19-031

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED
JUL 02 2019
HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: The Advanced Surgical Institute LLC
Street Address: 3523 W. 95th Street
City and Zip Code: Evergreen Park 60805
County: Cook Health Service Area: 7 Health Planning Area: A-04

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

Exact Legal Name: The Advanced Surgical Institute LLC
Street Address: 3523 W. 95th Street
City and Zip Code: Evergreen Park 60805
Name of Registered Agent: Alexander R. Domanskis
Registered Agent Street Address: 1 N Franklin Street, Suite 1200
Registered Agent City and Zip Code: Chicago 60606-3447
Name of Chief Executive Officer: Nouri Al-Khaled
CEO Street Address: 3545 West 95th Street
CEO City and Zip Code: Evergreen Park 60805
CEO Telephone Number: 708-878-8646

Type of Ownership of Applicants

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

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

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

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Bryan Niehaus
Title: Vice President
Company Name: Advis
Address: 19065 Hickory Creek Drive, Suite 115, Mokena, IL, 60448
Telephone Number: 708-478-7030
E-mail Address: bniehaus@advis.com
Fax Number: 708-478-7094

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

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

Post Permit Contact

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

Name: Nouri Al-Khaled, MD, FACC
Title: Manager
Company Name: The Advanced Surgical Institute, LLC
Address: 3523 W. 95th Street Evergreen Park, IL 60805
Telephone Number: 708-878-8646
E-mail Address: nalkhaled@aol.com
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: 3545 West 95th Street LLC
Address of Site Owner: 3545 W 95th Street, Evergreen Park, IL, 60805
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: THE ADVANCED SURGICAL INSTITUTE LLC
Address: 3523 W. 95th Street Evergreen Park, IL 60805

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

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

The Advanced Surgical Institute, LLC ("Applicant") proposes the establishment of an Ambulatory Surgical Treatment Center ("ASTC") with two operating rooms and seven recovery bays. The ASTC will be located in a building that is adjacent to the Applicant's "Heart, Vein, and Vascular Clinic" at 3523 W. 95th St. Evergreen Park, IL 60805.

The Project will require the modernization of existing space and the construction of a 750sqft addition. The total size of the proposed ASTC will be 6,500 departmental gross square feet (dgsf). The project does require the purchase of major medical equipment associated with cardiology services.

The Applicant is seeking approval for one category of service: cardiovascular.

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

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$10,584.62	$5,415.38	$16,000.00
Site Survey and Soil Investigation			
Site Preparation	$66,153.85	$33,846.15	$100,000.00
Off Site Work			
New Construction Contracts	$203,423.08	$104,076.92	$307,500.00
Modernization Contracts	$989,000.00	$506,000.00	$1,495,000.00
Contingencies	$98,900.00	$50,600.00	$149,500.00
Architectural/Engineering Fees	$79,120.00	$40,480.00	$119,600.00
Consulting and Other Fees	$25,827.46	$14,172.54	$40,000.00
Movable or Other Equipment (not in construction contracts)	$1,599,602.00	$126,319.00	$1,725,921.00
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	$1,419,000.00	$726,000.00	$2,145,000.00
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$4,491,611.00	$1,606,910.00	$6,098,521.00
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$1,419,000.00	$726,000.00	$2,145,000.00
Governmental Appropriations			
Grants			
Other Funds and Sources	$3,072,611.00	$880,910.00	$3,953,521.00
TOTAL SOURCES OF FUNDS	$4,491,611.00	$1,606,910.00	$6,098,521.00

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

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

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

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

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

Estimated start-up costs and operating deficit cost is $ $8,556,556 (no deficit)

Project Status and Completion Schedules

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

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): April 22, 2021

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

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

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:
☐ Cancer Registry ***< NOT APPLICABLE TO ASTC PROJECT***
☐ APORS ***<NOT APPLICABLE TO ASTC PROJECT***
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
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.

Facility Bed Capacity and Utilization ***NOT APPLICABLE TO ASTC PROJECT***

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

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

CERTIFICATION

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

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

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

SIGNATURE

Dr. Nouri Al-Khaled
PRINTED NAME

Manager
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19 day of June 2019

Signature of Notary

Seal

"OFFICIAL SEAL"
KIMBERLY A OERTEL
Notary Public, State of Illinois
My Commission Expires 11/21/2021

SIGNATURE

Dr. John Burke
PRINTED NAME

Member
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19 day of June 2019

Signature of Notary

Seal

"OFFICIAL SEAL"
KIMBERLY A OERTEL
Notary Public, State of Illinois
My Commission Expires 11/21/2021

*Insert the EXACT legal name of the applicant

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

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

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

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

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

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

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

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

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

4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

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

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

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

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

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

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

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

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.

3. Evidence that the shell space is being constructed due to:
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

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

G. Non-Hospital Based Ambulatory Surgery

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

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

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

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X

1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X

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

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

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

VI. 1120.120 - AVAILABILITY OF FUNDS

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

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
		1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
		2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
$6,098,521	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
		1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
		2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
		3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
		4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
		5) For any option to lease, a copy of the option, including all

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

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

SECTION VII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

Variance

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

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

SECTION VIII.1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION IX. SAFETY NET IMPACT STATEMENT

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

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

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

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

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

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

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

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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

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

Outpatient			
Total			

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

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

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

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

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

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

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

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

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

Section I, Identification, General Information, and Certification
Applicants

An Illinois Certificate of Good Standing is included in this Attachment for The Advanced Surgical Institute LLC as Attachment-1 Exhibit-1.

File Number 0776626-2

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

THE ADVANCED SURGICAL INSTITUTE LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON APRIL 23, 2019, 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* 26TH *day of* JUNE *A.D.* 2019 .

Authentication #: 1917703194 verifiable until 06/26/2020
Authenticate at: http://www.cyberdriveillinois.com

Jesse White

SECRETARY OF STATE

Section I, Identification, General Information, and Certification

Site Ownership

The site, 3523 W. 95th Street, Evergreen Park, IL 60805 is owned by 3545 West 95th Street LLC.

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

- Attachment 2-Exhibit 1: A copy of the lease from 3545 West 95th Street LLC to The Advanced Surgical Institute LLC.

LEASE

between

3545 West 95th Street, LLC.
("Landlord")

and

ADVANCED SURGICAL INSTITUTE, LLC
("Tenant")
June 20, 2019
1st Floor, approx. 6,500 rsf
3523 W. 95th St., Evergreen Park, IL

LEASE

First floor, approx. 6,500 rsf
3523 W. 95th St., Oak Lawn, IL

THIS LEASE is made as of June 20, 2019 by and between **3545 West 95th Street LLC,** an Illlinois limited liability company ("Landlord"), and **ADVANCED SURGICAL INSTITUTE LLC**, an Illinois limited liability company ("Tenant").

1. Certain Definitions:

A. Name of Tenant: Advanced Surgical Institute, LLC

B. Address of Tenant: Advanced Surgical Institute, LLC
3545 W. 95th Street
Evergreen Park, IL 60805
Attn: Managing Member

C. Term: Ten (10) years

D. Commencement: The Anticpated Commencement Date is October 1, 2019. The actual commencement date will be the date the Landlord delivers possession of the Premises to Tenant.

D. Premises: First floor, approximately 6,500 rentable square feet ("rsf"), as shown on the attached **Exhibit A**, and located in the Building at 3523 W. 95th St., Evergreen Park, IL.

E. Use: Medical space used for Ambulatory Surgical Center.

F. Security Deposit: $17,875 (which is one (1) month's Base Rent)

G. Base Rent: **Initial Term: Base Rent is calculated based on approximately $33/rsf and shall increase per annum in accordance with the following schedule:**

Year	Rate per RSF	Monthly Rent	Annual Rent
1	$33.00	$17,875.00	$214,500.00
2	$33.00	$17,875.00	$214,500.00
3	$33.00	$17,875.00	$214,500.00
4	$33.00	$17,875.00	$214,500.00
5	$33.00	$17,875.00	$214,500.00
6	$33.00	$17,875.00	$214,500.00
7	$33.00	$17,875.00	$214,500.00
8	$33.00	$17,875.00	$214,500.00
9	$33.00	$17,875.00	$214,500.00
10	$33.00	$17,875.00	$214,500.00

		Base Rent is exclusive of Additional Rent. Tenant is also responsible for Tenant's Proportionate Share of all Taxes and Operating expenses for the Building (as those terms are hereinafter defined).
H.	Proportionate Share	100%
I.	Brokers:	For Landlord: None For Tenant: None
J.	Premises Work:	Premises are delivered AS-IS and Landlord shall be required to make the appropriate chnages and alterations to make the building suitable for the build out of the Ambulatory Surgical Center. However, the actual build out remains the responsibility of the tenant.
L.	Buildout Payment:	The build out cost will be the responsibility of the tenant.

2. Grant, Term, Use and Options to Renew:

For the Term in 1.C above, Landlord hereby leases to Tenant, and Tenant hereby leases from Landlord, the Premises designated in Section 1.D above. This grant hereunder and the Premises are subject to all applicable building restrictions, planning and zoning ordinances, governmental rules and regulations, and all other encumbrances, easements, covenants, and restrictions of record as the same may hereafter from time to time be amended. The Term of this Lease shall begin on the "Commencement Date" set forth in Section 1.C. above and shall continue until the Termination Date set forth in Section 1.C. above, and any other earlier termination for Tenant default. The term "Lease Year" as used herein shall mean each consecutive twelve (12) month period beginning with the Commencement Date. Tenant shall use and occupy the Premises for the Use set forth in Section 1.E. and for no other purpose.

Provided Tenant is not in default under the terms and conditions of this Lease at the time of giving notice through to the date of renewal,

3. Security Deposit/Rent:

(a) The Security Deposit shall be paid concurrently with Tenant's execution of this Lease.

(b) Rent. Tenant hereby covenants and agrees to pay to Landlord for and throughout each Lease Year, beginning on the Commencement Date, in addition to all other sums to be paid by Tenant to Landlord under this Lease, Base Rent monthly in advance on the first day of each month during the Term, Base Rent in the amount set forth in Section 1.G. above. If the Commencement Date is any date other than the 1st day of the month, Tenant shall pay, on or before such date, the applicable pro-rata portion of monthly Base Rent, and all subsequent monthly Base Rent payments shall be due monthly in advance on the first day of each month. Base Rent shall be paid either via hard check sent to the office of Landlord, or via ACH transfer, in either case as the Landlord directs, or via other address/means as designated from time to time by written notice from Landlord to Tenant.

Tenant shall pay concurrently with the execution of this lease, the Build Out Payment described om Section 1. Tenant shall also pay to Landlord its Proportionate Share of Operating Expenses and Taxes (as those

terms are defined below), which shall be paid within five (5) business days after invoice from Landlord to Tenant from time to time ("Additional Rent").

Base Rent, Additional Rent and all other sums due and owing are sometimes referred to collectively herein as "Rent".

(c) In the event Tenant shall fail to pay any payment of Rent within five (5) days following the date such payment is due, Landlord shall have the right to assess and collect a late payment penalty of $100.00 plus a charge equal to five percent (5%) of the amount then so due. The foregoing shall not limit or otherwise restrict Landlord's rights hereunder in the event of non-payment or late payment of Rent.

(d) Tenant shall pay Base Rent in full to Landlord, without demand, deductions, set-offs or counterclaims, diminutions, abatements or rebates of whatsoever kind, nature and description. All payments and charges required to be made by Tenant hereunder shall be payable in United States funds, via ACH or other funds transfer as Landlord directs. Except as otherwise determined by Landlord, no payment to or receipt by Landlord of a lesser amount than the then amount required to be paid hereunder shall be deemed to be other than on account of the earliest amount of any obligations then due hereunder, notwithstanding any notation, legend, or instructions of Tenant to the contrary, which notations, legends or instructions shall be null and void. No endorsement or statement on any check or other communication accompanying a check for payment of any amounts payable hereunder shall be deemed an accord and satisfaction, and Landlord may accept such check in payment without prejudice to Landlord's right to recover the balance of any sums owed by Tenant hereunder or to pursue any other remedy available in this Lease, or under law, against Tenant. Landlord may require, in its sole discretion following a Default, payment to be made by certified funds or cashier's check.

(e) Operating Expenses: It is the intention of the Parties hereto, and they hereby agree, that this shall be a *triple net* Lease, and the Landlord shall have no obligation to provide any services, perform any acts or pay any expenses, charges, obligations or costs of any kind whatsoever with respect to the Premises, and Tenant hereby agrees to be solely responsible for the management of the Premises including paying its Proportionate Share of and utilizing qualified service providers and contractors to perform services associated with any and all Operating Expenses as hereafter defined for the entire Term or any extensions thereof. The term **"Operating Expenses"** is defined and shall include all costs to Landlord of operating and maintaining the Premises and related parking areas, and shall include, without limitation, real estate and personal property taxes and assessments, heating, electricity, water, waste disposal, sewage, operating materials and supplies, service agreements and charges, lawn care, snow removal, restriping, repairs, repaving, cleaning and custodial, security, insurance, the cost of contesting the validity or applicability of any governmental acts which may affect Operating Expenses, and all other direct operating costs of operating and maintaining the Premises and related parking areas. Notwithstanding the foregoing, Operating Expenses (and Tenant's obligations in relation thereto) shall not include any amount for which Landlord is reimbursed through insurance or by third. Notwithstanding that Landlord has no obligation whatsoever with respect to incurring Operating Expenses associated with the Premises, Landlord reserves the right to undertake any services deemed necessary in Landlord's sole discretion and Tenant shall immediately reimburse Landlord upon demand for any Operating Expenses incurred by Landlord which were the responsibility of Tenant.

(f) Taxes: Tenant shall pay, during the Term, its Proportionate Share of the real estate taxes and special taxes and assessments (collectively, the "taxes") attributable to the Premises and accruing during such Term. Taxes for any fractional calendar year during the Term hereof shall be prorated.

(g) Landlord may forcast and send to Tenant on a monthly basis (or at such other interval as Landlord reasonably determines) Landlord's estimates of Tenant's Proportionate Share of Operating Expenses and Taxes, calculated to approximate on a monthly basis, one twelth (1/12) of Landlord's estimate of Tenant's annual responsibility.Within ninety (90) days following the end of Landlord's fiscal year, Landlord shall make any required adjustments and send to Tenant the appropriate refund or additional billing to reflect Tenant's actual share of Operating Expenses based on final bills received by Landlord. Within ninety (90) days following Landlord's receipt of final tax bills for any calendar year, Landlord shall make any required adjustment and sent to Tenant the appropriate refund or additional billing to reflect Tenant's actual share ot Taxes.

4. Services: Landlord shall provide no Services and Tenant shall be solely responsible for the upkeep of the building.at its sole cost and expense.

5. Condition and Care of Premises/Janitorial/Waste Removal and Document Destruction:

(a) Tenant has inspected the Premises and agrees to accept the same in "as is" condition subject to ordinary wear and tear between the date hereof and the date Tenant takes possession. No promises of the Landlord to alter, remodel, improve, repair, decorate or clean the Premises or any part thereof, have been made, and no representation respecting the condition of the Premises or the Building, has been made to Tenant by Landlord. This Lease does not grant any rights to light or air over or about the property of Landlord. Except for any damage resulting from any act of Landlord or any tenant other than Tenant, or either of their employees, agents or invitees, and subject to the provisions of Section 14 to the extent covered by insurance, Tenant shall at its own expense keep the Premises in good repair and tenantable condition and shall promptly and adequately repair all damage to the Premises caused by Tenant or any of its employees, agents or invitees, including replacing or repairing all damaged or broken glass, doors, door frames, fixtures and appurtenances resulting from any such damage, under the supervision and with the approval of Landlord and within any reasonable period of time specified by Landlord. If Tenant does not do so promptly and adequately, Landlord may, but need not, make such repairs and replacements and Tenant shall pay Landlord the cost thereof on demand.

(b) Tenant, at Tenant's sole cost, shall obtain janitorial, medical waste disposal, and secure document destruction services for the Premises and the conduct of Tenant's business. Tenant's janitor vendor, medical waste disposal vendor, and secure document destruction services vendor, are subject to the advance review and approval of Landlord, not to be unreasonably withheld or delayed. Tenant's janitorial services are to include common area hallway and bathrooms, and Tenant is responsible for stocking bathroom with soap, paper towels and toilet tissue. Landlord remains responsible for maintenance and repair of the bathrooms. Provided that any maintenance or repair is not caused by Tenant's lack of reasonable care, Landlord will pay the cost of maintenance and repair.

Tenant assumes full and complete responsibility and liability for the proper and lawful disposal of all medical waste through dedicated medical waste disposal services, and the secure destruction of all protected health information through dedicated secure destruction services. Under no circumstances shall any medical waste or protected health information be disposed of through use of Building trash receptacles or Building trash removal services. Tenant's obligations under this paragraph are subject to the indemnification obligations in Section 12(e).

6. Return of Premises: At the termination of this Lease by lapse of time or otherwise or upon termination of Tenant's right of possession without terminating this Lease, Tenant shall surrender

possession of the Premises to Landlord and deliver all keys to the Premises to Landlord and make known to the Landlord the combination of any locks then remaining in the Premises, and shall return the Premises and all fixtures of the Landlord therein, to Landlord in as good condition as when Tenant originally took possession, except for ordinary wear, loss or damage by fire or other casualty, cause, condition or thing whatsoever, damage resulting from the act of Landlord or any tenant other than Tenant, their employees, agents or invitees, and alterations made with Landlord's consent, failing which Landlord may restore the Premises and such equipment and fixtures to such condition and the Tenant shall pay the cost thereof to Landlord on demand.

All installations, additions, partitions, hardware, light fixtures, non-trade fixtures and improvements, temporary or permanent, except movable furniture, cabinets, movable partitions, and machinery and equipment (even if bolted in place) belonging to Tenant, in or upon the Premises, whether placed there by Tenant or Landlord, shall be Landlord's property and shall remain upon the Premises, all without compensation, allowance or credit to Tenant; provided, however, that if prior to such termination or within ten (10) days thereafter Landlord so directs by notice, Tenant at Tenant's sole cost and expense, shall promptly remove such of the movable furniture, cabinets, movable partitions, and machinery and equipment (even if bolted in place) belonging to Tenant placed in the Premises by Tenant as are designated in such notice and repair any damage to the Premises caused by such removal, failing which Landlord may remove the same and repair the Premises and Tenant shall pay the cost thereof to Landlord on demand.

Tenant shall leave in place all floor coverings without compensation to Landlord. Tenant shall remove at its cost any reserved parking signage that Tenant installs, and any building monument signage for Tenant.

All obligations of Tenant hereunder shall survive the expiration or sooner termination of the Term of this Lease.

7. **Holding Over:** Tenant shall pay Landlord for each day Tenant retains possession of the Premises or any part thereof after termination of this Lease, by lapse of time or otherwise, an amount which is 200% the amount of Rent for a day (computed on a year of 360 days) based on the annual rate applicable under Section 1.G to the period in which such termination occurs. Nothing in this Section contained, however, shall be construed or operate as a waiver of Landlord's right of a re-entry or any other right.

8. **Rules and Regulations:** Tenant agrees to observe the reservations to Landlord contained in Section 9 hereof and agrees, for itself, its employees, agents, clients, customers, invitees and guests, to comply with the Rules and Regulations set forth in **Exhibit C** attached to this Lease and made a part hereof and such other rules and regulations as shall be adopted by Landlord pursuant to Section 9(k) of this Lease.

Any violation by the Tenant of any of the Rules and Regulations, or as may hereafter be adopted by Landlord pursuant to Section 9(l) of this Lease, or other Sections of this Lease, may be restrained; but whether or not so restrained, Tenant acknowledges and agrees that it shall be and remain liable for all damages, loss, costs and expense resulting from any violation by Tenant of any of said Rules and Regulations. Nothing in this Lease contained shall be construed to impose upon Landlord any duty or obligation to enforce said Rules and Regulations or other Sections of this Lease, and any failure to enforce shall not be deemed a waiver thereof for purposes of subsequent enforcement, or to enforce the terms, covenants and conditions of any other lease against any other tenant or any other persons, and Landlord shall not be liable to Tenant for violation of the same by any other tenant, its employees, agents, invitees, or by any other persons.

9. **Rights Reserved to Landlord:** Landlord reserves the following rights, exercisable without notice and without liability to Tenant for damage or injury to property, person or business and without effecting an eviction or disturbance of Tenant's use or possession or giving rise to any claim for setoff or abatement of Rent or affecting any of Tenant's obligations under this Lease:

(a) To change the name or street address of the Building.

(b) To install and maintain signs on the exterior and interior of the Building.

(c) To prescribe the location and style of the suite number and identification sign or lettering for the Premises occupied by Tenant, which shall be provided at the expense of Tenant.

(d) To retain at all times, and to use in appropriate instances, pass keys to the Premises.

(e) To grant to anyone the right to conduct any business or render any service in the Building, whether or not it is the same as or similar to the Use expressly permitted to Tenant by Section 1(e).

(f) To decorate, remodel, repair, alter or otherwise prepare the Premises for re-occupancy at any time after Tenant vacates or abandons the Premises.

(g) To enter the Premises at reasonable hours upon advance notice to Tenant for reasonable purposes, including inspection and supplying other service to be provided to Tenant hereunder.

(h) To require all persons entering or leaving the Building during such hours as Landlord may from time to time reasonably determine to identify themselves to Building security by registration or otherwise, and to establish their right to enter or leave in accordance with the Rules and Regulations attached to this Lease as **Exhibit C**. Landlord shall not be liable in damages for any error with respect to admission to or eviction or exclusion from the Building of any person. In case of fire, flood, interruption of services, invasion, insurrection, mob, riot, civil disorder, public excitement or other commotion, or threat thereof, Landlord reserves the right to limit or prevent access to the Building during the continuance of the same, shut down elevator service, activate elevator emergency controls, or otherwise take such action or preventive measures deemed necessary by Landlord for the safety of the tenants or other occupants of the Building or the protection of the Building and the property in the Building. Tenant agrees to cooperate in any reasonable safety program developed by Landlord.

(i) To control and prevent access to non-general public areas in accordance with the Rules and Regulations attached to this Lease as **Exhibit C**.

(j) To decorate and to make, at its own expense, repairs, alterations, additions and improvements, structural or otherwise, in or to the Building or any part thereof, and any adjacent building, land, street or alley, including for the purpose of connection with or entrance into or use of the Building in conjunction with any adjoining or adjacent building or buildings, now existing or hereafter constructed, and may for that purpose erect scaffolding and other structures reasonably required by the character of the work to be performed, and during such operations may enter upon the Premises and take into and upon or through any part of the Building, including the Premises, all materials that may be required to make such repairs, alterations, improvements or additions, and in that connection Landlord may temporarily close public entry ways, other public spaces, stairways or corridors and interrupt or temporarily suspend any services or facilities agreed to be furnished by Landlord, all without the same constituting an eviction of Tenant in whole or in part and without abatement of Rent by reason of loss or interruption of the business of Tenant

or otherwise and without in any manner rendering Landlord liable for damages or relieving Tenant from performance of Tenant's obligation under this Lease; provided, however, that reasonable access to the Premises shall be maintained and the business of Tenant shall not be interfered with unreasonably. Landlord may at its option make any repairs, alterations, improvements and additions in and about the Building and the Premises during ordinary business hours and, if Tenant desires to have such work done during other than business hours, Tenant shall pay all overtime and additional expenses resulting therefrom.

(k) From time to time to make and adopt such reasonable rules and regulations, in addition to or other than or by way of amendment or modification of the Rules and Regulations attached to this Lease as **Exhibit C**, or other Sections of this Lease, for the protection and welfare of the Building and its tenants and occupants, as Landlord may determine, and Tenant agrees to abide by all such rules and regulations.

10. Alterations and Improvements to the Premises:

In order to prepare the Premises for occupancy and the opening of Tenant's business, and the conduct of Tenant's business thereafter, Tenant may perform certain additions, alterations and improvements (together, "Improvements") to the Premises. Tenant shall not make Improvements to the Premises without Landlord's advance written consent in each instance, which consent shall not be unreasonably withheld or delayed so long as the requirments of this Section 10 are met. In the case Tenant desires to paint and/or make other minor improvements to the Premises that are not structural, do not require a permit, and will not exceed $5,000.00 per annum (at Tenant's sole cost and expense), Landlord's approval will be needed such as for Tenant's choice of color, carpeting, etc., to ensure the same are in accordance with Building standards.

All Improvements shall be at Tenant's expense and done by Landlord approved contractors retained by Tenant, and shall comply with all insurance requirements and with the requirements of all applicable laws, ordinances, codes and regulations. Tenant shall, prior to commencing Improvements, and at its sole cost and expense, furnish to Landlord copies of all applicable governmental permits and reasonable evidence that all Improvements will be constructed in accordance with all applicable building and safety codes prior to the commencement of construction. Before any contactor or subcontractor may commence any Improvements or obtain access to the Premises or any of the Building's mechanical systems, Tenant must provide Landlord with certificates of insurance from Tenant's contractor and all subcontractors, naming Landlord, as an additional insured in amounts and for coverages reasonably required by Landlord.

To the extent applicable to an Improvement, Tenant shall, at Tenant's sole expense, employ a licensed architect for the preparation of architectural construction drawings, including (i) furniture plans showing details of space occupancy, (ii) reflected ceiling plans, (iii) partition and door location plans, (iv) electrical and telephone plans noting any special requirements, (v) fire safety systems, (vi) detail plans and (vii) finish plans and schedules and specifications for the Improvement. Tenant shall also, at Tenant's sole expense, employ licensed mechanical and electrical engineers to prepare the mechanical and electrical drawings for the Improvement. To ensure compatibility with the mechanical and electrical base Building systems, Tenant may be required to use the same mechanical and electrical engineers as Landlord then uses to perform base Building work. Such architectural construction drawing and mechanical and electrical drawings are hereinafter collectively called "Tenant's Drawings". Tenant's said architects and engineers will be responsible for preparing Tenant's Drawings in form and substance acceptable to Landlord and Tenant and sufficient in all respects for issuance of a building permit.

Tenant's Drawings and any other Improvement shall be subject to Landlord's advance review and approval. Such review and approval shall not constitute any representation by Landlord that Tenant's Drawings are complete or an Improvement is suitable for their intended purpose, or that Tenant's Drawings or Improvement comply with applicable Building Code or any other applicable laws, ordinances and regulations, it being expressly agreed by Tenant that Landlord assumes no responsibility or liability whatsoever to Tenant or any other person or entity for such completeness, suitability or compliance. Tenant assumes all such responsibility and liability. Tenant is solely responsible for ensuring completion of Improvements in accordance with the Landlord approved Tenant's Drawings.

The costs of Improvements shall include demolition and the removal of rubbish from the Building and the transportation thereof to a dump; labor; material; building permit fees; outside hoisting, if any; premium cost of workers compensation; public liability and property damage insurance carried by contractors; Landlord's charge for reviewing and approving Tenant's Drawings at Landlord's then current standard hourly rates; and any other expenses incurred in connection with Tenant's Improvements.

Tenant shall timely pay to its contractors all costs in connection with Tenant's Improvements. Tenant shall deliver to Landlord copies of paid invoices and final, unconditional lien waivers from contractors, subcontractors, suppliers or materialmen. Tenant agrees to indemnify, defend and save Landlord harmless against and from any and all claims, damages, losses, liabilities and expenses (including reasonable attorneys' fees), arising out of any mechanic's and other liens and encumbrances to be filed or recorded against the Premises or the Building or against the interest of either Landlord or Tenant therein in connection with or as a result of Improvements. If any lien or encumbrance is so filed, then Tenant shall immediately discharge such lien or encumbrance of record or bond over such matter to the Landlord 's satisfaction. This paragraph shall survive the expiration or other termination of this Lease.

Tenant shall provide Landlord with a complete set of as-built architectural, mechanical, electrical and plumbing plans for any portion of the Premises which is improved.

During the construction/installation of any Improvement, Tenant shall not unreasonably disturb other occupants of the Building.

11. Assignment and Subletting: Tenant shall not, without the prior written consent of Landlord in Landlord's sole discretion (i) assign, transfer, sublease, mortgage, pledge, hypothecate or encumber, or subject to or permit to exist upon or be subjected to any lien or charge, this Lease or any interest under it, (ii) allow to exist or occur any transfer of or lien upon this Lease or Tenant's interest herein by operation of law, (iii) sublet the Premises or any part thereof, or (iv) permit the use or occupancy of the Premises or any part thereof for any purpose not provided for under Section 1.E of this Lease or by anyone other than Tenant and Tenant's employees. There shall be no assumption or assignment of this Lease pursuant to a bankruptcy or reorganization proceeding if such assumption or assignment would impair any other lease of Landlord. Without limiting Landlord's right and ability to otherwise withhold consent, no consent shall be provided unless there are no uncured Defaults under this Lease and Landlord is provided with adequate assurance of future performance of Tenant's obligations under this Lease. The posting of an irrevocable letter of credit securing payment of the Rent for the balance of the Term, including any option periods, shall be deemed adequate assurance.

Consent by Landlord to any assignment, subletting, use or occupancy, or transfer shall not operate to relieve Tenant from any covenant or obligation hereunder except to the extent, if any in Landlord's sole discretion, expressly provided for in such consent, or be deemed to be a consent to or relieve Tenant from obtaining Landlord's consent to any subsequent assignment, transfer, lien, charge, subletting, use or occupancy.

It is a condition of this Lease that Tenant is leasing the Premises for its own account and use and may not assign this Lease or sublet all or any part of the Premises for profit. With respect to any permitted assignment or sublease, Landlord hereby reserves and there shall be paid to Landlord as Additional Rent under this Lease (i) all payments and the value in money of any other consideration payable by the assignee for such assignment and (ii) all rents and other payments by the subTenant with respect to such sublease, but only to the extent that such rents or other payments exceed the Rent otherwise payable under this Lease with respect to that part of the Premises covered by such sublease. Such Additional Rent hereunder shall be due and payable to Landlord at the same time such payment, rent or other consideration is to be paid by the assignee or subTenant.

Notwithstanding anything to the contrary in this Section 11, if Tenant is a sole owner corporation or limited liability company and if during the Term of this Lease, the ownership of the interests which constitute control of Tenant changes by reason of sale, gift or death, Tenant shall notify Landlord of such change within five (5) days thereof, and Landlord, at its option, may at any time thereafter terminate this Lease by giving Tenant written notice of said termination at least sixty (60) days prior to the date of termination stated in the notice. The term "control" as used herein means the power to directly or indirectly direct or cause the direction of the management or policies of the Tenant. A change or series of changes in ownership of stock which would result in direct or indirect change in ownership by the stockholders or an affiliated group of stockholders of less than fifty percent (50%) of the outstanding stock shall not be considered a change of control.

12. Insurance and Indemnities.

(a) Tenant shall, at its sole cost and expense, obtain and maintain, commencing with the Commencement Date and continuing throughout the Term, insurance policies providing the following coverages:

(i) all-risk or fire and extended coverage insurance against fire, vandalism, malicious mischief, sprinkler leakage and such additional perils as now are or hereafter may be included in a standard extended coverage endorsement from time to time in general use in the State of Illinois, insuring all Premises improvements, Tenant personal property, and all leasehold fixtures and equipment, in an amount not less than the full replacement value thereof and, in any event, in at least such an amount as will prevent Tenant from becoming a co-insurer under the terms of such insurance policy. Any and all proceeds of such insurance, so long as the Lease shall remain in effect, shall be used only to repair or replace or pay for the items so insured (subject, however, to the provisions of Section 14 hereof);

(ii) a comprehensive policy of general liability insurance, protecting against any liability occasioned on or about any part of the Premises or appurtenances thereto, or arising from any of the acts set forth in Section 12 (e) hereof against which Tenant is required to indemnify Landlord, with such policy to be in the minimum amount of Two Million Dollars ($2,000,000.00) combined single limit coverage. Landlord shall have the right to increase such limitations from time to time during the Term, in accordance with reasonable and prudent insurance practices;

(iii) worker's compensation insurance having such limits, and under such terms and conditions, as are required by applicable law;

(iv) during the period of any construction by Tenant, reconstruction or alteration of the Improvements, builder's risk insurance in an amount equal to the completed value of the improvements;

(vi) such other types of insurance in such additional amounts as reasonably may be required by Landlord.

(b) Tenant shall require all contractors employed by it to maintain public liability insurance and broad form property damage insurance, including completed operations and contractual coverage to include the indemnity set forth in Section 12 (e), the limits of coverage of which are to be not less than Two Million Dollars ($2,000,000.00) for all perils for the Lease Year. Completed operations coverage shall be continued for not less than twelve (12) months after the date of acceptance of and full payment for completion of the Work. Broad form property damage insurance shall specifically include demolition and excavating. Tenant shall also require its contractors and subcontractors to carry worker's compensation and employer's liability insurance affording protection under the Worker's Compensation Law of the State of Kansas and employer's liability protection subject to a limit of not less than Five Hundred Thousand Dollars ($500,000.00) (or such higher amount as may be required by applicable law).

(c) All insurance policies required to be procured and maintained by Tenant under this Lease shall: (i) be issued by financially responsible insurance companies authorized to do business in the State of Illinois; (ii) be written as primary policy coverage and not contributing with or in excess of any coverage which Landlord may carry; (iii) insure and name Landlord as an additional insured as its interest may appear; and (iv) contain an express waiver of any right of subrogation by the insurance company against Landlord and Landlord's agents and employees. With respect to each and every one of the insurance policies required to be procured and maintained under this Lease, Tenant shall deliver to Landlord, upon request, a certificate of insurance for each such policy, together with evidence of payment of all applicable premiums. Each and every insurance policy required to be carried hereunder by or on behalf of Tenant (and/or its contractors) shall provide (and any certificate evidencing the existence of each such insurance policy shall certify) that, unless Landlord shall first have been given sixty (60) days' prior written notice thereof: (i) such insurance policy shall not be canceled and shall continue in full force and effect, (ii) the insurance carrier shall not, for any reason whatsoever, fail to renew such insurance policy, and (iii) no material changes may be made in such insurance policy (which shall also require Landlord's approval). The term "insurance policy" as used herein shall be deemed to include any extensions or renewals of such insurance policy. In the event that Tenant (and/or its contractors) shall fail promptly to furnish any insurance coverage hereunder required to be procured by Tenant (and/or its contractors) Landlord, at its sole option, shall have the right to obtain the same and pay the premium therefor for a period not exceeding one (1) year in each instance, and the premium so paid by Landlord shall be immediately due and payable by Tenant to Landlord as Additional Rent.

(d) Landlord and Tenant agree to use their efforts to have all fire and extended coverage and material damage insurance which may be carried by either of them endorsed with a clause providing that any release from liability of or waiver of claim for recovery from the other party entered into in writing by the insured thereunder prior to any loss or damage shall not affect the validity of said policy or the right of the insured to recover thereunder. Without limiting any release or waiver of liability or recovery contained in any other Section of this Lease but rather in confirmation and furtherance thereof, each of the parties hereto waives all claims for recovery from the other party their beneficiaries, as applicable, and each of them and their beneficiaries' respective partners, officers, directors, employees, and agents for any loss or damage to any of its property insured under valid and collectible insurance policies to the extent of any recovery collectible under such insurance policies. This waiver, however, shall be effective only when the

waiver is permitted by such insurance policy or by use of good faith efforts could have been included in or permitted by the applicable insurance policy at no additional premium expense. Notwithstanding the foregoing, Landlord and Tenant acknowledge and agree that the provisions of this Section 12 (d) are not intended and shall not be construed so as to either expand or limit the rights and obligations of Landlord and Tenant as set forth in Sections 12 (e) and (f) below.

(e) Tenant hereby indemnifies and agrees to defend and save harmless Landlord, and its officers, directors, partners, employees and agents and any mortgagee from and against any and all claims, actions, damages, liabilities, costs and expenses, including attorneys' fees and disbursements, to the extent that the same (i) arise from or are in connection with the Premises or the Use (including, without limitation, those arising from the possession, use, occupancy, operation, management, construction, repair, maintenance, medical waste disposal, protected health information destruction, or control of the Premises by Tenant and/or its agents, employees, contractors, licensees or invitees), or (ii) arise from or are in connection with any act or omission of Tenant or Tenant's agents, employees, contractors, licensees or invitees in the Building and/or on the land related thereto owned by Landlord, or (iii) result from any default, breach, violation or nonperformance of this Lease or any provision hereof by Tenant, or (iv) result from injury to person or property or loss of life sustained in or about the Premises, all regardless of whether such claims, actions, damages, liabilities, costs or expenses, including attorneys" fees and disbursements, are asserted or incurred before, on, or after the Commencement Date. Tenant's indemnity obligations hereunder shall not apply to any injury, claims, actions, damages, liabilities, costs or expenses, including attorneys' fees and disbursements, to the extent caused by Landlord or its agents and employees or the action of others having no direct business connection to Tenant. Tenant shall, at its own cost and expense, defend any and all actions, suits and proceedings which may be brought against Landlord or any mortgagee or the Premises with respect to the foregoing. Tenant shall pay, satisfy and discharge any and all judgments, orders and decrees which may be received against Landlord or any such mortgagee or master Landlord in connection with the foregoing to the extent of Tenant's required indemnity obligations hereunder. In the event Landlord or any other party so indemnified shall be made a party to any litigation commenced by or against Tenant, or if Landlord or any such party shall, in its sole discretion, intervene in such litigation (if it reasonably determines that intervention is necessary or desirable to protect its interest hereunder), then Tenant shall protect and hold them harmless and shall pay all costs, expenses and attorneys' fees incurred or paid by such party(ies) in connection with such litigation to the extent that such litigation asserts damages attributable to Tenant or Tenant's agents, employees, contractors, licensees or invitees. Tenant's obligations under this Section 12 (e) shall survive the termination, for any reason, of this Lease.

(f) Except with respect to any damages resulting from the negligence or intentional act of Landlord, its agents or employees, Landlord shall not be liable to Tenant, its agents, employees or customers, for any damage, loss, compensation, accident, or claims whatsoever resulting from: the necessity of repairing any portion of the Premises; any interruption in the use of the Premises; the use or operation (by Landlord, Tenant, or any other person or persons whatsoever) of any portion of the Premises (or any fixtures or equipment thereon); the termination of this Lease by reason of the destruction of the Premises; any fire, robbery, theft, or any other casualty; any leakage in any part or portion of the Premises; any water, wind, rain or snow that may leak into, or flow from part of the Premises; any acts or omissions of any occupant of any space adjacent to or adjoining all or any part of the Premises; any explosion, casualty, utility failure or malfunction, or falling plaster; the bursting, stoppage or leakage of any pipes, sewer pipes, drains, conduits, appliances and plumbing works; and any other cause whatsoever.

13. Fire or Casualty: If the Premises or the Building or any part of either is damaged or made untenantable by fire or other casualty, cause, condition or thing whatsoever, whether or not the Premises are damaged, and Landlord shall determine not to restore it, Landlord may, by notice to Tenant given within

sixty (60) days after such damage, terminate this Lease. Such termination shall become effective as of the date of such damage if the Premises are untenantable, otherwise as of a date sixty (60) days following the service of such notice of lease termination. Unless this Lease is terminated as hereinabove provided, if the Premises are made partially or wholly untenantable as aforesaid, Landlord shall restore the same at Landlord's expense with reasonable promptness. If as a result of a fire or other casualty, cause, condition or thing whatsoever a substantial amount of public space in the Building is damaged to such extent as to substantially interfere with Tenant's use of the Premises, or if the Premises are made partially or wholly untenantable, and in either case if Landlord fails within one hundred twenty (120) days after Landlord is able to take possession of the damaged space and Premises, to restore the damaged public space to eliminate substantial interference with Tenant's use of the Premises, or to substantially restore the Premises, either Landlord or Tenant may terminate this Lease as of the end of said one hundred twenty (120) days by notice to the other given not later than thirty (30) days after the expiration of said one hundred twenty (120) day period. In the event of termination of this Lease pursuant to this Section 13, Rent at the then current rate shall be prorated on a per diem basis (on the basis of a year of three hundred sixty (360) days) and paid only to the effective date of such termination. If 50% or more of the Premises are untenantable but this Lease is not terminated, all Rent shall abate from the date of the fire or other relevant cause, condition or thing until the Premises are ready for occupancy and reasonably accessible to Tenant; if part of the Premises are untenantable, Rent shall be prorated on a per diem basis and apportioned in accordance with the part of the Premises which is usable by Tenant until the damaged part is ready for Tenant's occupancy. In all cases, due allowance shall be made for reasonable delay caused by adjustment of insurance loss, strikes, labor difficulties or any cause beyond Landlord's reasonable control. Notwithstanding anything to the contrary in this Section 13, Tenant shall not have the right to terminate this Lease and Rent shall in no event abate if such fire or other casualty, cause, condition or thing was caused by the act or neglect of Tenant, its employees or agents.

14. Eminent Domain: If the Building, or any part thereof which includes a substantial part of the Premises, shall be taken or condemned by any competent authority for any public or quasi-public use or purpose, the Term of this Lease shall end upon and not before the date when the possession of the part so taken shall be required for such use or purpose, and without apportionment of the award to or for the benefit of Tenant. If any condemnation proceeding shall be instituted in which it is sought to take or damage any part of the Building, or the land under it, or if the grade of any street or alley adjacent to the Building is changed by any competent authority and such change of grade makes it necessary or desirable to remodel the Building to conform to the changed grade, Landlord shall have the right to cancel this Lease upon not less than ninety (90) days notice prior to the date of cancellation designated in the notice. In either of the events above referred to, Rent at the then current rate shall be apportioned as of the date of the termination. No money or other consideration shall be payable by Landlord to Tenant for the right of cancellation, and Tenant shall have no right to share in the condemnation award or in any judgment for damages caused by the change of grade.

15. Default: Landlord's & Tenant's Rights and Remedies:

(a) The occurrence of any one or more of the following matters constitutes a Default by Tenant under this Lease:

(i) Failure by Tenant to pay, within five (5) days after notice from Landlord of non-payment, any Rent provided for in this Lease;

(ii) Failure by Tenant to pay within ten (10) days after notice thereof from Landlord to Tenant, any other moneys due and payable from Tenant to Landlord under this Lease;

(iii) Failure by Tenant to observe or perform any of the covenants in respect of Assignment and Subletting set forth in Section 11;

(iv) Failure by Tenant to cure forthwith, immediately after receipt of notice from Landlord, any hazardous condition which Tenant has created in violation of law or of this Lease, including but not limited to improper disposal of medical waste;

(v) Failure by Tenant to observe or perform any other covenant, agreement, condition or provision of this Lease, if such failure shall continue for thirty (30) days after notice to Tenant by Landlord;

(vi) The levy upon under execution or the attachment by legal process of the leasehold interest of Tenant, or the filing or creation of a lien in respect of such leasehold interest;

(vii) Tenant vacates or abandons the Premises (the transfer of a substantial part of the operations, business, and personnel of Tenant to some other location being deemed, without limiting the meaning of the term "vacates or abandons," to be a vacation or abandonment within the meaning of this clause (vii), notwithstanding that Tenant shall thereafter continue to pay the Rent due under this Lease);

(viii) Tenant becomes insolvent or a debtor in a bankruptcy or reorganization or admits in writing its inability to pay its debts as they become due or generally is not paying its debts as they become due, or makes an assignment for the benefit of creditors, or applies for or consents to the appointment of a trustee or receiver for Tenant or for the major part of its property;

(ix) A trustee or receiver is appointed for Tenant or for the major part of its property and is not discharged within thirty (30) days after such appointment; and/or

(x) Bankruptcy, reorganization, arrangement, insolvency or liquidation proceedings, or other proceedings for relief under any bankruptcy law, or similar law for the relief of debtors, are instituted by or against Tenant, and, if instituted against Tenant, are allowed against it or are consented to by it or are not dismissed within sixty (60) days after such institution.

(b) If a Default occurs, Landlord shall have the rights and remedies hereinafter set forth, which shall be distinct, separate and cumulative and shall not operate to exclude or deprive Landlord of any other right or remedy allowed it by law:

(i) Landlord may terminate this Lease by giving to Tenant notice of Landlord's intention so to do, in which event the Term of this Lease shall end, and all right, title and interest of Tenant hereunder shall expire, on the date stated in such notice;

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

(iii) Landlord may enforce the provisions of this Lease and may enforce and protect the rights of Landlord hereunder by a suit or suits in equity or at law for the specific performance of any covenant or agreement contained herein, or for the enforcement of any other appropriate legal or equitable

remedy, including recovery of all moneys due or to become due from Tenant under any of the provisions of this Lease.

(c) If Landlord exercises either of the remedies provided for in Section 15.b(i) and (ii), Tenant shall surrender possession and vacate the Premises immediately and deliver possession thereof to Landlord, and Landlord may then or at any time thereafter re-enter and take complete and peaceful possession of the Premises, with or without process of law, full and complete license so to do being hereby granted to Landlord, and Landlord may remove all occupants and property therefrom, using such force as may be necessary, without being deemed in any manner guilty of trespass, eviction or forcible entry and detainer and without relinquishing Landlord's right to Rent or any other right given to Landlord hereunder or by operation of law.

(d) If Landlord terminates the right of Tenant to possession of the Premises without terminating this Lease, such termination of possession shall not release Tenant, in whole or in part, from Tenant's obligation to pay the Rent hereunder for the full Term, and the aggregate amount of the adjusted Rents as in effect at the time of such termination as determined pursuant to the provisions of Section 3 of this Lease for the period from the date stated in the notice terminating possession to the end of the Term shall at once mature and be immediately due and payable by Tenant to Landlord, together with any other moneys due hereunder, and Landlord shall have the right to immediate recovery of all such amounts. In addition, Landlord shall have the right, from time to time, to recover from Tenant, and Tenant shall remain liable for, all Adjustments and any other sums thereafter accruing as they become due under this Lease during the period from the date of such notice of termination of possession to the stated end of the Term. In any such case, Landlord may, but shall be under no obligation to, relet the Premises or any part thereof for the account of Tenant for such rent, for such time (which may be for a term extending beyond the Term of this Lease) and upon such terms as Landlord in Landlord's sole discretion shall determine, and Landlord shall not be required to accept any tenant offered by Tenant or to observe any instructions given by Tenant relative to such reletting. Also in any such case Landlord may make repairs, alterations and additions in or to the Premises and redecorate the same to the extent deemed by Landlord necessary or desirable and in connection therewith change the locks to the Premises, and Tenant shall upon demand pay the cost thereof together with Landlord's expenses of reletting. Landlord may collect the rents from any such reletting and apply the same first to the payment of the expenses of re-entry, redecoration, repair and alterations and the expenses of reletting and second to the payment of Rent herein provided to be paid by Tenant, and any excess or residue shall operate only as an offsetting credit against the amount of Rent as the same thereafter becomes due and payable hereunder, but the use of such offsetting credit to reduce the amount of Rent due Landlord, if any, shall not be deemed to give Tenant any right, title or interest in or to such excess or residue and any such excess or residue shall belong to Landlord solely; provided that in no event shall Tenant be entitled to a credit on its indebtedness to Landlord, in excess of the aggregate sum (including Base Rent and Adjustments) which would have been paid by Tenant for the period for which the credit to Tenant is being determined, had no Default occurred. No such re-entry or repossession, repairs, alterations and additions, or reletting shall be construed as an eviction or ouster of Tenant or as an election on Landlord's part to terminate this Lease unless a written notice of such intention be given to Tenant or shall operate to release Tenant in whole or in part from any of Tenant's obligations hereunder, and Landlord may, at any time and from time to time, sue and recover judgment for any deficiencies from time to time remaining after the application, from time to time, of the proceeds of any such reletting.

(e) In the event of the termination of this Lease by Landlord as provided for by Section 15.b(i), Landlord shall be entitled to recover from Tenant all the fixed dollar amounts of Rent accrued and unpaid for the period up to and including such termination date, as well as all other additional sums payable by Tenant, or for which Tenant is liable or in respect of which Tenant has agreed to indemnify Landlord under

any of the provisions of this Lease, which may be then owing and unpaid, and all costs and expenses, including court costs and attorneys' fees incurred by Landlord in the enforcement of its rights and remedies hereunder. In addition Landlord shall be entitled to recover as damages for loss of the bargain and not as a penalty the aggregate sum which at the time of such termination represents the excess, if any, of the present value of the aggregate Rents at the same annual rate for the remainder of the Term as then in effect pursuant to the provisions of Section 3 of this Lease, over the then present value of the then aggregate fair rental value of the Premises for the balance of the Term, such present worth to be computed in each case on the basis of an eight percent (8%) per annum discount from the respective dates upon which such Rents would have been payable hereunder had this Lease not been terminated, and (z) any damages in addition thereto, including reasonable attorneys' fees and court costs, which Landlord shall have sustained by reason of the breach of any of the covenants of this Lease other than for the payment of Rent.

(f) All property removed from the Premises by Landlord pursuant to any provisions of this Lease or of law may be handled, removed or stored by Landlord at the cost and expense of Tenant, and Landlord shall in no event be responsible for the value, preservation or safekeeping thereof. Tenant shall pay Landlord for all expenses incurred by Landlord in such removal and storage of such property so long as the same shall be in Landlord's possession or under Landlord's control. All property not removed from the Premises or retaken from storage by Tenant within thirty (30) days after the end of the Term, however terminated, shall be conclusively deemed to have been conveyed by Tenant to Landlord as by bill of sale without further payment or credit by Landlord to Tenant.

(g) In the event of any dispute under this Lease, the losing party shall pay the prevailing party's expenses.

(h) If Tenant is required to pay rent after termination of this Lease for the remainder of the Term, the rent for the remainder of the Term shall be its present value due in a lump sum with the present value calculated with a discount rate of 2%. Upon making such payment, Tenant shall promptly receive from Landlord all rents received by Landlord from other tenants on account of the Premises during the Lease Term, provided that the monies to which Tenant shall so become entitled shall in no event exceed the entire amount actually paid by Tenant to Landlord pursuant to the preceding sentence.

(i) Notwithstanding any other provision of this Lease, in the event that Landlord fails to fulfill any of Landlord's obligations under this Lease, Tenant shall have all remedies provided by law.

16. Subordination of Lease: The rights of Tenant under this Lease shall be subject and subordinate at all times to the lien of any first mortgage, trust deed or similar encumbrance now or hereafter at any time during the Term of this Lease in force on, covering or against the Building or any portion thereof, or the land or any portion thereof upon which the Building or any portion thereof is situated, whether such lien be on, cover or against a leasehold estate or the fee simple estate therein, or both. Although no instrument or act of Tenant shall be necessary to effectuate such subordination, Tenant, nevertheless, will execute and deliver such further instruments subordinating this Lease to the lien of any mortgage or trust deed as may be desired by the lender and requested by Landlord. Notwithstanding the foregoing, the rights of Tenant hereunder shall not be disturbed, diminished or interfered with, but shall continue in full force and effect so long as Tenant shall not be in default hereunder.

17. Security Deposit: Tenant hereby deposits with Landlord the amount set forth in Section 1.F. above, if any (the "Security Deposit"), as security for the performance of Tenant's obligations under this Lease. The Security Deposit may be applied, in whole, or in part, by Landlord to cure any Default or Defaults of Tenant under this Lease or to pay any amounts payable by Tenant hereunder, without limiting,

impairing, or being in lieu of any other remedy or remedies which Landlord may have on account of such Default. Upon any such application, Tenant shall immediately, upon demand by Landlord, pay to Landlord the amount so applied in order that Landlord shall have the full amount of the Security Deposit on hand at all times during the Term of this Lease. The Security Deposit shall in no event be deemed an advance payment of Rent or a limitation upon the damages recoverable by Landlord on account of any Default by Tenant hereunder. Provided that Tenant shall not be in Default in the performance of any of its obligations under this Lease, any balance of the Security Deposit remaining unapplied at the termination or expiration of this Lease shall be repaid to Tenant not later than thirty (30) days after such termination or expiration and Tenant's vacation of the Premises as provided hereunder. If the Premises are conveyed by Landlord, Landlord shall be released from all liability for repayment of the Security Deposit upon paying or giving a credit to its transferee for the amount of the Security Deposit and such transferee's assumption of the responsibility of repayment of the Security Deposit, and, if Landlord has complied with the forgoing requirements, Tenant shall look to Landlord's successor in interest for repayment thereof. The preceding sentence shall apply to each subsequent conveyance of the Premises. The Security Deposit shall not be assigned or encumbered by Tenant, and any such purported assignment or encumbrance shall be void.

18. Quiet Enjoyment: Upon payment by Tenant of the Rents and all other charges provided for under this Lease, and upon the observance and performance of all covenants, terms and conditions on Tenant's part to be observed and performed pursuant to this Lease, Tenant shall, at all times during the Term hereof, subject to the terms, covenants and conditions of this Lease, peaceably and quietly hold and enjoy the Premises, without any interruption or disturbance from Landlord or any other person or persons lawfully or equitably claiming by, through or under Landlord, subject to the terms and conditions of this Lease or any mortgage to which this Lease is subordinate. The rights of Tenant shall survive any foreclosure of the Building, and Landlord agrees for itself and for any other person acquiring title to the Building through a foreclosure that Tenant's possession of the Premises will not be disturbed during the Term of the Lease, as said term may be extended as said Premises may be expanded, by reason of a foreclosure.

19. Nonwaiver: No waiver of any condition expressed in this Lease shall be implied by any neglect of Landlord or Tenant to enforce any remedy on account of the violation of such condition, whether or not such violation be continued or repeated subsequently, and no express waiver shall affect any condition other than the one specified in such waiver and that one only for the time and in the manner specifically stated. Without limiting the provisions of Section 8, it is agreed that no receipt of moneys by Landlord from Tenant after the termination in any way of the Term or of Tenant's right of possession hereunder or after the giving of any notice shall reinstate, continue or extend the Term or affect any notice given to Tenant prior to the receipt of such moneys. It is also agreed that after the service of notice or the commencement of a suit or after final judgment for possession of the Premises, Landlord and Tenant may receive and collect any moneys due, and the payment of said moneys shall not waive or affect said notice, suit or judgment.

20. Estoppel Certificate: Tenant agrees that from time to time upon not less than ten (10) days prior request by Landlord, Tenant will deliver to Landlord a statement in writing certifying (a) that this Lease is unmodified and in full force and effect (or if there have been modifications that the lease as modified is in full force and effect and identifying the modifications), (b) the dates to which the Rent and other charges have been paid, and (c) that Landlord is not in Default under any provision of this Lease, or, if in Default, the nature thereof in detail.

21. Tenant-Corporation or Partnership: In case Tenant is a corporation, Tenant represents and warrants that this Lease has been duly authorized, executed and delivered by and on behalf of Tenant and constitutes the valid and binding agreement of Tenant in accordance with the terms hereof. In case Tenant is a partnership or limited liability company (LLC), Tenant represents and warrants that all of the persons who are general or managing partners, or members of said LLC, have executed this Lease on behalf of Tenant, or that this Lease has been executed and delivered pursuant to and in conformity with a valid and effective authorization therefor by all of the general or managing partners of such partnership, or members of such LLC, and is and constitutes the valid and binding agreement of the partnership or LLC, and each and every partner therein, or member therein, in accordance with its terms. Also, it is agreed that each and every present and future partner or member in Tenant shall be and remain at all times jointly and severally liable hereunder and that the death, resignation or withdrawal of any partner or member shall not release the liability of such partner or member under the terms of this Lease unless and until Landlord shall have consented in writing to such release.

22. Real Estate Brokers: Neither Tenant nor Landlord have dealt with any broker in connection with this Lease other than as set forth in Section 1.H. Each party indemnifies and holds the other, its beneficiaries and their respective agents and employees harmless from all claims of any other brokers arising through such indemnifying party in connection with this Lease. Landlord shall pay the foregoing brokers by separate agreement.

23. Assignment or Sale by Landlord: In the event Landlord shall assign this Lease or sell, convey or otherwise transfer its interest in the Building, whether voluntarily, involuntarily, by foreclosure (or by deed in lieu of foreclosure) or by operation of law or otherwise, the same shall operate to release Landlord from any future liability upon any of the covenants or conditions, express or implied, herein contained in favor of Tenant, subject however to Landlord's liability for the Security Deposit described in Section 17, and in such event Tenant agrees to look solely to the successor in interest of Landlord in and to this Lease. This Lease shall remain in full force and effect and shall not be terminated except in accordance with the express provisions hereof. Tenant hereby agrees that it will attorn to and recognize any successor to Landlord's interest in the Premises as the new Landlord under this Lease, and Tenant hereby covenants and agrees that it will execute any instruments required by such successor evidencing the same.

24. Notices: In every instance where it shall be necessary or desirable for Landlord to serve any notice or demand upon Tenant, notice will be sent to the Tenant address set forth in Section 1.B (or such other address of which Tenant notifies Landlord in writing), with a copy to: Alexander Domanskis, Boodell & Domanskis, LLC, 1 North Franklin Street, Suite 1200, Chicago, IL 60660 and shall be deemed delivered when (a) personally delivered to Tenant or its agent; (b) when left at such address after sending by recognized overnight delivery service such as FedEx or UPS; or (c) two (2) business days after sending by United States registered or certified mail, postage prepaid, addressed to Tenant at such address. Any such notice or demand to be given by Tenant to Landlord shall, until further notice, be served personally, by recognized overnight delivery, or by registered or certified mail to Landlord at 5151 W. 95th Street, 2nd Floor, Oak Lawn, Illinois 60453.

25. Miscellaneous:

(a) Each provision of this Lease shall extend to and shall bind and inure to the benefit not only of Landlord and Tenant, but also their respective heirs, legal representatives, successors and assigns, but this

provision shall not operate to permit any transfer, assignment, mortgage, encumbrance, lien, charge or subletting contrary to the provisions of Section 11.

(b) All of the agreements of Landlord and Tenant with respect to the Premises are contained in this Lease; and no modification, waiver or amendment of this Lease or of any of its conditions or provisions shall be binding upon Landlord unless in writing signed by Landlord.

(c) Submission of this instrument for examination shall not constitute a reservation of or option for the Premises or in any manner bind Landlord and no lease or obligation on Landlord shall arise until this instrument is signed and delivered by Landlord and Tenant.

(d) The word "Tenant" whenever used herein shall be construed to mean Tenants or any one or more of them in all cases where there is more than one Tenant; and the necessary grammatical changes required to make the provisions hereof apply either to corporations or other organizations, partnerships or other entities, or individuals, shall in all cases be assumed as though in each case fully expressed. In all cases where there is more than one Tenant, they shall be and remain at all times jointly and severally liable hereunder.

(e) Clauses, plats and riders, if any, signed by Landlord and Tenant and endorsed on or affixed to this Lease are part hereof and in the event of variation or discrepancy the duplicate original hereof, including such clauses, plats and riders, if any, held by Landlord shall control.

(f) The headings of Sections are for convenience only and do not limit, expand or construe the contents of the Sections.

(g) Landlord's title is and always shall be paramount to the title of Tenant, and nothing in this Lease contained shall empower Tenant to do any act which can, shall or may encumber the title of Landlord.

(h) Time is of the essence of this Lease and of each and all provisions thereof.

(i) All amounts (including, without limitation, Base Rent) owed by Tenant to Landlord pursuant to any provision of this Lease shall, unless another interest rate is provided herein, bear interest from the date due until paid at two points over Landlord's Prime Rate, from time to time in effect during such period, unless a lesser rate shall then be the maximum contract rate permissible by law, in which event said lesser rate shall be charged.

(j) This Lease may be executed in one or more counterparts, each of which shall be deemed an original.

(k) It is the intent of the parties hereto that all questions with respect to the construction of this Lease and the rights and the liabilities of the parties hereto shall be determined in accordance with the laws of the State of Illinois and the proper and agreed upon venue shall be Cook County, Illinois.

(l) In the event of any action or proceeding brought by either Landlord or Tenant under this Lease the prevailing party shall be entitled to recover for the fees of its attorneys in such action or proceeding,

including costs of appeal, if any. In addition, should it be necessary for Landlord to employ legal counsel to enforce any of the provisions herein contained, Tenant agrees to pay all attorneys' fees and court costs incurred.

(m) Neither this Lease nor any memorandum hereof shall be recorded without the express written consent of Landlord. If Landlord requests, Tenant shall execute and acknowledge a short form of Lease for recording.

26. Mechanic's Liens: Tenant shall never permit a mechanic's or other lien to be filed against the Premises, Landlord's interest in the Premises or the Building by reason of work, labor, service or materials performed or furnished, or alleged to have been performed or furnished, to Tenant or to anyone holding the Premises through or under Tenant. All lienable work in the Premises shall be performed in accordance with Section 10 of this Lease. If, however, any mechanic's or other lien shall at any time be filed against the Premises by reason of work, labor, services or materials performed or furnished, or alleged to have been performed or furnished, to Tenant or to anyone holding the Premises through or under Tenant, Tenant shall forthwith cause the same to be discharged of record or bonded to the satisfaction of Landlord. If Tenant shall fail to cause such lien to be so discharged or bonded within thirty (30) days after being notified of the filing thereof, then, in addition to any other right or remedy of Landlord, Landlord may bond or discharge the same by paying the amount claimed to be due, and the amount so paid by Landlord, including reasonable attorneys' fees incurred by Landlord in defending against such lien and in procuring the bonding or discharge of such lien, shall be due and payable by Tenant to Landlord as Additional Rent upon being billed therefor by Landlord.

27. Compliance With Laws: To the extent such compliance is not the obligation of the Landlord pursuant to the terms of the Lease, Tenant agrees to strictly comply with all applicable laws, ordinances, statutes and regulations whatsoever, of any governmental body or subdivision, including but not limited to The Americans with Disabilities Act ("ADA"), incident to its occupancy of the Premises and its use thereof. In order to ensure full compliance with the ADA, Tenant represents and warrants to Landlord that it will not use the Premises in any manner that would cause it to fall within the definition of a "public accommodation" under the ADA, unless and until any necessary accessibility guidelines have been met by Tenant, at Tenant's sole cost and expense, including for the 2nd floor bathrooms; provided, however, that as to the 2nd floor bathrooms, Tenant's cost and expense to meet any necessary accessibility guidelines shall not exceed $10,000.00 and Landlord shall be responsible for any such costs and expense in excess of $10,000. Furthermore, as to the 2nd floor bathrooms, Tenant shall have no obligation for any cost and expense to meet any necessary accessibility guidelines if there are 60 days or less remaining in the Term of Lease and the Term has not been extended pursuant to Tenant's exercise of option to renew. In addition to any other provisions of this Lease, Tenant agrees to indemnify and save harmless Landlord and Landlord's agents against and from any and all claims, costs, counsel fees, expenses and liabilities arising from any violation by Tenant of the provisions of the ADA or any other applicable laws, in connection with Tenant's occupancy of the Premises, to the extent such compliance is not the responsibility of Landlord pursuant to other provisions of the Lease. Landlord acknowledges that the responsibility to cause all elevators, stairways, entrances, corridors and exits to and in the Building (and in the Premises to the extent such items are considered structural elements), any other common area in the Building (excepting the 2nd floor bathrooms, but subject to the limitations above), and any exits and entrances to the Premises to be in compliance with the ADA and any other applicable laws is the responsibility of Landlord. Furthermore,

nection with Tenant's occupancy of the Premises, to the extent such compliance is not the responsibility of Landlord pursuant to other provisions of the Lease. Landlord acknowledges that the responsibility to cause all elevators, stairways, entrances, corridors and exits to and in the Building (and in the Premises to the extent such items are considered structural elements), any other common area in the Building (excepting the 2nd floor bathrooms, but subject to the limitations above), and any exits and entrances to the Premises to be in compliance with the ADA and any other applicable laws is the responsibility of Landlord. Furthermore, and in addition to any other provision of this Lease, Landlord agrees to indemnify and save harmless Tenant and Tenant's agents against and from any and all claims, costs, counsel fees, expenses and liabilities from any violation by Landlord of the ADA or any other applicable laws, in connection with the Building, to the extent such compliance is not the responsibility of Tenant pursuant to this or other provisions of this Lease. Landlord agrees to strictly comply with all applicable laws, ordinances, statutes and regulations whatsoever, of any governmental body of subdivision, with respect to the structural elements of the Premises except as may be required due to Tenant's negligence or intentional acts.

IN WITNESS WHEREOF Landlord and Tenant have executed this Lease as of the day and year first above written.

Landlord:
3545 West 95th Street LLC.

By: _____

Name: Nouri Al-Khaled

Title: Managing Partner

Tenant:
Advanced Surgical Institute, LLC

By: _____

Name: Nouri Al-Khaled

Title: Managing Partner

EXHIBIT A

Premises

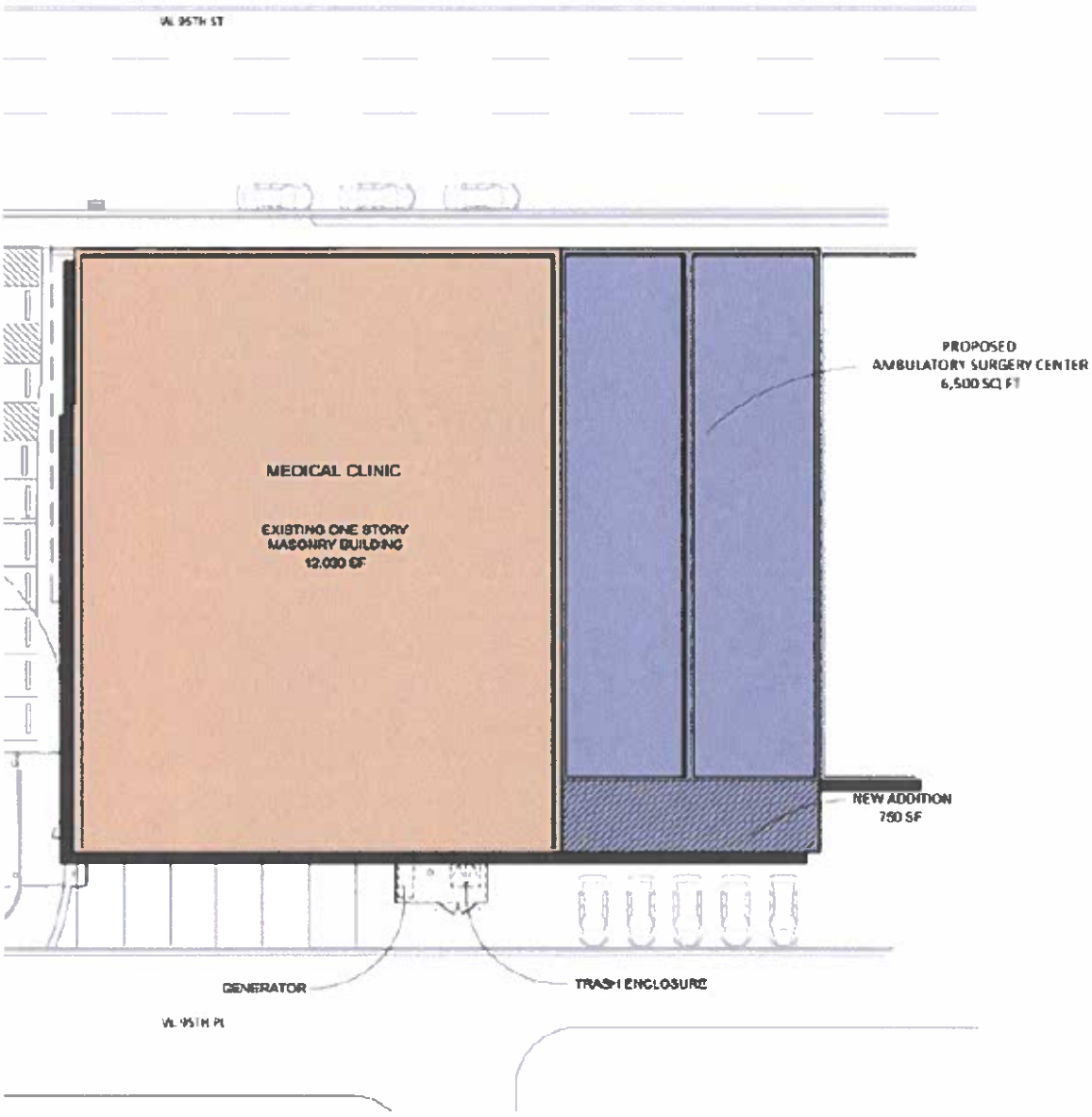


EXHIBIT B
INTENTIONALLY DELETED

EXHIBIT C

Rule and Regulations

(1) Protecting Premises. Before leaving the Premises unattended, Tenant shall close and securely lock all doors or other means of entry to the Premises and shut off all utilities in the Premises.

(2) Large Articles. Furniture, freight and other large or heavy articles may be brought into the Building upon reasonable prior notice to Landlord, and at times and in the manner designated by Landlord, and always at Tenant's sole responsibility. All damage done to the Building by moving or maintaining such furniture, freight or articles shall be repaired at the expense of Tenant. All furniture, equipment, cartons and similar articles desired to be removed from the Premises or the Building shall be listed by Tenant with Landlord and a removal permit therefor shall first be obtained from Landlord.

(3) Signs. Tenant shall not paint, display, inscribe, maintain or affix any sign, placard, picture, advertisement, name, notice, lettering or direction on any part of the outside or inside of the Building, or on any part of the inside of the Premises which can be seen from the outside of the Premises, without the written consent of Landlord, and then only such name or names or matter and in such color, size, style, character and material as may be first approved by Landlord in writing. Landlord reserves the right to remove at Tenant's expense all matter other than that above provided for without notice to Tenant.

(4) Advertising. Tenant shall not in any manner use the name of the Building for any purpose other than that of the business address of Tenant, or use any picture or likeness of the Building, or Landlord's name or words of similar import, in any letterheads, envelopes, circulars, notices, advertisements, containers or wrapping material without Landlord's express consent in writing.

(5) Compliance with Laws. Tenant shall comply with all applicable laws, ordinances, governmental orders or regulations and applicable orders or directions from any public office or body having jurisdiction, with respect to the Premises, Tenant's Use as described in the Lease, and the general use or occupancy thereof. Tenant shall not make or permit any use of the Premises which directly or indirectly is forbidden by law, ordinance, governmental regulation or order or direction of applicable public authority, or which may be dangerous to person or property.

(6) Hazardous Materials. Tenant shall not use or permit to be brought into the Premises or the Building any flammable oils or fluids, or any explosive or other articles deemed hazardous to persons or property, or do or permit to be done any act or thing which will invalidate or which if brought in would be in conflict with any insurance policy covering the Building or its operation, or the Premises, or any part of either; and will not do or permit to be done anything in or upon the Premises, or bring or keep anything therein, which shall not comply with all rules, orders, regulations or requirements of any organization, bureau, department or body having jurisdiction with respect thereto (and Tenant shall at all times comply with all such rules, orders, regulations or requirements), or which shall increase the rate of insurance on the Building, its appurtenances, contents or operation.

(7) Defacing the Premises and Overloading. Tenant shall not place anything or allow anything to be placed in the Premises near the glass of any door, partition, wall or window which may be unsightly from outside the Premises, and Tenant shall not place or permit to be placed any article of any kind on any window ledge or on the exterior walls. Tenant shall not remove Landlord's window treatments. Blinds, shades, awnings or other forms of inside or outside window coverings, or window ventilators or similar devices, shall not be placed in or about the outside windows in the Premises except to the extent, if any, that the character, shape, color, material and make thereof is approved by Landlord, and Tenant shall not do any painting or decorating in the Premises or make, paint, cut or drill into, drive nails, screws or other fasteners into or in any way deface any part of the Premises or Building without the written consent of Landlord. Tenant shall not overload any floor or part thereof in the Premises, or any facility in the Building or any public corridors or elevators therein by bringing in or removing any large or heavy articles, and Landlord may direct and control the location of safes and all other heavy articles and, if considered necessary by Landlord, require supplementary supports at the expense of Tenant of such material and dimensions as Landlord may deem necessary to properly distribute the weight.

(8) Obstruction of Public Areas. Tenant shall not take or permit to be taken in or out of other entrances of the Building, or take or permit on other elevators, any item normally taken in or out through the trucking concourse of service doors or in or on freight elevators; and Tenant shall not, whether temporarily, accidentally or otherwise, allow anything to remain in, place or store anything in, or obstruct in any way, any sidewalk, plaza, terrace, court, passageways, entrance, exit, stairway, corridor, hall, elevator, shipping platform or truck concourse. Tenant shall lend its full cooperation to keep such areas free from all obstruction and in a clean and sightly condition, and move all supplies, furniture and equipment as soon as received directly to the Premises, and shall move all such items and waste (other than waste customarily removed by Building employees) that are at any time being taken from the Premises directly to the loading platform at or about the time arranged for removal therefrom. All plazas, terraces, courts, passageways, entrances, exits, elevators, stairways, corridors, halls and roofs are not for the use of the general public and Landlord shall in all cases retain the right to control and prevent access thereto by all persons whose presence in the judgment of Landlord shall be prejudicial to the safety, character, reputation and interests of the Building and its tenants provided, however, that, nothing herein contained shall be construed to prevent such access to persons with whom Tenant deals within the normal course of Tenant's business unless such persons are engaged in illegal activities. No Tenant and no employee or invitee of Tenant shall enter into areas reserved for the exclusive use of Landlord, its employees or invitees.

(9) Additional Locks. Tenant shall not attach or permit to be attached additional locks or similar devices to any door or window, change existing locks or the mechanism thereof, or make or permit to be made any keys for any door other than those provided by Landlord. If more than two keys for one lock are desired, Landlord will provide them upon payment therefor by Tenant. Upon termination of this Lease or of Tenant's possession, Tenant shall surrender all keys to the Premises.

(10) Communication or Utility Connections. If Tenant desires signal, communication, alarm or other utility or similar service connections installed or changed, Tenant shall not install or change the same without the written approval of Landlord, and then only under the direction of Landlord and at Tenant's expense. Tenant shall not install in the Premises any equipment which requires a substantial amount of electrical current without the advance written consent of Landlord, and Tenant shall ascertain from Landlord the maximum amount of load or demand for use of electrical current which can safely be permitted

in the Premises, taking into account the capacity of the electric wiring in the Building and the Premises and the needs of other tenants of the Building, and shall not in any event connect a greater load than such safe capacity.

(11) Vending Machines. No vending machines of any description shall be installed, maintained or operated in the Premises without the written consent of Landlord.

(12) Outside Services. Tenant shall not obtain for use upon the Premises ice, drinking water, towel and other similar services on the Premises, except from persons authorized by Landlord and at the hours and under regulations fixed by Landlord.

(13) Toilet Rooms. The toilet rooms, urinals, wash bowls and the other apparatus shall not be used for any purpose other than that for which they were constructed and no foreign substance of any kind whatsoever shall be thrown therein and the expense of any breakage, stoppage or damage resulting from the violation of this rule shall be borne by Tenant who, or whose employees or invitees, shall have caused it.

(14) Intoxication. Landlord reserves the right to exclude or expel from the Building any person who, in the judgment of Landlord, is intoxicated or under the influence of liquor or drugs, or who shall in any manner do any act in violation of any of the rules and regulations of the Building.

(15) Nuisances and Certain Other Prohibited Uses. Tenant shall not (i) install or operate any internal combustion engine, boiler, machinery, refrigerating, heating or air conditioning apparatus in or about the Premises, (ii) carry on any mechanical business in or about the Premises without the written permission of Landlord, (iii) exhibit, sell or offer for sale, use, rent or exchange in the Premises or Building any article, thing or service except those ordinarily embraced within the permitted Use of the Premises, (iv) use the Premises for housing, lodging or sleeping purposes, (v) place any radio or television antennae on the roof or on or in any part of the inside or outside of the Building other than the inside of the Premises, (vi) operate or permit to be operated any musical or sound producing instrument or device inside or outside the Premises which may be heard outside the Premises, (vii) use any illumination or power for the operation of any equipment or device other than electricity, (viii) operate any electrical device from which may emanate electrical waves which may interfere with or impair radio or television broadcasting or reception from or in the Building or elsewhere, (ix) bring or permit to be in the Building any bicycle or other vehicle, or dog (except authorized service animals) or other animal or bird, (x) make or permit any objectionable noise or odor to emanate from the Premises, (xi) disturb, solicit or canvass any occupant of the Building, (xii) do anything in or about the Premises tending to create or maintain a nuisance or do any act tending to injure the reputation of the Building, or (xiii) throw or permit to be thrown or dropped any article from any window or other opening in the Building.

(16) Emergency Evacuation Plan. Tenant shall familiarize itself and cause its employees to become familiar with Landlord's Emergency Evacuation Plan, as the same may be amended by Landlord from time to time, including without limitation, the evacuation alarm procedures and evacuation routes, and shall keep posted in a conspicuous location on each floor of the Premises a copy of the Emergency Evacuation Plan and the Evacuation Route Floor Plan furnished from time to time by Landlord. Tenant shall cause its employees and invitees to comply with and participate in any emergency evacuation drills in

accordance with the Emergency Evacuation Plan. For each floor of the Building occupied in whole or in part by Tenant, Tenant shall appoint at least one (1) of its employees who regularly works on each floor to act as Warden to assist Landlord's personnel and municipal rescue units with the prompt and orderly evacuation of Tenant's employees and invitees from the Premises in the event of an emergency evacuation drill or an actual emergency. Tenant will promptly provide Landlord with a list of the name, phone number and location in the Premises of each such Warden and shall promptly advise Landlord of any changes in such list.

(17) Special Wiring. If Tenant requires wiring for a bell or buzzer system, such wiring shall be done by the electrician of Landlord only, and no outside wiring persons shall be allowed to do work of this kind unless by the written permission of Landlord or its representatives. If telegraph or telephonic service is desired, the wiring for same shall be approved by Landlord, and no boring or cutting for wiring shall be done unless approved by Landlord or its representatives, as stated. The electric current shall not be used for power or heating unless written permission to do so shall first have been obtained from Landlord or its representatives in writing, and at an agreed cost to Tenant.

(18) No Soliciting. Canvassing, peddling, soliciting and distribution of handbills or any other written materials in the Building are prohibited, and Tenant shall cooperate to prevent the same.

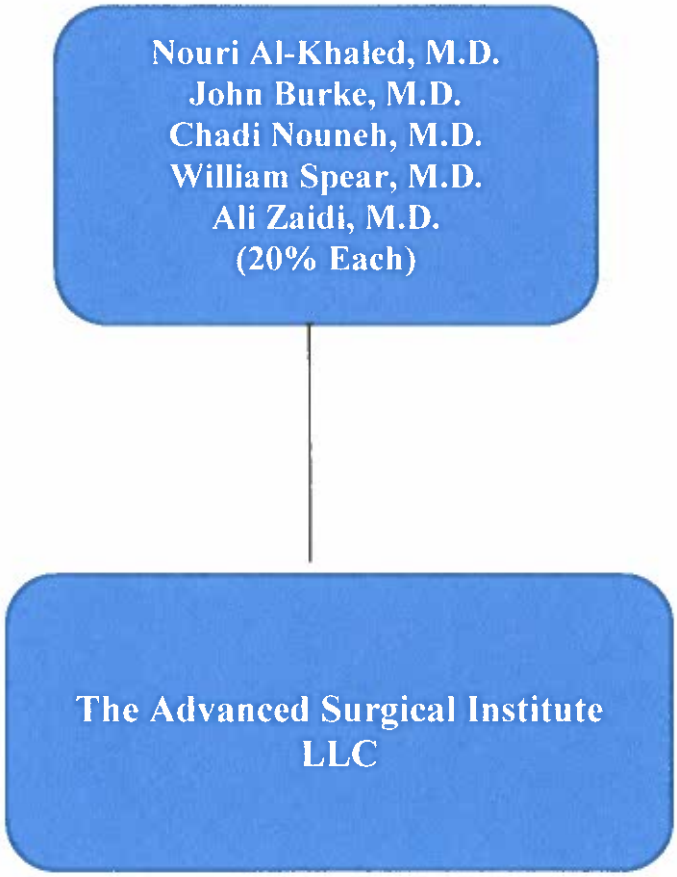
Section I, Identification, General Information, and Certification
Operating Entity/Licensee

Please see the attached Certificates of Good Standing for The Advanced Surgical Institute LLC. Persons with 5% or greater interest in the facility are listed below.

The Advanced Surgical Institute LLC	
Nouri Al-Khaled, M.D.	20%
John Burke, M.D.	20%
Chadi Nouneh, M.D.	20%
William Spear, M.D.	20%
Ali Zaidi, M.D.	20%

Attachment 3

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



Attachment 4

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

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

Please find included with this Attachment:

- A Flood Plain map generated using FEMA's flood map generator for 3523 W. 95th Street, Evergreen Park, IL 60805 indicating that the location is out of the flood zone.

June 13, 2019

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

Dear Ms. Avery,

I hereby certify and attest that the facility located at 3523 w. 95th Street, Evergreen Park, 60805 is not located in a special flood hazard area.

Sincerely,

Nouri Al-Khaled, M.D.
The Advanced Surgical Institute LLC

Notarization:
Subscribed and sworn to before me this 19 day of June, 2019.

Signature of Notary

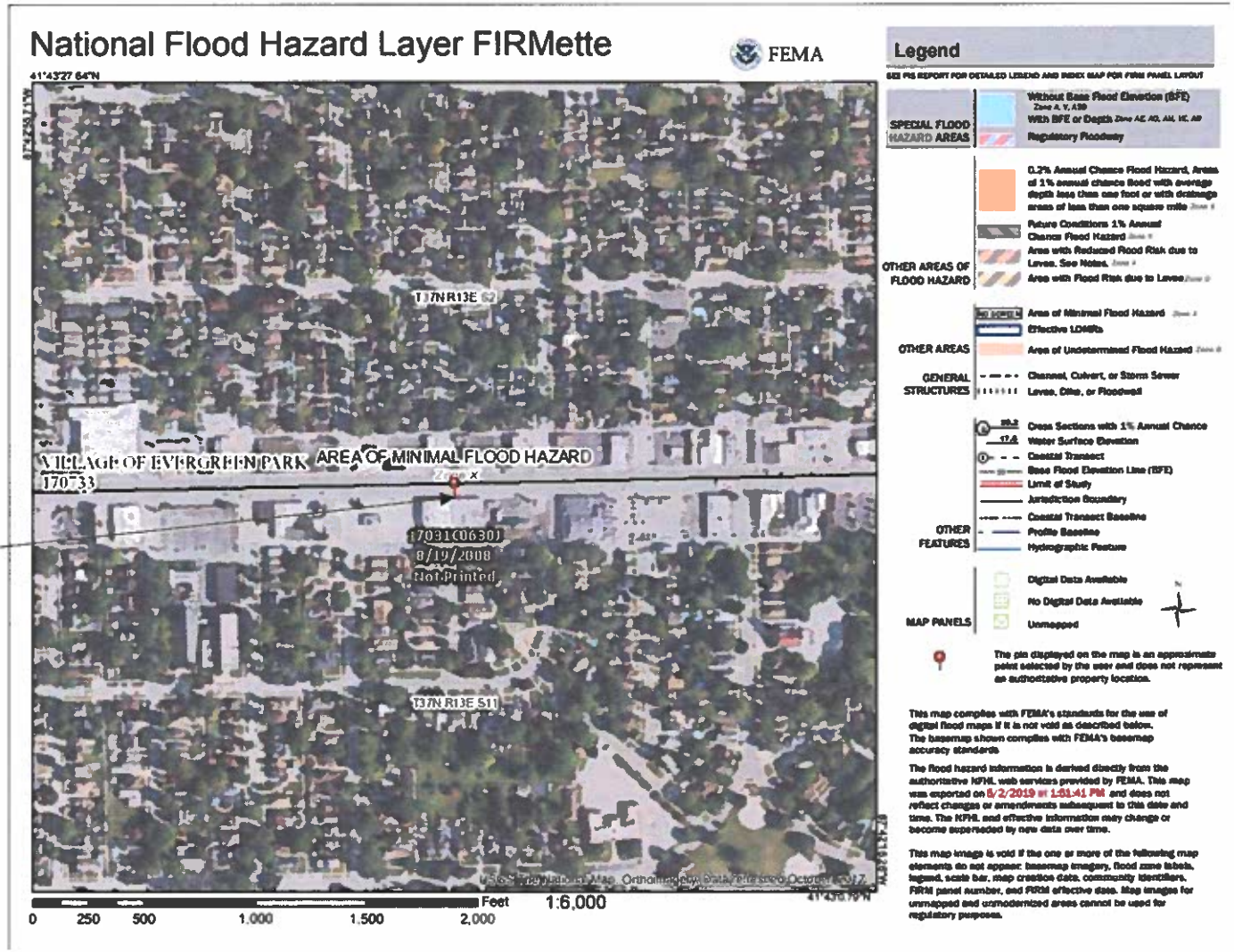
SEAL

"OFFICIAL SEAL"
KIMBERLY A OERTEL
Notary Public, State of Illinois
My Commission Expires 11/21/2021

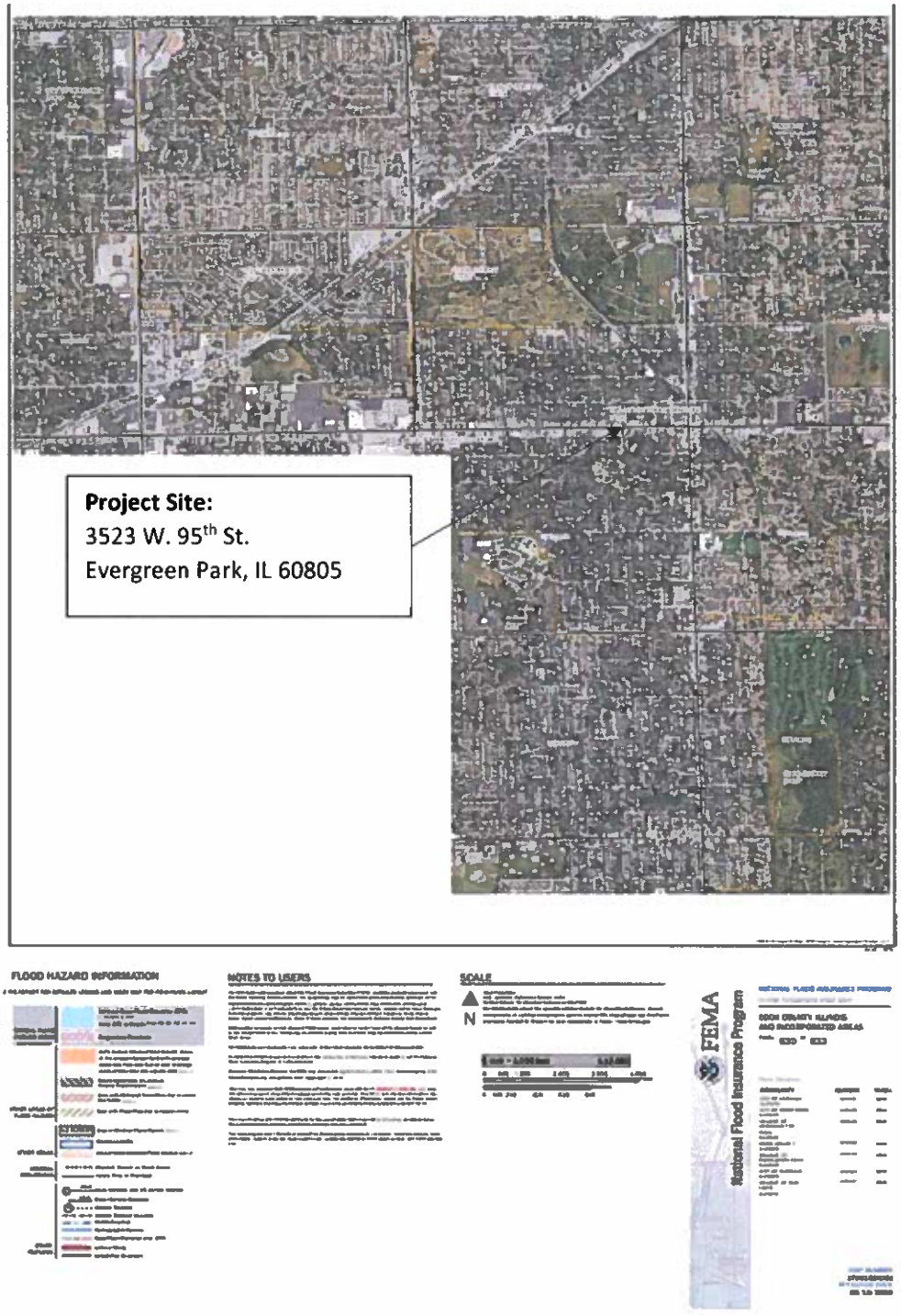
Attachment 5- Flood Plain Map

The map provided below identifies the Project Site, located at 3523 W. 95th Street, Evergreen Park, IL, as being part of Zone X, an "area of minimal flood hazard" as designated by the Federal Emergency Management Agency ("FEMA").

Project Site:
3523 W. 95th St.
Evergreen Park, IL 60805



The map below providers a broader view of where the Project Site is located within the county, once again showing that the Project site is within an area designated as an "area of minimal flood hazard" by FEMA.



Section I, Identification, General Information, and Certification

Historic Resources Preservation Act Requirements

Please find attached after this page a letter submitted to the Illinois Historic Preservation Agency by The Advanced Surgical Institute LLC ("Applicant"). The Applicant will submit the Historic Preservation Act determination from the Illinois Historic Preservation Agency once it is obtained from the agency.

Attachment - 6

After printing this label:
1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Warning Use only the printed original label for shipping. Using a photocopy of this label for shipping purposes is fraudulent and could result in additional billing charges, along with the cancellation of your FedEx account number.
Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com.FedEx will not be responsible for any claim in excess of $100 per package, whether the result of loss, damage, delay, non-delivery,misdelivery,or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim.Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental,consequential, or special is limited to the greater of $100 or the authorized declared value. Recovery cannot exceed actual documented loss.Maximum for items of extraordinary value is $1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our ServiceGuide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

June 25, 2019

Illinois Department of Natural Resources
Illinois State Historic Preservation Office
Attn: Review & Compliance
1 Natural Resources Way
Springfield, Illinois 62702

Re: Historic Preservation Act Determination

VIA FEDEX

Dear Dr. Leibowitz,

Pursuant to Section 4 of the Illinois State Agency Historic Resources Preservation Act, please accept this request for a formal determination that the establishment of an Ambulatory Surgical Treatment Center (ASTC) at 3523 W. 95th Street, Evergreen Park, IL, 60805 is in compliance with the statutory requirements. This request is being submitted by Advis on behalf of The Advanced Surgical Institute LLC for the purpose of completing a Certificate of Need application with the Illinois Health Facilities and Services Review Board.

This project involves the establishment of an ASTC within a currently existing building, with moderate buildout of the rear of the building. Construction will commence once Certificate of Need approval is obtained from the HFSRB.

Please find attached to this letter a printout showing the location of the property, its current condition, and a photograph of the current building. Based on Latitude: 41.720544 | Longitude: -87.709932

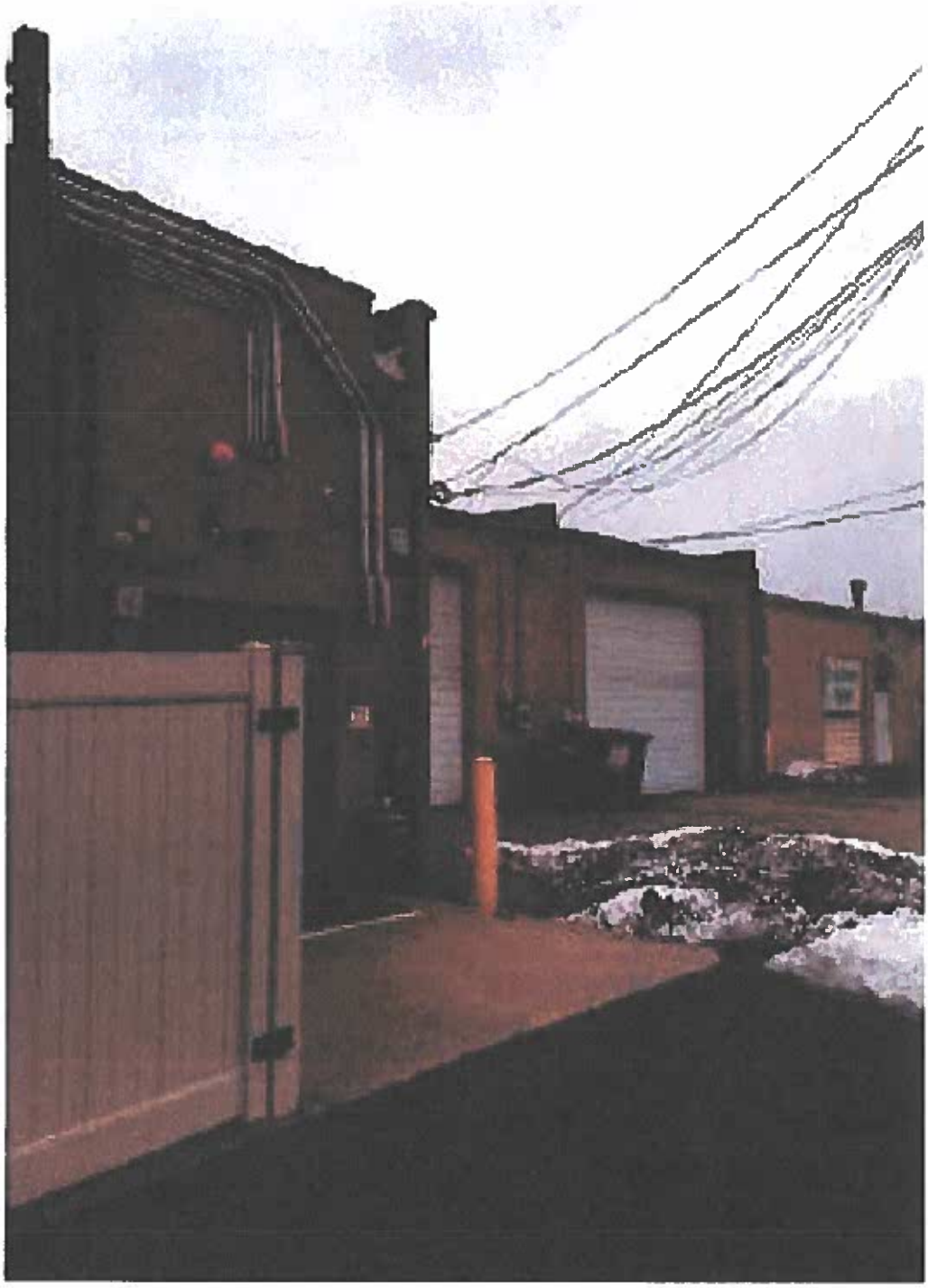
Thank you for your time and consideration. Once you have concluded your review, please send a letter indicating as such to my email bniehaus@advis.com, and to 19065 Hickory Creek Drive, Suite 115, Mokena, IL 60448. Feel free to contact me at (708) 478-7030 should you have any questions.

Sincerely,

Bryan Niehaus, JD
Vice President
Advis on behalf of The Advanced Surgical Institute LLC

EXISTING FRONT ELEVATION

EXISTING REAR ELEVATION




All American Comic Shop
Tech Squad
Peter Francis Geraci Law LLC
S Clifton Park Ave
Garden Cleaners & Laundry
Charlie's Diamond Jewelers
W 95th St
95th St
Chase ATM
3528 U.S. 12
Evergreen Car Wash
Citgo

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	$10,584.62	$5,415.38	$16,000.00
Site Survey and Soil Investigation			
Site Preparation	$66,153.85	$33,846.15	$100,000.00
Off Site Work			
New Construction Contracts (Base Building Upgrades)	$203,423.08	$104,076.92	$307,500.00
Modernization Contracts	$989,000.00	$506,000.00	$1,495,000.00
Contingencies (10%)	$98,900.00	$50,600.00	$149,500.00
Architectural/Engineering Fees	$79,120.00	$40,480.00	$119,600.00
Consulting and Other Fees (Equipment Planning) any other consultants?	$25,827.46	$14,172.54	$40,000.00
Movable or Other Equipment (not in construction contracts) (Itemized below)	$1,599,602.00	$126,319.00	$1,725,921.00
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment	$1,419,000.00	$726,000.00	$2,145,000.00
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$4,491,611.00**	**$1,606,910.00**	**$6,098,521.00**

SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)	$1,419,000.00	$726,000.00	$2,145,000.00
Governmental Appropriations			
Debt Financing	$3,072,611.00	$880,910.00	$3,953,521.00
TOTAL SOURCES OF FUNDS	**$4,491,611.00**	**$1,606,910.00**	**$6,098,521.00**

Equipment Itemization

OR Lights and Booms	2	$21,000.00	$42,000.00	OR
OR Tables	2	$21,000.00	$42,000.00	OR
Side Tables	6	$1,600.00	$9,600.00	OR
Double Ring Stands	2	$323.00	$646.00	OR
Electrosurgical Unit, Bipolar	2	$5,925.00	$11,850.00	OR
Kick Buckets	2	$159.85	$319.70	OR
Mayo Stands	2	$589.13	$1,178.26	OR
Mayo Stands (Large)	1	$731.60	$731.60	OR
IV Poles	2	$319.30	$638.60	OR
Light Boxes	2	$2,000.00	$4,000.00	OR
Surgeon Stools	2	$2,500.00	$5,000.00	OR
Anesthesia Stools	3	$1,000.00	$3,000.00	OR
Allura Xper FD20	1	$900,000.00	$900,000.00	OR
Blanket Fluid Warmer	2	$8,540.00	$17,080.00	OR
Waste Management Suction	2	$90.00	$180.00	OR
Crash Cart	1	$1,900.00	$1,900.00	OR
Headlights	2	$1,400.00	$2,800.00	OR
Microscope	1	$125,000.00	$125,000.00	OR
Anesthesia Cart	2	$2,000.00	$4,000.00	OR
Scrub Sink	2	$11,280.00	$22,560.00	OR
IV Infusion Pumps	7	$2,600.00	$18,200.00	Anesthesia
Anesthesia Machines/Setup	2	$39,000.00	$78,000.00	Anesthesia
Physiological Monitors	7	$3,500.00	$24,500.00	PACU
Computers	7	$600.00	$4,200.00	OR/PACU
Phones	8	$300.00	$2,400.00	OR/PACU
Equipment Carts		$3,000.00	$0.00	PACU
Equipment Carts	7	$1,500.00	$10,500.00	PACU
Linen Carts	2	$978.00	$1,956.00	PACU
Stools PACU	7	$406.00	$2,842.00	PACU
Stretcher Chairs	7	$2,500.00	$17,500.00	PACU
OR Carts	3	$4,000.00	$12,000.00	PACU
Patient Thermometer	7	$174.00	$1,218.00	PACU
Glovebox Holders	8	$42.00	$336.00	All
Hand Sanitizer Dispenser	10	$55.00	$550.00	All
Refrigerator	1	$2,400.00	$2,400.00	Staff Workroon
Microwave	1	$240.00	$240.00	Staff Workroom
Coffeemaker	1	$179.00	$179.00	Staff Workroom
Sharps Container (20 Gallon)	1	$344.00	$344.00	Decontamination
Work Station	1	$5,500.00	$5,500.00	Prep/Packaging
Sink	1	$350.00	$350.00	Decontamination
Shelving	3	$3,500.00	$10,500.00	Prep/Packaging
Sterilizer Steam	2	$39,000.00	$78,000.00	Prep Packaging

Washer	1	$55,000.00	$55,000.00	Decontamination
Lounge/Nourishment Equipment/ Icemaker	1	$5,500.00	$5,500.00	Staff Workroom
Waiting Area / Office Furniture	1	$123,500.00	$123,500.00	Waiting Area / Offices
Mobile C-arm	1	$75,721.84	$75,721.84	OR
			$1,725,921.00	Total
			$1,599,602.00	Total Clinical
			$126,319.00	Total Non-clinical

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
ASTC	$1,291,323.08		4,300	496.15	3,803.85		
Total Clinical	$1,291,323.08		4,300	496.15	3,803.85		
NON REVIEWABLE							
Non-Clinical	$660,676.92		2,200	253.85	1946.15		
Total Non-clinical	$660,676.92		2,200	253.85	1946.15		
TOTAL	**$1,952,000.00**		**6,500**	**750**	**5,750**		

Attachment 9

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

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

   The Advanced Surgical Institute LLC does not own or operate any other licensed health care facility.

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

   The Advanced Surgical Institute LLC does not own or operate any other licensed health care facility.

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

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

5. Not Applicable.

June 13, 2019

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

Dear Ms. Avery,

In keeping with 77 Ill. Adm. Code § 1110.110(a) (Background of the Applicant – Information Requirements) please find this letter of certification and authorization.

Specifically, this letter certifies that The Advanced Surgical Institute LLC has had no adverse actions taken against it in the three years (3) prior to the filing of this application.

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

Sincerely,

Nouri Al-Khaled, M.D.
The Advanced Surgical Institute LLC

Notarization:
Subscribed and sworn to before me this 19 day of June, 2019.

Signature of Notary

SEAL

"OFFICIAL SEAL"
KIMBERLY A OERTEL
Notary Public, State of Illinois
My Commission Expires 11/21/2021

Section III, Background, Purpose of the Project, and Alternatives – Information Requirements

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

PURPOSE OF THE PROJECT

1. The Applicant, The Advanced Surgical Institute LLC, herein requests HFSRB's approval to establish an Ambulatory Surgical Treatment Center ("ASTC"), to be known as known as The Advanced Surgical Institute ("ASI"). The applicant proposes to develop the facility with two (2) operating rooms and seven (7) recovery rooms. The ASTC will offer cardiovascular surgical services and will be located within space adjacent to their existing "Heart, Vein & Vascular Clinic" located at 3545 W 95th Street in Evergreen Park, Illinois. The physicians who will utilize the proposed ASTC are board certified interventional cardiologist and electrophysiologists who specialize in cardiology, electrophysiology, internal, vascular, and interventional medicine.

   The primary purpose of the project is to enable the applicant to meet the current and future needs of its patients by enabling the provision of non-hospital outpatient surgery that is high quality, lower cost, and accessible to the community. This ASTC will improve the health care and well-being of the patient population by offering patients requiring outpatient cardiac procedures the well-known benefits of an ASTC, including:

   - Decreased risk of infection
   - Decreased hospital stay
   - Overall decreased cost (30% less for cardiac procedures across all payers)
   - Improved outcomes with specialized staffing
   - Increased patient satisfaction
   - Increased patient comfort

   Today, the Geographic Service Area (GSA) does not have sufficient ASTC access to meet the patient demand. As documented within this application, Dr. Al-Khaled, Dr. Burke, Dr. Nouneh, Dr. Spear, and Dr. Zaidi have pledged sufficient historical volume to justify two (2) operating rooms by the second year of operation. Today, these physicians do not have an option within the Geographical Service Area (GSA) to conduct their procedures in a non-hospital ambulatory surgical center (ASTC).

   Currently there are nine (9) licensed ASTC's within the GSA. None of these ASTCs offer cardiovascular services today.

Facility - ASC			
Oak Lawn Endoscopy Center	60453	9921 Southwest Highway, Oak Lawn, IL	3.45 mi
Magna Surgical Center	60638	7456 S State Road, Suite 300, Bedford Park, IL	3.04 mi.
Center for	60453	6311 W. 95th Street, Oak	3.7 mi.

Reconstructive Surgery		Lawn, IL	
Palos SurgiCenter, LLC	60463	7340 W. COLLEGE DRIVE, Palos Heights, IL	5.56 mi.
Palos Hills Surgery Center	60465	10330 South Roberts Road, Ste 3000, Palos Hills, IL	5.64 mi.
Surgicore	60617	10547 S. EWING AVE., Chicago, IL	9.14 mi.
Forest Med-Surg Center	60458	9050 W. 81st Street, Justice, IL	7.21 mi.
Hyde Park Surgical Center	60615	1644 E 53rd St, Chicago, IL	8.44 mi.
South Loop Endoscopy & Wellness Center	60616	2340 S. Wabash, Chicago, IL	9.90 mi

An additional two (2) ASTCs are located within the GSA, but are not yet licensed and operational.

Vascular Access Centers of Illinois ("VAC")	60643	1701 W. Monterey Ave, Chicago, IL	3.13 mi.
Premier Cardiac Surgery Center ("Premier")	60803	11560 S. Kedzie Ave Ste 102, Merrionette Park, IL	2.66 mi.

Both the VAC and Premier ASTC are designed and intended to service an existing patient base. Neither the VAC or Premier ASTC is intended to or capable of servicing the surgical volume of the applicants. In fact, Premier is intended to operate as a hybrid OBL/ASTC with one operating room. This clearly restricts the ability of the facility to shoulder the volume contemplated by the applicants. Likewise, VAC is designed for dialysis vascular access for ESRD patients. It is not designed, equipped, or intended to provide the pacemaker and cardiac catheterization procedures performed by the applicants.

Given the lack of viable ASTC options within the GSA, Dr. Al-Khaled, Dr. Burke, Dr. Nouneh, Dr. Spear, and Dr. Zaidi are now pursuing the development of this surgical center to provide patients with access to the safest, most affordable site of service.

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

Removed from the hospital setting, ASTCs allow surgeons to be more efficient due to faster room turnover, specialized focuses, and designated surgical times that are not impacted by emergent and trauma cases that can create longer wait times for patients. With easier access to

facility parking, reduced wait times, dedicated staff, and optimized procedure flow, ASTC services result in higher patient satisfaction.

The proposed project is adjacent to the existing Heart, Vein, & Vascular clinic owned by the Applicant. Locating the ASTC directly next to the clinic will free up more of the physicians' time to tend to patient needs by wasting less time traveling to hospitals to meet patients for surgery. In this way, the Applicant's physicians can efficiently address its patients' cardiovascular needs at its own surgical space, on its own schedule.

The applicants are not alone in pursuing the development of a dedicated cardiovascular surgical center. There has been a flurry of activity in the ASTC marketplace for cardiac services. In addition to commercial payer support, recent CMS payment decisions have encouraged the migration of cardiac and vascular surgeries to the ASTC setting.

CMS created uncertainty in the marketplace in 2017 when they dramatically restructured reimbursement in the office-based laboratory ("OBL") setting for vascular access services. The result was significant decreases in payment in the OBL setting and a clear incentive and direction to pursue ASTC development to provide continued access. Although this payment reduction did not directly affect the procedures performed by the Applicant, this payment uncertainty plagues the wider cardiology community. The applicants do operate an OBL today, and are now seeking to develop a more stable and supported facility with this ASTC.

Most recently, CMS continued to acknowledge and support the delivery of safe, effective, and lower-cost cardiology care in a freestanding ASC in its 2019 payment rule, which added 12 cardiac catheterization codes to the list of ASC covered surgical procedures. Improvements in technology and clinical standards have made it possible for these procedures to be performed in the ASC setting with favorable outcomes and without an overnight hospital stay.

There are clear economic savings associated with the ASTC setting as well. Drs. Brent Fulton and Sue Kim concluded that ASTCs saved the Medicare program and its beneficiaries $7.5 billion from 2008 to 2011. The researchers noted that the study was focused upon the Medicare program, but noted that because ASTCs generally "charge private payers less than their hospital outpatient department counterparts, similar savings also exist in the commercial health market." (Medicare Savings Tied to Ambulatory Surgery Centers, University of California-Berkley School of Public Health, September 2013). Reduced costs also mean reduced co-pays and deductibles for our Medicare and Medicaid patient populations.

Per the below chart, some of the more common procedures intended to be performed in the Applicant's ASTC are significantly cheaper than the Medicare's hospital reimbursement rates (i.e. "OPPS"):

ASTC vs. Hospital (OPPS) Reimbursement Examples

CPT Code	Description	2019 Medicare ASC Rate	2019 Medicare OPPS Rate	Difference ($)	Savings %

93458	L hrt artery/ventricle angio	$1,359.80	$2,810.41	$1,450.61	52%
93459	L hrt art/grft angio	$1,359.80	$2,810.41	$1,450.61	52%
93460	R&l hrt art/ventricle angio	$1,359.80	$2,810.41	$1,450.61	52%
33208	Insrt heart pm atrial & vent	$8,065.52	$9,879.34	$1,813.82	18%
33249	Insj/rplcmt defib w/lead(s)	$27,057.89	$30,656.38	$3,598.49	12%
36556	Insert non-tunnel cv cath	$563.37	$1,093.63	$530.26	48%

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

ASCs are the preferred venue for cost savings, quality outcomes, and increased patient satisfaction. The Applicant needs the Board support to provide these benefits to its affiliated surgeons and its substantial patient base. Doing so will improve the health care services available to the community and improve their overall well-being.

2. **Market Area / GSA.**

As demonstrated on Attachment 24 Exhibit 2, the applicant intends to serve primarily Chicago's Southwest and Southern metropolitan areas surrounding the proposed location at 3523 W. 95th Street, Evergreen Park, IL, 60805. Section 1110.110(b) of the HFSRB's rules states that the Geographic Service Area (GSA) includes all zip codes within a 10-mile radius. The applicants have attached a map of the areas within 10-miles at Attachment 12 – Exhibit 1.

3. **Existing Problems.**

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

1. Need for Cardiology approved & focused ASTC Operating Rooms within the GSA
2. Need to Improve the Clinical Care Continuum for Applicant's Patients
3. Align with CMS, Payers, and Patients to Continue Transition from Hospital to ASTC Setting

4. **Source Documents**.

In addition to the below citations, the Applicant has attached relevant the articles following Attachment 12.

- MEDPAC, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 95 (Mar. 2010), *available at* http://www.medpac.gov/documents/Mar10_EntireReport.pdf.
- Cost and Benefits of Competing Healthcare Providers: Trade-Offs in the Outpatient Surgery Market, Elizabeth L. Munnich and Stephen T. Parente, University of Notre Dame, May 2013.
- Medicare Savings Tied to Ambulatory Surgery Centers, University of California-Berkley School of Public Health, Brent Fulton and Sue Kim, School of Public Health, University of California Berkely, September 2013.
- https://www.beckersasc.com/asc-transactions-and-valuation-issues/introducing-the-ambulatory-cardiovascular-center.html
- ASC at a Tipping Point: The New Reality of Surgical Service for Health Systems by ECG

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

As described above, the proposed facility will provide needed operating room capacity dedicated to cardiovascular surgeries in a low-cost, high-quality, and convenient setting. This will address the lack of viable ASTC options in the GSA, improve the continuum of care for the applicant's patients, and be responsive to the clear direction of CMS and commercial payers to transition surgical volumes from the hospital setting to the ASTC setting.

Patients are increasingly likely to seek treatment at ASTCs instead of hospital outpatient departments because of reduced costs, payer policies, and patient comfort with the setting. The Applicant will help meet this increase in demand and reduce costs for the patient, payors, and healthcare system as a whole. With high-quality outcomes, improved satisfaction, and reduced costs, the health care and well-being of the local patient population will be improved by this project.

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

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

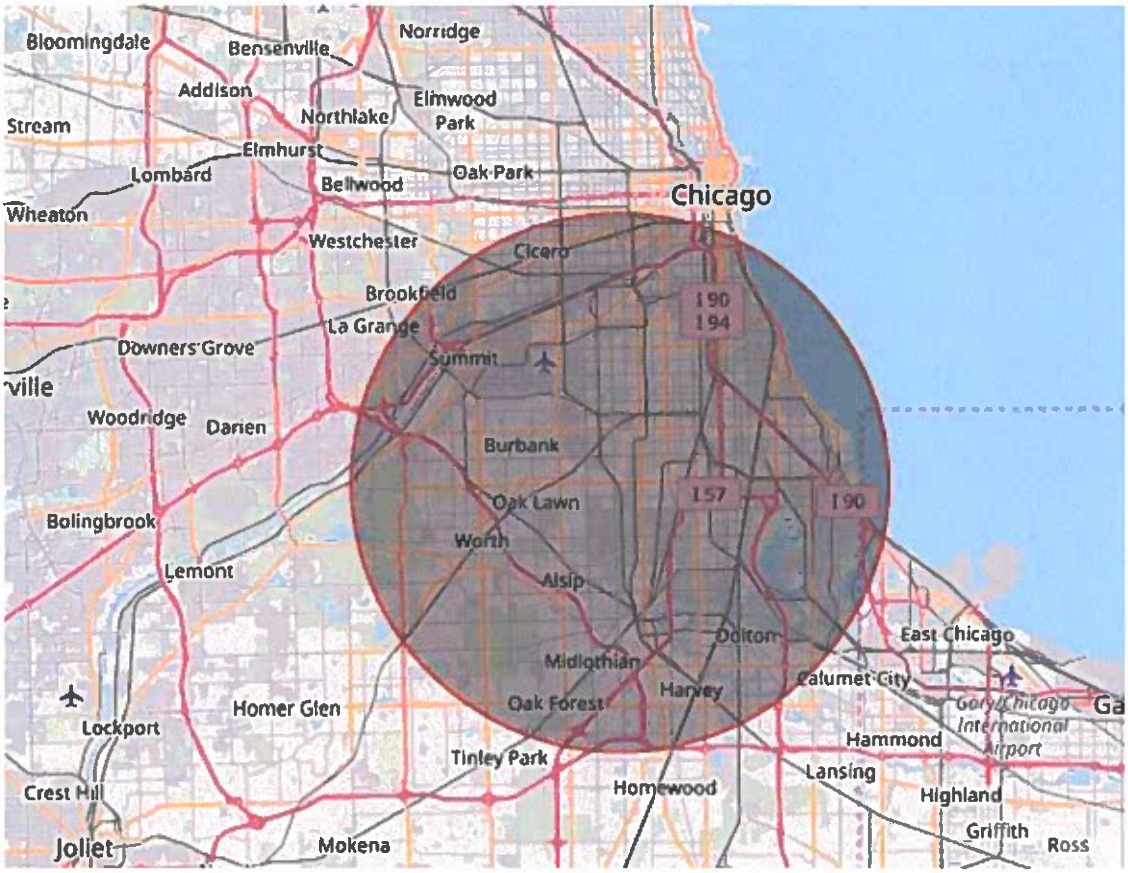
- The first goal is to finalize the drawings and obtain the necessary permit approvals within one month of receiving HFSRB approval.

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

7. **Modernization Description**

In addition to the foregoing, the project involves the modernization of existing physical space. The Applicant is creating the ASTC facility through the modernization of existing physician office space and retail space currently adjoining the physician office space. The existing building will require an approximately 750 sq. ft. building addition to accommodate the design requirements for the two operating room facility. The building's fire suppression system, HVAC, plumbing, medical gas, electric service, generator, fire alarm, and IT infrastructure will all be renovated or added to the existing space to meet required code.

10 Mile Radius From 3523 W. 95th Street, Evergreen Park, IL, 60805



Attachment 12 - Exhibit 1

By Elizabeth L. Munnich and Stephen T. Parente

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

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

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

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

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

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

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

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

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

This article addresses the possibilities for ASCs

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

Background On Ambulatory Surgery Centers

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

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

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

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

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

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

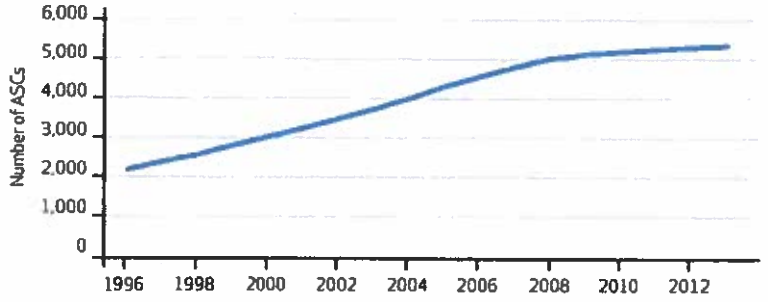
There is little evidence about the quality of care provided in ASCs or their ability to function as substitutes for hospitals in providing outpatient surgery. Comparisons of outcomes between these two types of outpatient facilities are complicated by the fact that ASCs tend to treat a healthier mix of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

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

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

EXHIBIT 1

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



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

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

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

Study Data And Methods

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

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

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

EXHIBIT 2

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

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

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

Study Results

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

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

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

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

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

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

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

Discussion

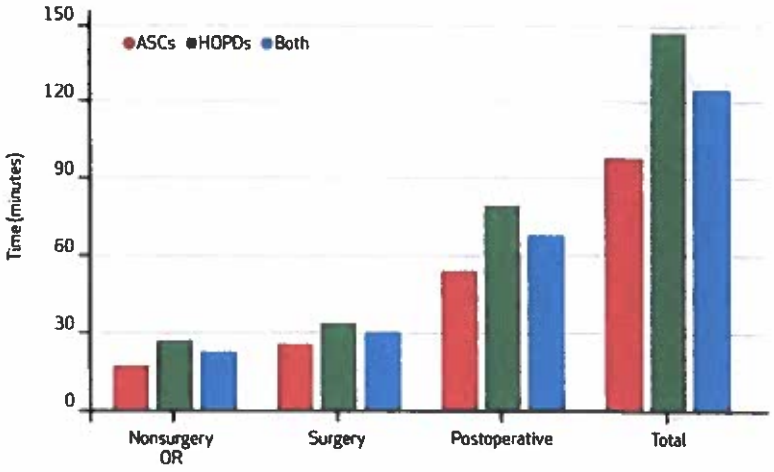
The findings presented here provide evidence that ASCs are a lower-cost alternative to hospitals for outpatient surgical procedures. The tremendous growth in the number of ASCs since the 1980s suggests that these facilities are quite flexible in meeting the growing demand for outpatient services. This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

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

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

EXHIBIT 3

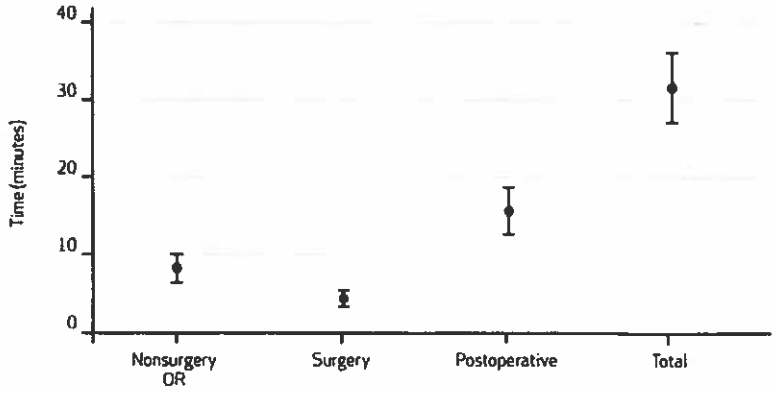
Average Outpatient Surgical Procedure Time, By Facility Type, 2006



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

EXHIBIT 4

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



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

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

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

25 million

Procedures

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

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

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

Conclusion

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

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

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

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

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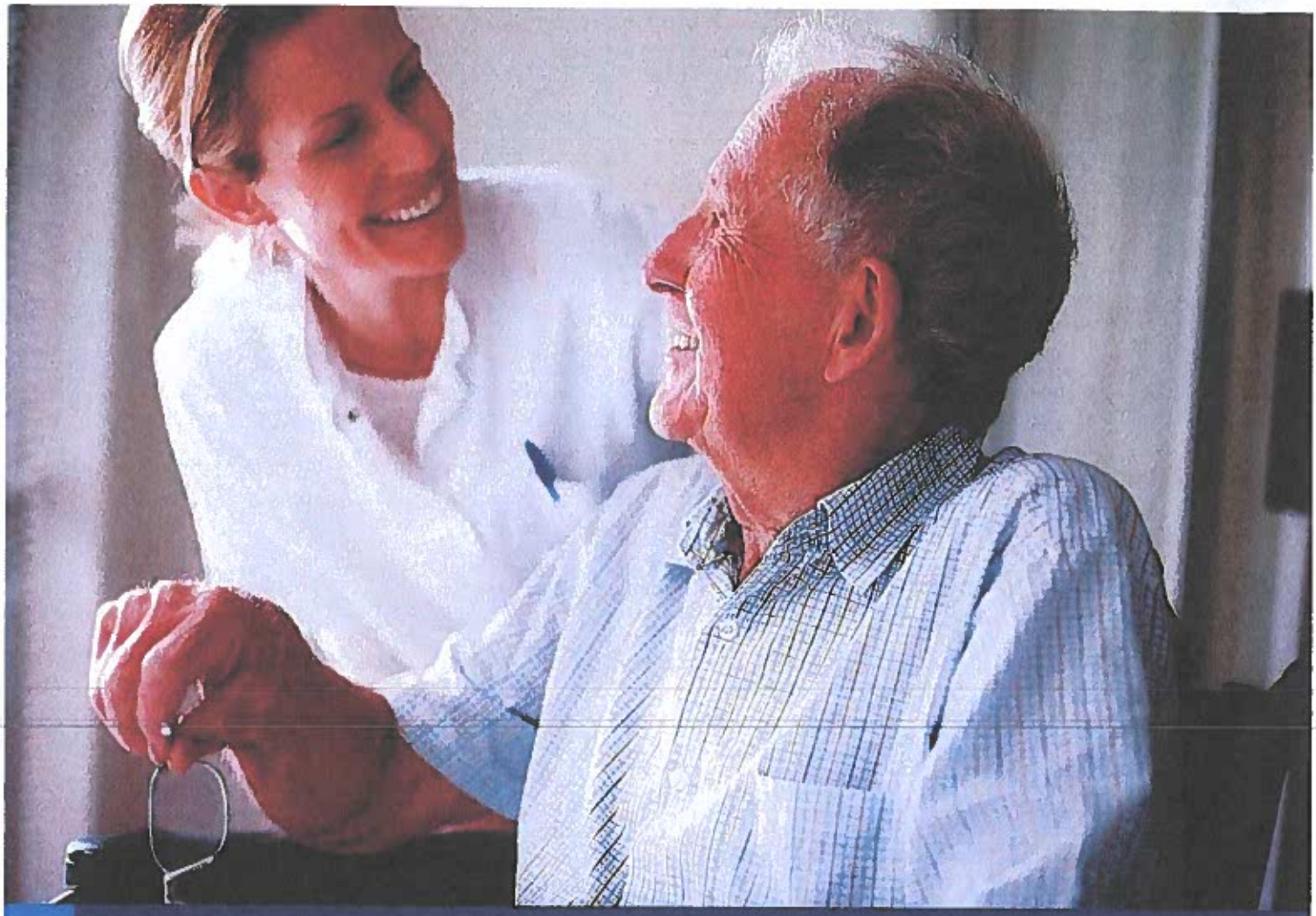

Medicare Cost Savings Tied to Ambulatory Surgery Centers

ASCA
Ambulatory Surgery Center Association

Produced with cost savings analysis from Berkeley UNIVERSITY OF CALIFORNIA

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Berkeley
UNIVERSITY OF CALIFORNIA

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4

EXECUTIVE SUMMARY

Even in today's divisive political environment, there's at least one important area of consensus among policymakers: the threat posed by rising health care costs to both our national economy and the federal and state governments' balance sheets. This concern is particularly acute in the Medicare program, where costs are expected to rise dramatically as new treatments are developed and a generation of Baby Boomers enters retirement. Burgeoning health care costs, it seems certain, will be near the top of Washington, DC's agenda for years to come.

As they work to reduce health care costs and extend the solvency of programs like Medicare, policymakers will confront tough choices in the months and years ahead. Yet, they must also be alert for reforms that cut costs while maintaining quality services for beneficiaries. This analysis by Professor Brent Fulton and Dr. Sue Kim of the University of California at Berkeley explores one possible way for policymakers to generate substantial Medicare savings without reducing services or quality of care.

This study examines ambulatory surgery centers (ASCs). ASCs are technologically advanced medical facilities that provide same-day surgical procedures, including important diagnostic and preventive services like colonoscopies. Today, more than 5,300 Medicare-certified ASCs serve communities throughout our nation. These ASCs perform many of the same procedures as hospital outpatient departments (HOPDs). ASCs, however, are able to provide care much more efficiently and without the often costly overhead associated with hospitals. According to an industry calculation, the Medicare program currently reimburses ASCs at 58 percent of the HOPD rate, meaning that Medicare—and the taxpayers who fund it—realize savings every time a procedure is performed in an ASC instead of an HOPD.

When one considers the millions of same-day surgical procedures performed in ASCs through the Medicare program each year, the nationwide savings add up quickly. In this study, University of California at Berkeley's Professor Brent Fulton and Dr. Sue Kim analyze the numbers to determine how much ASCs save the Medicare program and its beneficiaries. They begin by analyzing government data to identify how much money ASCs saved Medicare in recent years, and then, forecast how much more ASCs will save Medicare in the future. The key findings are the following:

- During the four-year period from 2008 to 2011, ASCs saved the Medicare program and its beneficiaries $7.5 billion. ASCs saved Medicare and its beneficiaries $2.3 billion in 2011 alone.

- $6 billion of these savings were realized by the federal Medicare program. The remaining $1.5 billion went directly to Medicare beneficiaries. In other words, Medicare patients nationwide saved $1.5 billion thanks to the less expensive care offered at ASCs.
- ASCs have the potential to save the Medicare program and its beneficiaries up to $57.6 billion more over the next decade.
- Beneficiaries themselves also stand to save considerably in future years. Because Medicare reimburses ASCs at a lower rate than HOPDs, patients also pay a smaller coinsurance amount in an ASC. The authors use the example of cataract surgery, noting that a Medicare beneficiary will save $148 on his or her coinsurance by electing to undergo surgery in an ASC instead of a hospital.

These findings have important implications for policymakers' ongoing discussion about how to most effectively reduce health care costs and the national budget deficit. The clearest implication is that, while public officials may indeed confront tough choices in the years ahead, the choice to encourage ASC use within the Medicare program is an easy decision. These findings suggest that ASCs offer a "win–win" for patients and the Medicare system, since they provide substantial savings without any corresponding reduction in quality or benefits.

While the future savings offered by ASCs are easily attainable, however, they are not inevitable. Indeed, a discrepancy in Medicare reimbursement policy could jeopardize the savings ASCs provide. Medicare uses two different factors to update ASC and HOPD payments—despite the fact that the two settings provide the same surgical services. ASC payments are updated based on the consumer price index for all urban consumers (CPI-U), which measures changes in the costs of all consumer goods; HOPD rates, meanwhile, are updated on the hospital market basket, which specifically measures changes in the costs of providing health care, and so, more accurately reflects the increased costs that outpatient facilities face.

Since consumer prices have inflated more slowly than medical costs, the gap in ASC and HOPD reimbursement rates has widened over time. If the reimbursement rate for ASCs continues to fall relative to their HOPD counterparts, ASC owners and physicians will face increasing pressure to leave the Medicare system and allow their facilities to be acquired by nearby hospitals. When an ASC is acquired by a hospital, the Medicare reimbursement rate jumps roughly 75 percent. This threatens to turn the cost-saving advantage of ASCs into a perverse market incentive that drives ASCs from the Medicare program.

Already, the widening disparity in reimbursement has led more than 60 ASCs to terminate their participation in Medicare over the last three years. If the reimbursement gap continues to widen, more ASCs will leave the Medicare program. As a result, more Medicare cases will be driven to the HOPD, causing costs to both the Medicare program and its beneficiaries to rise.

Thus, realizing the full potential savings that ASCs offer will likely require policymakers to step in and halt this continuing "slide" in ASC reimbursement rates. Because Medicare saves money virtually every time a procedure is performed in an ASC instead of an HOPD, any policies that reduce the widening reimbursement gap between ASCs and HOPDs, and that otherwise encourage the migration of cases from the hospital setting into ASCs, will increase total savings for the Medicare program and its beneficiaries.

I. AN INTRODUCTION TO AMBULATORY SURGERY CENTERS

Only 40 years ago, virtually all surgeries and diagnostic procedures were performed in hospitals. Today, however, standalone facilities known as Ambulatory Surgery Centers (ASCs) provide outpatient surgical care in an atmosphere removed from the competing demands that are often encountered in an acute care hospital.

ASCs, as this report details, offer patients a cost-effective alternative to hospital outpatient departments (HOPDs). The first ASC opened in 1970, and today, there are more than 5,300 Medicare-certified ASCs in the United States. The overwhelming majority of these ASCs are at least partially owned by physicians, which allows for better control over scheduling, as procedures are not often delayed or rescheduled due to staffing issues or competing demands for operating room space from emergency cases.

ASC surgeons perform a diverse range of procedures, many of them diagnostic or preventive in nature. For example:

- ASCs perform more than 40 percent of all Medicare colonoscopies, contributing to a decade-long decline in colorectal cancer mortality.
- The ASC industry also led the development of minimally invasive procedures and the advancement of technology to replace the intraocular lens, a procedure that is now used nearly one million times each year to restore vision for Medicare patients with cataracts. Once an inpatient hospital procedure, it can now be performed safely at an ASC at a much lower cost.

What is an ASC?

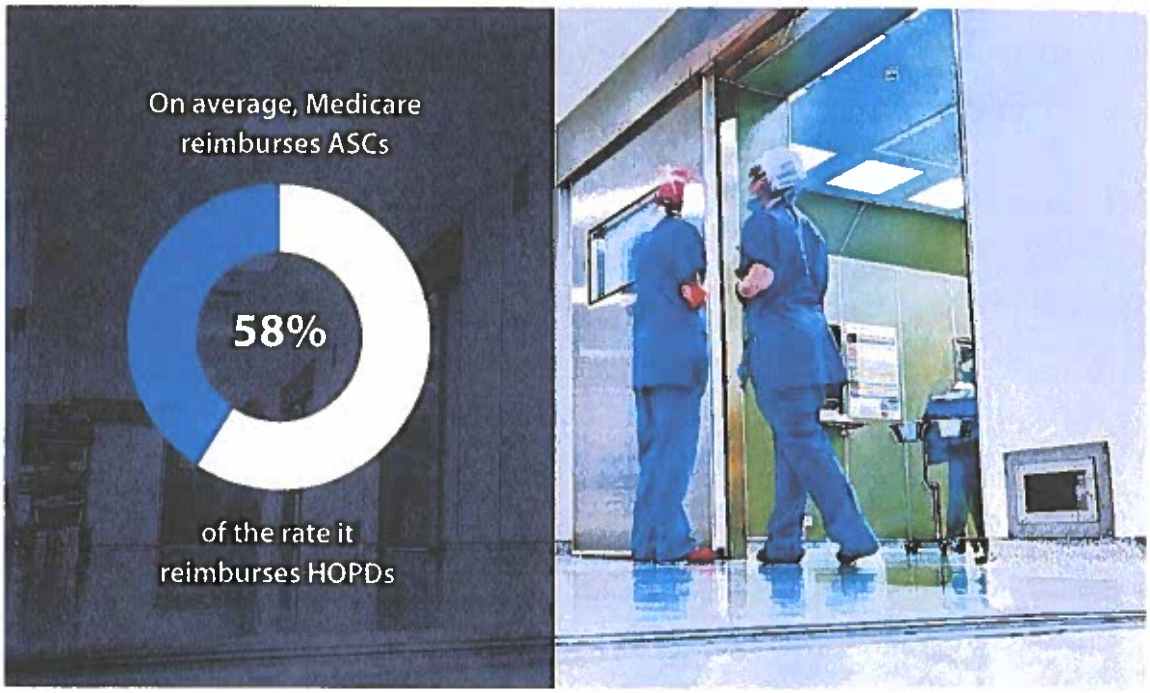
Ambulatory Surgery Centers are modern health care facilities focused on providing a range of same-day surgical care, the same types of procedures that were once performed exclusively in hospitals. Today, as a result of medical advancements and new technologies—including minimally invasive surgical techniques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

II. ASCS: SAVING THE SYSTEM

The more than 5,300 Medicare-certified ASCs in the United States today provide identical services to those performed at HOPDs throughout the country. ASCs are able to perform these surgeries much more efficiently than HOPDs. ASCs do not incur the often substantial administrative and overhead costs associated with a hospital. This enables ASCs to provide these services at substantially less cost to the Medicare program—and to its beneficiaries—than their hospital counterparts.

Today, Medicare reimburses ASCs at an average of 58 percent of the rate it reimburses HOPDs for the same procedures.

The savings that accrue over time, even for individual procedures, are significant. For example, in 2011, Medicare beneficiaries (excluding Medicare Advantage beneficiaries) had 1,709,175 cataract surgeries, of which, 1,120,388 were performed in ASCs and the other 588,787 in HOPDs. The parallel reimbursements per surgery were $951 for an ASC and $1,691 for an HOPD, meaning that every time a patient elected to receive treatment in an ASC, the Medicare program saved $740. When applied across the 1,120,388 cataract surgeries performed in ASCs during 2011, the total savings for this single procedure reached $829 million.



III. COST SAVINGS ANALYSIS

Data and Methodology

Professor Fulton and Dr. Kim conducted the following analysis, which looks at government data from the Centers for Medicare & Medicaid Services (CMS), to answer two fundamental questions. First, how much money did the Medicare program and its beneficiaries save from 2008 to 2011 because surgical and diagnostic procedures were performed at ASCs instead of HOPDs? Second, how much more could the Medicare program and its beneficiaries save over the next decade (2013–2022) if additional procedures move from HOPDs to the ASC setting during that timeframe?

Government data was used to ascertain the volume of procedures performed in ASCs, HOPDs and physician offices from 2008 through 2011, as well as the reimbursement rates for procedures done at ASCs and HOPDs. The volume data reports are from the Medicare Physician Supplier Procedure Specific file available from CMS. It excludes Medicare Advantage enrollees. The ASC reimbursement rates are from the ASC Addendum AA[1], and the HOPD reimbursement rates are from Hospital Outpatient Prospective Payment System Addendum.[2]

When forecasting future cost savings, the Berkeley analysts relied on CMS' predicted number of Medicare beneficiaries from 2013 to 2022. This data set also excludes Medicare Advantage enrollees.[3]

To ensure a realistic baseline for their analysis and predictions, the analysts limited the data set to the 120 procedures most commonly performed at ASCs in 2011, which represented 73 percent of the total volume of all procedures performed in ASCs in 2011.[4]

Past Savings

To estimate the savings generated by ASCs from 2008 to 2011, the analysts calculated the differences in reimbursement rates for each of the 120 procedures, then multiplied those differences by the number of procedures performed at ASCs. For example, the cataract surgery discussed in the previous section, when performed in an ASC, generated a total of $829 million in savings in 2011. They applied the same method for all of the 120 procedures in each year from 2008 to 2011. They broke the numbers into savings that accrued to the Medicare program and savings that directly benefited beneficiaries. The beneficiary share of the total savings was 20 percent over the four-year period. Professor Fulton's and Dr. Kim's analysis found the following:

- During the four-year period from 2008 to 2011, the lower ASC reimbursement rate generated a total of $7.5 billion in savings for the Medicare program and its beneficiaries.
- $6 billion of these savings were realized by the federal Medicare program. The remaining $1.5 billion was saved by Medicare beneficiaries themselves. In other words, Medicare patients nationwide saved $1.5 billion thanks to the less expensive care offered at ASCs.
- These savings increased each year, rising from $1.5 billion in 2008 to $2.3 billion in 2011. The increase results from the total number of procedures growing from 20.4 million to 24.7 million (or 6.6 percent annually) between 2008 and 2011 as well as the reimbursement rate gap widening between HOPDs and ACSs. These savings were realized despite the share of total Medicare procedures performed in ASCs decreasing over this period, falling from 22.9 percent in 2008 to 21.7 percent in 2011.

1 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html
2 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html
3 http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2011.pdf (p.51).
4 The data set was initially narrowed to 148 procedures, which represented about 90% of the total volume. Twenty-seven procedures were dropped because of missing data on the number of procedures or reimbursement rates. One additional procedure was dropped the ASC share was 100%, and it thus provided no basis for comparison with HOPDs.

These findings are illustrated in the following chart.

Descriptor	Annual Change	Total (2008—2011)	2008	2009	2010	2011
Number of procedures per 1,000 Medicare beneficiaries	5.6%		573.9	587.3	600.3	674.9
Procedures (million)						
ASC	4.7%	19.5	4.7	4.7	4.8	5.4
HOPD	5.9%	22.3	5.3	5.3	5.4	6.3
Physician office	7.7%	45.5	10.4	10.8	11.3	13.0
Total # of procedures	6.6%	87.3	20.4	20.8	21.5	24.7
ASC share*	1.5%	22.3%	22.9%	22.7%	22.3%	21.7%
Savings ($billion) **						
Program	16.6%	$6.0	$1.2	$1.4	$1.5	$1.9
Beneficiaries	14.8%	$1.5	$0.3	$0.4	$0.4	$0.5
Total***	16.3%	$7.5	$1.5	$1.8	$1.9	$2.3

Notes:

* The ASC share reported in the table is influenced by (or weighted for) high-volume procedures, such as cataracts. The analysts also calculated the ASC share based on a simple average across the 120 procedures. The ASC shares for 2008 to 2011 were 30.4%, 31.0%, 31.4% and 31.8%, respectively, each year, and averaged 31.1% over the four years.

**Savings are reported in nominal dollars.

***Totals may not sum and percentages may not total to 100% due to rounding.

Future Savings

The ASC industry is certain to continue generating savings to both the Medicare program and its beneficiaries over the next decade. The magnitude of these savings, however, will hinge on whether, and how much, the ASC share of surgeries grows within the Medicare program. That growth rate will, in turn, depend on market trends, demographic factors and how policymakers act—or decline to act—to encourage the use of ASCs within the Medicare program.

To estimate the savings Medicare would realize from having more procedures performed in ASCs from 2013 to 2022, Professor Fulton and Dr. Kim applied the methodology above to six scenarios. These six scenarios, which incorporate different assumptions about both the growth of ASC share and the overall growth of Medicare procedure rates, provide a range of possible savings offered by ASCs in the next decade.

The analysts divided the scenarios into two subsets. For subset A, they assumed that the number of procedures per 1,000 Medicare beneficiaries would remain constant at the 2010 rate. For subset B, they assumed that the 2011 rate would increase by 3 percent annually for each procedure.[5] Within each subset, the analysts examined three scenarios:

1. The ASC share of each procedure in 2011 will remain constant between 2013 and 2022. *This is a baseline assumption that assumes ASC share does not grow at all in the coming decade.*

2. The ASC share of each procedure will increase by 2 percent per year from 2013 through 2022, equivalent to the average increase across procedures from 2008 through 2011.[6] The analysts capped the share for any given procedure at 90 percent to avoid implausible assumptions.

3. The ASC share growth for each procedure will vary depending on that procedure's historical share growth rate. The analysts assumed three growth rates and, again, capped the share for any single procedure at 90 percent.

   - The "low" group included procedures that had negative or no growth in the share of procedures performed at ASCs during 2008–2011. The analysts assumed that the ASC share of these procedures will increase 1 percent annually from 2013–2022. This group included approximately 30 percent of the procedures.

   - The "middle" group included procedures that had up to 5 percent growth in share of procedures performed at ASCs during 2008–2011. It was assumed that the ASC share of these procedures will increase 5 percent annually from 2013–2022. This group included approximately 43 percent of the procedures.

   - The "high" group included procedures that had greater than 5 percent growth in share of procedures performed at ASCs during 2008–2011. This group had a median ASC share growth rate of about 11 percent annually during 2008–2011. The analysts projected that the ASC share of these procedures will increase 10 percent annually from 2013–2022. This group included approximately 27 percent of the procedures.

The estimated savings are tabulated in the following table. The savings analysis and predictions for each individual procedure are tabulated in the appendix.

5 The number of procedures per 1,000 Medicare beneficiaries significantly increased between 2010 and 2011 (see table on page 9). For the lower-savings estimates (subset A), the lower 2010 rate was used as a baseline. For the higher-savings estimates (subset B), the 2011 rate was used as the baseline.

6 The 2% annual average increase is based on a simple average across the 120 procedures, meaning the average is not influenced by (or weighted for) for high-volume procedures, such as cataracts.

Projected Savings ($Billion)	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-2017	2018-2022	2013-2022
A. Volume of Procedures per 1,000 Medicare Beneficiaries Remains Constant and:													
A1. ASC share remains constant	$2.3	$2.5	$2.8	$3.0	$3.2	$3.3	$3.5	$3.7	$4.0	$4.2	$13.7	$18.7	$32.5
A2. ASC share increases at 2% annually	$2.4	$2.7	$3.0	$3.3	$3.6	$3.8	$4.1	$4.4	$4.8	$5.2	$14.9	$22.5	$37.3
A3. ASC share increases either 1%, 5% or 10% annually (depending on the procedure)	$2.5	$2.8	$3.1	$3.5	$3.8	$4.2	$4.6	$5.0	$5.5	$6.0	$15.7	$25.3	$41.0
B. Volume of Procedures per 1,000 Medicare Beneficiaries Increases by 3% Annually and:													
B1. ASC share remains constant	$2.8	$3.1	$3.5	$3.9	$4.3	$4.7	$5.1	$5.5	$6.0	$6.6	$17.6	$27.9	$45.5
B2. ASC share increases at 2% annually	$2.9	$3.3	$3.8	$4.3	$4.8	$5.4	$5.9	$6.6	$7.4	$8.2	$19.1	$33.4	$52.6
B3. ASC share increases either 1%, 5% or 10% annually (depending on the procedure)	$3.0	$3.5	$4.0	$4.6	$5.2	$5.8	$6.6	$7.4	$8.3	$9.4	$20.2	$37.5	$57.6

Note: Savings are reported in nominal dollars. In all scenarios, the Berkeley analysts inflated the reimbursement amounts over time using a forecasted Consumer Price Index for All Urban Consumers, which averaged 2.4% from 2013–2022.

Conclusions

ASCs saved the Medicare program and its beneficiaries $7.5 billion over the four-year period from 2008 to 2011. Even under the most conservative assumptions, the future savings generated by ASCs are substantial.

- Under the baseline scenario, which assumes that neither ASC share nor Medicare procedure volume will grow over the next decade, ASCs will save the Medicare program an additional $32.5 billion during that time.
- As the share of procedures performed in ASCs grows within the Medicare program, so do the savings. If ASC share within the Medicare system increases even slightly, as in scenarios B2 and B3, the savings could exceed $57.6 billion over 10 years—an average savings of $5.76 billion each year.
- Medicare beneficiaries also save money by choosing ASCs, since a lower Medicare reimbursement rate means that patients, in turn, pay a smaller coinsurance. While the forward-looking portion of this study does not examine coinsurance rates for each procedure, it is clear that the savings realized by the Medicare program imply additional savings for beneficiaries. Using the example of cataract surgeries: a Medicare beneficiary will pay coinsurance of $338.20 for such a surgery to be performed in an HOPD, but only $190.20 for that same surgery in an ASC—a $148 savings that goes directly to the patient.

BY THE NUMBERS:

$7.5 billion

in savings generated by ASCS from 2008 to 2011

Up to

$57.6 billion

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

Up to

$5.76 billion

average future yearly savings

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

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

IV. POLICY IMPLICATIONS AND CONSIDERATIONS

An aging population, along with inflation in health care costs, means that the federal government's expenditures through the Medicare program are projected to increase substantially in the coming years. Consequently, policymakers in Washington, DC, are exploring potential ways to reduce projected Medicare outlays and extend the program's solvency. We believe that this study offers an important contribution to that discussion. Two specific policy concerns stand out.

AVOIDING ASC TO HOPD CONVERSIONS

Our first and most important observation is that, while the future savings offered by ASCs are easily attainable, they are not inevitable. Because they provide identical services to HOPDs but do so at an average of 58 percent of the reimbursement rate that the Medicare program pays HOPDs for those services, ASCs represent a source of value to the program and the taxpayers who fund it. A discrepancy in the way Medicare reimbursement rates are updated, however, threatens to marginalize ASCs' role within the program.

CMS currently applies different measures of inflation to determine the adjustments it provides to its payment systems for ASCs and HOPDs each year. For ASCs, that measure is the CPI-U, which is tied to consumer prices. The index for HOPD reimbursements, on the other hand, remains tied to the hospital market basket, which measures inflation in actual medical costs. Since consumer prices have inflated more slowly than medical costs, the gap in ASC and HOPD reimbursement rates has widened over time. As the reimbursement rate for ASCs continues to fall relative to their HOPD counterparts, ASC owners and physicians will face increasing pressure to leave the Medicare system and allow their facilities to be acquired by nearby hospitals.

When an ASC is acquired by a hospital, in what is known as "an ASC to HOPD conversion," the Medicare reimbursement rate jumps roughly 75 percent and all savings to the Medicare program and its beneficiaries are promptly lost. The continuing reduction in reimbursement led more than 60 ASCs to terminate their participation in Medicare over the last three years. If policymakers allow this gap in reimbursements to continue widening, the cost-saving advantage that ASCs offer could morph into a perverse market incentive that drives ASCs from the Medicare program.

Some in Congress have introduced legislation, which is titled the "Ambulatory Surgical Center Quality and Access Act," that aims to fix this problem. This bill would correct the imbalance in reimbursement indices and ensure that ASC reimbursements do not continue to fall relative to their HOPD counterparts. Additionally, it would establish an ASC value-based purchasing (VBP) program designed to foster collaboration between ASCs and the government and create additional savings for the Medicare system in the process.

ASCS AS PART OF BROADER COST-SAVINGS EFFORTS

Many of the policy options aimed at reducing Medicare costs that are being considered in Congress today involve important "trade-offs," where reduced outlays come at the expense of retirees' benefits. Often-discussed options such as raising the Medicare retirement age or increasing cost-sharing, for example, generate savings as a direct result of reducing the amount of benefits delivered by the Medicare program. The savings offered by ASCs, however, do not involve such trade-offs; they make it possible for the Medicare program, and its beneficiaries, to realize significant savings without any corresponding reduction in benefits.

There are more than 5,300 Medicare-certified ASCs throughout the country, all of which represent an important source of efficiency for the Medicare program and the taxpayers who fund it. We recommend that policymakers explore all potential options for encouraging further growth of ASC share within the Medicare system.

APPENDIX: METHODOLOGY AND CHART OF INDIVIDUAL PROCEDURE SAVINGS

The following table shows detailed statistics for the 120 procedures. In the table, the procedures are first sorted by the annual ASC share increase assumptions in Scenarios A3 and B3, which were 1, 5, and 10 percent annually (see Column "% ASC Share Growth Assumptions for A3 and B3"). Within the 1, 5, and 10 percent buckets, the procedures are then sorted based on the savings they generated in 2011 (see Column "Savings 2011").

The table shows the average annual change in the ASC share from 2008 through 2011, the 2011 ASC share of procedures and projected ASC share in 2022 if the share increases by 2 percent annually or in the range of 1 to 10 percent annually. In addition, it shows the 2011 and projected 2022 volume per 1,000 Medicare beneficiaries. Most importantly, those columns are followed by two sets of three columns that show the projected savings estimates in 2022 when the number of procedures per 1,000 Medicare beneficiaries remains constant and when the number of procedures per 1,000 Medicare beneficiaries increases by 3 percent per year. Within each set, the ASC share assumptions are based on the assumptions presented in the table on page 11.

The first row of the table illustrates that cataract surgeries (HCPCS 66984) alone generated a savings of $829 million in 2011. In 2011, the ASC share of this procedure was 56 percent, and that share either increases to 62 or 69 percent depending on the scenario. Depending on whether the number of cataract surgeries per 1,000 Medicare beneficiaries increases and the share of procedures performed in ASCs, the projected savings for Medicare and its beneficiaries range from $1.5 billion to $2.95 billion in 2022.

The last row of the table shows column totals and averages (see page 9). In 2011, there were $2.3 billion in savings for the 120 procedures, and the projected savings in 2022 range from $4.2 billion to $9.4 billion, depending on the scenario.

No.	HCPCS	HCPCS Description	Savings 2011 ($million)	Average Annual ASC Share Change 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			1% ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	A2. Savings for 2022 (ASC share increases 2% per year) ($million)	A3. Savings for 2022 (ASC share increase varies) ($million)	B1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	B2. Savings for 2022 (ASC share increases 2% per year) ($million)	B3. Savings for 2022 (ASC share increase varies) ($million)		
1	66984	Cataract surg w/iol 1 stage	$829	-3.56%	56%	69%	62%	54.9	76.0	$1,500	$1,870	$1,670	$2,370	$2,950	$2,650	1%	$740
2	66982	Cataract surgery complex	$63	-0.96%	52%	65%	59%	4.4	6.1	$116	$144	$129	$180	$224	$201	1%	$740
3	64483	Inj foramen epidural l/s	$60	-3.02%	35%	44%	39%	20.6	28.5	$106	$132	$119	$173	$215	$193	1%	$229
4	62311	Inject spine l/s (cd)	$53	-13.67%	26%	33%	29%	24.1	33.4	$73	$91	$82	$152	$188	$169	1%	$229
5	66821	After cataract laser surgery	$43	-2.96%	43%	54%	48%	16.2	22.4	$86	$107	$96	$124	$154	$138	1%	$169
6	29881	Knee arthroscopy/surgery	$25	-0.25%	39%	48%	43%	2.0	2.7	$51	$64	$57	$71	$89	$79	1%	$903
7	28285	Repair of hammertoe	$22	-0.22%	37%	46%	41%	2.4	3.3	$38	$47	$43	$64	$79	$71	1%	$681
8	43235	Uppr gi endoscopy diagnosis	$21	-0.18%	34%	43%	38%	6.1	8.5	$38	$47	$42	$59	$73	$66	1%	$268
9	64622	Destr paravertebrl nerve l/s	$18	-4.98%	35%	44%	40%	3.6	5.0	$28	$34	$31	$52	$64	$58	1%	$386
10	52000	Cystoscopy	$16	-0.03%	8%	10%	9%	24.4	33.8	$33	$41	$37	$47	$58	$52	1%	$224
11	62310	Inject spine c/t	$14	-13.54%	30%	37%	33%	5.5	7.6	$18	$23	$20	$39	$49	$44	1%	$229
12	29848	Wrist endoscopy/surgery	$11	-0.10%	51%	63%	57%	0.7	0.9	$20	$25	$23	$32	$40	$36	1%	$903
13	29823	Shoulder arthroscopy/surgery	$10	-2.73%	28%	35%	31%	0.7	0.9	$14	$17	$16	$29	$36	$32	1%	$1,460
14	63650	Implant neuroelectrodes	$9	-20.87%	24%	29%	26%	1.2	1.7	$10	$12	$11	$26	$32	$29	1%	$846
15	20680	Removal of support implant	$7	-1.14%	26%	32%	29%	1.1	1.5	$14	$17	$15	$21	$27	$24	1%	$720
16	28296	Correction of bunion	$7	-0.91%	41%	50%	45%	0.5	0.7	$15	$18	$17	$20	$25	$23	1%	$1,002
17	52005	Cystoscopy & ureter catheter	$7	-0.11%	25%	31%	28%	0.9	1.3	$12	$15	$13	$19	$24	$22	1%	$794
18	45381	Colonoscopy submucous inj	$7	-4.10%	43%	54%	48%	1.5	2.0	$7	$9	$8	$19	$23	$21	1%	$281
19	36561	Insert tunneled cv cath	$6	-1.43%	7%	8%	7%	2.6	3.7	$12	$15	$13	$17	$21	$19	1%	$927
20	29875	Knee arthroscopy/surgery	$5	-1.21%	46%	57%	51%	0.3	0.4	$8	$10	$9	$14	$17	$15	1%	$903
21	30520	Repair of nasal septum	$5	-0.30%	30%	37%	34%	0.6	0.8	$8	$9	$8	$14	$17	$15	1%	$773
22	52281	Cystoscopy and treatment	$5	-0.75%	9%	11%	10%	2.7	3.7	$11	$13	$12	$14	$17	$15	1%	$530
23	58558	Hysteroscopy biopsy	$4	-2.25%	13%	17%	15%	1.1	1.5	$7	$9	$8	$10	$13	$12	1%	$696
24	65426	Removal of eye lesion	$3	-0.03%	59%	73%	66%	0.2	0.2	$5	$6	$6	$8	$10	$9	1%	$736
25	64626	Destr paravertebrl nerve c/t	$3	-7.96%	38%	48%	43%	0.8	1.2	$4	$5	$5	$8	$10	$9	1%	$229
26	14041	Skin tissue rearrangement	$3	-2.49%	13%	16%	15%	1.0	1.4	$5	$6	$6	$7	$9	$8	1%	$519
27	43251	Operative upper GI endoscopy	$2	-0.85%	35%	44%	39%	0.6	0.9	$4	$5	$4	$6	$8	$7	1%	$268
28	64627	Destr paravertebral n add-on	$2	-0.43%	39%	48%	43%	1.9	2.6	$3	$3	$3	$6	$8	$7	1%	$80
29	44361	Small bowel endoscopy/biopsy	$2	-1.36%	53%	66%	60%	0.3	0.5	$4	$5	$4	$6	$7	$6	1%	$307
30	62264	Epidural lysis on single day	$2	-17.63%	29%	36%	32%	0.4	0.5	$2	$2	$2	$5	$6	$5	1%	$386

No.	HCPCS	HCPCS Description	Savings 2011 ($million)	Average Annual ASC Share Change 2003-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			5% ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	A2. Savings for 2022 (ASC share increases 2% per year) ($million)	A3. Savings for 2022 (ASC share increase varies) ($million)	B1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	B2. Savings for 2022 (ASC share increases 2% per year) ($million)	B3. Savings for 2022 (ASC share increase varies) ($million)		
31	13132	Repair of wound or lesion	$2	-4.69%	6%	7%	6%	5.3	7.4	$2	$3	$3	$5	$6	$5	1%	$140
32	62319	Inject spine w/cath l/s (cd)	$2	-18.47%	30%	38%	34%	0.4	0.5	$2	$2	$2	$4	$6	$5	1%	$386
33	64520	N block lumbar/thoracic	$1	-13.74%	23%	29%	26%	0.6	0.8	$1	$2	$2	$3	$4	$4	1%	$229
34	64450	N block other peripheral	$1	-1.62%	1%	2%	1%	10.2	14.1	$1	$1	$1	$3	$4	$3	1%	$226
35	11042	Deb subq tissue 20 sq cm/<	$1	-14.48%	1%	1%	1%	28.9	40.0	$1	$2	$2	$2	$3	$2	1%	$82
36	20552	Inj trigger point 1/2 muscl	$1	-7.74%	1%	2%	1%	8.3	11.5	$1	$1	$1	$2	$2	$2	1%	$163
37	43239	Upper gi endoscopy biopsy	$143	0.58%	45%	55%	76%	32.8	45.5	$243	$303	$416	$409	$509	$700	5%	$268
38	45380	Colonoscopy and biopsy	$107	1.11%	48%	59%	82%	21.8	30.2	$197	$245	$336	$306	$380	$523	5%	$281
39	45385	Lesion removal colonoscopy	$82	2.10%	46%	58%	79%	17.2	23.9	$162	$202	$278	$236	$293	$403	5%	$281
40	45378	Diagnostic colonoscopy	$66	0.27%	40%	49%	68%	16.2	22.4	$157	$195	$268	$190	$236	$324	5%	$281
41	29826	Shoulder arthroscopy/surgery	$38	1.27%	33%	40%	56%	2.2	3.1	$53	$66	$91	$110	$137	$188	5%	$1,460
42	G0105	Colorectal scrn; hi risk ind	$30	2.48%	52%	64%	88%	6.3	8.7	$54	$68	$93	$85	$105	$145	5%	$249
43	64721	Carpal tunnel surgery	$25	1.01%	40%	50%	68%	3.0	4.2	$50	$62	$85	$72	$90	$124	5%	$577
44	64623	Destr paravertebral n add-on	$24	4.03%	36%	44%	61%	8.1	11.2	$31	$39	$53	$69	$86	$118	5%	$229
45	G0121	Colon ca scrn not hi rsk ind	$24	2.22%	45%	56%	77%	5.8	8.0	$42	$52	$72	$68	$84	$115	5%	$249
46	29827	Arthroscop rotator cuff repr	$23	3.71%	32%	39%	54%	1.4	1.9	$44	$55	$75	$66	$82	$112	5%	$1,460
47	29880	Knee arthroscopy/surgery	$21	1.64%	41%	51%	71%	1.5	2.1	$44	$55	$76	$59	$73	$100	5%	$903
48	45384	Lesion remove colonoscopy	$19	0.93%	42%	52%	71%	4.5	6.3	$40	$49	$68	$56	$69	$95	5%	$281
49	67904	Repair eyelid defect	$17	3.55%	63%	79%	90%	1.2	1.7	$32	$40	$46	$48	$60	$69	5%	$603
50	64484	Inj foramen epidural add-on	$16	3.71%	34%	42%	58%	11.2	15.6	$23	$29	$40	$46	$58	$79	5%	$117
51	26055	Incise finger tendon sheath	$16	1.20%	44%	55%	76%	1.9	2.7	$28	$35	$49	$46	$58	$79	5%	$517
52	43248	Uppr gi endoscopy/guide wire	$14	0.86%	53%	67%	90%	2.6	3.6	$25	$31	$42	$39	$49	$66	5%	$268
53	29824	Shoulder arthroscopy/surgery	$11	0.45%	33%	42%	57%	1.0	1.4	$15	$19	$26	$32	$40	$55	5%	$903
54	49505	Prp i/hern init reduc >5 yr	$11	2.77%	15%	19%	26%	1.9	2.7	$23	$28	$39	$30	$38	$52	5%	$997
55	67917	Repair eyelid defect	$10	3.72%	60%	74%	90%	0.8	1.0	$18	$23	$27	$28	$35	$43	5%	$603
56	23412	Repair rotator cuff chronic	$10	3.46%	33%	41%	56%	0.6	0.8	$20	$25	$34	$27	$34	$47	5%	$1,426
57	14060	Skin tissue rearrangement	$9	0.50%	18%	22%	30%	2.6	3.6	$18	$22	$30	$25	$31	$43	5%	$519
58	55700	Biopsy of prostate	$8	2.92%	12%	14%	20%	5.1	7.0	$17	$21	$29	$24	$30	$42	5%	$393
59	66180	Implant eye shunt	$8	3.44%	52%	65%	89%	0.3	0.4	$16	$20	$27	$22	$27	$38	5%	$1,303
60	43450	Dilate esophagus	$8	1.82%	54%	67%	90%	1.9	2.7	$8	$11	$14	$22	$27	$36	5%	$198

No.	HCPCS	HCPCS Description	Savings 2011 ($million)	Average Annual ASC Share Change 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)[1]	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			% ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	A2. Savings for 2022 (ASC share increases 2% per year) ($million)	A3. Savings for 2022 (ASC share increase varies) ($million)	B1. Baseline: Savings for 2022 (ASC share remains constant) ($million)	B2. Savings for 2022 (ASC share increases 2% per year) ($million)	B3. Savings for 2022 (ASC share increase varies) ($million)		
61	25447	Repair wrist joint(s)	$7	1.12%	47%	58%	80%	0.4	0.5	$14	$17	$23	$21	$26	$36	5%	$1,184
62	43249	Esoph endoscopy dilation	$7	1.08%	30%	38%	52%	2.2	3.1	$12	$15	$20	$19	$24	$33	5%	$268
63	66170	Glaucoma surgery	$6	4.40%	61%	76%	90%	0.4	0.5	$13	$16	$19	$18	$23	$27	5%	$736
64	29822	Shoulder arthroscopy/surgery	$6	2.28%	36%	45%	61%	0.5	0.7	$10	$13	$17	$18	$23	$31	5%	$903
65	14040	Skin tissue rearrangement	$6	1.83%	16%	20%	27%	2.1	2.9	$13	$16	$22	$18	$23	$31	5%	$519
66	28270	Release of foot contracture	$5	3.02%	28%	35%	48%	0.8	1.1	$9	$12	$16	$15	$19	$26	5%	$681
67	15260	Skin full graft een & lips	$5	4.70%	18%	22%	31%	1.5	2.0	$10	$12	$17	$14	$18	$25	5%	$519
68	45383	Lesion removal colonoscopy	$5	1.36%	36%	45%	62%	1.3	1.8	$10	$13	$18	$14	$17	$24	5%	$281
69	66711	Ciliary endoscopic ablation	$5	1.70%	79%	90%	90%	0.3	0.4	$7	$8	$8	$14	$16	$16	5%	$539
70	67924	Repair eyelid defect	$5	3.72%	61%	76%	90%	0.3	0.5	$9	$11	$13	$13	$17	$20	5%	$603
71	52353	Cystouretero w/lithotripsy	$4	4.90%	13%	16%	21%	0.8	1.2	$8	$10	$14	$12	$15	$21	5%	$1,126
72	67028	Injection eye drug	$4	3.19%	1%	1%	2%	54.4	75.4	$6	$8	$11	$11	$14	$19	5%	$169
73	52234	Cystoscopy and treatment	$4	1.27%	19%	24%	33%	0.7	0.9	$7	$9	$13	$11	$13	$18	5%	$794
74	64718	Revise ulnar nerve at elbow	$4	3.70%	36%	45%	62%	0.5	0.7	$6	$8	$11	$11	$13	$18	5%	$577
75	28308	Incision of metatarsal	$3	1.92%	38%	48%	65%	0.4	0.5	$5	$7	$9	$10	$12	$17	5%	$681
76	26123	Release palm contracture	$3	1.37%	47%	58%	80%	0.2	0.3	$8	$10	$13	$10	$12	$17	5%	$897
77	26160	Remove tendon sheath lesion	$3	0.77%	44%	55%	75%	0.4	0.6	$6	$8	$11	$10	$12	$17	5%	$517
78	67950	Revision of eyelid	$3	2.29%	64%	80%	90%	0.2	0.3	$5	$7	$7	$9	$12	$13	5%	$603
79	52224	Cystoscopy and treatment	$3	4.95%	8%	11%	14%	1.3	1.9	$7	$9	$12	$9	$12	$16	5%	$794
80	52310	Cystoscopy and treatment	$3	0.06%	9%	11%	16%	1.8	2.5	$6	$8	$10	$9	$11	$15	5%	$530
81	67961	Revision of eyelid	$3	1.27%	55%	69%	90%	0.2	0.3	$5	$6	$9	$9	$11	$14	5%	$603
82	52235	Cystoscopy and treatment	$3	2.23%	14%	18%	24%	0.7	1.0	$6	$7	$10	$9	$11	$15	5%	$794
83	66986	Exchange lens prosthesis	$3	0.17%	63%	78%	90%	0.2	0.2	$5	$6	$7	$8	$10	$12	5%	$740
84	64479	Inj foramen epidural c/t	$3	0.16%	31%	38%	53%	1.1	1.5	$5	$6	$9	$8	$10	$14	5%	$229
85	66250	Follow-up surgery of eye	$2	1.83%	37%	46%	64%	0.3	0.4	$4	$5	$7	$6	$7	$10	5%	$539
86	14061	Skin tissue rearrangement	$2	1.01%	16%	19%	27%	0.7	0.9	$4	$5	$7	$6	$7	$10	5%	$519
87	17311	Mohs 1 stage h/n/hf/g	$1	3.76%	1%	2%	2%	14.8	20.5	$2	$2	$3	$3	$4	$5	5%	$162
88	13121	Repair of wound or lesion	$1	0.48%	6%	7%	10%	2.8	3.8	$1	$1	$1	$2	$2	$3	5%	$95
89	15823	Revision of upper eyelid	$41	6.61%	68%	85%	90%	2.4	3.4	$84	$105	$111	$117	$146	$155	10%	$671
90	50590	Fragmenting of kidney stone	$13	10.88%	18%	23%	52%	1.5	2.1	$25	$31	$72	$36	$45	$103	10%	$1,265

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

NOTES:

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

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

Medicare Cost Savings Tied to Ambulatory Surgery Centers

ASCA
Ambulatory Surgery Center Association

Produced with cost savings analysis from

Berkeley
UNIVERSITY OF CALIFORNIA

ASCA Ambulatory Surgery Center Association

Ambulatory Surgery Centers

A Positive Trend in Health Care

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

A TRANSFORMATIVE MODEL FOR SURGICAL SERVICES

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

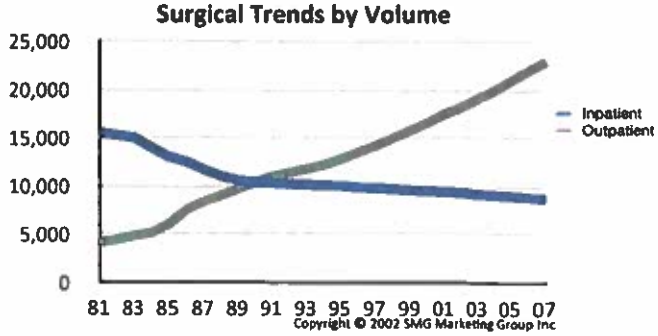
Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the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

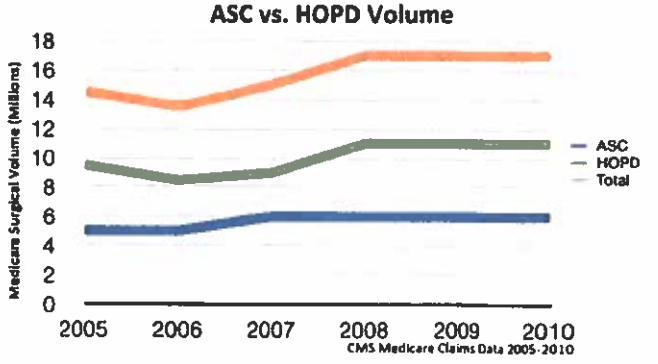
Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling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

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

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

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





ASCs PROVIDE CARE AT SIGNIFICANT COST SAVINGS

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

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

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

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

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

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

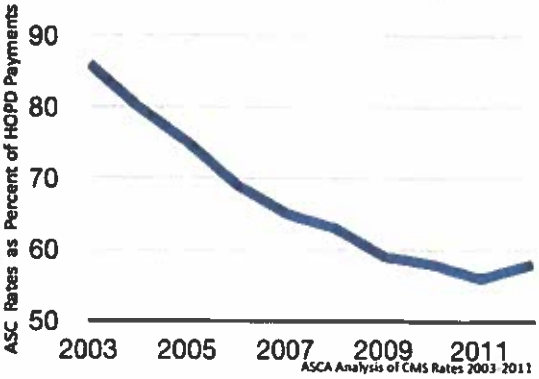
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased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

Cost Comparison:
ASC v. Hospital Outpatient Department

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

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

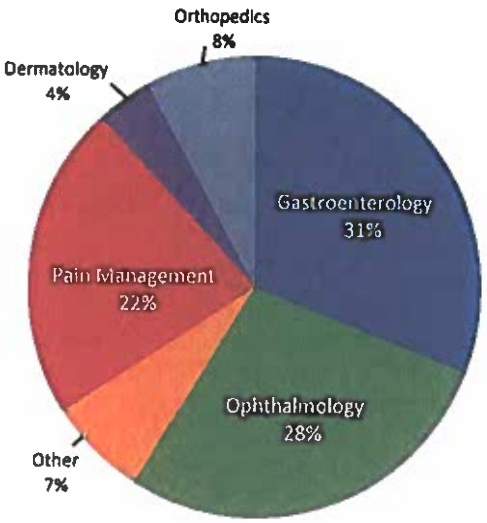
The Gap Between ASC and HOPD Payments Has Widened Significantly



THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

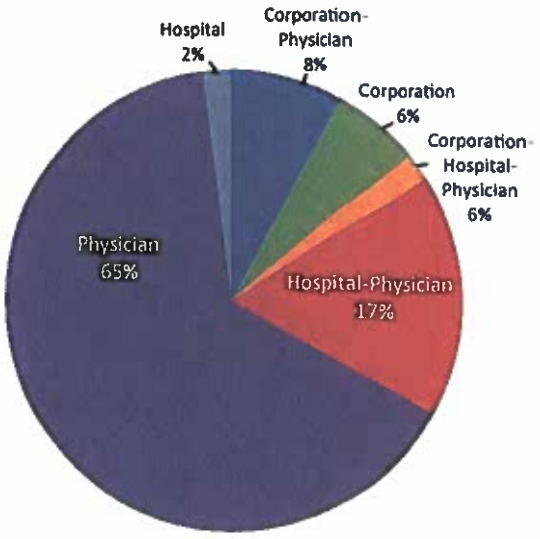
Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price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

Medicare Case Volume by Specialty



ASCA Analysis of CMS Claims Data 2010

ASC Ownership



ASCA's 2011 ASC Employee Salary & Benefits Survey

ASCs = Efficient Quality Care + Convenience + Patient Satisfaction

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

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

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

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

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

ASCs ARE HIGHLY REGULATED TO ENSURE QUALITY AND SAFETY

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

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

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

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

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

ASCs: A COMMITMENT TO QUALITY

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

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

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

Reporting Measures

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

76 Federal Regulation 74492 - 74517

Specific Federal Requirements Governing ASCs

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

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

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

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

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

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

Medicare Health and Safety Requirements

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

Source: 42 CFR 416 & 482

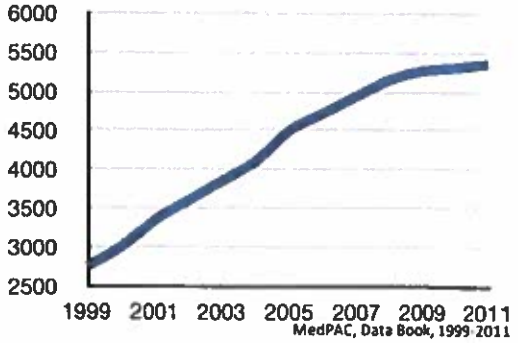
CONTINUED DEMAND FOR ASC FACILITIES

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

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

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

Number of Medicare Certified ASCs



MedPAC, Data Book, 1999-2011

ASCs CONTINUE TO LEAD INNOVATION IN OUTPATIENT SURGICAL CARE

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

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

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

POLICY CONSIDERATIONS

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

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

END NOTES

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

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

3 Oxford Outcomes ASC Impact Analysis, 2010.

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

5 ASCA Outcomes Monitoring Project, 3rd Quarter 2011.

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

Alternatives

The proposed project will provide The Advanced Surgical Institute LLC with the operational capacity within the ASTC to provide surgeries current facilities cannot support within the community today.

Three alternatives were evaluated and were rejected by the applicants.

1. **Maintain *Status Quo***

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

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

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

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

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

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

The next alternative considered was to reduce the size and the scope of the project. The applicant is currently seeking approval to establish a limited specialty ASTC, with two operating rooms and seven accompanying recovery rooms. The applicant investigated and considered the alternative option of only adding one operating room, but it was ultimately dismissed. The

current plan for one operating room and two recovery rooms is necessary to address the service demand for the facility, and to plan for the future expected demand.

As addressed within Attachments, 12, 15 and 24 of this application, the projected surgical volumes for surgeons at ASI will be compliant with the state standards for two (2) operating rooms by the second year of operations. The applicants demonstrate that the facility will operate at or above state utilization standards within the first two years of completion of the project. Limiting the expansion to one operating room also caused an increase in total costs per operating room. This is due to inefficiencies in design and construction for building out a single operating room versus two operating rooms with potential for two additional ORs.

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

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

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

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

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

1. Need for Cardiology approved & focused ASTC Operating Rooms within the GSA
2. Need to Improve the Clinical Care Continuum for Applicant's Patients
3. Align with CMS, Payers, and Patients to Continue Transition from Hospital to ASTC Setting

The cost of this alternative is **$6,098,521.00**

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

Size of Project – Expansion				
Service	**Proposed DGSF**	**State Standard**	**Difference**	**Met Standard?**
2 ORs	2,150 (Per Room)	2,200 DGSF/Treatment Room	(50)	Yes

The proposed project by Surgery Center of Illinois will incorporate 6,500 square feet, 4,300 of which is clinical space for the facility. This project meets the state standard for modernization construction of 2,200 DGSF per Treatment Room.

Additional Information:

The Applicant is proposing the establishment of an ASTC with two (2) operating rooms, a control room for operating room equipment, seven (7) recovery rooms, clean and soiled processing rooms, nurse stations, decontamination space, scrub stations, and patient toilets. In addition to this clinical space, the applicant is developing non-clinical patient waiting and reception space, administrative offices, public restrooms, mechanical rooms, and staff facilities.

The ASTC will be developed through the modernization of existing space located next to an existing physician office clinic, with limited new buildout at the back of the existing building. The facility is designed to comply with State, Federal, and local building codes and requirements.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(b), Project Services Utilization

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

By the second year after project completion, the ASTC's annual utilization shall meet or exceed HFSRB's utilization standards of 1,500 hours of surgical time per room. An applicant is deemed to meet this standard for one OR when they are providing any surgical volume up to 1,500 hours. It meets the requirement for a second operating room when volume exceeds 1,500 hours, a third when it exceeds 3,000 hours, and so on.

Based upon projected procedures documented within the physician referral letters included herein as Appendix-1, 1,336 operating room procedures will be performed at the ASTC within the first year after project completion. All these procedures were previously performed in the hospital setting. As identified below, the projected procedures were multiplied by the historical time per procedure to obtain the projected utilization for the two (2) operating rooms.

Referral Source	Historical 12 Month of Surgeries	Referrals for 12 months after expansion	Average Surgery Time	Total Hours
Consultants in Cardiology & Electrophysiology	1,645	**1,366**	1.80 Hours	2,404

Table 1110.234(b) Utilization					
	Dept./ Service	**Historical Utilization (Treatments)**	**Projected Utilization**	**State Standard**	**Met Standard?**
Year 1	ASTC	N/A	2,404 hrs.	Over 1,500 hrs. For 2 ORs	Yes
Year 2	ASTC	N/A	2,645 hrs.	Over 1,500 hrs. For 2 ORs	Yes

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

This project does not include Shell Space.

Section IV, Project Scope, Utilization, and Unfinished/Shell Space
Criterion 1110.120(e), Assurances

This project does not include shell space.

Section VII, Service Specific Review Criteria
Ambulatory Surgical Treatment Center
Criterion 1110.235 Planning Area Need

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

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

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

The applicant proposes to offer ASTC services within a facility with two (2) Operating Rooms. The facility plans to offer cardiovascular surgeries, with a focus in cardiac catheterization and pacemaker placement.

The applicant is fit, willing and able, and has the qualifications, background and character to adequately provide a proper standard of health care service for the community. Dr. Al-Khaled, Dr. Burke, Dr. Nouneh, Dr. Spear, and Dr. Zaidi currently run their clinical practice called Consultants in Cardiology & Electrophysiology. The Advanced Surgical Institute LLC is a newly created entity owned in equal parts by Dr. Al-Khaled, Dr. Burke, Dr. Nouneh, Dr. Spear, and Dr. Zaidi. The Advanced Surgical Institute LLC is the applicant for the proposed ASTC. The Advanced Surgical Institute LLC does not have ownership in any other IDPH licensed facility.

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

Geographic Service Area

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

B) See attached Exhibit 1 for the historical patient origin information by zip code for the most recent 12-months of operation from which data is available demonstrating more than 50% of admissions at local hospitals were from the GSA.

(c)(3) Service Demand – Establishment

A) Historical Referrals

i) The physicians associated with this project have included the attached physician referral letters which attest to the number of procures that they have performed in the latest 12-month period. As noted within the referral, the physicians anticipate referring 1,336 of the 1,645 surgeries they performed, accounting for a total of 2,404 hours of surgery.

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

B) Projected Service Demand – Projected Referrals

i) Based upon the historic utilization, in Appendix-1, the projected demand is sufficient to meet the state standards for utilization. The project will meet the state standard of more than 1,500 hours of surgery by the first year of operation.

	Referral Source	Historical 12 Month of Surgeries	Anticipated Referrals	Average Surgery Time	Total Hours
Year 1	Consultants in Cardiology & Electrophysiology	1,645	**1,336**	1.80	2,404
Year 2	Consultants in Cardiology & Electrophysiology	1,645	**1,470**	1.80	2,645

(c)(5) Treatment Room Need Assessment

A) As demonstrated by the physician referrals in Appendix-1, the facility currently projects to perform 1,336 procedures totaling 2,404 hours in the first year following project completion. The facility is projecting to exceed the utilization standards for its existing two (2) treatment rooms. As such, the proposed number of operating rooms is necessary in order to service the projected patient volumes.

B) Based upon the physician referrals and the historical caseload data, the applicants project the following patient treatments and average time per patient treatment, justifying the expected utilization of the two additional treatment rooms. The average hours are based upon national statistics for like procedures averaging to 1.3 hour per procedure with 15 minutes for prep and 15 minutes for cleanup.

	Specialty	Total Surgeries	Average Surgery Time	Total Surgery Hours
Year 1	**Cardiovascular**	**1,336**	**1.80 Hours**	**2,404**
Year 2	**Cardiovascular**	**1,470**	**1.80 Hours**	**2,645**

(c)(6) Service Accessibility

The proposed cardiovascular ASTC services are necessary to improve the access to care for resident of the service area, and it is clear that the services and procedures to offered are not currently available in the service area in compliance with section (c)(6)(C). Although there are nine (9) licensed ASTC's and two (2) approved but not yet operational ASTCs within the GSA, only the two ASTCs in development are intended to offer any cardiovascular surgical services. By design and function, neither of those facilities are intended to or capable of servicing the surgical volume and procedures contemplated by this project.

As a result, the residents to be served by this proposed facility do not have an option within the Geographical Service Area (GSA) to receive treatment in a non-hospital ambulatory surgical center (ASTC).

Existing Operational ASCs in GSA			
Oak Lawn Endoscopy Center	60453	9921 Southwest Highway, Oak Lawn, IL	3.45 mi
Magna Surgical Center	60638	7456 S State Road, Suite 300, Bedford Park, IL	3.04 mi.
Center for Reconstructive Surgery	60453	6311 W. 95th Street, Oak Lawn, IL	3.7 mi.
Palos SurgiCenter, LLC	60463	7340 W. COLLEGE DRIVE, Palos Heights, IL	5.56 mi.
Palos Hills Surgery Center	60465	10330 South Roberts Road, Ste 3000, Palos Hills, IL	5.64 mi.
Surgicore	60617	10547 S. EWING AVE., Chicago, IL	9.14 mi.
Forest Med-Surg Center	60458	9050 W. 81st Street, Justice, IL	7.21 mi.
Hyde Park Surgical Center	60615	1644 E 53rd St, Chicago, IL	8.44 mi.
South Loop Endoscopy & Wellness Center	60616	2340 S. Wabash, Chicago, IL	9.90 mi

Two (2) ASTCs are located in the GSA, but are not yet licensed and operational.

ASCs in Development within the GSA			
Vascular Access Centers of Illinois ("VAC")	60643	1701 W. Monterey Ave, Chicago, IL	3.13 mi.
Premier Cardiac Surgery Center ("Premier")	60803	11560 S. Kedzie Ave Ste 102, Merrionette Park, IL	2.66 mi.

Both the VAC and Premier ASTCs are designed and intended to service an existing, different patient base from the applicants. Neither the VAC or Premier ASTC is intended to or capable of servicing the surgical volume of the applicants. In fact, Premier is intended to operate as a hybrid OBL/ASTC with one operating room, which means this one-room facility will not even be an ASC full-time. This clearly restricts the ability of the facility to shoulder the volume contemplated by the applicants. Likewise, VAC is designed for fistula access procedures for dialysis patients. It is not designed, equipped, or intended to provide the pacemaker and cardiac catheterization procedures performed by the applicants.

(c)(7) Unnecessary Duplication/Maldistribution

A) The proposed project will not result in unnecessary duplication because the only two facilities offering cardiovascular ASTC services are not designed or capable of offering surgical access to the GSA residents the proposed facility will serve:

i) A list of the total population for GSA is attached as Exhibit 2.

ii) A list of all of the existing health care facilities within the GSA that **provide the ASTC services that are proposed by this project** are summarized below.

Approved & Not Operational - ASTCs			
Vascular Access Centers of Illinois	60643	1701 W. Monterey Ave, Chicago, IL	3.13 mi.
Premier Cardiac Surgery Center	60803	11560 S. Kedzie Ave Ste 102, Merrionette Park, IL	2.66 mi.

B) Maldistribution does not exist within the GSA:

i) See the table below demonstrating compliance:

	Population	**Rooms**	**Rooms to Population**
State	12,830,632	2,368	1:5,418
GSA	1,870,965	258	1:7,251

ii) No ASTCs in the GSA offer cardiovascular services and have a historical utilization below state standards. There are approved, but not yet operational ASTCs that will offer cardiovascular services, but they are currently without any historical volume and have pledged to exceed state standards based on patient referrals not associated with this project.

iii) As demonstrated in this filing, there is sufficient population within the GSA to meet the state utilization standards.

C) Impact on Area Providers

The proposed ASTC will not have a negative impact on existing providers within the GSA. As previously noted herein, the ASTCs within the market only include two (2) ASTCs with approval to provide cardiovascular services, and neither of these can accommodate the type and volume of procedures this facility will provide. Accordingly, the utilization levels of the facilities within the GSA will not be affected. The proposed project will shift some hospital volume to the ASTC setting, but the applicants will continue to offer inpatient services for medically necessary patients in the hospital setting.

(c)(8) Staffing

A) The Advanced Surgical Institute LLC will operate with sufficient staffing levels as required by applicable licensure. ASI will offer the staffing levels as necessary to provide patients with safe and effective care.
B) The services shall be performed by a physician who is board certified or board eligible by the appropriate professional standards organization or entity that credentials or certifies the health care worker for competency in that category of service.

(c)(9) Charge Commitment

1) A statement of all charges is attached as Exhibit 3.
2) Please see Exhibit 3, attached herein, which includes a commitment that the charges will not be increased for the first two years of operation.

(c)(10) Assurances

1) See Exhibit 4 for a signed statement of Assurances.
2) See Exhibit 4 for a signed statement of Assurances.

Zip Codes Within GSA

60402
60406
60415
60418
60419
60426
60428
60445
60452
60453
60454
60455
60456
60457
60458
60459
60462
60463
60464
60465
60469
60472
60480
60482
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60501
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60616

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60653
60655
60664
60668
60669
60670
60673
60675
60677
60678
60680
60681
60684
60685
60686
60687
60688

60690
60691
60693
60694
60695
60696
60697
60699
60803
60804
60805
60827

Patients by Zip Codes

1,266 / 1,645 Reside within the GSA

Zip Code Of Origin	# of Patients
29303	1
30228	1
32966	1
33411	1
33637	1
33860	1
34135	1
42321	1
46311	4
46319	1
46320	5
46323	1
46324	1
46327	1
46341	1
46360	2
46373	1
46383	2
46394	2
46410	2
60005	1
60007	2
60016	1
60041	3
60045	1
60051	2
60068	1
60084	4
60085	1
60126	1
60131	2
60156	1
60164	2
60176	1
60188	3
60193	4
60195	1
60302	1
60401	3
60403	1
60404	4
60406	9
60409	11
60411	9
60415	24
60417	5
60418	9
60419	6
60422	3
60423	11
60425	4
60426	2
60428	2
60429	2
60430	7
60432	1
60435	1
60438	8
60439	4
60440	5
60441	6
60442	4
60443	9
60445	24
60446	1
60448	1
60449	1
60451	5
60452	24
60453	160
60455	24
60456	19
60457	13
60458	9
60459	46
60461	2
60462	48
60463	34
60464	11
60465	35
60466	5
60467	26
60468	2
60469	1
60470	1
60471	10
60473	10
60475	4
60477	41
60478	6
60480	3
60481	2
60482	15
60487	16
60491	6
60501	3
60503	1
60504	3
60516	1
60525	1
60527	4
60543	1
60544	1

60558	3
60585	1
60605	1
60607	1
60608	3
60609	3
60610	3
60615	2
60616	6
60617	31
60619	33
60620	129
60621	14
60623	1
60624	1
60625	1
60628	73
60629	62
60631	4
60632	18
60633	1
60636	35
60637	4
60638	27
60639	2
60641	1
60642	1
60643	71
60644	1
60647	2
60649	7
60651	3
60652	61
60653	1
60655	62
60656	3
60803	44
60804	1
60805	43
60827	12
60901	1

60950	1
60954	1
61107	1
61281	4
61301	5
61350	1
61354	1
61401	4
61483	2
61611	4
61614	1
61615	3
61732	2
61761	2
61764	1
62832	1
65239	3
76244	1
98166	1
Grand Total	1645

Geographic Service Area Population by Zip Code

60402	63,963
60406	24,909
60415	14,338
60419	22,810
60426	29,784
60428	12,344
60445	26,258
60452	28,459
60453	56,754
60455	16,552
60456	4,344
60457	13,852
60458	15,139
60459	29,040
60462	40,120
60463	14,904
60464	9,618
60465	17,570
60469	6,010
60472	5,055
60480	5,210
60482	11,013
60501	12,002
60525	31,295
60534	10,581
60608	78,877
60609	60,994
60615	40,595
60616	53,331
60617	81,227
60619	62,992
60620	69,195
60621	30,496
60623	88,586
60628	67,942
60629	114,129
60632	91,644
60633	13,202
60636	34,461
60637	48,006
60638	58,990
60643	51,028
60649	44,223
60652	43,582
60653	31,820
60655	28,972
60803	22,362
60804	83,735
60805	19,796
60827	28,856
Total	1,870,965

*Population taken from American Community Survey - US Census

June 13, 2019

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

Dear Ms. Avery,

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

Sincerely,

Nouri Al-Khaled, M.D.
The Advanced Surgical Institute LLC

Notarization:
Subscribed and sworn to before me this 19 day of June, 2019.

Signature of Notary

SEAL

"OFFICIAL SEAL"
KIMBERLY A OERTEL
Notary Public, State of Illinois
My Commission Expires 11/21/2021

Charge Master

33010	Drainage of heart sac	$1,549.27
33206	Insert heart pm atrial	$21,836.07
33207	Insert heart pm ventricular	$21,782.56
33208	Insrt heart pm atrial & vent	$22,180.18
33210	Insert electrd/pm cath sngl	$10,183.75
33212	Insert pulse gen sngl lead	$16,164.97
33214	Upgrade of pacemaker system	$21,681.88
33215	Reposition pacing-defib lead	$3,591.75
33216	Insert 1 electrode pm-defib	$14,648.59
33222	Relocation pocket pacemaker	$2,194.31
33223	Relocate pocket for defib	$2,194.31
33224	Insert pacing lead & connect	$21,778.74
33227	Remove&replace pm gen singl	$16,036.52
33228	Remv&replc pm gen dual lead	$21,657.65
33229	Remv&replc pm gen mult leads	$35,157.62
33231	Insrt pulse gen w/mult leads	$74,425.37
33233	Removal of pm generator	$10,183.75
33235	Removal pacemaker electrode	$4,434.79
33240	Insrt pulse gen w/singl lead	$54,731.68
33241	Remove pulse generator	$4,434.79
33249	Insj/rplcmt defib w/lead(s)	$74,409.20
33262	Rmvl& replc pulse gen 1 lead	$53,023.27
33263	Rmvl & rplcmt dfb gen 2 lead	$53,803.59
33264	Rmvl & rplcmt dfb gen mlt ld	$74,582.89
33270	Ins/rep subq defibrillator	$74,271.86
33271	Insj subq impltbl dfb elctrd	$17,318.07
36556	Insert non-tunnel cv cath	$1,549.27
37197	Remove intrvas foreign body	$3,591.75
37211	Thrombolytic art therapy	$6,183.40
37221	Iliac revasc w/stent	$16,045.40
37224	Fem/popl revas w/tla	$7,941.26
37225	Fem/popl revas w/ather	$17,631.52
37226	Fem/popl revasc w/stent	$17,114.71
37228	Tib/per revasc w/tla	$15,085.32
37229	Tib/per revasc w/ather	$26,919.56
37230	Tib/per revasc w/stent	$26,414.99
37236	Open/perq place stent 1st	$15,790.14
37238	Open/perq place stent same	$16,152.54
37248	Trluml balo angiop 1st vein	$5,508.91

36556	Insert non-tunnel cv cath	$1,549.27
37211	Thrombolytic art therapy	$6,183.40
37228	Tib/per revasc w/tla	$15,085.32
93451	Right heart cath	$3,739.45
93455	Coronary art/grft angio s&i	$3,739.45
93456	R hrt coronary artery angio	$3,739.45
93458	L hrt artery/ventricle angio	$3,739.45
93459	L hrt art/grft angio	$3,739.45
93460	R&l hrt art/ventricle angio	$3,739.45
93461	R&l hrt art/ventricle angio	$3,739.45
93451	Right heart cath	$3,739.45

June 13, 2019

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

Dear Ms. Avery,

In keeping with 77 Ill. Adm. Code § 1110.110(c) please find this letter of assurances.

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

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

Sincerely,

Nouri Al-Khaled, M.D.
The Advanced Surgical Institute LLC

Notarization:
Subscribed and sworn to before me this 19 day of June, 2019.

Signature of Notary

SEAL

"OFFICIAL SEAL"
KIMBERLY A OERTEL
Notary Public, State of Illinois
My Commission Expires 11/21/2021

Section VIII, Financial Feasibility
Criterion 1120.120 Availability of Funds

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

First Midwest Bank

June 21, 2019

The Advanced Surgical Institute LLC
3523 W. 95th Street
Evergreen Park, IL 60805

Attention: Dr. Nouri Al-Khaled

Dear Dr. Al-Khaled:

It is my understanding that The Advanced Surgical Institute LLC plans to establish an ambulatory surgical treatment center ("ASTC") located at 8780 W. Golf Road, Niles, Illinois 60714. I further understand that The Advanced Surgical Institute LLC will require loans(s) for certain capital expenditures and equipment purchases for an amount not to exceed $4,000,000. You have been a good and valuable customer of First Midwest Bank for several years. Should the Illinois Health Facilities and Services Review Board approve the proposed project, and based upon the positive business experiences from working with The Advanced Surgical Institute LLC and yourself, First Midwest Bank is prepared to extend The Advanced Surgical Institute LLC up to $4,000,000 in credit exposure to finance the ASTC project.

I trust that this letter is sufficient for your needs. Should you, or the Illinois Health Facilities and Services Review Board, have any questions or comments, please do not hesitate to contact me directly at 708-576-7122.

Sincerely,

Mark P. Oganovich
Senior Vice President
First Midwest Bank

Attachment 33 - Exhibit I

Section IX, Financial Feasibility

Criterion 1120.130(a) – Financial Viability

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

Standards

The applicant that is responsible for funding the project must provide viability ratios. This project involves expansion of an existing Ambulatory Surgical Treatment Center, as such the applicable standards indicated in Appendix A have been applied.

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

Financial Viability Ratios

Viability Ratio Calculations: Current Ratio

Current Assets/Current Liabilities

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥1.5	1.21	1.42	1.73	Yes

The Advanced Surgical Institute LLC is able to meet the standard for Current Ratio by Year 3.

Viability Ratio Calculations: Net Margin Percentage

(Net Income/Net Operating Revenues) X 100

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥3.5%	10%	17%	24%	Yes

The Advanced Surgical Institute LLC is able to meet the standard for Net Margin Percentage.

Viability Ratio Calculations: Long Term Debt to Capitalization

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

State Standard	Year 1	Year 2	Year 3	Met Standard?
≤80%	72%	50%	31%	Yes

The Advanced Surgical Institute LLC is able to meet the standard for Percent Debt to Total Capitalization.

Viability Ratio Calculations: Projected Debt Service Coverage

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

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥1.75	3.8	6.1	8.9	Yes

The Advanced Surgical Institute LLC is able to meet the standard for Projected Debt Service Coverage.

Viability Ratio Calculations: Days Cash on Hand

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

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥45 days	63	139	253	Yes

The Advanced Surgical Institute LLC is able to meet the standard for Days Cash on Hand

Viability Ratio Calculations: Cushion Ratio

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

State Standard	Year 1	Year 2	Year 3	Met Standard?
≥3.0	3.8	8.6	16.2	Yes

The Advanced Surgical Institute LLC is able to meet the standard for Cushion Ratio.

The Advanced Surgical Institute LLC
PROJECTED BALANCE SHEET

	Year 1	Year 2	Year 3
ASSETS			
Current Assets			
Checking/Savings	1,421,915	3,235,967	6,087,956
Accounts Receivable	8,556,556	8,820,792	9,080,306
Total Current Assets	9,978,471	12,056,759	15,168,262
Fixed Assets			
Capital Expenditure	1,802,500	1,742,700	1,682,900
Furniture and Equipment	1,725,921	1,484,775	1,243,628
Depreciation	-300,946	-300,946	-300,946
Total Fixed Assets	3,227,475	2,926,528	2,625,582
TOTAL ASSETS	**13,205,945**	**14,983,287**	**17,793,844**
LIABILITIES & EQUITY			
Liabilities			
Current Liabilities	8,255,610	8,519,845	8,779,359
Total Current Liabilities	8,255,610	8,519,845	8,779,359
Long Term Liabilities			
Loan	3,578,351	3,203,180	2,828,010
Total Long Term Liabilities	3,578,351	3,203,180	2,828,010
Total Liabilities	11,833,960	11,723,025	11,607,369
Equity			
Building & Equipment	-49,930	24,294	98,518
Retained Earnings	921,915	2,735,967	5,587,956
capital contribution	500,000	500,000	500,000
Total Equity	1,371,985	3,260,261	6,186,474
TOTAL LIABILITIES & EQUITY	**13,205,945**	**14,983,287**	**17,793,844**

Surgery Center of Illinois, LLC Projected Financial Statements			
	Projected Year 1	**Projected Year 2**	**Projected Year 3**
Revenue:			
Surgeries and Injections Service (Reimbursement)	9,478,471	10,634,844	11,932,295
Procedure Volume	1,336	1470	1,617
Total Income	9,478,471	10,634,844	11,932,295
Expenses:			
Salaries	738,856	805,194	853,783
Repairs and Maintenance	50,000	51,500	53,045
Management Fees	473,924	531,742	596,615
Surgical Instruments/Supplies	4,568,086	4,586,790	4,607,365
Billing & Collections	284,354	319,045	357,969
Utilities	26,000	26,780	27,583
Rent Expense	214,500	214,500	214,500
Professional Fees	568,708	585,769	603,343
Contracted Services	150,000	154,500	159,135
Insurance	25,000	25,750	26,523
Depreciation	300,946	300,946	300,946
Employee Benefits	221,657	241,558	256,135
General Admin	200,000	206,000	212,180
Taxes and Licenses	50,000	51,500	53,045
Interest Expense & Loan	375,170	375,170	375,170
Bad Debt Expenses	284,354	319,045	357,969
Other Expenses	25,000	25,000	25,000
Total Expenses	8,556,556	8,820,792	9,080,306
Net Income	921,915	1,814,053	2,851,989

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

A. Reasonableness of Financing Arrangements:

See Attachment 36-Exhibit 1 for a signed, notarized statement from a representative of The Advanced Surgical Institute LLC that (1) borrowing is less costly than the liquidation of existing investments and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period and (2) that the selected form of debt financing for the project will be at the lowest net cost available.

B. Conditions of Debt Financing

See Attachment 36-Exhibit 1 for a signed, notarized statement from a representative of The Advanced Surgical Institute LLC that (1) borrowing is less costly than the liquidation of existing investments and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period and (2) that the selected form of debt financing for the project will be at the lowest net cost available.

C. Reasonableness of Project and Related Costs

Per the below tables, the applicant has met the project costs standards established by the state, with the exception of the Clinical OR equipment exceeding the State standard.

Table 1120 Appendix A			
	Application	**State Standard (Based on 2020 Construction Mid-Point)**	**Above/Below State Standard**
New Construction & Contingencies	$307,500.00	$435.03 x 750 sq. ft. = $326,274.76	Below State Standard
Modernization Construction & Contingencies	$1,644,500.00	$289.42 x 5,750 = $1,664,190.10	Below State Standard
OR Equipment	$1,599,602.00	$504,437.05 x 2 = $1,008,874.11	Above State Standard
Contingencies	$149,500.00	15% x $1,952,000.00= $270,375.00	Below State Standard
A/E Fees	$119,600.00	10.79% x $1,952,000.00 = $210,620.80	Below State Standard
Site Survey + Site Prep	$100,000.00	5% * $1,,952,000.00 = $97,600.00	Below State Standard
Pre-planning	$16,000.00	1.8% * $3,677,921.00 = $66,202.58	Below State Standard

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department	A	B	C	D	E	F	G	H	TOTAL COST
	Cost/ Sq. Ft.*		Gross Sq. Ft.		Gross Sq. Ft.		Const. $	Mod. $	(G + H)
	New	Mod.	New | Circ.		Mod. | Circ.		(A x C)	(B x E)	
Clinical	$410.00	$260.00	496.15		3,803.85		$203,423.08	$989,000.00	$1,192,423.08
Contingency-Clinical		$26.00	496.15		3,803.85			$98,900.00	$98,900.00
Clinical Sub-total	$410.00	$286.00	496.15		3,803.85		$203,423.08	$1,087,900.00	$1,291,323.08
Non-Clinical	$410.00	$260.00	253.85		1,946.15		$104,076.92	$506,000.00	$610,076.92
Contingency-Non-Clinical		$26.00	253.85		1,946.15			50,600.00	$50,600.00
Non-Clinical Sub-total	$410.00	$286.00	253.85		1,946.15		$104,076.92	$556,600.00	$660,676.92
Total	**$410.00**	**$286.00**	**750**		**5,750**		**$307,500.00**	**$1,644,500.00**	**$1,952,000.00**

D. Projected Operating Costs

OPERATING COSTS	
ASTC	$5,528,599.23
TOTAL	$5,528,599.23

Total Patient Treatments = 1,336
Operating Cost/Visit = $4,138.17*

*Applicant notes that the operating costs per visit appear higher than many other ASTCs due to the high supply expense associated with the device intensive cardiovascular procedures. In some instances, the reimbursement for a pacemaker procedure is up to 80% of the total fee paid.

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

CAPITAL COST	
Amortization	$375,170.31
Depreciation	$300,946.47
TOTAL	$676,116.78

Total Patient Treatments = 1,336
Capital Cost/Visit = $506.08

June 13, 2019

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

Dear Ms. Avery,

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

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

Sincerely,

Nouri Al-Khaled, M.D.
The Advanced Surgical Institute LLC

Notarization:
Subscribed and sworn to before me this 19 day of June, 2019.

Signature of Notary

SEAL

"OFFICIAL SEAL"
KIMBERLY A OERTEL
Notary Public, State of Illinois
My Commission Expires 11/21/2021

Section XI, Safety Net Impact Statement

1. **Material impact on safety net services in the community** The Advanced Surgical Institute LLC will not have a material impact on safety net services in the Chicago metropolitan area. The primary purpose of ASI is to deliver greater access for patients in the southwest-suburban area of Chicago. Thus, ASI will only improve access to safety net services.

2. **Material impact on the ability of another provider or health care system to cross subsidize safety net services:** ASI will not negatively impact the ability of other providers to cross-subsidize safety-net services. The limited scope of ASI reduces its potential impact on other providers. The referrals to ASI will be for cases previously performed at Illinois hospitals, where operating rooms are frequently placed on diversion status for elective procedures of this nature. Accordingly, the Applicant does not believe ASI will impact the ability of providers to cross-subsidize safety net services.

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

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

Section XI, Charity Care Information

The surgery center offers financial assistance to needy patients through its charity care program. The table below contain the relevant anticipated charity care and payor mix information for The Advanced Surgical Institute LLC by the end of its second year of operation:

CHARITY CARE			
	Year 1	Year 2	Year 3
Net Patient Revenue	$9,478,470.62	$10,634,844.04	$11,932,295.01
Amount of Charity Care (Charges in Dollars)	$284,354	$319,045	$357,170
Cost of Charity Care (in Dollars)	$284,354	$319,045	$357,170
Ratio of Charity Care to Net Patient Revenue	5%	5%	5%

Payor Mix (Projected)	Year 1	Year 2	Year 3
Medicare/Tricare/VA	543	597	657
Medicaid	106	117	128
Commercial	650	715	786
Charity/Indigent	37	41	45
Total Patients	1,366	1,470	1,616

Appendix I – Physician Referral Letter

Attached as Appendix 1 is a letter from Consultants in Cardiology and Electrophysiology projecting that 1,336 patients will be referred to the ASTC for surgeries within 12 months of project completion.

Consultants in Cardiology & Electrophysiology LLC

A. Tom Petropulos, MD, FACC
Thomas E. Bump, MD, FACC, FHRS
John H. Burke, MD, FACC, FHRS
Nouri Al Khaled, MD, FACC
William H. Spear, MD, FACC, FHRS
Chadi Nouneh, MD, FACC, FSCAI
Ali R. Zaidi, MD
Luay Rifai, MD, FACC
Wassim Ballany, MD
Abhimanyu Saini, MD

June 13, 2019

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

Dear Ms. Avery,

On behalf of Consultants in Cardiology & Electrophysiology, we are writing this letter in support of the Certificate of Need ("CON") application for the proposed ASTC facility, located at 3523 W. 95th Street, Evergreen Park, IL, 60805. The proposed facility will directly benefit our patients and improve access to outpatient cardiovascular services within the community for our practice.

Based on our records, we treated 1,645 patients for cardiovascular surgical services in the past 12 months. We anticipate referring 1,336 of these patients to the proposed facility during its first year of operation.

We respectfully request the Board approve the CON application for The Advanced Surgical Institute LLC so that the facility can provide ASTC cardiovascular surgical services for the population in the community. Thank you for your consideration.

CERTIFICATION

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

Sincerely,

Nouri Al-Khaled, M.D.
Interventional Cardiology

Chadi Nouneh, M.D.
Interventional Cardiology

William Spear, M.D.
Cardiology & Electrophysiology

John Burke, M.D.
Cardiology & Electrophysiology

Ali Zaidi, M.D.
Cardiology & Electrophysiology

Notarization:

Subscribed and sworn to me this 19 day of July, 2019.

Signature of Notary

"OFFICIAL SEAL"
KIMBERLY A OERTEL
Notary Public, State of Illinois
My Commission Expires 11/21/2021

SEAL

3545 W 95th Street
Evergreen Park, IL 60805
Phone (708) 346-5562
Fax (708) 346-2059

11800 Southwest HWY, Suite 209
Palos Heights, Illinois 60463
Phone (708) 346-5562
Fax (708) 346-2059

18210 S. LaGrange Road, Suite 102
Tinley Park, Illinois 60477
Phone (708) 346-5562
Fax (708) 346-2059

Historical Patient Utilization

Row Labels	Sum of Unit
ADVOCATE CHRIST HOSPITAL	**1026**
29303	1
32966	1
33637	1
34135	1
46311	2
46319	1
46320	2
46323	1
46324	1
46327	1
46360	2
46383	2
46410	2
60005	1
60007	2
60016	1
60041	3
60045	1
60051	2
60068	1
60084	4
60085	1
60126	1
60131	2
60156	1
60164	2
60176	1
60188	2
60193	4
60195	1
60302	1
60401	1
60404	4
60406	5
60409	5
60411	6
60415	18
60417	3
60418	3
60419	3
60422	1
60423	11
60425	4
60426	2
60428	2
60429	2
60430	4
60432	1
60435	1
60438	6
60439	4
60440	4
60441	6
60442	2
60443	6
60445	14
60446	1
60448	1
60451	5
60452	11
60453	127
60455	17
60456	12
60457	9
60458	6
60459	33
60461	2
60462	23
60463	11
60464	8

60465	17
60466	2
60467	16
60468	2
60471	10
60473	8
60475	4
60477	25
60478	5
60480	3
60481	2
60482	9
60487	5
60491	4
60501	3
60503	1
60504	3
60516	1
60525	1
60527	2
60543	1
60544	1
60558	2
60585	1
60605	1
60608	3
60609	2
60610	3
60615	1
60616	5
60617	26
60619	18
60620	44
60621	8
60623	1
60624	1
60628	39
60629	44
60631	4

60632	16
60636	19
60637	4
60638	19
60639	2
60643	35
60644	1
60647	2
60649	5
60651	3
60652	38
60655	30
60656	3
60803	30
60805	20
60827	6
60901	1
60950	1
60954	1
61107	1
61281	4
61301	5
61354	1
61401	4
61483	2
61611	4
61614	1
61615	3
61732	1
61761	2
61764	1
LITTLE COMPANY OF MARY HOSPITAL	**357**
30228	1
46394	1
60188	1
60406	2
60409	2
60415	3

60417	1
60418	1
60419	3
60430	2
60438	1
60440	1
60443	1
60445	3
60453	23
60455	2
60456	3
60457	2
60459	4
60462	1
60463	2
60477	2
60478	1
60487	1
60607	1
60609	1
60615	1
60617	4
60619	14
60620	84
60621	6
60625	1
60628	31
60629	17
60632	2
60636	15
60638	5
60641	1
60643	33
60649	2
60652	19
60653	1
60655	23
60803	7
60805	18
60827	6
61732	1
PALOS COMMUNITY HOSPITAL	**230**
33860	1
46373	1
60401	2
60403	1
60406	2
60409	3
60411	1
60415	3
60417	1
60418	5
60430	1
60442	2
60443	2
60445	7
60449	1
60452	13
60453	9
60455	5
60456	4
60457	2
60458	2
60459	9
60462	23
60463	21
60464	3
60465	18
60466	3
60467	10
60470	1
60477	14
60482	6
60487	10
60491	2
60527	2
60558	1

60616	1
60620	1
60628	1
60629	1
60638	3
60642	1
60643	2
60652	4
60655	8
60803	6
60804	1
60805	3
61350	1
62832	1
65239	3
76244	1
98166	1
SAINT JAMES HOSPITAL	**7**
60411	1
60422	2
60453	1
60458	1
60803	1
60805	1
ST MARGARET HOSPITAL	**25**
33411	1
42321	1
46311	2
46320	3
46341	1
46394	1
60409	1
60411	1
60438	1
60462	1
60469	1
60473	2
60617	1
60619	1
60628	2
60633	1
60636	1
60643	1
60655	1
60805	1
Grand Total	**1645**

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

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advis
YOUR SMART HEALTHCARE CONSULTANTS

June 28, 2019

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

Dear Ms. Avery,

Please find enclosed with this cover letter a completed Certificate of Need Application, submitted on behalf of the applicant The Advanced Surgical Institute LLC. The applicant proposes to establish an Ambulatory Surgical Treatment Center ("ASTC") to be located at 3523 W. 95th Street, Evergreen Park, IL 60805.

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

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

Sincerely,

Bryan Niehaus, JD
Vice President
Advis