18-049 [ORIGINAL]

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: Surgery Center of Illinois
Street Address: 6701 W. 95th Street
City and Zip Code: Oak Lawn, IL 60432
County: Cook Health Service Area: 007 Health Planning Area: 031

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

Exact Legal Name: Surgery Center of Illinois, LLC
Street Address: 6701 W. 95th Street
City and Zip Code: Oak Lawn, IL 60432
Name of Registered Agent: Kenndall Lynchey
Registered Agent Street Address: 1938 E Lincoln Hwy, STE 201
Registered Agent City and Zip Code: New Lenox, IL, 60451
Name of Chief Executive Officer: Daniel Troy
CEO Street Address: 16255 South Harlem Avenue
CEO City and Zip Code: Tinley Park, IL 60477
CEO Telephone Number: (708) 599-5000

Type of Ownership of Applicants

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

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- o 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: Bryan J. Niehaus
Title: Vice President
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: Robyn Composono
Title: Manager
Company Name: Surgery Center of Illinois, LLC
Address: 16255 South Harlem Avenue
Telephone Number: (708) 599-5000
E-mail Address: r.composono@advancedorthospine.com
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Oak Lawn 95th Properties LLC
Address of Site Owner: 6701 W. 95th Street Oak Lawn, IL 60453
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: Surgery Center of Illinois LLC

Address: 6701 W. 95th Street Oak Lawn, IL 60453

☐	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 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

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

The applicants are proposing to establish a new ambulatory surgical treatment center ("ASTC") located at 6701 W 95th Street, Oak Lawn, IL 60453. The applicant proposes to establish a limited specialty, ASTC with two operating rooms, offering orthopedic and pain management services. The applicants propose to modernize existing building space to build the facility.

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			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts	$1,992,173.92	$1,093,184.08	$3,085,358.00
Contingencies	$199,217.39	$109,318.41	$308,535.80
Architectural/Engineering Fees	$119,530.44	$65,591.04	$185,121.48
Consulting and Other Fees	$25,827.46	$14,172.54	$40,000.00
Movable or Other Equipment (not in construction contracts)	$979,450.00	$126,319.00	$1,105,769.00
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	$1,769,620.00	$971,060.00	$2,740,680.00
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$5,085,819.21**	**$2,379,645.07**	**$7,465,464.28**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$322,843.24	$177,156.76	$500,000.00
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$1,769,620.00	$971,060.00	$2,740,680.00
Governmental Appropriations			
Grants			
Debt Financing	$2,727,886.06	$1,496,898.22	$4,224,784.28
TOTAL SOURCES OF FUNDS	**$4,820,349.29**	**$2,645,114.99**	**$7,465,464.28**

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

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

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

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

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

Estimated start-up costs and operating deficit cost is $ $1,506,046.30 (no deficit)

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): 3/31/2020

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	$1,992,173.92		7,694		7,694		
Total Clinical	$1,992,173.92		7,694		7,694		
NON REVIEWABLE							
Administrative	$489,369.47		1,890		1,890		
Shell Space	$603,814.61		2,332		2,332		
Total Non-clinical	$1,093,184.08		4,222		4,222		
TOTAL	**$3,085,358.00**		**11,916**		**11,916**		

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

Facility Bed Capacity and Utilization

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

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

SECTION II. DISCONTINUATION

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 1110.290 – Discontinuation (State-Owned Facilities and All Relocations)

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 1110.290(b) for examples.

IMPACT ON ACCESS

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

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

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 Surgery Center of Illinois, 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

Dr. Daniel Troy
PRINTED NAME

CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 12 day of December 2018

Signature of Notary

Seal

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

SIGNATURE

PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

*Insert the EXACT legal name of the applicant

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.

1110.110(a) – Background of the Applicant

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 listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. 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.**

5. 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 1110.110(b) & (d)

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 1110.120 - 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. SERVICE SPECIFIC REVIEW CRITERIA

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
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	

1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 24, 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)**

VI. 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 33, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 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 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

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

Variance

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

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

SECTION VIII.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 36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 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 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. 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.

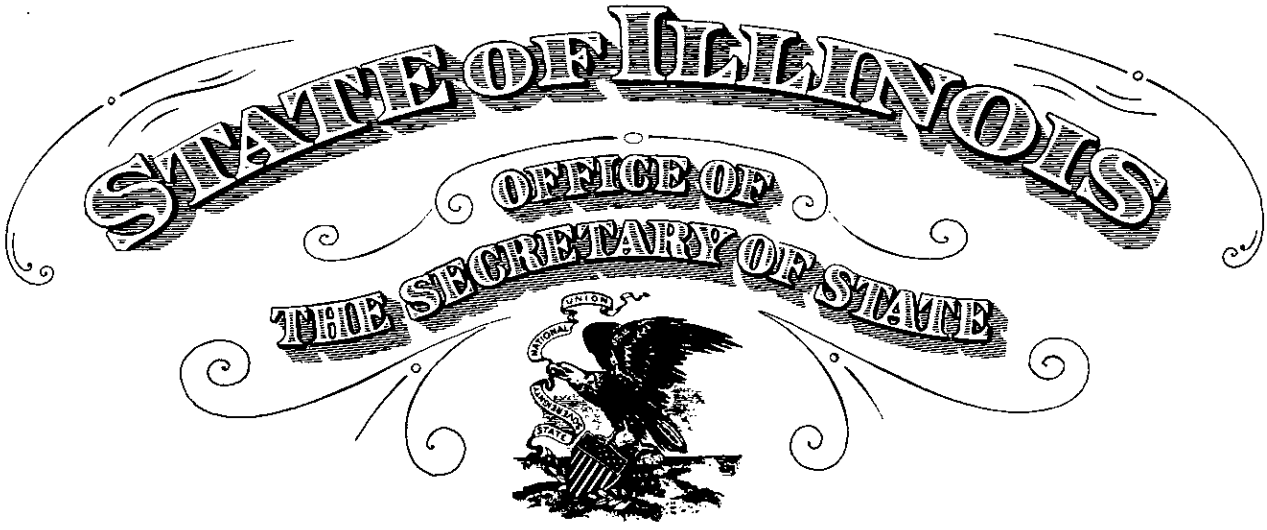
CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 38, 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 Surgery Center of Illinois, LLC as Attachment-1 Exhibit-1.

File Number 0554994-9



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

SURGERY CENTER OF ILLINOIS LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON DECEMBER 22, 2015, 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* 14TH *day of* DECEMBER *A.D.* 2018 .

Authentication #: 1834801852 verifiable until 12/14/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Attachment 1 - Exhibit I

Section I, Identification, General Information, and Certification

Site Ownership

The site, 6701 W. 95th Street, Oak Lawn, IL 60453 is owned by **Oak Lawn 95th Properties, LLC;**

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

- Attachment 2-Exhibit 1: A copy of the current lease from Oak Lawn 95th Properties, LLC and Surgery Center of Illinois, LLC.

LEASE

THIS LEASE, ("Lease") is made and entered into the _____ day of _____ 2018 between Oak Lawn 95th Properties, LLC, an Illinois limited liability company ("LESSOR") and Surgery Center of Illinois, 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 6701 W. 95th Street, Oak Lawn, IL, 60432 and for and in consideration of the covenants herein, LESSOR does hereby demise and lease to LESSEE the real property known as 6701 W. 95th Street, Oak LAwn, IL, 60432 ("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, 2029 ("Initial Term"). After the expiration of the Initial Term, this Lease shall automatically renew for four (4) consecutive five (5) year terms at the option of the LESSEE. 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:

Oak Lawn 95th Properties, LLC, LLC, an Illinois limited liability company

Daniel Troy, as Manager

LESSEE:

Surgery Center of Illinois, LLC, an Illinois limited liability company

Daniel Troy, 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 6701 W. 95th Street, Oak Lawn, IL, 60432 dated _____, 20____ ("Lease") between Oak Lawn 95th Properties, LLC, an Illinois limited liability company ("LESSOR") and Surgery Center of Illinois, 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 $22,839.00 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:

Oak Lawn 95th Properties, LLC, an Illinois limited liability company

Daniel Troy, as Manager

LESSEE:

Surgery Center of Illinois, LLC, an Illinois limited liability company

Daniel Troy, as Manager

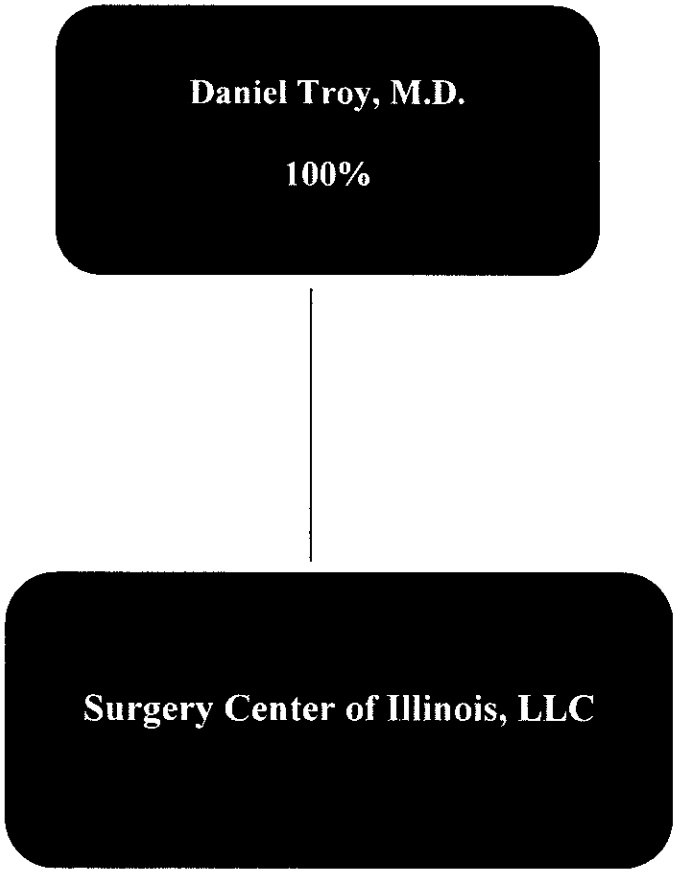
Section I, Identification, General Information, and Certification
Operating Entity/Licensee

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

Surgery Center of Illinois, LLC.	
Daniel Troy, M.D.	100%

Attachment 3

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



Attachment 4

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

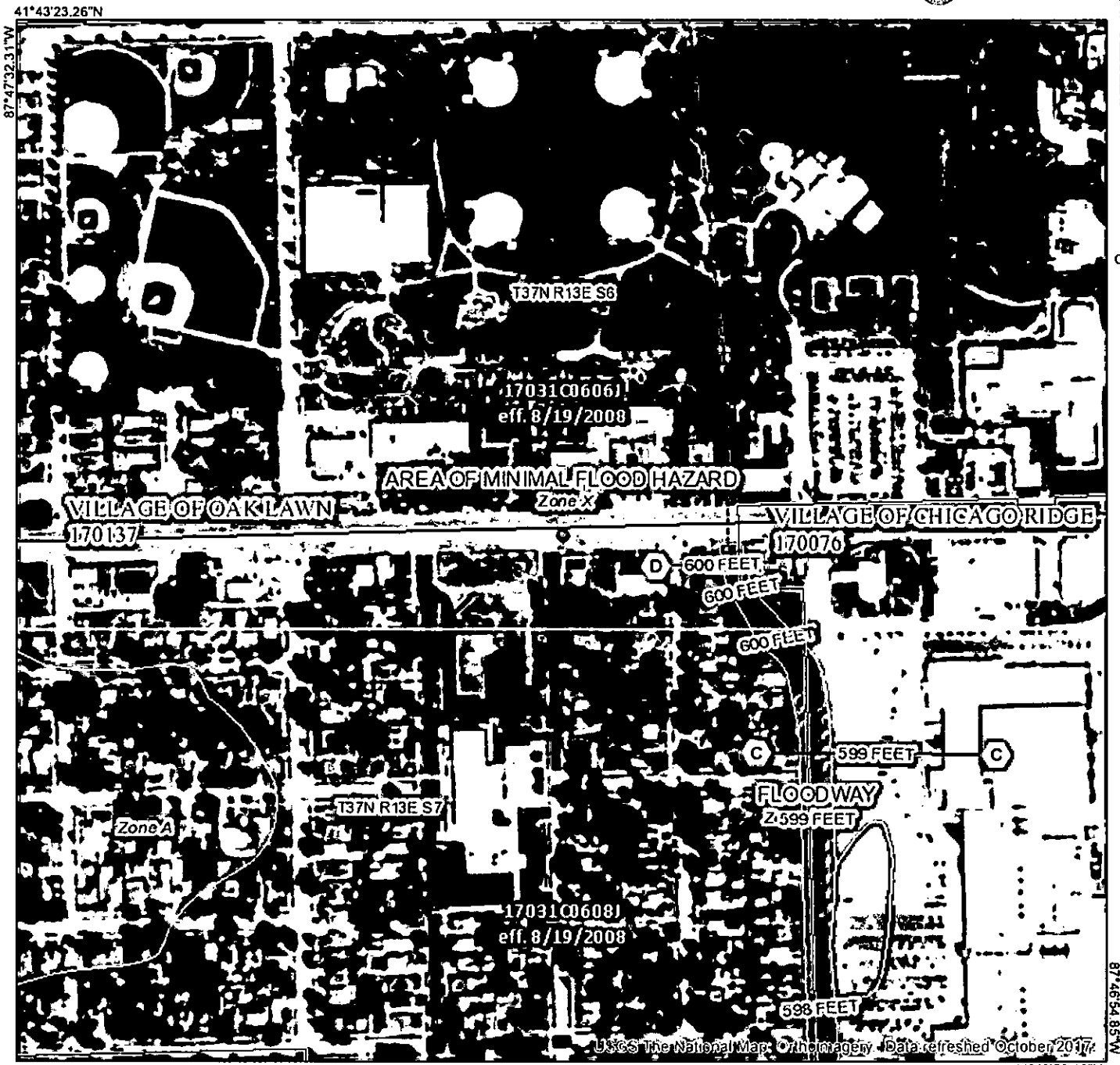
This project complies with Illinois Executive Order #2005-5.

Please find included with this Attachment:

- A Flood Plain map generated using FEMA's flood map generator for 6701 W. 95th Street, Oak Lawn, IL 60453 indicating that the location is out of the flood zone.

National Flood Hazard Layer FIRMette

FEMA



Feet 1:6,000

0 250 500 1,000 1,500 2,000

Legend

SEE FIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

SPECIAL FLOOD HAZARD AREAS
- Without Base Flood Elevation (BFE) *Zone A, V, A99*
- With BFE or Depth *Zone AE, AO, AH, VE, AR*
- Regulatory Floodway

OTHER AREAS OF FLOOD HAZARD
- 0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile *Zone X*
- Future Conditions 1% Annual Chance Flood Hazard *Zone X*
- Area with Reduced Flood Risk due to Levee. See Notes. *Zone X*
- Area with Flood Risk due to Levee *Zone D*

OTHER AREAS
- NO SCREEN Area of Minimal Flood Hazard *Zone X*
- Effective LOMRs
- Area of Undetermined Flood Hazard *Zone D*

GENERAL STRUCTURES
- Channel, Culvert, or Storm Sewer
- Levee, Dike, or Floodwall

OTHER FEATURES
- 20.2 Cross Sections with 1% Annual Chance
- 17.5 Water Surface Elevation
- Coastal Transect
- 513 Base Flood Elevation Line (BFE)
- Limit of Study
- Jurisdiction Boundary
- Coastal Transect Baseline
- Profile Baseline
- Hydrographic Feature

MAP PANELS
- Digital Data Available
- No Digital Data Available
- Unmapped

N

The pin displayed on the map is an approximate point selected by the user and does not represent an authoritative property location.

This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The basemap shown complies with FEMA's basemap accuracy standards

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 10/4/2018 at 3:07:26 PM and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: basemap imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for regulatory purposes.

SURGERY CENTER OF ILLINOIS, LLC

December 11, 2018

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

Dear Ms. Avery,

I hereby certify and attest that the facility located at 6701 W. 95th Street, Oak Lawn, IL 60453 is not located in a special flood hazard area.

Sincerely,

Daniel Troy, M.D.
Surgery Center of Illinois, LLC

Notarization:
Subscribed and sworn to before me this 12 day of December, 2018.

Signature of Notary

SEAL

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

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

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
Oak Lawn
CON - Rehabilitation to Establish an Ambulatory Surgical Treatment Center
6701 W. 95th Ave.
SHPO Log #007101618

November 30, 2018

Jake Beechy
The Advis Group
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 call 217/782-4836.

Sincerely,

Robert F. Appleman
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			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts (Base Building Upgrades)			
Modernization Contracts	$1,992,173.92	$1,093,184.08	3,085,358.00
Contingencies (10%)	$199,217.39	$109,318.41	$308,535.80
Architectural/Engineering Fees	$119,530.44	$65,591.04	$185,121.48
Consulting and Other Fees (Equipment Planning) any other consultants?	$25,827.46	$14,172.54	$40,000.00
Movable or Other Equipment (not in construction contracts) (Itemized below)	$979,450.00	$126,319.00	1,105,769.00
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	$1,769,620.00	$971,060.00	$2,740,680.00
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$5,085,819.21**	**$2,379,645.07**	**$7,465,464.28**

SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$322,843.24	$177,156.76	$500,000.00
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$1,769,620.00	$971,060.00	$2,740,680.00
Governmental Appropriations			
Debt Financing	$2,727,886.06	$1,496,898.22	$4,224,784.28
TOTAL SOURCES OF FUNDS	**$4,820,349.29**	**$2,645,114.99**	**$7,465,464.28**

Attachment 7

Equipment Itemization

1	OR Lights and Booms	2	$21,000.00	$42,000.00	OR
2	OR Tables	2	$21,000.00	$42,000.00	OR
3	Side Tables	6	$1,600.00	$9,600.00	OR
4	Double Ring Stands	2	$323.00	$646.00	OR
5	Electrosurgical Unit, Bipolar	2	$5,925.00	$11,850.00	OR
6	Kick Buckets	2	$159.85	$319.70	OR
7	Mayo Stands	2	$589.13	$1,178.26	OR
8	Mayo Stands (Large)	1	$731.60	$731.60	OR
9	IV Poles	2	$319.30	$638.60	OR
10	Light Boxes	4	$2,000.00	$8,000.00	OR
11	Surgeon Stools	4	$2,500.00	$10,000.00	OR
12	Anesthesia Stools	3	$1,000.00	$3,000.00	OR
14	Air Tourniquets ATS 3000	2	$3,995.00	$7,990.00	OR
15	Jackson Table (Flat Top & Spinal Top	1	$90,000.00	$90,000.00	OR
16	Wilson Frame	1	$5,300.00	$5,300.00	OR
17	Blanket Fluid Warmer	2	$8,540.00	$17,080.00	OR
18	Waste Management Suction	2	$90.00	$180.00	OR
19	Crash Cart	1	$1,900.00	$1,900.00	OR
20	Headlights	2	$1,400.00	$2,800.00	OR
21	Microscope	1	$225,000.00	$225,000.00	OR
22	Anesthesia Cart	2	$2,000.00	$4,000.00	OR

23	Scrub Sink	2	$11,280.00	$22,560.00	OR
24	IV Infusion Pumps	8	$2,600.00	$20,800.00	Anesthesia
25	Anesthesia Machines/Setup	2	$50,000.00	$100,000.00	Anesthesia
26	Physiological Monitors (Passport 12)	8	$5,000.00	$40,000.00	PACU
27	Computers	8	$600.00	$4,800.00	OR/PACU
28	Phones	8	$300.00	$2,400.00	OR/PACU
29	Equipment Carts	5	$3,000.00	$15,000.00	PACU
30	Equipment Carts	3	$1,500.00	$4,500.00	PACU
31	Linen Carts	2	$978.00	$1,956.00	PACU
32	Stools PACU	8	$406.00	$3,248.00	PACU
33	Stretcher Chairs	8	$2,500.00	$20,000.00	PACU
34	OR Carts	4	$4,000.00	$16,000.00	PACU
35	Patient Thermometer	8	$174.00	$1,392.00	PACU
36	Glovebox Holders	12	$42.00	$504.00	All
37	Hand Sanitizer Dispenser	12	$55.00	$660.00	All
38	Refrigerator	1	$2,400.00	$2,400.00	Staff Workroon
39	Microwave	1	$240.00	$240.00	Staff Workroom
40	Coffeemaker	1	$179.00	$179.00	Staff Workroom
41	Sharps Container (20 Gallon)	1	$344.00	$344.00	Decontamination
42	Work Station	1	$5,500.00	$5,500.00	Prep/Packaging
43	Sink	1	$350.00	$350.00	Decontamination
44	Shelving	6	$3,500.00	$21,000.00	Prep/Packaging

45	**Sterilizer Steam**	**2**	**$39,000.00**	**$78,000.00**	**Prep Packaging**
46	**Washer**	**1**	**$55,000.00**	**$55,000.00**	**Decontamination**
47	**Lounge/Nourishment Equipment/ Icemaker**	**1**	**$5,500.00**	**$5,500.00**	**Staff Workroom**
48	**Waiting Area / Office Furniture**	**1**	**$123,500.00**	**$123,500.00**	**Waiting Area / Offices**
49	**Mobile C-arm**	**1**	**$75,721.84**	**$75,721.84**	**OR**
				$1,105,769.00	**Total**
				$979,450.00	**Total Clinical**
				$126,319.00	**Total Non-clinical**

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
ASTC	$1,992,173.92		7,694		7,694		
Total Clinical	$1,992,173.92		7,694		7,694		
NON REVIEWABLE							
Administrative	$489,369.47		1,890		1,890		
Shell Space	$603,814.61		2,332		2,332		
Total Non-clinical	$1,093,184.08		4,222		4,222		
TOTAL	**$3,085,358.00**		**11,916**		**11,916**		

Attachment 9

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:

   Surgery Center of Illinois, 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:

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

3. See Attachment 11-Exhibit 1, which includes authorization from Surgery Center of Illinois, 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. See Attachment 11-Exhibit 1, which includes authorization from Surgery Center of Illinois, 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.

5. Not Applicable.

SURGERY CENTER OF ILLINOIS, LLC

December 11, 2018

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

Dear Ms. Avery,

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 Surgery Center of Illinois, LLC has had no adverse actions taken against it in the three years (3) prior to the filing of this application.

Furthermore, Surgery Center of Illinois, 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,

Daniel Troy, M.D.
Surgery Center of Illinois, LLC

Notarization:
Subscribed and sworn to before me this 12 day of December, 2018.

Jean Stripeik
Signature of Notary

SEAL

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 09/27

Section III, Background, Purpose of the Project, and Alternatives – Information Requirements
Criterion 1110.110(a) – Purpose of the Project, Safety Net Impact Statement and Alternatives

PURPOSE OF THE PROJECT

1. The Applicant, Surgery Center of Illinois, herein requests HFSRB's approval to establish an Ambulatory Surgical Treatment Center ("ASTC"), to be known as known as Surgery Center of Illinois ("SCI"). The applicant proposes to develop the facility with two (2) operating rooms and eight (8) recovery rooms. The ASTC will offer Orthopedic and Pain Management surgical services. A focus of the proposed surgery center is to develop an outpatient center of excellence with expanded operating and recovery rooms, with a rehabilitation component, to provide an outlet for the applicant's outpatient total joint demand in southwest Chicagoland.

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 orthopedic and pain management 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. Address the Need for Additional ASTC Orthopedic Surgical Services in GSA

Dr. Troy and the additional physicians from Advance Orthopedics associated with this project (See, attached Physician Referral Letters in Appendix I) focus on orthopedic surgery and pain management. In particular, they are dedicated to utilizing state of the art techniques and processes to provide the optimal environment and outcomes for their patients. As demonstrated within this application, Advanced Orthopedics has pledged sufficient historical volume to justify two (2) operating rooms by the first year of operation. Should the project be approved, the applicant anticipates volume will increase due to increased efficiencies in turnaround time, decreased travel by surgeons, and the planned expansion of surgeons within the practice.

The problem this project intends to remedy is that the Geographical Service Area does not have a viable option for Advanced Orthopedics to provide their surgical patients with a modern, local ASTC option.

Currently there are eight (8) licensed ASTC's within the GSA. Two (2) of the ASTCs did not perform orthopedic surgery in 2017. With regard to the remaining six (6) clinics, none currently possesses the space or equipment necessary to perform the complex spinal and total joint surgeries to be provided by the applicant. The applicant notes that Palos Hills Surgery Center is currently undergoing an expansion and modernization to enable its facility to provide some of these complex services. However, their facility is already operating at State standards on volume and the applicants have provided the HFSRB with evidence and committed that their facility will

be at capacity with their own internal practice volumes. Palos Hills Surgery Center is also designed as a Center of Excellence for the Hand and Upper Extremities, while the applicant is seeking to design and operate a Center of Excellence for Complex Spine and Total Joint Replacements.

Given the lack of viable ASTC options within the GSA, Dr. Troy and Advanced Orthopedics have been forced to utilize either hospitals within the GSA or ASTCs outside of the GSA to service their surgical patients. Historically, over 95% of Dr. Troy's patients originate from zip codes within 5 miles of the proposed facility. Traveling to other area ASTCs is a burden on the patients and the surgeons that this proposed facility would alleviate. The community will benefit from having more surgical ASTC surgical capacity for orthopedic surgery, including total joint replacement and spine, within the immediate vicinity.

The applicants will still provide medically appropriate inpatient care within area hospitals. However, as detailed below, the ASTC setting has many advantages for patients, providers, and the health care system over the hospital outpatient setting. Accordingly, the applicant is seeking to move its medically appropriate patients from the higher cost and time intensive hospital setting.

Coupled with this reality, is research showing outpatient total joint replacements are on the rise in the United States. Sg2, a leading health market analytic firm, reported that from 2012 to 2015, there was a 47 percent increase in elective outpatient hip and knee replacement procedures[1]. Sg2 predicts there will be 77 percent growth in joint replacements over the next 10 years, but inpatient total joint replacements are only projected to grow 3 percent over the same time period. The migration of total joint replacement procedures and higher acuity spine cases to the ASTC setting has been noted as a growing trend within the industry[2]. The movement of Medicare patients to the ASTC, coupled with growing demand from commercial and self-pay patients, is likely to drive growth in demand beyond the existing supply of appropriately equipped ASTCs within the market.

The proposed location will increase 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, Advanced Orthopedic.

B. Design & Operate a Modern ASTC Facility to Service Spine and Total Joint Patients

The applicant intends to offer spine and total joint services to a growing number of patients who elect to have such procedures performed on an outpatient basis. This is not just a choice of the applicant, but a trend being pushed by Medicare & Medicaid, private payors, workers

[1] http://newsroom.vizientinc.com/newsletter/research-and-insights-news/outpatient-joint-replacement-unnecessary-concern-or-market-rea

[2] http://www.pinnacleiii.com/wp-content/uploads/2017/03/Looking-Ahead-10-ASC-Trends-to-Watch-in-2017_White-Paper-Interactive-1.pdf

compensation payors, and employer-sponsored health plans. All recognize the value in moving high-cost procedures from the hospital to the ASC setting where medically appropriate. One of the problems within the GSA, and much of Illinois, is that many ASTC facilities in Illinois are not built to provide these more medically complex procedures for patients.

To meet the needs of patients seeking an affordable option for these higher-complexity cases, SCI intends to:

- Provide larger ORs (720 sq. ft.) to accommodate the required equipment (i.e. Jackson tables for spinal fusion surgeries and mobile imaging for complex procedures);
- Offer three (3) larger recovery rooms (165 sq. ft.) to accommodate the extended (Less than 24 hours) stays of patients in recovery (to accommodate patient visitors and early ambulation therapy);
- Provide a dedicated rehabilitation space (261 sq. ft.) to improve early access to post-surgical rehabilitation within the ASC episode of care at no additional cost to patients;
- Support an increased staffing presence (to provide early rehabilitation therapy and extended hours of operation); and
- Provide state of the art technology (mobile imaging, Jackson tables, and mobile patient monitoring devices) required to execute these goals.

The movement to the ASTC setting is due to the multitude of benefits for clinically appropriate patients. Key benefits of outpatient total joint replacement and spinal procedures over traditional inpatient surgery include:

- Decreased risk of infection
- Decreased hospital stay
- Overall decreased cost
- Improved pain management protocols
- Early mobilization
- Careful home monitoring
- Fewer complications
- Improved outcomes
- Increased patient satisfaction
- Increased patient comfort

C. Provide Enhanced Early Ambulation Rehabilitation Therapy Post-Surgery

The applicant is particularly excited about the potential to provide increased access to immediate post-surgical rehabilitation support. Data suggests that early ambulation for surgical patients is essential to the patient's road to recovery. The Physician Patient Alliance for Health and Safety

urges health institutions to establish best practices that prioritize patient ambulation.[3][4] Mobilization in the hours immediately following surgery is associated with quicker return of lower limb mobility and function, and a reduced risk for adverse complications, including deep vein thrombosis (DVT), pulmonary embolism, and urinary retention. By providing expanded recovery rooms and dedicated rehabilitation space within the ASC, the applicant will be able to provide a safer and more effective environment for these rehabilitation activities than many ASTCs within the GSA and the State.

D. Improve Clinical Care Continuum for Applicant's Patients

The location of ASTC in a location with an Advanced Orthopedics office will allow the applicant to institute a holistic and effective care continuum that is missing today. Currently, the applicant must provide consultations for surgeries at one of Advanced Orthopedics' offices, and then schedule surgery at another ASTC or Hospital location. The surgeon must then also schedule post-operative follow-up visits and rehabilitation back at the office. In addition to increasing travel times for patients and surgeons, this bi-furcation creates gaps in time between pre-surgery consultations and the surgeries themselves.

Ideally, most patients could have a pre-surgery consultation and surgery on the same day at the same location. By locating the proposed ASTC within the same building as an Advanced Orthopedic office, the scheduling conflicts and challenges will be alleviated, with decreased travel time for patients and providers. Finally, having post-operative rehabilitation within the building ensures the patient has one convenient location to serves the majority of his or her surgical needs. This is a model the Board has recognized in other ASTCs, and which Advanced Orthopedics is seeking for its own patient population. Improved care coordination through this design will benefit patients and providers.

E. Align with CMS, Payers, and Patients to Continue Transition from Hospital to ASTC 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

[3] Chua, Matthew J et al. "Early mobilisation after total hip or knee arthroplasty: A multicentre prospective observational study" *PloS one* vol. 12,6 e0179820. 27 Jun. 2017, doi:10.1371/journal.pone.0179820

[4] AJN, American Journal of Nursing: June 2017 - Volume 117 - Issue 6 - p 15

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).

ASTC vs. Hospital Reimbursement Examples

CPT	Description	ASC	OPPS	ASC Savings	Saving %
29881	Arthrs Kne Surg W/meniscectomy Med/lat W/shvg	$1,279.91	$2,645.23	$1,365.32	52%
23107	Shoulder Scope, Bone Shaving	$2,721.37	$5,606.42	$2,885.05	51%
29877	Arthrs Knee Debridement/shaving Artclr Crtlg	$1,279.91	$2,645.23	$1,365.32	52%
29848	Ndsc Wrst Surg W/rls Transvrs Carpl Ligm	$737.58	$1,349.94	$612.36	45%
29880	Arthrs Knee W/meniscectomy Med&lat W/shaving	$1,279.91	$2,645.23	$1,365.32	52%
29827	Arthroscopy Shoulder Rotator Cuff Repair	$2,721.37	$5,606.42	$2,885.05	51%
28285	Correction Hammertoe	$1,279.91	$2,645.23	$1,365.32	52%
29823	Arthroscopy Shoulder Surg Debridement Extensive	$1,279.91	$2,645.23	$1,365.32	52%
26055	Tendon Sheath Incision	$737.58	$1,349.94	$612.36	45%
29824	Arthroscopy Shoulder Distal Claviculectomy	$1,279.91	$2,645.23	$1,365.32	52%
22554	Under Anterior or Anterolateral Approach Technique Arthrodesis Procedures on the Spine (Vertebral Column)	$7,070.44	$10,122.92	$3,052.48	30%
22551	Under Anterior or Anterolateral Approach Technique Arthrodesis Procedures on the Spine (Vertebral Column)	$7,336.63	$10,122.92	$2,786.29	28%

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, dedicated staff, 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.)

Additional facts that document CMS's continued support for the ASC setting for orthopedic surgery include:

- CMS has added total joint codes and several high-value spine codes, including laminectomy, anterior cervical fusion, and posterior lumbar fusion procedures, to the ASC approved list and designed reimbursement to favor the ASC setting.

- In 2014, Medicare paid $50,000 on average per hospitalization for total hip and knee replacements, according to Advisory Board, totaling around $7 billion. However, outpatient total joints cost roughly half as much as inpatient procedures, serving as a driving force to move appropriate patients to ASCs in the future.

- CMS acknowledged that it is possible to deliver safe, effective, and lower-cost spine care in a freestanding ASC in its 2015 payment ruling, which added nine surgical spine codes to the list of ASC covered surgical procedures. Improvements in technology and clinical standards have made it possible for these procedures to be performed in the ASC setting with favorable outcomes and without an overnight hospital stay.

- In 2017, CMS approved meaningful rate increases for several total joint procedures, ranging from 45.2% to 58.7% (see below chart), with the intent to enable migration of such procedures to the ASC setting. CMS is identifying opportunities for savings, and responding by increasing the number and type of ASC-eligible cases and by providing incentives for ASC operators to perform them.

CPT Code	Description	2016 Medicare ASC Rate	2017 Medicare ASC Rate	Difference ($)	Difference (%)
24361	Reconstruct Elbow Joint	$7,887	$12,514	$4,628	58.7%
25446	Wrist Replacement	$7,887	$12,313	$4,426	56.1%
24363	Replace Elbow Joint	$7,887	$12,122	$4,236	53.7%
25442	Reconstruct Wrist Joint	$7,887	$12,107	$4,220	53.5%
24371	Revise Reconstruct Elbow Joint	$7,887	$11,684	$3,797	48.1%

23616	Treat Humerus Fracture	$7,887	$11,357	$3,471	44.0%
27443	Revision Of Knee Joint	$3,533	$4,981	$1,449	41.0%
25443	Reconstruct Wrist Joint	$2,486	$3,817	$1,331	53.5%
26531	Revise Knuckle With Implant	$2,486	$3,684	$1,198	48.2%
25445	Reconstruct Wrist Joint	$2,486	$3,609	$1,123	45.2%

- In 2018, CMS recognized the ability to provide more complex total joint replacement surgeries at outpatient locations, as it removed total knee arthroplasty (TKA) from the Inpatient Only list.[5] CMS praised the "innovations in TKA care [that] include minimally invasive techniques, improved perioperative anesthesia, alternative postoperative pain management, and expedited rehabilitation protocols," which made it possible for this procedure to be performed in the OP setting.

- In 2018, MedPac reiterated that:
  - ASCs may offer patients greater convenience than HOPDs, such as the ability to schedule surgery more quickly;
  - For most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower in ASCs than in HOPDs;
  - Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff;
  - Maintaining beneficiaries' access to ASCs is beneficial because services provided in this setting are less costly to Medicare and beneficiaries than services delivered in HOPDs. Medicare payment rates for surgical services performed in HOPDs are almost twice as high as the same surgical services provided in ASCs.

CMS is clearly motivated to identify opportunities for added savings, both by increasing the number and type of ASC-eligible cases and by providing incentives for ASC operators to perform them. However, they are actually lagging behind commercial payers in this push to the ASC outpatient setting. Health plans are increasingly implementing policies that redirect volume out of hospitals and into the ASC setting. For example, in October of 2016, UnitedHealthcare announced a policy that prohibits designated OP surgery procedures from being performed in the hospital outpatient department setting without authorization. ASCs are the preferred venue for cost savings and increased patient satisfaction.

F. Provide for 24/7 Emergency Operative Capabilities for Surgical Services

The applicants intend to address a common issue for area patients who required immediate access to care for traumatic injuries in a novel way; the applicant are proposing to offer care on an emergent 24/7 basis, meaning outpatient surgical services for patients requiring less than a 24-

[5] (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10417.pdf)

hour stay will be available at all times on call. The expanded emergent care hours will help treat those patients in dire need of surgical treatment, while still offering high quality low cost care in comparison to the hospital setting. In addition, it will help relieve surgical overload and by-pass status experienced at local hospitals, which have plagued patients and the applicant on several occasions.

Overall, the applicant will be able to offer a necessary service line in a more accessible setting for its client base at the proposed ASTC, which shall share a location with the clinical office. This will not only make it more accessible to a larger population, but also offer its patients a better continuum of care in a familiar setting.

1. **Market Area / GSA.**

As demonstrated on Attachment 24 Exhibits 1 & 2, the applicant 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 10-mile. The applicants have attached a map of the areas within 10-miles at Attachment 12 – Exhibit 1.

Zip Code	City	Population
60415	Chicago Ridge	14,039
60455	Bridgeview	16,138
60453	Oak Lawn	54,499
60459	Burbank	27,978
60457	Hickory Hills	14,110
60482	Worth	11,262
60465	Palos Hills	17,198
60456	Hometown	4,452
60458	Justice	14,226
60803	Alsip	22,757
60655	Chicago	29,138
60652	Chicago	39,126
60463	Palos Heights	13,286
60805	Evergreen Park	20,821
60501	Summit Argo	11,175
60638	Chicago	55,788
60480	Willow Springs	4,758
60464	Palos Park	9,520
60525	La Grange	32,475
60629	Chicago	113,984
60445	Midlothian	25,979
60534	Lyons	10,212
60472	Robbins	6,672
60643	Chicago	52,568
60620	Chicago	85,771
60406	Blue Island	25,370
60636	Chicago	51,451
60632	Chicago	87,577
60462	Orland Park	38,431
60402	Berwyn	60,373
60513	Brookfield	19,146
60452	Oak Forest	27,899
60469	Posen	4,703
60546	Riverside	15,700
60804	Cicero	86,133
60558	Western Springs	12,539
60621	Chicago	47,514
60526	La Grange Park	13,301
60521	Hinsdale	37,496
60628	Chicago	87,827
60609	Chicago	79,469
60827	Riverdale	33,209
60619	Chicago	74,963
60467	Orland Park	20,904
60623	Chicago	108,144
60141	Hines	247
60155	Broadview	8,254
60426	Harvey	47,649
60514	Clarendon Hills	17,313
60439	Lemont	20,004
60561	Darien	23,570
60130	Forest Park	15,688
60477	Tinley Park	56,840
TOTAL		**1,829,646**

Attachment – 12

2. **Existing Problems.**

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

A. Need for Additional ASTC Orthopedic Surgical Services in GSA
B. Need for a Modern ASTC Facility to Service Spine and Total Joint Patients
C. Ability to Provide Enhanced Early Ambulation Rehabilitation Therapy Post-Surgery
D. Improve Clinical Care Continuum for Applicant's Patients
E. Align with CMS, Payers, and Patients to Continue Transition from Hospital to ASTC Setting
F. Provide for 24/7 Emergency Operative Capabilities for Surgical Services

3. **Source Documents**.

- Chua, Matthew J et al. "Early mobilisation after total hip or knee arthroplasty: A multicentre prospective observational study" *PloS one* vol. 12,6 e0179820. 27 Jun. 2017, doi:10.1371/journal.pone.0179820
- AJN, American Journal of Nursing: June 2017 - Volume 117 - Issue 6 - p 15
- 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
- ASC at a Tipping Point: The New Reality of Surgical Service for Health Systems by ECG

4. **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, the proposed facility will enhance the continuum of care for the applicant's patients by enabling local, convenient 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 emergent treatment for patients 24/7. Additionally, the applicant will improve access to complex total joint replacement and spine care by building a modern facility with state of the art equipment.

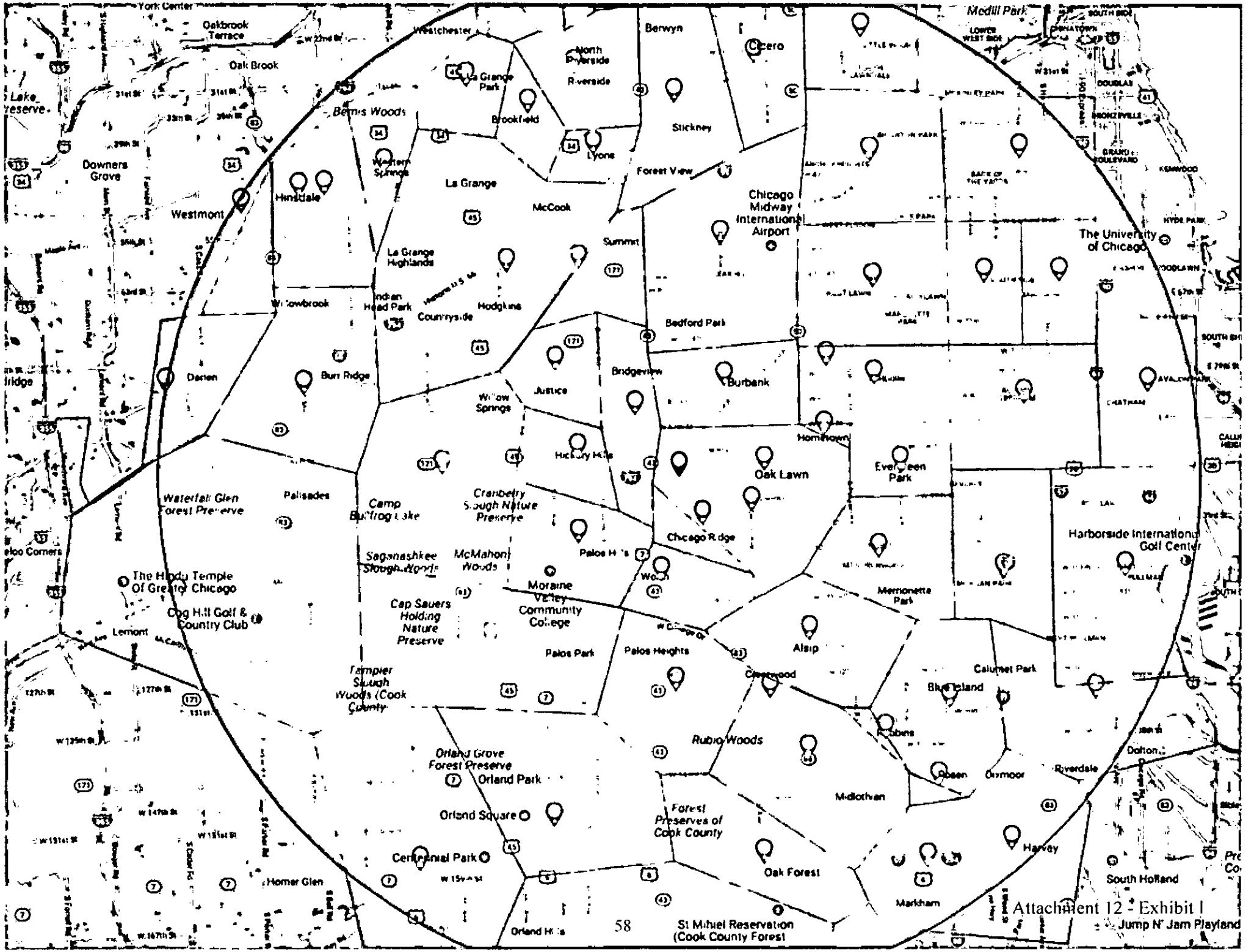
Patients are increasingly likely to seek treatment at ASTCs instead of hospital outpatient departments because of reduced costs, payer policies, and patient comfort with the setting. The Applicant will helped meet this increase in demand and reduce costs for the patient, payors, and healthcare system as a whole. The proposed project will not only provide specialized services its

patients which are otherwise lacking in the community, but will likely reduce wait times, and provide more convenient and faster scheduling for patients.

5. **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 within one month of receiving HFSRB approval.
- The second goal is to hire a contractor within two months after receiving HFSRB approval.
- The third goal is to complete construction for the ASTC within twelve months of receiving HFSRB approval.
- Finally, the ultimate goal is to have the facility approved for occupancy, operational, licensed, and Medicare-certified by within fifteen months of receiving HFSRB approval.



Attachment 12 - Exhibit I

PLOS ONE

RESEARCH ARTICLE

Early mobilisation after total hip or knee arthroplasty: A multicentre prospective observational study

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Abstract

Objective

Early mobilisation is recommended following total hip arthroplasty (THA) or total knee arthroplasty (TKA) to prevent venous thromboembolism (VTE). We sought to determine the proportions of patients that first mobilised on post-operative day 0 (POD 0) and factors associated with earlier time to mobilisation.

Methods

A prospective cohort study was conducted involving patients with hip or knee osteoarthritis who had undergone primary unilateral THA (n = 818) and TKA (n = 989) at 19 Australian hospitals. Patient-related (e.g. age, gender, body mass index), treatment-related (e.g. hospital site, presence of indwelling catheter) and mobilisation-related variables were collected on standardised forms. Time was measured by post-operative days, where POD 0 was defined as the day of surgery ending at midnight. Multivariate Poisson regression analysis identified associations between patient- and treatment-related covariates and time to mobilisation.

Results

Inter-hospital variation was evident, but overall, only 9.4% of THA and 5.6% of TKA patients mobilised on POD 0. For THA patients, earlier time to mobilisation was associated with hospital site and absences of an indwelling catheter and acute complications. For TKA patients, earlier time to mobilisation was associated with hospital site and absence of donor blood transfusion.

New South Wales. There was no additional external funding received for this study.

Competing interests: The authors have declared that no competing interests exist.

Conclusions

Few THA and TKA patients mobilise POD 0, although some hospitals appear more aggressive with their mobilisation attempts than others. Treatment-related factors, not patient-related, are associated with post-operative day of mobilisation, indicating the potentially pivotal role of service providers in promoting early mobilisation to improve health outcomes and reduce rates of VTE.

Introduction

Primary total hip arthroplasty (THA) and total knee arthroplasty (TKA) are commonly performed procedures with over 100,000 hip and knee replacements performed in Australia in 2015 [1]. They are recognised as effective interventions to restore limb function and alleviate pain associated with hip or knee arthritis [2]. However, the risk of venous thromboembolism (VTE) developing post-operatively remains a significant health concern. A proposed intervention to reduce rates of VTE is early mobilisation of patients following surgery; it is recommended in VTE prevention guidelines [3–6] and advocated in fast-track surgical protocols for THA and TKA [7, 8]. In the latter, mobilisation commences the same day of surgery.

Early mobilisation, or early ambulation, provides a range of health benefits beyond its potential prevention of VTE. A systematic review of early mobilisation protocols in various medical and surgical subspecialties found reduced rates of VTE and other post-operative complications such as pneumonia, atelectasis, urinary tract infections, sepsis, myocardial infarction and stroke [9]. Fast-track pathways for TKA and THA, where early mobilisation is a key feature, have reported reduced length of stay (LOS), reduced post-operative morbidity and mortality, improved patient satisfaction, and reduced VTE and its sequelae [8, 10–12].

Despite widespread endorsement of early mobilisation in the arthroplasty literature, there is currently no accepted definition. Aspects such as the ideal time to initiate mobilisation (e.g. post-operative day 0 [POD 0], POD 1) remains unclear and often left to the discretion of hospital staff [13]. This leads to practice variation and a potential lack of best practice. Notably, fast-track protocols initiate mobilisation within 2–4 hours post-operatively without apparent detriment to the patient, suggesting that mobilisation on POD 0 is safe and feasible [8, 12, 14].

The overarching aim of this study was to identify how early mobilisation is interpreted by Australian arthroplasty service providers following THA and TKA. The objectives were to determine: (1) the proportion of patients that first mobilised on POD 0, and (2) factors associated with an earlier time to mobilisation.

Materials and methods

Setting and study design

This was a sub-study conducted within a larger prospective observational study, EPOC (Evidence-based Processes and Outcomes of Care), an ongoing multicentre study concerned with acute-care and long-term outcomes for patients undergoing primary THA or TKA (ClinicalTrials.gov NCT01899443). The EPOC study had a part-random, part-convenience selection of 19 Australian sites identified through the National Joint Replacement Registry. The selection criterion was that each site must be a high-volume arthroplasty provider, defined as exceeding 275 hip or knee arthroplasties in 2012. Consecutive THA and TKA patients were enrolled between August 2013 and January 2015. Ethical and governance approvals were obtained from

several Human Research and Ethics Committees (HRECs): Hunter New England HREC (NSW); St Vincent's Health and Aged Care HREC (Queensland); The Prince Charles Hospital HREC (Queensland); Austin Health HREC (Victoria); Barwon Health HREC (Victoria); Epworth HREC (Victoria); Calvary Health Care Clinical and Research Ethics Committee (Tasmania and Riverina); and Calvary Healthcare Adelaide HREC (South Australia). Written informed consent was obtained from all eligible patients who agreed to participate.

The inclusion criteria for this sub-study were patients aged 18 years and older, osteoarthritis as the primary diagnosis and indicator for surgery, primary elective unilateral THA or TKA, and capable of providing informed consent. Those with cognitive impairment, undergoing revision THA or TKA, undergoing arthroplasty for other diagnoses (e.g. fracture, avascular necrosis) or presenting for arthroplasty of a second joint, but already recruited into the study, were excluded.

Data sources and variables

Hospital sites prospectively collected baseline, peri-operative and treatment-related patient data. For quality control purposes, the data submitted were audited by researchers via review of all medical records (paper-based and electronic) pertaining to the index episode of care. Patient-related variables included age, gender, body mass index (BMI), education level, comorbidities, American Society of Anaesthesiologists (ASA) score and pre-operative patient-reported outcome measures (PROMs). ASA score is a quantifiable measure of health status ranging from 1 (normal healthy patient) to 5 (moribund patient not expected to survive). Pre-operative PROMs included the EuroQol-5D visual analogue scale (EQ-5D VAS), which measures the patient's self-rated health on a scale from 0 ("worst imaginable health state") to 100 ("best imaginable health state") [15], and Oxford Hip Score (OHS) or Oxford Knee Scores (OKS), which captures joint-specific pain and function on a scale from 0 (worst outcome/most symptoms) to 48 (best outcome/least symptoms) [16].

Treatment-related variables included hospital site, hospital status (public hospital/private hospital), surgical hip approach (for THA), anaesthetic details, local infiltration analgesia (LIA), intra-articular drainage, indwelling catheter (IDC), donor blood transfusion, the presence of an acute complication and LOS. Acute surgical complications were categorised using the original and a modified version of the Clavien-Dindo (CD) classification, which is based on the type of therapy necessary to treat the complication [17]. Two authors independently categorised each complication into the original or modified CD classification. Any disagreements were resolved through discussion and consensus, and the consultation of a third author. Our modified CD was designed to capture complications known clinically to affect early mobilisation, such as excessive pain and swelling, headaches or migraines, nausea or vomiting [2], symptomatic anaemia or symptomatic hypotension [14], hypertension or labile blood pressure, and gastrointestinal symptoms (see S1 Table for full list of complications), which are excluded from the original CD classification. Our modified CD did not include asymptomatic anaemia as a complication, as it can be deemed a reasonable sequela after major surgery. Additionally, the presence of donor blood transfusion (which can be considered due to severe symptomatic anaemia) was regarded as a separate potential covariate influencing early mobilisation. LOS was determined as the length of time from the date of surgery until the date of discharge from the orthopaedic ward.

Outcome measures

The primary outcome of interest was the first post-operative day of mobilisation (i.e. the first post-operative day that patients walked, including any partial or full weight-bearing activities

such as walking on the spot, bed-to-chair and bed-to-toilet). Patients that began mobilising on the day of surgery, before midnight, were recorded under POD 0. Patients that mobilised the following day were recorded under POD 1, and so forth. The data were recorded on study-specific standardised forms by hospital site staff. We checked the accuracy and completeness of what was submitted on the standardised forms against the medical records (including paper and electronic entries).

Statistical analysis

Simple descriptive statistics, including means, medians, quartiles and proportions, were used to describe the overall and joint-specific cohorts and highlight population characteristics and the proportion of patients first mobilising on POD 0.

Statistical methods that allowed simultaneous consideration of multiple factors with an outcome of interest were used to identify associations between covariates and mobilisation outcomes. Poisson regression was used, as the primary outcome was count data. All patient- and treatment-related variables were included in regression analysis: age (separated into quartiles), gender, education level (none/year 10 and below/year11-12, trade certificate, diploma/graduate degree), comorbidities (none/$\geq$1 without daily medication/$\geq$1 with daily medication), BMI (separated into categories typically used to describe levels of obesity [$<25kg/m^2$, 25–$29.9kg/m^2$, 30–$34.9kg/m^2$ and $\geq 35kg/m^2$]), ASA score, pre-operative EQ-5D VAS (separated into above or below the median of 75), pre-operative OHS/OKS (separated into categories based on severity of joint impairment or symptoms [0–12, extreme to severe/13-24, severe to moderate/25-36, moderate to mild/37-48, mild to nil impairment or symptoms]), hospital site (several of the smaller 19 hospital sites were combined into one for analysis, resulting in 15 sites in total), hospital status (public hospital/private hospital), spinal or epidural block, regional nerve block, anterior hip approach (yes/other hip approach), LIA, intra-articular drain, IDC, presence of an acute complication and donor blood transfusion. Age was categorised into quartiles to provide more clinically meaningful information, as statistical analysis calculated the risk ratio (RR) to determine the quantitative effects of each covariate. As age is normally a continuous variable, the RR would refer to an increment of one single year, which is less meaningful in a clinical setting. Similar reasons applied to categorising other numerical variables such as BMI and OHS/OKS for statistical analysis. We identified missing data as missing completely at random, and performed a complete case analysis approach (excluding patients with missing information), as we believed the missing data would have minimal influence on the analysis results.

Independent variables individually associated with the outcome with a value of $P \leq 0.20$ on univariate Poisson analyses were selected for a backward stepwise Poisson regression model respectively. Backward stepwise regression was chosen given the exploratory nature of the analyses. A two-tailed value of $P < 0.05$ was considered significant and retained in the final backward stepwise regression models. RR was calculated in Poisson regression with 95% confidence intervals (CI) to determine the quantitative effects of each covariate. Log Poisson regression was used to calculate RR. THA and TKA patients were analysed separately. All statistical analyses were performed using SAS (version 9.4). This observational study was reported according to the STROBE guidelines.

The sample size for this nested study was dictated by the sample size (approximately 2000) for the main study, EPOC, which aimed to determine the relationship between receiving care that complies with guidelines and risk of a composite adverse event outcome. However, a post-hoc power calculation was performed to determine the power of this nested study. A minimum of 750 patients undergoing THA would provide 80% power (at 5% significance level) to

detect a possible RR of 1.55 for a variable of interest associated with early mobilisation, assuming that the early mobilisation rate (mobilising POD 0 or POD 1) is about 60%. The same calculation applies for a minimum of 750 patients undergoing TKA.

Results

Population characteristics

In the EPOC study, 3285 patients were screened, 2529 met the inclusion criteria, and 1900 consented and underwent surgery. Of these, 1807 patients underwent unilateral surgery and 93 underwent bilateral surgery. The 1807 unilateral patients were included in this study (Fig 1). The distribution of patient- and treatment-related characteristics for THA (n = 818) and TKA (n = 989) patients are shown in Table 1. In general, patients were elderly (mean age ± SD, 68.3 ± 8.7 years THA, 66.9 ± 9.7 years TKA), female (52.7% THA, 56.3% TKA) and overweight (mean BMI ± SD, 29.2 ± 5.8 kg/m^2 THA, 32.1 ± 6.6 kg/m^2 TKA). The most common comorbidities were gastrointestinal reflux, hypercholesterolaemia and hypertension.

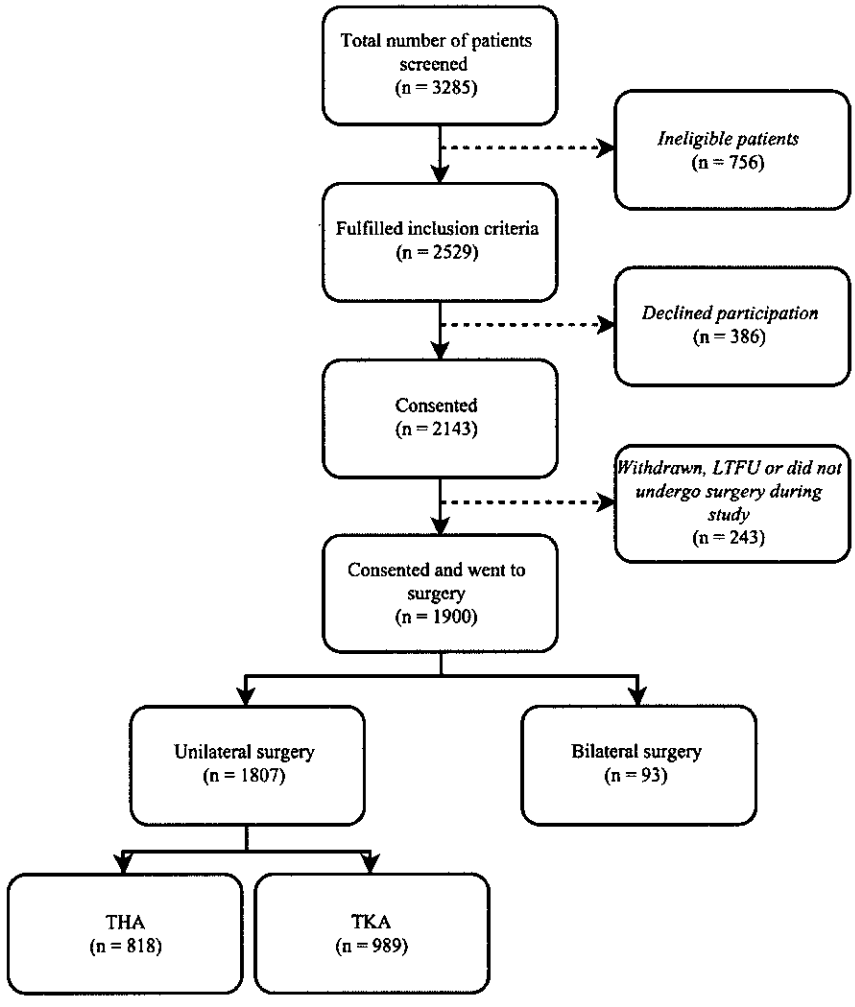

Fig 1. Flow diagram for study participation. LTFU = loss to follow up; THA = total hip arthroplasty; TKA = total knee arthroplasty.

https://doi.org/10.1371/journal.pone.0179820.g001

Table 1. Distribution of patient- and treatment-related characteristics of THA and TKA patients. Values are presented as N (%) unless indicated otherwise.

Parameter	THA (n = 818)	TKA (n = 989)
Patient-related characteristics		
Age, years		
• Quartile 1 (THA 18–58, TKA 18–62)	200 (24.5)	236 (23.9)
• Quartile 2 (THA 59–65, TKA 63–67)	191(23.3)	216 (21.8)
• Quartile 3 (THA 66–72, TKA 68–74)	217 (26.5)	286 (28.9)
• Quartile 4 (THA ≥73, TKA ≥75)	210 (25.7)	251 (25.4)
Female sex	431 (52.7)	557 (56.3)
BMI, kg/m^2		
• < 25	205 (25.1)	110 (11.1)
• 25–29.9	304 (37.3)	321 (32.6)
• 30–34.9	183 (22.5)	291 (29.5)
• ≥ 35	123 (15.1)	264 (26.8)
Education level		
• No education	0 (0)	5 (0.5)
• Year 10 and below	228 (28.3)	403 (41.2)
• Year 11-12/trade certificate/diploma	428 (53.1)	471 (48.2)
• Graduate degree	150 (18.6)	99 (10.1)
Comorbidities		
• None	131 (16.0)	81 (8.1)
• ≥ 1 without daily medication	81 (9.9)	46 (4.6)
• ≥ 1 with daily medication	606 (74.1)	862 (87.2)
ASA Score		
• ASA I	107 (13.3)	73 (7.6)
• ASA II	487 (60.3)	519 (54.2)
• ASA III	204 (25.3)	349 (36.4)
• ASA IV	9 (1.1)	16 (1.7)
• ASA V	0 (0)	1 (0.1)
Pre-operative EQ-5D VAS, no. above median (%)	445 (54.9)	517 (52.9)
Pre-operative OHS/OKS		
• 0–12	156 (19.3)	136 (13.9)
• 13–24	368 (45.7)	490 (50.3)
• 25–36	238 (29.5)	301 (30.9)
• 37–48	44 (5.5)	48 (4.9)
Treatment-related characteristics		
Hospital site		
• Site 1	92 (11.2)	200 (20.2)
• Site 2	19 (2.3)	32 (3.2)
• Site 3	118 (14.4)	58 (5.9)
• Site 4	18 (2.2)	51 (5.2)
• Site 5	23 (2.8)	56 (5.7)
• Site 6	93 (11.4)	17 (1.7)
• Site 7	31 (3.8)	24 (2.4)
• Site 8	61 (7.5)	61 (6.2)
• Site 9	24 (2.9)	20 (2.0)
• Site 10	17 (2.1)	46 (4.6)
• Site 11	101 (12.3)	145 (14.7)

(*Continued*)

Table 1. (*Continued*)

Parameter	THA (n = 818)	TKA (n = 989)
• Site 12	58 (7.1)	39 (3.9)
• Site 13	76 (9.3)	120 (12.1)
• Site 14	33 (4.1)	66 (6.7)
• Site 15	54 (6.6)	54 (5.5)
Public hospital status	314 (38.4)	538 (54.4)
Anaesthetic details		
• General anaesthetic	539 (66.0)	572 (57.8)
• Sedation	265 (32.4)	376 (38.0)
• Spinal or epidural block	458 (56.1)	649 (65.6)
• Regional nerve block	80 (9.8)	248 (25.1)
Hip surgical approach		
• Anterior hip approach[1]	254(31.1)	-
• Anterolateral/modified Hardinge	26 (3.2)	-
• Lateral/Hardinge	26 (3.2)	-
• Posterior/posterolateral	501(61.5)	-
• Superpath	8 (1.0)	-
Tourniquet	-	851 (86.7)
Local infiltration analgesia	639 (78.7)	715 (72.8)
Intra-articular drainage	299 (36.6)	479 (48.5)
Indwelling catheter	593 (72.6)	798 (80.7)
Donor blood transfusion	52 (6.5)	48 (4.9)
Acute complication original CD	146 (18.0)	288 (29.3)
Acute complication modified CD	267 (32.9)	387 (39.3)
Length of stay, mean ± SD	5.0 ± 2.4	6.1 ± 3.1

THA = total hip arthroplasty; TKA = total knee arthroplasty; BMI = body mass index; ASA = American Society of Anaesthesiologists; EQ-5D VAS = EuroQol-5D visual analogue scale; OHS = Oxford hip score; OKS = Oxford knee score; CD = Clavien-Dindo; SD = standard deviation.

[1]Anterior hip approaches include direct anterior approach (DAA), anterior minimally invasive surgery (AMIS) and Smith-Peterson

https://doi.org/10.1371/journal.pone.0179820.t001

The majority of operations (58% of the entire cohort) started in the morning, with 41% completed before 12 noon. Most patients had an IDC and no intra-articular drainage. For THA procedures, the posterior hip approach was most common (61.5%), followed by the anterior hip approach (31.1%). Using the original CD classification, 18.0% of THA and 29.3% of TKA patients experienced an acute complication. Using our comparatively sensitive modified CD classification, acute complications increased to 32.9% and 39.3% respectively. Three patients died post-operatively due to acute complications. Our modified CD showed a total of 936 complications occurred in 698 patients. The most common complications were minor or transient and included symptomatic anaemia or hypotension (27.8% of patients with a complication) followed by additional antibiotic treatment for any infective condition (19.9%) (see S2 Table for full list of frequency of complications).

First day of mobilisation

Only 9.4% of THA and 5.6% of TKA patients first mobilised on POD 0 (Table 2) (Fig 2). By the end of POD 1, 76.0% of THA and 69.6% of TKA had mobilised. By the end of POD 6, the entire cohort had mobilised.

Table 2. First day of mobilisation for THA and TKA patients. Values are presented as N (%) unless indicated otherwise.

	Post-operative day						
	POD 0	POD 1	POD 2	POD 3	POD 4	POD 5	POD 6
THA	76 (9.4)	538 (66.6)	168 (20.8)	20 (2.5)	5 (0.6)	-	1 (0.1)
TKA	55 (5.6)	629 (64.0)	254 (25.9)	31 (3.2)	10 (1.0)	2 (0.2)	1 (0.1)
Total	131 (7.3)	1167 (65.2)	422 (23.6)	51 (2.9)	15 (0.8)	2 (0.1)	2 (0.1)

POD = post-operative day.

https://doi.org/10.1371/journal.pone.0179820.t002

Factors associated with earlier time to mobilisation

For THA patients, univariate analysis found many variables associated with an earlier time to mobilisation including several hospital sites (3 of 15 sites), anterior hip approach, no spinal or epidural block, no intra-articular drainage, no IDC, no acute complication and no donor transfusion (Table 3). However, the majority of these variables associated with earlier time to mobilisation were not significant after multivariate analysis. Earlier time to mobilisation was more likely to occur in patients without an IDC (RR 1.38, 95% CI 1.09–1.73, p = 0.006), without an acute complication (RR 1.20, 95% CI 1.04–1.38, p = 0.013) and more likely to occur in several hospital sites (4 of 15 sites) (Table 3).

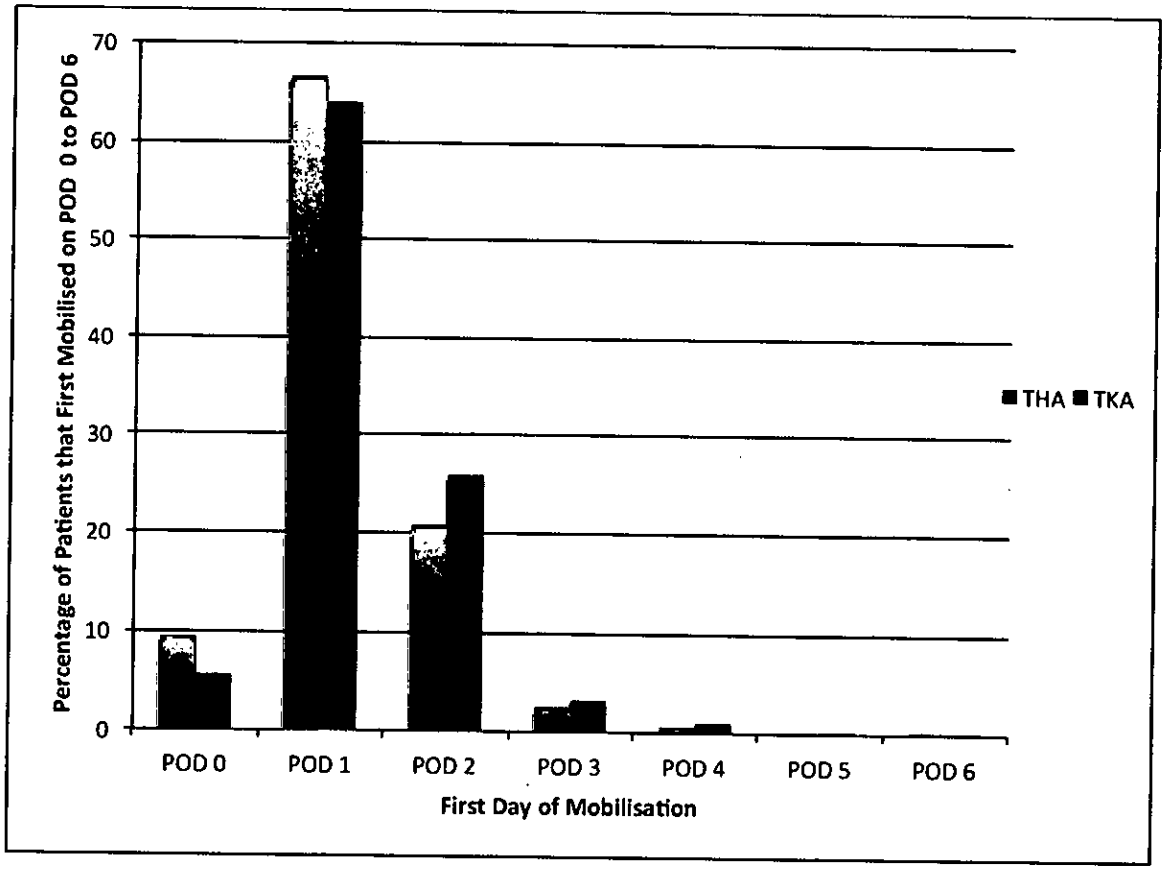

Fig 2. The percentage of patients that first mobilised on POD 0 to POD 6.

https://doi.org/10.1371/journal.pone.0179820.g002

Table 3. Poisson regression analyses for factors associated with time to mobilisation*.

	THA		TKA	
Parameter	Univariate RR (95% CI)	Multivariate RR (95% CI)	Univariate RR (95% CI)	Multivariate RR (95% CI)
Patient-related characteristics				
Age				
• Quartile 1	1.00	-	1.00	-
• Quartile 2	0.98 (0.82–1.18)	-	1.02 (0.87–1.20)	-
• Quartile 3	1.04 (0.87–1.25)	-	1.00(0.86–1.17)	-
• Quartile 4	1.05 (0.88–1.25)	-	1.05 (0.90–1.22)	-
Gender				
• Female	1.00	-	1.00	-
• Male	0.90 (0.79–1.02)	-	0.88 (0.79–0.99)†	-
BMI				
• < 25	1.00	-	1.00	-
• 25–29.9	0.94 (0.80–1.11)	-	1.09 (0.89–1.33)	-
• 30–34.9	0.99 (0.82–1.19)	-	1.14 (0.93–1.39)	-
• ≥ 35	1.01 (0.82–1.24)	-	1.21 (0.99–1.48)	-
Education level				
• No education	-	-	0.93 (0.42–2.08)	-
• Year 10 and below	1.00	-	1.00	-
• Year 11-12/trade certificate/diploma	0.97 (0.83–1.12)	-	1.03(0.92–1.16)	-
• Graduate degree	0.94 (0.77–1.13)	-	0.98 (0.80–1.19)	-
Comorbidities				
• None	1.00	-	1.00	-
• ≥ 1 without daily medication	1.02 (0.79–1.33)	-	1.02(0.73–1.41)	-
• ≥ 1 with daily medication	1.07 (0.90–1.28)	-	1.11 (0.90–1.36)	-
ASA Score				
• ASA I	1.00	-	1.00	-
• ASA II	1.01 (0.83–1.24)	-	1.08 (0.86–1.34)	-
• ASA III	1.11 (0.90–1.38)	-	1.12 (0.89–1.41)	-
• ASA IV	1.17 (0.64–2.11)	-	1.30 (0.83–2.02)	-
• ASA V	-	-	1.66 (0.41–6.74)	-
Pre-operative EQ-5D VAS				
• Below median (< 75)	1.00	-	1.00	-
• Median and above (≥ 75)	0.98 (0.86–1.12)	-	0.95 (0.85–1.06)	-
Pre-operative OHS/OKS				
• 0–12	1.00	-	1.00	-
• 13–24	0.89 (0.75–1.05)	-	1.04 (0.88–1.22)	-
• 25–36	0.90 (0.75–1.08)	-	1.01 (0.84–1.21)	-
• 37–48	0.95 (0.70–1.28)	-	0.91 (0.67–1.22)	-
Treatment-related characteristics				
Hospital site				
• Site 1	1.00	1.00	1.00	1.00
• Site 2	0.94 (0.61–1.44)	0.90 (0.58–1.38)	0.79 (0.56–1.12)	0.79 (0.56–1.12)
• Site 3	0.50 (0.38–0.66)§	0.68 (0.48–0.95)†	0.78 (0.60–1.02)	0.78 (0.60–1.02)
• Site 4	0.28 (0.13–0.59)§	0.33 (0.15–0.71)‡	0.46 (0.32–0.65)§	0.46 (0.32–0.54)§
• Site 5	0.77 (0.50–1.19)	0.72 (0.47–1.11)	0.76 (0.58–0.99)†	0.74 (0.56–0.97)†
• Site 6	0.83 (0.64–1.07)	0.83 (0.64–1.08)	0.77 (0.48–1.22)	0.74 (0.45–1.20)
• Site 7	1.09 (0.77–1.54)	1.24 (0.85–1.81)	0.95 (0.66–1.37)	0.96 (0.66–1.39)

(*Continued*)

Table 3. (*Continued*)

	THA		TKA	
Parameter	Univariate RR (95% CI)	Multivariate RR (95% CI)	Univariate RR (95% CI)	Multivariate RR (95% CI)
• Site 8	1.06 (0.81–1.39)	1.05 (0.80–1.38)	1.31 (1.06–1.63)†	1.33 (1.07–1.66)†
• Site 9	0.74 (0.48–1.14)	0.68 (0.44–1.05)	0.72 (0.46–1.12)	0.73(0.47–1.13)
• Site 10	0.59 (0.34–1.02)	0.67 (0.38–1.18)	0.48 (0.33–0.69)§	0.48 (0.33–0.69)§
• Site 11	1.20 (0.95–1.51)	1.16 (0.92–1.47)	1.24 (1.05–1.46)†	1.23(1.04–1.46)†
• Site 12	0.77 (0.57–1.04)	0.72 (0.53–0.99)†	0.77 (0.56–1.06)	0.77(0.55–1.09)
• Site 13	0.81 (0.62–1.07)	0.87 (0.65–0.16)	0.83 (0.68–1.02)	0.82 (0.67–0.99)†
• Site 14	0.65 (0.43–0.96)†	0.60 (0.40–0.89)†	0.70 (0.53–0.91)‡	0.69 (0.53–0.90)‡
• Site 15	0.88 (0.65–1.19)	0.90 (0.65–1.23)	0.81 (0.61–1.06)	0.78 (0.59–1.04)
Hospital status				
• Public hospital	1.00	-	1.00	-
• Private hospital	0.97 (0.85–1.10)	-	1.14 (1.02–1.27)†	-
Hip approach				
• Other hip approaches[1]	1.00	-	-	-
• Anterior hip approach[2]	0.82 (0.72–0.95)‡	-	-	-
Spinal or epidural block				
• No	1.00	-	1.00	-
• Yes	1.21 (1.06–1.38)‡	-	1.04 (0.93–1.17)	-
Regional nerve block				
• No	1.00	-	1.00	-
• Yes	1.00 (0.81–1.24)	-	0.98 (0.87–1.12)	-
Local infiltrative analgesia				
• No	1.00	-	1.00	-
• Yes	0.92 (0.79–1.07)	-	0.89 (0.79–1.01)	-
Intra-articular drainage				
• No	1.00	-	1.00	-
• Yes	1.16 (1.02–1.32)†	-	1.10 (0.98–1.22)	-
Indwelling catheter				
• No	1.00	1.00	1.00	-
• Yes	1.59 (1.35–1.87)§	1.38 (1.09–1.73)‡	1.34 (1.17–1.58)§	-
Donor blood transfusion				
• No	1.00	-	1.00	1.00
• Yes	1.27 (1.00–1.61)†	-	1.30 (1.03–1.62)†	1.29 (1.03–1.63)†
Acute complication (modified CD)				
• No	1.00	1.00	1.00	-
• Yes	1.20 (1.05–1.37)‡	1.20 (1.04–1.38)†	1.07 (0.96–1.20)	-

THA = total hip arthroplasty; TKA = total knee arthroplasty; RR = risk ratio; 95% CI = 95% confidence interval; BMI = body mass index; ASA = American Society of Anaesthesiologists; EQ-5D VAS = EuroQol-5D visual analogue scale; OHS = Oxford hip score; OKS = Oxford knee score; DAA = direct anterior approach; AMIS = anterior minimally invasive surgery; CD = Clavien-Dindo.

† $P < 0.05$

‡ $P < 0.01$

§ $P < 0.001$

[1]Other hip approaches include anterolateral/modified Hardinge, lateral/Hardinge, posterior/posterolateral and Superpath

[2]Anterior hip approaches include direct anterior approach (DAA), anterior minimally invasive surgery (AMIS) and Smith-Peterson

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For TKA patients, univariate analysis found many variables associated with earlier time to mobilisation including male gender, several hospital sites (6 of 15 sites), public hospitals, no IDC and no donor transfusion (Table 3). However, only two of these variables remained significant after multivariate analysis. Earlier time to mobilisation was more likely in patients without a donor blood transfusion (RR 1.29, 95% CI 1.03–1.63, p = 0.028) and more likely in several hospital sites (7 of 15 sites) (Table 3).

Discussion

Early mobilisation is frequently advocated after THA or TKA, yet there is inadequate information regarding the ideal time to begin mobilisation and which factors could be manipulated in order to encourage or permit earlier mobilisation. This novel study provides a snapshot of current practice in Australia on how early mobilisation after THA or TKA is interpreted and explores what factors may influence the post-operative day of mobilisation.

We observed that very few patients (<10%) mobilised on POD 0, despite a large proportion of operations (41%) completed before 12 noon, which theoretically should have provided adequate time to initiate mobilisation as per fast-track protocols [8, 12, 18, 19]. To our knowledge, mobilisation on POD 0 is safe and feasible. Studies with fast-track protocols for THA and TKA have initiated mobilisation for all patients on POD 0 [8, 12, 18, 19], or compared mobilisation on POD 0 with POD 1 [13, 20–22], with none reporting adverse events related to the earlier time.

In terms of time to mobilisation after THA or TKA, 'hospital site' was a significant covariate. This perhaps reflects hospital site protocols, as certain hospitals deliberately mobilised patients on POD 0 whilst other hospitals did not. Differences in mobilisation protocols may reflect uncertainty in the literature concerning what is meant by early mobilisation, but site resource constraints might also contribute to between-hospital protocol variations, as early mobilisation after surgery is resource intensive and often dependent on staff availability, which can be lacking on weekends or late in the evening [14, 21, 23]. The presence of an IDC was associated with delayed mobilisation after THA, which may reflect the mechanical interference of IDCs with walking and the existing hospital culture that begins mobilising patients to the bathroom after IDC removal for voiding of bladders. The presence of an acute complication was associated with delayed mobilisation after THA, which supports previous claims that post-operative complications such as pain, nausea, vomiting and hypotension can limit and delay mobilisation after THA or TKA [2, 14]. However, our results contrast another study, which found pain or nausea and vomiting were not associated with the patient's ability to undergo physiotherapy on POD 0 after THA or TKA [21]. Our finding that donor blood transfusion was associated with delayed mobilisation after TKA supports previous research that blood transfusion was associated with a lack of mobilisation on POD 0 after THA or TKA [24]. Likely reasons are that blood transfusions can take several hours, which delays mobilisation, and that patients requiring transfusion are unlikely to mobilise due to severe symptomatic anaemia. LIA should theoretically assist with full-weight bearing post-operatively, as a systematic review and meta-analyses reported that LIA improves early analgesia after THA or TKA in the 48-hour post-operative period [25, 26]. However, we found no significant association between LIA and our outcomes on multivariate analysis.

Interestingly, our multivariate analysis found no association between time to mobilisation and anaesthetic blocks, or THA patients receiving an anterior hip approach. Regional anaesthesia is known to cause a motor deficit [27], which could reasonably limit one's ability to ambulate. However, our findings suggest that there is no relation between this factor and how early patients begin to mobilise. Additionally, the anterior hip approach has faster recovery in

the first 2 weeks after surgery [28], which has been attributed to minimal muscle damage and soft tissue trauma with the anterior approach when compared with standard anterolateral or posterolateral approaches [29, 30]. Our findings suggest that there is no association between this hip approach and the time period for patients to first begin mobilising. We believe these findings reflect the major influence of hospital site, with hospital staff mobilising patients based on local protocol, irrespective of the type of surgical hip approach that was performed.

Our study found no patient-related factors were associated with time to mobilisation on multivariate analysis. This finding is indirectly supported by an earlier study that concluded on univariate analysis that age, BMI, number of comorbidities and ASA score were not associated with timing and the ability to undergo physiotherapy on POD 0 after THA or TKA [21].

Our study has several strengths. We described mobilisation outcomes for two large prospective cohorts of primary unilateral THA and TKA recipients with end-stage osteoarthritis. Our audit of all acute medical records for quality control provided the opportunity for clarification, accuracy checking and completion of missing data where required. Over 1000 data points per patient (though not all used) were collected to comprehensively account for many potential confounders. Furthermore, we focused on high-volume sites to reduce the 'noise' created by including sites relatively inexperienced in arthroplasty surgery, and we included both private and public sector providers from five Australian states to increase our generalisability to highly experienced centres nationally.

Several limitations were identified with our study. Firstly, no causal conclusions can be inferred from the observational study design. Secondly, we modified the Clavien-Dindo classification to include excessive pain and swelling, headaches or migraines, nausea or vomiting, symptomatic anaemia or symptomatic hypotension, hypertension or labile blood pressure, and gastrointestinal symptoms. We recognise that the properties of our modified CD classification are not previously established in literature, however, we believe these modifications are justified, given that these additional post-operative conditions are known clinically to affect early mobilisation. Thirdly, another potential limitation is that we recorded time to mobilisation in post-operative days and not hours after surgery. This may misrepresent how early patients mobilised, as those with afternoon operations who mobilised the following morning would have mobilised within a 24-hour window, suggesting a more aggressive mobilisation protocol than our data implies. However, if sites were mobilising patients based on hours post-surgery and not on a day-by-day protocol, we would have observed patients with morning operations being mobilised on the afternoon of surgery. This was not observed despite a large proportion of operations (41%) completed before 12 noon, thus we contend that Australian arthroplasty sites most typically commence mobilisation on POD 1. Finally, we only reported when patients commenced mobilisation, and not how much mobilisation is typically performed. We had originally intended to record the distances that patients mobilised on each post-operative day. However, we removed this secondary outcome from the study, as it was inadequately recorded on our data collection form and appeared prone to bias.

Future research might explore issues we identified, including whether THA and TKA patients are mobilised at appropriate times and whether early mobilisation is an effective intervention for improving health outcomes and reducing rates of VTE. Further aspects include whether early mobilisation activities are adequate, such as walking a clinically appropriate distance or performing specific rehabilitation exercises. Despite recommendation of early mobilisation for VTE prevention, no randomised controlled trials have investigated this relationship. Nevertheless, the EPOC study was designed in part to explore this relationship in the context of other variables (e.g. anticoagulants, stockings) and will report these findings in due course.

Conclusion

In contrast to recommendations in fast-track protocols, few THA and TKA patients (<10%) mobilise on POD 0 (the day of surgery) in Australian hospitals. For THA patients, earlier time to mobilisation was associated with hospital site, and absences of an indwelling catheter and acute complications. For TKA patients, earlier time to mobilisation was associated with hospital site and absence of donor blood transfusion. Encouragingly, treatment-related factors are associated with POD of mobilisation, indicating the potential pivotal role of service providers in promoting early mobilisation, especially if earlier mobilisation is shown to improve health outcomes and reduce adverse events.

Supporting information

S1 Table. This is the modified Clavien-Dindo classification used.
(DOCX)

S2 Table. This is the frequency of Acute Surgical complications.
(DOCX)

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

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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 free-standing 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.[12–14] However, if hospitals are better equipped to treat high-risk patients, treating higher-risk patients in ASCs could have negative consequences for patient outcomes.

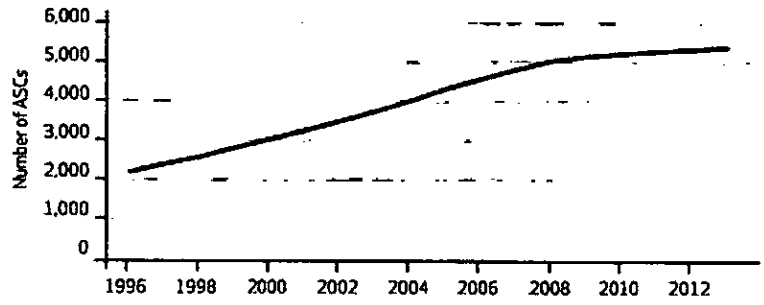
There is little evidence about the quality of care provided in ASCs or their ability to function as substitutes for hospitals in providing outpatient surgery. Comparisons of outcomes between these two types of outpatient facilities are complicated by the fact that ASCs tend to treat a healthier mix of 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 differences 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 procedures, after procedure type and observed patient characteristics are controlled 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.

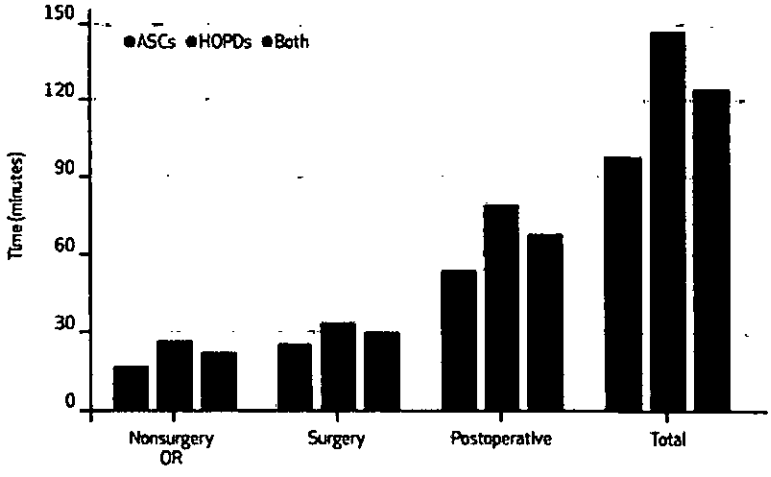
These results support the claim that ASCs provide outpatient surgery at lower costs than hospitals. However, they provide little information about what is driving these cost differences.

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.

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.

Discussion

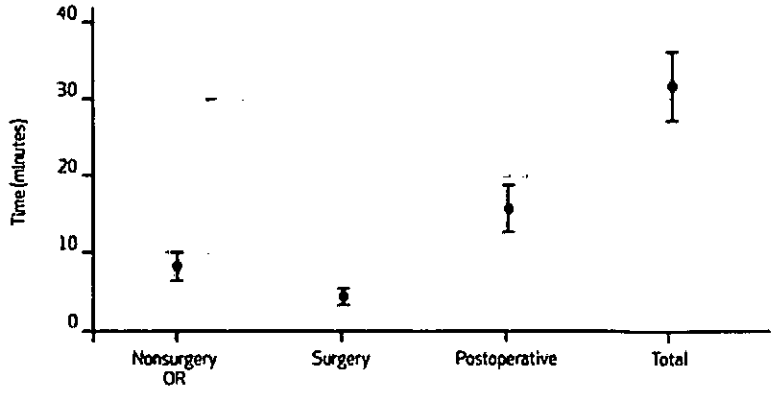
The findings presented here provide evidence that ASCs are a lower-cost alternative to hospitals for outpatient surgical procedures. The tremendous growth in the number of ASCs since the 1980s suggests that these facilities are quite flexible in meeting the growing demand for outpatient services. This 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 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.

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4

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.

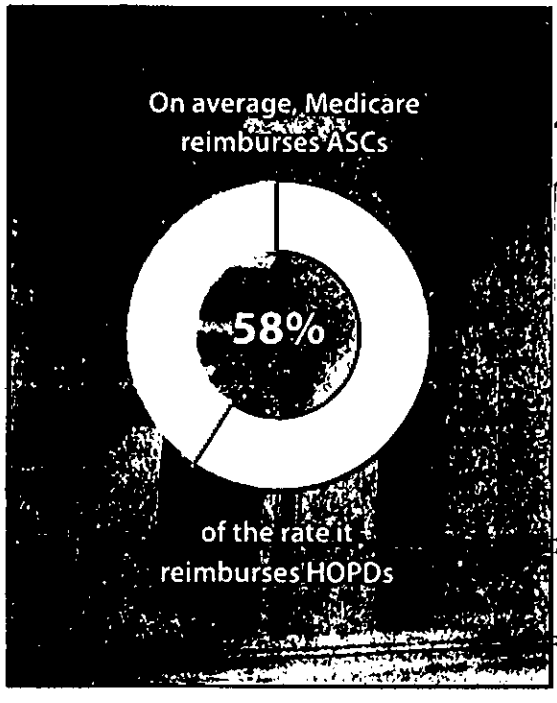
Ambulatory Surgery Centers are modern health care facilities focused on providing a range of same-day surgical care, the same types of procedures that were once performed exclusively in hospitals. Today, as a result of medical advancements and new technologies—including minimally invasive surgical techniques 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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3 http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2011.pdf (p.51).
4 The data set was initially narrowed to 148 procedures, which represented about 90% of the total volume. Twenty-seven procedures were dropped because of missing data on the number of procedures or reimbursement rates. One additional procedure was dropped the ASC share was 100%, and it thus provided no basis for comparison with HOPDs.

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.

Further, the above estimates are quite conservative. Even the most "optimistic" scenario assumes that ASC share growth per procedure grows only modestly more quickly than historical averages, and that Medicare volume grows at a modest, and historically consistent, rate. If policy decisions or other factors cause either growth rate to accelerate further, the savings generated by ASCs within the Medicare system would certainly exceed the $57.6 billion estimated here.

in savings generated by ASCS from 2008 to 2011

Up to

additional savings in Medicare program generated by ASCs over the next 10 years

Up to

average future yearly savings

A final note: although this study examined only data from the Medicare program, ASCs typically also charge private payers, including those in the Medicare Advantage program, less than their HOPD counterparts. Thus, similar cost savings also exist in the commercial health insurance market and in the Medicare Advantage program. We believe it is important to quantify these private-side savings as well and encourage others to examine this subject in future studies.

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 ($million)	Average Annual ASC Share Change 2003-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			% ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) ($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 (cd)	$2	-18.47%	30%	38%	34%	0.4	0.5	$2	$2	$2	$4	$6	$5	1%	$386
33	64520	N block lumbar/thoracic	$1	-13.74%	23%	29%	26%	0.6	0.8	$1	$2	$2	$3	$4	$4	1%	$229
34	64450	N block other peripheral	$1	-1.62%	1%	2%	1%	10.2	14.1	$1	$1	$1	$3	$4	$3	1%	$226
35	11042	Deb subq tissue 20 sq cm/<	$1	-14.48%	1%	1%	1%	28.9	40.0	$1	$2	$2	$2	$3	$2	1%	$82
36	20552	Inj trigger point 1/2 muscl	$1	-7.74%	1%	2%	1%	8.3	11.5	$1	$1	$1	$2	$2	$2	1%	$163
37	43239	Upper gi endoscopy biopsy	$143	0.58%	45%	55%	76%	32.8	45.5	$243	$303	$416	$409	$509	$700	5%	$268
38	45380	Colonoscopy and biopsy	$107	1.11%	48%	59%	82%	21.8	30.2	$197	$245	$336	$306	$380	$523	5%	$281
39	45385	Lesion removal colonoscopy	$82	2.10%	46%	58%	79%	17.2	23.9	$162	$202	$278	$236	$293	$403	5%	$281
40	45378	Diagnostic colonoscopy	$66	0.27%	40%	49%	68%	16.2	22.4	$157	$195	$268	$190	$236	$324	5%	$281
41	29826	Shoulder arthroscopy/surgery	$38	1.27%	33%	40%	56%	2.2	3.1	$53	$66	$91	$110	$137	$188	5%	$1,460
42	G0105	Colorectal scrn; hi risk ind	$30	2.48%	52%	64%	88%	6.3	8.7	$54	$68	$93	$85	$105	$145	5%	$249
43	64721	Carpal tunnel surgery	$25	1.01%	40%	50%	68%	3.0	4.2	$50	$62	$85	$72	$90	$124	5%	$577
44	64623	Destr paravertebral n add-on	$24	4.03%	36%	44%	61%	8.1	11.2	$31	$39	$53	$69	$86	$118	5%	$229
45	G0121	Colon ca scrn not hi 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	29880	Knee arthroscopy/surgery	$21	1.64%	41%	51%	71%	1.5	2.1	$44	$55	$76	$59	$73	$100	5%	$903
48	45384	Lesion remove colonoscopy	$19	0.93%	42%	52%	71%	4.5	6.3	$40	$49	$68	$56	$69	$95	5%	$281
49	67904	Repair eyelid defect	$17	3.55%	63%	79%	90%	1.2	1.7	$32	$40	$46	$48	$60	$69	5%	$603
50	64484	Inj foramen epidural add-on	$16	3.71%	34%	42%	58%	11.2	15.6	$23	$29	$40	$46	$58	$79	5%	$117
51	26055	Incise finger tendon sheath	$16	1.20%	44%	55%	76%	1.9	2.7	$28	$35	$49	$46	$58	$79	5%	$517
52	43248	Uppr gi endoscopy/guide wire	$14	0.86%	53%	67%	90%	2.6	3.6	$25	$31	$42	$39	$49	$66	5%	$268
53	29824	Shoulder arthroscopy/surgery	$11	0.45%	33%	42%	57%	1.0	1.4	$15	$19	$26	$32	$40	$55	5%	$903
54	49505	Prp i/hern init reduc >5 yr	$11	2.77%	15%	19%	26%	1.9	2.7	$23	$28	$39	$30	$38	$52	5%	$997
55	67917	Repair eyelid defect	$10	3.72%	60%	74%	90%	0.8	1.0	$18	$23	$27	$28	$35	$43	5%	$603
56	23412	Repair rotator cuff chronic	$10	3.46%	33%	41%	56%	0.6	0.8	$20	$25	$34	$27	$34	$47	5%	$1,426
57	14060	Skin tissue rearrangement	$9	0.50%	18%	22%	30%	2.6	3.6	$18	$22	$30	$25	$31	$43	5%	$519
58	55700	Biopsy of prostate	$8	2.92%	12%	14%	20%	5.1	7.0	$17	$21	$29	$24	$30	$42	5%	$393
59	66180	Implant eye shunt	$8	3.44%	52%	65%	89%	0.3	0.4	$16	$20	$27	$22	$27	$38	5%	$1,303
60	43450	Dilate esophagus	$8	1.82%	54%	67%	90%	1.9	2.7	$8	$11	$14	$22	$27	$36	5%	$198

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										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%	0.4	0.5	$14	$17	$23	$21	$26	$36	5%	$1,184
62	43249	Esoph endoscopy dilation	$7	1.08%	30%	38%	52%	2.2	3.1	$12	$15	$20	$19	$24	$33	5%	$268
63	66170	Glaucoma surgery	$6	4.40%	61%	76%	90%	0.4	0.5	$13	$16	$19	$18	$23	$27	5%	$736
64	29822	Shoulder arthroscopy/surgery	$6	2.28%	36%	45%	61%	0.5	0.7	$10	$13	$17	$18	$23	$31	5%	$903
65	14040	Skin tissue rearrangement	$6	1.83%	16%	20%	27%	2.1	2.9	$13	$16	$22	$18	$23	$31	5%	$519
66	28270	Release of foot contracture	$5	3.02%	28%	35%	48%	0.8	1.1	$9	$12	$16	$15	$19	$26	5%	$681
67	15260	Skin full graft een & lips	$5	4.70%	18%	22%	31%	1.5	2.0	$10	$12	$17	$14	$18	$25	5%	$519
68	45383	Lesion removal colonoscopy	$5	1.36%	36%	45%	62%	1.3	1.8	$10	$13	$18	$14	$17	$24	5%	$281
69	66711	Ciliary endoscopic ablation	$5	1.70%	79%	90%	90%	0.3	0.4	$7	$8	$8	$14	$16	$16	5%	$539
70	67924	Repair eyelid defect	$5	3.72%	61%	76%	90%	0.3	0.5	$9	$11	$13	$13	$17	$20	5%	$603
71	52353	Cystouretero w/lithotripsy	$4	4.90%	13%	16%	21%	0.8	1.2	$8	$10	$14	$12	$15	$21	5%	$1,126
72	67028	Injection eye drug	$4	3.19%	1%	1%	2%	54.4	75.4	$6	$8	$11	$11	$14	$19	5%	$169
73	52234	Cystoscopy and treatment	$4	1.27%	19%	24%	33%	0.7	0.9	$7	$9	$13	$11	$13	$18	5%	$794
74	64718	Revise ulnar nerve at elbow	$4	3.70%	36%	45%	62%	0.5	0.7	$6	$8	$11	$11	$13	$18	5%	$577
75	28308	Incision of metatarsal	$3	1.92%	38%	48%	65%	0.4	0.5	$5	$7	$9	$10	$12	$17	5%	$681
76	26123	Release palm contracture	$3	1.37%	47%	58%	80%	0.2	0.3	$8	$10	$13	$10	$12	$17	5%	$897
77	26160	Remove tendon sheath lesion	$3	0.77%	44%	55%	75%	0.4	0.6	$6	$8	$11	$10	$12	$17	5%	$517
78	67950	Revision of eyelid	$3	2.29%	64%	80%	90%	0.2	0.3	$5	$7	$7	$9	$12	$13	5%	$603
79	52224	Cystoscopy and treatment	$3	4.95%	8%	11%	14%	1.3	1.9	$7	$9	$12	$9	$12	$16	5%	$794
80	52310	Cystoscopy and treatment	$3	0.06%	9%	11%	16%	1.8	2.5	$6	$8	$10	$9	$11	$15	5%	$530
81	67961	Revision of eyelid	$3	1.27%	55%	69%	90%	0.2	0.3	$5	$6	$9	$9	$11	$14	5%	$603
82	52235	Cystoscopy and treatment	$3	2.23%	14%	18%	24%	0.7	1.0	$6	$7	$10	$9	$11	$15	5%	$794
83	66986	Exchange lens prosthesis	$3	0.17%	63%	78%	90%	0.2	0.2	$5	$6	$7	$8	$10	$12	5%	$740
84	64479	Inj foramen epidural c/t	$3	0.16%	31%	38%	53%	1.1	1.5	$5	$6	$9	$8	$10	$14	5%	$229
85	66250	Follow-up surgery of eye	$2	1.83%	37%	46%	64%	0.3	0.4	$4	$5	$7	$6	$7	$10	5%	$539
86	14061	Skin tissue rearrangement	$2	1.01%	16%	19%	27%	0.7	0.9	$4	$5	$7	$6	$7	$10	5%	$519
87	17311	Mohs 1 stage h/n/hf/g	$1	3.76%	1%	2%	2%	14.8	20.5	$2	$2	$3	$3	$4	$5	5%	$162
88	13121	Repair of wound or lesion	$1	0.48%	6%	7%	10%	2.8	3.8	$1	$1	$1	$2	$2	$3	5%	$95
89	15823	Revision of upper eyelid	$41	6.61%	68%	85%	90%	2.4	3.4	$84	$105	$111	$117	$146	$155	10%	$671
90	50590	Fragmenting of kidney stone	$13	10.88%	18%	23%	52%	1.5	2.1	$25	$31	$72	$36	$45	$103	10%	$1,265

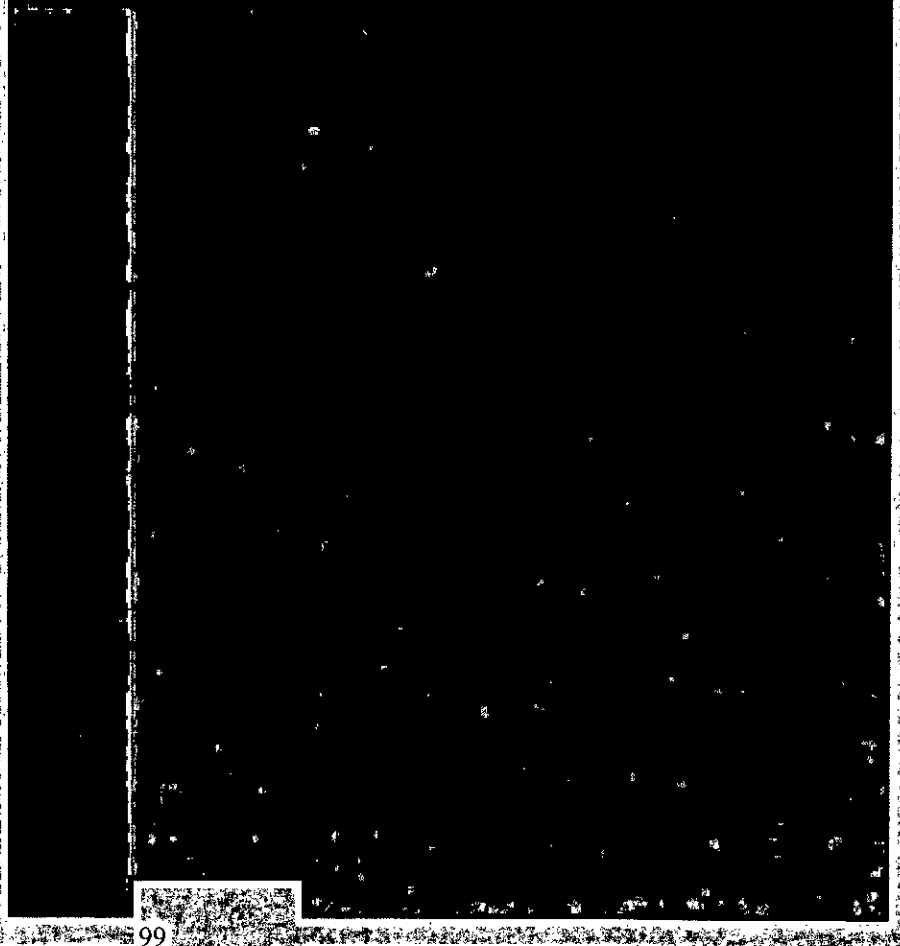
No.	HCPCS	HCPCS Description	Savings 2011 ($million)	Average Annual ASC Share Change 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			%-ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	A2. Savings for 2022 (ASC share increases 2%-s per year) ($million)	A3. Savings for 2022 (ASC share increase varies) ($million)	B1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	B2. Savings for 2022 (ASC share increases 2%s per year) ($million)	B3. Savings for 2022 (ASC share increase varies) ($million)		
91	67042	Vit for macular hole	$13	7.78%	42%	53%	90%	0.7	0.9	$26	$32	$55	$36	$45	$77	10%	$1,234
92	52332	Cystoscopy and treatment	$10	5.10%	13%	16%	36%	2.6	3.6	$15	$18	$42	$27	$34	$78	10%	$794
93	67041	Vit for macular pucker	$9	7.36%	40%	50%	90%	0.5	0.6	$19	$24	$42	$24	$30	$54	10%	$1,234
94	65855	Laser surgery of eye	$8	10.98%	22%	28%	63%	4.0	5.6	$18	$23	$52	$24	$30	$68	10%	$257
95	67900	Repair brow defect	$8	7.23%	68%	85%	90%	0.4	0.6	$14	$18	$19	$24	$30	$32	10%	$801
96	31255	Removal of ethmoid sinus	$8	11.19%	39%	49%	90%	0.6	0.8	$17	$21	$38	$22	$28	$51	10%	$933
97	67036	Removal of inner eye fluid	$6	10.53%	38%	47%	90%	0.4	0.5	$13	$16	$31	$18	$23	$43	10%	$1,234
98	31267	Endoscopy maxillary sinus	$6	11.09%	37%	46%	90%	0.5	0.7	$11	$14	$26	$18	$22	$44	10%	$933
99	30140	Resect inferior turbinate	$6	16.88%	39%	48%	90%	0.5	0.7	$12	$15	$28	$16	$20	$37	10%	$773
100	67108	Repair detached retina	$6	11.99%	34%	43%	90%	0.4	0.5	$11	$14	$29	$16	$20	$42	10%	$1,234
101	47562	Laparoscopic cholecystectomy	$5	11.18%	6%	7%	16%	1.8	2.5	$11	$14	$32	$16	$19	$44	10%	$1,442
102	66761	Revision of iris	$5	5.24%	27%	34%	78%	2.2	3.1	$11	$13	$31	$15	$19	$43	10%	$237
103	67040	Laser treatment of retina	$5	8.70%	33%	41%	90%	0.3	0.4	$10	$12	$27	$13	$17	$36	10%	$1,234
104	52204	Cystoscopy w/biopsy(s)	$5	7.61%	19%	24%	55%	0.8	1.1	$9	$11	$25	$13	$16	$37	10%	$794
105	20610	Drain/inject joint/bursa	$4	18.62%	0.5%	1%	1%	153.1	212.0	$8	$10	$24	$12	$14	$33	10%	$149
106	31256	Exploration maxillary sinus	$4	8.96%	37%	46%	90%	0.3	0.4	$7	$9	$18	$12	$14	$28	10%	$933
107	31276	Sinus endoscopy surgical	$4	22.38%	33%	41%	90%	0.4	0.5	$10	$12	$27	$11	$14	$31	10%	$933
108	64640	Injection treatment of nerve	$4	75.05%	13%	16%	36%	1.8	2.4	$6	$8	$18	$10	$13	$29	10%	$437
109	67255	Reinforce/graft eye wall	$3	6.57%	50%	63%	90%	0.3	0.3	$4	$6	$8	$9	$12	$17	10%	$706
110	69436	Create eardrum opening	$3	11.68%	40%	50%	90%	0.3	0.5	$6	$8	$14	$7	$9	$17	10%	$522
111	45330	Diagnostic sigmoidoscopy	$2	15.64%	17%	21%	48%	1.3	1.7	$5	$6	$14	$7	$9	$20	10%	$324
112	68815	Probe nasolacrimal duct	$2	9.08%	51%	64%	90%	0.2	0.3	$4	$5	$6	$7	$9	$12	10%	$603
113	46221	Ligation of hemorrhoid(s)	$2	59.92%	11%	14%	33%	1.7	2.4	$4	$5	$11	$6	$8	$18	10%	$296
114	67840	Remove eyelid lesion	$2	15.10%	8%	10%	24%	1.4	2.0	$4	$4	$10	$5	$6	$15	10%	$422
115	45331	Sigmoidoscopy and biopsy	$1	5.08%	34%	43%	90%	0.7	0.9	$3	$3	$7	$4	$5	$11	10%	$175
116	67210	Treatment of retinal lesion	$1	10.61%	7%	9%	21%	2.9	4.0	$3	$4	$9	$4	$5	$11	10%	$169
117	67228	Treatment of retinal lesion	$1	11.58%	7%	9%	20%	2.3	3.2	$2	$3	$6	$3	$4	$8	10%	$169
118	11642	Exc face-mm malig+marg 1.1-2	$1	7.98%	3%	4%	10%	3.5	4.9	$2	$2	$4	$3	$4	$8	10%	$226
119	64480	Inj foramen epidural add-on	$1	17.51%	29%	36%	83%	0.8	1.0	$2	$2	$5	$3	$3	$8	10%	$117
120	51700	Irrigation of bladder	$0.5	29.91%	3%	4%	10%	4.0	5.5	$1	$1	$3	$1	$2	$4	10%	$99
		Total or Mean**	**$2,307**	**3.46%**	**32%**	**40%**	**52%**	**5.62**	**7.78**	**$4,203**	**$5,231**	**$6,013**	**$6,604**	**$8,212**	**$9,383**	**N/A**	**$589**

NOTES:

*Increases volume per 1,000 Medicare beneficiaries by 3% annually.

**The reported totals are for savings. The remaining columns are simple means across the 120 procedures, for which the mean is not influenced by (or weighted for) high-volume procedures, such as cataracts. Savings are reported in nominal dollars. N/A: not applicable.

Medicare Cost Savings Tied to Ambulatory Surgery Centers



ASCA
Ambulatory Surgery Center Association

Produced with cost savings analysis from

Berkeley
UNIVERSITY OF CALIFORNIA

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.

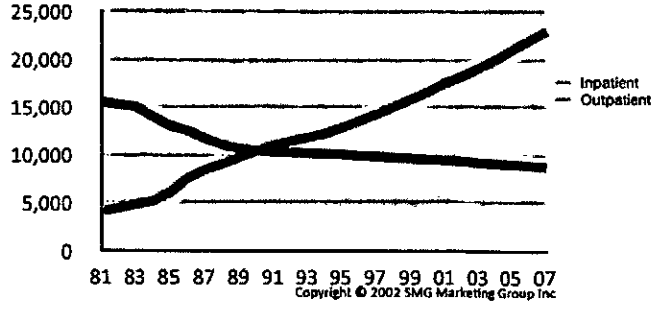
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling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

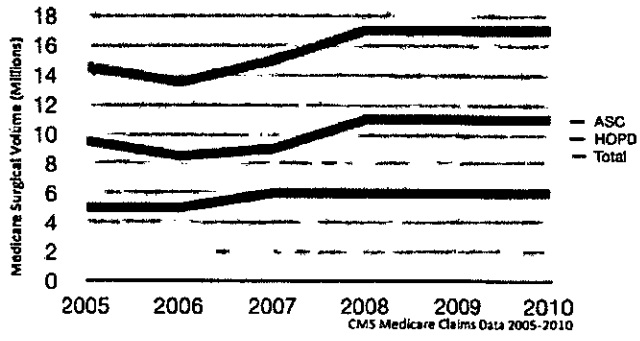
Given the history of their involvement in making ASCs a reality, it is not surprising that physicians continue to have at least some ownership in virtually all (90%) ASCs. But what is more interesting to note is how many ASCs are jointly owned by local hospitals that now increasingly recognize and embrace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

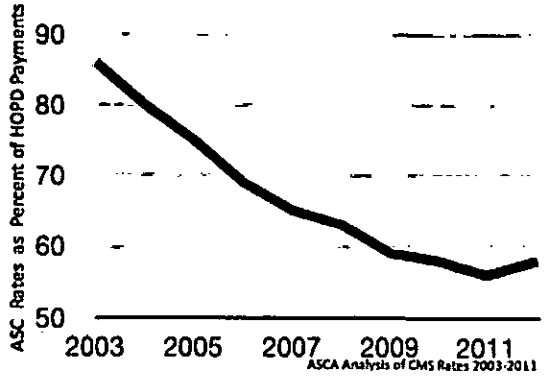
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased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

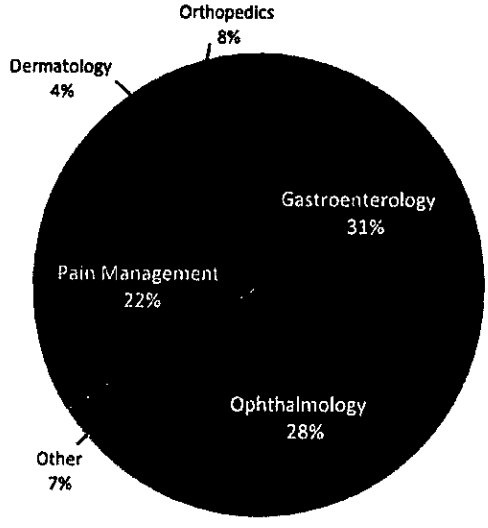


ASCA Analysis of CMS Rates 2003-2011

THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

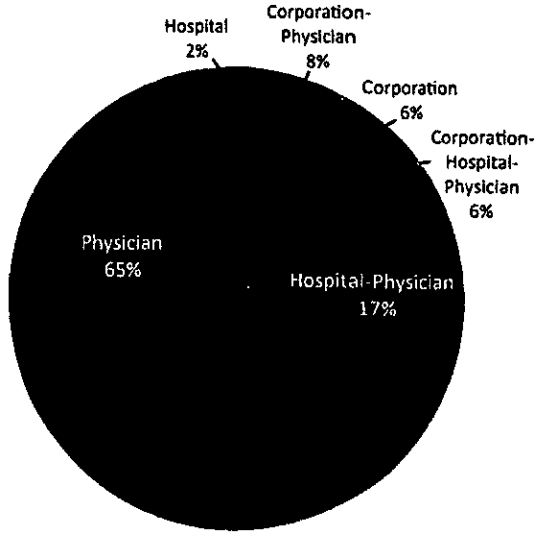
Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price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

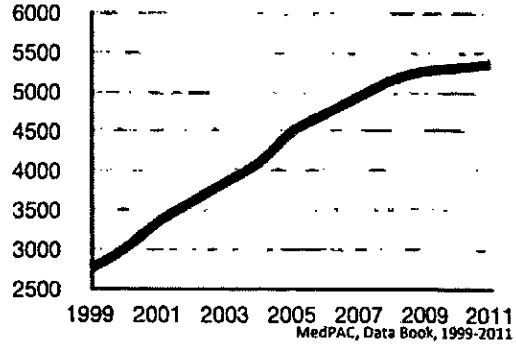
CONTINUED DEMAND FOR ASC FACILITIES

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

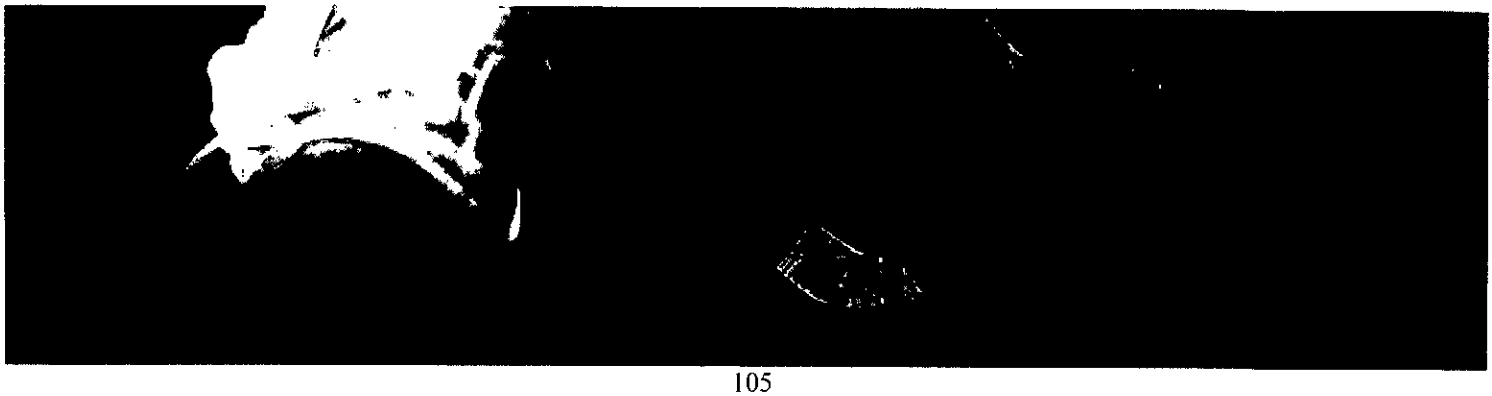
1 "Ambulatory Surgery Centers." Encyclopedia of Surgery. Ed. Anthony J. Senagore. Thomson Gale, 2004.

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 1110.110(c) – Purpose of the Project, Safety Net Impact Statement and Alternatives

Alternatives

The proposed project will provide the Surgery Center of Illinois, 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 spine and joint replacement surgeries. The inability to provide the quality of care for patients requiring specialized 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 SCI, where patients could receive immediate surgical attention in a more controlled environment. Additionally, SCI 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, or do not have capacity, 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 limited specialty ASTC, with two operating rooms and eight accompanying recovery rooms. The applicant investigated and considered the alternative option of only adding one operating room, but it was ultimately dismissed. The

current plan for one operating room and two 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 SCI will be compliant with the state standards for two (2) operating rooms by the second year of operations. 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 also caused 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 two operating rooms with potential for two additional ORs.

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 would have increased total costs per operating room and 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. Meet the Community Need for Additional ASTC Orthopedic Surgical Services in GSA
B. Design and Operate a Modern ASTC Facility to Service Spine and Total Joint Patients
C. Provide Enhanced Early Ambulation Rehabilitation Therapy Post-Surgery
D. Improve Clinical Care Continuum for Applicant's Patients
E. Align with CMS, Payers, and Patients to Continue Transition from Hospital to ASTC Setting
F. Provide for 24/7 Emergency Operative Capabilities for Surgical Services

The cost of this alternative is **$7,465,464.28**.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(a), Size of the Project

		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	$1,992,173.92		7,694		7,694		
Total Clinical	$1,992,173.92		7,694		7,694		
NON REVIEWABLE							
Administrative	$489,369.47		1,890		1,890		
Shell Space	$603,814.61		2,332		2,332		
Total Non-clinical	$1,093,184.08		4,222		4,222		
TOTAL	**$3,085,358.00**		**11,916**		**11,916**		

The proposed project by Surgery Center of Illinois will incorporate 11,916 square feet, 7,694 sq.ft. of which is clinical space. The construction plans also include necessary shell space allocation in the amount of 2,332 sq. ft. to plan for expected facility expansion.

The state standard for new construction is 2075-2750 BGSF per Treatment Room.

- Two OR Standard: 4,150 – 5,500
- Four OR Standard: 8,300 – 11,000

Furthermore, the space currently has shell space for the addition of two operating rooms and eight additional recovery rooms. The space is in line with state requirements based on a floor plan of four (4) operating rooms. There are numerous factors regarding why the filing does not meet the state standards for two (2) operating rooms, including:

- Shell Space: The applicant designed the facility to support future expansion without significant modifications. This resulted in an expanded floor design, including hallways and larger support areas designed to support four (4) ORs but also servicing the initial ASTC with two operating rooms.
- Inclusion of a 261 sq. ft. rehabilitation room to enable appropriate space for early post-surgical ambulation.
- Three (3) expanded 165 sq. ft. recovery rooms, with three (3) 61 sq. ft. private toilets, for patients with lengthy post-surgical stays up to, but not exceeeding 24 hours.
- Large Operating Rooms ("ORs") in excess of 700 sq. ft. each to provide room for equipment and staff on more medically complex procedures.

Accordingly, the applicant could not change the current space allocation without sacrificing the key components of this project that make it necessary and viable. Per State requirement where a project exceeds the State standard on square footage, the applicant has included a signed and notarized statement form the Medical Director attesting to the necessity of the expanded recovery and rehabilitation spaces.

Size of Project – Expansion			
Service	**Proposed Clinical GSF**	**State Standard**	**Met Standard?**
2 ORs with Shell Space	7,694	2075-2750 BGSF/Treatment Room	No
4 ORs	10,026	2075-2750 BGSF/Treatment Room	Yes

SURGERY CENTER OF ILLINOIS, LLC

December 11, 2018

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

Dear Ms. Avery,

In keeping with the requirements of Section 1110.120(a)(2)(A), I hereby certify that the proposed space is appropriate and neither excessive nor deficient in relation to the scope of services provided at the ASTC. The proposed space is justified by the clinical needs of providing patients with complex spine and total joint replacement surgery in an outpatient setting.

The proposed ASTC space is clinical necessary in order to provide safe, effective therapy post-surgery, to accommodate patients and visitors during longer than usual patient stays (less than 24 hours), and to provide sufficient room for advanced medical equipment. For these reasons the ASTC is designed at the upper limits of the current State standards. This reflects recent advances in medical technology and practice. Further, when assessing the total designed space, our ASTC will fall within state standards should the additional two shelled out operating rooms be approved by the HFSRB in the future. Providing shell space at this time ensures significantly reduced costs and interruption to patient services in the future.

In short, the space is clinically necessary, operationally prudent, and financially justified for this ASTC.

Sincerely,

Daniel Troy, M.D.
CEO / Medical Director
Surgery Center of Illinois, LLC

Notarization:
Subscribed and sworn to before me this 12 day of December, 2018.

Jean Stripeik
Signature of Notary

SEAL

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(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, 1,062 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 two (2) operating rooms.

In addition to the operating room procedures Dr. Troy anticipates 389 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 injections currently being performed by Dr. Troy 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
Daniel Troy	551	**551**	2.91	1895.2
Jonathan Watson	190	**190**	2.71	514.9
Paul Danielsky	156	**156**	3.39	528.8
Office based procedures	389	**389**	0.75	291.75

Table 1110.234(b) Utilization					
	Dept./ Service	Historical Utilization (Treatments)	Projected Utilization	State Standard	Met Standard?
Year 1	ASTC	N/A	2,647,hrs.	1,500 hrs.	Yes
Year 2	ASTC	N/A	3,526 hrs.	1,500 hrs.	Yes

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(d), Unfinished or Shell Space

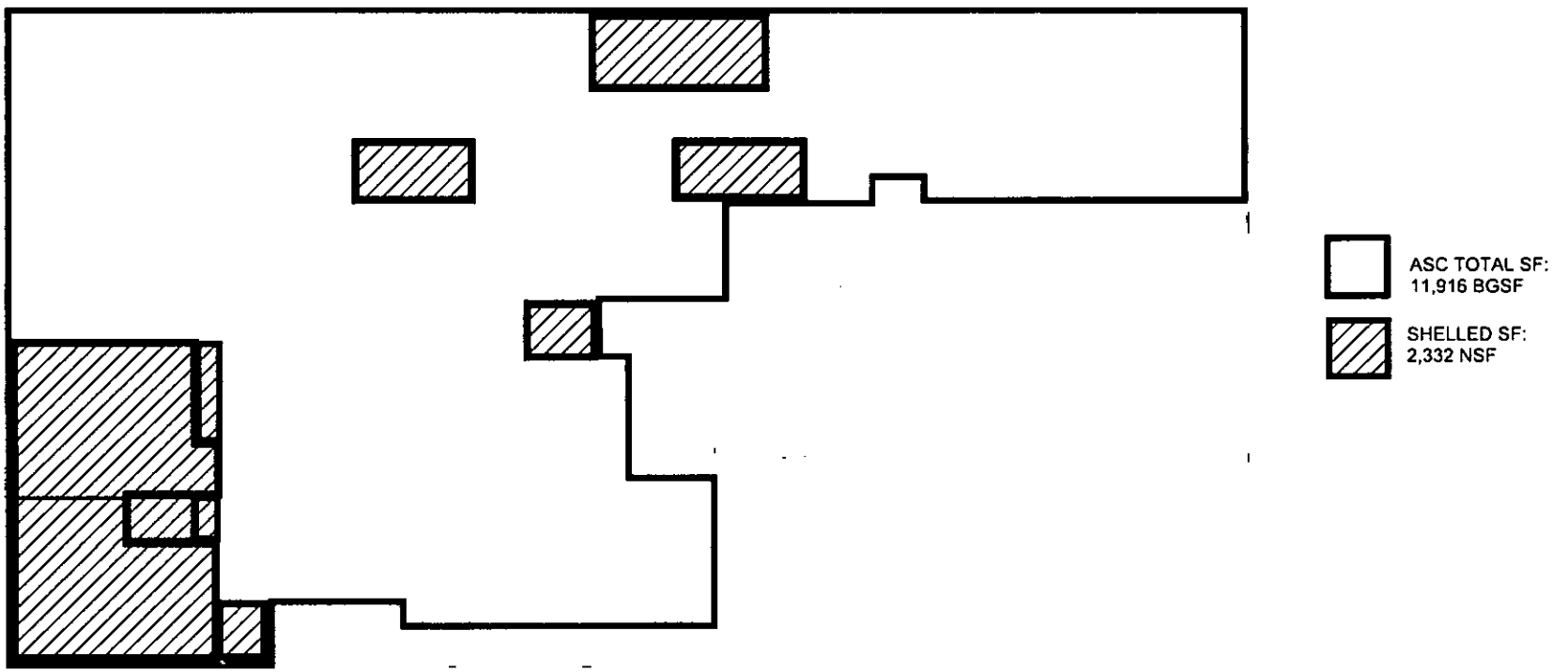
This project will include unfinished space designed to meet an anticipated future demand for service.

1. The shell space shall total 2,332 Gross Square Feet

2. The shell space is anticipated to be used as two additional Operating Rooms and eight (8) 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 expect a significant increase in patient referrals to the ASTC setting from procedures historically performed in an office-based setting, the growing patient base of the physicians supporting this project, and overall growth in non-hospital outpatient surgical demand among the general patient population.

Accordingly, the applicant is proposing to include shell space in the ASTC to accommodate future patient need.



Skender

SECOND FLOOR PLAN - SCHEMATIC DESIGN

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(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 volume. 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 1110.235 Planning Area Need

Pursuant to 77 Ill. Adm. Code 1110.235, the following sections are addressed for the establishment of a new ASTC:

- 111..235(c)(1)(D) – Background of Applicant
- 1110.235(c)(2)(B) – Service to GSA Residents
- 1110.235(c)(3) – Service Demand – Establishment of an ASTC
- 1110.235(c)(5) – Treatment Room Need Assessment
- 1110.235(c)(6) – Service Accessibility
- 1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution
- 1110.235(c)(7)(B) – Maldistribution
- 1110.235(c)(7)(C) – Impact to Area Providers
- 1110.235(c)(8) – Staffing
- 1110.235(c)(9) – Charge Commitment
- 1110.235(c)(10) – Assurances

(c)(1)(D) Identification of ASTC Service and number of Surgical/Treatment Rooms

The applicant proposes to offer multi-specialty ASTC services within a facility with two (2) Operating Rooms. The facility plans to offer orthopedic and pain management surgeries, with a focus in complex spinal and total joint surgeries.

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. Dr. Daniel A. Troy is a board-certified orthopedic surgeon who keeps current on the newest advances in orthopedic care including computer-assisted surgery and minimally invasive procedures. Dr. Troy current runs his clinical practice out of Advanced Orthopedic and Spine. Surgery Center of Illinois, LLC is a newly created entity 100% owned by Dr. Daniel Troy and is the applicant for the proposed ASTC. Surgery Center of Illinois, LLC does not have ownership in any other IDPH licensed facility.

(c)(2)(B) Service to GSA Residents

Geographic Service Area

A) See attached Exhibit 1 concerning a list of zip codes within the anticipated Geographic Service Area pursuant to state regulations.

B) See attached Exhibit 2 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.

(c)(3) Service Demand – Establishment

A) Historical Referrals

i) 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 897 surgeries to patients accounting for a total of 2,647.15 hours of surgery.

Please note, the applicant also anticipates referring 389 patients for injections, previously performed in an office setting, in order to provide a higher quality of care at a quality controlled ASTC location, adding an additional 291.75 hours. The injections are separately reimbursable on the Medicare ASC Fee Schedule.

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

B) Projected Service Demand – Projected Referrals

i) Based upon the historic utilization, in Appendix-1, the projected demand is sufficient to meet the state standards for utilization. Dr. Troy and the physician's associated with the project will meet the state standard of more than 1,500 hours of surgery by the first year of operation.

Physician	**Historical 12 Month of Surgeries**	**Anticipated referrals to RSC**	**Average Surgery Time**	**Total Hours**
Daniel Troy	551	**551**	2.91	1,603.41
Jonathan Watson	190	**190**	2.71	514.9
Paul Danielsky	156	**156**	3.39	528.84
TOTAL		**897**		**2,647.15**
Office based procedures	389	389	0.75	291.75

(c)(5) Treatment Room Need Assessment

A) As demonstrated by the physician referrals in Appendix-1, the facility currently projects to perform 897 procedures totaling 2,647.15 hours in the first year following project completion. Additionally, the applicant anticipates 291.75 hours via the transition of 389 historic office-base procedures that are better suited to be performed in a quality controlled ASTC setting. The facility is projecting to exceed the utilization standards for its existing two (2) treatment rooms. As such, the proposed number of operating rooms is necessary in order to service the projected patient volumes.

B) 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. The average hours was calculated using the hours established in section (c)(3) above.

Specialty	Total Surgeries	Total Surgery Hours
Orthopedic/Pain Management (ASTC/Hospital)*	**897**	**2,647.15**
Orthopedic/Pain Management (Office/ASTC)	**389**	**291.75**

(c)(6) Service Accessibility

Although there are eight (8) licensed ASTC's within the GSA, two of the clinics are currently performing above state standards, and two of the clinics do not perform orthopedic surgery. With regard to the remaining four clinics, none have the required equipment and/or necessary hours of operation needed to perform the complex spinal and total joint surgeries intended to be provided by the applicant.

In order to perform some of the complex surgeries that Dr. Troy and his staff will perform the facility will need to be able to provide for extended recovery stays, which could last up to 23 hours. No patient surgery is expected to result in the patient requiring more than a 23 hour recovery period. The current hours of operation of the existing ASTC facilities would not allow patients to remain in the facility for the extended period.

As a result of the obstacles to performing the surgeries at several locations within the GSA, the applicant is proposing the current project.

(c)(7) Unnecessary Duplication/Maldistribution

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

i) A list of the total population for GSA is attached as Exhibit 3.

ii) 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 summarized below.

Hospital Name	Address	City	Zip	Distance
Advocate Christ Medical Center	4440 West 95th Street	Oak lawn	60453	< 3
Palos Community Hospital	12251 South 80th Avenue	Palos Heights	60463	3.7
Little Company of Mary Hospital	2800 West 95th Street	Evergreen Park	60805	4.5
Holy Cross Hospital	2701 West 68th Street	Chicago	60629	6.2
MetroSouth Medical Center	12935 South Gregory Street	Blue Island	60406	6.9
Adventist La Grange Memorial Hospital	5101 S. Willow Springs Road	La Grange	60525	7.4
MacNeal Hospital	3249 South Oak Park Ave.	Berwyn	60402	7.8
Roseland Community Hospital	45 West 111th Street	Chicago	60628	8.5
St. Bernard Hospital	326 West 64th Street	Chicago	60621	8.9
Adventist Hinsdale Hospital	120 North Oak Street	Hinsdale	60521	9.2

ASTC Name	Address	City	Zip	Distance
Center for Reconstructive Surgery	6311 West 95th Street	Oak Lawn	60453	< 3
Palos Hills Surgery Center	10330 South Roberts Road, Suite 300	Palos Hills	60465	< 3
Magna Surgical Center	7456 S State Road, Suite 300	Bedford Park	60638	< 3
Palos Surgicenter, LLC	7340 W. College Drive	Palos Heights	60463	3.2
Forest Med-Surg Center	9050 W. 81st Street	Justice	60458	3.8
Ingalls Same Day Surgery Center	6701 West 159th Street	Tinley Park	60477	8.6
Preferred Surgicenter, LLC	10 Orland Square Drive STE 10-C	Orland Park	60462	7.4
Hinsdale Surgical Center	10 Salt Creek Lane	Hinsdale	60521	9.8

B) Maldistribution does not exist within the GSA:

i) See the table below demonstrating compliance:

	Population	Rooms	Rooms to Population
State	12,830,632	2,368	1:5,418
GSA	1,829,646	36	1:50,823.5

ii) Although some of the ASTCs within the area are not performing above state standards, the facilities do not have the capacity to offer the surgical services intended to be provided by the applicant.

iii) As demonstrated in (i) above, there is sufficient population within the GSA to meet the state utilization standards.

C) Impact on Area Providers

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 applicant currently provides his complex surgeries out of the hospital setting, in order to provide the patient with a more appropriate venue of care, since none of the ASTCs currently allow for extended stay recovery's, which the applicant proposes to offer. Secondly, the applicant does not currently utilize any of the ASTCs within the GSA. Accordingly, the utilization levels of the ASTCs within the GSA will not be affected.

(c)(8) Staffing

A) Surgery Center of Illinois will operate with sufficient staffing levels as required by applicable licensure. SCI will offer the staffing levels as necessary to provide patients with safe and effective care.

B) 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.

(c)(9) Charge Commitment

1) A statement of all charges is attached as Exhibit 4.
2) Please see Exhibit 4, attached herein, which includes a commitment that the charges will not be increased for the first two years of operation.

(c)(10) Assurances

1) See Exhibit 5 for a signed statement of Assurances.
2) See Exhibit 5 for a signed statement of Assurances.

Zip Code	City	Population
60415	Chicago Ridge	14,039
60455	Bridgeview	16,138
60453	Oak Lawn	54,499
60459	Burbank	27,978
60457	Hickory Hills	14,110
60482	Worth	11,262
60465	Palos Hills	17,198
60456	Hometown	4,452
60458	Justice	14,226
60803	Alsip	22,757
60655	Chicago	29,138
60652	Chicago	39,126
60463	Palos Heights	13,286
60805	Evergreen Park	20,821
60501	Summit Argo	11,175
60638	Chicago	55,788
60480	Willow Springs	4,758
60464	Palos Park	9,520
60525	La Grange	32,475
60629	Chicago	113,984
60445	Midlothian	25,979
60534	Lyons	10,212
60472	Robbins	6,672
60643	Chicago	52,568
60620	Chicago	85,771
60406	Blue Island	25,370
60636	Chicago	51,451
60632	Chicago	87,577
60462	Orland Park	38,431
60402	Berwyn	60,373
60513	Brookfield	19,146
60452	Oak Forest	27,899
60469	Posen	4,703
60546	Riverside	15,700
60804	Cicero	86,133
60558	Western Springs	12,539
60621	Chicago	47,514
60526	La Grange Park	13,301
60521	Hinsdale	37,496
60628	Chicago	87,827
60609	Chicago	79,469
60827	Riverdale	33,209
60619	Chicago	74,963
60467	Orland Park	20,904
60623	Chicago	108,144
60141	Hines	247
60155	Broadview	8,254
60426	Harvey	47,649
60514	Clarendon Hills	17,313
60439	Lemont	20,004
60561	Darien	23,570
60130	Forest Park	15,688
60477	Tinley Park	56,840
TOTAL		**1,829,646**

Zip Code	Total patients from Zip Code
60402	2
60406	5
60415	26
60418	15
60426	3
60428	5
60439	7
60445	27
60452	24
60453	170
60455	25
60456	4
60457	22
60458	7
60459	45
60462	73
60463	29
60464	20
60465	29
60467	31
60469	4
60472	2
60480	2
60482	15
60501	1
60525	1
60527	1
60609	2
60619	6
60620	23
60621	12
60623	1
60628	19
60629	26
60632	14

Zip Code	Total patients from Zip Code
60636	5
60638	32
60643	28
60652	17
60655	40
60803	29
60804	1
60805	27
60827	3
Total in GSA	**880**
Total Patients	**1,286**

Zip Code	City	Population
60415	Chicago Ridge	14,039
60455	Bridgeview	16,138
60453	Oak Lawn	54,499
60459	Burbank	27,978
60457	Hickory Hills	14,110
60482	Worth	11,262
60465	Palos Hills	17,198
60456	Hometown	4,452
60458	Justice	14,226
60803	Alsip	22,757
60655	Chicago	29,138
60652	Chicago	39,126
60463	Palos Heights	13,286
60805	Evergreen Park	20,821
60501	Summit Argo	11,175
60638	Chicago	55,788
60480	Willow Springs	4,758
60464	Palos Park	9,520
60525	La Grange	32,475
60629	Chicago	113,984
60445	Midlothian	25,979
60534	Lyons	10,212
60472	Robbins	6,672
60643	Chicago	52,568
60620	Chicago	85,771
60406	Blue Island	25,370
60636	Chicago	51,451
60632	Chicago	87,577
60462	Orland Park	38,431
60402	Berwyn	60,373
60513	Brookfield	19,146
60452	Oak Forest	27,899
60469	Posen	4,703
60546	Riverside	15,700
60804	Cicero	86,133
60558	Western Springs	12,539
60621	Chicago	47,514
60526	La Grange Park	13,301
60521	Hinsdale	37,496
60628	Chicago	87,827
60609	Chicago	79,469
60827	Riverdale	33,209
60619	Chicago	74,963
60467	Orland Park	20,904
60623	Chicago	108,144
60141	Hines	247
60155	Broadview	8,254
60426	Harvey	47,649
60514	Clarendon Hills	17,313
60439	Lemont	20,004
60561	Darien	23,570
60130	Forest Park	15,688
60477	Tinley Park	56,840
TOTAL		**1,829,646**

SURGERY CENTER OF ILLINOIS, LLC

December 11, 2018

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

Dear Ms. Avery,

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,

Daniel Troy, M.D.
Surgery Center of Illinois, LLC

Notarization:
Subscribed and sworn to before me this 12 day of December, 2018.

Signature of Notary

SEAL

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

Procedure Code	Svc Procedure Desc	
10060	Incision & Drainage Abscess Simple/Singl	219.24
10061	Incision&drainage Abscess Complicated/Mu	338.04
10120	Incision&removal Foreign Body Subq Tiss	326.16
10121	Incision&removal Foreign Body Subq Tiss	1628.64
10140	I&d Hematoma Seroma/Fluid Collection	314.28
10160	Puncture Aspiration Abscess Hematoma Bul	248.4
10180	Incision&drainage Complex Po Wound Infec	3188.31
11010	Dbrdmt W/Rmvl Fm Fx&/Dislc Skn&subq Tiss	895.23
11011	Dbrdmt W/Rmvl Fm Fx&/Dislc Skn Subq T/M/	895.23
11012	Dbrdmt Fx&/Dislc Subq T/M/F Bone	3188.31
11042	Debridement Subcutaneous Tissue 20 Sq Cm	485.7
11043	Debridement Muscle & Fascia 20 Sq Cm/<	762.93
11044	Dbrdmt Bone M&/F 20 Sq Cm/<	1628.64
11045	Dbrdmt Subcutaneous Tissue Ea Addl 20 Sq	173
11046	Dbrdmt M&/F Ea Addl 20 Sq Cm	247.83
11047	Debridement Bone Ea Addl 20 Sq Cm/<	422.01
11402	Exc B9 Les Mrgn Xcp Sk Tg T/A/L 1.1-2.0	332.64
11404	Exc B9 Les Mrgn Xcp Sk Tg T/A/L 3.1-4.0	1628.64
11740	Evacuation Subungual Hematoma	161.55
11760	Repair Nail Bed	762.93
11981	Insj Non-Biodegradable Drug Delivery Imp	473.13
11982	Removal Non-Biodegradable Drug Delivery	528.78
11983	Rmvl W/Rinsj Non-Biodegradable Drug Dlvr	766.29
12001	Simple Repair Scalp/Neck/Ax/Genit/Trunk	297.45
12020	Tx Superficial Wound Dehiscence Simple C	762.93
12042	Repair Intermediate N/H/F/Xtrnl Gent 2.6	485.7
13120	Repair Complex Scalp/Arm/Leg 1.1 Cm-2.5	762.93
13121	Repair Complex Scalp/Arm/Leg 2.6 Cm-7.5	762.93
13122	Repair Complex Scalp/Arm/Leg Ea 5 Cm/<	442.29
13131	Repair Complex F/C/C/M/N/Ax/G/H/F 1.1 Cm	485.7
13132	Repair Complex F/C/C/M/N/Ax/G/H/F 2.6 Cm	762.93
13133	Repair Complex F/C/C/M/N/Ax/G/H/F Ea 5 C	592.89
13160	Sec Clsr Surg Wound/Dehsn Extensive/Comp	2451.06
14040	Att/Rearrangement F/C/C/M/N/Ax/G/H/F 10	2451.06
20103	Exploration Penetrating Wound Spx Extrem	895.23
20206	Biopsy Muscle Percutaneous Needle	1628.64
20220	Biopsy Bone Trocar/Needle Superficial	1628.64
20225	Biopsy Bone Trocar/Needle Deep	1628.64
20240	Biopsy Bone Open Superficial	3188.31
20245	Biopsy Bone Open Deep	3188.31
20250	Biopsy Vertebral Body Open Thoracic	3839.73
20251	Biopsy Vertebral Body Open Lumbar/Cervic	8164.11
20525	Rmvl Foreign Body Muscle/Tendon Sheath D	3188.31
20526	Injection Therapeutic Carpal Tunnel	119.88
20527	Injection Enzyme Palmar Fascial Cord	132.84

20550	Injection 1 Tendon Sheath/Ligament Apone	72.36
20551	Injection Single Tendon Origin/Insertion	97.2
20552	Injection Single/Mlt Trigger Point 1/2 M	90.72
20553	Injection Single/Mlt Trigger Point 3/> M	105.84
20600	Arthrocentesis Aspir&/Injection Small Jt	67.12
20605	Arthrocentesis Aspir&/Injection Interm J	73.44
20610	Arthrocentesis Aspir&/Injection Major Jt	87.48
20612	Aspiration&/Injection Ganglion Cyst Any	100.44
20650	Insertion Wire/Pin W/Appl Skeletal Tract	3839.73
20660	Application Cranial Tong/Strtctc Frame W	906.06
20670	Removal Implant Superficial Spx	1628.64
20680	Removal Implant Deep	3188.31
20690	Application Uniplane External Fixation S	8164.11
20692	Application Multiplane External Fixation	21003.9
20693	Adjustment/Revj Xtrnl Fixation System Re	8164.11
20694	Removal External Fixation System Under A	2212.74
20900	Bone Graft Any Donor Area Minor/Small	8164.11
20902	Bone Graft Any Donor Area Major/Large	8164.11
20924	Tendon Graft From A Distance	8164.11
20931	Allograft For Spine Surgery Only Structu	417.81
20937	Autograft Spine Surgery Morselized Sep I	610.56
20939	Bone marrow aspiration for bone grafting	231.66
20974	Electrical Stimulation Bone Healing Noni	257.4
20985	Cptr-Asst Surgical Navigation Image-Less	516.81
21554	Exc Tumor Soft Tissue Neck/Thorax Subfas	3188.31
22010	I&d Deep Abscess Pst Spine Crv Thrc/Cerv	3384.09
22015	I&d Deep Abscess Pst Spine Lumbar Sac/Lu	3350.22
22212	Osteotomy Spine Pst/Pstlat Appr 1 Vrt Sg	5290.05
22216	Osteot Spi Pst/Pstlat Appr 1 Vrt Sgm Ea	1324.74
22310	Cltx Vrt Bdy Fx W/O Mnpj Req&w/Csting/Br	335.85
22325	Optx&/Rdctj Vrt Fx&/Dislc Pst 1 Vrt Sgm	5188.14
22327	Optx&/Rdctj Vrt Fx&/Dislc Pst 1 Vrt Sgm	5437.11
22511	Perc.Vertebroplasty Lumbosacral	3839.73
22513	Kyphoplasty thoracic	8164.11
22514	Perc vertebral augment kyphoplasty lumba	8164.11
22515	Perc vertebral augment kyphoplasty add't	13761.21
22532	Arthrodesis Lateral Extracavitary Thorac	6515.7
22534	Arthrodesis Lat Extracavitary Ea Addl Th	1316.88
22551	Arthrd Ant Interbody Decompress Cervical	22009.44
22552	Arthrd Ant Interdy Cervcl Belw C2 Ea Add	1477.89
22554	Arthrd Ant Min Discect Interbody Cerv Be	21210.9
22556	Arthrd Ant Min Discectomy Interbody Thor	6031.35
22558	Arthrodesis Anterior Interbody Lumbar	5485.11
22585	Arthrodesis Anterior Interbody Ea Addl N	1200.57
22586	Arthrodesis, pre-sacral interbody L5-S1	7536.93

22590	Arthrodesis Posterior Craniocervical	5804.88
22595	Arthrodesis Posterior Atlas-Axis C1-C2	5532.3
22600	Arthrodesis Pst/Pstlat Cervical Belw C2	4684.59
22610	Arthrodesis Posterior/Posterolateral Tho	4560.9
22612	Arthrodesis Posterior/Posterolateral Lum	15207.15
22614	Arthrodesis Posterior/Posterolateral Ea	1441.17
22630	Arthrodesis Posterior Interbody Lumbar	5762.04
22632	Arthrodesis Posterior Interbody Ea Addl	1203.75
22633	Arthdsis Post/Posterolatrl/Postinterbody	6715.29
22634	Arthdsis Post/Posterlatrl/Postintrbdyadl	1830.15
22802	Arthrodesis Posterior Spinal Dfrm 7-12 V	7516.83
22810	Arthrodesis Anterior Spinal Dfrm 4-7 Vrt	6921.51
22830	Exploration Spinal Fusion	2903.19
22840	Posterior Non-Segmental Instrumentation	2798.37
22842	Posterior Segmental Instrumentation 3-6	2812.14
22843	Posterior Segmental Instrumentation 7-12	3006
22844	Posterior Segmental Instrumentation 13/>	3592.92
22845	Anterior Instrumentation 2-3 Vertebral S	2708.61
22846	Anterior Instrumentation 4-7 Vertebral S	2809.32
22849	Reinsertion Spinal Fixation Device	4674.33
22852	Removal Posterior Segmental Instrumentat	2470.71
22853	Insertion Interbody Biomechanical Device	899.34
22854	Insertion Intervertebral Biomechanical D	1136.67
22855	Removal Anterior Instrumentation	4005.81
22856	Tot Disc Arthrp Art Disc Ant Appro 1 Ntr	33638.43
22857	Tot Disc Arthrp Art Disc Ant Appro 1 Ntr	6045.96
22858	Second level,cervical	1883.43
22859	Insertion Intervert Device w/o Interbody	983.67
22864	Rmvl Disc Arthroplasty Ant 1 Interspace	7862.55
23020	Capsular Contracture Release	3839.73
23035	Incision Bone Cortex Shoulder Area	2212.74
23040	Arthrotomy Glenohumeral Jt Expl/Drg/Rmvl	3839.73
23044	Arthrt Acromclav Strnclav Jt Expl/Drg/Rm	3839.73
23066	Biopsy Soft Tissue Shoulder Deep	3188.31
23105	Arthrt Glenohumrl Jt W/Synovectomy +-Bio	8164.11
23120	Claviculectomy Partial	3839.73
23130	Partial Repair Or Removal Of Shoulder Bo	3839.73
23184	Partial Excision Bone Proximal Humerus	8164.11
23330	Removal Foreign Body Shoulder Subcutaneo	895.23
23333	Removal foreign body shoulder deep	1628.64
23350	Injection Shoulder Arthrography/ Ct/Mri	419.04
23410	Open Repair Of Rotator Cuff Acute	8164.11
23412	Open Repair Of Rotator Cuff Chronic	8164.11
23415	Coracoacromial Ligament Release +-Acromi	8164.11
23420	Reconstruction Rotator Cuff Avulsion Chr	8164.11

23430	Tenodesis Long Tendon Biceps	8164.11
23450	Capsulorrhaphy Anterior Putti-Platt/Magn	9164.11
23455	Capsulorrhaphy Anterior W/Labral Repair	9164.11
23470	Arthroplasty Glenohumrl Jt Hemiarthropla	4140.45
23472	Arthroplasty Glenohumeral Joint Total Sh	5035.23
23473	Revision total shoulder;humeral or gleno	5626.02
23474	Rev total shoulder humeral and glenoid	6077.07
23485	Osteotomy Clav +-Int Fixj W/B1 Grf Non/M	15207.15
23500	Clsd Tx Clavicular Fracture W/O Manipula	335.85
23515	Open Tx Clavicular Fracture Internal Fix	8164.11
23525	Closed Tx Sternoclavicular Dislc W/Manip	335.85
23540	Clsd Tx Acromioclavicular Dislc W/O Mani	335.85
23550	Open Tx Acromioclavicular Dislc Acute/Ch	8164.11
23552	Optx Acromclav Dislc Acute/Chronic W/Fas	8164.11
23570	Closed Tx Scapular Fracture W/O Manipula	335.85
23585	Open Tx Scapular Fx W/Internal Fixation	8164.11
23600	Cltx Proximal Humeral Fracture W/O Manip	335.85
23605	Cltx Prox Humrl Fx W/Manipulation +-Skel	2212.74
23615	Open Treatment Proximal Humeral Fracture	21424.86
23616	Open Prox Humeral Fracture Prosthetic Rp	33453.33
23620	Cltx Greater Humeral Tuberosity Fx W/O M	335.85
23630	Open Treatment Grter Humeral Tuberosity	8161.11
23650	Clsd Tx Shoulder Dislc W/Manipulation W/	335.83
23655	Clsd Tx Shoulder Dislc W/Manipulation Re	2212.74
23700	Mnpj W/Anes Shoulder Joint W/Fixation Ap	2212.74
23930	I&d Upper Arm/Elbow Deep Abscess/Hematom	1628.64
23931	Incision&drainage Upper Arm/Elbow Bursa	1628.64
24006	Arthrt Elbow Capsular Excision Capsular	3839.73
24066	Biopsy Soft Tissue Upper Arm/Elbow Area	3188.31
24076	Exc Tumor Soft Tiss Upr Arm/Elbow Subfas	3188.31
24101	Arthrt Elbow W/Joint Expl +-Bx +-Rmvl Lo	3839.73
24102	Arthrotomy Elbow W/Synovectomy	3839.73
24105	Excision Olecranon Bursa	3839.73
24134	Sequestrectomy Shaft/Distal Humerus	8164.11
24149	Rad Rescj Capsl Tiss&htrtpc Bone Elbw Co	8164.11
24164	Implant Removal Radial Head	3839.73
24201	Removal Foreign Body Upper Arm/Elbow Dee	3188.31
24300	Manipulation Elbow Under Anesthesia	2212.74
24301	Muscle/Tendon Transfer Upper Arm/Elbow S	8164.11
24341	Repair Tendon/Muscle Upper Arm/Elbow Ea	8164.11
24342	Rinsj Rptd Biceps/Triceps Tdn Dstl +-Tdn	8164.11
24343	Repair Lateral Collateral Ligament Elbow	3839.73
24344	Rcnstj Lat Coltrl Ligm Elbow W/Tendon Gr	8164.11
24345	Repair Medial Collateral Ligament Elbow	8164.11
24346	Rcnstj Medial Coltrl Ligm Elbw W/Tdn Grf	15207.15
24358	Tnot Elbow Lateral/Medial Debride Open	3839.73

24359	Tnot Elbow Lateral/Medial Debride Open T	3839.73
24360	Arthroplasty Elbow W/Membrane	8164.11
24363	Arthrp Elbow W/Distal Hum&prox Ur Prostc	35553.93
24365	Arthroplasty Radial Head	15207.15
24366	Arthroplasty Radial Head W/Implant	2339955
24400	Osteotomy Humerus +-Internal Fixation	8164.11
24435	Repair Non/Malunion Humerus W/Iliac/Oth	20945.16
24498	Prophylactic Tx +-Methylmethacrylate Hum	15207.15
24500	Clsd Tx Humeral Shaft Fracture W/O Manip	335.85
24505	Cltx Humeral Shft Fx W/Manipulation +-Sk	2212.74
24515	Optx Humeral Shft Fx W/Plate/Screws +-Ce	15207.55
24516	Tx Humeral Shaft Fx W/Insj Imed Implt +-	15207.55
24530	Cltx Sprcndylr/Transcndylr Humeral Fx+-M	335.85
24535	Cltx Sprcndylr/Transcndylr Humeral Fx W/	2212.74
24538	Prq Skel Fixj Sprcndylr/Transcndylr Hume	8164.11
24545	Open Tx Humeral Supracondylar Fracture W	21251.46
24546	Open Tx Humeral Supracondylar Fracture W	31542
24560	Cltx Humeral Epicondylar Fx Medial/Lat W	335.85
24566	Prq Skel Fixj Humrl Epcndylr Fx Medial/L	2212.74
24575	Open Tx Humeral Epicondylar Fracture	15207.15
24576	Cltx Humeral Condylar Fx Medial/Lat W/O	335.85
24577	Cltx Humeral Condylar Fx Medial/Lateral	2212.74
24579	Open Treatment Humeral Condylar Fracture	15207.15
24586	Optx Periarticular Fracture &/Dislocatio	15207.15
24600	Treatment Closed Elbow Dislocation W/O A	335.85
24605	Treatment Closed Elbow Dislocation Req A	2212.74
24615	Open Tx Acute/Chronic Elbow Dislocation	8164.11
24620	Closed Tx Monteggia Fx Dislocation Elbow	2212.74
24635	Open Tx Monteggia Fracture Dislocation E	8164.11
24650	Closed Tx Radial Head/Neck Fx W/O Manipu	335.85
24655	Closed Tx Radial Head/Neck Fx W/Manipula	2212.74
24666	Open Tx Radial Head/Neck Fracture Prosth	23651.28
24670	Closed Tx Ulnar Fracture Proximal End W/	335.85
24675	Closed Tx Ulnar Fracture Proximal End W	2212.74
24685	Open Treatment Ulnar Fracture Proximal E	8164.11
24900	Amputation Arm Thru Humerus W/Primary Cl	2549.34
24930	Amputation Arm Thru Humerus Re-Amputatio	2673.63
25000	Incision Extensor Tendon Sheath Wrist	2212.74
25028	I&d Forearm&/Wrist Deep Abscess/Hematoma	3839.74
25031	Incision & Drainage Forearm&/Wrist Bursa	2212.74
25040	Arthrt Rdcrpl/Midcarpl Jt W/Expl Drg/Rmv	3839.73
25100	Arthrotomy Wrist Joint With Biopsy	2212.74
25101	Arthrt Wrst Jt W/Jt Expl +-Bx +-Rmvl Loo	3839.73
25111	Excision Ganglion Wrist Dorsal/Volar Pri	2212.74
25246	Injection Wrist Arthrography	521.97
25248	Expl W/Removal Deep Foreign Body Forearm	2212.74
25350	Osteotomy Radius Distal Third	11475.87

25360	Osteotomy Ulna	8164.11
25400	Rpir Nonunion/Malunion Radius/Ulna W/O A	8164.11
25405	Rpr Nonunion/Malunion Radius/Ulna W/Auto	8164.11
25445	Arthroplasty W/Prosthetic Replacement Tr	8164.11
25447	Arthrp Interpos Intercarpal/Metacarpal J	3839.73
25500	Closed Tx Radial Shaft Fracture W/O Mani	335.85
25505	Closed Tx Radial Shaft Fracture W/Manipu	2212.74
25515	Open Treatment Radial Shaft Fracture	8164.11
25525	Open Rdl Shaft Fx Closed Rad/Uln Jt Disl	8164.11
25530	Closed Tx Ulnar Shaft Fracture W/O Manip	335.85
25535	Closed Tx Ulnar Shaft Fracture W/Manipul	335.85
25545	Open Treatment Of Ulnar Shaft Fracture	8164.11
25560	Closed Tx Radial&ulnar Shaft Fractures W	335.85
25565	Closed Tx Radial&ulnar Shaft Fractures W	2212.74
25574	Open Tx Radial & Ulnar Shaft Fx Fixj Rad	8164.11
25575	Open Tx Rdl& Ulnar Shaft Fx Fixj Radius	8164.11
25600	Cltx Dstl Radial Fx/Epiphysl Sep W/O Mnp	335.85
25605	Cltx Dstl Rdl Fx/Epiphysl Sep +-W/Mnpj	2212.74
25606	Perq Skel Fixj Distal Radial Fx/Epiphysl	3839.73
25607	Optx Dstl Radl X-Artic Fx/Epiphysl Sep	11460.09
25608	Optx Dstl Radl I-Artic Fx/Epiphysl Sep 2	11441.31
25609	Optx Dstl Radl I-Artic Fx/Epiphysl Sep 3	11566.71
25622	Closed Tx Carpal Scaphoid Fracture W/O M	335.85
25628	Open Tx Carpal Scaphoid Navicular Fractu	8164.11
25630	Cltx Carpl B1 Fx W/O Mnpj Ea B1	335.85
25650	Closed Treatment Ulnar Styloid Fracture	335.85
25675	Closed Tx Distal Radioulnar Dislocation	335.85
26055	Tendon Sheath Incision	1040.94
26080	Arthrt Expl Drg/Rmvl Loose/Fb Iphal Jt E	2212.74
26113	Ex Tum/Vasc Mal Sft Tis Hand/Fngr Subfsc	1628.64
26115	Exc Tum/Vasc Mal Sft Tiss Hand/Fngr Subq	1628.64
26116	Exc Tum/Vas Mal Sft Tis Hand/Fngr Subfas	1628.64
26140	Synvct Prox Iphal Jt W/Xtnsr Rcnstj Ea I	2212.74
26160	Exc Les Tdn Shth/Jt Capsl Hand/Fngr	2212.74
26340	Manipulation Finger Joint Under Anes Eac	2212.74
26341	Maniplatn Palar Fascial Crd Post Inj Sin	190.08
26410	Repair Extensor Tendon Hand W/O Graft Ea	2212.74
26432	Cltx Dstl Xtnsr Tdn Insj +-Prq Pinning	2212.74
26445	Tenolysis Extensor Tendon Hand/Finger Ea	3839.73
26480	Tr/Trnspl Tdn Carp/Mtcrpl Hand W/O Fr Gr	3839.73
26525	Capsulectomy/Capsulotomy Iphal Joint Eac	2212.74
26531	Arthrp Mtcarphlngl Jt W/Prostc Implt Ea	11435.31
26540	Rpr Coltrl Ligm Mtcarphlngl/Iphal Jt	3839.73
26546	Rpr Non-Union Mtcrpl/Phalanx	8164.11
26600	Cltx Mtcrpl Fx 1 W/O Mnpj Ea B1	335.85
26605	Cltx Mtcrpl Fx 1 W/Mnpj Ea B1	335.85
26608	Prq Skel Fixj Mtcrpl Fx Ea B1	3839.73

26615	Open Tx Metacarpal Fracture Single Ea Bo	1628.64
26645	Cltx Carp/Mtcrpl Fx Dislc Thmb W/Mnpj	2212.74
26720	Cltx Phlngl Fx Prox/Middle Px/F/T W/O Mn	335.85
26725	Cltx Phlngl Fx Prox/Middle Px/F/T W/Mnpj	335.85
26727	Prq Skel Fixj Phlngl Shft Fx Prox/Middle	3938.73
26735	Open Tx Phalangeal Shaft Fracture Prox/M	3839.73
26750	Cltx Dstl Phlngl Fx Fngr/Thmb W/O Mnpj E	335.85
26756	Prq Skel Fixj Dstl Phlngl Fx Fngr/Thmb E	3839.73
26770	Cltx Iphal Jt Dislc 1 W/Mnpj W/O Anes	335.85
26776	Prq Skel Fixj Iphal Jt Dislc 1 W/Mnpj	3839.73
26785	Open Tx Interphalangeal Joint Dislocatio	3839.73
26852	Arthrd Mtcarphlngl Jt +-Int Fixj W/Agrft	8164.11
26860	Arthrd Iphal Jt +-Int Fixj	3839.73
26951	Amp F/Th 1/2 Jt/Phalanx 1 W/Neurect W/Di	3839.73
26990	I&d Pelvis/Hip Jt Area Dp Absc/Hmtma	3839.73
26991	I&d Pelvis/Hip Jt Area Infct Bursa	2212.74
27025	Fasciotomy Hip/Thigh Any Type	3157.56
27030	Arthrotomy Hip W/Drainage	3229.41
27033	Arthrotomy Hip Exploration/Removal Forei	3839.73
27052	Arthrotomy W/Biopsy Hip Joint	2212.74
27062	Excision Trochanteric Bursa/Calcificatio	3839.73
27080	Coccygectomy Primary	3839.73
27087	Removal Foreign Body Pelvis/Hip Deep	3839.73
27091	Rmvl Hip Prosth Comp W/Tot Hip Prosth Mm	5534.64
27093	Injection Hip Arthrography W/O Anesthesi	605.04
27095	Injection Hip Arthrography W/Anesthesia	796.74
27096	Injection Si Joint Arthrography&/Anes/St	513.27
27122	Acetabuloplasty Resection Femoral Head	3800.94
27125	Hemiarthroplasty Hip Partial	3922.62
27130	Arthrp Acetblr/Prox Fem Prostc Agrft/Alg	4699.74
27132	Conv Previous Hip Tot Hip Arthrp +-Agrft	5806.5
27134	Revj Tot Hip Arthrp Bth +-Agrft/Algrft	6659.04
27137	Revj Tot Hip Arthrp Actblr Only +-Agrft/	5109
27138	Revj Tot Hip Arthrp Fem Only +-Algrft	5310.03
27140	Osteotomy&transfer Greater Trochanter Sp	3074.43
27146	Osteotomy Iliac Acetabular/Innominate Bo	4448.04
27161	Osteotomy Femoral Neck Spx	4185.27
27170	B1 Grf Fem H/N Intertrchntric/Subtrchntr	4070.4
27178	Optx Slp Fem Epiphysis Clsd Mnpj 1/Mlt P	3171.75
27187	Proph Tx N/P/Pltwr +-Mma Fem Nck&prox Fe	3418.95
27197	Cltx Pel Ring Fx Dislc Diast/Sublxtj W/O	335.85
27198	Cltx Pel Ring Fx Dislc Diast/Sublxtj W/M	335.85
27200	Closed Treatment Coccygeal Fracture	320.76

27220	Cltx Acetabulum Hip/Sockt Fx W/O Mnpj	335.85
27226	Optx Pst/Ant Actblr Wall Fx W/Int Fixj	3641.07
27227	Optx Actblr Fx Invg Ant/Pst 1 Column/Fx	5767.29
27228	Optx Actblr Fx Invg Ant&pst 2 Columns Fx	6550.29
27230	Cltx Fem Fx Prox End Nck W/O Mnpj	1617.99
27235	Prq Skel Fixj Fem Fx Prox End Nck	3141.54
27236	Optx Fem Fx Prox End Nck Int Fixj/Prostc	4135.17
27244	Tx Inter/Pr/Subtrchntric Fem Fx Screw Im	4260
27245	Tx Inter/Pr/Subtrchntric Fem Fx Imed Imp	4260
27246	Cltx Grter Trchntric Fx W/O Mnpj	1314.36
27248	Open Treatment Greater Trochanteric Frac	2562.69
27252	Cltx Hip Dislc Traumtc Req Anes	2212.74
27253	Optx Hip Dislc Traumtc W/O Int Fixj	3238.53
27254	Optx Hip Dislc Traumtc W/Actblr Wall&fem	4409.88
27266	Cltx Post Hip Arthrp Dislc Req Anes	2212.74
27267	Closed Tx Femoral Fracture Prox Head W/O	2212.74
27269	Open Tx Femoral Fracture Proximal End He	4311.81
27280	Arthrodesis Sacroiliac Joint W/Obtaining	4836.6
27295	Disarticulation Hip	4407.42
27301	I&d Dp Absc Bursa/Hmtma Thi/Kne Region	3188.31
27305	Fasciotomy Iliotibial Open	3839.73
27310	Arthrt Kne W/Expl Drg/Rmvl Fb	3839.73
27323	Biopsy Soft Tissue Thigh/Knee Area Super	1628.64
27324	Biopsy Soft Tissue Thigh/Knee Area Deep	3188.31
27327	Excision Tumor Soft Tissue Thigh/Knee Su	1628.64
27328	Exc Tumor Soft Tissue Thigh/Knee Subfasc	3188.31
27331	Arthrt Kne W/Jt Expl Bx/Rmvl Loose/Fb	3839.73
27334	Arthrotomy W/Synovectomy Knee Anterior/P	3839.73
27345	Excision Synovial Cyst Popliteal Space	3839.73
27350	Patellectomy/Hemipatellectomy	3839.73
27356	Excision/Curettage Cyst/Tumor Femur W/Al	15207.15
27360	Prtl Exc B1 Femur Prox Tibia&/Fibula	3839.73
27370	Injection Knee Arthrography	499.41
27372	Removal Foreign Body Deep Thigh/Knee	3188.31
27380	Suture Infrapatellar Tendon Primary	8164.11
27385	Suture Quadriceps/Hamstring Rupture Prim	8164.11
27403	Arthrotomy W/Meniscus Repair Knee	3839.73
27405	Rpr Primary Torn Ligm&/Capsule Knee Coll	8164.11
27412	Autologous Chondrocyte Implantation Knee	5754.66
27415	Osteochondral Allograft Knee Open	24606.45
27415	Osteochondral Allograft Knee Open	4728.6
27420	Rcnstj Dislocating Patella	8164.11
27422	Rcnstj Dislc Patella W/Xtnsr Relignmt&/M	8164.11
27425	Lateral Retinacular Release Open	3839.73
27427	Ligamentous Reconstruction Knee Extra-Ar	8164.11
27428	Ligamentous Reconstruction Knee Intra-Ar	15207.15

27430	Quadricepsplasty	8164.11
27435	Capsulotomy Posterior Capsular Release K	3839.73
27438	Arthroplasty Patella W/Prosthesis	21082.23
27441	Arthrp Knee Tibial Plateau Dbrdmt&prtl S	15207.15
27442	Arthroplasty Fem Condyles/Tibial Plateau	22031.82
27445	Arthroplasty Knee Hinge Prosthesis	4333.5
27446	Arthrp Knee Condyle&plateau Medial/Lat C	22121.31
27447	Arthrp Kne Condyle&platu Medial&lat Cmpr	4694.31
27450	Osteotomy Femur Shaft/Supracondylar W/Fi	3457.11
27472	Rpr Non/Mal Femur Dstl H/N W/Iliac/Autog	4365.57
27486	Revj Tot Kne Arthrp +-Algrft 1 Comp	4866.18
27487	Revj Tot Kne Arthrp Fem&entire Tibl Comp	6098.76
27488	Rmvl Prosth Tot Kne Prosth Mma +-Insj Sp	4150.02
27495	Proph Tx N/P/Pltwr +-Mma Femur	3890.97
27496	Dcmprn Fasct Thi&/Kne 1 Cmprt	3893.73
27498	Dcmprn Fasct Thi&/Kne Mlt Cmprts	2212.74
27500	Closed Tx Femoral Shaft Fx W/O Manipulat	335.85
27502	Cltx Fem Shft Fx W/Mnpj +-Skn/Skel Tracj	2212.74
27506	Optx Fem Shft Fx W/Insj Imed Implt +-Scr	4627.71
27507	Optx Fem Shft Fx W/Plate/Screws +-Cercla	3362.91
27508	Cltx Fem Fx Dstl End Medial/Lat Condyle	335.85
27511	Open Tx Femoral Supracondylar Fracture W	3452.94
27513	Open Tx Femoral Supracondylar Fracture W	4308.45
27514	Open Tx Femoral Fracture Distal Med/Lat	3346.62
27517	Cltx Dstl Fem Epiphysl Sep W/Mnpj +-Skn/	2212.74
27520	Closed Tx Patellar Fracture W/O Manipula	335.85
27524	Optx Patllr Fx W/Int Fixj/Patllc&soft Ti	8164.11
27530	Cltx Tibl Fx Prox W/O Mnpj	335.85
27535	Open Tx Tibial Fracture Proximal Unicond	3103.23
27536	Optx Tibl Fx Prox Bicondylar +-Int Fixj	4111.68
27538	Cltx Intercondylar Spi&/Tubrst Fx Kne +-	335.85
27540	Open Tx Intercondylar Spine/Tubrst Fract	2773.44
27552	Closed Tx Knee Dislocation W/Anesthesia	2212.74
27556	Open Tx Knee Dislocation W/O Ligamentous	3043.92
27557	Open Tx Knee Dislocation W Ligamentous R	3648.51
27560	Closed Tx Patellar Dislocation W/O Anest	1121.19
27566	Optx Patellar Dislc +-Prtl/Tot Patellect	8164.11
27570	Manipulation Knee Joint Under General An	2212.74
27580	Arthrodesis Knee Any Technique	4963.89
27590	Amputation Thigh Through Femur Any Level	2827.92
27592	Amputation Thigh Thru Femur Open Circula	2396.37
27594	Amp Thigh Thru Femur Sec Closure/Scar Re	3839.73
27596	Amputation Thigh Through Femur Re-Amputa	2529.54
27602	Dcmprn Fasct Leg Ant&/Lat&pst Cmprt	3839.73
27603	Incision&drainage Leg/Ankle Abscess/Hema	3188.31
27604	Incision&drainage Leg/Ankle Infected Bur	2212.74

27607	Incision Leg/Ankle	3839.73
27610	Arthrotomy Ankle W/Expl Drainage/Removal	3839.73
27614	Biopsy Soft Tissue Leg/Ankle Area Deep	3188.31
27620	Arthrt Ankle W/Jt Expl +-Bx +-Rmvl Loose	3839.73
27635	Excision/Curettage Bone Cyst/Tumor Tibia	3839.73
27640	Partial Excision Bone Tibia	3839.73
27650	Repair Primary Open/Prq Ruptured Achille	3839.73
27654	Repair Secondary Achilles Tendon +-Graft	8164.11
27658	Repair Flexor Tendon Leg Primary W/O Gra	3839.73
27676	Repair Dislocating Peroneal Tendon W/Fib	8164.11
27687	Gastrocnemius Recession	3839.73
27695	Rpr Primary Disrupted Ligament Ankle Col	8164.11
27698	Repair Secondary Disrupted Ligament Ankl	8164.11
27707	Osteotomy Fibula	3839.73
27712	Osteot Mlt W/Relignmt Imed Rod	3830.79
27720	Repair Nonunion/Malunion Tibia W/O Graft	8164.11
27724	Rpr Non/Mal Tibia W/Iliac/Oth Agrft	4383.57
27726	Repair Fibula Nonunion/Malunion W Int Fi	8164.11
27750	Cltx Tibl Shft Fx W/O Mnpj	335.85
27752	Cltx Tibl Shft Fx W/Mnpj +-Skel Tracj	2212.74
27758	Optx Tibl Shft Fx W/Plate/Screws +-Cercl	15207.15
27759	Tx Tibl Shft Fx Imed Implt +-Screws&/Cer	15207.15
27760	Cltx Medial Malls Fx W/O Mnpj	335.85
27766	Open Treatment Medial Malleolus Fracture	8164
27780	Cltx Prox Fibula/Shft Fx W/O Mnpj	335.85
27784	Open Treatment Proximal Fibula/Shaft Fra	8164.11
27786	Cltx Dstl Fibular Fx Lat Malls W/O Mnpj	335.85
27788	Cltx Dstl Fibular Fx Lat Malls W/Mnpj	335.85
27792	Open Tx Distal Fibular Fracture Lat Mall	8164.11
27808	Closed Tx Bimalleolar Ankle Fracture W/O	335.85
27810	Closed Tx Bimalleolar Ankle Fracture W M	2212.74
27814	Open Treatment Bimalleolar Ankle Fractur	8164.11
27818	Cltx Trimal Ankle Fx W/Mnpj	2212.74
27822	Open Tx Trimalleolar Ankle Fx W/O Fixj P	8164.11
27823	Open Tx Trimalleolar Ankle Fx W Fixj Pst	8164.11
27824	Cltx Fx W8 Brg Artclr Prtn Dstl Tibia W/	335.85
27825	Cltx Fx W8 Brg Artclr Prtn Dstl Tib W/Sk	2212.74
27826	Open Treatment Fracture Distal Tibia Fib	8164.11
27827	Open Treatment Fracture Distal Tibia Onl	15207.15
27828	Open Treatment Fracture Distal Tibia & F	15207.15
27829	Open Tx Distal Tibiofibular Joint Disrup	8164.11
27842	Cltx Ankle Dislc Req Anes +-Prq Skel Fix	2212.74
27848	Optx Ankle Dislc W/Rpr/Int/Xtrnl Fixj	8164.11
27860	Mnpj Ankle Under General Anes	2242.74
27870	Arthrodesis Ankle Open	21521.34
27880	Amputation Leg Through Tibia&fibula	3235.77
27894	Dcmprn Fasct Leg Ant&/Lat&pst W/Dbrdmt M	2212.74

28090	Exc Lesion Tendon Sheath/Capsule W/Synvc	2212.74
28110	Ostectomy Prtl 5th Metar Head Spx	3839.73
28111	Ostectomy Complete 1st Metatarsal Head	3839.73
28112	Ostectomy Complete Other Metatarsal Head	3839.73
28118	Ostectomy Calcaneus	3839.73
28126	Resection Partial/Complete Phalangeal Ba	2212.74
28200	Rpr Tdn Flxr Foot 1/2 W/O Fr Grf Ea Tdn	3839.73
28220	Tenolysis Flexor Foot Single Tendon	861.84
28234	Tenotomy Open Extensor Foot/Toe Each Ten	2212.74
28285	Correction Hammertoe	3938.73
28400	Closed Tx Calcaneal Fracture W/O Manipul	335.85
28405	Closed Tx Calcaneal Fracture W/Manipulat	335.85
28415	Open Treatment Calcaneal Fracture	8164.11
28420	Open Treatment Calcaneal Fracture W Bone	21694.77
28430	Closed Tx Talus Fracture W/O Manipulatio	335.85
28445	Open Treatment Talus Fracture	8164.11
28450	Tx Tarsal B1 Fx Xcp Talus&calcn W/O Mnpj	335.85
28456	Prq Skel Fixj Tarsl Fx Xcp Talus&calcns	8164
28470	Closed Tx Metatarsal Fracture W/O Manipu	335.85
28485	Open Treatment Metatarsal Fracture Each	8164.11
28490	Cltx Fx Grt Toe Phlx/Phlg W/O Mnpj	312.12
28496	Prq Skel Fixj Fx Grt Toe Phlx/Phlg W/Mnp	3839.73
28510	Cltx Fx Phlx/Phlg Oth/Thn Grt Toe W/O Mn	245.16
28515	Cltx Fx Phlx/Phlg Oth/Thn Grt Toe W/Mnpj	317.52
28525	Open Tx Fracture Phalanx/Phalanges Not G	3839.73
28530	Closed Treatment Sesamoid Fracture	230.04
28575	Closed Tx Talotarsal Joint Dislocation W	3938.73
28576	Prq Skel Fixj Talotarsal Jt Dislc W/Mnpj	2212.74
28606	Prq Skel Fixj Tars Jt Dislc W/Mnpj	3839.73
28615	Open Treatment Tarsometatarsal Joint Dis	8164.11
28630	Cltx Metatarsophlngl Jt Dislc W/O Anes	276.48
28660	Cltx Iphal Jt Dislc W/O Anes	204.12
28730	Arthrd Midtarsl/Tars Mlt/Transvrs	22248.57
28805	Amputation Foot Transmetarsal	2476.83
28810	Amputation Metatarsal W/Toe Single	3839.73
28820	Amputation Toe Metatarsophalangeal Joint	2212.74
28825	Amputation Toe Interphalangeal Joint	2212.74
29065	Application Cast Shoulder Hand Long Arm	187.92
29075	Application Cast Elbow Finger Short Arm	171.72
29085	Application Cast Hand&lower Forearm Gaun	186.84
29105	Application Long Arm Splint Shoulder Han	164.16
29125	Application Short Arm Splint Forearm-Han	213.03
29130	Application Finger Splint Static	138.21
29345	Application Long Leg Cast Thigh-Toe	243
29405	Application Short Leg Cast Below Knee-To	152.25
29515	Application Short Leg Splint Calf Foot	133.92

29540	Strapping Ankle &/Foot	35.64
29805	Arthroscopy Shoulder Dx +-Synovial Biops	3839.73
29806	Arthroscopy Shoulder Surgical Capsulorrh	8164.11
29807	Arthroscopy Shoulder Surgical Repair Sla	8164.11
29819	Arthroscopy Shoulder Surgical Removal Lo	3938.73
29820	Arthroscopy Shoulder Surg Synovectomy Pa	8164.11
29821	Arthroscopy Shoulder Surg Synovectomy Co	3839.73
29822	Arthroscopy Shoulder Surg Debridement Li	3839.73
29823	Arthroscopy Shoulder Surg Debridement Ex	3839.73
29824	Arthroscopy Shoulder Distal Claviculecto	3839.73
29825	Arthroscopy Shoulder Lysis&rescj Adhesio	3839.73
29826	Shoulder Scope Bone Shaving	615.78
29827	Arthroscopy Shoulder Rotator Cuff Repair	8164.11
29828	Arthroscopy Shoulder Biceps Tenodesis	8164.11
29834	Arthroscopy Elbow Surgical W/Removal Loo	3839.73
29835	Arthroscopy Elbow Surgical Synovectomy P	3839.73
29837	Arthroscopy Elbow Surgical Debridement L	3839.73
29838	Arthroscopy Elbow Surgical Debridement E	3839.73
29846	Arthrs Wrst Exc&/Rpr Triang Fibrocart&/J	3839.73
29848	Ndsc Wrst Surg W/Rls Transvrs Carpl Ligm	2212.74
29861	Arthroscopy Hip Surgical W/Removal Loose	3839.73
29862	Arthrs Hip Debridement/Shaving Articular	8164.11
29863	Arthroscopy Hip Surgical W/Synovectomy	3839.73
29870	Arthroscopy Knee Diagnostic +-Synovial B	3839.73
29871	Arthroscopy Knee Infection Lavage & Drai	3839.73
29873	Arthroscopy Knee Lateral Release	3839.73
29874	Arthroscopy Knee Removal Loose/Foreign B	3839.73
29875	Arthroscopy Knee Synovectomy Limited Spx	3839.73
29876	Arthroscopy Knee Synovectomy 2/>compartm	3839.73
29877	Arthrs Knee Debridement/Shaving Artclr C	3839.73
29879	Arthrs Knee Abrasion Arthrp/Mlt Drlg/Mic	3839.73
29880	Arthrs Knee W/Meniscectomy Med&lat W/Sha	3839.73
29881	Arthrs Kne Surg W/Meniscectomy Med/Lat W	3839.73
29882	Arthroscopy Knee W/Meniscus Rpr Medial/L	3839.73
29884	Arthroscopy Knee W/Lysis Adhesions+-Mnpj	3839.73
29885	Arthrs Kne Drlg Osteo Diss Grfg	8164.11
29886	Arthrs Kne Drlg Osteo Diss Les	3839.73
29887	Arthrs Kne Drlg Osteo Diss Les Int Fixj	8164.11
29888	Arthrs Aided Ant Cruciate Ligm Rpr/Agmnt	8164.11
29889	Arthrs Aided Pst Cruciate Ligm Rpr/Agmnt	8164.11
29891	Arthrs Ankle Exc Ostchndrl Dfct W/Drlg D	3839.73
29894	Arthroscopy Ankle W/Removal Loose/Foreig	3839.73
29895	Arthroscopy Ankle Surgical Synovectomy P	3839.73
29899	Arthroscopy Ankle Surgical W/Ankle Arthr	8164.11
29914	Arthroscopy Hip W/Femoroplasty	8164.11

29915	Arthroscopy Hip W/Acetabuloplasty	8164.11
29916	Arthroscopy Hip W/Labral Repair	8164.11
35206	Repair Blood Vessel Direct Upper Extremi	2791.65
35226	Rpr Blood Vessel Direct Lower Extremity	3000.06
61783	Strtctc Cptr Asstd Px Spinal	875.04
62290	Njx Diskograpy Ea Lvl Lmbr	1052.91
63001	Lam W/O Facetec Foramot/Dskc 1/2 Vrt Seg	8164.11
63003	Lam W/O Ffd 1/2 Vrt Seg Thrc	8164.11
63005	Lam W/O Ffd 1/2 Vrt Seg Lmbr	8164.11
63012	Lam W/Rmvl Abnormal Facets Lmbr	4345.41
63015	Lam W/O Ffd > 2 Vrt Seg Crv	5485.74
63016	Lam W/O Ffd > 2 Vrt Seg Thrc	5644.14
63020	Laminotomy Incl Opn & Ndsc 1 Interspace	8164.11
63030	Laminotomy Incl Open & Ndsc 1 Interspace	8164.11
63035	Lamot Incl Open&ndsc Ea Addl Interspace	702.81
63042	Lamot Prtl Ffd Hrna8 Reexpl 1 Ntrspc Lmb	8164.11
63043	Lamot Prtl Ffd Hrna8 Reexpl 1 Ntrspc Ea	1016.67
63044	Lamot W/Prtl Ffd Hrna8 Reexpl 1 Ntrspc E	958.02
63045	Lam Facetec&foramot 1 Sgm Crv	8164.11
63046	Lam Facetec&foramot 1 Sgm Thrc	8164.11
63047	Lam Facetec&foramot 1 Sgm Lmbr	8164.11
63048	Lam Facetec&foramot 1 Sgm Ea Crv Thrc/Lm	780.45
63055	Transpedicular Dcmprn Spi Cord 1 Sgm Thr	8164.11
63057	Transpedicular Dcmprn 1 Sgm Ea Thrc/Lmbr	1182.39
63075	Dskc Ant Dcmprn Crv 1 Ntrspc	4905.57
63076	Dskc Ant Dcmprn Crv Ea Ntrspc	913.11
63081	Vcrpec Ant Dcmprn Crv 1 Sgm	6408.18
63082	Vcrpec Ant Dcmprn Crv Ea Sgm	986.61
63085	Vcrpec Tthrc Dcmprn Thrc 1 Sgm	6963.81
63087	Vcrpec Thoracolmbr Dcmprn Lwr Thrc/Lmbr	8803.77
63088	Vcrpec Thoracolmbr Dcmprn Lwr Thrc/Lmbr	877371
63090	Vcrpec Transprtl/Rpr Dcmprn Thrc Lmbr/Sa	7006.68
63091	Vcrpec Transprtl/Rpr Dcmprn Thrc Lmbr/Sa	64.27
63101	Vcrpec Lat Xtrcavitary Dcmprn Thrc 1 Sgm	8553.21
63267	Lam Exc/Evac Ispi Les Oth/Thn Neo Xdrl L	5011.5
63276	Lam Bx/Exc Ispi Neo Xdrl Thrc	6642.15
63281	Lam Bx/Exc Ispi Neo Idrl Xmed Thrc	7851.75
63287	Lam Bx/Exc Ispi Neo Idrl Imed Thoracolmb	10428.18
63655	Lam Implti Nstim Eltrds Plate/Paddle Edr	45017.64
63662	Rmvl Spinal Nstim Eltrd Plate/Paddle Inc	4499.73
63685	Insj/Rplcmt Spi Npgr Dir/Induxive Coupli	68676.78
63688	Revj/Rmvl Implted Spi Npgr	4499.73
64405	Njx Anes Grter Occipital Nrv	193.32
64450	Njx Anes Oth Prph Nrv/Branch	157.68

64479	Njx Anes&/Strd W/Img Tfrml Edrl Crv/Thrc	1050.45
64480	Njx Anes&/Strd W/Img Tfrml Edrl Crv/Thrc	367.77
64483	Njx Anes&/Strd W/Img Tfrml Edrl Lmbr/Sac	1050.45
64484	Njx Anes&/Strd W/Img Tfrml Edrl Lmbr/Sac	297.48
64490	Njx Dx/Ther Agt Pvrt Facet Jt Crv/Thrc 1	1050.45
64491	Njx Dx/Ther Agt Pvrt Facet Jt Crv/Thrc 2	199.56
64492	Njx Dx/Ther Agt Pvrt Facet Jt Crv/Thrc 3	304.53
64493	Njx Dx/Ther Agt Pvrt Facet Jt Lmbr/Sac 1	1050.45
64494	Njx Dx/Ther Agt Pvrt Facet Jt Lmbr/Sac 2	279.45
64495	Njx Dx/Ther Agt Pvrt Facet Jt Lmbr/Sac 3	174.48
64635	Dstr Nrolytc Agnt Parverteb Fct Sngl Lmb	2356.23
64636	Dstr Nrolytc Agnt Parverteb Fct Addl Lmb	196.35
64640	Dstrj Nulyt Oth Prph Nrv/Branch	263.52
64708	Neurp Major Prph Nrv Arm/Leg Opn Oth/Thn	2356.23
64712	Neurp Major Prph Nrv Opn Arm/Leg Sciatic	2356.23
64718	Neurp&/Trpos Ur Nrv Elbw	2356.23
64721	Neurp&/Trpos Median Nrv Carpl Tunnel	2356.23
64722	Dcmprn Unspecified Nrv	2356.23
64795	Bx Nrv	2356.23
64840	Sutr Post Tibl Nrv	6099.15
69990	Microsurg Tqs Req Use Oprating Mcrscp	279.36

SURGERY CENTER OF ILLINOIS, LLC

December 11, 2018

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

Dear Ms. Avery,

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

Specifically, this letter certifies that Surgery Center of Illinois, LLC attests that it will operate a peer review program 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, Surgery Center of Illinois, LLC 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,

Daniel Troy, M.D.
Surgery Center of Illinois, LLC

Notarization:
Subscribed and sworn to before me this 12 day of December, 2018.

Signature of Notary

SEAL

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

See Attachment 33-Exhibit 1 for documentation from First Midwest Bank indicating the availability of sufficient debt financing and cash for the proposed expansion and modernization project.

First Midwest Bank

December 4, 2018

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

Dear Ms. Avery,

It is my understanding that Surgery Center of Illinois, LLC plans to establish an ambulatory surgical treatment center ("ASTC") located at 6701 W. 95th Street Oak Lawn, IL 60453. I further understand that Surgery Center of Illinois, LLC will require loan(s) for certain capital expenditures and equipment purchases for an amount not to exceed $4,500,000.

Surgery Center of Illinois, LLC and Dr. Daniel Troy have been a good and valuable customer of First Midwest Bank for several years. Should the Illinois Health Facilities and Services Review Board approve the proposed project, and based upon the positive business experiences from working with Surgery Center of Illinois, LLC and Dr. Daniel Troy, First Midwest Bank is prepared to extend Surgery Center of Illinois, LLC up to $4,500,000 in credit exposure to finance the ASTC project.

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 708-576-7122.

Sincerely,

Mark Oganovich
Senior Vice President
First Midwest Bank

First Midwest Bank

December 4, 2018

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

Dear Ms. Avery,

This letter is written with respect to Dr. Daniel Troy. Dr. Troy is a longtime customer of First Midwest Bank. First Midwest Bank currently provides depository services for Dr. Troy. We hereby attest that Dr. Daniel Troy, owner of Surgery Center of Illinois, LLC, has funds available for the proposed Ambulatory Surgical Treatment Center project in the amount of $750,000 or higher amount as applicable.

We appreciate the opportunity to provide this information to you about Dr. Troy. Please do not hesitate to contact me at 708-576-7122 should you have any questions.

Sincerely,

Mark Oganovich
Senior Vice President
First Midwest Bank

Attachment 33 - Exhibit I

Section IX, Financial Feasibility

Criterion 1120.130(a) – Financial Viability

Please find in the *projected* viability ratios for Surgery Center of Illinois. 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	1.50	1.61	1.95	Yes

Surgery Center of Illinois, LLC 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%	18%	19%	23%	Yes

Surgery Center of Illinois, LLC 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%	79%	69%	55%	Yes

Surgery Center of Illinois, LLC 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	1.9	2.5	3.2	Yes

Surgery Center of Illinois, LLC 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	77	121	249	Yes

Surgery Center of Illinois, LLC 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	7.1	7.9	9.8	Yes

Surgery Center of Illinois, LLC is able to meet the standard for Cushion Ratio.

Surgery Center of Illinois, LLC
Exhibit I
Projected Financial Statements

	Projected Year 1	Projected Year 2	Projected Year 3
Revenue:			
Surgeries and Injections Service (charges)	4,132,037	4,338,639	4,555,571
Deductions From Revenue (insurance discounts)	(1,652,815)	(1,735,456)	(1,822,228)
Total Income	2,479,222	2,603,183	2,733,342
Expenses:			
Salaries	328,275	338,123	348,267
Bond Issuance Expense	0		
Repairs and Maintenance	37,826	38,960	40,129
Management Fees	157,530	162,256	167,124
Surgical Instruments/Supplies	239,929	247,127	254,541
Utilities	17,500	18,025	18,566
Rent Expense	286,695	286,695	286,695
Professional Fees	143,317	147,616	152,045
Insurance	25,000	25,750	26,523
Depreciation	179,612	179,612	179,612
Employee Benefits	66,206	68,192	70,238
General Admin	42,790	44,073	45,396
Taxes and Licenses	91,345	94,085	96,908
Interest Expense & Loan	400,912	400,912	400,912
Bad Debt Expenses	44,634	78,095	82,000
Other Expenses	25,000	25,000	25,000
Total Expenses	2,086,570	2,154,523	2,193,954
Net Income	392,652	448,660	539,389

SURGERY CENTER OF ILLINOIS,LLC
PROJECTED BALANCE SHEET

	Year 1	Year 2	Year 3
ASSETS			
Current Assets			
Checking/Savings	350,000	572,264	1,200,536
Accounts Receivable	2,479,222	2,603,183	2,733,342
Total Current Assets	2,829,222	3,175,447	3,933,878
Fixed Assets			
Capital Expenditure	3,085,358	3,085,358	3,085,358
Furniture and Equipment	1,005,000	1,005,000	1,005,000
Accumulated Depreciation	-179,612	-359,223	-538,835
Total Fixed Assets	3,910,746	3,731,135	3,551,523
TOTAL ASSETS	**6,739,968**	**6,906,582**	**7,485,401**
LIABILITIES & EQUITY			
Liabilities			
Current Liabilities	1,881,958	1,974,911	2,014,342
Liabilities			
Total Current Liabilities	1,881,958	1,974,911	2,014,342
Long Term Liabilities			
Loan	3,823,872	3,422,960	3,022,049
Total Long Term Liabilities	3,823,872	3,422,960	3,022,049
Total Liabilities	5,705,831	5,397,872	5,036,391
Equity			
Building & Equipment	266,486	667,398	1,068,309
Retained Earnings	392,652	841,313	1,380,701
capital contribution	375,000	0	0
Total Equity	1,034,138	1,508,710	2,449,011
TOTAL LIABILITIES & EQUITY	**6,739,968**	**6,906,582**	**7,485,401**

Attachment 35 - Exhibit I

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

A. Reasonableness of Financing Arrangements:

See Attachment 36-Exhibit 1 for a signed, notarized statement from a representative of SCI 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 36-Exhibit 1 for a signed, notarized statement from a representative of SCI 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 (Based on 2019 Construction Mid-Point)**	**Above/Below State Standard**
New Construction & Contingencies	N/A	N/A	N/A
Modernization Construction	$1,992,173.92	$280.99 x 7,694 = $2,161,971.91	Below State Standard
OR Equipment	$979,450.00	$489,744.71 x 2 = $979,489.42	Below State Standard
Contingencies	$199,217.39	15% x $1,992,173.92 = $298,826.09	Below State Standard
A/E Fees	$119,530.44	10.54% x $1,992,173.92 = $209,975.13	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		258.93**			7,694			$1,992,173.92	$1,992,173.92
Contingency-Clinical		$25.89			7,694			$199,217.39	$199,217.39
Clinical Sub-total		$284.82			7,694			$2,191,391.31	$2,191,391.31
Non-Clinical		$258.93			4,222			$1,093,318.41	$1,093,318.41
Contingency-Non-Clinical		$25.89			4,222			$109,318.41	$109,318.41
Non-Clinical Sub-total		$284.89			4,222			$1,202,502.49	$1,202,502.49
Total		$284.89			11,916			$3,393,893.80	$3,393,893.80

*Please note: The facility contains 2332 sq. ft. of Shell Space.
**Note: The cost per square foot have been rounded to the nearest two decimal points.

D. Projected Operating Costs

OPERATING COSTS	
ASTC	$978,046.46

TOTAL	$978,046.46

Total Patient Treatments = 1,286
Operating Cost/Visit = $760.53

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

CAPITAL COST	
Amortization	$400,912
Depreciation	$179,612
TOTAL	$580,524

Total Patient Treatments = 1,286
Capital Cost/Visit = $451.41

Attachment 36

SURGERY CENTER OF ILLINOIS, LLC

December 11, 2018

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

Dear Ms. Avery,

I hereby attest that, for the Surgery Center of Illinois, LLC 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,

Daniel Troy, M.D.
Surgery Center of Illinois, LLC

Notarization:
Subscribed and sworn to before me this 12 day of December, 2018.

Jean Stripeik
Signature of Notary

SEAL

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

Section XI, Safety Net Impact Statement

1. **Material impact on safety net services in the community:** Surgery Center of Illinois, LLC will not have a material impact on safety net services in the Chicago metropolitan area. The primary purpose of SCI is to deliver greater access for patients in the southwest-suburban area of Chicago. Thus, SCI 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:** SCI will not negatively impact the ability of other providers to cross-subsidize safety-net services. The limited scope of SCI reduces its potential impact on other providers. The overwhelming majority of referrals to SCI will be for cases previously performed at other Illinois ASTCs that do not provide safety-net services or in hospitals which have grown overcrowded and resulted in increased wait times and patient inconvenience. Accordingly, the Applicant does not believe SCI 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. The table below contain the relevant anticipated charity care and payor mix information for Surgery Center of Illinois, LLC by the end of its second year of operation:

CHARITY CARE			
	2020	2021	2022
Net Patient Revenue	**$2,479,222**	**$2,603,183**	**$2,733,342**
Amount of Charity Care (Charges in Dollars)	$44,634	$78,095	$82,000
Cost of Charity Care (in Dollars)	$44,634	$78,095	$82,000
Ratio of Charity Care to Net Patient Revenue	2%	3%	3%

Payor Mix (Projected)	2020	2021	2022
Medicare	386	463	556
Medicaid	64	77	92
Workers Compensation	129	155	186
Veteran (TriCare)	39	47	56
Commercial	643	772	926
Charity	25	31	37
Total Patients	1,286	1,545	1,853

Attachment 38

Appendix I – Physician Referral Letter

Attached as Appendix 1 are the letters from each physician projecting that 1,286 patients will be referred to the ASTC for surgeries within 12 to 24 months of project completion.

Daniel Troy, M.D.
Jose Perez-Sanz, M.D.
Kirsten Oliversen, M.D.
Paul Danielsky, M.D.
Jonathan Watson, M.D.
Dana Berns, D.P.M.

Advanced Orthopedic & Spine Care

6701 West 95th Street • Oak Lawn, IL 60453
16255 South Harlem Avenue • Tinley Park, IL 60477
Phone 708-599-5000 • Fax 708-599-0801
www.advancedorthospine.com

December 11, 2018

Courtney Avery
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nct Floor
Springfield, IL 62761

Dear Ms. Avery,

I am a physician specializing in Orthopedics. I support the proposal to establish the ambulatory surgical treatment center (ASTC) located at 6701 W. 95th Street, Oak Lawn, IL 60453, known as the Surgery Center of Illinois.

Over the past 12 months, I have referred five hundred and fifty-one (551) 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 five hundred and fifty-one (551) patients to the Surgery Center of Illinois 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.

Sincerely,

Daniel Troy, M.D.
6701 W. 95th Street,
Oak Lawn, IL 60453

Subscribed and Sworn to before me this

12 day of December 2018

Jean Stripeik
Notary Public

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

Referral Location and Patient Zip	Total Patients
Christ Hospital	**385**
46307	1
46310	1
46312	2
46324	5
46356	1
46383	1
46392	1
46404	2
46408	1
46538	1
47906	1
60015	1
60403	1
60406	2
60415	11
60417	1
60418	4
60419	1
60422	1
60423	7
60425	1
60426	1
60428	2
60430	5
60435	1
60438	4
60439	3
60441	1
60443	3
60445	4
60447	3
60448	3
60449	1
60451	1
60452	5
60453	45
60455	8
60456	2
60457	10

Referral Location and Patient Zip	Total Patients
60458	3
60459	18
60462	15
60463	3
60464	4
60465	8
60466	2
60467	6
60468	1
60469	2
60477	24
60478	3
60481	2
60482	2
60484	1
60487	18
60491	8
60501	1
60527	1
60532	2
60544	1
60560	1
60586	2
60609	2
60617	3
60619	1
60620	5
60621	5
60628	7
60629	12
60632	7
60636	1
60638	11
60642	1
60643	16
60649	1
60652	5
60655	11
60803	7
60804	1

Referral Location and Patient Zip	Total Patients
60805	7
60901	1
60914	1
60950	2
61360	1
CMIS	**130**
60031	1
60415	2
60418	9
60422	2
60423	4
60429	1
60430	1
60441	1
60443	1
60445	6
60448	5
60451	4
60453	25
60455	1
60456	2
60459	9
60462	7
60463	3
60464	3
60465	5
60466	2
60467	1
60477	12
60480	1
60482	1

Referral Location and Patient Zip	Total Patients
60487	2
60491	1
60586	1
60626	3
60628	2
60629	1
60632	1
60638	1
60655	5
60803	3
60805	1
Palos Hospital	**36**
60417	1
60423	4
60443	1
60452	2
60453	1
60455	1
60458	2
60459	1
60462	4
60463	4
60465	2
60477	3
60478	1
60487	5
60638	1
60655	2
60803	1
Grand Total	**551**

Daniel Troy, M.D.
Jose Perez-Sanz, M.D.
Kirsten Oliversen, M.D.
Paul Danielsky, M.D.
Jonathan Watson, M.D.
Dana Berns, D.P.M.

Advanced Orthopedic & Spine Care

6701 West 95th Street • Oak Lawn, IL 60453
16255 South Harlem Avenue • Tinley Park, IL 60477
Phone 708-599-5000 • Fax 708-599-0801
www.advancedorthospine.com

December 11, 2018

Courtney Avery
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nct Floor
Springfield, IL 62761

Dear Ms. Avery,

I am a physician specializing in Orthopedics. I support the proposal to establish the ambulatory surgical treatment center (ASTC) located at 6701 W. 95th Street, Oak Lawn, IL 60453, known as the Surgery Center of Illinois.

Over the past 12 months, I have referred one hundred and fifty-six (156) 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 one hundred and fifty-six (156) patients to the Surgery Center of Illinois 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.

Sincerely,

Paul Danielsky MD

Paul Danielsky, M.D.
6701 W. 95th Street,
Oak Lawn, IL 60453

Subscribed and Sworn to before me this

14 day of December 2018

Jean Stripeik
Notary Public

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

Referral Location and Patient Zip	Total Patients
Christ Hospital	**108**
46307	1
46310	2
46373	1
46383	4
46392	1
46394	1
46405	2
46407	1
46408	1
60016	1
60103	1
60409	1
60411	3
60415	2
60417	1
60418	1
60425	1
60426	3
60438	1
60439	2
60443	1
60445	1
60447	1
60453	7
60455	2
60459	4
60462	5
60465	2
60477	3
60482	1
60487	1
60617	5
60619	3
60620	6
60628	1
60629	9
60632	3
60633	3
60636	2
60638	3
60643	4
60652	6
60655	2
60803	2
Palos Hospital	**48**
60415	1
60439	1
60445	1
60448	1
60452	7
60453	5
60455	2
60457	1
60458	1
60462	6
60463	2
60464	2
60465	1
60467	1
60477	7
60482	2
60491	3
60525	1
60638	1
60803	2
Grand Total	156

Daniel Troy, M.D.
Jose Perez-Sanz, M.D.
Kirsten Oliversen, M.D.
Paul Danielsky, M.D.
Jonathan Watson, M.D.
Dana Berns, D.P.M.

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www.advancedorthospine.com

December 11, 2018

Courtney Avery
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nct Floor
Springfield, IL 62761

Dear Ms. Avery,

I am a physician specializing in Orthopedics. I support the proposal to establish the ambulatory surgical treatment center (ASTC) located at 6701 W. 95th Street, Oak Lawn, IL 60453, known as the Surgery Center of Illinois.

Over the past 12 months, I have referred one hundred and ninety (190) 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 one hundred and ninety (190) patients to the Surgery Center of Illinois 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.

Sincerely,

Jonathan Watson, M.D.
6701 W. 95th Street,
Oak Lawn, IL 60453

Subscribed and Sworn to before me this

13th day of December 2018

Jean Stripeik
Notary Public

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

Referral Location and Patient Zip	Total Patients
Christ Hospital	**145**
46307	1
46322	1
46324	1
46383	1
46408	1
53128	2
60411	1
60415	5
60417	3
60418	1
60423	2
60428	3
60429	2
60438	1
60439	1
60443	2
60445	5
60449	1
60451	1
60452	4
60453	18
60455	3
60457	2
60459	4
60463	2
60465	3
60466	2
60467	1
60472	1
60477	4
60478	1
60480	1
60482	3
60484	1
60487	6
60608	2
60613	1
60616	1
60617	1

Referral Location and Patient Zip	Total Patients
60619	1
60620	6
60621	1
60628	3
60629	5
60632	1
60633	2
60636	1
60638	3
60643	3
60649	1
60652	2
60655	8
60803	5
60805	4
60827	1
60950	2
Palos Hospital	**45**
46323	1
60415	1
60423	1
60445	1
60453	5
60457	1
60459	4
60462	3
60463	2
60464	1
60465	1
60467	4
60477	6
60482	1
60487	1
60517	1
60620	1
60629	1
60632	1
60651	2
60652	1
60653	1

Referral Location and Patient Zip	Total Patients
60655	3
60803	1
Grand Total	**190**

Daniel Troy, M.D.
Jose Perez-Sanz, M.D.
Kirsten Oliversen, M.D.
Paul Danielsky, M.D.
Jonathan Watson, M.D.
Dana Berns, D.P.M.

Advanced Orthopedic & Spine Care

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16255 South Harlem Avenue • Tinley Park, IL 60477
Phone 708-599-5000 • Fax 708-599-0801
www.advancedorthospine.com

December 11, 2018

Courtney Avery
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, 2nct Floor
Springfield, IL 62761

Dear Ms. Avery,

On behalf of Advanced Orthopedic & Spine Care, I am writing in support of the proposed application to establish an ambulatory surgical treatment center (ASTC) located at 6701 W. 95th Street, Oak Lawn, IL 60453, known as the Surgery Center of Illinois.

The physicians practicing at Advanced Orthopedic & Spine Care specialize in orthopedic and pain management surgery. Over the past 12 months, we have performed 389 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 389 patients to the Surgery Center of Illinois 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.

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.

Daniel Troy, M.D.
6701 W. 95th Street,
Oak Lawn, IL 60453

Subscribed and Sworn to before me this

12 day of December 2018

Notary Public

OFFICIAL SEAL
JEAN STRIPEIK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/09/21

Referral Location and Patient Zip	Total Patients
CMIS	**357**
46410	1
53108	2
60154	1
60402	1
60403	1
60406	2
60411	2
60415	11
60417	3
60418	5
60419	1
60423	11
60429	1
60430	5
60435	1
60441	2
60445	7
60448	12
60451	2
60452	8
60453	58
60455	11
60456	2
60457	5
60458	1
60459	9
60462	36
60463	9
60464	5
60465	7
60466	1
60467	12
60469	2
60471	1
60473	1
60476	1
60477	29
60478	1
60482	5
60487	13
60491	5
60544	3
60581	1
60586	3
60610	1
60620	3
60621	1
60628	3
60629	6
60638	7
60643	3
60652	1
60655	9
60803	9
60805	10
60827	3
65653	1
Oak Lawn Office	**1**
60453	1
Tinley Park Office	**31**
60015	1
60448	1
60452	2
60453	6
60457	1
60459	2
60462	1
60463	1
60465	1
60467	1
60477	2
60482	1
60487	2
60616	1
60637	2
60643	1
60655	2
60803	1
60805	2
Grand Total	**389**

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

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Appendix I 151

THE advisGROUP
YOUR SMART HEALTHCARE CONSULTANTS

December 17, 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 Surgery Center of Illinois, LLC. The applicant proposes to establish an Ambulatory Surgical Treatment Center ("ASTC") to be located at 6701 W. 95th Street, Oak Lawn, IL 60432

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
Vice President
The Advis Group