

**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: Midwest Surgical Centers, LLC		
Street Address: 13610 Route 59		
City and Zip Code: Plainfield 60544		
County: Will	Health Service Area: 9	Health Planning Area: 197

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

Exact Legal Name: Midwest Surgical Centers, LLC
Street Address: 13610 Route 59
City and Zip Code: Plainfield 60544
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 President: Sreenivas Reddy, M.D.
President Street Address: 13610 Illinois Route 59
President City and Zip Code: Plainfield 60544
President Telephone Number: (630) 842-1747

Type of Ownership of Applicants

☐ 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 they are organized and the name and address of each partner specifying whether each is a general or limited partner.	
APPEND DOCUMENTATION AS <u>ATTACHMENT 1</u>, 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, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: 312-212-4967 and 312-212-4952
E-mail Address: JMorado@beneschlaw.com and MSilberman@beneschlaw.com
Fax Number: 312-767-9192

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

Name: Juan Morado, Jr. and Mark J. Silberman
Title: CON Counsel
Company Name: Benesch Friedlander Coplan & Aronoff, LLP
Address: 71 S. Wacker Drive, Suite 1600, Chicago, IL 60606
Telephone Number: (312) 212-4967 and (312) 212-4952
E-mail Address: JMorado@beneschlaw.com and MSilberman@beneschlaw.com
Fax Number: (312) 767-9192

Site Ownership [Provide this information for each applicable site]

Exact Legal Name of Site Owner: N & D Properties, LLC
Address of Site Owner: 13610 South Route 59, Plainfield IL 60544
Street Address or Legal Description of the Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

Exact Legal Name: Midwest Surgical Centers, LLC	
Address: 13610 S. Route 59, Plainfield, IL 60544	
☐ Non-profit Corporation	☐ Partnership
☐ For-profit Corporation	☐ Governmental
☒ Limited Liability Company	☐ Sole Proprietorship ☐ Other
- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements [Refer to application instructions]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (<http://www.hfsrb.illinois.gov>). **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

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

Historic Resources Preservation Act Requirements [Refer to application instructions]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

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

Part 1110 Classification :

- ☒ Substantive
☐ Non-substantive

2. Narrative Description

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

Midwest Surgical Centers, LLC located at 13610 South Route 59, Plainfield IL 60544 ("Applicant") seeks to operate an ambulatory surgical treatment center ("ASTC") and provide General Surgery and Podiatry services.

This project is classified as substantive, in that it involves the establishment of an ambulatory surgical treatment center pursuant to 77 Ill. Admin. Code 1110.20(c)(1)(A)(i).

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$9,197	\$3,678	\$12,875
Site Survey and Soil Investigation	-	-	-
Site Preparation	-	-	-
Off Site Work	-	-	-
New Construction Contracts	\$1,414,299	\$565,628	\$1,979,927
Modernization Contracts	-	-	-
Contingencies	\$140,000	\$60,000	\$200,00
Architectural/Engineering Fees	\$124,458	\$49,775	\$174,234
Consulting and Other Fees	\$100,000	\$50,000	\$150,000
Movable or Other Equipment (not in construction contracts)	\$410,733	\$164,267	\$575,000
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value of Leased Space or Equipment	\$655,030	\$261,970	\$917,000
Other Costs to Be Capitalized	-	-	-
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	\$2,853,717	\$1,155,318	\$4,009,035
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	-	-	-
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	\$2,198,687	\$893,348	\$2,992,035
Leases (fair market value)	\$655,030	\$261,970	\$917,000
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	\$2,853,717	\$1,155,318	\$4,009,035
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:	Not Applicable	
Fair Market Value:	Not Applicable	
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 \$		

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: ☐ None or not applicable ☐ Preliminary ☒ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): <u>December 31, 2027</u>
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): ☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies ☒ Financial Commitment will occur after permit issuance.
APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable? ☒ Cancer Registry ☒ APORS ☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted ☒ All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

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

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
ASC Operating Rooms	\$2,853,717	-	3,098	-	3,098	-	-
Total Clinical	\$2,853,717	-	3,098	-	3,098	-	-
		-		-		-	-
NON-REVIEWABLE		-		-		-	-
Administrative	\$1,155,318	-	1,239	-	1,239	-	-
		-		-		-	-
Total Non-Clinical	\$1,115,318	-	1,239	-	1,239	-	-
TOTAL	\$4,009,035	-	4,337	-	4,337	-	-
APPEND DOCUMENTATION AS <u>ATTACHMENT 9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Facility Bed Capacity and Utilization – NOT APPLICABLE

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

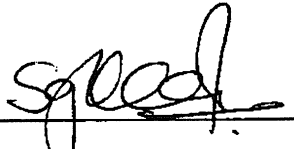
FACILITY NAME:		CITY:			
REPORTING PERIOD DATES:		From:		to:	
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal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

CERTIFICATION

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

- o in the case of a corporation, any two of its officers or members of its Board of Directors.
- o 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).
- o 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).
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

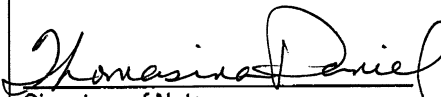
This Application is filed on the behalf of Midwest Surgical Centers, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. 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.

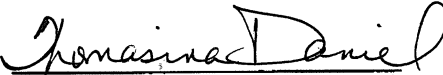

SIGNATURE
SREENIVAS REDDY
PRINTED NAME
Manager
PRINTED TITLE


SIGNATURE
Terence Chitamel
PRINTED NAME
MEMBER
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of September

Notarization:
Subscribed and sworn to before me
this 9th day of September


Signature of Notary


Signature of Notary

Seal
THOMASINA DANIEL
Official Seal
Notary Public - State of Illinois
My Commission Expires Apr 27, 2026

Seal
THOMASINA DANIEL
Official Seal
Notary Public - State of Illinois
My Commission Expires Apr 27, 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 (2 Operating Rooms)	3,098 GSF	2,750 GSF per treatment room	-2,402	YES

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	1,439 Patients	1,508 Hours	>1500 Hours	YES
YEAR 2	ASTC	1,439 Patients	1,553 Hours	>1500 Hours	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	
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	
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	
1110.235(c)(9) – Charge Commitment	X	
1110.235(c)(10) – Assurances	X	
APPEND DOCUMENTATION AS <u>ATTACHMENT 25</u> , 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.
<u>\$4,009,035</u>	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.
\$4,009,035	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)	
ASC	\$456.52	-	3,098	-	-	-	\$1,414,299	-	\$1,414,299
Contingency	\$45.19	-	3,098	-	-	-	\$140,000	-	\$140,000
TOTALS	\$501.71	-	3,098	-	-	-	\$1,554,299	-	\$1,554,299
* 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

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]:

1. The project's material impact, if any, on essential safety net services in the community, **including the impact on racial and health care disparities in the community**, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

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	-	-	-
Outpatient	-	-	-
Total	-	-	-
Charity (cost in dollars)			
Inpatient	-	-	-
Outpatient	-	-	-
Total	-	-	-
MEDICAID			
Medicaid (# of patients)	2022	2022	2022
Inpatient	-	-	-
Outpatient	-	-	-
Total	-	-	-
Medicaid (revenue)			
Inpatient	-	-	-
Outpatient	-	-	-
Total	-	-	-

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

SECTION X. CHARITY CARE INFORMATION

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

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

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

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

CHARITY CARE			
	2020	2021	2022
Net Patient Revenue	-	-	-
Amount of Charity Care (charges)	-	-	-
Cost of Charity Care	-	-	-

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

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: Midwest Surgical Centers, LLC 13610 S. Route 59
(Name) (Address)
Plainfield Illinois 60544 (708) 354-8881
(City) (State) (ZIP Code) (Telephone Number)

2. Project Location: 13610 S. Route 59 Plainfield Illinois
(Address) (City) (State)
Will Plainfield Township
(County) (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

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	23-24
2	Site Ownership	25-27
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	28-29
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	30
5	Flood Plain Requirements	31-32
6	Historic Preservation Act Requirements	33-38
7	Project and Sources of Funds Itemization	39-40
8	Financial Commitment Document if required	41-42
9	Cost Space Requirements	43
10	Discontinuation	N/A
11	Background of the Applicant	44-50
12	Purpose of the Project	51-94
13	Alternatives to the Project	95
14	Size of the Project	96
15	Project Service Utilization	97-98
16	Unfinished or Shell Space	99
17	Assurances for Unfinished/Shell Space	100
Service Specific:		
19	Medical Surgical Pediatrics, Obstetrics, ICU	N/A
20	Comprehensive Physical Rehabilitation	N/A
21	Acute Mental Illness	N/A
22	Open Heart Surgery	N/A
23	Cardiac Catheterization	N/A
24	In-Center Hemodialysis	N/A
25	Non-Hospital Based Ambulatory Surgery	101-123
26	Selected Organ Transplantation	N/A
27	Kidney Transplantation	N/A
28	Subacute Care Hospital Model	N/A
29	Community-Based Residential Rehabilitation Center	N/A
30	Long Term Acute Care Hospital	N/A
31	Clinical Service Areas Other than Categories of Service	N/A
32	Freestanding Emergency Center Medical Services	N/A
33	Birth Center	N/A
Financial and Economic Feasibility:		
34	Availability of Funds	124
35	Financial Waiver	N/A
36	Financial Viability	125
37	Economic Feasibility	126-127
38	Safety Net Impact Statement	128
39	Charity Care Information	129
40	Flood Plain Information	130-131

ATTACHMENT 1

Type of Ownership of Applicant

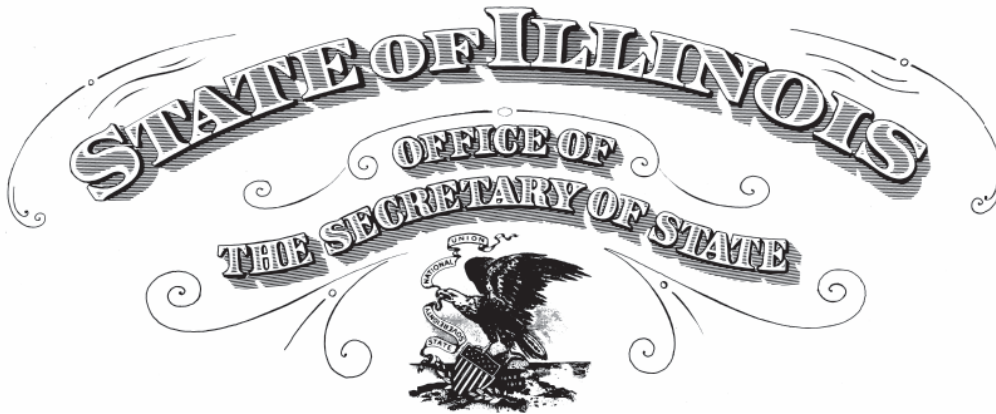
Included with this attachment are:

The Certificate of Good Standing for the applicant, Midwest Surgical Centers, LLC

ATTACHMENT 1
Certificate of Good Standing
Midwest Surgical Centers, LLC

File Number

1626875-5



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulas, 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

MIDWEST SURGICAL CENTERS, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MAY 22, 2025, 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 #: 2524102208 verifiable until 08/29/2026
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 29TH day of AUGUST A.D. 2025 .


SECRETARY OF STATE

ATTACHMENT 2

Site Ownership

Attached as evidence of control over the site is a copy of the facility's property tax statement for 2025 and letter of attestation of ownership. The tax document reflects that N & D Properties, LLC, is the site owner. The letter reflects that N&D Properties, LLC has one managing member, Dr. Sreenivas Reddy.

ATTACHMENT 2 Site Ownership



Will County CCAO
Dale D. Butalla, CIAO-M
302 N. Chicago Street
2nd Floor
Joliet, Illinois 60432
Phone: 1-815-740-4648

PIN 06-03-04-201-052-0000

Parcel Information

<< Prev Parcel

Next Parcel >>

PLAINFIELD TOWNSHIP

Owner Name: N & D PROPERTIES LLC

Street Address:
13610 S RT 59
PLAINFIELD IL 60544



[View on Bing Maps](#)

Subdivision: HOPE BUFFET

Property Class: 0060 Commercial

Homesite Acres: 0.00
Farm Acres: 0.00
Open Space Acres: 0.00
Non-Farm Acres: 1.00
Total Acres: 1.00



[GIS Map & Address Information](#)

[Will County Treasurer's Tax Information](#)

Assessment Information									
Year	Assess Level	Land Unimproved/Farm	Land Improved	Building Other/Farm	Building	Total	Market Value	Instant Date	Instant Amount
2025	SA/E	0	140,000	0	159,600	299,600	898,890		0
2025	TWP	0	140,000	0	159,600	299,600	898,890		0
2024	BOR	0	140,000	0	159,600	299,600	898,890		0
2023	BOR	0	140,000	0	159,600	299,600	898,890		0

Sale Information		
Sale Date	Sale Amount	Document Number
02/29/2024	1,000,000	R2024011850
12/01/2015	766,000	2015014548

Building Information	
----------------------	--

** Building information is submitted periodically from the [PLAINFIELD TOWNSHIP](#) Assessor; therefore, the building information listed may not be accurate or the most current. **

Style: MIDWEST PROPERTY PARTNERS LLC
Year Built: 2009
Total Sq. Ft: 6,840
Basement:
Garage:

Bathrooms:
Central Air:
Fireplace:
Porch:
Attic:

** For the most comprehensive building characteristics and relevant information, please contact the [PLAINFIELD TOWNSHIP](#) Assessor. **

Legal Description
LOT 1 IN HOPE BUFFET SUB, BEING A PUD IN THE NE1/4 OF SEC 4, T36N-R9E.

ATTACHMENT 2 Site Ownership

Midwest Surgical Centers, LLC

September 3, 2025

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

Re: Attestation of Site Ownership - Midwest Surgical Centers, LLC.

Dear Mr. Kniery:

As a representative of Midwest Surgical Centers, LLC., I, Sreenivas Reddy, M.D., hereby attest that the site of the proposed Midwest Surgical Centers, LLC ASC, located at 13610 Route 59, Plainfield, Illinois 60435 is owned by N&D Properties LLC, of which I am the sole owner.

Furthermore, I attest that the proposed location for the Midwest Surgical Centers, LLC ASC is not located in a flood zone. 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,



Sreenivas Reddy, M.D.
Manager
Midwest Surgical Centers, LLC

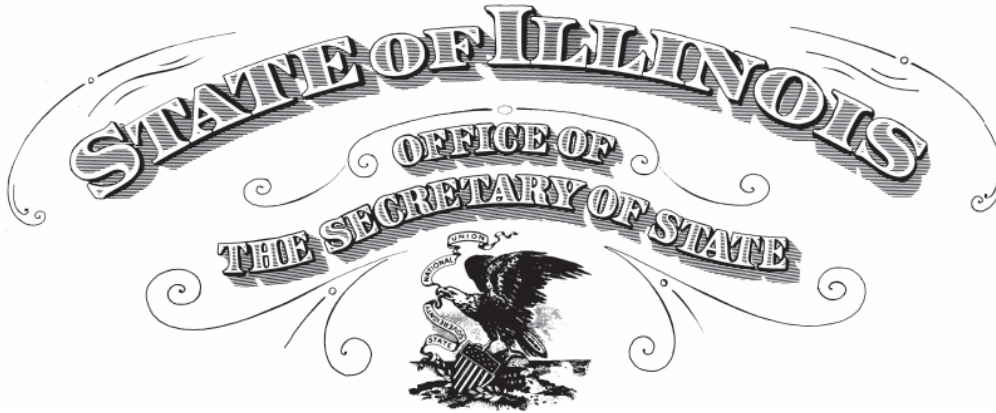
ATTACHMENT 3

Operating Entity/ Licensee

Midwest Vascular Care will seek licensure by the Illinois Department of Public Health following this project. Attached as evidence of the owner entity's good standing is a Certificate of Good Standing issued by Illinois Secretary of State.

ATTACHMENT 3
Operating Entity/Licensee
Certificate of Good Standing for
Midwest Surgical Centers, LLC

File Number 1626875-5



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, 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

MIDWEST SURGICAL CENTERS, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MAY 22, 2025, 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.

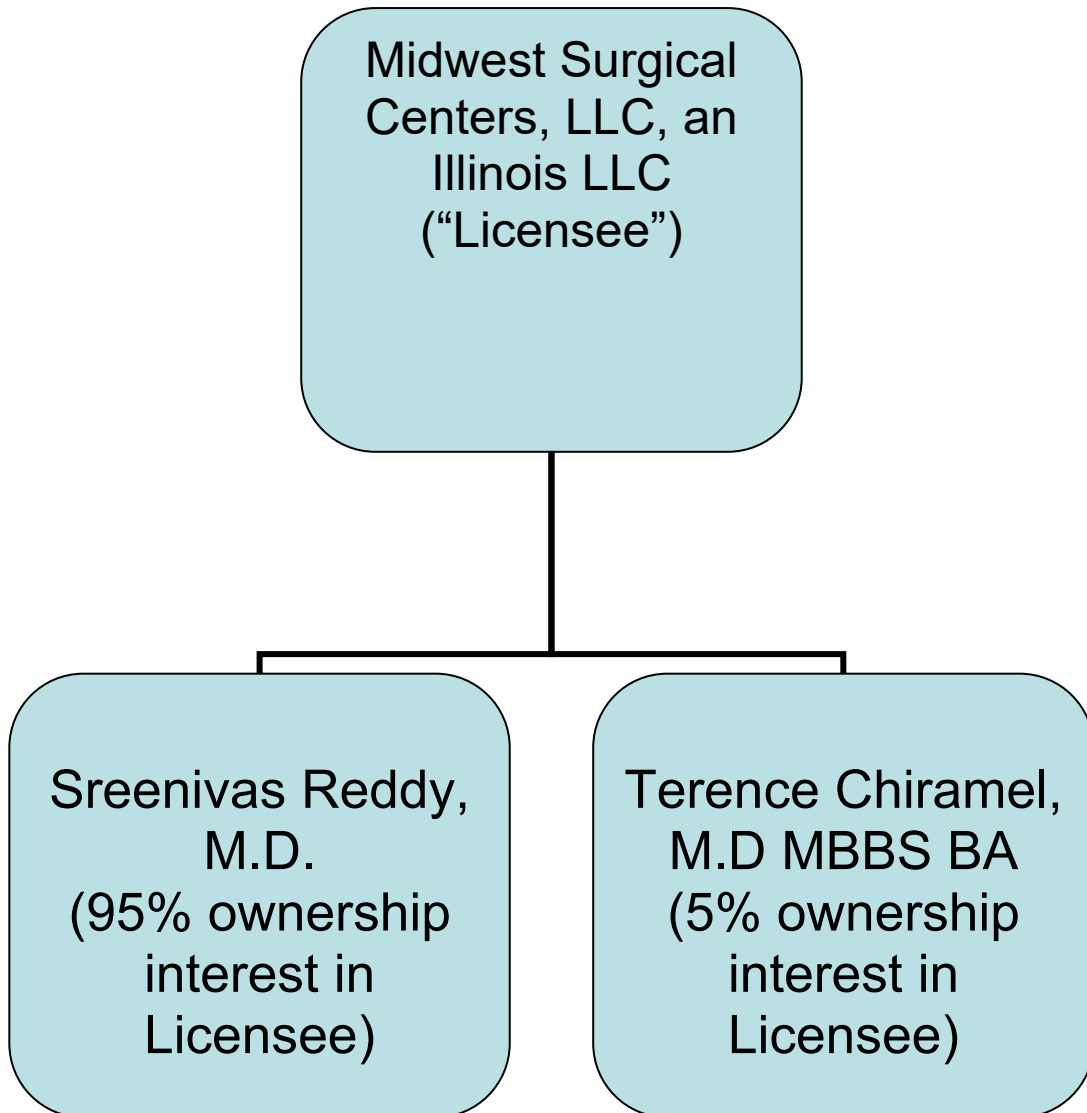


Authentication #: 2524102208 verifiable until 08/29/2026
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 29TH day of AUGUST A.D. 2025 .


ALEXI GIANNOULIS
SECRETARY OF STATE

ATTACHMENT 4
Organizational Relationships



ATTACHMENT 5

Flood Plain Requirements

Midwest Surgical Centers, LLC

September 3, 2025

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

Re: Midwest Surgical Centers, LLC - Flood Plain Requirements

Dear Mr. Kniery:

As representative of Midwest Surgical Centers, LLC, I, Sreenivas Reddy, M.D., affirm that our facility complies with Illinois Executive Order #2005-5. The facility location at 13610 S. Route 59, Plainfield IL 60544 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 as true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

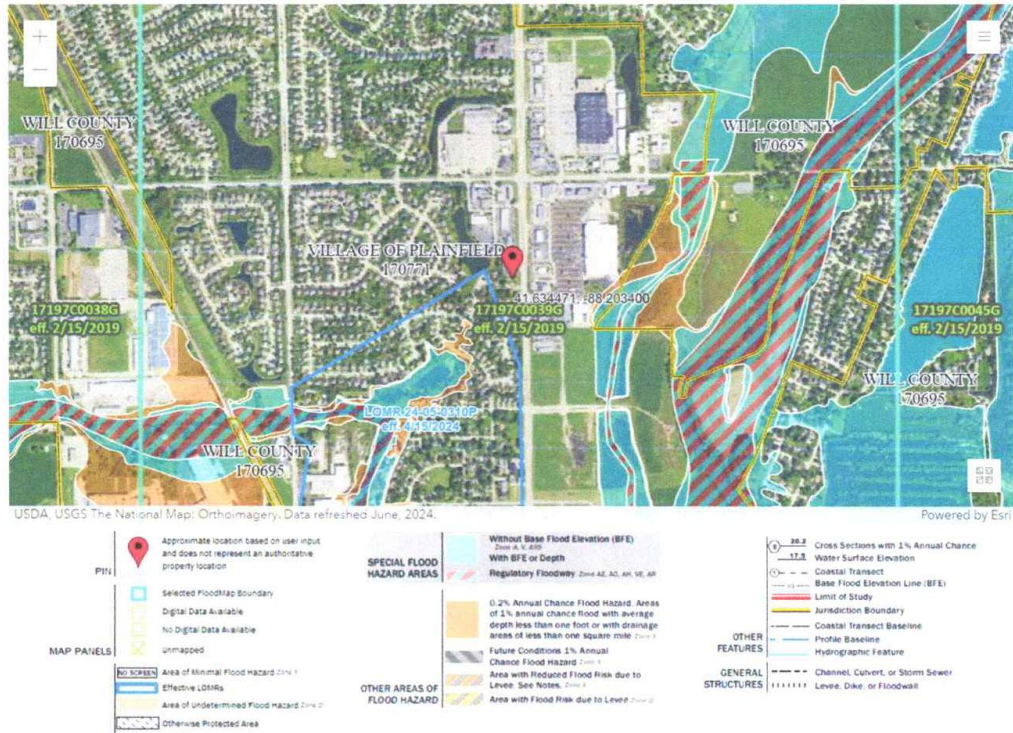
Sincerely,



Sreenivas Reddy, M.D.
Manager
Midwest Surgical Centers, LLC

ATTACHMENT 5 Flood Plain Requirements

Midwest Surgical Centers, LLC



ATTACHMENT 6

Historic Preservation Act Requirements

The applicant submitted a request for determination to the Illinois Department of Natural Resources – Preservation Services Division on August 29, 2025. A final determination was received and is enclosed with this attachment.

ATTACHMENT 6

Historic Preservation Act Requirements



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

August 29, 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, Midwest Surgical Centers, LLC ("Midwest Surgical") 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.). Midwest Surgical is submitting an application for a Certificate of Need from the Illinois Health Facilities and Services Review Board. Midwest Surgical intends to establish an ambulatory surgical treatment center ("ASTC") at 13610 S. Route 59, Plainfield IL 60544, and provide General and Podiatric Surgery services.

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

A handwritten signature in blue ink, appearing to read "Juan Morado, Jr.", written over a light blue rectangular background.

Juan Morado, Jr.

www.beneschlaw.com

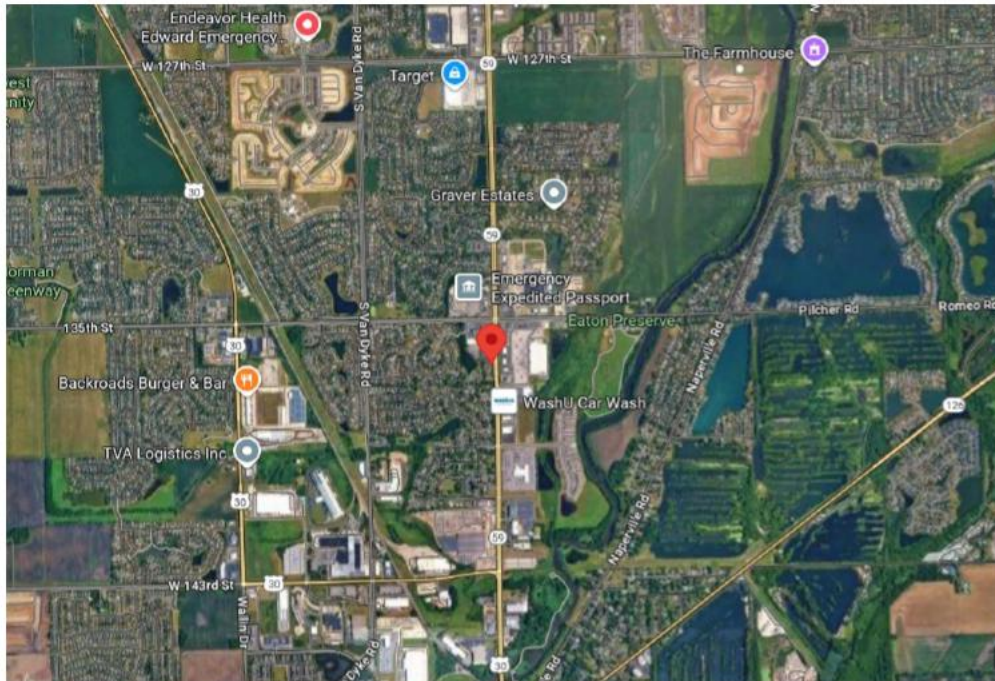
27451560 v2

ATTACHMENT 6

Historic Preservation Act Requirements

Mr. Jeffrey Kruchten
Page 2

**Topographic Map (13610 S. Route 59, Plainfield, IL 60544, red
pinpoint)**

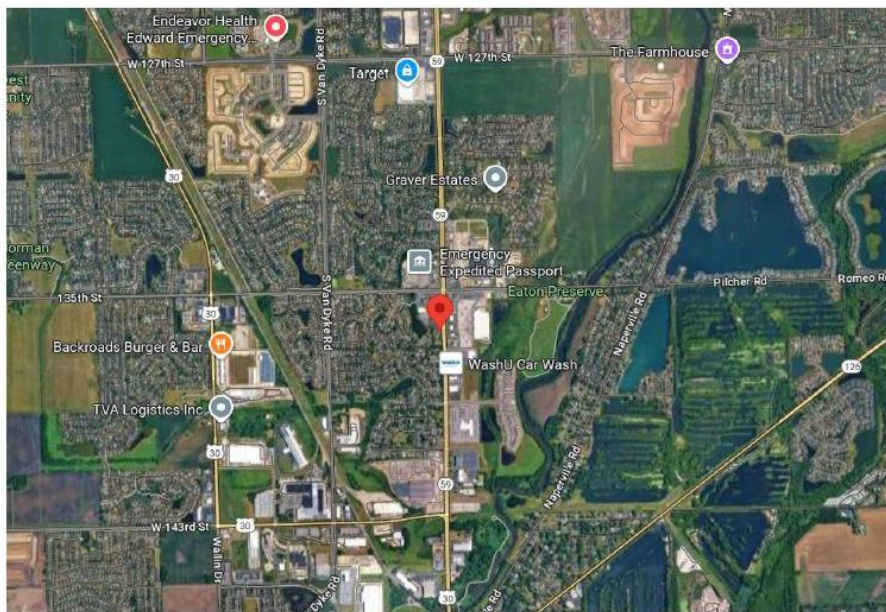


ATTACHMENT 6

Historic Preservation Act Requirements

Mr. Jeffrey Kruchten
Page 3

3D Aerial Map of 13610 S. Route 59, Plainfield, IL 60544



ATTACHMENT 6

Historic Preservation Act Requirements

Mr. Jeffrey Kruchten
Page 4

Street View of 13610 S. Route 59, Plainfield, IL 60544



ATTACHMENT 6

Historic Preservation Act Requirements



Illinois
Department of
**Natural
Resources**

JB Pritzker, Governor • Natalie Phelps Finnie, Director
One Natural Resources Way • Springfield, Illinois 62702-1271
www.dnr.illinois.gov

Will County
Plainfield
13610 S. Route 59
IHFSRB
CON - Rehabilitation to Establish an Ambulatory Surgical Treatment Center,
Midwest Surgical Centers, LLC

PLEASE REFER TO: SHPO LOG #009082925

September 22, 2025

Juan Morado
Benesch, Friedlander, Coplan and Aronoff LLP
71 S. Wacker Dr., Suite 1600
Chicago, IL 60606

The Illinois State Historic Preservation Office is required by the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420, as amended, 17 IAC 4180) to review all state funded, permitted, or licensed undertakings for their effect on cultural resources. Pursuant to this, we have received information regarding the referenced project for our comment.

Our staff has reviewed the specifications under the state law and assessed the impact of the project as submitted by your office. We have determined, based on the available information, that no significant historic, architectural, or archaeological resources will be affected within the proposed project area.

According to the information you have provided there is no federal involvement in your project. Be aware that the state law is less restrictive than the federal cultural resource laws concerning archaeology. If your project will use federal loans or grants, need federal agency permits (including non-reporting), use federal property, or involve assistance from a federal agency then your project must be reviewed under the National Historic Preservation Act of 1966, as amended. Please notify us immediately if such is the case.

This approval remains in effect for two (2) years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Remains Protection Act (20 ILCS 3440).

Please retain this letter in your files as evidence of compliance with the Illinois State Agency Historic Resources Preservation Act.

If further assistance is needed, please contact Jeff Kruchten, Principal Archaeologist, at 217/785-1279 or jeff.kruchten@illinois.gov.

Sincerely,

Carey L. Mayer, AIA
Deputy State Historic Preservation Officer

ATTACHMENT 7

Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$9,197	\$3,678	\$12,875
Site Survey and Soil Investigation	-	-	-
Site Preparation	-	-	-
Off Site Work	-	-	-
New Construction Contracts	\$1,414,299	\$565,628	\$1,979,927
Modernization Contracts	-	-	-
Contingencies	\$140,000	\$60,000	\$200,00
Architectural/Engineering Fees	\$124,458	\$49,775	\$174,234
Consulting and Other Fees	\$100,000	\$50,000	\$150,000
Movable or Other Equipment (not in construction contracts)	\$410,733	\$164,267	\$575,000
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value of Leased Space or Equipment	\$655,030	\$261,970	\$917,000
Other Costs to Be Capitalized	-	-	-
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	\$2,853,717	\$1,155,318	\$4,009,035
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	-	-	-
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	\$2,198,687	\$893,348	\$2,992,035
Leases (fair market value)	\$655,030	\$261,970	\$917,000
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	\$2,853,717	\$1,155,318	\$4,009,035
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 modernize an existing building to construct a 2 operating room ambulatory surgical treatment facility. 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 \$1,414,299 or \$456.52 per clinical square foot.

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 \$140,000 or 9.8% of the new construction contract costs.

Architectural/Engineering Fees - The clinical project cost for architectural/engineering fees are projected to be \$124,458 or 8% of the new construction and contingencies costs.

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.

Moveable Equipment Costs - The moveable equipment costs are necessary component for the operation of the updated operating rooms at the facility. The clinical costs divided among the 2 operating rooms that will be located at the facility and it equals \$205,366.50 per operating room or a total of \$410,733. The applicant is able to keep equipment costs down for this project by repurposing existing equipment from their existing office based lab.

FMV of Leased Space - The applicant intends to enter into a 10-year lease with an initial rent rate of \$121,436. The lease calls for annual increases in the amount of 1.030% per year

Rent Escalator	1.030	
Capitalization Rate	8.0%	\$ 28.00
Opening Lease Rate	\$ 28.00	Triple Net

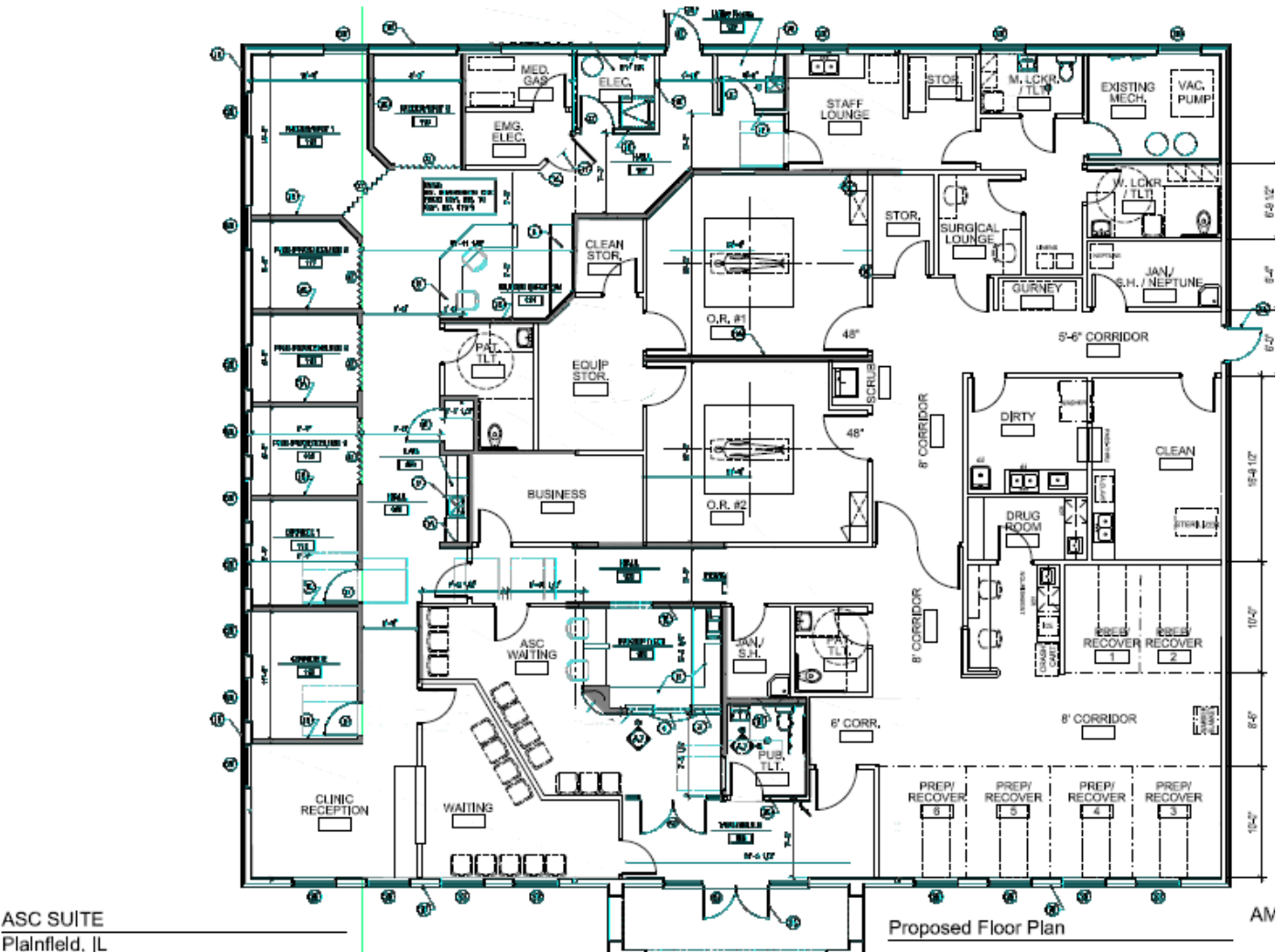
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Rent	121,436	125,079	128,831	132,696	136,677	140,778	145,001	149,351	153,831	158,446
TI Contribution- Landlord	\$0	-	-	-	-	-	-	-	-	-
	121,436	125,079	128,831	132,696	136,677	140,778	145,001	149,351	153,831	158,446
	\$ 28.00	\$ 28.84	\$ 29.71	\$ 30.60	\$ 31.51	\$ 32.46	\$ 33.43	\$ 34.44	\$ 35.47	\$ 36.53

ATTACHMENT 8

Project Status and Completion Schedules

The proposed project plans are still at a schematic stage. The proposed project completion date is upon approval by the Illinois Department of Public Health of the facility to perform General Surgery and Podiatry Surgery under a new license or by 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



ATTACHMENT 9

Cost Space Requirements

The proposed project involves the establishment of an ambulatory surgical treatment center with 2 operating rooms in a total of 4,337GSF.

		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							
ASC Operating Rooms	\$2,853,717	-	3,098	-	3,098	-	-
Total Clinical	\$2,853,717	-	3,098	-	3,098	-	-
		-		-		-	-
NON-REVIEWABLE		-		-		-	-
Administrative	\$1,155,318	-	1,239	-	1,239	-	-
		-		-		-	-
Total Non-Clinical	\$1,115,318	-	1,239	-	1,239	-	-
TOTAL	\$4,009,035	-	4,337	-	4,337	-	-

ATTACHMENT 11

Background of the Applicant

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 the new ASTC will provide a proper standard of health care services for the community.

Midwest Surgical Centers, LLC

Midwest Surgical Centers, LLC, located at 13610 South Route 59, Plainfield, Illinois 60544 ("Applicant"), seeks to establish and operate an ambulatory surgical treatment center ("ASTC") to provide General Surgery and Podiatry Surgery services.

The ownership of the Applicant is as follows:

- Sreenivas Reddy, M.D. – 95% ownership interest in Midwest Surgical Centers, LLC
- Terence Chiramel, M.D. MBBS, BA – 5% ownership interest in Midwest Surgical Centers, LLC

The ownership structure of the Applicant is further detailed in **Attachment 4**.

Neither Dr. Reddy nor Dr. Chiramel has a direct ownership interest in any other health care facility in Illinois. The Applicant certifies that no adverse actions have been taken against either owner or the Applicant entity during the three (3) years preceding the filing of this application. A certification letter attesting to this information is included at **Attachment 11**.

Additionally, the Applicant has provided a letter authorizing the Illinois Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") to access and verify all information contained in this application. This letter is included at **Attachment 11**.

Sreenivas Reddy, M.D. and Terence Chiramel, M.D., MBBS, BA

Sreenivas Reddy, M.D., is a board-certified Diagnostic Radiologist with fellowship training in Vascular and Interventional Radiology from Rush-Presbyterian-St. Luke's Medical Center in Chicago. He received specialty board certification from the American Board of Radiology in 2001 and was most recently certified by the American Board of Venous & Lymphatic Medicine (ABVLM).

Dr. Reddy has been in practice for more than twenty years and is the founder of the Vein and Vascular Centers. He has extensive expertise in minimally invasive treatments, including endovenous laser vein therapy (EVLT), sclerotherapy, uterine fibroid embolization (UFE), and arterial interventions, and is regarded as one of Chicago's leading specialists in vein and vascular care. He has been affiliated with Northwestern Medicine Delnor Hospital for more than a decade.

In addition to his clinical practice, Dr. Reddy serves as a Clinical Assistant Professor of Radiology at the Indiana University School of Medicine. He is an active member of several professional societies, including the Society of Interventional Radiology, the American Society of Vein and Lymphatic Medicine, the Radiological Society of North America, and the Chicago Medical Society. He also serves in leadership roles as Chair of the Illinois State Medical Board and as a member of the Cook County Health Foundation Board.

Dr. Reddy is deeply committed to advancing health equity and expanding access to high-quality care. He regularly volunteers his time and expertise to support underserved communities.

Terence Chiramel, M.D., M.B.A., is a physician leader with dual expertise in clinical medicine and healthcare business strategy. He earned his Doctor of Medicine degree from Sri Ramachandra Medical College and Research Institute in Chennai, India, and later completed a Master of Business Administration with a focus on strategic partnerships, finance, and marketing from the University of the People.

ATTACHMENT 11

Background of the Applicant

Dr. Chiramel currently serves as Vice President of Business Development – Clinical Strategy at EnSoftek, where he has led strategic implementation initiatives for more than seven years. In addition, he is Physician Administrator for both the Vein and Vascular Centers, SC, and Reddy Dermatology, SC, where he combines clinical oversight with operational and financial management.

Beyond his clinical and administrative roles, Dr. Chiramel is active in nonprofit and community-based organizations. He is the President of Hunger Hunt International, which advances education and clinical research initiatives, and serves on the Board of Directors of the Mental Health Association of Greater Chicago (MHAGC), where he supports education-based strategies to improve awareness, prevention, and treatment of mental health disorders.

Dr. Chiramel holds a Six Sigma Black Belt certification and has completed advanced training in healthcare management and research compliance through the Collaborative Institutional Training Initiative (CITI Program). He is committed to restoring passion in healthcare through innovation, education, and equitable access to quality care.

ATTACHMENT 11
Background of the Applicant

Midwest Surgical Centers, LLC

September 3, 2025

John P. Kniery
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Midwest Surgical Centers, LLC - Certification and Authorization

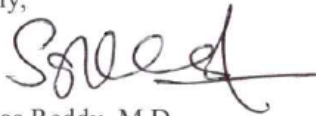
Dear Mr. Kniery,

As a representative of Midwest Surgical Centers, LLC, I, Sreenivas Reddy, M.D., 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 Midwest Surgical Centers, LLC, has no ownership interest in any other healthcare facility, and as such, has no adverse actions to report.

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,

A handwritten signature in black ink, appearing to read 'Sreed', with a long horizontal stroke extending to the right.

Sreenivas Reddy, M.D.
Manager
Midwest Surgical Centers, LLC

ATTACHMENT 11

Background of the Applicant

Sreenivas G. Reddy, MD

Sreenivas G. Reddy, MD
6699 S. County Line Road, Burr Ridge, IL 60527
Telephone: 630-8421747
Email: sgreddymd1@gmail.com

EXECUTIVE PROFILE

Senior board-certified and sought-after premiere healthcare provider with over 27 years of experience as a Doctor of Medicine. Leader with proven history of outstanding positive performance, achievement and recognition and driving patient-centered results, specifically in the Vascular and Interventional Radiology arena. Extensive medical facility, regional and corporate hospital expertise. Unparalleled record of excellence in strategic decision-making and policy direction. Participate in leadership roles with various national and statewide professionally organized medicine associations. Unwavering commitment to the highest levels of professional and personal excellence to improve patient care and health disparities.

EXECUTIVE EXPERIENCE

Vascular & Interventional Radiology **January 2018 - Present**
Vein and Vascular Centers, SC
7 N. Grant Street
Hinsdale, IL 60521

President and Chief Executive Officer of vein and vascular center. Manage, guide and direct major clinical operations employing twelve staff in delivering patient care. Expert interventional radiologist specializing in using imaging technology, such as X-rays and magnetic resonance resources and catheter-based procedures to diagnose and treat many diseases of the blood vessels and lymphatic system, among others. Strategically manage and direct operation to ensure operational efficiencies and effectiveness of patient care and in line with ultimate health care provisions.

Clinical Assistant Professor of Radiology (Volunteer) **June 2004 - Present**
Indiana University School of Medicine
Northwest Center for Medical Education
3400 Broadway, Gary, IN 46408

Instruct, mentor and advice students. Set up internships in practices for student's shadow, learn and grow in the field of interventional radiology and familiar them with all aspects of vascular disease.

Vascular & Interventional Radiologist **November 2007 – January 2018**
Northwestern Medicine-Delnor Hospital
Geneva, IL 60134

ATTACHMENT 11

Background of the Applicant

Sreenivas G. Reddy, MD

Premiere Board-certified diagnostic radiologist with a group practice providing vascular and interventional radiology services to patients in the Chicago metropolitan area. Perform endovascular laser and sclerotherapy vein treatments.

PREVIOUS POSITIONS

Vascular & Interventional Radiologist **June 2005 – November 2007**
Midwest Institute of Minimally Invasive Therapy
Loyola Medicine-Gottlieb Hospital

Interventional Radiologist **July 2001 – June 2005**
Methodist Hospital
8701 Broadway, Merrillville, IN 46410

EDUCATION

Doctor of Medicine (MD): American University of the Caribbean **1993**
School of Medicine
1 University drive at Jordan Road, Cupecoy, St. Maarten, N.A.

Doctor of Veterinary Medicine: College of Veterinary Medicine **1989**
Tirupati, AP, India

Bachelor of Science **1984**
S.V. Junior College
Tirupati, AP, India

POST GRADUATE EXPERIENCE

Fellowship: Vascular & Interventional Radiology **July 2000-June 2001**
Rush Presbyterian & St. Luke's Medical Center
600 S. Paulina Street, Chicago, IL 60612

Residency: Department of Diagnostic Radiology **July 1996-June 2000**
John H. Stroger Hospital of Cook County
1969 W. Ogden Avenue, Chicago, IL 60612

Residency: Department of Internal Medicine Residency **October 1994 – June 1996**
John H. Stroger Hospital of Cook County
1969 W. Ogden Avenue, Chicago, IL 60612

LICENSURE

State of Indiana (Current and active) **Since 2001**
State of Illinois (Current and active) **Since 1994**

SPECIALTY BOARDS CERTIFICATIONS

Diplomate, American Board of Venous & Lymphatic Medicine **2019**
American Board of Radiology **Recertified 2017- No Expiration**
Interventional Radiology/Diagnostic Radiology **Since 2002**
Diplomate, American Board of Radiology Certification **Since 2000**

ATTACHMENT 11

Background of the Applicant

Sreenivas G. Reddy, MD

LEADERSHIP

Chairman, Illinois State Medical Board	2024
Member, Illinois State Medical Board (Appointed by Governor)	2022-2025
Member, Illinois State Medical Disciplinary Board (Appointed by Governor)	2019-2022
Member, Chicago Medical Society COVID-19 Task Force	2020
Director, Independent physicians and Providers of Illinois	2020-Present
Member, Board of Director Cook County Health Foundation (Appointed by Cook County President)	2020-Present
Board of Director, American vein and lymphatic Society	2024-Present
Alternate delegate, American medical Association	2024-Present
President, American Association of Radiologists of Indian Origin	2019-2021
Board of trustee, Indian American Medical Association	2019-2021
Board of trustee, Chicago medical Society	2019-2021
President, Indian American Medical Association of Illinois	2018

MEMBERSHIPS

American Medical Association (AMA)
 American Venous & Lymphatic Society (AVLS)
 Society of Interventional Radiology (SIR)
 Radiologic Society of North America (RSNA)
 American College of Radiology (ACR)
 Indian American Medical Association of Illinois (IAMA)
 American Association of Radiologists of Indian origin (AARI)
 American Association of Physicians of Indian Origin (AAPI)
 Chicago Medical Society (CMS)
 Illinois State Medical Society (ISMS)

AWARDS

Physician of the Year Award, Indian American Medical Association of Illinois	2023
Presidential Award. American Association of Physicians of Indian Origin	2020
Leadership award, Chicago Medical Society	2019
Outstanding leadership award, Indian American Medical Association	2018
Outstanding Leadership Award. MEATF by Cong. Danny K Davis	2022
Distinguished Physician Award. Northwestern Medicine-Delnor Hospital	2017
Distinguished Community Service Award Presented by Congressman Danny Davis	2019

PUBLICATIONS

Sreenivas R Guddeti, MD; Donald W. Trepashko, MD; Bradley G. Langer, MD. Detection of pseudoaneurysm after heminephrectomy with Tc-99m Labelled Red Blood Cell Study. Clinical Nuclear Medicine. Nov, 1997 Vol.22. Pages: 800-801.

T.S. Ing, MD; *S.R. Guddeti, MD*; M.L. Yang. An acidic, pyruvate based peritoneal dialysis solution lowers the pH of a residual peritoneal dialysate fluid to a less extent than does an

ATTACHMENT 11

Background of the Applicant

Sreenivas G. Reddy, MD

equally acidic, lactate-based counterpart. American Society for Artificial Internal Organs. 1995;41(supple): 101

S. R. Guddeti, MD; P. Dunne, MD; P. Zuehlke, DO; B. Langer, MD. Ultrasound guided direct percutaneous embolization of the pseudoaneurysm in the region of the Pancreatic head in a trauma patient. Poster presentation RSNA annual meeting November, 1999.

S. R. Guddeti, MD; P. Zuehlke, DO; B. Langer, MD. Giant sigmoid diverticulum. Case report and discussion. Poster presentation RSNA annual meeting November 2000.

S. R. Guddeti, MD; A. Alagaratnam, MD; P. Zuehlke, DO; W. Trainor, MD;. Mycobacterium Avium Intracellulare infection and its atypical radiologic manifestations in AIDS patients. Poster presentation RSNA annual meeting November 2001.

ATTACHMENT 12

Purpose of the Project

Midwest Surgical Centers, LLC (the “Applicant”), located at 13610 South Route 59, Plainfield, Illinois, seeks authority from the Illinois Health Facilities and Services Review Board (“HFSRB”) to establish an ambulatory surgical treatment center (“ASTC”) and to provide General Surgery and Podiatry services. The project will serve patients within a 10-mile radius of the proposed facility, consistent with the Board-defined geographic service area. The Applicant anticipates that its patient base will reside primarily in Will and DuPage Counties.

The purpose of this project is to address a significant unmet need for outpatient surgical services, particularly vascular access procedures and related wound care. Patients requiring creation or maintenance of dialysis access (arteriovenous fistulas, grafts, tunneled dialysis catheters, and port revisions) currently must often be referred to hospital operating rooms. These hospital-based pathways can create delays in care, higher costs, and increased exposure to infection, particularly for patients with compromised immune systems.

Additionally, vascular surgeons and interventional specialists practicing in the service area regularly care for patients with diabetes, peripheral arterial disease, and renal failure, many of whom develop chronic wounds or ulcers that require both podiatric and surgical management. Ensuring timely access to wound care and vascular procedures is critical to preventing amputations, hospitalizations, and further morbidity.

Numerous studies have demonstrated that vascular access procedures can be performed safely and effectively in outpatient surgical centers, with reduced infection rates compared to hospital settings, lower complication rates, and higher patient satisfaction. The controlled outpatient environment minimizes exposure to multi-drug resistant organisms common in hospitals, and the streamlined care model allows patients to be treated more promptly. Importantly, dialysis access is a lifeline for patients with end-stage renal disease, and timely placement and maintenance directly impact survival and quality of life.

Further, performing vascular and wound-related procedures in an ASTC setting:

- Improves access by providing same-day or expedited scheduling.
- Reduces costs for patients, payors, and the healthcare system compared to hospital-based care.
- Enhances safety through lower infection risk and reduced length of stay.
- Supports continuity of care by keeping patients under the management of their established providers, rather than requiring referral out to hospital-based teams.

Examples include podiatric conditions involving trauma or deformity correction of the foot and ankle, which cannot be fully addressed under the Applicant’s existing service complement. Similarly, patients requiring general surgical intervention, such as hernia repair or abdominal access in connection with spine surgery (e.g., anterior lumbar interbody fusion), are often referred to hospitals, resulting in interruptions in continuity of care and delays in treatment. By offering General Surgery and Podiatry, the Applicant will be able to manage these cases in an outpatient environment, ensuring timely access, efficient use of surgical recovery space, and continuity of care.

ATTACHMENT 12

Purpose of the Project

From a clinical perspective, one notable innovation in general surgery and podiatric surgery is the development of minimally invasive techniques. These approaches involve smaller incisions, specialized instruments, and often in podiatry they can use endoscopy or arthroscopy to visualize and treat foot and ankle conditions. Minimally invasive surgery has been shown to reduce postoperative pain, decrease the risk of infection, and shorten recovery times (Frykberg et al., 2019). Additionally, these techniques often allow patients to return to their regular activities more quickly, which is particularly beneficial in an outpatient setting. Advancements in anesthesia techniques have made outpatient general surgery and podiatric surgery safer and more comfortable for patients. Regional anesthesia, such as peripheral nerve blocks and epidurals, allows for pain control without the need for general anesthesia. This reduces the risk of complications associated with general anesthesia and accelerates the patient's postoperative recovery (Hill & Stuchin, 2015).

Performing surgical procedures in an outpatient setting is generally more cost-effective than hospital-based surgery. Patients incur fewer expenses for overnight stays, and healthcare systems benefit from reduced overhead costs. A study by H. B. Menz found that outpatient podiatric surgery resulted in significant cost savings compared to inpatient procedures, making it a more financially sustainable option for healthcare organizations.

Outpatient settings are typically associated with lower rates of hospital-acquired infections. Patients undergoing surgery in a hospital may be at higher risk due to exposure to various pathogens, longer hospital stays, and more frequent contact with healthcare providers. The faster recovery time associated with outpatient podiatric surgery is a significant benefit for patients.

Recent studies have confirmed that vascular access procedures performed in ambulatory surgical centers are both safe and effective, with complication rates that compare favorably to hospital settings. In a large analysis of elective peripheral endovascular procedures, Chow et al. (2023) found access site complications occurred in fewer than 1.7% of cases, with significantly better performance in ASC environments compared to physician office settings. This evidence demonstrates that ASCs provide an appropriate and safe environment for these technically complex procedures, particularly for patients with end-stage renal disease who are at high risk of infection and other complications.

Infection control is a critical consideration for dialysis patients, as their vascular access is their lifeline. Multiple studies have shown that outpatient surgical centers are associated with lower surgical site infection (SSI) rates compared to hospital operating rooms. For example, Mitchell et al. (2014) reported deep infection rates of only 0.81% across more than 2,800 ASC procedures, a rate that compares favorably with hospital benchmarks. Similarly, Silber et al. (2023) noted that patients treated in hospital outpatient departments had higher 30-day revisit and complication rates compared to ASC patients undergoing similar procedures. For dialysis patients who face elevated risks from hospital-acquired infections, the ASC environment offers a safer and more controlled setting for timely interventions.

Cost savings are another compelling benefit of performing vascular access and related wound care procedures in ASCs. Fabricant et al. (2016) demonstrated that outpatient procedures in ASCs resulted in 17% to 43% lower direct costs compared to hospital-based surgeries, with savings driven by reduced overhead and shorter procedure times. The American Academy of Orthopaedic Surgeons has likewise reported that common outpatient procedures performed in ASCs generate roughly 35% lower total costs than those in hospital outpatient departments (AAOS, 2024). These findings are highly relevant to vascular access care, which is often repetitive over the course of a patient's dialysis journey; shifting these services into a more cost-efficient environment provides significant savings for patients, payors, and the healthcare system overall.

ATTACHMENT 12

Purpose of the Project

Finally, the ASC setting offers advantages in timeliness and patient experience that directly impact outcomes for this population. Dialysis patients frequently require urgent or semi-urgent access creation or revision, and delays in care can lead to missed dialysis sessions, hospitalization, or life-threatening complications. ASCs are able to schedule procedures more quickly than hospital operating rooms, which are often constrained by inpatient and emergency caseloads. By ensuring prompt access creation and maintenance, ASCs directly support continuity of care, reduce the likelihood of hospitalization, and improve survival for patients dependent on dialysis. Patient satisfaction studies also consistently show higher ratings for ASC-based care, citing convenience, shorter recovery times, and reduced exposure to hospital environments.

The Applicant's overarching goal is to expand access to essential vascular, general surgical, and podiatric care in an outpatient environment designed to provide timely, safe, and cost-effective treatment. To accomplish this, the project will establish clear, measurable objectives. First, the facility will reduce treatment delays by ensuring that vascular access procedures are provided within seven to ten days of referral, a significant improvement over the several-week wait times that are common in hospital settings. The Applicant is also committed to lowering infection risk, maintaining infection rates for outpatient vascular access procedures at or below one percent, consistent with national ASC benchmarks. In addition, the project will improve wound care outcomes, with a goal of reducing hospital admissions related to diabetic foot ulcers and vascular wounds by fifteen percent within the first three years of operation. Finally, the Applicant will focus on patient experience, targeting patient satisfaction scores exceeding ninety percent on measures of timeliness, convenience, and overall care within the first two years.

This project directly aligns with the Health Facilities and Services Review Board's priorities by demonstrating how a specialized ambulatory surgical treatment center can improve care delivery in Will and DuPage Counties. By shifting appropriate vascular, podiatric, and general surgical procedures from hospital operating rooms to a focused outpatient setting, the project will significantly improve access to timely care for vulnerable populations, including patients with kidney disease, diabetes, and other chronic conditions. It will enhance quality and safety outcomes through lower infection risk, while at the same time supporting cost containment for patients, providers, and payors. Most importantly, the project advances the overall health and well-being of the regional population by ensuring that those most in need of consistent, specialized care receive it in a safe, efficient, and patient-centered environment.

References:

- Frykberg, R. G., Armstrong, D. G., Boulton, A. J. M., & Diabetic Foot Surgery: A Comprehensive Team Approach (2019). *New Developments in Office-Based Foot Surgery*. *Diabetes Care*, 42(6), 969-972.
- Trellu, S., Lavigne, M., & Guillo, S. (2016). Imaging of Achilles Tendon Pathology: A Comparison of Preoperative Ultrasonography with Magnetic Resonance Imaging. *Foot & Ankle International*, 37(3), 315-321.
- Hill, N. & Stuchin, S. A. (2015). Local Anesthetics in Foot and Ankle Surgery. *Foot & Ankle Clinics*, 20(2), 155-166.
- Simões, C., Sequeira, S., & Reis, P. (2017). Peripheral Nerve Blocks in Foot and Ankle Surgery. *European Journal of Orthopaedic Surgery & Traumatology*, 27(7), 863-870.
- Menz, H. B., Morris, M. E., Bergin, S. M., & Young, M. J. (2019). Determinants of Cost and Choice of Surgical Technique for Hallux Valgus Surgery in a Publicly Funded Health Service. *The Journal of Bone & Joint Surgery*, 91(3), 634-641.

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- Roush, E. P., & Daoud, A. (2017). Impact of Surgical Site Infections in Podiatric Medicine and Surgery. *Journal of Foot and Ankle Research*, 10(1), 33.
- Chow, S. L., et al. *Outcomes of Elective Peripheral Endovascular Procedures*. *Journal of Vascular Surgery*, 2023. [Link](#)
- Mitchell, J., Harrow, B., & Schaffzin, J. *Surgical Site Infection: A Comparison of Multispecialty and Single-Specialty Ambulatory Surgery Centers*. *Journal of Patient Safety*, 2014; 10(4): 211–216. [PMC Article](#)
- Silber, J. H., et al. *The Safety of Performing Surgery at Ambulatory Surgery Centers*. *Medical Care*, 2023. [PMC Article](#)
- Fabricant, P. D., et al. *Cost Savings From Utilization of an Ambulatory Surgery Center*. *Journal of Pediatric Orthopaedics*, 2016; 36(2): 166–171. [PubMed](#)
- American Academy of Orthopaedic Surgeons (AAOS). *Ambulatory Surgery Centers Are More Cost-Effective than Hospital Outpatient Departments for Common Procedures*. AAOS Now, 2024. [AAOS](#)

ATTACHMENT 12 Purpose of the Project



Medicare Cost Savings Tied to Ambulatory Surgery Centers



Produced with cost
savings analysis from



ATTACHMENT 12

Purpose of the Project

Acknowledgements

Dr. Brent Fulton, Assistant Adjunct Professor and Research Economist, and Dr. Sue Kim, Research Scientist, both from the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California-Berkeley, conducted the cost savings analysis presented in this report.



ATTACHMENT 12

Purpose of the Project

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ATTACHMENT 12

Purpose of the Project

EXECUTIVE SUMMARY

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

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

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

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

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

ATTACHMENT 12

Purpose of the Project

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



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

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

Since consumer prices have inflated more slowly than medical costs, the gap in ASC and HOPD reimbursement

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

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

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

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I. AN INTRODUCTION TO AMBULATORY SURGERY CENTERS

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

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

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

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

What is an ASC?

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

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II. ASCS: SAVING THE SYSTEM

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

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

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



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III. COST SAVINGS ANALYSIS

Data and Methodology

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

Government data was used to ascertain the volume of procedures performed in ASCs, HOPDs and physician offices from 2008 through 2011, as well as the reimbursement rates for procedures done at ASCs and HOPDs. The volume data reports are from the Medicare Physician Supplier Procedure Specific file available from CMS. It excludes Medicare Advantage enrollees. The ASC reimbursement rates are from the ASC Addendum AA¹, and the HOPD reimbursement rates are from Hospital Outpatient Prospective Payment System Addendum.²

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

To ensure a realistic baseline for their analysis and predictions, the analysts limited the data set to the 120 procedures most commonly performed at ASCs in 2011, which represented 73 percent of the total volume of all procedures performed in ASCs in 2011.⁴

Past Savings

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

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

¹ http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html

² <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>

³ <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2011.pdf> (p.51).

⁴ The data set was initially narrowed to 148 procedures, which represented about 90% of the total volume. Twenty-seven procedures were dropped because of missing data on the number of procedures or reimbursement rates. One additional procedure was dropped the ASC share was 100%, and it thus provided no basis for comparison with HOPDs.

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These findings are illustrated in the following chart.

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

Notes:

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

**Savings are reported in nominal dollars.

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

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Future Savings

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

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

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

1. The ASC share of each procedure in 2011 will remain constant between 2013 and 2022. *This is a baseline assumption that assumes ASC share does not grow at all in the coming decade.*
2. The ASC share of each procedure will increase by 2 percent per year from 2013 through 2022, equivalent to the average increase across procedures from 2008 through 2011.⁶ The analysts capped the share for any given procedure at 90 percent to avoid implausible assumptions.

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

- The “low” group included procedures that had negative or no growth in the share of procedures performed at ASCs during 2008–2011. The analysts assumed that the ASC share of these procedures will increase 1 percent annually from 2013–2022. This group included approximately 30 percent of the procedures.
- The “middle” group included procedures that had up to 5 percent growth in share of procedures performed at ASCs during 2008–2011. It was assumed that the ASC share of these procedures will increase 5 percent annually from 2013–2022. This group included approximately 43 percent of the procedures.
- The “high” group included procedures that had greater than 5 percent growth in share of procedures performed at ASCs during 2008–2011. This group had a median ASC share growth rate of about 11 percent annually during 2008–2011. The analysts projected that the ASC share of these procedures will increase 10 percent annually from 2013–2022. This group included approximately 27 percent of the procedures.

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

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

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

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

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

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Conclusions

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

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

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

BY THE NUMBERS:

\$7.5 billion

in savings generated by ASCs from 2008 to 2011

Up to
\$57.6 billion

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

Up to
\$5.76 billion

average future yearly savings

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

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IV. POLICY IMPLICATIONS AND CONSIDERATIONS

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

AVOIDING ASC TO HOPD CONVERSIONS

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

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

When an ASC is acquired by a hospital, in what is known as "an ASC to HOPD conversion," the Medicare reimbursement rate jumps roughly 75 percent and all savings to the Medicare program and its beneficiaries are promptly lost. The

continuing reduction in reimbursement led more than 60 ASCs to terminate their participation in Medicare over the last three years. If policymakers allow this gap in reimbursements to continue widening, the cost-saving advantage that ASCs offer could morph into a perverse market incentive that drives ASCs from the Medicare program.

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

ASCs AS PART OF BROADER COST-SAVINGS EFFORTS

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

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

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APPENDIX: METHODOLOGY
AND CHART OF INDIVIDUAL
PROCEDURE SAVINGS

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

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

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

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

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No.	HCPCS	HCPCS Description	Savings 2011 (\$ million)	Average ASC Share 2008-2011	Baseline Share of Procedures	Projected ASC Share 2022 (% share increase per year)	Projected ASC Share 2022 (% share increase per year)	2011 Volume of Proce- dures (if Per-1,000 Beneficiaries Base- line)	Projected Volume of Proce- dures for 2022 (if Per-1,000 Beneficiaries Base- line)	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increase by 3% per Year			% ASC Annual Share Increase from Baseline for 2011	Reimburse- ment Difference from ASC for 2011
										A1. Baseline Savings for 2022 (ASC share increases constant) (\$ million)	A2. Savings for 2022 (ASC share increases 2% per year) (\$ million)	A3. Savings for 2022 (ASC share increases 3% per year) (\$ million)	B1. Baseline Savings for 2022 (ASC share increases constant) (\$ million)	B2. Savings for 2022 (ASC share increases 2% per year) (\$ million)	B3. Savings for 2022 (ASC share increases 3% per year) (\$ million)		
1	66984	Cataract surgery w/td 1 stage	\$829	-3.56%	56%	69%	62%	54.9	76.0	\$1,500	\$1,870	\$1,670	\$2,370	\$2,950	\$2,650	1%	\$740
2	66982	Cataract surgery complex	\$63	-0.96%	52%	65%	59%	4.4	6.1	\$116	\$144	\$129	\$180	\$224	\$201	1%	\$740
3	64483	Inj foramen epidural l/s	\$60	-3.02%	35%	44%	39%	20.6	28.5	\$106	\$132	\$119	\$173	\$215	\$193	1%	\$229
4	62311	Inj spine l/s (cd)	\$53	-13.67%	26%	33%	29%	24.1	33.4	\$73	\$91	\$82	\$152	\$188	\$169	1%	\$229
5	66821	After cataract laser surgery	\$43	-2.96%	43%	54%	48%	16.2	22.4	\$86	\$107	\$96	\$124	\$154	\$138	1%	\$169
6	29881	Knee arthroscopy/surgery	\$25	-0.25%	39%	48%	43%	2.0	2.7	\$51	\$64	\$57	\$71	\$89	\$79	1%	\$903
7	28285	Repair of hammertoe	\$22	-0.22%	37%	46%	41%	2.4	3.3	\$38	\$47	\$43	\$64	\$79	\$71	1%	\$681
8	43235	Upper GI endoscopy diagnosis	\$21	-0.18%	34%	43%	38%	6.1	8.5	\$38	\$47	\$42	\$59	\$73	\$66	1%	\$268
9	64622	Distal panarterial nerve l/s	\$18	-4.98%	35%	44%	40%	3.6	5.0	\$28	\$34	\$31	\$52	\$64	\$58	1%	\$186
10	52000	Gastrosomy	\$16	-0.03%	8%	10%	9%	24.4	33.8	\$33	\$41	\$37	\$47	\$58	\$52	1%	\$224
11	62310	Inj spine c/t	\$14	-13.54%	30%	37%	33%	5.5	7.6	\$18	\$23	\$20	\$39	\$49	\$44	1%	\$229
12	29848	Wrist endoscopy/surgery	\$11	-0.10%	51%	63%	57%	0.7	0.9	\$20	\$25	\$23	\$32	\$40	\$36	1%	\$903
13	29823	Shoulder arthroscopy/surgery	\$10	-2.73%	28%	35%	31%	0.7	0.9	\$14	\$17	\$16	\$29	\$36	\$32	1%	\$1,460
14	61650	Implant neuroelectrodes	\$9	-20.87%	24%	29%	26%	1.2	1.7	\$10	\$12	\$11	\$26	\$32	\$29	1%	\$846
15	20680	Removal of support implant	\$7	-1.14%	26%	32%	29%	1.1	1.5	\$14	\$17	\$15	\$21	\$27	\$24	1%	\$720
16	28296	Correction of bunion	\$7	-0.91%	41%	50%	45%	0.5	0.7	\$15	\$18	\$17	\$20	\$25	\$23	1%	\$1,002
17	52005	Gastrosomy & ureter catheter	\$7	-0.11%	25%	31%	28%	0.9	1.3	\$12	\$15	\$13	\$19	\$24	\$22	1%	\$794
18	45381	Colonoscopy submucosa inj	\$7	-4.10%	43%	54%	48%	1.5	2.0	\$7	\$9	\$8	\$19	\$23	\$21	1%	\$281
19	36561	Insert tunneled cv cath	\$6	-1.43%	7%	8%	7%	2.6	3.7	\$12	\$15	\$13	\$17	\$21	\$19	1%	\$927
20	29875	Knee arthroscopy/surgery	\$5	-1.21%	46%	57%	51%	0.3	0.4	\$8	\$10	\$9	\$14	\$17	\$15	1%	\$903
21	30520	Repair of nasal septum	\$5	-0.20%	30%	37%	34%	0.6	0.8	\$8	\$9	\$8	\$14	\$17	\$15	1%	\$773
22	52281	Gastrosomy and treatment	\$5	-0.75%	9%	11%	10%	2.7	3.7	\$11	\$13	\$12	\$14	\$17	\$15	1%	\$530
23	58558	Hysteroscopy biopsy	\$4	-2.25%	13%	17%	15%	1.1	1.5	\$7	\$9	\$8	\$10	\$13	\$12	1%	\$696
24	65426	Removal of eye lesion	\$3	-0.03%	59%	73%	66%	0.2	0.2	\$5	\$6	\$6	\$8	\$10	\$9	1%	\$736
25	64626	Distal panarterial nerve c/t	\$3	-7.96%	28%	48%	43%	0.8	1.2	\$4	\$5	\$5	\$8	\$10	\$9	1%	\$229
26	14041	Skin tissue rearrangement	\$3	-2.49%	13%	16%	15%	1.0	1.4	\$5	\$6	\$6	\$7	\$9	\$8	1%	\$519
27	43251	Operative upper GI endoscopy	\$2	-0.85%	35%	44%	39%	0.6	0.9	\$4	\$5	\$4	\$6	\$8	\$7	1%	\$268
28	64627	Distal panarterial in add-on	\$2	-0.43%	39%	48%	43%	1.9	2.6	\$3	\$3	\$3	\$6	\$8	\$7	1%	\$80
29	44361	Small bowel endoscopy/biopsy	\$2	-1.36%	53%	66%	60%	0.3	0.5	\$4	\$5	\$4	\$6	\$7	\$6	1%	\$307
30	62264	Epidural lysis on single day	\$2	-17.63%	29%	36%	32%	0.4	0.5	\$2	\$2	\$2	\$5	\$6	\$5	1%	\$386

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MEDICARE COST SAVINGS TIED TO AMBULATORY SURGERY CENTERS

No.	HCPCS	HCPCS Description	Savings 2011 (\$million)	Average Annual Change, 2008-2011	Baseline 2011 ASC Share of Procedures	Projected ASC share increase (per year)	Projected ASC share increase (values)	2011 Volume of procedures per 1,000 Medicare beneficiaries	Projected Volume of procedures for 2022 per 1,000 Medicare beneficiaries	Volume per 1,000 Medicare Beneficiaries Remains Constant				Volume per 1,000 Medicare Beneficiaries Increases by 2% per Year				% ASC Share Growth Assumption for A3 & B3	Remaining Difference Between ASCs and HOPDs
										A1: Baseline Savings for 2022 (ASC share remains constant)	A2: Savings for 2022 (ASC share increases 2% per year)	A3: Savings for 2022 (ASC share increases 2% per year)	A4: Savings for 2022 (ASC share increases 2% per year)	B1: Baseline Savings for 2022 (ASC share remains constant)	B2: Savings for 2022 (ASC share increases 2% per year)	B3: Savings for 2022 (ASC share increases 2% per year)	B4: Savings for 2022 (ASC share increases 2% per year)		
31	11132	Repair of wound or lesion	52	-4.69%	6%	7%	6%	5.3	7.1	\$2	\$3	\$3	\$3	\$5	\$6	\$5	\$5	1%	\$140
32	62319	Inject spine w/ cath/l/s (cd)	52	-18.47%	30%	38%	34%	0.4	0.5	\$2	\$2	\$2	\$2	\$4	\$6	\$5	\$5	1%	\$386
33	64520	N block lumbar/thoracic	51	-13.74%	23%	29%	26%	0.6	0.8	\$1	\$1	\$2	\$2	\$3	\$4	\$4	\$4	1%	\$229
34	64550	N block other peripheral	51	-1.62%	1%	2%	1%	10.2	14.1	\$1	\$1	\$1	\$1	\$3	\$4	\$3	\$3	1%	\$226
35	11042	Deb subq tissue 20 sq cm/<	51	-14.48%	1%	1%	1%	28.9	40.0	\$1	\$1	\$2	\$2	\$2	\$2	\$3	\$2	1%	\$82
36	20552	Inf trigger point 1/2 muscl	51	-7.74%	1%	2%	1%	8.3	11.5	\$1	\$1	\$1	\$1	\$2	\$2	\$2	\$2	1%	\$163
37	41239	Upper gi endoscopy biopsy	5143	0.58%	45%	55%	76%	32.8	45.5	\$243	\$303	\$416	\$409	\$409	\$509	\$700	\$500	5%	\$268
38	45380	Colonoscopy and biopsy	5107	1.11%	48%	59%	82%	21.8	30.2	\$197	\$245	\$336	\$306	\$306	\$380	\$523	\$300	5%	\$281
39	45385	Lesion removal colonoscopy	582	2.10%	46%	58%	79%	17.2	23.9	\$162	\$202	\$278	\$236	\$236	\$293	\$403	\$236	5%	\$281
40	45378	Diagnostic colonoscopy	566	0.27%	40%	49%	68%	16.2	22.4	\$157	\$195	\$268	\$190	\$190	\$236	\$324	\$236	5%	\$281
41	29826	Shoulder arthroscopy/surgery	538	1.27%	33%	40%	56%	2.2	3.1	\$53	\$66	\$91	\$110	\$110	\$137	\$188	\$91	5%	\$1460
42	60105	Colorectal scrm hi risk ind	530	2.48%	52%	64%	88%	6.3	8.7	\$54	\$68	\$93	\$85	\$85	\$105	\$145	\$85	5%	\$249
43	64721	Carpal tunnel surgery	525	1.01%	40%	50%	68%	3.0	4.2	\$50	\$62	\$85	\$72	\$72	\$90	\$124	\$72	5%	\$577
44	64623	Distal paravertebral in add-on	524	4.03%	36%	44%	61%	8.1	11.2	\$31	\$39	\$53	\$42	\$42	\$68	\$84	\$42	5%	\$249
45	60121	Colon ca scrm not hi risk ind	524	2.22%	45%	56%	77%	5.8	8.0	\$42	\$52	\$72	\$68	\$68	\$84	\$115	\$68	5%	\$249
46	29827	Arthroscopy rotator cuff repp	523	3.71%	32%	39%	54%	1.4	1.9	\$44	\$55	\$75	\$66	\$66	\$82	\$112	\$66	5%	\$1460
47	29880	Knee arthroscopy/surgery	521	1.64%	41%	51%	71%	1.5	2.1	\$44	\$55	\$76	\$59	\$59	\$73	\$100	\$59	5%	\$903
48	45384	Lesion removal colonoscopy	519	0.93%	42%	52%	71%	4.5	6.3	\$40	\$49	\$68	\$56	\$56	\$69	\$95	\$56	5%	\$281
49	67904	Repair eyelid defect	517	3.55%	63%	79%	90%	1.2	1.7	\$32	\$40	\$46	\$48	\$48	\$60	\$69	\$48	5%	\$603
50	64484	Inf foamten epidural add-on	516	3.71%	34%	42%	58%	11.2	15.6	\$23	\$29	\$40	\$46	\$46	\$58	\$79	\$46	5%	\$117
51	26055	Incise finger tendon sheath	516	1.20%	44%	55%	76%	1.9	2.7	\$28	\$35	\$49	\$46	\$46	\$58	\$79	\$46	5%	\$517
52	43248	Upper gi endoscopy/guide wire	514	0.86%	53%	67%	90%	2.6	3.6	\$25	\$31	\$42	\$39	\$39	\$49	\$66	\$39	5%	\$268
53	29824	Shoulder arthroscopy/surgery	511	0.45%	33%	42%	57%	1.0	1.4	\$15	\$19	\$26	\$22	\$22	\$40	\$55	\$22	5%	\$903
54	49905	Prep them init reduc>5yr	511	2.77%	15%	19%	26%	1.9	2.7	\$23	\$28	\$39	\$30	\$30	\$38	\$52	\$30	5%	\$997
55	67917	Repair eyelid defect	510	3.72%	60%	74%	90%	0.8	1.0	\$18	\$23	\$27	\$28	\$28	\$35	\$43	\$28	5%	\$603
56	23412	Repair rotator cuff chronic	510	3.46%	33%	41%	56%	0.6	0.8	\$20	\$25	\$34	\$27	\$27	\$34	\$47	\$27	5%	\$1426
57	14060	Skin tissue rearrangement	59	0.50%	18%	22%	30%	2.6	3.6	\$18	\$22	\$30	\$25	\$25	\$31	\$43	\$25	5%	\$519
58	55700	Biopsy of prostate	58	2.92%	12%	14%	20%	0.3	0.4	\$17	\$21	\$29	\$24	\$24	\$30	\$42	\$24	5%	\$393
59	66180	Implant eye-shunt	58	3.44%	52%	65%	89%	0.3	0.4	\$16	\$20	\$27	\$22	\$22	\$27	\$38	\$22	5%	\$1303
60	43450	Dilate esophagus	58	1.82%	54%	67%	90%	1.9	2.7	\$8	\$11	\$14	\$14	\$14	\$22	\$27	\$14	5%	\$198

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Purpose of the Project

MEDICARE COST SAVINGS TIED TO AMBULATORY SURGERY CENTERS

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No.	HCPCS	HCPCS Description	Savings 2011 (\$million)	Average Annual Change 2008-2011	Baseline 2011 ASC Share of Procedures	Projected ASC Share Increase (per year)	Projected ASC Share for 2022 (change increase values)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant				Volume per 1,000 Medicare Beneficiaries Increases by 2% per year				% ASC Annual Share Growth Assump- tion for 43 8.E3	Reimburse- ment Difference Between ASCs and HOPDs 2011
										A1.	Baseline: Savings for 2022 (ASC share remains constant) (\$million)	A2. Savings for 2022 (ASC share increases 2% per year) (\$million)	A3. Savings for 2022 (ASC share increases 2% per year) (\$million)	B1.	Baseline: Savings for 2022 (ASC share remains constant) (\$million)	B2. Savings for 2022 (ASC share increases 2% per year) (\$million)	B3. Savings for 2022 (ASC share increases 2% per year) (\$million)		
61	25447	Repair wrist joint(s)	57	1.12%	47%	58%	80%	0.4	0.5	514	517	523	529	521	526	536	536	5%	\$1,184
62	43249	Esoph endoscopy dilation	57	1.08%	30%	38%	52%	2.2	3.1	512	515	520	524	519	524	533	533	5%	\$268
63	66170	Glaucoma surgery	56	4.40%	61%	76%	90%	0.4	0.5	513	516	519	523	518	523	527	527	5%	\$736
64	29822	Shoulder arthroscopy/surgery	56	2.28%	36%	45%	61%	0.5	0.7	510	513	517	521	518	523	531	531	5%	\$903
65	14040	Skin tissue rearrangement	56	1.83%	16%	20%	27%	2.1	2.9	513	516	522	526	518	523	531	531	5%	\$519
66	28270	Release of foot contracture	55	3.02%	28%	35%	48%	0.8	1.1	509	512	516	521	515	519	526	526	5%	\$681
67	15260	Skin full graft ear & lips	55	4.70%	18%	22%	31%	1.5	2.0	510	512	517	521	514	518	525	525	5%	\$519
68	45383	Lesion removal colonoscopy	55	1.36%	36%	45%	62%	1.3	1.8	510	513	518	524	514	517	524	524	5%	\$281
69	66711	Gilary endoscopic ablation	55	1.70%	79%	90%	90%	0.3	0.4	507	508	511	516	514	516	521	521	5%	\$539
70	67924	Repair eyelid defect	55	3.72%	61%	76%	90%	0.3	0.5	509	511	513	517	513	517	520	520	5%	\$603
71	52353	Cystouretero w/ lithotripsy	54	4.90%	13%	16%	21%	0.8	1.2	508	510	514	518	515	521	526	526	5%	\$1,126
72	67028	Injection eye drug	54	3.19%	1%	1%	2%	54.4	75.4	506	508	511	514	511	514	519	519	5%	\$169
73	52334	Cystoscopy and treatment	54	1.27%	19%	24%	33%	0.7	0.9	507	509	513	517	511	513	518	518	5%	\$794
74	64718	Revisc ulnar nerve at elbow	54	3.70%	36%	45%	62%	0.5	0.7	506	508	511	514	511	513	518	518	5%	\$577
75	28308	Incision of metatarsal	53	1.92%	38%	48%	65%	0.4	0.5	505	507	509	512	510	512	517	517	5%	\$681
76	26123	Release palm contracture	53	1.37%	47%	58%	80%	0.2	0.3	508	510	513	517	510	512	517	517	5%	\$897
77	26160	Remove tendon sheath lesion	53	0.77%	44%	55%	75%	0.4	0.6	506	508	511	514	511	513	518	518	5%	\$517
78	67950	Revision of eyelid	53	2.29%	64%	80%	90%	0.2	0.3	505	507	509	512	509	512	516	516	5%	\$794
79	52224	Cystoscopy and treatment	53	4.95%	8%	11%	14%	1.3	1.9	507	509	512	516	509	511	515	515	5%	\$500
80	52310	Cystoscopy and treatment	53	0.06%	9%	11%	16%	1.8	2.5	506	508	510	513	509	511	514	514	5%	\$603
81	67961	Revision of eyelid	53	1.27%	55%	69%	90%	0.2	0.3	505	506	509	511	509	511	514	514	5%	\$794
82	52335	Cystoscopy and treatment	53	2.23%	14%	18%	24%	0.7	1.0	506	507	510	513	509	511	515	515	5%	\$794
83	66986	Exchange lens prosthesis	53	0.17%	63%	78%	90%	0.2	0.2	505	506	509	511	509	511	514	514	5%	\$740
84	64479	Inf foam eye epidual ct	53	0.16%	31%	38%	53%	1.1	1.5	505	506	509	511	509	511	514	514	5%	\$229
85	66250	Follow-up surgery of eye	52	1.83%	37%	46%	64%	0.3	0.4	504	505	508	510	508	510	514	514	5%	\$539
86	14061	Skin tissue rearrangement	52	1.01%	16%	19%	27%	0.7	0.9	504	505	508	510	508	510	514	514	5%	\$519
87	17311	Mole 1 stage h/wh/g	51	3.76%	1%	2%	2%	14.8	20.5	502	503	505	508	503	505	510	510	5%	\$162
88	13121	Repair of wound or lesion	51	0.48%	6%	7%	10%	2.8	3.8	501	502	504	506	501	503	508	508	5%	\$95
89	15823	Revision of upper eyelid	541	6.61%	68%	85%	90%	2.4	3.4	504	505	508	511	507	509	514	514	10%	\$671
90	50590	Fragmenting of kidney stone	513	10.88%	18%	23%	52%	1.5	2.1	505	507	510	513	507	509	514	514	10%	\$1,265

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Purpose of the Project

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MEDICARE COST SAVINGS TIED TO AMBULATORY SURGERY CENTERS

No.	HCPCS	HCPCS Description	Savings 2011 (\$million)	Average Annual ASC Share 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (3% increase per year)	2011 Volume of Procedures per 1,000 Medicare Beneficiaries	Projected Volume of Procedures per 1,000 Medicare Beneficiaries*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases by 3% per Year			% ASC Share Growth Assump- tion for A3 8.83	Reimburse- ment Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) (\$million)	A2. Savings for 2022 (ASC share increases 2% per year) (\$million)	A3. Savings for 2022 (ASC share increases 3% per year) (\$million)	B1. Baseline: Savings for 2022 (ASC share remains constant) (\$million)	B2. Savings for 2022 (ASC share increases 2% per year) (\$million)	B3. Savings for 2022 (ASC share increases 3% per year) (\$million)		
91	67042	Vit for macular hole	513	7.78%	42%	53%	90%	0.7	0.9	\$26	\$32	\$55	\$36	\$45	\$77	10%	\$1,234
92	52332	Cystoscopy and treatment	510	5.10%	13%	16%	36%	2.6	3.6	\$15	\$18	\$42	\$27	\$34	\$78	10%	\$794
93	67041	Vit for macular pucker	59	7.36%	40%	50%	90%	0.5	0.6	\$19	\$24	\$42	\$24	\$30	\$54	10%	\$1,234
94	65855	Laser surgery of eye	58	10.98%	22%	28%	63%	4.0	5.6	\$18	\$23	\$52	\$24	\$30	\$68	10%	\$257
95	67900	Repair brow defect	58	7.23%	68%	85%	90%	0.4	0.6	\$14	\$18	\$19	\$24	\$30	\$32	10%	\$801
96	31255	Removal of ethmoid sinus	58	11.19%	39%	49%	90%	0.6	0.8	\$17	\$21	\$38	\$22	\$28	\$51	10%	\$933
97	67036	Removal of inner eye fluid	56	10.53%	38%	47%	90%	0.4	0.5	\$13	\$16	\$31	\$18	\$23	\$43	10%	\$1,234
98	31267	Endoscopy maxillary sinus	56	11.09%	37%	46%	90%	0.5	0.7	\$11	\$14	\$26	\$18	\$22	\$44	10%	\$933
99	30140	Resect inferior turbinate	56	16.88%	39%	48%	90%	0.5	0.7	\$12	\$15	\$28	\$16	\$20	\$37	10%	\$773
100	67108	Repair detached retina	56	11.99%	34%	43%	90%	0.4	0.5	\$11	\$14	\$29	\$16	\$20	\$42	10%	\$1,234
101	47562	Laparoscopic cholecystectomy	55	11.18%	6%	7%	16%	1.8	2.5	\$11	\$14	\$32	\$16	\$19	\$44	10%	\$1,442
102	66761	Revision of iirs	55	5.24%	27%	34%	78%	2.2	3.1	\$11	\$13	\$31	\$15	\$19	\$43	10%	\$237
103	67040	Laser treatment of retina	55	8.70%	33%	41%	90%	0.3	0.4	\$10	\$12	\$27	\$13	\$17	\$36	10%	\$1,234
104	52094	Cystoscopy w/biopsy(s)	55	7.61%	19%	24%	55%	0.8	1.1	\$9	\$11	\$25	\$13	\$16	\$37	10%	\$794
105	20610	Drain/inject joint/bursa	54	18.62%	0.5%	1%	1%	153.1	212.0	\$8	\$10	\$24	\$12	\$14	\$33	10%	\$149
106	31256	Exploration maxillary sinus	54	8.96%	37%	46%	90%	0.3	0.4	\$7	\$9	\$18	\$12	\$14	\$28	10%	\$933
107	31276	Sinus endoscopy surgical	54	22.38%	33%	41%	90%	0.4	0.5	\$10	\$12	\$27	\$11	\$14	\$31	10%	\$933
108	64640	Injection treatment of nerve	54	75.05%	13%	16%	36%	1.8	2.4	\$6	\$8	\$18	\$10	\$13	\$29	10%	\$437
109	67255	Reinforce graft eye wall	53	6.57%	50%	63%	90%	0.3	0.3	\$4	\$6	\$8	\$9	\$12	\$17	10%	\$706
110	69436	Create eardrum opening	53	11.68%	40%	50%	90%	0.3	0.5	\$6	\$8	\$14	\$7	\$9	\$17	10%	\$522
111	45330	Diagnostic sigmoidoscopy	52	15.64%	17%	21%	48%	1.3	1.7	\$5	\$6	\$14	\$7	\$9	\$20	10%	\$324
112	68815	Proctosigmoidal duct	52	9.08%	51%	64%	90%	0.2	0.3	\$4	\$5	\$6	\$7	\$9	\$12	10%	\$603
113	46221	Ligation of hemorrhoids(s)	52	59.92%	11%	14%	33%	1.7	2.4	\$4	\$5	\$11	\$6	\$8	\$18	10%	\$296
114	67840	Remove eyelid lesion	52	15.10%	8%	10%	24%	1.4	2.0	\$4	\$4	\$10	\$5	\$6	\$15	10%	\$422
115	45331	Sigmoidoscopy and biopsy	51	5.08%	34%	43%	90%	0.7	0.9	\$3	\$3	\$7	\$4	\$5	\$11	10%	\$175
116	67210	Treatment of retinal lesion	51	10.61%	7%	9%	21%	2.9	4.0	\$3	\$4	\$9	\$4	\$5	\$11	10%	\$169
117	67228	Treatment of retinal lesion	51	11.58%	7%	9%	20%	2.3	3.2	\$2	\$2	\$6	\$3	\$4	\$8	10%	\$169
118	11642	Exc face-min nail+inag 1.1-2	51	7.98%	3%	4%	10%	3.5	4.9	\$2	\$2	\$4	\$3	\$4	\$8	10%	\$226
119	64480	Inf foam+epidural add-on	51	17.51%	29%	36%	83%	0.8	1.0	\$2	\$2	\$5	\$3	\$3	\$8	10%	\$117
120	51700	Irrigation of bladder	50.5	28.91%	3%	4%	10%	4.0	5.5	\$1	\$1	\$3	\$1	\$2	\$4	10%	\$99
Total or Mean**			\$2,307	3.46%	32%	40%	52%	5.62	7.78	\$4,203	\$5,231	\$6,013	\$6,604	\$8,212	\$9,383	N/A	\$589

NOTES:

*Increases volume per 1,000 Medicare beneficiaries by 3% annually.
 **The reported totals are for savings. The remaining columns are simple means across the 120 procedures, for which the mean is not influenced by (or weighted for) high-volume procedures, such as cataracts. Savings are reported in nominal dollars, N/A: not applicable.

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Purpose of the Project

Medicare Cost
Savings Tied
to Ambulatory
Surgery Centers



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Journal of Surgery

Research Article

Margulis R, et al. J Surg: JSUR-1144.

DOI: 10.29011/2575-9760.001144

Evaluation of the Safety of AV Fistula Creation Surgery in Ambulatory vs, Inpatient Hospital Setting

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Citation: Margulis R, Pedulla D, Bromberg A, Choice C (2018) Evaluation of the Safety of AV Fistula Creation Surgery in Ambulatory vs, Inpatient Hospital Setting. J Surg: JSUR-1144. DOI: 10.29011/2575-9760.001144

Received Date: 13 June, 2018; Accepted Date: 20 June, 2018; Published Date: 28 June, 2018

Introduction

The prevalence of End Stage Renal Disease (ESRD), defined as a reduction of kidney function to an estimated Glomerular Filtration Rate (eGFR) of less than 15 ml/min/1.73m², is rising in the United States, with over 661,000 patients receiving treatment for ESRD in 2013 [1]. While renal transplantation is the preferred treatment for ESRD patients, providing an improved quality of life and a reduction in mortality compared to dialysis, it is not an appropriate option for all patients and is associated with potentially long waiting times [2]. While waiting for an available kidney, patients must often undergo maintenance dialysis, which requires a reliable and stable access to the bloodstream typically in an easily accessible non-dominant upper extremity. This vascular access is most commonly provided through the creation of a primary Arteriovenous Fistula (AVF), which offers higher rates of patency and fewer complications than other vascular access methods such as tunneled catheters and synthetic bridge grafts [3].

Given the multitude of disorders and comorbidities associated with declining renal function such as cardiovascular disease, hypertension, and diabetes mellitus, AVF creation surgery has traditionally been performed in an inpatient hospital setting, [4,5] and patients have generally not been considered good candidates for surgery in a free-standing outpatient facility [6]. Such surgeries were commonly performed under general anesthesia, even with the anesthesia related risks in patients with advanced chronic kidney disease. Increasingly, AVF creation surgery has been carried out in an outpatient setting at ambulatory surgical centers. Several studies have demonstrated that these surgeries can safely be performed in such ambulatory centers with low postoperative complication rates, despite patient comorbidities [7] particularly when paired with a regional anesthetic technique instead of general anesthesia. A recent retrospective analysis has demonstrated that both local anesthesia and brachial plexus blocks are effective modalities in

AVF surgery with markedly low rates of conversion to general anesthesia [8]. In addition to the benefits of improved analgesia and lower rates of complications seen with regional anesthesia [9,10], brachial plexus blocks may also promote successful outcomes through increased arterial and venous dilation [11,12], improved fistula patency [13], and potentially decreased postoperative length of stay. Prior studies have demonstrated that AVF surgery can be safely performed in an outpatient setting with a mean postoperative stay of only 112 minutes [14].

While earlier studies have evaluated the safety of vascular access surgery as an outpatient procedure, there has not been a direct safety comparison to similar surgeries performed in an inpatient setting. This study sought to directly compare the rate of complications and post-surgical mortality in AVF creation surgeries performed in outpatient surgical centers and inpatient hospitals.

Methods

This was a multicenter retrospective study evaluating the safety and efficacy of AVF creation surgeries in an ambulatory setting compared to an inpatient hospital setting. The inclusion criterion was any patient who had undergone an AVF creation surgery in 2015 and 2016 at hospital centers included in the study. The exclusion criterion was any patient with missing medical records.

The Clinical Looking Glass (CLG) program was used to identify all AVF creation surgeries performed at the Hutchinson ambulatory surgical site at Montefiore Medical Center (MMC) and at the Moses or Weiler campuses of MMC, both inpatient hospital sites, in 2015 and 2016. The patients were separated into two groups: an outpatient surgery group, consisting of all patients whose surgeries were performed at the Hutchinson ambulatory center, and an inpatient surgery group, consisting of all patients whose surgeries were performed at the Moses or Weiler campuses.

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Purpose of the Project

Citation: Margulis R, Pedulla D, Bromberg A, Choice C (2018) Evaluation of the Safety of AV Fistula Creation Surgery in Ambulatory vs, Inpatient Hospital Setting. J Surg; JSUR-1144. DOI: 10.29011/2575-9760.001144

The medical records of patients in both groups were queried for relevant demographic data, specifically age and sex, and for the following data points:

- Hospital admission within 24 hours post-surgery
- Hospital admission within 7 days post-surgery
- Emergency department visit within 24 hours post-surgery
- Emergency department visit within 7 days post-surgery
- Mortality at 30 days post-surgery

In the statistical analysis, continuous variables were analyzed using Student's t-test, and categorical variables were analyzed using chi-square analysis. All analyses considered a p value of 0.05 to be statistically significant.

Data with patient-identifying information were collected on a password-protected computer to protect patient confidentiality. The Institutional Review Board of the Montefiore Medical Center approved this study and waived the requirement for informed consent.

Results

During 2015 and 2016, there were 179 outpatient AVF surgeries in the inpatient surgery group and 146 AVF surgeries in the outpatient surgery group. The groups were similar in most categories, including proportion of male and female patients, though the mean age was significantly higher in the inpatient surgery group than in the outpatient surgery group (61.8 vs 58.6 years, $p=0.0239$) (Table 1).

	Outpatient Surgeries	Inpatient Surgeries	P Value
Total Surgeries	146	179	-
Mean Age	58.6	61.8	0.0363*
Proportion Female	0.384	0.374	0.864
Proportion Male	0.616	0.626	

Table 1: Demographic characteristics of arteriovenous fistula surgery groups.

There were no deaths within 30 days in either group. There was no significant difference between groups in the rate of ED visits within 7 days or hospital visits (including admissions and ED visits) within 24 hours (Table 2). There was a significantly lower rate of inpatient admissions and total hospital visits within 7 days post-AVF creation for surgeries performed in the ambulatory center.

	Outpatient Surgeries (%)	Inpatient Surgeries (%)	P Value
All Inpatient Admissions: 7 Days	0.685	4.47	0.0386*
All Emergency Department Visits: 7 days	1.37	3.91	0.165
All Hospital Visits (ED Visit or Admission): 24 Hours	0.685	3.91	0.0619
All Hospital Visits (ED Visit or Admission): 7 Days	2.05	8.38	0.0131*

Table 2: Rates of hospital visits following arteriovenous fistula surgeries.

Discussion

The safety of vascular access surgeries performed in outpatient settings has been demonstrated in previous studies [7,14]. In spite of the numerous comorbidities commonly present in ESRD patients, these surgeries have been shown to result in low rates of postoperative complications. The results of this study align with those earlier findings, building upon them to provide a direct comparison of the safety of outpatient surgeries to those performed in more traditional inpatient settings through evaluation of post-operative hospital visits and mortality. The study found no greater rate, and in the case of hospital admissions and total hospital visits within 7 days, a significantly lower rate, of surgery-related hospital visits following AVF surgeries in ambulatory surgical centers. These results provide further support for performing these surgeries in outpatient settings. Previous data suggest that, in addition to being safe, vascular access surgeries performed in outpatient settings are also effective, particularly when paired with regional anesthesia techniques [15]. Because ESRD patients may have greater risk factors and comorbidities that may complicate the use of general anesthesia, an emphasis on regional anesthesia techniques at outpatient centers may be preferable [6,16]. In addition to avoiding general anesthesia, regional anesthesia use improves pain control, results in lower rates of complications, [9,10] and promotes successful outcomes in vascular access surgeries through vasodilation, vasodilation and improved fistula patency [11-13]. Other benefits of outpatient surgeries to patients include increased convenience and comfort, providing an alternative to the potentially intimidating and confusing hospital setting and allowing patients to recover in their own homes.

As the prevalence of ESRD and the concurrent demand for vascular access surgeries in dialysis patients continues to rise in the United States, potential opportunities for cost reduction become

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Citation: Margulis R, Pedulla D, Bromberg A, Choice C (2018) Evaluation of the Safety of AV Fistula Creation Surgery in Ambulatory vs, Inpatient Hospital Setting. *J Surg: JSUR-1144*. DOI: 10.29011/2575-9760.001144

increasingly significant. These results build on those of previous studies to demonstrate that AVF surgeries can be performed in outpatient settings with no significant impact on efficacy or safety. Surgeries performed in outpatient settings such as ambulatory surgical centers have reduced healthcare costs in the US by more than \$38 billion annually, with more than \$5 billion directly decreasing costs to patients through reduced coinsurance and deductible payments [17]. Movement of more surgical procedures to ambulatory centers could result in a total reduction of costs of \$55 billion annually. The movement of certain procedures, such as vascular access surgeries, to ambulatory centers specialized in performing scheduled outpatient surgeries can lead to increased efficiency and a reduction in hospital burden, freeing up inpatient centers for more invasive or emergent procedures. The current study has some notable limitations. The population of patients whose AVF surgeries were performed at the ambulatory center were significantly younger than those whose surgeries were performed in an inpatient hospital setting (58.6 vs 61.8 years), though the average age difference was less than three years and likely did not play an independent role in the measured differences in post-operative hospital visits. Rates of patient comorbidities were not measured or compared between the two groups, so it is possible that the patients who had outpatient surgeries were, on average, healthier and had fewer comorbidities than those who had inpatient surgeries. Additionally, the study focused on AVF surgeries in a single hospital system within a two-year period, limiting the number of patients in the study. Future studies should seek to include more patients across a greater number of centers and should take into account patient comorbidities that could impact post-operative complication rates. By offering a direct safety comparison between surgeries in inpatient and outpatient settings, this study provides valuable, compelling new information and further demonstrates that AVF surgeries can be safely performed in ambulatory centers without sacrifice to patient outcomes. These findings, in combination with the potential for reduced overall costs and hospital burden and increased convenience and comfort to patients, provide robust support for the movement of AVF surgeries to an outpatient setting.

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Abstracts

e465

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Introduction: The Nutcracker syndrome is an uncommon condition but with high morbidity, leading even to chronic renal failure when not treated. Endovascular treatment is nowadays the most popular approach, but some related complications as stent migration have been described.

Methods: A retrospective registry is performed, collecting patients who underwent an endovascular management of Nutcracker syndrome under IVUS examination in our center.

Results: Between January 2014 and March 2017 six patients (mean age 25,83 years) underwent a left renal vein stenting at our center due to Nutcracker syndrome. They were previously assessed with Doppler ultrasound. Four of them were treated due to gross haematuria, one of them due to varicocele and one due to flank pain. In all of them the renal vein diameter measure and compression diagnosis was performed under IVUS examination.

Technical success was 100%. Mean stent diameter was 14,8 mm. The patient presenting varicocele required gonadal vein catheterization and occlusion with coils. Two patients suffered intense postoperative back pain, showing no complications in CT-angio. There were no further postoperative complications observed. After the procedure, a daily dose of clopidogrel 75 mg for three months and aspirin 100 mg for life was indicated.

All of the patients presented complete symptoms resolution. One and 6 months and 1 year ultrasound follow up show a correct stent placement. There was neither stent thrombosis, nor stent migration observed.

Conclusion: IVUS is an important adjunct in endovascular Nutcracker syndrome treatment, because it provides an accurate diagnosis and an adequate stent sizing, that could improve previous reported outcomes and avoid possible complications. Further studies with more patients are needed.

P-119 Vascular Access Surgery can be Safely Performed in an Ambulatory Setting

Vascular Access

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Introduction: Vascular access surgery can be technically high-demanding, but most procedures can be safely performed in an ambulatory setting, decreasing costs and improving efficiency, but the evidence is weak. The objective of this study is to demonstrate the safety and

effectiveness of performing vascular access surgery in an ambulatory setting.

Methods: An historical prospective review including all vascular access open surgeries (vascular access creations and repairs, excluding catheters or endovascular repairs of previous accesses) performed by our Vascular Access Unit during the last 5 years (January 2013 to December 2017) was performed. Patient comorbidities, surgery details, hospital admission condition, and one-month follow-up patency and complications (significant infection, bleeding, readmission and reintervention) were reviewed. Comparisons between ambulatory condition and complications during follow-up were analyzed.

Results: In the last 5 years, 1414 vascular access surgeries were performed (67.8% access creations and 32.2% previous access repairs; mean age 66.6 years, 64.7% males, 66.4% in the left side) in 1012 patients. Most surgeries were performed under local anesthesia (59.2%) or axillary plexus block (38.4%), and mainly in an ambulatory setting, without hospital night stay (90.9%). 2.5% were emergent and 9.1% urgent surgeries. During first postoperative month follow-up, 22 cases (1.6%) needed readmission or reintervention (only 9 [0.6%] during first week); significant infection occurred in 14 (1.0%), but only 2 needed readmission and vascular access removal) and 13 cases (0.9%) showed important hematoma or bleeding (only 6 [0.4%] needing reintervention). Secondary patency of new vascular access creations was 94.1% at one month. Ambulatory setting was not related to a higher rate of readmissions, reinterventions, bleeding or infection ($P>0.05$ for all comparisons).

Conclusion: Arteriovenous access surgery can be safely performed in an ambulatory setting, in spite of complex cases, comorbidities, or the increasing use of axillary plexus blocks. Surgical results and access patency are good, and complications needing readmission remain very low, not related to the ambulatory condition.

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© Health Research and Educational Trust
DOI: 10.1111/1475-6773.12278
RESEARCH ARTICLE

Ambulatory Surgery Centers and Their Intended Effects on Outpatient Surgery

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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 Morrissey 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

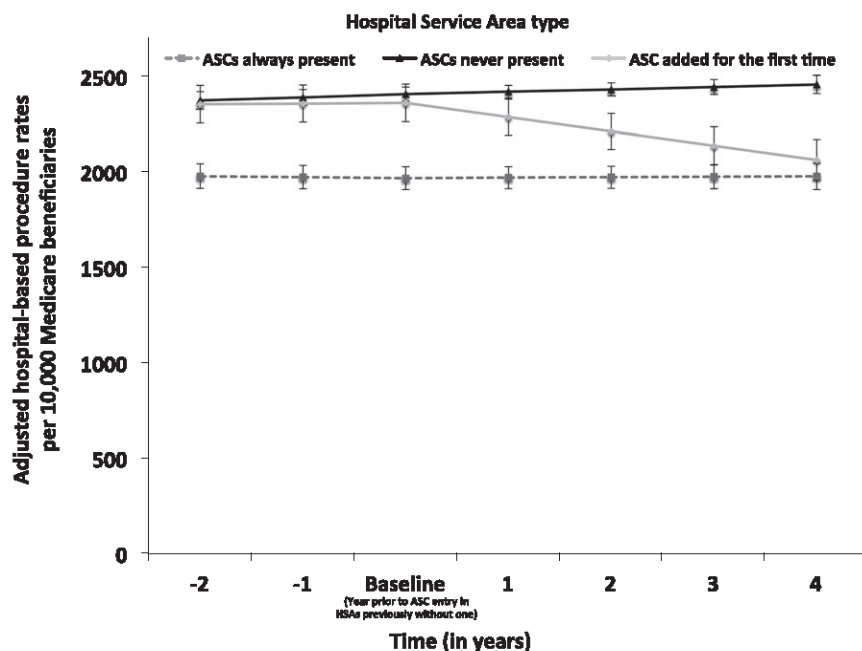
	Hospital Service Area Type			p-value	
	ASC Always Present	ASC Never Present	ASC Added for the First Time	Before Multiple PS Correction	After Multiple PS Correction
No. HSAs	837	2,154	255	—	—
No. patients in 2010	17,793,686	6,295,820	2,308,790	—	—
Age, mean	70.6	70.5	70.5	.55	.97
Gender, % female	55.0	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 Morrissey 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 rational 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; Strobe 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).

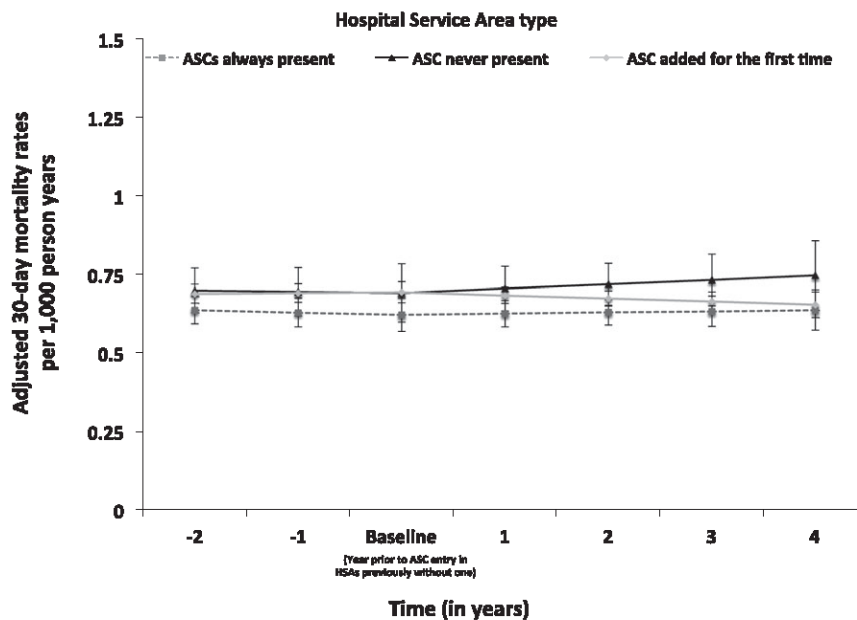
Figure 2: Adjusted Rates of Ophthalmologic (a), Gastrointestinal (b), and Musculoskeletal (c) Hospital-Based Outpatient Surgery in Markets Where ASCs Were Always Present, Never Present, and in Those Where an ASC Opened for the First Time. In the period after baseline, adjusted rates of hospital-based 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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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.

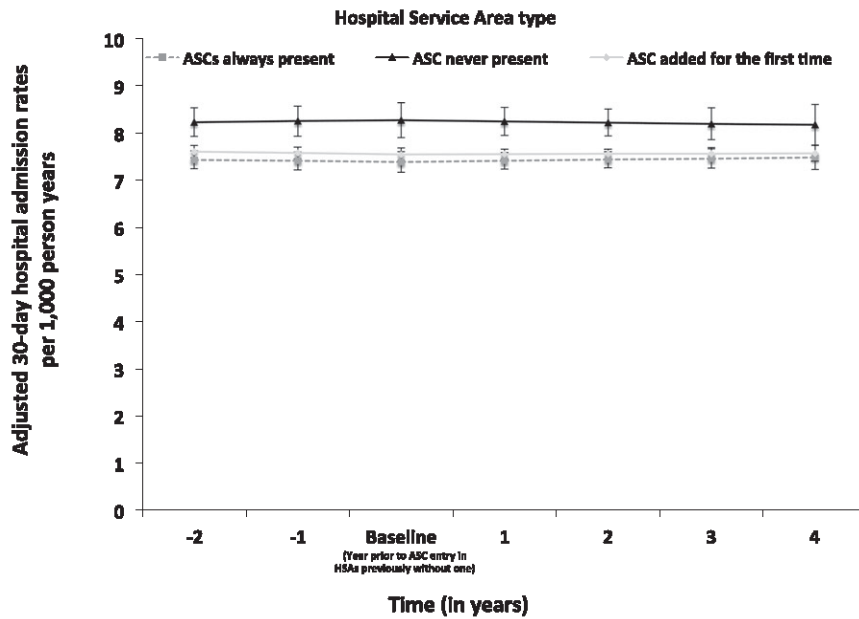
This study is the first of its kind to comprehensively assess the impact of ASCs on their intended effects on broad indicators of ASC quality. As

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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.

ACKNOWLEDGMENTS

Joint Acknowledgment/Disclosure Statement: This work was supported by funding from the Agency for Healthcare Research and Quality (R01 HS18726) to Dr. Hollenbeck. The views expressed herein do not necessarily represent the views of Center for Medicare and Medicaid Services or the United States Government.

Disclosures: None.

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.

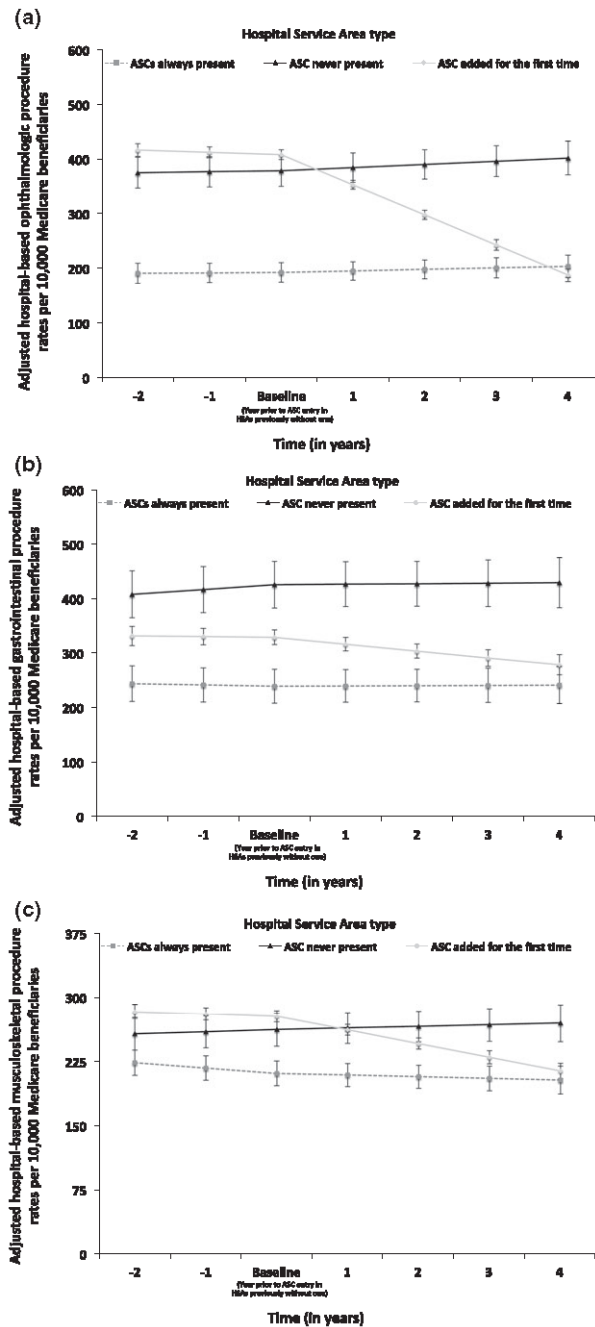
Appendix SA2: Common Procedures Performed in Both the Hospital and ASC That Comprised the Three Specialty Group Analyses.

ATTACHMENT 12

Purpose of the Project

Ambulatory Surgery Centers and Their Intended Effects

1501



ATTACHMENT 13

Alternatives

The Applicant explored several options before submitting this application to the Board requesting these categories of service for Midwest Surgical Centers, LLC.

Among other options, the Applicant considered maintaining the status quo, seeking out other ASTC's or Hospitals, or the Project as Proposed. For the reasons stated below, Applicant opted to seek the Project as Proposed.

Alternative #1: Maintain the Status Quo (No additional Cost)

Maintaining the status quo would involve no additional capital expenditures. However, continuing along the existing path would fail to address the unmet needs of patients who require podiatric and general surgical services. Patients treated at the facility frequently present with conditions that cannot be fully addressed under the current service complement, limiting timely access to care. Maintaining the status quo would perpetuate these access barriers and constrain the facility's ability to provide comprehensive care for musculoskeletal and related conditions. For this reason, the status quo is not a viable long-term solution.

Alternative #2: Utilization of Existing ASTCs and Hospital Surgical Suites (No financial cost to business / Significant cost to patient and payer?)

Another option would be to refer patients to nearby ASTCs or hospital surgical suites for podiatric and general surgical procedures. This alternative is suboptimal for several reasons. First, not all nearby ASTCs offer both categories of service, nor is there any guarantee that these facilities would accept referrals from the Applicant's patients. Second, reliance on hospitals would increase costs for patients and payors and could lead to unnecessary delays due to limited scheduling availability. Third, outsourcing services raises concerns regarding continuity of care, patient experience, and clinical outcomes. Fragmenting care across multiple providers increases the risk of inconsistent results and undermines the integrated, team-based model the Applicant has developed. As such, this option does not adequately address patient or community needs.

Alternative #3: Project as Proposed

The Applicant ultimately determined that the proposed project represents the most effective and responsible path forward. By providing Podiatry and General Surgery services at the facility, patients will benefit from improved access to care, reduced delays, and continuity of treatment within an existing, high-quality outpatient setting. The Applicant has demonstrated a successful track record of operating the facility, and has ramped up utilization consistent with prior projections. Incorporating these new service lines within the existing building will leverage current resources, interdisciplinary teams, and infrastructure, thereby minimizing incremental costs. The proposed project is the only alternative that both addresses unmet community needs and ensures the delivery of cost-effective, high-quality care.

ATTACHMENT 14

Size of the Project

The square footage identified in this application for the proposed project, which includes two operating rooms is necessary, not excessive, and consistent with the standards identified in Appendix B of 77 Illinois Admin. Code Section 1110, as documented below.

SIZE OF PROJECT				
DEPARTMENT / SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC (2 Operating Rooms)	3,098 GSF	2,750 GSF per treatment room	-2,402	YES

ATTACHMENT 15

Project Service Utilization

The annual utilization expected of an ASTC is 1,500 hours per surgical or procedure room. The proposal for this facility is to establish two surgical rooms, making the objective for demonstrating utilization in excess of 1,500 hours. Based upon historical utilization and proposed patient volume, the facility should meet the state standard by its second year of operation.

The number of 1,185 predicated referrals are derived from patients and procedures emanating directly from current patients of the listed in the graph below. If the proposed facility performs the expected 1,185 procedures in the first year of operation that will account for 1,508 hours of surgical time (using an average procedure time of 1.25 hours for vascular access procedures, and 1.88 hours for podiatric procedures). The average procedure time was determined based on an analysis of procedure times to determine the average time spent (including room set-up, procedure time, and clean-up) on a vascular access procedure over the last year. Based on the facility operating 250 days a year for 7.5 hours per day, one of the operating rooms would be operating at the state's target utilization and the second room would be warranted to meet patient demand and ensure access to care.

Physician Name	Number of Procedures in the last 12 months	Number of Proposed Referrals to ASC	Proposed Number of Surgical Hours Year 1	Proposed Number of Surgical Hours Year 2
Zain Rizvi, DPM	6	6	11	12
Steven Overpeck, DPM	6	6	11	12
Sreenivas Reddy, M.D.	349	210	263	270
Dan Hare, DPM	30	30	57	58
Syed Bkhari, M.D.	1030	915	1144	1178
Beck Tiernan, M.D.	18	18	23	23
Total	1439	1185	1508	1553

Category of Service	Average Procedure Time in Hours
General Surgery	1.25
Podiatry	1.88

ATTACHMENT 15

Project Service Utilization

Utilization Calculation	
Operational Days	250
Hours of Operation	7.5
Available Surgical Time per Room	1875
Surgical Hours in Year 1	1508
Surgical Hours in Year 2	1553
Number of Operating Rooms	2
State Target Utilization 80% (in hours)	1500
First Year Utilization Operating Room 1	80%
First Year Utilization Operating Room 2	0.43%
Second Year Utilization Operating Room 1	80%
Second Year Utilization Operating Room 2	3.53%

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 25

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

The primary purpose of this project is to provide necessary health care to residents of the geographic service area ("GSA") in which the ASTC will be located. Listed on the following pages, in accordance with 77 Ill. Admin. Code Section 1110.235(c)(2)(B), is the GSA consisting of all zip codes that are located within a 10-mile radius of the proposed site of the ASTC. We have also included a map of the multi-directional travel radii of the proposed ASTC site.

The proposed project is necessary to meet the needs of residents within the planning area, as described throughout this application. The project involves establishing a new ASTC in Will County with two operating rooms, which will provide sufficient capacity to meet the anticipated demand for outpatient surgical services. While existing hospitals in the area possess surgical capacity, extensive research and guidance from the Centers for Medicare & Medicaid Services confirm that outpatient procedures performed in an ASTC setting are less costly and equally safe when medically appropriate. The development of a new ASTC will therefore increase access to care while lowering costs for patients, payors, and the healthcare system overall.

The primary purpose of this project is to provide necessary health care services to residents of the geographic service area (GSA) in which the ASTC will be located. In accordance with 77 Ill. Admin. Code Section 1110.235(c)(2)(B), the GSA has been defined as all zip code areas located within a 10-mile radius of the proposed site. A full list of these zip codes is provided on the following pages, along with a map illustrating the multi-directional travel radii of the proposed ASTC site.

The project has been designed primarily to meet the needs of residents within the identified GSA. By locating the ASTC in Will County, the Applicant will ensure that area residents including those managing chronic conditions such as kidney disease, diabetes, and vascular complications will have timely and affordable access to surgical and treatment services in a community-based setting.

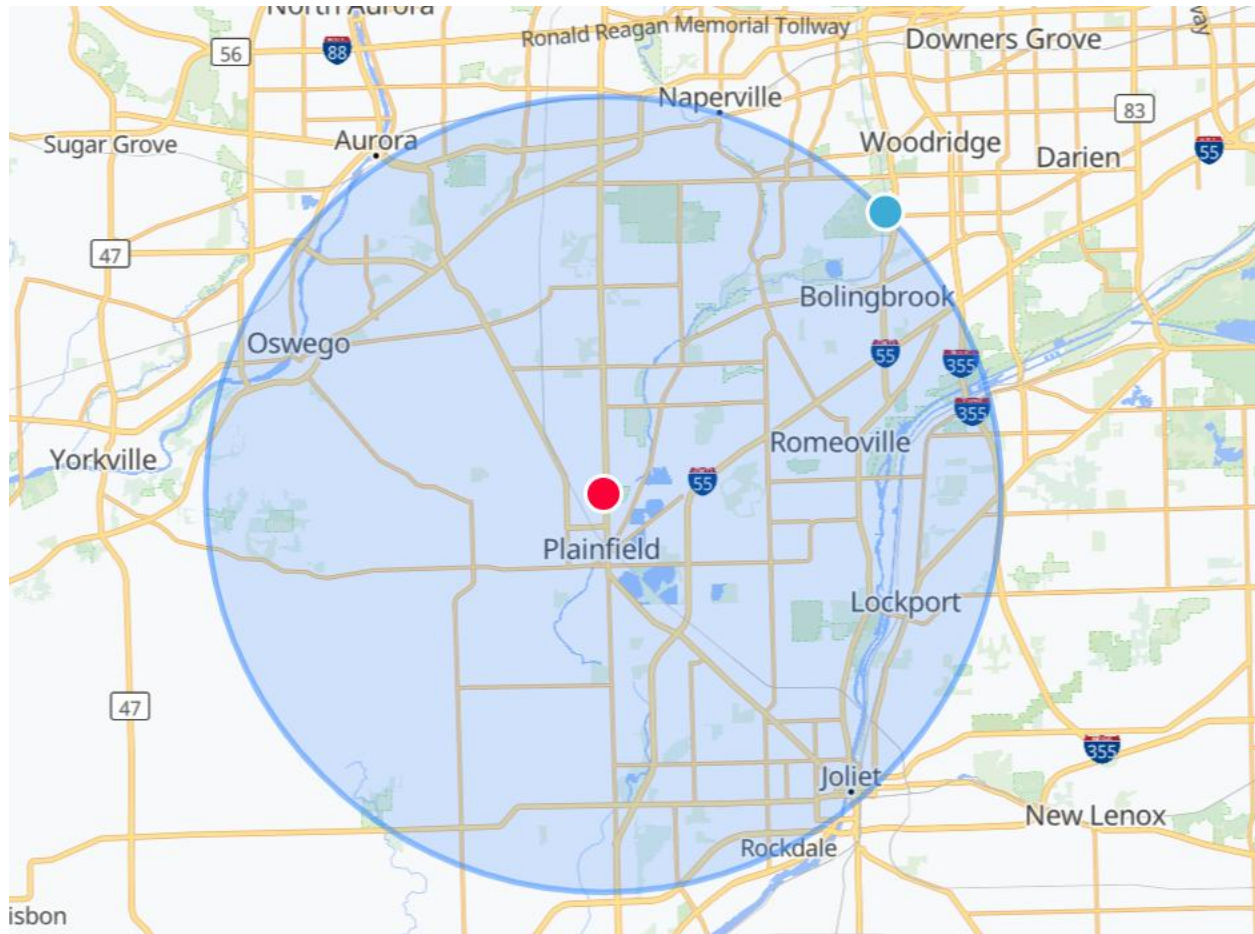
In compliance with 77 Ill. Adm. Code 1100.510(d), the GSA is defined as all zip code areas located within a 10-mile radius of the project site. A detailed list of the applicable zip codes is provided in the accompanying materials.

Patient origin information for the last twelve months is also provided in this application, organized by zip code. This information verifies that more than 50% of the admissions originated from residents of the GSA, consistent with regulatory requirements. Patient origin data is based upon the legal residence of each patient (excluding healthcare facilities) for the six months immediately preceding admission.

ATTACHMENT 25

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

10-Mile Radius from 13610 S. Route 59, Plainfield IL 60544



ATTACHMENT 25
Non-Hospital Based Ambulatory Surgery Service to GSA Residents –
1110.235(c)(2)(B)– Total Population

Zip Code	City	Estimated Population
60544	Plainfield	27,680
60585	Plainfield	24,920
60586	Plainfield	47,212
60431	Joliet	26,853
60490	Bolingbrook	21,907
60403	Crest Hill	17,667
60564	Naperville	45,616
60446	Romeoville	40,465
60543	Oswego	40,229
60435	Joliet	48,927
60503	Aurora	16,855
60404	Shorewood	19,916
60441	Lockport	37,093
60504	Aurora	38,901
60440	Bolingbrook	52,031
60436	Joliet	18,535
60565	Naperville	40,300
60538	Montgomery	28,898
TOTAL		594,005

ATTACHMENT 25
Non-Hospital Based Ambulatory Surgery Service to GSA Residents –
1110.235(c)(2)(B) – Nearby Facilities

Facility Name	Address	Distance to Facility	Categories of Service Offered	Medicaid Utilization %
Plainfield Surgery Center, LLC	24600 W 127 th St Bldg. C Plainfield, IL 60585	2.1 miles	-General Surgery -OB/Gynecology -Orthopedic -Otolaryngology -Plastic Surgery	0%
DMG Pain Management Surgery Center, LLC	2940 Rollingridge Road, Suite 200 Naperville, IL 60564	4.5 miles	-Pain Management	0%
AmSurg Surgery Center	998 129 th Infantry Dr Joliet, IL 60435	8.3 miles	-Gastroenterology -General Surgery -Neurological -OB/Gynecology -Ophthalmology -Oral/Maxillofacial -Orthopedic -Otolaryngology -Pain Management -Plastic Surgery -Podiatry	0%
Castle Surgicenter	2111 Ogden Ave Aurora, IL 60504	8.5 miles	-Orthopedic -Pain Management -Podiatry	0.1%

ATTACHMENT 25

Non-Hospital Based Ambulatory Surgery- Establishment of an ASTC– 1110.235(c)(3)

The Applicant has demonstrated that the proposed ASTC is necessary to accommodate documented service demand, as evidenced by both historical referral patterns and projected future caseloads from physicians practicing within the defined geographic service area.

Over the most recent 12-month period, the Applicant's physicians collectively referred 1,439 procedures to IDPH-licensed ASTCs or hospitals located within the GSA. Each physician has provided a signed and notarized referral letter, which includes the physician's name, specialty, office address, and attests to the number of procedures performed and referrals made during the reporting period. The referral documentation also identifies the patient's origin by zip code, the facility to which the referral was made, and the specialty of the referring physician. This information confirms that the volume of referrals originates primarily from residents within the defined GSA, consistent with regulatory requirements.

Based on these historical referral volumes, the Applicant projects a strong and sustainable caseload for the proposed ASTC within 24 months of project completion. Collectively, the physicians anticipate referring approximately 1,185 procedures to the new facility in Year 1, increasing to 1,553 procedures in Year 2. These projected referrals translate to 1,508 surgical hours in Year 1 and 1,553 surgical hours in Year 2. Importantly, the number of anticipated referrals for each physician does not exceed that physician's experienced caseload over the past 12 months, and projected market share remains consistent with historical utilization patterns.

The physicians supporting this project represent a mix of specialties directly aligned with the ASTC's proposed services, including podiatry (Drs. Rizvi, Overpeck, and Hare), general surgery (Drs. Reddy, Bokhari, and Tiernan). Together, these providers bring a demonstrated base of referrals and future demand that will ensure the facility is both well-utilized and responsive to the healthcare needs of the local population.

Each referral letter includes the physician's notarized signature and a verification that the patient referrals have not been used to support another pending or approved CON application for the same services, as required under 77 Ill. Adm. Code 1110.235(c)(3).

ATTACHMENT 25
**Non-Hospital Based Ambulatory Surgery-
Establishment of an ASTC– 1110.235(c)(3)**

Midwest Surgical Centers, LLC

June 25, 2025

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

Re: Referral Letter – Midwest Surgical Center

Dear Mr. Kniery,

My name is Syed Bokhari, MD and I am a general surgeon with Cardinal Surgical Associates. This letter contains the referral documentation required per 77Ill. Admin. Code Section 1110.235(c)(4)(B). During the 12-month period prior to submission of this letter, our practice referred a total of 1030 surgical cases to the following facilities:

Hospital or ASTC Name	Number of procedures completed in the last 12 Months	Number of procedures to be sent to the proposed facility
Silver Cross Hospital	530	415
VVC Plainfield	500	500
Total	1030	915

Based on my historical referrals, our existing waiting list, and plans to hire additional personnel, our practice anticipates referring 915 surgical cases by the second year of operation following completion of our project. Enclosed with this letter is a list of patient origins by zip code of residence. I certify that the patients we propose to refer reside within the proposed geographic service area.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and accurate to the best of my knowledge.

27451504 v4

ATTACHMENT 25
**Non-Hospital Based Ambulatory Surgery-
Establishment of an ASTC- 1110.235(c)(3)**

Midwest Surgical Centers, LLC

Sincerely,

Syed Bokhari, MD

Physician's Signature _____

Syed Bokhari

Date _____

9/15/23

(Please Print/Type Name) _____

Julie M Glade

Signature of Notary:

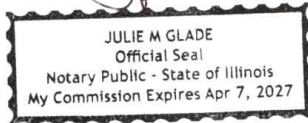
Subscribed and sworn to before me

this _____

1st

day of _____

September 2023



Seal

ATTACHMENT 25
**Non-Hospital Based Ambulatory Surgery-
Establishment of an ASTC– 1110.235(c)(3)**

Midwest Surgical Centers, LLC

June 25, 2025

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

Re: Referral Letter – Midwest Surgical Center

Dear Mr. Kniery,

My name is Sreenivas Reddy, MD and I am an interventional radiologist with Vein and Vascular Centers. This letter contains the referral documentation required per 77Ill. Admin. Code Section 1110.235(c)(4)(B). During the 12-month period prior to submission of this letter, our practice referred a total of 349 surgical cases to the following facilities:

Hospital or ASTC Name	Number of procedures completed in the last 12 Months	Number of procedures to be sent to the proposed facility
VVC Plainfield	165	165
VVC Hinsdale	115	30
VVC Downers Grove	69	15
Total	349	210

Based on my historical referrals, our existing waiting list, and plans to hire additional personnel, our practice anticipates referring 420 surgical cases by the second year of operation following completion of our project. Enclosed with this letter is a list of patient origins by zip code of residence. I certify that the patients we propose to refer reside within the proposed geographic service area.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and accurate to the best of my knowledge.

27451504 v4

ATTACHMENT 25
**Non-Hospital Based Ambulatory Surgery-
Establishment of an ASTC- 1110.235(c)(3)**

Midwest Surgical Centers, LLC

Sincerely,

Sreenivas Reddy, MD

Physician's Signature



Date

9/9/25

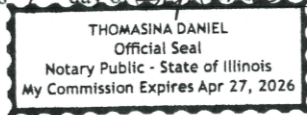
(Please Print/Type Name)

Thomasina Daniel / Thomasina Daniel

Signature of Notary:

Subscribed and sworn to before me

this 9th day of September



Seal

ATTACHMENT 25

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

The annual utilization expected of an ASTC is 1,500 hours per surgical or procedure room. The proposal for this facility is to establish two surgical rooms, making the objective for demonstrating utilization in excess of 1,500 hours. Based upon historical utilization and proposed patient volume, the facility should meet the state standard by its second year of operation.

The number of 1,185 predicated referrals are derived from patients and procedures emanating directly from current patients of the listed in the graph below. If the proposed facility performs the expected 1,185 procedures in the first year of operation that will account for 1,508 hours of surgical time (using an average procedure time of 1.25 hours for vascular access procedures, and 1.88 hours for podiatric procedures). The average procedure time was determined based on an analysis of procedure times to determine the average time spent (including room set-up, procedure time, and clean-up) on a vascular access procedure over the last year. Based on the facility operating 250 days a year for 7.5 hours per day, one of the operating rooms would be operating at the state's target utilization and the second room would be warranted to meet patient demand and ensure access to care.

Physician Name	Number of Procedures in the last 12 months	Number of Proposed Referrals to ASC	Proposed Number of Surgical Hours Year 1	Proposed Number of Surgical Hours Year 2
Zain Rizvi, DPM	6	6	11	12
Steven Overpeck, DPM	6	6	11	12
Sreenivas Reddy, M.D.	349	210	263	270
Dan Hare, DPM	30	30	57	58
Syed Bokhari, M.D.	1030	915	1144	1178
Beck Tiernan, M.D.	18	18	23	23
Total	1439	1185	1508	1553

Category of Service	Average Procedure Time in Hours
General Surgery	1.25
Podiatry	1.88

ATTACHMENT 25
**Non-Hospital Based Ambulatory Surgery-
Treatment Room Assessment– 1110.235(c)(4)**

Utilization Calculation	
Operational Days	250
Hours of Operation	7.5
Available Surgical Time per Room	1875
Surgical Hours in Year 1	1508
Surgical Hours in Year 2	1553
Number of Operating Rooms	2
State Target Utilization 80% (in hours)	1500
First Year Utilization Operating Room 1	80%
First Year Utilization Operating Room 2	0.43%
Second Year Utilization Operating Room 1	80%
Second Year Utilization Operating Room 2	3.53%

ATTACHMENT 25

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

The proposed ASTC will significantly improve access to outpatient surgical services for residents within the identified geographic service area (GSA), which encompasses a population of approximately 594,005 residents across 18 zip codes. In evaluating existing facilities, the Applicant has determined that the project meets the accessibility criteria outlined in 77 Ill. Adm. Code 1110.235(c)(4).

There are four IDPH-licensed ASTCs within the 10-mile GSA of the proposed site:

- Plainfield Surgery Center, LLC (2.1 miles away) – Procedures Offered: General Surgery, OB/Gynecology, Orthopedic, Otolaryngology, Plastic Surgery
- DMG Pain Management Surgery Center, LLC (4.5 miles away) – Procedures Offered: Pain Management only
- AmSurg Surgery Center (8.3 miles away) – Procedures Offered: Gastroenterology, General Surgery, Neurological, OB/Gynecology, Ophthalmology, Oral/Maxillofacial, Orthopedic, Otolaryngology, Pain Management, Plastic Surgery, Podiatry
- Castle Surgicenter (8.5 miles away) – Procedures Offered: Orthopedic, Pain Management, Podiatry

Despite the size of the service area and the concentration of Medicaid-eligible populations, none of the existing facilities demonstrate meaningful Medicaid participation. Three of the four ASTCs report 0% Medicaid utilization, while Castle Surgicenter reports only 0.1% Medicaid utilization. This reflects an effective absence of Medicaid access at existing ASTCs within the GSA.

The Applicant's proposed ASTC will provide vascular access procedures, wound care, podiatry, and related surgical services that are either unavailable or significantly underrepresented in the GSA. These services are essential for populations with high rates of chronic disease such as diabetes, peripheral vascular disease, and kidney failure requiring dialysis. Existing ASTCs focus primarily on orthopedic, pain management, and gastrointestinal specialties, leaving a clear gap in vascular and wound care services. Moreover, because Medicaid patients are not being served at the existing centers, large segments of the GSA population currently lack access to these critical services in an ASC setting.

Given the absence of Medicaid participation at existing facilities and the lack of accessible vascular access and wound care services in the GSA, the proposed ASTC is necessary to improve access and ensure that underserved residents, particularly Medicaid beneficiaries, can obtain timely and cost-effective care. The project will directly address unmet needs for the area's nearly 600,000 residents by expanding both the scope of services available and the inclusivity of patients served.

ATTACHMENT 25
**Non-Hospital Based Ambulatory Surgery Service Demand-
Unnecessary Duplication/ Maldistribution, Impact on Area Providers–
1110.235(c)(6)**

The proposed project will not result in unnecessary duplication of existing services within the geographic service area (GSA). The GSA, defined as all zip codes within a 10-mile radius of the proposed ASTC site, has an estimated population of 594,005 residents, based on the most recent census population data for the State of Illinois.

Within this GSA, there are currently four IDPH-licensed ASTCs: Plainfield Surgery Center, DMG Pain Management Surgery Center, AmSurg Surgery Center, and Castle Surgicenter. While these facilities provide a range of outpatient surgical services, none of them provide the combination of vascular access procedures, wound care, and podiatry services that will be offered by the proposed ASTC. In addition, three of the four facilities report 0% Medicaid utilization, and the fourth reports only 0.1%, effectively excluding Medicaid beneficiaries from outpatient surgical care in the area. Accordingly, the proposed project will complement rather than duplicate existing services by filling an identified service gap and expanding access for underserved patient populations.

The project will also not contribute to maldistribution. The following factors demonstrate compliance through the ratio of existing and proposed surgical/treatment rooms within the GSA compared to population does not exceed one and one-half times the statewide average. With nearly 600,000 residents, the demand base for two additional operating rooms is well within reasonable limits and does not reflect oversupply.

Additionally, based on the most recent 12-month utilization data, existing ASTCs are not operating at or above the 77 Ill. Adm. Code 1100 utilization standard for the specific services proposed by this project (vascular access and wound care). Instead, their service lines focus on orthopedic, pain management, and gastrointestinal procedures. Thus, the project will not be adding capacity to underutilized service lines; it will be introducing services that are currently unavailable or inaccessible to Medicaid patients in the GSA.

The GSA's large population base, coupled with high rates of chronic disease (diabetes, peripheral arterial disease, and end-stage renal disease), demonstrates more than sufficient demand to support the projected surgical hours for the proposed ASTC. Patient origin data and referral letters included in this application show a robust volume of projected cases, ensuring that utilization standards will be met and sustained.

The project will not lower utilization rates of other area providers below the standards set forth in 77 Ill. Adm. Code 1100. Because the proposed ASTC will focus on vascular access procedures, wound care, and podiatry with intentional inclusion of Medicaid patients, the project will draw from a patient population that is currently underserved rather than diverting patients from existing ASTCs. It is not expected that within 24 months of project completion, utilization of other ASTCs in the GSA will be reduced below IDPH standards, as these centers primarily serve populations in other specialties.

For these reasons, the project will not result in unnecessary duplication or maldistribution of services. Instead, it will correct the existing maldistribution by expanding Medicaid participation, introducing essential vascular access and wound care services not currently available in the GSA, and aligning surgical capacity with the needs of nearly 600,000 residents.

ATTACHMENT 25

Non-Hospital Based Ambulatory Surgery Staffing – 1110.235(C)(8)

The Facility will appoint Dr. Sreenivas Reddy as Medical Director. The applicant has not traditionally had any difficulties in staffing their existing offices nor do they anticipate difficulties in staffing the proposed ASTC. As needed, additional staff will be identified and employed utilizing existing job search sites and professional placement services. Upon establishing operations, it is anticipated that the following staff make up will be in effect:

- **Interventional Radiologist (1):** Primary physician performing the procedures.
- **CRNA (Certified Registered Nurse Anesthetist) (2):** Administers anesthesia and monitors the patient's status during procedures.
- **Radiology Tech (RT) (1):** Operates imaging equipment and assists in guiding procedures like angiography or catheterization.
- **RN (Registered Nurse) (2):** Assists with patient care, prepping, and intra-operative assistance.

- **Surgical Tech (2):** Prepares the surgical environment, assists with sterile instruments, and supports the physician during the procedure.
- **Vascular Surgeon (1):** Primary physician performing the vascular surgery.
- **Podiatrist (1):** Depending on the complexity, this might be for minor procedures like bunion removal or more complex lower-limb podiatry interventions.

- **Front Desk Staff (1-2):** For patient intake, scheduling, and handling patient inquiries.
- **Patient Care Coordinators (1):** To manage patient flow, provide pre-operative education, and ensure post-operative care instructions are followed.
- **Medical Assistants (MAs) (2):** To assist in prepping patients, updating records, and general patient care.
- **Billing & Insurance Specialist (1):** To handle coding and insurance claims for the various specialties.
- **Sterile Processing Technicians (1-2):** To sterilize instruments and ensure readiness for the next surgery.
- **Recovery Room Nurses (1):** Depending on the volume of cases, 1 RNs to monitor patients in post-anesthesia care units (PACU). They ensure patients are recovering well and ready for discharge.

- **Administrator/Manager (1):** To manage the day-to-day operations, compliance, staffing, and other administrative duties.
- **Surgical Center Director (1):** The director might oversee both clinical and operational aspects to ensure everything runs smoothly.
- **Cleaning Staff (1-2):** To ensure cleanliness and infection control between surgeries.

ATTACHMENT 25
Non-Hospital Based Ambulatory Surgery
Charge Commitment – 1110.235(C)(9)

Midwest Surgical Centers, LLC

September 3, 2025

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

Re: Midwest Surgical Centers, LLC – Charge Commitment

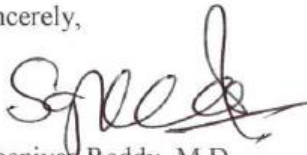
Dear Mr. Knierly:

As a representative of Midwest Surgical Centers, LLC, I, Sreenivas Reddy, 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 system 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 77 Ill. Admin. Code Section 1130.310(a).

Sincerely,



Sreenivas Reddy, M.D.
Manager
Midwest Surgical Centers, LLC

ATTACHMENT 25

Non-Hospital Based Ambulatory Surgery

Charge Commitment – 1110.235(C)(9)

CPT Code	Description	Charges
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	\$349.15
10160	Puncture drainage of lesion	\$354.75
10180	I and D complex po wound infection	\$845.34
20610	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION, MAJOR JOINT OR BURSA; WITHOUT ULTRASOUND GUIDANCE	\$198.00
20611	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION, MAJOR JOINT OR BURSA; WITH ULTRASOUND GUIDANCE	\$273.00
36005	Injection ext venography	\$830.49
36011	Place catheter in vein (Venogram)	\$2,324.63
36012	Place catheter in ovarian vein	\$2,853.66
36100	Establish access to artery	\$1,432.50
36140	Intro needle icath upr/lxtr artery	\$1,310.03
36160	Establish access to aorta	\$1,487.50
36200	Place catheter in aorta	\$1,620.00
36215	Place catheter in artery 1st Order	\$2,935.00
36216	Place catheter in artery 2nd order	\$3,125.00
36217	Place catheter in artery 3rd order	\$5,167.50
36218	Catheterization of each additional second, third, or higher order thoracic or brachiocephalic branch within the same vascular family	\$627.50
36245	Ins cath abd/l-ext art 1st	\$3,655.00
36246	Ins cath abd/l-ext art 2nd	\$2,360.00
36247	Ins cath abd/l-ext art 3rd order selective	\$4,140.00
36247	Ins cath abd/l-ext art 3rd order selective	\$4,140.00
36248	Ins cath abd/l-ext art addl	\$375.00
36465	INJECTION OF NON-COMPOUNDED SCLEROSANT WITH ULTRASOUND COMPRESSION MANUEVERS TO GUIDE DISPERSION OF INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; SINGLE INCOMPETENT EXTREMITY TRUNCAL VEIN (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHENOUS VEIN)	\$5,148.00
36466	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; MULTIPLE INCOMPETENT TRUNCAL VEINS (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHENOUS VEI	\$5,379.00
36468	SINGLE OR MULTIPLE INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS (TELANGEICTASIA) LIMB OR TRUNK	
36470	INJECTION OF SCLEROSANT; SINGLE INCOMPETENT VEIN (OTHER THAN TELANGEICTASIA)	\$345.00
36471	INJECTION OF SCLEROSANT; MULTIPLE INCOMPETENT VEINS (OTHER THAN TELANGEICTASIA), SAME LEG	\$621.00
36473	Clarivein	\$4,734.84
36474	Clarivein ADDITIONAL VEIN	\$907.59
36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; FIRST VEIN TREATED	\$4,929.00
36476	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY,	\$969.00

ATTACHMENT 25

Non-Hospital Based Ambulatory Surgery

Charge Commitment – 1110.235(C)(9)

CPT Code	Description	Charges
	INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION	
36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; FIRST VEIN TREATED	\$3,936.00
36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE	\$1,020.00
36482	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, BY TRANSCATHETER DELIVERY OF A CHEMICAL ADHESIVE (EG, CYANOACRYLATE) REMOTE FROM THE ACCESS SITE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS; FIRST VEIN TREATED	\$6,852.00
36483	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, BY TRANSCATHETER DELIVERY OF A CHEMICAL ADHESIVE (EG, CYANOACRYLATE) REMOTE FROM THE ACCESS SITE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS; SUBSEQUENT VEIN(S) TREATED IN A S	\$474.00
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	\$586.29
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	\$669.06
36558	Insert tunneled cv cath	\$2,515.00
36573	Insj picc rs&i 5 yr+	\$1,158.84
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	\$2,393.19
36584	Compl rplcmt picc rs&i	\$986.37
36589	Removal tunneled cv cath	\$521.79
36590	Removal tunneled cv cath	\$688.05
36595	Mech remov tunneled cv cath for Fibrin Sheath	\$1,836.00
36901	Diagnostic evaluation/ fistulogram	\$2,187.00
36902	Fistulagram with PTA - Angioplasty	\$3,735.00
36903	Fistulagram Stent with PTA - Angioplasty	\$13,056.81
36904	Declot	\$5,589.00
36905	Declot w Angioplasty Thrombolysis Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	\$7,022.00
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic	\$16,618.77
36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	\$1,824.24
36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition	\$4,364.97

ATTACHMENT 25

Non-Hospital Based Ambulatory Surgery Charge Commitment – 1110.235(C)(9)

CPT Code	Description	Charges
	to code for primary procedure)	
36909	embolization procedures performed on branch vessel(s) off the hemodialysis circuit.	\$5,733.93
37184	Prim art m-thrm bcl 1st vsl	\$5,559.00
37186	Sec art thrombectomy add-on	\$3,852.00
37191	Ins endovas vena cava IVC Filter Placement	\$5,840.65
37193	Rem endovas vena cava filter	\$4,253.80
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	\$7,868.00
37221	Iliac revasc w/stent Artery revascularization with transluminal stent placement(s), includes angioplasty within same vessel, when performed	\$10,648.53
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty List separately in addition to code for primary procedure	\$2,044.97
37223	Iliac revasc w/stent add-on	\$4,143.00
37224	Fem/popl revas w/tla	\$10,134.69
37225	FEM POP REVAS W ATHERECTOMY LEFT LEG	\$30,660.00
37225	FEM POP REVAS W ATHERECTOMY RIGHT LEG	\$30,660.00
37226	Fem/popl revasc w/stent LEFT	\$27,229.15
37226	Fem/popl revasc w/stent RIGHT	\$27,229.15
37227	Fem/popl revasc stnt & ather	\$36,387.00
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	\$12,002.00
37229	Tib/per revasc w/ather LEFT	\$30,783.87
37229	Tib/per revasc w/ather RIGHT	
37232	Tib/per revasc add-on	\$2,813.49
37233	Tibper revasc w/ather add-on	\$3,532.68
37238	Percutaneous place stent same	\$11,185.26
37239	perq place stent ea add	\$5,555.28
37241	Vasc embolize/occlude venous	\$16,111.00
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	\$26,083.40
37246	Radial Trluml balo angiop 1st art	\$5,567.13
37248	Trluml balo angiop 1st vein	\$1,557.60
37252	IVUS 1st vessel Intrvasc USG noncoronary	\$3,477.17
37253	IVUS 2nd vessel Intrvasc USG noncoronary	\$519.65
37700	LIGATION AND DIVISION OF LONG SAPHENOUS VEIN AT SAPHENOFEMORAL	\$843.00

ATTACHMENT 25 **Non-Hospital Based Ambulatory Surgery** **Charge Commitment – 1110.235(C)(9)**

CPT Code	Description	Charges
	JUNCTION, OR DISTAL INTERRUPTIONS	
37718	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN	\$1,482.00
37722	LIGATION, DIVISION, AND STRIPPING, LONG (GREATER) SAPHENOUS VEINS FROM SAPHENOFEMORAL JUNCTION TO KNEE OR BELOW	\$1,629.00
37735	LIGATION AND DIVISION AND COMPLETE STRIPPING OF LONG OR SHORT SAPHENOUS VEINS WITH RADICAL EXCISION OF ULCER AND SKIN GRAFT AND/OR INTERRUPTION OF COMMUNICATING VEINS OF LOWER LEG, WITH EXCISION OF DEEP FASCIA	\$2,001.00
37760	LIGATION OF PERFORATOR VEINS, SUBFASCIAL, RADICAL (LINTON TYPE), INCLUDING SKIN GRAFT, WHEN PERFORMED, OPEN, 1 LEG	\$2,124.00
37761	LIGATION OF PERFORATOR VEIN(S), SUBFASCIAL, OPEN, INCLUDING ULTRASOUND GUIDANCE, WHEN PERFORMED, 1 LEG	\$1,863.00
37765	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; 10-20 STAB INCISIONS	\$2,160.00
37766	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; MORE THAN 20 INCISIONS	\$2,580.00
37780	LIGATION AND DIVISION OF SHORT SAPHENOUS VEIN AT SAPHENOPOPLITEAL JUNCTION (SEPARATE PROCEDURE)	\$804.00
37785	LIGATION, DIVISION, AND/OR EXCISION OF VARICOSE VEIN CLUSTER(S), 1 LEG	\$1,179.00
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)	\$338.25
75605	Contrast exam thoracic aorta	\$350.00
75625	Contrast exam abdominal aorta	\$375.00
75630	Aorta leg Run Off arteries	\$457.50
75710	Artery x-rays arm/leg	\$442.50
75716	Artery x-rays arms/legs	\$472.50
75726	Artery x-rays abdomen	\$492.50
75736	Artery x-rays pelvis	\$405.00
75756	Artery x-rays chest	\$442.50
75774	Artery x-ray each vessel	\$290.00
75820	Vein x-ray arm/leg	\$301.95
75822	Vein x-ray arms/legs	\$425.91
75825	Vein x-ray trunk	\$311.85
75827	Vein x-ray chest	\$375.00
75901	Remove Fibrin Sheath cva device obstruct	\$780.36
76356	ULTRASOUND, SOFT TISSUES OF HEAD AND NECK (EG, THYROID, PARATHYROID, PAROTID), REAL TIME WITH IMAGE DOCUMENTATION	\$369.00
76356	ULTRASOUND, SOFT TISSUES OF HEAD AND NECK (EG, THYROID, PARATHYROID, PAROTID), REAL TIME WITH IMAGE DOCUMENTATION	\$ 90.00
76536	ULTRASOUND, SOFT TISSUES OF HEAD AND NECK (EG, THYROID, PARATHYROID, PAROTID), REAL TIME WITH IMAGE DOCUMENTATION	\$288.00
76700	ULTRASOUND, ABDOMINAL, REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	\$267.00
76700	ULTRASOUND, ABDOMINAL, REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	\$129.00
76700	ULTRASOUND, ABDOMINAL, REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	\$594.00

ATTACHMENT 25

Non-Hospital Based Ambulatory Surgery

Charge Commitment – 1110.235(C)(9)

CPT Code	Description	Charges
76705	LIMITED (EG, SINGLE ORGAN, QUADRANT, F/U) ECHO EXAM OF ABDOMEN	\$446.00
76705	LIMITED (EG, SINGLE ORGAN, QUADRANT, F/U) ECHO EXAM OF ABDOMEN	\$302.00
76705	LIMITED (EG, SINGLE ORGAN, QUADRANT, F/U) ECHO EXAM OF ABDOMEN	\$140.00
76706	Us abd1 aorta screen AAA	\$297.55
76770	ULTRASOUND, RETROPERITONEAL (EG, RENAL, AORTA, NODES), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	\$549.00
76770	ULTRASOUND, RETROPERITONEAL (EG, RENAL, AORTA, NODES), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	\$324.00
76770	ULTRASOUND, RETROPERITONEAL (EG, RENAL, AORTA, NODES), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	\$180.00
76775	DIGANOSTIC ULTRASOUND PROCEDURES OF THE ABDOMEN AND RETROPERITONEUM US EXAM ABDO BACK WALL LIMITED	\$279.00
76775	DIGANOSTIC ULTRASOUND PROCEDURES OF THE ABDOMEN AND RETROPERITONEUM US EXAM ABDO BACK WALL LIMITED	\$192.00
76775	DIGANOSTIC ULTRASOUND PROCEDURES OF THE ABDOMEN AND RETROPERITONEUM US EXAM ABDO BACK WALL LIMITED	\$ 93.00
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete) go beyond examination of the ovaries, to include medically necessary examination with a description and measurement of the uterus and adnexal structures, endometrium, bladder	\$293.35
76870	Us exam scrotum	\$219.21
76882	Inguinal Ultrasound	\$167.80
76937	Us guide vascular access	\$ 97.78
76942	ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT IMAGING SUPERVISION AND INTERPRETATION	\$192.00
76942	ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT IMAGING SUPERVISION AND INTERPRETATION	\$180.00
76942	ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT IMAGING SUPERVISION AND INTERPRETATION	\$153.00
76970	Post Operative Ultrasound	\$297.00
76970	Post Operative Ultrasound	\$ 60.00
76970	Post Operative Ultrasound	\$237.00
77001	Fluoroguide for vein device	\$339.51
77002	Needle localization by xrayFloro	\$358.08
93880	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; COMPLETE BILATERAL STUDY	\$995.00
93880	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; COMPLETE BILATERAL STUDY	\$797.00
93880	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; COMPLETE BILATERAL STUDY	\$194.00
93923	ABI Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels NONINVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, MULTIPLE LEVELS OR WITH PROVOCATIVE FUNCTIONAL MANEUVERS, COMPLETE BILATER	\$444.12
93925	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OF ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY	\$684.13
93925	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OF ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY	\$684.13
93925	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OF ARTERIAL BYPASS GRAFTS;	\$684.13

ATTACHMENT 25
Non-Hospital Based Ambulatory Surgery
Charge Commitment – 1110.235(C)(9)

CPT Code	Description	Charges
	COMPLETE BILATERAL STUDY	
93926	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OF ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY	\$488.00
93926	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OF ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY	\$420.00
93926	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OF ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY	\$ 78.00
93931	Upper extremity study	\$396.00
93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; COMPLETE BILATERAL STUDY	\$639.00
93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; COMPLETE BILATERAL STUDY	\$528.00
93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; COMPLETE BILATERAL STUDY	\$111.00
93971	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; UNILATERAL OR LIMITED STUDY	\$393.00
93971	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; UNILATERAL OR LIMITED STUDY	\$318.00
93971	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; UNILATERAL OR LIMITED STUDY	\$ 72.00
93975	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS, COMPLETE STUDY	\$921.00
93975	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS, COMPLETE STUDY	\$189.00
93975	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS, COMPLETE STUDY	\$732.00
93976	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS, LIMITED STUDY	\$534.00
93976	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS, LIMITED STUDY	\$128.00
93976	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS, LIMITED STUDY	\$408.00
93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	\$854.82
93986	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study	\$460.38
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	\$465.06
99072	PPE Supply Code	\$ 45.00
99151	Mod sed same phys/qhp <5 yrs	\$188.00
99152	Mod sed same phys/qhp 5/>yrs	\$139.05
99153	Each additional 15 minutes intra-service time (list separately in addition to code G0500 for primary	\$ 30.18

ATTACHMENT 25
Non-Hospital Based Ambulatory Surgery
Charge Commitment – 1110.235(C)(9)

CPT Code	Description	Charges
	service)	
99201	OFFICE OUTPATIENT NEW 10 MINUTES	\$144.00
99202	OFFICE OUTPATIENT NEW 20 MINUTES	\$242.00
99203	OFFICE OUTPATIENT NEW 30 MINUTES	\$348.00
99204	OFFICE OUTPATIENT NEW 45 MINUTES	\$530.00
99205	OFFICE OUTPATIENT NEW 60 MINUTES	\$666.00
99211	OFFICE OR OTHER OUTPATIENT SERVICES, ESTABLISHED PATIENT. TYPICALLY, 5 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.	\$ 69.00
99212	OFFICE OR OTHER OUTPATIENT SERVICES, ESTABLISHED PATIENT. TYPICALLY, 10 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.	\$141.00
99213	OFFICE OR OTHER OUTPATIENT SERVICES, ESTABLISHED PATIENT. TYPICALLY, 15 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.	\$234.00
99214	OFFICE OR OTHER OUTPATIENT SERVICES, ESTABLISHED PATIENT. TYPICALLY, 25 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.	\$345.00
99215	OFFICE OR OTHER OUTPATIENT SERVICES, ESTABLISHED PATIENT. TYPICALLY, 40 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.	\$465.00
99304	Under New or Established Patient Comprehensive Nursing Facility Assessments	\$292.00
99305	Under New or Established Patient Comprehensive Nursing Facility Assessments	\$417.00
99306	Under New or Established Patient Comprehensive Nursing Facility Assessments	\$533.00
99307	Under Subsequent Nursing Facility Care	\$142.00
99308	Under Subsequent Nursing Facility Care	\$222.00
99309	Under Subsequent Nursing Facility Care	\$294.00
99310	Under Subsequent Nursing Facility Care	\$436.00
G0500	Moderate sedation services provided by the same physician or QHP performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consc	\$153.73

ATTACHMENT 25
Non-Hospital Based Ambulatory Surgery
Assurances – 1110.235(C)(10)

Midwest Surgical Centers, LLC

September 3, 2025

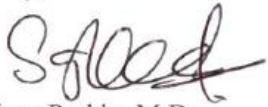
John P. Kniery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Floor 2
Springfield, IL 62761

Re: Assurances – Midwest Surgical Centers, LLC

Dear Mr. Kniery,

As a representative of Midwest Surgical Centers, LLC, I, Sreenivas Reddy, 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,



Sreenivas Reddy, M.D.
Manager
Midwest Surgical Centers, LLC

ATTACHMENT 34

Availability of Funds

The total estimated project cost is \$3,909,035. \$2,992,035 of that amount is attributable to construction, architectural/engineering fees, and equipment purchases. The balance of the project cost is related to the leasing costs for the new facility. Drs. Reddy and Chiramel will fund the project costs with loan. Drs. Reddy and Chiramel have a letter of commitment from a financial institution, and it is enclosed as evidence of their ability to obtain financing for the remainder of the project costs.

ATTACHMENT 36 Financial Viability



September 26, 2025

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

Re: Midwest Surgical Centers, LLC

It is my understanding that Midwest Surgical Centers, LLC of which Dr. Sreenivas Reddy is the managing member is submitting a Certificate of Need application to establish an ambulatory surgical treatment center at 13610 S. Route 59, Plainfield, IL 60544. Midwest Surgical Centers, LLC will require financing in the amount of approximately \$3,909,035.

Should the Illinois Health Facilities and Services Review Board approve their application and based upon a preliminary review of the financial information submitted from Dr. Reddy, American Bank & Trust would likely be prepared to extend Midwest Surgical Centers, LLC up to \$3,909,035. This is not a commitment to lend, rather it is based on a preliminary review of the financial information and formal approval is subject to the approval of our Board of Directors.

I trust that this letter is sufficient for your needs. American Bank has a solid relationship with Dr. Reddy and looks forward to working with him in the future. Should you, or the Illinois Health Facilities and Services Review Board have any questions or comments, please do not hesitate to contact me directly at (630) 845-4365.

Sincerely,

Garrett E. Buhle

Garrett E. Buhle
SVP, Chief Lending Officer
American Bank & Trust

www.ambankqc.com • Member

ATTACHMENT 37
Economic Feasibility
Project Operating Costs and Total Effect
of the Project on Capital Costs

Midwest Surgical Centers, LLC

September 3, 2025

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

Midwest Surgical Centers, LLC

Ill. Admin. Code Section 1120.120(a) Available Funds Certification

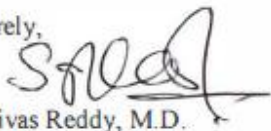
Ill. Admin. Code Section 1120.140(a) Reasonableness of Financing Arrangements

Dear Mr. Kniery:

As representative of Midwest Surgical Centers, LLC ("Midwest Surgical"), I, Sreenivas Reddy, M.D., hereby attest that the project costs will be \$3,909,035. Midwest Surgical will fund the entirety of the construction of the project and the necessary working capital and operating deficits through the first full fiscal year. Midwest Surgical will fund these costs with a loan from American Bank & Trust. Midwest Surgical has sufficient and readily accessible internal resources to fund the obligation required by the project.

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

Sincerely,



Sreenivas Reddy, M.D.
Manager
Midwest Surgical Centers, LLC

ATTACHMENT 37

Economic Feasibility

Cost and GSF by Service

Pursuant to Illinois Administrative Code Section 1120 Appendix A (a)(3), a project's 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 GSF. This project is slated to be completed in the final quarter of 2027 and the applicable RS Means standard is \$510.27 per GSF. The proposed cost per GSF for this project is \$501.71, and thus this project meets the Board's criteria.

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)	
ASC	\$456.52	-	3,098	-	-	-	\$1,414,299	-	\$1,414,299
Contingency	\$45.19	-	3,098	-	-	-	\$140,000	-	\$140,000
TOTALS	\$501.71	-	3,098	-	-	-	\$1,554,299	-	\$1,554,299
* Include the percentage (%) of space for circulation									

ATTACHMENT 38

Safety Net Impact Statement

Midwest Surgical Centers, LLC is a new entity and has no applicable historical data for this section of the application. However, it is anticipated that the proposed facility will have a positive material impact on essential safety net services in the community.

Drs. Reddy and Chiramel and their practice have long maintained a commitment to serving diverse communities in Chicago and the Chicagoland area. That diversity has included both racial and economic diversity. This is evidenced by the location of their current physician practice sites, and the proposed business plan for the facility which intends to service Medicaid patients and patients without regard to their ability to pay for procedures.

This project involves operating a new facility and should not have any impact on the ability of another provider to cross-subsidize safety net services.

ATTACHMENT 39

Charity Care

Midwest Surgical Centers, LLC is a new entity and has no applicable historical data for this section of the application. The project patient mix by payer source, anticipated charity care expense, and projected ratio of charity care to net revenue by the end of its second year of operation are included below. These projections are based on the existing patient base seen at Vein and Vascular Centers, SC over the last 12 months.

Insurance Type	Percentage of Payor Mix
Medicare	60%
Commercial	30%
Medicaid	9%
Other	1%

ATTACHMENT 40
Flood Plain Information

Midwest Surgical Centers, LLC

September 3, 2025

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

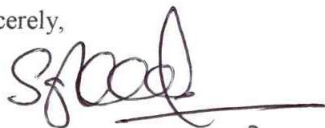
Re: Midwest Surgical Centers, LLC - Flood Plain Requirements

Dear Mr. Kniery:

As representative of Midwest Surgical Centers, LLC, I, Sreenivas Reddy, M.D., affirm that our facility complies with Illinois Executive Order #2005-5. The facility location at 13610 S. Route 59, Plainfield IL 60544 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 as true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

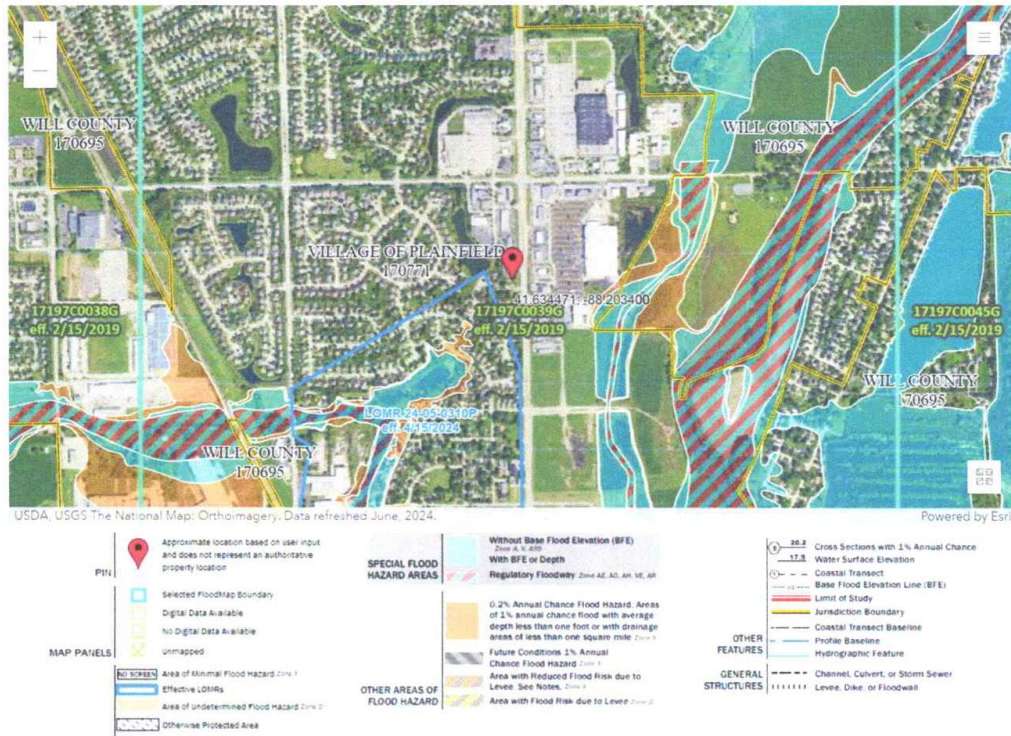
Sincerely,

A handwritten signature in black ink, appearing to read 'S Reddy', with a horizontal line extending from the end of the signature.

Sreenivas Reddy, M.D.
Manager
Midwest Surgical Centers, LLC

ATTACHMENT 40 Flood Plain Information

Midwest Surgical Centers, LLC



27451504 v4

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