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HEALTH FACILITIES & SERVICES REVIEW BOARD

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center
Street Address: 550 W. Ogden Avenue
City and Zip Code: Hinsdale 60521
County: DuPage Health Service Area: 007 Health Planning Area: 043

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

Exact Legal Name: Westmont Surgery Center, LLC
Street Address: 530 N. Cass Avenue
City and Zip Code: Westmont 60559
Name of Registered Agent: CT Corporation System
Registered Agent Street Address: 208 S. LaSalle Street, Suite 814
Registered Agent City and Zip Code: Chicago 60604
Name of Managing Member: Giridhar Burra, M.D.
CEO Street Address: 530 N. Cass Avenue
President City and Zip Code: Westmont 60559
President Telephone Number: (630) 917-0972

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Other
- ☐ 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.

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: Juan Morado, Jr. and Mark J. Silberman
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff
Address: 71 S. Wacker Drive, Suite 1600, Chicago, Illinois 60606
Telephone Number: (312) 212-4952
E-mail Address: JMorado@beneschlaw.com and MSilberman@Beneschlaw.com
Fax Number: (312) 767-9192

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City and Zip Code: Hinsdale 60521
County: DuPage Health Service Area: 007 Health Planning Area: 043

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

Exact Legal Name: IBJI ASC Ventures, LLC
Street Address: 900 Rand Road, Suite 300
City and Zip Code: Des Plaines 60016
Name of Registered Agent: Christopher A. Kantas
Registered Agent Street Address: 900 Rand Road, Suite 300
Registered Agent City and Zip Code: Des Plaines 60016
Name of President: Gregory H. Portland, M.D. (Manager)
President Street Address: 2401 Ravine Way, Suite 200
President City and Zip Code: Glenview 60025
President Telephone Number: (847) 998-5680

Type of Ownership of Applicants

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
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City and Zip Code: Hinsdale 60521		
County: DuPage	Health Service Area: 007	Health Planning Area: 043

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

Exact Legal Name: Illinois Bone and Joint Institute, LLC
Street Address: 900 Rand Road, Suite 300
City and Zip Code: Des Plaines 60016
Name of Registered Agent: Christopher A. Kantas
Registered Agent Street Address: 900 Rand Road, Suite 300
Registered Agent City and Zip Code: Des Plaines 60016
Name of President: Gregory H. Portland, M.D. (Manager)
President Street Address: 2401 Ravine Way, Suite 200
President City and Zip Code: Glenview 60025
President Telephone Number: (847) 998-5680

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

Exact Legal Name: IBJI Salt Creek ASC, LLC
Street Address: 900 Rand Road, Suite 300
City and Zip Code: Des Plaines 60616
Name of Registered Agent: Christopher A. Kantas
Registered Agent Street Address: 900 Rand Road, Suite 300
Registered Agent City and Zip Code: Des Plaines 60016
Name of President: Andre Blom (Manager)
President Street Address: 900 Rand Road, Suite 300
President City and Zip Code: Des Plaines 60016
President Telephone Number: (847) 998-5680

Type of Ownership of Applicants

- ☐ Non-profit Corporation
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- ☒ Limited Liability Company
- ☐ Other
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- o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

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Name: Juan Morado, Jr. and Mark J. Silberman
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Telephone Number: (312) 212-4952
E-mail Address: JMorado@beneschlaw.com and MSilberman@Beneschlaw.com
Fax Number: (312) 767-9192

Additional Contact [Person who is also authorized to discuss the Application]

Name: Christopher A. Kantas
Title: General Counsel
Company Name: Illinois Bone and Joint Institute
Address: 900 Rand Road, Suite 300 Des Plaines, IL 60016
Telephone Number: (708-707-2469
E-mail Address: CKantas@IBJI.com
Fax Number:

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

Name: Jessica Shapley
Title: Administrator
Company Name: Salt Creek Surgery Center
Address: 550 W. Ogden Avenue, Hinsdale, Illinois 60521
Telephone Number: (630) 869-4260
E-mail Address: jshapley@saltcreeksurgerycenter.com
Fax Number: (630) 794-8697

Site Ownership after the Project is Complete [Provide this information for each applicable site]

Exact Legal Name of Site Owner: Hinsdale Partnership, LLC
Address of Site Owner: 550 W. Ogden Avenue, Hinsdale, Illinois 60521
Street Address or Legal Description of the Site: **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Current Operating Identity/Licensee [Provide this information for each applicable facility and insert after this page]

Exact Legal Name: Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center
Address: 550 W. Ogden Avenue, Hinsdale, Illinois 60521

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

Operating Identity/Licensee after the Project is Complete [Provide this information for each applicable facility and insert after this page]

Exact Legal Name: Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

Address: 550 W. Ogden Avenue, Hinsdale, Illinois 60521

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

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

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

Organizational Relationships

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

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

Narrative Description

In the space below, provide a brief narrative description of the change of ownership. 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.

Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center ("Salt Creek"), an ambulatory surgical treatment center, seeks to relocate its facility at 530 N. Cass Avenue, Westmont, IL 60559 ("ASTC") to 550 W. Ogden Ave., Hinsdale, IL 60521. Salt Creek is currently licensed as a multi-specialty ASTC focused on General Surgery, Orthopedic Surgery, Pain Management, and Podiatry and is approved for four (4) operating rooms and two procedure rooms. The project proposes establishing a replacement facility providing the same services in six (6) operating rooms.

The relocation of this facility is being proposed in conjunction with the discontinuation of the current facility which is approximately two (2) miles away. The Applicant has concurrently filed an application with the Board to discontinue its operations at its current facility, contingent upon the approval and licensing of this facility so that there is no disruption in services.

The project is classified as substantive, in that it involves the relocation of a health care facility. 77 Ill. Admin Code Sec. 1110.20(c)(1)(A)(i).

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	$21,762	$23,238	$45,000
Site Preparation	$136,010	$145,240	$281,250
Off Site Work	-	-	-
New Construction Contracts	$6,983,520	$8,035,350	$15,018,870
Modernization Contracts	-	-	-
Contingencies	$310,365	$331,425	$641,790
Architectural/Engineering Fees	$96,719	$103,281	$200,000
Consulting and Other Fees	$120,898	$129,102	$250,000
Movable or Other Equipment (not in construction contracts)	$1,305,700	$1,394,300	$2,700,000
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value of Leased Space or Equipment	$1,870,042	$1,996,934	$3,866,976
Other Costs to Be Capitalized	$217,617	$232,383	$450000
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	$10,904,860	$12,222,776	$23,127,636
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	-	-	-
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	$9,034,818	$10,225,842	$19,260,660
Leases (fair market value)	$1,870,042	$1,996,934	$3,866,976
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	**$10,904,860**	**$12,222,776**	**$23,127,636**
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project ☒ Yes ☐ No

Purchase Price: $2,500,000

Fair Market Value: $2,500,000

The project involves the establishment of a new facility or a new category of service

☒ Yes ☐ No

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

Estimated start-up costs and operating deficit cost is: $1,469,216

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): December 31, 2027

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

☐ Purchase orders, leases or contracts pertaining to the project have been executed.

☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies

☒ Financial Commitment will occur after permit issuance.

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

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable?

☒ Cancer Registry

☒ APORS

☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

☒ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements – NOT APPLICABLE

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the 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 of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
ASTC	$10,904,860	-	22,990	22,990	-	-	-
Total Clinical	$10,904,860	-	22,990	22,990	-	-	-
NON-REVIEWABLE							
Administrative	$12,222,776	-	24,550	24,550	-	-	-
Total Non-clinical	$12,222,776	-	24,550	24,550	-	-	-
TOTAL	**$23,127,636**	-	**47,540**	**47,540**	-	-	-

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

Facility Bed Capacity and Utilization

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

FACILITY NAME: Salt Creek Surgery Center		**CITY: Westmont**			
REPORTING PERIOD DATES:	**From: January 1, 2022**		**to: December 31, 2022**		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	-	-	-	-	-
Obstetrics	-	-	-	-	-
Pediatrics	-	-	-	-	-
Intensive Care	-	-	-	-	-
Comprehensive Physical Rehabilitation	-	-	-	-	-
Acute/Chronic Mental Illness	-	-	-	-	-
Neonatal Intensive Care	-	-	-	-	-
General Long-Term Care	-	-	-	-	-
Specialized Long-Term Care	-	-	-	-	-
Long Term Acute Care	-	-	-	-	-
Other (operating rooms)	4	4,349	N/A	-4	0
TOTALS:	4	4,349	N/A	-4	0

CERTIFICATION

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

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

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

SIGNATURE

GIRIDHAR BURRA
PRINTED NAME

PRESIDENT
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 22nd day of July 2025

Teresa M Valente
Signature of Notary

Seal

OFFICIAL SEAL
TERESA M. VALENTE
Notary Public - State of Illinois
My Commission Expires 07/14/2026

SIGNATURE

Robert Thornes
PRINTED NAME

Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 25 day of July 2025

Signature of Notary

Seal

OFFICIAL SEAL
KATHERINE M BONAVOLANTO
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 03/11/2026

*Insert the EXACT legal name of the applicant

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

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

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
    a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.
    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.
    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.
    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.
4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

1) Identify **ALL** the alternatives to the proposed project:

   Alternative options **must** include:

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

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

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

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

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

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
    a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
    c. The project involves the conversion of existing space that results in excess square footage.
    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

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

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
ASTC	22,990 GSF (6 ORs)	16,500 GSF	6,490 GSF	NO

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

PROJECT SERVICES UTILIZATION:

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

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

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

UTILIZATION					
	DEPARTMENT / SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1	**ASTC**	8,545 procedure hours	75.9%	80%	NO
YEAR 2	**ASTC**	9,058 procedure hours	80.5%	80%	YES

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.
3. Evidence that the shell space is being constructed due to:
    a. Requirements of governmental or certification agencies; or
    b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
    a. Historical utilization for the area for the latest five-year period for which data is available; and
    b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

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

G. Non-Hospital Based Ambulatory Surgery

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

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

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

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X
APPEND DOCUMENTATION AS ATTACHMENT 25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

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

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

SECTION 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 Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion.
_____	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.
$23,127,636	d) Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated. 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate. 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc. 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment. 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent.
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$23,127,636	**TOTAL FUNDS AVAILABLE**

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

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

Variance

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

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

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

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

A. Reasonableness of Financing Arrangements

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

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

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

   A) A portion or all 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.

B. Conditions of Debt Financing

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

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
ASTC	$303.76		22,990	-	-	-	$6,983,520	-	$6,983,520
Contingency	$12.64		24,550	-	-	-	$310,365	-	$310,365
TOTALS	$316.40		47,540	-	-	-	$7,293,885	-	$7,293,885

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

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

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

Safety Net Information per PA 96-0031			
CHARITY CARE*			
Charity (# of patients)	**2020**	**2021**	**2022**
Inpatient	0	0	0
Outpatient	1	0	0
Total	**1**	**0**	**0**
Charity (cost in dollars)			
Inpatient	$0	$0	$0
Outpatient	$0	$0	$0
Total	$0	$0	**$0**
MEDICAID			
Medicaid (# of patients)	**2020**	**2021**	**2022**
Inpatient	0	0	0
Outpatient	0	0	0
Total	0	0	0
Medicaid (revenue)			
Inpatient	$0	$0	$0
Outpatient	$0	$0	$0
Total	$0	$0	$0

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

*** Note: IBJI and its physicians engage in various and significant provision of charitable and unreimbursed care, however since the care provided and the means of its provision do not conform to the HFSRB requirements for and definition of Charity Care, this amount is noted as being zero.**

SECTION X. CHARITY CARE INFORMATION

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

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

CHARITY CARE*			
	2020	**2021**	**2022**
Net Patient Revenue	**$9,191,339**	**$23,842,428**	**$30,828,075**
Amount of Charity Care(charges)	0	0	0
Cost of Charity Care	0	0	0

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

*** Note: IBJI and its physicians engage in various and significant provision of charitable and unreimbursed care, however since the care provided and the means of its provision do not conform to the HFSRB requirements for and definition of Charity Care, this amount is noted as being zero.**

SECTION XI. SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center 550 W. Ogden Ave.
(Name) (Address)

Hinsdale Illinois 60521 630-698-1800
(City) (State) (Zip Code) (Telephone Number)

2. Project Location: 550 W. Ogden Ave. Hinsdale Illinois
(Address) (City) (State)

DuPage Downers Grove North
(Country) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go to NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the icon in the top corner of the page. Select the pin tool icon and place a pin on your site. Print a FIRMETTE size image.

If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes ____ No _X_

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN? NO

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.

If the determination is being made by a local official, please complete the following:

FIRM Panel Number: _____ Effective Date: _____

Name of Official: _____ Title: _____

Business/Agency: _____ Address: _____

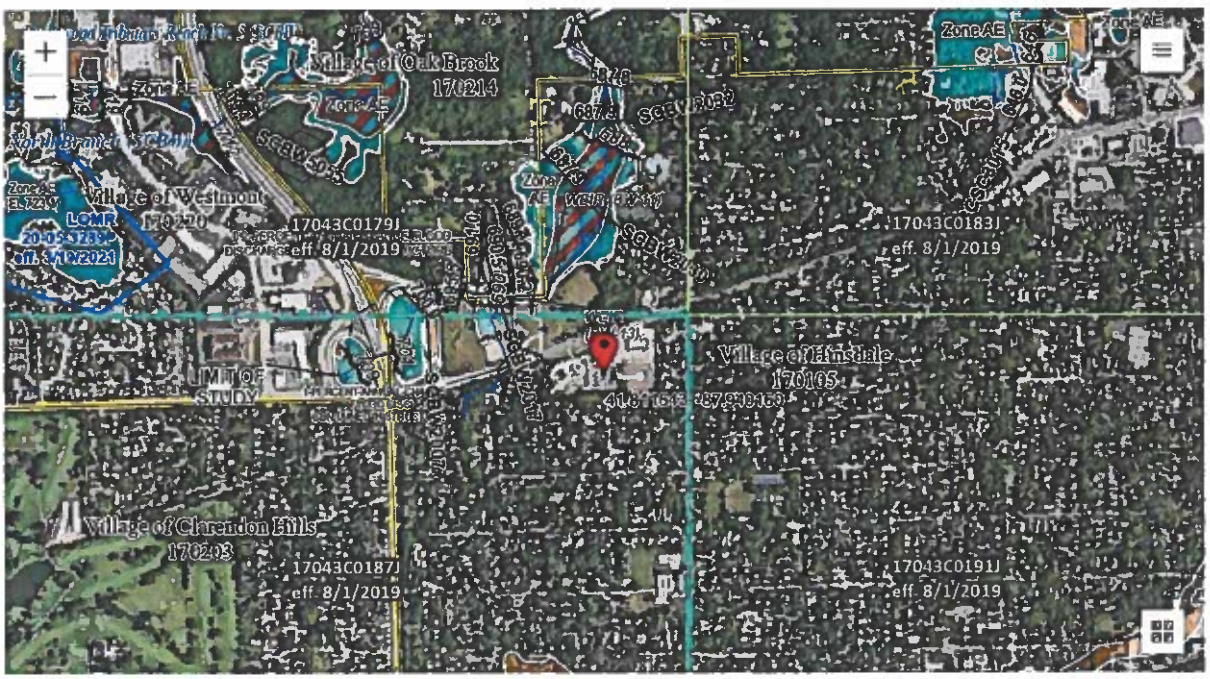
_____
(City) (State) (ZIP Code) (Telephone Number)

Signature: _____ Date: _____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems. **If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428**

FLOOD PLAIN MAP

550 W. Ogden Ave., Hinsdale, IL 60521



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

INDEX OF ATTACHMENTS

ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	27-31
2	Site Ownership	32-34
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	35-37
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	38
5	Flood Plain Requirements	39-40
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7	Project and Sources of Funds Itemization	47-49
8	Financial Commitment Document if required	50-51
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10	Discontinuation	n/a
11	Background of the Applicant	53-57
12	Purpose of the Project	58-99
13	Alternatives to the Project	100
14	Size of the Project	101
15	Project Service Utilization	102-103
16	Unfinished or Shell Space	104
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	Service Specific:	
18	Medical Surgical Pediatrics, Obstetrics, ICU	n/a
19	Comprehensive Physical Rehabilitation	n/a
20	Acute Mental Illness	n/a
21	Open Heart Surgery	n/a
22	Cardiac Catheterization	n/a
23	In-Center Hemodialysis	n/a
24	Non-Hospital Based Ambulatory Surgery	106-145
25	Selected Organ Transplantation	n/a
26	Kidney Transplantation	n/a
27	Subacute Care Hospital Model	n/a
28	Community-Based Residential Rehabilitation Center	n/a
29	Long Term Acute Care Hospital	n/a
30	Clinical Service Areas Other than Categories of Service	n/a
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	Financial and Economic Feasibility:	
33	Availability of Funds	146-147
34	Financial Waiver	148-151
35	Financial Viability	n/a
36	Economic Feasibility	152
37	Safety Net Impact Statement	153-154
38	Charity Care Information	155
39	Flood Plain Information	156-157

ATTACHMENT 1
Certificate of Good Standing

Included with this attachment are:

1. The Certificate of Good Standing for Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center (Licensee)
2. The Certificate of Good Standing for IBJI ASC Ventures, LLC
3. The Certificate of Good Standing for Illinois Bone and Joint, LLC
4. The Certificate of Good Standing for IBJI Salt Creek ASC, LLC

ATTACHMENT 1
Certificate of Good Standing - Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

File Number 0051479-9

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

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*

WESTMONT SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 02, 2001, 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.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 17TH *day of* JULY *A.D.* 2025 .

Authentication #: 2519803398 verifiable until 07/17/2026
Authenticate at: https://www.ilsos.gov

Alexi Giannoulias
SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing - IBJI ASC Ventures, LLC

File Number 1000735-6

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*

IBJI ASC VENTURES, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MAY 19, 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.

Authentication #: 2519803440 verifiable until 07/17/2026
Authenticate at: https://www.ilsos.gov

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 17TH *day of* JULY *A.D.* 2025 .

SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing - Illinois Bone and Joint Institute, LLC

File Number 0168922-3

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

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*

ILLINOIS BONE AND JOINT INSTITUTE, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON NOVEMBER 29, 2005, 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* 17TH *day of* JULY *A.D.* 2025 .

Authentication #: 2519803512 verifiable until 07/17/2026
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 1
Certificate of Good Standing - IBJI Salt Creek ASC, LLC

File Number 1065000-3

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

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*

IBJI SALT CREEK ASC, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON NOVEMBER 05, 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* 17TH *day of* JULY *A.D.* 2025 .

Authentication #: 2519603362 verifiable until 07/17/2026
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 2
Site Ownership

The site ownership rests with Hinsdale Partnership, LLC. That entity is owned by physicians affiliated with Illinois Bone and Joint Institute. Attached as evidence is a copy of the most recent tax bill.

ATTACHMENT 2
Site Ownership

MAKE CHECK PAYABLE TO: DU PAGE COLLECTOR - SEND THIS COUPON WITH YOUR 1ST INSTALLMENT PAYMENT OF 2024 Tax

MAIL PAYMENT TO: P.O. BOX 4203, CAROL STREAM, IL 60197-4203
PAY ON-LINE AT: www.dupagecounty.gov/treasurer
SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

09-02-212-007
HINSDALE PARTNERSHIP LLC
550 N MONROE ST
HINSDALE IL 60521

$29,453.31 PAID May 08, 2025

1

ON OR BEFORE:	PAY:
JUN 02, 2025	0.00

PAYING LATE?	PAY THIS AMOUNT:
JUN 3 THRU 30	0.00
JUL 1 THRU 31	
AUG 1 THRU 31	
SEP 1 THRU 30	
OCT 1 THRU 31	
NOV 1 THRU 19	

U.S. POSTMARK IS USED TO DETERMINE LATE PENALTY.

PAYMENT OF THIS 2024 TAX BILL AFTER OCTOBER 31, 2025, REQUIRES A CASHIER'S CHECK, CASH OR MONEY ORDER.

☐ CHECK BOX AND COMPLETE CHANGE OF ADDRESS ON BACK.

NO PAYMENT WILL BE ACCEPTED AFTER NOV 19, 2025

10902212007690590002945331 31

MAKE CHECK PAYABLE TO: DU PAGE COLLECTOR - SEND THIS COUPON WITH YOUR 2ND INSTALLMENT PAYMENT OF 2024 Tax

MAIL PAYMENT TO: P.O. BOX 4203, CAROL STREAM, IL 60197-4203
PAY ON-LINE AT: www.dupagecounty.gov/treasurer
SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

09-02-212-007
HINSDALE PARTNERSHIP LLC
550 N MONROE ST
HINSDALE IL 60521

2

ON OR BEFORE:	PAY:
SEP 02, 2025	29,453.31

PAYING LATE?	PAY THIS AMOUNT:
SEP 3 THRU 30	29,695.11
OCT 1 THRU 31	30,336.81
* NOV 1 THRU 19	30,788.71

*INCLUDES $16 COST SEE BACK OF BILL FOR EXPLANATION

U.S. POSTMARK IS USED TO DETERMINE LATE PENALTY.

PAYMENT OF THIS 2024 TAX BILL AFTER OCTOBER 31, 2025, REQUIRES A CASHIER'S CHECK, CASH OR MONEY ORDER.

☐ CHECK BOX AND COMPLETE CHANGE OF ADDRESS ON BACK.

NO PAYMENT WILL BE ACCEPTED AFTER NOV 19, 2025

20902212007690590002945331 32

Rate 2023	Tax 2023	Taxing District	Rate 2024	Tax 2024
		** COUNTY **		
0.0899	939.08	COUNTY OF DU PAGE	0.0832	945.40
0.0180	188.02	PENSION FUND	0.0165	187.48
0.0291	303.98	HEALTH DEPARTMENT	0.0250	284.08
0.0103	107.60	PENSION FUND	0.0114	129.54
0.1001	1,045.64	FOREST PRESERVE DIST	0.1213	1,378.32
0.0075	78.34	PENSION FUND	0.0097	110.22
0.0132	137.86	DU PAGE AIRPORT AUTH	0.0122	138.64
		** LOCAL **		
NO LEVY	0.00	DU PAGE WATER COMM	NO LEVY	0.00
0.0315	329.04	DOWNERS GROVE TWP	0.0303	344.28
0.0003	3.14	PENSION FUND	0.0001	1.14
0.0528	551.54	DOWNERS GR TWP RD	0.0506	574.96
0.0008	8.36	PENSION FUND	0.0008	8.82
0.2941	3,072.12	VLG OF HINSDALE	0.2673	3,037.32
0.1080	1,096.80	PENSION FUND	0.1166	1,324.92
0.1809	1,889.74	VLG HINSDALE LIBR	0.1536	1,745.36
0.0076	79.38	PENSION FUND	0.0084	96.44
NO LEVY	0.00	FLAGG CRK WATER REC	NO LEVY	0.00
		** EDUCATION **		
2.5107	26,226.26	GRADE SCHL DIST 181	2.4215	27,515.36
0.0448	467.98	PENSION FUND	0.0434	493.16
1.6596	17,335.84	HIGH SCHOOL DIST 86	1.5964	18,139.60
0.0439	458.58	PENSION FUND	0.0366	415.88
0.1907	1,992.00	COLLEGE DU PAGE 502	0.1794	2,038.80
		** TIF **		
5.3708	56,102.32	TOTALS	5.1841	58,906.62
2023	1,044,580	Assessed Value	2024	1,136,294

Mailed to:
HINSDALE PARTNERSHIP LLC
550 N MONROE ST
HINSDALE IL 60521

Property Location:
550 N OGDEN AVE
HINSDALE IL 60521

Township Assessor:
DOWNERS GROVE
630-719-6630

Tax Code:
9059

Property Index Number:
09-02-212-007

CHANGE OF NAME/ADDRESS: CALL 630-407-5900

* S OF A FACTOR 1.0878

1st INST PAID May 08, 2025
2nd INST DUE ON September 02, 2025

TIF Frozen Value	
Fair Cash Value	3,409,200
Land Value	578,721
+ Building Value	556,573
= Assessed Value	1,136,294 *
x State Multiplier	1.0000
- Equalized Value	1,136,294
- Residential Exemption	
- Senior Exemption	
- Senior Freeze	
- Disabled Veteran	
- Disability Exemption	
- Returning Veteran Exemption	
- Home Improvement Exemption	
- House Abatement	
= Net Taxable Value	1,136,294
x Tax Rate	5.1841
= Total Tax Due	58,906.62
- Less Advance Payment	
- Commercial Abatement	
+ PACE Reimbursement	
= Net Due as of 07/17/25	29,453.31

2024 DuPage County Real Estate Tax Bill
Gwen Henry, CPA, County Collector
421 N. County Farm Road
Wheaton, IL 60187

Office Hours - 8:00 am -4.30 pm, Mon - Fri
Telephone = (630) 407-5900

ATTACHMENT 2
Site Ownership

CHANGE OF NAME AND/OR MAILING ADDRESS - CHECK BOX ON FRONT OF COUPON

Property Index Number ☐☐ — ☐☐ — ☐☐☐ — ☐☐☐

Name

Mailing Address

City State Zip

Area Code and Phone Number

I certify that I am the owner and authorize the above name and/or address change.

Signature _____ Date _____

Print Name _____

CHANGE OF NAME AND/OR MAILING ADDRESS - CHECK BOX ON FRONT OF COUPON

Property Index Number ☐☐ — ☐☐ — ☐☐☐ — ☐☐☐

Name

Mailing Address

City State Zip

Area Code and Phone Number

I certify that I am the owner and authorize the above name and/or address change.

Signature _____ Date _____

Print Name _____

HELPFUL INFORMATION

Failure to receive a bill does not relieve the taxpayer of penalty if payment is late.
This is the only bill you will receive.This bill includes a separate payment coupon for each installment.
All checks are electronically deposited upon receipt, regardless of date on check. Funds must be in U.S. dollars.
Payments returned to us by your bank as unpaid will be subject to a $25.00 return item fee plus applicable penalties.
Personal checks received after 10/31/25 will be returned.
No payment will be accepted after 11/19/25 regardless of postmark.

CONVENIENT WAYS TO PAY

Banks: Thru 09/02/25 (see website for participating banks)
Mail Thru 09/30/2025:
DuPage County Collector, P.O. Box 4203, Carol Stream, IL 60197
Mail After 09/30/2025:
DuPage County Collector, 421 N. County Farm Rd, Wheaton, IL 60187
Online: Thru 10/31/25 using Bank account transfer or with Visa, Mastercard or Discover.
- 2.10% Credit Card convenience fee to service provider

Drop Box: Thru 11/03/25 by 8:00 am
South Parking Lot, 421 N. County Farm Rd, Wheaton
Phone: Thru 11/18/25 (855)795-3091 (Credit Cards with 2.10% fee)
In Person: Thru 4:30pm on 11/19/25
Treasurer's Office, 421 N. County Farm Rd, Wheaton

SENIOR CITIZEN PROGRAMS - 65 and older

SENIOR ASSESSMENT FREEZE and SENIOR EXEMPTION
Contact Supervisor of Assessments 630-407-5858

SENIOR CITIZEN DEFERRAL
Contact County Treasurer 630-407-5900

IMPORTANT DATES

06/02/25 1st installment due date
09/02/25 2nd installment due date
10/03/25 Payment deadline to avoid publication
10/21/25 Certified delinquent bills mailed
10/31/25 Last day to pay online
11/03/25 Certified funds required for payment
11/03/25 $10 newspaper publication fee assessment begins
11/19/25 In-office payment deadline 4:30pm
11/20/25 Tax Sale

***EQUALIZATION FACTORS**

Equalization factors imposed by the State and by DuPage County are used to insure that assessment levels in all nine townships are at the statutory level of assessment of 33.33% of fair cash value. The Illinois Department of Revenue equalization factor (state multiplier) is shown on the front of the bill. The DuPage County Supervisor of Assessments (S of A) equalization factor is also shown on the front of this tax bill*.

After September 30, 2025: Mail payment to the DuPage County Collector, 421 N. County Farm Rd., Wheaton, IL 60187
DuPage County Treasurer's website: www.dupagecounty.gov/elected_officials/treasurer

ATTACHMENT 3
Operating Entity/Licensee

Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center is licensed by the Illinois Department of Public Health. The license is in Good Standing.

ATTACHMENT 3
Certificate of Good Standing - Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

File Number 0051479-9

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

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*

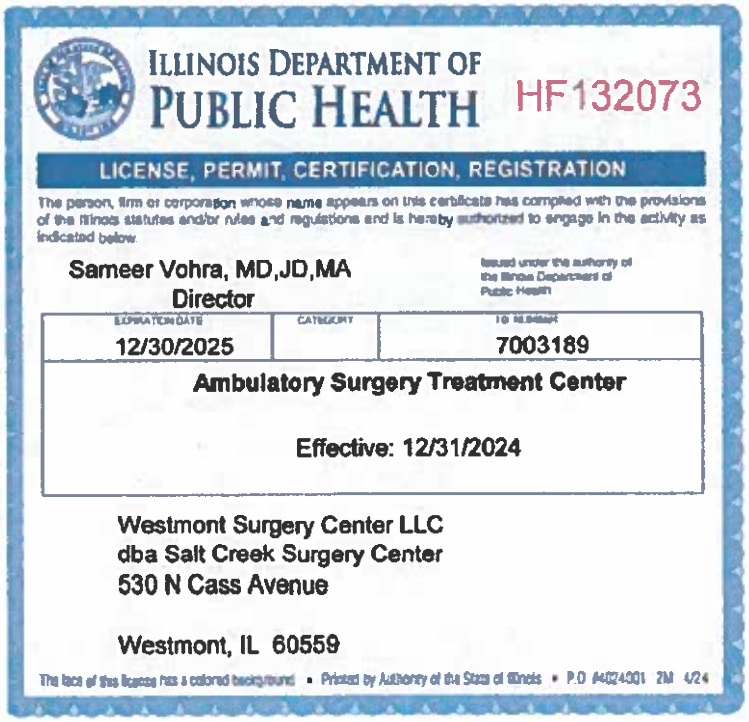
WESTMONT SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 02, 2001, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 17TH *day of* JULY *A.D.* 2025 .

Authentication #: 2519803398 verifiable until 07/17/2026
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

ATTACHMENT 3
IDPH License - Westmont Surgery Center, LLC
d/b/a Salt Creek Surgery Center



ILLINOIS DEPARTMENT OF PUBLIC HEALTH

HF132073

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Sameer Vohra, MD,JD,MA
Director

Issued under the authority of the Illinois Department of Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
12/30/2025		7003189

Ambulatory Surgery Treatment Center

Effective: 12/31/2024

Westmont Surgery Center LLC
dba Salt Creek Surgery Center
530 N Cass Avenue

Westmont, IL 60559

The face of this license has a colored background • Printed by Authority of the State of Illinois • P.O. #4024001 2M 4/24

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 12/30/2025

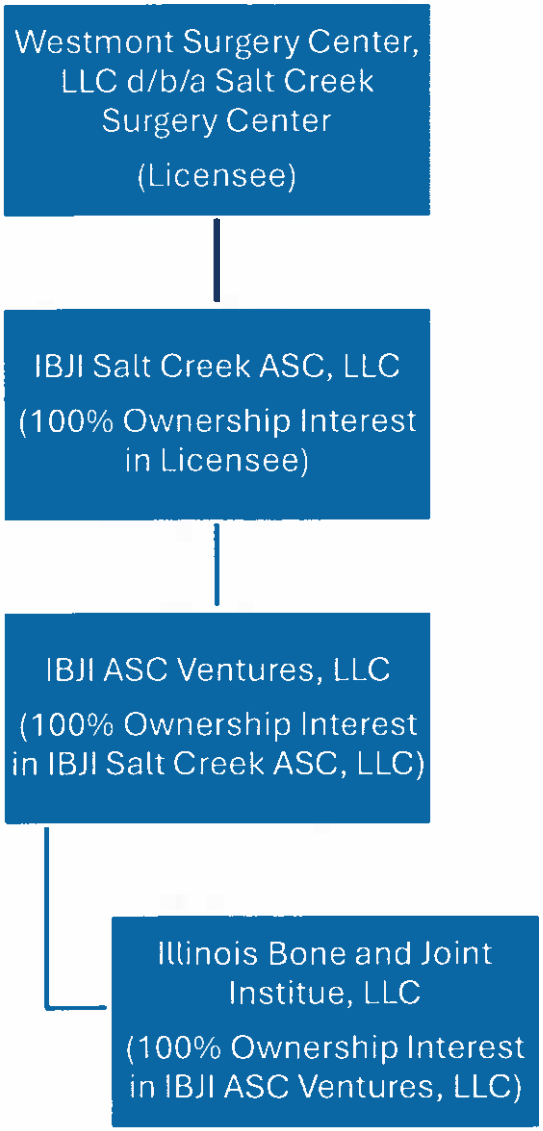
Lic Number 7003189

Date Printed 11/1/2024

Westmont Surgery Center LLC
dba Salt Creek Surgery Center
530 N Cass Avenue
Westmont, IL 60559-1503

FEE RECEIPT NO.

ATTACHMENT 4
Organizational Chart



ATTACHMENT 5
Flood Plain Requirements Letter

Salt Creek Surgery Center
530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

John Kniery
Board Administrator
Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: Flood Plain Requirements- Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center

Dear Mr. Kniery:

As representative of Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center, I Giridhar Burra, M.D., affirm that the proposed relocation for Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center complies with Illinois Executive Order #2005-5. The proposed location, 550 W. Ogden Ave., Hinsdale, IL 60521, is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").
I hereby certify this true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

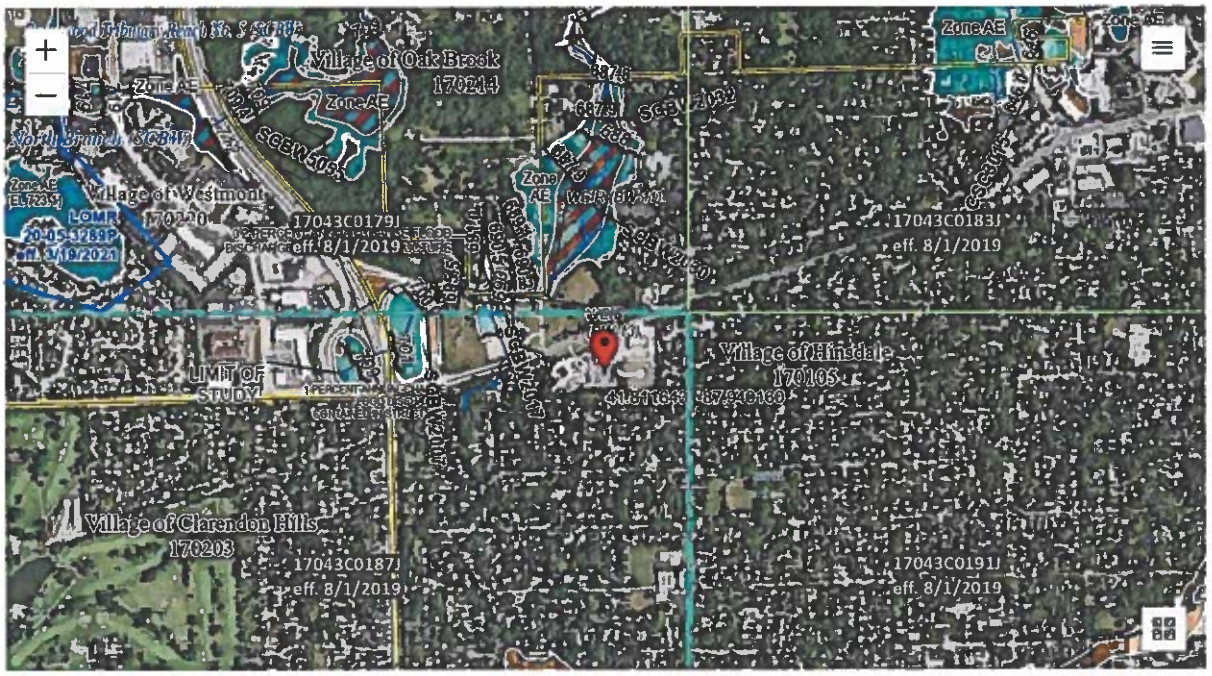
Giridhar Burra, M.D.
Managing Member
Salt Creek Surgery Center

Joint Commission

ATTACHMENT 5
Flood Plain Requirements Letter

FLOOD PLAIN MAP

550 W. Ogden Ave., Hinsdale, IL 60521



ATTACHMENT 6
Historical Preservation Act Requirements

The Applicant previously submitted a request for determination to the Illinois Department of Natural Resources - Preservation Services Division. A final determination has not been received to date but will be provided to the Board upon receipt. A copy of the request is enclosed below.

ATTACHMENT 6
Historical Preservation Act Requirements

Benesch

Juan Morado, Jr.
71 South Wacker Drive, Suite 1600
Chicago, Illinois 60606-4637
Direct Dial: 312.212.4967
Fax: 312.767.9192
jmorado@beneschlaw.com

July 21, 2025

VIA E-MAIL

Jeffrey Kruchten
Chief Archaeologist
Preservation Services Division
Illinois Historic Preservation Office Illinois Department of Natural Resources
1 Natural Resources Way
Springfield, IL 62702
SHPO.Review@illinois.gov

Re: Certificate of Need Application for Ambulatory Surgical Treatment Center

Dear Jeffrey:

I am writing on behalf of my client, Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center, ("Salt Creek ASC") to request a review of the project area under Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). Salt Creek ASC is submitting an application for a Certificate of Need from the Illinois Health Facilities and Services Review Board. Salt Creek ASC is relocating to a new location at 550 W. Ogden Ave., Hinsdale, IL 60521, and provide General Surgery, Orthopedic Surgery, Pain Management, and Podiatry, which requires a CON application.

For your reference, we have enclosed pictures of the existing lot and topographic maps showing the general location of the project. We respectfully request review of the project area and a determination letter at your earliest convenience. Thank you in advance for all of the time and effort that will be going into this review.

Very truly yours,

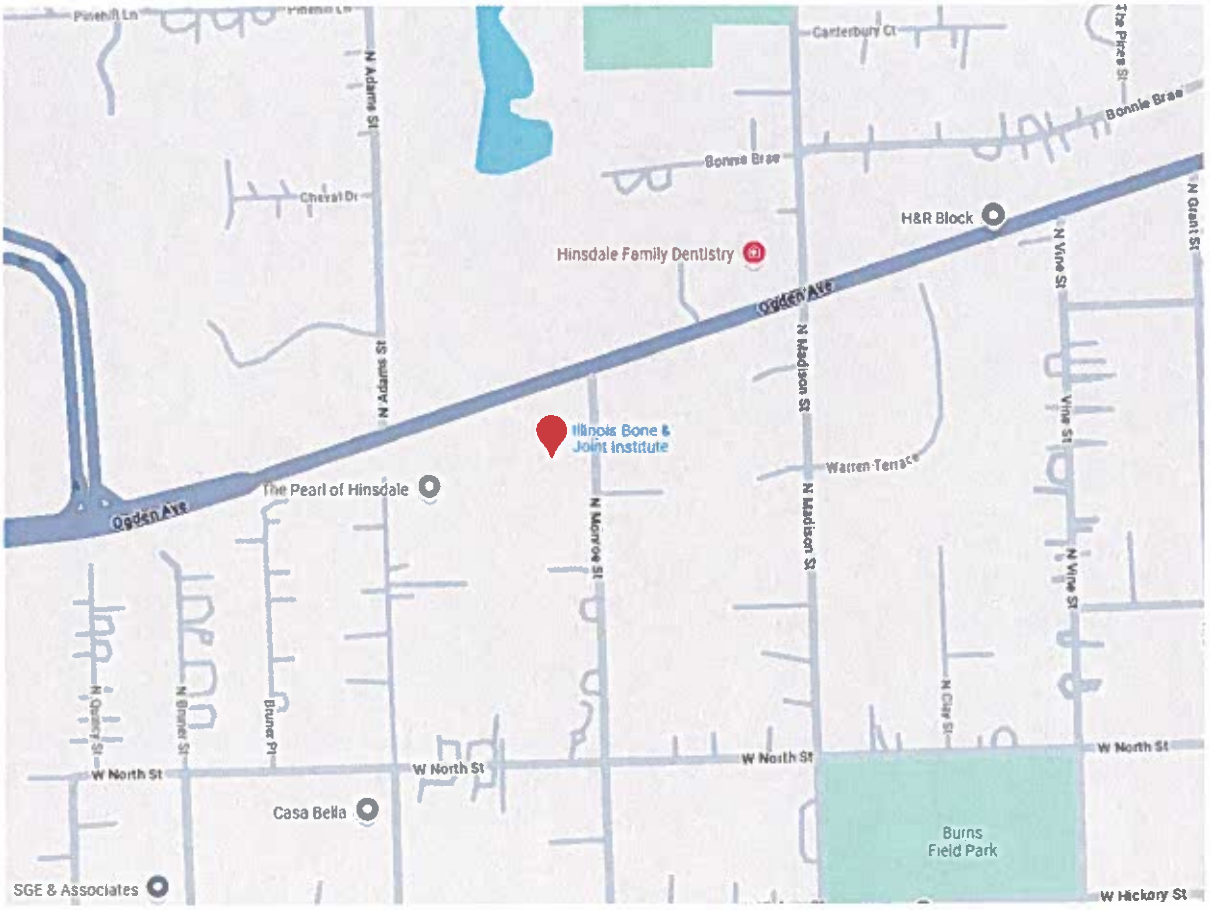
BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP

Juan Morado, Jr.

ATTACHMENT 6
Historical Preservation Act Requirements

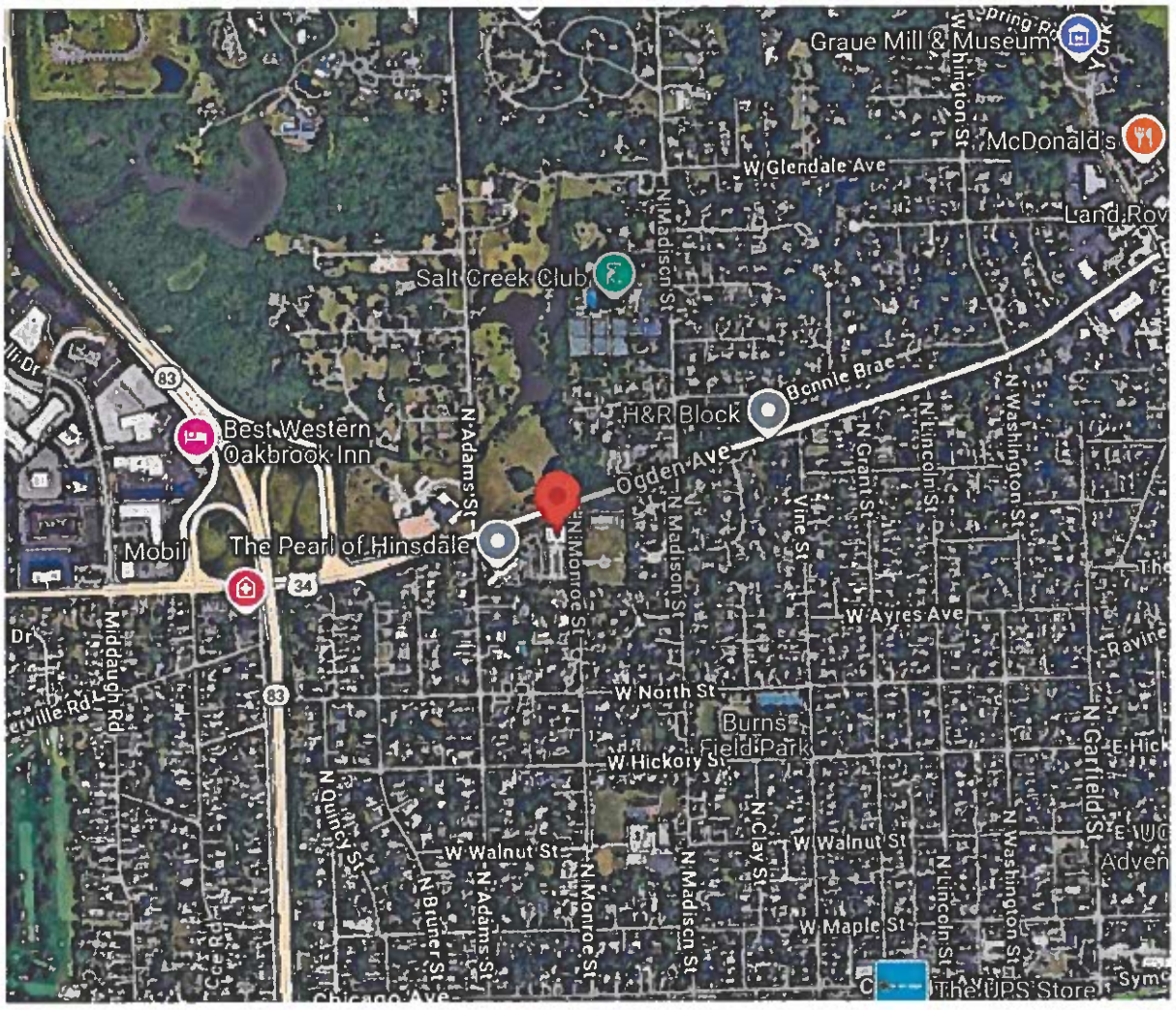
Attachment 1

Topographical Map



ATTACHMENT 6
Historical Preservation Act Requirements

Aerial Map



ATTACHMENT 6
Historical Preservation Act Requirements

Street view of property

ATTACHMENT 6
Historical Preservation Act Requirements

Aerial view

ATTACHMENT 7
Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs	-	-	-
Site Survey and Soil Investigation	$21,762	$23,238	$45,000
Site Preparation	$136,010	$145,240	$281,250
Off Site Work	-	-	-
New Construction Contracts	$6,983,520	$8,035,350	$15,018,870
Modernization Contracts	-	-	-
Contingencies	$310,365	$331,425	$641,790
Architectural/Engineering Fees	$96,719	$103,281	$200,000
Consulting and Other Fees	$120,898	$129,102	$250,000
Movable or Other Equipment (not in construction contracts)	$1,305,700	$1,394,300	$2,700,000
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value of Leased Space or Equipment	$1,870,042	$1,996,934	$3,866,976
Other Costs to Be Capitalized	$217,617	$232,383	$450000
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	$10,904,860	$12,222,776	$23,127,636
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	-	-	-
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	$9,034,818	$10,225,842	$19,260,660
Leases (fair market value)	$1,870,042	$1,996,934	$3,866,976
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	**$10,904,860**	**$12,222,776**	**$23,127,636**
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

ATTACHMENT 7
Project Costs and Sources of Funds

New Construction Contracts - The proposed project will result in the establishment of a 6 OR Ambulatory Surgical Treatment Center. The project building costs are based on national architectural and construction standards and adjusted to compensate for several factors. The clinical construction costs are estimated to be $6,983,520 or $303.76 per clinical square foot.

General Conditions	$399,058
Mechanical (Fire, Plumbing, HVAC, Electrical)	$3,391,995
Carpentry and Wood Work	$997,646
Structural Steel	$399,058
Doors and Windows	$199,529
Flooring	$299,294
Painting	$399,058
Ceiling Work	$159,623
Tile	$199,529
Signage	$39,906
Miscellaneous-Builder's Risk Insurance, Bonds, Contractor's Fees, etc...)	$498,823

Contingencies - The contingency costs listed are for unforeseeable events relating to construction costs that are not included in the construction contracts. The clinical costs are estimated to be $310,365 or 4.44% of the new construction contract costs.

Architectural/Engineering Fees - The clinical project cost for architectural/engineering fees are projected to be $96,719 or 1.33% of the new construction and contingencies costs.

Architectural Services	$96,719

Consulting and Other Fees - The Project's consulting fees are primarily comprised of various project related fees, additional state/local fees, and other CON related costs.

Legal Fees	$71,116.47
Permitting Fees	$7,111.65
CON Filing Fee	$14,223.29
Miscellaneous Fees	$28,446.59

Moveable Equipment Costs - The moveable equipment costs are a necessary component for the operation of the updated operating rooms at the facility. The clinical costs are being divided between the six proposed operating rooms, resulting in a cost of $217,616.67 per operating room or a total of $1,305,700. The applicant is able to keep equipment costs down for this project by repurposing existing equipment from their existing ASTC that is being discontinued.

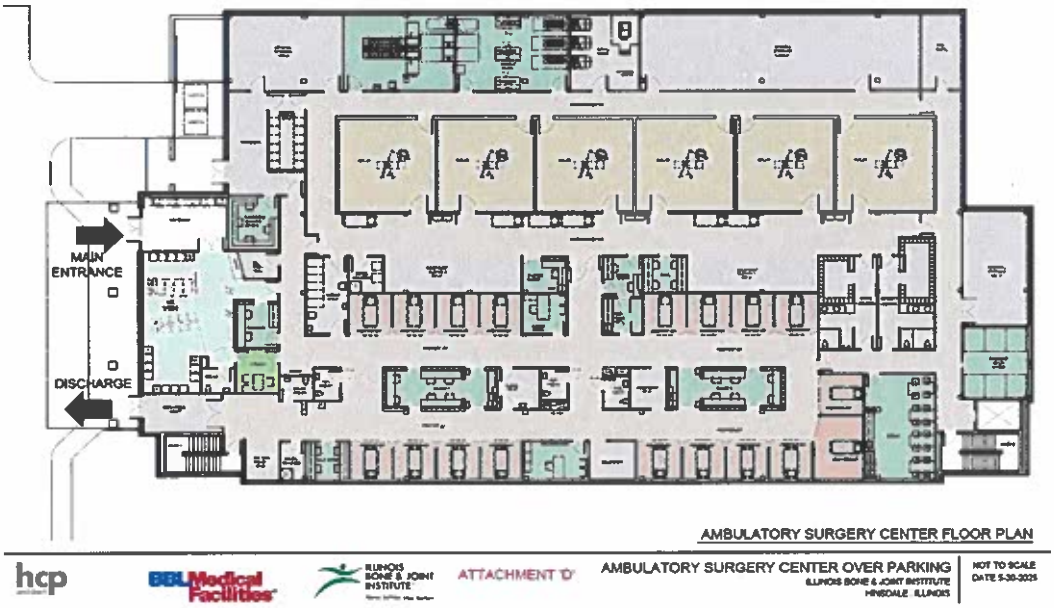
Communications	$34,665
Water Treatment	$491,082
Bio-Medical Equipment	$43,331
Clinical Furniture (Dialysis Chairs)	$86,662
Clinical Equipment	$462,195
Office Equipment	$72,218
Office Furniture	$115,549

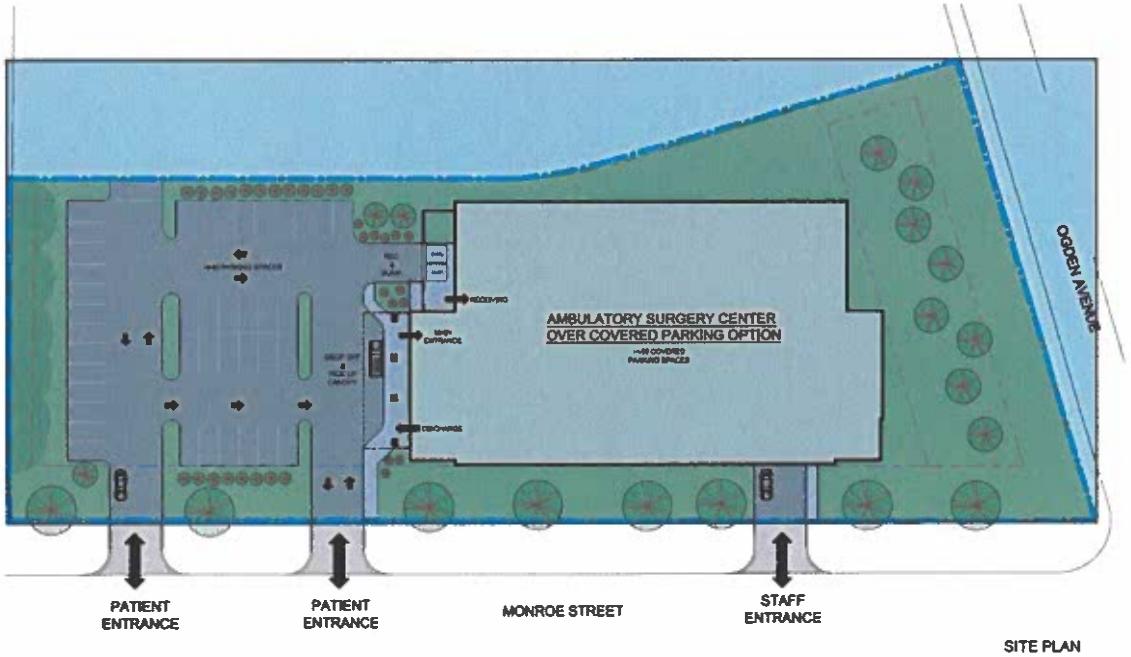
ATTACHMENT 7
Project Costs and Sources of Funds

FMV of Leased Space - The applicant intends to enter into a 5-year lease with an initial rent rate of $735,680/year (or $61,307/month). The lease calls for annual increases in the amount of 2.5% per year.

ATTACHMENT 8
Project Status and Completion Schedules

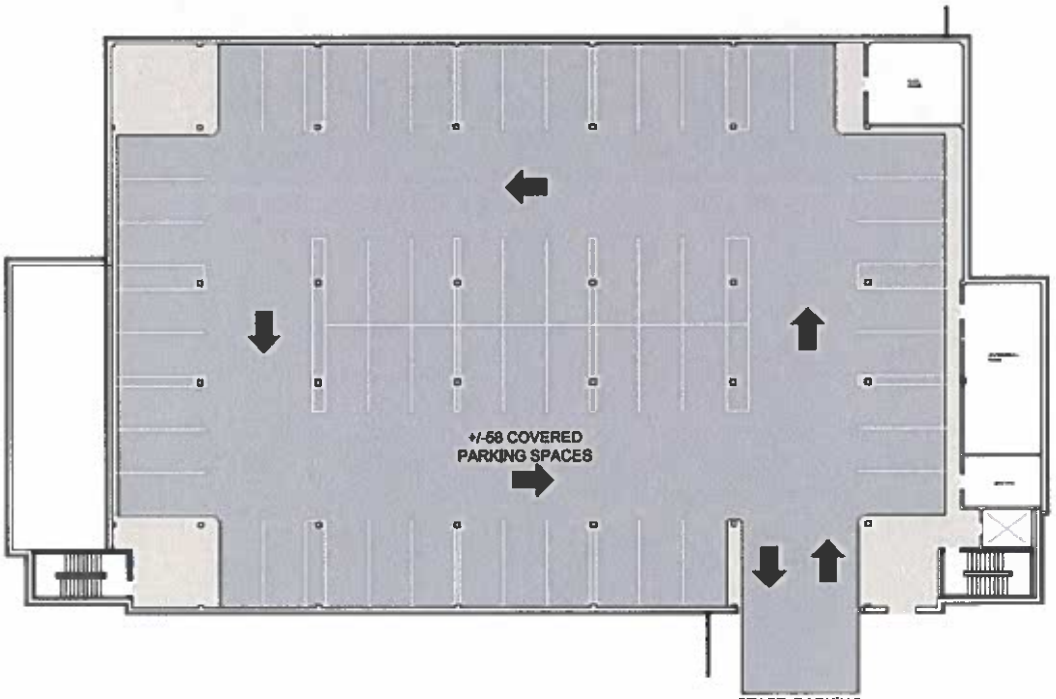
The proposed project plans are still at a schematic stage. The proposed project completion date is December 31, 2027. Financial commitment for the project will occur following permit issuance, but in accordance with HFSRB regulations.





ATTACHMENT 8
Project Status and Completion Schedules

RENDERING



PARKING LEVEL FLOOR PLAN

ATTACHMENT 9
Cost Space Requirement

The proposed project involves the establishment of an ASTC with 6 operating rooms in a total of 47,540 GSF.

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
ASTC	$10,904,860	-	22,990	22,990	-	-	-
Total Clinical	$10,904,860	-	22,990	22,990	-	-	-
NON-REVIEWABLE							
Administrative	$12,222,776	-	24,550	24,550	-	-	-
Total Non-clinical	$12,222,776	-	24,550	24,550	-	-	-
TOTAL	**$23,127,636**	**-**	**47,540**	**47,540**	**-**	**-**	**-**

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

ATTACHMENT 11
Background of the Applicants

The following information is provided to illustrate the qualifications, background and character of the Applicant and to assure the Health Facilities and Services Review Board that AST will provide proper care.

Salt Creek Surgery Center

Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center - This is the corporate entity that holds the license and owns the existing facility. Salt Creek Surgery Center is a physician-owned ambulatory surgical center located in Westmont, Illinois, and operated by physicians affiliated with the Illinois Bone & Joint Institute (IBJI). Specializing in outpatient orthopedic procedures, Salt Creek offers a high-quality, cost-effective alternative to hospital-based surgery. The center is designed for efficiency and patient comfort, focusing on minimally invasive techniques in areas such as sports medicine, joint reconstruction, hand and upper extremity surgery, and foot and ankle procedures. By operating independently, Salt Creek allows IBJI physicians to deliver personalized care in a streamlined setting that emphasizes convenience, safety, and positive surgical outcomes for patients.

1. The proposed project is brought by Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center. The ownership of the facility is reflected in Attachment 4.

2. Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center does not directly have an ownership interest in any other health care facility. The Applicant certifies that there have been no adverse actions taken during the three (3) years prior to the filing of this Application. A letter certifying the above information is included at Attachment 11.

3. We have included a letter authorizing access to the HFSRB and IDPH to verify information about the Applicant at Attachment 11.

IBJI Salt Creek ASC, LLC

IBJI Salt Creek ASC, LLC is a wholly owned subsidiary of Illinois Bone and Joint Institute, LLC ("IBJI") through IBJI ASC Ventures, LLC.

Illinois Bone and Joint Institute, LLC and IBJI ASC Ventures, LLC - IBJI ASC Ventures, LLC is a wholly owned subsidiary of Illinois Bone and Joint Institute, LLC ("IBJI"). Founded in 1990, Illinois Bone & Joint Institute (IBJI) has grown to become the largest independent orthopedic group in Illinois and one of the largest in the country. With more than 150 board-certified physicians specializing in every aspect of orthopedic care, IBJI provides comprehensive musculoskeletal services to patients of all ages. The practice's size and breadth allow it to offer highly specialized expertise in areas such as sports medicine, joint replacement, spine care, hand surgery, foot and ankle care, and pediatric orthopedics. By maintaining a collaborative approach among its physicians, IBJI ensures that patients benefit from coordinated treatment plans and integrated care across multiple specialties.

IBJI's model emphasizes not only surgical excellence but also a full continuum of non-surgical orthopedic care. In addition to physician services, the practice offers on-site advanced imaging, pain management, rheumatology, physical therapy, occupational therapy, and performance training. Its OrthoAccess® walk-in clinics have become a key part of the community, providing same-day access for acute orthopedic injuries without the need for emergency room visits. This integrated, patient-centered model helps streamline care delivery, improve communication among providers, and support faster recovery for patients—all within a single, coordinated system.

ATTACHMENT 11
Background of the Applicants

As a leader in musculoskeletal care in Illinois, IBJI is known for its commitment to innovation, outcomes, and service excellence. The group's network spans dozens of locations across the Chicagoland area, including surgery centers, rehabilitation facilities, and clinical offices. By fostering strong community ties and continually investing in clinical advancements, IBJI remains at the forefront of orthopedic medicine in Illinois. Its mission is not only to treat injuries and chronic conditions but to empower patients with education, preventive care, and long-term wellness solutions.

IBJI ASC Ventures, LLC owns 100% interest in the facility.

ATTACHMENT 11
Background of the Applicants

Salt Creek Surgery Center

530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

John Kniery
Administrator
Health Facilities and Services Review Board
525 W. Jefferson Street, Floor 2
Springfield, IL 62761

Re: Applicant Certification

Dear Mr. Kniery:

As a representative of Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center, located at 530 N Cass Ave, Westmont, Illinois 60559, I, Giridhar Burra, M.D., affirm that all questionnaires and data required by the Health Facilities and Services Review Board and IDPH (e.g. annual questionnaires, capital expenditure surveys, etc.) will be provided through the date of the discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.

I hereby certify this is true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Giridhar Burra, M.D.
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center

Joint Commission

ATTACHMENT 11
Background of the Applicants

Facilities owned by IBJI ASC Ventures, LLC and Illinois Bone and Joint Institute, LLC are included below:

Facility Name	IDPH Facility Number
Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center ("Applicant")	7003189
Plainfield Surgery Center, LLC	7003135
Ravine Way Surgery Center	7003080
OAK Surgery Center	7003244
Illinois Sports Medicine and Orthopedic Surgery Center, LLC	7003118

ATTACHMENT 11
Background of the Applicants

Salt Creek Surgery Center
530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: Certification and Authorization Letter- Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center-

Dear Mr. Kniery,

As a representative of Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center, IBJI Salt Creek ASC, LLC, IBJI ASC Ventures, LLC, Illinois Bone and Joint Institute, LLC, give authorization to the Health Facilities and Services Review Board and the Illinois Department of Public Health ("IDPH") to access documents necessary to verify the information submitted including, but not limited to: official records of IDPH or other state agencies, the licensing or certification records of other states, and the records of nationally recognized accreditation organizations.

I further verify that Westmont Surgery Center, LLC and IBJI Salt Creek ASC, LLC has no ownership interest in other healthcare facilities. IBJI ASC Ventures, LLC and Illinois Bone and Joint Institute, LLC own and operate the ASTCs listed below. These facilities have had no adverse actions to report for the past three (3) years. IBJI ASC Ventures, LLC and Illinois Bone and Joint Institute, LLC have an ownership interest in several healthcare facilities including:

Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center ("Applicant")
Plainfield Surgery Center, LLC
Ravine Way Surgery Center
OAK Surgery Center
Illinois Sports Medicine and Orthopedic Surgery Center, LLC

I hereby certify this is true and based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Giridhar Burra, M.D.
Managing Member
Salt Creek Surgery Center

Joint Commission

ATTACHMENT 12
Purpose of the Project

Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center ("Salt Creek") submits this application for a Certificate of Need to relocate its licensed ambulatory surgical treatment center (ASTC) from its current location at 530 N. Cass Avenue, Westmont, Illinois, to a new site at 550 W. Ogden Avenue, Hinsdale, Illinois. Salt Creek is a physician-led, multi-specialty ASTC with a strong focus on orthopedic surgery, pain management, podiatric surgery, and general surgery. This relocation is proposed in conjunction with the discontinuation of operations at the existing Westmont facility, a strategic move designed to address facility limitations, improve patient access, and enhance operational efficiency in delivering outpatient surgical care. The project qualifies as a substantive application under 77 Ill. Adm. Code 1110.20(c)(1)(A)(i) because it involves the relocation of an existing licensed healthcare facility.

The relocation of Salt Creek is driven by a combination of patient access needs, healthcare delivery trends, and operational realities. The existing Westmont facility faces physical constraints that limit its ability to meet the growing demand for outpatient surgical procedures, particularly in orthopedics. By relocating to a modern, better-configured site in Hinsdale—just two miles away—Salt Creek will be positioned to sustain its six-operating-room capacity in an optimized clinical environment. This move will not only preserve access for the community but also enhance the efficiency of care delivery, patient flow, and surgical scheduling, ultimately benefiting both patients and providers.

At the core of this project is the national and statewide shift in surgical care delivery, driven by the Centers for Medicare & Medicaid Services (CMS) and private payers, which strongly encourages the migration of suitable surgical procedures from hospital outpatient departments (HOPDs) to ambulatory surgical centers. CMS's additions to the ASC Covered Procedures List over the past decade have reflected this strategy, especially for orthopedic procedures such as total joint replacements. As of recent updates, common orthopedic procedures like total knee arthroplasty and hip replacement are not only approved for ASC settings but are also reimbursed at rates that incentivize the use of outpatient facilities. This policy shift recognizes the proven safety, efficacy, and cost savings associated with performing these procedures in ASCs rather than higher-cost hospital environments.

Numerous studies affirm that ASCs deliver high-quality outcomes comparable to, or better than, hospital-based settings for many elective procedures, while also providing significant cost savings. For example, outpatient total joint replacements performed at ASCs have demonstrated reduced complication rates, lower infection risks, shorter recovery times, and higher patient satisfaction. Additionally, ASCs consistently operate at lower cost structures, with per-procedure savings of 12–26% compared to hospitals, depending on procedure complexity. These cost savings directly benefit patients, payers, and public healthcare programs, such as Medicare and Medicaid, while also easing the financial burden on commercially insured patients who face growing out-of-pocket costs.

Orthopedics, in particular, represents one of the fastest-growing sectors of outpatient surgery, fueled by an aging population, rising rates of degenerative joint disease, and improved surgical techniques. National projections indicate a significant increase in demand for total joint replacements over the next decade, with some estimates forecasting a doubling of procedures by 2030. Salt Creek's relocation positions it to respond effectively to this demand by offering a streamlined, patient-friendly environment designed specifically for outpatient orthopedic care. This will also alleviate pressure on hospital surgical departments, allowing hospitals to focus resources on higher-acuity, emergent, or inpatient surgical needs.

Furthermore, Salt Creek's relocation aligns with the Illinois Certificate of Need program's objectives of promoting access, supporting cost-effective healthcare delivery, and ensuring the optimal use of existing healthcare resources. By enhancing its ability to provide high-quality outpatient surgical services in a lower-cost, non-hospital setting, Salt Creek will support state and national efforts to shift appropriate procedures away from higher-cost hospital environments—reducing overall healthcare expenditures while maintaining clinical excellence.

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This project also reinforces the value of physician-led, community-focused surgical care. Salt Creek is operated by physicians affiliated with Illinois Bone and Joint Institute (IBJI), the largest orthopedic group in Illinois, known for its leadership in musculoskeletal care. This affiliation ensures strong clinical governance, a commitment to quality outcomes, and a vested interest in meeting community needs. The relocation will allow IBJI's physician partners to continue providing patient-centered care in a setting designed for surgical efficiency, quality, and patient comfort.

In conclusion, this relocation project will maintain and enhance access to critical outpatient surgical services for Hinsdale, Westmont, and surrounding communities. It will strengthen Salt Creek's capacity to meet the growing demand for orthopedic, podiatric, pain management, and general surgical procedures. Moreover, it will align Salt Creek's operations with broader trends in healthcare policy, cost containment, and patient preference—helping ensure that high-quality surgical care remains both accessible and affordable for Illinois residents.

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HSR Health Services Research

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RESEARCH ARTICLE

Ambulatory Surgery Centers and Their Intended Effects on Outpatient Surgery

Brent K. Hollenbeck, Rodney L. Dunn, Anne M. Suskind, Seth A. Strope, Yun Zhang, and John M. Hollingsworth

Objectives. To assess the impact of ambulatory surgery centers (ASCs) on rates of hospital-based outpatient procedures and adverse events.
Data Sources. Twenty percent national sample of Medicare beneficiaries.
Study Design. A retrospective study of beneficiaries undergoing outpatient surgery between 2001 and 2010. Health care markets were sorted into three groups—those with ASCs, those without ASCs, and those where one opened for the first time. Generalized linear mixed models were used to assess the impact of ASC opening on rates of hospital-based outpatient surgery, perioperative mortality, and hospital admission.
Principal Findings. Adjusted hospital-based outpatient surgery rates declined by 7 percent, or from 2,333 to 2,163 procedures per 10,000 beneficiaries, in markets where an ASC opened for the first time ($p < .001$ for test between slopes). Within these markets, procedure use at ASCs outpaced the decline observed in the hospital setting. Perioperative mortality and admission rates remained flat after ASC opening (both $p > .4$ for test between slopes).
Conclusions. The opening of an ASC in a Hospital Service Area resulted in a decline in hospital-based outpatient surgery without increasing mortality or admission. In markets where facilities opened, procedure growth at ASCs was greater than the decline in outpatient surgery use at their respective hospitals.
Key Words. Ambulatory surgery, ambulatory surgery center, utilization

Pressures for improved efficiency and enhancements in perioperative care have prompted considerable growth in outpatient surgery in the United States. Of the 100 million procedures performed in 2006, approximately two-thirds were performed in the outpatient setting (Cullen, Hall, and Golosinskiy 2009). Concurrent with this evolution, there has been a proliferation of free-standing ambulatory surgery centers (ASCs) that are designed to offload volume from the more expensive hospital-based outpatient department (MedPAC 2013a,b).

Because ASCs provide outpatient surgery at a lower cost per episode (Centers for Medicare and Medicaid Services 2008; MedPAC 2013b), they

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have the potential to improve the efficiency of the delivery system insofar as they are able to reduce rates of hospital-based surgery without negatively impacting quality. Previous work in this area demonstrated modest declines in hospital-based surgery after ASC entry (Lynk and Longley 2002; Bian and Morrisey 2007; Courtemanche and Plotzke 2010), although these studies predated the proliferation of facilities that occurred in the last decade. Further, some worry that ASCs lack oversight and accountability, raising concerns about the quality of care delivered in these facilities (Office of Inspector General 2002). For instance, lapses in infection control (Schaefer et al. 2010) have further amplified these concerns and are partly responsible for the recent implementation of a value-based purchasing program for ASC payments by the Centers for Medicare and Medicaid Services (2010). The recent increase in surgeon-owned freestanding facilities (Ambulatory Surgery Center Association 2009), and their associated financial incentives, has the potential to exacerbate gaps in quality by encouraging the redistribution of less suitable patients (i.e., those with multiple medical problems) to ASCs.

For these reasons, we used national Medicare data to assess the extent to which freestanding ASCs have had their intended effects on the delivery system. In particular, we were interested in the impact of ASCs on rates of hospital-based outpatient surgery and quality, as measured by perioperative mortality and hospital admission.

METHODS

Study Subjects

We performed a retrospective cohort study of fee-for-service Medicare beneficiaries undergoing outpatient surgical procedures between 2001 and 2010. We used a 20 percent national sample of claims in the Carrier, Outpatient, Medicare Provider Analysis and Review, and Denominator files. We included only those patients aged 65–99 years who underwent a procedure at either a

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hospital-based facility or freestanding ASC and who were eligible for Medicare Part B. Information on age, race, and gender of patients was obtained from the Denominator file. Comorbidity was assessed using *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnoses codes submitted in the year preceding the index outpatient procedure and categorized into groups using established methods (Klabunde et al. 2000). Additional detail on the local health care and regulatory milieu was specified using data from the Area Resource File (Health Resources and Services Administration 2013) and the American Health Planning Association's National Directory (American Health Planning Association 2012). Specifically, we included measures of socioeconomic class, education, capacity for surgery (i.e., surgeons per capita and hospital discharges per capita), presence of certificate of need regulations, and population density.

Surgical procedures were enumerated using Healthcare Common Procedure Coding Systems codes. The type of procedure (inpatient vs. outpatient) and setting (hospital outpatient department vs. ASC) were determined using explicit codes in the Medicare files. We used Hospital Service Areas (HSAs), as described by the Dartmouth Atlas (Wennberg 1999), to reflect distinct health care markets. We chose HSAs, as opposed to another unit of geography, because outpatient surgery is elective, discretionary, and low risk. Thus, patients are likely to undergo such procedures where they commonly receive most of their primary health care (i.e., locally) as opposed to where they would be referred to for tertiary care.

Freestanding ASCs were identified in each HSA using the Provider of Services Extract reported by the Centers for Medicare and Medicaid Services (CMS). These files, released annually, provide detailed information on all Medicare-certified ASCs in the United States, including the facility location. HSAs were sorted into one of three mutually exclusive categories: (1) those with at least one ASC present as of January 1, 2001; (2) those initially without an ASC but in which at least one opened between 2001 and 2010; and (3) those without an ASC throughout the study. A small number of HSAs (n = 190, or 5.5 percent) had ASCs open and close during the study and were excluded from the analysis.

Outcomes

The primary objective was to assess the extent to which the opening of an ASC in a health care market had its intended effects of offloading surgery from the hospital without compromising quality. Our first outcome was population

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rates of hospital-based outpatient surgery, which includes all surgical procedures (i.e., Healthcare Common Procedure Coding System codes between 10,000 and 69,999) that were performed in either the hospital or ASC over the study period. Ideally, the opening of an ASC would facilitate the migration of outpatient surgery from the more expensive hospital to these facilities. For this measure, the numerator consisted of annual counts of hospital-based outpatient procedures within an HSA, and the denominator was comprised of Medicare beneficiaries eligible for Medicare part B residing in each HSA. Because of the stark differences in population size of the two ASC-containing HSA types (e.g., in 2010, a mean of 21,266 beneficiaries in HSAs where ASCs were always present and 9,020 beneficiaries in HSAs where ASCs were added for the first time), we secondarily examined changes in ASC surgery rates within these markets. One concern is that patient migration across HSA boundaries might explain some of the observed changes in procedure use at the hospital. That is, boundary crossing for surgery by a few beneficiaries in the relatively small HSAs where ASCs opened for the first time (e.g., to nearby larger markets with greater ASC capacity) could have a large impact on rates of hospital procedure use. To address this issue, we examined the direct effect of facility opening on procedures performed in the ASC and contrasted them with the observed change in hospital use within each HSA.

In addition to measuring procedure use, we also assessed the impact of ASC opening on quality, as measured by rates of hospital admission and mortality following outpatient surgery. Preferably, the opening of a new facility within a health care market would have no effect on rates of these events. That is, redistribution from the hospital to the ASC should occur without added patient risk. For these aspects of perioperative quality, we examined the impact of ASC opening on the entire population undergoing outpatient surgery (i.e., procedures performed in both the hospital and ASC). One outcome was hospital admission within 30 days after the index surgery. For this measure, the numerator consisted of counts of admissions. The denominator was the amount of time "at risk," expressed in person years, among eligible beneficiaries undergoing outpatient surgery annually. A similar measure was developed for perioperative mortality, in which the numerator consisted of all patients dying within 30 days of an outpatient procedure. Due to concerns that procedure selection might artificially lead to more favorable findings for ASCs (i.e., ASCs would preferentially select procedures with the lowest likelihood of adverse events), we also contrasted rates of mortality between hospitals and ASCs for the 10 most common procedures performed in both settings.

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Statistical Analysis

The three groups of HSAs (ASC always present, ASC never present, ASC opens for the first time) were contrasted according to beneficiary and regional characteristics using nonparametric statistics. To address differences between HSAs, we used multiple propensity score methods (Spreeuwenberg et al. 2010). To this end, we fit a multinomial logistic regression model in which the dependent variable was the HSA group and the independent variables were the aforementioned beneficiary and regional characteristics. The Hausman test was used to verify that the multinomial model met the Irrelevant Alternatives Assumption, and overlapping of the distributions was visually confirmed. For this model, the Wald χ^2 was 789.2 with 24 degrees of freedom ($p < .0001$) and the pseudo R^2 was 0.38. This approach enabled us to effectively calculate the predicted probability of each HSA of being assigned to one of the three market types. These probabilities were then included in subsequent models assessing relationships between HSA group and outcomes.

Longitudinal rates of hospital-based outpatient surgery were estimated after adjustment for their multiple propensity scores, aggregated patient, and regional characteristics using generalized linear mixed models. The unit of analysis was the HSA. We incorporated a random effect for each HSA to account for the correlation between repeated measures within a market. For HSAs where an ASC opened for the first time, "baseline" was classified as the year prior to the first facility opening within its boundaries. For the other two categories of HSAs, "baseline" was randomly assigned and proportionally matched to the "opened for the first time" category so that the distribution of baseline years matched the distribution of baseline years in the "opened for the first time" category. We accounted for temporal trends by introducing the calendar year as a fixed effect and contrasted changes in rates over time both within and between HSA groups. These models were fit using splines with a knot at baseline, which allowed for different linear trends to be assessed in the pre- and post-ASC introduction phases. Splines, interactions, and all adjustment variables were included as fixed effects. In addition to looking at overall rates of hospital-based outpatient surgery, we also sorted patients into groups of procedures (i.e., ophthalmologic, gastrointestinal, and musculoskeletal) commonly performed in ASCs (see Appendix for listing of codes) (MedPAC 2013b).

A similar modeling strategy was used to assess the impact of ASC opening on quality (i.e., hospital admission and mortality) among those undergoing

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an outpatient procedure. However, for these models, the patient was the unit of analysis.

All analyses were performed using *SAS v9.2* (Cary, NC, USA). The probability of a type I error was set at .05 and all testing was two-sided. The institutional review board at the University of Michigan approved this study.

RESULTS

An ASC was introduced into a previously naïve market in 255 HSAs. As shown in Table 1, aggregate beneficiary and regional characteristics varied across the three HSA types. While statistically significant differences were evident across market type for most characteristics, many of these were relatively small in magnitude. Of note, HSAs without ASCs had significantly fewer surgeons per capita and lower population densities (i.e., much more likely to be in a rural setting). All differences between markets abated after multiple propensity score adjustment.

As shown in Figure 1, adjusted rates of hospital-based outpatient surgery remained stable in all HSA types in the 2 years preceding baseline ($p = .22$ for test between the three slopes). However, in HSAs where an ASC opened for the first time, hospital-based outpatient surgery rates declined by 7.4 percent, or from 2,333 to 2,163 procedures per 10,000 beneficiaries ($p < .0001$ for test between the three slopes) during the 4-year period after opening. In contrast, rates of hospital-based outpatient surgery in HSAs where ASCs were always or never present increased by 7.8 percent and 6.6 percent, respectively. The declines in these two market types occurred at a similar pace with one another ($p = .11$ for test between the two slopes).

In terms of outpatient surgery use at ASCs themselves, rates in markets where they were always present remained relatively stable over time, increasing by 52 procedures per 10,000 between baseline and 4 years after baseline ($p = .60$ for trend). In contrast, rates of outpatient surgery in ASCs in HSAs where they opened for the first time increased by 624 procedures per 10,000 during the 4-year period after opening ($p < .001$ for trend). This increase was more than twofold greater than the decline in hospital-based outpatient surgery observed over the same period in these HSAs (i.e., a decrease of 299 procedures per 10,000 between baseline and 4 years after baseline).

The effect of ASC opening to lower rates of hospital-based outpatient surgery held true for each of the common procedures groups (Figure 2). Notably, the strongest relative impact was observed for ophthalmologic sur-

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Table 1: Characteristics of the Population Undergoing Outpatient Surgery Based on National Medicare Data

	Hospital Service Area Type			*p-value*	
	ASC Always Present	*ASC Never Present*	*ASC Added for the First Time*	*Before Multiple PS Correction*	*After Multiple PS Correction*
No. HSAs	837	2,154	255	–	–
No. patients in 2010	17,793,686	6,295,820	2,308,790	–	–
Age, mean	70.6	70.5	70.5	.55	.97
Gender, % female	55.0	53.8	54.9	<.001	.97
Race, % non-white	14.8	10.3	11.3	<.001	.41
Charlson score, % 2 or higher	25.8	23.1	25.0	<.001	.81
Living below poverty, %	14.0	16.0	13.6	<.001	.60
College education or more among those 25 years and older, %	23.5	16.2	23.1	<.001	.42
Log of hospital discharges per 10,000 population	8.8	8.4	8.8	<.001	.94
Log of surgeons per 10,000 population	4.4	2.9	4.4	<.001	.45
Certificate of need, %	64.8	67.7	62.1	.09	.88
Urban, %	79.6	28.0	65.8	<.001	.30

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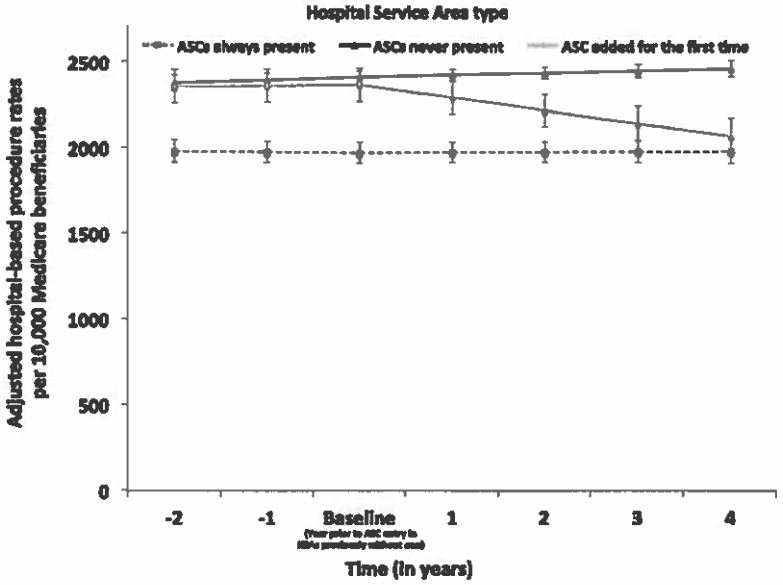
Figure 1: Adjusted Rates of Hospital-Based Outpatient Surgery in Markets Where ASCs Were Always Present, Never Present, and in Those Where an ASC Opened for the First Time. In the period prior to baseline, the rate of change in outpatient surgery across the three market groups was similar ($p = .22$). However, for the 4-year period following baseline, rates of outpatient surgery decreased more rapidly in markets where an ASC was added for the first time ($p < .001$ for change over time relative to HSAs always with and without ASCs)



gery (Figure 2a). Adjusted rates of hospital-based surgery declined by 53.9 percent by 4 years in HSAs where an ASC opened for the first time, or from 408.4 to 188.3 procedures per 10,000 beneficiaries ($p < .0001$ for test between the three slopes). Conversely, hospital-based rates of ophthalmologic surgery actually increased at a similar pace over the 4-year period after baseline in HSAs where ASCs were always and never present, or by 5.7 percent and 6.2 percent, respectively ($p = .11$ for test between the two slopes).

As shown in Figure 3, changes in mortality within 30 days for the 4-year period after baseline did not vary significantly across the three market types ($p = .43$ for test between the three slopes). For each of the 10 most common

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procedures performed in both settings, rates of mortality were similar or significantly lower for those performed in the ASC compared to the hospital. We found no significant change in hospital admission within 30 days of the index procedure (Figure 4) across the three market types. Rates of admission in markets where an ASC opened for the first time were flat during the 4-year period after baseline (7.6 admissions per 1,000 person years at baseline and 7.6 admissions per 1,000 person years at 4 years after baseline; $p = .56$ for test between three slopes).

COMMENT

The opening of a freestanding ASC was associated with significant reductions in hospital-based surgery within a health care market. In contrast to markets without ASCs, in which hospital-based outpatient surgery rates increased by 7 percent, those where an ASC opened for the first time experienced a 7 percent reduction. This redistribution was even more evident in some surgical disciplines, particularly ophthalmology. Importantly, the shift of outpatient surgery from the hospital to the ASC was not associated with higher rates of hospital admission or mortality. Collectively, our findings suggest that freestanding ASCs can safely achieve their intended effects of outpatient procedure redistribution to a less expensive setting without sacrificing quality, as measured by hospital admission or mortality.

Since the 1980s, the volume of outpatient procedures has grown considerably. Concurrent with this growth, there has been a sea change in the setting for these procedures, with movement out of the hospital and into the ASC (Ambulatory Surgery Center Association 2012). These freestanding facilities were originally championed by the federal government and payers as a means to curtail rising health care expenditures (Davis 1987). While previous studies have demonstrated the ability of these facilities to achieve their desired effects on hospital utilization (Lynk and Longley 2002; Bian and Morrisey 2007; Courtemanche and Plotzke 2010) and outpatient surgery quality (Hollingsworth et al. 2012) in some contexts, they were generally limited in scope or predated the recent proliferation of ASCs. Indeed, the number of ASCs essentially doubled during the first part of the last decade, with nearly 5,500 facilities in 2011 (American Hospital Association 2012). Because these facilities tend to be owned by the physicians who staff them (Ambulatory Surgery Center Association 2009), some worry that inherent financial incentives might spur utilization (i.e., induced demand).

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Implicit in the possibility of induced demand by owners of ASCs is the notion that there is an asymmetry of information between the physician and the patient such that the latter cannot make a rationale choice as to the health "value" of the procedure (Wennberg, Barnes, and Zubkoff 1982). Rather, the physician serves in the agency role for the patient. While several factors (e.g., patient preference, medical liability pressures) may cause surgeons to lower their threshold for surgery, many believe that the financial incentives associated with increased productivity (Conrad et al. 2002) and ASC ownership may fuel the use of outpatient surgery. While our study does not address the question of induced demand directly, we did observe that ASCs did not simply offload procedures from the hospitals within markets where new facilities opened for the first time. Four years after opening in these markets, the increase in outpatient surgery at ASCs was more than double the decline in such procedures performed in the hospital setting.

While unmet clinical need might explain this differential, prior empirical work in this area has suggested the possibility of induced demand. First, rates of discretionary outpatient surgery (e.g., knee arthroscopy, cataract surgery) are strongly correlated with the penetration of ASCs (i.e., the proportion of outpatient surgery delivered by ASCs) within a market (Hollenbeck et al. 2010). Second, physician owners of ASCs uniformly perform higher volumes of outpatient procedures (Hollingsworth et al. 2009, 2010; Strope et al. 2009) and patients who see these physicians are much more likely to have surgery compared to those of nonowners (Mitchell 2010). Third, physician owners preferentially manage well-insured patients (Gabel et al. 2008) and perform well-reimbursed procedures (Plotzke and Courtemanche 2011) at ASCs. Finally, the opening of an ASC in a health care market has been associated with significantly higher rates of outpatient surgery relative to markets without them (Hollingsworth et al. 2011; Hollenbeck et al. 2014). Importantly, this growth appears to be driven by procedures with less stringent clinical indications for their use (Hollingsworth et al. 2011).

Figure 2: Adjusted Rates of Ophthalmologic (a), Gastrointestinal (b), and Musculoskeletal (c) Hospital-Based Outpatient Surgery in Markets Where ASCs Were Always Present, Never Present, and in Those Where an ASC Opened for the First Time. In the period after baseline, adjusted rates of hospital-based outpatient surgery declined more sharply in markets where an ASC opened for the first time compared to HSAs with and without ASCs ($p < .01$ for all three specialty groups)

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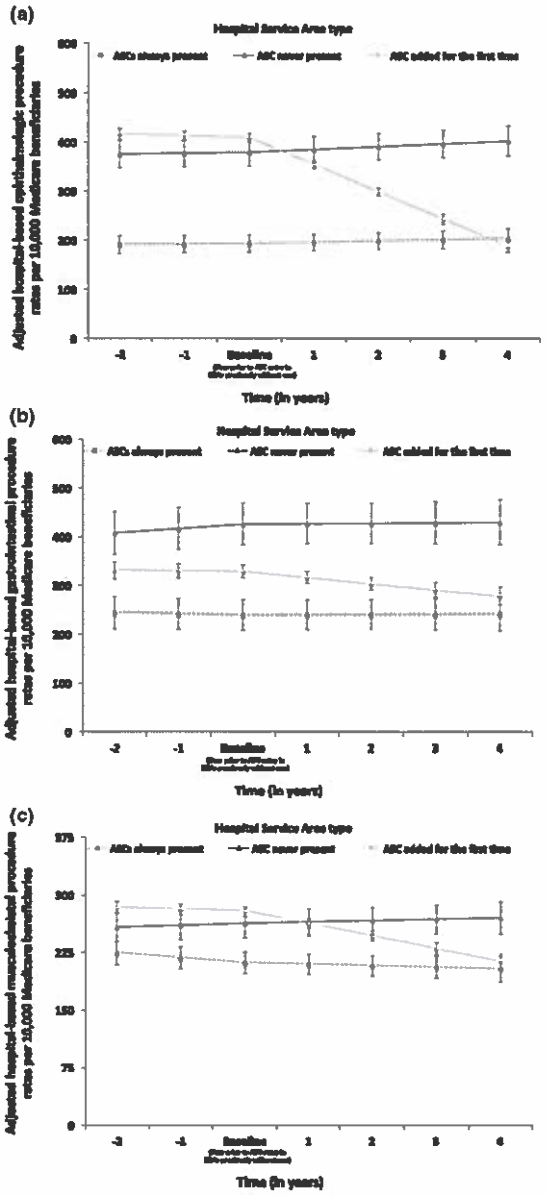

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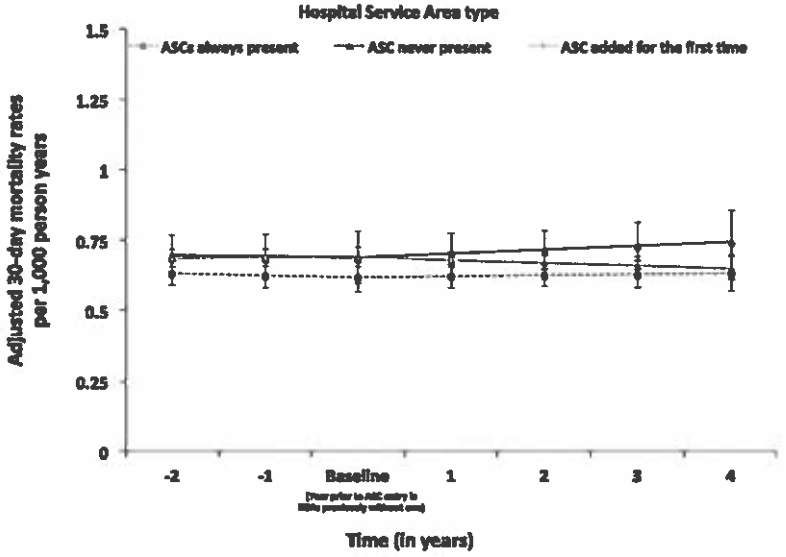
Figure 3: Adjusted Thirty-Day Mortality Rates among Patients Undergoing Outpatient Surgery in Markets with ASCs, Those without and Those Where ASCs Were Added for the First Time. Rates of mortality were similar across HSA groups before ($p = .84$ for test between three slopes) and after ($p = .43$ for test between three slopes) baseline



In addition to concerns surrounding induced demand, other implications of financially motivated procedure redistribution are untoward outcomes and poor quality. As per CMS Conditions for Coverage (Centers for Medicare and Medicaid Services 2011), ASCs are intended for procedures that do not require hospitalization. Unlike hospital outpatient departments, ASCs have limited access to specialty physicians and ancillary services that may be necessary to care for complicated surgical patients undergoing outpatient procedures. A potential consequence of procedure offloading to ASCs after their opening is that some patients may be inappropriately selected for treatment in these facilities, thereby inadvertently leading to higher rates of hospital admission and perioperative mortality.

This study is the first of its kind to comprehensively assess the impact of ASCs on their intended effects on broad indicators of ASC quality. As

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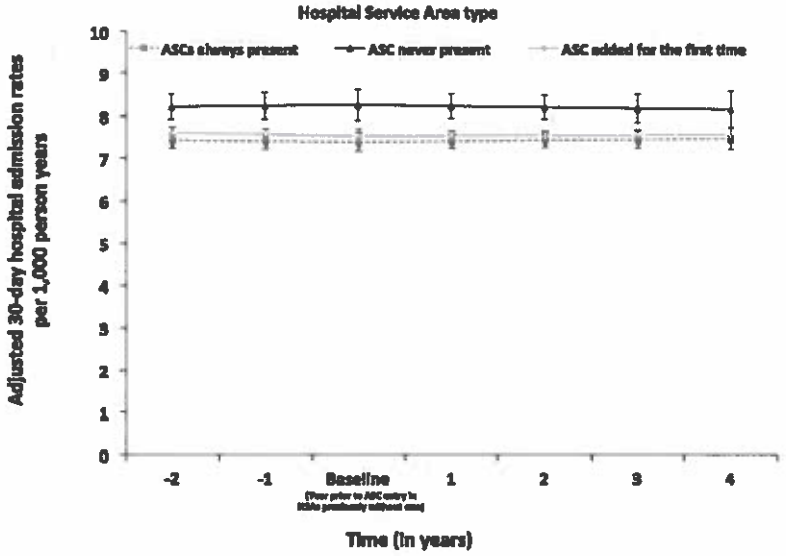
Figure 4: Adjusted Thirty-Day Hospital Admission Rates among Patients Undergoing Outpatient Surgery in Markets with ASCs, Those without ASCs, and Those Where ASCs Were Added for the First Time. Rates of hospital admission were similar across HSA groups before ($p = .43$ for test between three slopes) and after ($p = .56$ for test between three slopes) baseline



opposed to comparing quality between hospitals and ASCs, which would clearly bias against the hospital due to favorable patient selection, we instead focused on the effects of ASC opening on rates of adverse events for the entire population undergoing outpatient surgery. Importantly, procedure redistribution to the ASC was not associated with higher population-based rates of unexpected admission or mortality. Further, even within the most common procedures, we observed similar or lower rates of these adverse events at ASCs, implying that our population-level findings were not simply due to favorable procedure-mix selection by the ASCs. Collectively, our data suggest that the observed procedure redistribution from hospitals to ASCs had a negligible impact on these aspects of quality.

Our findings should be interpreted in the context of three limitations. First, because of our reliance on claims data, our measures of ambulatory surgical quality, though well accepted, are limited in scope. While we observed

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no ill effects of procedure redistribution on unanticipated hospital admission and mortality, there may have been improvements (or decrements) in quality that are underappreciated. For instance, due to their laser-sharp focus on specific procedure lines, ASCs may enhance quality by achieving better clinical outcomes. Second, because we are using Medicare claims, our findings do not reflect the effects of non-Medicare-certified ASCs on procedure redistribution and quality. However, as approximately 80 percent of all ASCs are Medicare-certified, our findings include facilities where the vast majority of outpatient surgery is performed. Third, although ASC opening was able to successfully offload procedures from the hospital, the subsequent utilization by these facilities outpaced the declines at hospitals within their respective markets. Thus, the broader effects of ASCs on utilization and overall health care spending remain unclear and are the focus of our ongoing research efforts. For instance, some worry that the cost savings garnered by ASC efficiency may be offset by financial incentives to increase procedure utilization.

These limitations notwithstanding, our findings have important implications with respect to ambulatory surgery. First and foremost, the rapid proliferation of ASCs in the 2000s was associated with significant reductions in hospital-based outpatient surgery. Because ASCs can provide similar care at a lower cost (Centers for Medicare and Medicaid Services 2008), such procedure redistribution could yield substantial cost savings to the Medicare program, at least on a per episode basis. These savings have the potential to be further amplified by the recent implementation of provisions in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 that greatly expanded the types of procedures eligible for payment in ASCs. Second, the observed redistribution did not come at the expense of quality as measured by population-based rates of mortality and hospital admission, suggesting that patient selection did not negatively impact these outcomes. However, procedure volumes at new ASCs were substantially greater than the declines in volumes at local hospitals.

The dissemination of freestanding ASCs results in a decline in outpatient surgery in the hospital. Insofar as thresholds for intervention remain constant, additional redistribution to these facilities may alleviate latent need and further reduce the use of the more costly hospital setting. Unfortunately, the within-market discrepancy between hospital volume declines and ASC volume increases raises the possibility of induced demand. Additional research surrounding the net effects of ASCs on outpatient surgery expenditures would be helpful for gauging their overall value to the health care system. Given the economics surrounding outpatient surgery and their importance to spending

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growth for Medicare, understanding the gains in health productivity relative to what is spent is of paramount importance to improving the efficiency of the delivery system.

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Disclaimers: None.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.

Appendix SA2: Common Procedures Performed in Both the Hospital and ASC That Comprised the Three Specialty Group Analyses.

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Journal of Orthopaedic Business

Hand and Upper Extremity Procedures Are Significantly More Cost Effective When Performed in Ambulatory Surgery Centers Versus Hospital Outpatient Departments

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Objectives: Orthopaedic surgery has a high rate of utilization of outpatient settings, including ambulatory surgery centers (ASC) and hospital outpatient departments (HOPD). We seek to compare costs at these outpatient facilities, ASC versus HOPD, for hand and upper extremity procedures.

Design: Database review was performed with publicly available data from the Center for Medicare and Medicaid Services (CMS) via the Medicare Procedure Price Lookup Tool.

Main Outcome Measurements: Current Procedural Terminology (CPT) codes for hand and upper extremity procedures. Total costs, facility fees, Medicare payments, and patient payments were obtained for each procedure code.

Results: Thirty-seven CPT codes were divided into arthroscopy, fracture, arthroplasty/arthrodesis, and other. Arthroscopy demonstrated cost savings in the total cost of the procedure, facility fees, Medicare payments, and patient payments in ASCs compared to HOPD. Fracture procedures had lower total costs, Medicare payments, facility fees, and patient payments in ASCs. When CPT codes were grouped together, there were 35% savings in total cost, 41% savings for facility fees, 36% savings in Medicare payments, and 28% in patient payments for procedures performed at ASCs.

Conclusions: ASCs demonstrate cost-savings across multiple procedures for the hand and upper extremity in various areas, including total costs, facility fees, Medicare payments, and patient payments when compared to HOPDs.

Level of Evidence: Level 4; Retrospective cost-analysis

Key Words: ambulatory surgery center, cost, hand, hospital outpatient departments, upper extremity

INTRODUCTION

Healthcare expenditure in the United States remains an ongoing topic of discussion for policymakers, state departments, and hospital officials. The United States remains at the top of the list for countries with the highest healthcare costs and the greatest portion of gross domestic product attributed to healthcare expenses.[1-2] Given the continual rise of costs, it is prudent to determine areas of savings while maximizing patient outcomes and decreasing overall disease burden. When evaluating the breakdown of U.S. healthcare spending, the most is consumed by inpatient hospital services.[3] Therefore, targeting inpatient resource utilization may be a promising area to mitigate the overall rise of U.S. healthcare costs. This has been recognized, as there has been a trend of transitioning from inpatient to outpatient settings for cost reduction while maintaining the same high level of care, especially in specialties such as orthopaedic surgery.[4-5] Moreover, the COVID pandemic pushed hospital capacity limits across the country unlike ever before, emphasizing the necessity to transition elective orthopaedic procedures from the inpatient to outpatient setting.[6-9]

Electively-based orthopaedic subspecialties, such as hand and elbow, sports, and foot and ankle, have dominated the outpatient space, with more recent literature demonstrating the safety of performing outpatient procedures in adult reconstruction and spine.[9-11] Different healthcare settings are utilized as treatment centers for elective hand and upper extremity procedures, including

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inpatient hospital operating rooms, hospital outpatient departments (HOPDs), ambulatory surgery centers (ASCs), and in-office procedures. Each facility's benefits are considered when deciding where patients would be most appropriately cared for based on the complexity of the procedure, patient comorbidities, and equipment necessities. The benefits of ambulatory surgery centers and hospital outpatient departments are well established, with significant cost-savings, increased efficiency, and high levels of patient satisfaction.[12-13]

Hand and upper extremity procedures performed in stand-alone ASCs result in low rates of postoperative utilization of urgent care and emergency department visits and infrequent hospital readmissions.[14] Furthermore, ASC surgical visits are 25% to 39% shorter than hospital outpatient department visits.[15] Carey reported that ASCs can effectively operate at lower costs than HOPDs across multiple surgical specialties.[16] However, there is limited literature evaluating the difference in costs associated with specific hand and upper extremity procedures in ambulatory surgery centers versus hospital outpatient departments. We seek to report on differences between these two healthcare settings, highlighting potential cost-savings in one over the other for hand and upper extremity procedures.

METHODS

Data Collection

Medicare is a federal health insurance program administered to United States citizens over 65 and those who meet certain eligibility requirements, including younger people with disabilities and patients with end-stage renal disease.[17] Due to previous legislation, Medicare has attempted to increase price and volume transparency via the publication of various online databases. The use of these databases to track volume and reimbursement data has been well-established within the orthopaedic literature.[18-23]

Ambulatory surgery centers and hospital outpatient departments allow for various outpatient procedures without the significant costs associated with hospital stays. The limitations on patient length of stay vary according to state and local regulations. The difference between the facilities relates to regulations specific to each center, with an ASC typically a freestanding facility with a distinct financial and administrative contract with Medicare and/or private insurance.[24,25] Conversely, an independent surgery center can still be considered an HOPD if it is close to a hospital and negotiates with the same financial and administrative contracts as the hospital governing body.

To evaluate differences in cost between ASCs and HOPDs, the Medicare Procedure Price Lookup Tool was queried for individual Current Procedural Terminology (CPT) codes approved for outpatient surgery by the Center for Medicare and Medicaid Services (CMS). The included CPT codes are included in Table 1. Procedures were grouped into arthroscopy, fracture, arthroplasty/arthrodesis, other procedure cohorts, and an overall cohort. Data regarding total costs, facility fees, surgeon fees,

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Table 1. CPT codes and description of procedure.

CPT Code	Procedure
Arthroscopy	
29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
29843	Arthroscopy, wrist, surgical; for infection, lavage and drainage
29845	Arthroscopy, wrist, surgical; synovectomy, complete
29846	Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement
Fracture	
25525	Open treatment of radial shaft fracture, includes internal fixation, when performed, and closed treatment of distal radioulnar joint dislocation (galeazzi fracture/ dislocation), includes percutaneous skeletal fixation, when performed
25526	Open treatment of radial shaft fracture, includes internal fixation, when performed, and open treatment of distal radioulnar joint dislocation (galeazzi fracture/ dislocation), includes internal fixation, when performed, includes repair of triangular fibrocartilage complex
25574	Open treatment of radial and ulnar shaft fractures, with internal fixation, when performed; of radius or ulna
25575	Open treatment of radial and ulnar shaft fractures, with internal fixation, when performed; of radius and ulna
25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
25628	Open treatment of carpal scaphoid (navicular) fracture, includes internal fixation, when performed
25651	Percutaneous skeletal fixation of ulnar styloid fracture
26727	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26756	Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each
Arthroplasty/Arthrodesis	
24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
25446	Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)
25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints
25800	Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints)
25820	Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal)
Other	
24359	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment
25000	Incision, extensor tendon sheath, wrist (eg, de quervains disease)
25111	Excision of ganglion, wrist (dorsal or volar); primary
25210	Carpectomy; 1 bone
25215	Carpectomy; all bones of proximal row
25240	Excision distal ulna partial or complete (eg, darrach type or sauve-kapandji resection)
25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
26045	Fasciotomy, palmar (eg, dupuytren's contracture); open, partial
26055	Tendon sheath incision (eg, for trigger finger)
26350	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); primary or secondary without free graft, each tendon
26352	Repair or advancement, flexor tendon, not in zone 2 digital flexor tendon sheath (eg, no man's land); secondary with free graft (includes obtaining graft), each tendon
26356	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament
64718	Neuroplasty and/or transposition, ulnar nerve at elbow
64721	Neuroplasty and/or transposition, median nerve at carpal tunnel

CPT = Current Procedural Terminology

Medicare payments, and patient payments were extracted for each procedure.

Statistical Analysis

Descriptive statistics were used to express each variable's mean and standard deviation. Given the non-parametric distribution of the data, Mann-Whitney *U* tests were utilized to assess differences in total costs, facility fees, surgeon fees, Medicare payments, and patient payments between ASC and HOPD for arthroscopy procedures, fracture procedures, arthrodesis/arthroplasty procedures, other procedures, as well as all a combined cohort including all available CPT codes. All tests were 2-sided, with significance set at a probability value of $p<0.05$.

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RESULTS

Arthroscopy Codes

When comparing four different CPT codes (**Table 1**), significant cost savings in the total cost of the procedure (1,886.00±58.72 vs. 3,418.00±58.78; p=0.009), facility fees (1,360.00±0 vs. 2,892.00±0; p=0.021), Medicare payments (1,509.00±47.27 vs. 2,734.00±47.27 p=0.021), and patient payments (376.75±11.87 vs. 682.75±11.87; p=0.021) in ASCs as compared to HOPD were identified (**Table 2**). This resulted in an approximately 45% savings for total costs, Medicare payments, and patient payments, as well as approximately 53% cost savings for facility fees if procedures are performed at an ASC compared to a HOPD. Surgeon fees were the same regardless of the surgery setting.

Fracture Codes

Twelve Medicare-approved outpatient CPT codes were identified (**Table 1**). Fracture procedures had significantly lower total costs (3,886.58±1,527.61 vs 5,975.92±1,890.96; p=0.021), Medicare payments (3,109.17±1,221.21 vs 4,780.75±1,511.90; p=0.021), facility fees (3,055.17±1,503.23 vs 5,228.67±1,725.74; p=0.018), and patient payments (776.92±305.46 vs 1,194.75±377.97; p=0.021) in ASCs (**Table 2**). This resulted in an approximately 35% savings for total costs, Medicare payments, and patient payments, as well as approximately 42% cost savings for facility fees if procedures were performed at an ASC as compared to a HOPD. Surgeon fees were the same regardless of the surgery setting.

Arthroplasty/Arthrodesis Codes

When comparing five different CPT codes (Table 1), overall costs at ASCs were lower for total costs of procedure (8,105.80±5,714.19 vs 10,734.40±6,643.11; p=0.347), facility fees (7,113.80±5,997.65 vs 9,742.40±6,344.16; p=0.343), and Medicare payments (6,484.20±4,365.60 vs 9.285.60.00±6,254.08; p=0.347). For these five procedures, the average amount of the procedure required to be covered by the patient was higher at the ASC than the HOPD (1,620.40±1,159.13 vs 1,447.60±440.43; p=0.917). However, none of these differences reached statistical significance. Surgeon fees were the same regardless of the surgery setting.

Other Codes

When comparing 16 different CPT codes (Table 1), significant cost savings in the total cost of procedure (1,815.81±686.56 vs 3,181.38±1,343.83; p=0.003), facility fees (1,240.63±551.50 vs 2,606.19±1,212.08; p<0.001), Medicare payments (1,452.63±549.27 vs 2,554.75±1,074.92; p=0.003), and patient payments (362.44±137.22 vs 635.31.17±268.69; p=0.003) in ASCs as compared to HOPD were identified (Table 2). This resulted in an approximately 43% savings for total costs, Medicare payments, and patient payments, as well as approximately 52% cost saving for facility fees, if procedures are performed at an ASC as compared

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to a HOPD. Surgeon fees were the same regardless of surgery setting.

Overall

When grouping all 37 procedural codes into a single cohort, significant cost savings in an ASC setting were demonstrated across all variables outside of surgeon fees. Total cost (3,345.00±3,026.81 vs. 5,133.98±3,655.54; p=0.002), facility fees (2,635.70±2,839.88 vs. 4,451.97±3,444.87; p<0.001), Medicare payments (2,675.92±2,421.41 vs. 4,201.32±3,269.11; p=0.002), and patient payments (668.41±605.40 vs. 931.65±448.42; p=0.002) were all significantly lower if performed at an ASC (Table 2). This resulted in an approximately 35% savings in total cost, 41% savings for facility fees, 36% savings in Medicare payments, and 28% in patient payments for procedures performed at ASCs. Surgeon reimbursements were the same regardless of the surgery setting.

Table 2. Mean and standard deviation of costs associated with ambulatory surgical centers and hospital outpatient departments for common hand and upper extremity procedures.

	ASC (Mean ± SD)	HOPD (Mean ± SD)	*p-value
Arthroplasty			
Total Cost	1,886.00±58.78	3,418±58.78	**0.009**
Doctor Fee	526.00±58.78	526.00±58.78	1.000
Facility Fee	1,360.00±0.00	2,892.00±0.00	**0.021**
Medicare Payment	1,509±47.27	2,734±47.27	**0.021**
Patient Payment	376.75±11.87	682.75±11.87	**0.021**
Fracture			
Total Cost	3,886.58±1,527.61	5,975.92±1,890.96	**0.021**
Doctor Fee	748.08±200.02	748.08±200.02	1.000
Facility Fee	3,055.17±1,503.03	5,228.67±1,725.74	**0.018**
Medicare Payment	3,109.17±1,222,21	4,780.75±1,511.90	**0.021**
Patient Payment	776.92±305.46	1,194.75±377.97	**0.021**
Arthroplasty/Arthrodesis			
Total Cost	8,105.80±5,794.19	10,734.40±6,643.11	0.347
Doctor Fee	992.00±339.47	992.00±339.47	1.000
Facility Fee	7,113.80±5,497.65	9,742.40±6,344.16	0.343
Medicare Payment	6,484.20±4,635.60	9,285.60±6,344.16	0.347
Patient Payment	1,620.40±1,159.13	1,447.60±440.42	0.917
Other			
Total Cost	1,815.81±686.56	3,181.38±1,343.83	**0.003**
Doctor Fee	575.19±177.11	575.19±177.11	1.000
Facility Fee	1,240.63±551.50	2,606.19±1,212.08	**<0.001**
Medicare Payment	1,452.63±549.27	2,544.75±1,074.92	**0.003**
Patient Payment	362.44±137.22	635.31±268.69	**0.003**
Overall			
Total Cost	3,345.00±3,026.81	5,133.97±3,655.54	**0.002**
Doctor Fee	682.27±246.91	682.27±246.91	1.000
Facility Fee	2,635.70±2,839.89	4,451.97±3,444.87	**<0.001**
Medicare Payment	2,675.92±2,421.41	4,201.32±3,269.12	**0.002**
Patient Payment	668.41±605.40	931.65±448.62	**0.003**

ASC = ambulatory surgical center; HOPD = hospital outpatient department; SD = standard deviation
*p-value calculated using Mann-Whitney *U* tests. **Bolding** indicates significance (p<0.05).

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DISCUSSION

Over the last few decades, there has been a shift and growth to free-standing ambulatory surgery centers, with a 77% increase in orthopaedic procedures performed in them between 2000 to 2007.[26] More recently, The Centers for Medicare and Medicaid Services (CMS) removed over 250 musculoskeletal procedures from the "inpatient only" list, allowing a wider breadth of outpatient and ASC utilization.[27] In orthopaedics, prior studies have demonstrated the safety of outpatient procedures that were once believed to require inpatient hospitalization, including total joint arthroplasty, and minimally-invasive spine procedures. [9-10]

Regarding hand and upper extremity surgery, procedures are smaller, less invasive, and shorter, and therefore, intrinsically more suitable to be carried out in the outpatient setting. One circumstance that would offset the benefits of outpatient settings, such as HOPDs and ASCs, is postoperative emergency department visits or hospital readmissions. Goyal et al. reviewed over 28,000 cases over 11 years of upper extremity procedures performed in ambulatory surgery centers, reporting 0.2% of adverse events, including only 18 postoperative transfers to the hospital and 21 admissions after discharge.[28] Furthermore, Sandrowski et al. substantiated the extremely low rate of ER visits and hospital readmissions, as only 1.6% of patients required further care at these facilities following over 500 hand and upper extremity procedures at a free-standing ASC.[14]

While the benefits of HOPDs and ASCs are well known regarding cost-savings, efficiency, and patient satisfaction, many have attempted to further delineate the differences in cost-savings and efficiency between the two healthcare facilities.[5,31] Carey reported rising costs had affected HOPDs to greater degrees than ASCs in numerous specialties, including gastroenterology, ophthalmology, and orthopaedics.[16] Among common orthopaedic procedures, it has been shown there are 26% lower total costs and 33% lower technical fees at ASCs than HOPDs.[32] Hair et al. demonstrated a 39% decrease in operative times in free-standing ambulatory care centers compared to hospital-based outpatient departments in numerous specialties with notable efficiency across all phases of care, including surgical time, time spent in the operating room, and postoperative care time.[33]

While previous reports portray the benefits of ASCs over HOPDs, there is a lack of literature focusing on cost-saving, specifically in hand and upper extremity procedures. Ngyugen et al. emphasized the cost savings ASCs can provide over HOPDs, up to 30%, following carpal tunnel release.[12] While they evaluated only one procedure, our study expands upon their finding by demonstrating large discrepancies between ASCs and HOPDs in total costs, facility fees, Medicare payments, and patient payments in over 20 common procedures.

We evaluated major categories of hand and elbow procedures, including arthroscopy, fracture fixation, arthroplasty/arthrodesis, and others involving nerve decompressions, flexor tendon

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repairs, and additional bony procedures. Areas of comparison related to cost saving include total costs, facility fees, Medicare payments, and patient payments. We demonstrated significant differences between ACSs and HOPDs, with cost-savings coming from ACSs in the majority of individual and grouped CPT codes across all variables, with the exception of surgeon's fees. In areas of arthroscopy and other CPT code categories, there was approximately 43-45% cost savings in total procedure costs, Medicare payments, and patient payments in ASCs over HOPD, with facility fees almost half at ACS than they are at HOPDs. Moreover, fracture fixation demonstrated 1/3rd less in total procedure costs, Medicare payments, and patient payments in ACSs when compared to HOPD, with 42% less for facility fees. These findings cannot be ignored, as they demonstrate an enormous healthcare expenditure that can be mitigated by performing most of these procedures at ASCs if both facilities are available to the surgeon and patient.

Although there was a trend towards cost-savings for ASCs in total procedure costs, Medicare payments, and facility fees for arthroplasty/arthrodesis codes, we did not demonstrate statistically significant differences. Patient payments were comparable at both facilities for arthroplasty/arthrodesis.

In the last three years, theoretical situations that would push the limits of healthcare worldwide have become an unfortunate reality. The COVID-19 pandemic had a notable physical and psychological impact on patients, healthcare workers, and hospitals; further, the financial impact was significant. There was an increased demand for medical supplies, hospital beds, and intensive care unit level of care, with disruption of supply chains leading to substantial financial challenges. The American Hospital Association estimated a loss of 202.6 billion for American healthcare systems, with large academic systems experiencing disproportionate financial stress as they maintain relatively small operating margins.[8, 29-30] Our study demonstrates the potential for significant cost savings as we move towards a system focused on evidence-backed, value-based care.

Limitations to this study are inherent to database studies, including appropriate coding and general data organization. This study's data was compiled from Medicare patients and does not reflect cost savings associated with private sector, Medicaid, or self-pay. Furthermore, while we sought to report on differences in costs, we did not evaluate the clinical outcomes or complication data between the two healthcare settings.

CONCLUSION

Outpatient settings, including hospital outpatient departments and ambulatory surgery centers, are primary healthcare facilities for patients undergoing hand and upper extremity procedures. As healthcare expenditure increases, it's prudent to determine possible areas of savings. While the benefits of ASCs over HOPDs have been established in the literature, specific subspecialty data regarding cost-saving is limited. We demonstrate the enormous cost savings in

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arthroscopy, fracture fixation, and many common procedures performed in the upper extremity in ASCs over HOPDs. Further prospective studies are warranted to unveil the potential benefits of ASCs over HOPDs, including clinical outcomes and efficiency measures.

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Safety and Efficiency of Cervical Disc Arthroplasty in Ambulatory Surgery Centers vs. Hospital Settings

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ABSTRACT

Background: Outpatient surgery has been shown safe and effective for anterior cervical discectomy and fusion (ACDF), and more recently, for 1-level cervical disc arthroplasty (CDA). The purpose of this analysis is to compare the safety and efficiency of 1-level and 2-level CDA performed in an ambulatory surgery center (ASC) and in a hospital setting.

Methods: The study was a retrospective collection and analysis of data from consecutive CDA patients treated in ASCs compared to a historical control group of patients treated in hospital settings who were classified as outpatient (0 or 1-night stay) or inpatient (2 or more nights). Surgery time, blood loss, return to work, adverse events (AEs), and subsequent surgeries were compared.

Results: The sample consisted of 145 ASC patients, 348 hospital outpatients, and 65 hospital inpatients. A greater proportion of 2-level surgeries were performed in hospital than ASC. Surgery times were significantly shorter in ASCs than outpatient or inpatient 1-level (63.6 ± 21.6, 86.5 ± 35.8, and 116.7 ± 48.4 minutes, respectively) and 2-level (92.4 ± 37.3, 126.7 ± 43.8, and 140.3 ± 54.5 minutes, respectively) surgeries. Estimated blood loss was also significantly less in ASC than outpatient and inpatient 1-level (18.5 ± 30.6, 43.7 ± 35.9, and 85.7 ± 98.0 mL, respectively) and 2-level (21.1 ± 12.3, 67.8 ± 94.9, and 64.9 ± 66.1 mL). There were no hospital admissions and no subsequent surgeries among ASC patients. ASC patients had 1 AE (0.7%) and hospital patients had 10 AEs (2.4%). Working patients returned to work after a similar number of days off, but fewer ASC patients had returned to work by the end of the 90-day period.

Conclusions: Both 1- and 2-level CDA may be performed safely in an ASC. Surgeries in ASCs are of shorter duration and performed with less blood loss without increased AEs.

Cervical Spine

Keywords: ambulatory surgery center, outpatient surgery, cervical disc arthroplasty, total disc replacement

INTRODUCTION

Bolstered by trends toward less invasive surgery, as well as modified anesthetic and pain management techniques, surgical procedures are increasingly performed as outpatient procedures across all surgical fields.[1] Concomitantly, ambulatory surgery centers (ASCs) have rapidly multiplied in the United States, so that outpatient surgeries are increasingly performed in an ASC.[2,3]

Similarly in relatively healthy patients, spine surgery has increasingly been performed in outpatient settings including ASCs since the 1980s.[1,4] Surgeons have analyzed spinal surgeries performed in patient cohorts ranging in size from less than 100 to over 1000 patients.[5–20] Furthermore, the comparative safety and effectiveness of spine surgery performed on an outpatient versus inpatient basis have been evaluated for a variety of procedures: lumbar discectomy,[21,22] lumbar decompression,[23,24] lumbar interbody fusion,[25,26] anterior cervical discectomy and fusion (ACDF),[27–32] and cervical disc arthroplasty (CDA).[33] The complexity of outpatient spine surgeries has also increased from microdiscectomy and decompression, to single-level fusion and multi-level fusion using an anterior approach.

Evidence of the safety of ACDF as an outpatient procedure has accumulated.[34] Indeed, surgeons have reported safely performing not only 1-level

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but 2-level[14,16,28,30,32] and 3-level ACDF.[11] In contrast, there is little published evidence of the safety of outpatient CDA despite the growing use of CDA as an alternative treatment to ACDF. Beyond the many published Food and Drug Administration (FDA) Investigational Device Exemption (IDE) studies of CDA, which included but did not separately subanalyze and report outpatient outcomes, only 2 studies, based on small patient samples, supported the safety of outpatient 1-level CDA.[33,35] Hence, the purpose of this analysis is to compare the safety and efficiency of 1-level and 2-level CDA performed in an ASC and hospital settings.

MATERIALS AND METHODS

Patient Sample

Surgeons retrospectively reviewed the charts of 213 patients who had undergone cervical arthroplasty at 1 or 2 levels with a specific artificial disc (Mobi-C, Zimmer Biomet, Westminster, Colorado). Consecutive patients who met all the inclusion criteria and none of the exclusion criteria were enrolled in this study. Patients had to be treated at 1 or 2 contiguous levels (C3-C7) for intractable radiculopathy (arm pain and/or a neurological deficit) with or without neck pain, or myelopathy due to a 1- or 2-level abnormality localized to the level of the disc space, and with a diagnosis of at least 1 of the following conditions: herniated nucleus pulposus, spondylosis (defined by the presence of osteophytes), and/or visible loss of disc height compared to adjacent levels. The surgery had to occur in an ASC (defined as a distinct financial entity that operates exclusively to provide outpatient surgical services) at least 6 months prior to enrollment in the study. The patients were treated at 9 ASCs across the United States from August 2013 to December 2015. Each study center received approval from a central institutional review board.

Historical Control

The study patients were compared to a historical control group composed of the patients from the FDA IDE trials of the same artificial disc (NCT00389597). Patients in the clinical trial suffered from symptomatic degenerative disc disease (DDD) with radiculopathy or myeloradiculopathy at 1 or 2 adjacent levels. The inclusion and exclusion criteria of the IDE trials were similar to the criteria of the ASC cohort. The clinical trial surgeries were performed at 24 clinical sites between April 2006 and March 2008.[36,37] None of the centers nor surgeons who participated in the FDA trials were part of this ASC study.

Patients Groups

The historical control hospital patients were further divided into inpatient and outpatient groups, based on the length of hospital stay. Hence, this study compares 3 patient groups:

- *ASC*: patients who underwent surgery in a distinct administrative and financial facility, operating exclusively for providing outpatient services.
- *Hospital Outpatient*: patients with 1 night or less stay in a hospital-administrated facility (per the Medicare definition).
- *Hospital Inpatient*: patients admitted for 2 or more nights of stay in a hospital-administrated facility (per the Medicare definition).

Demographic and Medical Data

The following information was collected from the patients' medical records: basic demographics (age, height, weight, and gender), work status, and workers' compensation status.

Safety Data

Adverse events (AEs) and subsequent surgeries were collected from the period after surgery to 90 days' postsurgery, corresponding to the Medicare-defined global period for major procedures. A complication was any adverse effect that was determined to be related or might have been related to the device or the cervical spine surgery. For the purposes of this study, this is defined as an event that caused a life-threatening illness, even if temporary in nature, or resulted in permanent impairment of a body function or permanent damage to a body structure; or necessitated medical or surgical intervention to preclude life-threatening illness, permanent impairment of a body function or permanent damage to a body structure (corresponding to the World Health Organization [WHO] classification of Grades 3 and 4 serious AEs).

Data were collected on secondary surgeries occurring on the day of surgery (admission to the ASC) or at any time during the 90-day period

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Table 1. Demographic characteristics: mean ± standard deviation or number (percent) of patients. Bold text indicates significance.

	ASC, N = 145	Hospital Outpatient, N = 348	*P* Values[a]	Hospital Inpatient, N = 65	*P* Values[b]
Age (range)	43.9 ± 9.5	44.1 ± 8.6	.88	45.5 ± 8.6	.82
Male (%)	60 (41.4%)	176 (50.6%)	.06	27 (41.5%)	.98
BMI (kg/m^2)	28.6 ± 6.3	27.4 ± 4.5	.20	27.9 ± 4.5	.93
Obese (BMI ≥ 30)	47 (32.4%)	101 (29.0%)	.45	22 (33.9%)	.84
Worker's compensation	29 (20.0%)	11 (3.2%)	**<.0001**	8 (12.3%)	.18
Preoperative work status			.73		.22
Working	96 (66.2%)	232 (66.7%)		35 (53.9%)	
Unable or not working	34 (23.5%)	73 (21.0%)		20 (30.8%)	
Retired/full time student	15 (10.3%)	43 (12.4%)		10 (15.4%)	

Abbreviations: ASC, ambulatory surgery center; BMI, body mass index.
[a]Adjusted *F*-tests and χ^2 comparison ASC to hospital outpatient.
[b]Adjusted *F*-tests and χ^2 comparison ASC to hospital inpatient.

postsurgery. Secondary surgeries are defined as any additional operation of the cervical spine. Data collected included the diagnosis, treatment, relation to index surgery, and the relation to the device. Additional information collected for subsequent surgeries included level(s) involved and type of surgery performed. Hospital admissions and emergency room visits were noted in the ASC group only.

Surgical Data

The following surgical data were collected: number of devices implanted, level of surgery, surgical time, and estimated blood loss. Anesthesia time was recorded for the ASC group only.

Return-to-Work Data

In the 90 days postsurgery, the number of patients who returned to work and the number of days of missed work were collected on patients who were working at the time of surgery.

Statistical Methods

The study was designed to test the noninferiority of ASC outcomes versus the historical controls in a hospital setting. The sample size calculation used an assumption of a 2% rate of complications for the ASC patients,[16,29,30] and a 4.3% rate of complications for hospital patients from the results of the Mobi-C IDE trial. Assuming a 1:3 sampling proportion with 80% power, $\alpha = 0.05$, and a minimum clinically significant difference of 3.5%, the minimum number of subjects needed was 440 (ASC, 110; hospital, 330).

Continuous variables were compared with ANOVA and categorical variables with χ^2. Due to the small number of AEs and secondary surgeries, Clopper-Pearson Exact binomial confidence intervals were calculated for each group. Statistical tests were 2-sided and *P* values ≤.05 were considered significant. Statistical analyses were performed with SAS (version 9.4, SAS Institute, Inc, Cary, North Carolina).

RESULTS

A total of 145 patients were treated in ASCs. Of the 413 historical controls, 348 were outpatients and 65 inpatients. Table 1 reports the demographic and baseline characteristics of the 3 groups. The ASC group had more workers' compensation patients than the hospital groups. The 3 groups were similar in all other demographic characteristics. A greater proportion of 2-level surgeries were performed in the hospital groups than the ASC group (Table 2). For that reason, the efficiency, safety, and return-to-work analyses are reported separately for 1- and 2-level surgeries.

In the 90-day period after surgery, only 1 device- or surgery-related AE was reported in the ASC group (0.7%), compared to 10 events reported in the hospital cohort (2.4%). The overall rate of AEs was 2.0% (7/348) for hospital outpatients and 4.6% (3/65) for hospital inpatients. These AE rates are lower than those assumed for the sample size calculations. Therefore, we applied a more conservative noninferiority margin to compare the ASC group to the hospital group. Using a noninferiority margin of 2%, the ASC group was noninferior to all hospital patients and to each hospital subgroup ($P < .05$). Due to the greater proportion of 2-level surgeries performed in the hospital group, further comparisons of AEs are reported separately for 1- and 2-level surgeries (Table 3).

The 1 AE reported in an ASC patient was a wound dehiscence. The wound dehiscence was superficial and treated in an emergency room but

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Table 2. Surgical procedures: number (percent) of patients. Bold text indicates significance.

	ASC	Hospital Outpatient	*P* Values[a]	Hospital Inpatient	*P* Values[b]
Procedure					
1-level	99 (68.3%)	160 (46%)	<.0001	19 (29.2%)	<.0001
2-level	46 (31.7%)	188 (54%)		46 (70.8%)	
Operated segments					
C3-C4	2 (2.0%)	1 (0.6%)	.73	0 (0%)	.24
C4-C5	8 (8.1%)	11 (6.9%)		0 (0%)	
C5-C6	50 (50.5%)	86 (53.8%)		14 (73.7%)	
C6-C7	39 (39.4%)	62 (38.8%)		5 (26.3%)	
C3-C5	1 (2.2%)	1 (0.5%)	.46	0 (0%)	.59
C4-C6	10 (21.7%)	50 (26.6%)		11 (23.9%)	
C5-C7	35 (76.1%)	137 (72.9%)		35 (76.1%)	

Abbreviation: ASC, ambulatory surgery center.
[a]χ^2 comparison ASC to hospital outpatient.
[b]χ^2 comparison ASC to hospital inpatient.

did not require surgery. Altogether, the ASC patients experienced 1 (0.7%) AE, 1 (0.7%) emergency room visit, no hospital readmission and no secondary surgery. The AEs reported in hospital patients (1-level [1] and 2-level [9]) were as follows: neck and/or arm pain (5), dysphagia (2), hematoma (2), and incorrectly placed device (1). Four hospital patients required a secondary surgery: 2 hematoma drainage, 1 laminectomy for radiculopathy, and 1 disc replacement to correct position.

Average surgical times (Table 4) were significantly shorter in ASCs than hospital outpatient and hospital inpatient times for both 1-level (63.6 vs. 86.5 vs. 116.7 minutes for ASC, outpatient, and inpatient, respectively) and 2-level (92.4 vs. 126.7 vs. 140.3 minutes, respectively). Similarly, estimated blood loss was significantly lower in the ASC than the 2 hospital groups for both 1-level (18.5 vs. 43.7 vs. 85.7 mL) and 2-level (21.1 vs. 67.8 vs. 64.9 mL) procedures. Anesthesia times (recorded in the ASC group only) were 110.1 ± 39.3 for 1-level CDA and 139.6 ± 53.9 for 2-level CDA.

Working patients returned to work after a similar number of days off work. However, a greater proportion of ASC patients had not returned to work in the 90-day postoperative period (Table 5). For 1-level CDA, the average numbers of days off work were 28.6, 23.4, and 41.6 (ASC, outpatient and inpatient, respectively). The percentages of 1-level patients who returned to work in the 90-day postoperative period were 47.0%, 82.0%, and 80.0%, respectively. For 2-level CDA the average numbers of days off were 38.4, 24.8, and 26.4, respectively. The percentage of 2-level patients who returned to work were 66.7%, 78.5%, and 72.0%, respectively.

DISCUSSION

The results of this study confirm the safety and efficiency of 1-level and 2-level CDA performed in the ASC setting. CDA in an ASC had a lower incidence of AEs and secondary surgeries than when performed in hospital. Surgeries in an ASC were of shorter duration and had less blood loss than in the hospital. While other factors may contribute to lower estimated blood loss (EBL) in an ASC, shorter surgery duration was significantly correlated with reduced EBL ($r = 0.45$; $P < .001$).

Past studies reporting on outpatient surgical procedures did not typically distinguish between hospital outpatient departments (HOPDs) and ASCs, so that either 1 or both settings were included in their reports. Indeed, in the only 2 studies of

Table 3. Adverse events and secondary surgeries: number (percent) of patients.

	ASC	95% CI[a]	Hospital Outpatient	95% CI	Hospital Inpatient	95% CI
1-level	N = 99		N = 160		N = 19	
Adverse events	1 (1.0%)	0.03%–5.5%	1 (0.6%)	0.02%–3.4%	0 (0.0%)	0%–17.6%
Secondary surgeries	0 (0.0%)	0%–3.7%	1 (0.6%)	0.02%–3.4%	0 (0.0%)	0%–17.6%
2-level	N = 46		N = 188		N = 46	
Adverse events	0 (0.0%)	0%–7.7%	6 (3.2%)	1.2%–6.8%	3 (6.5%)	1.4%–17.9%
Secondary surgeries	0 (0.0%)	0%–7.7%	2 (1.1%)	0.1%–3.8%	1 (2.2%)	0.06%–11.5%

Abbreviations: ASC, ambulatory surgery center; CI, confidence interval.
[a]Clopper-Pearson Exact binomial confidence intervals.

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Table 4. Surgical outcomes: mean ± standard deviation. Bold text indicates significance.

	ASC	Hospital Outpatient	*P* Values[a]	Hospital Inpatient	*P* Values[b]
1-level	N = 99	N = 160		N = 19	
Surgery time (min)	63.6 ± 21.6	86.5 ± 35.8	**.002**	116.7 ± 48.4	**.037**
Estimated blood loss (mL)	18.5 ± 30.6	43.7 ± 35.9	**.037**	85.7 ± 98.0	**.004**
2-level	N = 46	N = 188		N = 46	
Surgery time (min)	92.4 ± 37.3	126.7 ± 43.8	**<.0001**	140.3 ± 54.5	**<.0001**
Estimated blood loss (mL)	21.1 ± 12.3	67.8 ± 94.9	**<.0001**	64.9 ± 66.1	**.022**

Abbreviation: ASC, ambulatory surgery center.
[a]Adjusted *F*-tests comparing ASC to hospital outpatient.
[b]Adjusted *F*-tests comparing ASC to hospital inpatient.

outpatient CDA, the surgery was performed in HOPDs in 1 study[33] and ASCs in the other.[35] However, a difference in the safety of procedures performed in HOPDs and ASCs has been reported. A study compared 175,288 surgical procedures performed on Medicare patients at ASCs and 360,780 at HOPDs.[38] The following rates per 100,000 procedures were found: 30-day mortality rate (13.5 at outpatient hospital and 8.7 ASC), 30-day emergency room visit (365.7 vs. 183.2), and 30-day inpatient hospital admissions (548 vs. 165.3). This suggests that procedures were safer when performed in an ASC than an HOPD. Similarly, the current study also observed fewer AEs and secondary surgeries in ASC patients than our hospital outpatient cohort. Patient selection may have impacted the greater safety of CDA in ASCs in our study, given that ASC patients had fewer comorbidities and underwent fewer 2-level procedures than hospital outpatients.

Procedure costs and reimbursement were not analyzed in the present study but financial considerations may have influenced the choice of ASC versus hospital. This study observed a greater proportion of 2-level CDA performed in hospital: reimbursement may have been a factor influencing surgery location.

It should be noted that in the original FDA trial, 84% of the CDA patients required only a 1-night hospital stay or were discharged the same day as surgery. Hence, the standard for CDA may already be to perform this procedure in an outpatient setting. What this study demonstrates is that performing CDA in an ASC has no greater risk than CDA performed in the hospital. Similar levels of improvement have already been reported for 1- and 2-level ACDF in an ASC compared to the hospital.[31] The surgery and anesthesia times in this study are comparable to those reported in other outpatient cervical surgery studies.[15,16,19] As in most studies of outpatient cervical surgery, very few patients experienced AEs, needed to be readmitted, or underwent secondary surgery.[16,29,31,33]

More than 90% of existing ASCs are to some extent owned by physicians and 65% of ASCs are wholly owned by physicians.[39] Ownership of an ASC has been called a conflict of interest for surgeons, and is said to influence physician practice patterns and increase their rate of surgical procedures.[40,41] In an article, concern was expressed regarding the possible underreporting of postoperative morbidity of cervical spine surgery in ASCs (0.8% to 6%), while comparable inpatient cervical procedures reported a morbidity rate of up to 19.3%.[42] This reported difference in postoperative

Table 5. Return to work: mean ± standard deviation or number (percent) of patients. Bold text indicates significance.

	ASC	Hospital Outpatient	*P* Values[a]	Hospital Inpatient	*P* Values[b]
1-level	N = 99	N = 160		N = 19	
Working preoperatively[c]	66/99 (66.7%)	111/160 (69.4%)	.90	10/19 (52.6%)	.34
Returned to full time work within 90 days	31/66 (47.0%)	91/111 (82.0%)	**<.0001**	8/10 (80.0%)	.09
Days until returned to full time work	28.6 ± 23.2	23.4 ± 17.3	.76	41.6 ± 28.0	.51
2-level	N = 46	N = 188		N = 46	
Working preoperatively[c]	30/46 (65.2%)	121/188 (64.4%)	.74	25/46 (54.3%)	.56
Returned to full time work within 90 days	20/30 (66.7%)	95/121 (78.5%)	.17	18/25 (72.0%)	.77
Days until returned to full time work	38.4 ± 23.1	24.8 ± 18.0	.06	26.4 ± 20.4	.39

Abbreviation: ASC, ambulatory surgery center.
[a]Adjusted *F*-tests and χ^2 comparisons of ASC to hospital outpatient.
[b]Adjusted *F*-tests and χ^2 comparisons of ASC to hospital inpatient.
[c]Working full or part time preoperatively.

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morbidity could logically result if surgeons carefully select patients with fewer comorbidities in order to safely perform surgery at an ASC.[39] Patient selection in this study and choice of procedures (fewer 2-level CDAs) may have positively affected the safety of ASC surgeries.

Factors intrinsic to an ASC have been shown to improve its efficiency independently of financial interests. In this prior study, the efficiency of a hospital inpatient facility was found to be inferior to that of its own ASC.[43] Orthopedic procedures by the same surgeon were performed more efficiently and more rapidly at the ASC than the inpatient facility. In this reported scenario, both the inpatient and ambulatory facilities were owned and operated by the same hospital without financial incentive to the operating surgeon. Other studies also have found that having dedicated staff and operating rooms improves efficiency and reduces surgical time.[44,45] Furthermore, infection rates were found to be significantly lower in single specialty ASCs compared to multispecialty ASCs.[46] Similarly, this study shows that surgical times and estimated blood loss are lower in ASC patients than hospital outpatients, supporting the greater efficiency of ASCs.

While patients in the 3 groups returned to work after a similar number of days, a greater proportion of hospital patients than ASC patients had returned to work by 90 days after surgery for the single-level CDA case. A greater proportion of ASC than hospital patients were workers' compensation cases. Previous studies have shown a delay in return-to-work for workers' compensation patients.[47] The physically demanding nature of the work is assumed to be responsible for the delay in return-to-work, given that the workers' compensation patients are predominantly employed in heavy labor industries. However, in this study, nonworkers' compensation patients returned to work at a much lower rate in ASC surgeries (59.0%) than hospital outpatient (93.4%) and hospital inpatient surgeries (91.2%). We do not know what factors are responsible for this reported difference, although how this information was collected may have contributed to the difference.

Two key limitations of this study are the use of a historical control and a retrospective chart review. While ASC patients' charts were methodically and thoroughly reviewed, it is possible that patients may not have communicated all pertinent information to their physicians. Additionally, the type and definitions of data collected did not always match between IDE trial patients and the ASC cohort. Hence the number of comparisons between the ASC and hospital cohorts was limited by the availability of comparable data.

Although there are inherent limitations to retrospective studies, the available data support a conclusion of greater efficiency and safety of 1-level and 2-level CDA performed in an ASC compared to hospital settings.

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Economic Advantages of Performing Orthopaedic Surgical Procedures in Ambulatory Surgical Centres Over Hospital Out-Patient Settings

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Abstract

A study was conducted to compare the relative efficacy of ambulatory surgery centres (ASCs) and hospital outpatient departments (HOPDs) across eight orthopaedic procedures. The research was motivated by the fact that ASCs are becoming of increasing importance, even vitality, in the performance of a wide array of ambulatory surgical procedures including arthroscopy, arthroplasty, fracture repair, and laminectomy. As HOPDs continue to be hamstrung by resource constraints, ASCs can be seen to be cultivating ever more focused surgical expertise. Moreover, the ASC becomes a steadily more attractive alternative as HOPDs continue to be overburdened by the growing rate of ambulatory surgeries being performed on the hand, foot, ankle, and spine.
HOPD procedures are taxonomized by the ambulatory payment classification (APC) system while ASC procedures are described using current procedural terminology (CPT). A variety of quantitative and qualitative metrics were obtained that demonstrate that ASC procedures receive high marks. Indeed, ASC surgeries typically cost 25 to 50 percent less than their HOPD analogues and sport a 25 percent faster recovery time, partially as a result of dramatically decreased surgical site infections (SSI). Both patients and physicians further expressed a considerable degree of satisfaction with, and even preference for surgical procedures rendered at ASCs. One concern is that since many physicians hold ownership stakes in one or more ASC, this evident qualitative preference may, in fact, reflect personal bias. A follow-up study is postulated that is targeted at both assessing and reducing the effects of this perceived imparity

Keywords: Hospital outpatient department, Orthopaedic procedures, Ambulatory Surgery Centre.

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Introduction

Outpatient surgery has become an integral part of medical care across the globe. For instance, in the United States, the number of major and minor outpatient procedures undertaken in ambulatory surgical centers (ASC's) has risen dramatically over the past four decades. ASC's refer to health care facilities that play a central role in offering patients the much-needed convenience of having surgical procedures performed safely and in a timely manner outside hospital settings. Before the inception of ASC's, virtually all forms of surgeries were conducted in hospitals. Appointments characterized by long waiting periods were common during this time. Patients also spent several in-patient days in recovery. Additionally, medical practitioners faced different challenges, including working from limited operating rooms, difficulty in accessing new surgical equipment, and distractions of prolonged operating turnover times. The problems associated with hospital outpatient departments (HOPDs) compelled practitioners to look for change-driven strategies aimed at improving their performance. Though some countries still perform surgeries in these settings, the U.S. has made tremendous gains with regard to the development of ASCs. Individual physicians in the U.S. have assumed the leading role in promoting ASCs adoption as the cost-effective and a high-quality alternative to inpatient hospital surgical services. Since the inception of ASCs in the U.S., the facilities in question have resulted in high customer care, reduced healthcare costs, high quality, and excellent overall patient and physician satisfaction. ASC's complement managed care practioners, whose primary objective revolves around delivering quality, timely care at a significantly reduced cost. ASC's align perfectly well with the U.S. government's efforts to reduce its healthcare budget. The existing and potential economic benefits directly associated with ASC's involve decreasing costs without compromising patient and physician satisfaction levels.

The recently released current procedural terminology (CPT) codes are outpatient codes that determine the number of billable units of reimbursement that are allowable for a given procedure. HOPDs utilize ambulatory payment classifications (APC) codes for the same purpose. This paper will utilize the available literature on patient clinical outcomes regarding infection and reoperation rates examined over a 90-day period and show that eight common orthopaedic surgical procedures performed in ASC's are more economical compared to them being performed in the hospital outpatient settings. The orthopaedic surgery procedures evaluated are: shoulder arthroscopy with subacromial decompression and distal clavicle resection, knee arthroscopy with anterior cruciate ligament repair, open reduction and internal fixation of bimalleolar ankle fracture, open reduction and internal fixation of distal radius fracture, knee arthroscopy with medial and lateral meniscectomy, total knee arthroplasty, and one level lumbar laminectomy.

Patient Clinical Outcomes

Patients increasingly prefer outpatient surgery performed in ASC's to similar procedures undertaken in hospitals. The trend remains inextricably linked to positive patient clinical outcomes, such as reduced surgical site infections (SSIs) and reoperations, and advantages in cost, quality, and time factors (1). Hospitals continue to face a variety of resource-related challenges, including financial constraints, which inhibit their ability to meet the ever-growing demand for arthroplasty, hand, spine, and foot and ankle surgeries. For example, the Ambulatory Surgery Center Association (ASCA) reported that more than 5,300 ASC's provided over 25 million procedures in the country in 2005 (2). From the economic theory perspective, the rapid growth witnessed in the number of ASC's

serves as a clear indication that the market can expand at an increased rate when there is alignment of incentives of patients, payers, and providers.

SSIs and Reoperation Rates

Reoperation and SSI rates play a pivotal role in determining whether surgical procedures taken in ASCs are cost-effective. In their recent study, Toy et al. (3) set out to investigate the hospital admission and complication rates for patients who have undergone total hip arthroplasty (THA) surgery in an ASC with same-day discharge. Following the recent focus on bundled payments involving a 90-day episode-of-care, the researchers chose the same period to determine possible patient outcomes. Equally important, they reviewed reliable records of patients from two separate ASCs. In addition, they divided the 145 procedures (in 125 patients) involved in two groups based on when they were performed: early or later in surgeon's experience. To achieve the intended results effectively, they recorded any complications, hospital admissions, blood loss, time spent by patients at the facilities, and length of surgery.

This study demonstrates that same-day discharge to the patient's following total hip arthroplasty (THA) can be safely done without increased complications, hospital admissions, reoperations, or emergency room visits. In essence, the researchers established that only one of the 145 procedures, representing 0.7%, required direct admission to the hospital from the ASC (3). At the same time, only three of the arthroplasties (2%) required additional procedures within the global period. It is evident from the study that same-day discharge following THA done in an ASC tends to have limited complications, emergency room transfers, hospital admissions, and reoperations. In addition, with a CPT code of 27447 and APC number of 5115, total knee arthroplasties (TKAs) only costs $9,557.20 in ASCs, compared to $10,122.92 in HOPDs (Table 1) (4) (Near here). As this is a new code for ASCs, this difference in reimbursement is subject to change. Ultimately, the procedure is cheaper and fought with low complication rates when performed in an ASC setting.

In addition to TKAs done in ASCs, medical professionals remain interested in outpatient total elbow arthroplasties (TEAs) and THAs because of the increasing emphasis on efficient and high-quality medical care. In their retrospective study, Stone et al (5) employed a holistic approach to evaluating complications, hospital admissions, and reoperations in 28 patients with outpatient TEA discharged after the procedure for a 90-day period. In the follow-up, they not only recorded and examined postoperative complications but also the range of elbow movement measurements with the sole purpose of assessing the participants' outpatient experience at ASC. After performing univariate and multiple logistic regressions for each of the risk factors, they found that major complications occurred in approximately 7.1% of patients. Additionally, over the 90-day episode-of-care, 39.2% of patients had minor wound problems. Notably, their univariate regression analysis showed that the minor wounds in question had a strong correlation with smoking. Therefore, patient selection for this procedure in an ASC setting is critical.

Apart from reoperation and related complications, surgical site infections (SSIs) remain the most common surgical centre complication and serve as one of the main reasons for unplanned hospital admissions in the immediate aftermath of operations. SSIs account for more than 20 percent of healthcare-associated infections, particularly in hospitalized patients, leading to considerable morbidity, stays prolonged by up to 10 days, increased mortality rates, and cost between $20,000 and $27,600 per admission (6). Referring to the U.S. National Action Plan to Prevent Healthcare-Associated Infections (NAPPHAI), reducing SSIs remains one of the country's priorities. Initially focused on healthcare-associated infections experienced within acute care hospitals and related high-priority areas, the action plan now addresses additional healthcare settings, including ambulatory surgery. As much as there is little information regarding adverse events, such as SSIs, following operations undertaken in the ambulatory settings, the problems directly or indirectly linked to healthcare-associated infections from ASC procedures are minimal6. The researchers arrived at this conclusion based on the evaluation of improved data acquisition using CPT procedure codes for clinically significant site infections (CS-SSIs) associated with ASCs. In fact, at a Surgical Care Affiliate (SCA) surgicenter over a one-year period in Riverside, California, the post-operative infection was less than 1% for over 5,000 procedures7. In essence, the CPT codes enabled them to evaluate and establish the efficiency of performing surgeries in an ASC with the aim of reducing SSIs.

The ability to determine the incidence of CS-SSIs resulting from low-to moderate-risks involved in Medicare-certified outpatient

Table 1 Medicare ASC and HOPD Reimbursement Rates for Eight Orthopaedic Procedures.

Procedure	Medicare ASC Reimbursement	Medicare HOPD Reimbursement
Shoulder Arthroscopy with RCH, SubAcromial Decompression & Distal Acromioclavicular Resection and Debridement	$5,790.82	$10,896.88
Knee ACL Repair	$8,774.80	$16,503.30
Total Hip Arthroplasty	N/A	$10,122.92
Total Knee Arthroplasty	$9,557.20	$10,122.92
Open Reduction / Internal Fixation of Bimalleolar fracture with fluroscopy	$3,027.01	$5,838.73
Open Reduction / Internal Fixation of Distal Radial fracture with fluroscopy	$1,446.45	$5,838.73
Knee Arthroscopy with Medial and Lateral Meniscus Repair	$1,403.42	$2,645.23
Laminectomy with fluroscopy	$3,027.01	$5,838.73

*Total hip arthroplasty is not currently recognized as an outpatient procedure, and total knee arthroplasty has only recently been approved as an out-patient procedure.

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surgical settings plays a fundamental role in revealing the effect of ASCs in health care costs. Owens et al. (2014) undertook a retrospective analysis of ASC procedures complicated by various CS-SSIs, which require reoperation. In the study, they employed the use of healthcare cost, state outpatient, and ambulatory surgery databases to examine the information about infectious outcomes in ASCs located in America's geographically dispersed states, including Nebraska, Tennessee, Florida, Georgia, New York, Hawaii, California, and Missouri. These states, which represent about one-third of the country's population, recorded low rates of postsurgical visits because of SSIs. In particular, postoperative acute care visits occurred only in less than three percent of the 1,000 surgical procedures done in ASCs6. The insignificant rate of reoperation often translates to reduced clinical and economic burden given the already concerted effort toward minimizing overall health care cost in the U.S.

Other common ASC procedures that are more likely to produce more SSIs and potentially increase health care costs in the U.S. include anterior cruciate ligament reconstruction (ACL), hernia repair, cholecystectomy, and breast-conserving surgery (BCS). In a recent retrospective cohort study involving persons who had undergone these forms of ambulatory surgical operations, Olsen et al. (8) used commercial insurer claims and cost distribution to determine the impact of SSIs on health costs. Despite the sparse nature of data on SSIs costs following ambulatory surgeries, the researchers adhered to the recommended 90-day postoperative procedure to identify any infections requiring surgery or during the hospitalization period. Using quantile regression to control operative, patient, and postoperative factors, they found few cases involving severe infections, which either resulted in surgical treatment or hospitalization. The cases in question were directly linked to the increased costs of healthcare after the four procedures.

The most important aspect of the study conducted by Olsen revolves around the comparison of results obtained from in-patient surgery facilities and ASCs. In particular, the researchers report that HOPDs were characterized by higher costs for each of the four common procedures than freestanding ASCs, which contributed to lower costs (8). Drawing from patient satisfaction trends in Glenwood Surgery Center (SCA Facility 50138), the researchers attributed the difference in results to the ability of nursing staff in ASCs to address primary concerns, provide the much-needed explanations, and communicate delays in a timely manner [9]. Most importantly, the study has since acknowledged and appreciated the critical role played by medical staff during and after follow-up calls. Ambulatory outpatient surgery facilities serve as the best possible alternative to HOPDs, especially in minor and selective major surgeries involving low risks.

Time/Procedure Length

Time or procedure length remains one of the key aspects of outpatient surgeries. In essence, physicians need to examine four length-of-surgery measures, including 1) time in the operating room, 2) time in surgery (a subset of time in the operating room) 3) time in post-operative care, and 4) total procedure time (time in the operating room, time in postoperative care, and transport time between the operating room and the recovery room) (1). Although previous research has placed much emphasis on documenting differences witnessed in surgery time between HOPDs and ASCs, variations in procedure time tend to reflect only the underlying differences common in-patient characteristics, not those in efficiency between the facilities in question. To resolve this concern effectively, recent research has focused on comparing the relationship between procedure time and total time in the ASC setting, to that in the HOPD setting. In doing so, it becomes clear how health care cost varies based on efficiency between hospital-based surgeries and ambulatory-centered surgical procedures. Estimates obtained from recently sampled and reviewed studies have revealed that time savings for ASCs are shorter than that of HOPDs. In other words, ASCs remain substantially faster at performing low-risk outpatient procedures than hospitals, particularly when observed patient characteristics and procedure type are controlled throughout a study. On average, patients operated in ASC's spent approximately 31.8 fewer minutes than those whose procedures were undertaken in hospitals (1). This represents a 25% difference relative to the operation activities' mean procedure time of about 125 minutes. In this regard, for an HOPD and an ASC that have similar equipment and the same number of recovery rooms and staff, the ASC will be performing more procedures on a daily basis and at a cheaper cost than the hospital outpatient facility. This may explain how more time-efficient ASCs can operate with lower Medicare reimbursed payments per procedure.

The estimated charges for operating a patient in ASCs are between $29 and $80 per minute (1). These charges exclude fees for the anesthesia providers and surgeon involved in the procedure. The researchers' calculation shows that even with the exclusion of time savings as well as physician payments outside a facility's operating room, an ASC could generate higher savings of between $363 and $1,000 per outpatient surgical case. In essence, these findings support the widely held claim that ASCs play a pivotal role in providing outpatient surgery at relatively lower costs than HOPDs.

In addition to their role in reducing procedure time, Medicare-approved ASCs rarely pose significant adverse medical risks to individual patients. Referring to the selection of a covered procedure, particularly those payable under ambulatory surgical center payment system (ASCPPS), each of the stakeholders, including the secretary of Health and Human Services (HHS) involved must focus on selecting safe procedures for patients when performed in an ASC (10). Although, the Secretary of HHS remains tasked with the responsibility of choosing the right procedures, the ultimate decision regarding whether ASCs and HOPDs serve as the most appropriate settings for a surgical procedure is made by responsible physicians based on a patient's individual clinical needs. In the case of patients age 65 and above, the 2010 report released by the Agency for Healthcare Research and Quality (AHRQ) shows that about 32% of this patient population has a high-risk medical history of comorbidities. This is due to increased incidence of chronic illnesses and conditions, such as cancer, arthritis, and lung disease (11). Younger patients presented in operating rooms often have lower-risk medical profiles. With these conflicting clinical needs, a patient is operated either in an ASC or in an HOPD depending on the severity of their comorbidities.

ASCs typically record fewer adverse incidents than procedures performed in physician offices (12). For example, the incident rate of adverse incidents in ambulatory surgical settings and offices occurred 5.3 and 66 per 100,000 surgical procedures, respectively (12). At the same time, the rates witnessed in 100,000 operations were 0.78% and 9.2% in ASCs and physician offices, respectively. Additionally, the relative risks recorded for deaths and injuries for ASCs and offices differed significantly, leading to the conclusion that surgical procedures performed by stand-alone practitioners in their offices have 10-fold increased risks over those performed in an ASC. This fact supports that cost alone should not be the sole driving force for selecting the setting of surgical service. While ASC-based procedures reduce potential hospital admissions, mild to severe injuries, loss of life, and healthcare cost, office-centered surgeries show an increased incidence rate. If each of the office procedures could be done in ASCs, the researchers argue that about six deaths and over 43 procedures could be prevented every year (12).

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ASCs remain focused on providing individual patients with the best possible surgical experience, while at the same time ensuring the delivery of cost-effective care. The facilities at hand achieve this by saving the government, patients, and third-party payers' money. When comparing health care charges in HOPDs vs ASC throughout the country, the Medicare program, its principal beneficiaries, and related stakeholders save over $2.6 billion in benefits annually. This is because ASC reimbursement is significantly less for procedures (13). In addition, patient co-pays are concomitantly lower. Concisely, ASCs serve a significant role as the most suitable lower-cost alternative to outpatient surgical procedures.

Research on the efficiency of ASCs attributes their tremendous growth since the 1980s to the facilities' flexibility in meeting the rapidly growing demand for less-complicated outpatient surgery services. Despite their smaller footprint than HOPDs, ASCs remain less costly (10,13). First, they are less expensive to build even in urban and related environments, where vital resources such as land may be difficult to acquire. ASCs occupy minimal space, which means that their construction and general maintenance incur lower overhead costs. If the government formulated and implemented a change-driven policy that requires half of all the available procedures to be executed in ASCs, Medicare would be well positioned to save over $25 billion in the next one decade (13). In essence, all these are achievable following the benefit to insurers and Medicare from lower surgical prices in ASC settings.

Insurers, Medicare allowable rates, currently pay approximately half of the total amount paid in ASCs compared to HOPDs for performing the same surgical procedures. For instance, referring to CPT code 66982, extracapsular cataract extraction removal (ECER), Medicare pays a total of $1,671 for the surgery in HOPD, while under ambulatory payment classifications, (APCs), the program pays only $964 to ASCs for the same procedure (13). This high reimbursement gap in payment is one of the most recent discrepancies in the U.S. healthcare payment system. If the reimbursement gap of ASCs and HOPDs were only 16%, by 2017 the payment to HOPDs would have been approximately 82% more than ASCs (2).

Patients pay less for surgical procedure coinsurance done under ASCs than for those under HOPDs (percentage of payment rate). Therefore, Medicare beneficiaries end up paying $496 in coinsurance when they go through an ECER in an HOPD versus the $195 in ASCs (13). Without the introduction of ASCs, it is evident that healthcare expenditures in the U.S. would be amounting to hundreds of billions of dollars. As most private insurance companies use Medicare allowable reimbursement as a principle in reimbursement, the same rate of saving would apply. For this reason, employers benefit from reduced healthcare expense because employees embrace ASC services over HOPD services (14). Therefore, in theory, health care cost savings should be reflected by decreasing insurance premiums. This would financially benefit both the employee and the employers.

The wide gap between the reimbursement of ASCs and HOPDs plays a central role in threatening the various gains directly attributed to performing surgical procedures in an ASC setting. The payment differential plays a central role in creating an unsustainable market dynamic characterized by well-established hospitals strategically purchasing ASCs and converting them into HOPDs (15). This ploy of a hospital to convert an ASC into a HOPD that is located remotely, can result in higher medical costs. This occurs because once an ASC is acquired by a hospital, its ASC license can be terminated and converted into one of the hospital's units. This newly acquired unit will bill surgical procedures to the HOPD rates rather than ASC rates. As a result, the ASC will bill patients at higher rates.

Patient Satisfaction

Results obtained from recent surveys, studies, and systematic reviews show that patients are satisfied with the services and care they receive from ASCs. In particular, the majority of patients under ASC programs tend to cite reduced or lower costs, the ease involved in operation scheduling, the provision of safe and quality services, transparency, and increased personal attention as the main reasons for embracing ASCs (2). The ASC industry acknowledges and appreciates the important role played by disclosing pricing information in client satisfaction and overall loyalty (16). By making information about pricing available before surgery, ASCs promote transparency among all patients and Medicare beneficiaries. For the benefit of consumers, these disclosures set out the total price for the intended surgical procedures and specify the payment terms. By doing so, they empower healthcare consumers by providing the best opportunity to evaluate costs and compare prices among different healthcare providers. The U.S. ASC health care delivery model comprises of convenience, efficient care, and patient satisfaction. It revolves around enhancing patient care by enabling physicians and other practitioners to focus exclusively on small-scale processes in single settings rather than relying on hospital settings that typically have large-scale demands for the management's attention, space, and resources (16). With the limited number of surgical rooms and space, physicians can intensify quality control to ensure effectiveness in ASC processes. Additionally, the change-oriented and holistic model allows patients to gain quick access to their physicians, bringing concerns directly to responsible physician operators, particularly those that have direct knowledge about their cases. In essence, the three-dimensional framework adopted by ASCs improves customer satisfaction by reducing bureaucratic procedures usually encountered when dealing with various hospital administrators, who have less detailed knowledge about specific patients and their experiences.

ASCs can create and maintain physician ownership, which may help promote their presence in the health care market. As an extension of their practice, ASCs may allow physicians to increase the types of cases performed in these centers. This will ultimately reduce the patient wait-times for the procedures. In this way, ASCs encourage further specialization in the ambulatory setting. Unlike large-scale health institutions, such as hospitals, ASCs place greater emphasis on providing quicker, more responsive environments tailored to meet the changing individual needs of patients. With this lower bureaucratic system, ASCs enable physicians to exercise increased control over scheduling (17). As a result, the model decreases delays before or after performing given procedures. In hospital settings, physicians often delay or reschedule some surgical procedures following an institutional demand, including attending to emergencies. Unforeseen emergency room demands hinder practitioners' productivity and concomitant increase health care costs because patients are compelled to wait for many days before the operation or to leave the facility (17). Ultimately, physician ownership in ASCs allow surgeons to implement innovative strategies for leadership, governance, and quality improvement.

Patients identify ASCs and report improved satisfaction levels because the outpatient surgical facilities remain committed to quality. In fact, quality-care serves as one of the important hallmarks of ASC health care delivery model (5). The ASC community continues to show its commitment to offer quality collaboration through the ASC Quality Collaboration (AQC). The latter is an independent and transformation-driven initiative meant to promote safety and quality in ASCs. Tasked with the responsibility of developing meaningful and realistic quality measures for various ASC settings, AQC further oversees voluntary reporting by ASCs, ensuring accountability for the sake of the patients. A typical case in point involves the organization's

ATTACHMENT 12
Purpose of the Project

role in urging the Center for Medicaid Services (CMS) to focus on establishing standardized, comprehensive, and uniform quality and accountability reporting systems. Briefly speaking, the primary purpose of such systems would revolve around financial management, social responsibility, and performance. Accordingly, the already formulated quality measures aligned with the U.S. national plan goals, which revolve around transparency and healthcare cost reduction.

Apart from quality commitment, patients treated in ASCs tend to fare better than their counterparts who were operated in HOPDs. Using variations in ASC generated by the ongoing changes in APCs and Medicare reimbursements, Stone et al. (5) collected data on the safe surgery checklist and volume of procedures to determine patient satisfaction levels in selected HOPDs and ASCs. Considering the likelihood of patients who have undergone any of the highest-volume outpatient surgical procedures in an ASC or HOPD to visit EDs or have physicians operate them again, the researchers recorded patient outcomes. The highest-risk patients under Medicare program were less likely to visit EDs or be admitted to hospitals after having their surgeries performed in ASCs as compared to their high-risk Medicare counterparts treated in HOPDs5. At the same time, the researchers' satisfaction survey with an 85.7% response rate showed that 91.7% of patients reported happiness for going home in the immediate aftermath of their operations (5). Approximately, 96% reported additional confidence because they could exercise more control over their lives and funds during and after treatment. Undoubtedly, these findings serve as a clear indication that ASCs provide the much-needed quality care, regardless of patient's vulnerability levels.

Physician Satisfaction

Physicians developed ASCs in response to a myriad of challenges in their traditional hospital workplace, where they could not achieve the desired satisfaction levels. Besides complaints from patients who could wait for several days before receiving the recommended surgical services, medical professionals tasked with the responsibility of executing surgeries encountered and had to deal with slow and cumbersome operating turnover times, the inability to obtain new equipment due to poor, ineffective hospital policies and budgets, and frustrations involving scheduling delays (13). Even though Medicare has proved less receptive of these ASCs, individual physicians are quick to adopt and integrate technological advances in their operations, mainly by starting joint ASCs (16). This way, their morale has since reached an all-time high, while at the same, helping patients, including Medicare beneficiaries.

The ability of physicians to utilize new technologies to perform a growing range of simple to complex range of procedures safely on an outpatient basis not only show that they enjoy their work but also utilize their skills and potential. For example, physicians in the present-day society are now well-positioned to accomplish their operations within the shortest possible time because they employ the use of effective and less invasive techniques. Some of these new and result-oriented technologies include advanced anesthetics and endoscopic procedures (13). Traditionally, complex and multifaceted procedures needed long hours to complete, required physician operators to use major incisions, long-lasting anesthetics, as well as extended convalescence. The new approach employs the use of short-acting anesthetics and involves shorter recovery times. In other words, physicians no longer spend protracted follow-ups to ensure complete recovery from surgical procedures. All these advantages have far-reaching economic value because surgeons can maximize their talents, the government spends relatively less on health reimbursements, and patients remain well positioned to develop a quicker recovery in ASC settings.

The efficiencies attributed to ASCs revolve around the facilities' role in creating high-level flexibility among physicians. The disparities witnessed in recovery and preoperative times determine the differences in satisfaction and motivation levels between ASC and HOPD surgeons (1). Compared to the prevailing situations in HOPDs, for instance, ASC physician operators are more likely to operate from a single and strategically located facility. Since this location serves as their working point for multiple cases, the surgeons are in the best possible position to minimize delays (15). The small size and strategic location of ASC facilities reduce travel time wastage and increase physician productivity; thus, minimizing overall overhead costs that could be incurred in a complex hospital setting with many buildings and departments.

The turn-over time in operating rooms in ASCs remain significantly shorter than in HOPDs because teams of staff typically have more consistent and clear roles. Though hospital surgery departments are often organized in a systematic and proper manner, the presence of many employees, activities, and patients with a variety of needs play a central role in making physicians less productive and satisfied in the workplace (12). In contrast to employees in HOPDs who tend to work in shifts, staff members in ASCs usually have incentives to accomplish their duties quickly, leading to higher teammate satisfaction. On the other hand, hospitals tend to re-operate as well as add-on cases, which directly compete with planned and potential outpatient procedures, causing fatigue and decreased employee morale. The economic theory provides that favorable work environment in an organization is inextricably linked to satisfied employees, who often align their objectives with the already established organizational goals (16). It means that physicians working in an ASC remain committed to the whole process of holistic benefit maximization, while at the same time contributing toward the concerted effort aimed at minimizing health care costs both at the national and facility levels.

In addition to conducive work environments and timely execution of surgical procedures, ASCs contribute to increased physician satisfaction because of the ownership principle. Essentially, physicians with ownership stakes in a given ASC usually enjoy greater profits when and after performing procedures in such facilities rather than HOPDs (9,15). Individual physician's professional reimbursement is not linked to site of technical service. Physicians may share profitability of an ASC with ownership opportunities. Although some critics argue that this practice may lead to demand inducement, with some providers recommending unnecessary and risk-laden procedures in their ASCs, the government has strict quality laws in place, governing the operation of physician-owned ASCs (17). ASCs must be linked to group practice models or be an extension of the surgeon's practice. In essence, reduced operation costs benefits patients and physicians alike.

Physicians draw their satisfaction from the freedom involved in the decision-making process. As stated earlier, ASCs differ from hospital-based outpatient surgery centers because a group of individual physicians owns the facilities; they are empowered with the opportunity to opine on crucial decisions (9). For example, physicians have to decide on which patients to treat at HOPDs versus an ASC. The decision to operate a given patient at their ASCs may be driven by convenience, fulfilling amenities, greater flexibility with regard to scheduling procedures, and setting's efficiencies.

Physician-owners often consider economic, social, and non-economic factors when making vital decisions regarding whether to operate and treat given patients at their ASCs. A physician may choose to maximize their profits by treating a patient whose profit margin surpasses that of other patients with planned surgeries (15). In as much as this decision may be perceived negatively by opponents of

ATTACHMENT 12
Purpose of the Project

ASCs, proponents strongly argue that profit maximization alongside desirable patient outcomes conform perfectly well to the welfare agenda of any health care system16. For example, the act of treating the most at-risk patients for life-threatening complications at HOPDs involves optimizing better resources found in hospitals. Ultimately, recent studies have concluded that the differences between HODPs and ASCs suggest that hospitals can only maximize on their efficiencies and physician satisfaction by adopting highly specialized and unique organizational models.

Criticism

The profitability associated with ambulatory surgical procedures continues to place the image of ASCs in bad light. Critics argue that some physicians are neither driven by patient well-being nor overall healthcare reduction costs, but by their self-interests (17). In particular, this school of thought argues that the concept of physician ownership has since made ASC operations a business affair in which individual physicians place great emphasis on maximizing their income. Physicians receive the facility's fee share when their patients pay the ASCs. Since they typically receive nothing when such patients pay the HOPD, physicians may resort to hijacking patients that are more profitable, treating them in their own ASCs. This behavior could have adverse effects on the profitability of HOPDs and general hospital revenues. One of the Missouri-based hospitals, St. Louis, recently reported a significant drop in their annual revenue by more than 23% (17). The administrator cited an ASC near the hospital as the cause of the loss. The practice remains a major problem because many hospitals subsidize a number of healthcare services offered in their departments, such as uncompensated and charity care.

The incentive problems attributed to physician ownership of an ASC tend to have adverse effects on a healthcare facility's efficiency. For example, inefficiencies may be witnessed in health care delivery if physicians choose to assign patients to particular ASCs or HOPDs for profitability purposes, not patient needs (15). Anecdotal evidence suggests that ASCs have a negative impact on the financial performance of hospitals.

Conclusively, it is evident that patient clinical outcomes as well as patient and physician satisfactions justify the potential economic advantage of undertaking surgical procedures in ASCs rather than HOPDs. The expanded health insurance coverage in the U.S. has presented policymakers and related stakeholders with opportunities to identify and explore change-driven ways through which the country would accommodate the rapidly increasing demand for outpatient surgical services, compelling individual physicians to create ASCs. Serving as the immediate alternative to hospital-based outpatient surgeries, the ASCs were established with the sole purpose of improving health care quality and reducing health care costs by either eliminating or minimizing reoperation and infection rates. ASCs remain economically beneficial for many reasons. In particular, the facilities play a central role in creating high-level flexibility among physicians. Patients typically pay far less coinsurance for surgical procedures done in the ASC setting than for similar procedures undertaken in the HOPD. Additionally, insurers in collaboration with Medicare currently pay approximately half of the total amount paid in HOPDs for performing the same surgical procedures. Referring to CPT code 66982, extracapsular cataract extraction removal (ECER), for instance, Medicare pays a total of $1,671 for the surgery in HOPDs, while under APCs the program pays only $964 to ASCs for the same outpatient procedure. In essence, the overall economic benefits in a free market system attributed to ASCs revolve around efficient and flexible physician practice, the cost savings, patient satisfaction, high-level quality care.

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ATTACHMENT 13
Alternatives

Status Quo **(No additional CON costs / Healthcare Delivery Costs)**

Maintaining operations at the current Westmont facility would avoid any new CON-related capital expenditures. However, this option does not address the facility's existing physical constraints, which limit surgical throughput, patient flow, and operational efficiency. Continued use of the outdated space could result in deferred maintenance costs, reduced clinical efficiency, and diminished ability to accommodate increasing patient volumes or evolving standards of care. Ultimately this option would either yield increased expense of obsolescence from a healthcare delivery perspective and for these reasons, this option was not selected.

Acquisition of Existing Facility **(Potentially reduced CON cost due but administrative/functional barriers)**

Pursuing an existing healthcare facility would involve significant capital outlay for real estate acquisition, potential renovations, potential licensing hurdles (since the facility would require meeting existing design and construction standards) and there is the potential that an acceptable facility simply does not exist. As a result, identifying suitable facilities in the target service area could introduce delays in operational readiness and reduce the ability to tailor the site to Salt Creek's specific workflow needs. As such, this option was not selected.

Separate Second Facility **(Increased CON cost due to construction & land acquisition)**

Constructing a second facility while continuing operations at the current site would significantly increase overall capital costs and would require duplicative staffing and overhead. This approach would not optimize operational efficiency and would likely result in a misallocation of clinical resources across two underutilized sites. It also runs counter to CON goals of cost containment and efficient resource use. Accordingly, this option was not selected.

Project as Proposed

The proposed relocation allows Salt Creek Surgery Center to continue providing high-quality care while addressing the operational and spatial limitations of the current site. It supports long-term cost efficiency, improves access, and aligns with healthcare delivery trends favoring outpatient settings. This option represents the most fiscally responsible and operationally effective approach to sustaining and expanding ASTC services in the area. For this reason, this was the option selected.

ATTACHMENT 14
Size of the Project

The proposed project includes the relocation and renovation of an ambulatory surgical treatment center (ASTC) comprising six operating rooms within a total gross square footage of 22,990 GSF. While the project exceeds the state standard of 16,500 GSF for a six-operating-room ASTC, as set forth in Appendix B of 77 Illinois Administrative Code Section 1110, this variance reflects the renovation and adaptive reuse of an existing clinical space. The proposed layout is designed to promote efficient clinical workflows, comply with applicable life safety and infection control requirements, and appropriately accommodate the projected volume and scope of surgical services. As detailed below, although the gross square footage exceeds the benchmark, the proposed design is necessary to ensure patient safety, provider efficiency, and operational integrity.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	**PROPOSED BGSF/DGSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
ASTC	22,990 GSF (6 ORs)	16,500 GSF	6,490 GSF	NO

ATTACHMENT 15
Project Services Utilization

The expected annual utilization for an ambulatory surgical treatment center (ASTC) is 1,500 hours per surgical or procedure room. This proposal includes six operating rooms, setting the utilization benchmark at over 7,501 hours. Based on historical utilization patterns and projected patient volume, the facility is anticipated to meet or exceed the state's utilization standard within its second year of operation.

UTILIZATION					
	DEPARTMENT / SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1	**ASTC**	8,545 procedure hours	75.9%	80%	NO
YEAR 2	**ASTC**	9,058 procedure hours	80.5%	80%	YES

Specialty Type	**Number of Procedures**	**Number of Hours**	**Proposed Number of Procedures**	**Proposed Hours to ASC**
General Surgery	1	2	1	2
Orthopedic	4193	8386	4193	8386
Pain Management	107	89	107	89
Podiatric	49	69	49	69
Total	**4350**	**8545**	**4350**	**8545**

Specialty Type	**Average Procedure Time in Hours (including Prep Time, Procedure Time, and Clean-up)**
Podiatric	1.40
Pain Management	0.90
General Surgery	1.50
Orthopedic	2.00

Source: 2022 Annual HFSRB Questionnaire

We will be submitting a universal referral letter to address the regulatory requirements for referrals. Moreover, the zip code information provided within these documents demonstrates that the patient volume comes from within the geographic service area defined in subsection (c)(2)(B).

ATTACHMENT 15
Project Services Utilization

Note: The above utilization was obtained from actual utilization data regarding prior usage at the facility this project proposes to replace (via establishment and contemporaneous discontinuation). Subsequent to filing a "universal referral letter" will be submitted by the Medical Director to attest to the historical and future utilization of this facility.

BURGESS, BRIAN	Salt Creek Surgery Center	23
BURRA, GIRIDHAR	Salt Creek Surgery Center	882
CHOKSHI, NIKHIL	Salt Creek Surgery Center	51
CHUDIK, STEVEN	Salt Creek Surgery Center	944
DARWISH, ASHRAF	Salt Creek Surgery Center	387
DEAN, DANIEL	Salt Creek Surgery Center	200
DOUGHERTY, EVAN	Salt Creek Surgery Center	63
DURKIN, MICHAEL	Salt Creek Surgery Center	260
EHMKE, THOMAS	Salt Creek Surgery Center	440
FAJARDO, MARC	Salt Creek Surgery Center	466
GAMEZ, CARLA	Salt Creek Surgery Center	2
GHODASRA, JASON	Salt Creek Surgery Center	779
HO, BRYANT	Salt Creek Surgery Center	473
HURBANEK, JASON	Salt Creek Surgery Center	168
KEATING, TIMOTHY C.	Salt Creek Surgery Center	23
LAREAU, JUSTIN	Salt Creek Surgery Center	231
MILLER, STEVEN	Salt Creek Surgery Center	20
PATEL, RONAK	Salt Creek Surgery Center	896
PUPPALA, ANUJ	Salt Creek Surgery Center	20
RAMANAVARAPU, VIDYA	Salt Creek Surgery Center	72
RIFF, ANDREW	Salt Creek Surgery Center	331
SAMPAT, CHINTAN	Salt Creek Surgery Center	76
SHROUDER-HENRY, JASON	Salt Creek Surgery Center	190
STARON, JEFFREY	Salt Creek Surgery Center	61
TAUCHEN, ALEXANDER JOHN	Salt Creek Surgery Center	218
THORSNESS, ROBERT	Salt Creek Surgery Center	864
URBANOSKY, LEAH	Salt Creek Surgery Center	117

ATTACHMENT 16
Unfinished or Shell Space

NOT APPLICABLE The proposed project does not include plans for shell space.

ATTACHMENT 17
Assurances

NOT APPLICABLE The proposed project does not include plans for shell space.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents - 1110.235(c)(2)(B)

Pursuant to 77 Ill. Adm. Code Section 1110.235(c)(2)(B), applicants for a new or relocated ambulatory surgical treatment center (ASTC) must demonstrate that at least 50% of the projected patient volume will be residents of the identified Geographic Service Area (GSA).

Salt Creek Surgery Center, LLC d/b/a Salt Creek Surgery Center, currently located in Westmont, Illinois, proposes to relocate its licensed ASTC to a new facility at 550 W. Ogden Avenue, Hinsdale, Illinois. The proposed site is located within the same GSA as the existing facility and is approximately two miles away.

Historical patient origin data from Salt Creek Surgery Center confirms that the majority of patients served reside within the defined GSA. Specifically, this historical utilization pattern supports the projection that the relocated ASTC will continue to serve GSA residents at or above the 50% threshold.

The below information exhibits historical patient origin by zip code. However, please note that this information reflects the entirety of the surgeries being performed by the physicians who are performing surgeries at the current, and envisioned replacement, facility. Accordingly, there are a limited number of isolated surgeries included in this list that may have been performed at other IBJI ASTCs (based upon patient preference, equipment need, scheduling availability, or medical necessity). However, the limited number of extra surgeries reflected in this data (for which there was no feasible means of extracting) does not impact the application's demonstration of serving GSA residents well above the 50% threshold necessary to comply with the Board's rules.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents - 1110.235(c)(2)(B)

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
10024	2
27604	1
29588	1
29708	1
32277	1
32789	1
33785	1
33825	1
33931	1
34110	1
34113	1
34120	1
34135	1
34208	1
34715	1
37138	1
34613	1
37701	1
37067	2
38103	2
41101	2
42044	1
44236	1
45040	1
46221	3
46227	3
46303	6
46304	4
46307	2
46310	7
46311	4
46312	2
46319	7
46320	2
46321	3
46322	2

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
46323	2
46324	9
46341	1
46368	1
46373	8
46375	5
46383	2
46385	2
46394	2
46403	2
46410	2
46534	1
46574	3
46962	2
47909	1
47960	1
49117	1
49408	1
49635	2
53051	1
53105	1
53115	1
53158	2
53181	1
53182	1
53204	1
53217	1
54205	1
54246	1
54494	1
54937	2
54965	3
59937	1
60002	2
60004	3
60005	6

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents - 1110.235(c)(2)(B)

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
60007	3
60008	3
60010	4
60012	2
60013	2
60015	5
60016	1
60018	1
60022	1
60025	2
60026	2
60030	1
60031	1
60045	2
60046	1
60047	4
60048	1
60050	4
60053	1
60056	4
60067	4
60068	4
60069	1
60073	15
60074	3
60076	1
60090	16
60099	1
60101	8
60102	3
60103	7
60104	26
60106	3
60107	9
60108	2
60112	4

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
60119	3
60120	50
60123	5
60124	72
60126	33
60130	10
60131	9
60133	10
60134	14
60135	4
60136	29
60137	21
60139	12
60142	5
60143	43
60148	51
60152	10
60153	24
60154	25
60155	5
60156	9
60157	1
60160	14
60162	5
60163	6
60164	7
60165	2
60169	3
60171	5
60172	5
60173	5
60174	15
60175	5
60177	8
60178	28
60181	21

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents - 1110.235(c)(2)(B)

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
60185	16
60187	10
60188	19
60189	5
60190	12
60191	10
60192	10
60193	4
60194	2
60202	1
60301	9
60302	6
60304	18
60305	16
60401	18
60402	68
60403	138
60404	54
60406	29
60408	9
60409	77
60410	41
60411	20
60415	20
60416	24
60417	32
60418	6
60419	6
60420	44
60421	14
60422	71
60423	23
60424	5
60425	1
60426	39
60428	2

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
60429	12
60430	122
60431	117
60432	67
60433	19
60434	140
60435	147
60436	21
60438	132
60439	102
60440	157
60441	129
60442	40
60443	8
60444	11
60445	103
60446	88
60447	138
60448	75
60449	75
60450	259
60451	92
60452	52
60453	16
60464	24
60455	7
60456	9
60457	17
60458	16
60459	2
60461	42
60462	27
60463	14
60464	21
60465	5
60466	41

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents - 1110.235(c)(2)(B)

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
60467	32
60468	10
60469	5
60471	2
60473	4
60474	43
60476	2
60477	23
60478	14
60479	1
60480	66
60481	25
60482	11
60484	58
60487	75
60490	98
60491	34
60501	13
60502	17
60503	11
60504	12
60505	35
60506	31
60510	30
60512	79
60513	85
60514	114
60515	139
60516	156
60517	79
60518	1
60520	1
60521	87
60522	39
60523	25
60525	75

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
60526	96
60527	64
60531	32
60532	39
60534	6
60537	11
60538	47
60540	32
60541	20
60542	33
60543	76
60544	27
60545	23
60546	15
60548	3
60551	5
60552	57
60554	39
60555	58
60558	82
60559	34
60560	69
60561	58
60563	54
60564	58
60565	46
60585	122
60586	65
60601	3
60605	3
60607	7
60608	4
60609	8
60610	1
60611	1
60612	2

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents - 1110.235(c)(2)(B)

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
60613	1
60614	2
60615	2
60616	2
60617	5
60618	2
60619	3
60620	6
60621	1
60622	8
60623	6
60624	1
60628	16
60629	7
60630	5
60631	4
60632	3
60633	2
60634	21
60636	5
60637	24
60638	19
60639	1
60641	5
60642	2
60643	5
60644	6
60646	1
60647	6
60649	2
60651	11
60652	10
60653	3
60654	10
60655	6
60656	3

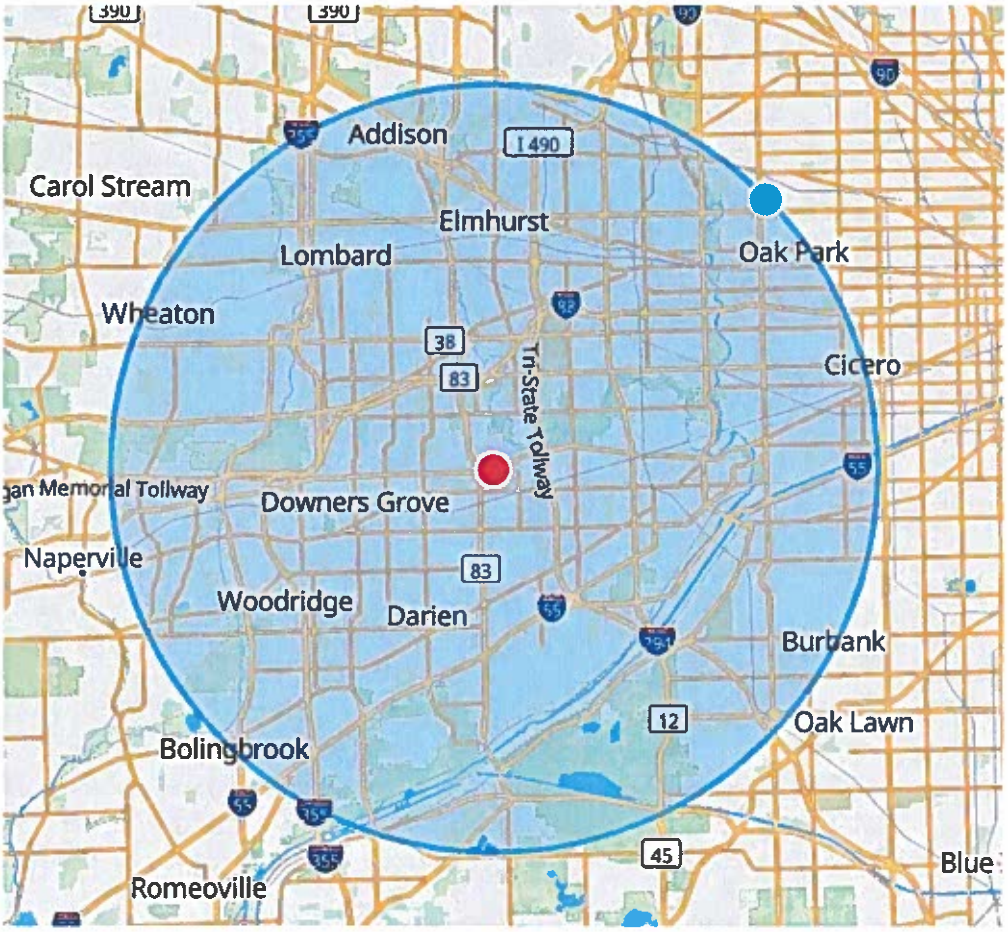
ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
60657	3
60659	1
60661	2
60706	14
60707	7
60714	1
60803	14
60804	9
60805	6
60901	19
60911	2
60913	2
60914	7
60915	2
60935	2
60940	3
60950	3
60953	1
60954	1
60955	2
60961	1
60970	1
61001	1
61008	2
61010	2
61016	1
61021	2
61036	4
61244	5
61301	12
61310	3
61341	17
61342	1
61348	3
61349	1
61350	11

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents - 1110.235(c)(2)(B)

ASTC PROCEDURES	
ZIP CODE	NUMBER OF PROCEDURES
61354	4
61360	6
61364	2
61367	1
61368	2
61373	2
61533	1
61560	2
61607	1
61611	1
61704	2
61705	1
61744	3
61761	2
61764	2
61771	1
61832	1
61873	3
61910	1
62257	1
62401	1
62568	1
62526	1
62938	1
63021	2
65606	2
73025	1
85043	2
85259	1
85374	1
85614	1
92663	1
	7372

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents- 1110.235(c)(2)(B)

10 Mile Radius from 550 W. Ogden Avenue, Hinsdale, IL 60521



ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service to GSA Residents - 1110.235(c)(2)(B)

Below is a list of zip codes with the population for each city within 10 miles of the proposed facility.

Name	Zip Code	Population
Hinsdale	60521	18,199
Western Springs	60558	13,629
Clarendon Hills	60514	10,320
Westmont	60559	24,363
Oak Brook	60523	10,347
La Grange Park	60526	13,810
La Grange	60525	32,613
Westchester	60154	16,895
Willowbrook	60527	29,139
Brookfield	60513	19,513
Hillside	60162	8,337
Darien	60561	23,139
Broadview	60155	8,011
Summit	60501	11,746
Downers Grove	60515	29,278
Lyons	60534	10,749
Riverside	60546	16,819
Justice	60458	14,504
Villa Park	60181	29,821
Downers Grove	60516	28,694
Berkeley	60163	5,285
Bellwood	60104	18,829
Willow Springs	60480	5,272
Elmhurst	60126	48,147
Hines	60141	131
Maywood	60153	23,512
Lombard	60148	52,784
Forest Park	60130	14,346
Berwyn	60402	64,706
Woodridge	60517	33,276
Hickory Hills	60457	14,420
Stone Park	60165	4,576
Bridgeview	60455	17,098
Melrose Park	60160	24,776
Glen Ellyn	60137	38,985
Chicago	60638	56,928
Lisle	60532	28,766
Melrose Park	60164	22,367
River Forest	60305	11,710
Oak Park	60304	17,842
Palos Hills	60465	18,530
Lemont	60439	24,327
Burbank	60459	29,451
Oak Park	60301	3,043
Cicero	60804	85,673
Franklin Park	60131	18,205
River Grove	60171	10,612
Oak Park	60302	33,698
Palos Park	60464	9,982

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service Demand- Establishment of an ASTC - 1110.235(c)(3)

Note: The utilization was obtained from actual utilization data regarding prior usage at the facility this project proposes to replace (via establishment and contemporaneous discontinuation). Subsequent to filing a "universal referral letter" will be submitted by the Medical Director to attest to the historical and future utilization of this facility.

BURGESS, BRIAN	Salt Creek Surgery Center	23
BURRA, GIRIDHAR	Salt Creek Surgery Center	882
CHOKSHI, NIKHIL	Salt Creek Surgery Center	51
CHUDIK, STEVEN	Salt Creek Surgery Center	944
DARWISH, ASHRAF	Salt Creek Surgery Center	387
DEAN, DANIEL	Salt Creek Surgery Center	200
DOUGHERTY, EVAN	Salt Creek Surgery Center	63
DURKIN, MICHAEL	Salt Creek Surgery Center	260
EHMKE, THOMAS	Salt Creek Surgery Center	440
FAJARDO, MARC	Salt Creek Surgery Center	466
GAMEZ, CARLA	Salt Creek Surgery Center	2
GHODASRA, JASON	Salt Creek Surgery Center	779
HO, BRYANT	Salt Creek Surgery Center	473
HURBANEK, JASON	Salt Creek Surgery Center	168
KEATING, TIMOTHY C.	Salt Creek Surgery Center	23
LAREAU, JUSTIN	Salt Creek Surgery Center	231
MILLER, STEVEN	Salt Creek Surgery Center	20
PATEL, RONAK	Salt Creek Surgery Center	896
PUPPALA, ANUJ	Salt Creek Surgery Center	20
RAMANAVARAPU, VIDYA	Salt Creek Surgery Center	72
RIFF, ANDREW	Salt Creek Surgery Center	331
SAMPAT, CHINTAN	Salt Creek Surgery Center	76
SHROUDER-HENRY, JASON	Salt Creek Surgery Center	190
STARON, JEFFREY	Salt Creek Surgery Center	61
TAUCHEN, ALEXANDER JOHN	Salt Creek Surgery Center	218
THORSNESS, ROBERT	Salt Creek Surgery Center	864
URBANOSKY, LEAH	Salt Creek Surgery Center	117

The expected annual utilization for an ambulatory surgical treatment center (ASTC) is 1,500 hours per surgical or procedure room. This proposal includes six operating rooms, setting the utilization benchmark at over 7,501 hours. Based on historical utilization patterns and projected patient volume, the facility is anticipated to meet or exceed the state's utilization standard within its second year of operation.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service Demand- Establishment of an ASTC - 1110.235(c)(3)

UTILIZATION					
	DEPARTMENT / SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	ASTC	8,545 procedure hours	75.9%	80%	NO
YEAR 2	ASTC	9,058 procedure hours	80.5%	80%	YES

Specialty Type	Number of Procedures	Number of Hours	Proposed Number of Procedures	Proposed Hours to ASC
General Surgery	1	2	1	2
Orthopedic	4193	8386	4193	8386
Pain Management	107	89	107	54
Podiatric	49	69	49	69
Total	**4350**	**8545**	**4350**	**8510**

Specialty Type	Average Procedure Time in Hours (including Prep Time, Procedure Time, and Clean-up)
Podiatric	1.40
Pain Management	0.90
General Surgery	1.50
Orthopedic	2.00

Source: 2022 Annual HFSRB Questionnaire

We will be submitting a universal referral letter to address the regulatory requirements for referrals. Moreover, the zip code information provided within these documents demonstrates that the patient volume comes from within the geographic service area defined in subsection (c)(2)(B).

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Treatment Room Assessment - 1110.235(c)(4)

The expected annual utilization for an ambulatory surgical treatment center (ASTC) is 1,500 hours per surgical or procedure room. This proposal includes six operating rooms, setting the utilization benchmark at over 7,501 hours. Based on historical utilization patterns and projected patient volume, the facility is anticipated to meet or exceed the state's utilization standard within its second year of operation.

UTILIZATION					
	DEPARTMENT / SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.**	**PROJECTED UTILIZATION**	**STATE STANDARD**	**MEET STANDARD?**
YEAR 1	**ASTC**	8,545 procedure hours	75.9%	80%	NO
YEAR 2	**ASTC**	9,058 procedure hours	80.5%	80%	YES

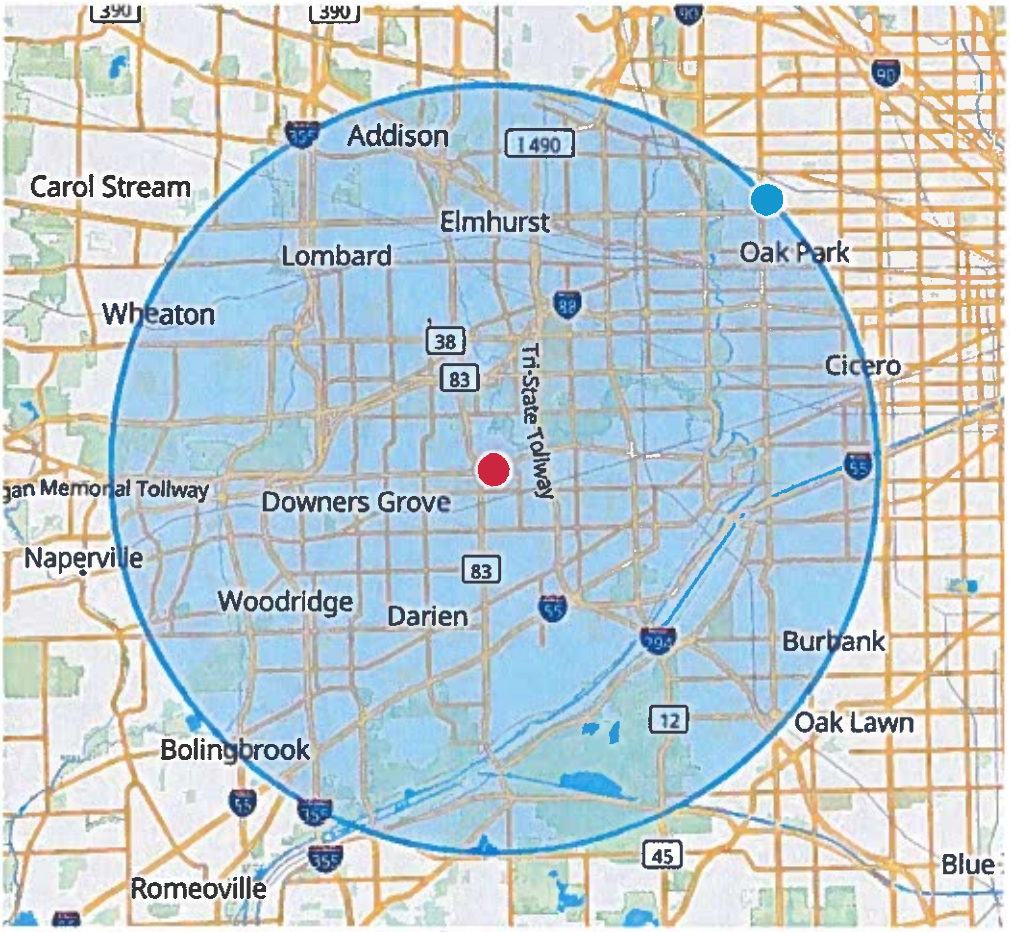
ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Service Accessibility - 1110.235(c)(6)

Westmont Surgery Center, LLC d/b/a Salt Creek Surgery Center ("Salt Creek") is committed to providing accessible outpatient surgical care to all residents of its service area, including Medicaid beneficiaries, uninsured individuals, and other underserved populations. As part of its proposed relocation to 550 W. Ogden Avenue in Hinsdale, Illinois, Salt Creek affirms that the project will maintain and enhance access to care in full compliance with the accessibility requirements of 77 Ill. Adm. Code 1110.235(c)(6).

The proposed relocation site at 550 W. Ogden Avenue in Hinsdale is located just two miles from the current facility and remains within the same geographic service area. The new location is accessible via major roadways and includes ample on-site parking, ensuring that transportation and physical access will not be a barrier to care.

This project aligns with the goals of the Illinois Certificate of Need Program by ensuring that outpatient surgical services remain accessible and cost-effective for all residents, including Medicaid recipients and other underserved populations. The relocation will not result in diminished access; instead, it will support the continued availability of high-quality, physician-led outpatient care in a more modern and efficient facility.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Unnecessary Duplication/Maldistribution, Impact on Area Providers - 1110.235(c)(7)(a)-(c)



ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Unnecessary Duplication/Maldistribution, Impact on Area Providers - 1110.235(c)(7)(a)-(c)

FACILITY NAME	DISTANCE	SPECIALTIES
Hinsdale Surgical Center 10 Salt Creek Lane Hinsdale, IL 60521	1.2 Miles	-OB/Gynecology -Ophthalmology -Oral/Maxillofacial -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Podiatry -Urology -Gastro-Intestinal
Chicago Prostate Surgery Center 815 Pasquinelli Drive Westmont, IL 60559	1.1 Miles	-Orthopedic -Podiatry
Chicago Vascular ASC, LLC 700 Pasquinelli Drive Westmont, IL 60559	.8 Miles	-ESRD Catheter
Rush Oak Brook Surgery Center 2011 York Road, Suite 300 Oak Brook, IL 60523	3.2 Miles	-Gastroenterology -General Surgery -Neurological -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Podiatry
The Oak Brook Surgical Centre, Inc. 2425 W. 22nd Street, Suite 101 Oak Brook, IL 60532	4.1 Miles	-General Surgery -OB/Gynecology -Ophthalmology -Orthopedic -Pain Management -Plastic Surgery -Podiatry -Urology
United Shockwave Services, Ltd. 120 N. LaGrange Road LaGrange, IL 60525	4.2 Miles	N/A
Children's Outpatient Services at Westchester 2301 Enterprise Drive Westchester, IL 60154	4.2 Miles	-Dermatology -Gastroenterology -General Surgery -Neurological -Ophthalmology -Oral/Maxillofacial -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Urology

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Unnecessary Duplication/Maldistribution, Impact on Area Providers - 1110.235(c)(7)(a)-(c)

Ambulatory Surgicenter of Downers Grove 4333 Main Street Downers Grove, IL 60515	4.1 Miles	-OB/Gynecology -Urology
Midwest Center for Day Surgery 3811 Highland Avenue Downers Grove, IL 60515	4.2 Miles	-Gastroenterology -Neurological -Ophthalmology -Otolaryngology -Pain Management -Plastic Surgery -Podiatry
Loyola Surgery Center 1S224 Summit Avenue, Suite 201 Oakbrook Terrace, IL 60181	4.4 Miles	-General Surgery -Neurological -Orthopedic -Otolaryngology -Pain Management -Podiatry
Elmhurst Outpatient Surgery Center, LLC 1200 S. York Road, Suite 1400 Elmhurst, IL 60126	4.4 Miles	-Gastroenterology -General Surgery -Laser Eye Surgery -Neurological -Ophthalmology -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Podiatry -Urology
Loyola University ASC – Loyola Outpatient 2160 South First Avenue Maywood, IL 60153	8.2 Miles	-Gastroenterology -General Surgery -Neurological -OB/Gynecology -Ophthalmology -Oral/Maxillofacial -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Podiatry -Urology
DMG Surgical Center, LLC 2725 Technology Drive Lombard, IL 60148	5.5 Miles	-General Surgery -OB/Gynecology -Ophthalmology -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Podiatry -Urology

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Staffing - 1110.235(c)(8)

The facility will appoint Dr. Michael Durkin who is a surgeon as Medical Director for the facility. The Applicant has not traditionally had any difficulties in staffing their existing offices nor do they anticipate difficulty in staffing the proposed ASTC. As needed additional staff will be identified and employed utilizing existing job search sites and professional placement services. Finally, existing staff of the Salt Creek Surgery Center will continue to be employed once the facility is relocated.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Staffing - 1110.235(c)(8)

Hinsdale Orthopaedics
A Division of Illinois Bone & Joint Institute

MICHAEL C. DURKIN, MD
CURRICULUM VITAE

EMPLOYMENT
Hinsdale Orthopaedics A Division of Illinois Bone and Joint Institute (Hinsdale, Illinois)
- President, 2011 - 2014
- Orthopaedic Surgeon, Partner, 2005 – Present
- Orthopaedic Surgeon, Staff Physician, 2002 - 2005

The Elmhurst Clinic (Elmhurst, Illinois)
- Orthopaedic Surgeon, Staff Physician, 1999 – 2002

HOSPITAL AFFILIATIONS
Current:
- Elmhurst Memorial Hospital – Elmhurst, Illinois
- Good Samaritan Hospital – Downers Grove, Illinois
  -Physician Partners PHO Board of Director
- Hinsdale Hospital – Hinsdale, Illinois
- LaGrange Hospital – LaGrange, Illinois

Previous:
- Edwards Hospital – Naperville, Illinois
- Provena St. Joseph Hospital (2002 – 2011) – Joliet, Illinois
- Silver Cross Hospital (2002 – 2011) – Joliet, Illinois
- Westlake Hospital (2000 – 2001) – Melrose Park, Illinois

SURGICAL CENTER AFFILIATIONS
- Salt Creek Surgery Center – Westmont, Illinois
  -Medical Director

PROFESSIONAL LICENSE / BOARDS
- Medical License: State of Illinois
- Board Certification: American Board of Orthopaedic Surgery (2011)

RESIDENCY TRAINING
- General Surgery, University of Illinois, 1993 – 1995
- Orthopaedic Surgery, University of Illinois, 1995 – 1999

Hospital Affiliations During Residency:
- University of Illinois Hospital (1993 – 1999) – Chicago, Illinois
- Cook County Hospital (1993 – 1999) – Chicago, Illinois
- Westside VA Hospital (1993 – 1999) – Chicago, Illinois
- Christ Hospital (1998) – Oak Lawn, Illinois
- Shriners Hospital (1997 – 1998) – Chicago, Illinois
- Ravenswood Hospital (1995 – 1996) – Chicago, Illinois
- Michael Reese Hospital (1998 – 1999) – Chicago, Illinois

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Staffing - 1110.235(c)(8)

MEDICAL EDUCATION

- Degree in Doctor of Medicine (1993)

Extracurricular Activities:

- University of Illinois Department of Psychiatry, 1990
- University of Illinois and Cook County Hospital, Department of Orthopaedics, 1992 – 1993

UNDERGRADUATE EDUCATION

- B.S. in Bioengineering, University of Illinois Urbana-Champaign, 1989

Extracurricular Activities:

- Student Senator and Member of the Student Senate Association
- Volunteer of Champaign County Special Olympics
- Participated in Intramural Ice Hockey, Flag Football, Basketball and Swimming
- Member of the Bioengineering Society
- Awarded the Philbrick Scholarship, University of Illinois Urbana-Champaign, 1988

POST GRADUATE EDUCATION

- American Academy of Orthopaedic Surgeons, 66th Annual Meeting, 1999
- American Academy of Orthopaedic Surgeons Comprehensive Review Course, Chicago, Illinois, 1999
- Arthroscopy Association of North America, Basic Shoulder Course, Rosemont, Illinois, 1999
- Total Joint Replacement, Current Concepts, Snowmass Village, Colorado, 2001
- Trauma Update, Current Concepts, Snowmass Village, Colorado, 2001
- American Academy of Orthopaedic Surgeons, 67th Annual Meeting, Orlando, Florida, 2000
- Shoulder Arthroplasty, Rosemont, Illinois, 2000
- Trauma Workshop Series, Chicago, Illinois, 2000
- Hip and Knee Arthoplasty Update, Vail, Colorado, 2001
- American Academy of Orthopaedic Surgeons, A Comprehensive Review Course, Chicago, Illinois, 2001
- American Academy of Orthopaedic Surgeons, The Shoulder, A Comprehensive Update, Albuquerque, New Mexico, 2001
- Tornier Shoulder Arthoplasty Course, Chicago, Illinois, 2001
- 2000 Shoulder Prosthesis Reviewed, Nice, France, 2001
- Contemporary Techniques and Issues in Orthopaedics Reconstructive Program, Vail, Colorado, 2001
- Hip and Knee Replacement Update, Whistler, British Columbia, 2002
- Foot and Ankle Techniques in the New Millennium, Rosemont, Illinois, 2002
- Preservation Uni-compartmental Knee Replacement, Rosemont, Illinois, 2003
- A Teaching Day for Locked Plating, Chicago, Illinois, 2003
- American Academy of Orthopedic Surgery, Annual Meeting, New Orleans, Louisiana, 2003
- Agility Ankle Replacement Course, Rosemont, Illinois, 2003
- Arthroscopy Association of North America Wrist and Elbow Course, Rosemont, Illinois 2003
- J&J Delta Shoulder Arthroplasty Course, 2004
- J&J CI Computer Assist Surgery Course, 2004
- Audio Digest CD, 2004-05
- Provena St. Joseph Medical Center, Dept of Surgery Committee, 2005 – Present
- Lecture to Physical Therapist, PT, RN, 2004
- Peer Observation, 2005
- AAOS Sports Medicine Course, 2006
- Total Hip & Knee Arthroplasty, 2007
- The Economics of Arthroplasty, The Efficient Hospital, 2007
- Orthopedic Symposium, Shoulder & Elbow Reconstruction, 2007
- AAOS 2007, Annual Meeting

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Staffing - 1110.235(c)(8)

- Annual Chicago Trauma Symposium, 2007
- Annual Chicago Medical Society, 2008
- 4th Annual Current Advances in Orthopaedics Sports Medicine and Trauma, Steamboat Springs, Colorado, 2008
- Wilderness Medicine, Big Sky, Montana 2011, 2012, 2013

MEDICAL SOCIETIES / ORGANIZATIONS

- Member of the American Academy of Orthopaedic Surgeons
- Member of the Illinois State Medical Society
- Member of the Will-Grundy Medical Society
- Member of the American Association of Hip and Knee Surgeons

COMMUNITY AFFILIATIONS / VOLUNTEER

- Joliet Jack Hammers Baseball Team, Team Physician
- Joliet Junior College Football Team, Orthopaedic Consultant
- Immaculate Conceptions, Willowbrook and York High School Football Teams
- York High School Athletes, Pre-season Physical Exams
- Nicaragua through Health Volunteers Overseas, 2014
- Dupage County Medical Society, 2019

PUBLICATIONS AND PAPERS PRESENTED

- "Clinical Outcomes, Hydroxyapetite Coated Total Hip Arthroplasties," American Orthopaedic Association Resident Meeting, Raleigh, North Carolina, 1999
- "Mathematical Analysis of Femoral Alignment in Total Knee Arthroplasties," Illinois Orthopedic Residency Meeting, Chicago, Illinois, 1999
- "Mathematical Analysis of the Alignment of the Tibial Component in Total Knee Arthroplasty," Senior Thesis Presentation, University of Illinois, 1999
- "Clinical Analysis of Cleft Feet" Publication, Abraham, Shirali, Waxman and Durkin, *The Journal of Pediatric Orthopaedics*, 1999

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Charge Commitment - 1110.235(c)(9)

Salt Creek Surgery Center
530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

John P. Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Floor 2
Springfield, IL 62761

Re: Charge Commitment – Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center

Dear Mr. Kniery,

As a representative of Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center , I, Giridhar Burra, M.D. hereby attest that a peer review program exists or will be implemented that evaluates whether patient outcomes are consistent with quality standards established by professional organization for the ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

Furthermore, I attest that in order to meet the objectives of the Act, which are to improve the financial ability of the public to obtain necessary health services and to establish an orderly and comprehensive health care delivery systems that will guarantee the availability of quality health care to the general public and cost containment and support for safety net services that we have enclosed a list of CPT codes and a proposed fee schedule.

We hereby commit that the charges will not increase, at a minimum, for the first 2 years of operation unless a permit is first obtained pursuant to Title 77 Ill. Admin. Code Section 1130.310(a).

Sincerely,

Giridhar Burra, M.D.
Managing Member
Salt Creek Surgery Center

Joint Commission

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Charge Commitment - 1110.235(c)(9)

CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
0707T	NJX BONE SUB MATRL INTO SUBCHONDRAL BONE DE	
10060	DRAIN SKIN ABSCESS SIMPLE	
10120	REMOVE FOREIGN BODY SIMPLE	
10121	REMOVE FOREIGN BODY COMPLIC	
10180	COMPLEX DRAINAGE, WOUND	
11010	DEBRIDE ASSOC OPEN FX/DISLOC SKIN/SUBQ	
11011	DEBRIDE ASSOC OPEN FX/DISLOC SKIN/MUSCLE	
11012	DEBRIDE ASSOC OPEN FX/DISLO SKIN/MUS/BONE	
11042	DEBRIDEMENT, SKIN, SUB-Q TISSUE,=<20 SQ CM	
11043	DEBRIDEMENT, SKIN, SUB-Q TISSUE,MUSCLE,=<20	
11045	DEBRIDEMENT, SKIN, SUB-Q TISSUE,EACH ADD 20	
11046	DEBRIDEMENT, SKIN, SUB-Q TISSUE,MUSCLE,EACH	
11730	REMOVAL OF NAIL PLATE	
11750	REMOVAL OF NAIL BED	
11760	RECONSTRUC OF NAIL BED	
11981	INSERTION DRUG IMPLANT DEVICE	
12001	RESUPERF WND BODY <2.5CM	
12004	RESUPERF WND BODY 7.6-12.5 CM	
12020	CLOSURE SUPERF WND DEHIS SIMPLE	
12034	LAYR CLOS WND TRUNK,ARM,LEG 7.6-12.5 CM	
13121	RECMPL WND SCALP,EXTR 2.6-7.5 CM	
13122	REP,SKIN,SCALP/EXTREM+5 CM/<	
13131	RECMPL WND HEAD,FAC,HAND 1.1-2.5 CM	
13132	RECMPL WND HEAD,FAC,HAND 2.6-7.5 CM	
13160	SECD CLOS SURG WND EXTEN/COMPLIC	
14040	ADJ TISS XFER HEAD,FAC,HAND <10 SQCM	
14041	ADJ TISS XFER HEAD,FAC,HAND 10.1-30 SQCM	
14350	FILLET FINGR/TOE FLAP W PREP	
15736	MUSCLE-SKIN FLAP,ARM	
15851	REMOVAL SUTURES/STAPLES REQUIRING ANESTHESI	
20103	EXPLORE WOUND,EXTREMITY	
20240	BONE BIOPSY,EXCISIONAL SUPERF	
20245	BONE BIOPSY,EXCISIONAL DEEP	
20520	REMOVAL OF FOREIGN BODY	
20525	REMOVAL OF FOREIGN BODY DEEP/COMPLIC	
20526	INJECT CARPAL TUNNEL	
20550	INJECT TENDON SHEATH/LIGAMENT	
20551	INJECT TENDON ORIGIN/INSERT	
20552	INJECT TRIGGER POINT, 1 OR 2	

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Charge Commitment - 1110.235(c)(9)

CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
20600	ARTHROCENTESIS ASPIR&/INJ SMALL JT/BURSA W/	
20605	ARTHROCENTESIS ASPIR&/INJ INTERM JT/BURS W/	
20610	ARTHROCENTESIS ASPIR&/INJ MAJOR JT/BURSA W/	
20611	ARTHROCENTESIS ASPIR&/INJ MAJOR JT/BURSA W/	
20612	ASPIRAT/INJECTION GANGLION CYST(S)	
20650	INSERT AND REMOVE BONE PIN	
20670	REMOVAL SUPERFICIAL IMPLANT	
20680	REMOVAL DEEP IMPLANT	
20690	APPLY BONE UNIPLANE,EXT FIX DEV	
20692	APPLY BONE MULTIPLAN,EXT FIX DEV	
20693	ADJUST EXTERN BONE FIX DEV W ANESTH	
20694	REMOVE EXTERN BONE FIX DEV W ANESTH	
20700	MANUAL PREP AND INSERTION DEEP DRUG DELIVER	
20701	REMOVAL DEEP DRUG DELIVERY DEVICE	
20702	MANUAL PREP&INSJ INTRAMEDULLARY DRUG DLVR D	
20703	REMOVAL INTRAMEDULLARY DRUG DELIVERY DEVICE	
20704	MANUAL PREP&INSJ I-ARTIC DRUG DELIVERY DEVI	
20705	REMOVAL INTRA-ARTICULAR DRUG DELIVERY DEVIC	
20900	REMV BONE FOR GRAFT MINOR	
20902	REMV BONE FOR GRAFT MAJOR	
20924	REMV TENDON FOR GRAFT	
20930	ALLOGRAFT FOR SPINE SURGERY ONLY MORSELIZED	
20936	AUTOGRAFT SPINE SURGERY LOCAL FROM SAME INC	
20939	BONE MARROW ASPIRATION BONE GRFG SPI SURG O	
20950	RECORD FLUID PRESSURE,MUSCLE	
20985	CPTR-ASST SURGICAL NAVIGATION IMAGE-LESS	
21501	I&D DEEP ABSC/HEMATOMA NECK/CHEST	
21556	EXC TUMOR SOFT TISSUE NECK/ANT THORAX SUBFA	
22015	I&D, POST SPINE, LUMB/SACR/LUMBOSAC	
22514	PERQ VERT AGMNTJ CAVITY CRTJ UNI/BI CANNULJ	
22551	ARTHRODESIS ANT INTERBODY INC DISCECTOMY, C	
22552	ARTHRODESIS ANT INTERBODY INC DISCECTOMY, C	
22558	ARTHRODESIS ANT INTERBODY MIN DISCECTOMY,LU	
22585	ARTHRODESIS ANT INTERBODY MIN DISCECTOMY,EA	
22610	ARTHRODESIS POSTERIOR/POSTEROLATERAL THORAC	
22612	ARTHRODESIS POSTERIOR/POSTEROLATERAL LUMBAR	
22614	ARTHRODESIS POSTERIOR/POSTEROLATERAL EA ADD	
22630	ARTHRODESIS POSTERIOR INTERBODY LUMBAR	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
22633	ARTHDSIS POST/POSTEROLATRL/POSTINTERBODY LU	
22634	ARTHDSIS POST/POSTERLATRL/POSTINTRBDYADL SP	
22830	EXPLORATION OF SPINAL FUSION	
22840	POSTERIOR NON-SEGMENTAL INSTRUMENTATION	
22842	POSTERIOR SEGMENTAL INSTRUMENTATION 3-6 VRT	
22845	ANTERIOR INSTRUMENTATION 2-3 VERTEBRAL SEGM	
22846	ANTERIOR INSTRUMENTATION 4-7 VERTEBRAL SEGM	
22849	REINSERT SPINAL FIXATION	
22850	REMOVE SPINE FIX DEV,HARRINGTON	
22852	REMOVE SPINE FIX DEV,POST SGMTAL	
22853	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/A	
22855	REMOVE SPINE FIX DEV,ANTERIOR	
22856	TOT DISC ARTHRP ART DISC ANT APPRO 1 NTRSPC	
22858	TOT DISC ARTHRP ANT APPR DISC 2ND LEVEL CER	
23040	DEEP INCIS SHLDR BONE CORTEX	
23071	EXCISION TUMOR SOFT TISSUE SHOULDER SUBQ 3+	
23073	EXC TUMOR SOFT TISSUE SHOULDER SUBFASCIAL 5	
23076	EXC TUMOR SOFT TISS SHOULDER SUBFASC <5CM	
23120	PARTIAL REMOVAL, CLAVICLE	
23140	EXCIS/CURET BENIGN TUMR CLAV/SCAPULA	
23150	EXCIS/CURET BENIGN TUMR PROX HUMERUS	
23190	PART REMV SCAPULA	
23220	RAD RESECT PROX HUMERUS FOR TUMOR	
23333	REMOVAL SHOULDER FOREIGN BODY DEEP SUBFASCI	
23335	PROSTHESIS REMOVAL HUMERAL AND GLENOID COMP	
23395	MUSCLE TRANSFER,SHOULDER/ARM,SINGLE	
23405	INCISE TENDON/MUSCLE,SHLDR,SINGLE	
23410	REPAIR ROTATOR CUFF,ACUTE	
23412	REPAIR ROTATOR CUFF,CHRONIC	
23430	REPAIR BICEPS LONG TENDON	
23450	REPAIR SHOULDER CAPSULE,ANTERIOR	
23462	REPAIR SHLDR CAPSU,ANT,CORACOID XFER	
23466	REPAIR SHLDR CAPSU FOR INSTABILITY	
23470	RECONSTRUCT PROX HUMERAL IMPLANT	
23472	RECONSTR TOTAL SHOULDER IMPLANT	
23473	REVIS SHOULDER ARTHRPLSTY HUMERAL/GLENOID C	
23474	REVIS SHOULDER ARTHRPLSTY HUMERAL&GLENOID C	
23500	CLOSED RX CLAVICLE FRACTURE	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
23515	OPEN TREATMENT CLAVICULAR FRACTURE INTERNAL	
23550	OPEN RX A-C JT DISLOC	
23552	OPEN RX A-C JT DISLOC,FASCIAL GRFT	
23570	CLOSED RX SCAPULA FX	
23585	OPEN RX SCAPULA FRACTURE	
23600	CLOSED RX PROX HUMERUS FRACTURE	
23615	OPEN TREATMENT PROX HUMERAL FRACTURE	
23620	CLOSED RX GR TUBEROSITY HUM FX	
23630	OPEN RX GR TUBEROSITY FX	
23650	CLOSED RX SHLDR DISLOCATION	
23655	CLOSED RX SHLDR DISLOC,ANESTHESIA	
23670	OPEN RX SHLDR DISLOC,GR TUB FX	
23700	MANIPULATN SHLDR JT W ANESTHESIA	
23930	INCIS/DRAIN ARM,DEEP ABSC/HEMATOMA	
23931	INCIS/DRAIN ARM/ELBOW INFECT BURSA	
24000	EXPLORE/DRAIN ELBOW FOR INFECT	
24006	ARTHROTOMY/CAPULE RELEASE ELBOW JT	
24071	EXC TUMOR SOFT TISSUE UPPER ARM/ELBOW SUBQ	
24075	EXC TUMOR SOFT TISS UPPER ARM/ELBOW SUBQ <3	
24101	EXPLORE ELBOW JOINT	
24105	REMOVAL OF ELBOW BURSA	
24120	EXCIS/CURET BENIGN ELBOW LESN	
24138	SEQUESTRECTOMY,OLECRANNON PROCESS	
24147	PARTIAL REMOVAL OLECRANNON PROCESS	
24149	RADICAL RESECT ELBOW, CONTRAC RELEAS	
24301	MUSC/TENDON XFER,ARM/ELBOW,SINGLE	
24341	MUSC/TENDON REPAIR EACH; ARM/ELBOW	
24342	REINSERT BI/TRICEPS TENDON,DISTAL	
24343	REELBOW LAT LIGMNT W/TISS	
24344	RECONSTRUCT ELBOW LAT LIGMNT W/GRAFT	
24345	REELBW MED LIGMNT W/TISS	
24346	RECONSTRUCT ELBOW MED LIGMNT W/GRAFT	
24358	TENOTOMY ELBOW LATERAL/MEDIAL DEBRIDE OPEN	
24359	TENOTOMY ELBOW LATERAL/MEDIAL DEBRIDE REPAI	
24363	ARTHROPLASTY,ELBOW,TOTAL PROSTH REPL	
24430	REPAIR NON/MALUNION HUMERUS	
24435	REPAIR NON/MALUNION HUMERUS,GRAFT	
24500	CLOSED RX MID HUMERUS FRACTURE	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
24515	OPEN FIXATN MID HUMERUS FRACTURE	
24516	OPEN ROD FIXATN HUMERAL SHAFT FX	
24530	CLOSED RX HUMERAL SUPRACONDYLAR FX	
24538	PERCUT FIX HUM SUPRACONDYLAR FX	
24545	OPEN TX HUMERAL SUPRACONDYLAR FRACTURE W/O	
24546	OPEN TX HUMERAL SUPRACONDYLAR FRACTURE W XT	
24566	PERCUT FIXATN HUMERAL EPICONDYLAR FX	
24575	OPEN TX HUMERAL EPICONDYLAR FRACTURE	
24579	OPEN TX HUMERAL CONDYLAR FRACTURE	
24582	PERCUT FIXATN HUMERAL CONDYLAR FX	
24586	OPEN RX PERIARTIC FX/DISLOC ELBOW	
24587	OPEN RX PERIARTIC FX ELBOW,IMPLNT	
24605	CLOSED RX ELBOW DISLOCATN,ANESTHESIA	
24615	OPEN RX ELBOW DISLOCATION	
24635	OPEN TX MONTEGGIA FRACTURE DISLOCATION ELBO	
24650	CLOSED RX RADIAL HEAD/NECK FX	
24665	OPEN TX RADIAL HEAD/NECK FRACTURE	
24666	OPEN TX RADIAL HEAD/NECK FRACTURE PROSTHETI	
24670	CLOSED TX ULNAR FRACTURE PROX END W/O MANIP	
24685	OPEN TX ULNAR FRACTURE PROX END	
25000	INCIS TENDON SHEATH,RADIAL STYLOID	
25001	INCIS FLEXOR TENDON SHEATH,WRIST	
25071	EXC TUMOR SOFT TISS FOREARM AND/WRIST SUBQ	
25073	EXC TUMOR SFT TISS FOREARM&//WRIST SUBFASC	
25075	EXC TUMOR SOFT TISSUE FOREARM &/WRIST SUBQ	
25076	EXC TUMOR SOFT TISS FOREARM&/WRIST SUBFASC	
25085	INCISION OF WRIST CAPSULE	
25105	EXPLOR WRIST JT/REMV SYNOVIUM	
25111	EXCIS PRIMARY GANGLION WRIST	
25112	EXCIS RECURRENT GANGLION WRIST	
25115	RAD EXCIS WRIST SYNOV/TENDON,FLEXOR	
25118	EXCIS SYNOV WRIST,EXTENS TENDON	
25119	EXCIS SYNOV WRIST,PART REMV ULNA	
25120	EXCIS/CURET BENIG BONE LES RAD/ULNA	
25130	EXCIS BENIGN LESN CARPALS	
25150	PART REMOVAL BONE,ULNA	
25151	PART REMOVAL BONE,RADIUS	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
25210	REMOVAL OF CARPAL BONE	
25215	REMOVAL OF PROX ROW CARPAL BONES	
25230	REMOVAL OF RADIAL STYLOID	
25240	EXCIS DISTAL ULNA,PART/COMPLETE	
25260	REFOREARM TEND/MUSC,FLEX,PRIM,EA	
25290	INCISE WRIST/FOREARM TENDON	
25295	RELEASE WRIST/FOREARM TENDON	
25301	FUSION TENDONS WRIST,FINGR EXTENSORS	
25310	TRANSPLANT FOREARM/WRIST TENDON	
25320	REVISE WRIST JOINT,CARPAL INSTABIL	
25337	RECONSTRUCT ULNA/RADIOULNAR	
25390	OSTEOPLASTY,RADIUS OR ULNA,SHORTEN	
25400	REPAIR NONUNION RADIUS OR ULNA	
25405	REPAIR NONUNION RADIUS OR ULNAW/GRAFT	
25415	REPAIR NONUNION RADIUS AND ULNA	
25440	REPAIR NONUNION SCAPHOID CARPAL BONE	
25447	REPAIR INTERCARP/CARP-METACARP JT	
25448	ARTHRP INTERCARPAL/CARP/MTCRPL JT SUSPENSIO	
25505	CLOSED RX RADIAL SHAFT FX,MANIPULATN	
25515	OPEN TREATMENT RADIAL SHAFT FRACTURE	
25525	OPEN RDL SHAFT FX CLOSED RAD/ULN JT DISLOCA	
25535	CLOSED RX ULNA SHAFT FX,MANIPULATN	
25545	OPEN TREATMENT OF ULNAR SHAFT FRACTURE	
25565	CLOSED RX RAD/ULNA SHAFT FX,MANIP	
25574	OPEN TX RADIAL & ULNAR SHAFT FX FIX RADIUS	
25575	OPEN TX RADIAL & ULNAR SHAFT FX FIX RADIUS	
25600	CLOSED RX DIST RAD/ULNA FX	
25605	CLOSED RX DIST RAD/ULNA FX,MANIPUL	
25606	PERCUT SKELETAL FIX, DISTAL RADIUS FX	
25607	OPEN RX DISTAL RADIUS FX, EXTRA-ARTICULAR	
25608	OPEN RX DISTAL RADIUS FX, INTRA-ARTICULAR,	
25609	OPEN RX DISTAL RADIUS FX, INTRA-ARTICULAR,	
25628	OPEN TX CARPAL SCAPHOID NAVICULAR FRACTURE	
25630	CLOSED RX CARPAL FX	
25645	OPEN RX CARPAL BONE FX,EACH BONE	
25650	CLOSED RX ULNA STYLOID FX	
25651	PERCUT SKELETAL FIX,ULNAR STYLOID FX	
25652	OPEN RX ULNAR STYLOID FX	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
25670	OPEN REPAIR WRIST DISLOCATION	
25671	PERCUT SKELETAL FIX,DIST RADIOULN DISLOC	
25825	FUSION/GRAFT INTERCARPAL	
26010	DRAIN FINGER ABSCESS,SIMPLE	
26011	DRAIN FINGER ABSCESS,COMPLICATED	
26040	RELEASE PALM CONTRACT,PERCUTANEOUS	
26045	RELEASE PALM CONTRACT,OPEN,PARTIAL	
26055	INCISE FINGER TENDON SHEATH	
26075	EXPLORE & TREAT METACARPO-PHAL JT	
26111	EX TUM/VASC MALF SFT TISS HAND/FNGR SUBQ 1.	
26113	EX TUM/VASC MAL SFT TIS HAND/FNGR SUBFSC 1.	
26115	EXC TUM/VASC MAL SFT TISS HAND/FNGR SUBQ <1	
26116	EXC TUM/VAS MAL SFT TIS HAND/FNGR SUBFASC<1	
26123	PART PALMAR FASCIEC,OPEN 1 DIGIT	
26125	PART PALMAR FASCIEC,OPEN ADDNL DIGIT	
26160	EXCIS TENDON SHEATH LESION, HAND/FINGER	
26180	EXCIS FINGER TENDON FLEXOR	
26210	EXCIS BENIGN BONE LESN,PHALANX	
26215	EXCIS/GRFT BENIGN LESN,PHALANX	
26235	PART REMV BONE,PROX/MID PHALANX	
26262	RAD RESEC DISTAL PHALANX	
26350	REPAIR FLEXOR TENDON,HAND,W/O GRAFT,EA	
26356	REPAIR FLEX TENDON,ZONE 2,HAND	
26357	REPAIR FLEX TENDON,ZONE 2,SECON,HAND,EA	
26370	REPAIR PROFUNDUS TENDON,PRIMARY	
26410	REPAIR EXTEN TENDON,DORSUM HAND,EA	
26418	REPAIR EXTEN TENDON,DORSUM FINGR,EA	
26426	REPAIR EXT TEND,CENT SLIP,SEC	
26432	REPAIR EXTEN TENDON,DISTAL INSERT,CLOSE	
26433	REPAIR EXTEN TENDON,DISTAL INSERT,OPEN	
26437	REALIGNMENT OF TENDONS,HAND	
26440	TENOLYSIS, FLEX TENDON,PALM/FINGER,EA	
26442	TENOLYSIS FLEX TENDON,PALM & FINGER,EA	
26445	TENOLYSIS EXT TENDON,HAND/FINGER,EA	
26460	TENOTOMY HAND EXTEN,SINGLE,OPEN,EACH	
26480	TRANSPLANT HAND TENDON	
26510	CROSS INTRINSIC TRANSFER,EA	
26520	RELEASE MC-P JT CONTRACTURE	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
26525	RELEASE I-P JT CONTRACTURE	
26530	ARTHROPLASTY MC-P JT,SINGLE	
26531	ARTHROPLASTY MC-P JT,IMPLANT	
26536	ARTHROPLASTY I-P JT,IMPLANT	
26540	FIX COLLAT LIG,MC-P JT,I-P JT	
26546	FIX NONUNION METACARPAL/PHALANX	
26548	FIX FINGER,VOLAR PLATE,I-P JT	
26567	CORRECT FINGER DEFORMITY	
26593	RELEASE MUSCLES OF HAND	
26605	CLOSED RX METACARPAL FX,MANIP	
26608	CLOSED RX METACARPAL FX,PERCUT	
26615	OPEN TX METACARPAL FRACTURE SINGLE EA BONE	
26650	PRQ SKEL FIXATION CARP/MTCRPL FX DISLOCATE	
26676	PERCUT FIX CARPOMETACAR DISLOC,NON-THUMB	
26685	OPEN TX CARPOMETACARPAL DISLOCATE NOT THUMB	
26686	OPEN RX C-MC DISLOC,COMPLEX	
26725	CLOSE RX PROX/MID FING SHFT FX,MANIP	
26727	PERCUT RX PROX/MID FING SHFT FX	
26735	OPEN TX PHALANGEAL SHAFT FRACTURE PROX/MIDD	
26746	OPEN TX ARTICULAR FRACTURE MCP/IP JOINT EA	
26750	CLOSE RX DIST FINGR FX	
26756	PERCUT RX DIST FINGR FX	
26765	OPEN TX DISTAL PHALANGEAL FRACTURE EACH	
26776	PERCUT RX IP JT DISLOCATION	
26785	OPEN TX INTERPHALANGEAL JOINT DISLOCATION 1	
26850	FUSION MC-P JT	
26860	FUSION FINGER JOINT	
26910	AMPUTATE METACARPAL+FINGER	
26951	AMPUTATION FINGER/THUMB	
26990	INCIS/DRAIN PELVIS/HIP,DEEP ABSCESS	
27030	DRAINAGE OF HIP JOINT	
27045	EXC TUMOR SOFT TISSUE PELVIS & HIP SUBFASC	
27048	EXC TUMOR SOFT TISSUE PELVIS & HIP SUBFASC	
27062	REMOVE TROCH BURSA/CALCIFICATN	
27066	EXCISISON BONE CYST BENIGN TUMOR,PELVIS/HIP	
27070	PARTIAL EXCISION SUPERFICIAL PELVIS	
27076	RAD RESEC ILIUM+ACETABULUM	
27090	REMOVAL OF HIP PROSTHESIS	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
27091	REMOVAL OF HIP PROSTHESIS,COMPLEX	
27096	INJECT SI JOINT ARTHRGRPHY&/ANES/STEROID W/	
27125	PARTIAL HIP REPLACEMENT	
27130	TOTAL HIP ARTHROPLASTY	
27132	CONV PREV HIP SURG TO TOT HIP ARTHROPLAS	
27134	REVISE TOTAL HIP REPLACEMENT	
27137	REVISE ACETABULAR PART OF TOTAL HIP	
27138	REVISE FEM PART OFTOTAL HIP	
27161	OSTEOTOMY OF NECK OF FEMUR	
27187	REINFORCE HIP BONES	
27197	CLSD TX PELVIC RING FX W/O MANIPULATION	
27215	OPEN FIX ILIAC FX,INTERN FIXATN	
27216	PERCUT FIX POST PELV RING FX	
27217	OPEN INTERN FIX ANTER PELV RING FX	
27218	OPEN INTERN FIX POST PELV RING FX	
27220	CLOSED RX ACETABULAR FX	
27226	OPEN INTERN FIX ACETABULAR WALL FX	
27227	OPEN INTERN FIX ACETABULAR FX	
27228	OPEN INTERN FIX COMPLEX ACETABUL FX	
27235	PERCUT FIX PROX/NECK FEMUR FX	
27236	FEMORAL FX, OPEN TX	
27238	CLOSED RX INTER/SUBTROCH FEMUR FX	
27244	TREAT INTER/SUBTROCH FX,W/PLATE/SCREW	
27245	OPEN FIX INTER/SUBTROCH FX,IMPLNT	
27246	CLOSED RX GR TROCHANTERIC FX	
27248	OPEN TREATMENT GREATER TROCHANTERIC FRACTUR	
27266	CLOSED RX POST HIP FIX DISLOC,ANESTH	
27269	OPEN TX FEMORAL FRACTURE PROXIMAL END HEAD	
27279	ARTHRODESIS SACROILIAC JOINT PERCUTANEOUS	
27280	ARTHRODESIS SI JT OPN W/OBTAINING B1 GRF IN	
27299	PELVIS/HIP JOINT SURGERY UNLISTED	
27301	INCIS/DRAIN THIGH/KNEE ABSCESS,DEEP	
27306	INCIS THIGH TENDON,ADDUC/HAMST,SINGL	
27310	EXPLOR/DRAIN KNEE,INFECTN	
27324	BX THIGH/KNEE SOFT TISSUES,DEEP	
27327	EXCISION TUMOR SOFT TISSUE THIGH/KNEE SUBQ	
27331	ARTHROTOMY/EXPLORE/TREAT KNEE JOINT	
27332	EXCIS KNEE CARTILAGE,MEDIAL OR LAT	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
27335	REMV SYNOVIUM KNEE,ANTER & POST	
27337	EXCISON TUMOR SOFT TISSUE THIGH/KNEE SUBQ 3	
27339	EXC TUMOR SOFT TISSUE THIGH/KNEE SUBFASC 5+	
27340	REMOVAL PREPATELLA BURSA	
27345	REMOVAL SYNOVIAL CYST,KNEE	
27347	REMOVE KNEE CYST/GANGLION	
27355	REMV BENIGN FEMUR LESION	
27356	REMV BENIGN FEMUR LESN/ALLOGRAFT	
27358	REMV BENIGN FEMUR LESN/INTERN FIX	
27360	PART REMV FEMUR/PROX TIB/FIB	
27365	RAD RESEC TUMOR,FEMUR OR KNEE	
27372	REMV FOREIGN BODY,KNEE/THIGH,DEEP	
27380	FIX INFRAPATELLA TENDON,PRIMARY	
27381	FIX PATELLA TENDN,SECONDARY	
27385	FIX QUAD/HAMSTR MUSC RUPT,PRIMARY	
27386	FIX QUAD/HAMSTR MUSC RUPT,SECOND	
27392	TENOTOMY,BI HAMSTR,KNEE-THIGH,MULTI	
27397	XPLANT HAMSTR TENDONS-PATELLA,MULTI	
27403	ARTHROTOMY,OPEN REPAIR MENISCUS	
27405	REPAIR COLLAT LIGAMT/CAPSULE,KNEE	
27409	REPAIR COLLAT & CRUCIATE LIG,KNEE	
27412	AUTOCHONDROCYTE IMPLANT KNEE	
27415	OSTEOCHONDRAL KNEE ALLOGRAFT	
27416	OSTEOCHONDRAL KNEE AUTOGRAFT	
27418	REPAIR ANTER TIBIAL TUBERCLE	
27420	REVISION OF UNSTABLE PATELLA	
27422	FIX UNSTABLE PATELLA,EXTEN REALIGN	
27425	LATERAL RETINACULAR RELEASE OPEN	
27427	LIGMT REVISION,KNEE,EXTRA-ARTIC	
27429	LIGMT REVISN,KNEE,INTRA/EXTRA-ART	
27430	REVISION QUADRICEPS	
27438	ARTHROPLASTY PATELLA WITH IMPLANT	
27446	PLASTY KNEE,MED OR LAT COMPARTMT	
27447	TOTAL KNEE ARTHROPLASTY	
27450	OSTEOTOMY FEMUR SHAFT,W FIXATN	
27457	OSTEOTOMY PROX TIB,AFTR EPIPHY CLOS	
27465	OSTEOPLASTY FEMUR SHORTENING EXCLUDING 6487	
27466	LENGTHENING OF FEMUR	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
27470	FIX NON/MALUNION FEMUR BELOW NECK	
27472	FIX NON/MALUNION FEMUR,W GRAFT	
27486	REVISE KNEE JOINT REPLACE,1 PART	
27487	REVISE KNEE JOINT REPLACE,ALL PARTS	
27488	REMOVAL OF KNEE PROSTHESIS	
27495	REINFORCE FEMUR	
27500	CLOSED RX FEMUR SHAFT FX	
27506	OPEN RX FEMUR FX+INTRAMED ROD	
27507	OPEN RX FEMUR FX+PLATE/SCREW	
27508	CLOSED RX FEMUR,DISTAL	
27510	CLOSED RX FEMUR,DISTAL+MANIP	
27511	OPEN TX FEMORAL SUPRACONDYLAR FRACTURE W/O	
27513	OPEN TX FEMORAL SUPRACONDYLAR FRACTURE W EX	
27514	OPEN TX FEMORAL FRACTURE DISTAL MED/LAT CON	
27520	CLOSED RX PATELLA FX	
27524	OPEN RX PATELLA FX	
27530	CLOSED RX TIBIAL PLATEAU FX	
27535	OPEN TX TIBIAL FRACTURE PROXIMAL UNICONDYLA	
27536	OPEN RX BILAT TIB PLAT FX	
27538	CLOSED RX TIB TUBER FX	
27540	OPEN TX INTERCONDYLAR SPINE/TUBRST FRACTURE	
27550	CLOSED RX KNEE DISLOCATN	
27556	OPEN TX KNEE DISLOCATION W/O LIGAMENTOUS RE	
27566	OPEN RX KNEECAP DISLOCATN	
27570	MANIPULATN KNEE JT+ANESTHESIA	
27590	AMPUTATE THIGH,THRU FEMUR	
27599	FEMUR OR KNEE JOINT SURGERY UNLISTED	
27600	DECOMPRESS ANT/LAT LEG CMPART	
27602	DECOMPRESS ANT/LAT+POST LEG CMPART	
27603	DRAIN LOWER LEG DEEP ABSC/HEMATOMA	
27606	INCIS ACHILLES TENDON+GEN ANESTH	
27610	EXPLORE/TREAT ANKLE JOINT	
27612	EXPLORE/RELEASE POST CAP ANKLE JT	
27619	EXC TUMOR SOFT TISSUE LEG/ANKLE SUBFASCIAL	
27620	EXPLOR ANKLE JOINT	
27625	EXPLOR ANKLE JT+SYNOVECTOMY	
27626	EXPLOR ANKLE JT+TENOSYNOVECTOMY	
27630	EXCIS LESN TENDON SHEALTH LEG/ANKLE	

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CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
27634	EXC TUMOR SOFT TISSUE LEG/ANKLE SUBFASC 5+C	
27635	EXCIS BENIGN LESN,TIB/FIB	
27638	EXCIS BENIGN LESN,TIB/FIB+ALLOGRFT	
27641	PARTIAL REMOVAL OF FIBULA	
27650	REPAIR ACHILLES TENDON,PRIMARY	
27652	REPAIR/GRAFT ACHILLES TENDON	
27654	REPAIR ACHILLES TENDON,SECONDARY	
27658	REPAIR FLEX LEG TENDON,PRIM,EA	
27659	REPAIR FLEX LEG TENDON,SECOND,EA	
27665	REPAIR EXTEN LEG TENDN,SECOND,EA	
27675	REPAIR PERONEAL TENDONS	
27676	REPAIR PERONEAL TENDONS,FIB OSTEOTMY	
27680	RELEASE TIB/FIB/ANKLE FLEX TENDON,EA	
27681	RELEASE TIB/FIB/ANKL FLEX TENDON,MUL	
27685	LENGTH/SHORT LEG/ANKL TENDON,SINGLE	
27687	GASTROCNEMIUS RECESSION	
27690	XFER SINGLE SUPERFICI LOW LEG TENDON	
27691	XFER SINGLE DEEP LOW LEG TENDON	
27692	XFER ADDNL LOWER LEG TENDON	
27695	REPAIR 1 COLLAT ANKLE LIGMNT,PRIMARY	
27698	REPAIR COLLAT ANKLE LIGMNT,SECONDARY	
27702	TOTAL ANKLE REPLACEMENT	
27703	SECONDARY RECONSTRUCTION,ANKLE JOINT	
27705	OSTEOTOMY TIBIA	
27707	OSTEOTOMY FIBULA	
27709	OSTEOTOMY TIBIA & FIBULA	
27715	LENGTHENING TIBIA/FIBULA	
27720	RNON/MALUNION TIBIA	
27724	RNON/MALUNION TIBIA+AUTOGRAFT	
27726	RFIBULA NONUNION/MALUNION W INT FIXATION	
27745	REINFORCE TIBIA	
27756	PERCUT RX TIBIA SHAFT FX	
27758	OPEN RX TIBIA SHAFT FX,SCREWS	
27759	TREAT TIBIAL SHAFT FX, INTRAMED IMPLANT	
27766	OPEN TREATMENT MEDIAL MALLEOLUS FRACTURE	
27767	CLOSED TREATMENT PST MALLEOLUS FRACTURE W/O	
27769	OPEN TREATMENT POSTERIOR MALLEOLUS FRACTURE	
27780	CLOSED RX PROX/SHAFT FIBULA FX	

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Charge Commitment - 1110.235(c)(9)

CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
27784	OPEN TREATMENT PROXIMAL FIBULA/SHAFT FRACTU	
27786	CLOSED RX DIST FIBULA FX	
27788	CLOSED RX DIST FIBULA FX,MANIP	
27792	OPEN TX DISTAL FIBULAR FRACTURE LAT MALLEOL	
27808	CLOSED TX BIMALLEOLAR ANKLE FRACTURE W/O MA	
27814	OPEN TREATMENT BIMALLEOLAR ANKLE FRACTURE	
27818	CLOSED RX TRIMALLEOLAR FX,MANIP	
27822	OPEN TX TRIMALLEOLAR ANKLE FX W/O FIX PST L	
27823	OPEN TX TRIMALLEOLAR ANKLE FX W FIX PST LIP	
27824	CLOSED RX WEIGHT BEAR DIST TIBIA	
27825	CLOSED RX WEIGHT BEAR DIST TIB,MANIP	
27826	OPEN TREATMENT FRACTURE DISTAL TIBIA FIBULA	
27827	OPEN TREATMENT FRACTURE DISTAL TIBIA ONLY	
27828	OPEN TREATMENT FRACTURE DISTAL TIBIA & FIBU	
27829	OPEN TX DISTAL TIBIOFIBULAR JOINT DISRUPTIO	
27832	OPEN TX PROX TIBFIB JOINT DISLOCATE EXC PRO	
27840	CLOSED RX ANKLE DISLOCATN	
27846	OPEN RX ANKLE DISLOCATN	
27848	OPEN RX ANKLE DISLOCATN+FIXATN	
27860	MANIPULATION ANKLE JT W ANESTHESIA	
27870	ARTHRODESIS,ANKLE,OPEN	
27880	AMPUTATION LOW LEG THRU TIB/FIB	
27892	DECOMPRESS FASCIOTOMY LEG,ANT/LAT	
28003	DEEP DISSEC FOOT INFEC,MULTIPLE	
28008	INCISION OF FOOT/TOE FASCIA	
28020	EXPLOR TARSAL/TARSOMETATAR JT	
28022	EXPLOR METATARSO-PHALANG JT	
28035	TARSAL TUNNEL RELEASE	
28039	EXCISION TUMOR SOFT TISSUE FOOT/TOE SUBQ 1.	
28041	EXC TUMOR SOFT TISSUE FOOT/TOE SUBFASC 1.5+	
28043	EXCISION TUMOR SOFT TISSUE FOOT/TOE SUBQ <1	
28060	PART EXCIS PLANTAR FASCIA	
28080	EXCIS INTERDIGITAL NEUROMA,EA	
28090	EXCIS TENDN/CAPSULE LESN,FOOT	
28092	EXCIS TENDN/CAPSULE LESN,TOES	
28100	REMV TALUS/HEEL BENIGN BONE LESN	
28102	REMV TALUS/HEEL BENIGN LESN,AUTOGRFT	
28104	REMV TARSAL/METATARSAL BENIGN BONE LESN	

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Charge Commitment - 1110.235(c)(9)

CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
28110	PART EXCIS 5TH METATARSAL HEAD	
28114	FULL EXCIS 2 - 5 METATARSAL HEADS	
28116	EXCIS TARSAL COALITION	
28118	REMOVAL OF HEEL BONE	
28119	REMOVAL OF HEEL SPUR	
28120	PART REMV TALUS OR CALCANEUS	
28122	PART REMV OTHR TARSAL/METATARSAL	
28124	PART REMV PHALANX OF TOE	
28126	RESEC ONE TOE PHALANGEAL BASE,EA	
28150	REMOVAL OF SINGLE TOE,EACH	
28175	RAD RESEC PHALANX,TOE	
28190	REMV FOOT FOREIGN BODY,SUBCUTANEOUS	
28192	REMV FOOT FOREIGN BODY,DEEP	
28200	REPAIR FLEX FOOT TENDON,EA	
28202	REPAIR/GRAFT FLEX FOOT TENDON	
28208	REPAIR EXTEN LEG TENDON,PRIM,EA	
28210	REPAIR/GRAFT EXTEN FOOT TENDON	
28220	RELEASE FLEX FOOT TENDON,SINGLE	
28230	INCISION FLEX FOOT TENDON(S)	
28232	INCISION FLEX TOE TENDON	
28234	INCISION EXTEN FOOT/TOE TENDON	
28238	RECONST POST TIB TEND,EXCIS ACC TAR NAV	
28250	DIVISN PLANTAR FASCIA/MUSCLE	
28270	CAPSULOTOMY MT-P JT,FOOT,EACH	
28285	REPAIR OF HAMMERTOE,ONE	
28289	REPAIR HALLUX RIGIDUS	
28291	HALLUX RIGIDUS W/CHEILECTOMY 1ST MP JT W/IM	
28296	CORRECT BUNION,METATARSAL OSTEOTOMY	
28297	CORRECT BUNION,LAPIDUS TYPE	
28298	CORRECT BUNION,PHALANX OSTEOTOMY	
28299	FOOT/TOES SURGERY UNLISTED	
28300	OSTEOTOMY HEEL BONE	
28306	OSTEOTOMY 1ST METATARSAL,BASE/SHAFT	
28307	OSTEOTOMY 1ST METATARSAL,AUTOGRAFT	
28308	OSTEOTOMY METATARSAL (NOT 1ST)	
28309	OSTEOTOMY METATARSALS,MULTIPLE	
28312	OSTEOTOMY,ANY PHALANX,ANY TOE	
28313	RECONSTRUC TOE DEFORM,SOFT TISSUE	

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Charge Commitment - 1110.235(c)(9)

CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
28315	REMOV SESAMOID BONE,1ST TOE	
28320	REPAIR NON/MALUNION TARSAL BONE(S)	
28322	REPAIR NON/MALUNION METATARSAL	
28400	CLOSED RX HEEL FX	
28406	PERCUT RX HEEL FX	
28415	OPEN TREATMENT CALCANEAL FRACTURE	
28445	OPEN TREATMENT TALUS FRACTURE	
28446	OPEN OSTEOCHONDRAL AUTOGRAFT TALUS	
28450	CLOSED RX TARSAL FX,EACH	
28455	CLOSED RX TARSAL FX,MANIP,EACH	
28456	PERCUT RX TARSAL FX,EACH	
28465	OPEN TX TARSAL FRACTURE XCP TALUS &CALCANEU	
28470	CLOSED RX METATARSAL FX	
28475	CLOSED RX METATARSAL FX,MANIP	
28476	PERCUT RX METATARSAL FX	
28485	OPEN TREATMENT METATARSAL FRACTURE EACH	
28490	CLOSED RX BIG TOE FRACTURE	
28505	OPEN TX FRACTURE GREAT TOE/PHALANX/PHALANGE	
28510	CLOSED RX TOE FX	
28525	OPEN TX FRACTURE PHALANX/PHALANGES NOT GREA	
28546	PERCUT RX TARSAL DISLOCATION	
28555	OPEN TREATMENT TARSAL BONE DISLOCATION	
28576	PERCUT RX TALOTARSAL DISLOCATION	
28585	OPEN TREATMENT TALOTARSAL JOINT DISLOCATION	
28606	PERCUT RX TAR-METATAR FOOT DISLOC	
28615	OPEN TREATMENT TARSOMETATARSAL JOINT DISLOC	
28645	OPEN TX METATARSOPHALANGEAL JOINT DISLOCATI	
28675	OPEN TREATMENT INTERPHALANGEAL JOINT DISLOC	
28715	FUSION FOOT BONES,TRIPLE	
28725	FUSION FOOT BONES,SUBTALAR	
28730	FUSION FOOT BONES,MIDTARSAL,MULTI	
28735	FUSION FOOT BONES,MIDTARSAL,OSTEOTMY	
28740	FUSION FOOT BONE,MIDTARSAL,1 JT	
28750	FUSION BIG TOE,MT-P JT	
28755	FUSION BIG TOE,I-P JOINT	
28805	AMPUTATION FOOT,TRANSMETATARSAL	
28810	AMPUTATION METATARSAL+TOE,SINGLE	
28820	AMPUTATION TOE,MT-P JT	

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Charge Commitment - 1110.235(c)(9)

CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
28825	AMPUTATION TOE,I-P JT	
29065	APPLY LONG ARM CAST	
29105	APPLY LONG ARM SPLINT	
29125	APPLY FOREARM SPLINT,STATIC	
29505	APPLY LONG LEG SPLINT	
29515	APPLY LOWER LEG SPLINT	
29805	SHLDR ARTHROSCOP,DIAGNOSTIC	
29806	SHLDR ARTHROSCOP,SURG,CAPSULORRHAPHY	
29807	SHLDR ARTHROSCOP,SURG,REPAIR,SLAP LESION	
29819	SHLDR ARTHROSCOP,SURG,W/REMOVAL,LOOSE/FB	
29821	SHLDR ARTHROSCOP,FULL SYNOVECT	
29822	SHLDR ARTHROSCOP,PART DEBRIDE	
29823	SHLDR ARTHROSCOP,EXTEN DEBRIDE	
29824	SHLDR ARTHROSCOP,SURG,DIS CLAVICULECTOMY	
29825	SHLDR ARTHROSCOP,LYSE ADHESNS	
29826	SHLDR ARTHROSCOP,PART ACROMIOPLAS	
29827	SHLDR ARTHROSCOP,SURG,W/ROTAT CUFF REPR	
29828	ARTHROSCOPY SHOULDER SURGICAL BICEPS TENODE	
29834	ELBOW ARTHROSCOP,REMV LOOSE BODY	
29835	ELBOW ARTHROSCOP,PART SYNOVECT	
29836	ELBOW ARTHROSCOP,FULL SYNOVECT	
29837	ELBOW ARTHROSCOP,PART DEBRIDE	
29838	ELBOW ARTHROSCOP,EXTEN DEBRIDE	
29840	WRIST ARTHROSCOP,DIAGNOSTIC	
29845	WRIST ARTHROSCOP,FULL SYNOVECT	
29846	WRIST ARTHROSCOP,EXCIS TRIANG CART	
29848	WRIST ARTHROSCOP,RELEASE XVERS LIG	
29855	TIBIAL SCOPE/SURG/FX AID,UNICONDYLR	
29860	HIP ARTHROSCOPY, DX	
29861	HIP SCOPE/REMOV LOOSE/FOREIGN BODY	
29862	HIP SCOPE/REMV BODY,PLASTY/RESECTN	
29866	KNEE SCOPE, AUTOGRAFT IMPANT	
29868	KNEE SCOPE, MENISC TRANSPLANT	
29870	KNEE SCOPE,DIAGNOSTIC	
29871	KNEE SCOPE,CLEAN/DRAIN	
29873	KNEE SCOPE, W/LATERAL RELEASE	
29874	KNEE SCOPE,REMV LOOSE BODY	
29875	KNEE SCOPE,PART SYNOVECT	

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Charge Commitment - 1110.235(c)(9)

CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
29876	KNEE SCOPE,FULL SYNOVECT	
29877	KNEE SCOPE,SHAVE ARTICULAR CART	
29879	KNEE SCOPE,ABRASN ARTHROPLASTY	
29880	KNEE SCOPE,MED/LAT MENISECTOMY	
29881	KNEE SCOPE,SINGLE MENISECTOMY	
29882	KNEE SCOPE,MED OR LAT MENIS REPAIR	
29883	KNEE SCOPE,MED+LAT MENIS REPAIR	
29884	KNEE SCOPE,LYSIS OF ADHESNS	
29885	KNEE SCOPE,DRILL OSTE DISSEC+GRFT	
29886	KNEE SCOPE,DRILL OSTEIT DISSEC	
29887	KNEE SCOPE,DRILL OSTE DISS+INT FIX	
29888	KNEE SCOPE,AID ANT CRUCIATE REPAIR	
29889	KNEE SCOPE,AID POST CRUC REPAIR	
29891	ANKLE SCOPE,EXCIS OSTEOCHON DEFCT	
29892	ANKLE SCOPE,AID REPAIR FX,BONE DEFCT	
29893	ANKLE SCOPE,PLANTAR FASCIOTOMY	
29894	ANKLE SCOPE,REMVL LOOSE BODY	
29897	ANKLE SCOPE,PART DEBRIDEMENT	
29898	ANKLE SCOPE,EXTENS DEBRIDEMNT	
29914	ARTHROSCOPY HIP W/FEMOROPLASTY	
29915	ARTHROSCOPY HIP W/ACETABULOPLASTY	
29916	ARTHROSCOPY HIP W/LABRAL REPAIR	
29999	UNLISTED PROC, ARTHROSCOPY	
62321	NJX DX/THER SBST INTRLMNR CRV/THRC W/IMG GD	
62323	NJX DX/THER SBST INTRLMNR LMBR/SAC W/IMG GD	
63003	LAM W/O FACETEC FORAMOT/DSKC 1/2 VRT SEG, T	
63017	LAMINECTOMY,>2 SGMT,LUMBAR	
63030	LAMNOTMY INCL W/DCMPRSN NRV ROOT 1 INTRSPC	
63035	LAMNOTMY W/DCMPRSN NRV EACH ADDL CRVCL/LMBR	
63042	REDO EXCIS LUMBAR DISK	
63047	LAMINEC/FACETECT/FORAMIN,LUMBAR 1 SEG	
63048	LAMINEC/FACETECT/FORAMIN,EACH ADDNL	
63056	DECOMPRESS SPINAL CORD,1 SEG	
63267	EXCIS INTRASP LESN,XDURAL,LUMBAR	
63272	EXCIS INTRASP LESN,INTRADUR,LUMB	
64450	INJECTION AA&/STRD OTHER PERIPHERAL NERVE/B	
64455	INJECT ANES/STEROID PLANTAR COMMON DIGITAL	
64483	INJECT ANES/STEROID FORAMEN LUMBAR/SACRAL W	

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
Charge Commitment - 1110.235(c)(9)

CPT	PROCEDURE DESCRIPTION	FEE SCHEDULE*
64484	NJX AA&/STRD TFRML EPI LUMBAR/SACRAL EA ADD	
64493	INJ DX/THER AGNT PARAVERT FACET JOINT,IMG G	
64494	INJ DX/THER AGNT PARAVERT FACET JOINT,IMG G	
64510	INJECT NERV BLCK,STELLATE GANGLION	
64520	INJECT NERV BLCK,PARAVERT SYMPATH	
64555	PERCUT IMPLANT,NEUROELEC,PERIPH NERVE	
64624	DESTRUCTION NEUROLYTIC AGT GENICULAR NERVE	
64633	DSTR NROLYTC AGNT PARVERTEB FCT SNGL CRVCL/	
64634	DSTR NROLYTC AGNT PARVERTEB FCT ADDL CRVCL/	
64635	DSTR NROLYTC AGNT PARVERTEB FCT SNGL LMBR/S	
64636	DSTR NROLYTC AGNT PARVERTEB FCT ADDL LMBR/S	
64702	REVISE/REPAIR FINGER/TOE NERVE	
64704	REVISE/REPAIR HAND/FOOT NERVE	
64708	NEUROPLASTY OTHER ARM/LEG NERVE,OPEN	
64712	NEUROPLASTY SCIATIC NERVE,OPEN	
64713	NEUROPLASTY BRACHIAL PLEXUS,OPEN	
64718	REVISE ULNAR NERVE AT ELBOW	
64721	REVISE MEDIAN N/CARPAL TUNNEL SURG	
64722	RELIEVE PRESSURE ON NERVE(S)	
64772	TRANSECT OTHR SPINAL N,XTRADURAL	
64782	EXCISE HAND/FOOT NEUROMA	
64790	EXCISE MAJOR PERIPH NEUROFIBROMA	
64818	SYMPATHECTOMY LUMBAR	
64831	REPAIR OF DIGIT NERVE	
64832	REPAIR EACH ADDNL DIGIT NERVE	
64910	NERVE REPAIR W/ALLOGRAFT OR SYNTH	

* An updated fee schedule is being processed and will be added to this application as a supplement to comply with the requirements of HFSRB regulations but, rather than have inconsistent information, we elected to allow for the completion of that process to occur but not delay the submission of this application.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery
1110.235(c)(10)(A) & (B)
Assurances

Salt Creek Surgery Center
530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

John P. Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Floor 2
Springfield, IL 62761

Re: Assurances – Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center

Dear Mr. Kniery,

As a representative of Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center , I, Giridhar Burra, M.D., hereby attest that it is the Applicant's full anticipation that, by the end of the second year following the proposed ambulatory surgical treatment center's opening the proposed facility will operate at or in excess of the utilization standards identified in 77 Ill. Admin Code Section 1110, Appendix B.

Sincerely,

Giridhar Burra, M.D.
Managing Member
Salt Creek Surgery Center

Joint Commission

ATTACHMENT 33
Availability of Funds

The total estimated project cost is $23,127,636. The Applicants have sufficient resources and will fund this project with debt through a mortgage and lease for the property. The Applicant has previously provided Board Staff with a copy of its audited financial report as evidence which reflects that the Applicant has sufficient funds on hand to complete the project.

ATTACHMENT 33
Availability of Funds

Salt Creek Surgery Center
530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

John P. Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Floor 2
Springfield, IL 62761

Re: Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center
77 Ill. Admin. Code Section 1120.120 (a) Available Funds Certification
77 Ill. Admin. Code Section 1120.140 (a) Reasonableness of Financing Arrangements

Dear Mr. Kniery,

As a representative of Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center, I, Giridhar Burra, M.D., hereby attest that the project costs will be $23,127,636 Westmont Illinois Bone and Joint Institute, LLC will fund the entirety of the construction of the project and the necessary working capital and operating deficits through the second full fiscal year. Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center has sufficient and readily accessible internal resources to fund the obligation required by the project, and to fully fund their other ongoing obligations.

I further certify that our analysis of the funding options for this project reflects that the funding strategy outlined herein is the lowest net cost option available.

Sincerely,

Giridhar Burra, M.D.
Managing Member
Salt Creek Surgery Center

Joint Commission

ATTACHMENT 34
Financial Viability

Pursuant to the requirements of 77 Ill. Adm. Code § 1120.13, the Applicant demonstrates financial viability to establish a new ASTC based on the following financial indicators derived from the enclosed pro forma and financial schedules:

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				**2029**
Current Ratio	N/A	N/A	N/A	1.625
Net Margin Percentage	N/A	N/A	N/A	37.7%
Percent Debt to Total Capitalization	N/A	N/A	N/A	80%
Projected Debt Service Coverage	N/A	N/A	N/A	n/a**
Days Cash on Hand	N/A	N/A	N/A	>45 days*
Cushion Ratio	N/A	N/A	N/A	n/a**

* As evidenced by previously provided audited financial statements for IBJI Institute, LLC and considering assets from facility being discontinued will be transferred to this entity to stabilize operational expenses
** Only debt related to this project is mortgage

ATTACHMENT 34
Financial Viability

IBJI-West Ogden Avenue
Budget - 80% Financing
Updated: March 14, 2025

Cost Description	25,720 SF; 2 story-1 story ASC 1 story parking Cost Breakdown
Land	2,500,000
Building Costs:	
Land Due Diligence, Survey, Coordination, Studies, Phase I, Contingency	45,000
1st Floor Garage Core/Shell	4,364,000
1st & 2nd Floors Site Development, Core & Shell	6,712,920
Contingency Allowance	285,240
Unsuitable Soils/Storm Water/Utility Extension Contingency Allowance	356,550
Fit Up: ASC 22,990 SF	6,437,200
Fit Up: Common & Support Areas	204,750
Demolition	281,250
Project Contingency	350,000
Additional Contingency	11,090
TOTAL HARD COSTS	21,548,000
CONSTRUCTION PERIOD COSTS:	
Construction Loan Points	85,000
Construction Lender Site Inspection Fees	15,000
Appraisal Fees	10,000
Construction Loan Legal Fees	20,000
Construction Loan Title Insurance	30,000
Recording Fees & Miscellaneous Closing Costs	7,000
Soils report	0
Construction Period Interest	700,000
Real Estate Taxes During Construction	50,000
TOTAL CONSTRUCTION PERIOD COSTS	917,000
PERMANENT LOAN COSTS:	
1st Mortgage Loan Points	-
1st Mortgage Lender Inspection & Other Fees	-
1st Mortgage Loan Legal Fees	-
1st Mortgage Title Insurance (need to confirm)	-
Improved Property ATLA Survey	10,000
TOTAL PERMANENT LOAN COSTS	10,000
PROJECT COSTS:	
Legal Fees - Entity Related, Oper. Agr., LLC, Offering	50,000
Owners Representative & Expenses	650,000
Legal Fees - Leases/Land	15,000
Insurance/Utilities	10,000
TOTAL PROJECT COSTS:	725,000
TOTAL COSTS	23,200,000
Less 1st Mortgage Loan Amount-80% Financing	(18,560,000)
DOWN PAYMENT REQUIRED (20%)	4,640,000
DOWN PAYMENT REQUIRED AT CONSTRUCTION START	4,640,000
Unit Value	10,000
Units	464

ATTACHMENT 34
Financial Viability

BMO-West Upton Avenue
Projected Financial Information

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
ASSUMPTIONS											
Number of Pdd Payments in Current Year		12	12	12	12	12	12	12	12	12	12
FINANCING ASSUMPTIONS-Budget	23,200,000										
1st Mortgage Loan Amount-Beginning of the year		18,540,000	18,341,771	17,983,073	17,542,589	17,158,910	16,790,570	16,315,955	15,851,385	15,397,081	14,837,071
1st Mortgage Interest Rate		6.25%	6.25%	6.25%	6.25%	6.25%	6.25%	6.25%	6.25%	6.25%	6.25%
Months Remaining		295	283	271	259	247	235	223	211	199	187
LEASE INCOME											
Current Year SF Leased		25,720.00	25,720	25,720	25,720	25,720	25,720	25,720	25,720	25,720	25,720
% of Total Leased (Calculated)		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Current Year Lease Rate per SF		67.66	69.00	70.38	71.79	73.23	74.69	76.19	77.71	79.26	80.85
Annual Lease Escalation (Calculated)		n/a	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Total Tenant Building Operating Expenses		205,760	209,875	214,073	218,354	222,721	227,176	231,719	236,354	241,081	245,903
Operating Expenses Paid by Tenant (Annual SF)		8.00	8.16	8.32	8.49	8.66	8.83	9.01	9.19	9.37	9.56
TAXABLE INCOME (LOSS)											
Base Rent		1,739,999	1,774,799	1,810,295	1,846,501	1,883,431	1,921,100	1,959,522	1,998,712	2,038,686	2,079,460
Tenant Operating Expense Reimbursements		205,760	209,875	214,073	218,354	222,721	227,176	231,719	236,354	241,081	245,902
Less Vacancy		0	0	0	0	0	0	0	0	0	0
Gross Operating Income		1,945,759	1,984,674	2,024,368	2,064,855	2,106,152	2,148,275	2,191,241	2,235,066	2,279,767	2,325,362
Less Tenant Building Operating Expenses		(205,760)	(209,875)	(214,073)	(218,354)	(222,721)	(227,176)	(231,719)	(236,354)	(241,081)	(245,902)
NET OPERATING INCOME		1,739,999	1,774,799	1,810,295	1,846,501	1,883,431	1,921,100	1,959,522	1,998,712	2,038,686	2,079,460
Less Other Tax Deductible Expenses:											
1st Mortgage Interest Expense		(1,150,917)	(1,130,518)	(1,108,712)	(1,085,545)	(1,061,867)	(1,034,501)	(1,006,640)	(978,892)	(945,225)	(911,521)
Tax Management Misc		(10,000)	(10,200)	(10,404)	(10,612)	(10,824)	(11,041)	(11,262)	(11,487)	(11,717)	(11,951)
Depreciation-Building		(528,205)	(519,872)	(519,872)	(519,872)	(519,872)	(519,872)	(519,872)	(519,872)	(519,872)	(519,872)
Total Other Tax Deductible Expenses		(1,689,192)	(1,660,589)	(1,639,008)	(1,616,029)	(1,591,563)	(1,565,513)	(1,537,779)	(1,508,251)	(1,476,814)	(1,443,344)
OPERATING TAXABLE INCOME		50,807	114,210	171,287	230,472	291,868	355,585	421,743	490,461	561,873	634,116
ANNUAL CASH FLOW											
Net Operating Income		1,739,999	1,774,799	1,810,295	1,846,501	1,883,431	1,921,100	1,959,522	1,998,712	2,038,686	2,079,460
Total Operating Income Receipts		1,739,999	1,774,799	1,810,295	1,846,501	1,883,431	1,921,100	1,959,522	1,998,712	2,038,686	2,079,460
Disbursements:											
1st Mortgage Principal & Interest Payment		(1,469,216)	(1,469,216)	(1,469,216)	(1,469,216)	(1,469,216)	(1,469,216)	(1,469,216)	(1,469,216)	(1,469,216)	(1,469,216)
NET CASH FLOW BEFORE TAXES		270,784	305,583	341,079	377,285	414,215	451,884	490,306	529,496	569,471	610,244
OTHER CALCULATIONS BY YEAR											
YEARLY DEBT SERVICE RATIO		1.18	1.21	1.23	1.26	1.28	1.31	1.33	1.36	1.39	1.42
(Net operating income divided by mortgage payment)											
ANNUALIZED CASH ON CASH RETURN		8.17%	9.23%	10.30%	11.39%	12.51%	13.64%	14.80%	15.99%	17.19%	18.42%
PRE-TAX PAYBACK PERIOD		270,784	576,367	917,446	1,294,731	1,708,947	2,160,831	2,651,137	3,180,634	3,750,104	4,360,349
ANNUALIZED RETURN ON TOTAL COST		7.50%	7.65%	7.80%	7.95%	8.12%	8.28%	8.45%	8.62%	8.79%	8.96%
(Annual net income divided by original cost of project)											

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ATTACHMENT 34
Financial Viability

Ogden/IBJI ASC Proforma

Option 1	Current Westmont ASC	ONE STORY Ogden ASC	UC	Breakeven
ORs	4	6		6
Procedure Rooms	-	-		
Rooms	-	-	-	
Cases	4,052	6,000		4,800
Revenue	31,226,597	46,238,791	-	36,991,033
Staffing	4,455,027	6,596,783	-	5,277,426
Rent	909,228	1,740,000	-	1,740,000
Equipment	755,549	1,423,761	-	1,423,761
Supplies	9,735,025	14,415,141	-	11,532,113
Other	2,939,486	4,648,295	-	4,648,295
Total Expense	18,794,315	28,823,980	-	24,621,595
Net Income	$ 12,432,282	$ 17,414,812	$ -	$ 12,369,438

ATTACHMENT 36
Economic Feasibility
Cost and GSF by Service

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
ASTC	$303.76		22,990	-	-	-	$6,983,520	-	$6,983,520
Contingency	$12.64		24,550	-	-	-	$310,365	-	$310,365
TOTALS	$316.40		47,540	-	-	-	$7,293,885	-	$7,293,885
* Include the percentage (%) of space for circulation									

Pursuant to Illinois Admin. Code Section 1120.Appendix A (a)(3) project cost must be at or below the RS Means for the new construction of an ASTC. At the time of this application the RS Means for the new construction of an ASTC in this area of the state is $495.41 per GSF. This project is slated to be completed in the 4th quarter of 2027 and the applicable RS Means standard is $510.27 per GSF. The proposed cost per GSF for this project is $316.40, and thus this project meets the Board's criteria.

ATTACHMENT 37
Safety Net Impact Statement

The project will not have a material impact, 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.

The Applicant facility will cease operations upon approval of a replacement facility and thus there will be no adverse material impact on the essential safety net services that it provides. Additionally, the discontinuation of its facility will not impact existing providers.

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**.

The project should not have any impact on the ability of another provider or health care system to cross subsidize safety net services.

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.**

The discontinuation of the facility will not impact remaining safety net providers as the licensee proposes to relocate less than a mile away.

ATTACHMENT 37
Safety Net Impact Statement

Safety Net Information per PA 96-0031			
CHARITY CARE*			
Charity (# of patients)	**2020**	**2021**	**2022**
Inpatient	0	0	0
Outpatient	1	2	0
Total	**1**	**2**	**0**
Charity (cost in dollars)			
Inpatient	$0	$0	$0
Outpatient	$0	$0	$0
Total	**$0**	**$0**	**$0**
MEDICAID			
Medicaid (# of patients)	**2020**	**2021**	**2022**
Inpatient	0	0	0
Outpatient	0	0	0
Total	0	0	0
Medicaid (revenue)			
Inpatient	$0	$0	$0
Outpatient	$0	$0	$0
Total	$0	$0	$0

***Note: IBJI and its physicians engage in various and significant provision of charitable and unreimbursed care, however since the care provided and the means of its provision do not conform to the HFSRB requirements for and definition of Charity Care, this amount is noted as being zero.**

ATTACHMENT 38
Charity Care Information

The projected patient mix by payer source by the end of its second year of operation is included below. These figures were estimated based on existing patient's payor mix treated by the physicians practicing at the existing location. The physicians associated with this project are already contracted providers with Illinois Medicaid Managed Care Organizations, such as BlueCross Blue Shield, CountyCare Health Plan, Molina Healthcare, and Meridian Health Plan. Those physicians will continue to treat patients with those plans at the proposed facility and all patients will be treated regardless of their ability to pay.

Projected Payor Mix

Payor Type	Estimated Number of Patients
Commercial	72%
Medicare	28%
Medicaid/ Medicaid MCO	n/a

CHARITY CARE*			
	2020	2021	2022
Net Patient Revenue	**$9,191,339**	**$23,842,428**	**$30,828,075**
Amount of Charity Care (charges)	0	0	0
Cost of Charity Care	0	0	0

***Note: IBJI and its physicians engage in various and significant provision of charitable and unreimbursed care, however since the care provided and the means of its provision do not conform to the HFSRB requirements for and definition of Charity Care, this amount is noted as being zero.**

ATTACHMENT 39
Flood Zone Letter

Salt Creek Surgery Center
530 North Cass Avenue • Westmont, Illinois 60559
Ph: 630-968-1800 • Fx: 630-968-2546 • saltcreeksurgerycenter.com

July 22, 2025

John Kniery
Board Administrator
Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: Flood Plain Requirements- Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center

Dear Mr. Kniery:

As representative of Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center, I Giridhar Burra, M.D., affirm that the proposed relocation for Westmont Surgery Center, LLC, d/b/a Salt Creek Surgery Center complies with Illinois Executive Order #2005-5. The proposed location, 550 W. Ogden Ave., Hinsdale, IL 60521, is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").
I hereby certify this true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

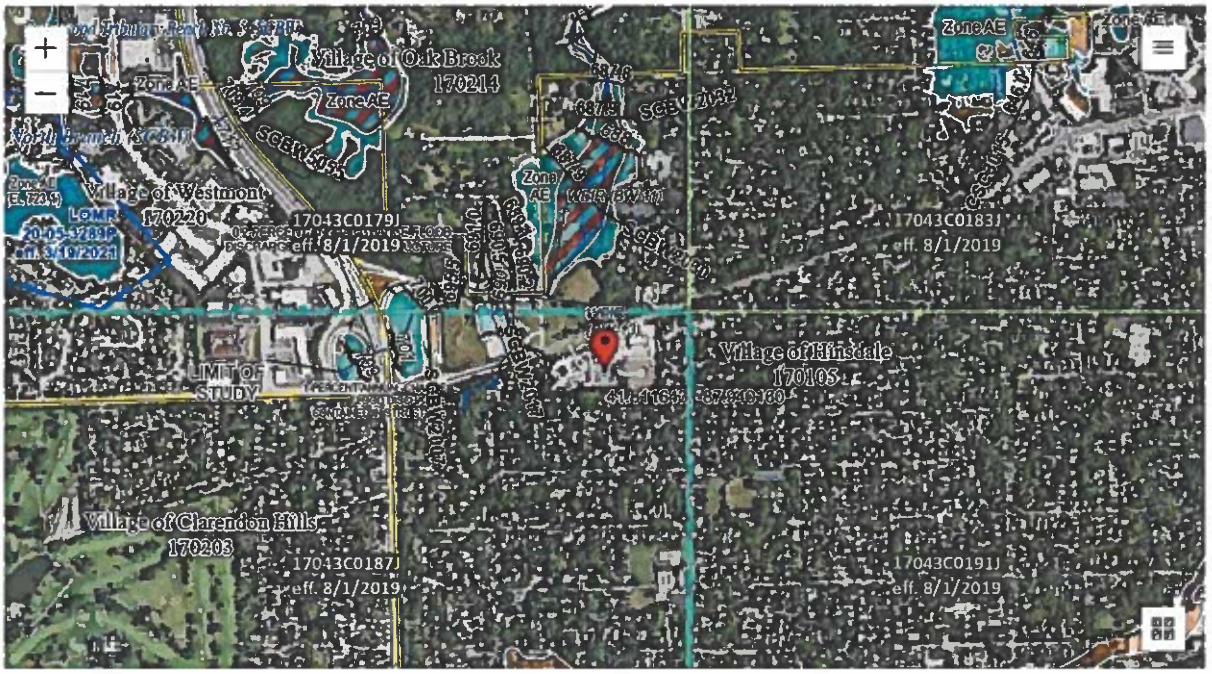
Sincerely,

Giridhar Burra, M.D.
Managing Member
Salt Creek Surgery Center

ATTACHMENT 39
Flood Plain Requirements Letter

FLOOD PLAIN MAP

550 W. Ogden Ave., Hinsdale, IL 60521



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