19-006 [ORIGINAL]

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

RECEIVED
FEB 13 2019
HEALTH FACILITIES & SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	Massac County Surgery Center, LLC		
Street Address:	1811 East 5th Street		
City and Zip Code:	Metropolis, IL 62960		
County: Massac	Health Service Area: 127	Health Planning Area: V	

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

Exact Legal Name:	Massac County Surgery Center, LLC
Street Address:	1811 East 5th Street
City and Zip Code:	Metropolis, IL 62960
Name of Registered Agent:	Greg Thompson
Registered Agent Street Address:	c/o Southern Orthopedic Associates 510 Lincoln Drive
Registered Agent City and Zip Code:	Herrin, IL 62948
Name of Chief Executive Officer:	Greg Thompson
CEO Street Address:	c/o Southern Orthopedic Associates 510 Lincoln Drive
CEO City and Zip Code:	Herrin, IL 62948
CEO Telephone Number:	918/997-6800

Type of Ownership of Applicants

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
X	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 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:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

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City and Zip Code:	Metropolis, IL 62960
County: Massac	Health Service Area: 127 Health Planning Area: V

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

Exact Legal Name:	OIWK Holdings, LLC
Street Address:	4787 Alben Barkley Drive
City and Zip Code:	Paducah, KY 42001
Name of Registered Agent:	Greg Thompson
Registered Agent Street Address:	c/o Southern Orthopedic Associates 510 Lincoln Drive
Registered Agent City and Zip Code:	Herrin, IL 62948
Name of Chief Executive Officer:	Greg Thompson
CEO Street Address:	c/o Southern Orthopedic Associates 510 Lincoln Drive
CEO City and Zip Code:	Herrin, IL 62948
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Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

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

Name:	none
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:	Greg Thompson
Title:	Member
Company Name:	OIWK Holdings, LLC
Address:	c/o Southern Orthopedic Associates 510 Lincoln Drive Herrin, IL 62948
Telephone Number:	618/997-6800
E-mail Address:	gthompson@orthopedicinstitute.com
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Massac County Surgery Center, LLC

Address of Site Owner: 1811 East 5th Street Metropolis, IL 62960

Street Address or Legal Description of the Site: 1811 East 5th Street Metropolis, IL 62960

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: Massac County Surgery Center, LLC

Address: 1811 East 5th Street Metropolis, IL 62960

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
X	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

X 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.

Massac County Surgery Center ("MASC") is an IDPH-licensed ambulatory surgical treatment center ("ASTC") approved to provide orthopedic and podiatric surgery services, consistent with a Certificate of Need ("CON") Permit awarded in 2013. Through this CON application, the applicants are seeking permission to add pain management as an approved service. The pain management specialists anticipated to refer patients to the ASTC currently perform a majority of their cases in Paducah, Kentucky, which is located approximately twelve miles from the ASTC.

OIWK Holdings, LLC ("OIWK"), an applicant to this CON Application for Permit, was established prior to the filing of the 2013 CON Application noted above, and has "control" of MCSC by virtue of its 51% ownership interest in MCSC. OIWK is owned by physician members (and the group administrator) of Southern Orthopedic Associates, S.C., which operates two divisions, one in Paducah, Kentucky, and one in Herrin, Illinois. The OIWK investors all practice out of the Paducah division.

This is a non-substantive project because it is not proposing the establishment of a new licensed health care facility or IDPH-designated category of service, the replacement of a licensed health care facility, or the discontinuation of a licensed health care facility or IDPH-designated category of service.

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			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$0	$0	$0
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$0	$0	$0

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

Note: The proposed project does not include any costs to be capitalized.

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 X No
Purchase Price: $_____
Fair Market Value: $_____

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

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

Estimated start-up costs and operating deficit cost is $ _____.

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

X None or not applicable ☐ Preliminary

☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): ___June 30, 2019_____

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
X 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:
X Cancer Registry
APORS—not applicable
X All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
All reports regarding outstanding permits –not applicable
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT 9, 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 _Massac County Surgery Center, LLC_* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Greg Thompson
PRINTED NAME

Executive Director
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29th day of January 2019

Signature of Notary

Seal

JULIANNE BOWLBY
Official Seal
Notary Public – State of Illinois
My Commission Expires Aug 22, 2021

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

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SIGNATURE	SIGNATURE
K. Brandon Strange, MD	
PRINTED NAME	PRINTED NAME
Board Member	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 4th day of February, 2019	Notarization: Subscribed and sworn to before me this _____ day of _____
Julianne Bowlby	
Signature of Notary	Signature of Notary
Seal	Seal

JULIANNE BOWLBY
Official Seal
Notary Public – State of Illinois
My Commission Expires Aug 22, 2021

*Insert the EXACT legal name of the applicant

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- 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);
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SIGNATURE	SIGNATURE
K. Brandan Strenge, MD	
PRINTED NAME	PRINTED NAME
Owner	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 4th day of February, 2019	Notarization: Subscribed and sworn to before me this _____ day of _____
Signature of Notary	Signature of Notary
Seal	Seal

JULIANNE BOWLBY
Official Seal
Notary Public - State of Illinois
My Commission Expires Aug 22, 2021

*Insert the EXACT legal name of the applicant

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SIGNATURE

Greg Thompson
PRINTED NAME

Managing Member
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 29th day of January, 2019

Julianne Bowlby
Signature of Notary

Seal

JULIANNE BOWLBY
Official Seal
Notary Public - State of Illinois
My Commission Expires Aug 22, 2021

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:

not applicable, no modernization

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:

not applicable, no 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.

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
X Orthopedic Surgery
☐ Otolaryngology
X Pain Management
☐ Physical Medicine and Rehabilitation
☐ Plastic Surgery
X 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

not applicable, project has no capitalized cost

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.

not applicable, project has no capitalized cost

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

not applicable, project has no capitalized cost

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

not applicable, project has no capitalized cost

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:

not applicable, no modernization

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	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	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

not applicable, non-substantive project

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	2016*	2017
Net Patient Revenue		**$454,331**	**$4,763,606**
Amount of Charity Care (charges)		$0	$0
Cost of Charity Care		$0	$0

*Partial year, the facility became operational in April, 2016.

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

File Number 0434415-4

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

MASSAC COUNTY SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 05, 2013, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* AUGUST *A.D.* 2018 .

Authentication #: 1822700960 verifiable until 08/15/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

File Number 0435580-6

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

OIWK HOLDINGS, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 23, 2013, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* AUGUST *A.D.* 2018 .

Authentication #: 1822700978 verifiable until 08/15/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

Illinois Health Facilities and
Services Review Board
Springfield, IL 62761

To Whom It May Concern:

I hereby certify that the site of the ambulatory surgical treatment center addressed in this Certificate of Need application is owned by Massac County Surgery Center, LLC.

Sincerely,

Greg Thompson
Manager

Notarized:

JULIANNE BOWLBY
Official Seal
Notary Public – State of Illinois
My Commission Expires Aug 22, 2021

ATTACHMENT 2

File Number 0434415-4

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

MASSAC COUNTY SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 05, 2013, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* AUGUST *A.D.* 2018 .

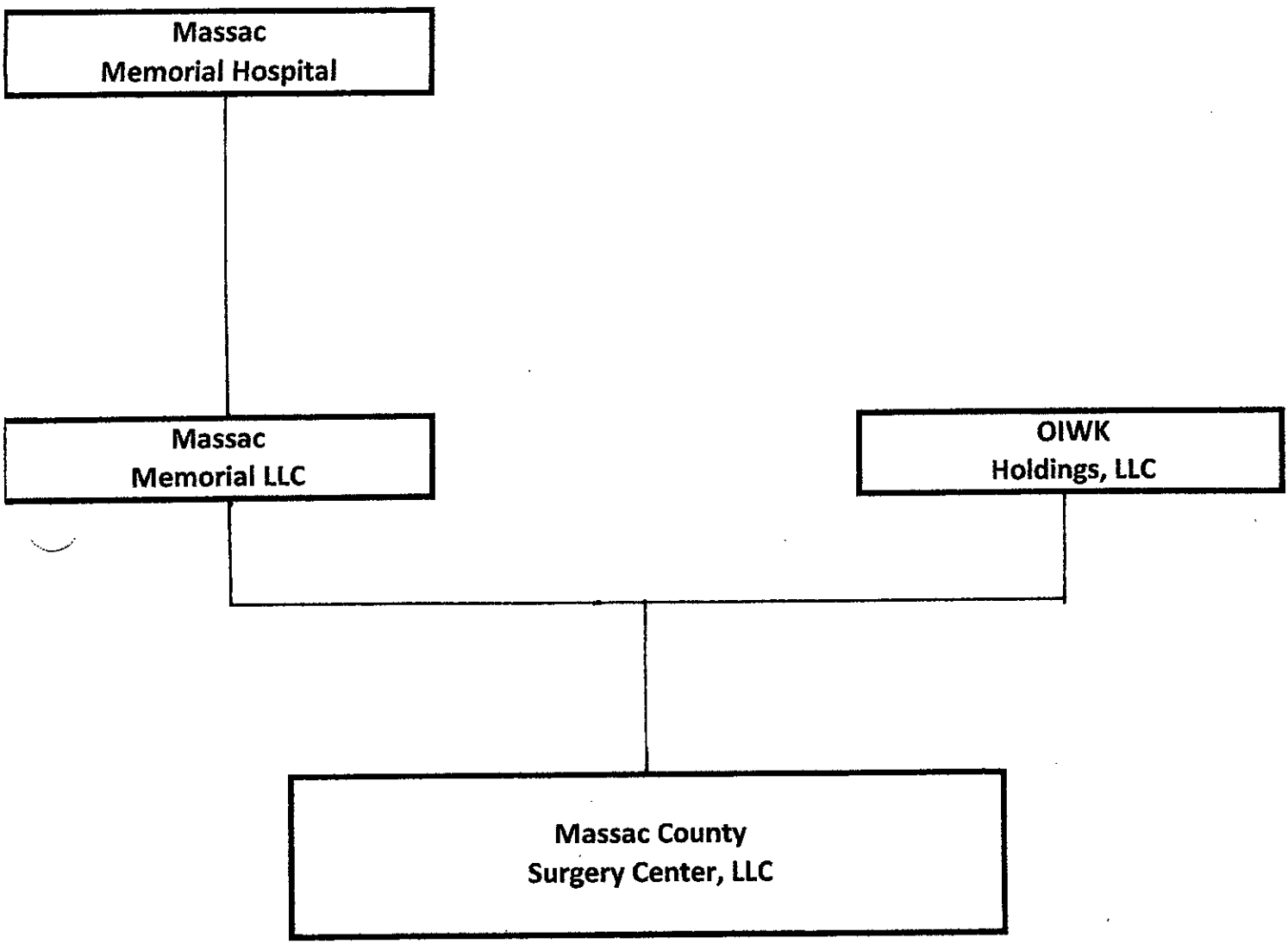
Authentication #: 1822700960 verifiable until 08/15/2019
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

ATTACHMENT 3

ORGANIZATIONAL CHART



ATTACHMENT 4

Ms. Courtney Avery
Illinois Health Facilities
And Services review Board
525 West Jefferson
Springfield, IL 62761

Dear Ms. Avery:

In accordance with Review Criterion 1110.230.b, Background of the Applicant, we are submitting this letter assuring the Illinois Health Facilities and Services Review Board that:

1. Massac County Surgery Center has not had any adverse actions against any facility owned and operated by the applicants identified in its 2019 Certificate of Need Application for Permit during the three (3) year period prior to the filing of this application, and
2. Massac County Surgery Center authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Sincerely,

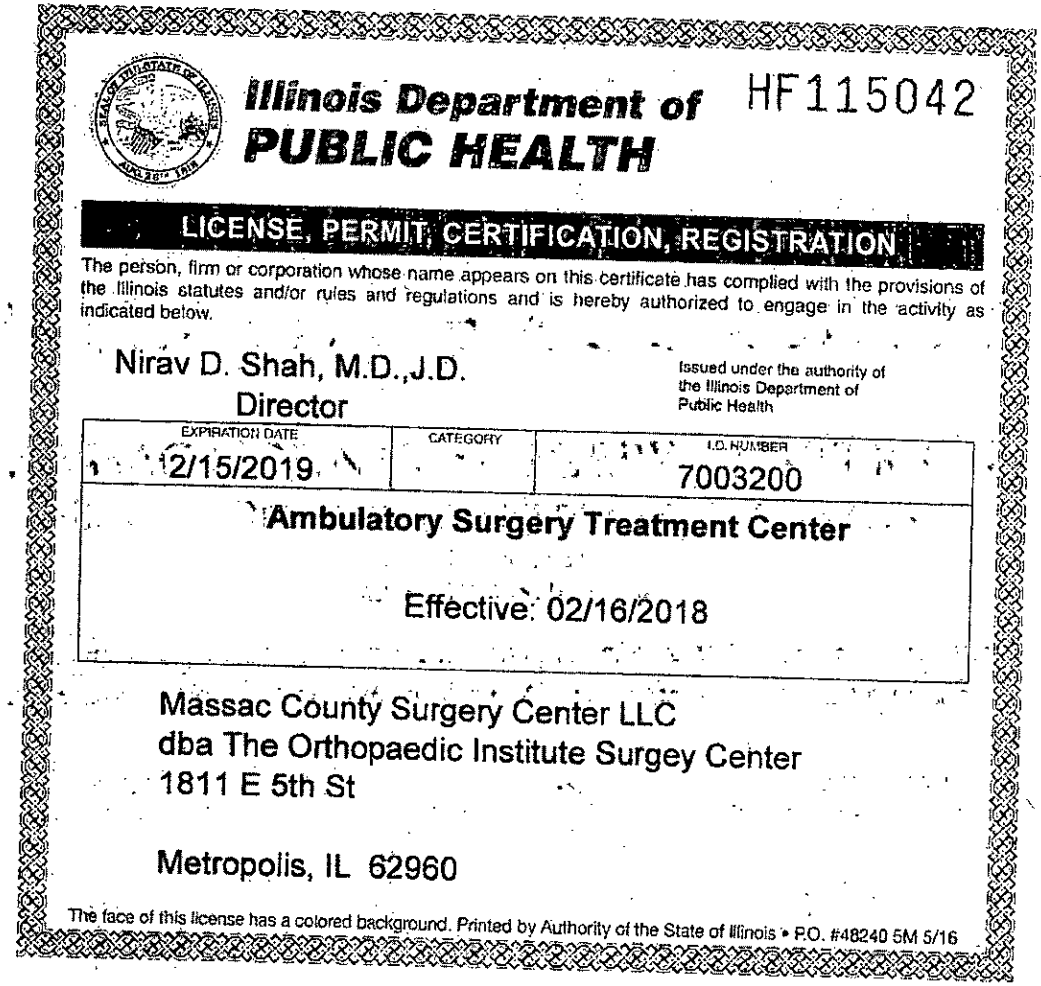
Greg Thompson
Manager

Date: January 24th, 2019

Notarized:

JULIANNE BOWLBY
Official Seal
Notary Public – State of Illinois
My Commission Expires Aug 22, 2021

ATTACHMENT 11



Illinois Department of PUBLIC HEALTH

HF115042

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Nirav D. Shah, M.D., J.D.
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	I.D. NUMBER
2/15/2019		7003200

Ambulatory Surgery Treatment Center

Effective: 02/16/2018

Massac County Surgery Center LLC
dba The Orthopaedic Institute Surgey Center
1811 E 5th St

Metropolis, IL 62960

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #48240 5M 5/16

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 2/15/2019

Lic Number 7003200

Date Printed 1/22/2018

Massac County Surgery Center LLC
dba The Orthopaedic Institute Surgey
1811 E 5th St
Metropolis, IL 62960

FEE RECEIPT NO.

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ATTACHMENT 11

UTILIZATION

Massac County Surgery Center ("MCSC") has three operating rooms, and in 2017 1,885 hours of utilization were recorded, with 1,510.25 hours being used for orthopedic cases and 374.75 hours being used for podiatric cases. No decreases in the volume of orthopedic or podiatric surgery performed in the ASTC are anticipated as a result of this project. Following the approval of this project, the utilization of the ASTC is anticipated to increase by 961 hours, by 2020 (following a brief "ramp-up" period), as a result of the 1,550 pain management cases projected to be referred to the ASTC. It is further anticipated, and based largely on the acceptance of the pain management procedures to be performed in the ASTC as a viable alternative to other treatment modalities, including the prolong use of opioids, that the number of referrals will continue to grow. As a result of that growth, utilization of the ASTC is anticipated to exceed 3,000 hours, annually, by 2021.

	Historical Utilization (HOURS)	PROJECTED UTILIZATION YEAR 1	PROJECTED UTILIZATION YEAR 2	STATE STANDARD	MET STANDARD?
ASTC	1,885	2,500	2,846	N/A	N/A

ATTACHMENT 15

ACCREDITATION
ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

grants this

CERTIFICATE OF ACCREDITATION

to

MASSAC COUNTY SURGERY CENTER LLC

D/B/A THE ORTHOPAEDIC INSTITUTE SURGERY CENTER

1811 E 5TH ST
METROPOLIS, IL 62960

In recognition of its commitment to high quality of care and substantial compliance with the Accreditation Association for Ambulatory Health Care standards for ambulatory health care organizations.

113387
Organization Identification Number

MEENA DESAI, MD
Chair of the Board

MAY 28, 2019
The Award of Accreditation expires on the above date

FRANK CHAPMAN, MBA
Past Chair of the Board

ASSOCIATION MEMBERS

ASCA Foundation • American Academy of Cosmetic Surgery • American Academy of Dental Group Practice • American Academy of Dermatology American Academy of Facial Plastic and Reconstructive Surgery • American Association of Oral and Maxillofacial Surgeons • American College of Gastroenterology American College Health Association • American College of Mohs Surgery • American Congress of Obstetricians & Gynecologists • American Dental Association American Gastroenterological Association • American Society of Anesthesiologists • American Society for Dermatologic Surgery Association American Society for Gastrointestinal Endoscopy • Association of periOperative Registered Nurses • Society for Ambulatory Anesthesia

5250 OLD ORCHARD ROAD, SUITE 200 • SKOKIE, IL 60077
PHONE: 847/853.6060 • E-MAIL: INFO@AAAHC.ORG • WEB SITE: WWW.AAAHC.ORG

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ATTACHMENT 11

PURPOSE

The proposed project is limited to the addition of pain management as an approved service to be provided at Massac County Surgery Center ("MCSC"). As such, the proposed project, which will bring approaches to pain management to the area, including non-opioid based therapies that are not readily available in a low-cost ASTC setting, which will improve the health care and well-being of area residents.

There are currently no other ASTCs in the HFSRB-designated geographic service area.

MCSC defines its market area as a fifty-mile radius from the ASTC, extending into far western Kentucky and far southeastern Missouri.

The goal of this project is to initiate pain management services at MCSC by mid-2019.

ALTERNATIVES

The scope of this application is limited to the addition of pain management as a service to be provided by an existing ASTC, and as such, with the exception of not seeking approval to add the service, there are no alternatives available to the applicant.

ATTACHMENT 13

SERVICE TO GEOGRPAHIC SERVICE AREA RESIDENTS

Consistent with Section 1100.510, the geographic service area ("GSA") for Massac County Surgery Center ("MCSC") extends 21 miles from its Metropolis site. The following twenty-six ZIP Code areas are located in the GSA:

62960	Metropolis, IL	62953	Joppa, IL
62943	Grantsburg, IL	62938	Golconda, IL
62910	Brookport, IL	42086	West Paducah, KY
62908	Belknap, IL	42002	Paducah, KY
62956	Karnak, IL	42001	Paducah, KY
62941	Grand Chain, IL	42022	Bandana, KY
62985	Simpson, IL	42053	Kevil, KY
62995	Vienna, IL	42003	Paducah, KY
42056	La Center, KY	42081	Smithland, KY
62923	Cypress, IL	42047	Hampton, KY
42058	Ledbetter, KY	62909	Boles, IL
42060	Lovelaceville, KY	42028	Burna, KY
62928	Eddyville, IL	62973	Perks, IL

Source: SearchBug

Historically, the majority of patients referred to MCSC reside in the GSA, which extends into far western Kentucky, located across the Ohio River from Massac County. As noted above, twelve of the GSA's twenty-six ZIP Code areas are located in western Kentucky; and as discussed in the Certificate of Need application addressing the establishment of MCSC, many of the physicians referring patients to MCSC have offices in Paducah, Kentucky. Paducah is located approximately twelve miles (driving distance) from MCSC.

During 2017, 1,262 patients were treated at the ASTC, with 654 of those patients residing in one of the ZIP Code areas identified above as being included in the GSA. While the primary

purpose of the ASTC is to serve residents of the GSA, and while a majority of the historical patient volume resides in the GSA, because of the unique circumstance of the primary referring physicians' offices being located in Kentucky, it is not surprising that a significant portion of the physicians' practice population resides to the east of Paducah, and outside of the HFSRB-designated GSA. That said, the applicants do not anticipate a significant change to the ASTC's patient origin as a result of this project, and anticipate that over 50% of the ASTC's patients will continue to be residents of the GSA.

Below is a 2017 historical patient origin analysis for MCSC.

ZIP Code	Community	Patients
42001	Paducah, KY	191
42003	Paducah, KY	181
62960	Metropolis, IL	99
42053	Kevil, Ky	44
42086	W. Paducah, KY	38
42058	Ledbetter, KY	16
62938	Golconda, IL	14
62910	Brookport, IL	12
42056	La Center, KY	11
42081	Smithland, Ky	10
62995	Vienna, IL	7
62953	Joppa, IL	6
62985	Simpson, IL	6
62908	Belknap, IL	5
62943	Grantsburg, IL	5
42002	Paducah, KY	4
62941	Grand Chain, IL	4
62956	Karnak, IL	1
	Other, non-GSA	608
		1,262

SERVICE DEMAND

The proposed project is limited to the addition of a pain management to the services approved to be provided at an established ASTC, without the addition of operating or procedure rooms. As noted elsewhere in this application, the ASTC has the capacity to accommodate the specialty/caseload addressed in this ATTACHMENT.

Referral letters from two pain management specialists, Drs. J. T. Ruxner and David Lindenberg , are provided in this ATTACHMENT. Those two physicians, together, documented 3,398 pain management procedures performed in 2017. The majority of those procedures were performed in The Orthopedic Institute's Paducah, Kentucky office, which is located approximately twelve miles from the ASTC. A portion of the procedures performed by these physicians are appropriate for an ASTC setting, with that determination made based on such factors as co-morbidity, safety, and patient age. The two surgeons, per the attached letters, together anticipate referring approximately 1,550 patients to Massac County Surgery Center during the second year following approval of this project.

Name (print): J. T. Ruxner, DO

Specialty: Pain Management

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of Massac County Surgery Center ("MCSC"), and its desire to add pain management as a specialty.

During 2016 and 2017 I performed outpatient procedures on approximately the following numbers of patients in the hospitals or licensed ASTCs identified below.

	2016	2017
Lourdes ASC (KY)	____ patients	8 patients
KY Office	2715 patients	3193 patients
_____	____ patients	____ patients

I estimate that I will refer 1400 patients to MCSC during its second year following the receipt of the requested Certificate of Need Permit.

Attached is a patient origin analysis of my 2016 and 2017 outpatients.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

J. T. Ruxner

Notarized: Hattm ID#583214
Commission Expires
7/17/21

ZIP Code	Community	State	% Patients
42001	Paducah	KY	15.3%
42003	Paducah	KY	13.6%
62960	Metropolis	IL	8.1%
42025	Benton	KY	7.6%
42066	Mayfield	KY	4.9%
42053	Kevil	KY	3.8%
42064	Marion	KY	3.3%
42029	Calvert City	KY	3.0%
42086	W. Paducah	KY	3.0%
42445	Princeton	KY	2.1%
42071	Murray	KY	2.0%
42038	Eddyville	KY	1.8%
42044	Gilbertsville	KY	1.6%
42087	Wickliffe	KY	1.4%
42055	Kuttawa	KY	1.3%
42058	Ledbetter	KY	1.3%
42082	Symsonia	KY	1.3%
42078	Salem	KY	1.0%
62910	Brookport	IL	1.0%
62938	Golconda	IL	1.0%
42051	Hickory	KY	0.9%
42056	La Center	KY	0.8%
42081	Smithland	KY	0.8%
62959	Marion	IL	0.8%
	Misc. <10	KY	11.6%
	Misc. <10	IL	6.7%
			100.0%

ATTACHMENT 25c4

Name (print): DAVID LINDENBERG, DO

Specialty: PAIN MGT.

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of Massac County Surgery Center ("MCSC"), and its desire to add pain management as a specialty.

During 2016 and 2017 I performed outpatient procedures on approximately the following numbers of patients in the hospitals or licensed ASTCs identified below.

	2016	2017
KY OFFICE	____ patients	205 patients
_____	____ patients	____ patients
_____	____ patients	____ patients

I estimate that I will refer 150 patients to MCSC during its second year following the receipt of the requested Certificate of Need Permit.

Attached is a patient origin analysis of my 2016 and 2017 outpatients.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

Notarized:

ID# 583214

Commission Expires
7/17/21

3-26-18

ATTACHMENT 25c4

ZIP Code	Community	State	% Patients
42001	Paducah	KY	15.3%
42003	Paducah	KY	13.6%
62960	Metropolis	IL	8.1%
42025	Benton	KY	7.6%
42066	Mayfield	KY	4.9%
42053	Kevil	KY	3.8%
42064	Marion	KY	3.3%
42029	Calvert City	KY	3.0%
42086	W. Paducah	KY	3.0%
42445	Princeton	KY	2.1%
42071	Murray	KY	2.0%
42038	Eddyville	KY	1.8%
42044	Gilbertsville	KY	1.6%
42087	Wickliffe	KY	1.4%
42055	Kuttawa	KY	1.3%
42058	Ledbetter	KY	1.3%
42082	Symsonia	KY	1.3%
42078	Salem	KY	1.0%
62910	Brookport	IL	1.0%
62938	Golconda	IL	1.0%
42051	Hickory	KY	0.9%
42056	La Center	KY	0.8%
42081	Smithland	KY	0.8%
62959	Marion	IL	0.8%
	Misc. <10	KY	11.6%
	Misc. <10	IL	6.7%
			100.0%

ATTACHMENT 25c4

THE ORTHOPAEDIC INSTITUTE
SOUTHERN ILLINOIS
WESTERN KENTUCKY

January 29, 2019

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of Southern Illinois Orthopedic Center ("SIOC"), and its desire to add neurosurgery, podiatry, and pain management as approved specialties.

Southern Orthopedic Associates, SC ("SOA") Illinois Division is a 12-physician practice with an office in Herrin, Illinois, and serving southern Illinois, including Herrin and Carbondale. Effective February 1, 2019 the practice expanded to offer pain management services provided by Dr. Tennyson Lee, who was recently hired.

SOA anticipated that virtually all of Dr. Lee's non-office procedures will be performed at SIOC, and that he will be performing approximately 200 procedures annually at SIOC within two years.

Attached is a patient origin analysis of SOA's 2016 and 2017 outpatients, and it is anticipated that Dr. Lee's individual patient origin will mirror that of the group.

The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

CEO 1-31-19
Greg Thompson, CEO

Notarized:

JULIANNE BOWLBY
Official Seal
Notary Public – State of Illinois
My Commission Expires Aug 22, 2021

TREATMENT ROOM NEED ASSESSMENT

Massac County Surgery Center has three operating rooms, and the proposed project does not involve the addition of any operating rooms or treatment rooms. 1,885 hours of operating room time were used during 2017. Based on the 2017 State-wide average of 0.62 hours per pain management case performed in an ASTC, and the 1,550 pain management cases documented in ATTACHMENT 27c4, 961 incremental hours of OR usage are projected. Together, and as a result of historical utilization plus the projected pain management referrals, 2,846 hours of OR utilization are projected. Based on the HFSRB's target of 1,500 annual hours per OR, sufficient OR capacity exists to accommodate the anticipated pain management cases.

UNNECESSARY DUPLICATION/MAL-DISTRIBUTION

The proposed project will not result in an unnecessary duplication or a mal-distribution of services.

A mal-distribution or surplus, per HFSRB definition, exists when the ratio of operating rooms and procedure rooms per 1,000 population in the GSA exceeds that of the State's ratio by 1.5 times. The proposed project does not add operating rooms or procedure rooms.

Per the HFSRB's 2017 *Facility Profiles*, there are seven operating and procedure rooms located in hospitals and ASTCs within the GSA, which has a population of 98,695 (SearchBug), resulting in a ratio of one OR/procedure room per 14,099 residents. The ratio for the State of Illinois is one OR/procedure room per 4,521 residents. Therefore, because the GSA ratio does not exceed the State ratio by 1.5 times, a mal-distribution does not and will not exist. Below is a listing of the hospitals and ASTCs referenced above.

ASTCs
    Massac County Surgery Center
Hospitals
    Massac Memorial Hospital

As is the case with virtually all ASTC projects, the applicant is unable to document with certainty that within 24 months after project completion, the proposed project will neither lower the utilization rate of other area providers below the target utilization standard or lower the utilization rate of facilities failing to meet the utilization standard. However, the vast majority of cases to be performed at Massac County Surgery Center, as documented in the physician referral letters provided in ATTACHMENT 25c4, are currently being performed in an office

setting, and as such, the project's impact on the utilization of hospitals and ASTCs will be negligible.

STAFFING

Missouri Ambulatory Surgery Center ("MASC") operates consistent with all staffing rules, licensure requirements and Joint Commission standards, and has not had difficulty in the recruitment of qualified staff. Due to the nature of the proposed project, minimal incremental staffing, if any, will need to be recruited to support the provision of pain management services. If the need for additional staff arises, word-of-mouth and newspaper advertisements in southern Illinois will be used as the primary recruitment tools.

Attached is the CV of MASC's Medical Director, Dr. Brian Kern.

STAFFING

Massac County Surgery Center ("MCSC") operates consistent with all staffing related licensure requirements and Joint Commission standards, and has not had difficulty in the recruitment of qualified staff. Due to the nature of the proposed project, minimal incremental staffing, if any, will need to be recruited to support the provision of pain management services. If the need for additional staff arises, word-of-mouth and newspaper advertisements in southern Illinois will be used as the primary recruitment tools

Attached is the CV of MASC's Medical Director, Dr. Brian Kern.

ATTACHMENT 27c8

800 S PARK AVE • SPRINGFIELD, IL 62704
PHONE (217)793-1880 • E-MAIL bkern@siumed.edu

BRIAN KERN, M.D.

OBJECTIVE

To practice sports medicine, general orthopaedics, arthroscopy and reconstructive surgery as well as provide on-field coverage for high school and college athletes.

EDUCATION

8/2008-7/2009
Southern California Orthopaedic Institute (SCOI) Fellowship in Sports Medicine, Arthroscopy, and Reconstructive Surgery (Van Nuys, Ca)

- Passed Part I examination of the American Board of Orthopaedic Surgery -- 90th percentile

7/2003-6/2008
Southern Illinois University School of Medicine and Affiliated Hospitals Orthopaedic Surgery Residency Program (Springfield, IL)

- Selected to attend The AOA Resident Leadership Forum
- OITE 2006 – 189 (92nd percentile)
- OITE 2005 – 186 (82nd percentile)
- OITE 2004 – 178 (95th percentile)
- OITE 2003 – 146 (89th percentile)
- USMLE Step 3 – 213

8/1999-5/2003
Southern Illinois University School of Medicine (Springfield, IL)

- Honors Neurology
- Illinois General Assembly Scholarship Recipient
- Surgery Interest Group
- USMLE Step 2 – 237
- USMLE Step 1 – 232

8/1998-5/1999
Saint Louis University Graduate Program (Saint Louis, MO)
Participated in a PhD program in Biomedical Sciences as part of my preparation for medical school.

8/1994 - 12/1997
Saint Louis University (Saint Louis, MO)

- Bachelors of Arts in Biology
- Recipient of scholarship to pitch Division I Baseball
- Finished senior season ranked in top ten in nation for strike outs per 9 innings
- Conference USA Pitcher of the Week

ATTACHMENT 27c8

8/1992 – 5/1994
Rend Lake Community College (Ina, IL)

- Associates of Science Degree
- Phi Beta Kappa Honor Society
- Junior College Academic All-American for Baseball/Basketball
- Male Athlete of the Year
- All-Conference Baseball

EMPLOYMENT

1/2000 – 1/2008 (planned date of honorable discharge)
Illinois Army National Guard

- Captain
- Top 10% Officer Basic Course
- Illinois Military Attendance Ribbon
- Army Achievement Medal
- Army Service Ribbon

5/1999 – 8/1999
Rend Lake Golf Course (Ina, IL)
Grounds crew/ maintenance worker

6/1996 – 3/1998
Oakland Athletics – Minor League Baseball Pitcher

- Dave Stewart Community Service Player of the Year 1996

1986-1994
Family owned cattle/ grain farm

RESEARCH

"Total Knee Arthroplasty with Cemented NexGen Legacy Posterior Stabilized (LPS) versus the NexGen Cruciate Retaining (CR) Implants: A Prospective Evaluation"
Brian Kern, M.D., Rita Trammell, Ph.D., and D. Gordon Allan, M.D.
Presented as a poster at the 4th Annual SIU School of Medicine Research Symposium 2005

"Effect of Cement Viscosity on Cement Mantle in the Total Knee Arthroplasty"
Brian Kern, M.D., Manish Paliwal, Ph.D., D. Gordon Allan, M.D.
Presented as a poster at the 5th Annual SIU School of Medicine Research Symposium 2007

HOBBIES AND INTERESTS

- Spending time with family and traveling
- Outdoor activities, skiing and boating
- Baseball, basketball, football and golf

ATTACHMENT 27c8

- Racquetball and bowling
- Running and weight lifting

REFERENCES

- **D. Gordon Allan, M.D., F.R.C.S., F.A.C.S.**
  Associate Professor and Chair, Division of Orthopaedics and Rehabilitation
  Department of Surgery, Southern Illinois University School of Medicine
  P. O. Box 19679
  Springfield, IL 62704-9679
  Phone: 217-545-8865
  E-mail: gallan@siumed.edu

- **Per Freitag, PhD, M.D., F.A.C.S.**
  Associate Professor, Division of Orthopaedics and Rehabilitation
  Department of Surgery, Southern Illinois University School of Medicine
  P.O. Box 19679
  Springfield, IL 62794-9679
  Phone: 217-545-8865
  E-mail: pfreitag@siumed.edu

- **Osarentin Idusuyi, M.D.**
  Associate Professor, Division of Orthopaedics and Rehabilitation
  Department of Surgery, Southern Illinois University School of Medicine
  P.O. Box 19679
  Springfield, IL 62794-9679
  Phone: 217-545-8865
  E-mail: oidusuyi@siumed.edu

- **Diane Hillard-Sembell, M.D.**
  Springfield Clinic Orthopaedics
  800 North 1st Street
  Springfield, IL 62702
  Phone: 217-528-7541

- **Rodney J. Herrin, M.D.**
  Orthopaedic Center of Illinois
  Clinical Instructor, Division of Orthopaedics and Rehabilitation, Southern Illinois University School of Medicine
  3136 Old Jacksonville Road, Suite 150
  Springfield, IL 62704
  Phone: (877)862-0624

ATTACHMENT 27c8

Illinois Health Facilities and
Services Review Board
Springfield, IL

RE: Massac County Surgery Center
Addition of Pain Management

To Whom It May Concern:

Through this letter, Massac County Surgery Center ("MCSC") provides the following assurance:

Consistent with Review Criterion 1110.235.c.9, MCSC will maintain the charge structure contained in ATTACHMENT 25c9 to its 2019 Certificate of Need Application for Permit ("CON Application")for a minimum of two years following the Completion of the aforementioned project, unless a Certificate f Need Permit is secured pursuant to 77 Ill. Adm. Code 1130.310(a) to increase the charge structure provided in the 2019 CON Application .

Sincerely,

Greg Thompson
Manager

Notarized:

JULIANNE BOWLBY
Official Seal
Notary Public - State of Illinois
My Commission Expires Aug 22, 2021

ATTACHMENT 27c9

Name	Quick code	CPT® Code	Procedure type	Type of service	Standard Fee
ADJACENT TISSUE TRANSFER/REARGMT TRUNK 10 SQCM/<	14000	14000			$ 3,752.00
ADJT TIS TRNS/REARGMT F/C/C/M/N/A/G/H/F 10SQCM/<	14040	14040			$ 3,752.00
ADJUSTMENT/REVJ XTRNL FIXATION SYSTEM REQ ANES	20693	20693			$ 6,937.00
ALLOGRAFT FOR SPINE SURGERY ONLY MORSELIZED	20930	20930	Orthopedic	Orthopedic	$ 17,200.00
ALLOGRAFT FOR SPINE SURGERY ONLY STRUCTURAL	20931	20931	Orthopedic	Orthopedic	$ 17,200.00
AMP F/TH 1/2 JT/PHALANX W/NEURECT W/DIR CLSR	26951	26951			$ 3,275.00
AMPUTATION FOOT TRANSMETARSAL	28805	28805			$ 11,169.00
AMPUTATION METATARSAL W/TOE SINGLE	28810	28810			$ 4,648.00
AMPUTATION TOE INTERPHALANGEAL JOINT	28825	28825			$ 4,648.00
AMPUTATION TOE METATARSOPHALANGEAL JOINT	28820	28820			$ 4,648.00
ANTERIOR INSTRUMENTATION 2-3 VERTEBRAL SEGMENTS	22845	22845	Orthopedic	Orthopedic	$ 4,900.00
ANTERIOR INSTRUMENTATION 4-7 VERTEBRAL SEGMENTS	22846	22846	Orthopedic	Orthopedic	$ 4,900.00
APP SKN SUB GRFT T/A/L AREA/100SQ CM /<1ST 25	15271	15271			$ 3,752.00
Application Biomechanical Device (PEEK Cage)	22851	22851			$ 12,398.62
APPLICATION LONG LEG CAST THIGH-TOE	29345	29345			$ 391.00
APPLICATION MULTIPLANE EXTERNAL FIXATION SYSTEM	20692	20692			$ 15,142.00
APPLICATION SHORT LEG CAST BELOW KNEE-TOE	29405	29405			$ 660.00
APPLICATION UNIPLANE EXTERNAL FIXATION SYSTEM	20690	20690			$ 6,937.00
ARTHDSIS POST/POSTERLATRL/POSTINTRBDYADL SPC/SEG	22634	22634	Orthopedic	Orthopedic	$ 24,800.00
ARTHDSIS POST/POSTEROLATRL/POSTINTERBODY LUMBAR	22633	22633	Orthopedic	Orthopedic	$ 24,800.00
ARTHRD ANT INTERBODY DECOMPRESS CERVICAL BELW C2	22551	22551	Orthopedic	Orthopedic	$ 35,044.00
ARTHRD ANT INTERDY CERVCL BELW C2 EA ADDL NTRSPC	22552	22552	Orthopedic	Orthopedic	$ 12,160.00
ARTHRD ANT MIN DISCECT INTERBODY CERV BELOW C2	22554	22554			$ 38,160.00
ARTHRD MIDTARSL/TARSOMETATARSAL MULT/TRANSVRS	28730	28730			$ 19,096.00
ARTHRD W/XTNSR HALLUCIS LONGUS TR 1ST METAR NCK	28760	28760			$ 19,096.00
ARTHROCENTESIS ASPIR&/INJ INTERM JT/BURS W/O US	20605	20605			$ 937.00
ARTHROCENTESIS ASPIR&/INJ MAJOR JT/BURSA W/O US	20610	20610			$ 937.00
ARTHROCENTESIS ASPIR&/INJ SMALL JT/BURSA W/O US	20600	20600			$ 937.00
ARTHRODESIS ANTERIOR INTERBODY EA ADDL NTRSPC	22585	22585			$ 16,974.00
ARTHRODESIS ANTERIOR INTERBODY LUMBAR	22558	22558			$ 20,353.00
ARTHRODESIS GREAT TOE INTERPHALANGEAL JOINT	28755	28755			$ 8,487.00
ARTHRODESIS GREAT TOE METATARSOPHALANGEAL JOINT	28750	28750			$ 19,096.00
ARTHRODESIS INTERPHALANGEAL JT W/WO INT FIXJ	26860	26860			$ 5,893.00

ARTHRODESIS MIDTARSOMETATARSAL SINGLE JOINT	28740	28740			$	19,096.00
ARTHRODESIS POSTERIOR INTERBODY LUMBAR	22630	22630			$	14,679.00
ARTHRODESIS POSTERIOR/POSTEROLATERAL EA ADDL	22614	22614			$	14,679.00
ARTHRODESIS POSTERIOR/POSTEROLATERAL LUMBAR	22612	22612			$	38,160.00
ARTHRODESIS PST/PSTLAT CERVICAL BELW C2 SGM	22600	22600	Orthopedic	Orthopedic	$	25,900.00
ARTHRODESIS SACROILIAC JOINT PERCUTANEOUS	27279	27279			$	61,670.00
ARTHRODESIS SACROILIAC JOINT W/OBTAINING GRAFT	27280	27280	Orthopedic	Orthopedic	$	13,400.00
ARTHRODESIS SUBTALAR	28725	28725			$	19,096.00
ARTHRODESIS TRIPLE	28715	28715			$	38,160.00
ARTHRODESIS WRIST LIMITED W/AUTOGRAFT	25825	25825			$	16,880.00
ARTHROPLASTY GLENOHUMERAL JOINT TOTAL SHOULDER	23472	23472			$	33,949.00
ARTHROPLASTY GLENOHUMRL JT HEMIARTHROPLASTY	23470	23470			$	33,949.00
ARTHROPLASTY PATELLA W/O PROSTHESIS	27437	27437			$	8,969.00
ARTHROPLASTY PATELLA W/PROSTHESIS	27438	27438			$	38,160.00
ARTHROPLASTY RADIAL HEAD	24365	24365			$	34,696.00
ARTHROPLASTY RADIAL HEAD W/IMPLANT	24366	24366			$	38,160.00
ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT EXTENSIVE	29898	29898			$	5,736.00
ARTHROSCOPY ANKLE SURGICAL DEBRIDEMENT LIMITED	29897	29897			$	5,736.00
ARTHROSCOPY ANKLE SURGICAL SYNOVECTOMY PARTIAL	29895	29895			$	7,108.00
ARTHROSCOPY ANKLE SURGICAL W/ANKLE ARTHRODESIS	29899	29899			$	11,585.00
ARTHROSCOPY ANKLE W/REMOVAL LOOSE/FOREIGN BODY	29894	29894			$	5,736.00
ARTHROSCOPY ELBOW SURGICAL SYNOVECTOMY PARTIAL	29835	29835			$	5,989.00
ARTHROSCOPY ELBOW SURGICAL W/REMOVAL LOOSE/FB	29834	29834			$	5,744.00
ARTHROSCOPY HIP SURGICAL W/REMOVAL LOOSE/FB	29861	29861			$	11,585.00
ARTHROSCOPY HIP SURGICAL W/SYNOVECTOMY	29863	29863			$	11,585.00
ARTHROSCOPY HIP W/FEMOROPLASTY	29914	29914			$	11,585.00
ARTHROSCOPY KNEE DIAGNOSTIC W/WO SYNOVIAL BX SPX	29870	29870			$	5,736.00
ARTHROSCOPY KNEE LATERAL RELEASE	29873	29873			$	5,736.00
ARTHROSCOPY KNEE REMOVAL LOOSE/FOREIGN BODY	29874	29874			$	5,736.00
ARTHROSCOPY KNEE SYNOVECTOMY 2/>COMPARTMENTS	29876	29876			$	5,736.00
ARTHROSCOPY KNEE SYNOVECTOMY LIMITED SPX	29875	29875			$	5,736.00
ARTHROSCOPY KNEE W/LYSIS ADHESIONS W/WO MANJ SPX	29884	29884			$	5,736.00
ARTHROSCOPY KNEE W/MENISCUS RPR MEDIAL&LATERAL	29883	29883	Orthopedic	Orthopedic	$	5,817.00
ARTHROSCOPY KNEE W/MENISCUS RPR MEDIAL/LATERAL	29882	29882			$	5,736.00

ARTHROSCOPY SHOULDER AHESIOLYSIS W/WO MANIPJ	29825	29825			$	11,585.00
ARTHROSCOPY SHOULDER BICEPS TENODESIS	29828	29828			$	11,585.00
ARTHROSCOPY SHOULDER DISTAL CLAVICULECTOMY	29824	29824			$	11,585.00
ARTHROSCOPY SHOULDER DX W/WO SYNOVIAL BIOPSY SPX	29805	29805			$	5,817.00
ARTHROSCOPY SHOULDER ROTATOR CUFF REPAIR	29827	29827			$	11,585.00
ARTHROSCOPY SHOULDER SURG DEBRIDEMENT EXTENSIVE	29823	29823			$	11,585.00
ARTHROSCOPY SHOULDER SURG DEBRIDEMENT LIMITED	29822	29822			$	5,736.00
ARTHROSCOPY SHOULDER SURG SYNOVECTOMY COMPLETE	29821	29821	Orthopedic	Orthopedic	$	5,736.00
ARTHROSCOPY SHOULDER SURG SYNOVECTOMY PARTIAL	29820	29820	Orthopedic	Orthopedic	$	5,736.00
ARTHROSCOPY SHOULDER SURGICAL CAPSULORRHAPHY	29806	29806			$	11,585.00
ARTHROSCOPY SHOULDER SURGICAL REMOVAL LOOSE/FB	29819	29819			$	11,585.00
ARTHROSCOPY SHOULDER SURGICAL REPAIR SLAP LESION	29807	29807			$	11,585.00
ARTHROSCOPY SHOULDER W/CORACOACRM LIGMNT RELEASE	29826	29826			$	11,585.00
ARTHROSCOPY WRIST SURGICAL SYNOVECTOMY PARTIAL	29844	29844			$	5,744.00
ARTHROTOMY ANKLE W/EXPL DRAINAGE/REMOVAL FB	27610	27610			$	6,937.00
ARTHROTOMY BIOPSY CARP/MTCRPL JOINT EACH	26100	26100			$	5,817.00
ARTHROTOMY BIOPSY INTERPHALANGEAL JOINT EACH	26110	26110			$	3,320.00
ARTHROTOMY BIOPSY MTCARPHLNGL JOINT EACH	26105	26105			$	5,817.00
ARTHROTOMY W/SYNOVECTOMY KNEE ANTERIOR/POSTERIOR	27334	27334			$	6,937.00
ARTHRP ACETBLR/PROX FEM PROSTC AGRFT/ALGRFT	27130	27130			$	50,923.00
ARTHRP INTERPOS INTERCARPAL/METACARPAL JOINTS	25447	25447			$	8,969.00
ARTHRP KNE CONDYLE&PLATU MEDIAL&LAT COMPARTMENTS	27447	27447			$	44,558.00
ARTHRP KNEE CONDYLE&PLATEAU MEDIAL/LAT CMPRT	27446	27446			$	40,314.00
ARTHRS AIDED ANT CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ	29888	29888			$	16,856.00
ARTHRS ANKLE EXC OSTCHNDRL DFCT W/DRLG DFCT	29891	29891			$	11,585.00
ARTHRS HIP DEBRIDEMENT/SHAVING ARTICULAR CRTLG	29862	29862			$	11,585.00
ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG	29881	29881			$	5,736.00
ARTHRS KNEE ABRASION ARTHRP/MLT DRLG/MICROFX	29879	29879			$	5,736.00
ARTHRS KNEE DEBRIDEMENT/SHAVING ARTCLR CRTLG	29877	29877			$	5,736.00
ARTHRS KNEE DRILL OSTEOCHONDRITIS DISSECANS GRFG	29885	29885			$	11,585.00
ARTHRS KNEE DRILLING OSTEOCHOND DISSECANS LESION	29886	29886			$	5,817.00
ARTHRS KNEE DRLG OSTEOCHOND DISSECANS INT FIXJ	29887	29887			$	13,025.00
ARTHRS KNEE W/MENISCECTOMY MED&LAT W/SHAVING	29880	29880			$	5,736.00
ARTHRS WRST EXC&/RPR TRIANG FIBROCART&/JOINT	29846	29846			$	5,740.00

ARTHRT ANKLE W/EXPL W/WO BX W/WO RMVL LOOSE/FB	27620	27620			$	6,937.00
ARTHRT ELBOW W/EXPLORATION DRAINAGE/REMOVAL FB	24000	24000			$	6,937.00
ARTHRT ELBOW W/JNT EXPL W/WOBX W/WORMVL LOOSE/FB	24101	24101			$	6,937.00
ARTHRT EXPL DRG/RMVL LOOSE/FB IPHAL JT EA	26080	26080			$	3,275.00
ARTHRT EXPL DRG/RMVL LOOSE/FB MTCARPHLNGL JT EA	26075	26075			$	5,817.00
ARTHRT KNE W/EXPL DRG/RMVL FB	27310	27310			$	6,937.00
ARTHRT KNE W/JT EXPL BX/RMVL LOOSE/FB	27331	27331			$	6,937.00
ARTHRT PST CAPSUL RLS ANKLE W/WO ACHLL TDN LNGTH	27612	27612			$	5,993.00
ARTHRT RDCRPL/MIDCARPL JT W/EXPL DRG/RMVL FB	25040	25040			$	6,937.00
ARTHRT W/BX INTERTARSAL/TARSOMETATARSAL JOINT	28050	28050			$	5,817.00
ARTHRT W/EXPL DRG/RMVL LOOSE/FB MTTARPHLNGL JT	28022	28022	Podiatry	Podiatry	$	5,993.00
ARTHRTOMY W/BX METATARSOPHALANGEAL JOINT	28052	28052			$	5,817.00
ASPIRATION & INJECTION TREATMENT BONE CYST	20615	20615			$	937.00
ASPIRATION&/INJECTION GANGLION CYST ANY LOCATJ	20612	20612			$	937.00
AUTOGRAFT SPINE SURGERY LOCAL FROM SAME INCISION	20936	20936	Orthopedic	Orthopedic	$	17,200.00
AVULSION NAIL PLATE PARTIAL/COMPLETE SIMPLE 1	11730	11730			$	282.00
BIOPSY BONE OPEN SUPERFICIAL	20240	20240			$	4,864.00
BIOPSY NAIL UNIT SEPARATE PROCEDURE	11755	11755	Podiatry	Podiatry	$	840.00
BIOPSY SKIN SUBQ&/MUCOUS MEMBRANE EA ADDL LESN	11101	11101			$	298.00
BIOPSY SOFT TISSUE THIGH/KNEE AREA DEEP	27324	27324			$	4,864.00
BONE GRAFT ANY DONOR AREA MAJOR/LARGE	20902	20902			$	6,937.00
BONE GRAFT ANY DONOR AREA MINOR/SMALL	20900	20900			$	6,937.00
BX SKIN SUBCUTANEOUS&/MUCOUS MEMBRANE 1 LESION	11100	11100			$	693.00
CAPSUL MTTARPHLNGL JT W/WO TENORRHAPHY EA JT SPX	28270	28270			$	4,648.00
CAPSULECTOMY/CAPSULOTOMY MTCARPHLNGL JOINT EACH	26520	26520			$	3,275.00
CAPSULORRHAPHY ANTERIOR W/CORACOID PROCESS TR	23462	23462			$	12,645.00
CAPSULORRHAPHY ANTERIOR W/LABRAL REPAIR	23455	23455			$	16,856.00
CAPSULOTOMY MIDFOOT MEDIAL RELEASE ONLY SPX	28260	28260			$	4,648.00
CLAVICULECTOMY PARTIAL	23120	23120			$	5,817.00
CLOSED TREATMENT ULNAR STYLOID FRACTURE	25650	25650			$	515.00
CLOSED TX BIMALLEOLAR ANKLE FRACTURE W/MANJ	27810	27810			$	3,320.00
CLOSED TX CALCANEAL FRACTURE W/MANIPULATION	28405	28405			$	1,285.00
CLOSED TX CARPAL SCAPHOID FRACTURE W/MANJ	25624	25624			$	3,320.00
CLOSED TX KNEE DISLOCATION W/ANESTHESIA	27552	27552			$	3,320.00

CLOSED TX METATARSAL FRACTURE W/O MANIPULATION	28470	28470			$ 515.00
CLOSED TX RADIAL HEAD/NECK FX W/MANIPULATION	24655	24655			$ 3,320.00
CLOSED TX RADIAL SHAFT FRACTURE W/MANIPULATION	25505	25505			$ 3,320.00
CLOSED TX RADIAL&ULNAR SHAFT FRACTURES W/MANJ	25565	25565			$ 3,320.00
CLOSED TX TARSOMETATARSAL DISLOCATION W/ANES	28605	28605			$ 937.00
CLOSED TX ULNAR SHAFT FRACTURE W/MANIPULATION	25535	25535			$ 937.00
CLSD TX SHOULDER DISLC W/MANIPULATION REQ ANES	23655	23655			$ 3,320.00
CLTX ARTCLR FX INVG MTCARPHLNGL/IPHAL JT W/MANJ	26742	26742	Orthopedic	Orthopedic	$ 3,320.00
CLTX DSTL FIBULAR FX LAT MALLS W/O MANJ	27786	27786			$ 937.00
CLTX DSTL PHLNGL FX FNGR/THMB W/MANJ EA	26755	26755			$ 515.00
CLTX DSTL RADIAL FX/EPIPHYSL SEP W/O MANJ	25600	25600			$ 515.00
CLTX DSTL RDL FX/EPIPHYSL SEP W/MANJ WHEN PERF	25605	25605			$ 3,320.00
CLTX FEM FX DSTL END MEDIAL/LAT CONDYLE W/MANJ	27510	27510			$ 3,320.00
CLTX FX W8 BRG ARTCLR PRTN DSTL TIB W/SKEL TRACJ	27825	27825			$ 3,320.00
CLTX HIP DISLOCATION TRAUMATIC REQ ANESTHESIA	27252	27252			$ 3,320.00
CLTX INTER/PERI/SUBTROCHANTERIC FEM FX W/O MANJ	27238	27238			$ 3,320.00
CLTX IPHAL JT DISLC W/MANJ REQ ANES	26775	26775			$ 570.00
CLTX METACARPAL FX W/MANIPULATION EACH BONE	26605	26605			$ 1,285.00
CLTX METACARPAL FX W/MANJ W/XTRNL FIXJ EA BONE	26607	26607			$ 5,817.00
CLTX METACARPAL FX W/O MANIPULATION EACH BONE	26600	26600			$ 515.00
CLTX METAR FX W/MANJ	28475	28475			$ 515.00
CLTX PHLNGL FX PROX/MIDDLE PX/F/T W/MANJ EA	26725	26725			$ 515.00
CLTX POST HIP ARTHRP DISLC REQ ANES	27266	27266			$ 3,320.00
CLTX POST HIP ARTHRP DISLC W/O ANES	27265	27265			$ 937.00
CLTX PROX FIBULA/SHFT FX W/O MANJ	27780	27780			$ 937.00
CLTX PROX HUMRL FX W/MANJ W/WO SKELETAL TRACJ	23605	23605			$ 3,320.00
CLTX PROXIMAL HUMERAL FRACTURE W/O MANIPULATION	23600	23600			$ 937.00
CLTX SHOULDER DISLC W/FX HUMERAL TUBRST W/MANJ	23665	23665			$ 3,320.00
CLTX TIBIAL FX PROXIMAL W/O MANIPULATION	27530	27530			$ 937.00
CLTX TIBIAL FX PROXIMAL W/WO MANJ W/SKEL TRACJ	27532	27532			$ 5,817.00
CLTX TIBIAL SHAFT FX W/MANJ W/WO SKEL TRACJ	27752	27752			$ 3,320.00
CLTX TIBIAL SHAFT FX W/O MANIPULATION	27750	27750			$ 937.00
CLTX TRIMALLEOLAR ANKLE FX W/MANIPULATION	27818	27818			$ 3,320.00
CLTX VRT FX&/DISLC CSTING/BRACING MANJ/TRCJ	22315	22315			$ 3,320.00

CORRECTION HAMMERTOE	28285	28285			$	5,817.00
CORRJ HALLUX VALGUS W/SESMDC W/1METAR MEDIAL CNF	28297	28297			$	12,645.00
CORRJ HALLUX VALGUS W/SESMDC W/2 OSTEOT	28299	28299	Podiatry	Podiatry	$	5,817.00
CORRJ HALLUX VALGUS W/SESMDC W/DIST METAR OSTEOT	28296	28296			$	5,817.00
CORRJ HALLUX VALGUS W/SESMDC W/PROX PHLNX OSTEOT	28298	28298			$	12,645.00
CORRJ HALLUX VALGUS W/SESMDC W/RESCJ PROX PHAL	28292	28292			$	5,817.00
DBRDMT FX&/DISLC SUBQ T/M/F BONE	11012	11012			$	4,922.00
DBRDMT SUBCUTANEOUS TISSUE EA ADDL 20 SQ CM	11045	11045			$	937.00
DBRDMT W/RMVL FM FX&/DISLC SKIN&SUBQ TISSUS	11010	11010			$	1,391.00
DBRDMT W/RMVL FM FX&/DISLC SKN SUBQ T/M/F MUSC	11011	11011			$	1,391.00
DCMPRN FASCT LEG ANT&/LAT&PST W/DBRDMT MUS	27894	27894			$	3,320.00
DEBRIDEMENT BONE EACH ADDITIONAL 20 SQ CM	11047	11047			$	937.00
DEBRIDEMENT BONE MUSCLE &/FASCIA 20 SQ CM/<	11044	11044			$	2,488.00
DEBRIDEMENT MUSCLE & FASCIA 20 SQ CM/<	11043	11043			$	1,285.00
DEBRIDEMENT MUSCLE &/FASCIA EA ADDL 20 SQ CM	11046	11046			$	937.00
DEBRIDEMENT SUBCUTANEOUS TISSUE 20 SQ CM/<	11042	11042			$	1,285.00
DECOMPRESSION UNSPECIFIED NERVE	64722	64722	Orthopedic	Orthopedic	$	3,947.00
DERMAL (SUBSTITUTE) TISSUE OF HUMAN ORIGIN, WITH OR WITH(	J7344	J7344			$	0.01
DESTRUCTION BENIGN LESIONS UP TO 14	17110	17110			$	462.00
DESTRUCTION PREMALIGNANT LESION 15/>	17004	17004			$	462.00
DRAINAGE FINGER ABSCESS COMPLICATED	26011	26011	Orthopedic	Orthopedic	$	2,488.00
DRAINAGE FINGER ABSCESS SIMPLE	26010	26010			$	394.00
DRAINAGE TENDON SHEATH DIGIT&/PALM EACH	26020	26020			$	5,817.00
DURAL GRAFT SPINAL	63710	63710	Orthopedic	Orthopedic	$	2,216.00
ENDOSCOPIC PLANTAR FASCIOTOMY	29893	29893			$	5,817.00
EX TUM/VASC MAL SFT TIS HAND/FNGR SUBFSC 1.5CM/>	26113	26113			$	3,035.00
EX TUM/VASC MALF SFT TISS HAND/FNGR SUBQ 1.5CM/>	26111	26111			$	3,035.00
EXC B9 LESION MRGN XCP SK TG S/N/H/F/G 0.5 CM/<	11420	11420			$	398.00
EXC B9 LESION MRGN XCP SK TG S/N/H/F/G 0.6-1.0CM	11421	11421			$	474.00
EXC B9 LESION MRGN XCP SK TG S/N/H/F/G 1.1-2.0CM	11422	11422			$	522.00
EXC B9 LESION MRGN XCP SK TG S/N/H/F/G 2.1-3.0CM	11423	11423			$	570.00
EXC B9 LESION MRGN XCP SK TG T/A/L >4.0 CM	11406	11406			$	2,488.00
EXC B9 LESION MRGN XCP SK TG T/A/L 0.5 CM/<	11400	11400			$	563.00
EXC B9 LESION MRGN XCP SK TG T/A/L 0.6-1.0 CM	11401	11401			$	1,162.00

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EXC B9 LESION MRGN XCP SK TG T/A/L 2.1-3.0 CM/<	11403	11403			$ 563.00
EXC B9 LESION MRGN XCP SK TG T/A/L 3.1-4.0 CM	11404	11404			$ 2,488.00
EXC LESION TDN SHTH/JT CAPSL HAND/FNGR	26160	26160			$ 3,320.00
EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT FOOT	28090	28090			$ 5,817.00
EXC LESION TENDON SHEATH/CAPSULE W/SYNVCT TOE EA	28092	28092	Podiatry	Podiatry	$ 3,320.00
EXC NEUROFIBROMA/NEUROLEMMOMA MAJOR PRPH NRV	64790	64790	Orthopedic	Orthopedic	$ 3,765.00
EXC NEUROMA HAND/FOOT XCP DIGITAL NERVE	64782	64782			$ 3,765.00
EXC NEUROMA MAJOR PERIPHERAL NRV XCP SCIATIC	64784	64784			$ 3,765.00
EXC TUM/VAS MAL SFT TIS HAND/FNGR SUBFASC<1.5CM	26116	26116			$ 2,488.00
EXC TUM/VASC MAL SFT TISS HAND/FNGR SUBQ <1.5CM	26115	26115			$ 2,488.00
EXC TUMOR SFT TISS FOREARM&/WRIST SUBFASC 3CM/>	25073	25073			$ 4,922.00
EXC TUMOR SOFT TISS FOREARM AND/WRIST SUBQ 3CM/>	25071	25071			$ 3,305.00
EXC TUMOR SOFT TISS FOREARM&/WRIST SUBFASC <3CM	25076	25076			$ 2,488.00
EXC TUMOR SOFT TISS UPPER ARM/ELBOW SUBQ <3CM	24075	24075			$ 2,488.00
EXC TUMOR SOFT TISS UPPER ARM/ELBW SUBFASC 5CM/>	24073	24073			$ 4,922.00
EXC TUMOR SOFT TISSUE FOOT/TOE SUBFASC <1.5CM	28045	28045			$ 4,922.00
EXC TUMOR SOFT TISSUE FOOT/TOE SUBFASC 1.5 CM/>	28041	28041	Podiatry	Podiatry	$ 4,922.00
EXC TUMOR SOFT TISSUE FOREARM &/WRIST SUBQ <3CM	25075	25075			$ 2,488.00
EXC TUMOR SOFT TISSUE LEG/ANKLE SUBQ <3CM	27618	27618			$ 2,488.00
EXC TUMOR SOFT TISSUE SHOULDER SUBFASCIAL 5 CM/>	23073	23073			$ 4,922.00
EXC/CURTG BONE CYST/B9 TUMORTARSAL/METATARSAL	28104	28104			$ 5,817.00
EXC/CURTG BONE CYST/BENIGN TUMOR CLAV/SCAPULA	23140	23140			$ 5,817.00
EXC/CURTG BONE CYST/BENIGN TUMOR H/N RDS/OLECRN	24120	24120			$ 5,817.00
EXC/CURTG CST/B9 TUM PHALANGES FOOT	28108	28108	Orthopedic	Orthopedic	$ 3,320.00
EXCISION GANGLION WRIST DORSAL/VOLAR PRIMARY	25111	25111			$ 3,320.00
EXCISION GANGLION WRIST DORSAL/VOLAR RECURRENT	25112	25112			$ 5,817.00
EXCISION INTERDIGITAL MORTON NEUROMA SINGLE EACH	28080	28080			$ 3,320.00
EXCISION LESION MENISCUS/CAPSULE KNEE	27347	27347			$ 5,817.00
EXCISION LESION TENDON SHEATH FOREARM&/WRIST	25110	25110			$ 3,320.00
EXCISION LESION TENDON SHEATH/CAPSULE LEG&/ANK	27630	27630			$ 5,817.00
EXCISION MALIGNANT LESION S/N/H/F/G 0.5 CM/<	11620	11620			$ 1,425.00
EXCISION MALIGNANT LESION S/N/H/F/G 1.1-2.0 CM	11622	11622			$ 1,425.00
EXCISION MALIGNANT LESION S/N/H/F/G 3.1-4.0 CM	11624	11624			$ 2,488.00
EXCISION NAIL MATRIX PERMANENT REMOVAL	11750	11750			$ 452.00

EXCISION OLECRANON BURSA	24105	24105			$	5,817.00
EXCISION PREPATELLAR BURSA	27340	27340			$	5,817.00
EXCISION TROCHANTERIC BURSA/CALCIFICATION	27062	27062			$	5,817.00
EXCISION TUMOR SOFT TIS FOOT/TOE SUBQ 1.5 CM/>	28039	28039			$	4,922.00
EXCISION TUMOR SOFT TISSUE FOOT/TOE SUBQ <1.5CM	28043	28043			$	2,488.00
EXCISION TUMOR SOFT TISSUE LEG/ANKLE SUBQ 3 CM/>	27632	27632			$	4,922.00
EXCISION TUMOR SOFT TISSUE SHOULDER SUBQ 3 CM/>	23071	23071			$	3,035.00
EXCISION TUMOR SOFT TISSUE THIGH/KNEE SUBQ <3CM	27327	27327			$	2,488.00
EXCISION/CURETTAGE BONE CYST/TUMOR TIBIA/FIBULA	27635	27635			$	5,817.00
EXCISION/CURETTAGE CYST/TUMOR CARPAL BONES	25130	25130			$	5,817.00
EXCISION/CURETTAGE CYST/TUMOR METACARPAL	26200	26200			$	5,817.00
EXCISION/CURETTAGE CYST/TUMOR PHALANX FINGER	26210	26210			$	3,320.00
EXCISION/CURETTAGE CYST/TUMOR RADIUS/ULNA	25120	25120			$	5,817.00
EXCISION/CURETTAGE CYST/TUMOR TALUS/CALCANEUS	28100	28100			$	5,817.00
EXCISION/CURTG BONE CYST/BENIGN TUMOR HUMERUS	24110	24110			$	5,817.00
EXPLORATION PENETRATING WOUND SPX EXTREMITY	20103	20103			$	1,391.00
FASCIECTOMY PLANTAR FASCIA PARTIAL SPX	28060	28060			$	5,817.00
FASCIOTOMY FOOT&/TOE	28008	28008			$	5,817.00
FASCIOTOMY PALMAR OPEN PARTIAL	26045	26045			$	5,817.00
FASCIOTOMY PALMAR PERCUTANEOUS	26040	26040			$	3,320.00
FASCIOTOMY PLANTAR FASCIA RADICAL SPX	28062	28062			$	5,817.00
FASCT PALM W/WO Z-PLASTY TISSUE REARGMT/SKN GRFT	26121	26121			$	5,817.00
FASCT PRTL PALMAR 1 DGT PROX IPHAL JT W/WO RPR	26123	26123			$	5,817.00
FASCT PRTL PALMR ADDL DGT PROX IPHAL JT W/WO RPR	26125	26125			$	1,893.00
FLUOROSCOPIC GUIDANCE NEEDLE PLACEMENT ADD ON	77002	77002			$	284.00
FLUOROSCOPY SPX UP TO 1 HOUR PHYS/QHP TIME	76000	76000	Orthopedic	Orthopedic	$	194.00
Foot/toe Bunion Correction Resection Of Joint W/implant	28293	28293			$	6,725.35
GASTROCNEMIUS RECESSION	27687	27687			$	5,817.00
HALLUX RIGIDUS W/CHEILECTOMY 1ST MP JT W/IMPLT	28291	28291			$	17,050.00
HALLUX RIGIDUS W/CHEILECTOMY 1ST MP JT W/O IMPLT	28289	28289			$	5,817.00
HEMIPHALANGECTOMY/INTERPHALANGEAL JOINT EXC TOE	28160	28160			$	5,817.00
Hyaluronan or derivative, hyalgan or supartz, for intra-articular inje	J7321	J7321			$	176.00
I&D BELOW FASCIA FOOT 1 BURSAL SPACE	28002	28002			$	5,817.00
I&D DEEP ABSC BURSA/HEMATOMA THIGH/KNEE REGION	27301	27301			$	4,922.00

I&D DEEP ABSC/HMTMA SOFT TISSUE NECK/THORAX	21501	21501			$ 4,922.00
I&D FOREARM&/WRIST DEEP ABSCESS/HEMATOMA	25028	25028			$ 5,817.00
I&D HEMATOMA SEROMA/FLUID COLLECTION	10140	10140			$ 488.00
I&D PELVIS/HIP JT AREA DEEP ABSCESS/HEMATOMA	26990	26990			$ 5,817.00
I&D SHOULDER DEEP ABSCESS/HEMATOMA	23030	23030			$ 4,922.00
I&D SOFT TISSUE ABSCESS SUBFASC	20005	20005			$ 2,488.00
I&D UPPER ARM/ELBOW DEEP ABSCESS/HEMATOMA	23930	23930			$ 2,488.00
IMPLTJ/RPLCMT ITHCL/EDRL DRUG NFS PRGRBL PUMP	62362	62362			$ 61,574.00
INCISION & DRAINAGE ABSCESS COMPLICATED/MULTIPLE	10061	10061			$ 533.00
INCISION & DRAINAGE ABSCESS SIMPLE/SINGLE	10060	10060			$ 339.00
INCISION & DRAINAGE COMPLEX PO WOUND INFECTION	10180	10180			$ 4,922.00
INCISION & DRAINAGE LEG/ANKLE ABSCESS/HEMATOMA	27603	27603			$ 4,922.00
INCISION & REMOVAL FOREIGN BODY SUBQ TISS COMPL	10121	10121			$ 2,488.00
INCISION & REMOVAL FOREIGN BODY SUBQ TISS SIMPLE	10120	10120	Orthopedic	Orthopedic	$ 507.00
INCISION BONE CORTEX FOOT	28005	28005			$ 5,817.00
INCISION EXTENSOR TENDON SHEATH WRIST	25000	25000			$ 3,320.00
INCISION LEG/ANKLE	27607	27607			$ 5,817.00
INCISION&DRAINAGE BURSA FOOT	28001	28001			$ 849.00
INCISION&DRAINAGE UPPER ARM/ELBOW BURSA	23931	23931			$ 2,488.00
INJECTION 1 TENDON SHEATH/LIGAMENT APONEUROSIS	20550	20550			$ 113.00
INJECTION ANES OTHER PERIPHERAL NERVE/BRANCH	64450	64450	Pain Managemen	Pain Manageme	$ 248.00
INJECTION ANESTHETIC AGENT AXILLARY NERVE	64417	64417	Pain Managemen	Pain Managemer	$ 1,648.00
INJECTION ANESTHETIC AGENT CERVICAL PLEXUS	64413	64413	Pain Managemen	Pain Manageme	$ 346.00
INJECTION ANESTHETIC AGENT FEMORAL NERVE SINGLE	64447	64447	Pain Managemen	Pain Managemer	$ 301.00
INJECTION ANESTHETIC AGENT SCIATIC NRV SINGLE	64445	64445	Pain Managemen	Pain Managemer	$ 378.00
INJECTION SINGLE TENDON ORIGIN/INSERTION	20551	20551			$ 152.00
INJECTION SINGLE/MLT TRIGGER POINT 1/2 MUSCLES	20552	20552			$ 144.00
INJECTION THERAPEUTIC CARPAL TUNNEL	20526	20526			$ 188.00
Injection, adenosine for therapeutic use, 6 mg (not to be used to re	J0150	J0150			$ 0.01
INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/ARTHRD	22853	22853	Orthopedic	Orthopedic	$ 9,800.00
INSJ BIOMCHN DEV NTRVRT DISC SPACE W/O ARTHRD	22859	22859	Orthopedic	Orthopedic	$ 9,800.00
INSJ BIOMCHN DEV VRT CORPECTOMY DEFECT W/ARTHRD	22854	22854	Orthopedic	Orthopedic	$ 9,800.00
INSJ STABLJ DEV W/DCMPRN LUMBAR SINGLE LEVEL	22867	22867			$ 50,187.00
INSJ/RPLCMT SPI NPGR DIR/INDUXIVE COUPLING	63685	63685	Orthopedic	Orthopedic	$ 54,094.00

JOINT SURVEY SINGLE VIEW 2 OR MORE JOINTS	77077	77077			$ 230.00
LAM EXC/EVAC ISPI LESION OTH/THN NEO XDRL LUMBAR	63267	63267	Orthopedic	Orthopedic	$ 13,255.00
LAM FACETECTOMY & FORAMOTOMY 1 SEGMENT CERVICAL	63045	63045	Orthopedic	Orthopedic	$ 13,255.00
LAM FACETECTOMY & FORAMOTOMY 1 SEGMENT LUMBAR	63047	63047	Orthopedic	Orthopedic	$ 13,255.00
LAM FACETECTOMY & FORAMOTOMY 1 SEGMENT THORACIC	63046	63046	Orthopedic	Orthopedic	$ 13,255.00
LAM FACETECTOMY&FORAMTOMY 1 SGM EA CRV THRC/LMBR	63048	63048	Orthopedic	Orthopedic	$ 13,255.00
LAM IMPLTJ NSTIM ELTRDS PLATE/PADDLE EDRL	63655	63655	Orthopedic	Orthopedic	$ 35,607.00
LAMINECTOMY W/O FFD 1/2 VERT SEG THORACIC	63003	63003			$ 12,645.00
LAMNOTMY INCL W/DCMPRSN NRV ROOT 1 INTRSPC CERVC	63020	63020	Orthopedic	Orthopedic	$ 12,524.00
LAMNOTMY INCL W/DCMPRSN NRV ROOT 1 INTRSPC LUMBR	63030	63030	Orthopedic	Orthopedic	$ 13,255.00
LAMNOTMY W/DCMPRSN NRV EACH ADDL CRVCL/LMBR	63035	63035	Orthopedic	Orthopedic	$ 12,524.00
LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC LUMBAR	63042	63042	Orthopedic	Orthopedic	$ 12,524.00
LENGTHENING HAMSTRING TENDON SINGLE	27393	27393			$ 5,817.00
LIGAMENTOUS RECONSTRUCTION KNEE EXTRA-ARTICULAR	27427	27427			$ 12,645.00
LIGAMENTOUS RECONSTRUCTION KNEE INTRA-ARTICULAR	27428	27428			$ 23,761.00
LIGMOUS RCNSTJ AGMNTJ KNE INTRA-ARTICULAR XTR	27429	27429			$ 23,761.00
LNGTH/SHRT TENDON LEG/ANKLE 1 TENDON SPX	27685	27685			$ 5,817.00
Lumbar Kyphoplasty 1 Vertebral Body	22524	22524			$ 37,613.05
Lumbar Or Thoracic Kyphoplasty; Each Add'l Body	22525	22525			$ 37,613.05
MANIPULATION ELBOW UNDER ANESTHESIA	24300	24300			$ 3,320.00
MANIPULATION KNEE JOINT UNDER GENERAL ANESTHESIA	27570	27570			$ 3,320.00
MANJ W/ANES SHOULDER JOINT W/FIXATION APPARATUS	23700	23700			$ 3,320.00
MARROW ASPIRATION ONLY	38220	38220			$ 606.00
METATARSECTOMY	28140	28140			$ 5,817.00
MICROSURG TQS REQ USE OPERATING MICROSCOPE	69990	69990	Orthopedic	Orthopedic	$ 1,600.00
NDSC DCMPRN SPINAL CORD 1 W/LAMOT NTRSPC LUMBAR	62380	62380	Orthopedic	Orthopedic	$ 17,872.00
NDSC WRST SURG W/RLS TRANSVRS CARPL LIGM	29848	29848			$ 5,035.00
NEUROPLASTY &/TRANSPOS MEDIAN NRV CARPAL TUNNE	64721	64721			$ 3,765.00
NEUROPLASTY &/TRANSPOSITION ULNAR NERVE ELBOW	64718	64718			$ 3,765.00
NEUROPLASTY &/TRANSPOSITION ULNAR NERVE WRIST	64719	64719			$ 3,765.00
NEUROPLASTY NERVE HAND/FOOT	64704	64704	Podiatry	Podiatry	$ 3,765.00
NEURP MAJOR PRPH NRV ARM/LEG OPN OTH/THN SPEC	64708	64708			$ 3,765.00
NJX ANES&/STEROID PLANTAR COMMON DIGITAL NERVE	64455	64455	Pain Managemen	Pain Managemer	$ 937.00
NJX PLTLT PLASMA W/IMG HARVEST/PREPARATION	0232T	0232T	Orthopedic	Orthopedic	$ 937.00

OPEN RDL SHAFT FX CLOSED RAD/ULN JT DISLOCATE	25525	25525			$ 12,645.00
OPEN REPAIR OF ROTATOR CUFF ACUTE	23410	23410			$ 12,645.00
OPEN REPAIR OF ROTATOR CUFF CHRONIC	23412	23412			$ 12,645.00
OPEN TREATMENT BIMALLEOLAR ANKLE FRACTURE	27814	27814			$ 12,645.00
OPEN TREATMENT CALCANEAL FRACTURE	28415	28415			$ 12,645.00
OPEN TREATMENT FRACTURE DISTAL TIBIA & FIBULA	27828	27828			$ 23,761.00
OPEN TREATMENT FRACTURE DISTAL TIBIA FIBULA	27826	27826			$ 12,645.00
OPEN TREATMENT FRACTURE DISTAL TIBIA ONLY	27827	27827			$ 23,761.00
OPEN TREATMENT GRTER HUMERAL TUBEROSITY FRACTURE	23630	23630			$ 12,645.00
OPEN TREATMENT INTERPHALANGEAL JOINT DISLOCATION	28675	28675			$ 5,817.00
OPEN TREATMENT MEDIAL MALLEOLUS FRACTURE	27766	27766			$ 12,645.00
OPEN TREATMENT METATARSAL FRACTURE EACH	28485	28485			$ 12,645.00
OPEN TREATMENT OF ULNAR SHAFT FRACTURE	25545	25545			$ 12,645.00
OPEN TREATMENT PROXIMAL FIBULA/SHAFT FRACTURE	27784	27784			$ 12,645.00
OPEN TREATMENT PROXIMAL HUMERAL FRACTURE	23615	23615			$ 32,600.00
OPEN TREATMENT RADIAL SHAFT FRACTURE	25515	25515			$ 12,645.00
OPEN TREATMENT TALUS FRACTURE	28445	28445			$ 12,645.00
OPEN TREATMENT TARSAL BONE DISLOCATION	28555	28555			$ 12,645.00
OPEN TREATMENT TARSOMETATARSAL JOINT DISLOCATION	28615	28615			$ 12,645.00
OPEN TREATMENT ULNAR FRACTURE PROXIMAL END	24685	24685			$ 12,645.00
OPEN TX ACROMIOCLAVICULAR DISLC ACUTE/CHRONIC	23550	23550			$ 12,645.00
OPEN TX ARTICULAR FRACTURE MCP/IP JOINT EA	26746	26746			$ 5,817.00
OPEN TX CARPAL SCAPHOID NAVICULAR FRACTURE	25628	25628			$ 12,645.00
OPEN TX CARPOMETACARPAL FRACTURE DISLOCATE THUMB	26665	26665			$ 5,817.00
OPEN TX CLAVICULAR FRACTURE INTERNAL FIXATION	23515	23515			$ 12,645.00
OPEN TX DISTAL FIBULAR FRACTURE LAT MALLEOLUS	27792	27792			$ 12,645.00
OPEN TX DISTAL PHALANGEAL FRACTURE EACH	26765	26765			$ 5,817.00
OPEN TX DISTAL TIBIOFIBULAR JOINT DISRUPTION	27829	27829			$ 12,645.00
OPEN TX FRACTURE GREAT TOE/PHALANX/PHALANGES	28505	28505			$ 5,817.00
OPEN TX FRACTURE PHALANX/PHALANGES NOT GREAT TOE	28525	28525	Orthopedic	Orthopedic	$ 5,817.00
OPEN TX HUMERAL EPICONDYLAR FRACTURE	24575	24575			$ 23,761.00
OPEN TX HUMERAL SUPRACONDYLAR FRACTURE W/O XTN	24545	24545			$ 33,347.00
OPEN TX HUMERAL SUPRACONDYLAR FRACTURE W/XTN	24546	24546			$ 51,961.00
OPEN TX KNEE DISLOCATION W/O LIGAMENTOUS REPAIR	27556	27556			$ 12,645.00

ATTACHMENT 3 of 29

OPEN TX METACARPAL FRACTURE SINGLE EA BONE	26615	26615			$ 5,817.00
OPEN TX METATARSOPHALANGEAL JOINT DISLOCATION	28645	28645			$ 5,817.00
OPEN TX MONTEGGIA FRACTURE DISLOCATION ELBOW	24635	24635			$ 12,645.00
OPEN TX PHALANGEAL SHAFT FRACTURE PROX/MIDDLE EA	26735	26735			$ 5,817.00
OPEN TX RADIAL HEAD/NECK FRACTURE	24665	24665			$ 12,645.00
OPEN TX RADIAL HEAD/NECK FRACTURE PROSTHETIC	24666	24666			$ 35,194.00
OPEN TX RADIAL&ULNAR SHAFT FX W/FIXJ RADIUS&ULNA	25575	25575			$ 12,645.00
OPEN TX RADIAL&ULNAR SHAFT FX W/FIXJ RADIUS/ULNA	25574	25574			$ 12,645.00
OPEN TX TARSAL FRACTURE XCP TALUS & CALCANEUS EA	28465	28465			$ 12,645.00
OPEN TX TRIMALLEOLAR ANKLE FX W/FIXJ PST LIP	27823	27823			$ 12,645.00
OPEN TX TRIMALLEOLAR ANKLE FX W/O FIXJ PST LIP	27822	27822			$ 12,645.00
OPTX ACROMCLAV DISLC ACUTE/CHRONIC W/FASCIAL GRF	23552	23552			$ 12,645.00
OPTX DSTL RADL I-ARTIC FX/EPIPHYSL SEP 2 FRAG	25608	25608			$ 17,345.00
OPTX DSTL RADL I-ARTIC FX/EPIPHYSL SEP 3 FRAG	25609	25609			$ 17,551.00
OPTX DSTL RADL X-ARTIC FX/EPIPHYSL SEP	25607	25607			$ 17,427.00
OPTX HUMERAL SHFT FX W/PLATE/SCREWS W/WOCERCLAGE	24515	24515			$ 23,761.00
OPTX PATLLR FX W/INT FIXJ/PATLLC&SOFT TISS RPR	27524	27524			$ 12,645.00
OPTX TIBIAL SHFT FX W/PLATE/SCREWS W/WO CERCLAGE	27758	27758			$ 23,761.00
OSTC COMPL ALL METAR HEADS W/PRTL PROX PHALANGC	28114	28114	Orthopedic	Orthopedic	$ 5,817.00
OSTC PRTL EXOSTC/CONDYLC METAR HEAD	28288	28288			$ 5,817.00
OSTECTOMY CALCANEUS	28118	28118			$ 5,817.00
OSTECTOMY CALCANEUS SPUR W/WO PLNTAR FASCIAL RLS	28119	28119			$ 5,817.00
OSTECTOMY COMPLETE 1ST METATARSAL HEAD	28111	28111			$ 5,817.00
OSTECTOMY COMPLETE 5TH METATARSAL HEAD	28113	28113			$ 5,817.00
OSTECTOMY COMPLETE OTHER METATARSAL HEAD 2/3/4	28112	28112			$ 5,817.00
OSTECTOMY PRTL 5TH METAR HEAD SPX	28110	28110			$ 5,817.00
OSTECTOMY TARSAL COALITION	28116	28116			$ 5,817.00
OSTEOCHONDRAL ALLOGRAFT KNEE OPEN	27415	27415			$ 36,808.00
OSTEOT W/WO LNGTH SHRT/CORRJ 1ST METAR	28306	28306			$ 12,645.00
OSTEOT W/WO LNGTH SHRT/CORRJ METAR XCP 1ST EA	28308	28308			$ 5,817.00
OSTEOTOMY CALCANEUS W/WO INTERNAL FIXATION	28300	28300			$ 12,645.00
OSTECTOMY TARSAL BONES OTH/THN CALCANEUS/TALUS	28304	28304			$ 12,645.00
PARTIAL EXCISION BONE OLECRANON PROCESS	24147	24147			$ 5,817.00
PARTIAL EXCISION BONE PROXIMAL HUMERUS	23184	23184			$ 12,645.00

PARTIAL EXCISION BONE TALUS/CALCANEUS	28120	28120			$ 5,817.00
PARTIAL EXCISION BONE TIBIA	27640	27640			$ 5,817.00
PARTIAL REPAIR OR REMOVAL OF SHOULDER BONE	23130	23130			$ 5,817.00
PARTICAL EXCISION BONE PHALANX TOE	28124	28124			$ 1,436.00
PATELLECTOMY/HEMIPATELLECTOMY	27350	27350			$ 5,817.00
PERQ SKEL FIXJ DISTAL RADIAL FX/EPIPHYSL SEP	25606	25606			$ 5,817.00
PERQ VERT AGMNTJ CAVITY CRTJ UNI/BI CANNULATION	22513	22513	Orthopedic	Orthopedic	$ 13,255.00
PERQ VERT AGMNTJ CAVITY CRTJ UNI/BI CANNULJ EACH	22515	22515	Orthopedic	Orthopedic	$ 11,000.00
PERQ VERT AGMNTJ CAVITY CRTJ UNI/BI CANNULJ LMBR	22514	22514	Orthopedic	Orthopedic	$ 13,255.00
PHALANGECTOMY TOE EACH TOE	28150	28150			$ 5,817.00
PINCH GRAFT 1/MLT SM ULCER TIP/OTH AREA 2CM	15050	15050			$ 1,285.00
POSTERIOR NON-SEGMENTAL INSTRUMENTATION	22840	22840	Orthopedic	Orthopedic	$ 18,700.00
POSTERIOR SEGMENTAL INSTRUMENTATION 3-6 VRT SEG	22842	22842	Orthopedic	Orthopedic	$ 26,500.00
PREP SITE TRUNK/ARM/LEG 1ST 100 SQ CM/1PCT	15002	15002			$ 3,682.00
PROSTHESIS REMOVAL RADIAL HEAD	24164	24164			$ 5,817.00
PRQ IMPLTJ NSTIM ELECTRODE ARRAY EPIDURAL	63650	63650			$ 20,956.00
PRQ SKEL FIXJ CARPO/MTCRPL DISLC THMB MANJ EA JT	26676	26676			$ 5,817.00
PRQ SKEL FIXJ DSTL PHLNGL FX FNGR/THMB EA	26756	26756			$ 5,817.00
PRQ SKEL FIXJ INTERPHALANGEAL JOINT DISLC W/MANJ	28666	28666			$ 5,817.00
PRQ SKEL FIXJ METACARPOPHALANGEAL DISLC W/MANJ	26706	26706			$ 5,817.00
PRQ SKEL FIXJ METAR FX W/MANJ	28476	28476			$ 5,817.00
PRQ SKEL FIXJ PHLNGL SHFT FX PROX/MIDDLE PX/F/T	26727	26727			$ 5,817.00
PRQ SKEL FIXJ SPRCNDYLR/TRANSCNDYLR HUMERAL FX	24538	24538			$ 12,645.00
PRQ SKEL FIXJ TARS JT DISLC W/MANJ	28606	28606			$ 5,817.00
PRQ SKELETAL FIX CARPO/METACARPAL FX DISLC THUMB	26650	26650			$ 5,817.00
PRQ SKELETAL FIXJ CALCANEAL FRACTURE W/MANJ	28406	28406			$ 12,645.00
PRQ SKELETAL FIXJ FEMORAL FX DISTAL END	27509	27509			$ 16,346.00
PRQ SKELETAL FIXJ METACARPAL FX EACH BONE	26608	26608			$ 5,817.00
PRTL EXC B1 TARSAL/METAR B1 XCP TALUS/CALCANEUS	28122	28122			$ 5,817.00
PRTL EXC BONE FEMUR PROX TIBIA&/FIBULA	27360	27360	Podiatry	Podiatry	$ 5,817.00
RCNSTJ ANGULAR DFRM TOE SOFT TISS PX ONLY	28313	28313			$ 5,817.00
RCNSTJ DISLC PATELLA W/PATELLECTOMY	27424	27424			$ 12,645.00
RCNSTJ DISLC PATELLA W/XTNSR RELIGNMT&/MUSC RL	27422	27422			$ 12,645.00
RCNSTJ DISLOCATING PATELLA	27420	27420			$ 12,645.00

RCNSTJ LAT COLTRL LIGM ELBOW W/TENDON GRAFT	24344	24344			$ 12,645.00
RCNSTJ POLYDACTYLOUS DIGIT SOFT TISSUE & BONE	26587	26587			$ 6,180.00
RCNSTJ PST TIBL TDN W/EXC ACCESSORY TARSL NAVCLR	28238	28238			$ 12,645.00
REALIGNMENT EXTENSOR TENDON HAND EACH TENDON	26437	26437			$ 5,817.00
RECONSTRUCTION NAIL BED W/GRAFT	11762	11762			$ 804.00
RECONSTRUCTION ROTATOR CUFF AVULSION CHRONIC	23420	23420			$ 12,645.00
RELEASE TARSAL TUNNEL	28035	28035			$ 3,765.00
REMOVAL EXTERNAL FIXATION SYSTEM UNDER ANES	20694	20694			$ 3,320.00
REMOVAL FOREIGN BODY FOOT DEEP	28192	28192			$ 2,488.00
REMOVAL FOREIGN BODY FOOT SUBCUTANEOUS	28190	28190			$ 895.00
REMOVAL FOREIGN BODY MUSCLE/TENDON SHEATH SIMPLE	20520	20520			$ 621.00
REMOVAL FOREIGN BODY UPPER ARM/ELBOW DEEP	24201	24201			$ 4,922.00
REMOVAL IMPLANT DEEP	20680	20680			$ 4,922.00
REMOVAL IMPLANT SUPERFICIAL SEPARATE PROCEDURE	20670	20670			$ 2,488.00
Removal of nail bed/finger tip	11752	11752			$ 5,474.56
REMOVAL SHOULDER FOREIGN BODY DEEP SUBFASCIAL/IM	23333	23333			$ 2,488.00
REMOVAL SUTURES UNDER ANESTHESIA SAME SURGEON	15850	15850			$ 1,169.00
REPAIR COMPLEX SCALP/ARM/LEG 2.6-7.5 CM	13121	13121			$ 1,625.00
REPAIR COMPLEX SCALP/ARM/LEG EA ADDL 5 CM/<	13122	13122			$ 937.00
REPAIR DISLOCATING PERONEAL TENDON W/FIB OSTEOT	27676	27676			$ 12,645.00
REPAIR EXTENSOR TENDON FINGER W/O GRAFT EACH	26418	26418			$ 5,817.00
REPAIR EXTENSOR TENDON HAND W/O GRAFT EACH	26410	26410			$ 5,817.00
REPAIR FIBULA NONUNION/MALUNION W/INT FIXATION	27726	27726			$ 12,645.00
REPAIR FLEXOR TENDON LEG PRIMARY W/O GRAFT EACH	27658	27658			$ 5,817.00
REPAIR INTERMEDIATE N/H/F/XTRNL GENT 2.5CM/<	12041	12041			$ 740.00
REPAIR INTERMEDIATE N/H/F/XTRNL GENT 2.6-7.5 CM	12042	12042			$ 755.00
REPAIR INTERMEDIATE N/H/F/XTRNL GENT 7.6-12.5CM	12044	12044			$ 1,285.00
REPAIR INTERMEDIATE S/A/T/E >30.0 CM	12037	12037			$ 6,460.00
REPAIR INTERMEDIATE S/A/T/E 2.5 CM/<	12031	12031			$ 755.00
REPAIR INTERMEDIATE S/A/T/E 20.1-30.0 CM	12036	12036			$ 1,285.00
REPAIR NAIL BED	11760	11760			$ 1,169.00
REPAIR NON/MALUNION HUMERUS W/O GRAFT	24430	24430			$ 32,671.00
REPAIR NONUNION/MALUNION TARSAL BONES	28320	28320			$ 23,761.00
REPAIR NONUNION/MALUNION TIBIA W/O GRAFT	27720	27720			$ 12,645.00

REPAIR PRIMARY OPEN/PRQ RUPTURED ACHILLES TENDON	27650	27650			$ 5,817.00
REPAIR SECONDARY ACHILLES TENDON W/WO GRAFT	27654	27654			$ 12,645.00
REPAIR SECONDARY DISRUPTED LIGAMENT ANKLE COLTRL	27698	27698			$ 12,645.00
REPAIR TENDON EXTENSOR FOOT 1/2 EACH TENDON	28208	28208			$ 5,817.00
REPAIR TENDON/MUSCLE UPPER ARM/ELBOW EA	24341	24341			$ 12,645.00
RESECTION PARTIAL/COMPLETE PHALANGEAL BASE EACH	28126	28126			$ 5,817.00
REVIS SHOULDER ARTHRPLSTY HUMERAL&GLENOID COMPNT	23474	23474			$ 1,893.00
REVIS SHOULDER ARTHRPLSTY HUMERAL/GLENOID COMPNT	23473	23473			$ 1,893.00
REVJ INCL RPLCMT NSTIM ELTRD PLT/PDLE INCL FLUOR	63664	63664			$ 32,864.00
REVJ INCL RPLCMT NSTIM ELTRD PRQ RA INCL FLUOR	63663	63663			$ 20,095.00
REVJ/RMVL IMPLANTED SPINAL NEUROSTIM GENERATOR	63688	63688			$ 6,939.00
RINSJ RPTD BICEPS/TRICEPS TDN DSTL W/WO TDN GRF	24342	24342			$ 12,645.00
RMVL FOREIGN BODY MUSCLE/TENDON SHEATH DEEP/COMP	20525	20525			$ 4,922.00
RMVL FOREIGN BODY UPPER ARM/ELBOW SUBCUTANEOUS	24200	24200			$ 649.00
RMVL SPINAL NSTIM ELTRD PLATE/PADDLE INCL FLUOR	63662	63662			$ 6,939.00
RMVL SPINAL NSTIM ELTRD PRQ ARRAY INCL FLUOR	63661	63661			$ 3,765.00
RPR COLTRL LIGM MTCARPHLNGL/IPHAL JT	26540	26540			$ 5,817.00
RPR DISLOC PERONEAL TENDON W/O FIBULAR OSTEOTOMY	27675	27675			$ 5,817.00
RPR DURAL/CEREBROSPINAL FLUID LEAK X REQ LAM	63707	63707	Orthopedic	Orthopedic	$ 8,000.00
RPR DURAL/CSF LEAK/PSEUDOMENINGOCELE W/LAM	63709	63709	Orthopedic	Orthopedic	$ 21,700.00
RPR EXTENSOR TENDON LEG PRIMARY W/O GRAFT EACH	27664	27664			$ 12,645.00
RPR FLEXOR TENDON LEG SECONDARY W/O GRAFT EACH	27659	27659			$ 12,645.00
RPR NON-UNION MTCRPL/PHALANX	26546	26546			$ 12,645.00
RPR NON/MALUNION METARSAL W/WO BONE GRAFT	28322	28322			$ 12,645.00
RPR NONUNION/MALUNION RADIUS&ULNA W/O AUTOGRAF	25415	25415			$ 12,645.00
RPR NONUNION/MALUNION RADIUS/ULNA W/AUTOGRAFT	25405	25405			$ 12,645.00
RPR NONUNION/MALUNION RADIUS/ULNA W/O AUTOGRAFT	25400	25400			$ 12,645.00
RPR PRIM DISRUPTED LIGM ANKLE BTH COLTRL LIGMS	27696	27696			$ 12,645.00
RPR PRIMARY DISRUPTED LIGAMENT ANKLE COLLATERAL	27695	27695			$ 12,645.00
RPR PRIMARY OPEN/PRQ RUPTURED ACHILLES W/GRAFT	27652	27652			$ 12,645.00
RPR PRIMARY TORN LIGM&/CAPSULE KNEE COLLATERAL	27405	27405			$ 12,645.00
RPR TDN FLXR FOOT 1/2 W/O FREE GRAFG EACH TENDON	28200	28200			$ 5,817.00
RPR TDN/MUSC FLXR F/ARM&/WRST PRIM 1 EA TDN/MU	25260	25260			$ 5,922.00
RPR/ADVMNT FLXR TDN N/Z/2 W/O FR GRAFT EA TENDON	26350	26350			$ 5,623.00

SECONDARY CLOSURE SURG WOUND/DEHSN EXTSV/COMPLIC	13160	13160			$ 3,682.00
SESAMOIDECTOMY FIRST TOE SPX	28315	28315			$ 5,817.00
SIMPLE REPAIR SCALP/NECK/AX/GENIT/TRUNK >30.0CM	12007	12007			$ 1,285.00
SINGLE NERVE BLOCK INJECTION ARM NERVE	64415	64415	Pain Managemen	Pain Manageme	$ 1,648.00
SMPL RPR SCALP/NECK/AX/GENIT/TRUNK 12.6-20.0CM	12005	12005			$ 1,285.00
SMPL RPR SCALP/NECK/AX/GENIT/TRUNK 20.1-30.0CM	12006	12006			$ 1,285.00
SPLIT AGRFT T/A/L 1ST 100 CM/&/1% BDY INFT/CHLD	15100	15100			$ 3,682.00
SUTR INFRAPATELLAR TDN 2 RCNSTJ W/FSCAL/TDN GRF	27381	27381			$ 12,645.00
SUTR QUADRICEPS/HAMSTRING MUSC RPT RCNSTJ	27386	27386			$ 12,645.00
SUTURE INFRAPATELLAR TENDON PRIMARY		27380			$ 12,645.00
SUTURE QUADRICEPS/HAMSTRING RUPTURE PRIMARY	27385	27385			$ 12,645.00
SYNDACTYLIZATION TOES	28280	28280			$ 5,817.00
SYNOVECTOMY EXTENSOR TENDON SHTH WRIST 1 CMPRT	25118	25118			$ 5,817.00
SYNOVECTOMY TENDON SHEATH FOOT FLEXOR	28086	28086	Podiatry	Podiatry	$ 5,817.00
TDN TRNSPLJ/TR FLXR/XTNSR F/ARM&/WRST 1 EA TDN	25310	25310			$ 5,817.00
TENDON SHEATH INCISION	26055	26055			$ 3,320.00
TENODESIS BICEPS TENDON ELBOW SEPARATE PROCEDURE	24340	24340			$ 12,645.00
TENODESIS LONG TENDON BICEPS	23430	23430			$ 12,645.00
TENOLYSIS FLEXOR FOOT SINGLE TENDON	28220	28220			$ 1,370.00
TENOLYSIS FLXR/XTNSR TENDON LEG&/ANKLE 1 EACH	27680	27680			$ 5,817.00
TENOTOMY ELBOW LATERAL/MEDIAL PERCUTANEOUS	24357	24357			$ 5,817.00
TENOTOMY EXTENSOR HAND/FINGER OPEN EACH TENDON	26460	26460			$ 3,320.00
TENOTOMY OPEN ELBOW TO SHOULDER EACH TENDON	24310	24310			$ 5,817.00
TENOTOMY OPEN EXTENSOR FOOT/TOE EACH TENDON	28234	28234			$ 3,320.00
TENOTOMY OPEN HAMSTRING KNEE HIP SINGLE TENDON	27390	27390			$ 5,817.00
TENOTOMY SHOULDER AREA 1 TENDON	23405	23405			$ 12,645.00
Thoracic Kyphoplasty 1 Vertebral Body	22523	22523			$ 37,613.05
TNOT ELBOW LATERAL/MEDIAL DEBRIDE OPEN	24358	24358			$ 5,817.00
TNOT ELBOW LATERAL/MEDIAL DEBRIDE OPEN TDN RPR	24359	24359			$ 5,817.00
TOT DISC ARTHRP ANT APPR DISC 2ND LEVEL CERVICAL	22858	22858	Orthopedic	Orthopedic	$ 5,035.00
TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC CRV	22856	22856	Orthopedic	Orthopedic	$ 29,408.00
TR/TRNSPL 1 TDN W/MUSC REDIRION/REROUTING DP	27691	27691			$ 12,645.00
TR/TRNSPL 1 TDN W/MUSC REDIRION/REROUTING SUPFC	27690	27690			$ 12,645.00
TR/TRNSPL TDN CARP/MTCRPL HAND W/O FR GRF EA TDN	26480	26480			$ 5,817.00

TRANSPEDICULAR DCMPRN SPINAL CORD 1 SEG LUMBAR	63056	63056	Orthopedic	Orthopedic	$ 12,524.00
TREATMENT CLOSED ELBOW DISLOCATION REQ ANES	24605	24605			$ 3,320.00
TX HUMRAL SHAFT FX W/INSJ IMED IMPLT W/W CERCLGE	24516	24516			$ 23,761.00
TX OPEN TENDON FLEXOR TOE 1 TENDON SPX	28232	28232			$ 1,265.00
TX OPN TENDON FLEXOR FOOT SINGLE/MULT TENDON SPX	28230	28230	Orthopedic	Orthopedic	$ 1,344.00
TX SPONTAN HIP DISLC ABDCT SPLNT/TRCJ W/O ANES	27256	27256			$ 515.00
TX SUPERFICIAL WOUND DEHISCENCE SIMPLE CLOSURE	12020	12020			$ 1,169.00
TX SUPERFICIAL WOUND DEHISCENCE W/PACKING	12021	12021			$ 937.00
TX TARSAL BONE FX XCP TALUS&CALCN W/O MANJ	28450	28450			$ 515.00
TX TIBL SHFT FX IMED IMPLT W/WO SCREWS&/CERCLA	27759	27759			$ 23,761.00
UNLISTED PROCEDURE SHOULDER	23929	23929			$ 5,553.00
VERTEBRAL CORPECTOMY ANT DCMPRN CERVICAL 1 SEG	63081	63081	Orthopedic	Orthopedic	$ 29,000.00
Vertebroplsty 1 vert body, lumbar	22521	22521			$ 12,398.62
Vertebroplsty ea add vert body	22522	22522			$ 12,398.62
					$ 4,821,597.94

ATTACHMENT 27c9

The involvement of the members of the Medical Staff in the peer review process is essential to the ongoing measurement, assessment and improvement of performance of the Center.

A routine review of randomly selected medical records will be performed by the physician peer reviewers.

Each chart will be reviewed for completeness of its content, adequacy of documentation, appropriateness of the procedure and all associated orders, evaluation of clinical judgment and skills in handling the case, the potential avoidance of complications, appropriateness of anesthesia plan, and appropriateness of medication selection.

The Peer Review Committee will utilize the following process in conducting peer review:

A. Each quarter the Director of Nursing will randomly select 5% of each physician's cases (Representative of each month during the previous quarter) and two records per anesthesia provider for a Physician & Anesthesia Peer Review. In addition to this set of records, any medical record involving a patient complication, infection or a serious event/incident will be automatically reviewed.

B. The Director of Nursing will collect the Physician Peer Review records list and place a Physician Peer Review checklist on top.

C. The records will be reviewed by a member of the Peer Review Committee. A physician may not review his/her own records.

D. The reviewing physician will complete a worksheet for each record reviewed. If he/she has commented about some aspect of care, then the record with the worksheet attached, will be returned to the procedural physician for comment. If there is no comment, the paperwork is separated from the record, and the record is filed.

Illinois Health Facilities and
Services Review Board
Springfield, IL

RE: Massac County Surgery Center
Addition of Pain Management

To Whom It May Concern:

Through this letter, Massac County Surgery Center ("MCSC") provides the following assurances:

1. MCSC intends to and anticipates that its operating rooms will be utilized consistent with or exceeding those utilization standards identified in Appendix B to Section 1110 by the end of the second year of the project's completion.
2. The charge structure provided in this Certificate of Need application will not increase for, at minimum, two years following the completion of the proposed project to add pain management as an approved specialty.
3. MCSC's peer review program, which is designed to identify whether the ASTC's patient outcomes are consistent with applicable quality standards, will be expanded to include the pain management services to be provided in the ASTC.
4. The ASTC does not have any "shell" space.

Sincerely,

Greg Thompson
Manager

Notarized:

JULIANNE BOWLBY
Official Seal
Notary Public – State of Illinois
My Commission Expires Aug 22, 2021

ATTACHMENTS 17 and 27c10

E. Once all records are reviewed, the Peer Review Committee will discuss the outcome of the review, targeting any problem area(s) in documentation, follow-up, etc.

F. The Administrator or Director of Nursing will summarize the findings of the review in the next Executive Committee meeting following the review session.

Consistent performance or documentation problems with a physician will be referred to the Executive Committee for review. All findings and recommendations will be reported to the Governing Body. Results of Peer Review are considered when recredentialing providers

PROJECTED OPERATING COSTS
and
TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS

MASSAC COUNTY SURGERY CENTER

YEAR 2 OPERATING COST per SURGICAL CASE

Projected Cases:	2,846	
Salaries & Benefits		$817,609
Medical Supplies		$953,000
		$1,770,609
per Surgical Case:	$	622.14

YEAR 2 CAPITAL COST per SURGICAL CASE

Projected Cases:	2,846	
Interest, Dep. & Amort	$	385,000
per Surgical Case:	$	135.28

Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by FedEX

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

RE: Massac County Surgery Center
Metropolis, Illinois

Dear Ms. Avery:

Enclosed please find two copies of a Certificate of Need ("CON") application filed on behalf of applicants Massac County Surgery Center, LLC and OIWK Holdings, LLC, and proposing the addition of pain management as a specialty to be provided at Massac County Surgery Center. Also enclosed is a check in the amount of $2,500.

Should you require any additional information, please do not hesitate to call me.

Sincerely,

Jacob M. Axel
President

675 North Court, Suite 210
Palatine, Illinois 60067

Phone (847) 776-7101
Fax (847) 776-7004