ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Innovia Surgery Cer	nter		
Street Address: 203 East Irving Park Road			
City and Zip Code: Wood Dale, Illinois 60191			
County: DuPage	Health Service Area:	007	Health Planning Area: 043

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

Exact Legal Name: Innovia Surgery Center, LLC
Street Address: 3 Golf Center Road #356
City and Zip Code: Hoffman Estates, Illinois 60169
Name of Registered Agent: State Registry Ltd.
Registered Agent Street Address: 3 Golf Center Road #356
Registered Agent City and Zip Code: Hoffman Estates, Illinois 60169
Name of Chief Executive Officer: Vera Schmidt
CEO Street Address: 1640 North Arlington Heights Road, Suite 110
CEO City and Zip Code: Arlington Heights, Illinois 60004
CEO Telephone Number: 847-255-7400

Type of Ownership of Applicants

\boxtimes

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: Vera Schmidt
Title: Chief Operations Officers
Company Name: Innovia Surgery Center
Address: 1640 North Arlington Heights Road, Suite 110, Arlington Heights, Illinois 60004
Telephone Number: 847-255-7400
E-mail Address: veras@innoviasurgery.com
Fax Number:
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:

Facility/Project Identification

Facility Name: Innovia Surgery Center				
Street Address: 203 East Irving Park Road				
City and Zip Code: Wood Dale, Illinois 60191				
County: DuPage	Health Service Area:	007	Health Planning Area: 043	

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

Exact Legal Name: Advantage Surgical Holdings LLC
Street Address: 203 East Irving Park Road
City and Zip Code: Wood Dale, Illinois 60191
Name of Registered Agent: State Registry Ltd.
Registered Agent Street Address: 3 Golf Center Road #356
Registered Agent City and Zip Code: Hoffman Estates, Illinois 60169
Name of Chief Executive Officer: Vera Schmidt
CEO Street Address: 1640 North Arlington Heights Road, Suite 110
CEO City and Zip Code: Arlington Heights, Illinois 60004
CEO Telephone Number: 847-255-7400

Type of Ownership of Applicants

	Non-profit Corporation
	For-profit Corporation
\boxtimes	Limited Liability Company

Partnership
Governmental
Sole Proprietorship

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.

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Fax Number:
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 after permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]

Name: Vera Schmidt
Title: Chief Operations Officers
Company Name: Innovia Surgery Center
Address: 1640 North Arlington Heights Road, Suite 110, Arlington Heights, Illinois 60004
Telephone Number: 847-255-7400
E-mail Address: veras@innoviasurgery.com
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Arizona - Illinois, L.P.

Address of Site Owner: 3 Golf Center Road, Suite 356 Hoffman Estates, Illinois 60169

Street Address or Legal Description of the Site: 203 East Irving Park Road, Wood Dale, Illinois 60191 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 <u>ATTACHMENT 2</u>, 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: Innovia Surgery Center, LLC					
Address: 203 East Irving Park Road, Wood Dale, Illinois 60191					
 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 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 <u>ATTACHMENT 4,</u> 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 <u>www.FEMA.gov</u> or <u>www.illinoisfloodmaps.org</u>. 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 (<u>http://www.hfsrb.illinois.gov</u>). NOTE: A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

APPEND DOCUMENTATION AS <u>ATTACHMENT 5,</u> 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 <u>ATTACHMENT 6</u>, 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.

Innovia Surgery Center, LLC and Advantage Surgical Holdings LLC (collectively, the "Applicants') seek authority from the Illinois Health Facilities and Services Review Board (the "State Board") to add neurological surgery and orthopedics to its existing ambulatory surgical treatment center located at 203 East Irving Park Road, Wood Dale, Illinois 60191 (the "Surgery Center"). The Surgery Center includes two operating rooms, which are housed in approximately 3,850 gross square feet of clinical space. No construction or other alterations to the Surgery Center will be required to add neurological surgery and orthopedics.

Procedures to be performed at the Surgery Center after permit issuance will include general dentistry, neurological surgery, obstetrics/gynecology, orthopedics, otolaryngology, pain management, plastic surgery, interventional radiology, and urology.

This project constitutes a non-substantive project because it will not result in the establishment of a health care facility.

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds				
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL	
Preplanning Costs				
Site Survey and Soil Investigation				
Site Preparation				
Off Site Work				
New Construction Contracts				
Modernization Contracts				
Contingencies				
Architectural/Engineering Fees				
Consulting and Other Fees				
Movable or Other Equipment (not in construction contracts)				
Bond Issuance Expense (project related)				
Net Interest Expense During Construction (project related)				
Fair Market Value of Leased Space or Equipment	\$1,667,275		\$1,667,275	
Other Costs to Be Capitalized				
Acquisition of Building or Other Property (excluding land)				
TOTAL USES OF FUNDS	\$1,667,275		\$1,667,275	
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL	
Cash and Securities				
Pledges				
Gifts and Bequests				
Bond Issues (project related)				
Mortgages				
Leases (fair market value)	\$1,667,275		\$1,667,275	
Governmental Appropriations				
Grants				
Other Funds and Sources				
TOTAL SOURCES OF FUNDS	\$1,667,275		\$1,667,275	

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 Purchase Price: \$ Fair Market Value: \$	Yes	🖾 No
The project involves the establishment of a new facility	or a new ca	tegory of service
If yes, provide the dollar amount of all non-capitalized operating deficits) through the first full fiscal year when utilization specified in Part 1100.	operating st the project a	tart-up costs (including achieves or exceeds the target
Estimated start-up costs and operating deficit cost is \$		<u> </u>

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): <u>June 30, 2024</u>				
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 <u>ATTACHMENT 8.</u> 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
APORS – NOT APPLICABLE
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 <u>MUST</u> equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the departments or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Not Reviewable Space [i.e., non-clinical]: means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers. [20 ILCS 3960/3]

		Gross Square Feet		Amount o	f Proposed Tot That I	al Gross S s:	Square Feet
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							

Facility Bed Capacity and Utilization – NOT APPLICABLE

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

FACILITY NAME:		c	CITY:			
REPORTING PERIOD DATES	: Fro	om:		to:	-	
Category of Service	Authorized Beds	Admiss	ions	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:						



203 E. Irving Park Road Wood Dale, IL 60191 (847) 385-0700 www.InnoviaSurgery.com

CERTIFICATION

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

- o 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
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of <u>Innovia Surgery Center, LLC</u>* 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 here with or will be paid upon request.

SIGNATURE

Vera Schmidt PRINTED NAME

<u>Chief of Operations</u> PRINTED TITLE

SIGNATUR

Joanna Lyszkowski PRINTED NAME

ASC Manager PRINTED TITLE

Notarization: Subscribed and sworn to before me this ______day of ______

Signature of Notar

Seal OFFICIAL SEAL HELENA PETROVIC NOTARY PUBLIC, STATE OF ILLINOIS *Insert the EXCOMINISSION ENDINES: 5/24/2625appl cant

Notarization: Subscribed and sworn to before be day of (0 this 🚺

Signature of Notary



CERTIFICATION

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

- o 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 <u>Advantage Surgical Holdings LLC</u>* 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

lle SIGNATURE

_Vinod Goyal, M.D. PRINTED NAME Vijay Goyal, M.D. PRINTED NAME

PRINTED TITLE

Manager

Notarization:

Manager PRINTED TITLE

Notarization: Subscribed and sworn to before me 2023 01 this day of

Signature of Notary

A	A A A A A A A A A A A A A A A A A A A	
Seal	OFFICIAL SEAL	
	HELENA PETROVIC	
	NOTARY PUBLIC, STATE OF ILLINOIS	1011
*Inser	the Excourts of the panes of the same	ant

day of UC TODES this

Subscribed and sworn to before me

Signature of Notary

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

- A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
- 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.
- 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 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.
 - 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.
 - A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
 - A certified listing of each applicant with one or more unsatisfied judgements against him or her.
 - 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.
- 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.
- 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 can submit amendments to previously submitted information, as needed, to update
 and/or clarify data.

APPEND DOCUMENTATION AS <u>ATTACHMENT 11</u>, 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 <u>ATTACHMENT 12, IN NUMERIC SEQUENTIAL</u> ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify <u>ALL</u> 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 <u>ATTACHMENT 13,</u> 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:

1. 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.

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

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

4. 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	STATE	DIFFERENCE	MET
	BGSF/DGSF	STANDARD		STANDARD?
	-	-	•	•

APPEND DOCUMENTATION AS <u>ATTACHMENT 14.</u> 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 <u>has established</u> utilization standards or occupancy targets in 77 III. 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 <u>ATTACHMENT 15.</u> 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:
- 1. Requirements of governmental or certification agencies; or

2. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:

1. Historical utilization for the area for the latest five-year period for which data is available; and

2. 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 <u>ATTACHMENT 16.</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

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.

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

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

APPEND DOCUMENTATION AS <u>ATTACHMENT 17.</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

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

G. Non-Hospital Based Ambulatory Surgery

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

ASTC Service
Cardiovascular
Colon and Rectal Surgery
Dermatology
☑ General Dentistry
General Surgery
Gastroenterology
⊠ Neurological Surgery
Nuclear Medicine
☑ Obstetrics/Gynecology
Ophthalmology
Oral/Maxillofacial Surgery
☑ Orthopedic Surgery
☑ Otolaryngology
🖂 Pain Management
Physical Medicine and Rehabilitation
☑ Plastic Surgery
Podiatric Surgery
🛛 Radiology
Thoracic Surgery
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	Х	х

°age 6

4.

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		Х
1110.235(c)(5) – Treatment Room Need Assessment	Х	Х
1110.235(c)(6) – Service Accessibility	х	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	х	
1110.235(c)(7)(B) – Maldistribution	х	
1110.235(c)(7)(C) – Impact to Area Providers	х	
1110.235(c)(8) – Staffing	х	Х
1110.235(c)(9) – Charge Commitment	X	Х
1110.235(c)(10) – Assurances	X	Х

APPEND DOCUMENTATION AS <u>ATTACHMENT 25.</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those 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 Secu from financial ir	rities – statements (e.g., audited financial statements, letters stitutions, 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 a showing anticip gross receipts a fundraising exp	nticipated pledges, a summary of the anticipated pledges ated receipts and discounted value, estimated timetable of and related fundraising expenses, and a discussion of past erience.
	c)	Gifts and Beque conditions of us	ests – verification of the dollar amount, identification of any se, and the estimated timetable of receipts.
<u>\$1,667,275</u> (<u>FMV of</u> <u>Lease)</u>	d)	Debt – a staten time, variable o anticipated repa financing propo	nent of the estimated terms and conditions (including the debt r permanent interest rates over the debt time, and the ayment schedule) for any interim and for the permanent sed 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

Page ð

<u>гт</u>				
	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.			
\$1,667,275	TOTAL FUNDS AVAILABLE			
APPEND DOCU	MENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE			
APPLICATION FORM.				

91571765.2

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if: "A" Bond rating or better

All the project's capital expenditures are completely funded through internal sources

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

The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

	Historica 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 <u>ATTACHMENT 36,</u> IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

Α.	Reasonable	ness of Financing Arrangements					
	The ap submit one of	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 portion or all the cash and equivalents must be retained in the balance sheet asset accounts 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.					
В.	Conditions	of Debt Financing					
	This c docum statem applica	riterion is applicable only to projects that involve debt financing. The applicant shall nent that the conditions of debt financing are reasonable by submitting a notarized nent signed by an authorized representative that attests to the following, as able:					
	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 .	Reasonable	eness of Project and Related Costs					
	Read the criterion and provide the following:						
	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)	А	В	С	D	E	F	G	Н	
	Cost/Squ New	Cost/Square Foot Gross Sq. Ft. New Mod. New Circ.*		Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	l otal Cost (G + H)	
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.

1. 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 <u>ATTACHMENT 37.</u> IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

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

1. The project's material impact, if any, on essential safety net services in the community, *including the impact on racial and health care disparities 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 each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all 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.

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

A table in the following format must be provided as part of Attachment 37.

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

SECTION X. CHARITY CARE INFORMATION

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

- 1. All applicants and co-applicants shall indicate the amount of charity care for the latest three <u>audited</u> 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 <u>must</u> 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 <u>ATTACHMENT 39</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Section I, Identification, General Information, and Certification <u>Applicants</u>

Certificates of good standing for Innovia Surgery Center, LLC and Advantage Surgical Holdings LLC (collectively, the "Applicants") are attached at Attachment - 1.

Innovia Surgery Center, LLC is the operator/licensee of the ambulatory surgical treatment center.

As the entity with final control over the operator/licensee, Advantage Surgical Holdings LLC is named as an applicant for this certificate of need application.

#23-046



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, 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

INNOVIA SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JUNE 25, 2021, 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 7TH

day of JULY A.D. 2023

Authentication #: 2318803090 verifiable until 07/07/2024 Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

#23-046



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, 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

ADVANTAGE SURGICAL HOLDINGS LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JANUARY 06, 2021, 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 7TH

day of JULY A.D. 2023

Authentication #: 2318803566 verifiable until 07/07/2024 Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

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

A copy of the lease between Innovia Surgery Center, LLC f/k/a Advantage Healthcare, Ltd. and Arizona Illinois L.P. is attached at Attachment – 2.

LEASE AGREEMENT

The lease is made between Arizona Illinois L.P. herein called "Lessor" and Advantage Health Care, Ltd. herein called the "Lessee".

Lessee hereby offers to lease space from Lessor, the premises is situated in the city of Wood Dale, County of Dupage, State of Illinois, described as 203 E Irving Park Road, Wood Dale, IL.

1. Terms and Rent. Lessor shall lease the above premises for a term of twelve years commencing on April 2, 2020, or upon completion of purchase/transaction of the building, whichever is sooner; and terminating 15 years from the date of commencement. The annual rental of \$103,932.58 payable in equal installments of \$8,661.05 on the first day of each month for that month's rental, during the term of the lease.

2. Use. Lessee shall use and occupy the premises for medical use and general office use, permitted within the zoning.

3. **Care and Maintenance of Premises**. Lessee shall, at his own expense and at all times; maintain the premises in good and safe condition, normal wear and tear expected. Lessee shall be responsible for all repairs required except the roof, exterior walls & structural foundation.

4. Utilities. All applications and connections for necessary utility services on the demised premises shall be made in the name of the Lessee only, and Lessee shall be solely liable for utility charges as they come due, including those for electricity and telephone services.

5. Security Deposit. Lessee shall deposit with Lessor the sum of \$8,661.05 as security deposit.

6. **Changes to Lease**. Changes to the lease agreement can be made at any time by mutual agreement of both parties.

7. **Option to Renew**. Lessee at its sole option shall have option to renew for ten (10) three (3) year periods each commencing at the expiration of the initial lease term. All of the terms and conditions of the lease shall apply during the renewal term except that the monthly rent shall be adjusted to reflect the change in the Consumer Price Index at the beginning of each new lease term after the expiration of the initial lease term.

8. Real Estate Taxes & CAM. Lessee shall be responsible for Taxes, Maintenance and CAM.

9. **Default**. A notice of 15 days shall be given for any default by either party and an additional time period of 15 days shall be allowed to cure such default.

10. **Notices**. Any notice shall be sent via certified mail with return receipt requested, or any other address so notified.

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#23-046

To Lessor: Arizona Illinois, L.P 909 W Euclid Ave. Arlington Heights IL 60006-1025

To Lessee: Advantage Health Care, Ltd. 203 E Irving Park Road Wood Dale, IL 60191

Authorized Representative

Authorized Representative

Missouri Arizona Properties, Ltd <u>General Partner</u> Arizona Illinois, L.P. Lessor

Advantage Health Care, Ltd.

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

The Illinois Certificate of Good Standing for Innovia Surgery Center, LLC is attached at Attachment – 3.

#23-046



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulias, 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

INNOVIA SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON JUNE 25, 2021, 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.



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day of JULY A.D. 2023

Authentication #: 2318803090 verifiable until 07/07/2024 Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

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

The organizational chart for Innovia Surgery Center, LLC is attached at Attachment – 4.



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

The proposed project is for the addition of neurological surgery and orthopedics to an existing ambulatory surgical treatment center ("ASTC"). There will be no construction or modernization associated with the proposed project. Accordingly, this criterion is not applicable.
Section I, Identification, General Information, and Certification <u>Historic Resources Preservation Act Requirements</u>

The proposed project is for the addition of neurological surgery and orthopedics to an existing ASTC. There will be no construction or modernization associated with the proposed project. Accordingly, this criterion is not applicable.

Section I, Identification, General Information, and Certification <u>Project Costs and Sources of Funds</u>

Table 1120.110						
Project Cost	Clinical	Non-Clinical	Total			
Fair Market Value of Leased Space or Equipment						
Real Estate Lease	\$1,117,275		\$1,117,275			
Equipment Lease	\$550,000		\$550,000			
Total Project Costs	\$1,667,275		\$1,667,275			

Section I, Identification, General Information, and Certification <u>Cost Space Requirements</u>

			Cost Space	e Table			
		Gross S	quare Feet	Amount	Amount of Proposed Total Gross Square Feet That Is:		
Dept. / Area	Cost	Existing	Proposed	New Modernized As Is			Vacated Space
CLINICAL							
ASTC	\$1,667,275	3,850				3,850	
Total Clinical	\$1,667,275	3,850				3,850	
NON CLINICAL							
Administration							
Total Non-							
clinical							
TOTAL	\$1,667,275	3,850				3,850	

Section III, Project Purpose, Background and Alternatives – Information Requirements Criterion 1110.110 (a), Project Purpose, Background and Alternatives

Background of the Applicant

- 1. The Applicants operate Innovia Surgery Center, LLC. Copies of the current license and accreditation are attached at Attachment 11A.
- A letter from Vera Schmidt, Chief of Operations, Innovia Surgery Center, LLC certifying no adverse action has been taken against any facility owned and/or operated by the Applicants during the three years prior to filing this application is attached at Attachment – 11B.
- An authorization permitting the State Board and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted, including, but not limited to: official records of IDPH or other State agencies; and the records of nationally recognized accreditation organizations is attached at Attachment – 11B.
- 4. The Applicant submitted an application for Project No. 23-032. By their signatures on the certifications, the Applicants attest the information previously submitted for Project No. 23-032 has not changed.

203 E Irving Park Koad Wood Dale, IL 60191-2045
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ACCREDITATION NOTIFICATION

August 4, 2022

Orga	nization	#	19945	Program Type	Ambulatory Surgery Center		
Decis	Decision Recipient		Mrs. Vera Schmidt, MT	CCN	14C0001179		
Orga	nization	Name	Innovia Surgery Center, LLC				
Addr	ess	14.00	203 E Irving Park Rd	E Irving Park Rd			
City	State	Zip	Wood Dale	IL	60191-2045		

Dear Innovia Surgery Center, LLC,

As an ambulatory surgery center (ASC) that has undergone the AAAHC/Medicare Deemed Status Survey, your ASC has demonstrated its compliance with the AAAHC Standards and all Medicare Conditions for Coverage (CfC).

Survey Date	7/14/2022-7/15/2022	Deficiency Level	Standard		
Type of Survey	Re-accreditation/Medicare Deemed Status				
Acceptable PoC Received	8/4/2022	Correction Method	Self Attestation, Plan of Action, Document Review		

Congratulations!

The AAAHC Accreditation Committee recommends your ASC for participation in the Medicare Deemed Status program. The Centers for Medicare and Medicaid Services (CMS) has the final authority to determine participation and effective dates in Medicare Deemed Status in accordance with the regulations at 42 CFR 489.13.

Accreditation Type	Full Accreditation	Recommend Medicare Deemed Status	Yes	
Accreditation Term Begins	8/1/2022	Accreditation Term Expires	7/31/2025	

SpecialCMS CO - BaltimoreCC:CMS Location 5 - Chicago

Accreditation Renewal Code: EDBED17119945

Next Steps

- 1. Leadership and staff of your ASC should take time to thoroughly review your Survey Report and Plan of Correction (PoC).
 - Subsequent surveys by AAAHC will seek evidence that deficiencies from this survey were addressed within the timeframes of your PoC.
 - The Summary Table provides an overview of compliance for each chapter applicable to your organization.



#23-046

Organization # 19945 Organization: Innovia Surgery Center, LLC August 4, 2022

Page 2

- 2. AAAHC requires **notification of any changes** within your organization in accordance with policies and procedures in the front section of the *Accreditation Handbook*. Visit the AAAHC website "I want to" section and select "Notify AAAHC of a change in my organization" and follow instructions.
- 3. AAAHC Standards, policies and procedures are reviewed and revised on an ongoing basis. You are invited to participate in the review through the periodic public comment process. Your organization will be notified when the proposed changes are available for review. You may also check the AAAHC website for details.
- 4. Accredited ASCs are required to maintain operations in compliance with the current AAAHC policies and Standards, which include the CMS Conditions for Coverage. Updates are published in the AAAHC *Handbooks*. Any mid-year updates are announced and posted to the AAAHC website, <u>www.aaahc.org</u>.
- 5. In order to ensure uninterrupted accreditation, your ASC should submit the *Application for Survey* approximately five months prior to the expiration of your term of accreditation. In states for which accreditation is mandated by law, the *Application* should be submitted six months in advance to ensure adequate time for review and scheduling the survey.

NOTE: You will need the Accreditation Renewal Code found above to submit your renewal application.

Additional Information

Throughout your term of accreditation, AAAHC will communicate announcements via e-mail to the primary contact for your organization. Please be sure to notify us (<u>notifyeast@aaahc.org</u>) should this individual or his/her contact information change.

If you have questions or comments about the accreditation process, please contact AAAHC Accreditation Services at 847.853.6060. We look forward to continuing to partner with you to deliver safe, high-quality health care.





#23-046 203 E. Irving Park Road Wood Dale, IL 60191 (847) 385-0700 www.InnoviaSurgery.com

October 11, 2023

Debra Savage Chair Illinois Health Facilities and Services Review Board 525 West Jefferson Street, 2nd Floor Springfield, Illinois 62761

Dear Chair Savage:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 that no adverse action as defined in 77 Ill. Admin. Code § 1130.140 has been taken against any health care facility owned or operated by Innovia Surgery Center, LLC in the State of Illinois during the three-year period prior to filing this application.

Additionally, pursuant to 77 Ill. Admin. Code § 1110.110(a)(2)(J), I hereby authorize the Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted as part of this application for permit. I further authorize HFSRB and IDPH to obtain any additional information or documents from other government agencies which HFSRB or IDPH deem pertinent to process this application for permit.

Sincerely,

Vera Schmidt Chief of Operations Innovia Surgery Center, LLC

Subscribed and sworn to me This II day of Cetober 2023 IAL SEAL **IELENA PETROVIC** OTANOT AN PUBLIC, STATE OF ILLINOIS MY COMMISSION EXPIRES: 5/24/2025



#23-046 203 E. Irving Park Road Wood Dale, IL 60191 (847) 385-0700 www.InnoviaSurgery.com

October 11, 2023

Debra Savage Chair Illinois Health Facilities and Services Review Board 525 West Jefferson Street, 2nd Floor Springfield, Illinois 62761

Dear Chair Savage:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 that no adverse action as defined in 77 Ill. Admin. Code § 1130.140 has been taken against any health care facility owned or operated by Advantage Surgical Holdings LLC in the State of Illinois during the three year period prior to filing this application.

Additionally, pursuant to 77 Ill. Admin. Code § 1110.110(a)(2)(J), I hereby authorize the Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted as part of this application for permit. I further authorize HFSRB and IDPH to obtain any additional information or documents from other government agencies which HFSRB or IDPH deem pertinent to process this application for permit.

Sincerely,

Mas

Vijay Goyal, M.D. Manager, Advantage Surgical Holdings LLC

Subscribed and sworn to me This <u>1</u> day of <u>October</u> , 2023	
Notary Public	OFFICIAL SEAL HELENA PETROVIC NOTARY PUBLIC, STATE OF ILLINOIS MY COMMISSION EXPIRES: 5/24/2025

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Section III, Project Purpose, Background and Alternatives – Information Requirements <u>Criterion 1110.110(b), Project Purpose, Background and Alternatives</u>

Purpose of the Project

 The Applicants seeks authority from the Illinois Health Facilities and Services Review Board (the "State Board") to add neurological surgery and orthopedics to its existing surgery center. The primary purpose of this project is to improve access to spine and orthopedic procedures to patients within the Applicants' geographic service area and to increase utilization at Innovia Surgery Center ("Innovia"), which currently has capacity.

The recent COVID-19 pandemic and advanced technology accelerated the shift from traditional hospital outpatient departments ("HOPD") to ambulatory surgical centers ("ASC"). Further, spinal surgery in the ASC setting has gained popularity with providers, patients and healthcare systems due to its efficiency and cost advantages combined with comparable clinical results. The shift to outpatient spinal surgery in ASCs has mirrored improvements in anesthesia protocols, pain management, perioperative infections, outcomes, and patient satisfaction with the ability for patients to leave the facility the same day and recover in the comfort of their own home. In addition to the clinical benefits, the transition is fueled by system wide financial concerns of escalating health care costs, which rise at a faster rate than the average annual income. With advances in surgical technique, anesthesia, and post operative care, the list of spine cases performed in ASCs has increased to include, Microlumbar discectomy, Lumbar laminectomy, Vertebroplasty, Kyphoplasty, Anterior cervical discectomy and fusion (ACDF) 1 or 2 level. Posterior cervical foraminotomy. Cervical disc arthroplasty 1 or 2 level, Lumbar fusions 1-2 levels (MIS-TLIF and LLIF), Posterior cervical fusion, ACDF 3 or more levels, and Lumbar fusions 3 or more level. The shift to outpatient spine surgery should continue as research supports the safety of these procedures, allowing patients to decrease their length of stay and overall healthcare costs.¹

Moreover, ASCs are becoming a more attractive location for physicians and patients. Physicians can operate in an environment over which they have more control, e.g., procurement, streamlined scheduling, and access to highly skilled staff, which enhances their ability to provide outstanding care and reduces burnout.² Patients benefit because it's a more accommodating environment with patients who are less sick; surgical outcomes are equivalent to hospitals, and they are less costly and less susceptible to propagating drug-resistant infections.³ ASCs offer a faster and more efficient care model, which provides more effective care. Additionally, patients in ASCs generally require fewer medications, which reduces opioid consumption, and have lower infection rates with over 50% of ASCs reporting no infections, which is integral in reducing the spread of drug-resistant infections. All of this is borne out in significantly higher patient satisfaction scores for ASCs, 92% compared to 70% in hospitals.⁴

¹ Gerling MC, Hale SD, White-Dzuro C, Pierce KE, Naessig SA, Ahmad W, Passias PG. Ambulatory spine surgery. J Spine Surg. 2019 Sep;5(Suppl 2):S147-S153. doi: 10.21037/jss.2019.09.19. PMID: 31656868; PMCID: PMC6790803 available at <u>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC679</u>0803/ #:~:text=The%20shift%20to%20outpatient%20spinal,comfort%20of%20their%20own%20home. (last visited Oct. 19, 2023).

² Nader Samii, JD/MBA and Alison Kuley, *The Business of Moving Spine Cases to Surgery Centers,* BECKER'S ASC REVIEW (Sep. 15, 2023) *available at* https://www.beckersasc.com/outpatient-spine/thebusiness-of-moving-spine-cases-to-surgery-centers.html#:~:text=Spine%20surgeries%20in%20an %20ASC,of%20%2440%20billion%20per%20year. (last visited Oct. 19, 2023).

³ Becker's Spine Review, Spine Surgery in the ASC (Aug. 31, 2023) available at https://www.beckersspine.com/ featured-insights/57683-spine-surgery-in-the-asc-a-win-for-patientsand-physicians.html#:~:text=An%20ASC%20is%20an%20attractive,to%20propagating%20drug%2 Dresistant%20infections. (last visited Oct. 19, 2023).

⁴ Samii, *supra* note 2.

Finally, Medicare and other payors generate significant savings when spine surgeries are performed in an ASC. Spine surgeries in an ASC typically cost 45-60 percent less than a hospital and can be as much as 90 percent less. Overall, researchers estimate that ASCs deliver an annual cost savings of \$40 billion per year.⁵

As shown in Table 1110.110(b) below, the Applicants identified 30 existing or approved health care facilities located within 10 miles of Innovia. Utilizing hospitals for procedures that can be safely performed in an outpatient surgery center is not an efficient use of scarce health care resources. A 2019 report by the Center for American Progress noted the escalation in health care costs is largely attributed to high prices charged by hospitals.⁶ This report highlighted that "hospitals are able to sustain profits and high prices because of their market power, which has grown as competition has dwindled and providers have consolidated."⁷ Prices set by hospitals are discretionary and not connected to underlying costs or market prices. Further, according to the March 2023 MedPac Report to Congress, Medicare payment rates for most ambulatory surgical procedures performed in hospital outpatient departments (HOPDs) are almost twice as high as in surgery centers.⁸

Table 1110.110(b) Facilities within 10 Miles of Innovia Surgery Center						
Facility Name	Address	City	Straight- Line Distance (Miles)			
DuPage Eye Surgery Center	2015 N Main St	Wheaton	8.69			
DMG Surgical Center	2725 S Technology Drive	Lombard	8.65			
The Oak Brook Surgical Centre	2425 W 22nd St	Oak Brook	8.07			
Loyola Surgery Center	1S224 Summit	Oakbrook Terrace	5.04			
OrthoTec Surgery Center	340 W Butterfield Rd	Elmhurst	6.82			
Rush Oak Brook Surgery Center	2011 York Rd	Oak Brook	8.12			
Elmhurst Outpatient Surgery Center	1200 S York Rd	Elmhurst	7.09			
Children's Outpatient Services at Westchester	2301 Enterprise Dr	Westchester	8.70			
River Forest Surgery Center	7427 W Lake Street	River Forest	9.82			
Elmwood Park Same Day Surgery	1614 North Harlem Ave	Elmwood Park	9.40			
Advanced Ambulatory Surgical Center	2333 N Harlem Ave	Chicago	9.08			
Belmont/Harlem Surgery Center	3101 N Harlem Ave	Chicago	8.80			
Schaumburg Surgery Center	929 W Higgins Road	Schaumburg	9.00			
Aiden Center for Day Surgery	1580 W Lake Street	Addison	2.88			
Illinois Hand & Upper Extremity Center	515 West Algonquin Road	Arlington Heights	5.91			
Northwest Surgicare	1100 W Central Rd	Arlington Heights	7.24			
Northwest Community Day Surgery Center	675 W Kirchhoff Rd	Arlington Heights	7.42			
Northwest Endo Center	1415 S Arlington Heights	Arlington Heights	6.59			

⁵ Id.

⁶ Emily Gee, *The High Price of Hospital Care*, CTR. AM. PROGRESS, 1, Jun. 2019 *available at* <u>https://www.americanprogress.org/wp-content/uploads/sites/2/2019/06/HospitalCosts-report.pdf</u> (last visited Aug. 31, 2023).

⁷ Id.

⁸ Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy 161 (Mar. 15, 2023) available at <u>https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf</u> (last visited July 5, 2023).

Table 1110.110(b) Facilities within 10 Miles of Innovia Surgery Center						
Facility Name	Address	City	Straight- Line Distance (Miles)			
	Road					
Northwest Community Outpatient Surgery Center	1455 Golf Rd	Des Plaines	7.68			
Lakeshore Gastroenterology & Liver Disease	150 River Road	Des Plaines	7.52			
Uropartners Surgery Center, LLC	2750 S River Rd	Des Plaines	6.25			
Golf Surgical Center, LLC	8901 Golf Road	Des Plaines	9.05			
UChicago Medicine AdventHealth GlenOaks	701 Winthrop Ave	Glendale Heights	5.47			
Elmhurst Memorial Hospital	155 E Brush Hill Rd	Elmhurst	7.26			
Gottlieb Memorial Hospital	701 W North Ave	Melrose Park	7.76			
Alexian Brothers Medical Center	800 W Biesterfield Rd	Elk Grove Village	3.59			
Northwest Community Hospital	800 W Central Road	Arlington Heights	7.22			
Advocate Lutheran General Hospital	1775 Dempster Street	Park Ridge	8.36			
Ascension Resurrection Medical Center	7435 W Talcott Ave	Chicago	8.46			

While there are 23 licensed ASTCs within the Innovia 10-mile geographic service area ("GSA"), only seven are approved to provide both neurological surgery and orthopedics and only one of those (Loyola Surgery Center) accepts Medicaid patients. Innovia serves an economically disadvantaged community with significant minority populations. According to the 2020 U.S. Census Bureau estimate, 6% of residents of the Innovia GSA live at or below the Federal Poverty Level ("FPL").⁹ Lack of health care access and education, and poverty has created health inequities in this community. Health inequities are differences in population health status and health conditions arising from social and economic inequalities.

Innovia has a proven track record of serving low-income patients. Innovia is Medicaid certified. Over the past four years, over 30% of its patients were Medicaid beneficiaries, compared to 3.7% in HSA 7, and 4% statewide.¹⁰ For patients with a demonstrated hardship who do not qualify for Medicaid, Innovia provides highly discounted rates and free care. From 2019 to 2022, over 16% of patients qualified for charity care, which is significantly higher than the 0.1% of charity care patients served in 2021 by HSA 7 surgery centers and 0.3% throughout the State.¹¹

Innovia Patients 2019 - 2022						
	2019	2020	2021	2022	Average	Percentage
Medicaid	54	339	265	50	177	32%
Medicare	-	2	1	-	1	0%

⁹ U.S. Census Bureau, American Community Survey, Poverty Status in the Past 12 Months available at https://data.census.gov/cedsci/table?q=poverty%20illinois&g=0400000US17&tid=ACSST1Y2018.S170 1&t=Poverty (last visited July 7, 2023).

¹⁰ 2021 ASTC Facility Health Service Area Summary Reports; 2021 ASTC Facility State Summary Report.

¹¹ <u>Id</u>.

Innovia Patients 2019 - 2022						
	2019	2020	2021	2022	Average	Percentage
Other Public	3	5	-	-	2	0%
Commercial	126	105	88	18	84	15%
Private Pay	419	202	185	7	203	36%
Charity Care	287	80	1	-	92	16%
Total	889	733	540	75	559	100%

Source: Illinois Health Facilities and Services Review Board, ASTC Facility Profile Reports (2019 – 2021); Illinois Health Facilities and Services Review Board 2022 Annual Ambulatory Surgery Center Questionnaire.

 Innovia serves patients in the northwest suburbs of Chicago within a 10-mile radius of the ambulatory surgical treatment center. A map of the market area of Innovia is attached at Attachment – 12. Travel times from Innovia to the GSA borders are as follows:

> East: Approximate 10-mile radius to Harwood Heights Southeast: Approximate 10-mile radius to River Forest South: Approximate 10-mile radius to Oak Brook Southwest: Approximate 10-mile radius time to West Chicago West: Approximate 10-mile radius to Hanover Park Northwest: Approximate 10-mile radius to Hoffman Estates North: Approximate 10-mile radius to Arlington Heights Northeast: Approximate 10-mile radius to Niles

3. The recent COVID-19 pandemic and advanced technology accelerated the shift from traditional hospital outpatient departments ("HOPD") to ambulatory surgical centers ("ASC"). Further, spinal surgery in the ASC setting has gained popularity with providers, patients and healthcare systems due to its efficiency and cost advantages combined with comparable clinical results. The shift to outpatient spinal surgery in ASCs has mirrored improvements in anesthesia protocols, pain management, perioperative infections, outcomes, and patient satisfaction with the ability for patients to leave the facility the same day and recover in the comfort of their own home. In addition to the clinical benefits, the transition is fueled by system wide financial concerns of escalating health care costs, which rise at a faster rate than the average annual income. With advances in surgical technique, anesthesia, and post operative care, the list of spine cases performed in ASCs has increased to include, Microlumbar discectomy, Lumbar laminectomy, Vertebroplasty, Kyphoplasty, Anterior cervical discectomy and fusion (ACDF) 1 or 2 level, Posterior cervical foraminotomy, Cervical disc arthroplasty 1 or 2 level, Lumbar fusions 1-2 levels (MIS-TLIF and LLIF), Posterior cervical fusion, ACDF 3 or more levels, and Lumbar fusions 3 or more level. The shift to outpatient spine surgery should continue as research supports the safety of these procedures, allowing patients to decrease their length of stay and overall healthcare costs.¹²

Moreover, ASCs are becoming a more attractive location for physicians and patients. Physicians can operate in an environment over which they have more control, e.g., procurement, streamlined scheduling, and access to highly skilled staff, which enhances their ability to provide outstanding care

¹² Gerling MC, Hale SD, White-Dzuro C, Pierce KE, Naessig SA, Ahmad W, Passias PG. Ambulatory spine surgery. J Spine Surg. 2019 Sep;5(Suppl 2):S147-S153. doi: 10.21037/jss.2019.09.19. PMID: 31656868; PMCID: PMC6790803 available at <u>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC679</u>0803/ #:~:text=The%20shift%20to%20outpatient%20spinal,comfort%20of%20their%20own%20home. (last visited Oct. 19, 2023).

and reduces burnout.¹³ Patients benefit because it's a more accommodating environment with patients who are less sick; surgical outcomes are equivalent to hospitals, and they are less costly and less susceptible to propagating drug-resistant infections.¹⁴ ASCs offer a faster and more efficient care model, which provides more effective care. Additionally, patients in ASCs generally require fewer medications, which reduces opioid consumption, and have lower infection rates with over 50% of ASCs reporting no infections, which is integral in reducing the spread of drug-resistant infections. All of this is borne out in significantly higher patient satisfaction scores for ASCs, 92% compared to 70% in hospitals.¹⁵

The Applicants identified 30 existing or approved health care facilities located within 10 miles of Innovia. Utilizing hospitals for procedures that can be safely performed in an outpatient surgery center is not an efficient use of scarce health care resources. A 2019 report by the Center for American Progress noted the escalation in health care costs is largely attributed to high prices charged by hospitals.¹⁶ This report highlighted that "hospitals are able to sustain profits and high prices because of their market power, which has grown as competition has dwindled and providers have consolidated."¹⁷ Prices set by hospitals are discretionary and not connected to underlying costs or market prices. Further, according to the March 2023 MedPac Report to Congress, Medicare payment rates for most ambulatory surgical procedures performed in HOPDs are almost twice as high as in surgery centers.¹⁸

While there are 23 licensed ASTCs within the Innovia's GSA, only seven are approved to provide both neurological surgery and orthopedics, and only one of those (Loyola Surgery Center) accepts Medicaid patients. Innovia serves an economically disadvantaged community with significant minority populations. According to the 2020 U.S. Census Bureau estimate, 6% of residents of the Innovia GSA live at or below the FPL.¹⁹ Lack of health care access and education, and poverty has created health inequities in this community. Health inequities are differences in population health status and health conditions arising from social and economic inequalities.

Innovia has a proven track record of serving low-income patients. Innovia is Medicaid certified. Over the past four years, over 30% of its patients were Medicaid beneficiaries, compared to 3.7% in HSA 7, and 4% statewide.²⁰ For patients with a demonstrated hardship who do not qualify for Medicaid, Innovia provides highly discounted rates and free care. From 2019 to 2022, over 16% of patients

¹³ Nader Samii, JD/MBA and Alison Kuley, *The Business of Moving Spine Cases to Surgery Centers,* BECKER'S ASC REVIEW (Sep. 15, 2023) *available at* https://www.beckersasc.com/outpatient-spine/thebusiness-of-moving-spine-cases-to-surgery-centers.html#:~:text=Spine%20surgeries%20in%20an %20ASC,of%20%2440%20billion%20per%20year. (last visited Oct. 19, 2023).

¹⁴ Becker's Spine Review, Spine Surgery in the ASC (Aug. 31, 2023) available at https://www.beckersspine.com/ featured-insights/57683-spine-surgery-in-the-asc-a-win-for-patientsand-physicians.html#:~:text=An%20ASC%20is%20an%20attractive,to%20propagating%20drug%2 Dresistant%20infections. (last visited Oct. 19, 2023).

¹⁵ Samii, *supra* note 2.

¹⁶ Emily Gee, *The High Price of Hospital Care*, CTR. AM. PROGRESS, 1, Jun. 2019 *available at* <u>https://www.americanprogress.org/wp-content/uploads/sites/2/2019/06/HospitalCosts-report.pdf</u> (last visited Aug. 31, 2023).

¹⁷ <u>Id</u>.

¹⁸ Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy 161 (Mar. 15, 2023) available at <u>https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_</u> Report_To_Congress_SEC.pdf (last visited July 5, 2023).

¹⁹ U.S. Census Bureau, American Community Survey, Poverty Status in the Past 12 Months available at https://data.census.gov/cedsci/table?q=poverty%20illinois&g=0400000US17&tid=ACSST1Y2018.S170 1&t=Poverty (last visited July 7, 2023).

²⁰ 2021 ASTC Facility Health Service Area Summary Reports; 2021 ASTC Facility State Summary Report.

qualified for charity care, which is significantly higher than the 0.1% of charity care patients served in 2021 by HSA 7 surgery centers and 0.3% throughout the State.²¹

4. Sources

Gerling MC, Hale SD, White-Dzuro C, Pierce KE, Naessig SA, Ahmad W, Passias PG. Ambulatory spine surgery. J Spine Surg. 2019 Sep;5(Suppl 2):S147-S153. doi: 10.21037/jss.2019.09.19. PMID: 31656868; PMCID: PMC6790803 *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC679 0803/#:~:text=The%20shift%20to%20outpatient%20spinal,comfort%20of%20their%20own%20home. (last visited Oct. 19, 2023).

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Becker's Spine Review, *Spine Surgery in the ASC* (Aug. 31, 2023) *available at <u>https://www.becker</u> sspine.com/featured-insights/57683-spine-surgery-in-the-asc-a-win-for-patients-and-physicians.html #:~:text=An%20ASC%20is%20an%20attractive,to%20propagating%20drug%2Dresistant%20infections. (last visited Oct. 19, 2023).*

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Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy 161 (Mar. 15, 2023) *available at* <u>https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_</u> Report_To_Congress_SEC.pdf (last visited July 5, 2023)).

5. The addition spine and orthopedic procedures at Innovia will improve access to patients, particularly underserved patients, within the Applicants' geographic service area and to increase utilization Innovia, which currently has capacity.

Innovia has a proven track record of serving low-income patients. Innovia is Medicaid certified. Over the past four years, over 30% of its patients were Medicaid beneficiaries, compared to 3.7% in HSA 7, and 4% statewide.²² For patients with a demonstrated hardship who do not qualify for Medicaid, Innovia provides highly discounted rates and free care. From 2019 to 2022, over 16% of patients qualified for charity care, which is significantly higher than the 0.1% of charity care patients served in 2021 by HSA 7 surgery centers and 0.3% throughout the State.²³

6. The goal of this project is to improve access to neurological (spine) surgery and orthopedics to patients residing in the Innovia GSA and to increase utilization at Innovia, which has capacity

²¹ <u>Id</u>.

²² 2021 ASTC Facility Health Service Area Summary Reports; 2021 ASTC Facility State Summary Report.

²³ <u>Id</u>.

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Innovia Surgery Center Geographic Service Area



Ambulatory spine surgery



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Spinal surgery in the ambulatory setting has gained popularity with providers, patients and healthcare systems due to its efficiency and cost advantages combined with comparable clinical results. With an increasing case variety and complexity performed in this setting, it is important to understand proper patient selection and preoperative preparation to minimize complications and optimize outcomes. The shift to outpatient spinal surgery in ambulatory surgery centers (ASC) has mirrored improvements in anesthesia protocols, pain management, perioperative infections, outcomes, and patient satisfaction with the ability for patients to leave the facility the same day and recover in the comfort of their own home. In addition to the clinical benefits, the transition is fueled by system wide financial concerns of escalating costs. Healthcare cost containment strategies are intensely debated as they rise at a faster rate than the average annual income (3.9% vs. 1.8% in 2017, respectively) (1,2). The transition to outpatient or ambulatory surgical centers is a simple solution to help reduce this financial burden for both patients and payors, but only if the safety of the patient is sustained. That being said, an increase in complications or readmission rates would negate the overall benefits of outpatient ASC use. Numerous studies assess the association of postoperative complications and outcomes of various spine surgeries when performed in an outpatient setting versus an inpatient setting (3-13). The studies have discovered several preoperative considerations the surgeon must take into account in order to best select where to perform the surgery. These factors include the type of surgical procedure and invasiveness, location and extent of the procedure, various patient comorbidities, and multiple operative factors that differ between patients and surgeons.

The list of spine case types performed in an ambulatory setting has increased with advances in surgical technique, anesthesia, and postoperative care (6). Table 1 shows a list of the common spine procedures performed in the ASC setting. The procedures marked with "*" indicate more recent procedures that have started transitioning to the ASC setting. These procedures may be associated with higher risks and increased operative difficulty and should be performed by more experienced surgeons who can consistently predict surgical time and operative parameters. In 2006, anterior cervical discectomy and fusion (ACDF) comprised 17% of all outpatient spine procedures (14). Idowu et al. published a retrospective study that showed nearly 30% of single level ACDF are performed in an outpatient setting while 70% are still performed inpatient in 2014. Other common spine procedures done in ambulatory centers include microlumbar discectomy (MLD), lumbar laminectomy (35% of cases are outpatient), posterior cervical foraminotomy, cervical disc arthroplasty (CA), and the less common posterior lumbar fusions (6.9% of cases are outpatient). All of these procedures displayed an increase in proportion of outpatient versus inpatient procedures performed between 2003-2014 (15). Gray et al. observed a similar increase in popularity of outpatient lumbar procedures between 1994 and 2000 and noted that discectomy was the most common procedure comprising 70-90% of all lumbar outpatient cases (16). The shift towards outpatient spine surgery should continue as safety of these procedures is supported with research, allowing patients to decrease their length of stay in a hospital and the overall healthcare costs.

Other than case type, several other factors are considered when choosing patients for the ambulatory setting.

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 $\label{eq:setting} \begin{array}{c} \textbf{Table 1} \ List \ of \ current \ spine \ procedures \ performed \ in \ the \ ASC \\ setting \end{array}$

ASC spine procedures
Microlumbar discectomy
Lumbar laminectomy
Vertebroplasty
Kyphoplasty
Anterior cervical discectomy and fusion (ACDF) 1 or 2 level
Posterior cervical foraminotomy
Cervical disc arthroplasty 1 or 2 level
Lumbar fusions 1-2 levels (MIS-TLIF and LLIF)*
Posterior cervical fusion*
ACDF 3 or more levels*
Lumbar fusions 3 or more levels*
* more recent procedures that have started transitioning to

*, more recent procedures that have started transitioning to the ASC setting. ASC, ambulatory surgery center; MIS-XLIF, minimally invasive surgery extreme lateral lumbar interbody fusion; LLIF, lateral lumbar interbody fusion.

Table 2 provides a comprehensive summary of studies evaluating preoperative characteristics and postoperative complications of inpatient and outpatient spine surgery. One and two level procedures are considered appropriate for outpatient, while greater than two level procedures are performed less frequently and usually in selected young healthy patients (3,4,6,8,10,11). A prospective study of 1-2 level ACDF performed in an outpatient setting using microsurgical techniques resulted in only two postoperative hematomas out of the 376 performed. Regarding 1-2 level lumbar decompression, seven out of 1,073 cases were complicated by postoperative hematomas including one retroperitoneal hematoma. All hematomas were detected prior to discharge within a postoperative observation period and every patient recovered without any hematoma-associated sequelae (18). A retrospective study by Mullins et al. found that 3-4 level ACDF had a higher complication rate when compared to 1–2 level ACDF, though there was no significant difference between complication rate of 3-4 level ACDF when done outpatient versus inpatient (11). Another study focusing on Medicare patients having an ACDF of 3 or more levels determined that outpatients might be associated with lower rates of readmissions, complications, and surgical charges. However, the data may be confounded by a much smaller sample size

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in the outpatient group and a discordance with conversion rates from outpatient to inpatient in large scale database studies (9). Even so, large database studies without clear ASC subgroups are more challenging to interpret as there is less clarity on the number of patients converted from outpatient to inpatient status after complications arise.

The increased acceptance of posterior lumbar fusions (PLF) in the outpatient setting correlates with significant advances in approach related morbidity reduction and improvements of pain management using a multi-modality approach. A retrospective cohort study matched outpatients and inpatients based off multiple characteristics including multi-level lumbar fusions. They found no significant difference in postoperative adverse events other than a lower blood transfusion rate in the outpatient group. The adverse events examined included wound-related infection, thromboembolic events, sepsis, pneumonia, urinary tract infection, myocardial infarction, unplanned intubation, wound dehiscence, renal insufficiency, cerebrovascular accident, death, renal failure, and being placed on a ventilator for >48 hours (6). Other studies failed to propensity match cohorts for comorbidities and as a result developed conclusions with selection bias and possible confounding factors (19). Other studies lack sufficient follow up to fully interpret the results (8-10). More extensive research is needed to verify this relationship across the multitude of spinal procedures done in an outpatient setting. However, as surgical technique continues to evolve the possibility of performing higher risk multilevel spine procedures is becoming more realistic in the outpatient setting. Therefore, surgeons are cautioned against performing spinal fusion procedures in the ASC on more than two levels when co-morbidity is present and the option for overnight stay is not available. Other than safety concerns, surgeons should know their own performance levels measured by typical length of stay for each surgery type. They should have a relatively reproducible level of pain control, patient mobility, and discharge time on procedures shifted to ASC's. Otherwise high transfer rates to inpatient hospital beds will damage the viability of the ASC they are using.

Increased risk of complications has a significant influence on choice of surgical setting. Patient comorbidities and factors are extremely important to consider in the context of the current literature. Martin *et al.* used a multivariate logistic regression analysis to evaluate 2,881 patients undergoing inpatient and outpatient single level ACDF for independent risk factors for complications within

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Table 2 Summary of the studies on the relationship between preoperative characteristics and postoperative complications of inpatient and outpatient spine surgery

Authors and year	Patients (N)	Study description	Procedures evaluated	Significant observations
Best <i>et al.</i> 2006 (17)	1,377 outpatients	Single surgeon, retrospective case series review	Lumbar microdiscectomy	5–18% of planned outpatient procedure patients were admitted to hospital due to complications being a leak, incisional infection, a hematoma or seroma, urinary retention, or recurrent disc herniation. 6.4% of outpatients had recurrent herniation. 1.7% of outpatients were converted to inpatient
Martin <i>et al.</i> 2014 (10)	597 outpatients <i>vs.</i> 2,317 inpatients	NSQIP, retrospective cohort	Single level ACDF	Patient age over 65yo, BMI >30, ASA 3 or 4, current dialysis, current corticosteroid use, recent sepsis, and operative times longer than 120 minutes were each independent risk factors for complication in multivariate analysis
Walid <i>et al.</i> 2010 (13)	97 outpatients vs. 578 inpatients	Retrospective cohort	ACDF, lumbar microdiscectomy, lumbar decompression with or without fusion	Prevalence of DM, congestive heart disease, coronary artery procedures, and use of antidepressants was higher in inpatient group. Age was higher in inpatients. Obesity seems to be a predictor of readmission with infection
Chin <i>et al.</i> 2016 (7)	30 outpatients <i>vs.</i> 40 inpatients	Multiple institutions, single surgeon comparative analysis, retrospective cohort	LLIF	Patients who had LLIF outpatient had statistically significant improvement in ODI scores compared with inpatient, no difference in VAS scores. Outpatient had shorter operative times and smaller EBL
Helseth <i>et al.</i> 2015 (18)	1,073 lumbar and 376 cervical outpatients	Prospective single institution study	Lumbar and cervical microsurgical decompressions (ACDF, posterior cervical foraminotomy, posterior lumbar microsurgical decompression)	Overall complication rate 3.5% for outpatient cervical and lumbar decompression. All life threatening hematomas were detected within 6 and 3 hours after cervical and lumbar surgery, respectively. Recommend outpatients to have low patient comorbidity (ASA class I and II), age <70 yo, and only perform one level lumbar disc, one level lumbar canal stenosis, or one level ACDF. Not suitable for outpatient ASA class \geq 3, discharge on the day of surgery not likely, noncooperative patient, moderate/severe myelopathy
Smith <i>et al.</i> 2016 (12)	873 outpatients <i>vs.</i> 160 inpatients	Case series	MIS-XLIF	Strongest baseline predictors of early postop discharge were less advanced diagnosis (non-deformity), younger age, elevated baseline hemoglobin levels, and lower BMI. Most predictive treatment variables for early postop discharge were fewer number of levels treated and elevated postop hemoglobin levels
Arshi <i>et al.</i> 2018 (4)	1,215 outpatients <i>vs.</i> 10,964 inpatients	PearlDiver Humana (Nationwide), retrospective case control	1–2 level ACDF	Adjusting for age, gender, and comorbidities, patients undergoing outpatient ACDF were more likely to undergo revision surgery for posterior fusion at both 6 months and 1 year post-op. Also, higher likelihood of revision anterior fusion at 1 year postop. renal failure was more frequently associated with outpatient ACDF. Every other complication was comparable out <i>vs.</i> in
Arshi e <i>t al.</i> 2018 (3)	770 outpatients <i>vs.</i> 26,826 inpatients	PearlDiver Humana (Nationwide), retrospective case control	1–2 level PLF	Patients undergoing outpatient PLF had higher likelihood of revision/extension of posterior fusion, conversion to anterior fusion, and stenosis requiring decompressive laminectomy within 1 year. Risk-adjusted rates of all other postop surgical and medical complications were statistically comparable. No trend toward increase or decrease of use across 2007–2015

Table 2 (continued)

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Authors and year	Patients (N)	Study description	Procedures evaluated	Significant observations
Mullins e <i>t al.</i> 2018 (11)	560 outpatients <i>vs.</i> 563 inpatients	Single surgeon single institution, retrospective cohort	ACDF	No statistically significant difference of complication rate between inpatient and outpatient any level ACDF. Significantly more complications occurred with 3 and 4 level surgeries than with 1 and 2 level procedures. Overall average inpatient cost was 26% higher than outpatient
Khalid <i>et al.</i> 2019 (9)	144 outpatients <i>vs.</i> 2,348 inpatients	Medicare Standard Analytical Files, retrospective cohort	3 or more level ACDF	Overall complication rates within 30 postop days were greater for inpatients than outpatients. More inpatients developed postop UTI and had increased risk of readmission with comorbidities of anemia, smoking, BMI >30. Outpatients had increased risk of readmission with comorbidities of anemia, DM 1 or 2, and BMI >30. Inpatient ACDF significantly higher than outpatient
Khalid <i>et al.</i> 2019 (8)	2,059 outpatients <i>vs.</i> 26,368 inpatients	Medicare Standard Analytical Files, retrospective cohort	1–2 level ACDF	30-day readmission rates were lower in outpatients. Inpatients had higher rate of UTI, DVT, MI while outpatients had higher rate of PE. Outpatients had increased readmission risk with comorbidities of DM, smoking, BMI >30
Mundell <i>et al.</i> 2018 (19)	370,195 outpatients	Meta-analysis	ACDF and lumbar laminectomy	Outpatients had younger age and no DM. Outpatients were associated with a lower likelihood of reoperation, 30-day readmission, complications, and with lower overall costs
Bovonratwet <i>et al.</i> 2018 (6)	360 outpatients vs. 36,610 inpatients	NSQIP, retrospective cohort	PLF with or without interbody fusion	No difference in postop adverse events in 30 days other than lower blood transfusions in outpatient group. No difference in rate of 30-day readmission. Outpatients tended to be younger, male, ASA \leq 2, lower DM lower HTN, less levels operated on, and less posterior instrumentation
Bovonratwet <i>et al.</i> 2018 (5)	373 outpatients <i>vs.</i> 1,612 inpatients	NSQIP, retrospective cohort	Single level cervical disc arthroplasty	No difference in 30-day perioperative complications or rate of readmission between out and in
Mannion <i>et al.</i> 2014 (20)	3,549	Eurospine Spine Tango Registry and private database, retrospective cohort	Lumbar surgery	In going from ASA1 to ASA3 surgical complications increased significantly from 5.0% to 14.5% and general complications increased from 2.9% to 15.7%. ASA had an independent effect of ASA grade on both complications and outcome
Prabhakar <i>et al.</i> 2017 (21)	-	Preoperative Assessment in ASC	Ambulatory surgery	Patients with OSA have increased attempts at laryngoscopy, increased difficulty with mask ventilation and proper laryngeal mask airway fit, increased need for postop oxygen, and increased use of vasoactive medications intraoperatively. Moderate and deep sedation in prone position can increased potential ventilatory issues in OSA because of limited reserve, increased oxygen consumption, and pulmonary mechanics effects of the lungs

BMI, body mass index; ASA, American Society of Anesthesiologist; ACDF, anterior cervical discectomy and fusion; PLF, posterior lumbar fusion; DM, diabetes mellitus; OSA, obstructive sleep apnea; NSQIP, National Surgical Quality Improvement Program; LLIF, lateral lumbar interbody fusion; ODI, Oswestry Disability Index; VAS, Visual Analog Score; EBL, estimated blood loss; UTI, urinary tract infection; DVT, deep venous thrombosis; MI, myocardial infarction; PE, pulmonary embolism; HTN, hypertension; ASC, ambulatory surgery center; MIS-XLIF, minimally invasive surgery extreme lateral lumbar interbody fusion.

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Table 2 (continued)



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thirty days. The study recommends inpatient admission for patients over sixty-five years old, body mass index (BMI) greater than 30 kg/m², American Society of Anesthesiologists (ASA) class of 3 or 4, current dialysis, current corticosteroid use, operative times >120 minutes, and sepsis within thirty days of surgery due to increased risk for any complication (all P value <0.05). Furthermore, any patient with a difficult airway or intubation, for example a patient with Mallampati score of 4, should be considered for inpatient admission because of the increased risk of airway compromise. This is especially important to consider for ACDF cases where there is close proximity between the airway and anticipated postoperative swelling. After propensity score matching for all of these independent risk factors, there was no significant difference in complication rate between inpatient and outpatient, and there was an increased rate of reoperation in the inpatient group (10). Khalid et al. performed two similar studies on outpatient ACDF (a 1–2 level study and a multilevel 3 or more study) which revealed that anemia, diabetes mellitus (DM), and BMI >30 kg/m² had increased risk of 30-day readmission due to complications (8,9). These risk factors are analogous to the risk factors found in a study by Smith et al., which reviewed patient outcomes in outpatient lateral lumbar interbody fusion (XLIF) and minimally invasive posterior lumbar fusions (MIS-PLF) to determine predictors of early postoperative discharge. The strongest baseline predictors of lower complications were a less advanced diagnosis, younger age, elevated baseline hemoglobin levels, and a lower BMI. The strongest variable predictors for lower complication rates were a fewer number of levels treated and elevated postoperative hemoglobin levels (12). A majority of the factors listed above are considered in the ASA classification system and contribute to a higher class (20). ASA class alone could be a helpful predictor of both complications and outcomes in spine surgery. In one study comparing outcomes of ASA classes 1 through 3, surgical complications of lumbar procedures increased from 5.0% to 14.5% and general complications from 2.9% to 15.7% with age of the patient having no unique variance in outcomes (22).

The impact of ASA classification and comorbidities on outcomes has been a focus of several studies. Helseth *et al.* performed a prospective single-center study of 1,449 outpatient spine procedures to develop a guideline for beginner surgeons using ASA and other significant factors. They suggested thresholds for patient selection including ASA class 1 or 2, age <70 years old, and operating on only a single level for lumbar or cervical procedures. Concerning the safety of outpatient spine procedures, they caution surgeons in their early career from using outpatient status in patients with ASA class of 3 or more, noncooperative patients (e.g., cognitive impairment), moderate/severe myelopathy, cervical degenerative spinal disease requiring corpectomy, laminectomy, or posterior fusion, or lumbar degenerative spine disease requiring laminectomy or instrumented fusion (18). This data correlates complexity of the procedure performed and patient comorbidities as independent risk factors for postoperative complications.

Anesthesiologists have a unique perspective on what cases have a higher risk when performed in an outpatient setting. They focus on certain details distinct from that of the surgeon, and therefore have valuable information to contribute to outpatient case selection. The ASA classification system does not recommend which patients should be done outpatient, but rather categorizes patients based on comorbidities allowing surgeons to weigh the risks. Obstructive sleep apnea (OSA) presents an important influence on the risk of patients undergoing spine procedures, especially in the cervical spine. Even though OSA has been shown to have no relationship between unplanned admissions or life threatening events in outpatient surgery, OSA patients have a significantly greater likelihood of intraoperative issues (23). OSA increases the risk of a difficult intubation and ventilation, the need for supplemental oxygen, and the use of vasoactive medications to correct hemodynamic derangements (21,23). The risk is amplified when patients are placed in the prone position for posterior spinal procedures. There is a significant increase in potential ventilation issues in OSA patients due to their limited reserve of oxygen, increased oxygen consumption, and the effects of sedation and being prone on pulmonary mechanics (21). The surgeon has a critical responsibility in determining the safest location for the patient, but the anesthesia team may also play an important role in preoperative considerations. Additional research should be done to evaluate the relationship between OSA and complications specifically after cervical spine procedures where approach related airway inflammation would complicate OSA respiratory mechanics.

Social, psychiatric, and cognitive issues also play a significant role in facility designation. Helseth *et al.* reviewed the impact of uncooperative patients and those with cognitive impairment (18). Additionally, patient household proximity to the facility and an appropriate emergency room should be considered. Those patients

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without family support and cognitive limitations for self care would complicate outpatient discharge. Surgeons should consider home care needs and family support in the context of the anticipated postoperative activity limitations. On one end of the spectrum, homeless patients or those with poor nutrition may require additional days in the hospital, for example. Furthermore, patients with low pain tolerance or high resistance to pain medication will pose higher risks during ambulatory discharge evaluations.

Whether or not research can establish guidelines or thresholds for patient selection in the ASC setting, individual surgeon outcomes should be considered. There is tremendous variability of skill level and experience that plays a large role in selecting the facility. Reviewing average length of stay for each procedure type and number of levels should be included in the early phases of shifting patients to ASC facilities. In summary, preoperative consideration for selecting a case for outpatient spine procedures should be based on multiple distinct patient specific factors. Most researchers across the board seem to agree that an increasing age specifically >65, a BMI >30 kg/m², ASA >2, extended operative times, quantity of levels operated on, and complexity of the instrumentation have a significant influence on whether a patient should be considered for outpatient surgery. Secondary considerations examined with less statistical strength include surgeon's experience, current dialysis, current corticosteroid use, sepsis within thirty days, difficult airways, anemia, diabetes, smoking, OSA, and positioning of patients in the operating room. The ASA classification system attempts to combine the comorbidities and independent risk factors associated with complications in order to simplify a patient's overall risk for surgery. Its use may end up being more influential in the future as the strength of its relationship in predicting complications and outcomes is supported further with research. Identifying these risk factors preoperatively is vital as it assists the surgeon in deciding whether or not a patient is suitable for ambulatory or outpatient spine surgery.

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Footnote

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References

- American Medical Association. Trends in healthcare spending. Available online: https://www.ama-assn.org/ about/research/trends-health-care-spending [Accessed 15th July 2019].
- Frazee G. 3 Charts that explain the rise in U.S. household income. Available online: https://www.pbs.org/newshour/ economy/making-sense/3-charts-that-explain-the-rise-inu-s-household-income [Accessed 15th July 2019].
- Arshi A, Park HY, Blumstein GW, et al. Outpatient Posterior Lumbar Fusion: A Population-Based Analysis of Trends and Complication Rates. Spine (Phila Pa 1976) 2018;43:1559-65.
- Arshi A, Wang C, Park HY, et al. Ambulatory anterior cervical discectomy and fusion is associated with a higher risk of revision of surgery and perioperative complications: an analysis of a large nationwide database. Spine J 2018;18:1180-7.
- Bovonratwet P, Fu MC, Tyagi V, et al. Safety of Outpatient Single-Level Cervical Total Disc Replacement. Spine (Phila Pa 1976) 2019;44:E530-8.
- Bovonratwet P, Ottesen TD, Gala RJ, et al. Outpatient elective posterior lumbar fusions appear to be safely considered for appropriately selected patients. Spine J 2018;18:1188-96.
- Chin KR, Pencle FJR, Coombs AV, et al. Lateral Lumbar Interbody Fusion in Ambulatory Surgery Centers. Spine (Phila Pa 1976) 2016;41:686-92.
- Khalid SI, Carlton A, Wu R, et al. Outpatient and Inpatient Readmission Rates of 1- and 2-Level Anterior Cervical Discectomy and Fusion Surgeries. World Neurosurgery 2019;126:1475-81.
- Khalid SI, Kelly R, Wu R, et al. A comparison of readmission and complication rates and charges of inpatient and outpatient multiple-level anterior cervical discectomy and fusion surgeries in the Medicare population. J Neurosurg Spine 2019: 1-7. [Epub ahead of print]
- Martin CT, Pugely AJ, Gao Y, et al. Thirty-Day Morbidity After Single-Level Anterior Cervical Discectomy and Fusion: Identification of Risk Factors and Emphasis on

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the Safety of Outpatient Procedures. J Bone Joint Surg 2014;96:1288-94.

- Mullins J, Pojskic M, Boop FA, et al. Retrospective singlesurgeon study of 1123 consecutive cases of anterior cervical discectomy and fusion: a comparison of clinical outcome parameters, complication rates, and costs between outpatient and inpatient surgery groups, with a literature review. J Neurosurg Spine 2018;28:630-41.
- Smith WD, Wohns RNW, Christian G, et al. Outpatient Minimally Invasive Lumbar Interbody: Fusion Predictive Factors and Clinical Results. Spine (Phila Pa 1976) 2016;41:S106-22.
- Walid MS, Robinson JS 3rd, Robinson ER, et al. Comparison of outpatient and inpatient spine surgery patients with regards to obesity, comorbidities and readmission for infection. J Clin Neurosci 2010;17:1497-8.
- Best MJ, Buller LT, Eismont FJ. National Trends in Ambulatory Surgery for Intervertebral Disc Disorders and Spinal Stenosis: A 12-Year Analysis of the National Surveys of Ambulatory Surgery. Spine (Phila Pa 1976) 2015;40:1703-11.
- Idowu OA, Boyajan HH, Ramos E, et al. Trend of Spine Surgeries in the Outpatient Hospital Setting Versus Ambulatory Surgical Center. Spine (Phila Pa 1976) 2017;42:E1429-36.
- Gray DT, Deyo RA, Kreuter W, et al. Population-Based Trends in Volumes and Rates of Ambulatory Lumbar Spine Surgery. Spine (Phila Pa 1976) 2006;31:1957-63.

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- Best NM, Sasso RC. Success and Safety in Outpatient Microlumbar Discectomy. J Spinal Disord Tech 2006;19:334-7.
- Helseth Ø, Lied B, Halvorsen CM, et al. Outpatient Cervical and Lumbar Spine Surgery is Feasible and Safe: A Consecutive Single Center Series of 1449 Patients. Neurosurgery 2015;76:728-37; discussion 737-8.
- Mundell BF, Gates MJ, Kerezoudis P, et al. Does patient selection account for the perceived cost savings in outpatient spine surgery? A meta-analysis of current evidence and analysis from an administrative database. J Neurosurg Spine 2018;29:687-95.
- Mannion AF, Fekete TF, Porchet F, et al. The influence of comorbidity on the risks and benefits of spine surgery for degenerative lumbar disorders. Eur Spine J 2014;23:S66-71.
- 21. Prabhakar A, Helander E, Chopra N, et al. Preoperative Assessment for Ambulatory Surgery. Curr Pain Headache Rep 2017;21:43.
- 22. American Society of Anesthesiologists. ASA Physical Status Classification System. Available online: https://www. asahq.org/standards-and-guidelines/asa-physical-statusclassification-system [Accessed 14th August 2019].
- Stierer TL, Wright C, George A, et al. Risk Assessment of Obstructie Sleep Apnea in a Population of Patients Undergoing Ambulatory Surgery. J Clin Sleep Med 2010;6:467-72.



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The business of moving spine cases to surgery centers

"Every success story is a tale of constant adaptation, revision and change." - Richard Branson

Never has this Richard Branson quote been more true than it is for the evolution of the healthcare delivery system, which will only be accelerated by the COVID-19 crisis. Historically, surgical procedures were performed in a hospital inpatient setting. With the advancement of technology, certain of these procedures moved to a hospital outpatient department (HOPD), and in recent years have moved to ambulatory surgery centers (ASCs). The initial specialties that moved to ASCs included ophthalmology, gastroenterology, pain management, urology, ENT, among others. Today, 61 percent of the procedures for these specialties are performed in ASCs. Orthopedics has trailed these other specialties, but is quickly catching up, as 44 percent of orthopedic procedures were performed in ASCs in 2015 and that number jumped to 52 percent in 2018.¹

On the other hand, spinal surgeries, due to their complex nature, have largely remained inside the hospital walls, with only 10 percent of such procedures performed in ASCs in 2018. That said, spinal procedures are on a trajectory similar to orthopedics as the number of ASCs specializing in spinal surgery rose from only 35 in 2013 to 145 in 2019, an increase of 314 percent. Further, the 10 percent of spinal procedures performed in ASCs today are projected to move to 30 percent by the early 2020s, an increase of 200 percent.¹

This dramatic movement in spinal procedures is being driven due to it being beneficial for patients, healthcare providers and payers, a rare win-win. For example, in an ASC, surgeons have greater control of the procurement process—there are fewer bureaucratic hoops to jump through. They can directly request the equipment, technology and materials they need, schedule procedures more conveniently, and assemble teams of highly skilled, specially trained staff. There are financial advantages for surgeons, too, as many have ownership in ASCs.

Patients looking for convenience, quality and comfort enjoy the benefits of an ASC. Their recovery is faster, and they have more say and flexibility in their discharge plans. With a reduced rate of infection (more than 50 percent of ASCs in the US have a 0 percent infection rate²), which is increasingly important to patients as a result of COVID-19, patients can be confident in their safety. Most patients also require fewer medications. For example, patients who underwent anterior cervical discectomy and fusion at an ASC consumed fewer doses of fentanyl, oxycodone and oral morphine equivalents. All of these circumstances lead to a 92 percent patient satisfaction rate, compared with 70 percent satisfaction rate in the hospitals. ²

Medicare and insurance carriers also generate significant savings when spine surgeries are performed in an ASC. Spine surgeries in an ASC typically cost 45-60 percent less than a hospital, and can be as much as 90 percent less. Overall, researchers estimate that ASCs deliver an annual cost savings of \$40 billion per year.³

Types of Spine Surgeries

The most common spine surgeries currently being performed in an ASC today are lumbar decompressions, lumbar discectomies, and 1 level anterior cervical discectomies and fusions. These procedures are approved by both commercial carriers and Medicare, are extremely successful, and offer a cost savings to payers. Anterior cervical discectomy surgery, for example, costs Medicare \$7,688 in an ASC versus \$10,713 in hospital outpatient departments. 1 Thus, this procedure costs 39 percent more in an HOPD than in an ASC.

A couple of trends have emerged this year. First, there has been an increase in cervical disk arthroplasty and interspinous process distraction device with open decompression procedures, which is also on Medicare's ASC-approved list.

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#23-046 Second, ASCs have experienced great success with lumbar posterior inter-body fusion surgeries carriers, with patients going home the same day of surgery. Medicare moved this surgery from the inpatient only list to the hospital outpatient list—which is a step in the right direction—but has not yet approved it for ASCs. CMS has added numerous spine codes to the ASC payables list over the past few years, particularly in situations where ASCs have demonstrated success with such cases for commercial carriers, so it seems likely that this high demand surgery will be transitioned to the ASC payables list in the near term.

Most recently, in 2020, Medicare moved the following six spine procedures off of the inpatient only list, but did not yet move them to the ASC approved list. These surgeries include:

1. Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace, single interspace and segment; lumbar. CPT code: 22633

2. Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace, single interspace and segment; lumbar; each additional interspace and segment. CPT code: 22634

3. Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical. CPT code: 63265

4. Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic. CPT code: 63266

5. Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar. CPT code: 63267

6. Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral. CPT code: 63268

As our country deals with the economic challenges of the coronavirus pandemic, cost savings in all areas will be a priority. Transitioning spine surgeries to the ASC-approved list provides Medicare with a unique opportunity to lower costs while reducing patients' exposure to infection that may be present in a more populated hospital setting.

Finally, since spine surgery is one of the higher reimbursing surgical specialties, incorporating spine into a multi specialty ASC can have a significant positive impact on the growth rate and profit margin structure for an ASC, which will ultimately lead to a considerable increase in the ASC's equity value.

Click here for Part II of this article series for a more in-depth discussion of the steps required to incorporate spinal procedures into your ASC, and the financial implications of doing so.

To learn more from National Medical, click here.

Reference:

1. Ambulatory Surgery Center Growth Accelerates Is Medtech Ready - Bain & Company.pdf

2. https://www.beckersasc.com/outpatient-spine/10-things-to-know-about-spine-surgery-in-ascs-for-2019.html

3. https://www.spineuniverse.com/resource-center/patients%27-guide-to-outpatient-spine-surgery/low-costshigh-quality-ambulatory

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Spine surgery in the ASC: A win for patients and physicians

The trend of surgical services migrating from high-acuity settings to ASCs is poised to continue.

This is due to improved patient experiences, greater physician autonomy and better economics. Adding to the growing appeal of ASCs is increased use of robotic-enabled surgery, which improves outcomes and productivity.

Becker's ASC Review recently spoke with Kenneth Nwosu, MD, an orthopedic spine surgeon at NeoSpine in the Greater Seattle area, about ASCs' attractive value proposition, the role of robotic technology in enabling ASCs to perform complex procedures and the rationale for performing spine surgeries in ASCs.

ASCs on the rise

Over the last several years, ASCs have become an increasingly attractive destination for physicians and patients. Health system leaders have taken note of this trend and are increasing investments in these facilities accordingly. More than 60 percent of hospitals and health systems nationwide plan to <u>increase investments in ASCs</u>, according to a 2022 survey of hospital executives and clinical leaders.

As Dr. Nwosu explained, the value proposition of ASCs is a win-win-win: "It's a win for providers to operate in an environment they have more control over, which reduces burnout. It's a win for patients because the environment consists of other patients who are less sick and it's less expensive."

Outpatient spine surgery is no exception. An ASC is an attractive option for spine surgery patients because — when patients are properly selected — they can enjoy equivalent surgical outcomes as they would in a hospital, but in an environment that is more accommodating, less costly and less susceptible to propagating drug-resistant infections. Patient selection requires screening for comorbidities or other circumstances, such as obesity or opioid use, which expose individuals to higher risk of complications.

Technology can help spine surgeons optimize patient selection and perform less-invasive procedures

There are two types of technology necessary to successfully transition spine surgery patients from HOPDs to ASCs. One type is software-based and facilitates proper patient selection by quantifying a patient's risk of needing hospitalization within 24 hours of having undergone surgery.

"It's difficult for the human mind to quantify all of the different variables that determine whether a patient ends up staying in a hospital or going home," Dr. Nwosu said. "When you have an AI instrument that can do that for you in a split second and give you that information, that's extremely valuable."

The other technology combines software-based solutions and physical instrumentation, which supports navigation, robotics and endoscopy. "These three [modalities] allow us to perform spine surgeries in a less invasive fashion, which is associated with less pain, less infection and less bleeding," Dr. Nwosu said. "All of these variables reduce the risk of a patient needing to be admitted into the hospital after surgery."

He added that robotic guidance allows spine surgeons to precisely place pedicle screws with much higher accuracy than they can in traditional open surgery — a consideration that is highly relevant when treating adjacent segment disease, for example.

There is another intangible but invaluable benefit to using robotic surgery, Dr. Nwosu said: "The most important benefit of robotic surgery is the cognitive relief it provides. It's hard to quantify but easy to qualify. Ask any surgeon and the amount of energy they have left to do another surgery is much higher when you're doing the previous surgery robotic versus non-robotic."

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D/20/23, 11:08 AM Spine surgery in the ASC: A win for patients and physicians #23-046 For advanced technology-enabled ASCs to thrive, payers must support the care delivery model

Longstanding health policies and practices are hard to change. One of those regulations restricts the type of procedures CMS covers when performed at an ASC, even as enabling technologies have advanced enough that most of those surgeries can be performed at a non-hospital setting at no higher risk — yet at lower cost. Further, CMS reimburses ASCs at a lower rate than it does HOPDs for identical surgeries.

To incentivize the incorporation of novel technologies that improve the patient and physician experience while reducing costs, Dr. Nwosu is hopeful payers will see the value of spine procedures performed in ASCs and will reimburse appropriately.

"We all talk about healthcare costs and how they are ballooning at a rapid rate," he said. "Payers have a lot of leverage to drive down costs by doing more cases in the ASC . . . the value proposition is clear. It's going to happen eventually, but I think it should be happening much sooner than it has been happening."

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REPORT JUN 26, 2019

The High Price of Hospital Care

The hospital industry is profiting from soaring rates charged to privately insured patients.







A resuscitation room is photographed at a hospital in Fremont, California, November 2018. (Getty/Aric Crabb/Digital First Media/Bay Area News)

Introduction and summary

Health care costs ranked among voters' top concerns in the 2018 midterm elections.¹ The federal government estimates that per capita health care expenditures reached \$10,739 in 2017 and that costs will continue to grow more than 5.5 percent annually over the next decade.² Slowing the increase in health



care costs will be impossible without reforms to the largest component of health care expenditures: hospital-based care.

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Hospitals receive \$1 out of every \$3 spent on health care,³ and the United States is projected to spend about \$1.3 trillion for hospital care alone in 2019.⁴ Collectively, hospitals boast a margin of 8 percent, a level higher than margins in the pharmacy industry or the insurance industry. Across America's acute care hospitals, total revenues exceeded expenses by more than \$64 billion in 2016, according to a Center for American Progress analysis. Experiences among individual hospitals vary, however, and about one-quarter of both for-profit and not-for-profit hospitals lost money in 2016.

Many hospitals are able to sustain profits and high prices because of their market power, which has grown as competition has dwindled and providers have consolidated through mergers and acquisitions. While the high expenditures in some regions of the country are at least partly explained by local input costs, utilization, or medical practice style, price variation is responsible for most of the geographic variation in expenditures among people with private insurance.⁵

Commercial insurers are estimated to pay about twice what Medicare does for hospital care. Across all payers, hospitals receive reimbursement averaging about 134 percent of what Medicare pays, according to CAP analysis detailed in this report. High prices do not always indicate better quality; in fact, they often mask inefficiencies in the hospital business.

The first portion of this report examines trends in hospital profits and pricing variation across geographic areas and payers. The second portion describes policy options to rein in the high cost of hospital care. A summary of these recommendations are as follows:

- End abusive hospital billing practices, including surprise billing and excessive charges
- Implement reference pricing to incentivize patients and put pressure on providers
- Implement rate regulation, setting or capping all payers' rates closer to costs
- Call for more public information on hospital pricing
- Enforce more antitrust measures for the hospital industry
- Impose site neutrality for payments

While most patients do not pay hospitals directly for the full cost of their care, those with private insurance are footing the bill for higher prices through higher The High Price of Hospital Care - Center for American Progress #23-046

insurance premiums and rising deductibles. Taming the overall growth of health care costs requires action to lower the prices Americans pay for hospital care.

Hospital profits are soaring

Hospital profitability has risen to its highest levels in decades, boosted by the nation's rebound from the Great Recession and the Affordable Care Act's expansion of health coverage.⁶ A common measure of hospital profitability is the total margin, which is the difference between revenues and expenses relative to revenues, considering all the hospital's business activity. As of 2016, the total margin across the hospital industry was 7.8 percent. The industry's operating margin—which measures the expenses and revenues that are directly associated with patient care—was 6.7 percent.⁷ (see Figure 1)



To place hospitals' total percent margin in perspective, acute care hospitals are more profitable than many other industries in the health care sector. Hospitals rank well above health insurers, pharmacies, and pharmacy benefit managers, though hospital margins are still below profit estimates for the medical device and drug manufacturing industry. (see Figure 2)



Some notable trends in the hospital industry have occurred alongside the growth in profits. First, hospitals have shifted their growth strategy to expanded outpatient services.⁸ Inpatient care now makes up slightly more than half, or 52 percent, of hospital revenue, compared with about 70 percent in 1995.⁹ Through

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acquisition of physician practices, hospitals now offer a wider array of services through their outpatient departments.

Second, with scores of hospital mergers occurring each year, ¹⁰ competition continues to dwindle. The market for health care providers is growing increasingly consolidated, resulting in higher prices for patients. Hospitals systems are growing more powerful, and indidivudal hospitals are also increasingly likely to belong to a multiprovider health system rather than operating independently.¹¹ Consolidation with physicians enables hospital systems to compete with nonhospital-based practices while qualifying for the federal program for outpatient drugs discounts and the higher Medicare reimbursement rates that the Centers for Medicare and Medicaid Services (CMS) pay to hospitals.¹² This is worrying news for the overall rise in American health care costs—and for American patients who pay the price.¹³

Research by Yale economist Zack Cooper and his team of researchers has demonstrated that greater hospital market concentration leads to higher costs for patients. Compared with regions served by four or more competing hospitals, regions with three hospitals have prices that are 5 percent higher; those with two hospitals have prices that are 6 percent higher; and those with a single hospital have prices that are 15 percent higher.¹⁴ (see Figure 3)



Northern California is among the markets that is dominated by a small number of powerful health systems. For example, Sutter Health has a sprawling network that comprises 24 hospitals, 35 outpatient centers, and 5,500 member physicians. A suit by the California attorney general alleges that prices in Northern California have risen faster than those in Southern California because Sutter Health engages in anticompetitive business practices, including abusing its bargaining position in negotiations with insurers.¹⁵ Price index data from the independent Health Care Cost Institute show that relative to the national median, health care prices in San Francisco are 64 percent higher, and those in San Jose, California, are 82 percent higher.¹⁶

A recent *Health Affairs* study lays bare that hospital facilities themselves, rather than the physicians who staff them, are the primary driver of rising hospital costs.¹⁷ From 2007 to 2014, inpatient hospital prices grew twice as fast (42 percent increase over the period) as physician prices (18 percent increase over the period). For outpatient services, hospital prices rose more than four times faster than physician prices—25 percent and 6 percent increases, respectively.

Hospital profits in 2016

To take a closer look at hospitals' profitability, CAP analyzed public financial data from hospitals around the nation. All Medicare-certified hospitals are



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CAP limited its analysis to the 3,062 nonfederal, acute care hospitals with valid data for 2016. Among these, 26 percent are for-profit, 61 percent are nonprofit, and 13 percent are public. (see Table 1) The Appendix at the end of this report contains details on the hospital sample used in this analysis.

As a whole, the U.S. hospital industry is profitable

	Number of hospitals	Percentage of hospitals	Operating margin	Total margin
All hospitals	3,062	100%	1%	7%
Ownership				
For profit	799	26%	10%	11%
Nonprofit	1,855	61%	0%	7%
Public	408	13%	-3%	5%
Rural/urban				
Rural	842	27%	-1%	6%
Urban	2,220	73%	1%	8%
Size				
Fewer than 100 beds	1,119	37%	2%	7%
100–299 beds	1,310	43%	2%	7%
300 or more beds	621	20%	0%	8%

Note: This analysis is restricted to nonfederal acute care hospitals reporting full-year data for 2016. See the Methodology section in XX CITE CAF REPORT XX for details REPORT XX tor detais. Source: CAP analysis of Centers for Medicare & Medicaid Services, "Cost Reports," available at https://www.cms.gov//esearch-statistics-da-t-and-system/downloadable-public-use-files/cost-reports/ (last accessed March 2019); CAP analysis of Jean Roth, "Healthcare Cost Report Information System (HCRIS) Data," available at https://www.nber.org/data/hcris.html (last accessed March 2019).

Operating margins-a measure of revenues and expenses directly associated with patient care—were 1 percent across the hospitals in CAP's sample. Operating margins were lower than total margins for all three categories of hospital ownership in 2016: 10 percent for for-profit hospitals, zero percent for nonprofit hospitals, and negative 3 percent for public hospitals. Hospitals in rural areas had slightly lower total margins than those in urban areas, at 6

If revenues and expenses beyond patient care are also included,¹⁸ then the hospitals' total profit margin in 2016 was 7 percent. There is wide variation in profitability among individual hospitals. Grouped by ownership type, for-profit hospitals had the highest total margin, at 11 percent. Total margins were lower among nonprofit hospitals (7 percent) and public hospitals (5 percent). Roughly one-quarter, or 27 percent, of hospitals lost money in in 2016, with public hospitals most likely to experience losses, at 40 percent. Total margins were negative for 26 percent of for-profit hospitals and 25 percent of nonprofit hospitals.

Total profit among the hospitals in CAP's sample was \$63.6 billion in 2016. That amount suggests that stronger rate regulation could save Americans tens of billions of dollars on hospital expenditures, even if rates were tailored to keep afloat loss-making hospitals that are crucial to patient access.

Determinants of hospital prices

Prices depend on where you live

percent and 8 percent, respectively.

Geographic variation in health care expenditures is well documented. Per capita health care expenditures in high-spending regions of the United States are about 40 percent higher than those in lower-spending regions.¹⁹ The variation spending among Medicare beneficiaries is largely driven by differences in

TABLE 1

utilization rather than in prices because reimbursement rates are set by the federal government, with some adjustment for regional costs.

Among the privately insured population, for whom reimbursement rates are negotiated between insurers and providers, prices play a much larger role in spending variation. A 2013 study by the National Academy of Medicine, formerly the Institute of Medicine, concluded that: "Variation in spending in the commercial insurance market is due mainly to differences in price markups by providers rather than to differences in the utilization of health care services." Regions with high spending tend to be those where providers have market power.²⁰

Pricing data for employer-sponsored plans show wide geographic variation in what hospitals are paid for care. Analyses of commercial claims from the Heath Care Cost Institute demonstrate the huge range of the price of care both within and across metropolitan areas.²¹ For example, the median price for a birth via a cesarean section delivery ranged from a low of \$3,636 in metropolitan Knoxville, Tennessee, to a high of \$20,721 in the San Francisco area. (see Figure 4)

FIGURE 4





Insured patients typically pay only a fraction of their hospital bills out of pocket, in the form of coinsurance or copayments, and most patients may not be aware of their hospitals' total charges. Nevertheless, the cost of high-priced care is passed on to consumers through health insurance premiums. The hospital markets with the least competition have health insurance marketplace premiums that are 5 percent higher than the average, a recent *Health Affairs* study found.²²

Prices depend on who is paying

There is a wide and growing gap between public and private rates. Although patients with private insurance account for one-third of hospital costs,²³ they are the source of most hospitals' profit. Private insurance rates for hospital services are well above hospitals' cost of providing care.

Although public and private reimbursement rates have indisputably diverged over time,²⁴ precise payment ratios depend on how supplemental governmental payments to hospitals are counted. According to the nonpartisan Medicaid and CHIP Payment and Access Commission, Medicaid reimbursement levels are generally higher than those of Medicare if supplemental payments are counted toward Medicaid payments.²⁵ A report by the Kaiser Family Foundation came to a similar conclusion. Without considering disproportionate share (DSH) payments to hospitals serving indigent populations, hospitals are reimbursed 93

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percent of cost for Medicaid patients. If DSH payments are included, Medicaid payments are 107 percent of cost.²⁶

Some recent studies have documented that private payment rates are much higher than of Medicare. Congressional Budget Office researchers estimated that the price of an inpatient stay was on average 189 percent of the Medicare rate in 2013.²⁷ Most recently, a RAND Corporation study found that employer-sponsored plans pay hospitals 241 percent of Medicare levels on average for inpatient and outpatient care, with some hospital systems receiving as little as 150 percent and as much as 400 percent of Medicare rates.²⁸ And a report on California hospitals found similar results, with private insurers paying 209 percent of Medicare rates.²⁹

Another commonly cited metric of hospital profitability is the payment-to-cost ratio, which represents average payment relative to average cost by payer, accounting for both patient-specific clinical costs and fixed costs such as equipment, buildings, or administrators' salaries. According to the American Hospital Association (AHA), private insurance payments average 144.8 percent of cost, while payments from Medicaid and Medicare are 88.1 and 86.8 percent of cost, respectively.³⁰

A separate but related question is how payment rates relate to marginal costs: If a hospital has an empty bed, can it expect to make or lose money by filling it with an additional patient? When rates are too low relative to the incremental cost of serving that patient, then hospitals have financial incentive to turn the patient away. Studies suggest that Medicare reimbursements are well above incremental cost. The Medicare Payment Advisory Commission (MedPAC) notes in its March 2019 report to Congress that Medicare payments exceed the marginal cost of caring for Medicare patients by 8 percent.³¹

However, because the degree to which hospitals manage their costs is a part of their business strategy, margins and payment-to-cost ratios may in fact understate the hospital industry's profitability.³² A hospital's costs—the denominator in the payment-to-cost ratio—are a combination of external factors such as the local costs for wages or utilities and the hospital's own behavior, including how efficiently it manages its resources.

A persistent argument in the debate over hospital payment is that hospitals engage in cost-shifting, raising prices on private payers to compensate for insufficient payment from public programs. There is scant evidence that hospitals have the ability to cost-shift and much stronger empirical evidence that high prices for private payers result from hospitals' market power.³³ An alternative explanation for the gap between public and private hospital rates is that hospitals that can demand high prices from private payers enjoy a bigger financial cushion and face less pressure to contain costs, which in turn makes Medicare and Medicaid payments look relatively low by comparison.³⁴

In support of the latter theory, a 2019 MedPAC analysis found that hospitals that face greater price pressure have lower costs. Relatively efficient hospitals, which MedPAC identified by cost and quality criteria, had higher total margins (8 percent) than less efficient hospitals (5 percent).³⁵ In other words, while it may be true that higher-priced hospitals have higher costs, such high-price hospitals also tend to operate inefficiently.

Hospitals' healthy bottom line

Given the disparity between the public and private reimbursement levels, the average payment a hospital receives depends on its payer mix. According to the

TABLE 2

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AHA, 40.8 percent of hospital costs are attributable to Medicare, 33.4 percent to private payers, 18.5 percent to Medicaid, and 4.2 to uncompensated care.³⁶ Together, these four payer categories are associated with 96.9 percent of hospital costs; the remainder of costs are associated with other government payers and nonpatient costs.

Payer	Payer share of hospital costs	Payment relative to Medicare
Medicare	40.8%	100%
Medicaid	18.5%	78%, 106%
Private payers	33.4%	189%, 241%
Jncompensated care	4.2%	0%
verage		134%
ote: The average among payers is weight emilipoints between the estimates for nd do not all cover the same time period course: CAP analysis of American Hospit rivate Payers, Medicare, and Medicaid, 1 e44.pdf Peter Cunningham and other ox Henry J. Kaiser Family Foundation, 2020 hilds payments and hei-impact-of-recent ommercial and Medicare Advantage FB Instangher Whaley, "Prices Pails to Hospit Physioner Whaley, "Prices Pails to Hospit Physioner 2010 analable at https://www.rap.	ted according to the American Health Association's reported shar private insurance and for Medicaid payment ratios. Data points in al. Association, "Trendwatch (Chartbook 2018; Table 44: Aggregate 995 – 2016" (Chicago: 2018), available at https://www.aha.org/syste 995, "Understanding Medicaid Hospital Payments and the Impact of 16), available at https://www.kf.org/report-section/understanding points-size-size-birde/i.i.ared Lame Meda and Lybe Neison," ns: 2017 Annual Research Meeting Academythealth' (Washington: ystern/filev/11 bit-congress-2017-2018/presentation/52819-press table by Private Health Plans Are High Relative to Medicare and Van el onnoub/research resourch (Was103).	e of patient costs by payer. CAP used the table come from multiple sources Hospital Payment-to-cost Ratios for terr/Sie2/2018-05/2018-chartbook-ta- Recent Policy Changes' Can Francis- rmedicaid-hos- An analysis of Hospital Prices for .U.S. Congressional Budget Office, instanon, df (Chapin White and y Widely' (Santa Monica, CA: RAND

A number of studies have reported hospital reimbursements by payer relative to Medicare levels;³⁷ the results are synthesized in Table 2. Combining the AHAreported payer mix with published estimates of rates relative to Medicare, CAP estimates that hospitals receive approximately 134 percent of Medicare rates across their main payers.

Payment reforms could achieve even greater savings if hospitals that currently lack competition were pressured to operate more efficiently and lower their costs. Current Medicare rates are designed to cover the costs that "reasonably efficient providers would incur in furnishing high-quality care."³⁸ This suggests that on average, hospitals are receiving payments that are well above what is needed to cover costs under efficient operation. Given that hospitals currently enjoy an 8 percent margin, average reimbursement across the major payers could be reduced down to 124 percent of Medicare rates while still enabling the industry as a whole to cover its current costs.

Policies to reduce the cost of hospital care

Several policy options could bring down hospital costs, many of which have already been implemented at the federal or state level, bringing down prices and slowing the growth of hospital expenditures. Hospital payment rates could be brought down directly through all-payer rate setting, reference pricing, or regulations to cap rates. Federal policies to improve competition in hospital markets-including stronger antitrust enforcement, fairer payment rules, and greater transparency-could also bring down prices and tame the growth of American hospital costs.

Ending abusive hospital billing practices

At a minimum, congressional and state legislators should act to stop the one of the most egregious billing practices associated with hospital care: surprise billing. Surprise bills typically come from out-of-network physicians working in an in-network facility and can also arise from emergency situations in which patients cannot be expected to locate an in-network provider, such as when suffering trauma from a bike accident or after being dropped off by an air ambulance.³⁹
More than a dozen states have already passed legislation to protect patients from surprise bills.⁴⁰ Bipartisan bills proposed in the U.S. House of Representatives and U.S. Senate within the past few months provide promising options for relief from surprise bills.⁴¹ To bring down the overall cost of hospital-based care, laws aimed at curbing the practice ought to not only provide protection to the patients who would be billed for excessive charges but also prevent providers from charging insurers rates that are far beyond the norm.

Reference pricing

Short of broad-based government action on hospital rates, individual payers can take steps to cut the cost of hospital care through reforms such as reference pricing. Under reference pricing, a payer sets the maximum it will pay for a service or bundle of services, which could be tied to a percentile in commercial claims or to Medicare rates. Providers that decline to accept the reference price are either excluded from the payer's network, or patients who choose that provider take responsibility for paying the difference out of pocket. Reference pricing incentivizes patients to visit lower-cost providers and puts pressure on providers to lower costs in order to keep their business.

Several states have implemented forms of reference pricing for public plans. The California Public Employees' Retirement System was among the first payers to adopt reference pricing for a limited set of scheduled procedures, including cataract surgery and joint replacements.⁴² Montana took a broader approach for its state employee plan by setting a reference price for all hospital services that average 234 percent of Medicare rates.⁴³ In Oregon, the state legislature passed a bill to set provider reimbursements for the state employee plans at 200 percent of Medicare.⁴⁴ And in Washington state, a new public option to be offered through the state's health insurance marketplace will cap aggregate provider payments at 160 percent of what Medicare pays.⁴⁵

Rate regulation

The most direct way for state or federal regulators to lower hospital prices would be to simply set reimbursement rates or cap them. By setting or capping all payers' rates closer to costs, state or federal regulators could bring down current hospital prices while also slowing price inflation. For example, former Obama administration officials Robert Kocher and Donald M. Berwick suggest capping hospital prices at 120 percent of current Medicare rates.⁴⁶ Others have suggested 125 percent of Medicare rates as a starting point.⁴⁷

Even with rates set to hit close to the current average and to allow efficient hospitals to earn some profit, rate regulation could generate savings by simplifying hospital administration and eliminate the need for rate negotiations between hospitals and payers.⁴⁸ Alternatively, assuming hospitals could cut costs by operating more efficiently, all-payer rates could be set below current levels to capture further savings.

Using AHA data, Stanford University researchers Kevin A. Schulman and Arnold Milstein calculated that reimbursing all hospital care at Medicare rates—as proposed in Sen. Bernie Sanders' (I-VT) Medicare for All bill—would reduce total payments by 15.9 percent, or \$151 billion among hospitals nationwide.⁴⁹ However, while hospitals and physicians could respond to rate cuts by reducing costs—for example, by improving efficiency—they may also attempt to make up for lost revenue. Faced with changes to prices alone, hospitals might increase the volume of services or shift their business toward higher-margin, lower-value services.

Rate regulation is most effective when combined with other payment reforms. Global budgeting can tame overall hospital costs by limiting the total amount spent on services rather than just the price at which care is provided. One of the most successful examples of state rate reform took place in Maryland, which has used all-payer rate-setting to regulate cost growth since the 1970s and, more recently, adopted global budgets for hospitals.⁵⁰

Regardless of the regulatory mechanism, lower payment levels present a tradeoff between cost-savings and patient access. Any rate-setting proposal should consider the financial sustainability of providers which is crucial to patient access, particularly those providers with already-low margins or located in rural areas, as well as the pace at which hospitals would be expected to adapt to major payment reforms.

Hospital price transparency

One popular response to the opacity and variation in hospital pricing has been to call for more public information on pricing. Price transparency can be most helpful to insurers and employers that desire to direct patients toward lowercost care. Transparency has limited value for patients. First, much of hospital care isn't shoppable: A patient can't price-compare emergency rooms after a bike accident or switch to a lower-priced anesthesiologist in the middle of surgery. Second, the salient price for the patient is not the insurer's negotiated charge but the out-of-pocket cost, which is a percentage of charges or a flat amount.

In 2018, the CMS began enforcing the Affordable Care Act provision requiring each hospital to post its list prices online. The price lists, known as chargemasters, typically name services using billing code jargon rather than plain English descriptions,⁵¹ and the information is neither standardized nor centralized, making side-by-side comparisons difficult.⁵² Another limitation of publishing price information is that chargemasters bear only a loose relationship to the negotiated rates that insurers actually pay.⁵³ The Trump administration is considering forcing hospitals to disclose the rates they negotiate for providers, medical devices, and drugs—information providers generally consider proprietary.⁵⁴

More antitrust enforcement for the hospital industry

The growing market power of hospitals and large physician practice groups warrants greater antitrust enforcement to protect consumers and competition. For too long, hospital mergers that harm competition and raise prices have been allowed to slip through. ⁵⁵ While mergers between hospitals in close proximity have the greatest effect on prices, ⁵⁶ economic research shows that cross-market mergers can also result in higher hospital prices by weakening insurers' bargaining power. ⁵⁷ Given the wealth of evidence that market power raises hospital costs without commensurate improvements in care quality, antitrust authorities should set a higher bar for hospital mergers and monitor health systems' anti-competitive conduct. The Federal Trade Commission and the U.S. Department of Justice need greater resources in order to monitor the large volume of mergers in the health care industry. ⁵⁸

Site-neutral payments

Medicare payment rules have generally paid higher rates for a service when delivered by a hospital than in another setting. In some cases, this means that Medicare is currently paying too much for services that could safely and

effectively be performed by other providers or facilities. In addition, the differential between hospital and nonhospital rates financially incentivizes hospital systems to acquire physician practices, thereby leading to greater consolidation among providers. Medicare payments for procedures that can be safely performed in nonhospital settings such as ambulatory surgery centers or physician offices should not stack the deck in favor of hospitals.

The CMS has already altered its payment rules to impose site neutrality for payments to ambulatory care centers and hospital outpatient services, which is expected to save \$760 million in 2019.⁵⁹ Expanding site neutrality policies to level payments across additional settings⁶⁰ such as between physician offices and hospitals outpatient departments, where clinically appropriate, would benefit taxpayers and Medicare beneficiaries alike.

Conclusion

The variation in hospital prices across markets, across payers, and over time demonstrates that many Americans are paying more than needed for hospital care. The industry overall remains highly profitable and, after decades of rapid consolidation, exercises tremendous power over payers in many markets. The rise in hospital prices, in turn, continues to drive up premiums and cost-sharing for patients, hitting individuals who have commercial insurance the hardest.

Serious efforts to control health care costs will require addressing the largest sources of U.S. health expenditures. Hospital payment reform is needed to lower costs and improve equity among patients and among payers.

About the author

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Appendix: Methodology

The Healthcare Cost Report Information System (HCRIS) data analysis in this report has been restricted to a sample of nonfederal, acute care hospitals, a subset of all hospitals included in the HCRIS. Data are for fiscal year 2016, the most recent year for which the CMS has a nearly complete set of hospital cost filings. The CMS audits only a small portion of the HCRIS reports for data related to hospital financing, and thus many data fields in the cost reports contain unreasonable values and other errors. CAP downloaded HCRIS datasets formatted for Stata statistical software from the National Bureau of Economic Research⁶¹ and supplemented those data with additional variables from the original HCRIS files available from the CMS.

Although hospitals are required to file cost reports annually, some reports contain more or less than 12 months of data. The analysis is restricted to hospitals filing reports covering 10 months to 14 months of data, a "full-year"

definition suggested by the CMS for the purposes of analysis.⁶² This analysis also excludes hospitals with total margins above 50 percent or below negative 50 percent, values that likely resulted from erroneous data. After exclusions, CAP's analytic sample comprises 3,062 hospitals.

Endnotes

Expand \sim

- 1 Ashley Kirzinger and others, "KFF Election Tracking Poll: Health Care in the 2018 Midterms" (Washington: Kaiser Family Foundation, 2018), available at <u>https://www.kff.org/health-reform/poll-finding/kff-election-tracking-poll-health-care-in-the-2018-midterms/.</u>
- 2 Centers for Medicare and Medicaid Services, "NHE Fact Sheet," available at <u>https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html</u> (last accessed June 2019).
- **3** Andrea M. Sisko and others, "National Health Expenditure Projections, 2018–27: Economic and Demographic Trends Drive Spending and Enrollment Growth," *Health Affairs* 38 (3) (2019).
- 4 Centers for Medicare and Medicaid Services, "NHE Fact Sheet."
- 5 Institute of Medicine, "Variation in Health Care Spending: Target Decision Making, Not Geography" (Washington: 2013), available at https://www.ncbi.nlm.nih.gov/books/NBK201637/.
- 6 Medicare Payment Advisory Commission, "March 2019 Report to the Congress: Medicare Payment Policy" (Washington: 2019), available at <u>http://www.medpac.gov/docs/default-</u> <u>source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0;</u> American Hospital Association, "Trendwatch Chartbook 2018: Table 4.1" (Chicago, 2018), available at
- https://www.aha.org/system/files/2018-05/2018-chartbook-table-4-1.pdf. 7 American Hospital Association, "Trendwatch Chartbook 2018: Table 4.1."
- 8 Joe Cantlupe, "Outpatient Care Expansion Comes Under Scrutiny," HealthLeaders Media, February 1, 2012, available at <u>https://www.healthleadersmedia.com/strategy/outpatient-care-expansion-comes-</u> under-scrutiny?page=0%2C1.
- **9** American Hospital Association, "Trendwatch Chartbook 2018: Table 4.2" (Chicago, 2018), available at https://www.aha.org/system/files/2018-05/2018-chartbook-table-4-2.pdf.
- 10 American Hospital Association, "Trendwatch Chartbook 2018: Chart 2.9" (Chicago, 2018), available at <u>https://www.aha.org/system/files/2018-05/2018-chartbook-chart-2-9.pdf.</u>
- 11 Emily Gee and Ethan Gurwitz, "Provider Consolidation Drives Up Health Care Costs: Policy Recommendations to Curb Abuses of Market Power and Protect Patients" (Washington: Center for American Progress, 2018), available at <u>https://americanprogress.org/issues/healthcare/reports/2018/12/05/461780/provider-consolidation-drives-health-care-costs/.</u>
- 12 Sunita Desai and J. Michael McWilliams, "Consequences of the 340B Drug Pricing Program," New England Journal of Medicine (378) (2018): 539–548.
- 13 Emily Gee and Ethan Gurwitz, "Provider Consolidation Drives Up Health Care Costs."
- 14 Zack Cooper and others, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured" (Cambridge, MA: National Bureau of Economic Research,

2015).

- **15** *People of the state of California ex rel. Xavier Becerra v. Sutter Health*, Complaint for violations of the Cartwright Act, Superior Court of the State of California for the City and County of San Francisco (March 29 2018), available at https://oag.ca.gov/system/files/attachments/press_releases/Sutter%20Complaint.pdf.
- 16 Health Care Cost Institute, "Healthy Marketplace Index," available at <u>https://healthcostinstitute.org/research/hmi/hmi-interactive#HMI-Price-Index</u> (last accessed June 2019).
- **17** Zach Cooper and others, "Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007–14," *Health Affairs* 38 (2) (2019).
- **18** Examples of nonoperating revenues and expenses for hospitals include those related to parking lots, gift shops, donations, public appropriations, and investments.
- 19 Institute of Medicine, "Variation in Health Care Spending."
- 20 Ibid.
- **21** Kevin Kennedy, "Past the Price Index: Exploring Actual Prices Paid for Specific Services by Metro Area," Health Care Cost Institute, April 30, 2019, available at https://www.healthcostinstitute.org/blog/entry/hmi-2019-service-prices.
- 22 Andrew S. Boozary and others, "The Association Between Hospital Concentration And Insurance Premiums In ACA Marketplaces," *Health Affairs* 38 (4) (2019).
- **23** American Hospital Association, "Trendwatch Chartbook 2018: Chart 4.5" (Chicago: 2018), available at <u>https://www.aha.org/system/files/2018-05/2018-chartbook-chart-4-5.pdf</u>.
- 24 Thomas Selden and others, "The Growing Difference Between Public And Private Payment Rates For Inpatient Hospital Care," *Health Affairs* 34 (12) (2015); Chapin White and Christopher Whaley, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely" (Santa Monica, CA: RAND Corporation, 2019), available at <u>https://www.rand.org/pubs/research_reports/RR3033.html</u>.
- 25 See slide 25 in Chris Park, "Comparing Medicaid Hospital Payment Across States and to Medicare" (Washington: Medicaid Payment Advisory Commission, 2016), available at <u>https://www.macpac.gov/wp-content/uploads/2016/09/Comparing-Medicaid-</u> Hospital-Payment-Across-States-and-to-Medicare.pdf.
- 26 Peter Cunningham and others, "Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes" (San Francisco: Kaiser Family Foundation, 2016), available at <u>http://files.kff.org/attachment/issue-brief-understanding-medicaidhospital-payments-and-the-impact-of-recent-policy-changes.</u>
- 27 Jared Maeda, "An Analysis of Hospital Prices for Commercial and Medicare Advantage Plans," (Washington: Congressional Budget Office, 2017), available at <u>https://www.cbo.gov/publication/52819</u>.
- 28 White and Whaley, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely."
- 29 Richard Kronick and Sarah Hoda Neyaz, "Private Insurers' Payments to California Hospital Average More Than Double Medicare's Payments" (Washington: West Health Policy Center, 2019), available at <u>https://www.westhealth.org/resource/privateinsurance-payments-to-california-hospitals-average-more-than-double-medicarepayments/.</u>
- **30** American Hospital Association, "Trendwatch Chartbook 2018: Table 4.4" (Chicago: 2018), available at <u>https://www.aha.org/system/files/2018-05/2018-chartbook-table-4-4.pdf</u>.

31 Medicare Payment Advisory Commission, "March 2019 Report to the Congress."

- 32 Kevin A. Schulman and Arnold Milstein, "The Implications of 'Medicare for All' for US Hospitals," *Journal of the American Medical Association* 321 (17) (2019): 1661–1662.
- 33 Austin B. Frakt, "How Much Do Hospitals Cost Shift? A Review of the Evidence," Millbank Quarterly 89 (1) (2011): 90–130, available at <u>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160596</u>.
- 34 Kronick and Neyaz, "Private Insurers' Payments to California Hospital Average More Than Double Medicare's Payments"; White and Whaley, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely."
- 35 Medicare Payment Advisory Commission, "March 2019 Report to the Congress."
- 36 American Hospital Association, "Trendwatch Chartbook 2018: Chart 4.5."
- 37 White and Whaley, "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely"; Maeda, "An Analysis of Hospital Prices for Commercial and Medicare Advantage Plans"; Cunningham and others, "Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes."
- 38 Medicare Payment Advisory Commission, "Hospital Acute Inpatient Services Payment System" (Washington: 2018), available at <u>http://medpac.gov/docs/default-</u> <u>source/payment-basics/medpac_payment_basics_18_hospital_final_v2_sec.pdf?</u> <u>sfvrsn=0.</u>
- 39 Sarah Kliff, "After Vox story, Zuckerberg hospital promises to change its aggressive billing tactics," Vox, February 1, 2019, available at <u>https://www.vox.com/2019/2/1/18206893/zuckerberg-hospital-er-surprise-billingsuspension</u>; Kaiser Health News, "Year One of KHN's 'Bill Of The Month': A Kaleidoscope Of Financial Challenges," December 21, 2018, available at <u>https://khn.org/news/year-one-of-khns-bill-of-the-month-a-kaleidoscope-of-financialchallenges/.</u>
- 10 Thomas Waldrop, "Meaningful Protection from Surprise Medical Bills," Center for American Progress, February 22, 2019, available at <u>https://americanprogress.org/issues/healthcare/news/2019/02/22/466565/meaningful-protection-surprise-medical-bills/.</u>
- **41** Loren Adler and others, "Breaking Down the Bipartisan Senate Group's New Proposal to Address Surprise Billing," Health Affairs Blog, May 21, 2019, available at https://www.healthaffairs.org/do/10.1377/hblog20190521.144063/full/.
- 42 J.C. Robinson and others, "Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications.," JAMA Internal Medicine 175 (11) (2015): 1783–1789.
- **43** Julie Appleby, "Holy Cow' Moment Changes How Montana's State Health Plan Does Business," Kaiser Health News, June 20, 2018, available at <u>https://khn.org/news/holy-</u> <u>cow-moment-changes-how-montanas-state-health-plan-does-business/</u>.
- 14 Hillary Borrud, "Oregon Democrats want to bring back double health insurance for state, school workers," *The Bulletin*, April 5, 2019, available at <u>https://www.bendbulletin.com/localstate/7067642-151/oregon-democrats-want-to-</u> bring-back-double-health.
- 45 Joan Altman, Christine Gibert, and Michael Marchand, "Cascade Care Implementation" (Seattle: Washington Health Benefit Exchange, 2019), available at <u>https://www.wahbexchange.org/wp-content/uploads/2018/12/HBE_AC_Cascade-Care-Implementation_190507.pdf</u>
- **16** Robert Kocher and Donald M. Berwick, "While Considering Medicare For All: Policies For Making Health Care In The United States Better," Health Affairs Blog, June 6, 2019, available at

https://www.healthaffairs.org/do/10.1377/hblog20190530.216896/full/.

- **47** Jonathan Skinner, Elliott Fisher, and James Weinstein, "The 125 Percent Solution: Fixing Variations In Health Care Prices," Health Affairs Blog, August 26, 2014, available at <u>https://www.healthaffairs.org/do/10.1377/hblog20140826.041002/full/</u>.
- 18 Emily Gee and Topher Spiro, "Excess Administrative Costs Burden the U.S. Health Care System" (Washington: Center for American Progress, 2019), available at <u>https://americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/.</u>
- 19 Schulman and Milstein, "The Implications of 'Medicare for All' for US Hospitals."
- 50 Harold Cohen, "Maryland's All-Payor Hospital Payment System" (Baltimore: Maryland Health Services Cost Review Commission, 2010) available at <u>https://hscrc.state.md.us/Documents/pdr/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf</u>; Arnav Shah and others, "Maryland's Global Budget Program: Still an Option for Containing Costs" (New York: The Commonwealth Fund, 2018), available at <u>https://www.commonwealthfund.org/blog/2018/marylands-global-budgetprogram-still-option-containing-costs</u>.
- 51 Katherine Hempstead and Chapin White, "Plain Talk About Price Transparency," Health Affairs Blog, March 25, 2019, available at https://www.healthaffairs.org/do/10.1377/hblog20190319.99794/full/.
- 52 Harris Meyer, "Hospitals vary in publishing CMS chargemaster price," Modern Healthcare, January 7, 2019, available at <u>https://www.modernhealthcare.com/article/20190107/TRANSFORMATION04/1901099</u> <u>31/hospitals-vary-in-publishing-cms-chargemaster-prices</u>.
- 53 Michael Batty and Benedic Ippolito, "Mystery Of The Chargemaster: Examining The Role of Hospital List Prices in What Patients Actually Pay," *Health Affairs* 36 (4) (2017).
- 54 American Hospital Association, "WSJ: Administration may try to publicize rates providers negotiate with insurers," March 8, 2019, available at <u>https://www.aha.org/news/headline/2019-03-08-wsj-administration-may-try-publicize-rates-providers-negotiate-insurers.</u>
- 55 Ibid.
- 56 Cooper and others, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured."
- 57 Leemore Dafny, Kate Ho, and Robin S. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry" (Washington: National Bureau of Economic Research, 2016).
- 58 Federal Trade Commission, "Remarks of Commissioner Rebecca Kelly Slaughter: Antitrust and Health Care Providers: Policies to Promote Competition and Protect Patients," Press release, May 14, 2019, available at <u>https://www.ftc.gov/public-statements/2019/05/remarks-commissioner-rebecca-kelly-slaughter-antitrust-health-care.</u>
- 59 Centers for Medicare and Medicaid Services, "CMS proposes Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System changes for 2019 (CMS-1695-P)," July 25, 2018, available at <u>https://www.cms.gov/newsroom/fact-sheets/cms-proposes-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center.</u>
- 30 Loren Adler and others, "CMS' positive step on site-neutral payments and the case for going further," (Washington: Brookings Institution, 2018), available at <u>https://www.brookings.edu/blog/usc-brookings-schaeffer-on-healthpolicy/2018/08/10/cms-positive-step-on-site-neutral-payments-and-the-case-for-goingfurther/.</u>
- 61 Jean Roth, "Healthcare Cost Report Information System (HCRIS) Data," National Bureau of Economic Research, available at <u>https://www.nber.org/data/hcris.html</u> (last

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accessed March 2019).

52 Kimberly Andrews, "Analyzing Hospital Medicare Cost Report Data Using SAS" (Williamsburg, VA: Southeast SAS Users Group, 2018), available at https://www.lexjansen.com/sesug/2018/SESUG2018_Paper-287_Final_PDF.pdf.

Section III, Project Purpose, Background and Alternatives – Information Requirements Criterion 1110.110(d), Project Purpose, Background and Alternatives

Alternatives

The Applicants explored several options prior to determining to add neurological (spine) surgery and orthopedics to its ASTC. The options considered are as follows:

Do nothing;

Utilize existing facilities; and

Add neurological (spine) surgery and orthopedics to the existing ASTC.

After exploring these options, which are discussed in more detail below, the Applicants decided to add neurological (spine) surgery and orthopedics to its ASTC. A review of each of the options considered and the reasons they were rejected follows.

Do Nothing

The first alternative considered was to maintain the status quo, whereby the Applicant would continue to perform previously approved surgical specialties at Innovia. The primary purpose of this project is to improve access to neurological (spine) surgery and orthopedics to patients within the Applicants' geographic service area and to increase utilization at Innovia, which currently has capacity.

The recent COVID-19 pandemic and advanced technology accelerated the shift from traditional hospital outpatient departments ("HOPD") to ambulatory surgical centers ("ASC"). Further, spinal surgery in the ASC setting has gained popularity with providers, patients and healthcare systems due to its efficiency and cost advantages combined with comparable clinical results. The shift to outpatient spinal surgery in ASCs has mirrored improvements in anesthesia protocols, pain management, perioperative infections, outcomes, and patient satisfaction with the ability for patients to leave the facility the same day and recover in the comfort of their own home. In addition to the clinical benefits, the transition is fueled by system wide financial concerns of escalating health care costs, which rise at a faster rate than the average annual income. With advances in surgical technique, anesthesia, and post operative care, the list of spine cases performed in ASCs has increased to include, Microlumbar discectomy, Lumbar laminectomy, Vertebroplasty, Kyphoplasty, Anterior cervical discectomy and fusion (ACDF) 1 or 2 level, Posterior cervical foraminotomy, Cervical disc arthroplasty 1 or 2 level, Lumbar fusions 3 or more level. The shift to outpatient spine surgery should continue as research supports the safety of these procedures, allowing patients to decrease their length of stay and overall healthcare costs.²⁴

Moreover, ASCs are becoming a more attractive location for physicians and patients. Physicians can operate in an environment over which they have more control, e.g., procurement, streamlined scheduling, and access to highly skilled staff, which enhances their ability to provide outstanding care and reduces burnout.²⁵ Patients benefit because it's a more accommodating environment with patients who are less

²⁴ Gerling MC, Hale SD, White-Dzuro C, Pierce KE, Naessig SA, Ahmad W, Passias PG. Ambulatory spine surgery. J Spine Surg. 2019 Sep;5(Suppl 2):S147-S153. doi: 10.21037/jss.2019.09.19. PMID: 31656868; PMCID: PMC6790803 available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6790803/ #:~:text=The%20shift%20to%20outpatient%20spinal,comfort%20of%20their%20own%20home. (last

^{#:~:}text=1 he%20shift%20to%20outpatient%20spinal,comfort%20of%20their%20own%20home. (last visited Oct. 19, 2023).

²⁵ Nader Samii, JD/MBA and Alison Kuley, *The Business of Moving Spine Cases to Surgery Centers,* BECKER'S ASC REVIEW (Sep. 15, 2023) *available at* https://www.beckersasc.com/outpatient-spine/the-

sick; surgical outcomes are equivalent to hospitals, and they are less costly and less susceptible to propagating drug-resistant infections.²⁶ ASCs offer a faster and more efficient care model, which provides more effective care. Additionally, patients in ASCs generally require fewer medications, which reduces opioid consumption, and have lower infection rates with over 50% of ASCs reporting no infections, which is integral in reducing the spread of drug-resistant infections. All of this is borne out in significantly higher patient satisfaction scores for ASCs, 92% compared to 70% in hospitals.²⁷

Finally, Medicare and other payors generate significant savings when spine surgeries are performed in an ASC. Spine surgeries in an ASC typically cost 45-60 percent less than a hospital and can be as much as 90 percent less. Overall, researchers estimate that ASCs deliver an annual cost savings of \$40 billion per year

While this alternative would result in no cost to the Applicants (compared to the nominal cost of adding the service), maintaining the status quo would not allow physicians can operate in an environment over which they have more control, which enhances care and reduces burnout. Patients would not benefit from a more accommodating environment with surgical outcomes are equivalent to hospitals in a less costly setting. Medicare and other payors would not benefit from the significant savings when spine and orthopedic surgeries are performed in an ASC.

Finally, surgical providers routinely make capital investments at the level contemplated by this application, so these investments are essentially ordinary course capital investments, which are well under the capital expenditure minimum for surgery centers.

There is no cost to this option.

Utilize Other Health Care Facilities

Another alternative the Applicant considered was utilizing existing health care facilities to provide an option for neurological (spine) surgery and orthopedics. As previously stated, no surgery center within the Innovia GSA is approved for both neurological surgery and orthopedics and provides the same levels of Medicaid and charity care as Innovia.

While there are 7 acute care hospitals and 23 ambulatory surgical treatment centers located within the Innovia GSA. Utilizing hospitals for procedures that can be safely performed in an outpatient surgery center is not an efficient use of scarce health care resources. A 2019 report by the Center for American Progress noted the escalation in health care costs is largely attributed to high prices charged by hospitals.²⁸ This report highlighted that "hospitals are able to sustain profits and high prices because of their market power, which has grown as competition has dwindled and providers have consolidated."²⁹ Prices set by hospitals are discretionary and not connected to underlying costs or market prices. Further,

business-of-moving-spine-cases-to-surgery-centers.html#:~:text=Spine%20surgeries%20in%20an %20ASC,of%20%2440%20billion%20per%20year. (last visited Oct. 19, 2023).

²⁶ Becker's Spine Review, Spine Surgery in the ASC (Aug. 31, 2023) available at https://www.beckersspine.com/ featured-insights/57683-spine-surgery-in-the-asc-a-win-for-patientsand-physicians.html#:~:text=An%20ASC%20is%20an%20attractive,to%20propagating%20drug%2 Dresistant%20infections. (last visited Oct. 19, 2023).

²⁷ Samii, *supra* note 2.

²⁸ Emily Gee, *The High Price of Hospital Care*, CTR. AM. PROGRESS, 1, Jun. 2019 *available at* <u>https://www.americanprogress.org/wp-content/uploads/sites/2/2019/06/HospitalCosts-report.pdf</u> (last visited Aug. 31, 2023).

according to the March 2023 MedPac Report to Congress, Medicare payment rates for most ambulatory surgical procedures performed in HOPDs are almost twice as high as in surgery centers.³⁰.

As discussed more fully in Section 1110.110(b), no licensed ASTC within Innovia's GSA offers neurological surgery and orthopedics while providing the levels of Medicaid and charity care as Innovia. Innovia seeks to improve access to these much-needed surgical procedures to economically disadvantaged patients in its community. Accordingly, there are no options within the Innovia GSA for these vulnerable patients.

Due to the underutilization of the surgery center and infeasibility of utilizing other providers, this alternative was rejected.

There is no cost to this option.

Add Neurological (Spine) Surgery and Orthopedics to the Existing ASTC

As more fully discussed above, Innovia has capacity to add more procedures. To increase utilization at the surgery center while at the same time increasing access to neurological (spine) surgery and orthopedics in a lower cost setting, Innovia decided to request the addition of neurological (spine) surgery and orthopedics to its existing ASTC. After weighing this low-cost option against others, it was determined that this alternative would provide the greatest benefit in terms of increased utilization and increased access to neurological (spine) surgery and orthopedics services.

The cost of this option is \$1,667,275

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³⁰ Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy 161 (Mar. 15, 2023) available at <u>https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_</u> Report_To_Congress_SEC.pdf (last visited July 5, 2023).

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

The Applicant proposes to add neurological (spine) surgery and orthopedics to an existing ASTC. Pursuant to Section 1110, Appendix B of the State Board's rules, the State standard is 2,750 gross square feet per operating room for a total of 5,500 gross square feet for 2 operating rooms. The total gross square footage of the clinical space of Innovia is 3,850 gross square feet (or 1,925 GSF per operating room). Accordingly, Innovia meets the State standard per operating room.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC	3,850	5,500	N/A	Below State Standard

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

The ASTC's annual utilization shall improve to be closer to the State Board's utilization standard. Importantly, Innovia is not adding capacity to the planning area, but is trying to increase utilization of its existing surgery center to be closer to the State Board standard by adding cases. In 2021, 540 surgical procedures (or 945 surgical hours) were performed at Innovia. Based on the application for Project. No. 23-023, Dr. Vipul Singhal anticipates referring 260 general dentistry cases to Innovia, and as documented in the physician referral letters attached at Appendix – 1, Dr. Robert Erickson anticipates referring 42 spine cases to Innovia within the first year after project completion and Dr. Samuel Park anticipates referring 60 orthopedic cases. Based upon Dr. Erickson's and Dr. Park's current experience, additional estimated surgical hours, including prep and cleanup, in the first year after project completion are as follows:

Surgical Specialty	Projected Referrals	Estimated Surgical Time	Estimated Total Surgical Hours After First Year Project Completion
OB/Gynecology	538	1.75 hours	945
General Dentistry	260	2 hours	520
Orthopedics	60	1.7 hours	102
Neurological (Spine Surgery)	42	1.7 hours	71
ENT	192	1.3 hours	250
Plastics	96	2.3 hours	221
Total	1,188		2,109

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

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

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

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

Section V, Service Specific Review Criteria Non-Hospital Based Ambulatory Surgery Criterion 1110.235(c)(2)(B), Service to GSA Residents

- Attached at Attachment 25A is a map outlining the intended GSA for Innovia. As set forth in Criterion 1110.110(b), the surgery center will serve patients residing in and around Wood Dale. Accordingly, the intended primary GSA consists of those areas within a 10-mile radius from Innovia.
- 2. Pursuant to Section 1100.510(d) of the State Board's rules, the normal drive time should be based upon the location of the applicant facility. Innovia is located in Wood Dale, and therefore the intended GSA is the radius of 10 miles from Innovia. A list of all zip codes located, in whole or in part, within a 10-mile radius of Innovia as well as the 2021 U.S. Census estimates for each zip code is provided in Table 1110.235(c)(2)(B)(i).

Table 1110.235(c)(2)(B)(i) Population within Geographic Service Area			
Zip Code	City	Population	
60004	Arlington Heights	52,334	
60005	Arlington Heights	29,622	
60007	Elk Grove Village	33,048	
60008	Rolling Meadows	23,191	
60016	Des Plaines	62,140	
60018	Des Plaines	29,161	
60056	Mount Prospect	56,912	
60068	Park Ridge	39,531	
60070	Prospect Heights	15,875	
60101	Addison	37,765	
60104	Bellwood	18,785	
60106	Bensenville	20,694	
60108	Bloomingdale	23,703	
60126	Elmhurst	47,822	
60131	Franklin Park	18,409	
60133	Hanover Park	37,545	
60137	Glen Ellyn	38,648	
60139	Glendale Heights	33,520	
60143	Itasca	11,673	
60148	Lombard	53,072	
60153	Maywood	23,547	
60154	Westchester	16,837	
60155	Broadview	8,005	
60157	Medinah	2,553	
60160	Melrose Park	25,417	
60162	Hillside	8,286	
60163	Berkeley	5,307	
60164	Melrose Park	21,719	

Table 1110.235(c)(2)(B)(i)			
Populatio	n within Geographic	Service Area	
Zip Code	Zip Code City		
60165	Stone Park	4,611	
60169	Hoffman Estates	34,188	
60171	River Grove	10,571	
60172	Roselle	24,407	
60173	Schaumburg	14,016	
60176	Schiller Park	11,680	
60181	Villa Park	30,488	
60187	Wheaton	30,465	
60191	Wood Dale	14,136	
60193	Schaumburg	40,150	
60194	Schaumburg	20,467	
60195	Schaumburg	4,865	
60305	River Forest	11,742	
60523	Oak Brook	10,173	
60630	Chicago	55,591	
60631	Chicago	30,589	
60634	Chicago	77,520	
60656	Chicago	28,665	
60706	Harwood Heights	24,272	
60707	Elmwood Park	41,309	
60714	Niles	31,208	
Total		1,346,234	

United States Census Bureau, 2021: ACS 5-Year Estimates Data Profiles *available at* https:// https://data.census.gov/table?tid=ACSDP1Y2021.DP 05 (last visited Jul. 5, 2023).

3. Pursuant to Section 1100.510(d) of the State Board's rules, the intended geographic service area shall be a 10-mile radius time from the proposed ambulatory surgical treatment center. As set forth throughout this application, Innovia serves Wood Dale and the surrounding areas within a 10-mile radius of the surgery center. Travel times to and from Innovia to the GSA borders are as follows:

East: Approximate 10-mile radius to Harwood Heights Southeast: Approximate 10-mile radius to River Forest South: Approximate 10-mile radius to Oak Brook Southwest: Approximate 10-mile radius time to West Chicago West: Approximate 10-mile radius to Hanover Park Northwest: Approximate 10-mile radius to Hoffman Estates North: Approximate 10-mile radius to Arlington Heights Northeast: Approximate 10-mile radius to Niles 4. Patient origin information by zip code for Dr. Erickson's and Dr. Park's admissions for the last 12month period is provided in Table 1110.235(c)(2)(B)(ii) below.

Table 1110.235(c)(2)(B)(ii) Patient Origin by Zip Code			
Zip Code	City	Patients	
60018	Des Plaines	4	
60053	Morton Grove	1	
60074	Palatine	1	
60101	Addison	5	
60106	Bensenville	3	
60126	Elmhurst	6	
60131	Franklin Park	4	
60148	Lombard	5	
60164	Melrose Park	2	
60171	River Grove	8	
60172	Roselle	1	
60181	Villa Park	3	
60188	Carol Stream	1	
60195	Schaumburg	1	
60304	Oak Park	7	
60402	Berwyn	1	
60411	Chicago Heights	1	
60419	Dolton	4	
60430	Homewood	6	
60438	Lansing	5	
60445	Midlothian	1	
60452	Oak Forest	2	
60461	Olympia Fields	12	
60471	Richton Park	3	
60475	Steger	7	
60477	Tinley Park	6	
60525	LaGrange	5	
60618	Chicago	5	
60620	Chicago	4	
60623	Chicago	2	
60624	Chicago	3	
60629	Chicago	4	
60631	Chicago	1	
60632	Chicago	3	
60634	Chicago	8	
60638	Chicago	1	
60639	Chicago	5	
60641	Chicago	5	
60642	Chicago	4	
60644	Chicago	2	
60651	Chicago	1	
60652	Chicago	1	

Table 1110.235(c)(2)(B)(ii) Patient Origin by Zip Code			
Zip Code	City	Patients	
60706	Harwood Heights	8	
60707	Elmwood Park	4	
60804	Cicero	8	
Total	174		

#23-046

Innovia Surgery Center Geographic Service Area



Section V, Service Specific Review Criteria Non-Hospital Based Ambulatory Surgery Criterion 1110.235(c)(3) – Service Demand-Additional ASTC Service

The physician referral letters providing the number of patients referred to health care facilities within the past 12 months and the projected number of referrals to the surgery center is attached at Appendix - 1. A summary of the physician referral letter is provided in Table 1110.235(c)(3) below.

Table 1110.235(c)(3)			
Hospital/ASTC	Cases Performed in the Last 12 Months	Anticipated Referrals to Innovia	
Rogers Park Surgery Center	39	21	
Hyde Park Surgery Center	25	13	
Chicago Surgery Center	34	17	
Lakeshore Surgery Center	7	5	
Pinnacle Pain Management	14	10	
Illinois Back & Neck Institute	3	3	
APM Surgery Center	15	12	
Fullerton Kimball Medical and Surgical Center	29	15	
Barrington Ambulatory Surgery Center	1	1	
Thorek Memorial Hospital	2	2	
Grand Ave Surgery Center	5	3	
Total	174	102	

Section V, Service Specific Review Criteria Non-Hospital Based Ambulatory Surgery Criterion 1110.235(c)(5) Treatment Room Need Assessment

- Pursuant to Section 1100.640(c) of the State Board's rules, ambulatory surgical treatment centers should operate 1,500 per room per year (including setup and cleanup time). Innovia currently has two operating rooms with a capacity for 3,000 hours per year. In 2021, 540 surgical procedures (or 945 surgical hours) were performed at Innovia. Based on the application for Project. No. 23-023, Dr. Vipul Singhal anticipates referring 260 general dentistry cases to Innovia, and as discussed throughout this application, Dr. Erickson and Dr. Park anticipate referring 102 cases. Accordingly, the Applicants project 1,188 cases (or 2,109 surgical hours) will be referred to Innovia.
- 2. The Applicants estimate the average length of time will be 1.15 surgical hours and 35 minutes for prep and clean up for a total of 1.7 hours per spine and orthopedic procedure.

V, Service Specific Review Criteria Non-Hospital Based Ambulatory Surgery <u>Criterion 1110.235(c)(6), Service Accessibility</u>

The primary purpose of this project is to improve access to spine and orthopedic procedures to patients within the Applicants' geographic service area and to increase utilization Innovia, which currently has capacity.

The recent COVID-19 pandemic and advanced technology accelerated the shift from HOPDs to ASCs. Further, spinal surgery in the ASC setting has gained popularity with providers, patients and healthcare systems due to its efficiency and cost advantages combined with comparable clinical results. The shift to outpatient spinal surgery in ASCs has mirrored improvements in anesthesia protocols, pain management, perioperative infections, outcomes, and patient satisfaction with the ability for patients to leave the facility the same day and recover in the comfort of their own home. In addition to the clinical benefits, the transition is fueled by system wide financial concerns of escalating health care costs, which rise at a faster rate than the average annual income. With advances in surgical technique, anesthesia, and post operative care, the list of spine cases performed in ASCs has increased to include, Microlumbar discectomy, Lumbar laminectomy, Vertebroplasty, Kyphoplasty, Anterior cervical discectomy and fusion (ACDF) 1 or 2 level, Posterior cervical foraminotomy, Cervical disc arthroplasty 1 or 2 level, Lumbar fusions 1–2 levels (MIS-TLIF and LLIF), Posterior cervical fusion, ACDF 3 or more levels, and Lumbar fusions 3 or more level. The shift to outpatient spine surgery should continue as research supports the safety of these procedures, allowing patients to decrease their length of stay and overall healthcare costs.³¹

Moreover, ASCs are becoming a more attractive location for physicians and patients. Physicians can operate in an environment over which they have more control, e.g., procurement, streamlined scheduling, and access to highly skilled staff, which enhances their ability to provide outstanding care and reduces burnout.³² Patients benefit because it's a more accommodating environment with patients who are less sick; surgical outcomes are equivalent to hospitals, and they are less costly and less susceptible to propagating drug-resistant infections.³³ ASCs offer a faster and more efficient care model, which provides more effective care. Additionally, patients in ASCs generally require fewer medications, which reduces opioid consumption, and have lower infection rates with over 50% of ASCs reporting no infections, which is integral in reducing the spread of drug-resistant infections. All of this is borne out in significantly higher patient satisfaction scores for ASCs, 92% compared to 70% in hospitals.³⁴

Finally, Medicare and other payors generate significant savings when spine surgeries are performed in an ASC. Spine surgeries in an ASC typically cost 45-60 percent less than a hospital and can be as much as 90 percent less. Overall, researchers estimate that ASCs deliver an annual cost savings of \$40 billion per

³¹ Gerling MC, Hale SD, White-Dzuro C, Pierce KE, Naessig SA, Ahmad W, Passias PG. Ambulatory spine surgery. J Spine Surg. 2019 Sep;5(Suppl 2):S147-S153. doi: 10.21037/jss.2019.09.19. PMID: 31656868; PMCID: PMC6790803 available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6790803/ #:~:text=The%20shift%20to%20outpatient%20spinal,comfort%20of%20their%20own%20home. (last visited Oct. 19, 2023).

³² Nader Samii, JD/MBA and Alison Kuley, *The Business of Moving Spine Cases to Surgery Centers,* BECKER'S ASC REVIEW (Sep. 15, 2023) *available at* https://www.beckersasc.com/outpatient-spine/thebusiness-of-moving-spine-cases-to-surgery-centers.html#:~:text=Spine%20surgeries%20in%20an %20ASC,of%20%2440%20billion%20per%20year. (last visited Oct. 19, 2023).

³³ Becker's Spine Review, Spine Surgery in the ASC (Aug. 31, 2023) available at https://www.beckersspine.com/ featured-insights/57683-spine-surgery-in-the-asc-a-win-for-patientsand-physicians.html#:~:text=An%20ASC%20is%20an%20attractive,to%20propagating%20drug%2 Dresistant%20infections. (last visited Oct. 19, 2023).

³⁴ Samii, *supra* note 2.

year.35

There are 30 existing or approved health care facilities located within 10 miles of Innovia. Utilizing hospitals for procedures that can be safely performed in an outpatient surgery center is not an efficient use of scarce health care resources. A 2019 report by the Center for American Progress noted the escalation in health care costs is largely attributed to high prices charged by hospitals.³⁶ This report highlighted that "hospitals are able to sustain profits and high prices because of their market power, which has grown as competition has dwindled and providers have consolidated."³⁷ Prices set by hospitals are discretionary and not connected to underlying costs or market prices. Further, according to the March 2023 MedPac Report to Congress, Medicare payment rates for most ambulatory surgical procedures performed in hospital outpatient departments (HOPDs) are almost twice as high as in surgery centers.³⁸

While there are 23 licensed ASTCs within the Innovia 10-mile geographic service area ("GSA"), only seven are approved to provide both neurological surgery and orthopedics and only one of those (Loyola Surgery Center) accepts Medicaid patients. Innovia serves an economically disadvantaged community with significant minority populations. According to the 2020 U.S. Census Bureau estimate, 6% of residents of the Innovia GSA live at or below the Federal Poverty Level ("FPL").³⁹ Lack of health care access and education, and poverty has created health inequities in this community. Health inequities are differences in population health status and health conditions arising from social and economic inequalities.

Innovia has a proven track record of serving low-income patients. Innovia is Medicaid certified. Over the past four years, over 30% of its patients were Medicaid beneficiaries, compared to 3.7% in HSA 7, and 4% statewide.⁴⁰ For patients with a demonstrated hardship who do not qualify for Medicaid, Innovia provides highly discounted rates and free care. From 2019 to 2022, over 16% of patients qualified for charity care, which is significantly higher than the 0.1% of charity care patients served in 2021 by HSA 7 surgery centers and 0.3% throughout the State.⁴¹

³⁵ *Id.*

³⁶ Emily Gee, *The High Price of Hospital Care*, CTR. AM. PROGRESS, 1, Jun. 2019 *available at* <u>https://www.americanprogress.org/wp-content/uploads/sites/2/2019/06/HospitalCosts-report.pdf</u> (last visited Aug. 31, 2023).

³⁷ <u>Id</u>.

³⁸ Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy 161 (Mar. 15, 2023) available at <u>https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_</u> Report_To_Congress_SEC.pdf (last visited July 5, 2023).

³⁹ U.S. Census Bureau, American Community Survey, Poverty Status in the Past 12 Months available at https://data.census.gov/cedsci/table?q=poverty%20illinois&g=0400000US17&tid=ACSST1Y2018.S170 1&t=Poverty (last visited July 7, 2023).

⁴⁰ 2021 ASTC Facility Health Service Area Summary Reports; 2021 ASTC Facility State Summary Report.

⁴¹ <u>Id</u>.

Section V, Service Specific Review Criteria Non-Hospital Based Ambulatory Surgery Criterion 1110.235(c)(7), Unnecessary Duplication/Maldistribution

1. <u>Unnecessary Duplication of Services</u>

a. Innovia will remain in its current location at 203 East Irving Park Road, Wood Dale, Illinois. A map of the Innovia's market area is attached at Attachment – 25A. A list of all zip codes located, in whole or in part, within a 10-mile radius of Innovia as well as the 2021 U.S. Census estimates figures for each zip code is provided in Table 1110.235(c)(7)(A).

Table 1110.235(c)(7)(A)(i) Population within Geographic Service Area			
Zip Code	City	Population	
60004	Arlington Heights	52,334	
60005	Arlington Heights	29,622	
60007	Elk Grove Village	33,048	
60008	Rolling Meadows	23,191	
60016	Des Plaines	62,140	
60018	Des Plaines	29,161	
60056	Mount Prospect	56,912	
60068	Park Ridge	39,531	
60070	Prospect Heights	15,875	
60101	Addison	37,765	
60104	Bellwood	18,785	
60106	Bensenville	20,694	
60108	Bloomingdale	23,703	
60126	Elmhurst	47,822	
60131	Franklin Park	18,409	
60133	Hanover Park	37,545	
60137	Glen Ellyn	38,648	
60139	Glendale Heights	33,520	
60143	Itasca	11,673	
60148	Lombard	53,072	
60153	Maywood	23,547	
60154	Westchester	16,837	
60155	Broadview	8,005	
60157	Medinah	2,553	
60160	Melrose Park	25,417	
60162	Hillside	8,286	
60163	Berkeley	5,307	
60164	Melrose Park	21,719	
60165	Stone Park	4,611	
60169	Hoffman Estates	34,188	
60171	River Grove	10,571	

Table 1110.235(c)(7)(A)(i)			
Populatio	Population within Geographic Service Area		
Zip Code	Zip Code City		
60172	Roselle	24,407	
60173	Schaumburg	14,016	
60176	Schiller Park	11,680	
60181	Villa Park	30,488	
60187	Wheaton	30,465	
60191	Wood Dale	14,136	
60193	Schaumburg	40,150	
60194	Schaumburg	20,467	
60195	Schaumburg	4,865	
60305	River Forest	11,742	
60523	Oak Brook	10,173	
60630	Chicago	55,591	
60631	Chicago	30,589	
60634	Chicago	77,520	
60656	Chicago	28,665	
60706	Harwood Heights	24,272	
60707	Elmwood Park	41,309	
60714	Niles	31,208	
Total		1,346,234	

United States Census Bureau, 2021: ACS 5-Year Estimates Data Profiles *available at* https:// https://data.census.gov/table?tid=ACSDP1Y2021.DP 05 (last visited Jul. 5, 2023).

b. A list of all existing and approved surgery centers located within the Innovia geographic service area is provided in Table 1110.235(c)(7)(A)(ii) below.

Table 1110.235(c)(7)(A)(ii) Facilities within 10 Miles of Innovia Surgery Center				
Facility Name	Address	City	Straight- Line Distance (Miles)	
DuPage Eye Surgery Center	2015 N Main St	Wheaton	8.69	
DMG Surgical Center	2725 S Technology Drive	Lombard	8.65	
The Oak Brook Surgical Centre	2425 W 22nd St	Oak Brook	8.07	
Loyola Surgery Center	1S224 Summit	Oakbrook Terrace	5.04	
OrthoTec Surgery Center	340 W Butterfield Rd	Elmhurst	6.82	
Rush Oak Brook Surgery Center	2011 York Rd	Oak Brook	8.12	
Elmhurst Outpatient Surgery Center	1200 S York Rd	Elmhurst	7.09	
Children's Outpatient Services at Westchester	2301 Enterprise Dr	Westchester	8.70	
River Forest Surgery Center	7427 W Lake Street	River Forest	9.82	

Table 1110.235(c)(7)(A)(ii) Facilities within 10 Miles of Innovia Surgery Center			
Facility Name	Address	City	Straight- Line Distance (Miles)
Elmwood Park Same Day Surgery	1614 North Harlem Ave	Elmwood Park	9.40
Advanced Ambulatory Surgical Center	2333 N Harlem Ave	Chicago	9.08
Belmont/Harlem Surgery Center	3101 N Harlem Ave	Chicago	8.80
Schaumburg Surgery Center	929 W Higgins Road	Schaumburg	9.00
Aiden Center for Day Surgery	1580 W Lake Street	Addison	2.88
Illinois Hand & Upper Extremity Center	515 West Algonquin Road	Arlington Heights	5.91
Northwest Surgicare	1100 W Central Rd	Arlington Heights	7.24
Northwest Community Day Surgery Center	675 W Kirchhoff Rd	Arlington Heights	7.42
Northwest Endo Center	1415 S Arlington Heights Road	Arlington Heights	6.59
Center	1455 Golf Rd	Des Plaines	7.68
Lakeshore Gastroenterology & Liver Disease Institute	150 River Road	Des Plaines	7.52
Uropartners Surgery Center, LLC	2750 S River Rd	Des Plaines	6.25
Golf Surgical Center, LLC	8901 Golf Road	Des Plaines	9.05
UChicago Medicine AdventHealth GlenOaks	701 Winthrop Ave	Glendale Heights	5.47
Elmhurst Memorial Hospital	155 E Brush Hill Rd	Elmhurst	7.26
Gottlieb Memorial Hospital	701 W North Ave	Melrose Park	7.76
Alexian Brothers Medical Center	800 W Biesterfield Rd	Elk Grove Village	3.59
Northwest Community Hospital	800 W Central Road	Arlington Heights	7.22
Advocate Lutheran General Hospital	1775 Dempster Street	Park Ridge	8.36
Ascension Resurrection Medical Center	7435 W Talcott Ave	Chicago	8.46

2. Maldistribution of Services

Expansion of services at Innovia will not result in a maldistribution of services. A maldistribution exists when an identified area has an excess supply of surgical/treatment rooms characterized by such factors as, but not limited to: (1) ratio of surgical/treatment rooms to population exceeds one and one-half times the State Average; (2) historical utilization of existing surgical/treatment rooms is below the State Board's utilization standard; or (3) insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above utilization standards.

a. Ratio of operating rooms to population.

As shown in Table 1110.235(c)(7)(B)(i), the ratio of population to operating/procedure rooms is 84% of the State Average.

TABLE 110.235(c)(7)(B)(ii)						
	Ratio of Surg	ical/Treatment Rooms	s to Population			
	Population Operating/ Rooms to Standard Met?					
	Procedure Rooms Population					
Geographic	1,346,234	233	1:5,778	YES		
Service Area						
State	12,671,469	2,626	1:4,825			

b. Historical Utilization of Existing Health Care Facilities

There are 30 existing or approved health care facilities located within 10 miles of Innovia. Utilizing hospitals for procedures that can be safely performed in an outpatient surgery center is not an efficient use of scarce health care resources. A 2019 report by the Center for American Progress noted the escalation in health care costs is largely attributed to high prices charged by hospitals.⁴² This report highlighted that "hospitals are able to sustain profits and high prices because of their market power, which has grown as competition has dwindled and providers have consolidated."⁴³ Prices set by hospitals are discretionary and not connected to underlying costs or market prices. Further, according to the March 2023 MedPac Report to Congress, Medicare payment rates for most ambulatory surgical procedures performed in HOPDs are almost twice as high as in surgery centers.

While there are 23 licensed ASTCs within the Innovia GSA, only seven are approved to provide both neurological surgery and orthopedics and only one of those (Loyola Surgery Center) accepts Medicaid patients. Innovia serves an economically disadvantaged community with significant minority populations. According to the 2020 U.S. Census Bureau estimate, 6% of residents of the Innovia GSA live at or below the FPL.⁴⁴ Lack of health care access and education, and poverty has created health inequities in this community. Health inequities are differences in population health status and health conditions arising from social and economic inequalities.

Innovia has a proven track record of serving low-income patients. Innovia is Medicaid certified. Over the past four years, over 30% of its patients were Medicaid beneficiaries, compared to 3.7% in HSA 7, and 4% statewide.⁴⁵ For patients with a demonstrated hardship who do not qualify for Medicaid, Innovia provides highly discounted rates and free care. From 2019 to 2022, over 16% of patients qualified for charity care, which is significantly higher than the 0.1% of charity care patients served in 2021 by HSA 7 surgery centers and 0.3% throughout the State.⁴⁶

c. Sufficient Population to Provide the Necessary Volume or Caseload

The Applicant currently operates an ASTC with two operating rooms and proposes to add neurological (spine) surgery and orthopedics to increase its utilization closer to the State Board's standard of 1,500 surgical hours per operating/procedure room. In 2021, 540 surgical procedures (or 945 surgical hours) were performed at Innovia. Based on Dr.

⁴² Emily Gee, *The High Price of Hospital Care*, CTR. AM. PROGRESS, 1, Jun. 2019 *available at* <u>https://www.americanprogress.org/wp-content/uploads/sites/2/2019/06/HospitalCosts-report.pdf</u> (last visited Aug. 31, 2023).

⁴³ <u>Id</u>.

⁴⁴ U.S. Census Bureau, American Community Survey, Poverty Status in the Past 12 Months available at https://data.census.gov/cedsci/table?q=poverty%20illinois&g=0400000US17&tid=ACSST1Y2018.S170 1&t=Poverty (last visited July 7, 2023).

⁴⁵ 2021 ASTC Facility Health Service Area Summary Reports; 2021 ASTC Facility State Summary Report.

⁴⁶ <u>Id</u>.

Erickson's and Dr. Park's referral letters, the Applicants project 102 cases (or 173 surgical hours) will be referred to Innovia. Accordingly, there is sufficient population to provide the volume necessary to utilize the operating rooms proposed by the project.

3. Impact on Other Health Care Facilities

- a. Expansion of surgical services at Innovia will not have an adverse impact on existing health care facilities in the GSA. There is no surgery center within the Innovia GSA approved for neurological surgery and orthopedics that also provides the same amounts of Medicaid and charity care as Innovia.
- b. Innovia will not lower the utilization of other area providers that are operating below the occupancy standards.

#23-046

Section V, Service Specific Review Criteria Non-Hospital Based Ambulatory Surgery <u>Criterion 1110.235(c)(8), Staffing</u>

Innovia is staffed in accordance with all IDPH and Medicare staffing requirements.

Section V, Service Specific Review Criteria Non-Hospital Based Ambulatory Surgery Criterion 1110.235(c)(9) Charge Commitment

1. A list of the procedures to be performed at Innovia with the proposed charge is provided in Table 1110.235(c)(9) below.

CPT CODE	DESCRIPTION	Medicare HOSPITAL PAYMENT	INNOVIA FEE
63042	Microlumbar discectomy	\$6,346	\$5,882
63047	Lumbar laminectomy	\$6,194	\$5,631
22511	Vertebroplasty	\$2,707	\$2,404
22513	Kyphoplasty	\$5,701	\$4,818
22551	Anterior cervical discectomy and fusion (ACDF) 1 or 2 level	\$12,834	\$12,168
63015	Posterior cervical foraminotomy	\$7,571	\$4,997
22856	Cervical disc arthroplasty 1 or 2 level	\$21,619	\$20,446
22630	Lumbar fusions 1-2 levels (MIS-TLIF and LLIF)	\$8,076	\$5,247
22590	Posterior cervical fusion	\$6,395	\$3,626
22552	ACDF 3 or more levels	\$2,045	\$919

Spine Procedure Codes

Orthopedics Procedure Codes

CPT CODE	DESCRIPTION	Medicare HOSPITAL PAYMENT	INNOVIA FEE
23470	Hemi-shoulder	\$3,929	\$2,709
29827	Total shoulder/ reverse shoulder	\$6,159	\$5,573
23474	Shoulder conversion	\$6,840	\$3,950
23078	Shoulder oncology	\$3,227	\$3,027
27438	Patella-femoral	\$12,133	\$11,662
27446	Uni-knee	\$12,378	\$12,017
27447	Total knee	\$12,487	\$11,894
27486	Knee revision	\$4,545	\$3,177
27364	Knee oncology	\$3,332	\$3,078

2. A letter from Vera Schmidt, Chief of Operations, Innovia Surgery Center, LLC committing to maintain the charges listed in Table 1110.235(c)(9) is attached at Attachment – 25G.



#23-046 203 E. Irving Park Road Wood Dale, IL 60191 (847) 385-0700 www.InnoviaSurgery.com

October 11, 2023

Debra Savage Chair Illinois Health Facilities and Services Review Board 525 West Jefferson Street, 2nd Floor Springfield, Illinois 62761

Re: Charge Commitment

Dear Chair Savage:

Pursuant to 77 Ill. Admin. Code § 110.235(c)(9)(B), I hereby commit that the attached charge schedule will not be increased, at a minimum, for the first two years after the addition of neurology and orthopedics at Innovia Surgery Center, LLC unless a permit is first obtained pursuant to 77 Ill. Admin. Code § 1130.310(a).

Sincerely,

Vera Schmidt Chief of Operations Innovia Surgery Center, LLC

Subscribed and sworn to me This I day of Cctober, 2023 OFFICIAL BEAL HELENA PETROMIC Notary Public MY COMMISSION EXPIRES: 5/24/2025

Section V, Service Specific Review Criteria Non-Hospital Based Ambulatory Surgery

Criterion 1110.235(c)(10), Assurances

Attached at Attachment – 25H is a letter from Vera Schmidt, Chief of Operations, Innovia Surgery Center, LLC, certifying that a peer review program exists or will be implemented for ASTC services.



#23-046 203 E. Irving Park Road Wood Dale, IL 60191 (847) 385-0700 www.InnoviaSurgery.com

October 11, 2023

Debra Savage Chair Illinois Health Facilities and Services Review Board 525 West Jefferson Street, 2nd Floor Springfield, IL 62761

Dear Chair Savage:

Pursuant to 77 Ill. Admin. Code § 1110.235(c)(10), I hereby certify that a peer review program exists or will be implemented 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.

I further certify that by the second year of operation after project completion, the annual utilization of operating rooms will meet or exceed the utilization standard specified in 77 Ill. Admin. Code § 1100.

Sincerely,

Vera Schmidt Chief of Operations Innovia Surgery Center, LLC

Subscribed and sworn to me This I day of October, 2023

Notary Public



Section VI, Availability of Funds <u>Criterion 1120.120</u>

The lease between Innovia Surgery Center f/k/a Advantage Healthcare, Ltd. and Arizona Illinois L.P. are attached at Attachments – 34A.

LEASE AGREEMENT

The lease is made between Arizona Illinois L.P. herein called "Lessor" and Advantage Health Care, Ltd. herein called the "Lessee".

Lessee hereby offers to lease space from Lessor, the premises is situated in the city of Wood Dale, County of Dupage, State of Illinois, described as 203 E Irving Park Road, Wood Dale, IL.

1. Terms and Rent. Lessor shall lease the above premises for a term of twelve years commencing on April 2, 2020, or upon completion of purchase/transaction of the building, whichever is sooner; and terminating 15 years from the date of commencement. The annual rental of \$103,932.58 payable in equal installments of \$8,661.05 on the first day of each month for that month's rental, during the term of the lease.

2. Use. Lessee shall use and occupy the premises for medical use and general office use, permitted within the zoning.

3. **Care and Maintenance of Premises**. Lessee shall, at his own expense and at all times; maintain the premises in good and safe condition, normal wear and tear expected. Lessee shall be responsible for all repairs required except the roof, exterior walls & structural foundation.

4. **Utilities**. All applications and connections for necessary utility services on the demised premises shall be made in the name of the Lessee only, and Lessee shall be solely liable for utility charges as they come due, including those for electricity and telephone services.

5. Security Deposit. Lessee shall deposit with Lessor the sum of \$8,661.05 as security deposit.

6. **Changes to Lease**. Changes to the lease agreement can be made at any time by mutual agreement of both parties.

7. **Option to Renew**. Lessee at its sole option shall have option to renew for ten (10) three (3) year periods each commencing at the expiration of the initial lease term. All of the terms and conditions of the lease shall apply during the renewal term except that the monthly rent shall be adjusted to reflect the change in the Consumer Price Index at the beginning of each new lease term after the expiration of the initial lease term.

8. Real Estate Taxes & CAM. Lessee shall be responsible for Taxes, Maintenance and CAM.

9. **Default**. A notice of 15 days shall be given for any default by either party and an additional time period of 15 days shall be allowed to cure such default.

10. **Notices**. Any notice shall be sent via certified mail with return receipt requested, or any other address so notified.

1
To Lessor: Arizona Illinois, L.P 909 W Euclid Ave. Arlington Heights IL 60006-1025

To Lessee: Advantage Health Care, Ltd. 203 E Irving Park Road Wood Dale, IL 60191

Authorized Representative

Authorized Representative

Missouri Arizona Properties, Ltd <u>General Partner</u> Arizona Illinois, L.P. Lessor

Advantage Health Care, Ltd.

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Section VII, 1120.130(b) Financial Viability Financial Viability

1. Financial viability ratios for the most recent three years for which financial statements are available and for the first full year after Project completion are provided in Table 1120.130(b) below.

Table 1120.130(b) Financial Viability Ratios				
	Historical Projected 3 Years			
Enter Historical and/or Projected Years:	2020	2021	2022	2025
Current Ratio	6.84	N/A	1.73	N/A
Net Margin Percentage	0.5%	4.2%	-137.2%	34.8%
Percent Debt to Total Capitalization	0%	0%	21468%	0%
Projected Debt Service Coverage	N/A	N/A	-4.69	N/A
Days Cash on Hand	4	4	2	117
Cushion Ratio	N/A	N/A	0	N/A

- 2. The financial viability ratio worksheet is attached at Attachment 36A.
- 3. Copies of the most recent three years of financial statements as well as the 2024 pro forma financial statements are attached at Attachment 36B.

Innovia Surgery Center Financial Viability Ratios

	Standard		2020		2021		2022		2025
Current Ratio									
Current Assets			\$8,213		\$2,578		\$3,481		\$274,849
Current Liabilities			\$1,200		\$0		\$2,009		\$0
Current Ratio	> 1.5		6.84		N/A		1.73		N/A
Net Margin Percentage									
Net Income		\$	4,063	\$	29,545	\$	(340,296)	\$	459,784
Net Operating Revenues		\$	771,807	\$	710,148	\$	247,979	\$	1,320,264
Net Margin Percentage	> 2.5%		0.5%		4.2%		-137.2%		34.8%
Long-Term Debt to Capitalization									
Long-Term Debt			\$0		\$0		\$316,010		\$0
Equity			-\$3,787		\$25,758		-\$314,538		\$267,471
Long-Term Debt to Capitalization	< 80%		0%		0%		21468%		0%
Projected Debt Service Coverage									
Net Income		\$	40,063	\$	29,545	\$	(340,296)	\$	459,784
Depreciation/Amortization			-		-		-		-
Interest Expense			-		-		2,822		-
Interest Expense and Principal Payr	nents		-		-		70,858		-
Projected Debt Service Coverage	> 1.50		N/A		N/A		(4.76)		N/A
Days Cash on Hand									
Cash		\$	8,213	\$	7,759	\$	3,481	\$	274,849
Investments		-	\$0		\$0	-	\$0	-	\$0
Board Designated Funds			\$0		\$0		\$0		\$0
Operating Expense		\$	730,788	\$	678,099	\$	585,453	\$	860,784
Depreciation		•	-	·	-		, _	•	, _
Days Cash on Hand	> 45 Days		4		4		2		117
Cushion Ratio									
Cash		Ś	8.213	Ś	7,759	Ś	3.481	Ś	274.849
Investments		Ŧ	5 <u>,</u> 5	7	\$0	7	\$0	Ŧ	ś0
Board Designated Funds			\$0		\$0		\$0		\$0 \$0
Interest Expense and Principal Pavr	nents		\$0		\$0		\$70,858		\$0 \$0
Cushion Ratio	> 3.0		N/A		N/A		0		N/A

INNOVIA SURGERY CENTER, LLC

OPERATING STATEMENT

FOR THE TWELVE MONTHS ENDING DECEMBER 31, 2020

Net revenue	771,807
Expenses	
Advertising Employee contracting Outside services Professional medical fees Equipment rental Depreciation Insurance Rent Utilities Telephone Office expense Postage and shipping Drugs and professional supplies Lab fees Laundry and uniform Cleaning Repairs and maintenance Landscaping and snow removal Legal and accounting Licenses and fees Dues and subscriptions Charitable contributions Bank/credit card fees	27,564 289,040 8,727 52,605 38,506 - 650 132,323 9,121 951 26,753 1,484 65,663 7,439 14,930 9,935 11,575 15,500 1,605 1,267 381 3,210
Total expenses	730,788
Operating income	41,019
Interest expense Taxes	- 956
Net income	40,063

Prepared by Ingold Associates, Ltd. James F. Ingold, CPA, MBA 2300 N. Barrington Road, Ste 400 Hoffman Estates, IL 60169

#23-046

INNOVIA SURGERY CENTER, LLC BALANCE SHEET AS OF DECEMBER 31, 2020

ASSETS

Current assets	
Cash	8,213
Accounts receivable, net	-
Prepaid expenses and other	
Total net current assets	8,213
Property and equipment	
Property and equipment	66,005
Accumulated depreciation	(66,005)
Total net property and equipment	· -
Other assets	-
Total Assets	8 213

LIABILITIES AND CAPITAL

Current Liabilities Accounts payable Employee contracting payable	-
Other	12,000
Total Current Liabilities	12,000
Loans	-
Total Liabilities	12,000
Capital Paid in capital Retained earnings	1,000 (4,787)
Total Capital	(3,787)
Total Liabilities & Capital	8,213

Prepared by Ingold Associates, Ltd. James F. Ingold, CPA, MBA 2300 N. Barrington Road, Ste 400 Hoffman Estates, IL 60169

INNOVIA SURGERY CENTER, LLC OPERATING STATEMENT

FOR THE TWELVE MONTHS ENDING DECEMBER 31, 2021

Net revenue	710,148
Expenses	
Advertising Employee contracting Outside services Professional medical fees Equipment rental Depreciation Insurance Rent Utilities Telephone Office expense Postage and shipping Drugs and professional supplies Lab fees Laundry and uniform Cleaning Repairs and maintenance Landscaping and snow removal Legal and accounting Licenses and fees Dues and subscriptions Charitable contributions Bank/credit card fees	$\begin{array}{c} 9,425\\ 305,375\\ 5,571\\ 10,664\\ 7,985\\ -\\ \\ 5,893\\ 109,540\\ 13,330\\ 801\\ 21,969\\ 773\\ 46,005\\ 5,016\\ 5,045\\ 27,320\\ 35,176\\ 8,070\\ 51,877\\ 2,850\\ 358\\ 870\\ 4,186\end{array}$
Total expenses	678,099
Operating income	32,049
Interest expense Taxes	- 2,504
Net income	29,545

Prepared by Ingold Associates, Ltd. James F. Ingold, CPA, MBA 2300 N. Barrington Road, Ste 400 Hoffman Estates, IL 60169

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INNOVIA SURGERY CENTER, LLC BALANCE SHEET AS OF DECEMBER 31, 2021

ASSETS

Current assets	
Cash	7,759
Accounts receivable, net	-
Prepaid expenses and other	17,999
Total net current assets	25,758
Property and equipment	
Property and equipment	66,005
Accumulated depreciation	(66,005)
Total net property and equipment	-
Other assets	-
Total Assets	25,758

LIABILITIES AND CAPITAL

Current Liabilities Accounts payable Employee contracting payable	-
Other	<u> </u>
Total Current Liabilities	-
Loans	
Total Liabilities	**
Capital	
Paid in capital	1,000 24,758
Retained earnings	24,700
Total Capital	25,758
Total Liabilities & Capital	25,758

Prepared by Ingold Associates, Ltd. James F. Ingold, CPA, MBA 2300 N. Barrington Road, Ste 400 Hoffman Estates, IL 60169

INNOVIA SURGERY CENTER, LLC OPERATING STATEMENT

FOR THE TWELVE MONTHS ENDING DECEMBER 31, 2022

Net revenue	247,979
Expenses	
Advertising Employee contracting Outside services Professional medical fees Equipment rental Depreciation Insurance Rent Utilities Telephone Office expense Postage and shipping Drugs and professional supplies Lab fees Laundry and uniform Cleaning Repairs and maintenance Landscaping and snow removal Legal and accounting Licenses and fees Dues and subscriptions Charitable contributions Bank/credit card fees	14,500 115,153 16,476 14,400 - 792 144,512 12,739 - 74,851 - 17,635 2,317 - 5,940 19,275 8,780 130,609 3,183 499 3,792
Total expenses	585,453
Operating income	(337,474)
Interest expense Taxes	- 2,822
Net income	(340,296)

Prepared by Ingold Associates, Ltd. James F. Ingold, CPA, MBA 2300 N. Barrington Road, Ste 400 Hoffman Estates, IL 60169

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#23-046

INNOVIA SURGERY CENTER, LLC BALANCE SHEET AS OF DECEMBER 31, 2022

ASSETS

Current assets	2 404
Cash Associate resolution pot	3,401
Accounts receivable, her	-
Prepaid expenses and other	
Total net current assets	3,481
Dreporty and agginment	
Property and equipment	66.005
Property and equipment	(66,005)
Accumulated depreciation	(88,003)
Total net property and equipment	
Other assets	-
Total Assets	3,481
×	
LIABILITIES AND C	APITAL
Current Liabilities	
Accounts navable	_
Employee contracting payable	
Employee contracting payable	
Other	2 000
Other	2,009
Total Current Lighilities	2 009
Total Current Liabilities	2,005
Loons	316.010
Loans	010,010
Total Liphilities	318.019
Total Liabilities	010,010
Capital	
Daid in canital	1 000
Patrined earnings	(315 538)
rvetanieu eannings	(010,000)

Total Liabilities & Capital

Total Capital

Prepared by Ingold Associates, Ltd. James F. Ingold, CPA, MBA 2300 N. Barrington Road, Ste 400 Hoffman Estates, IL 60169 (314,538)

3,481

INNOVIA SURGERY CENTER, LLC

OPERATING STATEMENT

FORECAST FOR THE TWELVE MONTHS ENDING DECEMBER 31, 2025

Net revenue	1,320,264
Expenses	
Advertising Employee contracting Outside services Professional medical fees Equipment rental Depreciation Insurance Rent Utilities Telephone Office expense Postage and shipping Drugs and professional supplies Lab fees Laundry and uniform Cleaning Repairs and maintenance Landscaping and snow removal Legal and accounting Licenses and fees Dues and subscriptions Charitable contributions Bank/credit card fees	602,510 3,570 25,602 10,796 - - 8,364 70,800 13,974 - 9,486 408 90,294 2,652 - 7,400 5,202 3,468 5,000 350 605
Total expenses	860,480
Operating income	459,784
Interest expense Taxes	-
Net income	459,784

Prepared by Ingold Associates, Ltd. James F. Ingold, CPA, MBA 2300 N. Barrington Road, Ste 400 Hoffman Estates, IL 60169

INNOVIA SURGERY CENTER, LLC BALANCE SHEET PROJECTION AS OF DECEMBER 31, 2025

<u>ASSETS</u>

Current assets	
Cash	274,849
Accounts receivable, net	-
Prepaid expenses and other	
Total net current assets	274,849
Property and equipment	
Property and equipment	66,005
Accumulated depreciation	(73,383)
Total net property and equipment	(7,378)
Other assets	-
Total Assets	267,471

LIABILITIES AND CAPITAL

Current	Liabilities Accounts payable Employee contracting payable		-
	Other		-
	Total Current Liabilities		-
	Chase Line of Credit Loan from Shareholder		-
	Total Liabilities	<u></u>	-
Capital	Paid in capital Retained earnings	266	1,000 3,471
	Total Capital	26	7,471
	Total Liabilities & Capital	26	7,471

Prepared by Ingold Associates, Ltd. James F. Ingold, CPA, MBA 2300 N. Barrington Road, Ste 400 Hoffman Estates, IL 60169

VIII, Economic Feasibility Review Criteria Criterion 1120.140(A), Reasonableness of Financing Arrangements

A letter from Vera Schmidt, Chief of Operations, Innovia Surgery Center, certifying the estimated project costs and related costs will be funded in total by borrowing is attached at Attachment – 37A.



#23-046 203 E. Irving Park Road

Wood Dale, IL 60191 (847) 385-0700 www.InnoviaSurgery.com

October 11, 2023

Debra Savage Chair Illinois Health Facilities and Services Review Board 525 West Jefferson Street, 2nd Floor Springfield, Illinois 62761

Re: Reasonableness of Financing Arrangements

Dear Chair Savage:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1120.140(a) that the total estimated project costs and related costs will be funded in total by That the total estimated project costs and related costs will be funded in total or in part by borrowing because 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 1.5 times, or 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.

Sincerely,

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Vera Schmidt Chief of Operations Innovia Surgery Center, LLC

Subscribed and sworn to me tober day of CC 2023 This /

Notary Public

OFFICIAL SEAL HELENA PETROVIC NOTARY PUBLIC. STATE OF ILLINOIS MY COMMISSION EXPIRES: 5/24/2025

Section VIII, Economic Feasibility Review Criteria Criterion 1120.140(B), Conditions of Debt Financing

A letter from Vera Schmidt, Chief of Operations, Innovia Surgery Center, certifying the estimated project costs and related costs will be funded in total by borrowing is attached at Attachment – 37A.

Section VIII, Economic Feasibility Review Criteria Criterion 1120.140C, Reasonableness of Project and Related Costs

• This project will not include any construction. Accordingly, this criterion is not applicable.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
	А	В	С	D	Е	F	G	Н	T . 10
Department (list below) CLINICAL	Cost/Squ New	Cost/Square Foot Gross Sq. F New Mod. New Circ.*		Sq. Ft. ew c.*	Gross Sq. Ft. Mod. Circ.*		Const. \$ (A x C)	Mod. \$ (B x E)	(G + H)
CLINICAL									
Contingency									
TOTAL CLINICAL									
NON- CLINICAL									
Admin									
Contingency									
TOTAL NON- CLINICAL									
TOTAL									
* Include the percentage (%) of space for circulation									

2. As shown in Table 1120.310(c) below, the project costs are below the State Standard.

Table 1120.310(c)				
	Proposed Project	State Standard	Above/Below State	
			Standard	
Fair Market Value of Leased	\$1,667,275	No State Standard	No State Standard	
Space or Equipment				

Section VIII, Economic Feasibility Review Criteria Criterion 1120.140D, Projected Operating Costs

Operating Expenses: \$860,480

Procedures: 1,188 procedures

Operating Expense per Procedure: \$724.31 per procedure

Section VIII, Economic Feasibility Review Criteria Criterion 1120.140E, Total Effect of Project on Capital Costs

Capital Costs (2024): \$0

Procedures (2024): 1,188 procedures

Capital Costs per Procedure: \$0 per procedure

Section IX, Safety Net Impact Statement

The proposed project is non-substantive as it involves the addition of neurological (spine) surgery and orthopedics to an existing ASTC. Accordingly, this criterion is not applicable.

Section X, Charity Care Information

CHARITY CARE				
	2020	2021	2022	
Net Patient Revenue	\$439,689	\$506,271	\$35,115	
Amount of Charity Care				
(charges)	\$64,000	\$75,940	\$0	
Cost of Charity Care	\$64,000	\$75,940	\$0	

The table below provides charity care information for the most recent three years for Innovia.

Appendix I – Physician Referral Letter

Attached as Appendix - 1 is the referral letters from Dr. Erickson and Dr. Park projecting 102 patients will be referred to Innovia within 12 to 24 months of project completion.

Debra Savage Illinois Health Facilities and Services Review Board 525 West Jefferson Street, 2nd Floor Springfield, Illinois 62761

Dear Ms. Savage:

I am a Spine surgeon. I am writing in support of the expansion of surgical specialties at Innovia Surgery Center. Changes in clinical practice and health care technology have expanded the provision of procedures in ambulatory surgery centers. Further, with increased focused on value-based care, ambulatory surgery centers provide a lower cost alternative to traditional hospital outpatient departments. The expansion of surgical specialties at Innovia Surgery Center will allow my patients to receive high quality care at lower cost and with greater convenience than at a hospital outpatient department.

Over the past twelve months (from January 1, 2022 to December 31, 2022), for the zip codes listed on Exhibit 1, I performed a total of 55 outpatient surgical procedures at the following hospitals and surgery centers. With the expansion of surgical specialties at Innovia Surgery Center, I expect to refer my cases as noted below. Of the total cases, 100% percent will reside within the proposed geographic service area of Innovia Surgery Center.

Hospital / Licensed ASTC	Hospital and Licensed ASTC (number of cases) Most recent 12 months	Projected Referrals to Innovia Surgery Center after Project Completion
Rogers Park Surgery Center	8	6
Lakeshore Surgery Center	7	5
Pinnacle Pain Management	14	10
Illinois Back & Neck Institute	3	3
A PM Surgical Center	15	12
Hude Bark Surgery Center	5	3
Deminister Ambulatory Surgery Center	1	ive 1 1 min 1
Barrington Amounatory Surgery Contor	2	2
Total	55	42

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Ms. Debra Savage Page 2

These referrals have not been used to support another pending or approved certificate of need application.

The information in this letter is true and correct to the best of my knowledge.

I support the expansion of surgical specialties at Innovia Surgery Center.

Sincerely,

Name: Robert K. Erickson, M.D. Title: Spine & Neurosurgcon Name of Practice: MCRO NEUR Practice Address: 720 N. NOPSO City, Illinois Zip Code: Munas H

Subscribed and sworn to me This 218t day of August 2023

and 1

Notary Public



2

Exhibit 1

Referrals by Patient Zip Code

Zip Code	Number of Cases
60188	1
60195	1
60053	1
60631	1
60706	1
60707	1
60644	1
60171	3
60634	3
60632	2
60652	1
60620	4
60525	3
60629	4
60707	3
60639	5
60171	5
60804	2
60623	2
60651	1
60624	2
60172	1
60074	1
60644	1
60624	1
60535	11
60632	1
60638	1
60525	1
Total	55



Debra Savage Illinois Health Facilities and Services Review Board 525 West Jefferson Street, 2nd Floor Springfield, Illinois 62761

Dear Ms. Savage:

I am an Orthopaedic surgeon. I am writing in support of the expansion of surgical specialties at Innovia Surgery Center. Changes in clinical practice and health care technology have expanded the provision of procedures in ambulatory surgery centers. Further, with increased focused on value-based care, ambulatory surgery centers provide a lower cost alternative to traditional hospital outpatient departments. The expansion of surgical specialties at Innovia Surgery Center will allow my patients to receive high quality care at lower cost and with greater convenience than at a hospital outpatient department.

Over the past twelve months (from January 1, 2022 to December 31, 2022), for the zip codes listed on Exhibit 1, I performed a total of 119 outpatient surgical procedures at the following hospitals and surgery centers. With the expansion of surgical specialties at Innovia Surgery Center, I expect to refer my cases as noted below. Of the total cases, 100 % percent will reside within the proposed geographic service area of Innovia Surgery Center.

Hospital / Licensed ASTC	Hospital and Licensed ASTC (number of cases) Most recent 12 months	Projected Referrals to Innovia Surgery Center after Project Completion
Rogers Park Surgery Center	31	15
Hyde Park Surgery Center	20	10
Chicago Surgery Center	34	17
Fullerton Kimball Medical and Surgical Center	29	15
Grand Ave Surgery Center	5	3
Total	119	60

These referrals have not been used to support another pending or approved certificate of need application.

The information in this letter is true and correct to the best of my knowledge.

I support the expansion of surgical specialties at Innovia Surgery Center.

Ms. Debra Savage Page 2

Sincerely,

Name: Samuel Park, MDTitle: Orthopedic SurgeonName of Practice: Specialty OrthopaedicsPractice Address: 911 North Elm Street, Suite 327, Hinsdale, IL 60521City, Illinois Zip Code: Hinsdale, IL 60521

Subscribed and sworn to me This 29th day of 0 2023

Notary Public

ANA OROZCO Official Seal Notary Public - State of Illinois My Commission Expires Mar 6, 2027

Exhibit 1

Referrals by Patient Zip Code

Orhthopaedic		
Zip Code	Number of Cases	
60461	12	
60126	6	
60181	3	
60131	4	
60706	7	
60304	7	
60106	3	
60148	5	
60101	5	
60634	5	
60018	4	
60402	1	
60804	6	
60641	5	
60164	2	
60618	5	
60642	4	
60430	6	
60471	3	
60475	7	
60419	4	
60452	2	
60477	6	
60438	5	
60411	1	
60445	1	
Total	119	

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

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1	Applicant Identification including Certificate of Good Standing	26 – 28
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4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	34 – 35
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21	Acute Mental Illness	
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27	Kidney Transplantation	
28	Subacute Care Hospital Model	
29	Community-Based Residential Rehabilitation Center	
30	Long Term Acute Care Hospital	
31	Clinical Service Areas Other than Categories of Service	_
32	Freestanding Emergency Center Medical Services	
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	Financial and Economic Feasibility:	
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