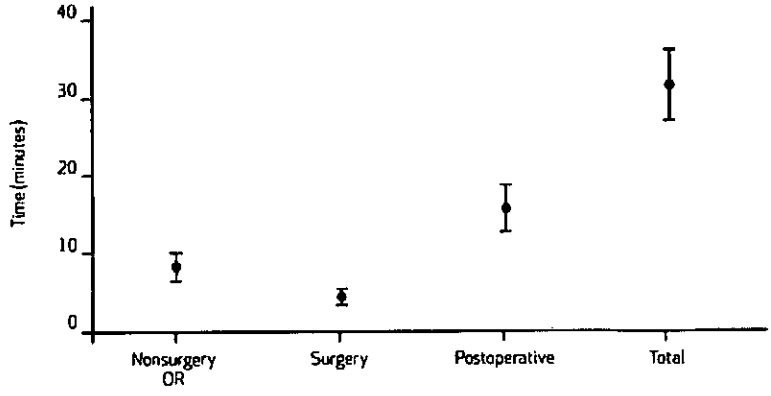
Average Outpatient Surgical Procedure Time, By Facility Type, 2006



SOURCE Authors' analysis of data from the 2006 National Survey of Ambulatory Surgery. **NOTES** Estimates were weighted using sample weights. ASC is ambulatory surgery center. HOPD is hospital outpatient department. "Both" is both types of facilities. OR is operating room. "Total" is total procedure time, from entering the operating room to leaving postoperative care, as described in the text.

EXHIBIT 4

Estimated Time Savings for Ambulatory Surgery Centers (ASCs) Relative to Hospital Outpatient Departments



SOURCE Authors' analysis of data from the 2006 National Survey of Ambulatory Surgery. **NOTES** Estimates and standard error bars represent results from separate ordinary least squares regressions of nonsurgical time in the operating room, surgery time, postoperative recovery time, and total time on an indicator for treatment in an ASC. [Total time is total procedure time, from entering the operating room to leaving postoperative care, as described in the text.] All regressions controlled for primary procedure, total number of procedures, patient's risk score, age, sex, disability status, type of insurance, and an indicator for whether the facility was located in a Metropolitan Statistical Area. The full specifications for these regressions are available in the online Appendix (see Note 25 in text). Data were balanced across surgery and postoperative time components; the final sample included 34,467 observations. Estimates were weighted using sample weights. Standard errors were clustered at the facility level. All estimates are significant ($p < 0.01$). OR is operating room

growth rates of 1–3 percent in the previous ten years.

We did not have adequate data on surgical volume in ASCs to produce an equally precise estimate for the projected demand in this sector attributable to the ACA. However, our results indicate substantial growth even in hospital outpatient surgical volume, which has been growing at a much slower rate than ASC surgical volume. The trends in the growth in the number of ASCs before the passage of the ACA and our model for projected growth in the number of hospital outpatient department procedures suggest that it will be increasingly important to identify ways to accommodate growing demand for outpatient surgery. This is particularly important since hospitals will also likely face increased demand for other types of outpatient visits besides surgery after the ACA is implemented.

25 million

Procedures

The roughly 5,300 ASCs in the United States provide more than 25 million procedures each year.

The rapid growth in the number of procedures performed at ASCs in recent years is a good indication of the ability of the market to expand quickly when there are sufficient incentives for it to do so. The range of surgeries performed in ASCs has increased considerably since the 1980s. In 1981 Medicare covered 200 procedures that were provided in ASCs. Today about 3,600 different surgical procedures are covered under Medicare's ASC payment system.[9] Consequently, the volume of procedures performed in ASCs has increased dramatically, and the share of all outpatient surgeries performed in freestanding ASCs increased from 4 percent in 1981 to 38 percent in 2005.[26,27] The Ambulatory Surgery Center Association has estimated that roughly 5,300 ASCs provide more than twenty-five million procedures annually in the United States.[27]

Physicians who have an ownership stake in an ASC obtain greater profits from performing procedures in these facilities rather than in hospitals. Since physicians receive the same payment for their services regardless of whether procedures are performed in an ASC or a hospital, one implication of ASCs' lowering the cost of outpatient surgery without the price being adjusted accordingly—therefore leading to higher profit per procedure—is that it could create greater incentives for providers to recommend unnecessary procedures in physician-owned ASCs, a concept known as demand inducement. Another consequence of demand inducement is that physicians may respond to the increased number of patients with health insurance—as a result of the ACA—by performing surgeries that are not clinically indicated. Future research should examine the implications of reductions in the cost of outpatient surgery for demand inducement.

Conclusion

The ASC market faces challenges to meeting increased demand for outpatient surgery. As noted above, recent reimbursement changes have lowered payments to ASCs, which reduces the incentives to start or expand these facilities.

This gap in reimbursement is likely to continue to widen because Medicare's reimbursement rates for hospital procedures are updated annually according to projected changes in hospital prices, whereas ASC reimbursements are updated annually according to projected changes in the prices of all goods purchased by urban consumers, and medical spending is increasing at a much faster rate than other spending in the US economy. Furthermore, the disparity between medical and other consumer spending is expected to increase over time.

Critics of ASCs argue that these facilities "cherry pick" profitable patients and procedures, diverting important revenue streams from hospitals.[28–31] In combination with research on the quality of care in ASCs,[15] the findings in this article indicate that ASCs are a high-quality, lower-cost substitute for hospitals as venues for outpatient surgery. Increased use of ASCs may generate substantial cost savings, helping achieve the ACA's goals of reducing the cost and improving the quality of health care delivery. ■

These findings were previously presented at the National Bureau of Economic Research Hospital Organization and Productivity Conference, Harwich, Massachusetts, October 4–5, 2013.

NOTES

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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

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.

Berkeley
UNIVERSITY OF CALIFORNIA

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.

- $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 HOPD 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 HOPDs, 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.

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.

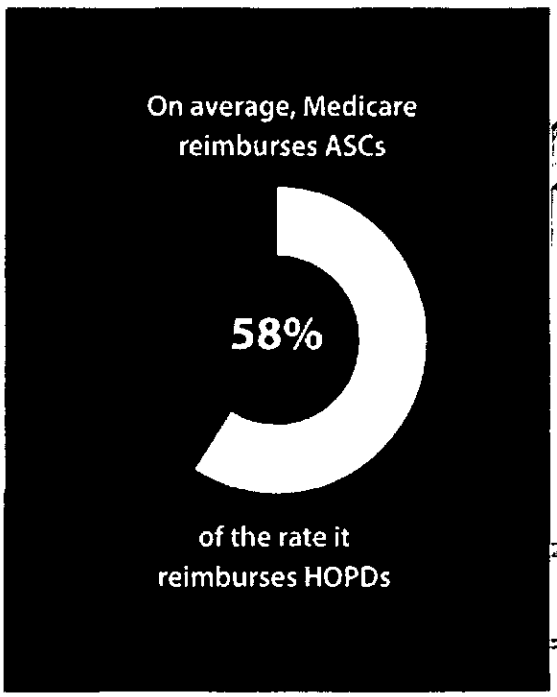
Ambulatory Surgery Centers are modern health care facilities focused on providing a range of same-day surgical care, the same types of procedures that were once performed exclusively in hospitals. Today, as a result of medical advancements and new technologies—including minimally invasive surgical techniques and improved anesthesia—a range of procedures can be performed safely and effectively on an outpatient basis.

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 HOPD, 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.



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.

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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.

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.

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.

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

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.

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.

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.

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.

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

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)		
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 (cti)	$2	-18.47%	30%	38%	34%	0.4	8.5	$2	$2	$2	$4	$6	$5	1%	$386
33	64520	N block lumbar/thoracic	$1	-13.74%	23%	29%	26%	0.6	8.8	$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	40.8	$1	$2	$2	$2	$3	$2	1%	$82
36	20552	Inj trigger point 1/2 musc	$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	8.58%	45%	55%	76%	32.8	45.5	$243	$303	$416	$409	$509	$700	5%	$268
38	45380	Colonoscopy and biopsy	$187	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	$282	$278	$236	$293	$403	5%	$281
40	45378	Diagnostic colonoscopy	$66	8.27%	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	$118	$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	1.81%	40%	50%	68%	3.8	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 rsk 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	29888	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	8.86%	53%	67%	90%	2.6	3.6	$25	$31	$42	$39	$49	$66	5%	$268
53	29824	Shoulder arthroscopy/surgery	$11	8.45%	33%	42%	57%	1.8	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	$18	3.72%	68%	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	8.8	$20	$25	$34	$27	$34	$47	5%	$1,426
57	14060	Skin tissue rearrangement	$9	8.50%	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%	8.3	8.4	$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

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)		
61	25447	Repair wrist joint(s)	$7	1.12%	47%	58%	80%	8.4	8.5	$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%	8.4	8.5	$13	$16	$19	$10	$23	$27	5%	$736
64	29822	Shoulder arthroscopy/surgery	$6	2.28%	36%	45%	61%	8.5	8.7	$18	$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	28278	Release of foot contracture	$5	3.82%	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	2.8	$18	$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
78	67924	Repair eyelid defect	$5	3.72%	61%	76%	90%	8.3	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	Cystascopy 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	8.7	$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	8.77%	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	$18	$9	$11	$15	5%	$530
81	67961	Revision of eyelid	$3	1.27%	55%	69%	90%	8.2	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	8.17%	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	$18	$14	5%	$229
85	66258	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%	8.7	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	$185	$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

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)		
91	67042	Vit for macular hole	$13	7.78%	42%	53%	90%	0.7	8.9	$26	$32	$55	$36	$45	$77	10%	$1,234
92	52332	Cystoscopy and treatment	$18	5.10%	13%	16%	36%	2.6	3.6	$15	$18	$42	$27	$34	$78	18%	$794
93	67041	Vit for macular pucker	$9	7.36%	40%	50%	90%	8.5	8.6	$19	$24	$42	$24	$30	$54	10%	$1,234
94	65855	Laser surgery of eye	$8	18.98%	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%	8.4	0.6	$14	$18	$19	$24	$30	$32	10%	$801
96	31255	Removal of ethmoid sinus	$8	11.19%	39%	49%	90%	8.6	0.8	$17	$21	$38	$22	$28	$51	10%	$933
97	67036	Removal of inner eye fluid	$6	18.53%	38%	47%	90%	8.4	8.5	$13	$16	$31	$18	$23	$43	10%	$1,234
98	31267	Endoscopy maxillary sinus	$6	11.09%	37%	46%	90%	8.5	8.7	$11	$14	$26	$18	$22	$44	10%	$933
99	38140	Resect inferior turbinate	$6	16.88%	39%	48%	90%	8.5	8.7	$12	$15	$28	$16	$20	$37	10%	$773
100	67108	Repair detached retina	$6	11.99%	34%	43%	90%	0.4	8.5	$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%	8.3	8.4	$10	$12	$27	$13	$17	$36	10%	$1,234
104	$2204	Cystoscopy w/biopsy(s)	$5	7.61%	19%	24%	55%	8.8	1.1	$9	$11	$25	$13	$16	$37	10%	$794
105	20610	Drain/inject joint/bursa	$4	18.62%	8.5%	1%	1%	153.1	212.8	$8	$18	$24	$12	$14	$33	10%	$149
106	31256	Exploration maxillary sinus	$4	8.96%	37%	46%	90%	8.3	8.4	$7	$9	$18	$12	$14	$28	10%	$933
107	31276	Sinus endoscopy surgical	$4	22.38%	33%	41%	90%	8.4	0.5	$18	$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	$18	$13	$29	10%	$437
109	67255	Reinforce/graft eye wall	$3	6.57%	50%	63%	90%	8.3	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%	8.2	8.3	$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%	8.7	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%	03%	0.8	1.8	$2	$2	$5	$3	$3	$8	10%	$117
120	51700	Irrigation of bladder	$0.5	29.91%	3%	4%	10%	4.8	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

Produced with cost savings analysis from

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.

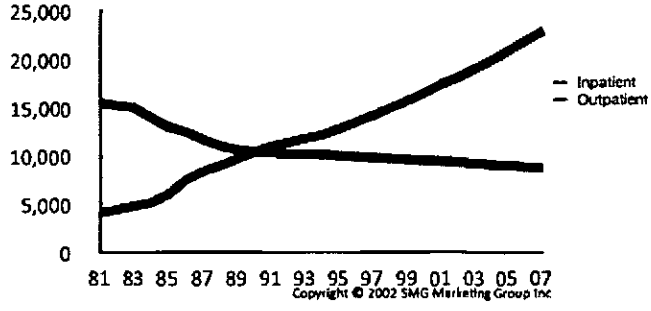
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling 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.

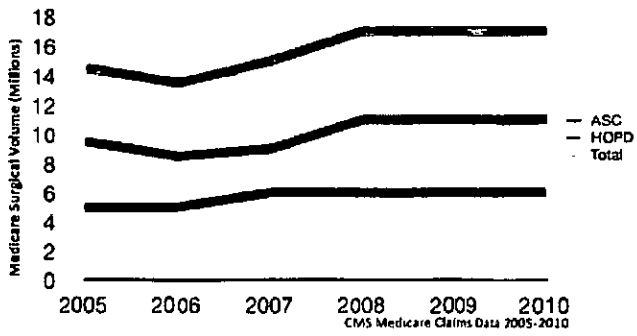
Given the history of their involvement in making ASCs a reality, it is not surprising that physicians continue to have at least some ownership in virtually all (90%) ASCs. But what is more interesting to note is how many ASCs are jointly owned by local hospitals that now increasingly recognize and embrace 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



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.

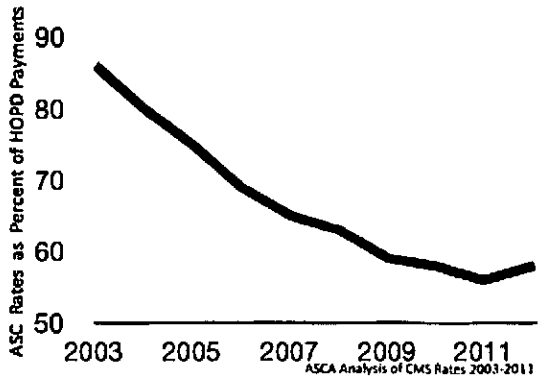
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased 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

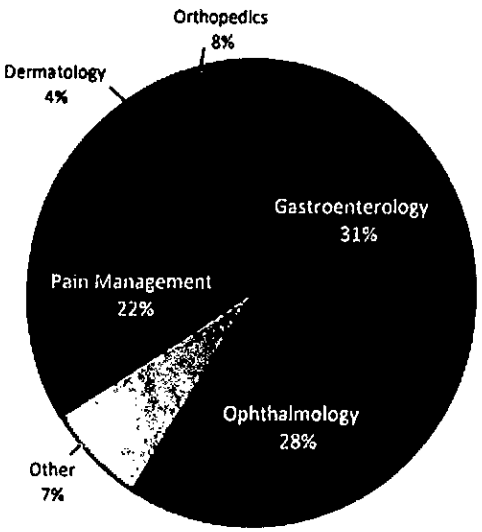


ASCA Analysis of CMS Rates 2003-2011

THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

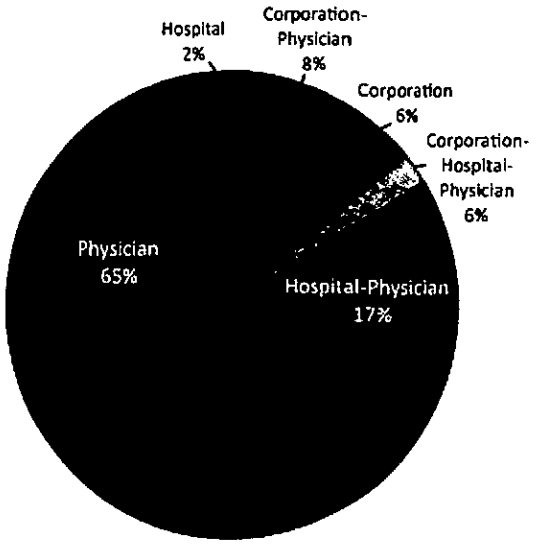
Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price 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.

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.

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 Proceduras	Jan 1, 2012
Influenza Vaccination Coverage for Health Care Workers	Jan 1, 2013

76 Federal Regulation 74492 - 74517

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

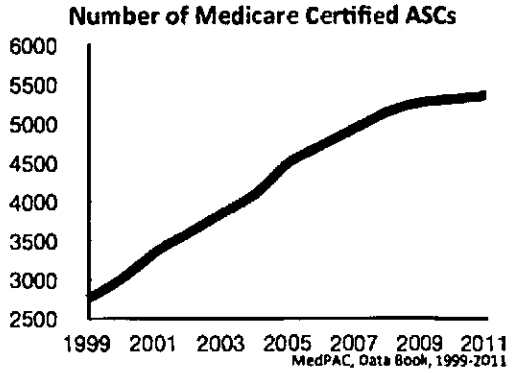
CONTINUED DEMAND FOR ASC FACILITIES

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

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.

Section III, Background, Purpose of the Project, and Alternatives
Criterion 1110.230(c) – Purpose of the Project, Safety Net Impact Statement and Alternatives

Alternatives

The proposed project will provide the Retina Surgery Center, LLC with the operational capacity within the ASTC to provide high quality, complex surgeries which are lacking within the community.

Three alternatives were evaluated and were rejected by the applicants.

1. **Maintain *Status Quo***

The first alternative considered was to maintain the status quo by not establishing a facility. This alternative was dismissed because it would not address the main purposes of the project, to increase capacity in line with demand and equip the facility with the necessary and preferred equipment to provide complex retinal surgeries. The inability to provide the quality of care for patients requiring specialized ophthalmological services deprives patients and the community of access to the high quality, lower cost, convenient, and specialized care needed.

As related in Attachment 12, research has shown that ASTCs are more convenient locations, with shorter waiting times, and easier scheduling relative to a hospital setting. Establishing an on-site ASTC would allow its surgeons to maintain more control over their work environment, customize surgical environments, and train its staff for their highly specialized services. This increases patient satisfaction and has a positive correlation with patient outcomes.

Exposing patients to the hospital setting also increases the risk of infection. This risk would be reduced at RSC, where patients could receive immediate surgical attention in a more controlled environment. Additionally, RSC seeks to provide its specialized care at a lower cost to patients than is available in the Hospital setting. Providing services at other local, multi-specialty ASTCs will not provide the specialized, central care these patients need. Further, most other area ASTCs are not equipped to provide the surgeries the applicants intend to address as part of this application.

There is no direct cost for the applicant associated with maintaining the status quo.

This alternative was rejected because maintaining the status quo does not address the identified issues upon which the project is based.

2. **Reducing the Scope and Size of Current Project**

The next alternative considered was to reduce the size and the scope of the project. The applicant is currently seeking approval to establish a single specialty, single operating room and accompanying recovery rooms for the ASTC (which shall include shell space for a second OR). The applicant investigated and considered the alternative option of only adding one operating room without shell space, but it was ultimately dismissed. The current plan for one operating rooms and 4 recovery rooms is necessary to address the service demand for the facility, and to plan for the future expected demand.

As addressed within Attachments, 12, 15 and 25 of this application, the projected surgical volumes for surgeons at RSC will be compliant with the state standards for one (1) operating room. The applicants demonstrate that the facility will operate at or above state utilization standards within the first two years of completion of the project. Limiting the expansion to one operating room without shell space is also anticipated to cause an increase in total costs per operating room. This is due to inefficiencies in design

and construction for building out a single operating room versus one operating room with potential for a second.

By expanding the facility to two operating rooms, the facility will be equipped to handle the new procedures and meet the existing and projected demand.

Due to the above conclusions, the applicants did not determine the exact cost of a build-out of just one operating room. The cost would likely have fallen below the current project costs. Although the reduction in rooms would have reduced the price of the immediate expansion and modernization project, it does not outweigh the benefit of adding two (2) operating rooms.

The alternative plan of only adding one operating room was therefore rejected by the applicants.

3. Establish a new ASTC to meet the needs of the community

The applicant chose to establish a new ASTC to include one Operating Room and support areas to meet its current and future patient demand. This was the only alternative that addresses all of the purposes for the project. Establishing an ASTC enables the applicants to:

A. The Community Need for Specialized Retina Surgical Services
B. Transition Surgeries from the Hospital to ASTC Setting to Reduce Costs
C. Provide for Emergency Operative Capabilities for Traumatic Injuries

The cost of this alternative is **$2,247,076.**

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(a), Size of the Project

The proposed project by Retina Surgery Center will incorporate 4,919 sq. ft. The entire 4,919 sq. ft. is necessary and will be used for the treatment of patients. The construction plans also include necessary shell space allocation in the amount of 647 sq. ft. to plan for expected facility expansion.

The state standard for new construction is 2075-2750 BGSF per Treatment Room.[1] With ASTC designated space totaling 4,919 sq. ft., there will be 4,919 sq. ft. per operating room at the facility, which although is outside of the applicable state standards, it is necessary to both accommodate the existing facility's physical configurations that has constraints and impediments. The functional designed of the facility allows for functional flow of patients and visitors. Patients begin at an Entry/Waiting/Reception space before entering the Pre-operation bays. There are also administrative staff areas nearby including a staff lounge and business office. This leg of the 'L'-shaped suite is dedicated as the first entering location for multiple uses including staff, visitors, and patients. This allows for a one-way flow into and then out of the surgical suite which would otherwise not be possible since the surgical suite fills the corner of the 'L' configuration. The remaining portion of the 'L'-shaped suite is then dedicated to the primary clinical areas as defined below.

Upon leaving the pre-op area past the control station, the semi-restricted operating suite is entered through a single set of double doors, promoting a one-way flow. Scrub stations and operating rooms fill the suite corner as sterilization (soiled, clean workroom, and clean storage), equipment storage, anesthesia workroom, and laundry/J.C. areas surround them. The surgical suite then includes one-way flow into the recovery area complete with both Stage I and Stage II bays, nurse station, and related support areas. Finally, patients can be discharged through the rear of the suite. Staff also have the opportunity to enter the rear of the suite and go through a unisex one-way-flow staff changing area to enter the semi-restricted surgical suite.

Furthermore, the space currently has space for the addition of another Operating Room and two additional recovery rooms. The space is in line with state requirements with the addition of a second operation room.

Once complete, the ASTC will have four (4) recovery rooms for one (1) operating room, within the state standard of four (4) recovery rooms per operating/procedure room.

The facility will also include shell space for an additional operating room and two (2) additional recovery rooms.

Size of Project – Expansion			
Service	**Proposed BGSF**	**State Standard**	**Met Standard?**
ASTC	4,919 BGSF (1 OR)	2075-2750 BGSF/Treatment Room	No
ASTC	4,919 BGSF (2 OR)	2075-2750 BGSF/Treatment Room	Yes

[1] See Section 1110 Appendix B.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(b), Project Services Utilization

This project includes a specific clinical service area: ASTC operating room, which has established standards found in Section 1110, Appendix B.

By the second year after project completion, the ASTC's annual utilization shall meet or exceed HFSRB's utilization standards. Based upon projected procedures documented within the physician referral letters included herein as Appendix-1, 201 operating room procedures will be performed at the ASTC within the first year years after project completion. As identified below, the projected procedures were multiplied by the historical time per procedure for each physician to obtain the projected utilization for the four (4) operating rooms.

In addition to the operating room procedures Dr. Michael anticipates 3,000 procedures currently provided in an office-based setting, but approved to be performed in an ASTC as a separately payable procedure, to be transitioned to the ASTC operating room setting in order to increase patient safety and quality of care outcomes. The office based intravitreal injections currently being performed by Dr. Michael will, in a large part, be performed at the proposed ASTC.

Physician	Historical 12 Month of Surgeries	Referrals for 12 months after expansion	Average Surgery Time	Total Hours
OR procedures	201	**201**	2.59434	521.5
Office based procedures	4,021	**3,000**	0.75	2,250

Table 1110.234(b)
Utilization

	Dept./ Service	Historical Utilization (Treatments)	Projected Utilization	State Standard	Met Standard?
Year 1	ASTC	N/A	2,771.5 hrs.	1,500 hrs.	Yes
Year 2	ASTC	N/A	2,771.5	1,500 hrs.	Yes

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(d), Unfinished or Shell Space

This project will include unfinished space designed to meet an anticipated future demand for service. Accordingly, this criterion is not applicable.

1. The shell space shall total 647 Gross Square Feet

2. The shell space is anticipated to be used an additional Operating Room and two (2) additional recovery rooms.

As a new project, the applicant does not have the historic patient data to demonstrate a generalized growth over a 5-year period. However, the applicant does expected a significant increase in patient referrals to the ASTC setting from procedures historically performed in an office-based setting as well as the general patient base based upon generalized patient demand increases. The applicant anticipates that a significant number of patients will opt to receive the historically office based procedures in an appropriate ASTC setting based upon patient desire for higher quality care. Accordingly, the applicant is proposing to include shell space in the ASTC to accommodate future patient need.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.234(e), Assurances

This project will include unfinished space designed to meet an anticipated future demand for service. The applicant will submit a CON application to the HFSRB to develop the shell space, regardless of the capital thresholds in effect at that time. It is estimated that the shell space will be submitted by the applicant within the next 5 years, based upon the increasing percentage of figures documented in Attachement-16. It is anticipated that completion of the build out for the shell space will take 9 months to complete.

Section VII, Service Specific Review Criteria
Ambulatory Surgical Treatment Center
Criterion 1110.1540, Planning Area Need

Pursuant to 77 Ill. Adm. Code 1110.1540, in addition to the background sections (a) and (b), the following sections are addressed for the expansion of an existing ASTC:

- 1110.1540(c)(2) – Service to GSA Residents
- 1110.1540(d) – Service Demand – Establishment of an ASTC
- 1110.1540(f) – Treatment Room Need Assessment
- 1110.1540(g) – Service Accessibility
- 1110.1540(h)(1) – Unnecessary Duplication/Maldistribution
- 1110.1540(h)(2) – Maldistribution
- 1110.1540(h)(3) – Impact to Area Providers
- 1110.1540(i) – Staffing
- 1110.1540(j) – Charge Commitment
- 1110.1540(k) – Assurances

a) Identification of ASTC Service and number of Surgical/Treatment Rooms

The applicant proposes to offer single-specialty ASTC services within a facility with one (1) Operating Room. The facility plans to offer ophthalmology services, with a focus in complex retina surgeries.

b) Background of the Applicant

1) The applicant is fit, willing and able, and has the qualifications, background and character to adequately provide a proper standard of health care service for the community. Retina Institute of Illinois, P.C. was founded in 2000 by John C. Michael M.D and offers complex retina services to patients in need. Retina Institute of Illinois, P.C. is a professional services corporation providing specialized services of the retina in the field of ophthalmology. Retina Surgery Center, LLC is a newly created entity also 100% owned by Dr. Michael and is the applicant for the proposed ASTC.

3) Retina Surgery Center, LLC does not have ownership in any other IDPH licensed facility.

See the attached Exhibit 1 to Attachment-25 (also attached as Attachment 11 Exhibit 1) for a signed statement from Retina Surgery Center, LLC certifying that no adverse action has been taken against any facility owned or operated by RSC and providing authorization for access to IDPH/HFSRB.

c) Service to GSA Residents

2) **Geographic Service Area**

A) See attached Exhibit 2 concerning a list of zip codes within the anticipated Geographic Service Area pursuant to state regulations.

B) See attached Exhibit 3 for the historical patient origin information by zip code for the most recent 12-months of operation from which data is available demonstrating more than 50% of admissions at local ASTCs and hospitals were from the GSA.

d) Service Demand – Establishment

1) Historical Service Demand

A) The physicians associated with this project have included the attached physician referral letters which attest to the number of procures that they have performed in the latest 12-month period. As noted within the referral, the physicians performed 201 complex surgeries to patients accounting for a total of 521.5 hours of surgery. Please note, the applicant also anticipates referring 3,000 patients for IVR injections to be served at the quality controlled ASTC location, adding an additional 2,250 hours.

Please see what has been attached as Appendix-1 regarding physician referrals to other IDPH facilities.

2) Projected Service Demand – Projected Referrals

B) Based upon the historic utilization, in Appendix-1, the projected demand is sufficient to meet the state standards for utilization. Dr. Michael and the physician's associated with the project will meet the state standard of 1500 hours of surgery by the second of operation.

Physician	Historical 12 Month of Surgeries	Anticipated referrals to RSC	Average Surgery Time	Total Hours
Dr. John Michael	**80**	**80**	**2.59434**	**202.4**
Dr. Matthew Wessel	**73**	**73**	**2.59434**	**205.0**
Dr. Preeti Poley	**48**	**48**	**2.59434**	**119.3**
Office-based Surgery Services	**4,021**	**3,000**	**0.75**	**2,250.0**

f) Treatment Room Need Assessment – Review Criterion

1) As demonstrated by the physician referrals in Appendix-1, the facility currently projects to perform 201 procedures totaling 526.7 hours in the first year following project completion. Additional, the applicant anticipates an additional 2,250 of hours via the transition of 3,000 historic office-base procedure that shall be done at the ASTC location. The facility is projecting to exceed the utilization standards for its existing one (1) treatment room. As such, the proposed number of operating rooms is necessary in order to service the projected patient volumes.

2) Based upon the physician referrals and the historical caseload data, the applicants project the following patient treatments and average time per patient treatment, justifying the expected utilization of the two additional treatment rooms. This is in addition to the historical utilization data, as referenced above.

Specialty	Total Surgeries	Average Time per Patient	Total Surgery Hours
Ophtalmology (ASTC/Hospital)*	**201**	**2.59**	**201**
Ophthalmology (Office/ASTC)	**3,000**	**.75**	**2,250**

g) Service Accessibility

There are twenty (20) licensed ASTC's within the GSA which offered ophthalmology services pursuant to 2016 data, yet very few have the capability to provide complex retina surgeries.

As indicated above, only two of the facilities offer the specialized equipment that is required to perform the specialized retina surgeries anticipated to be performed by Dr. Michael. The closer facility, Northwest Surgicare is about 23 minutes away, and has on several occasion canceled patient surgeries a single day in advance without sufficient reasoning. In addition, this surgery center utilizes a D.O.R.C. machine for retina surgeries, whereas Dr. Michael prefers and the area hospitals where Dr. Michael is credentialed utilize the Alcon machine to perform the surgeries. The familiarity with the machines is not important simply due to preference by the physician, but it allows the physician to improve patient experience and improve quality. It is important that in these complex retina surgeries that the physician is comfortable with each scenario that may arise, with different machines, the opportunity for experiencing an unknown issues are multiplied, often to the detriment to the patient. Overall, the machine differentiation and spotty scheduling history has led Dr. Michael to cease attempting to schedule his patients at Northwest Surgicare.

Only one other ASTC offers the equipment necessary to perform the surgeries the applicant specializes in, Belmont/Harlem Surgery Center. This facility also has restrictive admission policies that hinder the ability of the applicant to perform the necessary services for its patients. Belmont/Harlem only allows for retina surgery to be performed on Wednesdays and Fridays, does not allow any surgeries to be scheduled on Mondays or Tuesday, and are closed on Saturdays and Sundays. Many of the surgeries performed by Dr. Michael are very time sensitive and require quick action. As a result of many of the restrictive admission policies at Belmont/Harlem, Dr. Michael cannot provide his patients with the high quality care offered by him in a reasonable timeframe outside of a hospital location.

By providing his services at the hospital rather than an ASTC, the patient of Dr. Michael have a higher cost of care and at a less convenient setting. As noted in Attachment-12 above, ASTC services reduce the patient costs by upwards of 900%.

h) Unnecessary Duplication/Maldistribution – Review Criterion

1) The proposed project will not result in unnecessary duplication:

A) A list of the total population for GSA is attached as Exhibit 4.

B) A list of all of the existing health care facilities within the GSA that provide the ASTC services that are proposed by this project are attached as Exhibit 5.

Please note: that although there are underperforming hospitals and ASTC's identified in the area, the proposed ASTC will not impact the overall performance of these facilities. First, the complex surgeries performed by the applicant in the past 12-months were all performed at hospital locations. Between the seven hospitals utilized by the three physicians for the complex surgical services, there will not be a significant detriment to the number of hours performed at each location. Furthermore, the office-base procedures anticipated to be referred to the proposed ASTC will not account for a detriment to any location. Lastly, the services that the applicant is proposed to perform, complex retina surgery, is largely unavailable in the service area, and those locations where it is available is only via unfamiliar machinery, which may affect total patient care. The applicant is proposing to improve access to a necessary surgical service which is largely unavailable in the area, and is not currently available to any of the physician's patients in a timely manner.

2) Maldistribution does not exist within the GSA:

A) See the table below demonstrating compliance:

	Population	**Rooms**	**Rooms to Population**
State	12,830,632	2,368*	1:5,418
GSA	3,901,483	367	1:10,630

*Using 2015 data for hospitals due to error in 2016 data.

B) As identified in the chart above, there is only one facility that is currently operating above state standards. Despite this, we note that a Maldistribution of services will not occur for several reasons. First, of the 201 complex surgeries referred by the applicants in the past 12-months, all of which were previously performed at hospital locations and accounted for 526.7 hours. Secondly, the office based procedures anticipated to be referred to the proposed ASTC have historically not been performed at ASTC's, as such it will not affect Maldistribution. As a result, the applicant has identified that they intend to refer enough patients that will allow the proposed facility to operate above the state standards within two years.

C) As evidenced by the physician referral letters in Appendix-1, the applicants anticipate referring 201 patients which shall account for 526.7 hours of surgery. The applicant shall also refer 3,000 patients who previously obtained office-based procedures which shall account for 2,250 hours, above the state utilization standards specified in 77 Ill. Adm. Code 1100.

i) Staffing

1) Retina Surgery Center will operate with sufficient staffing levels as required by applicable licensure. RSC will offer the staffing levels as necessary to provide patients with safe and effective care.

2) The services shall be performed by a physician who is board certified or board eligible by the appropriate professional standards organization or entity that credentials or certifies the health care worker for competency in that category of service.

j) Charge Commitment

1) A statement of all charges is attached as Exhibit 6.

2) Please see Exhibit 6, attached herein, which includes a commitment that the charges will not be increased for the first two years of operation.

k) Assurances

1) See Exhibit 7 for a signed statement of Assurances.
2) See Exhibit 7 for a signed statement of Assurances.

RETINA INSTITUTE OF ILLINOIS

Diseases & Surgery of the Retina, Macula, and Vitreous

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Rumya R. Rao, M.D.
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December 29, 2017

Kathryn J. Olson
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson,

In keeping with 77 Ill. Adm. Code § 1110.230(a) (Background of the Applicant – Information Requirements) please find this letter of certification and authorization.

Specifically, this letter certifies that Retina Surgery Center LLC does not own any healthcare facilities and has had no adverse actions taken against them in the three years (3) prior to the filing of this application.

Furthermore, Retina Surgery Center, LLC authorizes the Health Facilities and Services Review Board and the Illinois Department of Public Health to access any documents necessary to verify the information submitted, including, but not limited to: official records of the IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.

Sincerely,

John Michael, M.D.
Retina Surgery Center, LLC

Notarization:
Subscribed and sworn to before me this 8th day of January,
~~2016.~~ 2018

Lisa Marie Janosek
Signature of Notary
SEAL

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

Exhibit I

Zip	city
60101	ADDISON
60005	ARLINGTON HEIGHTS
60004	ARLINGTON HEIGHTS
60010	BARRINGTON
60103	BARTLETT
60104	BELLWOOD
60106	BENSENVILLE
60163	BERKELEY
60402	BERWYN
60108	BLOOMINGDALE
60455	BRIDGEVIEW
60155	BROADVIEW
60513	BROOKFIELD
60089	BUFFALO GROVE
60188	CAROL STREAM
60110	CARPENTERSVILLE
60656	CHICAGO
60631	CHICAGO
60634	CHICAGO
60638	CHICAGO
60646	CHICAGO
60630	CHICAGO
60644	CHICAGO
60639	CHICAGO
60641	CHICAGO
60651	CHICAGO
60624	CHICAGO
60623	CHICAGO
60625	CHICAGO
60618	CHICAGO
60647	CHICAGO
60659	CHICAGO
60645	CHICAGO
60804	CICERO
60514	CLARENDON HILLS
60015	DEERFIELD
60018	DES PLAINES
60016	DES PLAINES
60515	DOWNERS GROVE
60118	DUNDEE
60120	ELGIN
60007	ELK GROVE VILLAGE
60126	ELMHURST
60707	ELMWOOD PARK

60203	EVANSTON
60201	EVANSTON
60202	EVANSTON
60130	FOREST PARK
60021	FOX RIVER GROVE
60131	FRANKLIN PARK
60137	GLEN ELLYN
60022	GLENCOE
60139	GLENDALE HEIGHTS
60026	GLENVIEW
60025	GLENVIEW
60029	GOLF
60030	GRAYSLAKE
60088	GREAT LAKES
60031	GURNEE
60133	HANOVER PARK
60706	HARWOOD HEIGHTS
60457	HICKORY HILLS
60035	HIGHLAND PARK
60040	HIGHWOOD
60162	HILLSIDE
60141	HINES
60521	HINSDALE
60192	HOFFMAN ESTATES
60169	HOFFMAN ESTATES
60143	ITASCA
60458	JUSTICE
60043	KENILWORTH
60525	LA GRANGE
60526	LA GRANGE PARK
60044	LAKE BLUFF
60045	LAKE FOREST
60047	LAKE ZURICH
60048	LIBERTYVILLE
60069	LINCOLNSHIRE
60712	LINCOLNWOOD
60148	LOMBARD
60534	LYONS
60153	MAYWOOD
60157	MEDINAH
60164	MELROSE PARK
60160	MELROSE PARK
60053	MORTON GROVE
60056	MOUNT PROSPECT
60060	MUNDELEIN

60714	NILES
60064	NORTH CHICAGO
60062	NORTHBROOK
60523	OAK BROOK
60301	OAK PARK
60302	OAK PARK
60304	OAK PARK
60067	PALATINE
60074	PALATINE
60465	PALOS HILLS
60068	PARK RIDGE
60070	PROSPECT HEIGHTS
60305	RIVER FOREST
60171	RIVER GROVE
60546	RIVERSIDE
60008	ROLLING MEADOWS
60172	ROSELLE
60194	SCHAUMBURG
60195	SCHAUMBURG
60193	SCHAUMBURG
60173	SCHAUMBURG
60176	SCHILLER PARK
60077	SKOKIE
60076	SKOKIE
60165	STONE PARK
60107	STREAMWOOD
60501	SUMMIT ARGO
60061	VERNON HILLS
60181	VILLA PARK
60087	WAUKEGAN
60085	WAUKEGAN
60154	WESTCHESTER
60558	WESTERN SPRINGS
60559	WESTMONT
60189	WHEATON
60090	WHEELING
60480	WILLOW SPRINGS
60527	WILLOWBROOK
60091	WILMETTE
60093	WINNETKA
60191	WOOD DALE
60099	ZION

Zip Code	Patient Count
60010	2
60015	1
60016	5
60018	2
60025	3
60026	1
60030	2
60031	6
60047	3
60048	1
60053	6
60056	6
60060	2
60068	2
60069	1
60074	1
60076	1
60077	3
60085	1
60090	3
60103	1
60107	1
60110	2
60133	1
60143	3
60169	1
60172	1
60188	1
60192	2
60193	2
60194	1
60402	1
60514	1
60523	2
60618	1
60625	2
60630	7
60631	1
60634	3
60641	3
60645	1
60647	2
60656	1
60659	4
60707	2
60712	1
60714	3
Grand Total	103

Exhibit 3

Zip	state	county	city	population
60101	IL	DUPAGE	ADDISON	39119
60005	IL	COOK	ARLINGTON HEIGHTS	29308
60004	IL	COOK	ARLINGTON HEIGHTS	50582
60010	IL	LAKE	BARRINGTON	44095
60103	IL	DUPAGE	BARTLETT	41928
60104	IL	COOK	BELLWOOD	19038
60106	IL	DUPAGE	BENSENVILLE	20309
60163	IL	COOK	BERKELEY	5209
60402	IL	COOK	BERWYN	63448
60108	IL	DUPAGE	BLOOMINGDALE	22735
60455	IL	COOK	BRIDGEVIEW	16446
60155	IL	COOK	BROADVIEW	7927
60513	IL	COOK	BROOKFIELD	19047
60089	IL	LAKE	BUFFALO GROVE	41533
60188	IL	DUPAGE	CAROL STREAM	42656
60110	IL	KANE	CARPENTERSVILLE	38557
60656	IL	COOK	CHICAGO	27613
60631	IL	COOK	CHICAGO	28641
60634	IL	COOK	CHICAGO	74298
60638	IL	COOK	CHICAGO	55026
60646	IL	COOK	CHICAGO	27177
60630	IL	COOK	CHICAGO	54093
60644	IL	COOK	CHICAGO	48648
60639	IL	COOK	CHICAGO	90407
60641	IL	COOK	CHICAGO	71663
60651	IL	COOK	CHICAGO	64267
60624	IL	COOK	CHICAGO	38105
60623	IL	COOK	CHICAGO	92108
60625	IL	COOK	CHICAGO	78651
60618	IL	COOK	CHICAGO	92084
60647	IL	COOK	CHICAGO	87291
60659	IL	COOK	CHICAGO	38104
60645	IL	COOK	CHICAGO	45274
60804	IL	COOK	CICERO	84573
60514	IL	DUPAGE	CLARENDON HILLS	9708
60015	IL	LAKE	DEERFIELD	26800
60018	IL	COOK	DES PLAINES	30099
60016	IL	COOK	DES PLAINES	59690
60515	IL	DUPAGE	DOWNERS GROVE	27503
60118	IL	KANE	DUNDEE	15851
60120	IL	KANE	ELGIN	50955
60007	IL	COOK	ELK GROVE VILLAGE	33820
60126	IL	DUPAGE	ELMHURST	46371
60707	IL	COOK	ELMWOOD PARK	42920
60203	IL	COOK	EVANSTON	4523
60201	IL	COOK	EVANSTON	43125

Exhibit 4

60202	IL	COOK	EVANSTON	31361
60130	IL	COOK	FOREST PARK	14167
60021	IL	MCHENRY	FOX RIVER GROVE	5545
60131	IL	COOK	FRANKLIN PARK	18097
60137	IL	DUPAGE	GLEN ELLYN	37805
60022	IL	COOK	GLENCOE	8153
60139	IL	DUPAGE	GLENDALE HEIGHTS	34381
60026	IL	COOK	GLENVIEW	13335
60025	IL	COOK	GLENVIEW	39105
60029	IL	COOK	GOLF	482
60030	IL	LAKE	GRAYSLAKE	36056
60088	IL	LAKE	GREAT LAKES	15761
60031	IL	LAKE	GURNEE	37947
60133	IL	COOK	HANOVER PARK	38103
60706	IL	COOK	HARWOOD HEIGHTS	23134
60457	IL	COOK	HICKORY HILLS	14049
60035	IL	LAKE	HIGHLAND PARK	29763
60040	IL	LAKE	HIGHWOOD	5431
60162	IL	COOK	HILLSIDE	8111
60141	IL	COOK	HINES	224
60521	IL	DUPAGE	HINSDALE	17597
60192	IL	COOK	HOFFMAN ESTATES	16343
60169	IL	COOK	HOFFMAN ESTATES	33847
60143	IL	DUPAGE	ITASCA	10360
60458	IL	COOK	JUSTICE	14428
60043	IL	COOK	KENILWORTH	2513
60525	IL	COOK	LA GRANGE	31168
60526	IL	COOK	LA GRANGE PARK	13576
60044	IL	LAKE	LAKE BLUFF	9792
60045	IL	LAKE	LAKE FOREST	20925
60047	IL	LAKE	LAKE ZURICH	41669
60048	IL	LAKE	LIBERTYVILLE	29095
60069	IL	LAKE	LINCOLNSHIRE	8384
60712	IL	COOK	LINCOLNWDOD	12590
60148	IL	DUPAGE	LOMBARD	51468
60534	IL	CDOK	LYONS	10649
60153	IL	COOK	MAYWOOD	24106
60157	IL	DUPAGE	MEDINAH	2380
60164	IL	COOK	MELRDSE PARK	22048
60160	IL	COOK	MELROSE PARK	25432
60053	IL	COOK	MORTON GROVE	23260
60056	IL	COOK	MOUNT PROSPECT	55219
60060	IL	LAKE	MUNDELEIN	37189
60714	IL	COOK	NILES	29931
60064	IL	LAKE	NORTH CHICAGO	15407
60062	IL	COOK	NORTHBROOK	39936
60523	IL	DUPAGE	OAK BROOK	9890

Exhibit 4

60301	IL	COOK	OAK PARK	2539
60302	IL	COOK	OAK PARK	32108
60304	IL	COOK	OAK PARK	17231
60067	IL	COOK	PALATINE	38585
60074	IL	COOK	PALATINE	38985
60465	IL	COOK	PALOS HILLS	17495
60068	IL	COOK	PARK RIDGE	37475
60070	IL	COOK	PROSPECT HEIGHTS	16001
60305	IL	COOK	RIVER FOREST	11172
60171	IL	COOK	RIVER GROVE	10246
60546	IL	COOK	RIVERSIDE	15668
60008	IL	COOK	ROLLING MEADOWS	22717
60172	IL	DUPAGE	ROSELLE	24537
60194	IL	COOK	SCHAUMBURG	19777
60195	IL	COOK	SCHAUMBURG	4769
60193	IL	COOK	SCHAUMBURG	39188
60173	IL	COOK	SCHAUMBURG	12217
60176	IL	COOK	SCHILLER PARK	11795
60077	IL	COOK	SKOKIE	26825
60076	IL	COOK	SKOKIE	33415
60165	IL	COOK	STONE PARK	4946
60107	IL	COOK	STREAMWOOD	39927
60501	IL	COOK	SUMMIT ARGO	11626
60061	IL	LAKE	VERNON HILLS	25748
60181	IL	DUPAGE	VILLA PARK	28836
60087	IL	LAKE	WAUKEGAN	26978
60085	IL	LAKE	WAUKEGAN	71714
60154	IL	COOK	WESTCHESTER	16773
60558	IL	COOK	WESTERN SPRINGS	12960
60559	IL	DUPAGE	WESTMONT	24852
60189	IL	DUPAGE	WHEATON	30472
60090	IL	COOK	WHEELING	37633
60480	IL	COOK	WILLOW SPRINGS	5246
60527	IL	DUPAGE	WILLOWBROOK	27486
60091	IL	COOK	WILMETTE	27020
60093	IL	COOK	WINNETKA	19570
60191	IL	DUPAGE	WOOD DALE	14310
60099	IL	LAKE	ZION	31104
TOTAL				3901483

Exhibit 4

Hospitals within 45-Minutes of Proposed ASTC

Hospital Name	Zip Code	Adjusted Distance (Min.)	Outpatient Procedures - Ophthalmology	OP OR Hours - Ophthalmology
Evanston Hospital	60201	26.45	57	73
Adventist Hinsdale Hospital	60521	29.9	63	144
Loretto Hospital	60644	37.95	29	15
Northwest Community Hospital	60005	20.7	3	5
Rush Oak Park Hospital	60304	41.4	306	337
Swedish Covenant Hospital	60625	33.35	1,074	1,056
Advocate Good Samaritan Hospital	60515	31.05	10	11
Advocate Good Shepherd Hospital	60010	44.85	1,292	1,417
Glenbrook Hospital	60026	10.35	2,208	1,274
Adventist GlenOaks Hospital	60139	36.8	520	648
Advocate Lutheran General Hospital	60068	8.05	30	68
Highland Park Hospital	60035	25.3	2,202	1,892
Vista Medical Center East	60085	41.4	50	53
Advocate Condell Medical Center	60048	27.6	1,325	1,812
Skokie Hospital	60076	16.1	1,391	1,084
Northwestern Lake Forest Hospital	60045	25.3	327	398
VHS West Suburban Medical Center	60302	41.4	618	767
VHS Westlake Hospital	60160	37.95	177	161
Elmhurst Memorial Hospital	60126	31.05	66	133
Gottlieb Memorial Hospital	60160	29.9	745	604
Loyola University Medical Center	60153	33.35	3	9
Community First Medical Center	60634	32.2	702	376.9

Hospital Name	Zip Code	Adjusted Distance (Min.)	Outpatient Procedures - Ophthalmology	OP OR Hours - Ophthalmology
Adventist La Grange Memorial Hospital	60525	35.65	453	777
Presence Saint Francis Hospital	60202	29.9	675	527
Presence Resurrection Medical Center	60631	19.55	820	592

Ambulatory Surgical Centers within 45-Minutes of Proposed ASTC

ASTC Name	Zip Code	Adjusted Distance (Min.)	Ophthalmology Procedures	Ophthalmology Hours
Advanced Ambulatory Surgical Center	60707	32.2	2	3.3
Ashton Center for Day Surgery	60192	33.35	346	175
Belmont Harlem Surgery Center	60630	32.2	925	511.34
Children's Outpatient Services at Westchester	60154	26.45	1	3
DMG Surgical Center, LLC	60148	37.95	1,813	1,697
Elmhurst Outpatient Surgery Center, LLC	60126	31.05	1,432	771.36
Hinsdale Surgical Center	60521	37.95	2,127	2,146.63
Hoffman Estates Surgery Center, LLC	60169	39.1	3,451	1,959.5
LGH-A/Golf ASTC, LLC dba Golf Surgical Center	60016	5.75	2,321	1,449.5
Loyola Ambulatory Surgery Center at Oakbrook, L.P.	60181	33.35	2	4
Loyola University Ambulatory Surgery Center	60153	42.55	1,314	1,834.8
Midwest Center for Day Surgery	60515	40.25	1,425	1,236.75
North Shore Surgical Center	60712	24.15	1,880	1,909

ASTC Name	Zip Code	Adjusted Distance (Min.)	Ophthalmology Procedures	Ophthalmology Hours
Northwest Community Day Surgery Center II, LLC	60005	25.3	1,185	896.86
Northwest Surgicare	60005	23	2,858	1,895.1
Northwestern Grayslake Ambulatory Surgery Center	60030	35.65	194	173.8
NovaMed Surgery Center of Chicago Northshore, LLC	60659	32.2	2,866	1,290
Novamed Surgery Center of River Forest, LLC	60305	41.4	1,059	613
The Oak Brook Surgical Centre, Inc.	60523	33.35	23	12.5
Eye Surgery Center of Hinsdale, LLC *2015 Data*	60521	40.25	N/A	1,633

RETINA INSTITUTE OF ILLINOIS

Diseases & Surgery of the Retina, Macula, and Vitreous

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December 29, 2017

Kathryn J. Olson
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson,

I hereby certify and attest to the understanding and commitment that facility charges at the
ASTC will not be increased for at least the first two years of the facility's operation, unless a
permit is first obtained pursuant to 77 Ill. Administrative Code 1130.310(a).

Sincerely,

John Michael, M.D.

Retina Surgery Center, LLC

Notarization:
Subscribed and sworn to before me this 8th day of January
~~2016~~. 2018

Lisa Marie Janosek
Signature of Notary

SEAL

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

EXHIBIT 6

HCPCS Code	Short Descriptor	Charges
J3300	Triamcinolone a injection	$ 10.00
67108	Repair detached retina	$ 5,381.70
J0178	Aflibercept injection	$ 2,079.00
67040	Laser treatment of retina	$ 5,381.70
67039	Laser treatment of retina	$ 5,381.70
67110	Repair detached retina	$ 1,357.71
J2778	Ranibizumab injection	$ 205.45
67025	Replace eye fluid	$ 2,928.51
67101	Repair detached retina	$ 1,371.66
67107	Repair detached retina	$ 5,381.70
67036	Removal of inner eye fluid	$ 2,928.51
67145	Treatment of retina	$ 738.78
J9035	Bevacizumab injection	$ 165.00
66820	Incision secondary cataract	$ 2,928.51
66821	After cataract laser surgery	$ 738.78
67028	Injection eye drug	$ 143.94
65091	Revise eye	$ 4,211.25
65093	Revise eye with implant	$ 4,211.25
65101	Removal of eye	$ 4,211.25
65103	Remove eye/insert implant	$ 4,211.25
65105	Remove eye/attach implant	$ 4,211.25
65110	Removal of eye	$ 4,211.25
65112	Remove eye/revise socket	$ 4,211.25
65114	Remove eye/revise socket	$ 4,211.25
65125	Revise ocular implant	$ 2,350.53
65130	Insert ocular implant	$ 4,211.25

HCPCS Code	Short Descriptor	Charges
65135	Insert ocular implant	$ 4,211.25
65140	Attach ocular implant	$ 4,211.25
65150	Revise ocular implant	$ 4,211.25
65155	Reinsert ocular implant	$ 4,211.25
65175	Removal of ocular implant	$ 4,211.25
65205	Remove foreign body from eye	$ -
65210	Remove foreign body from eye	$ -
65220	Remove foreign body from eye	$ -
65222	Remove foreign body from eye	$ -
65235	Remove foreign body from eye	$ 2,928.51
65260	Remove foreign body from eye	$ 2,928.51
65265	Remove foreign body from eye	$ 2,928.51
65270	Repair of eye wound	$ 2,350.53
65272	Repair of eye wound	$ 2,350.53
65275	Repair of eye wound	$ 4,211.25
65280	Repair of eye wound	$ 5,381.70
65285	Repair of eye wound	$ 5,381.70
65286	Repair of eye wound	$ 1,378.11
65290	Repair of eye socket wound	$ 4,211.25
65400	Removal of eye lesion	$ 1,168.77
65410	Biopsy of cornea	$ 2,350.53
65420	Removal of eye lesion	$ 2,350.53
65426	Removal of eye lesion	$ 2,350.53
65430	Corneal smear	$ -
65435	Curette/treat cornea	$ 136.41
65436	Curette/treat cornea	$ 625.14

HCPCS Code	Short Descriptor	Charges
65450	Treatment of corneal lesion	$ 437.91
65600	Revision of cornea	$ 716.43
65710	Corneal transplant	$ 5,381.70
65730	Corneal transplant	$ 5,381.70
65750	Corneal transplant	$ 5,381.70
65755	Corneal transplant	$ 5,381.70
65756	Corneal trnspl endothelial	$ 5,381.70
65757	Prep corneal endo allograft	$ -
65770	Revise cornea with implant	$ 6,785.07
65772	Correction of astigmatism	$ 1,168.77
65775	Correction of astigmatism	$ 2,350.53
65778	Cover eye w/membrane	$ -
65779	Cover eye w/membrane suture	$ -
65780	Ocular reconst transplant	$ 4,211.25
65781	Ocular reconst transplant	$ 5,381.70
65782	Ocular reconst transplant	$ 4,211.25
65785	Implt ntrstrml crnl rng seg	$ 5,381.70
65800	Drainage of eye	$ 2,928.51
65810	Drainage of eye	$ 2,928.51
65815	Drainage of eye	$ 2,928.51
65820	Relieve inner eye pressure	$ 5,381.70
65850	Incision of eye	$ 2,928.51
65855	Trabeculoplasty laser surg	$ 524.16
65860	Incise inner eye adhesions	$ 526.32
65865	Incise inner eye adhesions	$ 2,928.51
65870	Incise inner eye adhesions	$ 2,928.51

HCPCS Code	Short Descriptor	Charges
65875	Incise inner eye adhesions	$ 2,928.51
65880	Incise inner eye adhesions	$ 2,928.51
65900	Remove eye lesion	$ 2,928.51
65920	Remove implant of eye	$ 2,928.51
65930	Remove blood clot from eye	$ 2,928.51
66020	Injection treatment of eye	$ 2,928.51
66030	Injection treatment of eye	$ 2,928.51
66130	Remove eye lesion	$ 2,350.53
66150	Glaucoma surgery	$ 5,381.70
66155	Glaucoma surgery	$ 2,928.51
66160	Glaucoma surgery	$ 2,928.51
66170	Glaucoma surgery	$ 2,928.51
66172	Incision of eye	$ 2,928.51
66174	Translum dil eye canal	$ 2,928.51
66175	Trnslum dil eye canal w/stnt	$ 5,381.70
66179	Aqueous shunt eye w/o graft	$ 5,381.70
66180	Aqueous shunt eye w/graft	$ 5,381.70
66183	Insert ant drainage device	$ 5,381.70
66184	Revision of aqueous shunt	$ 2,928.51
66185	Revise aqueous shunt eye	$ 2,928.51
66220	Repair eye lesion	$ 2,928.51
66225	Repair/graft eye lesion	$ 2,928.51
66250	Follow-up surgery of eye	$ 2,350.53
66500	Incision of iris	$ 2,928.51
66505	Incision of iris	$ 2,928.51
66600	Remove iris and lesion	$ 2,928.51

HCPCS Code	Short Descriptor	Charges
66605	Removal of iris	$ 2,928.51
66625	Removal of iris	$ 2,928.51
66630	Removal of iris	$ 2,928.51
66635	Removal of iris	$ 2,928.51
66680	Repair iris & ciliary body	$ 2,928.51
66682	Repair iris & ciliary body	$ 2,928.51
66700	Destruction ciliary body	$ 2,928.51
66710	Ciliary transsleral therapy	$ 2,350.53
66711	Ciliary endoscopic ablation	$ 2,928.51
66720	Destruction ciliary body	$ 2,350.53
66740	Destruction ciliary body	$ 2,350.53
66761	Revision of iris	$ 555.33
66762	Revision of iris	$ 738.78
66770	Removal of inner eye lesion	$ 738.78
66825	Reposition intraocular lens	$ 2,928.51
66830	Removal of lens lesion	$ 2,928.51
66840	Removal of lens material	$ 2,928.51
66850	Removal of lens material	$ 2,928.51
66852	Removal of lens material	$ 5,381.70
66920	Extraction of lens	$ 2,928.51
66930	Extraction of lens	$ 5,381.70
66940	Extraction of lens	$ 2,928.51
66982	Cataract surgery complex	$ 2,928.51
66983	Cataract surg w/iol 1 stage	$ 2,928.51
66984	Cataract surg w/iol 1 stage	$ 2,928.51
66985	Insert lens prosthesis	$ 2,928.51

HCPCS Code	Short Descriptor	Charges
66986	Exchange lens prosthesis	$ 2,928.51
66990	Ophthalmic endoscope add-on	$ -
67005	Partial removal of eye fluid	$ 2,928.51
67010	Partial removal of eye fluid	$ 2,928.51
67015	Release of eye fluid	$ 2,928.51
67027	Implant eye drug system	$ 6,785.07
67030	Incise inner eye strands	$ 2,928.51
67031	Laser surgery eye strands	$ 738.78
67041	Vit for macular pucker	$ 2,928.51
67042	Vit for macular hole	$ 5,381.70
67043	Vit for membrane dissect	$ 5,381.70
67105	Repair detached retina	$ 738.78
67113	Repair retinal detach cplx	$ 5,381.70
67115	Release encircling material	$ 2,928.51
67120	Remove eye implant material	$ 2,928.51
67121	Remove eye implant material	$ 2,928.51
67141	Treatment of retina	$ 437.91
67208	Treatment of retinal lesion	$ 437.91
67210	Treatment of retinal lesion	$ 738.78
67218	Treatment of retinal lesion	$ 4,211.25
67220	Treatment of choroid lesion	$ 738.78
67221	Ocular photodynamic ther	$ 475.83
67225	Eye photodynamic ther add-on	$ -
67227	Dstrj extensive retinopathy	$ 4,211.25
67228	Treatment x10sv retinopathy	$ 532.77
67229	Tr retinal les preterm inf	$ 738.78

Exhibit 6

HCPCS Code	Short Descriptor	Charges
67250	Reinforce eye wall	$ 2,350.53
67255	Reinforce/graft eye wall	$ 2,928.51
67311	Revise eye muscle	$ 2,350.53
67312	Revise two eye muscles	$ 4,211.25
67314	Revise eye muscle	$ 2,350.53
67316	Revise two eye muscles	$ 2,350.53
67318	Revise eye muscle(s)	$ 2,350.53
67320	Revise eye muscle(s) add-on	$ -
67331	Eye surgery follow-up add-on	$ -
67332	Rerevise eye muscles add-on	$ -
67334	Revise eye muscle w/suture	$ -
67335	Eye suture during surgery	$ -
67340	Revise eye muscle add-on	$ -
67343	Release eye tissue	$ 2,350.53
67345	Destroy nerve of eye muscle	$ 372.72
67346	Biopsy eye muscle	$ 4,211.25
67400	Explore/biopsy eye socket	$ 4,211.25
67405	Explore/drain eye socket	$ 2,350.53
67412	Explore/treat eye socket	$ 2,350.53
67413	Explore/treat eye socket	$ 2,350.53
67414	Explr/decompress eye socket	$ 4,211.25
67415	Aspiration orbital contents	$ 2,350.53
67420	Explore/treat eye socket	$ 4,211.25
67430	Explore/treat eye socket	$ 4,211.25
67440	Explore/drain eye socket	$ 4,211.25
67445	Explr/decompress eye socket	$ 4,211.25

HCPCS Code	Short Descriptor	Charges
67450	Explore/biopsy eye socket	$ 4,211.25
67500	Inject/treat eye socket	$ 437.91
67505	Inject/treat eye socket	$ 125.67
67515	Inject/treat eye socket	$ 134.28
67550	Insert eye socket implant	$ 4,211.25
67560	Revise eye socket implant	$ 4,211.25
67570	Decompress optic nerve	$ 4,211.25
67700	Drainage of eyelid abscess	$ 437.91
67710	Incision of eyelid	$ 555.33
67715	Incision of eyelid fold	$ 2,350.53
67800	Remove eyelid lesion	$ 223.41
67801	Remove eyelid lesions	$ 272.82
67805	Remove eyelid lesions	$ 351.24
67808	Remove eyelid lesion(s)	$ 2,350.53
67810	Biopsy eyelid & lid margin	$ 380.25
67820	Revise eyelashes	$ -
67825	Revise eyelashes	$ 225.57
67830	Revise eyelashes	$ 1,168.77
67835	Revise eyelashes	$ 2,350.53
67840	Remove eyelid lesion	$ 594.00
67850	Treat eyelid lesion	$ 444.69
67875	Closure of eyelid by suture	$ 1,168.77
67880	Revision of eyelid	$ 2,350.53
67882	Revision of eyelid	$ 2,350.53
67900	Repair brow defect	$ 2,350.53
67901	Repair eyelid defect	$ 2,350.53

Exhibit 6

HCPCS Code	Short Descriptor	Charges
67902	Repair eyelid defect	$ 4,211.25
67903	Repair eyelid defect	$ 2,350.53
67904	Repair eyelid defect	$ 2,350.53
67906	Repair eyelid defect	$ 4,211.25
67908	Repair eyelid defect	$ 2,350.53
67909	Revise eyelid defect	$ 2,350.53
67911	Revise eyelid defect	$ 2,350.53
67912	Correction eyelid w/implant	$ 2,350.53
67914	Repair eyelid defect	$ 2,350.53
67915	Repair eyelid defect	$ 655.23
67916	Repair eyelid defect	$ 2,350.53
67917	Repair eyelid defect	$ 2,350.53
67921	Repair eyelid defect	$ 2,350.53
67922	Repair eyelid defect	$ 646.62
67923	Repair eyelid defect	$ 2,350.53
67924	Repair eyelid defect	$ 2,350.53
67930	Repair eyelid wound	$ 683.16
67935	Repair eyelid wound	$ 2,350.53
67938	Remove eyelid foreign body	$ 437.91
67950	Revision of eyelid	$ 2,350.53
67961	Revision of eyelid	$ 2,350.53
67966	Revision of eyelid	$ 2,350.53
67971	Reconstruction of eyelid	$ 2,350.53
67973	Reconstruction of eyelid	$ 2,350.53
67974	Reconstruction of eyelid	$ 4,211.25
67975	Reconstruction of eyelid	$ 2,350.53

Exhibit 6

HCPCS Code	Short Descriptor	Charges
68020	Incise/drain eyelid lining	$ 199.80
68040	Treatment of eyelid lesions	$ 93.45
68100	Biopsy of eyelid lining	$ 359.82
68110	Remove eyelid lining lesion	$ 474.78
68115	Remove eyelid lining lesion	$ 2,350.53
68130	Remove eyelid lining lesion	$ 2,350.53
68135	Remove eyelid lining lesion	$ 258.87
68200	Treat eyelid by injection	$ -
68320	Revise/graft eyelid lining	$ 2,350.53
68325	Revise/graft eyelid lining	$ 4,211.25
68326	Revise/graft eyelid lining	$ 4,211.25
68328	Revise/graft eyelid lining	$ 2,350.53
68330	Revise eyelid lining	$ 2,928.51
68335	Revise/graft eyelid lining	$ 4,211.25
68340	Separate eyelid adhesions	$ 2,350.53
68360	Revise eyelid lining	$ 4,211.25
68362	Revise eyelid lining	$ 2,350.53
68371	Harvest eye tissue alograft	$ 2,350.53
68400	Incise/drain tear gland	$ 660.60
68420	Incise/drain tear sac	$ 704.64
68440	Incise tear duct opening	$ 196.56
68500	Removal of tear gland	$ 4,211.25
68505	Partial removal tear gland	$ 4,211.25
68510	Biopsy of tear gland	$ 2,350.53
68520	Removal of tear sac	$ 4,211.25
68525	Biopsy of tear sac	$ 2,350.53

Exhibit 6

HCPCS Code	Short Descriptor	Charges
68530	Clearance of tear duct	$ 437.91
68540	Remove tear gland lesion	$ 2,350.53
68550	Remove tear gland lesion	$ 4,211.25
68700	Repair tear ducts	$ 2,350.53
68705	Revise tear duct opening	$ 437.91
68720	Create tear sac drain	$ 4,211.25
68745	Create tear duct drain	$ 4,211.25
68750	Create tear duct drain	$ 4,211.25
68760	Close tear duct opening	$ 406.02
68761	Close tear duct opening	$ 285.72
68770	Close tear system fistula	$ 2,350.53
68801	Dilate tear duct opening	$ -
68810	Probe nasolacrimal duct	$ 437.91
68811	Probe nasolacrimal duct	$ 2,350.53
68815	Probe nasolacrimal duct	$ 2,350.53
68816	Probe nl duct w/balloon	$ 2,350.53
68840	Explore/irrigate tear ducts	$ 239.52
68850	Injection for tear sac x-ray	$ -

Exhibit 6

RETINA INSTITUTE OF ILLINOIS

Diseases & Surgery of the Retina, Macula, and Vitreous

John C. Michael, M.D.
Rumya R. Rao, M.D.
Matthew M. Wessel, M.D.
Preeti R. Poley, M.D.

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Fax:(847) 855-2503

December 29, 2017

Kathryn J. Olson
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson,

In keeping with 77 Ill. Adm. Code § 1110.1540(k) please find this letter of assurances.

Specifically, this letter certifies that Retina Surgery Center, LLC attests that a peer review program exists that evaluates whether patient outcomes are consistent with quality standards established by professional organizations for the ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

Furthermore, RSC attests that by second year of operation after the project completion date, the annual utilization of the surgical/treatment rooms will meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100, as demonstrated herein.

Sincerely,

John Michael, M.D.

Retina Surgery Center, LLC

Notarization:
Subscribed and sworn to before me this 8th day of January, ~~2016.~~ 2018

Lisa Marie Janosek
Signature of Notary
SEAL

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

EXHIBIT 7

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

See Attachment 34-Exhibit 1 for documentation from First Bank & Trust indicating the availability of sufficient debt financing and cash for the proposed expansion and modernization project.

FIRST BANK & TRUST

October 3, 2017

Retina Surgery Center, LLC
8780 W. Golf Road
Niles, Illinois 60714

Attention: Dr. John Michael

Dear Dr. Michael:

It is my understanding that Retina Surgery Center ("ENTITY") plans to establish an ambulatory surgical treatment center ("ASTC") located at 8780 W. Golf Road, Niles, Illinois 60714. I further understand that Retina Surgery Center LLC will require loans(s) for certain capital expenditures and equipment purchases for an amount not to exceed $2,200,000. Retina Surgery Center, LLC and Dr. John Michael have been a good and valuable customer of Bank for several years. Based upon the positive business experiences from working with Retina Surgery Center, LLC and Dr. John Michael and subject to the completion of requisite due diligence and credit approvals, Bank is prepared to extend Retina Surgery Center, LLC up to $2,200,000 in credit exposure to finance the ASTC project.

This letter is not intended to be a should not be construed as a commitment by Bank to lend money; nevertheless, it is intended to serve as a statement of interest to engage in further discussions between Retina Surgery Center, LLC and BANK for the proposed financing opportunity and may form the basis for a discussion of various credit accommodations.

I trust that this letter is sufficient for your needs. Should you, or the Illinois Health Facilities and Services Review Board, have any questions or comments, please do not hesitate to contact me directly at 847-733-7400.

Sincerely,

John W. Close

John W. Close
Vice President
First Bank & Trust

FIRST BANK & TRUST

December 20, 2017

Kathryn J. Olson
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson,

This letter is written with respect to Dr. John Michael. Dr. Michael is a longtime customer of First Bank & Trust. I am the Managing Director and responsible for this relationship.

Dr. Michael has been a customer of First Bank & Trust since August 2004. The Bank currently provides personal and professional depository services John Michael. Dr. Michael maintains average balances in excess of 7 figures and is in good standing with the Bank. We hereby attest that Dr. John Michael, owner of Retina Surgery Center, LLC, has funds available for the proposed project in the amount of $1,000,000.

We appreciate the opportunity to provide this information to you about John Michael. Please do not hesitate to contact me should you have any questions.

Sincerely,

Simon Yohanan
Managing Director
First Bank & Trust

Section IX, Financial Feasibility

Criterion 1120.130(a) – Financial Viability

Please find in the *projected* viability ratios for Retina Surgery Center. As a new entity, we the applicant has provided supporting schedules to support the numbers documenting how the numbers have been compiled or projected. The ratios contained therein are calculated in accordance with the requirements of Section 1120, Appendix A.

Standards

The applicant that is responsible for funding the project must provide viability ratios. The standards for these ratios are contained in Section 1120. APPENDIX A. This appendix lists the standards for the various viability ratios based on type of provider.

This project involves expansion of an existing Ambulatory Surgical Treatment Center, as such the applicable standards indicated in Appendix A have been applied.

Meeting the Standards

A copy of the projected pro forma has been attached as Attached as Exhibit 1.

Financial Viability Ratios

Viability Ratio Calculations: Current Ratio

Current Assets/Current Liabilities

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥1.5	1.56	10.72	19.41	Yes

Retina Surgery Center is able to meet the standard for Current Ratio.

Viability Ratio Calculations: Net Margin Percentage

(Net Income/Net Operating Revenues) X 100

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥3.5%	12%	14%	19%	Yes

Retina Surgery Center is able to meet the standard for Net Margin Percentage.

Viability Ratio Calculations: Long Term Debt to Capitalization

(Long-Term Debt/Long-Term Debt plus Net Assets) X 100

State Standard	Year 1	Year 2	Year 3	Met Standard?
≤80%	58%	51%	44%	Yes

Retina Surgery Center is able to meet the standard for Percent Debt to Total Capitalization.

Viability Ratio Calculations: Projected Debt Service Coverage

Net Income plus (Depreciation plus Interest plus Amortization)/Principal Payments plus Interest Expense for the Year of Maximum Debt Service after Project Completion

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥1.75	7.1	11.6	15.4	Yes

Retina Surgery Center is able to meet the standard for Projected Debt Service Coverage.

Viability Ratio Calculations: Days Cash on Hand

(Cash plus Investments plus Board Designated Funds)/(Operating Expense less Depreciation Expense)/365 days

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥45 days	60	180	318	Yes

Retina Surgery Center is able to meet the standard for Days Cash on Hand

Viability Ratio Calculations: Cushion Ratio

(Cash plus Investments plus Board Designated Funds)/(Principal Payments plus Interest Expense) for the year of maximum debt service after project completion.

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥3.0	3.4	8.9	15.3	Yes

Retina Surgery Center is able to meet the standard for Cushion Ratio.

RETINA SURGERY CENTER
PROJECTED PRO FORMA

	Projected Year 1		Projected Year 2		Projected Year 3	
Revenue:						
Surgeries and Injections Service (charges)	3,780,215		3,893,621		4,010,430	
Deductions From Revenue (insurance discounts)	(1,890,107)		(1,946,811)		(2,005,215)	
Total Income	1,890,107		1,946,811		2,005,215	
Expenses:						
Salaries	449,486	24%	462,971	24%	476,860	24%
Bond Issuance Expense	24,000	1%				
Repairs and Maintenance	28,837	2%	29,703	2%	30,594	2%
Management Fees	120,098	6%	123,701	6%	127,412	7%
Surgical Instruments/Supplies	371,210	20%	382,346	20%	393,816	20%
Utilities	25,850	1%	26,626	1%	27,424	1%
Rent Expense	88,542	6%	91,198	5%	93,934	5%
Professional Fees	57,764	3%	59,497	3%	61,282	3%
Insurance	29,747	2%	30,639	2%	31,558	2%
Depreciation	162,852	1%	259,329	13%	193,999	10%
Employee Benefits	29,538	2%	30,424	2%	31,337	2%
General Admin	44,891	2%	46,238	2%	47,625	2%
Taxes and Licenses	69,640	4%	71,729	4%	73,881	4%
Interest Expense	61,053	3%	58,122	3%	55,041	3%
Bad Debt Expenses	56,703	3%	56,703	3%	56,703	3%
Other Expenses	89,800	5%	-	0%	0	
Total Expenses	1,710,011		1,729,224		1,701,466	
Net Income	180,097		217,587		303,749	

RETINA SURGERY CENTER
PROJECTED PRO FORMA

	Projected Year 1		Projected Year 2		Projected Year 3	
Revenue:						
Surgeries and Injections Service (charges)	3,780,215		3,893,621		4,010,430	
Deductions From Revenue (insurance discounts)	(1,890,107)		(1,946,811)		(2,005,215)	
Total Income	1,890,107		1,946,811		2,005,215	
Expenses:						
Surgical Instruments/Supplies	371,210	20%	382,346	20%	393,816	20%
Total COGS Expenses	371,210		382,346		393,816	
Net Operating Revenue	1,518,898		1,564,465		1,611,399	

RETINA SURGERY CENTER
PROJECTED PRO FORMA

	Year 1	Year 2	Year 3
ASSETS			
Current Assets			
Checking/Savings	194,460	536,155	970,603
Total Current Assets	194,460	536,155	970,603
Fixed Assets			
Furniture and Equipment	2,133,276	2,133,276	2,133,276
Accumulated Depreciation	-162,852	-422,181	-616,180
Total Fixed Assets	1,970,424	1,711,095	1,517,096
TOTAL ASSETS	**2,164,884**	**2,247,250**	**2,487,699**
LIABILITIES & EQUITY			
Liabilities			
Current Liabilities	125,000	50,000	50,000
Liabilities			
Total Current Liabilities	125,000	50,000	50,000
Long Term Liabilities			
Loan	1,184,883	1,129,567	1,066,267
Total Long Term Liabilities	1,184,883	1,129,567	1,066,267
Total Liabilities	1,309,883	1,179,567	1,116,267
Equity			
Capital Contribution	670,000	0	0
Capital	0	670,000	670,000
Retained Earnings	0	180,097	397,683
Net Income	180,097	217,587	303,749
Total Equity	850,097	1,067,683	1,371,432
TOTAL LIABILITIES & EQUITY	**2,159,979**	**2,247,250**	**2,487,699**

Section X, Economic Feasibility Review Criteria
Criterion 1120.140(a), Reasonableness of Financing Arrangements

A. Reasonableness of Financing Arrangements:

See Attachment 37-Exhibit 1 for a signed, notarized statement from a representative of Retina Surgery Center that (1) 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 and (2) that the selected form of debt financing for the project will be at the lowest net cost available.

B. Conditions of Debt Financing

See Attachment 37-Exhibit 1 for a signed, notarized statement from a representative of RSC that (1) 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 and (2) that the selected form of debt financing for the project will be at the lowest net cost available.

C. Reasonableness of Project and Related Costs

Per the below tables, the applicant has met the project costs standards established by the state.

Table 1120 Appendix A			
	Application	**State Standard**	**Above/Below State Standard**
New Construction & Contingencies	N/A	$410.06 / GSF	N/A
Modernization Construction	$774,975	$286.05 x 3,411 GSF = $975,716.55	Below State Standard
OR Equipment	$418,220	$475,480.30	Below State Standard
Contingencies	$89,800	10-15% x $1,398,714.66 = $139,871.47 - $209,807.19	Below State Standard
A/E Fees	$33,000	10.35% - 10.54%	Below State Standard
Site Survey + Site Prep	N/A	N/A	N/A
Pre-planning	N/A	N/A	N/A

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department	A	B	C	D	E	F	G	H	TOTAL COST
	Cost/ Sq. Ft.*		Gross Sq. Ft.		Gross Sq. Ft.		Const. $	Mod. $	(G + H)
	New	Mod.	New	Circ.	Mod.	Circ.	(A x C)	(B x E)	
Clinical	N/A	$774,975	N/A	N/A	3,411	N/A	$ 227.20	N/A	$ 227.20
Contingency-Clinical	N/A	$77,400	N/A	N/A	3,411	N/A	$ 22.69	N/A	$ 22.69
Clinical Sub-total	N/A	$ 852,375	N/A	$0.00	3,411	$0.00	$ 249.89	N/A	$ 249.89
Non-Clinical	$ 267,624	N/A	733	N/A	N/A	N/A	$ 365.11	N/A	$ 365.11
Contingency-Non-Clinical	$ 12,400	N/A	733	N/A	N/A	N/A	$ 16.92	N/A	$ 16.92
Non-Clinical Sub-total	$ 280,024	N/A	733	N/A	N/A	N/A	$ 382.03	N/A	$ 382.03
Total	**$280,024**	**$852,375**	**4,144**	N/A	N/A	N/A	N/A	N/A	N/A

*Please note: The facility contains 647 sq. ft. of Shell Space.

D. Projected Operating Costs

OPERATING COSTS	
ASTC	$ 1,028,095

TOTAL	$ 1,028,095

Total Patient Treatments = 3,201
Operating Cost/Visit = $ 321.18

E. Total Effect of the Project on Capital Costs for Year One

CAPITAL COSTS	
Amortization	$ 189,790.44
Depreciation	$ 162,852.32
TOTAL	$ 352,642.76

Total Patient Treatments = 3,201
Capital Cost/Visit = $110.17

RETINA INSTITUTE OF ILLINOIS

Diseases & Surgery of the Retina, Macula, and Vitreous

John C. Michael, M.D.
Rumya R. Rao, M.D.
Matthew M. Wessel, M.D.
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December 29, 2017

Kathryn J. Olson
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson,

I hereby attest that, for the Retina Surgery Center CON project, borrowing is less costly than the liquidation of existing investments and that the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

Furthermore, I certify that, as this project will require debt financing, the selected form of debt financing will be at the lowest net cost available.

Sincerely,

John Michael, M.D.
Retina Surgery Center, LLC

Notarization:
Subscribed and sworn to before me this 8th day of January
2016. 2018

Lisa Marie Janosek
Signature of Notary

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

SEAL

EXHIBIT 1

Section XI, Safety Net Impact Statement

1. Material impact on safety net services in the community. Retina Surgery Center will not have a material impact on safety net services in the Chicago metropolitan area. The primary purpose of RSC is to deliver greater access for patients in the Northwest-suburban area of Chicago that need specialized treatment for trauma to the eye and retina. Thus, RSC will only improve access to safety net services.

2. Material impact on the ability of another provider or health care system to cross subsidize safety net services. RSC will not negatively impact the ability of other providers to cross-subsidize safety-net services. The limited scope of RSC reduces its potential impact on other providers. The overwhelming majority of referrals to RSC will be for cases previously performed at either Dr. Michael's office or in hospitals which have grown overcrowded and resulted in increased wait times and patient inconvenience. Accordingly, the Applicant does not believe RSC will impact the ability of providers to cross-subsidize safety net services.

3. How the discontinuation of a facility might impact the remaining providers. The project will not involve a discontinuation of a facility. Thus, this criterion does not apply.

4. The proposed project involves the establishment of a new ASTC, and no information regarding the amount of charity care or Medicaid provided in the three years prior to this application is available. Thus, this criterion is not applicable.

Section XI, Charity Care Information

The surgery center offers financial assistance to needy patients through its charity care program. All those who inform the center that they cannot afford the services they have received may be eligible for financial assistance. The table below contain the relevant anticipated charity care information and projected payor mix for Retina Surgery Center, LLC by the end of its second year of operation:

CHARITY CARE			
	2018	2019	2020
Net Patient Revenue	**$1,518,898**	**$1,564,465**	**$1,611,399**
Amount of Charity Care (Charges in Dollars)	$56,703	$56,703	$56,703
Cost of Charity Care (in Dollars)	$56,703	$56,703	$56,703
Ratio of Charity Care to Net Patient Revenue	3%	3%	3%

Appendix I – Physician Referral Letter

Attached as Appendix 1 are the letters from each physician projecting that 201 patients will be referred to the ASTC for complex surgeries within 12 to 24 months of project completion. Also included is a letter from Retina Institute of Illinois, P.C. indicating the facilities intent to refer 3,000 patients to the ASTC for office based surgical service to be performed at the proposed ASTC within 12 to 24 months of the project completion.

RETINA
INSTITUTE OF
ILLINOIS

John C. Michael, M.D.
Rumya R. Rao, M.D.
Matthew M. Wessel, M.D.
Preeti R. Poley, M.D.

Diseases & Surgery of the Retina, Macula, and Vitreous

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December 29, 2017

Ms. Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Olson,

I am a physician specializing in ophthalmology surgery, I support the proposal to establish the ambulatory surgical treatment center (ASTC) located at 8780 West Golf Road, Niles, Illinois 60714, known as the Retina Surgery Center.

Over the past 12 months (ending on August 16, 2017), I have referred eighty (80) patients to an IDPH-licensed facility where the patient received treatment. The attached tables list the zip codes of residence for these patients and the facilities to which I referred patients.

I anticipate that I will refer 80 patients to the Retina Surgery Center in each of the two years following completion of the ASTC expansion.

These referral counts have not been used to support another pending or approved permit application for any other licensed hospital or ASTC for the subject services.

RETINA
INSTITUTE OF
ILLINOIS

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Sincerely,

Dr. John Michael
8780 W. Golf Suite 304
Niles, IL 60714

Subscribed and Sworn to before me this

8th day of January
~~2017~~ 2018

Lisa Marie Janosek
Notary Public

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

Location Patient Zip	Total Patients (80)
Centegra Huntley	**18**
60014	3
60016	1
60033	2
60050	1
60081	1
60098	4
60102	1
60103	1
60142	1
60152	1
60192	1
61011	1
Condell Huntley	**1**
60156	1
Condell Medical Center	**29**
60000	1
60002	1
60013	1
60014	1
60016	2
60018	1
60025	1
60031	3
60033	1
60047	3
60053	1
60056	1
60060	1
60071	1
60084	1
60085	1
60090	1
60140	1
60192	1
60446	1
60626	1
60630	1
60712	1
60714	1
Highland Park Hospital	**2**
60077	1
60634	1
Huntley Centegra	**1**
60098	1
Lutheran General Hospital	**11**
60013	1
60014	1
60016	1
60018	1
60025	2
60050	1
60613	1
60656	1
60660	1
60090	1
Northwest Community Hospital	**2**
60076	1
60402	1
Resurrection Medical Center	**7**
60026	1
60053	1
60056	1
60172	1
60641	1
60647	1
60707	1
Weiss Memorial Hospital	**9**
60056	1
60625	1
60626	1
60640	3
60641	2
60647	1

RETINA
INSTITUTE OF
ILLINOIS

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Diseases & Surgery of the Retina, Macula, and Vitreous

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December 22, 2017

Ms. Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Olson,

I am a physician specializing in ophthalmology surgery, I support the proposal to establish the ambulatory surgical treatment center (ASTC) located at 8780 West Golf Road, Niles, Illinois 60714, known as the Retina Surgery Center.

Over the past 12 months (ending on August 16, 2017), I have referred forty-eight (48) patients to an IDPH-licensed facility where the patient received treatment. The attached tables list the zip codes of residence for these patients and the facilities to which I referred patients.

I anticipate that I will refer 48 patients to the Retina Surgery Center in each of the two years following completion of the ASTC expansion.

These referral counts have not been used to support another pending or approved permit application for any other licensed hospital or ASTC for the subject services.

RETINA
INSTITUTE OF
ILLINOIS

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□ ***GURNEE***
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Fax:(847) 855-2503

Sincerely,

Dr. Preeti Poley
8780 W. Golf Suite 304
Niles, IL 60714

Subscribed and Sworn to before me
this

8th day of
January 20XX 2018

Lisa Marie Janosek
Notary Public

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

Location Patient Zip	Total Patients (48)
Condell Medical Center	**33**
60002	4
60030	2
60031	2
60033	1
60053	2
60060	1
60069	1
60073	1
60097	1
60098	1
60115	1
60123	1
60140	1
60142	1
60169	1
60523	2
60532	1
60613	2
60618	1
60630	2
60631	1
60634	1
60660	1
60707	1
Lutheran General Hospital	**1**
60074	1
Northwest Community Hospital	**1**
60659	1
Swedish Covenant Hospital	**10**
60053	1
60077	1
60102	1
60625	1
60630	1
60634	1
60645	1
60659	1
60714	2
Weiss Memorial Hospital	**3**
60133	1
60659	2

RETINA
INSTITUTE OF
ILLINOIS

Diseases & Surgery of the Retina, Macula, and Vitreous

John C. Michael, M.D.
Rumya R. Rao, M.D.
Matthew M. Wessel, M.D.
Preeti R. Poley, M.D.

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December 22, 2017

Ms. Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Olson,

I am a physician specializing in ophthalmology surgery, I support the proposal to establish the ambulatory surgical treatment center (ASTC) located at 8780 West Golf Road, Niles, Illinois 60714, known as the Retina Surgery Center.

Over the past 12 months (ending on August 16, 2017), I have referred seventy-three (73) patients to an IDPH-licensed facility where the patient received treatment. The attached tables list the zip codes of residence for these patients and the facilities to which I referred patients.

I anticipate that I will refer 73 patients to the Retina Surgery Center in each of the two years following completion of the ASTC expansion.

These referral counts have not been used to support another pending or approved permit application for any other licensed hospital or ASTC for the subject services.

RETINA
INSTITUTE OF
ILLINOIS

Diseases & Surgery of the Retina, Macula, and Vitreous

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Fax:(847) 855-2503

Sincerely,

Dr. Matthew Wessel
8780 W. Golf Suite 304
Niles, IL 60714

Subscribed and Sworn to before me
this

8th day of
January ~~2017~~ 2018
Lisa Marie Janosek
Notary Public

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

Location Patient Zip	Total Patients (73)
Centegra Huntley	**9**
60010	1
60013	4
60098	1
60102	1
60156	1
60630	1
Centegra Memorial Woodstock	**2**
60014	1
60102	1
Condell Medical Center	**55**
53105	2
60002	1
60010	1
60013	3
60014	3
60016	1
60031	1
60033	1
60048	1
60050	1
60051	4
60053	1
60056	2
60068	2
60081	1
60090	1
60097	2
60098	1
60102	2
60107	1
60110	2
60129	1
60142	5
60143	3
60156	1
60188	1
60193	2
60194	1
60622	1
60630	2
61012	4
Lutheran General Hospital	**6**
60002	1
60013	1
60014	1
60056	1
60077	1
60514	1
St. Alexius Medical Center	**1**
60015	1

RETINA INSTITUTE OF ILLINOIS

Diseases & Surgery of the Retina, Macula, and Vitreous

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December 29, 2017

Ms. Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Olson,

On behalf of Retina Institute of Illinois, I am writing in support of the proposed application to establish an ambulatory surgical treatment center (ASTC) located at 8780 West Golf Road, Niles, Illinois 60714, known as the Retina Surgery Center.

The physicians practicing at Retina Institute and myself specialize in ophthalmology surgery. Over the past 12 months (ending on August 16, 2017), we have performed 4,021 surgical procedures at our office-based clinics. The attached table listed the zip codes of residence for these patients.

If HFSRB approves the proposed application we anticipate to refer 2,600 patients to the Retina Surgery Center in each of the two years following completion of the ASTC expansion. Projected patient volume shall come from the proposed geographic service area of Retina Surgery Center.

RETINA INSTITUTE OF ILLINOIS

Diseases & Surgery of the Retina, Macula, and Vitreous

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Rumya R. Rao, M.D.
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I hereby attest that, to the best of my knowledge, all the information in this letter is true and correct and that these patient referrals have not been used to support another pending or approved CON application.

Sincerely,

Dr. John Michael
Retina Institute of Illinois, P.C.
8780 W. Golf Suite 304
Niles, IL 60714

Subscribed and Sworn to before me this

8th day of January
~~2017~~ 2018

Lisa Marie Janosek
Notary Public

OFFICIAL SEAL
LISA MARIE JANOSEK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/08/19

Zip Code	Patient Count
60645	175
60714	169
60068	158
60016	146
60625	146
60630	146
60659	146
60085	134
60076	123
60641	117
60025	105
60010	94
60087	94
60053	88
60030	82
60056	82
60067	82
60077	82
60031	76
60090	76
60631	76
60169	70
60646	70
60656	70
60007	64
60062	64
60634	64
60107	53
60192	53
60194	53
60005	47
60018	47
60099	47
60110	47
60193	47
60004	41
60133	41
60070	35
60618	35
60647	35
60048	29
60074	29
60173	29
60707	29
60712	29
60015	23
60047	23
60061	23
60064	23
60089	23
60091	23
60103	23
60188	23
60201	23
60706	23
60021	18
60120	18
60202	18
60026	12
60040	12
60060	12
60101	12
60104	12
60172	12
60176	12
60203	12
60639	12
60029	6
60043	6
60044	6
60108	6
60131	6
60148	6
60164	6
60171	6
60191	6
60402	6
60514	6
60527	6
60534	6
60559	6
60623	6
60624	6
60644	6
60651	6

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

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THE advisGROUP
YOUR SMART HEALTHCARE CONSULTANTS

January 10, 2018

Courtney Avery, Administrator
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery,

Please find enclosed with this cover letter a completed Certificate of Need Application, submitted on behalf of the applicant Retina Surgery Center, LLC. The applicant proposes to establish an Ambulatory Surgical Treatment Center ("ASTC") to be located at 8780 W. Golf Rd., Suite 102, Niles, IL 60714.

As detailed within the application, this project is substantive because it involves the establishment of a health care facility or a category of service.

Thank you for your attention to this matter. Please do not hesitate to contact me if you have any questions regarding the proposed ASTC project.

Sincerely,

Bryan Niehaus, JD, CHC
Senior Consultant
The Advis Group